

## Submission to:

### **Consultation - *Kava Pilot, Phase 2: Allowing the commercial importation of kava***

This submission is provided by Dr S. 'Apo' Aporosa, a New Zealand Health Research Council funded research fellow based at The School of Health, University of Waikato. My research focus is the effects of kava - when consumed at traditional consumption volumes - on cognition, driver safety, health and productivity. I am one of a very small number of kava researchers who work full-time investigating kava, its socio-cultural use and its effect on health. I have 16 peer reviewed kava-related publications (of which two are books) with another four currently under review. Associate Professor Matthew Tomlinson of Oslo University stated, "*Dr Aporosa must now be considered the world's leading researcher on the social use of kava (Piper methysticum)*" (Oct. 2016). I have been consuming kava for over twenty years, have farmed kava while living and working in rural Fiji, I actively engage with the Pacific diasporic kava drinking community in New Zealand and Australia, and I am a member of the Australian Kava Movement. I present these qualifications to support my submission.

Prior to answering selected questions as presented in the *Kava Pilot Phase 2: Allowing the commercial importation of kava, Consultation document*, I submit that the following conditions be used to guide all deliberations related to *Kava Pilot Phase 2* submissions in order to ensure the appropriate, responsive, considered and fair evaluation of those submissions:

1. The definition of kava, be strictly limited to that described in the Australia New Zealand Food Standard Code (the Food Standard), Standard 2.6.3 of the Food Standard, defined as:
  - "1. a beverage obtained by the aqueous suspension of kava root using cold water only, and not using any organic solvent, or
  2. dried or raw kava root."

Therefore, any submissions or submission sections that conflate kava with the "'modification' [of *Piper Methysticum*] into tablet/capsule form sold from pharmacies and health-food outlets, or the mixing of kava with other substances to create pop-culture foods and beverages" (Aporosa, 2019a, p.1), or cases in which kava is mixed with alcohol – a practice discouraged due to potential health implications (Kumar & Aporosa, 2017) – be ignored. This is because kava researchers argue that hybridised substances that include *Piper Methysticum* are not technically kava (Aporosa, 2019a; Aporosa, Atkins & Brunton, 2020; Lebot cited in Blades, 2018; Procyk & Lebot, 2013). This defined and bounded definition of kava (as presented in the Food Standard) will also ensure submission deliberations ignore the large body of research that utilised tablet/capsule forms of modified *Piper Methysticum* as part of the study methodology – studies that often (incorrectly) apply study findings to kava effects and kava users.

2. The kava submission deliberation panellists familiarise themselves with recent peer reviewed publications related to kava health and safety. Such publications (in suggested order of importance) include:

- Abbott, P. (2016). *Kava: A review of the safety of traditional and recreational beverage consumption (Technical Report)*. Rome: Food and Agriculture Organization of the United Nations and World Health Organization.
- Aporosa, S. A. (2019a). De-mythologizing and re-branding of kava as the new 'world drug' of choice. *Journal of Drug Science, Policy and Law*, 5, 1-13. doi:10.1177/2050324519876131
- Bonomo, Y., Norman, A., Biondo, S., Bruno, R., Daghli, M., Dawe, S., . . . Castle, D. (2019). The Australian drug harms ranking study. *Journal of Psychopharmacology*, 33(7), 759-768. doi:10.1177/0269881119841569
- Showman, A. F., Baker, J. D., Linares, C., Naeole, C. K., Borris, R., Johnston, E., . . . Turner, H. (2015). Contemporary Pacific and Western perspectives on `awa (*Piper methysticum*) toxicology. *Fitoterapia*, 100, 56–67. doi:10.1016/j.fitote.2014.11.012
- Aporosa, S. A., Atkins, M., & Brunton, R. (2020). Kava drinking in traditional settings: Towards understanding effects on cognitive function. *Journal of Human Psychopharmacology: Clinical and Experimental*, 35(2), e2725 (early view) doi:10.1002/hup.2725
- Aporosa, A. (2019). Australia's discussion of kava imports reflects lack of cultural understanding. *The Conversation*, June 9. Retrieved from <https://theconversation.com/australias-discussion-of-kava-imports-reflects-lack-of-cultural-understanding-115662>

Familiarisation with these publications will ensure deliberations are informed by balanced and authoritative research. As stated above, this also removes larger bodies of research in which findings are based on the use of tablets and tinctures modified from *Piper Methysticum* – substances Bwarenaba et al. (2017) report as containing kavalactone preparations with “modes of action [that] are not fully understood” (p.1).

