MEDICINES, POISONS AND THERAPEUTIC GOODS BILL 2013

Consideration in Detail

Resumed from 26 September.

Clause 99: Recording and notification of drug dependent status —

Debate was adjourned after the clause had been partly considered.

Clause put and passed.

Clause 100: Supply or prescription of drugs of addiction to or for drug dependent persons —

Mrs M.H. ROBERTS: Why has the penalty been set at what I believe is $30 000?

Dr K.D. HAMES: I am advised that the fine, which seems like a very large amount, has been set at that amount for two reasons. Firstly, it is because it is a very serious offence, and I will go through the detail of the offence in a minute. Secondly, it is a CPI conversion of the original amount taken through to today's dollars. Part of it is to stop people from going and getting very serious, heavy-duty drugs. OxyContin is the example I have got, which is a morphine derivative. It is a very addictive and serious drug. I gather it is the most commonly sought narcotic on the street. It sells for about $80 a tablet. One standard box of OxyContin, which someone might be able to get for $5.90 from the chemist with a pharmaceutical benefits scheme script, can be sold for $2 240. We clearly want to discourage people from taking advantage of the price that they could get for that drug. The original fine was, we think, $5 000—we do not know for sure. Clearly, we want a significant deterrent to people going and obtaining that drug.

Dr G.G. JACOBS: I have an interest in this area. I ask the minister to forgive me, but I would like to get on the record his opinion on a certain matter. This might not relate directly to the clause, but I am reading between the lines of the heading "Supply or prescription of drugs of addiction to or for drug dependent persons". I would like to get the minister's view and policy on this matter. We have methadone trials in Western Australia, but my question relates to heroin injecting rooms and heroin injecting trials. I want to get the minister's opinion, for the record, on whether the words "Supply or prescription of drugs of addiction to or for drug dependent persons" will in no way have an implication for heroin injecting rooms or heroin injecting trials in the state of Western Australia.

Dr K.D. HAMES: No, it does not relate in any way. As the member would know, we do not allow heroin injecting rooms in this state. Personally, I am strongly against them; I do not believe that they have a place. I know that that does happen elsewhere, but, personally, I do not believe it is appropriate and I am not a supporter of it. This clause simply relates to the prescription of drugs. As the member can see, it relates to a person who supplies a drug of addiction or prescribes a drug of addiction to a person whose name is included on the drugs of addiction record as a drug-dependent person. This provision already exists in the current legislation. If a doctor rings up and finds that someone is an addicted person and then continues to provide that person with a drug of addiction regardless, and OxyContin is a good example, then that doctor will commit an offence in doing that.

Mr P. ABETZ: I am very pleased to hear the minister's views on heroin injecting rooms and so on. Perhaps if we had a different Minister for Health, my reading of the clause is that it would allow regulations to be made that would enable such things to be possible. Do I read that correctly or is that not the case?

Dr K.D. HAMES: It is a little complicated because we are talking about different schedules of drugs. Schedule 9 drugs are not allowed to be prescribed to a person who is addicted to drugs. This clause will allow a new government or a new minister who has different views to change that. Suppose a new minister thought a heroin injection clinic was a good idea. Other governments have set them up. The minister could regulate to allow for the provision of drugs but not heroin because heroin is a schedule 9 drug. It would have to be moved out of schedule 9 to schedule 8 to allow those drugs to be provided through a heroin injection clinic. It is not just a simple matter. This clause allows for regulations to be made so that ministers of the day may put in provisions that they like relating to schedule 8 drugs. The Misuse of Drugs Act would have to be amended as well. It would not be a simple procedure but this clause does allow for change. We got a bit of overlap between heroin injection rooms and this clause because they do not specifically relate. We would have to do lots of other things as well. This clause allows for the minister of the day to regulate for someone to provide specific drugs that are allowable drugs to a person who was addicted.

Mr P. ABETZ: The reason that I asked that question is that for a regulation to come into effect, it has to go past the Joint Standing Committee on Delegated Legislation. Now that I am the chairman of that committee, one of the things I have learnt is that under the terms of reference of that committee, it is within its power. If I read those terms of reference, I would think it is within the power of the Department of Health or the minister to shift, say, heroin out of schedule 9 to schedule 8. Basically, the committee would say that is within its power and it

does not have a lot to say about it. Since I have become chairman of the delegated legislation committee, I have become very conscious of the fact that even though Parliament has the right to reject regulations, if something comes before the legislation committee, because of its terms of reference, if we do not think it is a good idea in a sense, that does not give us the power to move a disallowance motion. That creates a certain conflict for me. That is why I asked the question. It would seem to me that by making two different changes to regulations, bingo, a new minister could change that. I would be very concerned if this clause would make that possible.

