

# EXPERT ADVISORY COMMITTEE ON DRUGS MEETING

Wednesday, 29 November 2006, 8.30am – 1.30pm  
Terrace Room 4, Terrace Conference Centre, Level 3, St John House, 114  
The Terrace, Wellington

## MINUTES

### EACD MEMBERS PRESENT

Dr Ashley Bloomfield (Chair)	Rajesh Chhana
Dr Keith Bedford	Dr Helen Moriarty
Paul Campbell	Adrienne Fruean
Dr Stewart Jessamine	Professor Tim Maling
Dr Geoffrey Robinson	Peter Marshall

### SECRETARIAT ATTENDING

Chris Laurenson	Mark Heffernan
Bruce Atmore	Olivia Stapleton

#### 1. WELCOME

Dr Bloomfield welcomed members and introduced new Committee member Adrienne Fruean, the new consumer representative and new EACD Secretariat members; Mark Heffernan and Olivia Stapleton.

#### 2. APOLOGIES

Professor Doug Sellman

Dr Helen Moriarty joined the meeting at approximately 11.30am and Rajesh Chhana left the meeting after the agenda item 6 discussions.

#### 3. DECLARATION OF CONFLICTS OF INTEREST

No conflicts of interest were declared.

#### 4. CONFIRMATION OF THE MINUTES OF THE MEETING HELD 30 March 2006

The minutes of the meeting held on 27 July 2006 were confirmed as a true and accurate record of that meeting, subject to minor grammatical changes.

Authorisation was given for the minutes to be placed on the website.

It was noted that some members had expressed concern over the level of discussion detail included in the current format of the meeting minutes. The Committee discussed the process of finalising the minutes for publication and provided further directions to the Secretariat.

## **5.0 MATTERS ARISING FROM THE MEETING HELD 27 JULY 2006**

### **Report on actions arising from 27 July 2006**

#### **5.1 *Minute item 5.7 Methylone Trials***

The Chair advised that class C7 may not be an appropriate classification for methylone as this class provides generic analogue provisions. Legal advice is currently being sought on the most appropriate classification.

#### **5.2 *Minute Item 8 2C-T-7***

2C-T-7 was discussed under agenda item 11.

#### **5.3 *Minute Item 9 BZP Research***

The Minister has been updated on progress with the BZP research and informed that further advice on BZP will be provided following the current meeting.

BZP was discussed under agenda item 6.

#### **5.4 *Minute Item 11.1 General Business – Indan(e)s and Aminoindan(e)s***

Providing the EACD with an assessment of indan(e)s and aminoindan(e)s for further discussion was deferred due to other agenda priorities.

##### ***Action:***

**Secretariat to provide an assessment of indan(e)s and aminoindan(e)s for discussion at a future meeting.**

#### **5.5 *Minute Item 11.2 General Business - Thalidomide***

Providing the EACD with a paper on Thalidomide was deferred due to other agenda priorities.

##### ***Action:***

**Secretariat to prepare a paper for the Committee on Thalidomide for discussion at a future meeting.**

## 6. BZP UPDATE

The Secretariat had prepared an overview paper summarising recent research findings on benzylpiperazine (BZP) and phenylpiperazines. The EACD previously considered BZP in April 2004 and concluded that there was insufficient information available to provide the Minister with a recommendation as to whether this substance warranted classification under the Misuse of Drugs Act 1975. For this meeting, EACD members were provided with a package of relevant information on BZP including research reports, preliminary research reports, email correspondence, and a coroner's report. The following is a summary of the main findings and discussion points.

The Committee discussed the implications that classifying BZP in one of the Schedules to the Misuse of Drugs Act 1975 would have on enforcement agencies, and also the potential for increasing controls through the implementation of regulations. The practicality of operating and administering a regulations framework was questioned and the Committee's attention was drawn to the extent to which overlapping sections of the Medicines Act 1981 and Medicines Regulations would need to be considered. It was further noted that there would be a need to constantly update regulations in parallel with industry development and the capacity of the Ministry of Health to adequately implement such changes with current resources was questioned.