3. Kava submission panellists not engage with, or consider emotive commentary or sensationalised media reports as part of their deliberations. An example of this is:

- Zillman, S. (2019). *'It paralyzes everything': PM's kava plan flies in the face of elders' concerns and police evidence*. ABC News (Australia online), Feb. 4. Retrieved from <https://www.abc.net.au/news/2019-02-04/morrison-kava-import-plan-flies-in-face-police-evidence-elders/10775068>

Research clearly shows that kava does not cause paralysis, hallucinations or marked euphoria (Aporosa, 2019a; Aporosa et al., 2020). Therefore, the “It” in Zillman’s title, referred to as “...paralys[ing] everything” could not be kava, but instead must have been an entirely different substance or a modification of *Piper Methysticum* (as explained in point 1 above). Moreover, Darwin School of Medicine Professor Peter D’Abbs (1995), writing about the use of kava by Aborigines in the Northern Territories, stated: “it [*kava*] did not befuddle the mind and could therefore be used to stimulate 'clear-headed' discussions” (p.169).

4. Further to point 3 above, panel deliberations on kava submissions, treat with caution and scepticism anecdotal commentary and research suggesting correlation between kava and socio-cultural disharmony in Aboriginal communities. As early as 1995, Darwin School of Medicine Professor Peter D’Abbs (1995) – writing about kava in Aboriginal communities – argued that “traumatic social change” exacerbated by land confiscation, Government influence legal injustices and disempowerment over the previous 50 years, was a key driver to

Aboriginal socio-cultural upheaval; not kava (p.169). Eight years after making this comment, Hunter and D'Abbs (2003) wrote that kava appeared to have become the scape-goat for Aboriginal socio-cultural upheaval, citing "anecdotal and often sensational reports circulated about all-night [kava] binges, with ensuing detriment to families' health, rising absenteeism and even breakdowns in essential community services" (p.333).

Adding to concerns regarding the reliability of research related to kava use in Aboriginal communities, Trevena-Vernon's (2001) Northern Territory Health Services commissioned investigation aimed at tracking impacts from the 1998 *Kava Management Act*, provides a good example. In her report, she states "a general improvement in the health of individuals and community wellbeing [since the introduction of *Kava Management Act*]. Early indications of positive consequences included higher levels of disposable income, an increase in traditional and cultural activities—for example, fishing and hunting—and greater productivity within communities." (p.48). I communicated with Trevena-Vernon (2008, March 5, email) seeking to understand the methodology she had used during her investigation; specifically, how she had measured productivity loss and increase together with socio-cultural impacts associated with kava use and abstinence. Unfortunately, her response appeared to mirror several other similar enquiries I made with kava researchers in Australia (at institutions such as the *Menzies School of Health Research* in Darwin and the *Alcohol and Other Drugs Unit* at the Northern Territory Health Department). All appeared either evasive or circumspect in their responses, with Trevena-Vernon stating she could not discuss the research with me as "the reports were to remain closed" (2008, March 5, email). D'Abbs (1995) noted similar observations, reporting that "deliberations" that led to the establishment of the *Kava Management Act* were never made "available for scrutiny" preventing an assessment of the "evidence" (p.178). Additionally, Hunter and D'Abbs (2003) warn that correlations between drug substances and Aboriginal health and wellbeing are far from simplistic and must "include the historical and political forces informing the social determinants of indigenous ill-health generally." (p.334) This is supported by Spooner and Hetherington (2004), who, in their report entitled *Social determinants of drug use* (prepared for the Australian Government), makes it clear that problematic substance use is "a complex interplay of individual and environmental factors" (p.206). For Aboriginal and Torres Strait Islanders, those factors include "the brutality and trauma entailed in the European usurpation of the lands of peoples ... followed by successive policies of 'protection' and 'assimilation'" which resulted in the loss of cultural connectedness and "social cohesion" (p.194). Therefore, to suggest cause-and-effect conditions between Aboriginal and Torres Strait Islander kava use and socio-cultural disharmony lacks research rigour protocols, professionalism and considered process.

