

TRANSCRIPT

LAW REFORM, ROAD AND COMMUNITY SAFETY COMMITTEE

Inquiry into drug law reform

Melbourne — 18 September 2017

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**Necessary corrections to be notified to
executive officer of committee**

The CHAIR — We are now to hear from Dr Monica Barratt, who is from the National Drug and Alcohol Research Centre at the University of New South Wales. Hansard is recording what is being said — you are aware of that — and so a transcript of this will come back to you in a couple of weeks for you to check whether it is technically correct, and then it will go on the public record after that. Thank you for attending and thank you for the information you have already shared with us. We are looking forward to you outlining a little bit more about what you have shared with us already, and then we will have some discussion with you from there.

Dr BARRATT — Sure. I just wanted to confirm that my colleagues Professor Alison Ritter and Dr Caitlin Hughes already spoke about this particular submission and the Drug Policy Modelling Program in June. I was the one that was trying to call in from Manchester, but you were unable to reach me. The upshot of that technical problem was that I have been able to come here to meet you all in person, so I appreciate that. I have got a little bit of a statement. I am a research fellow at the Drug Policy Modelling Program, and this is part of the National Drug and Alcohol Research Centre at UNSW. I am not here representing the whole centre, as they have a wide variety of views, but I am certainly here to represent our submission.

I guess I just wanted to go straight to the submission. We made seven recommendations of laws that could be adopted in Victoria, which could improve our policy response to the drugs issue. We looked at particular legislative changes that could be made. Our recommendations included the adoption of seven reforms. The first reform was the removal of criminal penalties for the use and possession of all illicit drugs, so that is *de jure* decriminalisation. The second was the removing of laws preventing peer distribution of sterile injecting equipment. The third was passing laws to enable pilot studies of pill testing or drug-checking services. So that is one of the two recommendations that I can talk more about and can answer your questions about. The fourth was revising roadside drug testing laws, so considering replacing the zero tolerance with an evidence-based specified measure of impairment.

The CHAIR — A pity Bill has had to go so early.

Dr BARRATT — The fifth was revising existing drug law threshold quantities for trafficable quantities, so particularly increasing the thresholds for MDMA.

Ms PATTEN — But we have just gone all through the trouble of decreasing them last week.

Dr BARRATT — The sixth was removing deemed supply provisions in Victorian drug trafficking laws. The final one was just a discussion around legislative options for new psychoactive substances, and so that is the second one that I am happy to speak more on, just given that my expertise is in those two areas. As I said, I am open to discussing the others, especially the first one around decriminalisation, but my areas are in those two: pill testing or drug checking and new psychoactive substances.

Just a little bit about the first, pill testing or drug checking. I think the debate about pill testing is such that in Australia it tends to be based on this erroneous assumption that nothing is currently happening in Australia, and this is not the case. Australians have access to the most rudimentary of testing: colour reagent testing kits. There are many individuals across Australia using these testing kits in an attempt to understand the content and purity of illicit drugs that they may be deciding to take.

Australians have also been integral in the development of pillreports.net and other crowd-sourced information websites like that. These community-run websites involve experienced reports, photos, measurements and in many cases actually the reagent test kit results themselves. Also surveys of Australians who use drugs, some of which I have conducted, indicate that many are aware of and use these sorts of services. Further to the contribution of consumers to pillreports.net, there are cases where community members have taken this into their own hands and conducted this kind of testing as an unsanctioned practice, mainly because the demand is there for such testing.

I think there is an issue around making legislative change that could help ensure that if there was a model where health professionals and community workers could be involved in a testing or checking service, that the provision of such information would not be a breach of law for those people. This would help us to implement the kinds of systems that have been operating for many years in a number of countries around the world. Back in June I was actually in Manchester, and then I spent some time in some other parts of Europe and actually went and did some shadowing for a testing service run by Professor Fiona Measham, called The Loop, so I had some experience of that face-to-face.

Right now in Victoria we have the expertise, I believe, to create, implement and evaluate our own outreach model that would invite people who use drugs to submit samples for analysis and provide rapid feedback both to those consumers and to the wider community, and also to stakeholders, including law enforcement, health and frontline workers. Really this is about finding out what is happening before we see the fatalities and the hospitalisations that can result from contaminated or particularly high-strength drugs when people do not know what is in them. I would like to speak more about that, obviously, and answer any of your questions.

