Methamphetamine (‘Speed’ and ‘P’) in New Zealand

Executive summary

- Methamphetamine is an amphetamine-type stimulant generally manufactured from readily available pharmaceuticals, particularly pseudoephedrine.
- Methamphetamine can increase a user’s confidence and energy, induce euphoria and a sense of well-being, and decrease appetite.
- Use of the drug can cause serious health effects. These include paranoia, hallucinations, mood disturbance, delusions, and potentially death.
- Methamphetamine has recently been reclassified from a Class B2 to a Class A drug.
- Reclassification of the drug has occurred as concern grows over the drug’s negative impact on the health of New Zealanders and its connection with crime.
- The Government’s Methamphetamine Action Plan seeks to control drug supply, reduce demand, limit problems associated with the drug, and promote research.
- Approaches countering methamphetamine use include: education; law enforcement; control of precursors; treatment; and research.
This paper first describes methamphetamine, its effects and the pattern of usage in New Zealand. Moves being taken to counter the drug are then examined.

**Background:**

**Drug Use in New Zealand**

About 6 percent of New Zealanders will meet the clinical criteria for drug abuse or dependence at some stage during their lives.\(^1\) Approximately 5,200 New Zealanders die each year as a direct or indirect result of drug use. Of this figure 4,700 (90.3 percent) deaths result from tobacco use, and 400 (7.6 percent) from alcohol.\(^2\) According to the 2001 National Drug Survey the use of stimulants (including methamphetamine) by the approximately 5,500 respondents increased from 2.9 percent (approximately 159 people) in 1998, to 5 percent in 2001 (275). The use of cannabis increased from 19.9 percent (1,094) to 20.3 percent (1,116), and that of lysergic acid diethylamide or LSD fell from 3.8 percent (209) to 3.2 percent (176) (see Graph 1).\(^3\) In 2002 a total of 23,875 drug offences were recorded, of which 2,841 were non-cannabis offences.\(^4\) New Zealand is estimated to annually spend $52.03 million on drug treatment services.\(^5\)

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2. Ibid., p.8.
3. Ibid., p.3.
Methamphetamine is a form of amphetamine which tends to be stronger than amphetamine and dexamphetamine. It stimulates the central nervous system and its use can produce increased confidence, euphoria, a sense of well-being, increased energy, and decreased appetite. It is generally produced from readily available pharmaceuticals (mainly cough and cold medications containing pseudoephedrine) or from imported pseudoephedrine and ephedrine. The drug can be sniffed, injected, swallowed or smoked. Methamphetamine is readily absorbed into the bloodstream and the duration of effects varies. Those of powdered methamphetamine last for several hours, while the effects of crystal methamphetamine can last for up to 24 hours.

Methamphetamine is generally a white (some grades may be yellow/brown due to incomplete manufacturing processes or impurities), odourless, bitter tasting powder that is alcohol and water-soluble. The drug is also available in a clear crystal form high in purity. Street names for methamphetamine include ‘Speed’, ‘Wizz’, ‘Go’ and ‘Meth’. The crystal form of the drug is often referred to as ‘Ice’, ‘Pure’ (‘P’), ‘Crystal Meth’, ‘Glass’, or ‘Shabu’. ‘P’ is a crystalline powder form that is between 70 and 90 percent pure, while ‘Ice’, a crystal rock form, is generally the purest form available.

The 2001 National Drug Survey indicates that the use of stimulants (including methamphetamine) has increased in New Zealand (see Graph 1). Forty one percent of users thought stimulants were easier to obtain in 2001 than in the previous year, and 20 percent thought the price was lower. The survey further indicates that the use of stimulants has increased since 1998, particularly among those users aged 15 – 17 (from 1.6 percent in 1998 to 5.3 percent in 2001), and 20 – 24 years (from 5.8 percent to 10.5 percent). Amphetamine use has also been highlighted by magazines, newspaper articles, and on television.

New Zealand treatment agencies have noted that they have been dealing with a large number of middle aged professional people. A methamphetamine problem has also been identified amongst lower socio-economic Māori populations (such as in South Auckland, the Bay of Plenty, and the East Cape), amongst university students, and within the dance party scene. There has been a notable increase in intravenous drug users using methamphetamine (or methamphetamine users injecting it).

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7 EACD, p.8.

