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Official Committee Hansard

JOINT COMMITTEE ON THE AUSTRALIAN CRIME COMMISSION

Reference: Amphetamines and other synthetic drugs

FRIDAY, 13 OCTOBER 2006

MELBOURNE

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JOINT STATUTORY COMMITTEE ON THE

AUSTRALIAN CRIME COMMISSION

Friday, 13 October 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, Ian Macdonald and Polley and Mr Hayes 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

BERGIN, Ms Jenny, Director, Community Pharmacy Practice Division, National Secretariat, Pharmacy Guild of Australia 21

BOORMAN, Inspector Martin Charles, Officer in Charge, Traffic Alcohol Section, Technical Unit, Victoria Police 1

BROGAN, Mr Damon Gerard, Chief Executive Officer, VIVAIDS Inc. 46

DAVIDSON, Mr John William, Spokesperson, Enlighten Harm Reduction 32

HAZELWOOD, Ms Lisa (Purple), RaveSafe Coordinator, VIVAIDS Inc. 46

LODGE, Mr Michael Anthony, General Manager, New South Wales Users and AIDS Association Inc. 63

LOGAN, Mr Timothy John, President, Queensland Branch, and National Vice President, Pharmacy Guild of Australia 21

McBEATH, Mr Peter, Vice President, New South Wales Branch, Pharmacy Guild of Australia 21

O'BRIEN, Detective Inspector James Michael, Victoria Police 1

OVERLAND, Deputy Commissioner Simon, Victoria Police 1

QUINN, Ms Catherine, Manager, Drug and Alcohol Branch, Victoria Police Forensic Services Centre 1

RYAN, Mr John, Chief Executive Officer, Anex (Association for Prevention and Harm Reduction Programs Australia Inc.) 46

Committee met at 10.24 am

BOORMAN, Inspector Martin Charles, Officer in Charge, Traffic Alcohol Section, Technical Unit, Victoria Police

O'BRIEN, Detective Inspector James Michael, Victoria Police

OVERLAND, Deputy Commissioner Simon, Victoria Police

QUINN, Ms Catherine, Manager, Drug and Alcohol Branch, Victoria Police Forensic Services Centre

CHAIR (Senator Ian Macdonald)—I declare open this Melbourne hearing of our inquiry into amphetamines and other synthetic drugs. The terms of reference require the committee to examine the manufacture, importation and use of amphetamines and other synthetic drugs in Australia. This is the seventh hearing we have had. We have advertised for witnesses to this, and we are very pleased to welcome members of the Victorian police force to give evidence. Thank you very much for coming along. I acknowledge, as do all of the committee, that you are very busy people and have many important things to do, so we appreciate the time you have made available to give us the benefit of your experience in this area and to subject yourselves to questioning.

Our committee is a joint committee of both houses of parliament. It consists of Senator Polley from Tasmania; Mr Wood from Victoria, a former policeman whom you obviously all well know; Mr Hayes from New South Wales; and Senator Ferris from South Australia. There are some rules of our committee hearing that I do not think I will bother you with. Obviously, if there are questions we ask that are not appropriate for you to answer, you will tell us and—

Deputy Commissioner Overland—I think we are aware of the rules.

CHAIR—Yes, I am sure of that. I invite you to make an opening statement, and then I know the committee members would very much like to have a discussion with you and get some further information from you.

Deputy Commissioner Overland—Thank you very much, Mr Chair. Just by way of further introduction—although I will make some opening comments against the terms of reference—Kate Quinn is a forensic chemist. She is here and available to answer any questions that you might have around that line. Jim O'Brien is a detective inspector in the crime department, with a long history and experience in drug investigation, particularly around amphetamines and other synthetic drugs, so he can talk to you about those sorts of issues. Martin Boorman can also talk to you about the traffic issues and the drug testing that is now happening here in Victoria in relation to that. They will obviously be more than happy to answer your questions.

By way of introduction against your term of reference on the trends in the production and consumption of amphetamines in Australia and overseas, I guess you are probably aware of a lot of the data, but we do see it as an increasing problem and there is some evidence to support that. For instance, the United Nations drug report of 2006 suggests that Australia is the largest consumer of MDMA in the world. Obviously, that is being largely manufactured offshore and

then imported into Australia. We have had one example here in Victoria where we found it being produced locally, and that is perhaps something that will increase over time. Once the technology and the know-how becomes available here you could expect it to spread, and it is a growing problem. Our estimation, our intelligence, is that there are somewhere in the vicinity of 100,000 tablets of ecstasy being consumed per weekend across Australia, so it is a very significant problem.

Methamphetamine also is a significant problem. We have seen some changes in the manufacturing process away from pseudoephedrine as the precursor. We think there are reasons for that around much more effective control of pseudoephedrine through various strategies that have been put in place both here in Victoria and across Australia. They are now moving to two main types of method, one using phenyl-2-propanone as part of the process and the other using a process that is described as the 'Nazi' method which actually uses liquid ammonia. As I understand it, that is a particularly dangerous process. Ammonia is a very dangerous substance. It is potentially quite explosive and presents all sorts of hazards, both in the manufacture but then also in the disposal of the waste product, and most of that probably just goes straight down the drain.

With respect to some of the other trends that we see, looking at estimates on the percentage of the Victorian population who are using these drugs generally between 1993 and 2004, it is interesting that the figures for cocaine and heroin have remained reasonably stable over that period of time. There have been slight increases in cocaine usage per head of population in Victoria over that period of time. In relation to ecstasy, there has been quite a significant increase. Between 1993 and 2004 we think there has been about a 30 per cent increase in ecstasy usage. We now think that about three per cent of the population use ecstasy or designer drugs on a reasonably regular basis. With amphetamines, there has been a much more significant increase—a six-fold increase over that period of time. Again, we think that currently about three per cent of the population would use amphetamine on a regular basis. Cannabis still remains the highest used drug. We think the figure is around 10 per cent of the general population. Heroin is still a little under half a per cent and cocaine is about one per cent of the general population. That is the information that is available to us.

In terms of what we are doing about it, it remains a continuing focus for us. In Victoria, we are in the process—and it is quite remarkable that it is for the first time—of developing our own illicit drug strategy. The organisation has never had a force-wide strategy to deal with illicit drugs, and we are in the process of developing that. Obviously, amphetamines and other synthetic drugs will be a major focus of that strategy because we see that as the presenting issue in relation to drugs. There is a range of other things that we have done and will continue to do around investigations, around harm minimisation approaches, particularly with low-end users—people who are perhaps coming into the market for the first time. Our approach there is still really around trying to divert them out of the drug market and into health and rehabilitation programs as much as possible. I am not in a position to provide much useful evidence about the effectiveness of that, but that is certainly an approach that we adopt.

In relation to the higher end crime, we are doing a range of things. As I mentioned earlier, pseudoephedrine control is a big issue for us. We have a project in place with the Pharmacy Guild which is still coming fully online but which relates to electronic recording of sales of this product, linking it to identity and making that information available to us so that we can look at

identifying trends or issues emerging with respect to that. As I say, the market has moved on to other methods of production, so we will do that and then we will have to think about controlling other precursor chemicals.

There has been, and there is, work being done on that. It is happening across Australia. It is happening through the various ministerial councils that are in place to deal with this, but from our point of view it happens much too slowly. I guess we are all aware of the difficulties of trying to get truly national approaches to some of these issues, but we think it would be good if we could effective precursor chemical control in place right across Australia as a matter of priority.

There is a voluntary code that we have in place here with the plastics and chemicals industry. It is voluntary, so it is limited in its effectiveness. We think there is perhaps some more work that can be done around that. Certainly, we continue to focus on drugs generally. We think that drugs are a major driver of other crime, so it is an issue that is going to require continuing attention from us.

You have asked about the extent and nature of organised crime involvement. We think organised crime is involved in this area to a significant extent. There is a lot of evidence of that. I guess people are generally aware of the gangland murders that were happening here in Melbourne. They became prominent in 2004, but the history goes back well before that. We now believe we have that situation under control, but sitting in the background to that, the people involved in that are organised criminals. They are whole-of-life criminals; they are into making money through servicing illicit markets. It happens that at this point in time their commodity of choice is primarily amphetamines, so that provided the backdrop to a lot of the violence that we saw played out here. They are in that line of business because they see there are massive profits to be made, and they saw that there were low risks. I think we have significantly increased the risks that they are running, but they continue to operate in that area. Jim O'Brien might elaborate on some of that a little bit later in terms of some of the behaviour, the conduct and the methods that we see operating with respect to organised crime.

There is also some evidence that outlaw motorcycle gangs are involved in the manufacture of amphetamines. The statistics are not always clear but we have certainly had five major investigations in the last two years where we say outlaw motorcycle gangs have been directly involved in the manufacture of amphetamines, primarily for similar reasons—there is money to be made and they see it as quite a low-risk activity.

With respect to the nature of our response, we can talk about that in detail if you like. There is a range of things that we do. You would be aware generally of the myriad committees, interdepartmental committees, state government committees and health and law enforcement bodies that have a role in this area. It just seems to us that that has become hopelessly confused and there has been a piecemeal approach that has been built up over time. Now, if you map it, it is actually just a mishmash of different organisations and different relationships, and perhaps that is something that is worth thinking about.

CHAIR—I am sorry, I didn't hear you. Did you say that the act is confused?

Deputy Commissioner Overland—No. It is the arrangements that are in place between the Commonwealth-state around drugs policy generally. There are key players: there are health players, there are law enforcement players, there is a range of committees. I could show you a diagram but I won't. If you actually map it out, you get to understand that it is very, very complex and confused and it suggests that it is probably not the most efficient or most effective way to go about dealing with it.

For instance, those processes really dealt with the heroin situation that emerged in the late 1990s and there was a lot of focus on heroin. I think justifiably we can say that that has been a bit of a success story to a certain extent, although heroin has really just returned to long-term average usage rates. There was a spike, there was a reaction and you could say we have been effective but that we have just driven it back down to long-term historical usage rates. During the same period of time amphetamine and ecstasy use was going through the roof and we did not pick that up, and we actually did not respond to it. So I think there are some issues there.

Mr WOOD—Would you be able to supply a map for the committee to have a look at?

Deputy Commissioner Overland—I can supply a map to you, if you like. I actually have it here.

CHAIR—You said that you were not going to do that. Is there any—

Deputy Commissioner Overland—It is done for the purpose of almost ridicule.

CHAIR—That is why we are interested.

Deputy Commissioner Overland—I put it forward with that qualification. It has been done quite deliberately to spark some internal conversation within Victoria Police. It is not meant to offend, but it could easily do so. So I would ask you to treat it in that light. But that is a mapping of the current approach to drug policy as we understand it. I am not pretending that we have consulted on this. There may be people who take issue with it but it just shows you the complexity of the environment that we are now trying to operate in.

CHAIR—It is a common comment that we have heard and it is probably good to get something that we can actually look at. It looks like 'noodle nation'! Thank you. We will receive it in the spirit that you mention. This will be very useful to us.

Deputy Commissioner Overland—Dealing with adequacy of existing legislation and administrative arrangements, we have made some comments on the administrative arrangements. One of the things we see, particularly in this area and particularly dealing with organised crime, is that organised crime is very dynamic. Whenever we change, they change in response to our changes, so as we get more effective at dealing with pseudoephedrine, they move to a different form of production. You see that right across the board. Some of the changes that we are seeing at the moment that present a threat to us are around use of the internet to order precursor chemicals from overseas and have them imported—and there has been some evidence of iodine being purchased from the United States. Iodine is a chemical that often is required in the manufacture of amphetamines.

We are also seeing the smarter criminals moving to the use of voice over IP across the internet. At the moment that is not able to be intercepted. One of the key vulnerabilities that we exploit in this is their means of communication. At the moment they tend to use telephones and we are able to intercept that. In fact, it is a crucial tool in our fight against particularly serious organised crime and drug trafficking. The smarter criminals are now moving to voice over IP, which presents all sorts of difficulties to us in intercepting, and other communication tools across the internet, which presents problems to us. I think that is going to be a major issue for us generally, but particularly in relation to organised crime and drugs.

We have mentioned better control over precursor chemicals and we think there is a need to legislate with respect to that. There are moves here in Victoria to toughen up some legislation; for instance, very shortly we will have offences around possession of precursors and we think that is a good thing. If we find people in possession of precursor chemicals, unless they have a reasonable excuse, they are in a bit of trouble. That is often a problem for us. We can often detect laboratories but then we have to be very careful about what time we move because it can be a problem if we move too early and we do not actually get the drug. People say you can charge attempt but our experience is that that is not always very successful. It is quite clear what these people are up to, but without the drug we actually cannot prove one element of the offence and so it falls over. The other risk is we move too late and we miss the drug. As a matter of practicality it provides all sorts of difficulties to us.

We will also be legislating around possession of pill presses because they are other key tools in the production line. They produce the powder and then often, to sell it, they press it into pills and again there is no good reason why people should have pill presses unless they have a lawful excuse so that will become an offence, and we think that is a good thing as well.

Your final question was around assessment of the adequacy of the response by the Australia law enforcement agencies including the Australian Crime Commission. To focus on the Australian Crime Commission, which is obviously of most immediate interest to you, we have worked very closely with the Australian Crime Commission, particularly around Purana. They have provided an invaluable tool to assist us in that investigation and in fact there is a significant number of people now facing charges out of appearances in front of the Crime Commission around the giving of false evidence. They have been of enormous assistance to us in that. They are also very good at sharing intelligence with us and we think the quality of the intelligence coming out of that body has improved quite significantly and that is obviously very useful to us. We continue to work quite closely with them as opportunities present themselves. I will stop there and invite any questions that you might have.

CHAIR—Thank you very much, Commissioner. You mention bikie gangs and organised crime being involved in the manufacture and distribution—is that correct in both? What evidence is there of backyard mum and dad operations not really connected to organised crime? Is there such a thing or has organised crime driven out the mums and dads.

Det. Insp. O'Brien—Certainly, there are what you would call backyard type operations but you have to bear in mind that even those backyard operations are capable of producing anywhere between half a pound to a pound of methamphetamine, which is going to sell for between $60,000 and $70,000. A lot of these people may produce some for themselves and use some

themselves in the backyard operations but the majority of them onsell the majority of what they make.

I understand Queensland had something like 165 clan labs last year detected. Their type of industry in clan labs is completely different from that of Victoria in that we do not have those extremely small-scale operations. In the majority of cases we are looking at a minimum of four ounces production, with sales occurring out of that. In the higher end we are looking at people just not using it at all. It is just a commercial venture—commercial enterprise.

CHAIR—This suggests most of it as far as you are aware is organised rather than just someone having a go.

Det. Insp. O'Brien—The larger scale is organised and even the medium scale is organised but probably not at a lower level.

CHAIR—We were having a conversation before we started about the testing of drivers. Could you just repeat the statistics you were giving me so that we get it recorded?

Insp. Boorman—Between 2000 and 2005 the number of fatal collisions in Victoria with the presence of amphetamine type substances has doubled. It has gone from 2.9 per cent to 5.7 per cent and we are also seeing a threefold increase in the presence of MDMA in our fatalities on our roads. Following on from what Deputy Commissioner Overland said, there is definite evidence that the use is increasing. We started roadside testing in December 2004. We have done almost 25,000 tests now for about 450 confirmed positives. So we are also seeing about one per cent of the driving population driving with amphetamine type substances.

In Victoria we have two systems: there is driving whilst impaired, which is based on impairment. Out of those people the average age is about 30. That came in in 2000, so over the past five years 25 per cent of those people have had stimulants present. But that is a different demographic. They also have a lot of other drugs present. There is a lot of poly-drug use—70 per cent of them have poly-drug use. In terms of the roadside testing, there are two fundamental groups: there is what we would call your car drivers and your heavy vehicle drivers. In the car driver population there is a high level of use of methamphetamine. We have been intercepting about one in 44 people on average since inception with methamphetamines present. There is also the presence of cannabis as well. We are testing now for methamphetamine, cannabis and MDMA.

CHAIR—That is in trucks?

Insp. Boorman—No, this is across the population. In trucks we are detecting about one in 67 drivers testing positive to amphetamine type substances. So there is a significant use.

Senator POLLEY—Can I just clarify something, as this is something new and Tasmania is doing it now as well. With the testing regime that you have, what is the time period for the drug detection? Is this something that was perhaps taken the night before or is this something that was taken three days ago? What is the length of time that the drugs can be detected?

Insp. Boorman—It is a little bit dose and use dependent. For the person that uses in a social activity type situation, cannabis has a very short half-life, so we will not detect them probably four hours after use. With amphetamine type substances, because we are testing for the parent drug the half-life is not so great and we are detecting them up to eight hours after use.

Seeing as both the compounds that we are testing for are psychoactive if they are present, that would indicate that there is some impairment factor. Research conducted by the Victorian Institute of Forensic Medicine, which has subsequently been confirmed in Europe, shows that a person who has amphetamine type substances in their body is 2.2 times more likely to be involved in a vehicle collision. When we compare that with .05, which makes that twice as likely, a person driving with either of these substances is a significant risk, as bad as a person at a .05 blood alcohol concentration.

CHAIR—Can you give me again for the record those statistics you were giving me on roadside testing for alcohol versus roadside testing for drugs?

Insp. Boorman—For the first 12 months of the trial period we had a drug detection rate of one in 46 across the population. With the drug operations we also test for alcohol, and for alcohol it was one in 100. So drug use is at least twice as bad in the way that we are conducting our operations. Generally, with our random testing operations for alcohol—our booze bus operations—our detection rate is about one in 250 on average. So there is an extremely high level of use amongst drivers.

Mr WOOD—When you are doing the testing, are you doing the tests at the same time? If you do a breath test, are you at the same time doing a drug test? Obviously stations have statistics they need to meet, primarily with breath test stations, so there is going to be a difference if you set up at King Street on a Sunday morning compared to a Sunday afternoon up in the Dandenong Ranges.

Insp. Boorman—At the current time there is one dedicated unit doing the random drug testing. The process is similar to random breath testing—a person is selected out of a line of traffic and undergoes a preliminary breath test. If that is zero then the person undergoes a drug test.

Mr WOOD—So it is at the same time.

Insp. Boorman—Yes. The drivers are not targeted; the locales are. It has been a state-wide operation. We have conducted operations in the metropolitan area and also in our major regional centres.

Senator POLLEY—You have targeted areas where you know you are likely to pull up drivers for drugs? Are there hot spots around?

Insp. Boorman—There are. I think it is fair to say that the central business district of Melbourne is a targeted area. It is a place where people come to socialise. In fact, I was mentioning that we did an operation some time ago and we had to stop testing because every second driver that we tested was positive to drugs, and that was conducted at four o’clock in the

morning. In regional areas, the detection rate is perhaps not as high but proportionately, in terms of the population at present, it is still a very significant issue.

Mr HAYES—What is the statistic, Simon? Is it your assessment that three per cent of the population are regular takers of ecstasy?

Deputy Commissioner Overland—Yes. We are basing it on people's self-reporting; we are not basing it on detection rates. People are self-reporting.

Mr HAYES—Is there an age demographic? I am trying to get to the proportion of youth in Victoria that Victorian police would say are ecstasy affected.

Deputy Commissioner Overland—It is primarily within the younger portion of the community, but again I think some of the evidence we are seeing out of traffic is that the average age is around 26 in vehicles and 39 in trucks. So I do not think you can safely conclude that it is restricted to people in their 20s. Certainly, as a recreational drug, there is probably a stronger correlation there, but there is some evidence that it is present across the general and broader community.