On the second issue, the issue of how to deal with new or novel psychoactive substances, I am sure you would all be aware that legislation for a blanket ban on all of these substances not otherwise regulated has recently been passed in this state. It is difficult because that legislation has just been passed even while this inquiry is happening. It is a bit of a shame in a way. It is a very difficult problem for legislators. If they believe the existing system of prohibition must be preserved, I can see why a blanket ban would seem like a sensible option. But I think instead of solving the problem, the look that we have had at these sorts of legislations shows that it can just move the problem. That is one of the concerns we have.

There is some evidence that, for example, workplace and driver drug testing may result in substitution between drugs that are tested for and the newer drugs that are not tested for, say, here in Victoria. I think closing down the shopfronts and the advertising of so-called legal highs could certainly reduce harms by reducing supply in that area, and that is what these blanket bans will do. They have done that in other countries, for sure. But if the demand for intoxicants still exists, it will be filled elsewhere. So rather than assuming that the choice is between consuming a drug and not consuming a drug, the question we need to ask is, ‘Which drugs will be consumed when this blanket ban is enforced?’. Invariably there will be drugs available, so which ones are likely to cause the least harm?

The Drug Policy Modelling Program believes that if our first and most important recommendation is taken up — for example, decriminalisation of personal use and possession of prohibited substances — then there would be a lot less demand for novel substances in the first place.

Thanks for the opportunity to provide the initial statement, and I am happy to take questions.

The CHAIR — Thanks, Monica. Some of us also travelled to Britain recently and saw The Loop testing services in action at a music festival. I am wondering in terms of what you might propose is a good idea, is it just music festivals at which you think it is appropriate to provide pill testing services or where else might that be appropriate, in your view?

Dr BARRATT — I think one existing model to look at is the Dutch model. If you are in the Netherlands, you actually cannot get your drugs tested at a music festival or club environment. What you do instead is go to an office specifically set up for that purpose. You visit with a health worker there. It is outside of the environment where the drug taking might occur — so on a weekday or even an afternoon on a weekend. You have that engagement, there is less hustle and bustle and noise, and you are not already having had a bit to drink or perhaps even having already started taking drugs.

In that environment there is also more of an opportunity to use other methods. If you are in a music festival environment, the speed of getting a result becomes quite critical. If a person is going to take that result on, they need the result to come. It might be in 15 minutes or half an hour, but they cannot really wait 3, 4 or 5 hours or a day. But in the Dutch system they can get instant results, depending on the complexity of the substance they provide. If the substance they provide does not match and is not easily identifiable, the worker can say to them, ‘Look, we’re going to send this to the lab, and we’re going to get the best information possible. We’ll get that back to you in a couple of days’. They then go to a website or they get phoned for that information. That sort of system —

The CHAIR — Is that service provided by government or private organisations?

Dr BARRATT — It is provided by the government with the main aim of drug monitoring. What is really interesting about the Dutch system is that the Drug Information Monitoring System understands that in order to have consumers submit drugs voluntarily it needs to also have a harm-reduction focus, but the actual primary reason why it is funded is to monitor trends in drugs. What they are able to do is look across 20 years of data or 25 years of data, and say, ‘Look, we can see exactly what’s happening with the purity of ecstasy. We can see it

go down at this point and go up at this point'. We can actually start to really understand the drugs market in a way that unfortunately is quite difficult to do in Australia.

That is one of the reasons why I think that kind of system would be ideal. It could be supplemented with some kind of system that involved festivals. What we have seen in other parts of the world — I think it was evidence from Switzerland, from Zurich — is that it is a different kind of person that would attend the festival-based drug-checking service versus one that is in an office. So in terms of being able to provide outreach and access for people who would not otherwise seek help — and that is something we know that these services do — having some kind of service in the festival environment makes sense.

I think there could be some kind of overall system which is really aimed at monitoring what is going on in a rapid way and providing rapid, real-time feedback to all the stakeholders involved — not just the individual that is coming forward, but everybody. I think what was interesting shadowing Fiona at The Loop in Manchester was that I was there for about 5 hours in this place — we were not doing front-of-house testing at that point; what they were doing there was back of house — and police and welfare officers were coming in with samples occasionally and saying, 'Can you please put these at the front of the queue because so-and-so has brought this in and we want to know what it is'. That happened five times within about 3 hours. This service was dealing mainly with police-seized drugs that were not needed for any kind of prosecution and trying to understand what kinds of substances would have been on-site — and one would assume were on site but were not getting caught. They were able to look at that through that system as a monitoring service.

