ISSN 1175-3498 **ISSUE NUMBER SIXTY** APRIL 2020

the nathaniel report

A Publication of
THE NATHANIEL CENTRE
THE NEW ZEALAND CATHOLIC BIOETHICS CENTRE

in this issue

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The Nathaniel Centre is formally affiliated with Te Kupenga – Catholic Leadership Institute

IN THIS ISSUE… A NOTE FROM THE EDITOR

Welcome to Issue 60 of *The Nathaniel Report*

In our guest Editorial, *Cocooning or Culling: The Choice is Ours*, **Sinéad Donnelly** focuses on some disturbing attitudes towards our elders that have emerged in recent weeks as we deal with the realities of the COVID-19 virus. Are we willing to accept that our elders are likely to be disproportionately culled by COVID-19, or are we committed to cocooning them for the sake of saving as many of their lives as possible? And how does this all relate to the introduction of euthanasia in New Zealand?

Following on from this, and continuing the theme of end-of-life choice, we reprint the letter written by New Zealand Church Leaders to all MPs prior to the third reading of the End of Life Choice Bill in November last year. Speaking out of their extensive experience of actively caring for the dying and their whānau, the Leaders articulate seven points that highlight their grave concerns and underscore their opposition to the introduction of euthanasia and assisted suicide.

In our first article, *Courage in the Void of Suicide*, **Chris Bowden** draws on his extensive work as a suicide educator listening to and walking alongside those who have experienced the suicide of a loved one. He reflects on what it is like to walk and work in two worlds – the world of light and life (Te Ao Mārama) and the world of darkness (Te Pō).

Our second article, *Making Sense of the Cannabis Referendum 2020*, by **Staff of The Nathaniel Centre** provides important information about the nature of the second of the two referendum questions that voters will be asked to vote on at the upcoming general election: whether or not to legalise recreational cannabis.

Next, we offer the third in a series of articles on cannabis by **Lynne Bowyer and Deb Stevens:** *Legalising Cannabis – The Rhetoric and the Reality*. This piece examines various claims made by cannabis legalisation proponents, including the idea that legalisation will reduce the disproportionate incarceration rates of Māori for cannabis-related incidents. Their conclusion is that the legalisation of recreational cannabis is likely to create, or exacerbate further, situations that will undermine the well-being and achievements of marginalised individuals and communities.

In our final piece, *As Climate Change Worsens, So Does Our Grief and Distress*, **Jamie Manson** reflects on the distress we feel in response to the suffering of the creatures caught up in the climate crisis. Manson urges us not to pathologize the distress we experience, but rather to use it as an opportunity to listen more deeply so as live in more sustainable and sustaining ways.

We trust that you find something in this issue to stimulate you.

the nathaniel centre

THE NEW ZEALAND CATHOLIC BIOETHICS CENTRE

Faith and reason are like two wings on which the human spirit rises to the contemplation of truth…

POPE JOHN PAUL II

… faith consolidates, integrates and illuminates the heritage of truth acquired by human reason.

POPE BENEDICT XVI

The Nathaniel Centre was established in 1999 as an agency of the New Zealand Catholic Bishops' Conference. The key functions of The Nathaniel Centre include:

- developing educational opportunities in bioethics
- acting as an advisory and resource centre for individuals, and professional, educational and community groups
- carrying out research into bioethical issues, and promoting the study and practical resolution of ethical, social, cultural and legal challenges arising out of clinical practice and scientific research
- carrying out research and action to support the Church's pastoral response to bioethical issues taking into account the needs of different cultures and groups in society

Our Philosophy

Rapid advances in science have moral, ethical, and spiritual implications at an individual and societal level. While Catholic bioethics deals with the same realities as secular bioethics we are committed to bringing the light of the Gospel and the wisdom from the Church's moral tradition to the various issues under discussion.

Reason and faith do not exist in isolation; they guide our individual and collective search for truth and they complement each other when they meet in genuine service of those who suffer. In the words of Pope Benedict XVI: "Only in charity, illumined by the light of reason and faith is it possible to pursue development goals that possess a more humane and humanising value." In this way the work of bioethics appears as a practical expression of the reverence we have for the gift of life.

For The Nathaniel Centre the context of bioethics is pastoral, because the ethical issues arising in healthcare and the life sciences reflect the realities of people's lives.

Cocooning or Culling: The Choice is Ours

Sinéad Donnelly

I find it difficult to consider writing about euthanasia in this time of anxiety, uncertainty and fear.

Four weeks ago, I heard people, concerned about the rate of suicide in the elderly in New Zealand, conclude that euthanasia was a good thing because people could die with family around them rather than alone. I was stunned at the logic. A statistic about the high rate of suicide in the elderly must surely promote strenuous efforts to identify why people feel they want to end their lives and to reduce the high rate. Instead the policy analysts concluded: "Let's facilitate their deaths." I remain stunned and spinning at their logic. That was the moment my fear was born.

Three weeks ago, I overheard a surgeon speak positively about the coronavirus, noting that the "death rate is higher in the elderly – at least that's good". Two weeks ago, I read about the Euthanasia Expertise Centre (formerly known as the Dutch End of Life Clinic) being closed in view of the risk that the COVID-19 virus posed for the providers of euthanasia. According to the Centre's website: "In the interest of public health, our patients, their loved ones and employees of the expertise centre, it is no longer responsible to continue our current care provision." It is difficult to admit, says the Centre, but "euthanasia care is not a top priority in health care. The risk of infection is high and the Expertise Centre employs ambulatory doctors and nurses who also work elsewhere." The extreme irony of this is not lost on those of us strenuously opposed to legalising euthanasia because of the risk it will pose to the vulnerable.

Last week, the New Zealand government announced that people over 70 years should stay home as risk of coronavirus infection increases. I fear for my parents and friends in that age group. That same day I also read Shaw and Morton's article in the *Journal of Clinical Ethics*, 'Counting the Cost of Denying Assisted Dying', and I remain shocked and deeply troubled by the smooth, calculated and appalling logic of their argument that assisted suicide makes good economic sense: "The quality adjusted life years (QALY) benefits of permitting assisted dying are already substantial even if we only consider the patients who are helped to die. But farther QALY gains are possible because denying access to assisted dying means that patients remain alive (against their wishes), and this can necessitate considerable consumption of resources … a patient who is in great pain because of cancer with a life expectancy of around two years will continue to require pain medication and support from clinical staff and also carers for those two years. For each such patient, legalising assisted dying would avoid this waste of resources." I ask: Since when did it become a "waste of resources" to care for another person, to relieve another human being's pain?

Worryingly, references to the care of vulnerable people as a "waste of resources" are becoming frighteningly familiar. An English newspaper journalist, Jeremy Warner, recently suggested that the coronavirus could "prove mildly beneficial" to the English economy. Comparing the COVID-19 pandemic with the so-called Spanish Flu pandemic of 1918, Warner notes that the latter "disproportionately affected" young people. He then reasons that while the Spanish Flu had a "lasting impact on supply" because it killed off "primary bread-winners", this is unlikely to happen with coronavirus: "Not to put too fine a point on it, from an entirely disinterested economic perspective, COVID-19 might even prove mildly beneficial in the long-term by disproportionately **culling** elderly dependents."

