EDUCATION AND HEALTH STANDING COMMITTEE

Ninth Report — "Changing Patterns in Illicit Drug Use in Western Australia" — Tabling

DR J.M. WOOLLARD (Alfred Cove) [10.04 am]: I present for tabling the ninth report of the Education and Health Standing Committee, entitled "Changing Patterns in Illicit Drug Use in Western Australia".

[See paper 3433.]

Dr J.M. WOOLLARD: Before I start, I thank our principal research officer, Dr David Worth, and our research officer, Lucy Roberts. I also thank in particular Mr Neil Guard and Ms Julia Knapton from the Drug and Alcohol Office, and Professor Steve Allsop from the National Drug Research Institute, who all greatly assisted the committee in preparing this report for Parliament.

Illicit drug use is a serious problem, with social, health and economic costs. However, although it is a serious problem, I am pleased to say, in presenting this report, that we have some good news for Parliament, because the patterns in drug use show that there has been a decrease in the use of some illicit drugs. In presenting this report, I will talk a bit about the effect of illicit drugs, particularly on children and families. I will then talk about some of the recommendations of the committee.

The report shows that between 2001 and 2007, the use of illicit drugs has decreased in Western Australia. Cannabis use went down from 17.5 per cent to just under 11 per cent; amphetamine use went down from 5.8 per cent to 4.2 per cent; ecstasy use went up slightly, from four per cent to 4.1 per cent; cocaine use went up slightly, from 1.5 per cent to 1.8 per cent; and heroin use went down from 0.3 per cent to 0.2 per cent. That is good news. Unfortunately we do not have any more recent data than the data that was provided in the 2007 National Drug Strategy Household Survey. Although that data shows that there has been a decrease in the use of illicit drugs, unfortunately the data also shows that in some areas there is still a major problem with illicit drug use. That is the case particularly in the Kimberley. In the Kimberley, the use of cannabis and amphetamines is much higher than anywhere else in the state. The number of Indigenous people who use cannabis is twice the number of non-Indigenous people who use cannabis. So, a lot of work still needs to be done.

When people talk about illicit drug use, they often talk about harm minimisation. There are three aspects to harm minimisation. One aspect is disruption to the supply of illicit drugs. There is good news in Western Australia, because the police in Western Australia have been very effective in curtailing drug-related crime and reducing the supply and trafficking of drugs. The police in WA have discovered a large number of clandestine drug laboratories. So, the police are doing a very good job.

Reducing the demand for illicit drugs, primarily by prevention programs, is the second aspect. This is where I believe we need to put more funding and place more emphasis. We should have more programs that target, in particular, children. One of the magistrates who appeared before the committee said, "Children have no protective powers if they do not have an education". Major Jenny Begent of the Salvation Army says —

> … kids learn behaviour. It is in front of us every day. … They learn how to solve their problems by watching adult behaviour … Often using alcohol and substances is one of the ways they learn how to deal with issues.

In looking at reducing demand for drugs and alcohol, we have to start with toddlers. We must start educating students about drugs and alcohol at a preprimary or primary school level. We need to educate children and we need to educate their families. We know that many children are born with problems because their parents are drug users. We need to do more to reduce the demand; we need to make more of an effort to prevent drug use.

The third part of harm minimisation is to provide harm-reduction programs. Western Australia has a wide mix of drug treatment programs, but, again, we could do more in this area, particularly with our school health nurses. In other states they are involved in drug education and in some parts of the WA they have a minor role, but a lot more could be done. Of course, that is very difficult when we do not have the full complement of school nurses. I will come back to that point.

We need to ensure that children are protected at home and at school, because children living with parents who are drug users can suffer from poverty, inadequate supervision, domestic abuse and inappropriate adult behaviour. They may have inadequate accommodation or may experience frequent changes in accommodation. A report from the United Kingdom entitled "Hidden Harm – Responding to the Needs of Children of Problem Drug Users", states that one way to assist children is for every family with a child under five years of age to have a named health visitor. The health visitors were to be made aware of families within their area. That role could be fulfilled in Western Australia by our community or child health nurses. Even though this Parliament was made aware in 2008 that 105 full-time equivalent child health nurse positions were vacant, these positions have still not been filled. There is a huge gap that can still be addressed. In Scotland, school health nurses are actively

involved in the planning, delivery and evaluation of measures to prevent the use of drugs, alcohol and tobacco. School nurses provide advice, information and support to teachers, children, teenagers and their families. Again, this is where we have another gap, because the government was informed in 2008 that 135 full-time equivalent school health nurse positions were vacant, and they still have not been filled. Drug use and drug dependence are big problems. We need to do more for prevention and treatment, because we know that the community wants something done about this problem. From the results of the National Drug Strategy Household Survey, we know that the community does not want illicit drugs legalised. Ninety-five per cent of Australians oppose the legalisation of heroin, amphetamines and cocaine and 79 per cent oppose the legalisation of cannabis.