Dr K.D. HAMES: This clause already makes it possible. This is the current act. There are no changes here. There is nothing new here that changes what currently exists. As chair, presumably the member has not had it come before him because as a government, I have not chosen to support that. That is the will of an elected government. Whether or not we agree with the concept—I certainly do not—we have to make provisions in an act for the will of the government of the day to make changes that it believes are appropriate. As I said, to have a heroin injection room, it is not a matter of the minister making a regulation. We would have to amend the Misuse of Drugs Act as well. We would have to bring something before Parliament for something so radical. It has been done elsewhere, as the member knows. Whether or not we agree with it, I am sure there are people who think it is appropriate. I think New South Wales has heroin injecting clinics. They have continued under successive governments. The fact that I do not agree with them does not mean that other members of both sides do not. There is a mechanism that allows governments to set them up if that is the will of the government.

Dr G.G. JACOBS: In answer to the previous question from the member for Southern River, the minister said that this could never happen because heroin is a different drug; it is a schedule 9 drug. I would ask the minister to define a drug of addiction. I suggest to him that it is not just one particular schedule. Can he give us the definition? I do not know whether there is a definition in the bill.

Dr K.D. Hames: It is on page 64.

Dr G.G. JACOBS: Page 64 states —

> ***drug of addiction*** means —
>
> (a) a Schedule 8 poison; or
>
> (b) a Schedule 4 reportable poison;

Presumably, in this bill heroin is not a drug of addiction.

Dr K.D. HAMES: No, in this bill, it is not; it is a schedule 9 drug. Quite clearly, it is a drug of addiction. In the Misuse of Drugs Act, it is a drug of addiction but the member is right; in this bill, it is not.

Dr G.G. JACOBS: Does the minister think that is a problem? It is a drug of addiction. If we went out in the street and asked people what drugs of addiction are, I am sure they would believe that heroin is a drug of addiction. To say that this does not cover it probably shows some deficiency.

Dr K.D. HAMES: We are just referring to this particular section and what this section does. In this section, the changes that we are talking about that come under subclause (1), where something can be changed by regulation, do not apply to heroin. We got onto heroin because the member raised the question of heroin injection rooms.

Dr G.G. Jacobs: I am free to do that, aren't I?

Dr K.D. HAMES: The member can raise the issue.

Dr G.G. Jacobs: That is a question that people would have, and I am quite at liberty to do that.

Dr K.D. HAMES: I am not saying there is anything wrong with the question. All I am saying is that a bit of confusion has arisen because we were discussing heroin when heroin does not relate to this section. This clause does not relate to heroin because it is not listed in this section. In this section we are only dealing with schedule 8 and schedule 4 reportable drugs. The regulations for which we can make provisions regarding the supply of addiction is not for all drugs of addiction; this clause relates only to the drugs of addiction that we are talking about in this clause, which are schedule 8 or schedule 4 reportable poisons.

Dr G.G. JACOBS: Indeed, clause 100(1) does not in any way relate to heroin or heroin trials. The reason it does not is that heroin is a schedule 9 drug and this does not apply to heroin.

Dr K.D. HAMES: That is correct. That is why I said that this clause would allow a minister to include heroin but first the Misuse of Drugs Act would have to be changed, which has heroin listed under schedule 9, to move it to schedule 8. The government could do that. If the government wanted to have heroin injection rooms, first it would need to bring to Parliament a change to move heroin from schedule 9 to schedule 8, with schedule 9 drugs being prohibited substances. If we are going to have an injection room, we cannot have a prohibited substance being used, so it would have to be changed from being a prohibited substance to a schedule 8 drug, which can be provided by prescription, and then the regulation could be changed. The good news is that if the member were a

member of the Parliament where that occurred, he would have the opportunity in the future to oppose moving heroin, or any other drug for that matter, as it is a prohibited substance, from schedule 9 to schedule 8 and then it could be dealt with under this clause.

Dr G.G. JACOBS: The minister can relax because I want to move onto another subject, which is the mechanics of the practitioner space and the regulation-making provisions for the supply of drugs of addiction such as in the methadone program or in fact the suboxone program. I want the minister to be aware that a lot of the difficulties practitioners have in and around this regulation is in getting people of addiction on a program, particularly in regional centres. A lot are prescribed these medications under regulation from a pharmacy. Recently, a constituent of mine rang me about her son who had come home to be with the family and wanted to go on a suboxone program. Essentially, all the other issues had been ticked, but in fact there is no place available in the program for her son. I have spoken to other practitioners in town about getting this young man into a program. He had come back to be with the family, in this case in Esperance, but there was no ability to put that man in the Next Step program because the pharmacy could not take another case. Practitioners are very cognisant of pushing the pharmacist to say, "You've got to take on this person." I believe that pharmacists voluntarily provide this service. It is not up to practitioners to tell them they have to take this person; it is not even up to Next Step. I want the minister to be aware of this. I did not know where else to mention it, but as I think this applies to prescription drugs for people of addiction in a program, this is probably a relevant time to tell the minister there are significant issues in trying to treat this cohort of people because of the limited number of spaces in these programs, particularly in regional centres.