Ms PATTEN — Thanks, Monica. Just following on from that, we did get some statistics from Switzerland about the use of their drug-checking systems and the number of people who took drugs who accessed their websites. As in Zurich, they had them at the festivals as well as at an office next door. With the Dutch model is there a very high level of connection with it? Are the Dutch drug users accessing that website? Is there a high uptake of use of a system four days before you are going to a party?

Dr BARRATT — Yes, in the sense that when I have spoken to my colleague Tibor Brunt, who is one of the colleagues I know in the Dutch system, they do not have enough staff to meet demand, so they are not open long enough hours to meet the demand. They have said that they could definitely, with more funding, open for longer. I guess given the fact that their service is a monitoring service first and foremost, maybe the government is saying, 'We're getting enough monitoring here'.

My sense of it is that if they were primarily trying to reach as many people as possible on an individual level, they may indeed want to put more money into that service. But because it is that monitoring system and they get thousands of samples per annum, that provides them with a very strong capacity to monitor what is going on.

One of the examples was that there was a pill with a very high content of PMA, paramethoxyamphetamine, which is a particularly problematic substance when it is taken when people think it is ecstasy or MDMA. It comes on more slowly but is more toxic if you take too much, so people think that they have got a low-dose pill and they maybe take it again. This was in late 2014.

Ms PATTEN — Around Christmas time.

Dr BARRATT — It was a few years ago now. The Dutch system picked this up. They put out a warning very quickly, and they were able to do that through their warning system. They would not have picked it up without the consumer-submitted samples being tested, as the system does. Obviously we cannot show exact causality here. They did not have any deaths attributed to this drug in this particular sample in the Netherlands. We get the understanding that people do look at these warnings with credence — the Dutch warnings. Unfortunately in England that did not happen, and there were four deaths recorded in the week following that. So there was some discussion about really trying to get some of that Dutch information to England more quickly. It is obviously different here. We do not have that straight supply route of Dutch pills coming straight into our country like the UK does. So we cannot really rely on a Swiss system or a Dutch system to give us what we need here; we just do not have the information at this point.

Mr DIXON — Why did it not work in the UK, or why did people die?

Dr BARRATT — Because they did not have a warning system. So the warning —

Ms PATTEN — One nightclub put out a warning, did they not?

Dr BARRATT — Yes. So Fiona Measham —

Mr DIXON — Was it the UK first and then Holland or —

Dr BARRATT — Normally the drugs will turn up in Holland first, and then we will see them turn up in the UK later. I have only really noticed that through either looking at police seizure data or looking at these drug-checking results. The police seizure data usually is not made available rapidly enough, so it does exist, but it is further down the line that you would be able to make those links.

So in terms of actually rapidly warning the public about a particularly problematic either combination — like we had here in January in Chapel Street with the three drugs in one that were sold as MDMA. With these sorts of things it may not be that one drug is involved but even a whole combination, so being able to warn that that is out there immediately is I guess what we would like to have happen.

Mr THOMPSON — In terms of drug suppliers who may wish to submit pills for testing, what are your thoughts as to a preferred outcome being achieved for a particular motorcycle gang or a Mafia gang that gets the imprimatur for a particular drug that might be safe to take in Chapel Street or in Darlinghurst?

Dr BARRATT — I think the first point to make is that a program such as this can never say that a drug is safe to take. A drug is never safe to take. There are safer situations and there are more dangerous situations, but there is never a safe situation when it comes to taking a drug. If you want to remove all possible risk, then there would be no psychoactive drug taking at all. We know that for many people that is not the way that they living; that is not the way that most of us live in terms of all psychoactive substances. So psychoactive substances are out there. This is quite a pragmatic response in that respect.

I guess that what I have noticed is that the services that have been running for many years, for decades — the Spanish service and the Dutch service — all make the point that these drugs are not safe to take. What they are really wanting to find is not that — there are two options. Obviously you can get what you expect. Someone comes in and says, ‘I think I have ecstasy or MDMA. Can you please test my drug?’. Either you find out, ‘This is what I think it is; this is ecstasy or MDMA’, or you find out, ‘This is not what I think it is; it’s something else’.

