LAW REFORM, DRUGS AND CRIME PREVENTION COMMITTEE

Inquiry into the supply and use of methamphetamines, particularly ice, in Victoria

Canberra — 12 February 2014

Members

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Mr J. Ferris, Senior Research Fellow, Institute for Social Science Research, University of Queensland (via video conference).

The CHAIR — My name is Simon Ramsay. I am chair of the Law Reform, Drugs and Crime Prevention Committee.

Mr FERRIS — Good morning all.

The CHAIR — Jason, we are here at the Australian Institute of Criminology in Canberra. We have with us Russell Smith and Santanu Burman from the AIC.

As you know, we are conducting an inquiry into the supply and use of methamphetamines, particularly ice, in Victoria. There has been a significant escalation of this drug in a range of different demographics, particularly regional and Indigenous populations around Victoria, hence why we are conducting the inquiry. I understand that you are going to provide us with some information. We are particularly interested in your evaluation of Project STOP, about which we have received some information through a number of witnesses, and also in relation to real-time monitoring. We are looking forward to some commentary about your thoughts about that evaluation process.

Before we start, I have to read you the conditions under which you are presenting evidence to this hearing this morning; it will only take a few seconds, so just bear with me. All evidence taken at this hearing is protected by parliamentary privilege in accordance with reciprocal provisions and the defamation statutes in Australian jurisdictions as if you are giving evidence in Victoria and as provided by the Victorian Defamation Act 2005 section 27, the Constitution Act 1975 and the Parliamentary Committees Act 2003. Any comments you make outside the hearing may not be afforded such privilege. Any reporting of these proceedings enjoys qualified privilege for fair and accurate reporting as if the proceedings were in Victoria. Have you read the guide for presenting evidence to parliamentary committees?

Mr FERRIS — Yes, I have.

The CHAIR — Thank you. All evidence given today will be recorded. You will be provided with a proof version of the transcript in the next few weeks. We invite you to make some opening statements and then the committee would like to ask some questions of you, particularly in relation to Project STOP — if you have not covered it already with some of the questions you have already been provided with, as I understand — and other areas of interest. Thank you very much for coming, Jason. We grabbed you an hour earlier; we appreciate that — in Queensland you are a little bit behind us.

Mr FERRIS — Thank you very much. I am happy to be invited and happy to proffer the sort of research that myself and my team have been undertaking on Project STOP and hopefully give you some direction on where things are at with that research.

The CHAIR — Thank you. We are all ears. We have just lost a bit of audio — when your head was up it was much clearer.

Mr FERRIS — Much better posture. I will go into the questions that you have here, unless you want me to start somewhere else. I am happy to take questions as I progress if that works for you.

The CHAIR — That is fine.

Mr FERRIS — Your original proposal was basically what are the main findings from the evaluation of Project STOP? Can it be improved? Can the operations be improved? And how can that happen if so? I would like to start by stating that to date no entity has undertaken any outcome evaluation of Project STOP. As to the true essence of how effective Project STOP has been, there is no evidence in publication at the moment. We are in the process of creating and developing that evidence of Project STOP. What I am going to be presenting today is more from the work that we are currently doing, which can speak to the effectiveness of Project STOP and in that sense speak to the evaluation and the value of Project STOP. The research we have been undertaking has been a series of both descriptive and quantitative research.

Recently we did some time series analysis through which we have found, using the commencement of Project STOP at the end of 2005, that we were seeing some changes in methamphetamine-related offences within response to production, supply and trafficking. We are in the process of getting that research formalised and published, but we have certainly demonstrated a positive effect of Project STOP in the early period. That is one of the pieces of research that is certainly coming through in terms of its effectiveness.

Over the last year and a half I have been working with Ross Gallagher, who is the CEO at GuildLink. He has now provided us with both Queensland and Victoria's data of Project STOP. Now we are going through the process of using the whole data of Project STOP against offence data from police services as well as clan lab data coming from police services as well.

That is basically the research we are undertaking at the moment in terms of criminal activity. We are also beginning to do some research to look at health outcomes from Project STOP and the impact of Project STOP in terms of emergency department presentations, drug treatment as well as ambulance call-outs. That is the beginning picture. Do you have any questions about that?

The CHAIR — Not yet. Thank you.

