MEDICINES, POISONS AND THERAPEUTIC GOODS BILL 2013

Second Reading

Resumed from an earlier stage of the sitting.

DR K.D. HAMES (Dawesville — Minister for Health) [2.50 pm] — in reply: Mr Speaker, in continuing my remarks I thank you for your indulgence because just before question time I should have waited for you to stand up and tell me to sit down, rather than just sitting, which suggested my remarks had been completed. I think Mr Speaker has to say that business is interrupted, but we did not quite get to that point. Nevertheless, I will continue my remarks. To those who are busy having lots of conversations —

Point of Order

Mr R.H. COOK: The minister is discussing some very important matters, so while I am on my feet raising this point of order some people might excuse themselves from the chamber and not carry on their conversations.

The SPEAKER: Good idea; thank you. Members, if you wish to leave, do so now!

Debate Resumed

Dr K.D. HAMES: Thank you, member, for that bit of assistance.

I will refer to some of the specific issues raised by members and provide the responses from the department and the drafters of the legislation. These points were raised during the second reading debate, largely by the opposition but also this side. The first question was whether the oversupply regime is a current practice or a new practice. The response is that the oversupplied person is a new concept. Instead of specifying only the four drugs of addiction in schedule 8, we are adding a series of other medications, such as anabolic steroids, diazepam, temazepam and Stilnox—just to provide some examples of those medications that are frequently overused and misused. In fact, some members may recall some of our swimmers having a particular liking for Stilnox! The oversupplied person is a new concept that has been included to ensure that prescribers can be made aware of doctor shoppers; that is, persons who attend at multiple practices to obtain those medications. They are not necessarily drug-dependent persons, as some might be obtaining those drugs to sell. That is done fairly regularly with barbiturates. I am aware that people get hold of valium and diazepam to sell to people who are heroin addicts because if they cannot get heroin, they need something to help see them through those difficult periods until they get the next injection of heroin. Doctors are very reluctant to prescribe these medications. Diazepam, of course, is used as a sleeping tablet, but is very easily abused and misused and is a drug that people can become dependent on, if not addicted to. That phrase could be read in two ways. I mean that even if they are not addicted to them they could be dependent on them.

Mr R.H. Cook: Is it also true that all the CEO can do with the information is add that person's name to the register of drug-dependent persons? From that point of view I wonder whether the minister would comment on whether consideration was given to a completely different register. Why consolidate all these on the same register?

Dr K.D. HAMES: That would be better asked in consideration in detail when I can get advice. For now I will work through the answers to these questions. The second question was how the oversupply system would work in practice. It has been managed up to date and an oversupplied person can be identified in several ways: a medical practitioner may notify the department that a person is doctor shopping; a pharmacist may notify the department they have reason to believe the person is oversupplied based on dispensing records; and the department may determine that from prescriptions coming through, and it can obviously do further checks. The bill requires that a person must be informed when their name has been placed on the register. The person must be informed of the consequences, which is that a prescriber must be authorised to prescribe any more schedule 8 drugs. I made a point by interjection when the member for Collie–Preston said that it will stop a doctor being able to manage a patient and to give drugs. The point is that the doctor can still give those drugs should they believe they are necessary for the treatment. As is currently the case, a doctor or nurse can still administer doses if medically necessary. That is the choice of the doctor treating a patient.

A couple of things happen out there in general practice and not all of them are as we would like. Firstly, not all doctors are squeaky clean. There are doctors who run practices who do not notify that their patients are addicts. They get a collection of patients who are addicts coming to their practice and they build a thriving practice based on giving people whatever they want. I have talked to patients about this and they tell me they know doctors, who are not necessarily good doctors in my view, who do not necessarily make any effort to look after the problem of their patient, which is their addiction, and they just write whatever prescription the patient wants whenever they want it. The patient will come in and if they want valium, the doctor says, "Fine; how many do you want? Is 50 enough? Do you want 100?" There are those sorts of practices. They say, "You've got a bit of

back pain, let me give you some pethidine." Currently, there are 12 doctors who are not allowed to prescribe schedule 8 drugs because they have been caught in that sort of practice. Then there are doctors who are addicts themselves. The medical profession is no different from any other profession in the potential to develop addicts. Indeed, I worked in a practice in which a practitioner was a regular user of anabolic steroids. Members can see I did not use them! I worked in his office on occasion and he had drawers full of the stuff. I did not know at the time, but found out later, that he was a regular user and was on a restricted practice because he had been caught using them. He would have a regular stream of muscle-bound men coming into his office, and occasionally I got to see a note that he was giving regular injections of anabolic steroids to those people. He would write a script for a patient. From memory, there were about five phials in the one prescription. He would get the five phials for the patient and use one or two of them himself, with the agreement and understanding of the patient. They were almost in collaboration to get regular supplies of anabolic steroids. We need to be aware of this, and when a doctor refuses to put the name of a patient on the register, we have to wonder why, because that is not in the best interests of the patient.