I think it is obvious on this other side that that has a harm reduction potential. We have evidence that many people will discard or at least say that they will not take a drug when you ask them, ‘What will you do now you have this information?’. Given that almost all of them would have taken the drug anyway, we think it is a pretty good outcome if a large proportion of people say they will not.

The issue I think you are talking about is this other side: if it is ecstasy, then what message is then given to that person? If that person is a supplier, are they able to then say, ‘Well, my ecstasy has been given the seal of approval from the testing service’.

Mr THOMPSON — Like the outside of the tomato tin.

Dr BARRATT — Yes. So I think a lot of testing services have tried to reduce that chance — I do not think that they can fully eliminate the chance of word of mouth. They cannot eliminate the word of mouth. If someone wants to come in posing as a consumer and they have one ecstasy tablet on them and they put that forward and then they go off and want to use word of mouth to promote that they got it tested, it is hard to reduce that. Having said that, that is not really any different from hearsay when it comes to a consumer talking to a dealer about their drugs. The dealers already say things like this. They already say ‘It’s great. It’s quality’.

Ms PATTEN — ‘It is the best you will find.’

Dr BARRATT — So what all these services do is they do not, for example, provide written information, because written information that says, ‘This contains X, Y, Z’, could then be passed off or passed around. So there are different variations on what they have tried to do. Many of them have also said, ‘Look, you must never bring a suppliable amount to our service’. So they make it clear that you cannot do that. There is a whole bunch of things they try to do.

Mr GEPP — We are not quality control.

Dr BARRATT — Yes. The other way of thinking about this is that one of the long-term benefits of a drug testing or checking service is actually a reduction in mis-selling by dealers and a reduction in discrepant —

Ms PATTEN — Because they know they will get caught.

Dr BARRATT — Yes. In a way although playing the role of being a quality controller is obviously concerning to people to imagine, if, the other way around, it meant that suppliers were less likely to supply adulterated products, then in the end that is going to be a good outcome. I guess that is my response. I think there are ways of dealing with it. Certainly other countries have had to deal with that very issue, and they have managed to move through it in a way that has been acceptable to their politics as well.

Mr GEPP — You are not going to say to somebody, are you, ‘Yes, that’s ecstasy’? Six tablets can have —

Dr BARRATT — When I say ‘ecstasy’, it is MDMA.

Mr GEPP — But that is the point, isn’t it? You could have six tablets in front of you and each of them can have a different chemical compound. They could all be ecstasy —

Dr BARRATT — Yes. When I said ‘ecstasy’, I should have clarified —

Mr GEPP — No, no. But that is how mainstream society would view that, wouldn’t they? I am not being critical, but they would say, ‘Yes, that is ecstasy’, the point being that it can be a very wide variety of what is called —

Dr BARRATT — With ecstasy you do not know what you are going to get.

Mr GEPP — Yes.

Dr BARRATT — That is our campaign in Australia. I think one of the issues that I have come up against in talking about drug checking or pill testing in Australia is that we do have a drug use prevention campaign that is based on the idea that you do not know what you are going to get. So this sort of turns it around and says, ‘Well, maybe we need to know what we are going to get’. If someone is going to take a drug like this, should they know what they are going to get, rather than have this idea of a substance that is completely unknown.

The fact that we continually survey Australians — last year we did another survey of festivalgoers, and when you asked them about use of this service and you asked them if they would discard a drug if the results came back that it was an unknown substance or an unwanted substance, the vast majority say they would. I think that is the first step in thinking, ‘Well, that would prevent some individuals from potentially coming to certain harms’. It does not prevent all harm, because ecstasy itself can cause harm. But I guess the golden question about how much harm would you prevent is about how much of the harm currently happening is to do with adulteration and lack of information about purity and how much is it about the actual substance. That is going to vary for different substances.

I want to make a point, which I do not think is made in our submission, because it is something that has happened in the last few months, is that this also applies to drugs like heroin. In Canada and North America at the moment you may be aware that there is a real issue now with fentanyl and fentanyl analogues being present in heroin and also in other illicit substances in very small amounts, but because these drugs are so potent, they are causing overdoses and deaths, which are really concerning. At the moment one of my Canadian colleagues I met with a few weeks ago when we were in Helsinki was saying, ‘Look, the Canadian government is seriously considering funding this kind of service particularly so that it can reach not just people at festivals or people who would attend a party, but really it could reach a wide variety of people who use drugs and pick up the fentanyl so that there is the capacity to avoid fentanyl-laced drugs and to avoid the deaths associated with that’. So it really, I think, changes the nature of this kind of service —

Ms PATTEN — Or at least know that they have got fentanyl so they can adjust their drug taking.