Dr K.D. HAMES: The member is correct; one of the difficulties we have is that there might be within the metropolitan area pharmacists and doctors who are prepared to undertake either of those two programs. In the country, it is not so easy. One might find that the doctor is willing to do it but the pharmacist is not. That being the case, it is just not possible to undertake those programs. The Department of Health tries to work with country pharmacists and doctors to encourage people to participate, to make it easier for those in the country who want to go through either program. As the member for Eyre said, it is not easy, but he has raised it as a point to make sure that I know. I have to say that I was not so much aware, but people within the department certainly are. I understand the problem.

Dr G.G. JACOBS: Is there any financial recompense for pharmacists in doing this on behalf of these programs? Is there any financial incentive for them to do it? Do they do it out of the goodness of their heart? Every time we as practitioners ask a pharmacist whether they can take on Joe Blow, they say they are basically providing this service; they have their cohort and cannot take on anybody else. The doctors are flat out. Not all doctors want to work in this space, so sometimes there is a limited number of prescribing doctors. Are these people doing these programs out of the goodness of their heart and is there any ability for the state government to say, "Hang on; you're running this program. You don't live in Perth where you can go to Next Step; you want to live with family in your home town, and that is great, with all the social supports and whatever. How do we make this system work better?" Is it about providing some sort of financial recompense to make it worthwhile for the pharmacist to do it, or do they do it out of the goodness of their heart? That is what they keep telling us.

Dr K.D. HAMES: They largely provide the service out of the goodness of their heart. They get some funds, but not from the state. They charge the client $5 a day, because they normally have to get their medication daily. That amount covers the cost of their time in providing the drug. At present there are no plans for the state government to provide an incentive. I do not know what sort of financial incentive would need to be provided to get somebody to do that. I think it would need to be fairly large in comparison with the number of people who would be in a methadone program at any one time in Esperance—say if they were paid $100 a time. It is in comparison with the total income of the pharmacist. I do not know about the pharmacists the member for Eyre knows, but the pharmacists I know tend to earn quite a bit in a year. I think the amount of money they get through that on an annual basis would be pretty minuscule. Besides which, I think if I had whatever amount of money that worked out to in total, I would have a lot better things to spend it on in rural areas than to encourage pharmacists to provide methadone programs or the like. I think $5 is a pretty cheap price for patients getting the treatment. We have to rely on the goodwill of both doctors and pharmacists to continue this in the country.

Clause put and passed.

Clause 101: Practitioner to inform CEO of oversupplied status of client —

Mr P. ABETZ: Clause 101(1) states —

> An authorised health professional who reasonably believes that a client of the professional is an oversupplied person commits an offence if the practitioner does not make a report in accordance with subsection (2).

Subsection (2) refers to 48 hours. In a busy practice, that is a fairly short period. I am certainly not a doctor but I would imagine that sometimes a doctor would not be really sure and would mull it over and then come to that conclusion after a period. I wonder whether practitioners consider 48 hours a reasonable time frame.

I know some people working in the drug rehabilitation field are a little concerned that if the drug addict or drug-dependent person knows that by going to a doctor for help, such as at the Fresh Start clinic, the Fresh Start clinic needs to report that to the government and that might create difficulties for some addicts.

Dr K.D. HAMES: This division relates to oversupplied persons. This clause does not relate to clinics such as George's that do not deal with oversupplied persons. They deal with people who are addicted to certain drugs. This does not apply to them. It is currently 48 hours. Again, there is no change. We have received no complaints. No people have said that this is not an appropriate period. I would like to point out that this is one of those instances in which the fine was much larger. I propose to move an amendment, once we get to clause 132, to reduce that fine from $15 000 to $5 000. This does not relate to George.

Mr P. ABETZ: Further on that, my understanding is that George O'Neil's clinic deals with people who may have opiate addiction and maybe heroin addiction, but I would have thought there would be many who are addicted to prescription opiates and go doctor shopping to get them. OxyContin is apparently one of the most common drugs; in fact, George told me not so long ago that OxyContin addiction is overtaking heroin addiction in Perth, so he would certainly be treating some of those patients.