The member for Collie–Preston was not in the chamber when I talked about this previously, but he was worried about what happened to those registers. No-one in Collie or any other town would see that register. I do not know whether the member knows that in 1980 I almost became a doctor in Collie. I nearly moved there; the only problem was I could not find a house. If I was the doctor in Collie and someone came to me from that town and wanted a drug of addiction, I would be the only person who would know. People have all sorts of stories. The member for Eyre talked about all the stories people tell doctors; we hear so many stories. People are so clever with the stories they come in with. There are the standard things: someone has come from the east and has forgotten their prescription; the dog ate it; it blew out the window—people give all sorts of reasons. Some people bring their X-rays with them and they have a large disc prolapse; they say clear things and some are so believable. Normally, they are not regular patients; they come on a Saturday or Sunday because they know it is hard to get hold of people; doctors are busy and it is difficult to ring the register. They came in at those difficult times with an absolutely convincing story and if the doctor rang the register, the patient would not be on it because they had just come over from the east. Sometimes they say that they are under the care of a particular specialist. I would ring that specialist if I could get hold of him, but if a patient comes on a Sunday, I cannot get hold of the specialist. I ask the specialist whether they are really treating that particular patient and whether they are giving the patient such and such a drug, but the process can be very difficult. Going back to the example of me being the doctor in Collie, the only person who would know about a patient being on the register is me. My secretary would not know, nor would my other staff. They are not allowed to read my personal notes about patients, so the only people who would know are me and the health department, which has the list. People in the health department do not know anyone in Collie so they will not —

Mr M.P. Murray: What about the bit about the CEO in the legislation? I picked a fault in the legislation about the CEOs having the list and being able to release that information. Is it only one CEO or is it CEOs?

Dr K.D. HAMES: That information about schedule 8 drugs can be released to only two people. The first is a registered medical practitioner who rings the register. The doctor must give clear identification so that the register knows it is dealing with a registered medical practitioner. Then information can be released stating simply yes, that patient is on the list or no, that patient is not on the list.

Mr R.H. Cook: Minister, that is not true. The CEO, having been informed by Dr A in Collie that they believe someone is a drug-dependent person, has the right to then inform other doctors—Dr B and Dr C—of that. We can discuss it further in consideration in detail.

Dr K.D. HAMES: I am not sure that that is the case, but it would make sense; however, it is still only doctors who are in the know, and we have laws around confidentiality and patient issues. No receptionist, secretary or anyone else will know anything about that patient. The way patients get caught out sometimes is by going to a chemist repeatedly to get prescriptions filled. If they have any sense, they will not. They will nick off to Bunbury or Harvey or wherever else so that people do not know what they are doing. However, it is in the best interests of that patient to have the doctor know that they are addicted to drugs. Again, we talked about what a doctor has to do if he knows a patient is an addict. I knew lots of my patients were addicted to things. I remember one patient in particular who was addicted to heroin and we used to have regular discussions about her addiction, but I did not tell police or anyone else. There is no requirement for me to inform anyone about that, and, frankly, if there was, I would not do it. I would cop any fines, because dealing with her heroin addiction is not something that I think I need to report to police.

Mr R.H. Cook: The legislation specifically states that if you are aware that she has an addiction to a schedule 9 drug, you have to report it.

Dr K.D. HAMES: I have to report it?

Mr R.H. Cook: Again, we can discuss it in consideration in detail. I would defend your right to treat her addiction, but the bill, according to our reading, does not provide that right.