Mr HAYES—Is it safe to conclude that in the various age groups it is the drug of choice?

Deputy Commissioner Overland—It seems to be more so, yes. It does seem to be more a drug of choice. One of the things we are trying to understand is that there are markets within markets. So it is not safe to say there is a drug market. There are some people who will use ecstasy, there are some who will use amphetamines, there are some who will use cocaine and there are some who will use heroin—and there is some distinction between those markets—but we are seeing more polydrug use as well. That means people are shifting between drugs, depending on availability and a whole range of other factors.

Mr HAYES—In connection with another matter you mentioned at the outset, is the Victorian diversion program administered by the police or is that under judicial supervision?

Deputy Commissioner Overland—Both. We have some discretion to divert directly into drug treatment programs—and we tend to use that particularly with cannabis and to try and get young people to take that pathway—but there are also options through the judicial process to send people off for treatment.

Mr HAYES—Two issues seem to have emerged. One is the consequence of addiction, and obviously you have some part in the diversion program. But what we are seeing more and more is people simply taking recreational drugs—being, as I said earlier, a drug of choice.

Deputy Commissioner Overland—We have seen a bit of a shift with the so-called designer drugs, particularly ecstasy. It is a recreational drug, so people take it on Friday and Saturday nights. They do not take it any other time and they take it for the purpose of going out and having a good time. How effective treatment would be around that sort of usage, again, I do not have that information; I do not have that data. The point we would make, though, is that individuals are choosing to do this, but you do not have to work back too many steps before you understand that they are providing a marketplace in which organised crime operates and

flourishes. If you are buying a tablet in a nightclub on a Friday night within, I think, two or three steps back you are dealing with some pretty serious organised criminals.

Senator FERRIS—What happens when you stop people at four o'clock in the morning, do a drug test and find that they are positive to some of these chemicals? What do you do with that person then?

Insp. Boorman—We have legislative authority to prohibit them from driving. The sample that we have taken is sent away for confirmatory analysis. Once that is received we take action in terms of instituting a proceeding. What we are finding with our random drug testing is that 90 per cent of the people we are dealing with are first offenders—they have not had previous traffic issues and, in fact, for the vast majority it is their first contact with the criminal justice system—whereas the drive whilst impaired people, who come under the other process, are drug dependent. Sixty per cent of them are unemployed, nearly 80 per cent of them have a crime history and 70 per cent have a history of drug use. So you have a different cohort in that respect.

Senator FERRIS—You say that you take them away from their car and remove them from their vehicle and so on and that the vehicle has to be left on the side of the road or wherever you stop them. What do you do with them then? Do they get released to wander off? What happens?

Insp. Boorman—With respect to the drink driving and drug driving process, in Victoria we do not operate under arrest; it is compliance under penalty. If anybody refuses to comply with a lawful requirement then they are charged with that sort of offence. Once we process them, they are free to leave. In terms of their vehicles, we make arrangements for a relative to come and collect them or the vehicle stays where it is, or gets towed away.

Senator FERRIS—That is a good process in the city, but what happens if it is a young person in a country area and it is four o'clock in the morning? You do testing like that where you would remove them from their car and they might be the only person in the car. Do you try and contact their parents? Presumably, you just do not turn them out on a dark road.

Insp. Boorman—Certainly not. We recognise that we have a duty of care and we make all the inquiries necessary to satisfy ourselves that the person is not exposed, wherever possible. In some cases, we have no control over that. In the majority of cases, a parent or a partner will come and collect, or somebody else who is not drug or drink affected.

Mr HAYES—Do you do drug testing in the police force?

Deputy Commissioner Overland—No, we do not. It is one of the things we have been trying to negotiate to have put in place.

Mr HAYES—I want to go back to your view about drug of choice, particularly ecstasy. I think about two years ago the NSW Policy Integrity Commission started drilling into that aspect.

Deputy Commissioner Overland—We understand that we draw our workforce from the general population. We do screen and we are careful about the sorts of people we let join the organisation. But, that said, we still see trends in the broader organisation reflected within our own. We do see some evidence that some of our own people use these drugs on a recreational

basis. It is one of the reasons why we want drug testing in the organisation. We think that there is good policy reasons for it, given that we let our people drive cars at fast speeds and carry weapons, and use those weapons—and use them with force. We think there are duty of care and occupational health and safety issues and a whole range of issues that justify that. Unfortunately, we have not been able to either get the legislative basis for that or negotiate it on an industrial basis.

Mr HAYES—In terms of the statistics you present for the population of Victoria, it would have to be pretty concerning.

Deputy Commissioner Overland—It is, I think, because it actually presents a whole series of risks. We believe drugs are a major driver of other crime—what we call volume crime, particularly burglaries and theft of motor vehicles and theft from motor vehicles. So it causes that harm. I think it also provides a market place in which organised crime operates. It actually feeds high-end criminal activity. Obviously, we are also concerned about the longer term health and social impact of drug use.

There is some evidence emerging—and I guess it is disputed—about the long-term impact of cannabis use. There is also some quite concerning evidence starting to emerge about the long-term impact of use of amphetamines and other synthetic drugs, extending to the point where there is a view that it may cause organic brain damage with long-term use. That is of particular concern to us because, ultimately, those people are more likely to continue to come into contact with the justice system. Health issues aside, they are likely to present a continuing problem for us over the years to come.

Senator FERRIS—Ms Quinn, as an analytical chemist, would you like to add anything in respect of the long-term effects of these drugs?

Ms Quinn—I think that what Deputy Commissioner Overland said is very true—and not only the drug component but the other components within the tablet are also going to have health issues from the relationship that many of those are carcinogenic substances. So you are not only dealing with substances that are going to affect people’s minds from a health perspective; you also have the issue of other illnesses such as Parkinson’s disease and Huntington’s disease. All those sorts of things have been associated with some of the primary chemicals that are used in the industry. In the long term, I think we are potentially looking at a significant health problem which is certainly acknowledged by probably all of us around this table.

Mr WOOD—Deputy Commissioner, you mentioned the point before that at a night club you may be one step away from major criminal activity. What other information do you actually need to assist in this fight? We spoke about the fact that a voluntary code of practice is not working. In regard to that, what information do you actually want to be given? I have given very strong vocal support to CrimTrac. Would you support the proposal that chemical manufacturers supply information when a person purchases chemicals that could be used for terrorism or for making drugs? If they supplied that information to police, it could be stored on a national database like CrimTrac. What are your thoughts?

Deputy Commissioner Overland—On that issue, we certainly advocate stronger precursor control, and that means working with the pharmaceutical industries and the agricultural

industries that have these chemicals, often for quite legitimate purposes. They can be used for many purposes that are quite lawful, but clearly some of these drugs or chemicals are diverted into the illicit market. We think that the evidence around improvements in pseudoephedrine control indicates to us that stronger precursor control generally will help. I might also ask Jim O'Brien to come in and talk about a couple of issues, because there are some vulnerabilities around the chemists who are vital to the production process and there are also some legislative issues.

Det. Insp. O'Brien—Basically, in relation to the people who have the ability to cook this, particularly at the higher end of the market in relation to the amphetamine trade and MDMA, we would say there are a limited number of people within the Australian community who have the high-end abilities to do that. We might be talking about a figure of between 500 and 1,000 people across this country. What has been happening—and we have evidence of a number of instances of this—is that these people who have this high-end knowledge are caught producing, generally after a very resource-intensive and costly investigation by the law enforcement agency involved, only to be seen to be released on bail for an extensive period of time due to the delay in forensic examination. They then have to face a significant court process, they need to raise funds for that court process to pay their barrister and as a result they are straight back into the market again. These people, albeit they are an integral part of the trade, are generally controlled by organised crime and the principals within organised crime. Once we charge these principals within organised crime, again on the basis of delay these people are being granted bail consistently across the board.

What we would say is that there is a need for some form of legislation in relation to people who are involved in the conduct of a continuing criminal enterprise, where this is an ongoing form of trade for them and has been over a period of time and where there are a number of people involved—say, five or more. Where it can be shown that there is supervision, organisation or control and substantial assets are being derived, we say that a different course of action should be taken in relation to those recidivous offenders and they should be dealt with differently by the courts. Otherwise, we are just going to continue to lose the battle because these people are granted bail and are back out there producing within 24 hours, and we have a number of instances of this.

Mr WOOD—So are you suggesting amendments to Commonwealth legislation?

Det. Insp. O'Brien—We are saying that there is a need for some form of legislation over and above the substantive offence of drug trafficking a large commercial quantity for the people who are involved in the organisation, control and supervision of these criminal enterprises.

Mr WOOD—Would you be able to submit something on that?

Det. Insp. O'Brien—Certainly. There is current legislation in the US in relation to that very subject.

Mr WOOD—It would be very handy for us to look at that to see what you actually want.

CHAIR—What does the US legislation actually say, for example?

Det. Insp. O'Brien—Basically that, if the prosecution can prove that there are five or more offenders involved and that it is a continuing criminal enterprise, not a one-off situation—and there have been a number of instances of that in organised crime in Victoria since 2002 which would be public knowledge—delay in the prosecution brief being prepared should not be grounds for bail.

Mr WOOD—You have my support on that. Can I go back to the other question I raised before. I am not sure if you will actually want to answer this. To fight the war on drugs or terrorism would the Victorian police like to know who is buying what chemicals through chemical manufacturers, to be automatically notified of that and for the information to be stored in CrimTrac?

Det. Insp. O'Brien—There is a move already in relation to legislation to do that in Victoria. That matter is not finalised. I believe it is probably going back into the national circuit for further discussion in relation to the input from the chemical companies, and in particular the Plastics and Chemicals Industries Association and Science Industry Australia. We are looking at some form of notification within Victoria. We are probably looking at some form of mandatory reporting for the higher end level of chemicals that are currently listed within category 1 or the code of the practice and perhaps mandatory reporting for those within categories 2 and 3.

Mr WOOD—So you are definitely supportive. That is the answer I am trying to get.

Det. Insp. O'Brien—Very supportive.

Senator POLLEY—Going back to the issue of health and crime statistics, is there any evidence in Victoria that demonstrates that assaults and serious crimes have increased because of the drug activities? Would it be fair to say that those users are putting themselves in a state more vulnerable to sexual assault and other activities like that? Do you have any comments?

Deputy Commissioner Overland—Certainly the evidence is that the problem drug in assaults is actually alcohol. That tends to be prevalent in a high percentage of assaults, either family violence matters or assaults in the streets. There has been a slight increase in assaults across Victoria. It is one of the crime categories that has not reduced. Some of that is down to increased reporting around family violence, which we are encouraging. We are not always well positioned to know whether drugs are a factor because we would not necessarily test people at the time. We tend to know about alcohol because it tends to have a more obvious effect. It is not always as clear that drugs are present. I do not know that I can take that much further.

Senator POLLEY—We have heard evidence in the submissions before us today in relation to pill testing. I know in South Australia they have rave parties and they do have some doctors there. We have heard evidence for and against that. I was wondering (a) whether the Victorian police know whether there is any pill testing happening in Victoria and (b) whether or not you have a view?

Senator FERRIS—Do you attend rave parties and in what capacity?

CHAIR—That is not a personal question!

Deputy Commissioner Overland—We do not support pill testing. I guess we understand the arguments for it. Kate is better qualified to comment on the science of it. Our view is that, unless you do this stuff pretty carefully and you fully understand what is in a pill, you run all sorts of risks in doing it in a half-baked way, if I can put it that way. I think the science is such that you really need to do it pretty rigorously in a controlled way to be very clear about what is in there.

Senator POLLEY—There is also the issue of liability. When you hand a drug back and something happens—

Deputy Commissioner Overland—That does flow. We do not support it for those reasons. We understand the arguments for it but we think it is quite dangerous. No, we do not attend rave parties.

Senator FERRIS—I mean the police. Do the police go either in a formal capacity or an undercover capacity to rave parties? Do they take dogs? If you know one is on, what do you do?

Deputy Commissioner Overland—We do from time to time use drug-detecting dogs. We are not all that keen, to be honest, to go into those situations. We have found from past experience they can be quite volatile and doing that can actually cause more problems than it solve. It does not mean we do not do it but we do it pretty cautiously.

Senator FERRIS—Not in uniform?

Deputy Commissioner Overland—It depends. We certainly have stopped operating in nightclubs in the belief that, if we could actually find drugs and make arrests, that would enable us to work our way back up the supply line. We have found from experience that that does not really work and that it just creates a whole series of risks. We think there are more effective ways of dealing with the supply side. As I say, we are a little bit cautious about being too present in nightclub environments because there is a whole series of risks not only to our staff but also to the patrons.

Mr WOOD—My background was the Melbourne East police station. One day I had a young constable come up to me and say, ‘You wouldn’t believe the nightclubs, how out of control they are with drugs,’ because we were not patrolling there. Again, if we tried to send undercover police in there and if they tried to arrest someone, all hell would break loose. Do you have any strategies in place prior to entry so that you have police dogs there? The only reason I say this is that previously you said that in Australia each weekend there are 100,000 people using these tablets. What are the police doing? I know you are doing a hell of a lot, but how can we actually stop people going in there and saying, ‘Hey, if I go in here, I can actually use my drug tonight’?

Deputy Commissioner Overland—We work with owners of licensed premises around this. If we get a sense that it is an issue, we have licensing inspectors who focus particularly on licensed premises and the way they conduct their business. We do work with them around responsible service of liquor. If we become aware that there are drug issues, we try and work with them. We think that is a more effective way of dealing with it—actually putting some of the onus and the responsibility back onto the people who are running the nightclub or the hotel to try and make sure as best they can that it is clean.

Having said that, even they cannot guarantee that. As I say, we do use drug detector dogs; we do run operations. We tend to run them in the street, though, without actually going into licensed premises. As I say, it is not that easy. If we do run an operation, if we do go into a licensed premises, we are aware that there are some risks around that. The first thing that happens is that all the drugs go on the floor, down the toilet or, worse still, people might be inclined to swallow them. So we do not see that that is necessarily the most effective way to try and deal with that particular problem.

Mr WOOD—Is there anything in the legislation here that is proposed or being reviewed? Obviously, with the licensed premises, the management has a duty of care and if you have a person who is intoxicated they are removed. If there is a person under the influence of drugs, I am trying to think about putting more responsibility onto the licensee. I know there are going to be certain places around Melbourne, as there are in other states, where there is a greater use of drug use and the management may be turning a blind eye to it. Is there any legislation which can force a person to take responsibility? Have you heard of any legislation overseas or elsewhere?

Deputy Commissioner Overland—I think licensees now have responsibilities in order to retain their licence, anyway. There are times when we take licensees to court, or have them taken to court, because we say they are not discharging their responsibilities. That is more often around service of alcohol or control of behaviour. Senator Polley asked the question before about sexual assault, and I did not quite get to that. Drink spiking is an issue, but again we have found it more effective to actually work with licensees. There is a strategy in place. There is an awareness. We try to make people aware of the issue. We try and work with the licensees and their security staff just to keep an eye out for this but also to have people takes basic precautions. Don't leave drinks unattended—those sorts of things. Clearly, there has been a rise in drink spiking and sadly it is often associated with sexual assault. I am not sure that legislation is necessarily going to provide the answer to those things. I think it is actually much more about using these different sorts of strategies to work with people and try and deal with it in that way.

CHAIR—The statistic you gave right at the beginning which Mr Wood just repeated: was it 100,000 pills or 100,000 people a weekend?

Deputy Commissioner Overland—Our intelligence is saying 100,000 tablets.

CHAIR—Per weekend?

Deputy Commissioner Overland—Per weekend across Australia.

Mr WOOD—What is Victoria's figure?

Deputy Commissioner Overland—I do not have that figure but if you break it down roughly on population—I am just trying to do the maths; I am not sure.

Mr WOOD—I assume the heavy states are going to be Victoria, New South Wales and Queensland.

Deputy Commissioner Overland—They would be, but I think there is evidence that these drugs are freely available right across Australia. They tend to predominate in major urban areas.

Senator POLLEY—I make the point that one of the major concerns for my state is that heroin usage was really minor in Tasmania, but with these sorts of drugs the usage is increasing to the point where we are actually on the map, which is a real concern. My concern in relation to spiking drinks is the idea of putting your faith in licensees. I was on the licensing board in Tasmania previously. We have had some horrendous cases where it has actually been the licensees who have been the perpetrators. Luckily, they are in jail now, but that is a major concern.

Mr WOOD—That was the point I was raising before. When you have crowd controllers selling drugs and the management know that—

Deputy Commissioner Overland—But there are measures in place that allow us to deal with that. Clearly, if a licensee is behaving in that way then there are criminal offences, but you can also take their licence off them, under existing arrangements. Similarly, if employees are involved then there are criminal offences. At the end of the day, you do have to rely on people actually complying. I think the laws that are in place are adequate, but you still rely on compliance.

CHAIR—Kate, it was suggested that you might be able to give us some thoughts or some evidence on the accuracy of testing that happens around Victoria.

Ms Quinn—Pill testing is now based largely on commercial kits that are available. They are essentially a colour test kit. You take a scraping from the tablet, drop a couple of drops of liquid onto it and you will get a colour from that. The colour is indicative of a class of drugs or a particular reaction but not a specific drug. For amphetamine type stimulants—the methamphets and amphets—you will get an orange colour; for ecstasy you will get black. But if you have amphetamine and ecstasy together you will just see black, because black will override orange, for example.

There is no component splitting in there, so you have no sense of what is in the tablet other than that the darkest reaction will be the predominant one. You have no way of assessing the quantity of material in there. It does not give you a purity test. There will be a lot of people saying, 'Oh, yes, it is a faint test, so you've got a lower level,' or 'It is a strong test, so you've got a higher level.' That really does not mean anything. The test responds to a certain quantity and it really depends how much you have in that sample, not how much is in that tablet. Because the tablets are not necessarily made to a pharmaceutical grade they are not necessarily homogeneous, so the little scrape may have been from the low side of the tablet et cetera, which is why when we analyse everything is ground and you have these scientific practices.

I guess the big issue is that the techniques that are used in the field do not allow component splitting or separation of the components within a tablet. When you take it back to a laboratory, that is exactly the type of techniques that we have. We have separation and identification techniques, so we can look at all the components in there that are active drug components. We will get some information about the other components, because there is always something else in there—tablet binding agents and all those sorts of things. None of that you can get from pill testing.

The South Australian model is interesting because they are using a doctor. That is similar to an overseas model. The doctor is not there to talk about the tablet; they are really there to talk about the potential of what might be in the tablet. They are using that as an education system. There are lots of to-and-fros about that, but their pill testing still does not give them any greater analysis in the field. I think what is happening in the South Australian model is that they are taking some of those scrapings back to the laboratory for further information. There is some potential argument for that. Some of the people in the using community say that what is available in rave parties is different to what is on the street. In 20 years I have never seen that to be displayed. You might get a rush of a substance that might be in there, but generally the community eventually displays the same sort of model. So you are unlikely to get one dangerous tablet in that rave and never see that anywhere else in the country.

Mr WOOD—What is a dangerous tablet?

Ms Quinn—That is a very interesting question, because a standard MDMA tablet that hundreds of people take every weekend could kill one person and not affect the other. To me, they are all dangerous. They are dangerous substances. A lot of people look at them and say that they are medical substances, so therefore they must be safe. But medicine is always dispersed in a particular usage for a particular problem at a particular quantity, and assessing your health.

CHAIR—What is sometimes said is that all drugs are bad but there could be some scraping in it that will kill you because it is a really shoddy production.

