COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

JOINT COMMITTEE ON THE AUSTRALIAN CRIME COMMISSION

Reference: Amphetamines and other synthetic drugs

TUESDAY, 16 MAY 2006

SYDNEY

BY AUTHORITY OF THE PARLIAMENT

INTERNET

The Proof and Official Hansard transcripts of Senate committee hearings, some House of Representatives committee hearings and some joint committee hearings are available on the Internet. Some House of Representatives committees and some joint committees make available only Official Hansard transcripts.

The Internet address is: **http://www.aph.gov.au/hansard**

To search the parliamentary database, go to:
http://parlinfoweb.aph.gov.au

JOINT STATUTORY COMMITTEE ON THE

AUSTRALIAN CRIME COMMISSION

Tuesday, 16 May 2006

Members: Senator Ian Macdonald *(Chair)*, Mr Kerr *(Deputy Chair)*, Senators Ferris, Ludwig and Polley and Mrs Gash, Mr Hayes, Mr Richardson and Mr Wood

Members in attendance: Senators Ferris, Ludwig and Ian Macdonald and Mr Kerr, Mr Richardson and Mr Wood

Terms of reference for the inquiry:

To inquire into and report on:

The manufacture, importation and use of Amphetamines and Other Synthetic Drugs (AOSD) in Australia.

In particular:

a. Trends in the production and consumption of AOSD in Australia and overseas.

b. Strategies to reduce the AOSD market in Australia.

c. The extent and nature of organised crime involvement.

d. The nature of Australian law enforcement response.

e. The adequacy of existing legislation and administrative arrangements between Commonwealth and State agencies in addressing the importation, manufacture, and distribution of AOSDs, precursor chemicals and equipment used in their manufacture.

f. An assessment of the adequacy of the response by Australian law enforcement agencies, including the ACC.

WITNESSES

Committee met at 9.15 am

ARBLASTER, Dr Christopher, Marketing and Development Director, Australian Self-Medication Industry

CHAIR (Senator Ian Macdonald)—Welcome. Dr Arblaster, thank you for being with us today. You are aware of the terms of reference of the committee. Although these hearings are public, they are protected by parliamentary privilege. If at any time you need to get information from others or there are policy questions you are not prepared to answer, as long as you let us know, that will be quite in order. This is a very important inquiry into amphetamines and other synthetic drugs. We have already had three days of hearings, which have been very useful to the committee. We are very interested to hear your evidence. Perhaps you could make an opening statement and then subject yourself to the questioning of the committee.

Dr Arblaster—I am the person who is principally in charge of managing substances on behalf of the Australian Self-Medication Industry. I am here representing what is called 'self-medication'. Perhaps I can take a second to explain what that term is. It is not self-medication in the sense that you might be thinking of—that is, the way in which people are currently using various substances. This is an organisation that represents the manufacturers, sponsors and marketers of over-the-counter products such as Panadol, Nurofen and other sorts of heavy-end analgesics, as well as cough-cold preparations.

The ASMI also represent companies that manufacture and market herbal substances, including vitamins and minerals—what we call complementary type products. We represent the full spectrum of things you would typically be able to walk into a pharmacy, grocery or health food store and buy without a prescription. That is the spectrum of what we look after, and that is all we look after. We do not get involved in prescription medicines at all.

We are an organisation that has been going for over 30 years, and we represent a membership of about 80 per cent of the companies in the market. That we are the peak body is the best way to describe it. I hope that gives you a bit of a background as to whom I represent.

You will have no doubt seen the short paper I put together with views and comments on this issue. I will highlight a few of the key elements within that document. Pseudoephedrine has been a product on the market for about 30 years. It is a substance that is widely used in cough-cold preparations, as well as in nasal decongestants and in antihistamine combinations. These days it is typically used in combination with analgesics, maybe with an antihistamine such as—if I can use brand names it might be easier—Claratyne and so forth.

Some consumers or patients—whatever you want to call them—will be using this substance on a very frequent basis. There is a subset of the population who need it almost continuously, because they are quite severe sufferers from allergic reactions, so it is a very important substance from their perspective. I guess most people in this room would have taken a pseudoephedrine compound product at some point in their life to ease a cough or a cold.

It is a very safe substance, and that is the reason for its previous scheduling. It was scheduled as a 'pharmacy-only product'—that is, it had to be within a pharmacy but not necessarily behind

a counter or under the control of the pharmacist. You could walk into some pharmacies in some states and just pick it up and buy it off the shelf within the pharmacy and walk out with it.

Mr WOOD—Was that pseudoephedrine?

Dr Arblaster—It was pseudoephedrine-containing products or cough-cold preparations. Codral and Demazin would be typical sorts of brand names that you would find on the shelf. It was the case until January this year that you could just walk in and purchase them that way. You could not buy them in grocery stores; they had to be under the supervision of a registered pharmacist, one way or another.

Senator FERRIS—It is right across Australia. It is federal not state legislation that limits them.

Dr Arblaster—By and large, yes. There are some minor variations—if you want me to go into those—at a state level, but the scheduling is done on a national basis.

Senator FERRIS—That is what I thought.

Dr Arblaster—And that is organised by a group called the NDPSC, which is the National Drugs and Poisons Schedule Committee, which is run out of the Department of Health and Ageing.

ASMI has worked for a number of years on this problem. It was probably in the late nineties when the 'diversion' of this product—that is, criminal elements, if I can use that term, were buying or stealing the substance from retail pharmacies—became quite an issue. In early 2001, ASMI set up a special team or subcommittee to try and see how best the industry could support activities with other stakeholders to manage this diversion of pseudoephedrine into methamphetamine.

I will just go through some of the points that ASMI worked on. This was a whole-of-industry team. It was unusual for ASMI to allow nonmembers to participate in it, but we were trying to capture companies which were not members of ASMI. They participated quite freely in trying to get a whole-of-industry approach to this problem. The first step was to put in place a code of practice for how these products would be promoted and stored by manufacturers and then promoted within pharmacies.

The code of practice was authorised by the ACCC. The significant reason for doing that was to show that we were not being anticompetitive. Also, the ACCC has processes and clauses that it likes to see in these sorts of codes from a consumer protection point of view as much as anything else. The code was actively reviewed from time to time, particularly in 2004 when the New South Wales Poisons Advisory Committee came out with some recommendations on how these products should be stored within pharmacies. Those suggestions were basically that the drug should be either out of sight or out of reach of the consumer—although the scheduling did not change—and we supported those.

The code went into quite a few issues about security, because it is not only at the retail pharmacy level that these products can be diverted. As you can imagine, there are warehouses

around the country that contain either the active raw material for use in the manufacture of these products or the finished products for the manufacturers or the multiple wholesalers in the distribution chain. There are all those elements whereby pseudoephedrine can be obtained by the criminal elements of this country.

We also undertook an awareness campaign that cost the industry well over $50,000 to make in particular retail pharmacists aware of how these products should be stored and to limit their stockholdings. Clearly, one of the things that is attractive to the people who want to get hold of this stuff from a criminal point of view is when they see more stock sitting on the shelf. That is an open temptation. 'This pharmacy has got a lot,' and, therefore, it is a prime target for either pilfering or break and enter and all sorts of activities. We were trying to limit the amount that could be purchased from a company at any one time. Back in the dim Dark Ages, pharmacists were very used to stocking up for the cough and cold season—the winter buy in, as it was called—and pharmacists would typically buy in gross amounts, to use an old term, because they got a special deal. To have that lying around is not good practice from lots of points of view. So the manufacturers said, 'No, we won't do that anymore. We'll try and limit that.' How to manage that was also in the code of practice so that pharmacists could just order it more or less as required and have minimum stockholdings.

The other thing I would like to highlight is that ASMI from the very early days has been an active participant in what is called the national working group on the prevention and diversion of illicit chemicals, not only supporting particular activities to do with our area, pseudoephedrine substances, but being involved in other areas in which the committee has got involved. It could be tablet presses or glassware or all sorts of things. We have not missed a meeting. We have been there all the time and been supportive of the various subcommittees it has had from time to time. I think that group does some wonderful work, and it is a great opportunity for all the jurisdictions and all the stakeholders to really club together and try and tackle it from a wholesome type perspective rather than each group trying to do their own little thing. The Attorney-General's Department is to be congratulated for keeping that going and being very proactive with it.

I think it is appropriate to mention what has happened with some of the scheduling changes in terms of the size of the market for these products. Has that made any change? Yes, it has. Back, I think, in 2002 there was the single active agent. Not only could you buy it in combinations, but you could buy it as a single active agent—and the typical brand name would be something like Sudafed—in tablets of 30 milligrams and maybe 60 milligrams as well. That was scheduled to S3—pharmacist only, as the pharmacists prefer to call it. You had to physically ask the pharmacist for it and he had to physically hand it over to you. That was the law. So that did make quite a dent in sales of that particular product. So scheduling did have an impact at that point in time. However, I suppose it did push the criminal element then to seek the combination products and use those for their extraction to get the active ingredient.

Senator FERRIS—Do you have those figures for the changes in the sales following the change in the scheduling?

Dr Arblaster—That is a very good question. I do have a chart here which I am more than happy to leave with the committee. I am afraid I only have one copy. I printed it off this morning.

Senator FERRIS—I am sure that is no problem.

Dr Arblaster—I can table this copy or if you would prefer a colour version I can send that to you.

CHAIR—The committee will accept that as an exhibit.

Dr Arblaster—That is data from 2004. It is moderately robust data from an audit that was done of sales out of wholesalers into retail pharmacy. That is how it was undertaken. It was done by a group called Intercontinental Medical Statistics, or IMS. I would say it is probably 90 to 95 per cent accurate.

CHAIR—Why, given the fact that it has to be purchased from a pharmacist, would the sales drop off? Does that demonstrate that those who did not want to get it from the pharmacist were getting it for the wrong reasons?

Dr Arblaster—That is quite a possibility.

CHAIR—It would not worry legitimate users, would it, whether you pick it up off the shelf or go and ask the pharmacist for it? It might take you 30 seconds longer.

Dr Arblaster—Under the regulations, in some states when it went to S3 it went to S3R, which is S3 recordable. New South Wales was a case in point. So it was a little bit tedious for consumers. It feels a bit intimidating to have to give your name and address just for the sake of getting something you have always taken. It is okay if you have a relationship with that particular pharmacist. It did make it that much harder for the criminal element because not only do the criminal element purchase these products but they also physically steal them from the store. A lot of shoplifting goes on in this environment as well.

Mr WOOD—I know a lot of my local pharmacies put all those products behind the counter, simply to stop the shoplifting.

Dr Arblaster—Yes.

CHAIR—Shoplifting for the wrong reasons.

Dr Arblaster—Yes.

Senator FERRIS—It proves the point of the listing.

CHAIR—Yes.

Dr Arblaster—More recent data, which I must admit is anecdotal, received from some companies that are not as robust as that, shows that in the last 12 months the whole market has dropped 25 per cent and will drop even more due to the current scheduling that has taken place as of 1 January, when all products went to prescription only or to pharmacist only, or S3, status. What is happening now is that, with that change in scheduling, a lot of companies have said, 'We don't want to be in this market anymore and we're pulling out.' The product they might have had

was, shall we say, a relatively minor product for them. It might have had a turnover of something like $1 million in their hands but, from their point of view, it was a relatively minor product in the overall portfolio of products that they have.

CHAIR—I do not want to labour the point, but again you are saying that because of that people have stopped using what was obviously a very convenient product.

Senator FERRIS—Or abusing.

CHAIR—But surely the amount that was taken for the wrong reasons, compared to the amount taken for the right reasons, would have been infinitesimal? You are saying that that is not the case.

Dr Arblaster—No-one has any data on it. We wish we did. It is hard to put a true handle on it. Anything up to 50 per cent of the market might have been for illicit use.

CHAIR—Fifty per cent of the market?

Dr Arblaster—It could be. We do not know.

Mr WOOD—My background was in the police force. From dealing with pharmacies I found that the reason that they would put the product behind the counter was that if people shoplifted they would not just take one packet; they would take 10 or 15 packets at once. If they had 10 or 15 druggies coming in there a day, they had to hide it.

CHAIR—But as a percentage of total use that is still high.

Mr WOOD—It is huge.

Dr Arblaster—Unfortunately, it is quite significant.

Senator FERRIS—It is the quickest legal way to get it.

Dr Arblaster—Scheduling it and making it that much harder to get, even for legitimate consumers, means that people revert to other products that are a lot easier to get hold of just from a convenience point of view. So that will have an impact on the marketplace. I do not want to belabour the point too much on these market figures, because it is early days yet. We need to wait until the wash-out occurs of all the storage changes. As soon as a product goes S3, storage is required. Most pharmacies do not have huge storage areas for such classifications of products. Therefore, they are forced to reduce the number of packs or brands they might hold, as well as the quantity they hold, just because they physically do not have the room to store it.