### 6.1 *Report by Wilkins et al, Centre for Social and Health Outcomes Research and Evaluation (SHORE), Massey University*

Earlier this year the Centre for Social and Health Outcomes Research and Evaluation (SHORE) at Massey University published a report titled "Legal party pill use in New Zealand: Prevalence of use, availability, health harms and 'gateway effects' of Benzylpiperazine (BZP) and Trifluorophenylmethylpiperazine (TFMPP)." The study population comprised a random sample of 2,010 people aged between 13-45 years. The report was discussed at the July 2006 EACD meeting. The prevalence findings were again noted. It was also noted that the correct full name of TFMPP is 'trifluoromethylphenylpiperazine'.

#### Dependency

Members commented that the dependency rates in the study were relatively low (2.2%) compared with the psychological dependency rates of subjects in the Medical Research Institute of New Zealand (MRINZ) study (approximately a fifth of the sample). It was noted that 25% of the subjects in the MRINZ study had alcohol dependency, indicating that this discrepancy in dependency rates may have been due, in part, to the study population for the MRINZ study.

The Committee noted that aspects of the culture of BZP use, including the administration of other licit and illicit drugs to mitigate the adverse effects of 'the come down' following use, could be an indication that BZP is not considered to be a pleasant drug.

### Gateway Theory

Evidence from this study provides little support for the gateway theory, that easy access to party pills increases young people's propensity to try illicit stimulants. However, it was noted that the gateway theory is complex and the cross-sectional nature of the study precludes drawing any conclusions on a possible gateway effect.

It was noted that BZP is invariably used in association with alcohol, suggesting that:

- alcohol use may lead to a situation where BZP is then taken either to experiment with the substance or to counter the depressive effects of alcohol
- label warnings on party pills that advise users to avoid alcohol consumption when using BZP seem to be ineffective.

### Intravenous BZP administration

One member highlighted the finding that a very small minority of BZP users were injecting themselves with BZP. Although only one individual out of a sample of 2,010 people reported injecting BZP, it was considered important to note that intravenous use of a drug forms part of the criteria for assessing the harms of a substance in other jurisdictions.

### Long term effects

The study contains no information on long-term effects. It was noted that there is evidence of BZP being used daily for weight loss purposes and that none of the papers presented to the Committee provide evidence on the long term effects of BZP use.

### ***Noted:***

**The authors of the study will be notified of the incorrect spelling of the full name of TFMPP in the title of their report.**

## **6.2 *Report by Sheridan and Butler, School of Pharmacy, University of Auckland***

A study by Sheridan and Butler (2006) titled "Legal party pills and their use by young people" was considered. This study employed a qualitative research design and obtained results from young people aged 16-24 years. Results were also obtained from key informants including representatives from alcohol and other drug services, health services, education, youth organisations, health promotion, the legal party pill industry, event organisations and national drug organisations.

### Labelling

The Committee commented that this study highlights the ineffectiveness of the recommended dose and warnings placed on BZP labels as users tend to consult and follow the advice of friends over the advice provided by the manufacturers of the products. One member commented that perhaps resources should be channelled into BZP awareness and education as opposed to labelling requirements.

While labelling requirements may have little effect on the amount of BZP administered, it was noted that dosages could potentially be decreased by a) increasing the price and/or b) placing restrictions on the amount of BZP per tablet.

### BZP use

The Committee noted that party pills may not be decreasing the demand for illicit drugs as BZP's inferior 'high' may render the substance an undesirable substitute for illicit stimulants. It was noted that while the industry claims that party pills have decreased the demand for methamphetamine, the National Drug Intelligence Bureau and Customs Service have stated that they have no evidence that use of these substances has levelled off or declined.

The legal status of BZP was noted as a possible strong motivation for individuals to take party pills, suggesting that some users may be taking BZP because it is considered safer than illicit drugs and because accessing BZP does not expose individuals to the risks of legal prosecution.

Users may be making a trade off between the quality 'high' but expense and illegal status of illicit drugs, versus the relative cheapness and legal status of BZP, yet inferior 'high'. Users may also be implementing strategies to manage the adverse side effects such as the use other licit and/or illicit substances.

### **6.3 Letter dated 24 November 2006 and preliminary study results, National Poisons Centre, University of Otago**

The National Poisons Centre is in the final stages of compiling research into cases of poisoning due to piperazine-based party drugs (PBPD) in New Zealand.

