

12 October 2007

Clerk of the House  
Health Committee  
Parliament Buildings  
Wellington

## **Misuse of Drugs (Classification of BZP) Amendment Bill**

The New Zealand Drug Foundation – Te Tūāpapa Tarukino o Aotearoa welcomes the opportunity to comment on the proposal to reclassify BZP, and its analogues and derivatives. We would also value the opportunity to appear before the Committee to speak to this submission.

This submission sets out what we believe can reasonably be concluded from current evidence about BZP and its harms, then analyses the potential impacts of the Bill. In developing this submission, we have consulted with a number of people and organisations within the alcohol and drug sector. We have also reviewed research findings on BZP. Our comments are influenced by the Drug Foundation’s guiding principles, including evidence-based best practice and policy, and harm minimisation.

We note that the Bill covers not only benzylpiperazine (BZP) but trifluoromethylphenylpiperazine (TFMPP) and several analogues and derivatives. However, for the purposes of this submission, the term “BZP” will be used for simplicity.

### **Drug Foundation recommendations**

On balance, and after extensive consideration, the Drug Foundation considers that the costs of reclassification outweigh the benefits.

We recognise that the health harms of BZP products are real, and are both more widespread and more serious than they appeared at the time of the 2005 Amendment Act. However, we believe that within a properly enforced legislative environment the overall risks are, as the European Commission stated recently, relatively low.

We also believe that the harms to existing and future BZP users from making these products illegal may be serious. Banning BZP products is likely to reduce their use, but is very unlikely to eliminate use. Prohibition is more likely to move manufacturing and retail into the uncontrolled criminal illegal sector. We consider that the safety of young people and other BZP users would be better served by strong regulation with firm enforcement, rather than by an illicit free market.

Rather than making BZP illegal, we urge the Committee to keep its existing classification under the Misuse of Drugs Act, and to recommend the introduction of the strong and fully enforced regulatory regime provided for in the Act.

## **Research evidence on BZP**

The Drug Foundation appreciates the work done to build an evidence base on BZP. However, while recent research forms a useful resource, there are still gaps in the evidence base, which we discuss below.

We are also concerned that much of the research is still not available to the public, including some which appears to have had considerable influence on the Expert Advisory Committee on Drugs' (EACD) recommendation. We believe this puts concerned members of the public at a disadvantage compared to officials and others with full access to information, and limits informed public participation in the legislative process.

## **BZP use in the general population and by 'vulnerable populations'**

It is clear that in a very short period of time, 'party pills' have become normalised in New Zealand society. Around one in every five New Zealanders has tried party pills at least once, and just over 15 percent have used them in the last year<sup>1</sup>. The sheer amount of pills sold (at least 10 million, according to industry figures) means that a significant body of New Zealanders have extensive experience of use, including benefits and harms.

On the basis of 2006 research by the Centre for Social and Health Outcomes Research and Evaluation (SHORE), most users were aged 18-24. This would be expected, given that this group is not only the most likely to be experimenting with psychoactive substances but the age group to whom party pill marketing has been targeted. However, the Drug Foundation shares concerns expressed at findings in the same research that 16.3 percent of 15-17 year olds and 3 percent of 13-14 year olds had tried party pills.<sup>2</sup> Given that the Misuse of Drugs Amendment Act 2005 set an age limit of 18 for buying BZP products, this shows that existing law has not been adequately enforced.

## **Likelihood and severity of harms to health**

The Drug Foundation has seen no evidence to support claims by some users that BZP has any therapeutic value.<sup>3</sup> We note that it is currently being used in some 'diet pills.'

