

AN OPTIMAL REGULATORY MIX FOR METHAMPHETAMINE PRECURSORS?

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Responding to methamphetamine problems

- How should governments respond to the problem of domestic, illicit production of methamphetamine?
- NZ PM John Key:

The government is adopting a multi-pronged approach to fighting this dangerous scourge by cracking down on precursors, breaking the supply chain, better routes into treatment, supporting families and community, and strengthening leadership and accountability.

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Developing an optimal response

- What are the available policy and regulatory options?
- What evidence is there about their usefulness, costs and side effects?
- Is there enough evidence to suggest an optimal response, and if so, what is it?

Why precursor regulation?

- About 90% of Australian ATS produced locally
- Methamphetamines produced in clandestine laboratories, using mainly locally obtained precursors
- Precursors mainly diverted from licit uses, especially pharmacy sales
- International drug control policy has dictated law enforcement and regulatory approaches to controlling precursors

What options have been tried?

1. Increased border and domestic policing of ATS and precursors – *international*
2. Restrict pseudoephedrine sales (PSE) – quantities, packaging, product placement etc – *all Australia & USA & NZ*
3. Restrict sales of PSE to pharmacy only – *all Australia & some USA states & NZ*
4. Require logging of sales & proof of identity – *some states eg Vic*
5. Require centralised electronic monitoring & reporting of sales – *Queensland, Oklahoma, Kentucky*
6. Restrict PSE to prescription only – *Oregon*
7. Restrict PSE to prescription only & limit prescribing – *proposed NZ*
8. Ban PSE products – *Mexico*

Assessing what works? At what costs?

- What is success?
 - Reduced illicit methamphetamine use/demand?
 - Reduced local illicit methamphetamine production/supply?
 - Unintended consequences?
- How is this measured?
 - Prevalence surveys, hospital admissions, treatment demands
 - Detection of clandestine laboratories/ STLs
 - Identification & measurement of side-effects
- Are the outcomes worth the costs?

Project STOP evaluation

Policy options for regulating precursors

1. Do nothing new – continue current approaches
2. Increase reactive policing
3. Ban PSE products
4. Restrict PSE to prescription only
5. Require ID and monitor sales – Project STOP

What do we know about what works best, in what circumstances, & at what cost?

Option 1 – current approaches

- Federal government criminalises illicit:
 - trafficking, cultivation, sale, manufacture, import, export, possession of ATS, pre-trafficking in precursors, harms caused to children

Criminal Code 1995

- And regulates licit ATS and their precursors:
 - National Diversion Prevention Strategy
 - Rescheduled ATS and precursor products to prescription or pharmacy sales only

Therapeutic Goods Act 1989

Option 1 – current approaches (cont)

- States and territories also
 - Criminalise pre-trafficking etc
 - Regulate how pharmacies sell products, labelling, storage & identity verification
- But variations in criminal offences, penalties & in regulatory approaches
 - Voluntary, cooperative & enforced cooperative models
- Complex, fragmented policy & regulatory environment

Variations in current state regulatory approaches to precursors

	Qld (Enforced)	Vic (Co-op)	Tas (Vol)
Restrict quantity, storage, sale by pharmacist, dispensing, labelling	Yes	Yes	Yes
Pharmacists required to <u>take reasonable steps</u> to identify purchaser, assess validity of use, report suspicions to police	Yes	Yes	No
Pharmacists required to obtain photo ID, enter sales on register, <u>send to police</u> , <u>make available to health regulator</u>	Yes	No	No

Option 2 – increased reactive policing

- Multiplicity of agencies
- Variations between jurisdictions
- Increasing involvement of organised crime
- Resource intensive
- What works best? Neighbourhood-wide approaches? Problem-oriented policing? Partnership approaches? Crackdowns? Raids? Hotspot directed patrols?
- Lack of an evidence base on what works

Option 3 – ban PSE products

- Substitute products not as effective for licit use
- Consumer inconvenience
- Health & economic costs from less effective treatments
- May shift illicit supply to importation of PSE
- Likely to strengthen involvement of organised crime

Option 4 – make PSE prescription only

- Substitute products not as effective for licit use
- Consumer inconvenience
- Shifts decision-making burden from pharmacist to medical practitioner
- Health & economic costs from less effective treatments/ more doctor visits
- May shift illicit supply to importation of PSE
- May strengthen involvement of organised crime

Option 5 – improve monitoring

- Project STOP
 - Data recording & decision-making tool that tracks PSE sales in real time
 - Records buyer ID, product, date, location, sale or denial of sale, duress
 - Accessible by police, health regulators, pharmacy guild
 - Has mapping & intelligence functions
 - Can be adapted to other products
 - in >95% Qld pharmacies, 63% nationally
 - Funded for national roll-out, but inconsistent regulatory frameworks across states
- Makes pharmacists burden bearers for reducing PSE diversion & imposes significant costs

What is the evidence on the options?

- First wave USA federal restrictions on large scale PSE led to
 - fewer clan labs, meth-related arrests, meth-related hospitalisations & treatment, & lower purity
- But restrictions on small scale PSE had little impact
Cunningham et al 2009
- Data on price & arrestee use show little change in demand from federal restrictions Reuter et al 2003
- So *Combat Meth Act 2005* imposed retail level restrictions

The evidence (cont)

- US state regulation on retail PSE varies between:
 - No extra state regulation
 - Restrictions on display, quantities, require ID – 41 states
 - Pharmacy only sales – 11 states
 - Prescription only sales – Oregon
 - Centralised/electronic monitoring – Oklahoma, Kentucky

The evidence (cont)

- US outcomes?
 - Clan lab detections declined nationally after *Combat Meth Act*, virtually eliminated in Oregon, 90% reduction in Oklahoma
 - Detections now rising again, and since 2008, an increased flow from Mexico, despite its PSE ban
 - Increase in labs much smaller in Oregon than most other states
 - But small scale producers smurfing & crossing borders to circumvent state regulation
 - Shifting patterns/methods of production
 - Slight decrease in prevalence, but stable treatments
- Overall, domestic production will increase in the short term (NDIC 2009)

Implications for Australia?

- Meth market is highly adaptive, and can switch between imports & domestic production, & changed methods of production & supply
- State differences enable circumvention of regulation
- Prescription only PSE has best effect on clan labs, but this is an imperfect measure, and costly
- Improved monitoring on its own not enough – requires regulation enforcing compliance to be effective
- What is the best regulatory environment for monitoring via Project STOP?

An enforced regulation approach

- Shift to more coercive regulatory enforcement style



Figure 1. A pyramid of enforcement responses.

(Source: Ian Ayres and John Braithwaite, *Responsive Regulation: Transcending the Deregulation Debate*. New York: Oxford University Press, 1992, page 35)

Implications

- Project STOP may be able to achieve similar results to options 3 & 4, but for less cost & inconvenience
- But Project STOP on its own may not be enough – regulatory context matters
 - Shift to enforced rather than voluntary cooperation
 - Consistency between jurisdictions
 - Comprehensive policy, to avoid easy switches to other suppliers/ methods of production/drugs