8 Ibid., p.3.


10 Ibid.

11 Ibid. With regard to evidence that the problem has become more widespread it should be noted that the increase in arrests and seizures of amphetamines probably reflects, at least in part, the greater awareness of these drugs and additional Police efforts to counter the problem. Furthermore, drug users generally only come to the attention of medical professionals when their drug use has become seriously problematic and, in the case of amphetamines, this can be preceded by months or even years of regular use and problems (Ibid.).

In the late 1990s it was estimated that worldwide there were 28.7 million users of amphetamine-type stimulants (or 0.5 percent of the world population). It is more difficult to obtain specific figures on methamphetamine. However, 4 percent of the United States population during 2000 reported trying methamphetamine at least once in their lifetime.

The brain is comprised of billions of nerve cells (or neurons). Most neurons have three important parts: a cell body that contains the nucleus and directs the activities of the neuron; dendrites, short fibres that receive messages from other neurons and relay them to the cell body; and an axon, a long single fibre that carries messages from the cell body to the dendrites of other neurons. To communicate with each other neurons use chemical messengers known as neurotransmitters. When one neuron wants to send a message to another neuron it releases a neurotransmitter from its axon into the small space that separates the two neurons. There are many different neurotransmitters, but the one that is most affected by methamphetamine is dopamine (the chemical affecting how pleasure is experienced). When something pleasurable happens, certain axons release dopamine. The dopamine attaches to receptors on the dendrites of neighboring neurons and passes on the pleasure message. This process is stopped when dopamine is released from the receptors and pumped back into the neuron that released it, where it is stored for later use. Usually neurons recycle dopamine. But methamphetamine is able to fool neurons into taking it up just like they would dopamine. Once inside a neuron, methamphetamine causes that neuron to release dopamine.

A large single dose of methamphetamine may cause increased body temperature and convulsions, strokes, and possibly death. Preliminary research suggests that permanent brain damage can occur and other research indicates that methamphetamine abuse during pregnancy may cause problems. Users may experience paranoia, hallucinations, mood disturbance and delusions. Findings from an Australian survey published in 1993 indicated that 80 percent of amphetamine users reported mood swings, 71 percent paranoia, 46 percent hallucinations, 43 percent aggressive episodes and 16 percent violence. To extend the euphoria, and delay negative effects, users often go on prolonged binges of drug taking along with forgoing sleep and other needs. After these binges a pronounced crash occurs which generally includes a deep depression, fatigue, headaches, poor sleeping and a strong desire to use the drug again.

According to the 2001 New Zealand National Drug Survey, respondents who used stimulants experienced negative effects in terms of energy and vitality (19.2 percent), and health (9.6 percent) (see Table 1).

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17 EACD, p.9.
Table 1: Identified areas of life that were harmfully affected by the use of stimulants in 2001 – New Zealand

<table>
<thead>
<tr>
<th>Area of life</th>
<th>Last-year users (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Energy and vitality</td>
<td>19.2</td>
</tr>
<tr>
<td>Financial position</td>
<td>12.2</td>
</tr>
<tr>
<td>Health</td>
<td>9.6</td>
</tr>
<tr>
<td>Work or work opportunities</td>
<td>9.9</td>
</tr>
<tr>
<td>Friendship and social life</td>
<td>7.0</td>
</tr>
<tr>
<td>Outlook on life</td>
<td>5.8</td>
</tr>
<tr>
<td>Home life</td>
<td>3.5</td>
</tr>
<tr>
<td>Children’s health or wellbeing</td>
<td>0.2</td>
</tr>
</tbody>
</table>

Source: Wilkens et al

Currently little data is available on methamphetamine hospital admissions in New Zealand. However, figures on Emergency Department (ED) admissions from the Auckland District Health Board showed that between 1 January 2002 and 31 October 2002, 36 people were presented at EDs with methamphetamine related conditions.\(^{18}\)

Data from the 2000 Drug Abuse Warning Network (DAWN), which collects information from hospital emergency departments in the United States, showed that methamphetamine related episodes increased from approximately 10,400 in 1999 to 13,500 in 2000, a 30 percent increase.\(^{19}\)

Death can occur from methamphetamine concentrations in the blood of greater than 0.5 mg/L. Fatal overdoses are more likely to occur among inexperienced or episodic high dose users, than among regular users who have developed a tolerance to the drug. Methamphetamine also increases the risk of a stroke in relatively young people.\(^{20}\) It was reported in March 2003 that methamphetamine had been linked with five deaths in New Zealand.\(^{21}\)

