

# TRANSCRIPT

## LAW REFORM, ROAD AND COMMUNITY SAFETY COMMITTEE

### **Inquiry into drug law reform**

Melbourne — 13 November 2017

#### Members

Mr Geoff Howard — Chair

Mr Bill Tilley — Deputy Chair

Mr Martin Dixon

Mr Mark Gepp

Ms Fiona Patten

Ms Natalie Suleyman

Mr Murray Thompson

#### Witness

Mr Shane Neilson, head of the high risk and emerging drugs determination, drug intelligence hub, Australian Criminal Intelligence Commission.

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

**The CHAIR** — We have now got Shane Neilson, who is the head of HRED at the Australian Criminal Intelligence Commission, who is going to address us. Welcome, Shane.

**Mr NEILSON** — Thank you.

**The CHAIR** — You might not be aware that this is the last day of our public hearings after an extensive period of hearing from people in Victoria as well as travelling outside of Victoria. We are looking forward to your contribution today. You will see that we have got Hansard recording our discussion, and you will get a transcript of this part of the discussion within a couple of weeks and you can make sure it is technically correct. After that it goes onto the public record. If you would like to outline the work that you do — I see you have got a presentation to provide — then after that we will enter into a discussion with some questions to follow up on some of the issues you raise.

### **Visual presentation.**

**Mr NEILSON** — Certainly. Good afternoon. Thank you for the opportunity to appear before the committee and provide evidence about the Australian Criminal Intelligence Commission's drug data reports in particular but also related issues.

The ACIC is Australia's national criminal intelligence agency, and our powers make us uniquely equipped with intelligence, investigative and information delivery functions. The CEO of our agency is also the director of the Australian Institute of Criminology, our national research and knowledge centre on crime and justice. So my comments this afternoon will take into account the perspectives of both the ACIC and also the AIC. I have provided in written form the submission I am going to make today, so in terms of time I think I will just skate through the points to draw some things to your attention.

The committee is no doubt aware that serious and organised criminals are at the centre of Australia's illicit drug markets, motivated by greed, power and profit. We know that serious and organised crime groups continue to generate significant profits from the sale of illicit substances, with the prices paid for illicit drugs in Australia being amongst the highest in the world. For that reason the importation, manufacture, cultivation and distribution of illicit drugs and related precursors in Australia are significant concerns for government at all levels, law enforcement and the intelligence agencies.

In recognition of the threat posed by drugs in Australia, the board of the ACIC has approved a high-risk and emerging drugs determination, or special operation, and I am the head of that determination. The special operation covers all illicit drug markets, and the committee is no doubt aware the National Drug Strategy has its three pillars of demand, supply and harm reduction. So my special operation has been structured and very much operates with those three pillars in mind. I note that the committee's terms of reference are also squarely and appropriately focused on harm reduction.

In June 2015 the ACIC made a tangible contribution to the National Ice Taskforce and strongly supported the task force's recommendations, in particular the need for improved data and research on drug markets; the importance of a greater focus on demand reduction initiatives, including in particular appropriate treatment and education; and also fine-tuning the national response of law enforcement agencies collectively to the supply side of the methylamphetamine market.

Now one of the good things about the task force recommendations is that although they looked at the problems caused by crystal methylamphetamine, they were designed so many of those recommendations could have application across drug markets. So we are applying them equally to a whole range of different markets.

The third issue that I think is important to understand before I get into the precise matters I want to discuss is some overarching context about the priorities drug wise that the ACIC sees. I had the benefit of hearing the end of what Victoria Police said, and I was quite interested in that because we are seeing increasingly that problems at one level are problems at other levels, the context is just different.

The drug markets that are causing the most concern to the ACIC right now are the methylamphetamine, cocaine and pharmaceutical opioid markets. But what is interesting about that is that the reasons are slightly different, particularly in pharmaceutical opioids. We remain concerned about the high and apparently resilient level of demand for methylamphetamine across Australia, the disproportionate harm that this drug, particularly in its

high purity form, causes to families and communities, its hold on many regional and rural communities, the combination of bulk imports of finished product and precursors, and what we believe to be an increase in sophisticated manufacture of the drug from imported precursor chemicals or chemicals that have been diverted locally.