I have said that the police do a wonderful job. Our Drug Court is another body that does a wonderful job. A study in New South Wales compared 309 offenders one year after attending that state's Drug Courts with a match group that did not. It found that Drug Court attendees had a lower frequency of reoffending. Therefore, we need more drug courts, not only in Perth, but also in our regional centres. We also need more people in our regional centres helping people who have problems with illicit drugs. We also need more drug support staff in our prisons. We know that a lot of people are in prison because of alcohol-related violence and criminal activity, that 50 per cent of heroin users will go to prison at some time and that illicit drug users are often readmitted to prison on a regular basis. In 2005–06 only about 10 per cent of prisoners who needed rehabilitation programs were able to access them. That is another gap. Hopefully we can work with those prisoners when they are in prison, and when they are released have them followed up by the Drug and Alcohol Office to ensure that they remain drug free.

I have spoken about working with disadvantaged families. We should be working with people in these disadvantaged families antenatally to try to get future parents to cut back on their drug use, and child health nurses should work with children from infancy to early childhood—zero to four years of age. When children are identified as part of a family with parents who use drugs, there could be family home visiting at both primary and secondary school levels by either the school health nurse or the community health nurse. We have to give more support to children living in those families. If we do not give those children support, they may get behind at school, may not attend school, may not be employable and may then possibly turn to drug use themselves later in life.

The main problem we found with illicit drug use was cannabis use. Cannabis is the major drug problem in WA. Although the proportion of Western Australians using cannabis has gone down from 17 per cent in 2001 to 10.8 per cent in 2007, cannabis users are not seeking treatment. People do not appreciate the problems associated with cannabis use, particularly mental health problems. People are aware that tobacco is full of toxins, but a lot of people unfortunately do not appreciate that cannabis goes a step further. Not only does cannabis have more toxins than tobacco, but also it can cause mental health problems. Young cannabis users are now binge smoking, and that can affect them when they smoke and for the rest of their lives. We need to focus on a campaign to encourage people, particularly children, not to take up cannabis. That is one of the things that the committee would like to see in the review of the Cannabis Control Act.

The committee then looked into cocaine use, the figures for which have increased slightly.

When the committee looked into heroin use, it found that there was a problem with the number of people using prescription opioids. Therefore, we need more medical specialists in the community, in the tertiary hospitals and in the secondary hospitals who can deal with pain management because more and more people rely on prescription opioids. A few problem opioid users are exacerbating the problem because they are selling their prescription drugs on the black market.

Amphetamine use has gone down. One of the things we have been reading about recently, particularly from the liquor industry, is that the reason we have so much violence is because of amphetamine use. That is not the case, because binge drinking and violence is not just a problem in WA. As we said when we presented our Kimberley report, alcohol is a problem in all other states and it is a problem overseas. In countries such as Germany, the use of amphetamines is one-tenth that of Australia, and in France it is one-twentieth; however, there is still that link between alcohol and violence. Today we are focusing on illicit drug use, but any suggestion that the problem of violence out there in the community is because of amphetamines needs to be corrected; the main problem we have is alcohol. That is a diversionary tactic by the liquor industry and those people supporting the industry.

I bring the Parliament's attention to the fact that 26 June is International Day against Drug Abuse and Illicit Trafficking. I hope the state government will coordinate a campaign for this day by providing the police with funding to advise the community what to look for in drug users and what to look for in clandestine drug laboratories. As part of the campaign, the community could be encouraged to call the police with their concerns.

The data we presented in our recommendations to this Parliament, unfortunately, is slightly out of date; it is 2007 data. Accurate data needs to be presented to this Parliament on an annual basis so that funding can be made appropriately to deal with the problems of illicit drug use. I have mentioned before that we need to particularly

look at the effect of cannabis on young people. The committee would like to see additional drug and alcohol counselling positions in our tertiary and secondary hospitals, with services operating seven days a week, especially at peak times, for people who are admitted with illicit drug or alcohol problems. The committee would like to see, as I said before, more pain medicine specialists. It would like the government to tell Parliament what it is going to do to try to decrease the use of inhalants by children.

Several years ago a federal parliamentary report recommended that in dealing with illicit drug use we move to a recovery model; that is, rather than keeping people on methadone or other drugs for many years, we try to get people being treated for drug dependency off those drugs. That is another recommendation from this committee. Rather than putting patients on alternatives to heroin—yes, they go on other substances like suboxone or naltrexone—we put more of an emphasis on trying to make the community more free from illicit drugs.