The study's authors concluded that toxicity of BZP is not necessarily dependent on dose and therefore severe side effects may emerge after consumption of relatively small quantities of BZP. It was noted that the MRINZ study administered 300mg of BZP (a quantity argued by the authors as representing the average dose taken by recreational BZP users) and reported that 41% of subjects who took BZP experienced adverse side effects.

Members felt this study used a small dataset and that dose range studies would need to be undertaken to determine the toxicity profile of BZP.

**Noted:**

The Chair advised that he will provide feedback to the authors of the study regarding the recommendations made in the report.

**6.4 Email of 28 November 2006 from Dr Bruce Russell, School of Pharmacy, University of Auckland**

Dr Russell provided a brief summary of the research undertaken by the School of Pharmacy on the potential effects of BZP on human memory and neurological function. The Chair noted that Dr Russell had confirmed there were 28 people in the study.

The Committee noted that in comparison to the MRINZ study, results showed much lower reports of adverse side effects. This could be due to the administration of lower doses of BZP (250mg), the use of pharmaceutical preparations of BZP as opposed to commercially sourced products, or the demographic of the sample population.

**6.5 Confidential draft report dated 24 November 2006 from Medical Research Institute of New Zealand**

This study conducted by MRINZ aimed to investigate the effect of BZP and TFMPP, either alone or in combination with alcohol, on driving performance. An interim safety analysis was undertaken after 35 subjects had completed the investigative models and, due to concerns about the frequency, nature, and severity of the side effects that participants had reported, a decision was made to halt the study. 41% of participants in the BZP/TFMPP group (with or without alcohol) suffered an adverse event following use of the piperazines. No severe events were reported in the placebo, or alcohol-only groups.

It was noted that the adverse events experienced by 41% of the sample is consistent with the relatively high rate of reported negative or adverse effects from the other studies. The increase in blood pressure observed in this study was considered to be a common effect associated with stimulant use.

This study is one of the first controlled studies to examine BZP and TFMPP and Committee members considered the doses used in the study to be realistic and accurately reflect the typical recreational piperazine dose used.

**Blood levels**

Results from the analysis of mean blood concentrations over a 10 hour period were discussed and show that both BZP and TFMPP had a long half life, while blood alcohol levels peaked quickly and dropped sharply. Therefore, an important finding from this study is that BZP has a delayed onset of action and prolonged elimination and clearance. This finding was discussed in regard to the effect it may have on the dose that users take, as they may take a further dose if the effects are not felt relatively quickly.

#### Other issues and potential confounders of the study findings

The Committee commented that some subjects may have been BZP and/or alcohol dependent. Members also noted the apparently paradoxical finding that some of the adverse side effects reported by some subjects during the course of the study had never been experienced previously despite most subjects being experienced BZP users. The experiment was conducted during the morning in a clinical environment and subjects fasted for six hours prior to BZP administration. While it was noted that this may not accurately replicate the environment in which BZP would generally be taken, it was felt to be unlikely that this would fully explain the observed adverse effects.

#### **6.6 *Interim report dated 28 November 2006, Environmental Science and Research (ESR)***

The primary rationale for this research was to pharmaceutically test a number of legal party pills for consistency in levels of piperazines with the dose information on the product label and between doses of a given product.

It was noted that results showed discrepancies in the levels of piperazines in a variety of party pill products compared with what is being advertised on their packaging labels. One particular brand showed a relatively large variation in BZP content. It was noted that the testing method needs to be further validated and test results weighted appropriately. The Committee agreed that while this paper provides an insight into the manufacturing standards of current BZP products the results would need confirmation from further testing.

#### **6.7 *New Zealand Medical Journal paper by Gee et al, published December 2005***

The Committee had previously seen the report by Gee et al (2005) entitled "Toxic effects of BZP-based herbal party pills humans: a prospective study in Christchurch, New Zealand". The study documented all presentations to the Christchurch Hospital Emergency Department use between 1 April and 1 September 2005 that were associated with piperazine.

It was noted that findings from this study are also covered in the National Poisons Centre report.

Recent media comment by the lead author suggests that Christchurch Hospital is seeing less BZP-related admissions, suggesting that perhaps BZP use is changing and/or products are becoming safer in some way.