Euthanasia, like the coronavirus, will infect us all. The negative attitudes which euthanasia breeds in society towards those who most need our care, attitudes which are being increasingly openly expressed, will harm all of us, in particular our elders.

Reflecting on all I had heard and read, and wondering how to lift myself out of this depressing hole, I turned to the St Patrick's Day address given by Ireland's Taoiseach (Prime Minister), Leo Varadqar. Noting that at some stage in the coming weeks the Irish government would be advising older people to stay at home because of COVID-19, and that there would be a need for systems to ensure they had food and were checked on, Varadqar added: "We call it **cocooning** and it will save many lives."

I was immediately uplifted and consoled by the concept of "cocooning" as a metaphor for the safe and ongoing care of our vulnerable and treasured elders. It sits in stark contrast to the harsh, cold, utilitarian notion of "culling".

Euthanasia, like the coronavirus, will infect us all. The negative attitudes which euthanasia breeds in society towards those who most need our care, attitudes which are being increasingly openly expressed, will harm all of us, in particular our elders.

We know exactly how euthanasia will grow and the harm it will do. We have watched what it has done in countries where the germ of the idea was first seeded. It needs to be contained now, and in New Zealand we still have a chance to do that.

Culling or cocooning is New Zealand's choice.

Reference:

https://metro.co.uk/2020/03/11/telegraph-journalist-says-coronavirus-cull-elderly-benefit-economy-12383907/?ito=cbshare

Sinéad Donnelly – A Reflection

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With the euthanasia referendum looming and COVID-19 threatening, I find consolation in the observation of an Irish colleague and friend, Dr Nora Donnelly PhD. Nora eloquently compares a New York newspaper photograph of the Reverend Mychal Judge (68), Chaplain of the New York City Fire Department, with a 15th Century Flemish painting by the artist Van der Weyden titled "Descent from the Cross".

The photograph of Mychal Judge, referred to by some as the "American Pieta", shows his body being carried by rescue workers after he was fatally injured by falling debris from the collapse of one of the New York's Twin Towers. Judge, the first certified fatality of the September 11, 2001 attacks, was killed while administering the last rites to deputy fire chief Bill Feehan and others killed in the tragedy. Father Mychal was a well-known Franciscan friar who ministered to the homeless, the hungry, recovering alcoholics, people with AIDS, the sick and injured, immigrants, gays and lesbians.

Van der Weyden's "Descent from the Cross", also referred to as the "Deposition of Christ" (created 1435) shows the moment when Jesus' body is removed from the cross to be taken away for burial. His lifeless body is held by Joseph of Arimathea and Nicodemus. There are nine participants in the scene, including Mary, the mother of Jesus, who has collapsed in a deathly faint beside her son, the beloved disciple John, and a young woman thought to be Mary Salome.

Dr Nora Donnelly writes:

"… this painting – and the image from the newspaper – does depict suffering and anguish in horrible circumstances, but neither one of them is about grief.

They are about forces much more powerful and sacred than that.

They are about the fact that love and mercy and kindness are so substantial and so strong that they can finally prevail over sadness and death.

They are about seeing love and mercy, tenderness and kindness in action among ordinary people. They are about noticing the height and the breadth and the depth of human decency in action among a caring community.

They are about the compassion that good and holy people feel in the face of the suffering of others. They are about the power of sympathy to heal the pain of loss.

They are about sacred love and love of the sacred."

Dr Sinéad Donnelly (MD, FRCPI, FRACP) is an Irish medical graduate with international experience specialising in Palliative and General Medicine. While working at Wellington Hospital, Sinéad is also Associate Professor Palliative Medicine at Otago University Medical School, Wellington, involved in undergraduate Palliative medicine education and research. As deputy chair of the Care Alliance, Sinéad has consistently campaigned for the protection of the vulnerable against the risks of euthanasia.

NZ Religious Leaders Oppose the End of Life Choice Act

Religious Leaders of New Zealand

At the General Election being held on the 19th of September 2020, all voters will be asked to record on their ballot papers whether or not they support the End of Life Choice Act coming into force.

In November last year, just prior to the 3rd and final reading and vote on the End of Life Choice Bill, New Zealand Religious Leaders from the Anglican, Baptist, Islamic, Lutheran, Presbyterian, Salvation Army and Roman Catholic traditions wrote a joint letter to all MPs urging them to vote against the Bill passing into law. Their arguments remain salient. The letter is reprinted below.

6 November 2019

Dear Member of Parliament,

We, the undersigned religious leaders, wish to take this opportunity to share with you our grave concerns about the final form of the End of Life Choice (EOLC) Bill.

A record number of New Zealanders have already expressed their views to you about this proposed law, both for and against its implementation. We add our voices to this important conversation, hopeful that you will take into account the matters we raise below before ultimately deciding which way you will vote.

We speak out of our extensive experience of actively caring for the dying and their whānau. We understand very well the stresses and fears as well as the opportunities and gifts associated with the dying process. We know the need for, and the effectiveness of, quality, holistic and compassionate end of life palliative care – care that is able to address not just the physical suffering of people who are dying, but also their, and their whānau/friends', emotional, spiritual and psychological suffering.

While there are various religious arguments that could be employed when debating this issue, both for and against, we accept that these are not engaging for those who are not of a religious persuasion. Thus, the following concerns are of an ethical, philosophical and practical nature:

- The proposed EOLC Bill is more radical than the one recently passed in Victoria, Australia, as well as assisted suicide laws in the United States. When a jurisdiction includes 'euthanasia' as well as 'assisted suicide' as an option, as the EOLC Bill does, the numbers availing themselves of an assisted death are up to ten times greater than if it is restricted to 'assisted suicide'. This makes it hard to justify that the proposed law change is just for a very small number of patients in exceptional circumstances.
- Recent reports from Canada and the United States make it clear that numerous patients are choosing assisted death for reasons related to unmet service needs. High quality palliative care is not yet equitably accessible throughout Aotearoa New Zealand and, until it is, there is a strong likelihood that New Zealanders will also choose assisted death because of a lack of other meaningful choices. In such a context, there is the real risk that people in lower socio-economic groups will find themselves being channelled unnecessarily and unjustly towards a premature death.
- It cannot be specifically ruled out that introducing an assisted death regime will not have an adverse effect on our already tragic rates of suicide – there is some evidence from overseas jurisdictions to indicate that the practice of assisted death may lead to a rise in (non-assisted) suicide rates over time. The precautionary principle dictates that we should not proceed with introducing assisted death until the evidence shows there is no direct causal link.

It is unacceptable to us that New Zealanders with a terminal illness should choose assisted death for reasons related to issues such as social isolation, fear of being disabled or fear of being a burden on carers or society, issues which are all very real in Aotearoa New Zealand right now.