The committee would also like to see more behaviour-oriented programs. That could come back to putting in more work with our school health nurses. We need to make sure that doctors, nurses, all allied health professionals, teaching staff and student teachers are taught about the signs and symptoms of illicit drug use so that when they detect problems at school, they can report this to someone, and all nurses and all health professionals would have the ability to give brief counselling to someone who is identified as using drugs or alcohol in large measures and then refer them to a specialist in the area.

MR P. ABETZ (Southern River) [10.24 am]: In the mid-1990s, while serving as a pastor in Willetton, I was asked by Dr George O'Neil to establish a drug rehabilitation support group for heroin addicts taking naltrexone tablets. I set up a support group for these people and another one for the families of the addicts. My leading the group, which over time gave support to people recovering from a variety of drug addictions, including cannabis and speed, gave me insights into the painful journeys of addicts and their families, which no amount of reading or research could have provided. It is a tragedy that the incredible pain and trauma that drug addiction causes begins for 77 per cent of addicts with taking their first dose of drugs for no other reason than curiosity, and soon enough they find themselves addicted. This highlights the fact that our primary focus must be on preventing the production and sale of illicit drugs and on teaching our young people the devastating effects of drugs not only on themselves but also on their extended family and friends. We need to equip our young people to say no to drugs. Thankfully that message is getting through, with the younger generation having lower drug-taking rates than their older counterparts, and indeed from 1998 to 2007 the number of people using cannabis in WA has halved.

One of the interesting things that was repeatedly submitted to the committee was that young people who have a strong, stable family are much less vulnerable to drug taking. Being part of a faith community also results in a much-reduced likelihood of drug taking. Anything we as a government can do to strengthen the biological traditional family and give kids a sense of belonging will pay dividends in reduced drug taking. Another interesting finding is that prevention programs that target the whole family rather than just children are far more effective in reducing drug use.

Although it may seem self-evident that the focus of treatment should be to move a person towards a drug-free lifestyle, that view is not shared by many in the drug policymaking elite. There are two very different philosophical approaches to dealing with people on drugs. There is the harm-reduction approach, which basically says that it is a person's right to take drugs if they choose to do that, and we as a society have the responsibility to make it as safe as possible for the drug taker so that the focus is on reducing the harm they cause to themselves and to the wider community. This philosophical approach has been vigorously promoted by the International Harm Reduction Association and its supporters, who also advocate the legalisation of all illicit drugs. The harm-reduction school is amply resourced through various George Soros-funded groups such as the Drug Policy Alliance, which, with help from his Open Society Institute and MoveOn.org, spearheads almost all drug-legalisation efforts not only in the US but also in Australia. The alliance operates a well-funded, well-oiled publicity machine that monitors the world media and, within hours of anyone opposing its stand, issues media releases to present its pro-legalising agenda. Dr Alex Wodak from St Vincent's Hospital in Sydney is the doyen of this well-funded movement in Australia.

The harm-reduction approach gave rise to the methadone program. Heroin addicts in this program are provided with a daily dose of a long-acting opioid called methadone, which is very cheap. The average dose costs 40c. As a short-term measure to help addicts come to terms with the issues in their life, this can be a very useful strategy, but the harm-reduction approach has resulted in over 1000 people being on this so-called treatment for 10 years or more here in Western Australia. Tragically, 90 per cent of people in Australia on methadone remain on social security benefits as their primary source of income, and at least 70 per cent of those on methadone top up with other drugs and so remain trapped in a cycle of addiction.

In many parts of the world, there has been a backlash against the harm-reduction approach. Sweden abandoned it in 1980s, and it now has the lowest drug-taking rate in Europe. The newly elected government in Britain has moved to what is now referred to as the "recovery model". The recovery model focuses on moving people

toward the goal of living a drug-free lifestyle. As a committee we want to see greater emphasis on this approach here in Western Australia, and we have made various recommendations to that effect.

That people can recover from drug addiction, given the right environment and input, is clearly evidenced from the outstanding work done by Teen Challenge, which started in the US in the late 1950s and is now replicated in over 1 000 centres throughout the world, including the one in Esperance. Research shows that five years after completing their 12-month program, 70 to 85 per cent of people have remained totally drug-free and have re-entered mainstream society. We owe it to those addicted to drugs and to their families to do everything in our power to help move them to a drug-free lifestyle rather than keep them in the cycle of addiction.

I am thankful the committee has recommended that people on pharmacotherapy treatments not stay on that program ad infinitum, but that a clear program must be established to reduce their intake over time, with a view to helping them move to a drug-free lifestyle.

