# SELECT COMMITTEE INTO ALTERNATE APPROACHES TO REDUCING ILLICIT DRUG USE AND ITS EFFECTS ON THE COMMUNITY

## INQUIRY INTO ALTERNATE APPROACHES TO REDUCING ILLICIT DRUG USE AND ITS EFFECTS ON THE COMMUNITY

**TRANSCRIPT OF EVIDENCE**
**TAKEN AT PERTH**
**MONDAY, 10 JUNE 2019**

**SESSION ONE**

**Members**

**Hon Alison Xamon (Chair)**
**Hon Samantha Rowe (Deputy Chair)**
**Hon Aaron Stonehouse**
**Hon Michael Mischin**
**Hon Colin de Grussa**

_____

**Hearing commenced at 2.48 pm**

**Professor SIMON LENTON**
**Director, National Drug Research Institute, Curtin University, sworn and examined:**

**The CHAIR**: Hello, thank you very much for coming in. On behalf of the committee, I would very much like to welcome you to this hearing. Today's hearing will be broadcast. Before we go live, I would like to remind you that if you have any private documents in front of you, you just need to keep them flat on the desk to avoid the cameras. Could we please begin the broadcast.

I would like to introduce you to who you are meeting with as well. These are my parliamentary colleagues: Hon Colin de Grussa; Hon Michael Mischin; you know me, Hon Alison Xamon; this is Ms Lisa Penman, she is here to provide expertise to the committee; Hon Samantha Rowe, the Deputy Chair of this inquiry; and Hon Aaron Stonehouse. Thank you very much for being here. I now require you to take either the oath or affirmation.

[Witness took the affirmation.].

**The CHAIR**: You will have also signed a document entitled "Information for Witnesses". Have you read and understood that document?

**Prof. Lenton**: I have, yes.

**The CHAIR**: These proceedings are being recorded by Hansard and broadcast on the internet. Please note that this broadcast will also be available for viewing online after this hearing. Please advise the committee if you object to the broadcast being made available in this way.

**Prof. Lenton**: I do not.

**The CHAIR**: A transcript of your evidence will be provided to you. To assist the committee and Hansard, could you please quote the full title of any document that you refer to during the course of this hearing for the record and please be aware of the microphones and try to talk into them, ensuring that you do not cover them with papers or make noise near them. I am going to remind you that your transcript will be made public and if you wish to provide the committee with details of any personal experiences during today's proceedings, you should request that the evidence be taken in private session. If the committee grants your request, then any public and media in attendance will be excluded from the hearing. Until such time as the transcript of your public evidence is finalised, it should not be made public. I advise you that publication or disclosure of the uncorrected transcript of evidence may constitute a contempt of Parliament and may mean that the material published or disclosed is not subject to parliamentary privilege.

The committee has received your submission. Would you like to make an opening statement to the committee?

**Prof. Lenton**: Not really; the submission is clear. I am happy to take questions on the submission or any other matters. I know you have had many other people present before you and you may wish to follow-up with me about other matters that are not included in our submission. I will do the best I can to respond to those questions. So, I am happy to take questions.

**The CHAIR**: The Australian drug harms ranking study was released this year. Were there any unexpected results?

**Prof. Lenton**: I guess what was not unexpected for us was the place that methamphetamine took in those rankings in Australia compared to other countries. But no, from our point of view there was not much.

**The CHAIR**: Nothing unexpected?

**Prof. Lenton**: I do not think so.

**The CHAIR**: What are the sorts of differences that you note between states? What is unique particularly to WA?

**Prof. Lenton**: I am not sure what you are asking there. In terms of the drug harm ranking study?

**The CHAIR**: Yes. Like, particular types of drug use.

**Prof. Lenton**: The drug harm ranking study did not look at different states. Are you talking about the Illicit Drug Reporting System?

**The CHAIR**: Yes.

**Prof. Lenton**: The Australian drug harm ranking study is a study ranking the perceived harmfulness of various drugs. That is headed by Professor David Nutt, but I presume that is not what you are referring to. I think what you are referring to is the Illicit Drug Reporting System, and the existing related drugs reporting system. Would that be right?

**The CHAIR**: Yes, because also we were trying to unpick the difference between regional and Perth as well.

**Prof. Lenton**: One of the challenges with both of those studies is that they are based in capital cities around Australia, so they do not collect data from the regional regions. I cannot really answer a question on regional versus WA, unfortunately. What I will say is that there have been trends over time. The real advantage of those studies is that they ask a sentinel group of drug users, whose characteristics we try to keep pretty constant from year to year, so that we can look at trends over time. They are not a representative group of drug users, so they do not represent all drug users within the state or territory. Really, it enables us to look at changes over time in a group of people who have a lot of knowledge of the drug market. What we have seen over time is, I guess, a couple of things. A number of things have remained stable, but we have seen over time, since 2000, a rise in methamphetamine use, which you will all be familiar with, which is pretty constant across the country. In recent years, we have seen a re-emergence of opioid-related problems and opioid use—not so much heroin itself, but more pharmaceutical opioids, which you will be —