- In Oregon, which keeps detailed records of the reasons people request assisted suicide, the key motivational drivers are existential in nature rather than relief from unremitting pain. It is unacceptable to us that New Zealanders with a terminal illness should choose assisted death for reasons related to issues such as social isolation, fear of being disabled or fear of being a burden on carers or society, issues which are all very real in Aotearoa New Zealand right now.
- In Canada, what was initially promoted as an important safeguard – limiting assisted death to those facing a "foreseeable death" because of a terminal illness – has now been judged by a Superior Court to be an obstacle to free choice for people with long-term conditions or disabilities. We genuinely fear that the EOLC Bill will face similar legal challenges that will likewise lead to a broadening of the scope in Aotearoa New Zealand.

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Courage in the Void of Suicide

Chris Bowden

As a suicide educator, there is a powerful message that draws me to the Māori creation story again and again – that message is: Mai I Te Pō Te Ao Mārama (from the darkness into the light). This is the idea that new life emerges from the void.

I walk and work in two worlds – the world of light and life (Te Ao Mārama) and the world of darkness (Te Pō). I see a great deal of darkness, suffering, pain and despair. I also have the privilege of seeing how people find the courage and resources to find the light and continue living after being impacted by suicide.

A lot of work I do happens in the void (Te Kore), the space between the darkness and the light. For me, the void is a state of chaos, possibility and potential for growth and transformation. This is how I see the world of trauma, suffering and suicide.

Supporting and educating people who are suffering involves listening, hearing, acknowledging and showing you understand and validate their experience; being emotionally present with them and attuned, having an open heart and mind.

For the suicidal, the void is the thing that pulls them towards suicide. It is the promise of silence, an end to the suffering they experience or the burden they think they cause others. It is a painful place, a place of helplessness and hopelessness.

For the bereaved, the void is a space they find themselves in after suicide. There is a void in their life. They have been gutted, lost someone close to them, grieve for their loss and long to see them again. The void is also the silence and lack of support or compassion they encounter from others; it is difficult to understand what it is like to lose a loved one to suicide and that lack of understanding means people don't know what to say or do to support others. The void is also the silence of the bereaved themselves. They don't know how to explain it to others. Grief is exhausting, they don't have the energy to teach people how to support them.

Suicide education is about prevention, intervention and postvention.

In terms of prevention, we educate people about what the risk and protective factors are for suicide and how to address them at an individual, family/whānau and community level; how to identify vulnerable groups and individuals; how to reduce stigma towards mental illness and suicide; how to promote help-seeking; and how to offer support and refer people to professional and other forms of support.

Intervention means educating professionals, clinicians and first responders about how to engage with someone who is suicidal; the key principles of supporting suicidal people; risk assessment; how to promote coping; the use of safety planning; and aspects of culturally responsive and ethical practice.

And for postvention we educate people who support those affected by suicide and the bereaved about how suicide affects those left behind; the needs of the bereaved; and how to offer effective support.

Suffering can change our worldview and values and even reveal aspects of our character that were previously unknown. We can see suffering as a burden or as something that can lead to transformation.

Supporting and educating people who are suffering involves listening, hearing, acknowledging and showing you understand and validate their experience; being emotionally present with them and attuned, having an open heart and mind.

Being a suicide educator entails being an 'expert companion' – sitting alongside survivors rather than trying to 'do things' to them. I have learnt over the years that people's suffering is not mine to own. It is mine to understand, bear for a little and then give back in a way that makes it easier for them to carry on.

Carl Jung says finding meaning in suffering makes bearable what would otherwise be unbearable. Lionel Corbett, a Jungian analyst and 'depth' psychologist, asserts in his book *The Soul in Anguish: Psychotherapeutic Approaches to Suffering* that suffering can be developmentally useful, enabling wisdom and understanding we might not otherwise have had.

Suffering can change our worldview and values and even reveal aspects of our character that were previously unknown. We can see suffering as a burden or as something that can lead to transformation.

The root of the word 'suffer' is also the root of the word 'fertile', so it is also related to the idea of bearing fruit. Psychologically, then, suffering can produce something; it's not random or meaningless, nor merely something to get rid of. It can act as either a fertiliser or a poison.

Suffering can make us more empathic, compassionate and appreciative of everyday life. It can deepen our spiritual life, dissolve problems such as arrogance and lead to post-traumatic growth and resiliency.

Suicide educators can help survivors understand this. That new life and development can come from the dark and chaos of the void.

Another way we help survivors is by teaching them realistic strategies that promote resilience. Survivors often need to learn how to cope with overwhelming grief, to be reminded of the knowledge and strategies they already have, and to draw on prior experience and learning.

According to depth psychology, the only way to move past suffering is to engage with it, go deeper and allow it to transform

into something else. We can't change what has happened to survivors, we can't undo the undoable, but we can help them adjust and adapt.

One of the ways we can do this is by teaching them how to change their narratives about suffering. I try to help survivors understand that the stories we tell about what has happened shape who we are, who others think we are, our identities and our ways of being in the world.

Encouraging them to tell their stories, explore them, challenge them and edit them slowly can lead to changes in thinking, feeling and behaviour.

For example, we might encourage them to focus on the enduring love they have for someone rather than the means by which that person took their life. Or to tell a story about someone who had a great influence on them. We are effectively encouraging self-creation – for people to move from the darkness into the void and then into the light with a new identity and narrative.

When we teach survivors how they can reinterpret and rewrite their experiences, we promote the hope that they do not need to be trapped in victim narratives. We help them reposition themselves and empower them.

Suicide educators also work with the people who support the suicidal and bereaved. We educate professionals and volunteers about evidence-based practices (what works), secondary trauma and how to engage in self-care and work sustainably.

It takes courage to work in the void, to enter the dark night of your soul and live with uncertainty – never knowing if the people you work with are going to make it. But we need people to remember, the darkest hour comes just before the dawn and there is always the possibility of transformation.

Dr Chris Bowden (BA Hons I, MA, Ph.D Health) is a lecturer in Te Puna Akopai / School of Education, Victoria University of Wellington Te Herenga Waka. He teaches in the area of child, adolescent and human development and educational psychology. His areas of expertise include child and adolescent mental health, educational interventions, coping and resiliency, trauma, and trauma-informed education. His research focuses on suicide bereavement, male suicide-loss survivors and male sexual abuse survivors. He is an advocate of solutions-focused, narrative and gender-responsive approaches.

Chris has been working in the area of suicide prevention and postvention for many years and is an agent of the Regional Child and Youth Mortality Review Group which works to make recommendations to prevent deaths and improve systems and responses. In 2018 Chris was a recipient of a Life Keepers National Suicide Prevention Award.

This article was originally published on the Newsroom website on 20 January 2020. It is an adaptation of 'Working in the void: Suicide, suffering, trauma and transformation', Te Herenga Waka –Victoria University of Wellington's inaugural Faculty of Education Annual Lecture. It has been reprinted here with the permission of the author. The original piece is available via this link – https://www.newsroom.co.nz/@ideasroom/2020/01/20/942848/suicide.