Dr BARRATT — Yes, so it is not to say that fentanyl itself could not be used knowingly in a way that would not result in overdose, but with fentanyl and then the NBOMe products what we are seeing is much more

highly potent drugs, drugs at a microgram level of potency. Really if things are slightly wrong with those drugs in terms of the dosage, or if it is an unknown dose, then there is just much more capacity for harm there.

The CHAIR — Did you want to make some comments about the testing of psychoactives and what might be alternatives to the legislative process?

Dr BARRATT — Sorry, is that a question?

The CHAIR — Yes.

Dr BARRATT — Okay. I think my concern about the way that we are dealing with the novel or new psychoactive substances is we seem to be dealing with legislation on the supply side. If we want to think about actually why people are taking these novel or new psychoactive substances, then we should look at the rationales behind that and think, ‘Well, maybe we can change it at that level’ — like, what is the demand? We did a survey about five years ago — me and colleagues — when synthetic cannabis or the fake weed was starting to be used around Australia in around 2011. At that time a lot of people were using it, sort of curious about what is it like, but there was still that drive around people who were getting workplace drug testing, people who were getting driver drug testing and people who were also under orders from the court for drug testing. This is definitely one of the drivers. One of the other drivers at the time was that it was legal.

At the time people were keen to avoid the possible penalties and possible stigma of arrest on a use-and-possession charge for cannabis. If you actually have a look at the types of drugs that are involved in the use-and-possession charges across Australia, it is predominantly cannabis. Even though we have diversion systems and even though some of our states have fines and that sort of thing, we still have this high proportion of people who are entering the criminal justice system. Trying to avoid that, we are now in a situation where everything that is psychoactive that is not already regulated through the other instruments that exist is now prohibited.

One of the concerns that I would have with that approach is that there is no room there for the possibility of a low-risk, low-harm psychoactive substance that could be on a par with alcohol. That could exist, but we are not allowing for that in this new legislation. We are saying if it is psychoactive, it is therefore a problem. It is not possible to live with that.

Ms PATTEN — Can I just carry on from that a little bit? Maybe because the lower house members passed this piece of legislation at the beginning of this year it is probably a distant dream for you, but we passed it last week. One of the issues around that is the definition of ‘psychoactive effect’. It was a substance that had a psychoactive effect —

Dr BARRATT — Then you had to define what that was.

Ms PATTEN — Then you had to define what a psychoactive effect was in that it had to have a significant effect on your moods, your nervous system and your motor skills. Then if you look at the Oxford definition of ‘significant’, we tried to tease out whether taking two glasses of wine is a significant psychoactive effect. You are still allowed to drive with two glasses of wine, so is that not? If this substance felt like you had had two glasses of wine, was that legal? Did you guys look at that in any depth?

Dr BARRATT — Yes. The potential for hallucinations — what is the word? In the hallucinations part there is no ‘significant’. So even very, very minor perceptual changes, that is a psychoactive effect. That is interesting. I would say caffeine would elucidate that sort of minor perceptual change. Having said that, I understand that this legislation is in order to try and achieve a certain effect, and one of the effects I believe it would achieve and I think across the world it has achieved is basically stopping the legal sale in shops of drugs that could cause this kind of effect. That is what has happened —

The CHAIR — It is a catch-all.

Dr BARRATT — because I guess the shop owners will say, ‘Well, it’s just too much of a risk for me now with this legislation’. Having said that, if there was a case before a court where somebody tried to actually prove that their substance did or did not have a psychoactive effect, there could be some reduction in the legitimacy of this kind of legislation.

Ms PATTEN — It has been thrown out in Queensland just in the last couple of weeks.

Dr BARRATT — So that is a concern. The law wants to be a legitimate instrument.

The CHAIR — I guess the question then is —

Dr BARRATT — What do we do?

The CHAIR — Where have you seen better or more effective legislation?