Ms Quinn—That is true, and with respect to some of the substances that we see, PMA is a very good example of that. PMA is probably most prevalent in South Australia. That seems to be the state that it crops up in every now and then. That substance has a toxicity that is lower, so people are affected at a lower level more quickly. Across the range of designer drugs you have different levels of toxicity; some of them will have a greater effect earlier than will be the case for other substances. But when you make an illicit tablet, you are not, in making it, controlling what that toxicity is. So you might take a tablet with PMA in it today and it is fine, and in the next batch you get, they have gone a little bit too heavy on it and the people who take it will in fact die from that tablet.

CHAIR—And the testing that is done in the rave parties—

Ms Quinn—Won’t differentiate that.

CHAIR—I will follow this up later today but I think someone told us in Brisbane that for $80,000 you could buy a machine or something that is reasonably accurate. Are you familiar with that comment?

Ms Quinn—They could be talking about an ion scan. Ion scans are used at airports, for example. So when you go through the ion scan and someone takes that little swipe off your suitcase, that is the technique it is using. It is still only an indicative test. The only confirmation test that you can have is a laboratory test, which is run against known standards at that time when everything is prepared in a laboratory concentration. So with a GC/MS, for example, that we would use, that is one component of the test. That piece of equipment costs about $120,000. But you must then have known standards—known purity, known concentration—otherwise you

get a result that means nothing; you just get a peak, and someone says, 'That's 10.' But you have to compare that to the size of a peak of something that you know is 10, otherwise how do you really know what that is?

Mr WOOD—How long would it take to analyse one tablet, to say whether it is so-called 'safe'?

Ms Quinn—If we were looking at it from the point of view that if I was given a tablet right now and asked to confirm that—

Mr WOOD—What is safe?

Ms Quinn—That is a very good question.

Mr WOOD—What I am trying to prove is that it will take a heap of time to actually come up with this analysis.

Ms Quinn—If you gave me a tablet now and I was in my laboratory and you asked me to determine what was in that, it would take me about half an hour to tell you what components were in it and then, based on what was in it, I would have to say whether there was one or more components in there. We would then have to set about quantifying that to determine what the quantities are. That might take, if we did nothing else, a couple of hours—so maybe three to four hours to get confirmation.

CHAIR—I do not want to misquote Enlighten—I think they were the people who gave evidence in Brisbane. Have you had this face-to-face discussion? They, or someone, will tell us that there is a way of doing it that is not perfect but which means that they might save some lives by doing so. Have you had that technical discussion with—

Ms Quinn—We have had a number of conversations and it is probably fair to say that we have a difference of scientific opinion on that. The quality of evidence that they are looking at would not be suitable for me to send someone to court and possibly to prison. I guess I would say that, if it is not suitable for that, it is not suitable to tell someone it is safe to take and that their life will not be at risk.

CHAIR—You have this difficult moral and legal question for the police force: you are saying you know that at a rave party that is happening down the street there are people in there who are taking drugs and probably there are people there selling drugs. For the right reasons, you do not go in there. Those who support harm reduction say, 'Look, we also know that but at least we're going in, and out of tonight's efforts we might save a life.' Aren't they right? If they save two lives that night, aren't they doing a good job?

Deputy Commissioner Overland—Obviously, if they save two lives, we would think that is a good outcome. It is an interesting issue, isn't it, in terms of—

CHAIR—It is very difficult.

Deputy Commissioner Overland—Do they do longer term harm by doing that? Is that then encouraging other people to think it is safe to become involved? They might save two lives that night but, because of the message they send, 20 other people might decide to use the substance and three of them might die. You just do not know in this area; nothing is ever simple and straightforward. The point we make is that they are illicit substances; it is an offence to use them. We try to police that industry as effectively as we can but it is difficult. The point is that people take enormous risk in using this substance.

CHAIR—I understand all that but you said that 100,000 tablets are taken each weekend and, I suspect, it is increasing and so we are losing the battle—not through any fault of yours or your colleagues elsewhere. I do not know what the solution is.

Mr HAYES—If we are talking about hotels and things like that, your licensing branch is going to be out there enforcing the various requirements associated with that. If someone is going to run a venue, whether it be a licensed venue or otherwise, and you know that drugs are being taken there, is there not some obligation to be involved? I was advised that in New South Wales there was a licensed venue and people were going in and it was obvious they were taking ecstasy tablets. The proprietors were not selling bottled water; patrons paid about $5 for a plastic glass of water. This was to save dehydration. Now if that is the sort of thing occurring, shouldn't some responsibility be enforced on operators of venues?

Deputy Commissioner Overland—We agree, and that is the point I was trying to make: we do try to work with licensees and operators to make sure they are aware of their responsibilities and meet those.

Mr HAYES—It is the people who run a venue where it is likely that illicit drugs will be consumed. Are they going to take all the necessary steps to minimise the impact of it or are they going to continue to make a profit out of it?

Deputy Commissioner Overland—We think a lot of them do and we work with them and find that is a much more effective way of trying to deal with that issue as opposed to sending police in, which has a myriad of problems. That being said, how many night spots are there? How many can we physically police? How do you decide? It is much more effective to work with the licensees and the people in control. A lot of them do work effectively with us. The point is that even if they are attentive, even if they are trying to do the right thing, there is nothing to stop people coming in with drugs that they then sell. Often with all the best will in the world it is not possible to stop that. From our point of view there is a couple of things to consider. One is that the licensees and their staff are not directly involved themselves—if they are that is obviously a problem and then we would take a different approach. The second thing is that they do have reasonable and responsible practices in place so that they actually minimise the potential for those things to happen.

Senator FERRIS—Ms Quinn, you might be able to supply a paper to the committee that might answer this question more fully. If you do a random sampling of some amphetamines or ecstasy tablets you pick up, how does the inconsistency work? For example, from 20 tablets that you might have tested did three of them have this or four of them have that? It may be that somebody has presented a paper or you have presented a paper on this because I imagine it is

quite an interesting exercise. Can you provide us with a paper that demonstrates a sample of tablets and the inconsistencies you talked about?

Ms Quinn—I have done that on a previous occasion; I have probably not updated that data recently. I am able to look at all the seizures that we have had of tablets by the Victorian police and break those down into major drug components and major other components, so I can update that data and provide you with that.

Senator FERRIS—What I would like to have a look at is, for example, a chemical analysis that demonstrates the inconsistency and the dangers of some of the inconsistencies in these tablets. If you could supply that to the committee it would be very helpful.

Ms Quinn—Certainly, it will take me a few days but I will put that together.

CHAIR—Are you saying that five ecstasy tablets will have different components?

Ms Quinn—Let us choose the Mitsubishi logo, for example: you will find that there are a range of those tablets; you will find a range of colours of those tablets and a range of drug make-ups within those tablets. So it is not saying that just because it is that logo it is consistently all the same drug content, if I am getting what you are saying correctly, and I can look through that.

Senator FERRIS—That is exactly what I wanted to try and show. Kids who got a red something-or-other last week might think, 'Oh well, if I get a red one this week, it will be the same as what I got last week or it might have been the same as my friend got half an hour ago.'

Ms Quinn—I can certainly break that down, to give you some idea of what that looks like.

Senator FERRIS—It would be very useful if you are able to do that. Thank you very much.

Senator POLLEY—My question goes back to your opening statement in relation to the reality being that criminals seem to be able to be one step ahead—for instance, with mobile phones. You made a comment about voice over the internet. Is it because there is not a way of intervening in that process or is it because of a lack of legislation or a lack of resources that that is causing a problem in being able to detect and follow through on the importation of the ingredients into this country?

Deputy Commissioner Overland—It is probably a bit of a combination of all three. Certainly, there are some technical issues that need to be worked through. It is then a matter of ensuring that we do have appropriate legislation to access this information. Some of it is about putting responsibility back onto the providers of internet services. The telecommunications industry is regulated, so the telcos understand their responsibilities and there are good arrangements in place that facilitate our access to that sort of technology and information, and that needs to be replicated. It is a significant issue for all law enforcement.

Senator POLLEY—So it is in a range of areas, not just this one?

Deputy Commissioner Overland—Yes.

CHAIR—We could have gone on all day here, from our point of view. Thanks very much for coming along and for the information you have given us. We very much appreciate it.

Deputy Commissioner Overland—Thank you.

[11.33 am]

BERGIN, Ms Jenny, Director, Community Pharmacy Practice Division, National Secretariat, Pharmacy Guild of Australia

LOGAN, Mr Timothy John, President, Queensland Branch, and National Vice President, Pharmacy Guild of Australia

McBEATH, Mr Peter, Vice President, New South Wales Branch, Pharmacy Guild of Australia

CHAIR—I welcome the representatives of the Pharmacy Guild of Australia. This committee is a joint committee of the Australian parliament. We are a committee that oversights the Australian Crime Commission, and we are conducting this inquiry into the manufacture, importation and use of amphetamines and other synthetic drugs. We have received a submission from you, and I will shortly invite you to make an opening statement, if you feel you would like to, or if there is anything you wish to add to or amend in your submission.

We will be asking you questions but you are not obliged to answer anything about confidential matters or which, for other reasons, you do not want to answer. Hearings in this committee are protected; privileged. You can abuse me and call me all sorts of names and I cannot sue you for it! The committee members have a number of questions they would like to put to you. Mr Logan, would you like to make a short opening statement? Do you have anything to add about the capacity in which you appear?

Mr Logan—I am from the Queensland branch of the Pharmacy Guild. Jenny is our consultant pharmacist. She is based in our national secretariat. She does a lot of research and other things for this type of occasion. My colleague Peter McBeath is an ex national councillor from the New South Wales Branch of the Pharmacy Guild. Peter has some pharmacies in some of the bigger private hospitals in Sydney. My background is that in addition to being the Queensland branch president of the Pharmacy Guild I also have my own pharmacy in Nambour. I have also practices in Townsville and on the Atherton Tableland. I am also the Deputy Chair of the Pharmacist Board of Queensland.

CHAIR—It is the Pharmacy Guild of Australia?

Mr Logan—That is right. I am a national vice president of the Pharmacy Guild of Australia.

CHAIR—Where did you work in Townsville?

Mr Logan—We used to call it Nathan’s Plaza, but we have stopped that. I lived in Kirwan from 1990 to 1995, so up in your neck of the woods.

CHAIR—Yes, indeed. Mr Logan, do you wish to make a short opening statement?

Mr Logan—Yes. I am assuming that the members of the committee have seen the submission that the Pharmacy Guild put in earlier this year. Basically, there are no amendments to the content and recommendations contained therein. The attitude of the Pharmacy Guild is that while a runny nose is not a life-threatening illness, it is a problem that can cause loss of productivity and it can make your day generally miserable. The unfortunate thing that our profession is facing as it applies to your committee's investigations is that a rather useful drug which is safe in many other respects happens to be a precursor for these so-called party drugs and the criminal element that is involved in sourcing them puts the community in danger and puts our members, who are the owners of pharmacies and the staff working therein, in danger.

We have the attitude that we do not feel that the baby should be thrown out with the bathwater. The Queensland branch of the Pharmacy Guild has developed what we call a software decision support tool called Project STOP, which you may have seen mentioned several times in the submission. It is working very well in Queensland. The health department and the police department have been delighted with the progress. You probably saw a report of a number of successful prosecutions. There are an even greater number of arrests that have occurred and an even greater number of investigations that are occurring at the moment. Would you like me to explain briefly how that works?

CHAIR—We would. We have read this in the submissions and have had some evidence about this somewhere else, but could you briefly recapitulate for us.

Mr Logan—The Queensland legislation, in particular among the states, authorises and requires pharmacists not only to request, or even require, photographic identification for someone coming in and requesting a pseudoephedrine containing medication but also to record the nature of the identification if you do not know the person. The Pharmacy Guild developed a software support tool that linked in to a database that was accessible by the health department and the police department, so all the requirements were being met in that they had quite stringent requirements with regard to access and security of the data. Basically, if you come in to a pharmacy and the pharmacist does not know you and you ask for a medication containing pseudoephedrine, we request a driver's licence, typically; it can be an 18-plus card or it can be a passport. We enter the serial number of that particular identity document into the software; it is a web based tool and goes via the internet to a central database. If you have purchased that product in the last three days, it will show up on the computer.

Mr HAYES—Can that be viewed or is that just for the pharmacist's—

Mr Logan—If you were the possessor of that ID document and you presented that ID document. Similarly, if someone has forged the document and pasted their own photograph on it, it will show up. The pharmacist is then able to record the action they took: whether they allowed the sale because the person had not appeared; whether they disallowed the sale because it was quite apparent that someone with that identification document had presented it to a number of pharmacies in the past couple of days; or whether they allowed what is called a safety sale, where you are unsure but you want to flag to the police that you felt it might have been a bit questionable but you supplied it for your own safety's sake or because you felt there was not sufficient reason to refuse the sale. That gives a data trail for the police to mine and detect people who inappropriately access the medication for diversion purposes.

Mr HAYES—When you say it is a trail for the police, what does it do for the pharmacist at that stage? Does that give him some information as to whether or not he should sell it?

Mr Logan—Instead of, say, looking at someone who might be a bit scruffy and thinking they look like a diverter and looking, perhaps, at someone dressed nicely, like some of the members opposite here, and thinking they are obviously very respectable and you will supply them, we were finding that we were unable to make that generalisation. As a matter of fact, even in my own community in Nambour, they would go into the RSL and say to a lovely little old lady playing the pokies, 'If you want $50, go into the pharmacy and buy me a packet of pseudoephedrine.' They were getting around it like that. There were a few arrests of people of whom you would think butter would not melt in their mouths—some lovely old people, a couple of grey nomads who were funding their trip round Australia by buying pseudoephedrine tablets wherever they went. This has allowed Queensland pharmacies to make informed decisions. They are still able to give these medications to people who genuinely need them and who genuinely get a benefit from them, but the anecdotal evidence from my colleagues is that they are getting harassed less by the drug runners. In my pharmacy in Nambour I can say that I hardly ever have to knock back people now, which was a significant problem before.

Mr WOOD—Is this compulsory in Queensland?

Mr Logan—In Queensland the health drugs and poisons regulations require that if a pharmacist does not know the person who requests the medication they have to record the nature of the ID. I do not have to use the Project STOP tool—that is completely up to me—but I have to record it so that it can be accessed by whichever regulatory authority wants it.

CHAIR—You know me, because I have dealt with you, so let me take my town: there are four or five pharmacists in town and they all know me.

Mr HAYES—You could go to all of them!

CHAIR—Seriously, if I went to each one and bought a cold and flu tablet, would each one of them record on their computer—which goes to a central database—that I had bought that from them?

Mr Logan—We have two issues here. Probably because they knew you they might be inclined not to record your identity. However, the scheduling of the pseudoephedrine-containing medication requires them to label the medication, and usually the best way to do that is through your dispensing software, which keeps a record. If you were a bit hard up and the parliamentary pay rises had not come through and you were seeking an alternative source of income, you would eventually get detected, but there is no doubt the system—

CHAIR—Is every cold and flu tablet that is purchased in Queensland recorded now somewhere?

Mr Logan—In Queensland it has to be at least recorded in the pharmacy, but about 70 per cent of pharmacies are using the software support tool the guild developed. It is provided at no charge to all pharmacies, whether they are members of the Pharmacy Guild or not.

CHAIR—That sends it direct to a central data collection?

Mr Logan—It is stored centrally. As I say, the police have access rights. They cannot edit it or manipulate it, but they are able to access it.

CHAIR—Are you able to access it?

Mr Logan—I can only see what has happened in my pharmacy.

Mr WOOD—The New South Wales police gave evidence and they were very scathing of what was going on in New South Wales. Pretty much what you have in Queensland would cover a lot of their concerns. You are having people going around to different pharmacies, just walking in and buying up. There was no security glass. They were very supportive of a code of practice. I even think the figures given out to us were—this was evidence from someone from a pharmaceutical company, a professional lobby group or whoever gave evidence—that 40 per cent of pseudoephedrine tablets are walking out the door illegally.

CHAIR—In a certain part of Sydney.

Mr McBeath—Yes, that is possible in a certain part of Sydney, I assume.

Mr WOOD—No, I do not think it was actually a certain part. I think that was the evidence given. He backed down from his evidence soon after, but he still made the point that, if you have strong safeguards, that is going to stop them, and that is obviously where you guys need to come to the party.

Mr McBeath—I come from New South Wales—and, by the way, Tim's introduction said I am in hospital pharmacy, but I happen to have two pharmacies that are not hospital based. One is in a large shopping centre in a suburban area and the other one is at Westmead, which has been a hotbed of drug trafficking and drug dealing going back as long as I have been around.

In New South Wales currently we are having difficulty convincing the regulators that Project STOP is not in breach of privacy legislation. The Pharmacy Guild in New South Wales would be very keen to introduce Project STOP, and if you read our paper one of our real concerns is that there is lack of consistency of legislation across the states, which is causing us all concerns and always has been a concern. At the back of the submission there is a form which I use in my pharmacies to record the sale of all pseudoephedrine based cold and flu products. It is mandated under the schedule 3 legislation in New South Wales that pharmacists must keep a record, but it is not mandated that you have to produce identity to obtain a schedule 3 or a pseudoephedrine product.

Mr HAYES—But you have to keep a record of it?

Mr McBeath—We have to keep a record, but we cannot force somebody to give us identity. It is a real issue.

Mr HAYES—But you are still obliged to make the sale?

Mr McBeath—No, you are not obliged to make the sale. That is always a judgement and, as Tim said, it is very difficult—and we all know it is very difficult, because I have been involved earlier in this type of hearing—to pick the drug runner, because often the one who gets through is the most respectable-looking person or the lovely little old lady. There is a lot of evidence to support that. So you cannot pick the person and, if somebody comes in and obviously has some distress and asks for a cold and flu product, what are you to do? You make an assessment that, yes, the person seems to have the symptoms and they have made a reasonable request and so you would go with the sale. I had a lawyer who went absolutely ballistic in one of my pharmacies when he was asked for identity. He said we had no right to get it, that it was an invasion of his privacy, and he went absolutely off his tree.

CHAIR—He needed a sedative; he did not know how to ask for it.

Mr McBeath—That may be true. All I am saying is that there is a difficulty there. If it were mandated by legislation that people were required to produce identity to obtain these products that would certainly assist us all in administering the problem.

Mr HAYES—So the guild would be supportive of extending what is occurring in Queensland now?

Mr McBeath—The guild is supportive of that. The guild has made submissions to that effect.

Mr Logan—We have met with regulators in each jurisdiction to demonstrate the tool to them, and it is universally met with, 'Gee, what a good idea.' The record fulfils an obligation, but for someone to go and collate that information, read the handwriting, put it into a database and then use that to make any informed decision about where diversion is going is just hopeless.

Mr HAYES—Would it be technically possible to use the Queensland system? I suppose, if you are going around collecting these for nefarious purposes, you do not exactly recognise boundaries and no-go zones.

Mr Logan—As a matter of fact the federal Attorney-General has made some funding available to roll it out. However, we are faced with the problem that the attitude of the privacy commissioners, both state and federal, is, 'If it's so important, why isn't it regulated?' and the regulators are saying: 'Look, don't worry about it. We want it. Privacy won't be a problem,' but no-one is prepared to sign off and say: 'Okay. We'll give privacy a public interest clearance,' or, 'We'll change our regulation.'