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- While it is well known that fear and depression drive requests for assisted dying, referral for psychological evaluation is extremely rare in overseas jurisdictions. We are well aware that there is already a shortage of mental-health specialists in Aotearoa New Zealand, including up to 1000 psychologists. This highlights, yet again, why our healthcare infrastructure is not currently in a position to support a safe implementation of the EOLC Bill should it be passed.
- We are greatly disturbed by the failure of parliament to include an amendment to the EOLC Bill which would allow for institutions to exercise a right of conscience not to participate. This denial of choice can only be described as the unethical imposition of assisted death on those carers and healthcare providers for whom the provision of assisted dying would directly contradict their medical, ethical, philosophical, spiritual and/or historical traditions. The EOLC Bill should protect state funding for healthcare or aged care services so that it cannot be made conditional on an institution's willingness to provide assisted death in circumstances where it is deemed incompatible with the ethos of the care provider.

We understand both the need to balance, as well as the difficulty of balancing, individual choice with the common good of society. We also recognise the great distress faced by some patients and their whānau and friends in the case of certain intractable and prolonged terminal illnesses. However, on balance, in the current circumstances, we firmly believe that legalising medically-assisted dying will open the gateway to many foreseen and unforeseen consequences which will be damaging to individuals, families and the social fabric of our communities.

This is not the right time to be contemplating the introduction of euthanasia and assisted suicide in Aotearoa New Zealand. Only when effective palliative care is a real choice for all New Zealanders will we as a country be in a position to have a proper discussion about offering assisted dying as an additional end-of-life option. In the meantime, the urgent need is for more resources to be directed towards enhancing the equitable provision of quality palliative care throughout Aotearoa New Zealand, as well as addressing the rising rates of depression and social isolation of our elders.

Making Sense of The Recreational Cannabis Referendum 2020: A Quick Guide

Staff of The Nathaniel Centre

As part of the 2020 General Election, voters will be asked to indicate if they support the legalisation of recreational cannabis in New Zealand.

The referendum question is: *"Do you support the proposed Cannabis Legalisation and Control Bill?"*

A draft of the Cannabis Legislation and Control Bill can be found here:
https://www.referendum.govt.nz/materials/Cannabis-Legalisation-and-Control-Bill.pdf

What is the Cannabis Referendum all about?

- The referendum is about deciding **whether to legalise recreational cannabis**.
- The referendum **is not about medicinal cannabis or about the production of industrial hemp**.

If more than 50% of voters vote "No", recreational use of cannabis will remain illegal. If more than 50% vote "Yes", the Government has stated that it is "committed to following through with legislation that is closely modeled on a draft Bill". While New Zealanders will be able to have input into the final law through the usual Select Committee Process, the final decision about the specifics of the Bill and, ultimately, whether to even pass any Bill, will remain with the next Parliament.

Commentary: *The referendum question does not alert voters to the fact that the proposed new law focuses on the* ***possession, use, supply and growth of cannabis for recreational purposes****. Many people are confusing the referendum question with the use of cannabis/cannabis-based products for medical purposes.* ***Medicinal cannabis is not part of the referendum question.*** *Regulations to enable a Medicinal Cannabis Scheme were passed on 18 December 2019 and came into effect on 1 April 2020. The intent of this Scheme is to improve access to medicinal cannabis products made to a quality standard. In addition, under the Misuse of Drugs (Medicinal Cannabis) Amendment Act (2018), individuals requiring alleviation of their pain/suffering already have an exception and statutory defence for possessing and using cannabis. The ongoing need for this exemption will be reviewed depending on the referendum outcome.*

What about the option of decriminalising recreational cannabis?

The referendum **is not about decriminalising recreational cannabis possession, use, growth or supply**. Decriminalisation offers an alternative path for reforming the laws around recreational cannabis use, but the 2020 referendum question does not offer decriminalisation as a choice.

Commentary: *The question is posed by some that New Zealand should consider* ***decriminalising*** *recreational cannabis rather than legalising it. However, the 2020 referendum question excludes that as an option. There is an important conversation, yet to be had, about the merits of decriminalising recreational cannabis. Legalisation is the act of removing all legal prohibitions against the use of cannabis whilst controlling its potency, production and supply. Decriminalisation, on the other hand, is "the act of removing criminal sanctions against an act, article, or behavior. Decriminalization of cannabis means it would remain illegal, but the legal system would not prosecute a person for possession under a specified amount. Instead, the penalties would range from no penalties at all, civil fines, drug education, or drug treatment" (see https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6181739/). Decriminalising cannabis would still allow our country to take a more health-based approach that focuses on addiction and on reducing demand.*

There are good arguments to be made that the current laws and regulations around the possession and use of recreational cannabis are not working well; that certain groups of people are more disadvantaged by these laws than others, including the way the law is applied. Saying 'NO' to legalising recreational cannabis will still allow us the opportunity in the future to revisit our current laws, including the possibility of some form of decriminalisation.

What are the current laws regarding recreational cannabis?

- Under the current law, it is illegal to use, possess, grow and/or supply cannabis for recreational use.
- There are three classes of illegal drug – Class A ("very high risk"), Class B ("high risk"), and C ("moderate risk"). Cannabis is classed according to its THC concentration. Cannabis oil and hashish (processed cannabis) is a Class B drug. Cannabis seed and cannabis plant (unprocessed cannabis) is a Class C drug.
- The penalties range from a $500 fine for possession to a 14-year jail term for supply or manufacture. Cultivation can result in a jail term of up to seven years and/or a $2000 fine.
- A conviction may make it harder to get a job, harder to travel and harder to get financial credit.

Commentary: *Justice Department Statistics show that in 2019 a total of 4,057 charges for cannabis offences were convicted. A further 514 charges had an "other proved" outcome, meaning the charges were either proved and discharged without conviction or resulted in diversion. The number of cannabis convictions in New Zealand has dropped steadily since 2010 by 64%. This includes a drop in the number of instances where people were only convicted for cannabis – meaning they were not convicted of any other offences on the same day – from 2653 instances in 2009 to 540 in 2018. Only eight people were sentenced to jail terms for cannabis possession or use in 2018. Research carried out by David Fergusson et al, in a paper titled* ***Arrests and convictions for cannabis related offences in a New Zealand birth cohort*** *(see https://www.ncbi.nlm.nih.gov/pubmed/12681525) shows that "Māori, those with a previous arrest record for non-cannabis related offences and those reporting involvement in violent/property offending were more likely to be arrested or convicted than other cohort members having the same level of cannabis use."*

The same research by Fergusson et al shows that an arrest/conviction for a cannabis related offence does not reduce the use of cannabis, with up to 95% either increasing their use or continuing with the same level of cannabis use following arrest. These findings reinforce concerns about the administration, application and effectiveness of the current laws with respect to reducing cannabis use, including ethnic bias. However, while there is a clear need to revisit our current laws, there are strong arguments to be made that legalising recreational cannabis (i) is not the best way to address such issues and (ii) will lead to further problems, especially for young persons. (See, for example, the article in this issue: ***Legalising Cannabis – the Rhetoric and the Reality****, by Dr Lynne Bowyer and Dr Deb Stevens as well as their previous two articles in Issues 57 and 58 of The Nathaniel Report).*

What are the aims of the proposed new law?