The following provides submission feedback to selected questions as presented in the *Kava Pilot Phase 2: Allowing the commercial importation of kava, Consultation paper*:

Question 1: *Are you supportive of the use of import permits (option 2) to allow kava importation to be controlled and monitored?*

I submit that import permit regulation be limited to the collection of data specific to commercial kava importation. This would exclude kava brought into Australia in personal baggage. The current 4kg limit on kava at the boarder does not allow import taxation. Taxation on kava provides an incentive for the Australian Government to remove the current restrictions and open the import market. Additionally, removing the current restrictive regulations on kava demonstrates a meaningful commitment by the Australian Government to the Pacific Step-up strategy, particularly in supporting sustained economic growth due to increased revenue potential from kava exports. Concerning limits on kava brought in to Australia in personal baggage, it is submitted that Australia follows New Zealand and simply require kava to be declared on entry, without limit or importation tax.

***Question 2:** Under option 2 what requirements or conditions do you think are responsible and necessary to be placed on commercial entities in order to allow them to import commercial quantities of kava?*

No other regulatory burdens are necessary with the exception of restricting kava to persons under 18 years of age, a responsibility limited to the immediate supplier or retailer.

***Question 3:** In addition to state and territory government restrictions on the supply and consumption of kava within their jurisdictions, what other restrictions should be imposed on holders of permits for importing kava into Australia?*

It is submitted that kava be regulated from a centralised national body as opposed to states and territories as this creates confusion and regulation inequity. Arguments that individual states and territories require autonomy over kava possession and use are most likely aimed at limiting kava use by Aborigine peoples. As explained in Section 4 above, arguments linking kava and Aboriginal socio-cultural impacts are weak and lack research rigour. Moreover, to cite Darwin School of Medicine Professor Peter D'Abbs (1995), much of the Aborigine community focused kava commentary (and research) has been driven by "sensational reports ... bureaucratic encroachment ... and public health bureaucracy" as opposed to fact and "scientific legitimacy" (p.179).

***Question 4:** Should kava be sold with further warnings about potential harm, such as those in the food standards? What are your views on what these warnings should be?*

The current Food Standards require the following warnings to accompany kava when supplied: 'Use in moderation' and 'May cause drowsiness'. The question is the purpose of these warnings; whether it is to provide accurate information or to give the illusion of safety? Research is still unclear regarding kava consumption volumes relative to cognitive impairments and safety. Therefore, what constitutes 'moderate' kava use is unclear? Ethnographic research in Fiji shows many kava drinkers consume on average 3.6 litres during a six-hour period for up to six days per week (Aporosa, 2014). The WHO report: "On balance, the weight-of-evidence from both a long history of use of kava beverage and from the more recent research findings indicates that it is possible for kava beverage to be consumed with an acceptably low level of health risk" (Abbott, 2016, p.26, underline added for emphasis). Therefore, the value of the warning 'Use in moderation' is questionable.

Similarly, while the use of ‘may’ regarding kava use causing ‘drowsiness’ provides flexibility, this is also an area that requires yet to be completed research. For example, in a literature review summarising the effects of kava on cognition, Aporosa et al. (2020) present findings ranging from kava “significantly impaired visual attention and increased body sway” to kava “enhanced visual attention and working memory” (p.2-3). The same paper further presents the findings of a study in which kava drinkers attended a typical kava session (6 hours / 3.6 litres of kava) and were tested using an industry standard measure of drug driving. No impacts to reaction and divided attention were found (Aporosa et al, 2020). Admittedly, that study has recently been repeated using a new measure with the results expected in a few months. However, what this demonstrates is the utility, accuracy and subjectivity of the current required warnings on kava products, suggesting that any additional warnings (in addition to ‘Use in moderation’ and ‘May cause drowsiness’) be excluded at this time.