Mr FERRIS — Excellent — —

The CHAIR — Jason, I am not sure what you did then, but we have lost audio. That is better.

Mr FERRIS — There really is a tilt down problem going on.

The CHAIR — Yes. Heads up!

Mr FERRIS — I thought it might be of value to let you know about Project STOP's structure. As you are aware, the idea of Project STOP is to stop the diversion of pseudoephedrine. In that sense we are saying we are trying to stop people taking pseudoephedrine from pharmacy and then running off somewhere and turning that into methamphetamines. For everyone else in the community, Project STOP is no more than an exercise of pulling out your drivers licence if you have to or showing proof of need to the pharmacist to get some pseudoephedrine.

In some of the research we have been doing we have been looking at in a yearly snapshot the volume of people who are purchasing more than 21 packets of pseudoephedrine in a given year. We are using this random number — and I can give you some detail about how we got that number — to be illustrative of a pseudo runner. This is the language that gets used around those who are basically going to pharmacies and diverting the pseudoephedrine. To date, in Queensland roughly 1 in 1000 transactions are related to an individual who is purchasing more than 21 packets of pseudo in any given year. In Queensland as well about 1 in 100 are purchasing more than 10. Ten is this threshold that we are allowing for; 21 is excess. Ten is a questionable area of what is going on.

In Victoria, as I mentioned, GuildLink has given us both Queensland and Victorian data at the moment. The same numbers are for those who are in excess of 21-plus times — it is about 1 in 1000 — but those who are in excess of 10-plus times is only 4 in 1000. That number is a lot less, which might be a function of the process of what is going on in Victoria where Project STOP is not mandatory; it is a voluntary system.

I thought it might be interesting for you guys to know from Project STOP data — just to get a picture of what transactions look like in Project STOP — in Queensland we have a population of 4.6 million, and roughly half a million transactions are being processed through Project STOP in a given year. In Victoria there are about 5.7 million people, and only about 250 000 transactions — so half that number — being processed in a given year. Again, this is a function of the voluntary system occurring in Victoria compared to Queensland.

The CHAIR — Jason, we are going to ask you about the mandatory position, but what are the pros and cons of Project STOP coming from the pharmacy? Are there costs associated with introducing a mandatory approach to Project STOP for the pharmacist at that point, or is there a

reluctance by the community to furnish the information in purchasing over and above the 10 packets? Where is the blockage?

Mr FERRIS — As I understand it, up until the last year Project STOP in Queensland was freely provided to pharmacists through the Queensland branch of GuildLink Australia, and supported by the Queensland pharmacy guild for that distribution of Project STOP. There was a lot of support via the guild and a lot of support by the pharmacies to have the program in place and basically respect this process of a tool that can be used to help assist reducing transactions to those who may be trying to divert pseudoephedrine.

In the last year, with the pressure on the guild to keep Project STOP active but the cost that GuildLink then has in running it, they have begun to ask pharmacies who are non-pharmacy union members to pay for it to cover the costs of keeping it running for those who are non-members. I believe this has gone to all states and territories, it is just not in Queensland, for those who are choosing not to use Project STOP, although it is mandatory that an electronic system is used.

There is no research that speaks to the community section of having to present identification or be screened for having legitimate use of needing pseudoephedrine. But I certainly know from following this over the last few years — looking at chat room sites and blog sites, including things like Whirlpool or Bluelight — that the rhetoric has all gone now about having to present ID. I think a lot of people, especially in Queensland and other places, have learnt to adjust to it. It is a bit like if you look 19 or 20, you always have to show your ID when you go into a bar. I think people have let that go to the point that I certainly know anecdotally lots of people in Queensland are prepared now when they are offered the phenylephedrine equivalent — the PE equivalent — they will say to the pharmacist, 'Listen, can I get the real McCoy stuff you have out in the back office; here's my drivers licence?'. There is no evidence to say that that is broad, but it certainly appears, at least in Queensland, that the adjustment on the community side of having to present your ID and show legitimate cause is certainly now a moot point. As far as I am aware, pharmacists are certainly happy to have it as a system to help policing. Julianne Webster, who did her PhD in this area, certainly has got evidence to show through community pharmacy surveys that there is certainly a positive response for pharmacists to use Project STOP to help policing.

The CHAIR — There are a couple of other questions, Jason, from Mr Scheffer and Mr Southwick. If you are happy, I might invite them to ask the questions now while we are on this point of the evidence.