Overseas, the number of methamphetamine related deaths in the United States rose from 234 in 1992 to 487 in 1996.\(^{22}\)

Risk of Dependency

Regular users risk drug dependency, experienced as increased tolerance to the drug, problems in controlling usage, and withdrawal symptoms. Findings published in 2000 suggest that users progress more rapidly from initial use to regular use, and a subsequent need for treatment, than users of other stimulants such as cocaine.\(^{23}\) Users who inject methamphetamine, or smoke pure methamphetamine, may also be more likely to become dependent, given the speed of onset and the intense rush associated with these modes of administration.\(^{24}\) Although physical addiction can be overcome within two weeks, the psychological consequences can continue for years.

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\(^{20}\) EACD, p.10.

\(^{21}\) *SCN Select Committee News – Meetings for week ending Friday 14th March 2003*.


\(^{23}\) EACD, p.11.

\(^{24}\) Ibid., p.11.
In mid-2002 the Auckland rehabilitation centre Higher Ground reported a three-fold increase in methamphetamine abuse cases, and simultaneously a decline in the average age of those on its programme from 31 to 25 years. Similarly, the Auckland City Mission’s social detoxification centre has experienced an increase in the number of methamphetamine users, and a corresponding decline in the average age from 29 to 21 years.25

There is currently no recognised treatment protocol for methamphetamine dependence.26

**Therapeutic Value**

There are few accepted therapeutic uses for methamphetamine. The drug has been used in the past to treat children for attention deficit hyperactivity disorders, in the treatment of obesity and narcolepsy (a sleeping disorder), and as a nasal decongestant and in bronchial inhalers. However, the therapeutic use of methamphetamine has ceased due to the availability of other medications.27

**Effects of Production**

Apart from the potentially serious effect of the drug on users the drug producers themselves (commonly known as ‘cooks’) face health risks. According to the Police most ‘cooks’ have little knowledge of chemistry and this, combined with the risky nature of producing methamphetamine, has increased the health danger.28

There have been reports that ‘cooks’ have died in New Zealand both from exposure to the hazardous chemicals used in the process and from using the drug themselves.29 The prosecutor of an individual associated with a methamphetamine laboratory commented in September 2002 that

> These laboratories pose a real risk to the community, the criminals operating them, and the law enforcement officers investigating them as they involve a number of volatile chemicals undergoing a range of chemical reactions, often maintained by people with little or no knowledge of chemistry. This danger is compounded by the use of makeshift equipment and little attention to matters of safety.30

Overseas, in the United States at least five or six methamphetamine producers are killed each year in explosions and/or fires in clandestine laboratories.31 Recent years have seen an increase in the number of injuries to untrained American Police officers who investigate and/or dismantle clandestine laboratories without proper safety equipment.32

The risk posed to children living with parents who produce drugs including methamphetamine is also a concern. The Commissioner for Children, Roger McClay, stated in 2002 that "I've got to say that these sorts of parents (parents manufacturing drugs) are so irresponsible that their children shouldn't be with them . . . These children are in need of care and protection, there's no doubt about it."33

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26 EACD, p.11.
27 Ibid., p.10.
28 Philp, p.42.
29 Zander, p.19; and Philp, p.42.
32 Ibid.
The hazards of producing methamphetamine are multiplied when the threat to the local community is taken into account. The Police have found dangerous chemicals stored in homes. Vapours from the production process can seep into fibrous walls and pose a serious threat. It can cost almost $20,000 to make a property habitable after use as a methamphetamine laboratory.

The link between crime and methamphetamine in New Zealand is a serious concern. According to the Police there is anecdotal evidence that one major gang has been making methamphetamine since the 1980s. Seizures of methamphetamine have increased from 1.8 kilograms to 6.4 kilograms (see Table 2), and the number of clandestine methamphetamine laboratories found has increased from two in 1996 to 83 in 2002 (see Table 3). The number of people arrested for possession of amphetamine-type substances increased from 161 in 1998, to 387 in 2001. In February 2003, 45 people faced charges relating to supplying pseudoephedrine as a precursor substance (the chemicals used to produce amphetamines) under the Misuse of Drugs Act 1975.

In the United States the number of Drug Enforcement Agency (DEA) methamphetamine related arrests rose from 1,893 in 1993 to 7,587 in 1998, an increase of over 300 percent. In 1999 approximately 21 percent of all DEA arrests were for methamphetamine related drug violations.