Mr WOOD—What are the actual storage requirements?

Dr Arblaster—It is out of reach of the consumer—that is, well behind the counter. Some states may say it has to be in a dispensary. It could be visible to the consumer; it is not a necessary requirement that it has to be out of sight as well.

Mr KERR—One of the issues your submission raises—and I do not know the weight you put on this—is the shift away from pseudoephedrine as an effective product for the conditions for which it is legitimately utilised as it is being substituted for by products that are less effective in that regard. Presumably, that means there is some general reduction in overall population health, and to a degree that was what I was trying to ascertain from you. Is this having a significantly detrimental effect, or is it just a marginal thing that we should not be too concerned about?

Dr Arblaster—It is possibly unfortunate for some consumers. However, the fact of the matter is that it is still available for those who really need the more effective product. There will be some people who will take the substitute product, phenylephrine, which is now becoming more widely available. The reason why it was not more widely available until this point in time was that its level of efficacy was not as good as pseudoephedrine's. It might work in some consumers and, for those it does work in, it may work to a lesser extent. And then there are others in whom it has limited activity. I guess those people taking phenylephrine will be in a situation where they are feeling unpleasant symptoms for a longer period than they would otherwise.

Mr KERR—I just want to clarify that. You are not saying the production of efficacious products has ceased and that they are unavailable for those who require them, are you? We are not facing an unintended consequence of magnitude at this stage?

Dr Arblaster—No. For the true hardcore sufferer, if I can use that term, the product is still available. I think that is critical, to try to maintain a degree of availability for those consumers. People are not dying in the streets because they cannot get pseudoephedrine.

CHAIR—Doctor, have you finished with your opening statement?

Dr Arblaster—I have a couple of other points to make, if I may.

CHAIR—Yes. We have not started asking you questions yet; these are just little asides.

Dr Arblaster—There were a few issues I made in the submission that you will have noticed. One is about advertising. It is important to note, and I hope I spelt it out well there, that there is absolutely no evidence to suggest that advertising increases the size of the market. All it does is allow products to be brand switched, for consumers to say, 'I'll take Codral rather than Demazin,' or vice versa. That would be the purpose of advertising. It does not actually induce more people to say—the crooks already know where the stuff is. They do not have to be told. It is for allowing free competition within the marketplace, and it is important to maintain that, even though it is becoming a less important product to many manufacturers.

The other important issue I would like to comment upon is that there has been some significant rescheduling going on in the last few months, and we need to allow time for that to unfold and then reassess the situation before any further steps are put in place in terms of how these products are made available to consumers. My understanding is that the national working group has set up a separate group, or subcommittee within that group, to investigate that. I am just trying to track what is going on following those changes. I am part of that, along with others. It is important that that happens. No one activity such as rescheduling, for example, can necessarily be the whole answer to this. You need a complete package of activities to try to curb this unfortunate use of a very good substance.

Mr RICHARDSON—Doctor, in regard to your submission and Project STOP it has been interesting. Western Australian police claimed it, the Brisbane police claimed it yesterday and now the Pharmacy Guild is claiming it. However, it was done for all the right reasons—an electronic database for pseudoephedrine. Has that worked? What effect has it had? What effect will it have?

Dr Arblaster—I have to rely on data provided by the Pharmacy Guild to give this answer. That is where I get my information from—it is the data source. My understanding is that it was a pilot started in Queensland through the Queensland Pharmacy Guild up there. It has shown what appear to be quite dramatic effects already in that there have been well over 100 investigations or even apprehensions of people who have been trying to get hold of the product illicitly—not legitimately, but illicitly. It is forcing the criminal element to go to further lengths to try to obtain this product. They know the pharmacies involved in Project STOP and they have stopped going to them.

Mr RICHARDSON—How long has it been in operation now?

Dr Arblaster—Since, I think, November last year in Queensland. It has been rolling out into the other states more or less as we speak. It has been a remarkable tool both for the pharmacists, who know that there could be a potential criminal in their store who wants this, as well as, obviously, the police departments, enabling them to get onto those individuals quickly.

Mr RICHARDSON—The criminals have found the pseudoephedrine harder to get hold of. I know from my experience that they went to Rohypnol. What is the latest with that? They were going in and purchasing Rohypnol to get the same sorts of experiences.

Dr Arblaster—That I really don't want to comment upon. I would have thought, just from a pharmacological basis, Rohypnol is a sleeping product, not a waker upper.

Senator FERRIS—They have the same ingredients.

Mr RICHARDSON—This is what we are finding. I left the police force a couple of years ago now. Is that still occurring or have they gone on to something else? That is obviously the next concern. As you put safeguards in place, for those who have addictions or are trying to make money from them, what is the next logical progression?

Dr Arblaster—I think you would have to ask people more enlightened in that aspect than me, I am afraid.

Mr KERR—I guess I have no real concerns about the direction you have approached this from. I suppose the questions that are illuminated though are: if we increase attention on and limit the availability of precursors in this area, to what extent is this capable of being bypassed by the use of other chemical precursors? To what extent now has the industry of production of illicit drugs in a sense become malleable enough to overcome the removal of a particular precursor? There was some suggestion in your submissions that you can move from some precursors to others. The question I ask is: where to from here in the future, if we are pursuing this course of removing precursor chemicals?

Dr Arblaster—There are other substances that have been discussed at the national working group. One of them is sassafras oil, which is obviously used in cooking and other areas. It is a far more complicated chemical process to make it into an illicit substance. But one would suspect that, if pseudoephedrine sources dry up, the criminal element would be forced to move into substances such as that and maybe others that we do not know of yet. However, I think one should bear in mind that it is not just at retail pharmacies that pseudoephedrine is available. Customs does some good work in trying to prevent illegal imports of bulk, raw pseudoephedrine into this country. That is another source of pseudoephedrine, and we should not forget about that other aspect. From time to time, you hear reports of Customs picking up those substances, which are not being imported for legitimate areas.

Mr KERR—Are they readily available and in production in other countries?

Dr Arblaster—Yes.

Mr KERR—And they are not the subject of the same regulatory regimes we have?

Dr Arblaster—That is correct. Asian countries such as China and perhaps India would be international sources.

Senator FERRIS—I want to pursue something you raised in your submission, but first I want to clarify something. You have advertising companies as part of your membership. Does that mean advertising agencies?

Dr Arblaster—That is correct.

Senator FERRIS—You say in your submission there is no proven link between advertising and the illicit diversion market, yet surely the evidence you have given us this morning showing that perhaps 50 per cent of the market is illicit came as no surprise to you.

Dr Arblaster—No-one knew how big it was—

Senator FERRIS—So why would you make the statement that there is no proven link between advertising and illicit diversion when you have never checked it out?

Dr Arblaster—No-one has done the research, so you cannot say one way or the other.

Senator FERRIS—Why haven't you done that research?

Dr Arblaster—Because people have deemed that it may not be that critical to the outcome. The other thing is that the criminals, as I have pointed out, know where the stuff is.

CHAIR—They do not need to see it on television?

Dr Arblaster—Yes. They raid warehouses—

Senator FERRIS—I understand all of that, but in the responsible market that you are in—and you are clearly the spokesman for it—I would have thought it would be an extension of your

work to know. People are not having more coughs and colds—probably more of them are having flu vaccines—so there must have been some questions in your mind about why this market was expanding so rapidly. I am wondering why, given that you have advertising agencies as members, you would not have thought to do some work on it.

Dr Arblaster—If I can backtrack a second: the market has not expanded rapidly—though it depends on what time frame you look at.

Senator FERRIS—But, as Mr Wood has said, there are people out there stealing six boxes from a shop in one hit, and the shops have to replenish supplies.

Dr Arblaster—The market data going back a long time has been moderately stable. The growth in the market in terms of the volume of product being used—not necessarily the value, but the volume—would be three to five per cent a year, which is basically the normal population growth and nothing more than that. The issue of diversion has been going on more or less since the nineties. How one overlays what is diversion and what is legitimate use in that time is very tricky.

Senator FERRIS—Have you ever had conferences at which pharmacists have talked to each other about these products disappearing from their shops?

Dr Arblaster—We have had lots of discussions with the Pharmacy Guild and the Pharmaceutical Society of Australia on this issue. They, and not the industry, are the responsible bodies to determine that because they are the retail chain.

Senator FERRIS—I understand that. But you are all in the same basket and it puzzles me why, if you suddenly discovered that perhaps 50 per cent of the market for a product was disappearing because of illicit use—and you said up to 50 per cent—you did not pre-empt that with some research. Why can't you tell us that these responsible bodies have been looking at this issue over those years?

Dr Arblaster—You would never be able to determine, through sales data or through any other research data, what was or was not legitimate use.

Senator FERRIS—I do not want to labour the point, but I think you get my drift: if a pharmacist is losing six boxes a day from shoplifting and is having to buy more, surely it is not going to take him very long to work out that the issue is related to something other than a cough or a cold.

CHAIR—I know you have not done the research, but do you have a feel for how much is used by the crooks—(a) that they have just shoplifted or (b) that they have actually paid for across the counter?

Dr Arblaster—I have no idea. The police jurisdictions may be in a far better position to supply that answer.

Senator FERRIS—They may be, except that I would have thought on-the-ground evidence was quite interesting. As this has been so well known for so many years now, it surprises me that your agencies have not got together to talk about it.

Dr Arblaster—There is a certain degree of market research done about how much people would take under normal circumstances, for example, but not about the effect of advertising. The effect of advertising basically is a brand-switching exercise; it is nothing more than that. Data shows that you do not get enormous growth in such a stable market as the cough and cold market. The biggest determinant of the size of the cough and cold market is how severe the winter is.

Senator FERRIS—And the number of people who have had flu injections, presumably.

Dr Arblaster—Maybe.

Senator FERRIS—There are variables in that market.

Dr Arblaster—Flu is a different disease from a cold.

Senator FERRIS—It is just an interesting point. I think it is very clear that the advertising agencies who are members of your organisation could have a role to play here, and I wonder if you have ever consulted them on it.

Dr Arblaster—No, we have not in that sense.

Mr WOOD—I am not sure if there has been a campaign using the advertisers and the marketers to educate the pharmacies across Australia. From my experience, it is the pharmacies that realise they are getting hit and they take their own action. The simple action they are taking is more for economic reasons, particularly with a smaller pharmacy. I think that is where the advertising and marketing would be very effective.

Dr Arblaster—As mentioned in our submission, ASMI did run an awareness campaign. We know that it got to all pharmacists. We used a lot of devices to explain to them why they should put this substance out of reach. Your experience is one thing; my experience is another. I could walk into, say, three pharmacies on the Central Coast or all the pharmacies in North Sydney and find the stuff still out on the shelf, despite an education campaign and all sorts of activities undertaken by the guild to advise them that this is an issue that they should do something about. You could walk into those stores and freely pick it up. In one store on the Central Coast, I could walk through the front door, take a bagful of the stuff and be out before anyone knew.

CHAIR—You would think as an economic imperative they would want to have it behind the counter.

Dr Arblaster—We used tote bin flyers in the awareness campaign that we ran, and every pharmacist in the country would have received at least four flyers explaining what to do because of the problem. We gave them fridge magnets for police department numbers, counter cards, posters to put in store et cetera.

Senator FERRIS—What is the international experience with these sorts of medications? Are you able to tell us whether there are similar out-of-sight, out-of-reach arrangements in other countries? Do you liaise with other countries regarding their experiences?

Dr Arblaster—We do, to some extent, yes—I have answered that bit first. The United States has a significant problem and is only now just beginning to take these products out of reach and out of sight, to some extent.

Senator FERRIS—What about the European Community rules?

Dr Arblaster—The European Community does not seem to be as big a problem. In some parts of the European Community it has always been out of reach, anyway.

Senator LUDWIG—I suppose no-one has really belled the cat yet, but, if you have research that tells you that 50 per cent of the market is going to the illicit trade, has any work been done with the pharmacies themselves? People have spoken about theft from the stores but there is another way you can do it, as well. You can order the material in and divert it at the point of buying from the manufacturers and distributors. You represent the distributors, so what work have you done to ensure that the product is not being diverted to an illicit market?

Dr Arblaster—I will just go back to your first point. There is absolutely no research at the moment that shows how much is being diverted and how much is not, from the retail pharmacy side. There are a lot of guesstimates, and I was just trying to be constructive when I threw up the number of 50 per cent. We cannot hang our hats on it. It could be 25 per cent; I do not know. In terms of—if I understood your question correctly—other areas within the distribution channel—

Senator LUDWIG—There are a number of stages in the distribution channel. One of them is the retailer, but there are also wholesalers and distributors coming back so I do not want to pick on one particular group. We have been talking about theft from a store, but we do not know how significant that is and whether that is feeding the illicit drug market. Anecdotally, we say that it might be, but that is only one method. The other method is through the distribution chain itself. How secure is that distribution chain? That is an area which you can, and should, be responsible for, I imagine, because you represent both the manufacturers and the distributors in this market.