Dr K.D. HAMES: It depends whom the doctor needs to report to. I was talking about reporting to police; I would have no problem with reporting her to the health department, but I would not report her to the police. Again, it is a matter of dealing with the issue of the patient. I am not saying that I would not tell the health department she was addicted to other stuff—this particular patient was a registered addict—but I would not tell the police in order to deal with that issue. It is no good for the member to give me a page of stuff! In fact, that is schedule 8, so I will get there. This is a case of doing things from knowledge, and then finding that legislation is not quite as I thought it was! We will work our way through those issues during the consideration in detail stage.

A question was raised about George O'Neil and the reporting of his patients. Remember, he is not giving his patients drugs of addiction. In fact, he is giving them naltrexone, which is the opposite. He is giving them as an implant a substance that neutralises the effect of drugs and he therefore does not need to report his patients.

Mr R.H. Cook: Yes, he does.

Dr K.D. HAMES: I guess under the provisions of schedule 9 drugs, if they are heroin addicts, they could be on the register. I have mainly been thinking about schedule 8 and schedule 4 drugs, rather than schedule 9 drugs. Maybe he does have to report them. Who knows? That is his issue. Whatever the case is, this legislation does not change it.

Mr R.H. Cook: It does, in main part because of the size of the fine.

Dr K.D. HAMES: Only within the 48 hours —

Mr R.H. Cook: He then has to run the risk of a very large fine. You may argue that $5 000 means that he will just run the gauntlet because he is saving souls, but the fact of the matter is that it is still there.

Dr K.D. HAMES: I think the issue was that if he was not reporting them, and he was going to get pinged for it, the fine would not be the issue, but the concept of it would be. He would have been doing the same thing for years and years, so whatever he is doing is what he is doing and if someone wants to ping him, that is their business.

Where are we up to? How does a person remove their name from the register? I talked about that before and gave that answer by interjection. An application can be made to the CEO and the register can be amended if the information is not accurate or there is an error—a whole range of things can be said—and if the patient can prove it, they can have their names removed from the register.

Mr M.P. Murray: Just on that, would that patient then have to take it through the court system?

Dr K.D. HAMES: No, the name can be removed without going through the court system. The patient can appeal to the State Administrative Tribunal if they do not agree. This raises another thing I talked about when the member for Collie–Preston was not in the chamber. A person addicted to drugs for a period of time can easily start again. I do not know whether the member has ever been a smoker, but I was, and this also applies to alcoholics, which is probably the best example. People who have been alcoholics and who have been off alcohol for 10 years need to pick up only one drink and off they go again. I have seen the same with cigarette smoking over and again. People can stop smoking for ages, then have a stressful event and pull one cigarette out of the packet, and then go back to smoking a packet a day before they know it. People who have been addicted to drugs previously have the potential to be addicted again in the future. Someone who is on the register and who has not used drugs for a considerable time can come to me 10 years down the track and ask me for morphine or pethidine, for example. Their name will still be on the register. We can ask whether they should be off the register, but if that person does not ask me for morphine, I do not have to ring up to see whether their name is on the drug register. Why would I? They are coming to me because of their cough, their cold, their backache or whatever it is. However, if they asked for morphine, that would trigger the response from the doctor. If someone asked me for morphine, I would ring up and check the drug register and I would be told that that person was on the register, but that there had been no recent calls, because a record of calls made is kept. I would call in, and my call would be registered as my saying, "Is this person an addict?" and being told, "Yes. There have been no calls for 10 years, but, yes, this is a registered addict." It is absolutely critical that I know that, because I can talk to that patient and say, "Look, I have it on my register that you're a registered addict, but apparently you haven't had drugs for 10 years. Why do you need them now?" Then I can deal with whatever they came to me for. The last thing I want is to not know and give that person the morphine, and the next thing they are back on it again. It is absolutely critical that the doctor knows. So, it is not in the best interests of patients to have their name off the register, unless they were not an addict in the first place. Again, I go back to it. A person may go to see their doctor for their backache. No-one will ever look to see whether they are an addict. It is only if the person asks for drugs of addiction that the doctor will ever look it up.

There were a couple of other issues, such as how well the register is working. The current record of persons with drug-dependency issues is a useful tool for advising doctors and ensuring patients receive the most appropriate treatment. I have already said that. Information on the register is utilised on a daily basis. As a general practitioner, I would not do it very often—maybe between 10 and 20 times a year. I regard that as not often. That is how many times I would need to ring. I can tell members that word spreads very fast. A person may have come to me with a story, and for whatever reason I did not ring or I was not able to ring. That person convinced me that they were not an addict and I gave them the drug that I was convinced they needed. Suddenly, the week after, about 10 people would come to see me, because they would say, "That doctor is an easy touch." That is how it goes. The doctor is flooded with people coming to his practice from all over the metropolitan area because of one time he has done that when he thought he was doing the right thing, but then he thinks, "Obviously, I've stuffed that one up."