The first challenge, then, that I will pose to the committee, and this is a national challenge, is to disrupt effectively domestic manufacture of methylamphetamine and other drugs. These have been manufactured using in many cases non-controlled chemicals at both the border and also in states and territories. Many of these chemicals have little or no legitimate industrial application. Australia does not have an enormous chemical industry, so almost all of our chemicals are imported. Now despite that, a lot of the chemicals that are imported do not have industrial application and find their way into illicit drug manufacture, and this is an ongoing and current concern for us.

The issue is actually being considered right now at commonwealth, state and territory level. There is a range of initiatives that flowed out of the nationalised task force report and then the end user declaration working group so that the sales of chemicals around the country can be monitored and centrally recorded within the Australian Criminal Intelligence Commission and then state and territory partners alerted where there are concerns about particular purchases. The other thing that is important is consistent national precursor legislation so a chemical cannot be legal at one level and then illegal at a different jurisdictional level or there are inconsistencies across jurisdictions. That is the methylamphetamine and the precursor markets.

The cocaine market is a high-risk market and demand for cocaine appears to be increasing, albeit from a low base. Cocaine is different to methylamphetamine, which can be manufactured locally, because it must be imported. A variety of very sophisticated organised crime groups dominate this aspect of the supply side of the cocaine market. So the challenge there simply — well, not simply — is just to battle with the sophisticated groups that are bringing the cocaine into Australia from offshore.

But the third market, the pharmaceutical opioid market, is the one that at the moment is providing unique challenges to us and other agencies. It was interesting to hear that you have got the insights from North America. It is very interesting in that Mexico is one of the huge problems — you would probably understand from being there — in that fentanyl can be domestically manufactured in Mexico and brought over the border into the United States. Thank heavens we do not have that problem at present. We have seen no evidence of domestic manufacture of fentanyl, and we do not wish to ever see any evidence of domestic manufacture of fentanyl.

The opioids that we are particularly concerned about are obviously fentanyl and related substances. You mentioned carfentanyl, which of course is a veterinary substance and there is really only a very small niche market legitimately for that substance, and oxycodone and fentanyl, which obviously have far greater legitimate uses. We see the threat more in terms of potential rather than current risk for oxycodone and fentanyl, and we are aware, having said that, that people are dying in Australia from overdoses of these drugs and others are suffering phenomenally from overdoses. So the current threat is real enough and we need to be concerned, but thankfully the level of threat in Australia has not yet reached the levels being experienced in some countries in Europe and North America. There is still time for steps to be taken to prevent the threat from escalating, and we are working with a whole range of stakeholders in the medical and health sector in the industry to achieve this.

The interesting thing too when we are facing pharmaceutical opioids of course is to pick apart a market where there is a significant legitimate component. The other thing is you have got a market where grams or fractions of a gram of a substance can be lethal. This is one of the issues, so we are having to recalibrate our response from, for example, in the case of cocaine being concerned by yacht-loads or container loads of drugs to a quantity that can be available in an envelope or in air cargo and cause significant harm. Also, the people who are doing the importation look different. They are not sophisticated organised crime groups. They may well be users of the substance in the social context or criminal opportunists, not sophisticated organised crime groups.

That is the context for looking at the need for better data and research. If I can take you back just quickly to the National Ice Taskforce, the task force recognised the need for better data on drug markets in Australia. Drug data has traditionally been dominated by surveys which have been based on self-reporting by relatively small samples of the Australian population. So when the task force looked at the need to measure demand and supply, they quickly realised there was a need for another component rather than self-report surveys to reliably measure demand.

This is not to say that traditional surveys are not of any use — they certainly are and have particular uses — but they do not measure demand. So we were fortunate in the period following the ice task force that our minister allocated \$3.6 million over three years from the confiscated assets fund for us to develop a national wastewater drug monitoring program. The reason for that is that we wanted to reliably measure demand.