The observation that patients are presenting with seizures is an important finding considering seizures can be potentially lethal. Seizures are also related to the use of other substances and indeed many of the patients in this study were polydrug users. However, three case reports in this document describe seizures in individuals with only BZP detectable in their urine samples.

**6.8 *Email dated 23 November 2006 from Mr Matt Bowden, Chair of the Social Tonics Association of New Zealand (STANZ)***

The Committee noted an email from Mr Bowden requesting that the Committee consider taking steps to set a maximum dose limit on party pills.

Members identified the need for further evidence to determine if there is a safe dose limit that could ensure public safety. The possibility that placing dose limits on party pills is a way in which the industry can create an artificial barrier to new products was also raised. Members agreed that there was no robust evidence to substantiate Mr Bowden's claim that the availability of party pills is decreasing the demand for methamphetamine.

**6.9 *Report from the Levin Coroner on an inquest completed on 23 May 2005***

Members agreed there was no evidence in the Coroner's report to link use of BZP to this death. The fact that there have been no reported BZP-related deaths in New Zealand is an important point when comparing BZP to the harm caused by alcohol and illegal drugs.

**6.10 *October 2006 research report by Gee et al at Christchurch Hospital***

The Committee noted the supplementary information provided in this report. The evidence confirms the same types of side effects resulting from BZP use and confirms the drop in presentations to this emergency department in the preceding 12 months.

**6.11 *Confidential draft report by Wilkins et al, Centre for Social and Health Outcomes Research and Evaluation (SHORE), Massey University***

The Committee noted that adverse effects such as paranoia and auditory hallucinations were significant reactions. However, the Committee questioned the relevance of assessing the relationship between adverse effects and demographic data and that it is difficult to distinguish between cause and effect between such variables.

At this point the chair welcomed Dr Helen Moriarty to the meeting.

**6.12 *Petition by Jacqui Dean, Member of Parliament for Otago***

The Chair noted that it was useful for the Committee to have an understanding of the public's views on the impact of BZP on communities. Jacqui Dean had provided the Chair with a submission on BZP and had met with the Chair and EACD Secretariat to discuss her submission, with the Minister's approval. The submission was noted by the EACD.

The consumer representative on the Committee agreed that party pills are easily accessible and the presence of shops selling party pills that are in close proximity to schools is a concern for communities and parents.

Members discussed the importance of considering anecdotal evidence when assessing the social impact of a drug. It was noted that some of the criteria outlined in the Misuse of Drugs Act 1975 for assessing a drug are broad and therefore require the Committee to consider social factors in addition to epidemiological evidence. Customs and Police informed the Committee that New Zealand is increasingly becoming recognised as a primary BZP export source, and that New Zealand's international reputation needs to be considered when making a recommendation on BZP. While the recommendations provided by the EACD are only one part of advice considered by the Minister, the Committee needs to present any information to the Minister that may be important or salient to his decision.

### **Options for providing advice**

Three possible options for the basis of advice to the Minister were outlined.

1. Sufficient information is now available to suggest that use of BZP poses at least a moderate risk of harm and therefore it should be classified as either a Class A, B or C drug in the Misuse of Drugs Act 1975. The advantages and disadvantages of classifying BZP would need to be outlined.
2. The EACD does not believe that the information supports a recommendation on classification but that more regulations should be put in place under BZP's current restricted substance status. The implications of this option would need to be outlined.
3. The EACD does not believe there is enough information to recommend classification and the status quo should therefore be maintained.

Members then assessed BZP against the nine EACD criteria outlined in section 4B of the Misuse of Drugs Act 1975.

**a. *The likelihood or evidence of drug abuse, including such matters as the prevalence of the drug, levels of consumption, drug seizure trends, and the potential appeal to vulnerable populations.***

- BZP is widely available, accessible and actively marketed.
- BZP is widely used: around 20% of people aged 13 to 45 have ever used party pills containing BZP, including nearly 50% of males aged 20 to 24. Around 15% of people aged 13 to 45 admit to using party pills in the past year.
- BZP is almost invariably used with alcohol.
- BZP is also included in some preparations intended for daily use such as dieting agents.
- Public perception is that party pills are being targeted to people under-18 years of age. Evidence also shows that under-18 year olds are using BZP.