### Table 2. Seizures of methamphetamine in New Zealand 1999-2002

<table>
<thead>
<tr>
<th>Year</th>
<th>Kilograms of methamphetamine seized</th>
</tr>
</thead>
<tbody>
<tr>
<td>1999</td>
<td>1.8</td>
</tr>
<tr>
<td>2000</td>
<td>2.1</td>
</tr>
<tr>
<td>2001</td>
<td>3.8</td>
</tr>
<tr>
<td>2002</td>
<td>6.4</td>
</tr>
</tbody>
</table>


### Table 3. Clandestine methamphetamine laboratories detected in New Zealand 1996-2002

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of labs discovered</th>
</tr>
</thead>
<tbody>
<tr>
<td>1996</td>
<td>2</td>
</tr>
<tr>
<td>1997</td>
<td>2</td>
</tr>
<tr>
<td>1998</td>
<td>1</td>
</tr>
<tr>
<td>1999</td>
<td>6</td>
</tr>
<tr>
<td>2000</td>
<td>9</td>
</tr>
<tr>
<td>2001</td>
<td>41</td>
</tr>
<tr>
<td>2002</td>
<td>83</td>
</tr>
<tr>
<td>Total</td>
<td>144</td>
</tr>
</tbody>
</table>

Source: Ministerial Action Group on Drugs, p.13.

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34 Philp, p.42.
35 *Waikato Times* 1 April 2002, p.28.
36 Philp, p.42.
38 Wilkens, et al.
39 Deborah Benson, ‘Reporting system put to the test’, *New Zealand Pharmacy*, 3 March 2003, p.16. It should be noted that it is not an offence to purchase pseudoephedrine if there is no intention to later use it for producing methamphetamine.
The drug can substantially increase aggressiveness and tendencies toward violent behaviour.41 According to the Ministerial Action Group on Drugs some methamphetamine users "are prone to paranoia and irrational behaviour that can result in violence".42 The Police also report significant violence in and around the methamphetamine scene.43

Similarly, the media has highlighted the link between drug use and violence. It has been reported that the convicted murderer of two people in South Auckland and the convicted murderer of another three people at the Mt Wellington-Panmure Returned Services’ Association in 2002 used methamphetamine.44 The media has also reported that health sector workers, especially emergency department staff, have experienced more violence and outbursts directed at them, an increase that has been linked to methamphetamine use.45

The need to raise money to buy the drug, and the chemicals and instruments involved in producing it, has been linked to crime. In mid-2002 methamphetamine was selling on New Zealand streets for about $100–180 per gram (‘P’ was selling for $1,000 per gram). In comparison, a tab of LSD could be purchased for approximately $30–40, and 1.5 grams of cannabis could be bought for $20.46 Detective Sergeant Darryl Brazier, head of the Auckland Organised Crime Squad, has said

If you have any sort of meth addiction you will use $200 a day, $1400 a week. Where’s that money coming from? It comes from burglaries, robberies, car thefts, and from the vice scene, prostitution and standovers.47

Another concern is the involvement of organised crime in the manufacture of methamphetamine. The Police have linked many methamphetamine laboratories to gangs, and have noted increased cooperation between gangs in the drug trade.48 According to the former head of the Christchurch Criminal Investigation Branch, new gangs are also being formed to concentrate on producing methamphetamine.49

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43 Ibid., p.12.
44 ‘Bell's drug of choice linked to rise in violence’, New Zealand Herald, 12 December 2002; and “P’ is for psychotic - users linked with rising violence’, New Zealand Herald, 14 December 2002.
45 ‘Hospital violence fuelled by drugs’, Dominion Post, 19 February 2003, p.11.
46 Ministerial Action Group on Drugs, Methamphetamine Action Plan, 22 May 2003, p.13. In early 2003 it was reported that methamphetamine was selling for $100-120 a gram. In comparison, ‘P’ was being sold for about $100 a "point bag", so named because the tiny bag contains .1g, ‘High speed life of an addict’, Daily News, 1 February 2003, p.20.
47 Philp, p.43.
48 Philp, p.38 and p.40.
49 David Haslett, correspondence with Paul Bellamy, 14 June 2003.
Internationally, the United Nations has reported a clear link between organised crime and the trafficking of amphetamine-type stimulants, and their precursor chemicals. There is evidence that trafficking groups are beginning to diversify into synthetic drugs. For instance, in South-East Asia some of the groups that were involved in heroin trafficking are now moving into methamphetamine or amphetamine. Australia has also experienced problems with the domestic production of methamphetamine being dominated by organised crime groups.\textsuperscript{50} The trend towards the production of amphetamine-type stimulants in the same area or country in which they are sold, thus eliminating long-distance trafficking routes, makes law enforcement more difficult.\textsuperscript{51}