The measuring of supply is a little simpler in that you can look at seizures at the border, you can look at domestic seizures, you can look at arrests and a range of other indicators. There are limitations to that data too, but it gives you some idea of supply. Demand is a bit trickier because it is not just the number of people that are taking the drug that is important, it is the quantity that is being taken, and of course this is where wastewater is very important — it measures the quantity of the substance that is being used in a society and it gives us a more holistic picture of what is going on. There are no hidden populations, there is no breach of privacy, it is not intrusive, and it can be applied in small or very large populations regularly and quickly.

At present the monitoring program that we have established covers more than half of the Australian population. It collects data from all states and territories, it contrasts use in capital cities and regional areas and at present it measures 14 different illicit and licit substances. It permits the ACIC and a wide range of our stakeholders with whom we share data to make evidence-based decisions on drug issues using contemporary data. It also allows us — and we are still developing this capability to realise its full potential — to monitor existing responses to see if they work or not, or to what extent they work. For example, it may well be that you encourage a supply-side response in a particular town to see if that reduces the use of the drug in a particular town, or it may well be an education program, a treatment program, to see over a period of time whether that changes the level of use. For roughly \$1.2 million a year, we think we have a reasonably reliable coverage of drug use in, as I said, more than half of the population. The challenge for me at the moment, after 2019 when the funding runs out, is to make this an enduring source of funds.

The other thing we do is that we have our illicit drug data report, which is now in its 15th year. We use that illicit data drug report with our wastewater data to publicly release a large amount of data, including drug purity and prices, the forensic profile of some drugs, so we can work out the source and method of manufacture, and we also look at border detections and national seizures and arrests, as I mentioned. The illicit drug data report is itself a rich sort of data concerning the supply side of drug markets, but also dynamics such as price and purity, which are usually a pretty good indicator of how much drug is available in the community.

Another evidence-based source of data that our colleagues at the Australian Institute of Criminology use is the Drug Use Monitoring in Australia program. That is called DUMA. That was established as long ago as 1999. It is a quarterly collection of drug use and criminal justice information from people detained by police at sites across Australia. The sites at the moment are in Adelaide, Brisbane, Perth and Sydney, although I understand there are negotiations around whether that can be extended to Victoria. If so, I think that would be an excellent initiative.

The beauty of this data is that not only are the people interviewed about their drug use, but 70 per cent of them consent to provide a urine sample. Once that is analysed there is a very interesting comparison done between what they think they have taken, or report they have taken, and what they have actually taken, and invariably there is a greater or lesser distinction in that. It covers five classes of drugs, some amphetamines, benzodiazepines, cannabis, cocaine and opiates. Those data sources put together provide us with a pretty good picture of what is happening in drug markets nationally. As I said, I think there is significant benefit in extending DUMA to additional sites, including in Victoria.

I was also interested to hear your questions around drug driving. We see this as something of the future. It is evolving, as you know, nationally, but it is an excellent indication of what people are consuming, or people who drive, who tend to be a pretty forward cross-section of society and certainly drug-using people. We think in years to come it will become a very rich source of data, which again we can place alongside wastewater and other data to measure drug use.

Wastewater analysis doubtless works best when it is complemented by as much data as possible from law enforcement, the health sector, academia and the justice system. Triangulated drug data, collected and collated once but used often and for many different purposes, offers policy and operational decision-makers with the best opportunity to make confident, meaningful and appropriate decisions.

I think I will leave it there, if that is okay. I am happy to take questions on the matters I have raised or on any other matters that you may care to.

**The CHAIR** — The first question I was going to follow up with is: in having the data you collect available, who is the main user of that data — the police, or is it more the health area that would use that data?

**Mr NEILSON** — It is designed for everyone to use. It is made public. It is put on our website for that very reason. At the moment it is used by policy agencies, so in the commonwealth space, the Attorney-General's Department, the department of justice. Health agencies also use it to compare with their own data. It is also used by academic institutions, because they have a significant responsibility nationally in collecting survey data. So it is a broad church, and it is deliberately so. In an operational sense what we are finding is that police agencies are coming to us when they are making resourcing decisions and saying, 'Where is the particular problem at its worst?', and that is a good thing. We are seeing that selectively at the moment, but we hope in the future more comprehensively with local government departments and also departments of the state. I think that is where wastewater offers its greatest potential.