***Question 5: What are your views on the potential health, social and cultural impacts of kava, and do you have any evidence to share?***

Since colonial contact in the Pacific, themes related to kava “health, social and cultural” use have included a variety of myths and misunderstandings, some of which have been published in peer reviewed books and journals. Several of the more common kava health myths are discussed at length in a recent issue of the journal *Drug Science, Policy and Law*, supported by a comprehensive literature review (Aporosa, 2019a). That paper concludes by making it clear that the “medical evidence is plain; that kava is non-alcoholic [and does not cause inhibition, hallucinations or marked euphoria], non-addictive, does not cause liver failure and according to the WHO, has not been the direct cause of any fatalities for the past 10 years worldwide.” (p.8)

In that kava health publication (*Drug Science, Policy and Law*), I do acknowledge that “No drug is harm-free and neither is the article suggesting kava provides the ultimate, idyllic alternative to all substances.” (p.7) However, when kava’s harm levels are “compared against the health and socio-cultural implications of even moderate alcohol consumption ... kava rates extremely well.” (p.8) For instance, that paper draws on the 2019 Australian drug harm ranking study informed by 25 drug experts of which several are Australian Government research advisors (Bonomo et al.). That study assessed the harm levels of 22 drug substances and ranked alcohol (with an overall score of 77) as “causing the greatest overall harm” in Australia (p.763). That score was higher than tobacco (at 32) and cannabis (at 17), a drug recently legalised/decriminalised in the ACT. Conversely, kava was ranked as the least-most harmful of the 22 assessed substances, with an overall harm score of **3**. Therefore, this would suggest that this current consultation process should be more-so focused on alcohol and to a lesser extent cannabis as opposed to kava, particularly with the wide availability of alcohol in Australia. Alcohol in Australia was directly responsible for more than 5500 deaths in 2014 (Gao et al., 2014, p,vii) whereas, to reiterate an earlier comment, kava has not been directly implicated in a single death worldwide in the past 10 years (Aporosa, 2019a). Additionally, alcohol use is linked to the justice and health systems financial burdens due to alcohol being a dominant factor in injury and violence. It is worth pointing out that as a former policeman with seven years’ service (NZ), and having attended several thousand kava sessions over the past 20 years, I have not once witnessed a single act of aggression or violence at a kava

venue; nor did I ever attend a job, or hear about a kava related disruption. Indeed, drug researcher Dr Edwin Lemert (1967) stated, kava does not “release aggressive impulses; if anything, kava inhibits or disassociates them. You cannot hate with kava in you” (p.333).

Other common health and socio-cultural implications frequently linked to kava include kava dermopathy / skin damage and being responsible for ‘taking men away from their families’. Concerning these matters, I recently commented in a kava health publication:

“Aporosa does accept that high kava use over a prolonged period can cause kava dermopathy, or a drying and peeling of the skin. However, this subsides a week or so after use is slowed or ceased, without any residual effects. Regardless, this has not stopped the ‘myth’ [or criticism] that kava dermopathy ‘proves’ kava is dangerous, nor has it limited criticism linking kava dermopathy with abusive kava use. Aporosa responds that ‘while this harmless drying of the skin may not look attractive to some, to others it is considered to represent the kava user’s enthusiastic engagement with their culture. It comes down to perspectives.’ Aporosa adds that people who use alcohol to excess can also exhibit problems such as the reddening of facial skin and a bulbous nose. However, these concerns are rarely spoken of, regardless that these symptoms represent medical concern, unlike kava dermopathy. As for the claim that kava drinking is time consuming and ‘takes men away from their families’, Aporosa argues that excessive television watching, gaming or involvement with sport can do the same thing – it’s about how people choose to spend their time. ‘Kava, as opposed to personal choice, or even poor choice, has become the scape-goat and the point of criticism’” (Aporosa & Foley, 2020).