Ms Bergin—Attorney-General's have looked into this issue. My understanding is that they believe it is not a privacy issue but an issue of what mechanism we will use to record the unique identifier that is needed for all of the pharmacies to track where they have more than one request. The paper based system gives an individual pharmacy the ability to say, 'You asked for this yesterday and therapeutically perhaps it's not appropriate to make another sale today.' The advantage of Project STOP is that, with these multiple requests, you can see where the runner is moving geographically. It is an issue of the unique identifier and what system is acceptable across the states and territories for the pharmacies to be able to track these requests.

Mr Logan—The Attorney-General has made available these funds but requires the Pharmacy Guild to indemnify the government against any misdemeanour or whatever occurs, which could include privacy. This is where our problem is. We have also shown this product to a lot of the regulators in the United States, particularly in Illinois. There was great deal of interest, including some from one of the big drug chains over there. Everyone who sees it says, 'This would address one of our big issues.' It allows you to track any diversion but it is a disincentive for people to source the product for diversion, because they know that pharmacies are tracking this and there is a risk of them getting caught. We have never heard exactly what proportion of amphetamines on the streets are being sourced from pseudoephedrine. We know it is a problem, and you see the pictures; the police show us the pictures of cars with truckloads of—

Mr HAYES—You heard the evidence this morning. I think the police were saying this morning that it is declining in terms of the proportion of drugs—

Mr Logan—They are looking to get the drug in a 44-gallon drum from overseas and drop it off the coast of Darwin now. I think that is probably where it is. I guess we are saying that it would be unproductive to either get rid of pseudoephedrine or make it prescription only. It would be a huge load on the MBS. The alternative medication phenylephrine has variable bioavailability—in other words, it might work okay for Jenny but not for me—whereas pseudoephedrine is much more consistent in that regard. Phenylephrine has a bit more scope for interactions and maybe some pressor effects to elevate blood pressure. There is a reason why pseudoephedrine was the market leader. It was a more effective, more useful medication.

If regulations could be amended to permit other jurisdictions to require pharmacists to record identification, I believe those jurisdictions will have the same good results for this source of pseudoephedrine and amphetamine production as Queensland has. I guess it will push it somewhere else, but at least it will not be a problem through pharmacy and the community will still have access to a useful medication.

CHAIR—Did I read that some other state is actually trialling the STOP program or did I imagine that?

Mr Logan—A couple of states are looking at it closely and liaising with their regulators. The ACT is trying to get it through at the moment; Tasmania is very interested; New South Wales—

Mr McBeath—New South Wales will be very active in trying to get it through.

Mr Logan—We are just trying to get over this privacy hurdle at the moment, so—

CHAIR—I could never understand that. I do not care if anyone knows that I am having cold and flu tablets today.

Mr Logan—There are significant safeguards around. There is a pharmacists' code of ethics. All pharmacists who own a pharmacy are accountable to the Pharmacy Board, which is required to have a code of ethics. A breach of privacy would be considered unprofessional conduct and the pharmacist's registration would be accountable if that breach were serious enough. If a pharmacist did use that information improperly, they would certainly be buying themselves a

mess of trouble. Pharmacists have a reputation, I believe, of being very careful with people's health information.

Mr McBeath—I would suggest that we have far more important health information in our pharmacies about people than whether or not they bought a cold and flu tablet.

CHAIR—Exactly right.

Senator FERRIS—We had some evidence very early in this enquiry about the need for pharmacists to store the cold and flu tablets behind the counter or in an inaccessible position. How often do you check your pharmacies to make sure that people are actually abiding by that? Have you had a random study?

Mr Logan—That is an issue for the pharmacy board of the state or the health department in the state. For instance, I can say that in Queensland it is required that they be kept out of public reach and the compliance with that is very high. What they call the environmental health unit, which has responsibility for scheduled medicines, recently did what they call a sweep—

Senator FERRIS—What about all the other states?

Mr McBeath—In New South Wales, if it were not 100 per cent compliance, I would suggest it was totally unintentional within a pharmacy. Every pharmacy in New South Wales is inspected annually by an inspector from the Pharmacy Board, without notice, and that would be something that all inspectors would look for to ensure that the poisons regulations are adhered to. A pharmacist is in serious trouble if a breach of that is found and could well be brought before the board. That would be reported in any report. My belief is that the likelihood of a breach would be very minimal.

Ms Bergin—My understanding is that the level of active inspection would vary between states and territories, depending on resources. Some would have annual inspections but others would probably be based on complaint. They would investigate a complaint. But we do have the Quality Care Pharmacy Program. This is a standard within the program. We have a self-regulation process, whereby we have assessors checking that pharmacies are meeting the standards. To be QCP accredited they would have to meet this standard.

Mr Logan—There is a carrot as well. There is some funding available for pharmacists who achieve accreditation out of the third and now the fourth community pharmacy agreement.

Senator POLLEY—So those processes would then pick up? I might add, I think Queensland is doing a great job; I experienced it firsthand when I got sick, when I was up there for a committee meeting. If a pharmacist gets to know their clients, are there any safeguards to ensure that there is not an unhealthy relationship between certain customers and the amount of medication that is going through that pharmacy?

Mr Logan—Speaking of Queensland—and I am pretty sure it would be similar in other states—every six months both the Pharmacy Board and the department of health monitor warehouse withdrawals of medications containing pseudoephedrine. If anyone is sticking out

like the proverbial sore thumb, enquiries are made—please explain—and the believability of that statement can lead to other enquiries.

Let us take Peter, for an example, who owns a few pharmacies: he might do a buy through one pharmacy to get better commercial terms and then distribute them, so that might be a reason why you might stick out. I know in Queensland there is one person who is bit of a renegade who has seen the writing on the wall and sold his pharmacy, but he will still be accountable to the board and will probably end up being prosecuted for just being too lax. He was not a user of the Project STOP tool and he just said, ‘It is not my job to be the policeman; if you want it I will give it to you,’ and he has bought himself a mess of trouble.

Mr McBeath—In New South Wales, with the form that you have seen there, and again this was brought about by our legislation that was brought in, those forms are required to be retained in the pharmacy for a period of 18 months. So you do have some sort of audit check on the volume, and it would be very easy to pick up if there was some aberration in the volume of a product, as Tim has suggested, you could very quickly pick up whether or not there was a lack of balance between the recording and the purchasing.

CHAIR—Someone in Sydney—I forget who and I should have looked up the *Hansard*—said, almost as a throwaway line, that there was a certain suburb, which I will not name, in Sydney where they never took the cold and flu tablets back behind the counter but left them out and they were losing a hell of a lot just through theft.

Mr McBeath—I think we have got some time frames here. Recently, the change to the scheduling of pseudoephedrine products has made it a legal requirement now to put them out of customer access. Prior to that, many pharmacists—and I was certainly one—had always kept those types of products out of general customer access. I guess within a profession there were some different ways that people thought their profession should be practised. I am of the belief that it is a medicinal product that is deserved of advice whenever it is purchased. Others believed it was more a commodity product and did not need that level of advice unless the consumer sought the level of advice.

I guess if you look around the world everyone has different opinions. In the United States some of these products can be purchased readily. We were discussing that before. Pseudoephedrine has now become a problem in the United States, such that a number of states have suddenly brought in regulations, but in many states you can buy 144 packets of pseudoephedrine tablets and put them in your dillybag and walk through the supermarket checkout. All I am saying is we all have different standards.

Mr HAYES—Have you met Roger Corbett on this?

Mr McBeath—I have not gone down that pathway. I have recently been in the United States and I have recently been in other parts of Europe. I think that the Australian pharmacy is more proactive in this area than anywhere else in the world.

Ms Bergin—I would just like to reiterate one point that is in the submission. Whenever there is a change, and there have been a number of changes like the scheduling change, we do not have data throughout the supply chain to measure the effects. When you make a change to try

and fix the problem, the criminals usually manage to do something else. Unless we have good data to monitor what we are doing, I do not think we can make effective policy changes. I will just give you an example. Ice is being smoked or injected. Our anecdotal advice is that the local product is not as good and what you would have expected with the amount of smoking and injecting use did not happen because the void is being filled, and this is anecdotal, from importation of ice from overseas. So I would just like to stress to the committee that I think we really need good data. We do not even know what the extent of the contribution of any diversion from pharmacy is to the total problem.

When you think that there are milligrams in tablets and kilograms in drums, you will realise that it is a lot of work to acquire that amount through pharmacy. We are doing everything we can, but we suspect that the importation factor might be growing and that other measures need to be put in place. Unless we have the data, we cannot really substantiate that.

CHAIR—Thank you very much for coming. You obviously rearranged your schedule to appear before the committee and we very much appreciate it.

Senator FERRIS—I have just been in the United States as well. It was amazing to see what the corner store sold in terms of pharmacy products in the United States compared with here.

Mr McBeath—And what they cannot sell, because what we sell is reasonably cost-effective—for instance, analgesics. You cannot buy codeine in the United States. Everything is different.

Senator FERRIS—The range of stuff on supermarket shelves is extraordinary.

Mr Logan—You wonder why health is about 15 per cent of their GDP when you see things like that.

Senator FERRIS—You should have seen the alternative stuff.

CHAIR—You mentioned the Attorney-General had given some money.

Mr Logan—Yes—allocated some money.

CHAIR—What is the current status of that? I understand you have not taken it up because of the conditions attached to it.

Mr Logan—It was because of the indemnity requirement that the government requested at the time. I would be able to send you some advice or correspondence about that situation.

CHAIR—In the short term, could you repeat what you said.

Mr Logan—The government wanted us to indemnify it against any legal issues that might come about from people using the Project STOP tool. I guess if a pharmacist was sued because of their misuse of it and the government had sponsored the promotion of that tool, and had endorsed it to a certain extent, they wanted to be indemnified. Forgive me, I am the world's worst lawyer. I could get you a copy of the correspondence if you wished.

CHAIR—Could you do that. I hope you have got that wrong. It sounds to me ridiculous that the government would be asking for an indemnity. I am sure you are right, though I hope you are not. I would like to get the details of it.

Mr Logan—The advice I just had an hour before I started speaking to you was that it had not been resolved—there has been a bit of toing and froing and the issue is still there. Whether it is our lawyers being a little precious, I am not sure. In something like this, we would normally seek another opinion. I would be very happy to get that back to you.

CHAIR—You mentioned a lawyer. I happen to have been a lawyer once and was very vocal about having to give his name. Has there been instances amongst Pharmacy Guild members where a refusal to supply a particular drug has resulted in perhaps even more than verbal abuse?

Mr Logan—Being on the Pharmacists Board of Queensland, I can say that we have had a number of complaints of pharmacists being too over zealous—if that is not a redundancy—in taking this whole monitoring thing to the nth degree and almost shining a light in people’s eyes when they are asking them queries. I think Senator Polley mentioned that she was feeling crook and probably the last thing you want is an absolute interrogation. You can do these things fairly sensitively or you can be abrupt, I guess. We have had a number of complaints of pharmacists going further than what we consider common courtesy would dictate.

Mr HAYES—Who does that? Is it the pharmacist or your attendants?

Mr Logan—Because pseudoephedrine medications are schedule 3 or pharmacist only medicines, it requires some input from a pharmacist.

Senator FERRIS—Conversely, have pharmacists been attacked?

Mr Logan—There have been ram raids. A colleague of mine on the Queensland branch committee refused someone the other night and they reached around and grabbed her shelf contents and ran out of the pharmacy. She was there with a junior staff member on a Thursday night, so she did not go running after them. I have not heard of any actual assaults.

Mr McBeath—I have not heard of any physical assaults, but I have personally suffered one ram raid in my shopping centre pharmacy—

Mr Logan—There have been hold-ups.

Mr McBeath—and two break and enters over consecutive weekends where they came through the roof, purely looking for pseudoephedrine products.

Mr Logan—It used to be that they would look out for the benzodiazepines—Valium and that sort of thing—that that would be the drug of choice. Our profession has responded to the problem as it has occurred, and our first step was to say to the companies that provided this stuff: ‘Forget about the three-gross buys and that sort of thing to get better commercial terms. Pharmacists need to minimise their stockholding.’ They had these huge stockholdings out the back, and it was just like ants to a picnic.

Mr McBeath—There is a very large genuine requirement for the product, so it is not as though you put two or three packets on the shelf. In the middle of winter, my shopping centre pharmacy might make 20 or 30 sales a day to people who have a cold symptom because this is the best product for them. Jenny was saying something before—and I have seen no evidence; I do not know whether anyone else has—as to the extent of the diversion from pharmacy. We have anecdotal things, as Tim was saying, in that we see a picture of a whole lot of packets, but in the context of products that sell millions and millions of packets to a legitimate market, I am not sure of the extent of the diversion market.

It is there—I am not saying it is not there; we know it is there in pharmacy—but how big a problem it is I do not know. I must admit that I am very proud of my colleagues and our profession for the fact that, really, pretty much on anecdotal evidence we have done things about it. Historically, whenever our profession makes supply difficult those who would like to get it find some other way. There is a lot of evidence, as you may or may not be aware of, of break and enters and armed hold-ups occurring in pharmacies.

Mr Logan—The last recommendation in our submission suggested a bit of a public relations, that one of the government's health messages that it commonly puts out might be: 'Why is the pharmacy asking me these questions?' These products can be diverted and these drugs can cause harm or result in violent antisocial behaviour, and we publicise this with our 'Ask a Pharmacist' campaign. I do not know if you have seen that around the place. We try to explain to people that we are not just nosey parkers, that we really do have a genuine rationale for requesting some information.

Mr McBeath—And that is where legislation helps us, because you can then go out there and say, 'This is the law; it applies everywhere', and then people understand. As members of the community, you know that if you want certain types of medication you need a doctor's prescription and you accept that as the way it is. I think that would really help us if that was the way it was with the pseudoephedrine products.

CHAIR—I think we have taken on your principal submission that we really do need national guidelines or national consistency legislated or regulated so that the pharmacist is not at fault. Thank you very much for that. We thank you very much for your submission and for coming some distance to give evidence again. I personally appreciate the work the Pharmacy Guild does. It is a very professional organisation. I have found your members to be very professional—and I get sick everywhere so I see them all over the country.

Senator POLLEY—Thank you for also looking after me.

[12.22 pm]

DAVIDSON, Mr John William, Spokesperson, Enlighten Harm Reduction

CHAIR—Welcome, Mr Davidson. You are aware of the nature of our inquiry and I think you are aware of the rules and regulations that we have in these inquiries. We have your submission. Thank you very much for that. We have spoken to you before, but we appreciate you coming along. I wonder if there is anything you want to say before we raise some questions with you.

Mr Davidson—I would like to thank the committee for the chance to come back and speak with you again to, I guess, further clarify and expand upon a lot of the points that were raised in the first session. A lot has happened since last we met. I have just come back from Europe, where I have been studying the pill-testing programs in various countries as part of my ongoing project to research the different systems that are being used in the world and to evaluate them from an Australian perspective, with the idea of developing our own system as a hybrid of those. This trip was planned before I found out the very interesting fact that the Victorian state government have issued a tender for a feasibility study into an illicit tablet monitoring system. This happened only a week before I left.

CHAIR—Sorry, I just did not hear you. What was the tender for?

Mr Davidson—They issued a tender for ‘the preparation of a feasibility study for the development and implementation of an illicit tablet information and monitoring service’. Essentially, this is a very careful bureaucratic euphemism for pill testing, but it is one that I am quite happy with. This is what my last presentation was all about—the fact that there are two important parts of a pill-testing service, or whatever you care to call it. The first is a monitoring service, to have an idea of what is out there in the market. As we have seen, we do not know, to a large degree. It seems as though these problems sneak up on the government out of nowhere and suddenly we have an ice epidemic or whatever. The second part is the information service that goes hand in hand with it. The Victorian government has issued this tender. The tender is still being decided upon. I believe 20 October is when it will be decided upon. I foresee that Enlighten Harm Reduction will work with whoever does get the tender, as we are the experts in this field.

Looking at the tender itself and the scope of it, I am very optimistic about it. It is very open-minded and it is about looking at the various possibilities. It is not just about looking at other models around the world and about how they have been implemented, the successes and the failures of those models, but also specifically about how they could be adapted for our local environment. That is the framework from where I am coming this second time around. This has all happened in the intervening time. Progress has actually occurred. A state government has taken the initiative. A lot of my presentation to you was about showing the various investigations that have been done in pill testing, which have been very slow over the last few years. Every one of them says, ‘We need to do more research,’ and that is it. This is now saying, ‘We need to do the research, but we also have to look at the model’. What is appropriate? What could work? Get the stakeholders together.’ That is a very key part of this tender document. It talks about getting the key stakeholders together, the people who would use such a service.

In my mind there would be four main areas. They would be: law enforcement—all the people who were here at the table beforehand; specifically Kate Quinn but also the operational aspects of it; and health professionals—this includes the hospitals that have to deal with the people who come in under the effect of illicit drugs, but also they are a source of data as well in the illicit samples that come into their possession quite often in the manner of their work. In a hospital situation someone will come in and say, 'This is my friend. She is very sick. She took this pill. What is in it?'

Currently there is no system for dealing with that scenario. It is a very common scenario but there is no system in place for it. We lose that avenue of data collection right there. The law enforcement area do collect data, but they are woefully underfunded. And because everything is based around the prosecution, as we know, there is a six- to nine-month gap between someone's arrest and the time they go to prison. A lot of that is to do with the laboratory testing of those pills or whatever the case may be.

So the major players are law enforcement, the health care sector and, in addition to that, the entertainment sector. I have just come back from Europe. In England and also in the Netherlands there are amnesty bin situations. Again, if someone is going into a nightclub and they are searched and pills or other drugs are found upon them, in Europe it is slightly different because the possession of these small amounts is not considered a crime. It is basically a case of saying, 'We'll take this off you, get out of this nightclub and never come back again, but we will not charge you'. They are then in possession of these illicit drugs. In Australia this scenario happens every weekend. Of those 100,000 people who take a pill every weekend, quite a few of them are idiots who try to go to a nightclub with a bulging bag in their pocket. They have been searched and they have been sprung. Again, there is no system in place to analyse that data.

A fourth part is user submitted samples—this is basically where I came into this entire thing—the idea of someone having their pill test and being told what it is. I believe this is a vital part of it and it is what happens in the European models in the Netherlands and other countries, where a user can go into an environment, such as a place that looks essentially like a doctor's surgery. It is a specific environment like a needle exchange program area that is set up specifically for pill testing. They come into that environment; they deal with professionals and the pill testing is just simply one component not so much a treatment model but an assessment model. The Austrian model is particularly interesting, where everybody who works in the pill-testing services are professionals. They are psychologists, doctors—everyone. If someone comes to get their pill tested, it is professional.

Mr HAYES—So what you are saying with respect to the examination of the product is that you have a string of professionals all there at the nightclub—

Mr Davidson—No. I must clear this up. In previous testimony I said, 'We cannot keep talking about this in the framework of reagent testing in a rave club.' That is about as useful and up to date as—

Senator FERRIS—We also heard it from the police forensic chemist.

Mr Davidson—I know. That is the thing. That is what I am commenting on.

Senator FERRIS—We know you are.

Mr Davidson—The fact that she is talking about my work is as relevant as trying to reform the blacksmithing industry. This is the past. This is not what happens. We have not tested at a rave with reagent kids for a number of years, because we know this model is flawed and we said that from the very beginning. But every country that has an established pill-testing regime—the Netherlands and everywhere else—started off with that model. The Netherlands now has a laboratory based model where people go to a specific location, like a needle exchange place but it is more specific. They have been doing that for 15 years.

Senator FERRIS—She said that takes three to four hours.