**Mr DIXON** — Just in a practical sense on that wastewater, where do you actually do the test? Is it at the local treatment plant?

**Mr NEILSON** — Yes.

**Mr DIXON** — That is basically the source?

**Mr NEILSON** — Yes. In very simple terms, there is an inflow pipe at every wastewater treatment plant around the country and it is done before it is processed in any way, shape or form, because once it starts being processed that obviously introduces all sorts of other chemicals in the process.

**Mr DIXON** — So, for example, the Carrum treatment plant, which does basically the south and east of Melbourne. You cannot get any narrower than that, can you? You cannot look at suburbs? You can just say the south and east, okay.

**Mr NEILSON** — No. That is right.

**Mr DIXON** — Because I can see in country towns and smaller areas, it is very specific there.

**Mr NEILSON** — Absolutely. That is right.

**Ms PATTEN** — Thank you, Shane, that is really interesting, and that wastewater information is fascinating. One of the things that I think it found was this increased use of methamphetamine. When you triangulate the other data, if you look at the national household survey or if you look at the police stats, they would say that it has kind of plateaued, yet the wastewater tells a different story. Can you comment on that?

**Mr NEILSON** — Yes, sure. What it is looking at is use in the community in areas that have been sampled. The household survey is people's perceptions of what is happening. They are not always drug users. There is no way when you randomly sample a group that you can tell what percentage of people are actual drug users, whereas we would like to think with wastewater there is a substantial capture of all those who consume in the population that is covered by the treatment plant, whether they like it or not, because they contribute to the water supply. So I think that is part of the reason for the difference.

The figures are actually interesting in some areas because they are closer than you might think. Wastewater is showing that the trend has flattened out probably since October 2016. I will be fascinated to see the most recent figures. I have not seen them yet, but in a week or so I will be getting the figures from the middle of this year. It is clear that in some places methylamphetamine is flattening out, and I think the reason for that is that it has simply got to the point where it is so pure and so prevalent it just cannot get any more pure. Also, of course, eventually you get to a situation where the responses start to kick in, so really what we are trying to work out is whether we are at that point now and things are starting to look better.

**Ms PATTEN** — Is that connecting into your data that you are collecting — the treatment data? So you are starting to see, with Shepparton, for example, that there is an increase in treatment referrals, and that is going into your data collection?

**Mr NEILSON** — They are separate things because they are separate collections. All the health data is being collected by the health agencies. We do not collect that data.

**Ms PATTEN** — But you access it?

**Mr NEILSON** — Absolutely, we access it. There tends to be a greater correlation between that sort of data, the ambulance data, and the data from the hospitals than there is between the survey data and wastewater. This is why the task force had access to as much data as they could possibly get. They looked at it and they said, ‘There is a series of data — ambulance data that show things going up, there is wastewater data that shows things going up, but the survey data is showing it is either flatlining or going down’. So there is a disconnect there, and the trick was to understand what the disconnect was. One thing was measuring demand and use, and the other thing was measuring people’s perceptions of what they were doing and that was a different thing. When you understand that, you understand —

It is important to know how many people are using, just to quote one example, for our health department, because you need to know how many hospitals you need and how much treatment you need. When you start looking at things like diversion, for example, it is critically important that you know that you have got sufficient treatment facilities in the places where the problem is.

**Ms PATTEN** — Yes, that is absolutely true. I think this is really good. Just following on from that, I know that when we saw those reports come out earlier this year, which said that methamphetamine was the most frequently used illicit drug in Victoria, of course that is not what the national drug household survey says. It says cannabis is.

**Mr NEILSON** — No, we said that. We said ‘of the drugs tested’, so it is very important.

**Ms PATTEN** — Why can’t you or why don’t you test for cannabis?

**Mr NEILSON** — There are two reasons for that. The first is there is still a very high level of uncertainty around testing for cannabis, to a level where we just do not think for our dollar it is worth doing. The other thing too is I think it is now well established that cannabis has for decades now been the highest used illicit drug in Australia, and it really has not changed much. So we thought why would we pour money into confirming what we all know. What we did was, for the dollar, we thought it was a lot better to try to understand about the level of use of fentanyl and oxycodone, and also cigarettes and tobacco.

