



EXPERT ADVISORY COMMITTEE ON DRUGS (EACD) MEETING

MINUTES

Chair: Dr Bob Boyd

**Friday, 19 March 2004, 1.30 pm – 4.30 pm
201 Second Floor South – Ministry of Health Main Building, Molesworth
Street, Wellington.**

Members present

Dr Bob Boyd (Chair)
Dr Stewart Jessamine
Dr Keith Bedford
Dr Helen Moriarty
Inspector Wim Van Der Velde
Matthew Roseingrave
Keremete Warbrick
Professor Tim Maling

Apologies

Dr Doug Sellman
Dr Geoffrey Robinson

Secretariat attending:

Matthew Andrews
Colin Lee
Helen Hunter

Preliminary paper on Amphetamine

The EACD considered the preliminary paper on amphetamine. It was raised by members that the preliminary paper was not well targeted and often provided information that didn't differentiate between methamphetamine and amphetamine.

It was noted that amphetamine is not used as a medicine in New Zealand, although dexamphetamine is used therapeutically to treat some conditions in New Zealand. It was also noted that it would not be a simple process to chemically convert amphetamine into methamphetamine.

It was noted that it can be difficult for users to differentiate between amphetamine and methamphetamine and amphetamine has sometimes been sold as methamphetamine. However, it was noted to have different precursors for its production than methamphetamine.

Agreed: to recommend to the Associate Minister of Health that amphetamine be reclassified as a Class B1 controlled drug.

Agreed that a presumption for supply be set at 5 grams or more of amphetamine, or 100 flakes, tablets, capsules or other drug forms, each containing some quantity of amphetamine.

Preliminary paper on Ketamine

The EACD considered the preliminary assessment on Ketamine. Ketamine is primarily a veterinary tranquilliser.

Ketamine is being used for recreational purposes in New Zealand, and Australia is reporting high levels of its use. Ketamine is used widely in the New Zealand dance scene. It has also been identified in poly drug users seeking treatment and two significant seizures have been made under the Medicines Act 1981.

There is some interest in substances similar to Ketamine as possible palliative care drugs.

It was raised that it is important for the EACD to seek advice from practitioners on possible classification as a B1 substance.

Agreed: That the secretariat consults with the following organisations on an in-principle B1 classification:

- **The College of Anaesthetists**
- **The Veterinary Surgery Association**
- **Parke Davis (the producers of Ketamine in New Zealand)**
- **Any other producers that are identified**

4. Preliminary paper on Benzylpiperazine

The EACD considered the preliminary paper on Benzylpiperazine (BZP). BZP is a common ingredient in a number of 'legal high' products that are currently being sold through licensed premises, 'head' shops, petrol stations and dairies.

Some concerns were raised that some internet suppliers of these products are supplying them to customers in countries where they are illegal.

The EACD discussed the risk to public health resulting from adverse reactions between BZP and Selective Serotonin Re-uptake Inhibitors (SSRI's). It was noted that this was a concern and that even some of the producers of these products had identified the risk, and that it would need some consideration.

The EACD discussed that BZP products are currently sold as dietary supplements. It was felt by the committee that, in light of what the dietary supplement classification had been intended for, BZP products did not fit appropriately into the dietary supplements category. It was discussed that the NZFSA had received expert advice that BZP was not a food. It was also noted that in July 2005 the dietary supplements category will be replaced and that it would be unlikely that BZP would fit into the new categories.

The EACD discussed the health impacts that BZP may have. It was noted that overdose on BZP was unlikely and that very few people were being noted at Emergency Department's as a result of BZP use. However, the EACD noted that there was not the violence or aggressive behaviour being seen that is common with alcohol use.

Some concern was expressed by the EACD that making BZP unavailable it could lead to a substitution of these products for more harmful illicit drugs. Some concerns were expressed that BZP use could lead back into drug use for some people recovering from stimulant dependencies.

Agreed: That the EACD would recommend the following to the Minister: After considering all of the information put to the Committee and the classification criteria in the Misuse of Drugs Act 1975, the EACD makes the following recommendations to the Associate Minister of Health:

- (a) After considering the evidence the EACD believes that there is no current schedule of the Misuse of Drugs Act 1975 under which BZP could reasonably be placed.**
- (b) The Minister of Food Safety should be requested to consider the appropriateness of permitting the chemical, BZP to be sold as a dietary supplement in New Zealand when it has no known nutritional value.**
- (c) The EACD recommends that the Minister direct the Ministry of Health to conduct further research into the potential harms associated with the use of BZP.**
- (d) The EACD recommends that the Minister direct the Ministry of Health to investigate the possibility of gathering prevalence data on BZP via the introduction of routine toxicology screening via community laboratories.**

- (e) **The EACD recommends that the Minister direct the Ministry of Health to examine options for new categories of classification that can incorporate some levels of control and regulation, such as an 18 plus age limit, without prohibiting access to these substances completely.**
- (f) **This paper should be made publicly available (eg, posted on the National Drug Policy website www.ndp.govt.nz) as soon as practicable.**

5. Consistency in scheduling

The EACD considered matters around consistency in scheduling raised in a letter by Keith Bedford. It was discussed that similar substances should be dealt with in an orderly and consistent manner.