Research so far has shown that side-effects of BZP products (including desired effects that continue after a reasonable time or are stronger than anticipated) are common. A distinctive pattern of adverse effects has emerged from emergency department presentations, self-reports, and the single clinical trial reported: trouble sleeping, poor appetite, stomach pains/nausea, tremors and shakes, and headaches.<sup>4</sup> However, some effects may be due to other constituents of party pills, as well as to interactions with

alcohol or other substances, as most users take BZP products with alcohol, and many mix it with other illicit drugs.<sup>5</sup>

There is evidence of some serious adverse effects. The 80 Christchurch cases reported by Gee, Richardson, Woltersdorf and Moore over six months in 2005 included 15 toxic seizures, epileptic attacks and severe respiratory and metabolic acidosis, and two people required intensive care. Some adverse reactions persisted up to 24 hours<sup>6</sup>. While the researchers noted that these reactions may be limited to people with pre-existing vulnerability, they are nevertheless of concern for such people. The side-effects experienced by participants in the Medical Research Institute of New Zealand (MRINZ) study, although not warranting hospital admission, were serious enough to cause the researchers to stop the trial before completion.<sup>7</sup>

We note that research so far has not established any dose-response relationship between the amount of BZP taken and the likelihood of a seizure or other serious effect. Some severe reactions have occurred in people who had (or claimed to have had) low doses of BZP. At present, there is no scientific evidence of a 'safe dose' of party pills, and we note clinicians' concerns about this. Nothing is yet known about other factors that may contribute to the risk or severity of adverse events such as genetic predispositions, interactions with other psychoactive drugs or with medicines.<sup>8</sup>

For this reason, EACD placed some emphasis on the study by MRINZ, where the product and dosage were standardised, and which controlled for the additional effects of alcohol. However, the high rates of adverse events in this study are at considerable variance with the population studies (and may have been in part due to other factors in the study).<sup>9</sup>

The evidence so far is that negative effects in the general population are mainly low-level, and very small as a proportion of BZP consumed. Perhaps the most useful research is that by Theron, Jansen and Miles (2007), who reviewed presentations to an Auckland emergency department for overdoses of a number of legal and illegal drugs, including BZP. Of presentations in 2004, 809 (60.87 percent of all overdose admissions) were for alcohol, compared to 21 (1.58 percent of all admissions) for party pills. This compares with the 2.86 percent of admissions for ecstasy overdoses and 6.4 percent for GHB overdoses in the same period.<sup>10</sup> Even assuming that the upward trend over time noted by these researchers has continued, BZP is unlikely to contribute substantially to admissions for drug overdoses. These findings are consistent with those in the SHORE study - in which only 1.0 percent of party pills users had visited an emergency department and 0.4 percent had been admitted to a hospital because of party pill use - and the experiences of BZP users interviewed by Sheridan et al (2006).<sup>11</sup> The EACD also noted in May 2007 that emergency centre presentations, including to Christchurch, seemed to be decreasing.<sup>12</sup>

## **Risks of dependence**

As any significant psychoactive substance has dependence potential, the risk of BZP users developing dependence is of concern. Evidence so far is limited and inconsistent: where only 2.2 percent of participants in the SHORE study met the study's criteria for dependency, a fifth of subjects (all regular BZP users) in the MRINZ study showed "tolerance or withdrawal symptoms".<sup>13</sup> It should be noted, however, that evidence of dependence has often not emerged until several years after use of a particular substance

becomes established. How much BZP dependence might lead to health and social harms, as well as the impact on treatment services, cannot be accurately forecast. The only information so far on people presenting to treatment services with problems related to BZP use is anecdotal. The Drug Foundation would like to see more timely collection and publication of data on all substance use.<sup>14</sup>

## **BZP as gateway or substitute**

Another concern raised by many is whether BZP may be a ‘gateway’ to using other drugs, or whether, as asserted by some in the BZP industry, it is a less harmful substitute for illicit drugs such as amphetamines.