Dr K.D. HAMES: He may well be, but they do not go to George for their supply. This clause is about people who go back to a doctor over and again and the doctor clearly provides them with in excess of the normal requirements for that drug. That person may then go to George for treatment, but they would not go to him to continue their oversupply, because George would not provide them with the drug they are seeking; he would provide them with the opposite—naltrexone, which counteracts the drugs they have been oversupplied with.

Mr P. ABETZ: To clarify that, the way I read clause 101—perhaps I am not taking it in context; I am not quite sure—is that an authorised health professional —

Dr K.D. Hames: You have to start with the clause heading—"Practitioner to inform CEO of oversupplied status of client". So read on from that.

Mr P. ABETZ: A client is anyone who comes through the door. If George believed that the person was oversupplied, even though George had never written a script for that person, I would have thought that the GP at the Fresh Start clinic would have to make the report if they came to the conclusion that the person was oversupplied by other doctors.

Dr K.D. HAMES: There is a fair bit of flexibility for the doctor in working this out. A person might say to him, "I am addicted to such and such and I have been getting a lot of them." The doctor can treat them for being addicted, and that is what George would do. George would not go out of his way to find ways to get himself into trouble. He would say that the person is addicted to a drug and therefore he would treat them. He does not have to make the logical connection that, under this definition, the person is an oversupplied person who is running around getting drugs, form that view in his notes and therefore report them. George would not do that; he is not that silly. George would see that they are a person of addiction and, in his view, are addicted to a particular drug and he would therefore offer them treatment to address that. In that case, if anyone wanted to prosecute him—if they were silly enough—he would have an arguable excuse. He would have to have firmly formed the view in his head that they were an oversupplied person, not just someone addicted to a particular drug.

Mr P. ABETZ: But surely if George gave that person a naltrexone implant, the only basis on which he would give that naltrexone implant is that he would have come to the conclusion that the client was telling the truth that he was an oversupplied person because he had been doctor shopping and getting the oxycodone from umpteen doctors.

Dr K.D. HAMES: That is the drug–dependent person argument, not the oversupplied-person argument.

Dr G.G. JACOBS: What criteria does an authorised health professional, whom I call a doctor, use to come to the decision that someone is oversupplied? I will get off the George scenario, if the minister is listening.

Dr K.D. Hames: It was just a reaction to you saying that it must be a doctor. No, it must not be a doctor; it must be a doctor or a pharmacist.

Dr G.G. JACOBS: I will stick with the doctor scenario. If someone goes to a GP clinic, how would the doctor gain that information about the person being potentially oversupplied?

Dr K.D. HAMES: The information I have been given relates to the example I gave before about the patient of mine from Kalgoorlie. I think the member was here when I talked about him. He had been coming to see me for

a long period. He was a car salesman in Kalgoorlie. He came up with a wonderful story of developing migraines whenever he drove a car to Perth. He was such a nice guy. He would come to see me and I would normally give him an injection of pethidine for his severe migraine. He would come to me only three times a year at the most. One day I happened to be in the chemist and I saw a prescription with his name on it from a nearby doctor for something else, not for a drug of addiction; I think it was for a blood pressure tablet. I wondered why he was seeing another doctor. I rang the other doctor at the Bayswater clinic. He told the other doctor exactly the same story. The doctor said, "He's a lovely guy. He comes down from Kalgoorlie and I see him only about three times a year. I give him a shot of pethidine." I rang around and found that he was seeing five or six different doctors and telling them exactly the same story. I suspect that he would have done the same in Kalgoorlie and told the doctor that he had just got back from Perth and he had a migraine. He probably saw three or four doctors in Kalgoorlie as well. When I fronted him about it, he was very glad that I had caught him. I certainly formed the view, largely from his own testimony, that he was an oversupplied person. But, alternatively, the doctor might be provided with information from the department. That does not quite relate to this clause, because the doctor is not reporting them to the department; the doctor is finding out, but they certainly know from that source. Someone may confess to the doctor that they had been going to lots of different chemists or doctors and getting the same stuff. Clearly, in my case, it was evidence that led to the patient confessing to me.

Dr G.G. JACOBS: Aside from some fortuitous accident whereby the doctor discovers this, such as the person confessing, if a patient came to see me and told me a story such as the minister's patient, who needed an injection because he got migraines, what checks and balances would I have as a practitioner to make some sort of decision about whether they were oversupplied? I will go into this further as we go along this evening because there are major deficiencies in the practitioner's ability to access information and data if patients have been shopping downtown and spinning the practitioner the greatest story. What tools does the practitioner have to safeguard against the issue of oversupply?