- Drug seizures are not relevant in this case, although the EACD is aware that Australian jurisdictions are seizing BZP that has been ordered over the internet and shipped from New Zealand.

**b. *The specific effects of the drug, including pharmacological, psychoactive, and toxicological effects***

- BZP is an amphetamine-like substance with significant stimulant effects. The EACD is of the opinion that the current evidence suggests that BZP's potency is approximately one tenth that of the equivalent weight of dexamphetamine.
- Compared with other substances currently controlled under the Misuse of Drugs Act 1975, the pharmacological, psychoactive and toxicological profile of BZP indicates that the risk associated with BZP use is lower than that of methamphetamine, and broadly similar to that of ephedrine.
- There are perceived beneficial effects (e.g. wakefulness and increased sociability).
- Adverse effects are common, in particular insomnia, headaches, flushes, nausea and vomiting, and some of these may be a result of piperazines other than BZP e.g. TFMPP. Seizures have been reported.
- Studies show a relatively slow onset of effect, which can lead users to take repeat or high doses to gain a more rapid effect. BZP is excreted relatively slowly, which produces a prolonged duration of effect that possibly contributes to the pronounced "come down" effect.
- The effects of chronic use are unknown.
- A controlled trial demonstrated frequent and severe adverse effects from BZP and TFMPP.
- There is potential for severe toxicity in some individuals, which has been reported after relatively low doses.
- BZP is often taken with alcohol and other drugs, making toxicological effects difficult to predict.

**c. *The risks, if any, to public health***

- Although there are no formal reports, there is potential for harm to others e.g. the effects of rebound fatigue or acute intoxication on driving performance or operation of machinery
- There is concern that BZP use has been 'normalised', potentially creating or contributing to an increased risk of a culture of drug use that may encourage individuals to participate in other substance use.
- Potential benefits of having BZP legally available may be that some users who would otherwise use more harmful drugs especially methamphetamine are using BZP as a legal (and safer) alternative.
- As with alcohol and other psychoactive drugs, there is the potential to affect neurodevelopment in adolescents.
- There is a suggestion of links with New Zealand's culture of risky alcohol consumption
- Evidence shows very low levels of intravenous BZP use presently, hence there is a low risk of blood-borne communicable diseases

associated with its use. The availability of raw BZP powder and the potential to extract BZP powder from capsules creates a potential risk of increased intravenous use.

- There is a public perception that the legal status implies that BZP has been through a robust regulatory process and is thus considered 'safe', even though the products are not subject to any form of safety or quality review before they enter the market.
- There is no evidence of aggressive behaviour, sexual assault or date rape type behaviours.
- There have been no recorded deaths solely as a result of BZP use. Use of BZP is associated with a high rate of adverse effects: severe adverse effects occur unpredictably and have been reported at relatively low doses.
- Adverse effects associated with BZP use may also discourage users from taking BZP in the future.

**d. *The therapeutic value of the drug, if any***

- No evidence in any robust scientific studies to date has shown that BZP has any therapeutic use in humans.
- At least one product containing BZP is actively marketed in pharmacies as an aid to weight loss. Some anecdotal evidence of contribution to weight loss, which would fit with its status as a stimulant.

**e. *The potential for use of the drug to cause death***

- No evidence to date of any deaths in New Zealand or internationally caused solely by BZP consumption.
- However, toxic effects, especially BZP-related seizures that have been described even at relatively low doses, have the potential to lead to death.
- The potential to cause death is increased from the way in which BZP is frequently used with other substances (e.g. alcohol) and in high doses.

**f. *The ability of the drug to create physical or psychological dependence***

- Some evidence suggests that BZP has the ability to create dependence.

**g. *The international classification and experience of the drug in other jurisdictions***

- BZP is not classified in any international drugs treaties.
- The United Nations Office on Drugs and Crime International Narcotics Control Board has previously written to New Zealand requesting information on our experience with BZP and intentions regarding possible controls.
- Australia and the USA have made BZP illicit, although on the basis of little or no experience with the drug.

- There is a growing international perception of New Zealand being a primary BZP supplier, which has the potential to impact on New Zealand's international reputation.