Mr M.P. Murray: Minister, probably the opposite side of that is what concerns me—I do not want to harp on it—and that is the issue of people not going to the doctor because they may be put on the register. I mean health-wise.

Dr K.D. HAMES: Why would a person do that? A person may already be using illegal drugs such as heroin or whatever the drug may be. As a rule, why would they go to the doctor? Sometimes they might do it to find a substitute drug, but the substitute does not fix their addiction; it just continues it. They might go to the doctor to try to get off the drug, but a doctor does not give someone drugs of addiction to get them off them unless it is under the methadone program. So the doctor might use valium or one of those drugs to help someone get off the drug. But it is more a whole range of other things such as counsellors and people like George O'Neil who help people get off drugs. The person may go to the doctor. If that person goes to that doctor three or four times in a row to get that same drug, the doctor may well say, "Look, you're addicted. I need to put you on the register." What are the consequences of that for that person? There are not any. The only consequence is if that person goes shopping around to other doctors to get the drug, instead of staying with the same doctor, they will know the person is a drug addict and deal with it accordingly. They will think, "Well, if that person knows that, they will not go to get the drug; they will go back on heroin instead." I find very few cases in which those people are still on heroin. They use morphine or whatever else it is as just a bridging gap. They run out of money, and they cannot get enough to go and get some more, so they will get a tablet or a jab or whatever to see them through until they get enough money for their next dose. I see that over and again. I remember the member saying, "Will that register stop it?" Again, I made the point that I made when the member was not here at the start. This is not a new thing. It is the case now; it is the current legislation. We went through the regulations in the 1980s. The issue about drugs of addiction has been in the bill since it was first introduced. The register has been there for a long time. It is there now. If people that members know went to someone 10 years ago, they will be on the register.

Mr R.H. Cook: We questioned the integrity of the register.

Dr K.D. HAMES: If the Deputy Leader of the Opposition thinks he can get the name of someone who is on that register, he should go ahead. I challenge him to try to get the name of a single person on that current register. I would bet any money he likes that he would not be able to get it.

Mr R.H. Cook: I do know people who are on that register.

Dr K.D. HAMES: Did they confess to the Deputy Leader of the Opposition? The Deputy Leader of the Opposition can find out if they confess to him.

Mr R.H. Cook: Over 14 000 are on that register. Only 70 people have managed to remove their names from it.

Dr K.D. HAMES: Sure.

Mr R.H. Cook: That does not really suggest that the system is working all that well.

Dr K.D. HAMES: I do not see where there is a downside to that. I do not see what is wrong with only 70 people removing their names. As I said, I do not want people —

Mr R.H. Cook: I know. Your contention is that you are happy for people to stay on there for time immemorial.

Dr K.D. HAMES: I am happy for them to stay on it forever. There is no stigma —

Mr R.H. Cook: That is not what the current legislation or the legislation before us envisages, yet that seems to be the case.

Dr K.D. HAMES: It seems to be the practical outcome of it, but, as I have said before, a person can get removed from the register if they want to. A lot of people just do not bother. If a person is not an addict anymore, if it is a confidential list, and if a person has to go through a process of trying to convince a department that they are not

using anymore, what is the benefit to them of doing that? If no-one is ever going to see it, there is no downside to a person's name being on the list.

Mr R.H. Cook: A person may not be wild about the idea of every doctor they go to seeing their name on it.

Dr K.D. HAMES: I do not know that a person would bother. If I had been an addict who smoked and my name was on a registered smoking addict list, why would I bother getting it taken off? I do not smoke now; I know I do not smoke. What does it matter? If that is a confidential list that nobody sees, I do not think people would bother. I think people who are drug addicts have a lot more in life to worry about than whether their name is on a confidential list. The fact is that not many people go through the process. I think the Deputy Leader of the Opposition is right. Probably the ones who have come off are deceased. Maybe a few who were not addicts in the first place may want to fight to clear their names, or there may be people who feel so good about coming off drugs that they want to make sure that things are right. There is a process under which people can do that. I was discussing that before, at the start of my comments. I am not sure how a person would do that. They could have regular blood tests, I guess. If they can show that they have not used drugs for a long time, they can have their name taken off the list.