The stated purpose of the Cannabis Legalisation and Control Bill "is to regulate and control the cultivation, manufacture, use, and sale of cannabis in New Zealand, with the intent of reducing harms from cannabis use to individuals, families, whānau, and communities," by:

- controlling the potency and content of cannabis and cannabis products available for use;
- shifting users away from the illicit market to the licit market;
- prioritising social equity outcomes;
- restricting market growth and reducing the demand for cannabis over time;
- confining use of cannabis to private homes and licensed premises;
- prescribing conditions for personal growing and sharing of cannabis;
- imposing a minimum use / purchase age of 20 years old;
- restricting marketing and advertising;
- ensuring the proceeds of cannabis sales contribute to the economy and are taxed appropriately;
- ensuring revenue raised contributes to relevant health-related measures.

Commentary: *In overseas jurisdictions, the legalisation of cannabis has not led to an end of the black-market supply of cannabis, primarily because regulated cannabis costs more as a result of being subject to testing and taxes. A 2018 report on the impact of cannabis legalisation in Oregon estimates that nearly 70% of legally produced cannabis remains unsold. Some argue that legalisation provides an opportunity to regulate THC levels in order to better control what can be accessed. However, placing limits on the type of product likewise creates an opportunity for illegal suppliers to offer a wider range of product with higher THC levels.*

As with many other Western nations, the use of cannabis by teens has already been dropping steadily in New Zealand since 2001 (see https://theconversation.com/teen-use-of-cannabis-has-dropped-in-new-zealand-but-legalisation-could-make-access-easier-132165). A 2017 Norwegian study (see https://onlinelibrary.wiley.com/doi/abs/10.1111/add.13901), sought to understand how this downward trend fits with fewer teenagers thinking of cannabis as a harmful drug and more being seemingly willing to try it. Their conclusion is that changing social interaction patterns mean younger people have fewer face-to-face opportunities to use cannabis. Therefore, declining teen use in states that have decriminalised cannabis does not prove that age restrictions work because it "has likely fallen in those states for the same reasons it has fallen elsewhere" (see https://theconversation.com/teen-use-of-cannabis-has-dropped-in-new-zealand-but-

legalisation-could-make-access-easier-132165). While the law will only allow legal access for those over 20, it has been estimated that, under the current law, up to 80% of teenagers have tried cannabis by the age of 20, most before leaving high school (see https://www.noted.co.nz/health/health-health/young-kiwis-and-cannabis-weed-is-not-a-big-deal). Legalising cannabis for those over 20 will make it even easier for young people to access it in the same way that under-age adolescents currently access alcohol and tobacco primarily through friends and family rather than retailers.

When most people think about cannabis use, what comes to mind is 'smoking a joint'. However, the proposed New Zealand legislation will also allow cannabis to be available in a range of edibles.

Some facts about cannabis

- Cannabis has been used around the world for 4000 years as an analgesic for surgeries, to treat headaches and for other therapeutic, ceremonial, and recreational purposes.
- The plant contains at least 144 compounds known as cannabinoids. The two most researched cannabinoids are δ-9-tetrahydrocannabinol, known as THC, and cannabidiol, known as CBD.
- THC is the psychoactive ingredient in cannabis that causes the 'high' cannabis-users experience. CBD is a non-psychoactive ingredient in cannabis known to have a mellowing effect. Research suggests CBD counteracts (or may reverse) the psychoactive effects of THC.
- Cannabis can be smoked, inhaled, eaten in cakes or lollies, brewed as a tea, or applied as a balm.
- Cannabis comes in three forms: the unprocessed form that consists of dried leaves and flowers; hashish (hash), a processed form that consists of blocks of dried resin; and hash oil, another processed form that consists of a liquid extracted from hashish. Hashish and hash oil have higher levels of THC.
- Our bodies have a naturally occurring endocannaboid system that regulates our appetite and digestion, metabolism, pain, inflammation and other immune responses, mood, memory, motor control, sleep, cardiovascular system, muscle formation, bone growth, liver function, reproductive system, stress-response, skin and nerve function. The THC in cannabis binds to our body's receptors, which is why cannabis influences us.
- This 'binding action' explains the effects of cannabis, including: a feeling of elation (a high); giddiness; mellowness; changes in sensory perception (colours may seem brighter, music more vivid); changes in perception of time and space; mood changes; higher heart rate; reduction in blood pressure; impairment of concentration and memory; reduced psychomotor coordination; increase in appetite; faster breathing; feelings of paranoia and disorientation.
- If cannabis is smoked, the THC is absorbed quickly into the bloodstream and reaches the brain in minutes. If cannabis is eaten, the THC is absorbed more slowly, delaying the onset of action for up to two hours and prolonging the duration of effect. Intoxication can last for several hours.
- Cannabis can cause various physical ill-effects, particularly in the cardiac and respiratory systems.
- There are indications that cannabis may be implicated in poor psychological outcomes, including acute psychosis, schizophrenia, anxiety and depression, poor motivation, and negative effects on learning and memory.
- "There are some reasons to think that adolescents may be uniquely susceptible to lasting damage from marijuana use (see https://www.apa.org/monitor/2015/11/marijuana-brain). At least until the early or mid-20s, 'the brain is still under construction'."
- A "number of studies have found evidence of brain changes in teens and young adults who smoke marijuana … [A review of 43 studies of chronic cannabis use and the brain] found consistent evidence of both structural brain abnormalities and altered neural activity in marijuana users. Only eight of those studies focused on adolescents, but the findings from those studies suggested that both structural and functional brain changes emerge soon after adolescents start using the drug" (quoted in https://www.apa.org/monitor/2015/11/marijuana-brain).
- However, the relationships between cannabis and its effects are complex and involve many factors. Some studies find a strong association between cannabis use and poor outcomes, whilst others find weaker associations. Further work is needed to establish a conclusive picture.
- Cannabis impairs driving ability. A study of blood taken from Canadian drivers involved in fatal accidents showed that drivers who tested positive for cannabis are five times more likely to die than sober drivers. When cannabis is combined with alcohol, the risk of a fatal accident jumps to 40 times more likely than a sober driver. That risk is present even just with moderate levels of cannabis and blood alcohol under the drink-driving limit (see https://www.drugfoundation.org.nz/matters-of-substance/november-2013/driving-high/).
- The biochemical composition of today's cannabis is different to cannabis from the 60s-80s, effectively making it a stronger drug. **This change in composition means that earlier research into cannabis is out-of-date, as that previous work involved researching the effects of cannabis with lower levels of THC and higher levels of CBD.** Up-to-date research into the effects of contemporary cannabis is still emerging.