Mr Davidson—What she is talking about there is the GC/MS testing, which I agree is the gold standard for both qualitative and quantitative testing. The qualitative testing tells you what is in the pill. I agree with Kate Quinn that reagent testing—which I am trying to say to you is not what we are talking about—only identifies one substance; it cannot tell you the range of substances. GC/MS can do that and also tell you how much is in the pill. The IMS system that I was talking about, the $80,000 machine, which we are asking to be the replacement for something like a reagent system, tells you the full spread of everything.

Mr HAYES—You would have to take your pill there and say: 'This is what I intend to take. What's in it?' But, in the vast majority of the market, isn't the purchase made close to the point of consumption?

Mr Davidson—No. That is a completely wrong assessment of the market. The vast majority of people who consume ecstasy in Australia would be purchasing it before they go out. I can tell you that without a shadow of the doubt. The classic model is that, within a social circle, there will be one person who will buy pills for the friends. That person will buy a 10-pack or 20-pack and distribute it to their friends. That may mean they are perceived as being a dealer but, when you are talking about that low-level situation of someone getting it for their friends, it becomes a very—

Mr HAYES—If you have a 10-pack or 20-pack, you are talking about commercial quantities. If they caught with that—

Mr Davidson—Yes, you are—if you are one person in a group of 10 friends, five of whom use ecstasy, and you have sold them two pills each for the next month. This is not a model of distribution. The point I am trying to make is that—

Senator FERRIS—They are technically a dealer.

Mr Davidson—Yes, they are.

CHAIR—Please keep to your point.

Mr Davidson—The question was: when do people buy the pill? Most people buy the pill beforehand and outside the environment. The Netherlands model is based on the presumption that the person who buys the pills for their social circle will go into a testing service and test one

pill from a batch. On that test, they decide whether they will distribute it to their friends. It is both for their personal consumption and for distribution.

Senator POLLEY—How do you know that the 10 or 20 pills have all come from the one batch that you are testing? You are still playing Russian roulette, aren't you?

Mr Davidson—Yes, you are. But this reduces the possibility a lot further than would otherwise be the case. Drugs are harmful and dangerous, and I am the first person to admit that. Anyone who takes drugs is undertaking a risky behaviour. But this is part of everybody's life. All of us undertake risky behaviour in one way or another, whether it be not putting your seatbelt on or having a few too many drinks and deciding to drive home. We understand that risky behaviour does happen; what we try to do is to put models in place that can help people reduce their risk.

Senator POLLEY—But the model that you are espousing has obvious flaws in that there is no guarantee that those tablets, in packs of 10 or 20, are coming from the one batch.

Mr Davidson—I always like to answer this by using the words of the head of the therapeutic goods association two and a bit years ago when, you would remember, there was a big scare over vitamins.

Senator FERRIS—Vitamin tablets are not going to kill you if you take one that has the wrong components in it.

Mr Davidson—May I finish? I just want to quote what the head of a government authority said in regard to this. He said that he felt underresourced and could not guarantee 100 per cent the entire pharmaceutical market. Do we give up if we cannot guarantee 100 per cent effectiveness? Why can't we attempt, for 10 or 20, 90 per cent? This is the argument that was made against condoms back in the eighties with AIDS. Fundamentalists believed that people who had premarital sex were bad people so we should not do anything to help them. They identified the fact that condoms—

Senator FERRIS—That is not going to kill them. These tablets kill.

Mr Davidson—AIDS is going to kill you.

Senator FERRIS—Hang on, you were talking about premarital sex.

Mr Davidson—Could I complete my analogy?

Senator FERRIS—I think they are dangerous comparisons, because they are not exactly the same. But they are convenient to your argument.

Mr Davidson—Sure! You just asked Kate Quinn to supply evidence showing what was in pills in order to forward your argument. I listened to what you said. That is fine. We all do that. That is part of the game. What I am saying is: if I cannot guarantee 100 per cent effectiveness with a solution am I not allowed to the table?

CHAIR—We will hold our questions until you have finished what you want to tell us.

Mr Davidson—I have essentially come to the point of saying we are at the point where the state government is moving forward in the direction of looking at all of these questions and assessing them. What I am saying to you as representatives of the federal government is that it would be ideal to work this on a national level but that is not going to happen. We have a state government that is making an attempt to work with this thing because, regardless of what happens, 100,000 people are going to keep taking these pills. Our state government is trying to move forward. I ask the federal government to be supportive, if possible, of this state government move. If that is not possible in this political climate—as I understand that it probably is not—at least do not be obstructive. There is a history of the federal government obstructing and directly interfering in initiatives of the state government in the area of harm reduction. This is not contentious and this is essentially what I ask the committee today.

CHAIR—Do we have details of where we could find this?

Mr Davidson—I can give you an idea of where to get it, but the tender itself has closed.

CHAIR—Is that something you were going to tender for? Is your organisation capable of that?

Mr Davidson—I did not tender at the time because I was virtually about to step on a plane to go overseas when I found out about this. Quite a few organisations that I know and trust have applied for it. Enlighten will no doubt be involved in this process as it goes along, because there is probably no-one else in Australia to study this for as long and as in depth as we have.

CHAIR—You say that Holland—which I do not think is always a great example of—

Mr Davidson—But they do have lower rates of usage than us. That is the thing I have to say as soon as I hear someone say they do not approve of that.

CHAIR—Across the spectrum?

Mr Davidson—Across the spectrum. You name a drug and they have lower rates of usage.

Senator FERRIS—Lower rates of all drugs?

Mr Davidson—Yes.

Senator FERRIS—Lower rates of marijuana?

Mr Davidson—Yes. Seriously—in some regards, yes.

CHAIR—The UN has these figures and Australia is the biggest in ecstasy. There are professional clinics down on the corner of Exhibition and Collins streets that you go into and say: ‘Here’s my pill. Test it for me.’ That would mean, in that country, a total acceptance of the fact that people are taking them. Is it at all illegal in—

Mr Davidson—Yes, it is totally illegal. This is the thing about harm reduction. Never lose sight of the fact that harm reduction is part of your drug policy. All of this is harm reduction in

practice. It is exactly the same way with a needle and syringe program: the people in that environment are going to be using those needles for a crime. We understand that the greater good of harm reduction means that we should put this into process. This is exactly the same thing. That is how the Netherlands have used it for years—and the drugs are illegal.

CHAIR—I will put to you the argument that we put to everyone. These clinics will say to a young person that the government must think it is not too bad to take drugs even though they say it is illegal. They will think: 'I can get my pill tested and, if it is okay, I will swallow it and nothing will happen to me because I have had it tested.' So someone who might have been frightened away by a good advertising campaign will now say that the government is condoning it and—

Mr Davidson—We are still waiting for a good advertising campaign that is effective. We have to look at the research. What I tabled last time and I talked about it in great depth is research that has been done in this country directly addressing these questions: seeing whether there a correspondence between the offering of these services and the increasing use of them. The exact opposite is the case. When ecstasy non-users are presented with the results of pill testing in those environments, they are less likely to start taking ecstasy. That is the research and it is in my submission. It is European research—Dirk Korf's paper. It is empirical evidence. I advise you to read these papers; at least read these points. We can always come back to the idea of common sense but we know the real world is different; we know that, when we get out there, things are different. This has now been studied in depth.

Mr HAYES—Are you saying this is part of the deterrent?

Mr Davidson—It is part of the demand reduction strategy, yes.

Mr HAYES—Because they would take a decision upon themselves and say, 'I will go and I will check this.' The fact that you go and check it is starting to have the impact.

Mr Davidson—People that are taking it see the results displayed and say, 'My assumptions are confirmed. I am seeing on this lab result that there are bad things in it'. Kate Quinn's point about carcinogenic material is very important. That is one of the things that we want to do. Imagine this: You come in and have your pill tested and I say to you, 'This has methamphetamine and MDMA in it, but it also has this particular leftover reagent as part of the process. Are you aware that this is carcinogenic? Here is some material, a safety data sheet on that showing the carcinogenic qualities of what is in the pill.' Is that an effective demand reduction—

CHAIR—Does this place in Amsterdam actually say to them, 'Well here is what was in your pill and that one will give you cancer'? Does it say that?

Mr Davidson—No, because they are not looking into that area. This is actually a new area, the idea of identifying these sorts of contaminants and using that. They are not currently doing that. They are currently just naming the illicit parts.

Mr HAYES—Once you have that information, and you realise that there is an element of a carcinogen in this product and off you go, but if you either sell that on or give it to your mates—

Mr Davidson—I guess you could take that up with Philip Morris as far as carcinogenic products go.

Senator FERRIS—Come on. They are all labelled—

Mr HAYES—There is enough litigation about that.

Mr Davidson—Exactly. I want to put labelling on the pills.

Senator FERRIS—But if the label goes on the box how do you know that the label refers to what is in the box? We just had evidence that one tablet that looks the same as another might be totally different.

Mr Davidson—But the process I am talking about is that you test this exact pill, and show the results on the screen. We are talking about the leap in technology here; not about what Kate Quinn was talking about, about the difference between a reagent testing, which is very limited, and a high-tech GC-MS. We have a middle ground which gives instantaneous results of the entire spectrum of the contents of the pill to a person immediately.

Senator POLLEY—Does it give you the amount of each of those agents?

Mr Davidson—No, but this is the interesting thing about it. Identifying the substance is a great leap forward. The argument is whether you actually want to give that information to a person. The government argument often about this is that we do not want to tell people that this pill contains a lot of MDMA because then people would want to go out and get that pill. That is an argument that is constantly given to me about supplying information. I am now saying, 'Well isn't quantitative important?' Perhaps it is not. We have to look at that. What is more important to say to someone, 'This is the substance you are taking', or 'This is how much you are taking'. Again this is something that needs to be addressed in these inquiries. It needs to be looked at.

Senator POLLEY—Everyone quotes what is happening in Europe. The issue is that we are not just talking about the loss of life. It is also about the psychotic episodes. It is also about creating extra demand on our health system through mental illness, which is already totally underfunded and actually a shameful reflection on all states and the federal government. What about the legal position when somebody comes along, you test the pill and you say, 'Okay, this has got this, this and that in it'. They take that pill and they have a psychotic episode. In Europe, Amsterdam, Germany and everywhere else that you have mentioned, how do they deal with the legal implications of the fact that the pill has been handed back, the person takes it, they have a psychotic episode or they die. That is a big issue.

Mr Davidson—It is a big issue, but look at it this way. Remember there are 99,999 other people who have not had their pill tested that weekend.

Senator POLLEY—I am sorry; if I die, I think my family might miss me.

Mr Davidson—I know. Remember the model in Austria that I mentioned about the psychologists and doctors. You do a questionnaire and they talk to you about your drug use and your state of mental health, whether you are on any other anti-depressants and that type of thing.

They sit you down and assess that sort of thing. At the end of it, quite honestly they say, ‘Mixing this drug with SSRIs, which you are currently on, is very dangerous for your mental health. You have just described to me that you had a psychotic break episode two months ago. Do you really think it is a good idea to be taking this drug at this moment in time?’

Senator POLLEY—But these drugs can have an effect with—

Senator FERRIS—If they are addicted to—

Mr Davidson—Excuse me?

Senator FERRIS—If they are addicted to a drug, do you think they are going to go in and say to a counsellor, ‘I had a psychotic episode two months ago, but test this pill’.

Senator POLLEY—Or that they had no psychotic episodes.

Mr Davidson—Excuse me. We are talking about recreational users of MDMA. To use the word ‘addicted’ in that sentence really loses all credibility in this argument. I am sorry. You have to look at the model of non-problematic recreational—

Senator FERRIS—Get real.

Mr Davidson—No, I am sorry, you have to get real with this. The fact that there are non-problematic recreational—

Senator FERRIS—I basically do not have to do anything.

CHAIR—Now, now.

Mr Davidson—You are dismissing my arguments by talking about something completely different. You have asked me here as an expert on a drug that is used recreationally in the majority by non-problematic drug users. I have to speak within those boundaries. To throw up words like ‘addiction’ to dismiss my arguments—come on!

Senator FERRIS—You do not know if they are addicted.

CHAIR—Let us question civilly.

Mr HAYES—Can I get back to what you were saying before about the person with their 20 pills. You made the point that the practice is they probably purchase with the view to going out and distributing them to their colleagues or whatever. In terms of the advice that person gets, that is only to them; they are not going to transmit any of that advice that they got.

Mr Davidson—Yes, they are.

Mr HAYES—Not in terms of recent psychotic incidents, psychological impact or the other professional services—

Mr Davidson—The advice given to them in that environment they pass on. This is it: this model is the distribution of information of social groups via mavens. A maven is a term for a person within a social group who is the nexus of information. We all know that within our group we have a person we go to if we want to get a good deal on a used car. They will know where to look it up and have the information about this and that. It is the person who collates information and distributes it within a group. It is a very standard social model. They are the people we target because they are the people who will distribute the drugs. A social group looks to them to try to reduce the risk to them by saying: 'You know how to get your drugs tested. You know how to not get ripped off. We want you to sort it out.' The reciprocal thing is that that person knows they want to look after their social group. We have to target a lot of Australia's social models and the way they exist in the real world. We cannot assume things—that people go to crack houses and buy pills with money they got from stealing a stereo. That paradigm of the heroin junkie is not what we are talking about here. That is not what I am here to represent.

Senator POLLEY—Could you answer my question on the legal implications of how they deal with it in Europe? I do not think you actually answered my question.

Mr Davidson—It is a classic case of duty of care, and it has to be acknowledged with the prescription of legal drugs as well. There is a duty of care to research everything, if there is an unknown or something beyond the scope of that person's ability to be able to treat. That has to be taken on a case-by-case basis, doesn't it? Again, I would rather have the situation where someone gets advice. We may save 99 out of those 100 from a bad situation. As for that one person out of that 100—I am sorry. But, then again, we are talking about 100 and of the 100,000 who are taking it otherwise. I am trying to help. We are trying to put together models to help these people who are taking these hundreds of thousands of pills every weekend. We can sit here wringing our hands all we like about the 'what ifs' or we can actually get down and do the work and try to sort this out.

I know this is a hard political thing to sell. I would like to get back to your saying that it gives the impression to someone that it is okay to take drugs. I always hear, 'It's the message we are sending.' I have to be honest with you: when I hear that, I know it is a politician saying, 'It's the message we are sending.' But it is not that message and it is not to that person that they are worried about sending it. You do not want to send the message to your constituents and to the tabloid media that you are soft on drugs. You have set yourselves up for this fall by being tough on drugs. Any deviation from that makes you appear weak, and politicians do not want to appear weak.

The problem we have is that we have a war on drugs that you are losing. The fact is proposing things outside of that and discussing that in the wider media leaves you open to the charges that you are soft on drugs. I understand politically the importance of that. I understand that is why potential Victorian tenderers have been given these euphemistic terms of illicit tablet monitoring systems and all of that. Regardless of how you want to wrap it up, it has to move forward. These are problems that do need to be addressed. We are sitting in the parliament here where Dr Pennington gave his report on cannabis all those years ago. It was presented because the government asked him to. It took one *Herald Sun* editorial to put it in the trash bin. It did not get talked about ever again. We have to move beyond that to the issues.

CHAIR—I accept your point that 100,000 pills are consumed every weekend in Australia. I agree with you that clearly we are losing. How you address it is what we are trying to address. Senator Ferris has some questions.

Senator FERRIS—Mr Davidson, I would like to take you through what you might see as a scenario. Tell me if I am wrong, because I am trying to draw out of what you have been saying for the last half an hour what actually would happen in a practical sense. The majority of these people are young, they want to go to a dance party in the city somewhere and it might happen that their parents take them into town and drop them off, so they get into town with a family member and they have got in their pocket the tablet that they have got from somebody. How are you going to make sure that when those people go into the dance party they have had the tablet tested? How are you going to maximise that opportunity?

Mr Davidson—Well, there is the testing service—

Senator FERRIS—Hang on! Are you going to have one in the city here? What is your scenario? You might be able to tell us that as a result of the European experience. I would like to finish this before you jump in and respond. So there would be several of them in the city? We have got a needle exchange facility up at the Cross for safe use there, so it is the same principle, I assume. So you would expect them to say, ‘Before we go into the party we’ll walk down the road and we’ll put in our pills and have them tested.’ Are you going to charge them for that? If they have paid 50 bucks—or whatever they have paid—for a pill, are you going to give it back to them if it is really dangerous—because it is actually their property—or are you going to say, ‘Look, this is so carcinogenic’ and so this and so that ‘that it’s unsafe, so don’t take it.’ But are you going to give it back to them?

CHAIR—You have been asked the scenario as to how you do it so it is over to you, Mr Davidson.

Mr Davidson—I addressed a lot of these points the last time that we talked but I will go through them again. Firstly, I just want to ask if we can stop talking about the whole rave party scenario. The majority of use is outside the rave environment now. Raves are a very dwindling subculture. Now it is happening in pubs and clubs and wherever. Moving on, the regional centre system that they have in Europe is much like you say: a needle exchange. But they have regional centres and there is a central body that coordinates them. What happens is that people that go in have their pills tested and if they need further testing they go to the central one for more rigorous testing. I am trying to remember the second part of your question.

Senator FERRIS—It is this: if it is a test that shows that tablet is potentially lethal, do you give it back to them or throw it in the bin?

CHAIR—I will stop you there. You might repeat these questions bit by bit. That might be an easier way.

Mr Davidson—That is okay. As for that, firstly, no-one is going to give their pill to be tested if they know they are not going to get it back. This is the only way that you can get people in through the door. The second thing as to that concerns the models that we have developed. Enlighten has been working in the Australian system. Because it is very constrictive because of

legislation and because of the political environment, we have had to develop alternative strategies. We have now developed a system where a person can test the pill without ever having seen it. I mentioned this before.

Someone will go into an automated booth. There will be a little video touch screen that says, ‘Welcome to the testing lab. We would like you to put your pill down on this thing here.’ That thing weighs the pill, takes a picture of it and takes a measurement of it with software and then, with the current technology we have, the little video screen says—and this is in a booth that is entirely enclosed so the workers cannot see whatever is going on—‘Reach over to your right and take out the plastic container with a wooden stick in it. Take the wooden stick out, press it against the pill lightly, put it back in the plastic container and seal it. Now put your pills away. We never want to see them again. This is a very important part: you cannot show us your pills.’ The person does that, gets out and brings it to the person who does the testing of that stick. What we have is so accurate that we can test the residue left on that stick down to the picogram level.

CHAIR—That seems to be contrary to the evidence that we have heard.

Mr Davidson—We have said that we have a scientific disagreement. It really is about the technicality of it. Her argument was about quantitative analysis with IMS and the fact we cannot tell how much is in that. But this was a point about whether that is a vital part of the information that we pass on.

Senator FERRIS—Get back to where you were going to tell me about this. If the pill comes up as being highly lethal, dangerous, carcinogenic or whatever it is and the person has put the pill away and they have gone out with the little stick, what happens then?

Mr Davidson—The person would advise them of the contents of that pill in the strongest possible terms. The thing is that if you are then going to go to the point of saying, ‘I’m now going to take this property off you and arrest you’ and that type of thing—

Senator FERRIS—He might go outside and sell it for 25 bucks to someone else. If you don’t—

Mr Davidson—The thing is also that we would never have known about that particularly dangerous pill. That information then goes into the system and—

Senator FERRIS—I understand all of that and I accept all of that. I am just trying to leave time in the next five minutes for other people to ask questions. That is all.

Mr Davidson—We can talk about specific scenarios all you like, and nitpick through them, or we can talk about the issue.