It is also noted that the *Kava Pilot, Phase 2 Consultation document* cites additional kava health concerns as including “weight loss ... laziness ... and an increase in liver enzymes (which may be an early indicator of cholestasis)”. (p.10) I would suggest that many of these concerns arise from commentary associated with the Aboriginal community, with this being the reason I argued in Section 4 (above) that kava submission panel deliberations treat with caution and scepticism anecdotal commentary and research suggesting correlation between kava and health and socio-cultural disharmony in Aboriginal communities. The Bonomo et al. (2019) Australian drug ranking study, I would argue, also adds to that call for caution. In that study which ranked 22 drug substances and identified kava as the least-most harmful at **3** points, Bonomo et al. explain that this value represents a harm-score of **2** “to the user” (health factors) and **1** “to others” (socio-cultural). In comparison, alcohol scored 36 for harm to the user and 41 to others. This demonstrates the exceedingly small impact level of kava on health and the wider community, raising the question as to why the *Kava Pilot, Phase 2 Consultation document* needed to list the health concerns. Having done so though, it is worth responding to these “health impacts”:

Although the *Kava Pilot, Phase 2 Consultation document* points to “weight loss” associated with “high levels of kava consumption” as a health concern, this stands in opposition to some who have voiced concerns that lengthy kava drinking leads to obesity due to lengthy periods being sedentary (Grace, 2003; Chambers, 2018). Therefore, is kava a contributing factor in weight loss or gain? Similar subjectivity exists concerning the claim that kava use leads to people being “lazy”. In my doctoral research, I investigated kava and productivity in Fiji (Aporosa, 2014). That study demonstrated the risk of making simplistic cause and effect links between kava use and laziness. While there were some participants who stated kava made people lazy, others cited some heavy kava users who were highly productive following kava consumption. Conversely, others explained

situations in which some non-kava users were considered 'lazy'. In a follow up article to that study, and drawing on more than 20 years of kava drinking experience with thousands of users in more than 15 countries, I write, "The reality is, lazy people are lazy regardless of whether they have consumed kava. It is a shame that kava has been singled out as the cause of this." (Aporosa, 2016) I would argue that of greater concern is research showing "Hangovers are causing 11.5 million 'sick days' a year at a cost of \$3 billion to the Australian economy" (Medew, 2015). Moreover, this poses the question as to why kava has heavier restrictions on it in Australia when compared to alcohol if laziness (and productivity) are key concerns.

Concerning reports in the Consultation document that kava "increase[s] ...liver enzymes (which may be an early indicator of cholestasis)" (p.10): Australian Professor Robert Moulds (formally of the Fiji School of Medicine [FSM]) is clear that raised liver enzymes resulting from kava use is of little concern. He and FSM physician and lecturer Dr Jioji Malani (2003) discussed this in a publication. Acknowledging that kava use can elevate liver enzyme levels, namely GGT (γ-glutamyl transferase) and decrease blood lymphocytes, they then ask rhetorically, "How relevant is the finding that some... heavy kava drinkers have raised serum GGT levels?" (p.452) In response they commented that the association between heavy kava consumption and

"raised serum GGT levels is... difficult to determine. Alcohol causes raised serum GGT levels and can cause acute hepatitis and acute liver failure as well as chronic cirrhosis of the liver. However, other drugs (eg, phenytoin) also commonly cause raised GGT levels, reflecting CYP450 enzyme reduction, yet seldom (if ever) cause acute liver failure or cirrhosis of the liver. Hence, raised GGT levels do not necessarily imply 'subclinical' liver toxicity." (p.452).

In 2010 I discussed "subclinical liver toxicity" with Professor Mould at the FSM. He responded that observed abnormalities "are a common concern among doctors who are unfamiliar with the liver function test results of kava drinkers". He added that "while elevated GGT and white blood cells [lymphocytes] were abnormal [to those unfamiliar with kava's effects on the liver], this does not mean that this abnormality is of concern. Jioji [Malani] and I have written on this", referring to the publication drawn on in the previous paragraph and a 2002 article by Dr. Malani entitled *Evaluation of the effects of kava on the liver*. This would challenge the claim in the *Kava Pilot, Phase 2 Consultation document* which states "an increase in liver enzymes [from kava use] ... may be and early indicator of cholestasis".

Admittedly, the health concerns presented in the *Consultation document* are followed by a caveat that there is "evidence that these affects are commonly reversible upon the cessation of use and that consumption of kava has no effect on the cognition of users". If then there are no health concerns, this raises the question as to why some were listed in the *Consultation document*.