Dr Arblaster—There are pharmaceutical wholesalers such as Sigma, API and Symbion—being the three main ones—who will have this in multiple depots around the place. They are not part of ASMI as such because they run a different sort of business. We have had discussions with all of them and they are aware of the security issues. Some of them have taken steps to improve their security in this area and the tracking of bulk material before it gets manufactured or released for manufacture or finished goods ready to go to the retail sector. So they have had increased security. My understanding is that they consult the various police jurisdictions to assist them in making sure that that is undertaken appropriately. With our members, it was part of the code of practice that they had to tighten up on security. A lot of companies did that. However, there is an occasional break-in, because the criminals know it is there. Despite their best attempts, product can be stolen at that part of the chain.

Senator LUDWIG—Perhaps I am not making myself fundamentally clear. It is not only break-ins or theft; there are also people in the supply chain who divert it to the illegal market.

They over-order and they otherwise do not supply it to the end user, or maybe there is a bad chemist in the process who orders more than they need and diverts it into the illegal market. Has any work been done in that area? STOP is directed at one area, but is it also directed to the supply chain? Unless you have a secure supply chain you are really dealing only with one end of the market.

Dr Arblaster—The manufacturers in the part of the chain you are talking about have put in various security checks on their staff et cetera. Sure, there is the odd rotten apple in lots of industries and there has been some theft of product as a result of those elements, but by and large that is fairly minor. I think that goes to the point that the control mechanisms in place are fairly robust.

CHAIR—Thank you very much for your submission and your time. We appreciate that you are very busy, and your evidence has obviously been of great interest to the committee.

[10.01 am]

LAIDLAW, Detective Superintendent David, Commander, Drug Squad, New South Wales Police

WILLINGHAM, Detective Inspector Paul, Investigations Coordinator, Chemical Operations, Drug Squad, New South Wales Police

CHAIR—Welcome. Thank you for making your time available and for your submission. I think you would be aware that you are not required to answer any questions relating to policy matters and you are to be given the opportunity of referring questions like that to either the minister or a superior officer. You would be aware of the parliamentary privilege that attaches to your evidence today. I invite you to make an opening statement, and then the committee would be very interested to raise some questions with you.

Det. Supt Laidlaw—We will rely on our submission to you today and answer any questions that you feel should come from that. Paul Willingham is an authority within the state, nationally and internationally in relation to his knowledge of clandestine lab and precursor issues. He has represented a number of boards in all those areas and is highly regarded by a lot of other police forces around the world. Frank Hansen, who is the manager of the drug and alcohol coordination component of the drug squad, offers his apology for not being here today. He is currently representing the police force on a couple of national bodies over in Perth. However, he is willing to speak to you at a later date in another jurisdiction if you wish. We rely on our statement and would like to answer any questions.

CHAIR—I forgot to mention that on the committee's side there are a couple of former members of your profession. I will get Mr Wood to lead off with the questioning. He was formerly a Victorian policeman. He will be followed by Mr Richardson, who was a South Australian policeman. I will then throw you over to the former lawyers and journalists for them to get stuck into you.

Det. Supt Laidlaw—We get the friendly ones first!

Mr WOOD—What is the data exchange amongst law enforcement agencies with regard to the usage of drugs in seizures? One of the issues I have been closely looking at is the purchase of chemicals for terrorist type activity, but I have been told by members in the drug squad that there is actually a close association. Is there anything in place with the drug law enforcement agencies across the country?

Det. Insp. Willingham—With respect to precursors and domestic manufacture issues, there is a subgroup with extra support in each jurisdiction that focuses on clandestine laboratories. That is a very specialist area and, just by its specialist nature, it has created a family of like-minded investigators. The nature of many of these investigations is that they overlap borders. We frequently discuss issues on investigations. However, we come together annually and in a range of fora where we are able to report on state trends, on what we have seen and on what we are likely to see. Fora are coordinated by the Commonwealth Attorney-General's Department. There

are training initiatives. For example, last week there was a national safety training program coordinated by the National Institute of Forensic Science that brought together all of the clan lab chemists and key investigators from around the country for a week. They had the opportunity to listen to overseas experts and to share their stories and their trends. Data exchange, trend exchange and the giving of general information are fairly healthy.

Mr WOOD—What is the requirement in order to purchase chemicals from manufacturers? My background is in organised crime. The bikies would get false IDs or aliases and then purchase a number of chemicals. They would even set up companies which appeared to be legitimate. They would not even use photo ID. What is the set-up over here? I know you would have a very strong relationship with chemical manufacturers to give you the heads-up. One of the issues I have been pushing is that people need photo ID with some sort of biometric just to eliminate, as much as possible, people using fraudulent means to purchase drugs. I am not sure that you can comment on that, but if you can it would be appreciated.

Det. Insp. Willingham—Certainly the purchase of precursors and any of the other solvents and reagents that are used in drug manufacture became a concern to us in the early 1990s when drug manufacture first started to appear on the scene, with isolated labs. In 1994, the first code of conduct was established between the two peak bodies. There is the Plastics and Chemicals Industries Association, which is known as PACIA. In those days it was called the Scientific Suppliers Association. They represented the other scientific areas that looked after the glassware, pill presses and other equipment. So the chemical industry and the scientific industry were represented by two associations. We struck up a code that put three categories of chemicals in risk order and applied a reporting condition to some of the categories, and we applied end-user declarations. End-user declarations needed to be accompanied by photographic identification. It basically set up a whole reporting structure that was uniform across the country. But it was a voluntary code and, as with all voluntary codes in industry, it comes back to the police to support it, encourage it and provide feedback. These codes are not in the normal business of industry and, unless we are out there pushing it in some areas, the code dries up.

Mr WOOD—Just to follow up on that, if I went out tomorrow and obtained a fake drivers licence or whatever else, I could purchase chemicals? My greatest concern is that I could establish an alias. You have experience with all the labs that you have been busting. Have they actually been acquiring these chemicals? Have they done it with legitimate purchases or have they been stealing?

Det. Insp. Willingham—Some set up their own company as a front to divert chemicals. It depends on what substance you are after. For some substances you need more than a fake drivers licence; you need an account with a particular company and you need a business history. For other chemicals that are not as critical, you need photographic ID and an end-user declaration, which at least provides a trail of the purchase. Without that, we would be swamped with cash sales with absolutely no record of the purchase. But for all of the important chemicals known to us as direct precursors and reagents, there is some accountability and some record as to who purchased them and whether they used a company's details or a fake ID. There is still some trace.

Mr WOOD—That is obviously the last stage. After you have made the bust you can go and do your evidence track-down.

Det. Insp. Willingham—Yes, we can backtrack.

Mr WOOD—You find with bikies they normally send the new guy on the block to do all the dirty work, but you would probably already know he is connected to a bikie gang. What I am pushing for is an ID card where a person must have a fingerprint or biometric so we know who that person is. How much assistance would that be in drug detection before you get to the stage where you have the lab and they have gone out onto the street to sell the drugs?

Det. Insp. Willingham—If there were a perfect identification method, it would certainly make our job a heck of a lot easier. On a weekly basis we are assessing end-user declarations that are potentially suspicious. If they are a new customer, or if the combination of chemicals they have requested or their own industry knowledge is unusual—there are a lot of people out in the chemical industry who have a very good feeling for who is legitimate and who is not, and it is the same in the pharmacy industry. We basically encourage them to know their customers. Their gut feeling and their intuition is, quite often, gold. This whole code, which eventually led to various states picking it up in various forms of regulations as it developed, is bigger than a regulation; it is about the attitude of industry to go that step further.

Mr WOOD—Obviously law enforcement is doing a fantastic job with the amount of labs at the moment getting busted but at the same time it shows how many you must be missing—this is right across the country—simply because the chemical manufacturers are handing out more chemicals.

Det. Supt Laidlaw—That is true. We do not catch them all.

Mr WOOD—That is what I am saying. So even though the manufacturers are working very well with their code of practice, at the same time—as you stated before—any formal, bulletproof ID would greatly assist law enforcement agencies.

Det. Supt Laidlaw—We can only minimise the situation with regard to that. As Paul said about the ID, if we had one, as you are saying, it would work wonders—it would help us. But you would still find that the criminal element will endeavour to find a way around it, so we just have to try to be one step ahead if we can.

Mr RICHARDSON—Following a similar line: have the New South Wales Police been involved in Project STOP, the electronic recording of pseudoephedrine sales?

Det. Supt Laidlaw—Part of the code of practice that was set up with Paul is that we have a pseudo hotline at work that the pharmacists use to contact us when they have a suspicion about a sale or the like. With our liaison and our partnership with the industry, we were able to go that one step. Now, with Project STOP, this is obviously another leap forward for us.

Mr RICHARDSON—Can you share with the committee how many investigations you may have done over the last, say, six months, how many prosecutions and what are the penalties coming out as a result?

Det. Insp. Willingham—In New South Wales we presently do not have Project STOP up and running. It is still being trialled in Queensland. We were hoping to have it rolled out last month. I

think there has been a slight delay with our own state regulations—they need to be tweaked to fit in with Project STOP's ID requirement. At present in New South Wales the S3R has a recording provision, but it is not precise enough about the type of recording provision. The beauty of Project STOP is that it actually does something with the records.

At the moment our S3R system requires a pharmacist to keep the records, but what happens to those records? They are not in a position to be analysed or profiled. We are relying at the moment on a percentage of pharmacists that go above and beyond what they are asked to do and actually take the time to phone the drug squad or fax in a report on someone suspicious. Just a percentage of pharmacists are doing that, probably about 10 per cent. Last year we were able to process 63 possess precursor offences and from those I think there were about 58 that were the subject of pseudoephedrine running.

Mr RICHARDSON—Do you want to say something about the penalties that they get or about the penalties the clandestine lab cooks are getting?

Det. Insp. Willingham—Our state based legislation has a 'possess precursor with intent' clause. It seems to be working okay. Sometimes it is difficult to show the intent. It is inferred by the way the person has accumulated the tablets and has maybe used false IDs or has a list of pharmacies across the state and has done a massive pseudo run whereby they have thousands of tablets in the boot. Certainly the higher level ones are getting custodial sentences. In proportion, the actual cooks that we are locating in drug labs seem to be being dealt with appropriately. We are locking up a pseudo runner once a week, and this is after the rescheduling has kicked in from 1 January. There are still pseudo runners out there. There is still that diversion occurring but fortunately it is not in the numbers—we are not catching them with the thousands of tablets we were catching them with two or three years ago; it is the hundreds. The numbers are accumulating.

Mr RICHARDSON—I notice you say in your submission that the rescheduling has had some significant effect. This may be your own personal opinion or you may not like to comment—should it be minimum sentence instead of maximum sentence?

Det. Supt Laidlaw—As law enforcement officers we always say maximum because that is what the legislators have decided, so therefore we feel that that should be the sentence. Depending on whether there are contributing circumstances to lessen the sentence, they should get the maximum and then work their way off it. That is my own view.

CHAIR—What are pseudo runners?

Det. Insp. Willingham—It is a colloquial term for someone who will shop from pharmacy to pharmacy. Their business or their trade is to go to as many pharmacies as possible and purchase as many pseudoephedrine packets as possible.

CHAIR—Purchase rather than shoplift?

Det. Insp. Willingham—Purchase and/or steal—

Senator FERRIS—Acquire.

Det. Insp. Willingham—Acquire. The records that these individual pharmacists are keeping will quite often record the amount of products stolen from a pharmacy as well as purchased.

CHAIR—And you say you are jailing one a week?

Det. Insp. Willingham—Yes.

Det. Supt Laidlaw—As part of our notification process with the pharmacies, we might get a pseudo shopper out Bathurst way or even further beyond. The pharmacists let us know and we can then track him because the next pharmacist then contacts us. We can then send law enforcement in to do the appropriate arrest. It has been a very good project.

Senator LUDWIG—It seems that the statistics the committee has been given indicate a rise in the use of amphetamines and the like. Is that your experience as well?

Det. Supt Laidlaw—There certainly has been a rise. There was—I hate to use the term—a 'heroin drought'. To us it was not a heroin drought; it was just people not wanting to use it. They decided to go with the amphetamine type stimulants. There was a rise. From about 2000, it has been fairly consistent.

Unfortunately, I think that the demographics mean that you are getting younger people using it. Drug users are no longer down the lower end of the socioeconomic chain; they are more society sorts of people. Also, there are poly-drug users. Drug users often use a number of stimulants over a period of time to bring them up, take them back down and get them back to work on Monday morning.

Senator LUDWIG—The efforts by the police in New South Wales, Queensland and other states are obviously not dampening the supply of these drugs onto the market?