The SHORE study found gateway effects limited. While 13.5 percent of their respondents “started out using legal party pills but now mostly use illegal drugs”, 44.1 percent “were using illicit drugs but now mostly use legal party pills”, and a similar proportion used both illegal drugs and legal party pills with no change in their levels of illegal drug use. The Victoria University study, as reported in the media (the research is not yet publicly available) found very few party pill users using or interested in trying methamphetamine.<sup>15</sup>

On the other hand, BZP seems to have little effect as a substitute for methamphetamine: 27.9 percent of the current legal pill and illicit drug users only ‘use legal party pills when they cannot get illicit drugs’, and 45.2 percent ‘use legal party pills so they do not have to use illegal drugs’.<sup>16</sup> The lead researcher in the Victoria University study has been quoted as saying that “a very small sample of the first study’s participants use ‘party pills as a way of weaning themselves off their P addiction.’<sup>17</sup> In our view, comments by Customs that methamphetamine use does not seem to be declining referred to in the 2006 EACD report,<sup>18</sup> cannot be used as evidence for or against a relationship, as it is not possible to say what the level of methamphetamine use would have been if party pills were not available.

## **Gaps in the evidence base**

The Drug Foundation notes that there remain significant gaps in knowledge about BZP and similar substances. We are still not clear why a decision could not have been postponed for a few months, so that all research projects could be completed, peer reviewed, and (most importantly) available to the public.

Among the research gaps noted by reviewers such as the EACD, and by the European Monitoring Centre on Drugs and Drug Addiction (EMCDDA)<sup>19</sup> is the lack of information about the toxicology of BZP, especially its interaction with other party pill constituents; interactions with other commonly used drugs, and interaction with medicinal drugs.

The Drug Foundation hopes that, irrespective of the decision on legal status, the Committee will strongly recommend that research continue into the long-term effects of BZP. In particular, health service planners will need information on the effects for regular long-term users, including the risks of developing some level of dependency, difficulties in stopping using BZP, and effective cessation support and treatment. Some level of service will be needed whether BZP is reclassified or not, if the risk of developing dependence is as high, or higher, than it appears from current evidence.

## Overseas research

In July 2007, the EMCDDA released the report of a BZP risk assessment by its scientific committee. The report came after case reports of seizures and of increased BZP use, as in New Zealand. The report concluded that “the long term effects of the substance are still unknown”, but that it was clear BZP could lead to medical problems. The problems cited were those found in New Zealand. The report concluded that:

“...due to its stimulant properties, risk to health, the lack of medical benefits and following the precautionary principle, there is a need to control BZP, but the control measures should be appropriate to the relatively low risks of the substance.”<sup>20</sup>

## Legislative and regulatory options

In our 2004 and 2005 submissions on the Misuse of Drugs Amendment bill, the Drug Foundation supported the new Restricted Substances model. We argued that tighter and improved regulations over party pills allowed greater control than an outright ban. We also urged that research be done urgently, and made available to the general public. The question now is whether the amount of evidence is overwhelming enough to support the EACD proposal.

In the Drug Foundation’s view, the options for proceeding from the present situation are:

1. Accepting that on current evidence, the level and severity of harms warrants prohibition, and reclassifying BZP, TMFPP, and their analogues and derivatives into Class C1.
2. Accepting the level of harms, and reclassifying BZP into another part of Class C.
3. Recognising that BZP causes moderate harms, and limiting those harms by introducing, enforcing and monitoring a strong regulatory regime, as provided for in the Misuse of Drugs Amendment Act 2005.

In our view the advice presented to the Minister leaves a number of issues to be considered in deciding the costs and benefits of banning BZP. These include:

- The proportionality of harms from BZP compared to other legal and illicit drugs (such as cannabis, which is in the C1 category proposed for BZP).
- The effects of prohibiting BZP on its future use - such as whether users would simply cease party pill use, source BZP illicitly, or move to other potentially more dangerous drugs. The last two possibilities could lead to other harms to the health of users, as well to criminalising users and creating a new illicit drug market.
- The likely benefits to the community and health services from prohibiting BZP.

- The costs of prohibiting BZP to law enforcement agencies, health services and the community.