The *Consultation document* also describes several "Social impacts of kava", acknowledging the cultural importance and significance of kava within the Australian Pacific community. This is important, particularly in light of kava's relaxant non-intoxicant effects allowing for "clear headed discussion" (D'Abbs, 1995, p.169) which provides an ideal alternative to alcohol and other mind-altering substances. Social scientists are clear that throughout history, humans have always used drug substances of one sort or another and will continue to do so (Jay, 2012). I would therefore

argue that the Australian Government, in relaxing the import regulations on kava allowing unrestricted importation, would demonstrate social responsibility by providing access to what 25 Australian drug experts have ranked as the country's least-most harmful drug of the 22 assessed substances (Bonomo et al.). Additionally, the Australian Government would also be supporting the societal and cultural wellbeing of those in their Pacific community. For instance, following the implementation of the 2 kilogram limit on kava coming into Australia in 2007, the *Sydney Morning Herald* reported that in the months following that restriction,

“We have witnessed a sad increase in violence in the Pacific Island community ... What is now happening is alcohol has become the substitute for kava; kava's promotion of a gentle sense of contentment is being replaced with the violence so often associated with excessive drinking. The good work done with young people by fostering their traditional culture will be undone by pushing them towards alcohol.” (Pinomi, 2008)

Tongan doctoral kava researcher Edmond Fekoho (2014, 2015) explains the critical role that kava venues play in diasporic communities as “cultural classrooms”, places where respect, language and traditions are taught, made possible because of kava's significance as a cultural keystone species (also see Aporosa, 2019b) and its use not resulting in the euphoric effects or socio-cultural harm of most other drug substances. Fekoho also discusses the importance of kava as an alternative to alcohol in Pacific communities (Holt & Fekoho, 2018), a benefit that is also encouraging kava use among Europeans (FCS, 2016). Therefore, it could be argued that by limiting kava the Australian Government is promoting alcohol use and related anti-social behaviour – factors likely to reduce with greater access to kava.

The benefits of kava over alcohol is also recognised by indigenous Australians. In a recent video made in Arnhem Land in which elders from the Bakamudu Clan discuss question raised in the *Kava Pilot, Phase 2* consultation document, the speak about the destructiveness of alcohol in their community, how it is responsible for “a lack of respect” to oneself, others and property. Conversely, these same clansmen explain the value of kava in facilitating quality discussion, allowing them to explore themes such as “sharing and caring ... safety, health and social issues” (Halafihi, 2020, 29m.50sec.). Interestingly, this discussion is had while sitting drinking kava with one of the elders explaining at the beginning of the video that “your culture [the Pacific culture] is within our culture, thank you”.

The *Consultation document* also states that “Despite this [positive reports of kava use in Pacific communities], there have been news reports of social harms in some communities where the kava is not consumed in a traditional manner (Clough 2009).” It is argued that “some communities” refers to Aborigine communities. The reliability of these “news reports” is the reason I requested (in Section 3 above) submission panellists not engage with or consider emotive commentary or sensationalised media reports as part of their deliberations. It is also the reason I suggested (in Section 4 above) submission panellists treat with caution anecdotal commentary and research arguing correlation between kava and socio-cultural disharmony in Aboriginal communities. It is argued that the comments within the previous paragraph by Bakamudu clansmen do not fit within these warning parameters as that video pertains directly to this consultation process.

The statement asserting “there have been news reports of social harms” cites work by Dr Alan Clough. It should be noted that this Clough study was published in 2003 and not 2009, making it 17 years old. Kava health knowledge has increased considerably since that time. For instance, Clough cites “dermopathy characteristic of heavy users” as a concern. In an earlier section I acknowledge,

“that high kava use over a prolonged period can cause kava dermopathy, or a drying and peeling of the skin. However, this subsides a week or so after use is slowed or ceased, without any residual effects. Regardless, this has not stopped the ‘myth’ that kava dermopathy ‘proves’ kava is dangerous, nor has it limited criticism linking kava dermopathy with abusive kava use” (Aporosa, 2020).