Det. Supt. Laidlaw—I think we are—

Senator LUDWIG—Or do you think you are making some progress, but it is an ever-increasing—

Det. Supt. Laidlaw—One would hope we are, but we can always do it better. How we set up our strategies would probably indicate that. We can always do our job better, no matter what field we are in. We are just looking for better ways to fight the fight, so to speak.

Senator LUDWIG—Are there any current impediments that you find stop you from being able to combat it in a realistic way? We can talk about sufficient police on the street, but in a more technical sense: is the legislation suitable for what you are meeting on the street? Are the means by which you police the street for this type of effort and the educational programs in place sufficient to assist you? There are a range of matters.

Mr WOOD—Are you also using the Commonwealth legislation that went through last year?

Det. Supt. Laidlaw—Yes, we are. We are part of the national ATS strategy—the law enforcement component of it—and the priority there is prevention. So if we are going to be able

to educate, then on a national level that is where our focus should be. If we can reduce demand by educating younger people—schoolchildren through to adolescents and young adults—then maybe we can start winning the fight. We make our own efforts in relation to law enforcement and supply; we just have to look at the prevention part of it. The legislation is there; it is a matter of it being used in the appropriate manner when it leaves our forum of law enforcement and goes to the judiciary. We feel the legislation is adequate. The continuing work that we have been doing with pharmaceutical, chemical and scientific glassware companies has been to work together to try to make illicit use more difficult.

Senator LUDWIG—Has there been an emphasis on terrorist related issues and counter-terrorism measures at the expense of the war on drugs?

Det. Supt. Laidlaw—No, as you said earlier, they go hand in hand. We have our own counter-terrorism unit within the New South Wales police force that works alongside us with that, so I do not see that because one is now the flavour of the month the other is diminishing. I think we are working very well hand in hand.

Det. Insp. Willingham—They each have separate reporting programs. The terrorism related incidents are reported to the national level, whereas at the moment drug precursor suspicious notifications are reported at the state level. Already there has been a lot of crossover and we are sharing information, so some suspicious activity is being reported to one level and another at another level. There has been a lot of joint investigation so far. If I could make one point about legislation: something in precursor control that we have been frustrated with is this code of practice that we were talking about before. Various states have picked up part of it over the years. It was a voluntary code in 1994. South Australia picked up part of it in 1996, Queensland picked up part of it in 2000, we picked up part of it in 2001 and Western Australia did so in 2004. So whenever each jurisdiction has picked it up, it has picked up that list at that particular time. The problem is that this list is growing and evolving, and it is being reviewed each year. We do not have an effective way for all jurisdictions to keep the list up to date.

Senator LUDWIG—An effective precursor list is something the federal government could in fact do, coordinated on behalf of all of the states and ensuring that there is model legislation. It is something that Model Criminal Code officers could also do.

Det. Insp. Willingham—I think we are working towards that. The Commonwealth Attorney-General's Department have set up an expert scheduling working group. Part of their terms of reference is to review that list. There will be a mechanism that involves consultation with industry and that involves looking at the impact of any new substances. It should be a model that the states can draw from. There are a lot of dedicated individuals in every state, but some of the lists of the states are way out of date. It would be nice to—

Mr WOOD—What information is essentially on the list? Is it just names of people?

Det. Insp. Willingham—I am sorry?

Mr WOOD—The code of practice.

Det. Insp. Willingham—It is a list of compounds and equipment. At the moment it has three categories. The first category consists of precursors and substances that are very close to the actual drug itself. The second category is critical reagents and other chemicals that have a very high black market value. They are the two lists that have been picked up in regulations in one way or another across most of the states.

Mr WOOD—But also you could incorporate the two. I know that in Victoria the legislation has gone through high-consequence dangerous goods and chemicals, but it had a number of chemicals which would be used for drug trafficking. Victoria had this list. If you had that legislation across the whole country incorporated into the code of practice, would that make your job easier?

Det. Supt Laidlaw—Yes. We work together, cross-border. That is another issue. As we were saying, the criminals go across borders, so if we had generic legislation across states it would make our lives as investigators a lot easier because there would not be any of this wondering about which list a substance belonged to.

CHAIR—That is coming through very clearly from our inquiries.

Senator FERRIS—I believe you gentlemen were sitting here when we heard evidence from the previous witness who talked about how, despite the S3 and S4 changes, some pharmacies are not complying. Would you ever consider having a policeman on the beat calling into a pharmacy just to check on whether or not that is being done, or is that going too far done the chain?

Det. Insp. Willingham—It is something we grappled with last year actually, because more and more we are asking pharmacists to act like police officers, and as police officers we are expected to take on the role of a pharmacist. Our pharmacists are an industry partner who are providing us with 1,200 intelligence reports a year that are helping us lock up a pseudo runner once a week. Yet to get the point across last year that some members of their profession were greedy and were probably not managing these high-risk products safely enough, we had to take the extraordinary step of breaching pharmacists ourselves under the Poisons and Therapeutic Goods Regulation, which we did not want to do. But I think it took that level of action to send the message to pharmacists that law enforcement as well as the health department will check on them, because the diversion was becoming such an important issue.

Senator FERRIS—During evidence that we heard in Queensland yesterday, I asked a question about complementary legislation and was assured that, for example, police at Tweed Heads in New South Wales can work in Queensland and police at Coolangatta in Queensland can work in New South Wales. Detective Superintendent Laidlaw, you mentioned a moment ago that there was more that could be done in that area. Do you have some specific examples of where, despite the best efforts, it is still falling short?

Det. Supt Laidlaw—Not really. We have legislation in relation to controlled operations. That is where we use either an undercover operative or a civilian participant who will purchase illicit drugs from the supplier. I suppose our sister state is the ACT. It does not have the same legislation, so there are difficulties around Queanbeyan and in the Monaro area. We had an investigation in that area where we had to rely upon New South Wales legislation and had to try

to drag the criminal out to Queanbeyan so that they would conduct the purchases there. Those sorts of issues of trying to work together with different legislation come into play.

Senator FERRIS—I am sure that is something we will take up. I am gratified to hear you are picking one of these people up every week, but, when looking at yesterday's evidence from Queensland, two graphs that were presented to us intrigued me. I have them here. They both reflect a similar principle—indicated by these two lines—and show that a person's use of amphetamines consistently takes place at a friend's house, which is by far the most frequent source of first supply and repeated supply. Also, it is demonstrated that the source of a person's first and current use of ecstasy is a friend. These are Queensland statistics; are you able to tell me whether you have similar statistics? Also, does this make it more difficult for you? This is less of a dealer-client industry than, say, heroin or even cocaine are. With this the next-door neighbour can have a production plant in the back shed, for example. Can you reflect on some of the statistical information from a New South Wales point of view?

Det. Supt Laidlaw—BOCSAR would be the best avenue for those statistics, but the statistics are a concern to us in law enforcement because MDMA users will go and drop a pill at their own house before they go out to party, so there is a problem for law enforcement in detecting users.

Mr WOOD—Are you referring to MDMA?

Det. Supt Laidlaw—I was an NDLERF board member. Part of the problem we were having—with names like 'Party Drugs Initiative', 'recreational drugs' and 'ecstasy'—was that we are driving towards not calling them that but rather calling them what they are: it is 'MDMA' and it is 'heroin'; we prefer not to call them ecstasy and smack. As law enforcers we are trying to educate the public. It is not ecstasy—it is not good for you; it is actually harmful. So we call it MDMA in all of the work that we undertake. It better educates our police, especially within New South Wales but also nationally. I think you will have found in other hearings that they have often been referring to ecstasy as MDMA.

Mr WOOD—How much do you think the media is to blame in calling it a party drug every time?

CHAIR—Or recreational drug.

Det. Supt Laidlaw—Only yesterday there was the Wendell Sailor incident, and they are calling them recreational drugs. When we talk to our media, we refer to it as MDMA. You will see sometimes that, in some of the captions in newspapers that we have, they will call it MDMA and put in brackets 'ecstasy'. We are trying to work towards that. I suppose the media are there to sensationalise; they are there to sell papers, to be quite honest.

Senator FERRIS—This is a street lingo, so, to be fair to them, I think it can be understood. I am the journalist, not the lawyer! But, to be fair, I think people do refer to things by acceptable colloquialisms. The other piece of information that absolutely staggered me yesterday was from a law professor, who told us that, in discussing this with his students in a university class, most of them had no idea that these drugs were illegal. They admitted to having tried them without realising that what they were actually doing was committing an unlawful act that, as young law students, could affect their futures. Is it a problem for police that young people using these

drugs—and I notice that the age group with the heaviest pattern of use is under 25—do not realise that these do have the same status as heroin, cocaine or some of the other well-known illegal drugs? Can you explain to us the difficulty for you in that?

Det. Supt Laidlaw—As I explained to Senator Ludwig when discussing drug use in that age demographic, we as law enforcement, together with other agencies such as Health, have to educate these people. As you said, they had no idea, so therefore they have not been educated appropriately. That is where we have to drive strategies to educate these people to let them know that it is illicit and unlawful—and, not only that, it is harmful. We are driving towards that era.

Senator FERRIS—Again, is that the harmful thing? Those people who saw the *Four Corners* program a couple of weeks ago could not fail to have been terrified by the extent to which some of these people will go to continue to use these drugs. It was very clear to me that they had no idea the damage they were doing in some of those cases. Have you got any education programs that you can direct us to, perhaps here or internationally, that you think have been successful—perhaps from international conferences you might have had representatives at?

Det. Supt. Laidlaw—We have a number of diversion programs, like the Cannabis Cautioning Scheme and MERIT, the Magistrates Early Referral into Treatment scheme—those sorts of programs. The Young Offenders Act—

Senator FERRIS—They are all getting them after they have done it. What about beforehand?

Det. Supt. Laidlaw—But there you are educating your peers. These young people who are getting into trouble can then go to their mates and colleagues to say, 'This is what happened to me. Don't let it happen to you.' We have to start somewhere. We can start either at the school level by going into perhaps the senior primary schools starting at year 6 and then filtering through to the high school area to adolescents. We all know that 14- to 16- to 18-year-olds are all 10 feet tall and bulletproof! We have got to try to educate them as well. It is a number of steps that we have to do.

Senator FERRIS—If you do come across anything that is international and has been seen to be successful—for example, there was a Drugs Are Dumb campaign that I had some connection with some years ago. I do not know whether it is still going. It was being run in Sweden. I just wondered if you had come across any successes.

The other evidence that I would like you to reflect on that we got yesterday was from a pill-testing agency. We have had this evidence also in South Australia, where individuals—doctors and volunteers—will go to dance parties, rave parties or whatever and offer to do a pharmacological analysis of a tablet for a person who may be considering using it.

CHAIR—Who has bought it to use.

Senator FERRIS—Just a moment, Chair, I was just going to say that I emphasise that they do not say this tablet is safe to use. They do an analysis and tell the person, 'These are the ingredients in this tablet.' They are not condoning the use of it. I emphasise that.

Mr WOOD—They were used at underage raves—

CHAIR—Hang on, they said 'very rarely'.

Senator FERRIS—Perhaps I can finish my question. I just want you to reflect on that and I ask: are you aware if it is happening here in New South Wales, in Sydney, and what is the legal status of it here? These people admitted to us yesterday that they are activists and they are aware that they are in fact breaking the law, but they have not been charged or even arrested for it. Could you take us through what New South Wales Police's policy is on this? Have you come across it, have you done anything about it and have you got a personal view on it?

Det. Insp. Willingham—We do not actually have a specific policy on it or a set of guidelines that we have instituted, say, around supervised injecting rooms. There is a legal opinion that someone using a pill-testing kit like that could fall into areas of aiding and abetting and other offences.

Senator FERRIS—That was the view of the Queensland Police.

Det. Insp. Willingham—Whether we would actually proceed with that is another thing. However, as an organisation we are very reluctant to support any initiative like that, knowing the capabilities of these simple tests. They are based on marquis reagents—very simple indicators. They have false positives and false negatives. They are very limited in the information they can provide, in our eyes, as far as just picking up an active ingredient. They are unable to determine purity or identify any other admixtures. There is a real fear of a false sense of security there. It is limited by such a simple test. It seems inappropriate that something like that could send the wrong message.

There are a range of concoctions in our tablets here, with our own operators and the flood of pill presses that are coming into the country—which is another issue we would love to talk about. There are a lot of tableting operations that involve imported tablets that are recrushed, reblended and bulked up with other admixtures. MDMA is manufactured from scratch here. MDA is manufactured from scratch here. There are other tablets that are methylamphetamine based, with caffeine, ketamine and other admixtures. So we have a whole range of things in our tablets, and these very simple pill-testing kits are really only good at giving a guide as to one of the active ingredients. I do not—

CHAIR—Their argument, though, is that the kids have bought them, paid big money for them, and that they are coming there to take them. Even if the tests are relatively inexpensive and perhaps not fully accurate, they will save a few from further harm. That is their argument.