In 2002 the Expert Advisory Committee on Drugs (EACD) recommended to the Minister of Health the reclassification of methamphetamine from Class B2 to Class A to better reflect the risk of harm associated with the drug.\textsuperscript{52} With reference to the criteria set out in s4B(2) of the Misuse of Drugs Act 1975, the recommendation resulted from the following conclusions:

- That the use and manufacture of methamphetamine in New Zealand is growing, seizures are increasing and it has potential to appeal to vulnerable populations.
- There are pronounced long-term physical and psychological adverse effects associated with methamphetamine abuse.
- There are significant risks to public health from intravenous use of methamphetamine, as well as the dangers posed by illicit clandestine laboratories.
- There are few, if any, therapeutic applications for methamphetamine.
- Methamphetamine has been linked to deaths both in New Zealand and overseas.
- There is a high physical and psychological dependence potential.

The EACD recommendation resulted in a recommendation by the Minister to the Governor-General to make an Order in Council under section 4(1) of the Act reclassifying the drug. This was done in the Misuse of Drugs (Changes to Controlled Drugs) Order 2003.\textsuperscript{53} In addition, the Order proposed the classification of methcathinone as a Class B1 drug, 4-methylthioamphetamine as a Class B2 drug and pemoline and aminorex as Class C5 drugs. The latter substances are amphetamine-type synthetic drugs whose classification is required to meet international obligations under the United Nations drug classification framework, as set out in the Convention on Psychotropic Substances (Vienna 1971).

Methamphetamine was first added to the schedules of the Misuse of Drugs Act 1975 by the Misuse of Drugs Amendment Act (No.2) 1987. Reclassification from Class B2 to Class A will result in increased penalties and greater Police powers for search and seizure. The penalties will increase as follows:

- Life imprisonment for importation, manufacture or supply, increased from a maximum of 14 years imprisonment for Class B drugs.
- Up to 14 years imprisonment for conspiracy to commit an offence under the Act, increased from a maximum of 10 years imprisonment.
- Up to six months imprisonment or a $1,000 fine or both for possession and use, increased from a maximum of three months imprisonment or a $500 fine or both.\textsuperscript{54}

\textsuperscript{50}EACD, p.14.
\textsuperscript{52}EACD, Advice to the Minister: Methamphetamine, 2002. See also Misuse of Drugs Act 1975 s4B.
\textsuperscript{53}SR 2003/47.
\textsuperscript{54}For further information on penalties see Misuse of Drugs Act 1975, ss 6(2)a-c and (2A); and ss 27 and 32 (1).
The reclassification also increases search and seizure powers under s18 of the Act, giving the Police the power to search for and seize methamphetamine without a warrant.\textsuperscript{55}

Under section 4A of the Act, the Order in Council requires approval by the House of Representatives and a separate commencement order before it can come into force. Under sessional orders of the House, the notices of motion to approve such Orders in Council stand referred to the Health Select Committee.\textsuperscript{56} The Committee examined the Order in April 2003 and recommended that the related notice of motion be approved.\textsuperscript{57} The Committee’s report states that “it is anticipated that the reclassification of methamphetamine should reduce the prevalence of the drug in New Zealand society over the long term”, as well as serving “as a signal that methamphetamine is one of the most dangerous of drugs”.\textsuperscript{58} The Committee noted its concern with regard to evidence that methamphetamine use, supply and manufacture is linked to violent crime. The report indicates that a key element in addressing use of methamphetamine is restricting the supply of the drug, as well as providing for a public education programme “to counter any perception that methamphetamine is a relatively harmless party drug”.\textsuperscript{59} However, the Green Party’s minority view opposed the reclassification of methamphetamine, on the grounds that there were no sound arguments to show that increasing the classification would reduce the use of amphetamines in New Zealand.\textsuperscript{60}