**The CHAIR**: So this is fentanyl and those sorts of things; is that what you mean?

**Prof. Lenton**: Yes, primarily drugs like OxyContin rather than fentanyl. Fentanyl is of high concern because of its high potency and its low weight. We have seen cases of people misusing transdermal fentanyl patches that are a pain-control patch. They are a patch that sticks on, and we know that people cut those up, extract the fentanyl and inject them. You will be aware of some of the problems that have been seen in North America, with an exponential increase in rates of opioid overdoses largely to do with fentanyl, particularly in places like British Columbia and some places on the east coast of the US. That seems to be because people who supply those markets have been putting fentanyl into street heroin. Street heroin does not actually contain much street heroin in those places, but 70-plus per cent of street deals in Vancouver, for example, have fentanyl in them. We have not seen a lot of evidence of that happening in Australia yet. Most of the fentanyl that we have seen has been people using the patches, so they know that they are using fentanyl. There have been a couple of isolated cases of clusters of overdoses where it seems that people have bought what they thought was heroin but actually did contain fentanyl. Work that we are doing in the medically

supervised injecting centre in Sydney and other places that are monitoring what is happening with the street heroin market in Australia suggests that, as yet, we are not seeing a lot of evidence of street heroin samples containing fentanyl.

**The CHAIR**: But is it anticipated that we are likely to follow global trends in terms of these sorts of opioids?

**Prof. Lenton**: It is interesting. In general, I would say that it probably is the case that we will see it, but I was just at a conference in Paris two weeks ago of the International Society for the Study of Drug Policy and there was an interesting paper presented there trying to understand why fentanyl seems to have got into some markets and not into others. Even within the US and North American context, it does seem patchy in terms of where it appears and where it does not appear. It is not the case that there is a universal, if you like, involvement of fentanyl within street heroin markets; it does seem to be patchy. I think because of the low cost, easy manufacture and high potency, we would say, okay, it is probably going to get here, but we have seen markets in North America where it really has not appeared either. It seems to be a lot about the supplier side of the market. It may be that where suppliers have well-established heroin supply mechanisms, they have not switched to fentanyl, but there have been shifts; for example, some of the Mexican cartels seem to have very quickly got into heroin and very quickly switched to fentanyl. So, we do not really know whether it is going to occur in Australia. It probably will. We are looking out for it. We are designing interventions, including overdose prevention information and providing test kits for people to test their drug samples to see whether they contain fentanyl. It may come. We do not know when or if it will come; it is unclear.

**The CHAIR**: You mentioned that opioids are on the increase. It would probably not surprise you that much of the evidence that has been received by this committee has focused on meth as a primary issue of concern. Could you just elaborate a little bit more on what you are seeing in terms of the increase in the use of opioids? Are you suggesting to the committee that it is an issue that we need to be keeping a close eye on, because most of the people are talking about the concern around meth?

**Prof. Lenton**: Clearly, methamphetamine is still a major problem in what we are seeing. We are not seeing increasing rates of numbers of methamphetamine users, but what we are seeing is increasing rates of problems, so the people who are using tend to be more likely to be dependent and experiencing significant problems.

**The CHAIR**: Why do you think that is the case that we are not necessarily seeing a huge level of additional uptake around meth? What do you attribute that to?

**Prof. Lenton**: What we see is that drug-use patterns come in cycles; they come in waves. The evidence from both the National Drug Strategy Household Survey data and data that we are doing with these sentinel samples suggests that we are not seeing large numbers of new initiates. I think people are pretty aware of what are some of the harms associated with methamphetamine and what some of the risks are. People make decisions about their drug use in terms of those kinds of things, but what we are seeing is that those people who are using are using more frequently. There has been a shift to crystal methamphetamine over the last few years. As you would have heard, it is much more potent, much more bioavailable, much more likely to produce dependence and much more likely to produce problems. Among those people who are using, we are seeing more people experiencing significant problems.

Can I just come back to the opioids trend data? When we look at opioid overdose trends, particularly fatalities, we have seen a gradual increase over the last four or five years. We are not back at the levels where we were —

**The CHAIR**: This is specifically in Perth?

[3.00 pm]

**Prof. Lenton**: No, this is across the country, but we have seen it in Perth as well. It has been pretty constant across the country. We are seeing increasing rates of both nonfatal and fatal overdoses. Opioids are much more deadly drugs than methamphetamine. We know that methamphetamine produces a range of problems that you would have heard about in terms of risk of mental health problems and aggression and so on, but opioids produce fatalities at high dose, so it is much more deadly. There have been deaths associated with methamphetamine use due to, largely, stress on the cardiovascular system and we are likely to see those increase over time, but if you compare, them to opioid fatalities, I think they are about one-tenth or less of the number of fatalities that we see from opioids. A return or an increasing rate of opioid use is of great concern in terms of deaths, and we have been seeing those deaths increasing over time and, increasingly, studies of toxicology of people who have had fatal overdoses suggest that pharmaceutical opioids such as OxyContin and some of the others, as well as fentanyl, have been an increasing proportion of those deaths over time.

**The CHAIR**: Can I ask a little bit about the issue of pharmacotherapy? The committee has heard that there is presently no pharmacotherapy proven to be effective for methamphetamine dependency, but we are aware that NDRI is very involved in this space. Could you provide a bit of an overview of what I understand are called the N-ICE trials operating?

**Prof. Lenton**: I will not, because I think it would be better if you spoke to the person who is running that trial from our institute, who is Professor Rebecca McKetin, who was unable to attend at short notice today, but would be able to attend the committee subsequently, and I think you should invite her to come and speak to the committee.