Det. Supt Laidlaw—To save their lives, I think $30 that they have lost buying a pill is beneficial to them. That is why we cannot condone it.

Senator FERRIS—Are you aware of these operatives in New South Wales and in particular in Sydney?

Det. Supt Laidlaw—Not that I know of.

CHAIR—Well, they are not operatives; these are well-meaning volunteers.

Senator FERRIS—Chair, could I just ask my questions—

CHAIR—Yes. Well, you have got to—

Senator FERRIS—without you putting your spin on them?

CHAIR—You have got to put—

Senator FERRIS—Can you just answer my question? They are operatives. They are activists. They self-identified as being activists who are about changing the law within 10 years. The *Hansard* record will show that. So can I go back to my question: are you aware of them operating in Sydney?

Det. Insp. Willingham—They do not have a high profile in Sydney. We would assume that some are out there on some occasions. They are being targeted, but they certainly do not have a high profile and they are not applying to become licensed or registered or seeking some sort of discretion guidelines.

Senator FERRIS—Well, they couldn't, because it is an illegal activity, because these things could be, for example, an exhibit in a subsequent event that might happen. If you were aware of them going to an underage dance party, for example, would the New South Wales Police be interested in that? Would the drug squad be interested in that? Would they attend on that basis?

Det. Supt Laidlaw—We deem it as being an unlawful act. Therefore we would have to react as part of the organisation's need to quell drug supply and drug use. So we would react and act accordingly. As we said, we do have the discretion to charge. We may avail ourselves of that discretion or we may not.

Senator FERRIS—I see that we are almost out of time. I have one last question. Why do you think we lead the world in drugs of this type?

Det. Insp. Willingham—In consumption or availability?

Senator FERRIS—Yes.

Det. Supt Laidlaw—That is a bit of a hard one. I suppose our remoteness—

Senator FERRIS—Is it brought about by the heroin drought, for example? Or is it brought about by the lower cost or the easier availability? I just wonder if you, as people who are working in this field every day, have a view on why it is that we have suddenly got such a huge increase in the consumption of these chemical based drugs of this type.

Det. Insp. Willingham—It is not cost. The costs here are actually higher than for the European user, so that is why we are an attractive market to send this commodity to. But we are influenced by not only European markets but American markets, so we are a unique situation where, even though we are geographically isolated, we have the rest of the world influencing us. Unfortunately, with the promotion of recreational drugs, party drugs and things like that, I think

we have developed a culture of acceptance of these types of harmful, destructive substances. So it is not an easy one to answer.

CHAIR—Mr Kerr has a few questions, and then I—

Senator FERRIS—I was just going to ask: is Detective Superintendent Laidlaw able to add anything to that?

Det. Supt Laidlaw—No, I agree with what Paul has said. We are in such isolation from the rest of the world, and we are a big nation, so across the board there is quite a populace here that is using them. That is because, as Paul said, the market is there. As educators, we must educate them about the party drugs, the recreational drugs. With not only ecstasy but fantasy and all those sorts of names, we have to start drilling down to say, 'Well, it is not attractive.' That is probably one way we can do it.

CHAIR—Mr Kerr has a few questions and I have a few questions. But before we get right off the subject, I am surprised that you have not heard of these pill testers. They are not in my view 'operatives'. They are very well-meaning people out there trying to save some lives. They are very public in Adelaide, Queensland, in the ACT, I think—they are called Enlighten Harm Reduction—and Western Australia too. They are not in it for personal gain or anything like that, and they class themselves as being part of the education process. I wonder: if you did arrest one of these well-meaning volunteers, with your experience of New South Wales juries could you hazard a guess about how a jury might react? I think you would be struggling to get a conviction before a jury. I am not sure it would be a jury offence, but—

Det. Supt Laidlaw—It all depends on how the prosecution puts the case, really, and how they address that, rather than guess or pick what 12 good, tried and tested men and women may say—and they may be of the view, 'Well, it is bad, so we will convict.' But, as with all of our trials, it is hard to pick a jury and which way they are going to jump.

CHAIR—I am well aware of that. Mr Kerr, our senior counsel!

Mr KERR—I suppose the great Australian public jury is out there—at least, a large percentage of them—using amphetamines, because that is what our statistics show increasingly, notwithstanding law enforcement. One issue that picks up on Project STOP is that each law enforcement initiative we take tends to have a displacement effect, and we have to anticipate that and plan for it. This is a large market where, as you point out, the price for the product is greater in this country than it is overseas, and we have to think about the logical consequence of closing the door on the mom and pop operators—the language used in Queensland yesterday. We know that there is already an effective trafficking route for ecstasy from overseas, and some amphetamines, but at the moment the majority is home cooked.

My prediction is that we would move from having a domestic, small-scale, mini-lab type production to a much higher, more sophisticated and integrated international operation. That is the sort of prediction you could make. Therefore, my question is: to what extent have we anticipated that and built in arrangements for Customs, the AFP and state law enforcement? The activities that you used to undertake—that is, busting these little labs—will now have no significance in terms of the market; the drugs will be coming in from overseas through an

operation with a different level of sophistication and perhaps even a different distribution system.

Det. Supt Laidlaw—With Project STOP we anticipate that, and we are looking at strategies in relation to pharmaceutical companies, where robberies, break and enters or the like may occur. We are educating pharmaceutical companies to address those security issues. But we look to Customs to stop the imported stuff coming in, because once it hits the border it then becomes our problem. As for what steps they are taking, I could not answer.

Mr KERR—But you do understand the point I am making?

Det. Supt Laidlaw—Absolutely. Yes.

Mr KERR—If state law enforcement is effective in knocking over the domestic production of amphetamines—and there are established routes and market opportunities—then in a sense it is cost-shifting across to federal law enforcement. I am just wondering what arrangements have been put in place, because the strategy may be very successful in terms of removing that section of the economic industry but may immensely benefit international organised crime as an unintended consequence.

Det. Insp. Willingham—Your prediction as far as the shift in manufacturing activities is exactly what we are aiming for: to take out these small mum and dad, small-level manufacturing operations. Drug manufacture went down to such a low level and proliferated because it required such a low skill base and all of the ingredients were available from the pharmacy, from the hardware store and the pool shop, with maybe the odd bit of glassware from a glass supplier. The labs were becoming so small that they were becoming almost impossible to investigate. They were small and moving all the time. Something like Project STOP, which may manage pseudoephedrine diversion, will still have a displacement effect sideways into other areas of drug manufacture that do not start off with pseudoephedrine. I believe we will still have a domestic manufacturing issue here, but it will go back to P2P style cooks and other—

Mr KERR—It is years since I was at university doing the sex, drugs and rock and roll that was fashionable in my time!

Det. Insp. Willingham—It will go back to other methods of drug manufacture that do not use pseudoephedrine. It will start it off with ingredients such as phenylacetic acid and phenyl-2-propanone. These are longer and more time-consuming ways to make speed, but they are still out there and still available. Without stealing Customs' thunder, they are in the middle of drawing expertise from all the states and territories that have been doing precursor control and busting the labs. They are in the middle of a fairly large campaign to train their own intelligence officers and investigators in precursor identification, indicators and suspicious combinations. They are also taking that a step further and taking it offshore. They did training last year in Jakarta, Indonesia. They have plans for further training programs in August this year in the Philippines and our other Asian neighbours. I guess that is our future threat, and we need to transfer some of our successful industry controls and apply those overseas. That is where the future sources are likely to be.

Mr KERR—The submission that the Crime Commission put in mentions the home production of drugs in New South Wales and talks about 58 clandestine laboratories. It mentioned that 46 were producing speed and that six were producing ecstasy. That leaves a few that must have been producing something else. What else is being produced in home cook-ups that would be relevant to our inquiry?

Det. Insp. Willingham—We get odd manufacture methods. There was one that was making methcathinone. Methcathinone is another pathway to making a drug called Cat, which can then be converted to ephedrine which can then be converted to amphetamine. Different psychostimulants and some unusual scheduled substances are created from time to time. There is a lot of literature from overseas that devotes a lot of time to tryptamines and phenylethylamines, which are other psychotropic compounds that are not mainstream drugs.

Mr KERR—Coming back to the general question about education and early intervention, one of the things that troubles me personally about this debate is that we have heard evidence—I think it was from the Queensland police but it may have been from the Crime Commission; I am not certain—that what we really need to do is be more effective in demonising the effect of illicit drugs. There have been comments from members of the committee that the press plays a role in not doing that or not doing that sufficiently.

One thing that troubles me is that this debate is conducted as if the smart course is either to demonise something or to glorify it. It troubles me because it seems that there are very real harms associated with most patterns of drug use, including tobacco and alcohol. It is a bit like crying wolf. If we keep shouting out about how bad these drugs are, and kids know that many of their peers are using them without apparent effect, when something really bad comes along that actually does snuff out young lives or fry people's brains then they are not going to listen because we have demonised this stuff, and they are out there doing something else entirely different. That worries me, particularly as the report you have mentioned says that two-thirds of amphetamine use in New South Wales is now geared up to ice or base. Again, I do not want to demonise it, but my understanding is that it represents a significant increase in the prospects of psychotic episodes and, indeed, threats to law enforcement and to others because of the violence and the like associated with it.

I wonder whether you would comment on this. I do not know whether ice—crystal meth—is home cook-up stuff or whether it is coming in from overseas. I am wondering about cold-blooded factual stuff—not something that people will think about as just a group of adults telling them, 'Don't do this stuff,' which they will dismiss, but rather something that is blunt enough to get through and be believable. That is a very long introduction to a question that probably has no simple answer, but it does trouble me the way we discuss these drugs. It particularly troubles me in the eye of the storm that I see as likely to be looming with no effective treatment protocols for people who are adversely affected by ice or base.

Det. Supt Laidlaw—It is about education. We spoke earlier about having a user with these mental illness or psychosis symptoms making the presentation to their peers and saying, 'This is what it's done to me.' It is not some adult telling them, 'This is bad for you,' like a parent telling a child; it is more on that base, and that is where we may have to go to really get the message across. It would be demonising it on an appropriate level, I think, as opposed to being like a parent telling a child.

Det. Insp. Willingham—We certainly risk losing credibility if we overstate the harms but, in teaching or spreading the information to our industry partners, one of the most effective ways to reinforce that message is to focus on the destructive nature of the drugs and show the case studies of the change in physical appearance of drug users, show the actual evidence of the portions of the brain that are being affected with long-term use and show the harms—that appeals to the mums and dads—of the industry. It is an important part of our message, but it has to be balanced and we have to keep our credibility and not overstate it. But now, unfortunately, we are pitching to a market that is taking a more potent form of methylamphetamine than it has been used to taking—a substance of three, five or 10 per cent purity as opposed to 70 or 80 per cent purity.

Mr KERR—Crystal meth?

Det. Insp. Willingham—Ice, yes.

Mr KERR—Is that being made in Australia? Is that a home cook-up or is that an import?

Det. Insp. Willingham—There is a growing proportion of it being produced here. When it first hit the streets it was exclusively imported. Our domestic manufacturers are now seeing that they have to compete with the imported product, and there are more and more labs that are going to that final purification process and converting their base or paste to ice.

Mr KERR—I know this should not be reassuring but in some ways it is, because one of my concerns about the displacement effect was that, if home manufacture has not yet moved into the ice and base market and we then substitute for imports, you actually bring in a flood of this stuff. But you are suggesting that it already has some displacement into the domestic manufacture.

Det. Insp. Willingham—Certainly.

CHAIR—Mr Kerr's point about demonising was emphasised on Triple J, which ran a 60-minute segment, for us almost. It had about 30 kids ringing in very quickly last Friday week. That was the message that came through, that the advertising is saying, 'This is terrible stuff,' and yet they see their friends doing it every Saturday and their friends are fine on Sunday, so they are just not believing it.

You mentioned in your submission that the Crime Commission seizure of criminal assets is quite considerable and actually provides an avenue to partially fund covert police activities. How significant is that source of revenue?

Det. Supt Laidlaw—It is quite significant. The seizure value is quite substantial for the criminal element because they are losing all their assets they have gained from their illicit act. As to the amount of funding that goes towards policing, that is up to the government to decide because it goes into revenue and then gets distributed from there.

CHAIR—Your submission actually said that it partially funds covert policing.

Det. Supt Laidlaw—They do in relation to when we utilise the Crime Commission for covert surveillance initiatives such as telephone interception, listening devices and that sort of thing and for purchasing equipment so that we can conduct those sorts of investigations.

CHAIR—I appreciate it stops their revenue-making capacity. You seize the proceeds of crime as well as a result of these drug investigations.