Clough’s (2003) research also cites low body weight and raised GGT (liver) levels, subjects already discussed (above) in which cause and effect harm is highly questionable. Clough also raises concerns about the amounts of kava being consumed in Aboriginal communities: “(mainly men) spending more than 14 hours a week in kava drinking activities and drinking in excess of 425 g/week a level comparable to the ‘very heavy’” (p.47). Commenting on Fijian kava drinking, Associate Professor Matt Tomlinson (2016) explains that it is not uncommon for men to drink kava for periods in excess of 40 hours over a seven-day period (also see Aporosa, 2008, p.68). Additionally, data collected during my doctoral research based in Fiji suggests men are consuming on average more than Clough’s Aborigine participants (Aporosa, 2014). It would therefore be expected that Clough’s health concerns would be mirrored in Fijian and other Pacific kava using communities. However, to draw again on the WHO, they are clear that “On balance, the weight-of-evidence from both a long history of use of kava beverage and from the more recent research findings indicates that it is possible for kava beverage to be consumed with an *acceptably low level of health risk*.” (Abbot, 2016, p.26, underline added for emphasis).

Concern was also raised in the *Consultation document* about purchasing kava and the implications of “negative financial impacts on communities (Clough, Burns & Mununggurr 2000).” I would argue that this a mute argument as unhealthy food items, alcohol and cigarettes together with a variety of other consumables and activities are having “negative financial impacts” on the budgets of peoples from all ethnicities across Australia. However, it appears that household incomes spent specifically on kava in Aborigine communities have been identified as the dominant contributor to community economic concerns. As discussed in Section 4 above, by drawing on research from Australia, problematic substance use is “a complex interplay of individual and environmental factors” (Spooner & Hetherington, 2004, p.206). Concerning socio-cultural dysfunction in Aborigine communities in the Northern Territories, Australian Professor Peter D’Abb’s (1995) argued this has been exacerbated by land confiscation, Government influenced legal injustices and disempowerment over the previous 50 years which led to “traumatic social change”, and not kava (p.167).

Regardless that the *Consultation document* states, “that consumption of kava has no effect on the cognition of users”, it later raises concern regarding the potential impact of kava on driving. This is research I am currently undertaking, funded by the New Zealand Health Research Council with results expected by mid-year. There is an expectancy that kava has mild disruption to attention (over-focus) and temporal order judgement, therefore posing a risk to safe driving. These

impairment levels though, appear to be vastly less impacting than those caused by alcohol (Aporosa, et al., 2020). Moreover, alcohol's danger to safe driving has not been used as reason to prevent or restrict the commercial importation of alcohol.

This section has addressed several of the health and social concerns regarding kava in Australia. Although I have countered with arguments and research – notably the Australian drug ranking study - that present kava in a favourable light when compared with some of the concerns presented in the *Consultation document*, I must again acknowledge that “No drug is harm-free and neither ... [am I] suggesting kava provides the ultimate, idyllic alternative to all substances.” However, when kava's harm levels are “compared against the health and socio-cultural implications of even moderate alcohol consumption ... kava rates extremely well.” (Aporosa, 2019a, p.8)

*Question 6: Are you concerned about any particular risks that may be caused by allowing the commercial importation of kava?*

It is anticipated that the removal of import restrictions on kava will increase use in both the Pacific and non-Pacific communities as people seek an alternative to alcohol. The uptake of kava in America is evidence of this (Wolinski, 2018). The main concern regarding “particular risk” will be those who choose to mix kava with other substances or drink kava and drive and in-turn come to the attention of health officials or the judiciary. Regardless that the ingested substance may be a modification of kava, or that a kava user chose to make a poor decision and drive, I am concerned that ‘kava’ will be cited as the problem. This is similar to the scape-goating of kava in comments such as kava takes “men away from their families” (as discussed above).

*Question 7: Do you have any suggestions for how to limit any potential negative impacts or risks of using kava and / or commercially importing kava into Australia?*

Yes, through education such as the recommended publications list in Section 2 above and the support of further kava health research.