**Ms PATTEN** — Have you got any ideas then about how we would actually ascertain the number of people who use cannabis on a regular basis, because, as you have put it and the police also commented, the national drug household survey is not a terribly useful document because it is self-assessing and, as you say, it is a very small sample of actual drug users. Where would we get the figure for cannabis, for example?

**Mr NEILSON** — I guess it comes back to why do you want the figure? I do not have a health background, but from a law enforcement background it is probably not as important. From a health background it probably is important when the person gets to a stage where they need treatment, or whether there is a prevention initiative that is needed. Probably the best way of doing that is really relying on hospital data to be honest, or ambulance data, unfortunately. So it is not something that is easily predicted.

**Ms PATTEN** — It is unlikely that a cannabis user is going to present at a hospital or an ambulance.

**Mr NEILSON** — Not unless it is got to the stage where there is a psychosis and that would require sustained —

**Ms PATTEN** — That is right, and that would be quite unusual.

**Mr NEILSON** — Yes. You come back to the surveys, I think.

**Ms PATTEN** — That is right, and then you go —

**Mr NEILSON** — And you accept the uncertainty, and that is the problem.

**Ms PATTEN** — Just to finish this up, the survey says 2 per cent have tried methamphetamine in the last 12 months —

**Mr NEILSON** — Six months.

**Ms PATTEN** — Yes, whatever it is. What does your survey tell us about that number?

**Mr NEILSON** — That it significantly understates the figure.

**Ms PATTEN** — So what figure do you have?

**Mr NEILSON** — It is a very difficult question for us to answer in terms of how many people, because wastewater does not tell you that. What it tells you is the level of use, and that is more important to us because what we try to work out is the quantity of the drug that is in the community, because once you know that you can look at what you have seized and the difference is what you have missed. That is critically important in terms of drug policy and operational decision-making. Sometimes you can work out in what parts of the country you are missing it,

**Ms PATTEN** — Well, it is from an enforcement perspective, but from a treatment or harm reduction perspective actually getting an idea of the demographic, and getting an idea of the actual numbers that we are looking at, is probably more important.

**Mr NEILSON** — Yes, I agree with that. I think in terms of methamphetamine, if you look at people becoming dependent users and probably needing treatment I think it is one in five, and then you look at the quantities involved. The way we look at it is we look at average doses and then estimate from there how many people are involved. It is not as simple as that. This is not an exact science, because you have got to factor in purity. There is absolutely no doubt at all that a lot of the harm that comes from methamphetamine comes from the fact that it is ice predominantly now, where it used to be speed — the powder form — and so it is more pure, but that does not take away the fact that there are now more users than there were as well, and they are in areas where law enforcement and health is reasonably spread out.

**Ms PATTEN** — You say there are more users. I am just trying to get an idea of what that number is or what that percentage is.

**Mr NEILSON** — We do not know the number of users.

**Ms PATTEN** — So you know it is not 2 per cent?

**Mr NEILSON** — No, we know it is a lot more than that. What we go on, from a law enforcement point of view, is reporting from police on the ground in various locations, and also from people who are providing services. For example, the not-for-profit sector is bearing the significant brunt of this, because the treatment options available are still problematic in relation to methamphetamine; it is difficult. I think it is 80 or 90 per cent recidivism within two years for people who are initially treated. So that is a wicked challenge; it really is. I cannot give you an accurate figure of how people are using simply because we do not look primarily at that.

What we try to understand is where clusters of new use is happening. We look at it purely in terms of demand and supply, and we are saying, ‘Well, if there is methamphetamine in a particular location, then some organised crime group is taking advantage of an opportunity there’. Disruption, then, is about a law enforcement response, a treatment response and an education response perhaps.