From the evidence presented to the committee, there is a clear problem in the medical education of doctors in the drug and alcohol area. Western Australia is the only state without an alcohol and drug clinical teaching facility attached to its hospital system. As a result, the universities are beholden to the Alcohol and Drug Authority to provide this service. Although the ADA provides personnel for lectures to medical students, it provides only very, very limited clinical placements. As it is, our hospitals treat the lion's share of drug and alcohol cases in their emergency departments, and once stabilised, very few qualify for admission to the Drug and Alcohol Office treatment facility, known as Next Step Specialist Drug and Alcohol Services, because the DAO criteria require a person to be in almost perfect health. A person with mental health issues is not eligible to enter that facility. We were told that, as a result, hospital staff have pretty much given up referring people to Next Step and instead ring the Fresh Start Recovery program, which is the rehab service run by Dr George O'Neil, who, being a very soft-hearted man, never says no.

Professor Gary Hulse expressed deep concern at the very limited number of medical students who are placed at Next Step, albeit the committee did not take the time to further explore his suggestion that the Next Step facility be attached to a major teaching hospital—where other facilities, such as an intensive care unit, are available—so that the full range of people's drug problems can be dealt with. I believe this is an issue that should be further explored either by our committee or by the Ministers for Health and Mental Health, because Next Step is clearly very limited in what it is doing, and this puts significant pressure on our tertiary hospitals, which continue to do the lion's share of the work that the ADA was set up to do.

One of the most exciting developments in opioid addiction treatment in the past 10 years has been Dr George O'Neil's development work on naltrexone implants. The scientific evidence published in peer-reviewed research journals indicates that with a little more research, there should be sufficient data to satisfy all the criteria for Therapeutic Goods Administration registration.

The former Minister for Mental Health, Dr Graham Jacobs, should be congratulated on agreeing to fund a researcher to review the data, and to advise government as to the further research needed before a successful TGA application can be launched. It is disappointing that the DAO bureaucracy took over 18 months to make such an appointment, and that the appointment of another person to do a clinical audit has still not taken place two years after the DAO was instructed to do so by the minister. It is disappointing that Edith Cowan University has withdrawn its tender for this clinical review out of frustration with the DAO stonewalling. For far too long, it appears that the DAO has seen Dr O'Neil's work as a threat, rather than an innovation worthy of every support it can offer. Sadly, the harm-reduction advocates have gone to great lengths to denigrate the work of Dr O'Neil. I suspect the reason is that if naltrexone implants achieve TGA registration, they will inevitably replace the methadone and buprenorphine substitution therapies. After all, why keep someone addicted to opioids, with all the associated problems of having to go to the pharmacy every day or every second day, when one implant will keep the craving away and make it impossible to get a high from using any other opioid for between six and nine months. Given that the data shows that the death rate among people on methadone is far higher than those on naltrexone implants, there is every possibility that naltrexone implants will become the gold standard for opioid addiction. And that will totally destroy any justification for the legalising of any opioid drugs so eagerly sought by the harm reduction lobby.

I look forward to the results of the current review of the extra research needed before a successful TGA application can be launched.

MS L.L. BAKER (Maylands) [10.34 am]: I will start by thanking our long-suffering committee team. Dr David Worth is an amazing researcher and I really appreciate the opportunity to work with him. Going back, Michael Burton, Renee Gould, Tim Hughes—I am sure it is not the committee's fault that there have been so many researchers on this inquiry—Alice Jones, John Seal-Pollard and, now, the wonderful Lucy Roberts. I thank them all for the efforts they put in to help the committee produce this very complex report, "Changing Patterns in Illicit Drug Use in Western Australia". To our chair and members of the committee team, thank you very much.

I will refer in particular to drugs and their role in the increase in the number of people in our prisons. I will draw on a number of parts of the report, in particular recommendation 24, which is, I think, the last recommendation the committee makes. Recommendation 24 states —

> The Minister for Corrective Services and the Attorney General report to Parliament by December 2011 on what processes have been put in place to ensure the closer cooperation of the Courts and the Department of Corrective Services in managing the diversion programs offered to convicted children and adults in Western Australia.

To preface the reason for that recommendation as succinctly as I can, I will talk about the Western Australian Network of Alcohol and Other Drug Agencies, known as WANADA, which stated in evidence given to the committee —

> … the workload associated with DCS clients is significantly higher than for clients in the general community with drug-related problems.