Dr K.D. HAMES: This particular clause does not have a lot of application and there will not be a lot of need for its use for exactly the reasons that the member has mentioned. There is not a lot of information to get. It is much more likely to be the department that collects stuff from other doctors and then tells the doctor that the patient is an oversupplied person. This clause would be seldom used by a doctor, unless the doctor formed that view through whatever circumstances they use to deal with the patient. The doctor does not have to form the view that they are an oversupplied person based on their prescription record. It would be only if the doctor happened to find, as I did, that the person was clearly an oversupplied person. If I did not report them as being an oversupplied person, I would be acting contrary to this clause. The circumstances in which that occurred, as the member would know from his own experience, do not come along very often for exactly the reasons that the member has said.

Dr G.G. JACOBS: What the minister is in fact saying is that it really covers only the bad apples—the doctor who would be complicit in this. Basically, my defence could be that I did not know that this person was oversupplied, he shopped around and I did not have any data in front of me. We have no real-time data today. I can try to get data on this patient but there is always a three-month window, data is not current and it does not tell me whether this person has been doctor shopping. I could inadvertently fall for the story and write out the script and I would not know. My defence is that I have no system by which to gauge whether this person is oversupplied and, therefore, I would have a defence. The only reason that this clause is in the bill is that perhaps there may be doctors who are complicit with the patient in this oversupplied area or are actually people who oversupply themselves.

Dr K.D. HAMES: That is not true. I go back to the fact that this is not a clause just for doctors. This clause is also for pharmacists. If a pharmacist gets a doctor's prescription for the drug and then gets one from three other general practitioners in the same town, that pharmacist should quite quickly form the view that this is an oversupplied person. We know what quantities of drugs are normally prescribed. The member would prescribe whatever the appropriate quantity was for that patient and if they came in with four prescriptions on the same day, the pharmacist should quite reasonably form the view that that person was an oversupplied person. That pharmacist then has the responsibility of reporting this to the Department of Health, which is good, because the member cannot be charged because he has written just one prescription. The Department of Health then lets the member know that he has been prescribing drugs to an overprescribed person.

Clause put and passed.

Clause 101 put and passed.

Clause 102: CEO may include oversupplied person on drugs of addiction record —

Mr P. ABETZ: I refer to clause 102(3)(a) under which, before the CEO makes a decision under subsection (1) to include the name of a person on the drugs of addiction record, he must inform the person of his belief and the

grounds on which it is based. Is there scope within that provision, when a person has informed a doctor or pharmacist that they are an oversupplied person, for that information to not be mailed to the oversupplied person's home address for family reasons? Could the information be sent to the person's authorised health professional to pass on to their client rather than be mailed to the family address?

Dr K.D. HAMES: We have discussed this before. What the chief executive officer sends to the person is not a letter that says we think they are an oversupplied person or using a drug of addiction; what is sent is a request to contact the Department of Health. It could be for anything; it could be for a Pap smear result. There is no way of knowing from that letter the reason to contact the Department of Health, but once contacted, the department will deal with that person.

Dr G.G. JACOBS: Could the minister tell us about including an oversupplied person on a record, and is that record available to authorised health professionals in their everyday prescribing of medication?

Dr K.D. HAMES: That is covered in the next clause, so perhaps we could deal with that then.

Clause put and passed.

Clause 103: Recording and notification of oversupplied status —

Dr G.G. JACOBS: Clause 103 is "Recording and notification of oversupplied status". Can the minister tell us about the record? Is it a computerised record? Is this record of oversupplied people available for future and potential practitioners? Does this type of record provide assistance for future prescribing to potentially oversupplied people by practitioners?

Dr K.D. HAMES: I have been provided with the following information and I will read out components of it.

Mr P. Abetz: It means the minister does not understand it.

Dr K.D. HAMES: Well there is one section. I have a great deal of time for lawyers, as I am sure the member knows, but there is a minor English grammar problem with the sentence. I quote —

> Notification of other prescribers or dispensers
>
> - Enables the Department to inform doctors of a person's 'oversupplied' status through a secure real time database.

I think this answers a component of the member's question —

> - Enables the Department to inform doctors who have prescribed for the patient and pharmacists who have already dispensed to the patient that the patient has been determined to be 'oversupplied'.

Dr G.G. JACOBS: I need clarification of that. If, for example, my colleagues want me to do some work in my general practice—where I normally never turn up—and I have a patient come in front of me, what are the mechanics of me being able to get a real-time record of the oversupplied status of this potential patient? How do we do that?

Dr K.D. HAMES: This clause relates to the capability through legislation to develop that real-time database in the future. It is not available yet, but it is anticipated that at some stage in the future it will be available. For now, the member will have to ring the Department of Health to get the information. This clause has been put into the bill to create the capacity for future changes that should not be too long in coming, from our point of view, rather than the likelihood of developing the database. That is something that I think is critically important and this clause creates the ability to do that.