Mr SCHEFFER — Jason, I want you to go back a step. You said that the Project STOP tool was freely provided. What actually is the tool? What is provided?

Mr FERRIS — Project STOP is basically a piece of software that gets installed on a pharmacy computer. That piece of software is quite minimal in the information that you enter. Basically somebody comes into the office and says, 'I would like to get some Codral cold, please. Can I get one with the proper medication inside?', not knowing it is pseudo. The pharmacist then can visually screen and determine legitimacy of use. If they say they want to go ahead with the sale — —

Mr SCHEFFER — What does 'screen and determine legitimacy of use' mean?

Mr FERRIS — I guess that is moderately open, but the idea is they have to as part of the regulation determine legitimacy, so they might say, 'Can you tell me why you need Sudafed?', and the customer is going to say, 'My nose is severely blocked, I am feeling really drained. I can't get through the day at work without sniffling and I need something to dry it all up. I have had this cold now for a couple of days'. The idea is that the pharmacist certainly does not judge by presentation, but I am sure that certainly comes into play. The idea of determining legitimacy of use is just to say, 'Does this customer need a medication with PSE in it for the purposes that they are stating?'. I guess some hay fever medication also has pseudoephedrine-based medication in there as well, and they should screen on that same process as well. Is that clear?

Mr SCHEFFER — Yes, thank you.

Mr FERRIS — Once the pharmacy is moving to the next step of saying yes and to sell this product to the customer, they then go to their computer, which at the moment is separate to their system of sales. They enter all this information into the database, which basically says, if we are in Queensland, the type of identification presented — let us say a drivers licence — the drivers licence number, typically a first name, surname and then what is being purchased. There are fields for other information but most pharmacies do not complete all that information. Other fields are gender, date of birth, things like that that can be put in, but the main thing most pharmacies do is the identification number of the drivers licence or passport or other piece of identification used and typically the name.

At that point when they click the next button, Project STOP has already taken that piece of information and searched to see if that information has been presented already within the last 24 or 48 hours, depending on what the thresholds are in each state and territory where it is being used, and if that has occurred, then the information of that person's previous transaction history is presented on a window screen to show when previous transactions had occurred. I believe in Queensland that is up to 180 days that that history can be presented.

The idea here is that the pharmacist now has a decision-making process for saying this person has now presented twice in the last 24 hours to purchase 24 tabs of Sudafed, which that person has indicated they are using for themselves — so it is not a parent who is getting it for their children — and now the pharmacist can act on that decision and say, 'Sorry, I'm going to deny this transaction' and not sell to the client, thinking that, 'You shouldn't be using this now because you've basically taken 48 tablets of Sudafed in the last 48 hours and that is exceeding the dose. If you still have symptoms in a couple of days, please come back'. Or they can still sell and continue with the transaction process.

They can also sell under duress — this is, in essence, they have gone to say no and the customer is saying, 'Listen, mate, I am just in here. I have got a cold. Please give me this because I cannot work without it', and they might click the 'Sell under duress' button and still complete the transaction.

Once all of that is done in Project STOP, that is the end of Project STOP's information at that point. Then the pharmacist will run up the sales with anything else that might have been purchased on a separate machine. That information is all directly put back in the server, which is housed by GuildLink, and that is why it is real time so you get that history of previous events occurring directly.

Mr SOUTHWICK — Could I just pick up on a couple of issues with regards to that? Firstly, the information that the pharmacist sees — that is, once the transaction is complete, the pharmacist has no more access to that information? Is that correct, or the pharmacist can look up the database for anybody and check out what sales they have been having? It is a question of security.

Mr FERRIS — I certainly hear your question. I do not know for sure, but I am pretty sure that the only people who have access to get someone's history without it being a current transaction are police and law enforcement and Queensland Health or other health services which are allowed legitimately to have access to the information being stored on the server by GuildLink. I would like to say that pharmacists cannot go and look at anyone they think they want to have a look at to see what they are doing and be proactive in trying to find people who are pseudo runners.

Mr SOUTHWICK — Right, I will leave it there for the moment.

The CHAIR — Thanks, Jason.