Legalising Cannabis – the Rhetoric and the Reality

Lynne Bowyer and Deb Stevens

Introduction

The referendum regarding the legalisation of recreational cannabis has been set to coincide with the date of New Zealand's general election.[1] Legalisation proponents argue that cannabis use should be framed as a health issue rather than a criminal justice issue. It is claimed by some that legalisation will reduce the disproportionate incarceration rates of Māori for cannabis-related incidents. For example, Green Party drug reform spokesperson Chloe Swarbrick states that the prohibition-based model for cannabis is not working and has induced inequity for Māori who are disproportionately convicted.[2] Similarly, the New Zealand Drug Foundation argue that drug law reform is a big issue for tangata whenua, as Māori are disproportionately represented in drug convictions.[3] The argument about reducing disparity is problematic, as it overlooks the complexity of embedded racism within the dominant colonial narrative, and hence in our social/economic/political institutions. Research in jurisdictions that have legalised cannabis shows that while the overall number of convictions fall considerably across all demographics, marginalised minority groups are still disproportionately represented in conviction figures.[4]

Further, a closer look at the research gathered across jurisdictions that have already legalised recreational cannabis suggests that legalisation creates or exacerbates situations that further undermine the well-being and achievements of marginalised individuals and communities. These include: spawning an addiction-for-profit industry; generating health issues along the lines of those created by the alcohol and tobacco industry; bolstering a thriving black market.

This article draws predominantly on research undertaken in Canada and certain jurisdictions in the USA that have recently made the recreational use of cannabis 'legal' in some form. There are differences between the legal systems of the USA, Canada, and New Zealand. However, in relation to the legalisation of recreational cannabis, these countries share the same underlying colonial narrative, which has created and sustained institutions, practices and policies that have produced and perpetuated historically disenfranchised indigenous communities.

The rhetoric and the reality

In New Zealand, a key message being promulgated is that legalising cannabis will provide a solution for the drug-related issues that disproportionately affect marginalised groups. The same argument was made by legalisation proponents in overseas jurisdictions. However, when looking at research undertaken in jurisdictions that now have some form of legal recreational cannabis use, it is clear that the rhetoric does not match the reality. In the USA, 11 states have legalised recreational cannabis (although laws about possession, distribution, personal cultivation, and concentrates differ across state lines). Washington State and Colorado were the first to do so in 2012.[5] Following legalisation, research shows that minority/marginalised groups remain disproportionately prevalent in arrest and imprisonment statistics for cannabis-related crimes, possession and use.

…when cannabis was first legalised in Washington State, but was not yet available through the retail market, relative arrest rates of African Americans were two and a half times higher than for Caucasians. When the commercial retail market was opened in 2014, the disparity climbed, so that African Americans were being arrested five times more often than Caucasians

Examining data from Washington State between 2012-2015 shows that the overall number of cannabis arrests fell substantially across all demographics. However, the relative disparities between African American and Caucasian cannabis arrests increased. Between 2012-2014, when cannabis was first legalised in Washington State, but was not yet available through the retail market, relative arrest rates of African Americans were two and a half times higher than for Caucasians. When the commercial retail market was opened in 2014, the disparity climbed, so that African Americans were being arrested five times more often than Caucasians.[6]

The Colorado division of the criminal justice department has documented data collected in 2017 which shows that the "marijuana-related African American arrest rate in Colorado was nearly twice that of Caucasians (233 in 100,000 versus 118 in 100,000)".[7] Additionally, "39% of African American marijuana-related arrests in 2017 were made without a warrant, while only 18% of Caucasians were arrested without one."[8]

Washington DC is part of the district of Columbia, a jurisdiction that legalised cannabis use through a ballot referendum in late 2014. An official report by the Washington D.C. metropolitan police department covering the years immediately following legalisation (2015–2017), shows that "although total marijuana-related arrests decreased … among adults, 84.8% of marijuana distribution or public consumption arrestees were African Americans."[9]

Although in several states that have legalised cannabis the number of arrests have gone down, this is not necessarily always the case. In Denver, "the average number of annual Hispanic arrests for marijuana has increased by 98% since legalisation

(107 average annual arrests pre-legalization versus 212.25 post-legalization); the average number of arrests for African Americans increased 100.3% from 82.5 per year to 165.25 per year."[10]

However, research shows that in all 11 jurisdictions of the USA that have legalised recreational cannabis use, the "disproportionate impact of drug arrests remains stubbornly high, contrary to what legalisation proponents suggest".[11]

A drug conviction has serious repercussions for a person's future possibilities; it narrows life opportunities, making it more difficult to get employment, to travel and to move into more life-affirming and sustainable social spaces.[12] Clearly, if there is a reduction in actual arrest numbers, this will alleviate some negative impact on minority/marginalised groups, just as it will alleviate that impact for all others who may now avoid arrest and conviction. However, a decrease in numbers does not equate to addressing and alleviating the disproportionate conviction rates of marginalised/minority groups. Legalising cannabis does nothing to address the complex issues of systemic racism that pervade the dominant colonial narrative, and hence the social/political/economic institutions generated and supported by that narrative. We must be alert to the form that arguments take, as the pro-legalisation argument based on addressing conviction disparities is not a legitimate one.

Other negative impacts of legalisation on marginalised/minority groups

In the same way that the tobacco industry in the past, along with the current alcohol industry, targets markets and establishes higher-density distribution points in lower socioeconomic areas, the cannabis industry in the USA has done the same. In Oregon, the 'Oregon-Idaho High Intensity Drug Trafficking Area' found that "marijuana sites were disproportionately concentrated among low-income and historically disenfranchised communities,"[13] whilst "an overlay of socioeconomic data with the geographic location of pot shops in Denver shows marijuana stores are located disproportionately in disadvantaged neighbourhoods."[14]

At the same time, although cannabis outlets in the USA are heavily concentrated in disadvantaged areas, the ownership of these outlets does not lie with the people of the community. Nationally, "less than 2% of all pot shops are owned by minorities of any community."[15] Thus, the economic opportunities and social equities promulgated by proponents of cannabis legalisation are missing in practice. Instead, the exploitation of marginalised people is on-going and takes many forms.

In addition to this, higher crime rates map onto areas in which cannabis outlets have been established. In Colorado, 2017 data showed that crimes related to cannabis had increased 284% since 2012, whilst data collected by the National Institutes of Health (NIH) also showed that the density of cannabis outlets was linked to increased property crimes in nearby areas.[16] In Denver, communities near cannabis outlets "saw 84.8% more property crimes each year" than those without an outlet nearby.[17]

It is further argued by some that if the possession and use of cannabis is made legal, it will not only create an income stream for the government, it will also get rid of the black-market and the associated gangs. However, this has not been the case in either Canada or California. The Canadian government-authorised sellers have been unable to keep up with the newly created demand, and the prices charged by government-authorised sellers are higher than those of the black-market. The range of cannabis products available is also greater on the black-market. Hence, the black market continues to find support and continues to thrive.[18] It is estimated that California's cannabis black market is worth approximately $3.7 billion – more than four times the size of the state's legal market.[19]

Recreational cannabis as a health issue

While the reframing of cannabis use from a criminal justice issue to a health issue is central to the 'legalise cannabis' rhetoric, precisely what is captured by the idea of a 'health issue' is not spelled out. As a corollary, neither are the 'treatment' options. It is apparent that if the recreational use of cannabis is legalised, addiction is a foreseeable outcome for a number of people, all the more so if the availability of cannabis is going to intersect with other negative social/economic/political/interpersonal trajectories that people are on.[20] This can be readily deduced from the evidence of developed addictions in Māori as a result of the increased availability and consumption over time of both tobacco and alcohol, something that is arguably inextricably linked with our colonial structures.