Dr G.G. JACOBS: Just for an understanding—I think this is worth talking about—what do we have to do as government in regard to software, hardware, technology and moneys? How do we get this system operating to make it real-time software that is useful for practitioners in the field so that they do not have to ring up the Department of Health or go through some paper record? I understand the privacy arrangements and the privacy act, but these are oversupplied people or potentially oversupplied people who have been considered eligible by the CEO to go on a record. It is therefore really important that we work through and put a bit of flesh on how we are going to make it work for practitioners with potentially oversupplied people in front of them, without making it too onerous. It is onerous enough to ring up the Health Insurance Commission and get someone who does not live anywhere nearby—probably on the eastern coast—and tell them why a patient should be on a special authority drug. We do not need any more of that, but what we need is an ability to find out the status of patients. I would like the minister to walk us through some of the technology and how this will be delivered. I know this bill enables it, but let us talk about how it will work.

Dr K.D. HAMES: From that extensive question I can extract two comments. The first is that we are working on it, and the second is that it is currently in Tasmania. The commonwealth has apparently developed the capacity to do that. It requires software, of course, and investment by government, and we are working on it.

Dr G.G. JACOBS: I have been in politics long enough to know that that is just a fob off. I feel like the opposition. What is the opposition doing on this bill?

Mrs M.H. Roberts: I am waiting for clause 106. You've spent about an hour talking about two or three clauses so far.

Dr G.G. JACOBS: Yes, but it has not been completely irrelevant, though, has it —

Mrs M.H. Roberts: It's been close to it. It's been fairly irrelevant to the clauses that have been discussed, and the minister has actually told you that.

Dr G.G. JACOBS: — because we actually know more about it than the member does.

The ACTING SPEAKER (Mr I.C. Blayney): Member for Eyre, come to your point.

Dr G.G. JACOBS: When it comes into this space, I know quite a bit about it. Basically, we need to have a bit of a time line.

Dr K.D. HAMES: I am advised that within the next two years we hope to have such a system up and running. That is not an unreasonable time frame from where we are at now, but it is not so far into the future that it is not something we are working on now and planning. So, I think two years is a good option.

Clause put and passed.

Clauses 104 and 105 put and passed.

Clause 106: Purposes for which drugs of addiction record is kept —

Mrs M.H. ROBERTS: I refer to clause 106(e), which reads —

> (e) to carry out any of the CEO's functions under this Act or any other written law.

Can the minister advise me what CEO functions he envisages will be applied under this clause? What CEO functions is this for?

Dr K.D. HAMES: I am advised that this applies to the chief executive officer, who in this case is the director general of the Department of Health, in planning, for example, the provision of services in public hospitals—that is, working out what services he needs in, say, Fiona Stanley Hospital. He is able to look at the records of patients who have drugs of addiction and use that information in the provision of the service that he might want at that hospital in terms of what is available to manage those patients with drugs of addiction. It just gives him the capacity to carry out whatever his responsibilities are as a CEO when that list may affect that. The opportunities would be pretty slim, as the member can imagine. It may be, for example, putting in place the computer systems that we have just talked about and ascertaining, when they decide whether that software needs to be ready in two years, whether 100, 500 or 1 000 people are addicted. He might need that information to know the importance of putting in a system such as that.

Dr G.G. JACOBS: Is this a significant change from the old act? What record is kept and what ability is there to plan, monitor and evaluate services for the control of the supply or prescription of drugs in Western Australia today? How is that done today with the record that we have today, if at all?

Dr K.D. HAMES: I understand that these things are already done, but it is not in the current legislation. It is a new clause, but it sets out clearly that these are the things that may be done with the records. As the member knows, the records are kept by the health department, and the member and I access them in the way we normally do. This clause sets in legislation the things that are done at present, but it is not clear that those things are all permitted.

Mrs M.H. ROBERTS: I have just been contemplating the answer that the minister gave me. He was basically implying that clause 106(e) would enable the CEO to look at the addiction records for a particular purpose, but that is not the way it is written. This is not legal-speak; it is just plain English–speak. It states —

> The drugs of addiction record is to be kept for the following purposes —

So, it is to be kept for the purpose of the CEO carrying out any of their functions. It seems to be not just the capacity for the CEO to look at a record in order to make a decision about running the health department, but the records can be kept for the purpose of the CEO undertaking their functions. It is those functions that I was inquiring about originally. It just seems to me to be a very open clause.