Dr BARRATT — Yes. I think this is one of those wicked problems. You can attack it from this direction, as in looking at supply, whereas you can turn around and look at demand and think, ‘How can we affect demand? How can we actually make it so that people do not want to take these substances?’, because when you actually talk to most people who use drugs about the new and novel substances, very few of them prefer those. So there are surveys that we have done. The Global Drug Survey is one example. It is an annual survey. We have looked at this issue on a number of occasions, and 80 to 90 per cent of people, if you ask them ‘If you had these two drugs side by side, MDMA and a substitute MDMA, or cocaine and a synthetic substitute for cocaine, or cannabis and a synthetic substitute, which would you choose?’, invariably choose the original traditional drug. They do not choose this one over here. So the reasons for choosing this sort of synthetic version tend to then relate to other policies that have driven them towards that. That is where I think some change could be made to reduce the chance of people intentionally wanting to take a novel psychoactive substance.

The unintentional taking of a novel psychoactive substance is coming back to the issue we spoke of earlier, which is a drug-checking or pill-testing and monitoring service which would then show up quickly and rapidly for people where there is some novel substance that they had no intention of taking — for example, in January in Chapel Street where there were NBOMes sold as MDMA or ecstasy. These are strong hallucinogenic substances. I have spoken to a number of people who were, unfortunately, involved as consumers, and they experienced prolonged psychedelic trips that they had no intention of taking. Some of them ended up in hospital, but some of the ones I spoke with just managed it. They were very upset about what happened. When I asked that question, ‘If you’d known?’, they said, ‘Well, of course I wouldn’t have taken it’. So I think there is a connection between the two issues for me in terms of policy.

Ms PATTEN — Can you go back to roadside testing? It is a really difficult subject. Just as we know that just the pure presence of a substance such as THC or the metabolites of it can make you break the law, it does not necessarily mean that you are impaired. Have you looked at it? Has anywhere in the world actually addressed this in a satisfactory way?

Dr BARRATT — I am just looking back to our submission, as I did not actually look into this myself.

Ms PATTEN — Okay. That is all right, Monica.

Dr BARRATT — But there are a couple of countries there that actually have specified limits.

Ms PATTEN — So they do a blood limit, like 5 nanograms or something?

Dr BARRATT — Yes, for THC here and MDMA. So I think that is something that especially the USA is having to grapple with at this moment, given that they have certain states where it is not an offence under state law now to consume cannabis. They are trying to manage this and look at ways in which they might test for a specific threshold, but I believe it is quite different from alcohol in terms of working out what that is. So it is a complex area, but I think there is some evidence that you can do that.

One of the unintended consequences is that potential shift to other drugs. We look at cannabis, amphetamines, MDMA, and we do not look at this vast other list of psychoactive substances here in Victoria. So it is sort of saying, ‘Well, these are the most popular. Let’s look at these and let’s make sure people are not driving under the influence of these’. But certainly when it comes to festivals and people knowing, people are targeted as they leave festivals — LSD, cocaine, GHB, ketamine and a whole list of other drugs that can be taken in the festival environment, including the novel psychoactive substances. So is that what we are trying to do? I think that is an unintended consequence of the way the drug-driving testing laws are right now.

Ms PATTEN — NDARC collects data. You do an annual survey, did you say?

Dr BARRATT — I was talking about the Global Drug Survey.

Ms PATTEN — The Global Drug Survey.

Dr BARRATT — Yes. NDARC does a number of annual surveys.

Ms PATTEN — Is that information that has been collated? We keep hearing that there is just not enough data or research around drug use in Australia.

Dr BARRATT — What kind of research is there not enough of that you have been hearing?

Ms PATTEN — It seems that so many of the submissions or people that we have spoken to just say the data is just not there — ‘Anecdotally we say this is how people use drugs, but there’s not substantial data’.

Dr BARRATT — I think there are a number of different data sources. I guess it just depends on what question you have. What has become apparent to me in doing the fellowship that I have been doing and especially looking at this drug-checking issue and novel psychoactive substances is that there are particular areas where we do not have the sort of information that I see our other colleagues in other countries have. So when I see how they are able to say, ‘We have thousands and thousands of samples per year that we’re rapidly testing. We’re able to see what this discrepancy is between what people expect the drug to be and what it actually is. We’re also able to link that to hospitalisations and deaths, and we’re able to see connections’, then of course when a policy is implemented, that means they have got a system there without spending any additional money to generate the data. They can then say, ‘Well, this policy came in there and we can then see this change’ or ‘no change’ or ‘an unintended change’. So I think there are some systems we could increase in that respect.