Det. Insp. Willingham—It is an indirect source. We have a cost-sharing arrangement with some investigations with bodies like the New South Wales Crime Commission that are indirectly funded from these asset confiscations. There are other pools of funds that are available if the criteria of the investigation fit that.

CHAIR—Are the actual dollar amounts publicly available somewhere or are they kept secret for all the right reasons?

Det. Supt Laidlaw—Hopefully they are kept secret, but I do not know. You will have to speak to the Crime Commission.

CHAIR—I thought you were inviting a question on pill presses and what could be done about them. Not quite knowing what question you wanted, I will make it a general question. Can you give us your thoughts on pill presses and how we can do something about them?

Det. Insp. Willingham—As we stand at the moment, somebody—a facilitator or an individual—can order a tablet press or a pill press and bring it into the country and literally sell it in the *Trading Post* or on eBay to individuals who have no legitimate use for it. The subject of pill presses and these tableting machines is being evaluated by a research group at the moment. We believe there needs to be a level of Commonwealth control over them, say, a simple licensing regime—

CHAIR—So there is no restriction on them at all?

Det. Supt Laidlaw—No.

Det. Insp. Willingham—administered by the Therapeutic Goods Administration. That needs to be in company with a state based offence that would have possession an offence without lawful excuse, so there would be some reverse onus. At the moment there is no offence to bring in a pill press—

CHAIR—Who would be lawfully using a pill press? Pfizer, I guess, have a huge manufacturing pill press for their legitimate activities. Who would legitimately use a tiny press? We heard some evidence that they were actually cooking up in the boot of a car, so it was a mobile operation.

Det. Insp. Willingham—Apart from the pharmaceutical industry—

CHAIR—They would not use little presses you buy on eBay.

Det. Insp. Willingham—and the R&D sections of that industry, the herbal and nutrition industries use these tableting operations, but they are only a small part of the market. For the amount of presses that we have tracked coming into the country via Customs—

CHAIR—There is nothing you can do about that per se.

Det. Supt Laidlaw—At the moment.

Det. Insp. Willingham—So we are very anxious to establish some sort of licensing system that could work in with the states to basically verify the legitimacy of a person wanting to bring in a pill press and then to have some other state based offence.

CHAIR—It is obviously something that should be done at a national level.

Mr RICHARDSON—With the states.

Det. Insp. Willingham—Moves are afoot. However, we are held up with research, evaluation and industry consultation.

CHAIR—Is this just New South Wales or nationally as well?

Det. Insp. Willingham—Nationally.

CHAIR—What we can do is perhaps push that along a bit faster.

Det. Supt Laidlaw—Yes, please.

Mr WOOD—Thank you very much. Your evidence has been excellent. I thank you both for that, for sharing your knowledge. One thing that concerns me is this. My background is that I was a sergeant at the Melbourne East police station. At the time it was the second-busiest station in the state, but we actually processed the highest number of drug users and heroin users. I think in 12 months we processed over 1,000 mainly heroin users. Nearly everything was heroin. We had the trainees coming through the Melbourne East police station. It was a training ground. What they would tell us is, 'You guys are completely missing all the nightclubs with the ecstasy tablets and whatever else.' The problem was that we could not actually put an operation of senior, experienced police in there, because we would stand out.

Mr KERR—I don't know why!

Mr WOOD—I can dress up a tiny bit!

Senator FERRIS—I think this would be the problem!

Mr KERR—I can't believe that, Jason. Being bald is very fashionable these days!

Mr WOOD—I think it is my police look which probably would give me away. That was the concern we had. If we look at the figures, and even if these figures are half close, they show that

the usage level in Australia for these types of drugs is absolutely astronomical. I know that at the high level you are hitting them hard. My suggestion was to use trainees coming out of the academy. The Queensland police in their submission yesterday said that is what they actually do but that it was more planned operations, whereas to me there need to be ongoing operations every Friday night. That is the problem. You have these young guys in the nightclubs and the rave parties with no police actually making physical arrests so that people actually see it. Is this actually occurring in New South Wales? Rather than planned operations, is this just part of your normal, routine, covert work?

Det. Supt Laidlaw—As part of the drug response, we have a number of tiers. We at the drug squad concentrate on the upper echelon to the mid-level drug. The regions and the local area commands concentrate on the street- to the mid-level drug. We have set up initiatives through a mid-level drug response paper that was put through to our deputy commissioner, where local area commands and regions get dedicated drug units. That is where we see the problem with a lot of associated crime. A lot of the local area commands and regions are addressing that. They are going out and going to these parties, whether or not through a planned operation. One would hope it would be planned to some degree. They go in there utilising both street undercover operatives and dedicated undercover operatives, which are a little bit different. We have different levels of expertise in that area. The undercover branch utilises people who are towards the upper echelon, whereas even some members within other parts of our organisation are taken off the streets from their normal work and put into an undercover position. They go into that street level buyer to look at that market.

Mr WOOD—What I meant was would you only react, as suggested yesterday, on the specific information of an individual who is always there, rather than routinely go in there blind to see what you actually come up with?

Det. Supt Laidlaw—That is intelligence gathering too, I suppose, to that degree. Our resources are not infinite. We would not utilise our resources where there might be something there. We would have to have that intelligence to go in to have a look to see where there is something.

Mr WOOD—Thank you.

CHAIR—You have been very generous with your time and your information and advice. Obviously, we could have gone for another two or three hours. We do not want to repay your generosity by getting you into trouble, because we are meeting with the commissioner privately in half an hour's time. We are going to blame you for being late!

Det. Supt Laidlaw—I will be ringing in first!

CHAIR—We do not want to make that worse than it is. Thank you very much for what you have done. It has been very useful to us. All the best with your ongoing fight against a real problem.

Det. Insp. Willingham—Thank you. All the best with yours as well.

[11.14 am]

DEGENHARDT, Dr Louisa, Senior Lecturer, National Drug and Alcohol Research Centre, University of New South Wales

MATTICK, Professor Richard Phillip, Director, National Drug and Alcohol Research Centre, University of New South Wales

McKETIN, Dr Rebecca, Research Fellow, National Drug and Alcohol Research Centre, University of New South Wales

CHAIR—Welcome. Thank you very much for coming along. I should not make judgments but I am told that the National Drug and Alcohol Research Centre is one of the premier research organisations in this country. You are aware of the terms of reference, and I think you are aware of the privilege that attaches to your evidence. I now invite you to make an opening statement.

Prof. Mattick—Our centre was set up to improve the treatment response to drugs and alcohol in Australia, and that is our main mandate. We also cover a range of other activities, including drug trends. If necessary, I will hand over to Dr Degenhardt in a few minutes to talk about drug trends through our illicit drug reporting system and also the Party Drugs Initiative, as it has been called. We analyse data from the Australian Institute of Health and Welfare and report on that data nationally. In addition, Dr McKetin has been responsible for estimating over the recent past the number of dependent amphetamine and methadone users in Australia. She has also prepared a methylamphetamine market report, which was funded by the National Drug Law Enforcement Research Fund. I presume you have access to that report. She is currently running a study looking at a cohort of dependent methylamphetamine users who are seeking or receiving treatment.

In addition to that, the centre has had a longstanding interest in treatment responses. As I said at the beginning, our role is to look at improving the quality of treatment responses for alcohol and other drugs. We did the first trials of amphetamine substitution for amphetamine dependants internationally and we have an interest in using other pharmacotherapies, including a wakening agent called modafanil—registered in Australia for a number of purposes—as a substitution for people who are dependent on psychostimulants.

The centre has about 70 different people; you are seeing only a small number of them here today. We have a large range of activities. To answer your questions I have brought with me two people who have extensive expertise in drug trends. Dr McKetin also has a very strong knowledge of the Sydney and New South Wales markets and trends. That is broadly our background. As neither of my colleagues wants to add to my remarks, we are now open to questions.

CHAIR—Professor Mattick, I am not sure how long you have been here.

Prof. Mattick—A few minutes.

CHAIR—I was going to say that if there was anything you heard us asking earlier that you thought needed a different perspective on it you should feel free to challenge us or challenge other witnesses. If you happen to have read any of the transcripts and you think there are inaccuracies or clarifications, please do not hesitate to use this opportunity to comment. We will now proceed to questions.

Mr KERR—The submission from New South Wales Police said that about 75 per cent of amphetamine use in New South Wales was now either crystal meth or base. In your submission, you note that most of the crystal meth has been imported, with there being some local manufacture. One of my concerns has been that if we shut down local cooking of amphetamines we will actually shift the market much more towards higher grade and more dangerous products, such as ice, which is imported. My concern would be much less if that has already happened by way of domestic manufacture. I wonder, firstly, if you could give your own assessment of whether 75 per cent of the market has already shifted across to ice or base and, secondly, the degree to which those are domestic manufactures or imported products.

Dr McKetin—I believe the figures that were cited by the New South Wales Police arose from our research on the Sydney methamphetamine market. They were based on interviews with 310 methamphetamine users in Sydney. We estimated that 34 per cent of the methamphetamine consumption was ice—crystalline methamphetamine. A further 37 per cent was the more pure 'base' methamphetamine and the rest was a low purity powder methamphetamine.

What we are seeing is that these more pure forms of the drug have really taken a strong hold, particularly among people who inject methamphetamine, because they are much more potent than the powder form and injecting drug users prefer that stronger effect. More dependent users also prefer it. What we are also seeing is that young, non-injecting drug users are taking up smoking ice. That is another market for the drug that did not exist previously.

We are seeing some evidence of domestic manufacture. We interviewed 34 ice dealers. I think 32 per cent of them said that they believed that their ice was being domestically produced. They did not see it, but that is what they believed. A further nine per cent said it was either domestically produced or imported. That would suggest that there is domestic production happening, but we are not clear to what extent it is occurring. That raises the concern that, if you restrict domestic production, it is not clear to what extent that will reduce the methamphetamine market. We already know that this drug is imported and we also know that there is a lot of the drug being produced locally, irrespective of whether it is being sold as base or ice.

Mr KERR—If it has no effect on the market, that may be said to be an inefficient use of resources. But if it actually increases the scale of harm as an unintended consequence, you would have to anticipate that and prepare for it. The other thing relates to treatment regimes. As I understand it—and please correct me if I am wrong, because everyone's perceptions in these areas can often be exaggerated—those who have a long-term pattern of use of ice often exhibit very profound psychological damage and present behaviours that potentially harm others in a way that makes the drug a greater social harm than its precursors—heroin and the like. To the best of my knowledge, at the moment there is no effective regime for treatment. Is that so? You specialise in treatment regimes.

Prof. Mattick—I disagree. I think this is a view that is driven by the fact that we had an effective pharmacotherapy for opioid dependence—methadone; and others have come on stream over the recent past: buprenorphine and naltrexone. There are effective interventions that simply need to be made available—I want to talk about this later, but I will raise it now—to reduce demand and reduce harm but also as a crime prevention measure. There is quite good evidence that treatment can reduce criminal activity. Don Weatherburn and our centre have done work in the area of opioids, showing with actual arrest data that there are fewer arrests when people are in treatment for opioid dependence than when they are out of treatment. Whether the arrest period is before or after treatment, people in treatment do better and they gain from that.

With amphetamines I do not think we have really attempted to provide treatment because it has been overshadowed as an area by opioid dependence in Australia. That was quite reasonable—there were nearly 1,000 people a year dying, and there still are 300 or 400 dying from opioid dependence, heroin use. But it is wrong to characterise it by saying that we do not have treatments. We do not have an effective pharmacotherapy. But in terms of cost-effective treatments, pharmacotherapies, certainly for opioid dependence, are relatively cost effective in the absence of anything else. Cognitive behavioural therapies, interventions and other treatments are quite effective, and they are relatively cheap to deliver—we just do not do them in Australia.

Mr KERR—Can you explain what you mean by cognitive—

Prof. Mattick—Cognitive behavioural therapies are essentially—

Mr KERR—Counselling.

Prof. Mattick—It is more than counselling, but you can characterise it that way. It is a structured approach to getting the individual to look at the harms that are occurring to them and to their friends and families as a consequence of, in this case, illicit drug use. It is getting them to change the way in which they view that and to value other things. It gives them techniques to avoid using, to avoid relapse—getting them to avoid situations where they may relapse. It is aimed at people who are largely dependent, but that is an issue with regard to treatment. You can use briefer interventions for those who are earlier stage, but as a response nationally we have not rolled out an intervention for amphetamine dependence. That is characterised as if we do not have an effective treatment—but we have just not provided it.

Mr KERR—This is my misunderstanding, too. I am just trying to get a picture. You were saying that research exists that says you can have effective outcomes dealing with people who have persistent patterns of use of ice amphetamines.

Prof. Mattick—Yes.

Mr KERR—Is that a cost-effective process? When you say ‘effective’ can you give us some sort of image of what level of effectiveness we are discussing?