Senator FERRIS—I know about the larger issue. I am trying to get to a point of knowing how you think the system would operate. That is what I asked you, and you have answered it.

Mr Davidson—This tender is for me and a lot of other professionals to work through.

Senator POLLEY—I have a couple of quick questions. In relation to your scenario that this state government and others start doing pill testing, you made a comment that you had not seen a successful or appropriate advertising agency. Would you strongly advocate that you shouldn’t take drugs and drive?

Mr Davidson—Absolutely.

Senator POLLEY—So that is part of the whole package. The other issue relates to New Zealand. My understanding is that there are experiments now with legalised commercial availability of the party drug BNZ—

Mr Davidson—BZP.

Senator POLLEY—Yes, that is it. Can you describe that drug—its characteristics and effects—because in a few weeks I will be going to New Zealand and I would be most interested to see if I can follow up on some of this.

Mr Davidson—Sure. Would you like to meet some of the people involved?

Senator POLLEY—I have to see if there is time in the schedule, but it is certainly something I am interested in.

Mr Davidson—I knew we would probably run out of time for this question. I developed a briefing paper on this which I will just quickly describe. This came from the Shaw study, which was part of a national household survey on legal party use.

I will give you a little bit of background. BZP was not made illegal. The whole thing about drugs is that you make them illegal. They exist because someone makes them and then you have to make them illegal. The New Zealand government just didn’t take that step. They said, ‘Okay, this drug, which exists and has not been made illegal, will be put in a new schedule called category D.’ So they have A, B and C, similar to the UK system. They invented a new category D, which is essentially for over-18s’ recreational drugs. That is essentially what it is. In this experiment they put BZP in as an alternative to amphetamine. They looked at the rate of methamphetamine abuse, which was going up sharply, and said, ‘We need to address that.’ This was the way they addressed the methamphetamine problem.

In Australia just last month we made BZP illegal and never looked into the idea of an alternative. I will just read some figures from this study which are very illustrative of the effect that BZP has had in New Zealand. The study showed that 25 per cent of the population had tried these party pills—the BZP pills—and 44.1 per cent of the users of the pills stopped using other illegal drugs while using this legal alternative. That is 44 per cent gatewaying-off. Now, 30.5 per cent tried party pills before other illegal drugs; 45 per cent used the party pills to avoid illegal drugs—to avoid having to break the law. Only 0.3 per cent reported significant negative impacts and 98 per cent reported being not addicted. I think there was only one person in the survey who reported being addicted. There is a further breakdown of these figures into that.

Senator POLLEY—You could table that, then we could read it.

Mr Davidson—Absolutely; I table that.

Senator POLLEY—What does that drug do? Does it have the same characteristics?

Mr Davidson—They are described as being one-tenth as potent as amphetamine—that is of a normal amphetamine, not methamphetamine.

Senator POLLEY—Does it say in that paper how long this experiment had been going?

Mr Davidson—Since 2000—2000 was when it was scheduled.

Senator POLLEY—Do the users of that drug then stay on that—

Mr Davidson—Yes.

Senator POLLEY—or is there evidence to suggest that they go back to their old habits?

Mr Davidson—What they have found now is that there is a glut in the market of methamphetamine and the price has dropped because demand has dropped for methamphetamine. So that is quite indicative of the effect of this: substitution of a safer alternative. It is not safe; there are still adverse things. The paper by Dr Gee, from Auckland Hospital, is referenced down the bottom. He is not a big fan of it at all so he has done a very big study on the adverse effects of it. And a lot of people do present to him, but a lot of those people have also drunk a hell of a lot of alcohol and taken BZP and a lot of other things as well.

Senator POLLEY—My final question: do you support decriminalisation of the use of marijuana and other drugs?

Mr Davidson—Enlighten does not endorse decriminalisation or legalisation of any drugs. Enlighten is a body that believes harm reduction, which is the current government's policy, just needs to be re-emphasised. We can actually do a lot of work within the current legislative system. It is up to other bodies and other people to work with these models, but all I can say is that we have looked at it. These figures are very surprising, and I would like the government to look at it. But Enlighten does not endorse that. We want to work within it; within the current legislative system we can do a lot more.

Mr HAYES—You have a lot of strong points on this. What is it you are really asking of the federal government?

Mr Davidson—I think the point I made earlier: we have a state government making an attempt to move forward, and there is a long history of the federal government being both obstructive and—

Mr HAYES—There are actually different laws.

Mr Davidson—I understand that, but I am talking about a political element here, as opposed to a legal element—very distinctly, the political agendas of the different governments and how they come into play in the public sphere. We know this is going to be battled out in the public

sphere. The media space is controlled by the people with agendas. We know that something has to be done about this area of drugs. A state government is trying to do that. If it falls on its face and fails, the federal government can say it is no skin off its nose. But let the state government try. We have seen this happen too many times with injecting rooms and all of that. Just let it try.

CHAIR—But this has obviously got this far without it becoming a huge political bunfight.

Mr Davidson—It is a bit of a bunfight in New Zealand, I must admit.

CHAIR—I am sorry, not this one; this one.

Mr Davidson—Well, that is the thing.

CHAIR—What is it you are asking us not to have a bunfight about?

Mr Davidson—Exactly.

CHAIR—Well, there has not been a bunfight.

Mr Davidson—Not so far. But we are about to get to that point. I mean, the way they described their terms of reference, they came out of 2004, when the premiers council released a report saying that pill testing should not happen and pill-testing kits should be banned. In response to that, a lot of people looked at that and said: ‘Now, come on. You’ve just totally ignored all the evidence.’ We had an international harm reduction conference here that year, and all these people that wrote this report were there. I and a lot of other people said to them, ‘Come on, be honest.’ And that describes how they then went back through committees, internally looked at it and said: ‘Okay, we do need to look at this. This is crucial; we need to move forward.’ And now this is the first of the public ones of those. We are about to get into that realm.

Mr HAYES—Each of the other state governments took a different point of view. Indeed, originally so did the Victorian government on that. Certainly we acknowledge that Victoria seem to be going it alone now, but their initial point of view was consistent with that of the other state premiers.

Mr Davidson—It was, but this is a bold initiative, particularly as there is an election coming up. I just ask you to be supportive, if you can, or if that is not possible then just not be obstructive.

CHAIR—Thank you very much for that. Thank you for coming back again. That is new information, and we appreciate you bringing it to us.

[1.02 pm]

BROGAN, Mr Damon Gerard, Chief Executive Officer, VIVAIDS Inc.

HAZELWOOD, Ms Lisa (Purple), RaveSafe Coordinator, VIVAIDS Inc.

RYAN, Mr John, Chief Executive Officer, Anex (Association for Prevention and Harm Reduction Programs Australia Inc.)

CHAIR—I now call Anex, the Association for Prevention and Harm Reduction Programs Australia Inc., and VIVAIDS. Thank you very much for coming along, all of you. You know our terms of reference, and you know the rules of the committee. We always try to be polite to our witnesses, and we are very keen to hear your views on these matters. We might start with you, Mr Ryan, if you have something else that you want to raise with us apart from what you had in your submission, which we received in June this year. If there is anything you want to update or summarise, please do it now.

Mr Ryan—Thanks for the opportunity to speak to the committee. We did provide a submission. I wanted to make a few comments on top of that. We kept our submission strictly to the terms of reference. I am pleased to see that the committee has taken the opportunity as it has heard submissions around the country to hear from a variety of people on a variety of issues. We would certainly encourage that kind of thinking in relation to the matters before you.

The complexity of these issues is enormous. They certainly do not lend themselves to simple, silver bullet solutions. One of the challenges that we have faced as an organisation that represents service providers, as distinct from an organisation that represents consumers of illicit drugs, has been the dynamism of the drug market, the rapidity of change in the drug market, and the consequent reduced capacity for the service system to respond to the drug market adequately.

A couple of weeks ago we hosted the first Australasian Amphetamine Conference. It generated a lot of media. There was a lot of interest in the conference also from delegates from around Australia. It was basically sold out at 350 people. We did not know how many to expect because it was the first conference of its type. The variety of speakers at the conference ranged from law enforcement to researchers, service providers and drug consumers, which was very valuable. The feedback from the delegates, who also reflected that range, was that it was an opportunity to build bridges and linkages.

One of the challenges for us as the Australian community is how to face up to not only the fact that, as we have heard today, 100,000 pills will be consumed next weekend but also the fact that drug use is not an issue for somebody else or somebody else’s family; it is now so large that it is affecting all of our families. I am sure everybody here has cousins or partners of cousins that are affected by drug use. I think the challenge is to strongly support evidence based approaches and compassionate approaches to these issues and to be very conscious of the potential to alienate large sectors of the community.

At the conference we focused an afternoon session on the media. We called it ‘If it bleeds, it leads’. I guess in polite terms it was a robust discussion. The variety of speakers included the managing editor of the *Telegraph* in Sydney and representatives from *60 Minutes*, the *Sydney Morning Herald* et cetera. There was a diversity of media. There was also a diversity of people in the room who commented on the challenge of providing factual information to the community about these complex issues. One of the challenges is to provide layers of information dependent on the needs of the audience.

For example, we know from concentrating on needle and syringe programs and injecting drug use that there are literally thousands of people in Australia injecting drugs who are not aware of the risks that they are taking, the potentially fatal consequences or, just as importantly, the morbidity consequences of their behaviour. We cannot expect the *Telegraph* or the *Age* to provide that sort of information. What we do need to provide to parts of the community is absolutely full, frank and fearless information and advice, because people are operating with minimal or mythical understanding of the issues and the risks that they are taking. I think as a community we have an obligation to face up to that.

I think the other big issue that was certainly a focus of the conference was the impact on families of illicit drug use. There are some excellent family support organisations around Australia who are struggling with these issues, and they also read the mainstream media and can be quite demoralised or humiliated by some of the information that they read. I think those sort of peer support organisations, such as Family Drug Support in New South Wales, play an absolutely key role because we do not have the capacity to rely only on law enforcement or only on the pharmacies or only on health service providers or only on peer based drug user organisations. The real challenge for all of us I think is to make sure that we get the balance right, but the balance has to be complex and it has to acknowledge that there are areas of specific need.

I would just like to say that I think one of the specific needs in relation to amphetamine injecting particularly is in relation to the needle and syringe program and how adequate that service is, having been developed in the eighties to prevent HIV—which it has done incredibly well. It certainly has a long track record in Australia of bipartisan support in every state and territory and nationally, but what it does not have I think in adequate amounts at the moment is the capacity to catch up with the changes in the drug market, particularly amphetamine injection. That requires a real emphasis on workforce development for the needle and syringe program sector. It is certainly not only in Kings Cross. There are more than 3,000 needle and syringe programs in Australia, including pharmacy based ones. That is the size of the injecting drug market in Australia.

Targeting campaigns to workers to make sure that the workers are skilled enough to deal with clients coming in the door as well as using that huge interface to deal with those people who are injecting amphetamines is very important. It is not only good for those people who walk in the door but also has a cumulative effect on the drug market or consumers in the drug market of increasing their knowledge and capacity. Ultimately I think we need to be looking forward to a situation where that population of injecting drug users is shrinking. One of the best ways to do that is to improve access to health services and to deal with the barriers to access to health services that exist for people who use illicit drugs because of the stigmatisation of these issues. We have a real challenge to make sure that we use the needle and syringe program as a gateway

into health services, including drug treatment but also including the myriad other health issues that should be addressed but which are often ignored until they get to a crisis situation—which means it is expensive not only in dollar terms but also in terms of lives.

Senator FERRIS—Mr Ryan, you heard me attempting to draw out that scenario. I notice in a couple of your recommendations that you suggest that the current needle exchange staff be, if you like, upskilled to carry out some of this work. Would there be anything in the scenario that I put to a previous witness that you would like to comment on? Would you see his response and my questions as being sort of what you are talking about?

Mr Ryan—To be perfectly honest, I was not listening intently to the conversation so I am not quite sure of the exact matters in the scenario.

Senator FERRIS—I will draw to your attention one of your recommendations, I think it was the first one. You talk about upskilling people in needle exchanges. Are you familiar with that one?

Mr Ryan—Yes.

Senator FERRIS—Could you talk about how you would see that working?

Mr Ryan—It is obviously a very challenging issue for all of us. What we have globally is fundamentally an epidemic of drug using in rich countries, poor countries and in-between countries. The challenge that the needle and syringe program faces is to try to be a part of the solution to that issue. One of the ways that we do that is obviously by providing injecting equipment. There are no drugs provided through needle and syringe programs and there is certainly no encouragement given to use drugs through needle and syringe programs. The emphasis is on sending a message that drug use is risky and injecting is risky. As a community we have an obligation to minimise that risk and this is how we are doing it.

In relation to amphetamine use, I think the challenge for needle and syringe program workers—of whom there are thousands, in pharmacies, community health centres and hospitals—is to be better acquainted with the clients' needs and better able to address their clients' needs. That does not include moral judgements about their behaviour.

Senator FERRIS—No, I was not thinking that. I am trying to get to whether you think that a needle exchange could perform the role of pill testing, for example. In your submission you recommend:

> ... the continued investment in workforce development and training options for frontline staff at Needle and Syringe Programs, including the development of education and training resources to deal with amphetamine related issues.

Is that the type of thing you mean?

Mr Ryan—No. One of the amphetamine related issues for needle and syringe programs is vein care issues. People are not injecting in hygienic or sterile circumstances and they are often injecting frequently. The needle and syringe program is not seeing the party pill users or the so-called recreational users that were being referred to before. We are seeing the harder end of the

equation. Whilst it is true that there might be lots of ecstasy consumption in pubs and clubs in the suburbs every Saturday night, the people who are accessing needle and syringe programs are much more likely to be dependent drug users—unlike those people in the pub having an occasional pill or whatever—and, because they are injecting, they are obviously consuming drugs via the highest risk method.

So we are not referring to pill testing. It is not within the scope of what we do. We are talking about specific education about amphetamines and amphetamines risks and ways of dealing with amphetamine related problems. I would not see that as a high priority. I am dealing with the priorities of today, and the priorities of today are those people out there in regional, rural and metropolitan areas who are injecting amphetamines.

CHAIR—We have further questions for you, but we might just ask whether the representatives of VIVAIDS would like to make an opening statement.

Mr Brogan—Our principal submission was mostly framed in terms of our RaveSafe project, which Ms Hazelwood is the coordinator of. If it is okay with the committee, Ms Hazelwood will speak to that and perhaps raise another couple of issues and then there are some issues that I would like to speak to.

CHAIR—Thank you.

Ms Hazelwood—Basically, RaveSafe is a peer based program that has been running for just over 11 years now. We have had many different funding structures and many situations that we have been set up to run. I believe that, at the moment, we are at our peak and running better and bigger than we ever have before. We have 12 key peer educators or volunteers who go out to parties and hand out information on harm reduction strategies and ways to reduce risk while at parties and taking drugs.

At these events, we have a place where people can sit down, chill out and relax and talk to us. We give them a space to relax and get away from the noise, the music and all of that. While they are sitting there relaxing they can talk to our peers about anything that they want to talk about—and that ranges greatly. All of the peer educators are trained in first aid. So if something is going wrong or if someone is highly drug affected and needs further medical assistance, we can pass that on to first aid or the ambulance service that is usually at the parties that we attend. We are currently funded to do 15 events a year and we maintain 12 volunteers.

Senator FERRIS—Who funds you?

Ms Hazelwood—The Department of Human Services in Victoria fund us currently. The events that we go to have to be over 500 people, so that stops us from going to nightclubs, bars or anything like that. We can only go to main events. One of our main resources is a party pack. I have brought one for each of you. In our party pack we have brief information on some of the key things that we stress about how to look after yourself while you are at a party. We have also got a condom, lube, a lollipop and a bit of information on GHB, because that has been our major drug of concern in Victoria in the past. That is reducing, thankfully. There is also some information on chlamydia.

They are very successful packs. We have given out over 45,000 resources in the last financial year. Most people take the lollipop out to consume immediately while they are talking to us, maybe pick up a few questions from the brochure and then put it in their pockets and take it away for later. With any questions that they have, nine times out of 10 we can provide extra information. If we cannot answer a question we aim to get back to them within a week of that question being posed. We take their contact details to do that.

Mr HAYES—So they identify themselves and give you a contact address.

Ms Hazelwood—I have never had a problem when people have been seeking information, no. We are very nonjudgemental about our approach to everything. We are all out of the dance party scene as well, so that barrier is knocked out straightaway. I think they see us as one of them but someone who is a bit more skilled and a bit more knowledgeable in the areas that they have questions about. We can transfer that sort of information fairly easily.

Another part of RaveSafe is that we work with services and stakeholders of the dance party community in Victoria. As an example of what we have produced, we have produced a code of practice for safer dance parties, with the Department of Human Services, which included guidelines for providing free or low-cost drinking water. We have also worked with several other community projects to ensure that the training of their staff is up to date and that the training of our staff is up to date. We have partnerships with quite a few different organisations, including Turning Point and Enlighten.

One of the major concerns that has come up over the past few years has been that we have definitely seen the traditional rave population and rave drugs moving into mainstream nightclubs and venues. They have moved into the dance party nightclubs and things like that but also into bars and other night-time entertainment areas that have traditionally not seen these drugs. That is quite concerning, because they are receiving little, if any, harm reduction or messages to do with these drugs while going to these places. RaveSafe currently is one of two programs of its kind running in Australia. There is nothing reaching the nightclub population in Australia, as far as I am aware.

Mr HAYES—It would be a lot harder to run a service like yours for nightclubs, I would imagine.

Ms Hazelwood—Definitely. We have come up with a model that we would hope would work and are seeking funding for that model at the moment.

Senator FERRIS—I am quickly reading this little brochure. It says:

Purchase yourself a pill testing kit from bong shops or—

and then you give a website address—

http://www.ez-test.com.au/.

Can you take me through what you mean by that?

Ms Hazelwood—They are the places that people can purchase pill-testing implements to be able to test pills.

Senator FERRIS—Are you satisfied that they are reliable? I am not sure if you were here we had the evidence from the forensic chemist about the difficulty of reliable testing kits.

Ms Hazelwood—I am aware of their inability to detect major substances. However, it is something that we see as a valuable tool in assessing what is in your pill. It gives you an indication. It is better than nothing.

Senator FERRIS—It might be, but the original advice that was given by the forensic chemist was that the difficulty of some of the simple and fast tests and analysis was in being consistent and whether it was simply a qualitative test by colour or a quantitative test by proper analysis. I am just thinking that, because you are recommending this, there could be a duty of care issue here. I wonder whether you as an organisation have tested this and where this website is based. It has '.com.au', so I assume it is an Australian one. What can you tell me about that?

Ms Hazelwood—It is the EZ-Test website. EZ-Test has the tests that we can buy in Australia at the moment and it has extensive messages on harm reduction and the limitations of the tests on the website, as far as I am aware. They should be all the same.

Mr Brogan—Most of the education that we try to do—a great deal of it—is face to face, and take-home resources are useful but it is our interactions with punters that are probably more useful. We are very careful and clear. We are frequently asked about pill-testing kits and our line is that we are not prepared to say that, after having tested a pill with any of the currently available kits, it is a safe thing to do or it is a wise thing to do. But we do believe that they can be useful in detecting some potential harms, and we know that some people choose not to use a drug after finding a harmful substance in it. So for those reasons, while VIVAIDS and RaveSafe are not experts on pill-testing kits and regimes, as Mr Davidson might be, it is our position that, if used judiciously, they probably contribute to less harm rather than more. But we would never say that a pill is safe because it has been tested.

Senator FERRIS—No, but you do not put that proviso on here.