By the resolution of 13 May 2003, the House approved the Order in Council. The Misuse of Drugs (Changes to Controlled Drugs) Order Commencement Order 2003 brought the Order in Council into force on 30 May 2003.\textsuperscript{61}

The classification of methamphetamine as Class A is higher than its equivalent classification in the United Nations Convention on Psychotropic Substances (Vienna 1971) where it is listed in Schedule II (equivalent to New Zealand Class B). Drugs are listed in the various schedules annexed to the Convention according to the differences in their dependence-producing properties, their therapeutic value and their risk of abuse. In its report the Health Select Committee noted this difference, but justified a higher classification because of “the drug’s harm potential and current prevalence in New Zealand”.\textsuperscript{62}

\textsuperscript{55} Misuse of Drugs Act 1975 s18 (2) and (3).
\textsuperscript{56} Misuse of Drugs Orders
Resolved, That –
1. Any notice of motion to approve an Order in Council made under section 4(1) of the Misuse of Drugs Act 1975 stand referred to the Health Committee for examination;
2. The Health Committee must report to the House on any such notice of motion within 28 days of the notice of motion being lodged; and
3. No motion to approve an Order in Council under section 4(1) of the Misuse of Drugs Act 1975 be moved until either the Health Committee has reported to the House on the notice of motion or 28 days have elapsed since the motion was lodged, whichever is earlier. (5 September 2002).
\textsuperscript{57} Notice of Motion 20 March 2003. That, pursuant to section 4A of the Misuse of Drugs Act 1975, this House approves the Misuse of Drugs (Changes to Controlled Drugs) Order 2003 (SR2003/47) made under section 4 of the Act.
\textsuperscript{58} Report of the Health Select Committee, Misuse of Drugs (Changes to Controlled Drugs Order 2003), 9 April 2003, p.3.
\textsuperscript{59} ibid., p.5.
\textsuperscript{60} ibid., p.7.
\textsuperscript{61} SR 2003/116. For further information on this procedure see Misuse of Drugs Act 1975 s4A.
\textsuperscript{62} Report of the Health Select Committee Misuse of Drugs (Changes to Controlled Drugs Order 2003), 9 April 2003, p.7.
Under the United Kingdom Misuse of Drugs Act 1971 most amphetamines are Class B. The penalty for possession is up to 5 years imprisonment plus a fine and 14 years imprisonment for supply. If amphetamines are prepared for injection they are Class A substances and supply offences can incur life imprisonment.

Similarly the United States Controlled Substances Act differentiates between methamphetamine in injectable form as a Schedule II substance (abuse may lead to severe dependence)\(^63\), and in other forms as a Schedule III substance (abuse may lead to moderate or low dependence).\(^64\) Queensland’s Drugs Misuse Regulations 1987 place methamphetamine in Schedule II, while heroin and cocaine are Schedule I drugs. The Drug Misuse and Trafficking Act 1985 (New South Wales) classifies methamphetamine as a Schedule I drug.

The recently released Methamphetamine Action Plan outlines the New Zealand Government’s policy on the drug. The plan seeks to control drug supply, reduce demand, limit problems associated with the drug, and promote additional research.

To control drug supply the plan includes possible changes to the Misuse of Drugs Act 1975 to allow increased powers for the Police and New Zealand Customs Service to control the supply of precursors, and improves drug monitoring and surveillance systems. The plan seeks to limit demand through measures including Community Action Programmes that target communities with methamphetamine problems, focusing on community ownership and solutions with support from public health providers. To limit problems associated with the drug the plan aims to improve the resourcing of treatment services, support greater liaison with Australian health services, develop a methamphetamine treatment protocol, and provide improved support and supervision mechanisms for those having direct contact with methamphetamine users. Research into the drug will include work on the morbidity and mortality rates associated with methamphetamine use, improving analysis of methamphetamine related apprehension and seizure statistics, and the organising of regular meetings/symposiums to bring together those working on the drug.\(^65\)

Measures advocated to counter methamphetamine usage include:

**Education:** There is debate over school drug programmes. This has arisen as the effectiveness of programmes has been questioned and concerns have been voiced that such activities might stimulate interest in the drug.\(^66\) At the same time, hope has been expressed that programmes might encourage people to make more informed decisions. Support for programmes that raise awareness of methamphetamine dangers has come from the Regional Alcohol and Drug Service (RADS). In the United States knowledge of the drug has been increased via the Partnership for a Drug-Free America that has mounted a campaign to explain drug dangers.\(^67\)