Of course, WANADA is the peak body that has direct responsibility to monitor and report on how the network of alcohol and drug agencies in our state is coping with the workload it is presented with. It has constantly stated that the Department of Corrective Services is not adequately funded to pass on money to WANADA to allow the agencies within WANADA to do a good job of helping clients with drug problems. These are very particular, specific problems, and need a particular, specific type of intervention. I quote —

> The importance of these NGOs to the successful operation of the DCS diversion programs was made clear to the Committee:
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> > *we are obliged to fulfil the orders of the court, or to work within the orders of the court. Quite often those orders may place requirements or impositions that are very difficult for us to deliver on … Sometimes the court places conditions that say this person has to attend a program or be given a certain sort of intervention, and the program or intervention does not exist. It puts our staff in an untenable position because they are either required to try and do something, and they make referrals that are a waste of space, or they are breaching the person because the person cannot comply with that sort of requirement because it does not exist.*

That is the reality of what is going on and the gaps between the Department of Corrective Services, the drug agencies, the Department of Health, DAO and the like in our state at the moment. As far back as 2009, WANADA went on the record, stating —

> "The state government needs to face facts – at least 37% of all crime is drug-related," … "Treatment leads to less crime so fewer prisoners. We need the government to address this major cause of crime with prevention and treatment, rather than the victims of crime and taxpayers having to cop the consequences of non-treatment later."
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> …
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> "Alcohol and other drug agencies are struggling to meet the demand with the current number of Justice referrals," … "Meanwhile, many offenders are not able to access the treatment they need to change their offending behaviour."

The state faces a major problem and I would welcome more investment from this government in those preventive strategies—as the committee's report suggests. In support of the committee recommendation that the state government look into intervention and prevention programs, I would like to cite the Life Education Australia program, which, as it happens, is located in my electorate.

The committee's report states —

> In 1974 the Life Education Centre was set up … at the Wayside Chapel in Kings Cross. Life Education WA is the State's largest non government provider of drug and health education to primary school children and an important part of this work focuses on prevention programs. The Committee heard it is now "being approached by preschool and kindergartens because our focus is in the early stages—teaching children about respecting themselves and their bodies."
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> …
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> In Western Australia Life Education focuses on pre-primary and primary schools, while in other jurisdictions secondary school programs are also offered.

As stated in the report, the modules that Life Education teaches —

> … incorporate the topic of illicit drugs through activities which assist students to:
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> - explore the potential harms from illicit drug use;

- assess the rules, laws and policies in relation to the use of illegal drugs;
- access and assess information products and services in relation to illicit drugs;
- describe the short and long term effects of illicit drug use in the community; and
- identify skills and strategies for dealing with group-related illicit drug use harm.

The figures available to us finish in 2008, and they are the ones we have referred to. We are not sure what is happening with drug use in the state at the moment because those figures are not currently accurately collected. When the Gallop government ran programs, there was a significant drop in the use of illicit drugs. We are hoping to see that that drop has continued. The Gallop government withdrew funding from Life Education in 2003—a very long time ago. That could have been because there was a significant drop; I am not sure.

The Life Education program seems to bring a very good and valuable set of strategies for primary school interventions in our state. I encourage this government to look at the good work Life Education is doing. I believe Life Education is currently putting submissions to the state government to provide work over four years to reach about 65 000 students throughout the state.

In conclusion, this has been an exhausting report. Although I was not able to join the committee on its overseas travel, I know there are very many problematic areas in the illicit and licit drug sphere. All areas deserve constant monitoring and resources—probably more than they are getting at the moment. I encourage this government to read the ninth report of the Education and Health Standing Committee carefully. The report contains some very sound recommendations about the way we should go forward, in particular to start counting trends in drug usage in the state at the moment and how that might be changing. Thank you very much for the opportunity to commend this report to the house.

DR G.G. JACOBS (Eyre) [10.42 am]: I, too, would like to comment on the Education and Health Standing Committee's ninth report, entitled "Changing Patterns in Illicit Drug Use in Western Australia". I am a very recent member of this committee. It is indeed a privilege to have the opportunity to sit on this committee to deal with areas that interest me. The committee made 17 findings and 24 recommendations. I would like to tell the house about the areas the committee is dealing with and the scope of the work. Essentially, the list of illicit drugs includes cannabis; amphetamines; methamphetamines such as ecstasy; analgesics; cocaine; tranquilisers; hallucinogens; inhalants; heroin, and, indeed, the impacts of methadone; and some legal drugs, or licit drugs, that are used illicitly.

To step back a little, I think finding 1 is encouraging. It is important that we do not become complacent. Finding 1 states —

> Data from the 2007 National Drug Strategy Household Survey indicates that the level of use of most illicit drugs has reduced in both Australia and Western Australia since 1998.

The committee identified that there is a four-year time lag in the information we can get from such reports. Recommendation 1 states —

> As part of its annual reports, the Drug and Alcohol Office collate and publish the data on the use of illicit drugs in Western Australia for the preceding year.

It is important for us in Western Australia to know the latest data and trends.