Mr FERRIS — You are welcome. I might just go through these points. Feel free to move around as we are doing it as well if necessary. Your next point is: how effective has Project STOP been in curtailing the diversion of precursors such as pseudoephedrine for illicit use? I have got a note response here that I need to say that Project STOP can only have an impact on pseudoephedrine that is diverted by pharmacies. Project STOP has no impact on border-based precursors coming in or stuff that might be manufactured by pharmaceutical companies in

Australia and distributed without knowledge of where it ends up. Only once it is on the pharmacist's shelves and it is processed through Project STOP can information about the transaction have meaning. One way of saying that is a pharmacist can certainly take product off their shelves and give it directly to a customer without entering this, and therefore that information is never known.

Mr SOUTHWICK — Would it be fair to say, Jason, that purchasers might know which pharmacists are currently using the Project STOP system and those that are not, and therefore be purchasing from the stores that currently do not have Project STOP in place?

Mr FERRIS — Yes. Later on I will speak about that again, but that is exactly it. Those who are with intent trying to divert PSE will either through their networks know which pharmacies are compliant and using Project STOP according to its processes and regulations and those pharmacies which are not. If you are going to be a sensible pseudo runner, you will certainly target those where you might not present as well. In saying that, there are certainly people who are potential pseudo runners and that does not bother them. Hence I have got data with people within a given year with up to 100 transactions from pharmacies. Some of those pharmacies are repeat pharmacies who have distributed PSE over 20 times to the same person in a given year. These numbers are quite excessive if PSE is only being used for stopping the common cold.

In response to diversion, there is no current evidence to answer how effective Project STOP is in reducing the diversion of PSE, but we are in the process of using outcome measures such as clan labs to find the links between PSE and Project STOP and clan lab detection. The reason we are using clan labs, at least in Queensland where we are seen as having a blow-out in the number of clan labs that are being detected, is that most of the clan labs are being considered to be addiction-based clan labs. These are small clan labs where the people operating them are basically producing for themselves and their very small circle of friends.

These clan labs are the ones where the pseudoephedrine-based medications are certainly being detected as well. Whether or not they have come from a pharmacist or come through the internet and hidden market processes or through friends and colleagues outside of Australia, we do not know. We certainly see the presentation of blister packs, so medication, in the small lab process. About 80 per cent of all clan labs in Queensland are considered these addiction-based ones.

We are using the links between Project STOP data and the clan lab information to start being able to address the effectiveness of Project STOP relative to the outcomes, being the clan labs. I can certainly say that from the descriptive data we have been seeing at Project STOP alone the high-volume transactions related to individuals who look like pseudo runners has begun to decrease. That can be blurred by these people, one, being detected and therefore not being able to keep up their pseudo running; or, two, trying to identify other ways to circumnavigate Project STOP or still go through the Project STOP system but not be detected as the same person. In this case I am referring to fake IDs as a process.

Mr SOUTHWICK — Do you know how much you are able to make? Do you need multiple packets of Codral tablets?

Mr FERRIS — Basically, if you are a good cook, about two packs — 48 pills makes just over a gram of methamphetamine.

Mr SOUTHWICK — Okay.

Mr FERRIS — It takes about 8 to 12 hours, if you know what you are doing, to process it.

The CHAIR — Jason, can we move to question 3, because obviously Victoria has a specific interest in relation to the proposed mandatory aspect of Project STOP. Could you go back? I am a little confused. The funding issue is quite an important one to understand. Initially your opening remarks were around the members of the guild and the non-members, who I think are union members. What happens with the funding for those who are not members of the guild? I presume the membership is 60 per cent to 70 per cent of total pharmacies.

Mr FERRIS — Yes, I think it might even be a little bit higher, but I am not too sure of the exact figure. As far as I understand from conversations with Ross Gallagher and Kos Sclavos, the pharmacy that is not a guild member and wants to have Project STOP is charged an annual nominal fee. I am thinking I remember from the conversation it is around $400 to have it installed, and therefore the data can then be captured.

The main reason why Project STOP is still the one being distributed is that in Queensland the regulation states that there must be an electronic record of a transaction, so a pharmacist could, if they wanted to, get an Excel spreadsheet and put everything into it. The second regulation says that this information is accessible by law enforcement and other parties who need to get access to it, which now makes it a bit of a problem, because if you have an Excel spreadsheet on your pharmacy computer and you cannot share that easily with law enforcement — although it is available — you are certainly not meeting the requirement of the second regulation. Project STOP itself, as a repository of all transactions, operates in a way that meets both the pharmacies' needs to electronically store the information and have it readily available to law enforcement and other government officials, who get the information from the server, not from the pharmacists.