**The CHAIR**: Yes. We were hoping that she would be able to be here today.

**Prof. Lenton**: She was not available.

**The CHAIR**: You are not able to give any expert advice to this committee around the issue of pharmacotherapy around methamphetamine use?

**Prof. Lenton**: I think you are better off talking to Rebecca about that.

**The CHAIR**: In the event that we are not able to speak to her, because, of course, the committee has limited opportunities to be able to—we have got lot a people we are hearing from. If you could give a broad overview —

**Prof. Lenton**: Let me say that there is obviously a lot of activity around looking to find a medication that can help with methamphetamine dependency. Because of the pharmacotherapy of methamphetamine, it is very challenging thing to be done. There are different drugs that are being looked at—baclofen—N-Acetyl-Cysteine is the one that we are looking and Rebecca is doing her trial on. There has been the use of drugs that are also stimulants to try to find a maintenance drug that could be used, much like methadone or ibuprofen as maintenance for opioids. There has been a lot of hope, but there has not been a lot of tangible evidence that it is easy to find a drug that either blocks craving or is a substitute for methamphetamine. I will not stretch the level of my expertise beyond giving you that statement, which is to say that it is a challenge and we are yet to find something that will work for methamphetamine.

**The CHAIR**: That is consistent with the public evidence that we have been hearing. At this point it would appear that it is just a matter of people effectively going cold turkey and receiving the supports that they require with a rehabilitation setting, ideally, to be able to kick meth addiction.

**Prof. Lenton**: I do not know that it is just cold turkey. People can be supported in their withdrawals, but we do not have the same kind of pharmaceutical armamentarium that we have for opioids applying to methamphetamine. It is the case that non-pharmacological interventions primarily are where we are at for methamphetamine at the moment.

**The CHAIR**: You would be aware that one of the things that this committee is looking at is the legal regimes around how to address the issue of illicit drug use. One of the things that the committee has been looking at is the idea of compulsory detox as opposed to compulsory rehabilitation. Do you have any thoughts on where compulsory detoxification may lie within a legislative framework, or do you have any views about that?

**Prof. Lenton**: I was on the Premier's methylamphetamine task force. This matter was brought before that committee as well. At that stage there was a trial happening in New South Wales looking at the feasibility of it. I am actually not sure what the outcome of that New South Wales trial is, but my understanding is that—we certainly did not recommend that there be compulsory treatment for methamphetamine. What we did recommend was that there was—recognising that in the acute phase there was a real challenge about how people manage when they are acutely psychotic on methamphetamine and at the moment it falls to police and emergency departments to manage after hours, when a lot of the problems occur. For that reason we recommended that there was some capacity to develop a service that was an acute management service to people who really needed that. That does not mean it is mandatory treatment. It was more about seeing that acute phase people need somewhere safe where they can be looked after and a lock-up for having them trying to be managed in an ED is not the best place for that to happen.

**The CHAIR**: Do you have any thoughts on compulsory rehabilitation?

**Prof. Lenton**: I do not think there is any evidence that it works.

**The CHAIR**: So your thoughts would be that it is probably not worthwhile pursuing?

**Prof. Lenton**: There is a trial going on. I am not sure what the outcome of that is. I think it will find, like other attempts, that it, really, has not worked and does not work. My understanding of the state of the evidence at the moment is that there is no evidence to support compulsory rehabilitation.

**The CHAIR**: Referring to your submission to this inquiry, NDRI have submitted that there could be some benefits to removing criminal penalties for drug possession. I was wondering whether you are happy to elaborate on that.

**Prof. Lenton**: The evidence is, if you take cannabis, for example, only about three per cent of people who use cannabis in any one year actually get apprehended by the police. Most people use cannabis do not get apprehended by the police. What we know, from work but I was involved in 10 to 15 years ago, is about giving people a criminal record for a minor cannabis offence does not influence their behaviour very much because cannabis use in the six months before they are apprehended is very similar to the cannabis use in the six months after they are apprehended. Criminalising people with a criminal conviction, at least for cannabis, where most of the work has been done, does not suggest that it changes people's behaviour very much. The adverse consequences of a criminal conviction are substantial for people, in terms of their future employment prospects, their ability to get accommodation, becoming more identified as part of the criminal justice system and so on—travel and all the things that occur as a result of a criminal record.

**The CHAIR**: Can I just ask: what study is that, please?

**Prof. Lenton**: These were a suite of studies that were done—I will have to dig out the —

**The CHAIR**: I am happy to take that on notice, if that is helpful, because we are able to do that and send the questions to you later.

**Prof. Lenton**: Sure. These were studies that were done as part of the social impact of minor cannabis offences that were done for the national drug study body back in mid 1990s. There is a whole suite of references.

**The CHAIR**: I will list that as question A1 and we can send that to you with the transcript. If we were able to get that, that would be very helpful.

**Prof. Lenton**: I am happy to do that. Sure.

**The CHAIR**: Would the NDRI have the same views in relation to drugs which are more harmful, such as meth?

**Prof. Lenton**: Sorry. The question is —

**The CHAIR**: In the submission the NDRI suggested that it would be better to decriminalise personal possession for drug use. You were talking about cannabis. Would you say the same thing for other drugs, such as opioids or meth?

**Prof. Lenton**: I may not be remembering it properly, but I do not think we said that drugs should be decriminalised in our submission.