At the National Drug and Alcohol Research Centre — NDARC — we have the annual survey of regular ecstasy users, so that is ongoing, funded by the commonwealth. We have the annual survey of people who inject drugs, so these are 100 people in every state and territory who do this survey on an annual basis. That provides some baseline information among regular users. It is sort of a sentinel monitoring system, so it is not saying it would represent all people out there but just gives a sense of things like whether prices are changing or particular drugs are changing over time and this sort of thing, or methods of use or particular harms. So I think there are a number of different sources that we have.

I know there is also a program that NDARC has almost finished at this point looking at what are all the available sources of data that we could use for an early warning system. I understand that that is currently happening, funded by the commonwealth. That will come to a reporting stage very soon. It will be an overview of: how quickly can we collate the information that is currently being collected anyway for administrative purposes across Australia into an early warning system?

When I spoke further with people about the early warning system, what they are talking about there is three months. They are not talking about the kind of thing that I would like to see, which is sort of ‘What is happening this weekend in terms of the party scene?’, so it is a different kind of early warning system. It is still really important. We need to have quicker access to the data that exists so we can get there quicker, rather than saying, ‘Well, this report comes out but it refers to data from two years previous’. What use is that? So I think it is important that we get earlier and earlier systems, but actually getting something that is responsive in a rapid or real-time manner is where I think we should look.

Ms PATTEN — So something like a drug-checking trial would actually enable us to collect even some of that demographic information?

Dr BARRATT — Absolutely — something like what is happening in Amsterdam or in the Netherlands, that kind of model. What is really interesting about it is it is not particularly expensive. You can start with the cheaper technology, then you can add more expensive technology if it becomes available. Also, having spoken to some universities, they have said, ‘Well, we have the technology; we just need the legislative change or the approvals to use that technology for this purpose’. We need to know that we can take these prohibited substances in a way where the chain of evidence is sound and legal’, so that is all we really need. We are happy to do this kind of work with very minimal input.

There are a number of proposals that we could put forward, but I do not think it is finance at the moment that is stopping these sorts of proposals. I think it is more of a concern about the politics of the proposals. I think it is

possible on the one hand to say in the same sentence that you can want to reduce drug use across the board and you can also want to reduce the harms amongst people who continue to use drugs. The two things are not incompatible politically.

Ms PATTEN — I just have one other question. When we were at Loop one of the questions was: ‘Where did you obtain the substance that you have given to us?’. I noted, just looking at a couple of the sheets, that quite a few of them had said, ‘The internet’.

Dr BARRATT — Yes.

Ms PATTEN — Are we seeing that in Australia as well — that there is a substantial increase in people accessing their drugs online rather than through friends and dealers?

Dr BARRATT — Yes. In the Global Drug Survey the segment in that survey that I run, which I have run for the last five years, is around purchasing drugs from the darknet or the online drug markets, originally Silk Road and then moving on to a much wider variety of darknet markets. What we have seen over the past three years with that survey is an increase year on year — from a small base, though. It is still less than 10 per cent of people. When we talk to people who are using drugs regularly, it does not seem to be higher than around one in 10. The thing is it might be one in 10, but it does not mean that suppliers are not then using the darknet to supply and then sell face to face. So someone might not realise that their drugs originally came from that place.

Ms PATTEN — That their dealer bought them online and then is onselling them?

Dr BARRATT — That is right. So that is another area of work that I have been spending quite a lot of time on, and I have a grant to do some more work on that over the next three years, funded though the National Health and Medical Research Council. So yes, I did not really include that in here, but I am happy to provide more about that.

Ms PATTEN — Early days. Thanks, Monica.

The CHAIR — Thank you for sharing your research with us.

Dr BARRATT — Thank you so much for having me. I really appreciate the time.

The CHAIR — It is good that we finally caught up with you.

Dr BARRATT — Yes.

Ms PATTEN — You were talked about in Portugal at EMCDDA, because we did not get a chance to talk about how their system worked.

Dr BARRATT — Yes.

Ms PATTEN — So are you going to become one of those points? What are those points called?

Dr BARRATT — Focal points?

Ms PATTEN — Focal points.

Dr BARRATT — I do not know. I do not think so. I do not know if Australia is part of that.

Ms PATTEN — We are not, but they were saying that they were talking about how it would be great if we were.

Dr BARRATT — Yes, it would be good, and I think that is something that NDARC could do for sure.

The CHAIR — Good. Thanks, Monica.

Committee adjourned.