I now turn to the issue of harm minimisation. Finding 4 addresses the very contentious issue of harm minimisation. On the streets, "harm minimisation" suggests that, okay, there is the use of illicit drugs; we will essentially allow that to occur but we will try to reduce the harm. It is really important to recognise the finding that suggests that harm minimisation in Western Australia is about not only reducing the risk, but also dealing with supply and demand. The term "harm minimisation" is often interpreted in different ways by different stakeholders. A really important part of the strategy for this committee was to look at ways to reduce supply and demand in this war against the use and abuse of illicit drugs.

As a country member representing large parts of the Goldfields, and having read in the report about the reduced use of cannabis, I know that there are certain spikes in Western Australia. Significantly, one is in the Kimberley and the other is in the Goldfields. In part, finding 5 states —

> … data show that its use remains a significant health and justice issue, particularly in regions such as the Kimberley and the Goldfields. The Government expects that new cannabis laws will further lower the consumption of cannabis in the State, particularly among young users who access the cannabis intervention requirement …

As the former Minister for Mental Health, it was a great desire of mine to support people who infringe. Support is about education on use and abuse; it is about moving to a drug-free life and not going on a downward spiral. It is really important that we follow those people up and provide wholesome education and wholesome methods to deal with this problem in order to make a difference. Finding 1 states that the level of illicit drug use is going down; however, there is a peak in the use of amphetamines. Finding 6 of the committee's report states —

> The high level of consumption of amphetamines and ecstasy by Western Australians over the past decade has created a significant demand on the State's health, Police and Justice systems. The State now has one of the highest amphetamine usage rates in the world.

Finding 7 states —

> The misuse of prescription opioids has become a significant problem within Western Australia and the number of people misusing them is now at a similar level to the number consuming heroin.

That was probably the basis of some of recommendations 6 and 7, which referred to the Minister for Health—he is not in the house at the moment, but I hope he is listening—and recommended that he fund a minimum of eight full-time equivalent pain medicine specialists and supporting staff across Western Australia in the state budgets from 2012 to 2014. This is about treating people with chronic pain, so that they do not misuse and abuse opiates in dealing with their chronic pain. That is very important.

I am obviously going to run out of time, but I want to put the whole issue of heroin into perspective. We are talking about 0.2 per cent of people in Western Australia. When we talk about substitution, which is essentially the methadone program, of which buprenorphine and Suboxone are a part, we include the issue of psycho-social rehabilitation and opioid blocking programs such as the well-publicised George O'Neil Fresh Start Recovery program with naltrexone implants. It is really important to have accountability in all the issues and in the different modalities of treatment for drug addiction. That includes the Fresh Start Recovery program. The report referred to the need to have research and clinical audits. As the member for Southern River has said, it may well be that George O'Neil's naltrexone implants will be the gold standard in the treatment of heroin addiction, but it has to get Therapeutic Goods Administration approval. It is really important that this process is accountable.

The follow-up issues in drug treatment are very important. Recommendation 9 reads —

> All opioid treatment programs need to provide to the Drug and Alcohol Office follow-up short and long-term (greater than five years) data on all patients to assist in evaluating the effectiveness of these programs, including rates of abstinence.

That is really important. What happens to these people when they have the first treatment, but they get lost to follow up? Are they still off drugs in five years? What has happened to them? It is really important in evaluating our treatment modalities that we have that information.

In summary, we are going in the right direction but we have more work to do. We have to be accountable and look at the outcomes. We have to have updated and current figures to assess treatment. It is a difficult area. We must have education. The report refers to that, but I have not been able to cover it all.

I draw recommendation 8 to the attention of the Deputy Leader of the Opposition. The committee recommended a plan to deal with the use of inhalants by Western Australian schoolchildren aged 16 to 17 years. I commend this report to the house.

MR P.B. WATSON (Albany) [10.53 am]: It gives me great pleasure today to support the ninth report of the Education and Health Standing Committee, titled "Changing Patterns in Illicit Drug Use in Western Australia". First of all, I would like to thank the staff. I do not know how Dr David Worth did it. The amount of pressure put on Dr Worth was at times unreasonable, but as always he has been very professional, and his research ability has been tremendous. I have been working with Dr Worth for a while. I know that Dr Worth is leaving us soon, but he has been a tremendous asset. I would also like to thank Michael Burton, Renee Gould, Timothy Hughes, Alice Jones, John Seal-Pollard and Lucy Roberts, who have all been part of our team. This report has been a huge undertaking. We have heard a huge number of witnesses. We have travelled and been to conferences. This inquiry has resulted in a much better picture about drug problems, not only in Western Australia, but also all over the world. There is no easy fix. No-one is going to get up today and say that they have the answer. There is no answer to this at the moment. We have to keep chipping away at the problem. It is an enormous problem that affects not only young schoolchildren due to people going into schoolyards trying to sell drugs, but also teenagers and adults. Even seniors are affected by drugs—not necessarily illicit drugs, but prescription drugs. This is something that affects the whole community.