Dr McKetin—Six sessions, one week apart, will reduce someone’s level of methamphetamine use. It will increase the prevalence of abstinence in that population. It will reduce a lot of the associated harms: HIV, risk behaviour and crime, for example.

Senator FERRIS—Who is administering programs like that?

Dr McKetin—Currently, they have been trialled here in Australia and also in the United States and been found to be quite effective. At the moment it is implemented in some treatment agencies. It is up to the treatment agency which approach they would like to take. I know individually of some agencies that do take this approach. Others take a different psychosocial approach, which may be effective. At the moment we are looking at treatment outcomes within the community to try to understand whether what people are actually doing out there is working. But we do not understand to what extent people are taking up these treatment options that have been proved to be effective.

Senator FERRIS—There is no methadone type of approach?

Prof. Mattick—Our centre has done a lot of work on methadone. We have done some of the most important work—I say somewhat immodestly—in Australia and internationally over the recent past in terms of summarising the evidence. We think methadone is a very important intervention. But one should not be seduced into thinking that you need a pharmacotherapy to deal with drug or alcohol problems. It is simply not true. Interventions which work with the individual, which help them to prevent relapses, are quite effective. A pharmacotherapy will work while the person is taking it, but it tends to stop working when the person stops taking it. A talking therapy—as they are sometimes characterised and which I think takes away from their value—can be very effective and relatively cheap.

The issue of cost-effectiveness is not fully investigated, but these interventions are not expensive to deliver. They are relatively inexpensive to deliver. We simply have not provided it and we have not provided it in a way which people can access. That does not just mean face-to-face intervention. We do not use the internet particularly well. We do not provide interventions in ways so that people can log in, perhaps have their own user name, get some information, have a profile on themselves and learn about the harms. You have talked about the harms, but these harms are often not terribly visible to the users—they do not necessarily see them as clearly as perhaps others do. But providing some way where they can get an amphetamine check-up, where they can start to understand their health outcomes is what we do not do well.

CHAIR—Can you put this in perspective. We have had a bit of evidence, including the Triple J program I have referred to, that a lot of young people say, 'I will take it this weekend but then I won't take it for another month,' or 'I'll take it perhaps for a couple of weeks and then I won't take it for a while.' Some of the evidence from users is that when they move on in years they give it away altogether. Do you have some sort of general statistics that you could give us of those who try it—perhaps this is not something we should be publicising—and what percentage get hooked so much that they need methadone type treatment?

Dr Degenhardt—I do not know about that in terms of following people up and looking at their natural history of methamphetamine use. The people we have been talking about so far are the dependent users and they form the minority of methamphetamine users in this country.

CHAIR—Do you have a percentage on the minority?

Dr McKetin—We know that about half a million Australians have used the drug in the past year. By way of comparison, we estimate that there are around 73,000 dependent users. So a proportion of them are using probably two to three days a week or more heavily. Only a small proportion of them would like pharmacotherapy because it is very hard to take every day—it stops you from eating and sleeping. So we do not know what proportion of the 73,000 in Australia would benefit from a pharmacotherapy.

CHAIR—It is about 15 per cent.

Dr McKetin—Approximately. That would be a very rough estimate, but it gives you some idea that the majority of these people are using the drug recreationally and it is only a small proportion who are getting into trouble with it.

Mr KERR—And among the 73,000 who, you say, are dependent users, there would there be a wide range of manifestations, ranging from people who have lost control of their lives completely to those who have had marginal impact but who you would still categorise as dependent. Is that right?

Dr McKetin—That is exactly right. We are basing it on symptoms of self-reported dependence. There are people who are using the drug two or three days a week and it is starting to impact on their functioning—typically, you start to see quite an impact on people's functioning when it is more than two days a week. It varies from those who are holding it together and might still be able to maintain employment but are starting to have problems, through to people who are quite affected by the drug and are using it almost every day.

Mr WOOD—Is 'dependent' the same as an addiction—like heroin addiction—or is it different? Secondly, would people know that they are addicted to it or dependent on it, like a heroin user?

Prof. Mattick—Dependence and addiction are the same thing. Heroin users often do not think they are dependent; it is part of the nature of the phenomenon to a certain extent. The group we are talking about is the group among which, by and large, harm occurs—psychosis, disarray, loss of functioning—and I think that is where our attention should be focused. The challenge for Australia is that, to a certain extent, the genie is out of the bottle. There is such large exposure to these drugs, particularly among young people, that unless we do something quite profound—and it is hard to think what that would be—within a generation people will think it is relatively innocuous.

Mr WOOD—How come young people do not realise they can be addicted? I have asked that question of other witnesses in the inquiry and they have not come straight out and said, 'Yes, you can be addicted to it.' But you are saying that now. Young people would not believe they would be getting addicted to the drug. How do we develop an education program, because we keep hearing that if it is on TV they take no notice of it, so how do we go about that?

Prof. Mattick—We have been quite poor in Australia at responding in an accurate way, and that is driven by the politics of what groups want to do about drugs and about sending the correct messages. We run relatively brief programs for illicit drugs; we have ads on TV which tend to run for six months or so, depending on the contracts with the media organisations. But we do not

have consistent ongoing campaigns—and what is being done on tobacco smoking is a really good example—which give the same message over time. And that would be effective. These one-shot campaigns are not particularly useful, in my opinion. The other problem is that we do not teach people about the nature of the symptoms of dependence, whether it be alcohol, cannabis or, in this case, amphetamines. We do not let them know what dependence looks like so that they do not think, 'This is not me.'

Mr WOOD—How do you know an education campaign actually works? Has it been done overseas?

Prof. Mattick—Smoking is a very good example. We have been able to reduce smoking rates by having a very consistent campaign over time. These things are a bit of a battle. We are not going to stop drug use from occurring. But what you can do is provide reasonable information to people, who can access it and learn what these drugs can do, and hope that they will make the decisions. Then you can have policing, treatment and other strategies. But one strategy we have not done well is educating, and not as a one-off measure but as a persistent, ongoing thing. This drug use is not going away.

Mr WOOD—What is the trend now? Is it going to get worse? Is it as bad as it gets?

Dr Degenhardt—Over the past 10 years we have definitely seen an increase in the harms related to methamphetamine use, and there seems to be a shift to the stronger forms of the drug Rebecca was talking about before. In the past few years it has definitely not gone down. If anything, it has continued to slightly increase. We are monitoring that. It does seem that among regular injecting drug users and regular ecstasy users the use of crystal methamphetamine and other sorts of methamphetamine is remaining at the same levels that we have been tracking over recent years. It does not seem to be abating in any way.

Senator FERRIS—Is there a pharmacological addiction to amphetamines? This is something that I was not aware of. I am very aware of the addictive properties of other well-known drugs. What are the pharmacological properties of addiction to amphetamines, ice and so on?

Dr McKetin—It is interesting that you ask that. One of the reasons, and this relates to your question earlier, that people do not perceive amphetamine or methamphetamine to be associated with addiction is that you get really strong physical withdrawal symptoms with opiates and you do not tend to get them with methamphetamine. What you do get is a pharmacological syndrome, you could say. Mood changes, sleep patterns change, appetite changes, and there are a whole lot of other very strong craving and emotional changes that go hand in hand with methamphetamine dependence. It is a pharmacological addiction but it is in a different part of the brain so you get different effects than you would from heroin. Does that make sense?

Prof. Mattick—I think the other part, to answer your question, is that the so-called neurobiological basis, which is what you were referring to in your question, for dependence on alcohol and opioids is not that well understood, despite a sense that it is. Why and how people become dependent on opioids and how that could be reversed at the level of the central nervous system is not that clear. There is not agreement. There is a lot of research, but it is not well known. The same is true of alcohol. It is not just pharmacological or neurological; it is a learnt process. We do not understand it as well as we could. That is part of the answer to your question.

There is a myth that we understand some areas really well. The neurobiological basis of opioid and alcohol dependence is not that clear.

Senator FERRIS—I understand it is clearer than what you are saying it is for amphetamine use.

Prof. Mattick—Yes.

Senator LUDWIG—It seemed to me your earlier evidence was that there are programs being trialled that have been evaluated, from overseas experiences, as being relatively effective against the use of these types of amphetamines or stimulants. Yet there is an apparent disconnect between the service delivery agencies and the ability for them to trial that research and adopt it in their programs, or there is resistance from them to it. Do I understand that rightly?

Dr McKetin—First, I want to clarify that the approach that we discussed has been trialled in Australia.

Senator LUDWIG—That is the cognitive behavioural therapy.

Dr McKetin—Yes. That was in Newcastle with Dr Amanda Baker.

Senator LUDWIG—What was it called? Usually there are names attached to the programs.

Dr McKetin—Brief intervention for methamphetamine use using cognitive behavioural therapy and motivational interviewing.

Senator FERRIS—Do you have any material from that trial that you could make available to the secretariat?

Dr McKetin—Yes. The answer to the second part of your question is that I think at the moment there is not enough public awareness or awareness within the field that this approach is effective and we could have improved capacity to implement it. I do not think it is that the treatment centres are resisting it, but they may not in some circumstances have the human resources to implement the training.

Senator LUDWIG—It is about capacity. They would need to access grant moneys, employ or train relevant people to utilise the cognitive behavioural therapy, employ it and then, obviously, be in the locations where there is a need for those programs. Am I painting a more fulsome picture?

Dr McKetin—Yes.

Senator LUDWIG—What could be done to improve that? Would it require federal government money? The evidence before this committee is that there has been a huge growth in use. You are not saying it is not growing. You are, in fact, confirming that. The police say they are doing all that they can but they are certainly not arresting the growth. That is one way to minimise the use of this drug. Another way, of course, is to get people off the drug. I will come to the other ways shortly. What do you need for these programs to be utilised?

Prof. Mattick—Firstly, I think there will be a national amphetamine strategy developed over the next period of time, and you may be aware of that. That is likely to occur. Yesterday the MCDS signed off the national alcohol counterstrategies. The amphetamine strategy will be developed and that may bring federal money with it. That is a decision for others.

We need to set this in a context as well. One thing that people do not think about with regard to drug use is that this is a growing epidemic. What has occurred with heroin use from the early sixties through to now is this huge growth in use. We are seeing the same with amphetamines and with other drugs—with cannabis. The response has to be that if you want to deal with that you have to put resources in, and you cannot treat these things as static, as if they have always been there and we do not need to put extra resources in. It is not the same as schizophrenia where we have a relatively level rate in the community and it has been like that for a number of years. So the answer is yes, resourcing has to occur.

How that occurs is a matter for the departments of health and others. I think it will occur. It will occur through processes like this, through this group listening to what is being said and responding to it. Part of the answer is, however, not to think that we have to have pharmacotherapy. It is rolling out good, sensible, supportive programs like the Quit program that was run for tobacco.

Senator LUDWIG—That is why I was talking about the particular intervention you have highlighted because it is not pharmacologically based.

Prof. Mattick—The Quit program was run for tobacco—and we do have a very good pharmacotherapy for nicotine dependence and it is effective and we understand the neurological basis of nicotine dependence better than we do other drugs. It is therapy and intervention which is simply dealing with the same kinds of approaches of getting people to value why they are smoking or not smoking, why they are using amphetamines or why they might not. It is getting them to deal with relapse situations, providing them with reasonable tools, and it is effective. And we can do that with this drug type. It is wrong to think that this has to be different; it does not.

The other thing I think you need to be very careful about is being drawn into the notion that there is a cure and that these people will not go back and use drugs again. What you can do is help them to manage their drug use. One of the problems with this area is that we want abstinence, but in sexually transmitted diseases, in hypertension, in diabetes and in other areas we do not look for a cure—we look to manage conditions. That is what you should be thinking about rather than how we get these people abstinent. How do we help them to manage themselves until they mature out of it—or stop using and get on with their lives—and minimise the damage?

Senator LUDWIG—The other issue you mentioned was public education as being fundamental to the overall approach. That is why I suspect you have mentioned in these hearings the way we have addressed smoking. Yesterday some information came out about a drink-spiking campaign. By the look of it, there is going to be a significant federal government approach to drink spiking. Important as that is, wouldn't you have expected, given the level of AOSDs, that we would have had a campaign on amphetamine use and the like rather than on drink spiking, or in addition to drink spiking for that matter, come out of yesterday's meeting?

Prof. Mattick—I am not privy to that. I am on the Australian National Council on Drugs and I have an awareness of a range of things that are going on, which are not terribly secret. Part of what is public is that there will be a national amphetamine strategy and that will probably be delivered towards the end of this year. There is movement on this and there has been a fair bit of attention to it. You are right, but I think it is this kind of process which generates that momentum. It is the success in heroin dependence and the reduction in deaths which gives space for us to think about other things and attend to them. It is occurring.

Mr RICHARDSON—There has been an alarming increase—56 per cent—from 1999-2000 to 2003-04 in admissions to hospital with psychostimulants in the system. That is alarming in itself, and you have seen that happen through your period of time. It probably follows, similarly to in Senator Ludwig's questions, the magic wand effect.