***h. Any other matters for consideration that the Minister may consider relevant***

- A key concern is the widespread availability of BZP with few restrictions on how BZP can be sold and by whom.
- Most party pills also include TFMPP, which may be responsible for some of the adverse effects. Other piperazines, about which there is no safety information, are now being included in some party pills.
- A possible mechanism for reducing demand and funding regulatory and enforcement activities could be subjecting party pills to taxation other than GST e.g. an excise tax.
- Should BZP be made illegal, this may discourage people who continue to use it from seeking medical attention if they experience adverse effects.
- A key policy issue that needs an explicit decision is whether New Zealand wishes to have a legal market for psychoactive drugs.

The studies carried out to date have documented real harm and there is still no information about the possible long-term consequences of BZP use. In addition, and importantly, BZP has no proven therapeutic use in humans. The Committee was particularly concerned about the current wide availability and supply of BZP in locations that children and young people can easily access.

It was agreed that based on the evidence now available, there is enough information to report that BZP poses at least a moderate risk of harm and to justify recommending its scheduling under the Misuse of Drugs Act 1975.

The Committee noted that there are potential advantages in retaining BZP as a restricted substance, as the Misuse of Drugs Amendment Act 2005 has provisions allowing a range of restrictions to be put in place. Likewise, there is no guarantee that scheduling a substance as a controlled substance under the Misuse of Drugs Act 1975 reduces the availability or potential risk of harm from a drug.

In theory, a regime could be put in place to control, *inter alia*, the availability, advertising and supply of BZP, which would address some of the concerns about its current availability and use. However, in practice this will require the establishment of a significant administrative and enforcement capacity, for example as there is for pharmaceuticals and for the legal drugs tobacco and alcohol.

Members discussed the need to rate BZP in comparison to other drugs to help assess what would be an appropriate classification for BZP. BZP was considered to rate lower than methamphetamine (Schedule 1, Part 1), has a similar harm profile to methylphenidate or Ritalin (Schedule 2, Part 2) and MDMA (Schedule 2, Part 2), and has a similar side effect profile to

pseudoephedrine and ephedrine (Schedule 4, Part 1) although BZP has no therapeutic effect.

Concerns were raised that classifying BZP as an illegal drug may drive the BZP market 'underground', removing the current labelling requirement and therefore increasing the potential risks associated with BZP use. While scheduling BZP as a controlled substance under the Misuse of Drugs Act 1975 is no guarantee that the availability and use of BZP will decrease, recent experience with GHB (Fantasy) suggests it can be effective. In addition, the widely-described negative effects of BZP use (such as insomnia, headaches and nausea) suggests that this is not likely to be a drug that people will actively seek if it is less available, more expensive and carries risks associated with illicit status.

The Committee reached a consensus on recommending that BZP be scheduled as a Class C substance under the Misuse of Drugs Act 1975. Key reasons behind this recommendation include:

- the potential for individual toxicity that has been reported in some individuals after relatively low doses and the risk potential of BZP to cause seizures.
- the potential for use to cause harm to public health, such examples being the operation of machinery or a vehicle either whilst under the influence, or whilst impaired from rebound fatigue following use.
- the recreational context of BZP use and lack of therapeutic purposes.

***Noted:***

**The wording in the legislation should cover benzylpiperazine and derivatives and phenylpiperazine derivatives and related substances of concern, whilst excluding certain piperazine derivatives used in medicines such as Sildenafil citrate (Viagra) and cyclizine.**

**Agreed recommendations to the Minister:**

- 1. that BZP be classified under Schedule 3 Part 1 (Class C1) of the Misuse of Drugs Act 1975**
- 2. that the classification as a Class C1 drug covers all known analogues and derivatives of benzylpiperazine and phenylpiperazine that have no known therapeutic use**
- 3. that BZP be removed from Schedule 4 of the Misuse of Drugs Amendment Act 2005 in order that it no longer be a restricted substance**
- 4. that work continue to further develop the regulatory framework and enforcement capacity that would support the Restricted Substances provisions of the Misuse of Drugs Amendment Act 2005.**

## **7. PARTY PILLS SUBMISSION BY JACQUI DEAN MP**

The party pill submission by Jacqui Dean was discussed under agenda item 6.