**The CHAIR**: What could be the view of NDRI?

[3.10 pm]

**Prof. Lenton**: I think the evidence for criminal penalties do for other drugs, such as methamphetamine, heroin and so on, is less clear than it is for cannabis. You have got to treat each individual drug on its merits about what is the appropriate legislative regime that should apply for it. I think we are pretty clear about what the evidence says for cannabis.

We know, based on the emerging evidence from the North American experience, that making cannabis as available as alcohol and tobacco is not what we should be recommending. But, on the other hand, based on the evidence from methamphetamine, I would be much less inclined to recommend removing criminal penalties for methamphetamine than I would be for cannabis, because we do not really have the evidence for methamphetamine.

**The CHAIR**: What about opioids?

**Prof. Lenton**: Again, opioids are potentially deadly drugs. I think that we need to have an alternative response, which might not be about a criminal justice intervention but might be about regulated availability under particular circumstances. We have that for people involved in methadone treatment and buprenorphine and so on, and perhaps we should be expanding the range of drugs that might be available, particularly for people who do not do well on methadone and buprenorphine. But I think the evidence for legalising opioids is not there yet.

**The CHAIR**: What about so-called party drugs like ecstasy and LSD?

**Prof. Lenton**: Again, I do not think you can clump them all together. We have seen in Europe—in the Netherlands and other places—moves to make what they call smart drugs available across the counter. I suspect that the strongest case could be made for drugs like MDMA, but, again, I think we are really in the dark in terms of we do not really have any examples internationally of those drugs being made legally available, so we do not really know what the impact will be.

**The CHAIR**: I suppose the committee has quite clearly distinguished between being made legally available and decriminalisation in terms of for personal possession and use. So leaving the

legalisation argument aside, do you have any thoughts about whether there is a place for the decriminalisation of the possession and use of those drugs?

**Prof. Lenton**: Okay. I would advise the committee not to use the term "decriminalisation", because I think it is confusing and often misunderstood. A lot of people think it means removing all legal penalties, and conflate it with legalisation.

**The CHAIR**: Yes, they do.

**Prof. Lenton**: A better term would be thinking like "prohibition with civil rather than criminal penalties", which is really a better description of what has happened with cannabis in the various states in this country that have explored those options, including for a brief time, of course, under the Gallop government in this state, which I declare I was involved in for a number of years. There is a whole range of what we call mid-range options between criminal penalties on the one hand and full legalisation on the other. At the kind of minimal end, we talk about maintaining prohibition but having lower penalties. In a sense, that is what the cannabis infringement notice scheme in Western Australia, the cannabis expiation notice system in South Australia and the SCON system in the ACT were about—they all maintain prohibition but have reduced penalties without a criminal record for people under a certain amount. We then have a lot of other options, such as not penalising home supply—home growing—for example. We have things like cannabis social clubs; we have government control of supply, and government control of the wholesale part of the market; we have non-profit organisations running supply operations, such as what happens with alcohol in New Zealand, where community alcohol trusts actually sell alcohol in some areas. Then we have a limited number of commercial operators, and then full commercial supply at the other end. That is what we have seen in relation to alcohol and tobacco in this and many other countries for many years, and we are seeing it in relation to cannabis in many American states and in Canada. There is a whole range of options.

Often we just talk about prohibition, with strict criminal penalties, or full legalisation. We think that the bottom of the harm curve—I apologise for drawing it in space—is actually in those middle-ground options. Where you have strict criminal penalties and you do not have any legal supply, you get problems due to contamination and involving criminal organised gangs and all the problems due to criminalisation, so the currently illegal drugs. Where you have full commercial availability, you get problems associated with widespread use, you get promotion, you get excessive use and you get excessive harm in the community. Our view is that there is probably somewhere at the bottom of that curve that we should be looking at, and depending on various drugs, we might find different places at the bottom of that curve, and we should be talking much more about the options in that mid-range that are likely to reduce harm at the bottom of the curve than we are about full legalisation or full criminalisation. I do not know if that has answered your question.

**The CHAIR**: Yes. Thank you very much. Hon Aaron Stonehouse might have some further questions.

**Hon AARON STONEHOUSE**: Yes, thank you. I have a few questions around different cannabis regulatory regimes and CSCs. I think your report said that there may be some benefits from removing criminal penalties for drug possession around cannabis, and the Chair went on to talk about other drugs, like meth and opioids. You mentioned methadone. You hinted at what I think might have been prescription heroin. I am aware that that is done some countries. Switzerland is currently doing it. Is there any evidence to show that having a prescription heroin regime encourages heroin use or leads to an increase in heroin use?

**Prof. Lenton**: There is a general question about signalling—what things signal to the general population. There is not a lot of evidence that having confined treatment regimes has any impact on macro levels of drug use. What we do know is that commercialisation has a massive impact on

levels of drug use in the community. I know of no evidence that the Swiss heroin program has resulted in an increase in rates of heroin use in Switzerland, and remember that that program is very regulated in that it is for people who have not done well on some of the lower threshold interventions such as methadone and buprenorphine. I suspect some members of the committee might have visited Switzerland. Did you guys visit Switzerland?

**The CHAIR**: Yes.

**Prof. Lenton**: As far as I know, you probably know more about it, having spoken to people over there. I do not know of any evidence that those kinds of programs have resulted in increasing rates of general use in the community.