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\(^63\) 21 USC 812 1970.
\(^64\) Ibid.
**Law Enforcement:** The Police have stressed the importance of dealing with the problem. Measures include the establishment of the first Police unit dedicated to the detection of clandestine drug laboratories in 2000. The 2003 Budget allocated “$6.6 million over four years to fund two police teams trained in the clean-up of clandestine methamphetamine laboratories”. Co-operation between the Police and the New Zealand Customs Service has led to major drug seizures, as in May 2002 when a New Zealander was charged with importing 863g of crystal methamphetamine – one of the largest hauls in New Zealand to date.

More broadly, the International Narcotics Control Board and the United Nations International Drug Control Programme promote cooperation between countries against drugs.

**Control of Precursors:** Pharmacists monitor the purchase of methamphetamine ingredients. Pharmacies have provided the Police with names, addresses, car registration numbers, drivers’ licence details, the number and type of pseudoephedrine-containing products requested, and the dates and times of purchase. Pharmacists have also asked customers to show photo identification before selling products containing pseudoephedrine.

Similar moves have occurred overseas. In the United States the Methamphetamine Control Act 1996 broadened controls on precursor substances used in the production of methamphetamine. Purchasers of significant quantities of precursor chemicals above a set threshold, are required to provide their name, address and other information at the time of sale. The Act expanded controls on the distribution of lawfully marketed drug products that contain the listed chemicals ephedrine, pseudoephedrine and phenylpropanolamine. Large quantity purchases of those products must be reported to the DEA. The DEA and Wal-Mart retailer announced in 1997 a scheme whereby cash registers were programmed to limit sales of some allergy, cold and diet products. The Methamphetamine Anti-Proliferation Act 2000 also addressed the diversion of drug products containing pseudoephedrine and phenylpropanolamine from retail and mail order sources to the illicit production of methamphetamine. The Act reduces the thresholds for single transactions and adds a requirement for specified package sizes. Experience in Australia and the United States indicates that stricter control of precursors can have an impact on domestic production.

In addition to the moves by pharmacists, some have argued that legitimate manufacturers also have responsibilities to reduce the supply of precursors.

**Treatment:** Although there is no recognised treatment protocol, therapies either being used or considered include aversion therapy and substitution therapy, and a search is currently underway for the methamphetamine equivalent of methadone. There are also various therapies that are claimed to be effective. Jackson County, Missouri, has been a model in the United States for its methamphetamine eradication strategy. This has involved a diversion programme whereby non-violent offenders are given the option of treatment over jail. Defendants who complete a 12 to 18 month treatment programme have their criminal charges

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69 *New Zealand Herald*, 31 May 2002.
70 Benson, p.16.
71 21 USC 830, 802, 814.
72 United Nations General Assembly Special Session.
73 Ibid., see also 21 CFR 1310, 1313.
74 Wilkins *et al*.
76 Little, pp.20-21.
dismissed. Compliance rates reportedly range from 50 to 70 percent.\textsuperscript{77} In Australia, an experiment has been run with some success that involves providing the pharmaceutical dexamphetamine to methamphetamine users.\textsuperscript{78}

\textit{Research:} Research is being undertaken in Australia and New Zealand into altering legal pharmaceutical medications so that they cannot be converted into illegal substances.\textsuperscript{79} This work has been difficult, and although alternative medication not containing pseudoephedrine is being developed it could be after 2004 before it reaches the market.\textsuperscript{80}

\textbf{Conclusion}

Methamphetamine usage has the potential to appeal to vulnerable populations and to have serious consequences. The drug stimulates the central nervous system, but has negative repercussions on both physical and psychological health with death a possible outcome. These repercussions are particularly concerning as New Zealanders are increasingly using the drug. The drug has also been linked to crime in New Zealand. Crimes are being committed to obtain money to buy the drug and the resources to manufacture it. Usage may increase the propensity for violence, and gangs are involved in its supply. The Government has sought to address the problem with the reclassification of the drug to Class A and the release of the Methamphetamine Action Plan. This plan seeks to control drug supply, reduce demand, limit problems associated with the drug, and increase research.

\textsuperscript{77} United Nations General Assembly Special Session.
\textsuperscript{79} Little, p.21.
\textsuperscript{80} Ibid., p.21.
Suggestions for further reading / links


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