One of the interesting points to come from the inquiry is that cannabis use in Western Australia halved between 1998 and 2007. I would like to congratulate the Gallop and Carpenter governments for their input into this,

because they took a lot of pressure over some of the decisions they made, but the proof is in the pudding. Even though cannabis use has dropped in Western Australia, it is still a big problem in the community. The committee travelled to the Kimberley, and we heard of instances in which a whole lot of ganja, as they call it up there, would come into a town such as Fitzroy Crossing and, instead of using it over a period of time, they would sit down and smoke it until it all went. Members can imagine what that is doing to people's bodies and minds.

The use of other drugs has increased, including amphetamines. As Dr Jacobs just stated, WA has one of the highest rates of amphetamine use in the world. This is a huge problem. The chairman of our committee said that violence is a result of alcohol and amphetamine use. However, until amphetamine use became prevalent, if someone went to a nightclub and got into a fight—not that I ever did—and someone hit the ground, that was it and everyone would walk away. Now, young people are so fuelled up on amphetamines that they will take on not only their mates, but also the police. Alcohol is a problem, but the mixture of alcohol and amphetamines is an even greater problem.

The issue that surprised me the most was the use of opiates. The report reads —

> Pharmaceutical Benefits Scheme figures show the number of opioid prescriptions almost tripled, from around 2.4 million in 1992 to seven million in 2007. The RACP estimates that between 5–10% of these opioid prescriptions are being misused.

People go to their doctors for prescriptions. The committee has recommended that doctors be given more training on alcohol and illicit drug addictions so that they can pick up whether someone has an issue with pain or has an addiction problem. Once they get these painkillers, some seniors sell them for huge amounts on the black market. They probably get them cheaply on the PBS and they can sell them for probably $150 a tablet. A lot of people use those tablets instead of heroin. That is a huge problem that probably slips under the radar of a lot of people. The reports states —

> According to DAO, the total prescriptions for oxycodone in Western Australia increased 13% in 2008, with nearly 131,000 scripts filled. In the first 5 months of 2009, 59,888 scripts were filled, …

The misuse of these prescription drugs has become a significant problem in Western Australia and the number of people misusing them is now at a similar level to the number of people who consume heroin. This is one of the hidden problems, and it was great to see that the committee was able to sniff that out—to eke that out!

The report referred to harm minimisation. We will probably disagree on this as everyone has their own idea on what this should be. The World Health Organization stated that the way it looks at stopping drugs is through addressing supply, demand and harm reduction. We look at harm reduction in many ways. I notice that the United Kingdom has introduced a road to recovery strategy, which is interesting. I note that in Scotland, with a population of five million people, there are 55 000 drug addicts and 550 drug deaths a year. In 2006–07 the UK had 320 000 addicts, which was nearly double the number in 1998, of which 210 000 needed some sort of treatment, mainly methadone. People told the committee about getting off methadone. Someone told us that there are problems when people are taken off methadone. If someone is not taken off methadone quickly enough or goes back to drugs on the street, there can be real problems with brain damage. A witness in the UK said that it is not healthy for an addict to go from methadone to abstinence and maybe back onto street drugs and then through multiple rounds of detox programs, because it may cause serious brain damage. I think getting people off methadone is a great idea, but we must take everything into account; we cannot simply say, "Get everyone off methadone." There must be a program for users to go through.

I am concerned about the lack of data. Most of the data that the committee looked at was probably four or five years old. There is the Fresh Start Recovery program and other programs, but we have no follow-up and we do not know what happens to people down the track. I think, and the committee suggests, that every year the Department of Health should have a follow-up program to find out where all this money is going and whether the programs are working. I am a little concerned about the amount of money that is going to Fresh Start when so many other groups also need funding, particularly the groups working on the street. A lot of money has been put into Fresh Start over the years and I know it is doing a good job, but, as a taxpayer, I am concerned about the amount of money that is going into that program.

The committee looked at an injecting centre in New South Wales. Many people say that we should not have injecting centres. The injecting centre was put in after the final report of the royal commission in New South Wales because a lot of illegal shooting galleries were operating in Kings Cross. The injecting centre was being run only on a trial basis, but the new government is now running it on a full-time basis. I am not saying that we should have an injecting centre in Western Australia, because I do not think there is the demand. However, it is something we should look at in the future. The people using those injecting centres are not young kids; they are people aged 30 to 35 who have had the problem for a long time and are going into a safe place instead of

injecting on the streets. Another issue that came up was the need for more support services at these centres. We would need to look at that.