Dr K.D. HAMES: I am being told that this clause relates only to this bill, so it is not all of the CEO's functions; it is only his functions as they relate to his responsibility under this bill—that is, the management of drugs of

addiction. Of course, it is not just paragraph (e); it is paragraphs (a), (b), (c) and (d) also. The records are kept for all those purposes. That is just one purpose in five.

Dr G.G. JACOBS: I think I am joining the member for Midland in her argument.

Dr K.D. Hames: No, I think she has accepted my argument.

Dr G.G. JACOBS: In 25 years of practice, if we have a record that is kept, I certainly have not heard about planning, monitoring and evaluating, and publishing general or statistical information relating to drugs of addiction. The minister may say that we have, but can he say that that stuff is done today, or is this something that will be done, because the evidence for it is pretty thin in the past?

Dr K.D. HAMES: I understand that at present the CEO is provided with a de-identified annual report on this information—that is, the number of patients and the like. That report is provided now without names, but with statistics that help him manage that component of his responsibility.

Dr G.G. JACOBS: The clause refers to compiling and publishing this information.

Dr K.D. HAMES: Yes, de-identified total number of patients on the register.

Dr G.G. JACOBS: Can I ask you, Madam Acting Speaker: How does the practitioner access that information? Is it sent to them or do they have to ask for it somehow? Is it in the Drug and Alcohol Office information? Is it in the newsletter of Drug and Alcohol Office?

Dr K.D. Hames: How would she know?

Dr G.G. JACOBS: I am asking you.

Dr K.D. HAMES: The member said he was asking the Acting Speaker!

That information is not available for a doctor to find out; that is for the CEO. This clause relates to that information. A doctor can find out about an individual patient who comes to see them once their identity is confirmed, but a doctor is unable to get that detail that the CEO is able to access.

Dr G.G. JACOBS: I must be thick! It states that the purposes for which the drug of addiction record is —

Mrs M.H. Roberts: You may well say that, but we cannot possibly say that. It is a famous line.

Dr G.G. JACOBS: Ha-ha! It states —

> **106. Purposes for which drugs of addiction record is kept**
>
> …
>
> (b) to compile and publish general or statistical information relating to drugs of addiction;

Does “publish” not mean it is available to the general public?

Dr K.D. HAMES: Mr Madam Acting Madam Chair —

The ACTING SPEAKER (Ms J.M. Freeman): Just Acting Speaker is fine.

Dr K.D. HAMES: Madam?

The ACTING SPEAKER: Acting Speaker is fine. Madam Adam.

Dr K.D. HAMES: A bit old-fashioned, is it not? Acting Speaker Ma’am.

The ACTING SPEAKER: Minister.

Dr K.D. HAMES: I have to try again, sorry! Some of the information is published now, but not all of it. Some of it is published in an annual report. That is clause 106(b). The member is compiling these together, but they are separate individual clauses that relate solely to themselves. They are not cumulative; they are singular. The word “and” should be inserted at the end of each subclause under clause 106. This allows the collection of those records and the publication of the number of persons with addiction. This clause is in the bill to allow the CEO to get access to other information if he needs it, but we do not know at this stage what information that may be.

Mr P. ABETZ: Is that information published by the Drug and Alcohol Office in its annual report and those sorts of sources? The member for Eyre is asking: where can the public find this information that is compiled and published on the basis of these records being kept? It is my understanding that it is the DAO, but I could be wrong.

Dr K.D. HAMES: This is not the stuff that the Drug and Alcohol Office has. DAO does not have access to all this stuff. This is all the information on the use of schedule 8 drugs. Only the Department of Health has all that information.

Dr G.G. JACOBS: The record is compiled and, as the clause states, general or statistical information relating to drugs of addiction is published. Where does a practitioner find information on where we are going in Western Australia; how many people are addicted; to what sort of medications they are addicted; and some general statistical information relating to drugs of addiction? That information is published and must be accessed from somewhere.

Dr K.D. HAMES: You can get it from the annual report on the stimulant program, which is on the Department of Health website.

Clause put and passed.

Clause 107: Amending information in drugs of addiction record —

Dr G.G. JACOBS: Presumably a person who has been deemed an oversupplied person and is included on the record may at any time apply to the CEO for an amendment. How does Joe Blow, who is on the record as an oversupplied person, go about contacting the CEO to amend this information? Tell us about how that process works and how that person has that conversation with the CEO.

Dr K.D. HAMES: This is a new process, so we are just working our way through it. First, they would contact the health department. They would be put through to the department because that is where the record is kept. They would be directed to the people who contacted them in the first place. They would contact us and say that they should not be on the record and they want to get off. Second, they would have to provide 100 points of identification to prove that they are who they say they are, and it is not someone else trying to do it. Then they would be talked through the process. They would be provided with an application form. They would be told the criteria, which are that the record may be amended if there is an error or an omission, the information is not accurate or not up to date, or the information is misleading. The department would go through the reasons the person is on the register.