The CHAIR — I am sorry to harp on this, but there are two issues: one is that Project STOP is basically the software that has been developed, but there is also state legislation required for the requirement for electronic identification or documentation of those drugs that are deemed to be used for illicit purposes. Victoria not having a mandatory system has two parts. One it does not have legislation for the electronic requirement, and I guess there is then a decision about whether it uses the Project STOP software or something else, depending on what the legislation is. Is that right?

Mr FERRIS — Yes. I am sure you guys are aware that Tasmania and the government are working on the electronic recording and reporting of controlled drugs. Again this is just another piece of software that can be used by doctors, pharmacists and other health professionals to electronically record transactions, dosing scripts and all of that information. Any piece of software could meet the requirements. I guess it is just that Project STOP was developed specifically for PSE-related transactions. It has the capacity for extension, but that was never its purpose.

I will segue here. Back in 2008–09 when the bird flu outbreak occurred, Project STOP was used as a tool to keep track of Tamiflu sales. So they actually came up with an agreement whereby Tamiflu would be measured to see how much was being distributed around Australia among all of those people who were using Project STOP at the time. That happened almost overnight. They were able to extend the capacity of Project STOP.

The electronic recording is a Queensland thing, as you say. I think in Victoria it is also just a function of determining legitimate need, and there is no need for electronic recording in Victoria if I am correct on that. I think you can get away with recording, which is, if you wanted to, the old ledger system and pen and paper. Again, there is no capacity to share that information, so a pharmacist can be seen to be doing the right thing but the information the pharmacist holds is not shared with the information of other pharmacies and therefore you cannot detect, trace or track pseudo runners, if that is the purpose of Project STOP or the purpose of the regulations around reducing the diversion of pseudoephedrine.

The CHAIR — All right. Thank you.

Mr FERRIS — You're welcome. As I mentioned, we have data from GuildLink for both Queensland and Victoria, and I am happy to share at least one of these reports which we did for GuildLink in response to a summary of what we took out of Project STOP directly to demonstrate to them what information does exist in Project STOP. Basically what we see is that some Victorian pharmacies have quite happily adopted and taken up using Project STOP as a piece of software. I am just trying to quickly find some numbers for you now. I might come back to that. I think it is around 60 per cent or 70 per cent of pharmacies in Victoria that do use Project STOP, but whether or not they use it to its full extent is a separate question. I might enter a transaction, but I might choose which transactions I enter.

In Queensland, a pharmacist could do the same thing, but they are supposed to enter all transactions. At least from our perspective Queensland provides what happens in a mandatory system if all things are working to full effect, and in Victoria the data we have gives us an idea of what happens in states where Project STOP is available but not being used to its full effect.

For example, not all pharmacies are using Project STOP. Therefore, as we mentioned earlier, a pseudo runner might find where those pharmacies are and then target those pharmacies, and that information no-one collects unless you get sales ledger information to identify pharmacies that have a high throughput of pseudoephedrine-based medications. You might then become concerned with what is going on there.

The CHAIR — Can I just ask: we have talked about over-the-counter pharmaceuticals, but what about — New Zealand has actually introduced a requirement of 'prescription only' for those pharmaceuticals that could be used as precursors for methamphetamines. Is that taking it one step too far in relation to trying to reduce access?

Mr FERRIS — It is a great question, because the premise here now is who does the burden fall on. In New Zealand, by moving it to the doctor, you are now creating a greater drive to chase this particular medication. Basically it is saying, 'I have a cold. I have to go and see the doctor in the morning'. I have to pay my — I do not know what New Zealand's health system is, but over here I either use my Medicare card or pay my consultancy fee. I then get my prescription for pseudoephedrine for Codral cold. I then go to the pharmacy and I can collect it.

At the moment Australia still has a script-based process for getting PSE, of which the pharmacies are still supposed to enter as well, but it also means that a person who gets a script may purchase in bulk, so how much PSE do they get? If you can then doctor shop to get a large prescription, you can probably get more drug at once and use it illegitimately or illegally rather than for the purposes of stopping a cold. There is no logical reason that doctors cannot prescribe scripts other than the sheer fact that you are just changing the market system of how it moves through. I imagine that the community might respond a bit more about having to go see a doctor rather than walking to a pharmacy to pick up Codral Cold & Flu.