Mr R.H. Cook: Under the current legislation, you write to the CEO if you haven't been receiving treatment for that addiction for a period of five years.

Dr K.D. HAMES: But how do they prove it? I guess there is no record of the person getting any drugs.

Mr R.H. Cook: The current legislation envisages a very limited number of outlets in relation to the methadone program.

Dr K.D. HAMES: Yes, that is true.

Mr R.H. Cook: So they would know that you haven't been back for five years.

Dr K.D. HAMES: I just do not think that people would necessarily bother.

Mr R.H. Cook: What I am saying is that what you are describing is a very different model from —

Dr K.D. HAMES: Could I have an extension? I cannot have an extension.

Mr R.H. Cook: I will be quiet then and let you finish; sorry.

Dr K.D. HAMES: I will just wind up. There was a question about how many prosecutions there had been. There are 12 registered medical practitioners who are not able to access schedule 8 medicines. I do not know what number I said before, but 12 is the correct number. There was also a question about the penalties in other states. In the Australian Capital Territory, the penalty for doctors is $14 000. In New South Wales, there has not been an update for a long time. Its penalty is only $2 200. In the Northern Territory, it is $2 880. In Queensland, it is $6 600. In South Australia, it is $4 000, but there is a potential imprisonment component as well. In Tasmania, it is $6 500, and in Victoria, it is $14 436. That is where the $15 000 came from. It was thought to be in that general ballpark of the ones that have been upgraded recently, but, as I have said, I have agreed to —

Mr R.H. Cook: Is that for not adding names to a register?

Dr K.D. HAMES: Yes. I have agreed to $5 000.

I think that covers as much as I need to cover. We will do the rest in consideration in detail. That concludes my second reading remarks.

Question put and passed.

Bill read a second time.

Leave denied to proceed forthwith to third reading.

Consideration in Detail

Clause 1: Short title —

Mr R.H. COOK: One of the issues that has come to my mind in the lead-up to the consideration of this bill is that there seems to be a certain amount of knowledge gap in the content and detail of it. Could the minister provide us with a quick overview of the consultation process in the drafting of the bill? I do not mean from the early days of 2004 when it all began. As the minister keeps saying, I have had contact with a number of health stakeholders who were not even aware of the detail of the legislation.

The ACTING SPEAKER (Mr I.M. Britza): I remind members that we are confined to the clause. It is not a debate.

Dr K.D. HAMES: This bill has been worked on for a long period. Certainly, for the whole of my career as Minister for Health, this bill has been out there. I am aware that the legislation was released publicly in 2011 so

people who have been involved in the profession have had ample time to look at it. My adviser is madly scribbling out a list of the people who have been spoken to. The bill has been around for a long time. I notice that the copy of the bill I have here is draft 6. It has been through different iterations since then. Eight drafts have been completed in total, clearly after discussion with different groups. This might not be the complete list, but there has been consultation with the public, the Pharmacy Guild of Australia, the Pharmaceutical Society of Australia, nurses and government, medical practitioners, the Western Australian Substance Users Association, the WA Networks of Alcohol and Other Drug Agencies, allied health practitioners, the police, our own Department of Health and the Drug and Alcohol Office.

Mr R.H. COOK: I did not hear in that list the WA chapter of addiction medicines. I was wondering whether some of those people were consulted.

Dr K.D. Hames: They have been also.

Clause put and passed.

Clause 2 put and passed.

Clause 3: Terms used —

Mr R.H. COOK: Could the minister enlighten us on what sort of delegations will exist in relation to the role of the CEO under this bill? The CEO is helpfully defined as the chief executive officer of the department but obviously we do not expect the director general of the department to be undertaking recording, disclosure and other administrative tasks on the registrar of dependent persons. Could the minister provide a brief description of how those delegations are expected to work in reality?

Dr K.D. HAMES: As in most things in health, there are clearly responsibilities set out for delegations depending on the issue. In this case, it is from the director general to the executive director of public health, Dr Tarun Weeramanthri, also the principal medical adviser, Dr Bangor-Jones, and the gentleman on my right. Those three are the delegated persons.