**Hon AARON STONEHOUSE**: It seems evident to me that some of the benefits is that some of these people who have a dependence are now sourcing their heroin from a safer source, less crime, and they are guaranteed the quality and the potency of the drug they are getting. Is there any reason why that same model and that same logic could not be applied to meth—a prescription model for meth, for people who are not able to quit through other treatment methods, keeping in mind that there is no replacement therapy for meth? Is there any reason why the economics of a heroin prescription model would not apply to a meth prescription model?

**Prof. Lenton**: You should speak to a pharmacologist. I am not a pharmacologist; I am a clinical psychologist. But my understanding is that the pharmacology of heroin and stimulants like amphetamine are very different. Whereas you can get a level of satiation at a cellular level for opioids, that is not necessarily the case with amphetamines. A lot of the studies that have been done trying to explore whether providing drugs like Ritalin or dexamphetamine might result in some sort of reduced level of methamphetamine use suggest that the pharmacology of stimulant drugs like methamphetamine does not lend itself to the same kind of blockade effect that you get with methadone and drugs like buprenorphine and opioids. It is a biological and pharmacological difference rather than an economic or philosophical issue. But, to be honest, it is not my area of expertise, so I would encourage you to follow up with a pharmacologist about that matter.

**Hon AARON STONEHOUSE**: Looking at the CSCs and the models that your submission looked at, something that I found interesting about the CRCs is that they seem incredibly onerous. They seem like a very onerous way to go about cultivating cannabis and supplying cannabis. Is there any evidence to show that it is more onerous? What is the effect on the black market when you have these types of community cannabis social clubs? Is it effective in eliminating the criminal element of cannabis cultivation and trade on the black market, or does it still persist, because at a glance it seems as though unless you live in a commune or something where people are willing to set aside a building to cultivate cannabis and appoint a board and people who can run that, there is already a large commercial operation in the black market cultivating cannabis that can probably do it cheaper without having to comply with all these requirements. What has been the effect on the black market if CSCs are employed?

[3.20 pm]

**Prof. Lenton**: The first answer to that is we do not know, but let me get to that in a different way. All proponents of drug law reform argue that one of the goals is to undermine the black market. The reality is that even with commercial supply, such as we have seen in North America—in the US and Canada—the black market is not eliminated. It is probably reduced, but it is not eliminated. Given that full commercial availability has not eliminated the black market, I have no reason to believe that cannabis social clubs will eliminate or make a substantial dent in the black market. What we have seen in North America is that there has been a huge reduction in the price per dose of cannabis over time since 2014. We have seen increasing potencies, particularly potent products other than

cannabis flower, so shards and all sorts of things, which are high potency, and that over time they become a greater part of the market. So full commercialisation has not eliminated the black market, and I do not think cannabis social clubs will eliminate the black market. That is not their purpose.

**Hon MICHAEL MISCHIN**: What is their purpose?

**Prof. Lenton**: Their purpose is to recognise that if you are going to make cannabis available, you need to recognise that you cannot just do that by self-supply. Take the Australian example. The last time we asked about what proportion of people who smoke cannabis in Australia grow their own supply it was in 2010 in the National Drug Strategy Household Survey. The estimate was three per cent. So three per cent of people who smoked cannabis in one year actually grew cannabis as their main source of supply. We have done studies with regular cannabis users, looking at social supply, and we have found that probably up to a third of young people—people under the age of 30 who regularly smoke cannabis—say they grow cannabis as part of their supply, but most people do not grow cannabis to self-supply and probably would not. Unless you are going to have a legal supply pathway, such as by having government-controlled supply or some of the other mid-range options I have talked about, you need to find another way for most people to access their cannabis.

**The CHAIR**: Is there any chance that the reason they are not growing it at the moment is because it is illegal and if you are busted growing plants, then it is a crime?

**Prof. Lenton**: That is part of it, but even if you could get that three per cent up to double or triple, the evidence is pretty likely that you are not going to get it over 50 per cent. Most people will not be bothered to grow their own cannabis.

**Hon MICHAEL MISCHIN**: It is like people who are not bothered growing their own tobacco.

**Prof. Lenton**: Yes, or brewing their own beer. I think self-supply should be an important part of any legal regime for cannabis, but it would be naive to think that most cannabis users will grow cannabis for their own supply, particularly when you think about the circumstances of most people who smoke the majority of cannabis. The evidence is that roughly 20 per cent of people smoke 80 per cent of the cannabis in a market. In the US where they have got information on how much cannabis is produced in the legal market and where that is going, it is about 22 per cent and 83 per cent, but it is roughly 20 to 80 per cent. So when you think about it, most of the cannabis is being smoked by a small number of people. Often those people are economically and socially disadvantaged. Probably a high proportion of them are living in rental accommodation where they do not have control over what they can do in their backyards and so on. So the reality is that a lot of cannabis is being smoked by people who really do not have the capacity to grow their own cannabis at the moment. I think self-supply is probably going to be part of the market but not the majority of the market. You need to find a way for people to access cannabis, unless you have a legal supply, without necessarily being able to grow their own cannabis. That is where cannabis social clubs come in.

**Hon MICHAEL MISCHIN**: That problem is highlighted in the case of decriminalisation, let us say, of other drugs when you still have to have access to heroin from somewhere, having dispensed with over-the-counter at a pharmacy, whether part of a prescription or otherwise, it is not going to work.

**Prof. Lenton**: Are you saying that it will not work?

**Hon MICHAEL MISCHIN**: It still means you are going to have a commercial producer of what is a harmful drug and somehow dispensing it.