All these options must be considered in the context of the fact that BZP regulation, as provided for in the Misuse of Drugs Amendment Act 2005, has not yet been properly implemented. While the purchase age limit and the ban on public advertising have been promulgated, no regime for enforcement has been introduced. Neither have regulations on the content, manufacturing, packaging and labelling of products. It is important to note that the present situation cannot be considered a failure of the Restricted Substances regulatory model.

## **Possible effects of prohibition**

New Zealand has not recently tried the experiment of banning a drug that is widely available, and that may be easy to produce illegally. For this reason, neither supporters nor opponents of prohibition can predict the outcomes with any accuracy.

The historic experience of prohibition is that a significant proportion of users will reduce or cease using a prohibited substance. However, if a substance has widespread and regular use, and many users perceive it as having benefits to them, a considerable number of users will shift to acquiring the substance from illicit sources. If BZP is easy to manufacture as some sources indicate, and if profits are worthwhile, dealers in party drugs may simply expand their product range to include BZP. Availability (and therefore price) might depend on how easily enforcement agencies could cut off the availability of BZP ingredients.

We note that many people who have used BZP have already cut down or stopped use, citing its unpleasant effects. In this context, current users may respond to a ban by stopping BZP use completely; replace it with more alcohol, and/or other currently legal products such as salvia, or new ‘designer’ substances; keep using illicitly produced BZP; or shift to other illicit drugs such as ecstasy or amphetamines. Most likely the effects would be different for sub-groups of users:

- Casual BZP users, and users with an aversion to using illegal drugs (a significant proportion of those interviewed in Sheridan et al’s 2006 research), would probably stop their use, or use illicit party pills very occasionally.
- Those who already use BZP along with other illicit drugs (around a quarter of users in the SHORE study)<sup>21</sup> might source their BZP from current dealers – although on the basis of user experience, many experienced drug users might decide the benefits of using BZP were not worth its adverse effects, or the additional costs.
- High users of BZP, some of whom may have a level of dependence, might stop/reduce use, source BZP illicitly, or replace BZP with other illicit or legal substances.

## **Benefits of prohibition**

Prohibition would have the immediate effect of stopping advertising and marketing of BZP. It would also make BZP much less available, withdrawing it from local dairies and from the multiplicity of inner city outlets. It is probable that the current easy access (two

thirds of users in the SHORE research said they could buy legal party pills in “less than 20 minutes”) has contributed to the high rate of use.

In those circumstances, casual use would almost certainly decline rapidly. This would most probably lower the numbers of users presenting to health services with overdoses and other side effects.

Prohibition would also be likely to increase the price of the BZP available through illicit sources. This may deter many current users from buying BZP, as would the need to source products illegally, which research participants have indicated would be a deterrent. Lowering BZP use in the general population might in turn reduce the numbers of current or potential users with dependence problems.

From the international policy perspective, prohibition would bring New Zealand into line with the United States and Australia, and the direction of European Union countries.

### **Costs of prohibition**

The costs of prohibition would be both directly financial (enforcement costs) and indirect, in the forms of health and social costs.

The Drug Foundation will be interested to see Police and Customs estimates of resources needed if another drug is added to their enforcement tasks. These costs may depend on how easily imports of BZP can be intercepted, as well as whether drug dealers see a market for BZP products.

We note the potential costs and difficulties in managing any prohibition regime when manufacturers are constantly developing new ‘designer’ drugs. BZP might simply be replaced with other legal substances, since retailers in New Zealand and the United Kingdom are increasingly marketing ‘BZP-free’ drugs.

It is unclear how a ban would impact on health services. Support and treatment services are likely to be needed whether BZP is reclassified or not, if the risk of developing dependence is as high, or higher, than it appears from current evidence. If the MRINZ findings that a significant proportion of users have developed tolerance are accurate, alcohol and other drug services and primary healthcare may have a sudden influx of people in need. However, Sheridan et al (2006) are reported to have found that most young people who decided to cut down or stop BZP use had no problem.

The Drug Foundation believes it would be irresponsible to tell users of any substance to stop its use without ensuring adequate support for cessation.