The CHAIR — I think you might be right.

Mr FERRIS — I do have something else here just with the New Zealand stuff. I am just looking for it. It is basically covering that. It basically becomes a bit of a function also of doctor shopping, that still very much occurs now with S8s and other illicit substances, which are — the burden just moves to the doctor. That is all.

It is of interest to note that Queensland enters script-based information as well — so whether or not the script was presented. When I talked about the information that was there before, there is a tick box for a script. I think with this script there is also a tick box with how much was requested at the time. So if you have asked for four boxes, then that will be ticked off. This might occur, one, if it is head cold medication that they are seeking or, two, if you are looking for antihistamine-based medication which has PSE in it as well.

One place where this might occur, and we are getting some data tips for this, is in mining sites, for example. Up in Queensland, in Mount Isa where our mines are, relative to the number of pharmacies that exist, there is a high volume of PSE that is sold. That might be because of the six-weeks-on or whatever system they are having. There might be purchasing greater amounts in an acute time and going into the mines in case they get a cold rather than having to see the doctor afterwards. That needs a bit more exploring, but we are certainly seeing this hot spot occurring in Mount Isa, and equally in Mackay, where the fly-in fly-out process might occur.

Mr SOUTHWICK — Can I just ask two questions, Jason, very briefly? When was the legislation introduced into Queensland for compulsory reporting of Project STOP?

Mr FERRIS — I believe in 2007. I did have a PowerPoint slide I was going to print out, but when the internet went down, I lost all that. I believe in 2007 it became a mandatory requirement that electronic recording was to be used. It was never actually that Project STOP was to be used.

Project STOP has never been espoused as being, 'This is what must be used', but internally by the Queensland branch of the pharmacy guild they promoted Project STOP because the side arm party, GuildLink, had produced it and made it available. It was also an extension of a previous program which the guild had developed called Pseudo Watch, which pre-existed the 2005 regulations coming in about managing and being aware of pseudoephedrine being diverted.

Mr SOUTHWICK — And our laws in Victoria? What is explicit in our legislation?

Mr FERRIS — Right now I could not tell you. I do know I have it somewhere, but I have been focused on Queensland so much I forgot about the Victorian regulations. I can get it for you if you need it though.

Mr SOUTHWICK — Okay, good. Finally, do you know of any leakage of product that has been delivered to pharmacy from drug companies getting into the hands of runners or drug users?

Mr FERRIS — Okay, this is the point I was raising before about the chain of command — where it goes in. A nice little word that gets put in the literature is 'rogue pharmacists'. Project STOP cannot detect a rogue pharmacist, but it can detect a non-complying pharmacist, and that is because it is quite obvious that if I have sold in the last year more than 20 packets of Codral cold to the same client and entered that information into Project STOP, somehow I am not doing my job as a pharmacist. What happens with what you are saying here is that I get my crate of pseudoephedrine-based medications to the back door, and of those 100 boxes only 90 make it into my office. I cannot pick up that 10 unless you start bringing in sales and ledger data for pharmacists. We cannot detect rogue pharmacy. We can certainly detect non-complying pharmacy behaviour.

Queensland Health and I have been having conversations about this because they are very interested in that very process of non-compliance actions by pharmacists, so they are interested in the data we have at the moment about non-complying pharmacy behaviour. But without looking at the ledgers, you cannot answer that question.

Mr SOUTHWICK — Quickly, is there evidence of deregulation of pharmacies that you have come across as a result of this sort of impropriety?

Mr FERRIS — Yes. Queensland Health in particular has taken a number of pharmacies to QCAT, the Queensland Civil and Administrative Tribunal. I believe just last year there were at least six pharmacists who had lost their licence to operate in Queensland. They have not lost their licence nationally but at least to operate in Queensland. I certainly know of two when I was reading the media who were definitely related to lack of compliance in using Project STOP appropriately, and I think the other four had some links to Project STOP as part of a bigger net of what was going on. So Queensland Health has certainly been on the back of this. Because of their downsizing since last year, they have certainly backed off this as one of the key areas of focus at the moment.

Mr SOUTHWICK — Thank you.