*Question 8: What benefits may be achieved from commercially importing kava into Australia?*

This will have major positive benefits for kava growing nations through export earnings and support the broader efforts of the Pacific Step-up Strategy. It will also increase kava supply to the Australian Pacific community providing them with a key input of cultural practice and a likely increase in “cultural classrooms” in which respect etc. are taught (as discussed above). Increased kava to the Pacific community will simultaneously reduce their alcohol use and its associated negative socio-cultural implications. It will also provide non-Pacific people in Australia with an alternative to alcohol, one that is vastly safer and provides for clear-minded conversation unimpeded by the effects of disinhibiting intoxication. It is anticipated that greater availability to kava will reduce some of the justice and health system financial burdens linked to alcohol and injury and violence.

*Question 9: What businesses may be involved in the commercial importation and supply of kava and how will kava potentially be priced, marketed and retailed?*

It is suggested that Australia follow New Zealand's lead in this allowing both big business and small home-based retailers to import, price, market and sell kava.

Question 10: *What methods should be used to monitor and evaluate the success and impacts of the pilot?*

Question 11: *What methods should be used to monitor and evaluate the health, social, economic and regulatory impacts of kava consumption during the pilot?*

Question 12: *Who may be able to contribute to the monitoring and evaluation of the pilot?*

Question 13: *What data should be collected to effectively measure the health, social, and economic and regulatory impacts of kava?*

Concerning Questions 10-13: it is suggested that a specific researcher (Doctorate level) with kava health and cultural expertise; with a desire to collaborate with offshore kava researchers; and motivated to recruit and supervise post-graduate students to research kava health and social issues, be funded and positioned within an academic setting tasked with the monitoring and evaluation of the themes within Questions 10-13.

In summary, this response to the *Kava Pilot Phase 2: Allowing the commercial importation of kava, consultation document* demonstrates a variety of positives in allowing the commercial importation of kava into Australia. Firstly, it supports the Australian Government's commitment to the Pacific Step-up Strategy. It also demonstrates that kava poses very little threat to the health and social conditions of Australians. As stated in the journal *Drug Science, Policy and Law*, the "medical evidence is plain; that kava is non-alcoholic, non-addictive, does not cause liver failure and according to the WHO, has not been the direct cause of any fatalities for the past 10 years worldwide." (Aporosa, 2019a, p.8). Australia's own drug harm ranking study supports this, scoring kava as the country's least-most harmful substance at **3** points; that value representing a harm-score of **2** "to the user" (health factors) and **1** "to others" (socio-cultural) (Bonomo et al. 2019). This has particular relevance when compared with alcohol which is widely available in Australia. UK Professor David Nutt, a world renowned neuropsychopharmacologist, medical doctor and psychiatrist who advised the Australian drug harm ranking study, makes a valuable comment in his new book regarding the 'harm to others' score of alcohol ranked at **41**: "the cost of all alcohol harms are largely picked up by others – that is, you and me. The logical conclusion is, if government drug policy is about harms, alcohol should be the primary focus" (Nutt, 2020, p.233), a focus well ahead of kava. Additionally, kava has the potential to enhance health and social conditions considering kava keystone role in the Pacific community and the potential of kava as an alternative to alcohol for all ethnicities including First Australians as identified by elders of the Bakamudu Clan in response to this consultation.

This submission also raised significant questions such as:

- Why has kava, and not alcohol, been the focus of restrictions in Australia?
- Why has Australia not followed New Zealand and most other countries in recognising kava's safety levels, particularly as kava has for some time been classified as a 'food' under the Australia New Zealand Food Standard Code?

- How was it possible that cannabis was legalised/decriminalised in an Australian State, a substance with a moderate level of harm according to the Australian drug ranking survey, whereas kava – with a minimal harm ranking – has remained illegal in some areas of Australia and restricted in others?

This demonstrates why *Kava Pilot Phase 2: Allowing the commercial importation of kava consultation* deliberations are important and must consider recent peer reviewed publications. Emotive commentary or sensationalised media reports must be ignored, and anecdotal commentary and research suggesting correlation between kava and socio-cultural disharmony in Aboriginal communities must be treated with caution and scepticism. This is to ensure appropriate, responsive, considered and fair evaluation of all submissions.

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