Perhaps the most significant social cost is that of making a significant number of New Zealanders, mainly young people, law breakers for consuming or possessing a psychoactive substance. A C1 classification would mean that anyone possessing BZP could incur serious legal penalties, which would also impact on their study, employment and future prospects, as well as other long-term costs such as being declined entry to certain countries. As New Zealand does not currently have a national diversion programme, an inevitable result would be further inequalities between users who can access local police diversion schemes, and those who cannot.

## **Acceptability of prohibition**

There is little experience on how the New Zealand public would take banning a currently legal product. There has been extensive media coverage of some communities and groups who have called for local bans. SHORE found that 60.6 percent of all its respondents (that is, not solely party pill users) felt current regulation of party pills was “too light”, and 45 percent said they supported “outright prohibition”. However, these views were not in the context of a serious public debate where differing evidence and perspectives might be considered.

## **Other issues to be considered**

This Committee should take into account the possible health impacts if prohibition results in BZP users shifting to other currently legal substances. The ‘legal high’ market is innovative, competitive and well developed. Retailers in New Zealand and other countries have already responded to the possibility of BZP prohibition by promoting ‘BZP-free’ products.<sup>22</sup> It is also possible that the significant uptake of a substitute product would bring out health harms in that product previously been hidden by the low level of use.

We note concerns raised about the proportionality of harms between BZP and other drugs; in particular, the relative harms of BZP and alcohol. Theron, Jansen and Miles’ research confirms that harms from New Zealand’s most popular legal drug are not only common, but are often severe. There is also the issue of fairness, highlighted by the Health Committee of the 2007 Youth Parliament, if a drug which is disproportionately used by young people is banned while harmful products used by older people (alcohol and tobacco) remain unclassified.

Another issue that has been raised, including by the EACD, is how prohibition or regulation may be seen internationally. The United Kingdom Advisory Council on the Misuse of Drugs (ACMD) has been considering the legal status of BZP. This issue can be looked from differing perspectives: while there could well be some value from New Zealand ‘coming into line’ with other countries, equally New Zealand could benefit from being seen as leading the way in managing harms from drugs without prohibition.

## **Alternatives to prohibition**

As noted above, the Misuse of Drugs Amendment Act 2005 provides for a regulatory regime for BZP, which has not yet been implemented. This included the appointment of enforcement officers. Improved and enforced regulations could remove the public concern about the density and nature of sale points such as dairies, garages and alcohol outlets. They could also address marketing practices which have raised public concern, such as intensive point of sale advertising, internet sales, single pill packaging and sales of BZP powder. We believe that extensive marketing of BZP products, almost to saturation point in some city centres, has contributed substantially to the high rate of use, as well as to concern in some communities. Submissions to the Ministry of Health on the reclassification proposal showed that many New Zealanders were unaware that BZP products were classified under the Misuse of Drugs Act.

We recognise that introducing, enforcing and monitoring regulations entails costs to agencies charged with enforcement. We also note concern from public health providers that enforcement could be done by giving smokefree or liquor enforcement officers additional responsibilities without additional resources, reducing their ability to meet other requirements. This risk could be reduced by levying an excise on BZP, similar to that already levied on alcohol. The levy would need to be set at a level that offsets the costs to Health and other agencies, and also support health information campaigns on BZP products. A tax might also act as a deterrent to use by young people, who are particularly sensitive to product price. A number of people and organisations have supported this proposal.

Public opinion on appropriate measures is diverse. SHORE found that of those who believed the current regulation of legal party pills should be strengthened, 60 percent wanted to see the sale of legal party pills “prohibited from convenience stores”. About half of respondents wanted sellers of legal party pills to have to obtain a special license, and a further half of respondents wanted “mandatory health warnings on all packaging” and “age restrictions on purchasing to be increased to 20 years old”. A similar proportion wanted legal party pills “prohibited for everyone”. Similarly, there was no overwhelming view in submissions on the reclassification proposal.