**Prof. Lenton**: But, I think, regulated supply through a pharmacy is not the same as commercial production. You are not having marketing; you are not having a whole lot of players. You can regulate as a government what are the conditions under which people could supply any drug

through a pharmacy system: what are the quality controls, what are the dosages, what does the packaging look like and all that kind of stuff. Pharmacy regulation is one of the best examples of regulated drug supply. Interestingly, in Uruguay, the three options they have for people within the Uruguay scheme, which was the first country to legalise cannabis—it came into place in 2014 and I assume you have heard about the Uruguay scheme—it is self-supply, pharmacy supply or cannabis social clubs.

**Hon MICHAEL MISCHIN**: The pharmacy supply, though, has to be financially competitive with the underground market otherwise there will be very little incentive to go towards it.

**Prof. Lenton**: You are right. Two things I would say is that lots of people would prefer to access their drugs from a legal supply network than a criminal supply network, and might be prepared to pay a price premium in order to do that, so it does not have to undercut the illegal market, because price is not the only thing that people consider when they think about where they get their drugs from. For example, it is the case in Uruguay that cannabis social clubs are only a small part of the market, and they tend to be accessed more by middle-class, affluent, university-educated white males as a high proportion of the market. The pharmacies are limited. I think there are only a dozen pharmacies in Uruguay that actually can supply cannabis, so that is limited. Still, even in Uruguay, they are going to the illicit market to access their cannabis.

**Hon AARON STONEHOUSE**: Can I go back to commercial cannabis in North America? It has been raised with us before that the existence of the black market in places like Colorado is an example of that model not working to eliminate the black market. As I understand it, one of its intended goals was to eliminate that market. Is that a failure of that commercial role in Colorado or is that a consequence of their federal system whereby Colorado may have legalised cannabis and have a commercial model but the surrounding states do not and, therefore, there is an incentive for criminal organisations to set up in Colorado where they are not prosecuted for cultivating cannabis and then illegally ship it to other jurisdictions? If that is the case, that does not necessarily seem to be an indictment on the commercial model as such, but rather the existence of different laws in different jurisdictions in a large continent.

**Hon MICHAEL MISCHIN**: Can I add to that, that the other consideration is it may be inherent in any commercialised model, whether it is a state doing it in a federal system or otherwise, but there may be something inherent in the idea of a regulated or commercialised model that is not going to eliminate the underground market with this particular type of product.

**Prof. Lenton**: I have two answers. One is we do not know yet. There is evidence of cross-border sales and people whipping in to buy cannabis from Colorado and whipping back out of the state. If you look at the states around Colorado, there is evidence of that interstate trafficking or interstate supply; I do not think we know yet. But the other thing I would say is that I think, at best, particularly in the short term, legal availability of drugs has the capacity to reduce the illicit market, but I think it is naive to expect that it will totally eliminate the illicit market. You always have regulations, by the nature of the beast, about what kind of drugs are available in a legal market and who can access them. For example, there is an age issue —

**The CHAIR**: Absolutely.

**Prof. Lenton**: We understandably put an age limit on things—18 or 21 or 25—depending on where you are. There is always going to be a demand for people who are under 18 to get access to drugs, and they are going to get it from somewhere. So there is always going to be illicit access. What we need to find is what is the best regulated availability model that reduces net harm in the community across the board. I do not think we should get caught up in removing the black market. I think it is a naive goal; I think it is easy to say it, but the evidence is that it is very hard to do.

**The CHAIR**: We have received quite a lot of evidence that cannabis is a particular concern for children and young people, and particularly for Aboriginal children and young people in regional and remote areas. Would you say there is any risk of exacerbating this problem if we were to change the legal regime around cannabis?

**Prof. Lenton**: I think it depends on what we change it to.

[3.30 pm]

**The CHAIR**: What do you think would make it worse, and what do you think could potentially, at the very least, be benign?

**Prof. Lenton**: I think full commercialisation is likely to make it worse. We know from alcohol and tobacco that when you make drugs widely available and put them in the hands of commercial enterprises that are profit-driven, you can do what you can as a government to try to regulate that, but it is damn tough. Once you get it into commercial hands, commercialism takes over, and we spend decades trying to catch up. Tobacco is a good example of that. We have controls in place, which make it very expensive; we police sale to minors—all the stuff that we know has been effective in tobacco, but, boy, would we do it now the way we did it when we first made tobacco available? I suggest we probably would not. I think it would be a mistake to go to a commercial market. That is the first thing I would say off the top. We know that criminalising people does not necessarily have a great deal of impact. Many people still access drugs, because the likelihood of being apprehended is particularly low. I think we have to recognise that whatever hopes we have for criminalisation, the evidence is that it probably does not do what we would like it to do in terms of reducing harm and access, so we need to look at the mid-range options.

**The CHAIR**: The police gave evidence to this committee that they thought that maintaining the criminalisation of marijuana was critical and would be a positive step. Do you have any comments in relation to that?