Agreed: That the EACD agree with the comments in Keith Bedford's letter and that the letter be attached to the minutes.

6. Letter regarding medicinal cannabis use

The EACD considered a letter relating to issues around the medicinal use of cannabis.

Agreed: To respond to the letter explaining policies relating to medicinal cannabis use and the requirements of the schedules.

7. Australian National Drugs and Poisons Schedule

It was raised by a member that a number of drugs had been put into Sections 8 and 9 of this Schedule. It was agreed that this information would be provided to the EACD.

8. Temazepam gel-caps

It was brought to the EACD's attention that the Therapeutic Goods Agency had successfully persuaded producers to discontinue the marketing of gel-caps of temazepam. Gel-caps of temazepam are misused by opiate users, misuse that can lead to a number of adverse reactions, including, blocked arteries and limb loss etc.

Agreed: That the EACD will be provided more information and preliminary assessments on benzodiazepines including temazepam.

9. Next meeting

Agreed: That the next meeting will be on the afternoon of 4 June 2004.

04 February 2004

Dr Bob Boyd
Chair
Expert Advisory Committee on Drugs
C/o Public Health Directorate
Ministry of Health
PO Box 5013
WELLINGTON

Dear Bob

Consistency in Scheduling Related Substances

During the last meeting of the EACD, by teleconference, on 18 December, the Committee agreed to recommend to the Associate Minister of Health that Ecstasy (MDMA) be reclassified as a Class B1 controlled drug.

In the minutes of the meeting it is recorded that: "The EACD noted that a move from B2 to B1 did not necessarily note an increase in the risk to the public health of the substance but acknowledged the increasing problems associated with enforcement relating to ecstasy."

I continue to support the recommendation and agree with the minute note.

I made a brief comment at the close of that meeting about the desirability of being consistent in scheduling closely related substances and I would like to expand on that comment by drawing your attention to the situation regarding some substances closely related to MDMA.

"Ecstasy" is a street term without a precise definition but is commonly taken to refer to 3,4-methylenedioxyamphetamine. (MDMA). The Misuse of Drugs Act uses the abbreviation "MDMA" but follows this with a systematic chemical name: 2-methylamino-1-(3,4-methylenedioxyphenyl)propane. Although much of the "ecstasy" in circulation in New Zealand contains MDMA, two other closely related substances also occur. These are MDA (methylenedioxyamphetamine) and MDEA (methylenedioxyethylamphetamine). MDA, MDMA and MDEA are respectively the un-substituted, N-methyl substituted and N-ethyl substituted analogues of the same chemical structure. From my reading I think it unlikely that a user would be able to tell them apart by subjective effect and I would hesitate to differentiate between them in terms of my assessment of their inherent risk to

public health. It may be of interest to note that MDA is a minor metabolite of MDMA. I personally prefer to refer to these substances as the “ecstasy class” of drugs rather than differentiate between them.

Currently MDA is listed as a Class A controlled drug. MDA has never been a major illicit drug in New Zealand. I suspect that it was included in Schedule 1 of the original Act as a pre-emptive measure because some European countries have had problems with MDA abuse.

MDMA was added as a Class B2 controlled drug in a later Amendment.

MDEA was added as a Class B2 controlled drug much later again (Misuse of Drugs Amendment Act 1996), under the heading: “N-ETHYL MDA (2-ethylamino-1-(3,4-methylenedioxyphenyl)propane)”. Prior to this Amendment MDEA would have been covered by the Controlled Drug Analogue provisions of the Misuse of Drugs Act as a Class C controlled drug.

This means that we now have three substances listed respectively in Class A, Class B1 and Class B2 that I would not differentiate between in terms of my assessment of their inherent risk to public health. We have acknowledged in the case of MDMA that the main justification for recommending the change from B2 to B1 for MDMA is the increasing problems associated with enforcement. It may be that because MDA and MDEA are minor contributors to the illicit drug “scene” in New Zealand that the Committee is satisfied with the status quo but I would prefer us to explicitly consider the issue and move towards consistency where this is appropriate.

The discussion could be broadened to include other less-closely related substances such as one known by the abbreviation “MBDB”, but that can keep!

Yours sincerely

Keith Bedford
Forensic Programme Manager