However, I want to focus more on the 14- to 18-year-olds. As we know, there are additional admissions which involve the hospital departments and their resources, ambulance personnel, the police and policing resources. What do we do about it? Do we throw money into the resources? Do we throw even more money into education? Would you try to confine your answer to the 14- to 18-year olds, including legislation and possible prosecution and therefore the diversion methods and techniques. Is there enough? It is pretty overarching, isn't it?

Dr McKetin—I do not know how much the increase in psychosis over the last five years or so is related to methamphetamine use among the 14- to 18-year-old age bracket. Most of the people who experience psychosis from this drug are quite dependent on it. People who are 14 to 18 are not typically dependent on the drug; they are just going through the experimental stage of use and do not usually use it frequently. In that context, my first reaction to your question is that, if you want to target that age group, it would seem that preventative measures would be more appropriate. It is not necessarily going to be related to what is happening in emergency departments.

Dr Degenhardt—I would agree with that. There has been some interesting research about what do you do with young people, for example, in schools and how the schools deal with it when drug use is detected. Research has come out of Victoria comparing school policies in schools in Victoria with those in the United States, and it is quite interesting. There is a much more supportive policy with the students in Victoria, where they work with the kids and do not necessarily expel them, versus the situation in the United States, where they have a zero tolerance approach. That is getting more and more air time, with people discussing whether or not that is what we need to have here.

What was interesting about that research is that they found that when kids in the United States got expelled because they were detected using drugs they ended up going down a really terrible path that was significantly worse than for the young children in Victoria. It was a really nice example of how even school based policies can have a really important impact on a young person's life and that it is probably more appropriate to try to work with the young person, keep them within the school system and try to support them in making choices that do not involve drug use, rather than to simply remove them from the school system. Increasingly, schools represent a really important part of young people's lives and probably an increasing share of the pastoral care and the support that young people get, so maybe keeping them integrated seems to be an important thing.

Mr RICHARDSON—Thank you for sharing that. I was a police youth officer for a little while, and I was involved with exclusions and inclusions—specifically, marijuana in young people. Being a part of that twofold exclusion and/or inclusion had quite an impact, even if it was down to just the assignment that the young person had to do or investigating the actual effects, as we have spoken about here. 'Demonising' is the term we should look at, rather than highlighting the name of it and the possible high that can happen. Thank you for sharing that.

Dr McKetin—There might be another thing that is relevant to that. NDARC are just beginning a trial of a program that will be implemented in schools as a preventative measure for psychostimulants. It is a computer based education program. We can share the details of that with you as well.

Mr RICHARDSON—I have a final question—and I do not know whether you touched on it while I was out—in relation to the internet chat room you had as a result of the *Four Corners* program. Did you gain anything as a result of that chat room?

CHAIR—Could I ask also you about that program, which many people have seen—and the secretariat has kindly made a copy of the transcript for those of us who did not see it. Was that an accurate portrayal or was it a bit over the top? Were there some parts of that program that were overemphasised or underemphasised?

Dr McKetin—That program focused on several very heavily injecting users. No doubt those people exist—they were interviewed, and there are other people out there like them. We do see people like them. But I think what came through from the chat room is that this is a drug that affects a broad range of people. A lot of those people were emailing in and saying: 'What about my friends? They have got a job and they are smoking ice on the weekend. That show didn't look like them at all.' I think that shows that this not a drug that you can stereotype in the same way that people often did with heroin.

Dr Degenhardt—The other important thing, not only for users, was that it was a really good example of how a depiction of users can really not resonate with the users because it was not be consistent with most users' experiences. The potentially negative effect of that sort of portrayal of crystal methamphetamine is that people who do not know anything about this drug get incredibly scared and very fearful and have what is actually an inaccurate view of what crystal methamphetamine users in Australia look like. And it is particularly parents and the general community who then will respond in a potentially ill-informed manner and out of fear rather than from a good evidence base.

CHAIR—In your submission you used the term ATS, whereas we are using the term AOSDs. Do you have a preference for one or the other? Does it make any difference? Should there be some standardisation?

Prof. Mattick—Standardisation in this area is a bit difficult. We tend to use the term that others use. ATS was captured by the international groups more than by Australians. It came from overseas, I think.

Dr McKetin—I drafted the submission and I used the term ATS because it is the more generic term used under the United Nations convention, so I adopted that for the document. There is no other reason for it.

CHAIR—Is the quality and purity of the product a major issue in your research? What is your view on the quality of ATS available on the Australian scene and is there anything that can be done about the variability?

Dr McKetin—There are a couple of issues here. I will comment from the methamphetamine perspective, because that is my area. We are concerned about the high purity form of crystalline methamphetamine, particularly because it is smokeable. That introduces a different market, a different group of people, to using it, particularly younger users. However, most of the methamphetamine that we see on the street appears to be cut with glucose, so we are not too worried about the quality in terms of adulterants. The biggest concern is the increasing purity of it. However, what we also see is that most of the harms are among people who are dependent. Those people will use the high-purity form and the low-purity form, depending on what they can get. So it is not necessarily the case that if the purity went down those people would disappear. It is not just that somebody is using a high-purity form of the drug; it is that they are dependent on it. That is the thing that we have to focus on.

CHAIR—With the backyard operators, do you find that there are really nasty substances coming in that not only do not do what they are sold as doing but can have very harmful effects almost outside the drug related psychosis?

Dr McKetin—With regard to methamphetamine, that is less of a concern than for ecstasy and other drugs. I do not have any good data on the adulterants that are in methamphetamine. It seems to be predominantly glucose. There may be some other adulterants or by-products of the manufacturing process, but we have not seen fatalities, for example, from that. Users do not seem to be as concerned about it as they are for other drugs.

CHAIR—I am not sure whether you were here when we were discussing it but you would be aware of Dr Caldicott's issues and of Enlighten Harm Reduction. Do you have a view on those pill-testing issues?

Dr Degenhardt—I always think it is good to be clear about these things. There are, as you probably know, different ways that you can test pills. For most users in Australia—and this is talking about ecstasy tablets—if they are testing pills they will use reagent tests. I think it is good that people want to find out about the drugs that they are taking, but it is also important for them to know what the limitations of those tests are. The tests will indicate that a drug is there. They will not say how much of the drug is there, they will not say what other drugs are there and they do not necessarily pick up in a very accurate way exactly what the mix of drugs is. So although testing does give information it is important that users know that it does not necessarily give them the full picture. As for the pill testing that Dr Caldicott and the people from Enlighten are talking about, I know that they have access to basically a pretty hot testing kit.

CHAIR—A pretty what?

Dr Degenhardt—Hot. Sorry!

CHAIR—Sophisticated?

Dr Degenhardt—Yes, sophisticated; sorry! From a tiny amount of the pill, it will give you a very good breakdown of exactly what is in the tablet, how much and so on. What you get into there is the issue of not only how you get the pills tested—obviously, it is illegal to be in possession of those tablets, so there are issues of illegality—but also, if you get over that issue, how many testing kits you can realistically have, because they are very expensive—you are talking over $100,000 per kit—and how many events you can realistically cover and all those sorts of things. So there are illegal and pragmatic issues with those more sophisticated testing kits.

Mr WOOD—If I can follow that up now—and this is where you might be able to help me out with overseas research. Would a young person who might be on the sidelines watching who sees a pill-testing station set up regard it as some person with authority saying it is safe to use drugs? Or would they be thinking, 'Hang on, these people here are trying to help me out; to make sure I don't go down the wrong path, they are going to give me some information'? If a person sitting on the sidelines sees 20 people lined up waiting to get their drugs tested, does that mean that that person will be more inclined to go get some drugs themselves and then line up, or do they think, 'This is really bad'?

Dr Degenhardt—That is a good question. The people who are involved in pill testing are peer based organisations, so they are actually not coming from a position of 'we are authority figures'. They are coming from a position of 'we are people who are involved in the same scene as you'.

Mr WOOD—But would that young person realise that when they see them?

Dr Degenhardt—It is very obvious. From the way that the tent will look, the way that the people are dressed and the way that the information is presented, it is very obviously a peer based organisation. As far as I know, there is absolutely no evidence to suggest that having harm reduction interventions like that situated within a party in any way increases drug use by patrons of that party.

Senator LUDWIG—What evidence of harm minimisation is there?

Dr Degenhardt—There is evidence from the Netherlands—and it works very differently there, obviously, as you probably know—that people who choose to submit their pills for testing, who attend those tents to get their pills tested, will change their mind about whether or not to take that tablet. Based on what is in the pill, they may choose to use less or to dispose of the tablet, because these are people who wish to use their drugs in a safer way. So on the basis of that evidence, yes, the people who are accessing that service do seem to be interested in reducing harm. And if the tablet does not contain what they want or it seems very strong or anything like that they will change their behaviour as a result.

Mr WOOD—Has any research actually been done with young users? That is my problem. I am very much opposed to pill testing. I look at it as being dangerous. Obviously, it is about how a young person perceives pill testing and whether they are going to be encouraged or, conversely, walk away. Have you held focus groups or undertaken any research into this? These

groups are based in Melbourne, and, when I heard that they went to rave parties, huge alarm bells went off in my head. I have listened to both police agencies, and they had the same concerns. Obviously, you are undertaking a lot of the research, and I need to know, for when I go back to Victoria, what my approach is.

CHAIR—But don't be intimidated by his view.

Mr WOOD—At the same time—

Senator FERRIS—You always have to make a comment on it.

Mr WOOD—Senator Macdonald has totally different views from me; therefore, I see you as being the independent experts.

Dr Degenhardt—The worry that you have is, I know, a worry that a lot of people in law enforcement have, and it is about the appearance of condoning or encouraging drug use. As far as I know, there has not been any research done that has examined young people's perceptions of what pill-testing kits mean and how they think about drug use.

I think there are a number of things it could say, such as the people running the organisation giving information about safer ways to use drugs if people chose to do so. They are intending to promote a culture of safer drug use. There has been no research, as far as I know, on what impact that has on those attending these events, but definitely these people are trying to achieve less risky patterns of drug use among people who are already engaging in it. Many people who are attending dance parties may have used drugs in the past or they may be using them at the event.

Mr WOOD—And that is why I did not have a great concern. Someone else who may be an ongoing drug user may know the drugs, but it is of concern for the young person sitting on the sidelines who has never experienced the drug before. I am trying to find out if research has been undertaken there.

Dr Degenhardt—As far as I know, there has not been any done.

CHAIR—I am not telling you my view, because I do not want you to try to be nice to me and agree with me, but in your earlier evidence you actually said there was no research that suggests that it has had that impact of encouraging young people to think it is safe to take it—

Dr Degenhardt—But we definitely need to do more with it.

CHAIR—but you have not had research saying the opposite either.

Dr Degenhardt—Yes. I imagine the people from Enlighten would say the same to you, if they have not done so already. They think there should be a lot more research done, because many people have these questions and we do not know what the answers are.

Mr KERR—I think they are actually advocating a 12-month trial.

Dr Degenhardt—I have spoken with David Caldicott previously, and my understanding is that they do want to do an empirical investigation of this.

Mr RICHARDSON—The thing that people miss in this concept is the fact that the biochemical make-ups of me, Rebecca and Richard, who are, say, being handed the tablet from the pill tester, are different. The pill tester says, 'It has this, this and this in it; however, you should not take it.' But the person who has the tablet or three tablets gives one to Duncan, whose biochemical make-up is totally different to that of this person. Isn't it true that a person can have an unbelievably adverse affect to one tablet because of their chemical make-up?

Dr Degenhardt—An 'unbelievably adverse affect' to something—

Mr RICHARDSON—Or an OD, absolutely.

Dr Degenhardt—I guess it depends on which drugs you are talking about. If, for example, they said, 'Look, it contains a moderate amount of MDMA,' from what I understand there have been very few drug-related deaths caused by MDMA in Australia but we know that there are millions of people who have used the drug. I think the risk of dying from an overdose of that drug is actually fairly small, if you compare those two numbers. The difference between the effects of the same drug on two different people is an issue, but many users will know that and often try to titrate their dose—but obviously they are taking a risk in trying to do that without any—

Mr RICHARDSON—I think it is more, like I said, in relation to the person who has brought three or four tablets to the rave party. My son, or your son or daughter, for example, comes along and is not going to take them, but the peer group says, 'It's been tested. It's okay; it's got this in it.' But that person has a reaction to it. We may say that one or two or 111 deaths over 500,000 people who take it is not many, but, if it is your or my son or daughter, one death is far too many.

CHAIR—Regrettably, I think we have just about exhausted our time. Again, I thank you very much for coming along, for your submission and for the work you do. It has been enlightening to all of us. Keep up the good work.

Committee adjourned at 12.04 pm