Dr G.G. JACOBS: Presumably the minister has this form or he will be drawing up this form.

Dr K.D. HAMES: Not yet, but we will have it.

Dr G.G. JACOBS: The CEO might agree with the argument that a person's entry on the record needs to be either modified or removed, but what recourse does the person have if they get a negative ruling?

Dr K.D. HAMES: There is an opportunity for them to argue their case before the State Administrative Tribunal. That is their only alternative. If they cannot get the chief executive officer to agree with their submission, they can apply for SAT to do an assessment and make a decision.

Dr G.G. JACOBS: Does the person building a case for an amendment to or removal from the record require a reference? Does the treating doctor add to the person's case by saying, "I know this person; he or she has reformed." Is a referral or reference process part of establishing that the patient or the potentially oversupplied person has reformed?

Dr K.D. HAMES: As I said, this process is still being worked through, but our brief discussion indicates that the patient would need to be given every opportunity to provide evidence that they were not addicted. I think it would be most beneficial to them to have something from their doctor saying that the doctor believes they are not addicted. They could also of course get evidence from other sources, but clearly that evidence would be less reliable. The patient should be given every opportunity to provide whatever information they can get to back up their case.

Clause put and passed.

Clause 108: CEO may authorise disclosure of information —

Dr G.G. JACOBS: Subclause (3) reads —

> The CEO must, on payment of the fee prescribed by the regulations (if any), provide a copy, or a certified copy, of the information

What is the payment or the fee?

Dr K.D. HAMES: That amount has not been determined yet, but it will be a processing fee based on the cost of doing it, which is anticipated to be in the order of $50 perhaps.

Clause put and passed.

Clauses 109 to 125 put and passed.

Clause 126: Warrant to enter place —

Mrs M.H. ROBERTS: I have had a look at this clause and I realise I can answer my own question.

Clause put and passed.

Clauses 127 to 131 put and passed.

Clause 132: General penalties —

Dr K.D. HAMES: I will move an amendment standing on the notice paper in my name. This relates to the penalty. I have reached agreement with the shadow minister and others about the extent of the fee, which was intended to be $15 000. We have agreed that $5 000 would be a more reasonable amount. I therefore move —

Page 85, in the Table at line 8 — To delete —

"s. 97(1)" and "s. 101(1)".

Amendment put and passed.

Dr K.D. HAMES: I move **—**

Page 86, before line 1 — To insert the following new Table —

(4) The penalty for an offence under a provision listed in the Table is $5 000.

Table

s. 97(1)	s. 101(1)

Amendment put and passed.

Clause, as amended, put and passed.

Clauses 133 to 137 put and passed.

Clause 138: Liability of employer for acts of employee —

Mr P. ABETZ: Just for clarification, subclauses (3) and (5) seem at first reading a little contradictory. I just want some clarity on that. I am referring to the liability of the employer for the acts of an employee. My daughter is a pharmacist who employs some people. On one hand, subclause (3) states —

> If an employee … is alleged to have committed an offence under this Act as an employee, the employer may be charged with the offence —
>
> (a) whether or not the employee is charged with the offence; and
>
> (b) whether or not the employee acted without the employer's authority or contrary to the employer's orders or instructions.

That just seems grossly unfair to me. If my daughter gives clear instructions to trained staff and they choose to disobey, I do not believe she should be charged, yet subclause (5)(b) states —

> … it is a defence … that
>
> (b) the employer took all the measures to prevent the commission of the offence that the employer could reasonably be expected to have taken having regard to all the circumstances.

To me that seems contradictory. Could the minister please clarify that for us?

Dr K.D. HAMES: It is not contradictory. The subclauses are very much synchronised. If the member's daughter has staff and does not give a rats—I am sorry; does not care less—whether or not they do the wrong thing without the employer's authority, or the employer might even say, "Don't you do that", then walks away, never checks and does not care whether they do these things or just lets them go off and do stuff, that is still an offence. But the defence in subclause (5) is that if the pharmacist can clearly show that they have been diligent in their job as a pharmacist to make sure that their staff have done the right thing, and the staff then still act against their instructions, that is their defence and they are no longer liable. It just refers to a pharmacist who does not spend enough time in the pharmacy, lets their staff do those things and tries to protect themselves by saying, "He won't do this", but lets him go ahead and do it without any care.

Mr P. Abetz: Thank you.

Clause put and passed.

Clauses 139 to 209 put and passed.

Title put and passed.