The close connection between alcohol and tobacco companies and the newly created cannabis industry is abundantly clear from business investments made in Canada. In 2018, Altria, the parent company of Phillip Morris who make Marlboro cigarettes, invested nearly $2 billion into a Canadian cannabis cultivator.[21] In July 2019, Imperial Brands, the fourth largest tobacco company in the world, announced a $100 million investment into Auxly, another Canadian cannabis company.[22] Constellation Brands, an alcohol conglomerate, has invested $4 billion dollars into the Canadian cultivator 'Canopy Growth'.[23] Cannabis is set to be the next addiction-for-profit industry.

Now, although large corporations – and therefore governments through taxation – will make money from people's cannabis use, many point out that some of this money will be set aside for use by government to treat the health issues created along the way. In Canada, for example, $186 million of tax revenue was collected in the first five and a half months after legalisation and this amount is expected to increase over time. However, it currently remains unclear how the money will be spent, including how much will be used for drug-use prevention and treatment.[24] This ironic situation also holds for New Zealand, where it is envisaged that the cost of drug-use interventions will be met through profits made by the newly created cannabis industry.[25]

A number of health issues directly related to the legalisation of recreational cannabis have also come to the fore. At a children's hospital in Colorado, medical doctors have monitored and documented the impact of cannabis legalisation and its associated commercialisation on adolescent emergency department and urgent cares visits.[26] Their research has found a significant increase in adolescent marijuana-associated emergency department and urgent cares visits following legalisation, with greater numbers of young people requiring

treatment for acute medical or psychiatric symptoms following marijuana use. While it could be pointed out that this was a limited survey, it highlights the need for further multiple-modality research to fully evaluate the impact of legalised and commercialised marijuana on the adolescent population.

Additionally, early onset and regular cannabis use has been shown to compromise a person's ability to learn. Cannabis use can cause acute impairments in the brain's cognitive capacity and ability to hold information, resulting in temporary deficits in learning, attention and working memory.[27] Research also points to the fact that this deficit in cognitive function cannot be recovered in later life.[28] Data from the Canterbury University longitudinal study, which follows a cohort of 1265 children since birth, shows "evidence of clear and consistent associations between the extent of cannabis use and subsequent educational achievement including leaving school without qualifications, failing to enter university and failure to obtain a university degree. Young people who were frequent or heavy cannabis users were over five times more likely to leave school without qualifications and 3.3–4.5 times less likely to enter university or obtain a university degree."[29] It is well known that educational underachievement increases the risk of unemployment and exacerbates the cycle of social disadvantage.

Furthermore, evidence continues to accumulate that shows an association between adolescent cannabis use and psychosis, and adolescent cannabis use and its association with other substance use.[30] A European study has found a four-times increase in the likelihood of psychosis among people using high-potency cannabis on a daily basis.[31] In 2017, a USA study also found that adolescents between the ages of 12–17 "reporting frequent use of marijuana showed a 130% greater likelihood of misusing opioids".[32] The US Surgeon General, Jerome Adams states: "Marijuana's increasingly widespread availability in multiple and highly potent forms, coupled with a false and dangerous perception of safety among youth, merits a nationwide call to action."[33]

In regard to foetal and child health, the American College of Obstetricians and Gynaecologists and American Academy of Paediatrics recommend that women do not use cannabis if they are contemplating pregnancy, during pregnancy and/or breastfeeding, due to potential adverse effects on the foetus and child's developing neurological system.[34]

The respiratory effects of cannabis use are not significantly different from those exhibited by tobacco smokers.[35] Habitual smoking of cannabis is associated with multiple respiratory problems such as persistent coughing and wheezing, sputum production and bronchial mucous pathologies.

Importantly, it should be noted that the level of THC present in cannabis products has increased significantly in recent decades.[36] For example, the average joint of cannabis in the 1970s contained approximately 1–2% THC. In current times, a regular joint can be 20–25% THC.[37] Such significant increases in the THC content raise the concern that the consequences of cannabis use may be much worse than reported in past literature.[38] Recent studies in Canada show that "exposure to second-hand marijuana smoke leads to cannabinoid metabolites in bodily fluids" (oral fluids, blood and urine), and people experience psychoactive effects after such exposure.[39] Researchers recommend prohibiting recreational cannabis smoking in spaces where there are children, elderly people, and those with respiratory illness. It is recommended that we should "scrutinise marijuana smoking with the same diligence as we scrutinise tobacco use".[40] More than a few people have posed the question as to why, in New Zealand, we would pass a law tolerating the smoking of cannabis at the very same time we have declared a desire for New Zealand to be smoke free by 2025.[41]

To conclude

There is no evidence to suggest that legalising cannabis will provide a solution to the drug-related issues that disproportionately affect marginalised/minority groups. These issues include negative impacts on health, education, employment and criminal convictions. Although in some jurisdictions where recreational cannabis has been made legal there is a reduction in the overall conviction numbers, legalisation does nothing to reduce the disproportionate conviction rate of marginalised/minority people. As Sabet and Jones state:

"By inappropriately perpetuating the idea that social justice cannot be addressed without full-scale legalization, proponents have ensured confusion around the underlying issue of social justice, seeking to legitimise legalisation and commercialisation by tacking it on to an entirely separate issue."[42]

Given the way in which corporations are already organising themseves for legal recreational cannabis use, we need to ask ourselves: "Who will really benefit from such legalisation?"

In view of the inequities entrenched in our current social/political/economic structures, and looking at the evidence in front of us, it would be fair to say that many of the negative social, economic and health outcomes of cannabis consumption will befall those already on the margins. If we are serious about social justice and the well-being of all people in New Zealand, we must work to ensure that the racial inequities embedded in our social/political/economic structures are eradicated. We need to shape institutional structures that honour Te Tiriti and hold all people well. In the current context, legalising recreational cannabis will likely only exacerbate the marginalisation of those already on the margins, whilst others prosper at their expense. Evidence from overseas has shown this to be the case.

A better way forward may be to take the time to explore and publicly discuss the decriminalisation of cannabis. Decriminalisation involves removing the criminal penalties for possession and use, without actually making possession and use legal. Decriminalisation would facilitate the separation of cannabis use from issues of social justice and provide space in which the wider negative social/economic/political/health issues that plague marginalised people can be fully addressed.