We believe that a lesson should be learned from the present situation, and that the processes by which such products are introduced and regulated should be fully examined. Such a system needs to recognise that as fast as one substance is banned, another ‘designer drug’ will be introduced. What is needed is a process that ensures research into the safety of new psychoactive substances is carried out early, not several years after their introduction.

## **Other provisions in the Bill**

The Drug Foundation supports the proposed six-month amnesty, if the Committee recommends reclassification of BZP. As mentioned earlier, we also believe that health services must be available to provide support for BZP users who may find cessation difficult.

## **Other Misuse of Drugs Act issues**

### **New Zealand Bill of Rights and presumption of supply**

The Committee should consider seriously both the immediate and broader issues raised by the Attorney-General’s report on consistency between this Bill and the Bill of Rights Act 1990. The immediate issue is what amount of BZP should be enough for a reasonable conclusion that the substance is for supply. That issue is important, since supply offences reverse a fundamental principle of New Zealand’s legal system that people accused of an offence be considered innocent until proven guilty.

At the broader level, the report by implication also raises the problem of how a decision on a level should be set, and who should determine such a level. To answer the concerns expressed by Supreme Court justices in the report would require a substantial rethinking of presumption of supply in the Misuse of Drugs Act.

The Drug Foundation has advocated for an overhaul of the Misuse of Drugs Act for several years, and welcomes the proposed Law Commission review. The present Act is a patchwork of amendments, many of them ad hoc responses to short-term public or political concerns, based on different legislative and regulatory approaches. The Bill before this Committee is yet another in a long list of amendments to the principal Act.

We believe the issues raised by the Attorney-General's report show the need for New Zealand drug policy to be made within a robust framework, using considered processes.

## **Possession of needles and syringes**

The Drug Foundation believes the present Bill also provides an opportunity for the Committee to review provisions in the Misuse of Drugs Act that cause continuing difficulties for New Zealand's Needle and Syringe Exchange Programme (NEP).

Changes introduced in the Misuse of Drugs Amendment Act 2005 changed the burden of proof for the offence of "having in one's possession a needle or syringe for the purpose of commission of an offence against the Act" from the defendant to the prosecution. It also moved the defence from regulations to primary legislation.

At that time the Drug Foundation and other organisations urged the complete decriminalisation of possession of needles and syringes. However, the Committee at that time was influenced by the Police and retained the offence. The Committee did recognise needle exchange concerns about the amount of resources used to support the defence of people found in possession of a needle or syringe, but believed the reversal of burden of proof would mean that "prosecutions would proceed only where there was evidence of unlawful possession."<sup>23</sup>

We understand that in practice, the issue has not been the number of prosecutions, but the use of the legislation to arrest people who can then be searched for drugs.

International research supports the experience of the New Zealand Needle Exchange and other groups that fear of being picked up and arrested reduces needle return. This increases needle and syringe sharing among IV drug users, and also increases the chances of needles being dumped rather than returned for safe disposal.

It is the Drug Foundation's view that keeping this offence undercuts New Zealand's efforts to reduce transmission of blood-borne viruses in the community by providing needle exchange and health service to intravenous drug users. We view that legislation should focus on reducing the harm, to IVD users, those they associate with and the community at large, which results from needle sharing, in particular the transmission of HIV and Hepatitis C. Evaluations of the New Zealand Needle and Syringe Exchange Programme Review have found that it saved more than \$3.35 for every \$1 spent, and has made a significant

contribution to New Zealand's success in keeping rates of HIV and Hepatitis C low by international standards. The Drug Foundation urges the Committee to take this opportunity to remove this final barrier. New Zealand recently removed the barrier of cost (since the introduction of the one-for-one exchange programme), and now needs to remove this barrier of fear. Indeed, we consider this issue to be of much greater importance than the legal status of BZP.

Please contact me if you require any further information or clarification on our submission.

Yours sincerely

Ross Bell  
Executive Director

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