## **9. UK CRITERIA ON DRUG SCHEDULLING**

In response to an EACD request, the Secretariat has prepared a paper summarising the process for classifying drugs in New Zealand, Australia and the United Kingdom. The paper is intended to inform a discussion about a more systematic approach and more detailed criteria in determining the most appropriate classification for a substance.

The Committee agreed there are limitations with the current process of drug classification and that the EACD should consider ways to improve the process. It was suggested that it would be useful to consider the Australian Risk Management standards for determining the implications of classification.

### ***Noted:***

**The paper should be revised to clarify the jurisdiction of Australian states in relation to their reference to National Schedules.**

### ***Agreed:***

**That the Secretariat revise this paper for consideration at the next EACD meeting to include information on the Australian Risk Management standards. The UK publication “Drug classification: making a hash of it?” would also be made available to EACD members.**

## **10. ZOPICLONE**

The Secretariat presented a revised paper that provided the EACD with further information, including international research, on zopiclone.

The Committee noted that the World Health Organization’s Expert Committee on Drug Dependence determined that zopiclone has a low abuse potential and therefore that it did not warrant international control. Members commented that the abuse liability of zopiclone was not as high as benzodiazepines and, while anecdotal evidence suggests that zopiclone may be subject to abuse, its use in New Zealand is not commonly diverted outside of therapeutic purposes.

***Agreed:***

The Committee agreed to maintain a watching brief regarding any updates on the classification of zopiclone by the World Health Organization. It was agreed that no further actions would be taken to recommend the classification of zopiclone under the Misuse of Drugs Act 1975 in New Zealand at this stage.

The Chair is to inform the Minister and the Secretariat is to write to manufacturers and inform them that no further action will be taken.

## **11. LEGAL STATUS OF 2C-T-7**

The Secretariat presented a paper summarising the advice obtained on the legal status of 2C-T-7. Dr Keith Bedford noted that while the advice indicates that 2C-T-7 could be considered a controlled drug analogue based on scientific evidence that it is substantially similar to another controlled drug, he doubted whether such an argument would be legally rigorous and he still considers the legal status of 2C-T-7 ambiguous.

The Committee agreed that it is difficult to schedule 2C-T-7 in the Misuse of Drugs Act 1975 with the current available evidence. The Committee recommended that amending the definition of amphetamine analogues in Part 7 of Schedule 3 of the Misuse of Drugs Act 1975 to include alkythio radicals would be the most appropriate action.

***Agreed:***

**That the Committee recommend to the Minister that the definition of amphetamine analogues in Schedule 3, Part 7 of the Misuse of Drugs Act 1975 be amended to include “and/or alkylthio radicals” after “alkylamino radicals”.**

**The recommended amendment would be brought to the attention of the Minister for his direction on appropriate legislative action.**

## **12. GENERAL BUSINESS**

One member noted the importance of discussing the finding from the UK Parliamentary Committee report titled “Drug Classification: making a hash of it?” that there is no conclusive evidence to support the gateway theory. It was agreed that evidence in support of the gateway theory is weak and it would be useful to provide the EACD with the available evidence given strong political interest in the gateway theory.

***Agreed:***

**The Secretariat is to provide the EACD with a paper summarising evidence on the gateway theory, drawing in particular on work conducted in the UK.**

### **13. NEXT MEETING**

The Committee confirmed that meeting from 8.30am to 1.30pm was an appropriate timeframe and that it was useful for the Secretariat to provide bound copies to members of the papers to be considered.

Dr Geoffrey Robinson informed the Committee that his paper assessing alcohol against the EACD criteria is almost complete. The Committee noted that the assessment matrix used by the equivalent UK Committee has been used to assess the relative harms associated with different drugs, including alcohol and tobacco, about which there is a lot of evidence on the harms. The Chair noted that a paper on the UK work is being readied for publication. The Committee felt that it would be useful to see a copy of Dr Robinson's paper to consider as part of the discussion at the next meeting on ways to further improve the assessment of harm of different substances.

***Agreed:***

**That Dr Robinson would provide a copy of his paper assessing alcohol against the EACD criteria for the information of EACD members at the next meeting.**

***Action:***

**The next meeting to be scheduled for early April 2007 and arranged by the Secretariat, along with a full date schedule for all three EACD meetings that are to be held in 2007.**

The meeting closed at 1 pm.