**Prof. Lenton**: It would not surprise me that the police would say that.

**The CHAIR**: Why is that?

**Prof. Lenton**: Because they have not been given a political space in which to entertain other options. If you really want to find what regulatory model or legislative approach is going to work for a variety of substances, then politicians really need to make the decision and say, "We are going to look at this." We cannot do things like drug testing at festivals, exploring other options for cannabis or thinking about how we could treat opiates or amphetamine any differently if Parliament does not make a bilateral decision that it is time that we explored these options. I have spent 15 years of my life doing research on legislative options for cannabis, which fed into the changes that the government made in 2004, which were overturned in 2008 when the Liberal Party got back in. I do not think that does anybody any good. One of the challenges for drug issues is that they are highly politicised; it is very easy for people to be accused of being soft on drugs, so everything clams up. I think that is a major problem. It is a political problem. What is great about this committee is that the people I am looking at across the table are across the spectrum, and that is fantastic. The committee recommendations will be really important, and then what gets through Parliament, if anything, and what comes out of that. I think that if there is a real willingness to make decisions about how we manage psychoactive substances in our community, politics needs to be taken out of it.

**The CHAIR**: I think there is a genuine concern within the community to not want to be seen to be promoting drug use, and I think there is a genuine concern that any relaxation around the current

laws may be seen as doing that, particularly for children and young people. Do you have any comments on that?

**Prof. Lenton**: Yes. Look, it is very important that we know that a lot of the harms associated with substance use are particularly for people who start early and people who use frequently. We know that brains develop up until people's early to mid-20s. All the evidence around substance use is that we should be doing everything we can to make people delay onset, and to not be using frequently. That is what we should be doing; that is a really important prevention message. As part of that, we need to be facilitating this conversation with parents and their kids, with GPs and their patients, and we need to have low-threshold interventions that are about allowing people very early on to say, "I am using pretty frequently and I am having some problems." We should be removing the stigma that gets in the way of people seeking assistance for their substance-use problems at an early stage. That is an absolute given.

**The CHAIR**: There has been a lot of publicity—you touched on this just then—around drug-related deaths over east, particularly at festivals. What sort of ecstasy-related harms are we seeing in Western Australia, if any?

**Prof. Lenton**: I would have to take that question on notice.

**The CHAIR**: We are happy to take it on notice.

**Prof. Lenton**: I am not even sure that I am the best person to answer that. I do not think we have seen the large numbers of deaths yet in WA that we have seen in other places, but there are other harms to people due to toxicity, overheating and so on. Can I make some general comments about the issue of festival drug checking and pill testing?

**The CHAIR**: Please do.

**Prof. Lenton**: Okay. The first thing I would say is there is evidence from two Australian studies—including one recently published by a PhD student of mine, Jodie Grigg—that suggests that when we ask festival goers about the use of illicit substances, 60 to 65 per cent of people who have attended a festival said that they used illicit substances at the last festival that they attended. Within a group of people who go to a venue, at least two-thirds—that is probably an underestimate—have said that they used an illicit substance. That is a reality that we need to engage with. We might think that that is not a great thing, we might think we would rather people did not use substances, but even with illegality, sniffer dogs, all that stuff, we have 65 per cent of people saying that they used an illicit drug at their last festival.

The second thing I would say is that we know that the evidence around the effectiveness of sniffer dogs is pretty poor. Most people get drugs into festivals without being detected by sniffer dogs. I think I referred in my submission to evidence that shows that when people believe there are going to be sniffer dogs in attendance at a festival, they have a whole lot of strategies to deal with that to get their drugs in. We also know that the most risky drug use purchases happen in festivals where people are rushed for time, they do not know the person that they are buying from, and so on. If people ditch their drugs or do not take drugs in and try to buy them at the festival, the evidence is that that is likely to be most harmful.

**Hon SAMANTHA ROWE**: On that issue, is there any evidence of the amount of drugs that are purchased at the festival as opposed to people going who already have drugs? Do people take their drugs to the festival, or do they go to the festival and purchase drugs there? Do you have any of that information?

**Prof. Lenton**: I could look at the evidence we have to answer that question. I do not know off the top of my head what the answer to that is, but most people go —

**Hon SAMANTHA ROWE**: With the intention of taking pills.

**Prof. Lenton**: With the intention, yes.

**Hon SAMANTHA ROWE**: Do you think there is then a place for pill testing and services around that pill testing?

**Prof. Lenton**: Sure. Yes.

**Hon SAMANTHA ROWE**: To educate as well as to check what is in the drug?

**Prof. Lenton**: Yes. I will use the term "drug checking" rather than "pill testing", because increasingly it is not pills—it is crystal substances that people are using, rather than pills. For example, ecstasy is now increasingly being sold in crystal form—sometimes in capsules, sometimes in small bags—and people believe that it is more potent and more pure because it is in crystal form. That may or may not necessarily be the case. What I will say around drug checking/pill testing is that I think we need to change the way we think about this stuff. We need to treat these as other public venues where we need to have appropriate medical and health services to make these venues as safe as possible, like going to the footy, or another concert, or any public event. We need to think of them as events where we need to have appropriate healthcare services, which includes things like adequate medical services, triage, and referral to accident and emergency departments for people who are in real difficulty. We need to have information for people who need access to toilets, water, and all that kind of stuff. We need to have an overarching approach that understands the reality of these environments—for example, the reality that probably 60 to 65 per cent or more of the people at this venue will be taking an illicit substance.