I urge everyone to read this report. A lot of hard work has gone into this report and there are a lot of great ideas in it. I congratulate the staff. We are not going to fix these problems straightaway, but a report such as this will go a long way in helping us with this cause against illicit drug use in Western Australia.

MR M.P. WHITELY (Bassendean) [11.03 am] — by leave: I promise this will be a very short contribution. I want to pick up on two things relating to the report titled "Changing Patterns in Illicit Drug Use in Western Australia". I want to add some clarity to recommendation 7, but the first thing I want to pick up on is a comment by the chairman of the committee, the member for Alfred Cove. Those who are saying that there is a problem with amphetamine violence—I am one of those people who are saying it—are saying not that it is in isolation from alcohol, but that it is in combination with alcohol. I think the member for Albany highlighted that point. Let us not make this a competition between how evil alcohol is and how evil amphetamines are. The problem is that people are going out and abusing amphetamines—very often prescription amphetamines—on weekend benders when they are full of grog and they become agitated and violent. That is a really serious problem. In fact, people can drink more grog because they are taking amphetamines.

It might be worth having a listen to the archives of the "Friday free-for-all" on *Mornings with Paul Murray* and some of the things Jane Marwick has said about the problem of amphetamines, particularly prescription amphetamine abuse, when used in combination with alcohol and how it changes the behaviour of some young people when they go out. Jane Marwick did an informal survey of young people in pubs because of stories she was hearing from her 19-year-old daughter. It is not a case of either-or; alcohol and amphetamines are both problems in isolation, but together they are a potentially lethal combination.

The other thing I briefly want to comment on is recommendation 7, which states —

> The Minister for Health request the Department of Health to examine the need to expand the pseudoephedrine monitoring program to include both prescription opioids and benzodiazepines.

This recommendation relates to my budget reply speech that I made yesterday when I highlighted the issue of prescription drug abuse. I spoke at some length about the article that appeared in *The West Australian* of 11 April titled "Doctors like dealers for prescription drug addicts". The article highlights the problems with a range of prescription drugs, including sleeping tablets, OxyContin, stimulants and other drugs. There is a very simple solution to this problem and it is outlined in this statement by Lenette Mullen, who is the president of the Western Australian branch of the Pharmacy Guild of Australia —

> Every doctor and every pharmacy in this State has stand-alone computers, but these computers don't talk to each other so there is no simple centralised record of who is getting what …

If we simply made pharmacy computers able to talk to one another, when someone wants to be dispensed a prescription for whatever drug it might be—it could be stimulants or sleeping tablets—the pharmacist would know whether that person has already been dispensed a month's supply the day before, for example. If we had computers that spoke to each other across the state, we could stop people from filling prescriptions for the same drug at multiple pharmacies. All these scripts are dispensed by pharmacists and we can catch the oversupply at this bottleneck. A statewide computer system would go an awfully long way. It would not stop the problem of people faking the symptoms of various conditions and seeking prescription drugs, but they would be able to get the drugs only in therapeutic doses. The problem is that people are going from doctor to doctor—they are doctor shopping—and then they are pharmacy shopping. People go from pharmacy to pharmacy to pharmacy. If we simply had a system that allowed computers in one pharmacy to talk to computers in another, we could solve the problem. Lenette Mullen has been advocating that system on behalf of the Western Australian branch of the Pharmacy Guild of Australia for a very long time. I know Lenette and she is a very sensible woman. The pharmacists certainly do not have a vested interest in this system; they are making the recommendation for the public benefit. Pharmacists would obviously get fewer sales, but they would have a safer customer base.

I raised this issue with the Minister for Health yesterday and he interjected on me to say that I should take it up with Hon Nicola Roxon. I thought he interjected to say that he would take it up with Hon Nicola Roxon. Frankly, it will not have a great deal of effect if I take the issue up with Hon Nicola Roxon. The Minister for Health needs to grab this issue. It is a really simple solution and it is an easy sell. The Minister for Health can go to the federal Minister for Health and Ageing and say, "I have a way of saving you money and making people healthier." Stopping this pharmacy-shopping process would cost a limited amount; we only have to develop some software. The system would save an enormous amount because these drugs are subsidised by our taxes via the pharmaceutical benefits scheme. I applaud recommendation 7, but I do not think it goes quite far enough. I suggest that, to make it more specific, the program should apply to all potential drugs of abuse and addiction, all Schedule 8 drugs, and it should allow computers at one pharmacy to talk to computers at another. If there are

privacy concerns about that and we need to make some adjustments to laws or regulations, I am sure it is not beyond the wit or wisdom of this Parliament to make those adjustments.

Thank you for the opportunity to make this contribution.