**Mr THOMPSON** — You note in your submission that the federal Minister for Justice allocated moneys from the confiscation program to look after wastewater drug usage monitoring. Is that going to be an ongoing program beyond the three years? I think I sensed that they are keen that it does continue into the future. Is that probable?

**Mr NEILSON** — We would like that, and I would love to say it is inevitable. What happens is that the confiscated assets fund is such that you can only go once to the well, because it has to be something novel and it has to have a set time frame. So we have got three years worth, the \$3.6 million, and so the challenge for me and my agency is to find, by the end of 2019, an enduring source of funds to continue the wastewater program across the country.

**Mr THOMPSON** — With the testing sites — I am not sure how many wastewater treatment plants there are across the nation; there would be some small country towns — how broad is the coverage, in percentage terms, of all wastewater treatment plants in the nation?

**Mr NEILSON** — That is a very interesting question. I will have to take that on notice, because what happens is the universities actually have the relationships with the treatment plants, and they probably know the percentage that they have got covered. I think it is probably — no, I would not like to —

**Mr THOMPSON** — No, please don't —

**Mr NEILSON** — No. They do an amazing job, and they have relationships of different types between 50 and 70 sites. Generally the sites that we favour are those that have big populations, or which cover one geographic area. Because in terms of responses, and measuring responses, a finite area is probably ideal — 200 000 to 300 000 people — so you can really look at the impact of a particular decision-making process and monitor it. Whereas, as was mentioned earlier, if you have got a whole third —

**Mr THOMPSON** — Half of Melbourne.

**Mr NEILSON** — Yes, if you have got half of Melbourne, it is very hard to work out where the good work by a health or law enforcement agency is having an impact.

**Mr THOMPSON** — Just by way of follow-up, the member for Nepean has a wastewater treatment, or effluent outlet, plant in his electorate —

**The CHAIR** — You want one too?

**Mr THOMPSON** — We have one in the south-east and in the west of Melbourne. Melbourne's sewage treatment was the best in the world when it was first developed in the latter part of the 19th century. It effectively covers the Sandringham electorate in fine form — except there is an overflow point at the Black Rock pumping station which has caused duress and distress from time to time. But coming back to my question, what is the methodology for the collection of water for analysis? Again, those with Port Phillip Bay electorates know that with the EPA there is a practical device of test tube samples being taken to measure *E. coli* levels, where people might wade out and with a test tube capture data for water sampling, and then it is sent away for analysis. Just to help our practical understanding of what is done, do they wade into the effluent to get the appropriate samples?

**Mr NEILSON** — What happens is essentially they have got automatic samplers that grab a sample out of the inflow. They do that over a period of time, and then it is collected by the university and brought back to a central location and analysed. Effectively it is an up-market version of a test tube, but it is significantly more sophisticated than that. Really once it gets back to the lab it is no different to watching *CSI* — it is simply analysing the content and then the spectra and —

**Mr THOMPSON** — So the collection is part of an existing process as such?

**Mr NEILSON** — It is an extension of an existing process, and that is exactly right. You are quite right: there are a whole lot of public health reasons to analyse water. This is really an extension of that.

**The CHAIR** — One little question I have: when you were talking about cannabis and why you do not test for cannabis I understood — there were two parts to the reason — that first you said it was because it is hard to actually detect with clarity or something like that —

**Mr NEILSON** — Yes, there is significant uncertainty. All of these substances are analysed in terms of how they break down in wastewater. I understand the reason is that for cannabis there is a greater than normal uncertainty as to how that breaks down in wastewater.

**The CHAIR** — Okay, because I was surprised. I was comparing that to roadside drug testing, where of course they do test for cannabis, and yet if you are saying that it is hard to test with certainty, I am wondering how then roadside drug testing can test with the level of certainty that they require.

**Mr NEILSON** — That is the difference, yes. If it was exactly like it was in roadside, it would be a lot simpler, but it is just simply not like that, because first of all it has to go through a human body and then go into the wastewater and then all the way through the system.

**The CHAIR** — Thank you very much for that, Shane. That was certainly pretty insightful comment on data collection and where you are heading.

**Mr NEILSON** — Okay. Thank you very much.

**Witness withdrew.**