We need to understand that as a reality, and we need to do what we can to provide adequate health care in those venues. There is pretty good evidence now accruing overseas that suggests that having drug-checking services ought to be a part of that kind of intervention, and remember that these are not just, "We test your drug and tell you what's in it and then we send you off." For many people who go to these events and front up to the services, this is the first time they have ever spoken to a health professional about their drug use. Many are young people; many have never been in drug treatment and have never spoken to anyone before. Many of them go not knowing what is in the substances that they are taking, and this is the first time that anyone has actually had a conversation with them about their use, and certainly the first time that anyone has actually investigated what they believe they are taking, and can say, "Well you thought you were taking this, but actually our indication, within the bounds of error and so on, is that we think that this drug contains this." That is pretty important information for people to have.

[3.40 pm]

The process is usually a half-hour process, and people are never told that the drugs they are taking are safe. They are always told that any drug use is risky. We cannot be dead certain about what is in what you have got. High potency pure ecstasy is highly toxic and highly risky, so it is not just about purity or contaminants and all that kind of stuff. I have got kids who are 14 and 16, who are going to be moving into this environment. I would like them to be in an environment that is less risky, rather than more risky, and for me that means that we have appropriately trained professional people that these young people can talk to about their choices and about their behaviour. I think that is something that we should be trialling in an Australian context. What has been shown in the UK is that when you compare a festival that did not have a drug-checking service with when it was then implemented the year after, there was a 95 per cent reduction in the number of emergency transports to hospital for people experiencing drug-related toxicity.

**The CHAIR**: I am happy to ask this on notice, but can we have the details of that report, please?

**Prof. Lenton**: It is Measham, 2018.

**The CHAIR**: That is question number A3.

**Prof. Lenton**: I will provide you with that, yes.

It is not going to be a silver bullet. It is not going to prevent every death or adverse event that happens. We need to be doing all sorts of things to dissuade young people from using substances, but if you have got a venue where upwards of 60 to 65 per cent of people are using illicit substances, it is a great opportunity to provide some really accurate information about harm to these people, and a lot of it is about emphasising harm. They are never told that the drugs are safe, because no drug use is safe.

**Hon COLIN de GRUSSA**: Professor, I just have a couple of questions following on from that theme. You said that 60 to 65 per cent of people who attend the festivals had said that they used drugs. At those festivals where there is a drug-checking or testing regime, does that reduce the consumption rates, as the evidence is suggesting, or does it just make it safer?

**Prof. Lenton**: Two things: firstly, we do not know whether it reduces consumption rates yet. What we do know is what happens to people when they are told, "You think you got this, but you have actually got this." The evidence is that about a third of people just say, "Yes, okay, dispose of it in the disposal bin that you've got here." A small proportion of people say, "Okay, I'm gonna go away and dispose of it and I'm also going to tell my mates that what we thought we bought ain't what we got", and a small proportion of people in the UK sample said, "I'm going to go back to my dealer and tell them they sold me this and they told me it was this, but actually it wasn't, and that's a problem." We have got evidence that, where what people purchase is not the same as what the tests show up, significant proportions of them decide to not take it at all. Others say they will take less, and so on.

**Hon COLIN de GRUSSA**: This would probably be hard to answer, but would there be an effect on the quality of supply overall?

**Prof. Lenton**: That is a really good question. There has been some evidence from the Netherlands that there was a reduction in the toxicity of pills as a result of their implementation of not only drug-checking services at festivals, but also street-based drug-checking services. But that evidence is probably not as solid as we would like it to be. What I would say to you is that in 2014 there was a batch of pills called superman logo that was shown to have PMMA in them—a very toxic substance. In the Netherlands they put out a warning through newspapers, radio and television that there are these particularly toxic pills on the market. They had no deaths in two weeks. The UK, in the same period, had five deaths from that particular pill in that same two-week period.

**Hon COLIN de GRUSSA**: So they are given that ability to have an early warning system as well as telling the individual?

**Prof. Lenton**: Correct.

**Hon COLIN de GRUSSA**: You said earlier that sniffer dogs were not particularly effective. You were suggesting there that consumers, if you like, are adapting to hiding the substances. Are the dogs acting as a deterrent in any way?

**Prof. Lenton**: They may be, but the evidence suggests that many people find other ways around it, and some of those are more harmful. If you look at the evidence on the studies that have been done on sniffer dogs, they get lots of false positives. They get lots of people, where they pull people up and say, "You've got drugs on you", and when they actually try to find them, they cannot find the drugs on them. In our study, from memory, only four per cent of people that carried drugs into—

no, in fact, that is wrong; I think there are 187 people who said they were checked—I would have to check these figures—and none of them actually got detected by the sniffer dogs.

**The CHAIR**: Unfortunately, we have run out of time. It would have been great to be able to continue to pick your brains, so thank you very much. I want to thank you very much for attending today. Could we please end the broadcast?

A transcript of this hearing will be forwarded to you for correction. If you believe any correction should be made because of typographical or transcription errors, please indicate these corrections on the transcript, and errors of fact or substance must be corrected in a formal letter to the committee.

**Prof. Lenton**: In a formal letter to the committee?

**The CHAIR**: Yes, please, but you will get the instructions on that. We have got a number of questions on notice that we talked about, on which we are just wanting to get some additional information, so when you receive your transcript of evidence, the committee will also advise you when to provide your answers to questions taken on notice. If you want to provide additional information, or elaborate on particular points, you may provide supplementary evidence for the committee's consideration when you return your corrected transcript of evidence. If, in the course of going through that, anything is prompted, please feel free to give more information to the committee. Thank you very much for attending today. That was really helpful.

**Hearing concluded at 3.47 pm**

_____