The CHAIR — And to be fair, Queensland has one of the highest manufacturing clan labs across all states, haven't they? You have a pseudoephedrine problem in the manufacturing of methamphetamines through the use of precursors.

Mr FERRIS — That is correct. The work I have been doing with QPS at the moment — Queensland Police Service — is actually focused directly around that very question of the association between looking at Project STOP transaction data and clan lab detection data because 80 per cent of those clan labs are addiction-based small labs.

On the bigger ones that come through, unlike Mexico and other countries where they pay people very small amounts of money to spend all day popping the blisters, and Mexico and other countries having better avenues to get precursors in their raw form, the middle-sized and large labs in Australia I do not think are doing that to that extent. So it is all the addiction-based smaller labs where I think the diversion from pharmacy medications is occurring. We are hoping to

demonstrate that with a hot spot pharmacy focus as well as a pseudo runner behaviour focus and associated clan labs.

Mr SCHEFFER — Jason, just thinking about the future of your research into the impact of Project STOP on health and thinking about hospital data, for example, how would you distinguish Project STOP from other health initiatives and changes?

Mr FERRIS — Sure. If I understand — because you just broke up a couple of times — basically you are trying to demonstrate using any health outcome data, how can we attribute those changes to the existence of Project STOP and transaction data? Is that correct?

Mr SCHEFFER — Yes, and also taking into account other health initiatives or changes in the drug market.

Mr FERRIS — Yes. Ingrid McGuffog just recently finished her PhD here on the very topic of Project STOP's impact on market using the proxy outcome measure of drug treatment access. She basically looked at the very question of saying, 'Since the introduction of Project STOP, what has been the change in methamphetamine-related drug treatment access in the community?'. She broke that up in two parts: those who accessed drug treatment of their own accord, and those who were diverted to treatment by law enforcement. She has definitely found that with the introduction of Project STOP there was a blow-out in the amount of diversion that was occurring through law enforcement and a reduction in the amount that was occurring through community direct admissions — so putting myself in directly. But because of the volume of or how many people could go into treatment, the community might want it to be more but all places were taken by those who were diverted through the criminal system.

One of the problems with time series work is the very critical question is, 'What else is going on?'. What you do at the time is you try to put in control groups. She had control groups of heroin users modelled at the same time and found that with the introduction of Project STOP and the impact of treatment, the changes with heroin users — so this is now capturing any other regulations or processes that might have related to a more global drug focus — did not change heroin users, but it was still a changed scene for those who were methamphetamine users. You sort of try to model out other effects that you are aware of by having control groups where those effects should impact them, which means you can determine how much of that information is attributed to other current policies and procedures that are in place. She certainly had evidence that Project STOP did have an acute effect for about a year and a half and she just did not have enough data to go into 2011–12 at the time of her PhD.

It is possible to do. It takes some good skill sets to do it, but it is possible. The biggest critical question is knowing what other things are in place and being able to extract that piece of knowledge out of the data to leave you with what you believe to be the cause of the changes.

The CHAIR — I think we have probably exhausted both you and our questions, Jason, but we appreciate the amount of information you have given us, particularly on Project STOP, which we are particularly interested in from Victoria's point of view and what recommendations we might make as part of this inquiry.

Mr FERRIS — Yes. If I have got a chance, you did have one question here which I think it might be of value for me to answer. It is your question on whether other states and territories should use Project STOP, so should it become national? Your question was:

> Should provisions with regard to the purchasing, monitoring and recording of pseudoephedrine-containing products and other precursors be nationally consistent and uniform?

I thought it might be of value for me to speak to that now, and if there are any other questions, I would be happy to answer.

I would like to say 'Yes, it should be nationally available' if the focus is to try to reduce the amount of diversion that is going on. If governments and higher bodies start saying, 'This is not of interest any more', then it is a moot point, but if there is still a push — and, as you say, in Victoria

at the moment there is this resurgence of ice and there is certainly a regional focus; I know a lot of people down there who are my colleagues who are — —

The CHAIR — Can you hear us, Jason?

Mr FERRIS — I did lose you. Sorry.

The CHAIR — We have got you back, thanks very much.

Mr FERRIS — Do you want me just to finish what I was saying?

The CHAIR — Yes.