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Endnotes: See page 15.

As Climate Change Worsens, So Does Our Grief and Distress

Jamie L Manson

I'm not the type of person who cries easily at commercials or even the news. But the recent news reports of the destruction of potentially half a billion animals broke me — specifically an image of a small koala bear who was badly burned in a fire. Her fur badly singed, she stretched out her paws, literally crying like a baby. She expressed the emotions of a wounded child who was not only distressed but confused by what had hurt her so badly. I burst out sobbing, surprising even myself, and was unable to finish my breakfast. My sorrow was quickly replaced by rage, specifically at the human beings, or perhaps the human condition, that made this suffering possible.

This feeling isn't new to me. I live on the south shore of Long Island. Traces of human carelessness and callousness are littered all along our coastline, even during the coldest months of the year. Even on the briefest of walks, you cannot avoid finding plastic bags and bottles, beer cans, and deflated balloons on your path. I try to pick up as much as I can whenever I can, but it is a Sisyphean task. And all I am left thinking about is all the junk I won't be around to pick up and imagining what bird or turtle or other majestic sea creature might be maimed or killed by what I have missed. Walks on the beach aren't as peaceful as they used to be.

There is a growing conversation about what some call climate anxiety, or climate depression, or even climate rage. I feel like I cycle through all three of these states at regular intervals.

The situation is serious enough that the BBC created an entire "Climate Emotions" series, examining the kinds of therapies that are being offered to cope with the sense of grief and loss that climate change is stirring in people's psyches, and whether it is wrong to be hopeful or optimistic about reversing climate change.

Of course, there are countless victims of the effects of global warming who are suffering post-traumatic stress. Ask anyone who had to flee one of the infernos in California or Australia, or survivors of cyclones or floods.

But another form of climate stress is emerging. In her recent essay, "Under the Weather", Ash Sanders writes about psychiatrist Lise Van Susteren, who has coined the term *pre*-traumatic stress disorder to describe those who are suffering stress, insomnia, intrusive thoughts about the climate disaster that is gradually impinging on us. Every night when she went to bed, Van Susteren "would see refugees surrounded by barbed wire, animals trapped in the path of a hurricane, people stranded in floodwaters". She would also see a child asking her repeatedly why she hadn't done anything to stop it.

Both the BBC series and Sanders ask a similar question: Should we be pathologizing what is actually a reasonable and even healthy response to an existential threat?

One thing society doesn't seem to need treatment for is how to respond to the casualties of climate change. Celebrities have dumped millions of dollars into aid for Australia, and koala conservation agencies have been flooded with volunteers. The compassion is there, but only after the fact, when the suffering becomes unavoidable. And yet, throwing money and people-power at clean-up, rescue and relief can't be a sustainable model given that things are only going to get worse.

Back in 2014, I interviewed St. Joseph Sr. Elizabeth Johnson about her then-new book *Ask the Beasts: Darwin and the God of Love*. In our conversation, she was particularly concerned about extinction, pointing out that an estimated 350 species are going extinct every day.

"We are breaking twigs off of the tree of life," she told me. The Australian fires may have lopped off several branches.

Johnson's treatment for a sick society is to call for a new kind of conversion. "We have to be converted to the Earth," she told me, adding that our care for the planet must become "an intrinsic part of our love of God".

As a Catholic, I want to believe in the intrinsic goodness of every human person, but some days I see myself slipping into a more Calvinist mindset in my increasing fear that perhaps we really are totally depraved.

But several of Johnson's profoundly Catholic ideas keep bringing me back from the brink of despair. "The ecological crisis makes clear that the human species and the natural world will flourish or collapse together," she writes in her book *Abounding in Kindness*. We have to turn away from "the delusion of the separated human self and the isolated human species" and instead we must recover, in the depths of our being, "our capacity for communion with the natural world".

Like every creature on this Earth, we are vulnerable and we are striving to live and to flourish.

If we believe that the living God created and empowered the evolutionary world, Johnson writes, then it is "fair to affirm that the Creator God is with creatures in their magnificent living and flourishing, their suffering and dying, holding each in redemptive love, drawing them into an unimaginable eschatological future in which all will be made new."

"The world's affliction even at its worst does not have the last word," Johnson also writes. "Or so we hope." Some days that eschatological hope, though it does not seem nearly adequate enough, is all I have to cling to.

Johnson named her book *Ask the Beasts* from a line in the Book of Job 12:7, which begins, "Ask the beasts and they will teach you; the birds of the air, and they will tell you." We haven't really thought to ask the beasts about what redemption might actually

mean, Johnson told me in that interview. Indeed, if we want to understand who the living God might be, we need to look at the complex, beautiful, evolutionary life that is flowing through all living beings. Perhaps if we listen to them, they will also know what might save us?

I still cannot get that image of the suffering koala bear out of my head, and I cannot stop hearing her cries. But perhaps in addition to crying along with her, it is time to also listen to what she is trying to tell us, not only about the living God who suffers with her, but also about what we must desperately and urgently do in order to survive.

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This article was originally published in the National Catholic Reporter on 28 January 2020 as part of the EarthBeat series that reports on stories of climate crisis, faith and action. It has been reprinted here with permission of the author. The original piece is available via this link – https://www.ncronline.org/news/earthbeat/grace-margins/climate-change-worsens-so-does-our-grief-and-distress.

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the nathaniel centre

THE STORY BEHIND THE NAME

The red flowers of the Pohutukawa appear in December each year. At Cape Reinga on the northern tip of New Zealand there is a lone Pohutukawa, thought to be 800 years old. In Māori tradition the spirits of the dying travel to Cape Reinga where they slip down the roots of the sacred Pohutukawa into the sea, to journey back to their origin in Hawaiki.

Nathaniel Knoef was born on 12 December 1998, as the Pohutukawa flowers were beginning to appear. He died on 2 February 1999 as the same flowers faded, giving way to the seed from which new Pohutukawa would grow. At his birth Nathaniel was diagnosed with incurable health problems and in the few weeks of his life his parents faced many ethical issues associated with his care. Their story clearly highlighted the need ordinary people have for access to support in dealing with the growing number of ethical issues which surround the gift of life.

The naming of New Zealand's national Catholic Bioethics Centre in honour of Nathaniel is a sign of the Centre's commitment to those who are most vulnerable in the complex ethical situations which develop in their lives.

Thanks

The staff of The Nathaniel Centre wish to thank all their benefactors whose support has been instrumental in the establishment and continued work of the Centre. The Nathaniel Centre is supported by the New Zealand Catholic Bishops' Conference and also relies upon fees for its services, and individual donations for its continued operation and growth.

We are grateful to the Bishops' Conference and all who support us through donations. We provide a receipt for all donations received. The receipt states the Charities Commission registration number.

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If you wish to support the ongoing work of the Centre by making a donation or if your circumstances prevent you from helping us now, would you consider making a bequest to The Nathaniel Centre in your will? If you would like information on how to do this please contact:

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