Mr Brogan—I will make sure that is corrected.

Ms Hazelwood—We also have other resources, which have been provided to us by Enlighten, around the limitations and the nature of those testing kits. If someone were to ask me about a testing kit or anything to do with pill testing, I would definitely refer them to Enlighten.

CHAIR—What is your own legal position? Aren't you almost an accessory before, after or during the fact of possession of an illegal substance?

Senator FERRIS—You're the lawyer, Chair!

Ms Hazelwood—As far as I am aware, I do not know whether or not the person I am talking to has an illegal substance on them. I do not see it. I have no part in them partaking in an illegal activity, so I cannot see how I would be seen to be an accessory.

CHAIR—So you do not actually look at their pill?

Ms Hazelwood—We do not do any pill testing whatsoever.

CHAIR—You just talk to people?

Ms Hazelwood—I talk to them about drugs and about information around drugs.

CHAIR—And with your first aid experience, if you see someone that looks like—

Ms Hazelwood—Yes, and from my professional experience and the training that I have been given, I will answer those questions to the best of my ability, make sure that they understand that I am only answering them to the best of my ability and direct them where to get more accurate and credible information where applicable.

CHAIR—Your organisation is an incorporated body, is it?

Ms Hazelwood—VIVAIDS is, yes.

Mr Brogan—VIVAIDS is the incorporated association. RaveSafe is one of our funded programs. VIVAIDS has been incorporated since 1987. It came about primarily as part of the community role in the partnership against HIV-AIDS. Originally it had a focus on injecting drug users, but over the years its focus has broadened to include injecting and other illicit drug use.

CHAIR—Do you have legislative indemnity from someone who says, 'Because of what you told me I did this and it turned out to be wrong, so I'm going to sue you'?

Mr Brogan—We do not have legislative indemnity; we have a constitution and service agreements with the government. Obviously, we have professional indemnity insurance and it is our role to make sure that we do not void that insurance by acting in an inappropriate manner.

CHAIR—Do you want to say anything else in addition to what you have said?

Mr Brogan—One of the issues I want to raise because it has come up and has been getting a bit more attention since we put in our submission is about the selective random drug testing regime in Victoria. To put that in context, our current approach to reducing alcohol and drug related harms in this country is still a harm minimisation approach, which involves law enforcement, demand reduction, community education and harm reduction—that is, working with people who might be using drugs to reduce the level of harm.

With regard to making the roads safer for drivers and families in the community, I cannot contemplate that anyone does not think that is a good idea. Drug users are still members of the community. Someone's decision to take an illicit drug at a particular time does not divorce them from the social contract in which they have responsibilities, but they also have rights. There has been a great deal of publicity about the Victorian random drug testing regime and interest in it from interstate. I believe New South Wales and South Australia are modelling their approach on the same thing. We believe that there are some limitations to this scheme, and I would like to take this opportunity to address a few of those.

The great success of the alcohol campaigns—the road safety campaigns involving alcohol use—are that as well as a punitive arm, a law enforcement arm, there has been a great deal of education. There has been education about safer levels and more responsible drinking and campaigns about life loss, trauma and the legal consequences. We have seen a great deal of success. The number of deaths per head of population from alcohol road fatalities has greatly decreased.

People would like to see a comparable program related to illicit drugs because, intuitively, it makes sense that drugs that affect your mind are going to affect your driving. With the broad aims of that, I have no problems at all; however, in the application, we do not have a consistent system. With alcohol there is good scientific evidence that a standard amount of this drug in your bloodstream, not a metabolite of the blood, gives a good indication of how long ago you have had the drug, if is it still affecting you and causing a level of impairment, and the penalties are based upon that.

With the illicit drug testing regime that is currently in place, it does not seem to be equitable or as useful as it could be. We are testing for cannabis, MDMA and amphetamines but we not testing for heroin, LSD, GHB, benzodiazepines, morphine, or the minor or major tranquilisers. Many or all of these drugs probably cause levels of impairment.

A good public health campaign draws in the people who are at risk of harm or who might be involved in increasing harm to others and makes them a part of the campaign. The alcohol campaign has done that, but a road testing campaign that seems to be selective and targeting drug users in the guise of road safety sort of excludes those people and puts them outside the picture.

CHAIR—For example, someone might think, ‘I’m going to drive, therefore I’ll take heroin rather than ecstasy.’

Mr Brogan—That is always a risk and one of the unintended harmful consequences of having a very selective, small regime. But the big problem is that someone might have taken some amphetamines last night. They believe they are safe to drive today, but we are not giving them the education. We are not saying, ‘This amount of amphetamines will impair you and more than that won’t.’ We are not saying, ‘If you’ve had it in the last eight hours it’s going to impair your driving.’ We have not been giving them the kind of information to work with to make—

CHAIR—It is very hard to do that.

Mr Brogan—It is hard to do that. Any detected level attracts the penalty. It is going to make people work at ways to avoid being detected rather than help reduce risk on the road.

Ms Hazelwood—There is also no education campaign around this at all. It has been introduced and implemented with no education. There is not even a message out there saying ‘have a designated driver’ as there is with alcohol—no messages are reaching drug users.

Mr HAYES—That is the difficulty: alcohol is legal so you can have that campaign, and I think that works quite well. Anecdotally, the information I get back from my kids is that they have designated drivers. The kids are very good in terms of alcohol.

Mr Brogan—If you give people something to work with—

Mr HAYES—We heard the evidence from the cops this morning. The Victorian road tests show that it is extraordinarily high. And that is only testing for—

Mr Brogan—I would like to talk about the quality of the evidence that has been presented to the public in Victoria. Most probably, none of the scientific evidence that has been presented to you today has been through a process of peer review—that means other scientists looking at the quality of the work. This has been government commissioned research that has then been enacted. Whether what they say actually stands up at all, who knows? But the main thing is that they are comparing apples with oranges; they are not comparing the same thing. Part of what they use to justify the measures is that 30 per cent of people involved in fatalities have a detectable drug in their system. Yes they do, and that includes prescribed and over-the-counter medications—all the drugs. Also, there is no investigation into the extent to which the drugs in the presence of the people involved in fatalities contributed to the fatality—that is, whether there is a causal link.

Ms Hazelwood—They also sit the drug buses outside big rave parties, for example, and book everyone.

Mr Brogan—It is not random.

Ms Hazelwood—The massive statistic that they were preaching about this morning is highly skewed by the fact they sit in front of a party. For example, last weekend it was a dance party where there were 7,500 people and they tested every second person who came out of the party.

Senator POLLEY—Don't you think the police force have a duty of care? If they know there is a rave party going on, they have a responsibility to test those drugs to protect the mums and dads and the kids who are driving on the roads and to keep them safe. The other issue is that when you are talking about an advertising campaign for alcohol, which has worked very effectively, alcohol is, whether you like it or not, a legal drug. We all know that we should all drink less. Likewise, it is very hard to send a message to the community that if you pop a pill on Friday night it is all right to drive on Saturday morning. That is very hard. The other issue is that it is all very well to talk about harm minimisation. You are the people at the coalface. Why are so many of our young people, and people of all ages, consuming so many drugs? What is wrong with our society that alcohol is no longer the drug of choice? My understanding is that the figures for heroin are increasing again because of supply. Why are so many people turning to drugs as a way of escapism or whatever?

Mr Brogan—I do not really feel qualified to talk to you about why people are taking drugs or whether they are taking more today than they used to. I have been working in this area for about 15 years and I have seen pretty high and consistent drug use in the community for some time. What we do get is changing patterns. We had an oversupply of heroin up until about 2001. We have had a dip but it is coming back again. The evidence is catching up and telling us what we have all known.

As someone working in the area, I feel that road safety is too important. The safety of our families and the people we care about is too important to play drug war politics. Yes, we should

be trying to send the right message. There is nothing wrong with saying, 'Don't take these drugs; if you take these drugs and drive you are a bloody idiot.' At the same time, we should have some way of informing people of ways they can reduce the risk to themselves and to others on the road.

A system that penalises people for any detectable level of a drug or its metabolite in their system that is not linked to impairment is seen by many to be an offence to reason—an inequitable thing—that is singling them out for being drug users, not for being a threat on the road. What we ask for are much better science and evidence that can tell the community and people who use drugs what the levels of impairments are with these drugs and what the withholding periods are.

CHAIR—It is not about unsafety on the roads; it is about unsafety to your own health in the long term, perhaps—although I think it is fairly clear that there are health consequences.

Mr Brogan—Health consequences of drugs do tend to attract some research, but we do not know whether MDMA is more or less impairing in terms of controlling a motor vehicle than amphetamine because the science has not been done—or if it has been done, it has not been published.

CHAIR—Are you saying that because there is no link between bad driving and drug taking the police should not be stopping these people and testing them?

Mr Brogan—No. The police have always had the power to pull over someone who they believe is drug and alcohol affected and test them. We are saying that this supposed random drug testing—that is based on a very small number of drugs, that does not bring a pile of over-the-counter and prescription drugs into the picture, that is not based on detectable levels and demonstrated scientifically to relate to impairment and inability to drive a motor vehicle safely—is going to be counterproductive in the long term.

CHAIR—In regard to roadside breath tests, I understand you are saying that there should be some link between driving a car and safety and the taking of the drug.

Mr Brogan—.05, yes.

CHAIR—That is what you are saying, but I am saying: isn't it a question of police helping people not to harm ourselves in the future? Even though we might drive quite normally, in 20 years time we might be brain dead or something because of these drugs.

Mr Brogan—Given the huge number of people who are taking drugs in the community, I think more effort should be put into helping those people abstain from drug use at appropriate times and make decisions that will help them drive safely, rather than targeting and penalising them. Let's not think about those drivers; let's think about the people they might kill.

Mr HAYES—I think you make a good point there. Apart from testing people on the road for drugs, I have not really given much thought to people who may be on Valium or Serepax or something else and what that does for their driving ability. I have never thought about it in that context.

Mr Brogan—If you have dealt with them, you would have some idea.

Mr HAYES—I think it is very good and helpful that you have raised that. Purple, in terms of the functions that you guys go to with your trained personnel, how do people come up to you and why do they come up to you?

Ms Hazelwood—Usually we have a little store. We have a fairly good reputation, considering that we have been around for 11 years. A lot of the older and more experienced ravers have seen us, know who we are and know our history. That helps with our reputation somewhat. We set up a little store with couches and beanbags, and put a 'RaveSafe' sign out the front. We have oranges and apples. We have information, earplugs, condoms and all sorts of different little resources and things that people can use while at the party that make people want to come to us. We quite often stand out the front of our store handing out these packs that you can see. We want to get them into people's hands, to get them the information they need to know and to let them know where they can get more information. The other way people sometimes engage with us is when they are freaking out a little—they are not 100 per cent well within their space—and someone will bring them to us knowing that we can look after them to some extent.

Mr HAYES—Ordinarily, what do they want to talk to you about?

Ms Hazelwood—They are genuinely interested in what they are doing to their bodies and how they can make themselves healthier and better while still making the choices that they make.

Mr HAYES—John, the people you represent are certainly at the other end of spectrum. You are not talking about recreational drug taking; you are talking about people with addictions. What is your view of the effectiveness of the heroin injecting rooms, for instance, at Kings Cross?

Mr Ryan—We are a Victorian based organisation, so I am not intimately familiar with the injecting facility in Sydney other than through reading the research and evaluation. Based on, from my reading, the very rigorous evaluation, it makes some sense to stick with the evidence, and the evidence is that it has been effective on a number of its criteria.

Mr HAYES—It is very controversial, obviously, but how do you see the program going in terms of ultimate diversional activity? How would you measure its success? Obviously, firstly, there is needle exchanging, but I know that they put a lot of counselling effort into the one in New South Wales. I am not familiar with the one operating in Victoria. How should we measure the success of the needle exchange program?

Mr Ryan—It is an excellent question that deserves some determined effort. The basic criteria for assessing the needle and syringe program has been its capacity to prevent HIV transmission, for which it gets a high distinction. The role of the program expanded in the early nineties without an expansion in resourcing—it just expanded in terms of its scope of responsibilities to include blood-borne viruses. Hepatitis C was sort of tacked onto its job description. The problem is that, unlike HIV, there was already a lot of hepatitis C in the community. It is extremely infectious compared to HIV and it needed a much more sophisticated response than just pretending you can change the description of the program and it will have a different impact in

the community. We still have people accessing the needle and syringe program who are 60 per cent hepatitis C positive, but we still call the program the prevention program. Even though that number is less than what it was in 1991, it is still extraordinarily high and we are not taking the measures that would be adequate to address the hepatitis C epidemic.

It goes back to that issue around the understanding of risk. There are an enormous number of NSP clients—injecting drug users—who do not actually understand the intricacies of hepatitis C infection and put themselves at risk. There are also a number of clients whose injecting practices are risky, because of other issues such as their drug dependence or their mental health issues et cetera. We do not adequately deal with those issues through the needle and syringe program, because we still have a sort of minimalist blood-borne virus mindset, I think. For example, amphetamines became quite a big issue and we wanted to convene a conference around it. Part of the reason for that was because the feedback we were getting from needle and syringe programs was that the complexity of presentations by clients had increased significantly, while our capacity to deal with it had not caught up with the drug market or the people in the drug market. The question was: how do we actually build and share knowledge and build networks and share information?

You get a situation where, for example, there is no allocated workforce development money from national funding for needle and syringe program workers. We have our capacity to distribute injecting equipment for the purposes of preventing blood-borne viruses, but we have not adequately exploited that opportunity for conversations about X, Y or Z—it might be about the drugs people are consuming, their housing situation, their sexual health; it could be about a number of issues—and then exploiting that trusting and respectful conversation or interaction in order to provide access to specialists in, for example, drug treatment services, mental health services or reproductive health services.

That sort of integration is not happening adequately from the coalface at NSP into the health system. It happens patchily. For example, about 10 per cent of programs have specialist funded staff to deliver that sort of work, but another 90 per cent are still based on the HIV model, which was very much focused on one issue that was, in retrospect, something that other countries have not dealt with adequately. We have, but it is a lot more complex now and I do not think we have caught up with that.

It is really about workforce development. That is why we have focused quite specifically on the need to skill up those workers, but workforce development is not just training. We are looking at it as a way of actually building health infrastructure around the front door that the NSP provides.

Mr HAYES—At the conference there were law enforcement officers, lawyers and health workers, as you said, together with drug users. As this was your first conference, what emanated from drug users?

Mr Ryan—Unfortunately we were absolutely swamped by interest from media, which saw me mostly absent from the conference, but the good thing is that we are pulling together the findings from the conference. There was a deliberate intent to the way we structured the program, which was that we had an absolutely diverse range of speakers but we limited almost all of them to about 10 minutes plus five minutes for clarification questions and then opened it

up to the floor because there was an enormous thirst for conversation and trying to nut through the problems. Of all of the experts at the conference, no-one pretended that there is a simple solution to it, and there was absolutely a consensus that it requires a linked up and nuanced approach.

I think that the people who came from drug user organisations like VIVAIDS and from other states and territories were of the same mind. In fact, they were making comments such as, 'Ten years ago I would have been arrested for speaking to Inspector X, but now we're actually having a conversation about health issues and law enforcement issues and trying to come closer together.' If you would like a more sophisticated description of the conference, I would be happy to provide that to you, if the committee still has the opportunity. It will not be available, though, for about another month.

CHAIR—Our researcher attended the conference, actually, and has given us some information. We have a very good little paper from our researcher on that. How many of you are there?

Ms Hazelwood—How many organisations such as RaveSafe?

CHAIR—Well, yes, that too, but how many people work with you?

Ms Hazelwood—There is the coordinator, who is me, and then I have 12 peers who work with me, who are volunteers.

CHAIR—How are you funded?

Ms Hazelwood—By the Department of Human Services.

CHAIR—Do you know what your budget is, approximately?

Ms Hazelwood—It is about $85,000 a year.

Mr Brogan—They have to go out to 15 major events. A lot of them are outdoors and in the country—

CHAIR—So yours is very part time? The coordinator might be full time, but the 12 assistants are all—

Ms Hazelwood—They are volunteers.

Mr Brogan—They are members of the community who want to do something for the health of their community.

CHAIR—Is this replicated elsewhere in Australia, are you aware?

Ms Hazelwood—There is one other, which is partly funded—to maybe a quarter of what RaveSafe is—in Brisbane, in Queensland. But I am not sure of any other programs that are

currently funded to run. As far as I am aware, and I have been looking in recent weeks, there is not anything else.

CHAIR—Are you both from the same group?

Mr Brogan—VIVAIDS is an incorporated organisation. We have a number of programs and nine staff, of which one is Purple and the RaveSafe program. Because VIVAIDS has had a focus in the past on reducing harms from injecting drugs, such as people who inject amphetamines and heroin and stuff like that, and a big focus on preventing hepatitis C and HIV and overdose deaths, RaveSafe has sort of amalgamated with us as part of our new focus on broadly reducing harms for illicit drug users.

CHAIR—The funding is relatively secure, as far as you know? Are you providing a return for the investment? Does the government think that?

Mr Brogan—In terms of RaveSafe, in 2003 the Victorian parliamentary inquiry into drugs and crime recommended that the funding be increased. The state coroner has said that there should be more of this sort of education for people—how to recognise, cope with and respond appropriately to adverse drug events. I think there is a great deal of support from experts for our programs. We are funded by DHS; 90 per cent of our funding comes from the Department of Human Services. It is on a three-year cycle, which we are just at the beginning of. I guess we are as secure and as insecure as many other community based organisations that receive health funding.

CHAIR—Without being provocative to our last witness, do you have either a corporate or a personal view on drug testing?

Mr Brogan—Our organisational view, which we have presented before, is that it is probably a good idea. We would like to see the technologies improved—and I think they are improving—so that if testing regimes became available people would get some qualitative and quantitative advice on the kinds of drugs they use. Even with the current limitations, if the test were available to people, as long as they know that it is not a comprehensive test, being able to detect something in a drug that is harmful and informing the person of that when they are considering taking it has the capacity to reduce harms that would otherwise occur. Without testing, you do not have the opportunity to prevent those harms.

Ms Hazelwood—I would like to point out that in the past, when we have worked in places where Enlighten were testing—this is a few years ago—a considerable number of people were asking questions about RaveSafe. We have set up side by side—if Enlighten are there, we are there; they are testing pills, we are providing information. The considerable number of people who have come to talk about drugs and their harms has been amazing. The response is just phenomenal, to the point where we cannot keep up. Even just by using the pill testing as a hook to get people to a service to talk about the harms of drugs, the response is phenomenal. When we have partnered up, we have been overwhelmed with the response of people trying to get information from us.

Mr HAYES—So it is causing people to ask more questions?

Ms Hazelwood—It is causing people to ask more questions. It is causing people to access information.

Mr HAYES—Regarding people you would see on a Saturday night—'Saturday night' is the wrong terminology because it would probably be a large-scale event, with 500-plus people—who would come and talk to you? Would they be people who would be inclined to test a substance?

Ms Hazelwood—I think that no-one wants to cause themselves harm, that they would want to do things in the safest possible way. If it were to prove that something is safer for them then, yes, I can definitely say that they would want to test their pills.

Mr HAYES—Whereas, in terms of people who inject, that would probably not be the case, would it? Would they be inclined to test?

Mr Brogan—I managed an NSP program for number of years in South Australia and, from my experience, yes, if people were able to get their drugs tested legally, overwhelmingly they would.