Mr FERRIS — The principal question is: should it be nationally consistent and uniform? I would answer that something needs to be. It does not have to be Project STOP, but something needs to be. One of the big things that is certainly present from the work from Alison Ritter that we are aware of — and we talked about it earlier on today — is pseudo runners will go to good lengths and distance to get their medication for producing methamphetamine. If it costs 20 bucks to buy a packet of Sudafed, 40 bucks to buy that packet and make a gram of speed and a gram of speed is worth $500, there is good incentive to do that — or a gram of methamphetamines.

One of the big things is if you do not have it nationally consistent, you get pushing of the problem across borders, so you get the Queensland runners going into New South Wales, all the way down to Victoria. You also cannot put all this information together cohesively to at least determine whether or not a system such as Project STOP or anything else does do its job. This is one of the drawbacks to all of this.

Over in the States just this week there was a release on i-STOP, which is an internet electronic real-time recording for controlled drugs, of which the state health person was saying, 'This is the bee's knees of everything'. However, they do not have enough information yet to ascertain how great it is. But that is the same idea with Project STOP or a similar national focus.

The main thing I want to say is that there needs to be something that is nationally consistent if stopping diversion is still a priority. And if, as you are saying, the regional areas of Victoria and Indigenous communities and others across Australia have all their niche pockets of where it is a problem, then it does need attention.

The CHAIR — Thanks very much, Jason. Are you happy to table the notes that you have prepared for this teleconference to the committee?

Mr FERRIS — By all means; yes, I am.

The CHAIR — That would help us and would certainly help the writers of the report. Thank you. Do you have any closing remarks you would like to make?

Mr FERRIS — Other than in probably about six months time, if this is still a question that you guys are approaching, I am currently under way on three grants to answer a good component of the critical questions you have here, using all the information I have discussed, especially for Queensland and with some extension to the Victorian data. So basically just keep that in mind because I will have better evidence. I am not being speculative by any means, but I cannot be as authoritative as I would like to be because the data does not exist as an answer yet.

Mr SOUTHWICK — Just before you go, Jason, you mentioned i-STOP. What jurisdiction was that?

Mr FERRIS — I will send you the link. Basically it sets up a real-time database that tracks every prescription for opioid that get billed in New York state. It must be only across New York. They are very proud of what they are doing, but it is still new. It was released in 2013, following legislation. Similar to that — and you will see in my notes — there are systems in the US that were developed by the national [inaudible] for the model state drug laws to track over-the-counter sales of PSE. That is across 20 states in the US at the moment. There is no release of information to date

on a measure of effectiveness because it is still too early. That is all in my notes when I send them through.

The CHAIR — Is Queensland using end-user declarations as a means for tracing?

Mr FERRIS — Are you are asking if when I go in I have the right to say, 'Don't put my information in.'?

The CHAIR — No, you are required to declare on what basis you are purchasing the product.

Mr FERRIS — I think that is part of the process of the pharmacist asking, 'Why is it that you need it?'. So the question should be coming from the pharmacist, 'You are asking for Sudafed. Can you tell me why you need it?'. That is when they should be going, 'I am all stuffed up in my nasal cavities. I have been unwell for the last couple of days. I have to work hard this week'. But I am not too sure, without going out and doing some mystery shopper sort of stuff, how well that engagement between pharmacists and the community occurs.

On the flip side of that, as I was saying earlier, I do believe that the community in Queensland has persevered over the last five years with being asked to show ID, but I think it is a moot point for them now. I think either they come in with ID in hand or at least tell the pharmacist, 'I want the good stuff, not the PE stuff'.

Mr SOUTHWICK — Just one other thing, are there penalties for those who do not tell the truth when they are purchasing products from pharmacists?

Mr FERRIS — Penalties for the community person or to the pharmacy?

Mr SOUTHWICK — The purchaser.

Mr FERRIS — Nothing that I have ever seen directly. I could ask that question of the people here at QPS as to whether or not anyone has ever been charged with lying to the pharmacist as to why they purchased it. If they are ever being asked that question, they have already got a small lab that they have probably been detected with and are in trouble with a whole lot of other things rather than lying about the way they have got hold of pseudoephedrine.

Mr SOUTHWICK — Thank you.

The CHAIR — Jason, you have been very free with your time, which we appreciate. Thank you very much. It has been a really interesting teleconference.

Mr FERRIS — Thank you very much.

Witness withdrew