Mr Ryan—There is an enormous sort of cultural gap between the policy and media discourse in relation to drugs and what actually happens at 10 am on a Sunday. Some people are going to church; other people are down on nightclub strips continuing their party from the night before. Whilst it is true that people do not want to deliberately cause themselves damage, we all know that—I mean, I gave up smoking cigarettes this Monday just gone—

Mr Brogan—Talk to me next Monday, John!

Mr Ryan—people do take health risks for supposed pleasure. It is very complex. It goes to Senator Polley's question before: why do people take drugs? We do not actually have the solution. Some of it is no doubt genetic and biochemical. Some of it is no doubt cultural. But having a blanket statement that 'Drugs are dangerous; don't take drugs; you're going to damage yourself either in the short or the long term' and expecting an invincible 18-year-old to believe that message from someone in a suit is culturally insensitive.

CHAIR—At this point, could I come back to you. Would you say that most young people have got the message that drugs and alcohol—for my generation—really are no good for you? But, as John was saying, I still drink alcohol. I know it is no good for me, but I still do it. But do most young people who go to the places where you work accept—do they know—that they are not really good for you, but the enjoyment overrides the possible risk?

Ms Hazelwood—I think by seeking information they are showing that they know they are no good for them. They are seeking really credible information that is going to assist to make it a healthier experience, because they are going to do it anyway. It is just like having limits on drinking. We cannot say nationally that there is going to be a limit: 'You can have this much and it will be okay with you.'

CHAIR—They did try that in America years ago. It did not work.

Ms Hazelwood—There are definite messages around alcohol and how to be safer while drinking alcohol, and there are definite messages that we can give that do make drug taking safer, but not safe. People do want to move towards safer drug use.

CHAIR—I will just put to you, though, an argument made by some people which I have been putting to witnesses. That argument is: 'Oh, well, I know drugs are bad so I won't take them—but, hang on, here's a government sponsored little booth in the corner that will test my pill and tell me if it's going to kill me. Therefore, whilst I wouldn't have taken the risk before, now, because I can get it tested by a government sponsored agency, I'll have it if they tell me it's okay.' What would you say to that argument, based on the people you deal with in your work?

Mr Brogan—They have already taken the decision to use the drug.

Ms Hazelwood—Yes. By the time people are at a party and have it in their possession, they have already made the decision that they are going to take that pill, I believe.

CHAIR—Okay. I am only talking about the people who have come to the party and have never taken drugs before, but who then look around and say: 'That person's having a good time. They must've taken drugs. Maybe I'll have a go at it and see if I can have that good a time—but I'll take my pill here before I go.'

Ms Hazelwood—I would assume that that person eventually would make that decision by themselves, irrespective of whether or not there is a booth in the corner where they can test that pill.

Mr Brogan—I think that, echoing Mr Davidson's evidence, all we can really go on is the evidence. The evidence is overwhelming that, where pill testing does exist, there has not been an increase in demand or consumption of the drugs; in fact, there have been decreases. That is the evidence we have.

CHAIR—Some of the committee will challenge whether that evidence is very good or comprehensive evidence.

Mr Brogan—I refer the committee to Mr Davidson. I believe you have kept his submissions!

CHAIR—Yes, of course. I think we have the details of that research.

Ms Hazelwood—Another issue that is really high on my agenda at the moment, and you asked questions about this earlier, is the police use of sniffer dogs at parties. I can tell you that at every large event that I have been to in the last 12 months there has been a sniffer dog operation that has caused direct harm to people coming into contact with that operation. I am concerned that they state that it is to catch people who are trafficking or dealing drugs. The New South Wales Ombudsman has just released a very thorough and extensive report about the use of sniffer dogs in New South Wales that suggests that 19 searches in every 10,000 searches result in a successful prosecution for trafficking, so they are not achieving the goals that they say are the reasons behind them introducing these dogs.

CHAIR—Is it fair—

Ms Hazelwood—One of our major concerns is that we have several reports of people taking huge risks upon seeing the dogs to avoid detection and to avoid being prosecuted or sent through drug diversion.

Mr HAYES—Only people with commercial quantities would be prosecuted, though.

Ms Hazelwood—Yes.

CHAIR—But the kids do not know that—is that what you are saying?

Ms Hazelwood—No, they do not, and so they take everything that they have on them. They are taking large amounts. They are changing from relatively safer drugs like ecstasy to GHB, which is a highly dangerous drug that has caused deaths in the past, because, reportedly, the dogs cannot smell that.

Mr Brogan—It seems to be less easily detected.

Mr HAYES—That is a different thing. That is not the kids seeing the dogs, panicking and deciding to do something to get rid of the drugs—take them, throw them or something else; this is actually planning how to beat the system.

Ms Hazelwood—Yes. That is happening.

Mr Brogan—Both things have harmful consequences.

Ms Hazelwood—Both things are happening. People are immediately taking everything and people are going to extensive lengths to plan—

Mr HAYES—They are not going to be the same people who want drugs to be tested, either.

Ms Hazelwood—I think that you would be surprised.

CHAIR—Thank you very much for your time, all of you. Thank you for the work that you continue to do to try and solve this very difficult problem. We as a committee certainly appreciate you taking the time to come along and speak to us, and we thank you for your written submissions as well.

[2.13 pm]

LODGE, Mr Michael Anthony, General Manager, New South Wales Users and AIDS Association Inc.

CHAIR—Welcome. We have received your submission, for which we thank you very much. If you would like to make any comments going to your submission, we would be very pleased to hear those—or any updating since the submission was made. I assume, as you are from the New South Wales Users and AIDS Association, you are from New South Wales?

Mr Lodge—That is right.

CHAIR—So you have come a long way; thank you very much for doing that. We missed you when we were in Sydney, so thanks for coming down here to give us the benefit of your advice today. Over to you.

Mr Lodge—Thank you very much for the invitation. I am pleased to be here. I thought I would quickly recap on our submission. What we would like to emphasise is the notion of healthy public policy that comes out of health promotion theory. That really lays down a policy imperative that says, 'Do no harm.' Whatever policy or program you want to initiate, you need to understand what the negative consequences of that might be. Sometimes they can actually undermine the intent of the actual policy or program.

We would like to emphasise the difference between the notions of risk and harm, that risk is a potential and harm is the expression of that risk. We think there should be a better balance in resources between the three components of the Australian approach to harm minimisation so that demand reduction and harm reduction get an equal share. We would suggest that they are more effective around drug policy than supply reduction. We recognise that human beings have used drugs for thousands of years and it is very unlikely that we will be able to implement a set of policies that eliminate drug use.

We think that street-level harassment of users creates a number of specific problems. Some of those are that it moves the problem from one suburb to another, that when the police begin an intensive operation in one area the problem very quickly shifts to another and does not eradicate it. Inappropriate policing can cause people to discard used injecting equipment inappropriately and make the environment unsafe. In many ways it can reduce access to health services, so that there is less access to education, less access to primary health care and reduced access to the means of preventing blood-borne viruses. Inappropriate drug law enforcement reinforces the level of social isolation and demonstrates a commitment to social exclusion for drug users.

Our health system promotes this idea that everybody is entitled to good health care, that we value people as human beings, yet in the way that we often operationalise drug laws there is a counter message that says to people: 'You're a dirty rotten junkie and you don't deserve anything. You deserve to be excluded from this community because you choose to seek your pleasure in this way.' I think that flows on into negative community attitudes to needle and syringe programs and pharmacotherapy programs like methadone. That is just a short recap.

Mr HAYES—Have needle and syringe programs been reasonably successful so far?

Mr Lodge—Extraordinarily. There is a mountain of research internationally and particularly from Australia that very clearly says that needle and syringe programs do not promote drug use amongst people who were not going to do it anyway. They are highly effective in reducing transmission. When we look back through the program in Australia since its inception, something like 25,000 HIV cases have been avoided and 21,000 cases of hepatitis C have been avoided, therefore saving the health system in this country an enormous amount of money.

CHAIR—Are you an action group? Do you actually work with people with drug problems or are you a policy group?

Mr Lodge—We do both. We are a sister organisation to VIVAIDS. Nearly each jurisdiction in Australia has a similar organisation. There is our organisation in New South Wales, VIVAIDS in Victoria. SAVIVE in South Australia, QHiN in Queensland and WASUA in Western Australia, and there was CAHMA in the ACT.

CHAIR—VIVAIDS did not acknowledge you as a similar organisation. Do you actually do the same thing? Do you send people to major events?

Mr Lodge—We do not have a rave safe program as such. We have a small funding program called TRIBES, which is to try to generate grassroots education work amongst subgroups of drug users who are not in regular contact with health services.

CHAIR—I suppose you have answered this question by saying, ‘We’ve been doing this for 10,000 years,’ but do you think there is an apparently increasing use of synthetic drugs in the last few years?

Mr Lodge—I think it is a very complex area of investigation and one we are not very good at. An academic from Canada, Robin Room, looked across the 20th century and very clearly identified waves of drug use—rises in the increase of per capita alcohol consumption and the rise of particular epidemics, for want of a better word, in opiate use and in the use of cocaine. I do not know that we understand what triggers these epidemics. They die away for a few years and then come back in some other form. When we go back through history and look at the Roman republic, we see that there are lots of firsthand reports from ancient sources about illicit drug use. There is evidence from ancient Egypt of cocaine-like substances. For thousands of years we have been brewing potions and doing all kinds of things to seek a level of intoxication. Some cultures put that drug use within a religious ceremonial context and confine it to particular classes of people. In cultures like ours it is much more diffuse. Innately, human beings from time to time desire a level of intoxication—a way of changing their consciousness.

CHAIR—How long have you been here today?

Mr Lodge—I caught the tail end of VIVAIDS.

CHAIR—You have missed some of the other evidence then. Are you conscious of pill testing in Sydney?

Mr Lodge—It is not something that happens very much in New South Wales at all. It is much more widespread in Victoria. You have Blue Light and those kinds of organisations.

CHAIR—You have no association to have a view of that?

Mr Lodge—Our association's view is that, because the technology is so rudimentary, we cannot really articulate a benefit. If someone has already bought their pill and goes along to a dance party and has their pill tested, it cannot be tested for every contaminant. It is a single test. Generally, people test for PMA, which is in the process of cooking MDMA, which is ecstasy. If people stop that process early, what is left is a product called PMA, which is highly toxic.

Mr HAYES—It was suggested earlier that it would probably be less likely that that would be done in a single instance, but it may be by someone going along with a batch of 10 to 20 pills and having one of those tested. But, at an event, you do not think that once someone makes a purchase they would go and do that?

Mr Lodge—People are after a level of intoxication, and some people have personal preferences. As the precursor controls and supply interdiction for ecstasy have improved, local manufacturers have changed what goes into the pills. So, in order to mimic an ecstasy effect, they will often use methamphetamine, caffeine or ketamine so that there is a combined stimulant-hallucinogenic effect. Some people would prefer pure MDMA, so they might say, 'That pill's got too much,' or 'It's got methamphetamine; it's not what I'm interested in.' So I do not know that it is a deterrent.

Mr HAYES—They would not get into that discussion on purchase, would they? They would not get into that sort of detail when they were going to make an acquisition.

Mr Lodge—No, generally not. I think most people rely on the advice of the dealer, who will say, 'People report psychedelic effects with this pill,' or that another type of pill will be more amphetamine. They generally rely on what their dealer tells them.

CHAIR—You said in your submission, as I recall, that if people are going to take drugs it would be better if they smoked them rather than injected them. Is that an accurate summary?

Mr Lodge—In relation to methamphetamine. We do not have a type of heroin in Australia that allows smoking, as opposed to in the UK where it is smokeable. In our submission we were talking in particular about methamphetamine. By and large, its best psychoactive effects come when it is smoked. In South-East Asia people will often use pieces of alfoil and 'chase' it—it is a crystal and as it is heated it becomes a liquid and then vaporises, so it travels along the alfoil. There are problems with that, with inhaling fumes from the alfoil, and I think most people prefer to smoke it.

CHAIR—But your point is that—

Mr Lodge—If we take away the glass pipes then people are more likely to move to injecting, which increases the range of risks.

CHAIR—The other risks associated with it?

Mr Lodge—Yes.

Mr HAYES—Those other risks become more long term in their effects, their impacts?

Mr Lodge—I am talking about exposure to blood-borne virus and injection site trauma. Most people do not have very good practice around their injecting.

Mr HAYES—By the time they make the decision to use injecting would they be classified as being addicted?

Mr Lodge—No, there is a very specific set of criteria that define dependence. It relates to the degree of craving, the frequency of use, the centrality of drug use to people's lives and a deterioration of their social functioning. We have the spectrum of drug use from functional, for want of a better term, at one end right through to dependent. There are a number of classification systems that will help clinicians determine the degree of dependence.

Mr HAYES—We are trying to look at recreational drug taking and dependency—obviously there is a link at some stage; I am not sure what the percentage is—without trying to mix those two categories up. Is it your position that simply making the transition to injecting is a fast-track to dependency?

Mr Lodge—It need not be, but I think in practice it is—

Mr HAYES—What is the gut feeling?

Mr Lodge—It demonstrates that people are willing to take a greater number of risks to get the effect.

Mr HAYES—The evidence given to us is that only about five per cent of drug takers are prepared to inject. Based on that figure, as reported to us, I am assuming that once you have decided to take that step then you are really making a significant decision to go further down in that culture.

Mr Lodge—Yes, but our point is that it is not necessarily a natural progression and that most people are happy to stay smoking. But if you take away that means of ingesting the drug then they are more likely to move to injecting and expose themselves to a greater range of harms.

CHAIR—Your submission says we should be concentrating on demand reduction, supply reduction and harm minimisation. But you also say that trying to stop the flow of precursor drugs that we know of at the moment is pushing the manufacturers into perhaps less safe precursors. If you do not attack the precursor inputs to drugs how else can you get supply reduction?

Mr Lodge—Each of those components of harm minimisation has a place in public policy. At the moment, the resources are weighted towards supply reduction, and that creates a problem because it means that, if it is done badly, people do not access health services or the means of prevention for blood-borne viruses. The thrust of our submission is that we can do policing

better; that is, we can do policing in such a way that the negative consequences are not as evident.

In the early 1990s, New South Wales decided that they would reschedule over-the-counter amphetamines—the no-doze and stay-awake tablets—because of their widespread use amongst the trucking industry. What happened, though, was that the drivers moved on to illicit amphetamines and were no longer getting a pharmaceutical-grade product and were not able to ensure the dose. So, in that case, we made a public policy decision that we thought was about deterring people from use, but we made the situation worse.

Our submission is: yes, supply reduction is important but we need to be careful how we do it. We need to assist police in improving the ways that they evaluate their operations and to become aware of the kind of negative consequences that can arise. If we look at, say, Cabramatta, and the policing blitz that happened there in the late 1990s, rates of hepatitis C went up and there was lots of social dislocation. We could have done that a lot better. That is our point: that we should not see supply reduction in itself as a virtue. It is a tool to improve the law and order in society and improve public safety but, in using that tool, we should not compromise people's health.

CHAIR—Someone mentioned earlier that supply reduction is a much more popular political decision for governments to take, or an easier—

Mr Lodge—It is.

Mr HAYES—It has economic impacts too.

CHAIR—Yes.

Mr Lodge—I think we have oversold the impact of deterrence. We think that we can create a system that deters people from use, by increasing penalties and increasing the rate at which they might be detected—and that simply does not pan out in reality. Policing does not deter people once they have decided that drug use is the way that they want to seek their pleasure.

CHAIR—History shows that prohibition never worked with alcohol back in Chicago or wherever it was in Al Capone's day, and it is very difficult to find something that you can try to do to stop something that is harmful. You are the New South Wales Users and AIDS Association—and I assume that 'AIDS' is acquired immune deficiency rather than help for those users. How far back was the Grim Reaper advertising campaign? Was it 20 years or so ago?

Mr Lodge—It was in 1985 and 1986.

CHAIR—Quite clearly, it was very successful. I heard a news report last night that said that it was perhaps needed again. Do you think something like that would be useful in deterring people from taking drugs?

Mr Lodge—I do not think so. Most people in health do not see that the Grim Reaper campaign was particularly successful, except that it raised the profile of HIV-AIDS within the Australian community. There were negatives—for example, it raised anxiety amongst groups of people who were never at risk. The AIDS information line had 80-year-old grandmothers, who

had not been sexually active in a long time, ringing up worried that they might have contracted AIDS. So we raised the anxiety and we demonised sex in some ways but we did not give people appropriate ways to reduce their anxiety or necessarily change their behaviour.

There is an emerging body of literature around what they are calling ‘the social determinants of health’ or ‘the social determinants of drug use’. It looks at all of the personal characteristics that we have as individuals and can identify factors which protect us from drug dependence, mental illness and a whole range of other impairments to our functioning as human beings. That is emerging as a really strong area. It will mean quite a significant change in the way our institutions mould individuals and the way that families try to create healthy, functioning, happy people.

I will go back to my earlier point about the dual messages we have in this society. We say to people: ‘Your health is important. We want you to value yourself. You have an innate integrity as a human being.’ But then we go around the back with these other messages: ‘Don’t use drugs. Nasty, horrible, dirty people use drugs so don’t do it.’ For those people that become drug users, those negative psychological traits are internalised.

CHAIR—But the advertising does not say drug users are nasty, horrible, dirty people. I would assume proper drug advertising would say, ‘Don’t do this, because it could affect your health in the future.’

Mr Lodge—We do not know the answers to those kinds of questions. Looking at amphetamines in particular, most of the molecules that people use recreationally were developed through the pharmaceutical industry but panned out to not be effective for the purpose for which they were designed. I do not know that we can, say, look at someone who is on dexamphetamine for ADHD versus someone who recreationally uses methamphetamine and say that the one that uses methamphetamine suffers more psychological or physical damage than the person on dexamphetamine. That level of science is just not there. Because we have the prohibition, we are not able to do that kind of scientific investigation.

Mr HAYES—A scientific investigation would not be precluded simply because of prohibition of it, would it? You are looking at established cohorts and—

Mr Lodge—If you were trying to get up a research project within a university, it went to an ethics committee and you said you wanted to administer a particular dose of cannabis or methamphetamine to the participants, it would not get ethics approval. I went to a conference in Brisbane earlier in the year where a neuropsychiatrist was putting up scans of brains of people that had used different kinds of amphetamines. It was embarrassing. He was pointing at it saying: ‘Look at the dark spots here and the dark spots there. I’m not quite sure what it means but I know it can’t be good.’ That has been passing for science. We do not know what the long-term harms are because we have not done the research, by and large. It is very difficult to tease out the health effects that are related to the context within which those drugs are used. If we look at somebody who has become ill or damaged, the question is: was it because their life became chaotic and they did not have food, clothing and shelter or was it because they binged every weekend and did not sleep for a whole weekend—are their deleterious health effects the result of the action of the drug itself or the attendant behaviours?

Mr HAYES—Are they more at risk from health issues?

Mr Lodge—The more people use and the more frequently they use, the more problems they will have. I guess because of the black market and—

Mr HAYES—At what stage do they become a victim of the drug culture?

Mr Lodge—I guess at the stage when the other important things in their lives fall away—when their attachment to their family, to relationships and to their job gets superseded by an attachment to drugs.

CHAIR—A lot of people would disagree, naturally, with some of the things you are suggesting. Thanks very much. Do you have any other question, Mr Hayes?

Mr HAYES—There are a couple of things about which I would not mind coming back to you later, Mr Lodge, but we can do that in correspondence.

Mr HAYES—I move that we accept the tabled documents.

CHAIR—That is seconded and carried.

Committee adjourned at 2.40 pm