Mr R.H. COOK: Are they the only people who would view the record?

Dr K.D. HAMES: They are the only ones who are allowed to make decisions relating to the list. The only people who are allowed to see the list are those in the department's pharmaceutical services branch. They have responsibility for administering the legislation. Generally, when I ring up to get information on someone who is addicted, I do not get the senior people; I get someone within the department who manages the list. I notice that it is a secure office and has a secure database. It is separate from other people within the health department. Only people within that branch have access to that database. I ring up and get the duty person within that branch, who would look at that list and provide or record the name.

Mr R.H. COOK: In short, how many people would be exposed to the list and have working knowledge and tasks related to the list?

Dr K.D. HAMES: I am told that fewer than 20 would have access to the list. Of course, not all of those people would see it on a daily basis. They would be doing their normal and other duties. About five people would have working daily access to that list.

Mr M.P. MURRAY: I refer to the definition of "authorised health professional" on line 17. What is the technical difference between an authorised health professional and a health professional?

Dr K.D. HAMES: The term "health professional" covers all doctors, whereas an "authorised health professional" covers only a small group of doctors who are authorised to prescribe a particular medication. For example, Ritalin, which is used for attention deficit hyperactivity disorder, can be prescribed only by a paediatrician, so they are the authorised professional for prescribing that particular drug.

Mr P.B. Watson: Is that right? Can a doctor not prescribe that?

Dr K.D. HAMES: No; unless it has changed since I was practising, but we were certainly not allowed to prescribe Ritalin.

Clause 3 put and passed.

Clauses 4 to 93 put and passed.

Clause 94: Terms used —

Mr R.H. COOK: I move —

Page 64, lines 14 to 17 — To delete the lines and insert —

Drug dependent person means a person is addicted to drugs if —

(a) he is under a state of periodic or chronic intoxication produced by consumption of a drug of addiction or any substitute therefor;

(b) he is under a desire or craving to take a drug of addiction or any substitute therefor until he has so satisfied that desire or craving; or

(c) he is under a psychic or physical dependence to take a drug of addiction or any substitute therefor.

Obviously we are now getting closer to where most of our anxieties exist. One of the key issues about this clause is the definitions. The definition given for a drug-dependent person is —

> … a person who has acquired, as a result of repeated administration of drugs of addiction or Schedule 9 poisons, an overpowering desire for the continued administration of a drug of addiction or a Schedule 9 poison;

I think this area is a particular cause of concern because what this bill does is actually very different from what we had in place before, although the minister claims that we are doing fairly much what was in place before. Under the current legislation there is a very specific definition of this sort of person and the act uses the definition of addiction that I just read out. I draw members' attention to the Drugs of Addiction Notification Regulations 1980 under the Health Act 1911. The definitions in the regulations describe a very specific set of conditions for someone who has an addiction is described, which are —

> For the purposes of these regulations a person is addicted to drugs if —
>
> (a) he is under a state of periodic or chronic intoxication produced by consumption of a drug of addiction or any substitute therefor;
>
> (b) he is under a desire or craving to take a drug of addiction or any substitute therefor until he has so satisfied that desire or craving; or
>
> (c) he is under a psychic or physical dependence to take a drug of addiction or any substitute therefor.

We have gone from a very tight definition of addiction to a much broader and what could be described as a lower level definition of addiction. I refer members to the report "Pharmaceutical drugs misuse problems in Australia" from the National Centre for Education and Training on Addiction at Flinders University. I think it was produced for a Council of Australian Governments meeting. It states —

> Some (e.g. Monheit, 2010) maintain that there is a distinction between physical dependence and addiction, and that all patients on longer-term opioid treatment become physically dependent to some extent and experience withdrawal symptoms if they cease their medication, but that this does not necessarily mean the patient has an 'addiction'.

That is saying that a patient who is on long-term painkillers, or opioids, will, over a short time, develop a certain level of addiction. The report is not saying that that person is an addict for the purposes that we are trying to describe in this legislation; it simply says that the person has a drug dependency as a result of taking prescribed medication over a long time. The fact is that we are seeing a whole new group of people being captured by this legislation. They are not just those types of people that we commonly conjure up in our minds when we refer to an addict. By and large, they are responsible drug users who have been, for one reason or another, medicated for a time and, as a result, now find themselves caught up in this legal maze of addiction-related legislation. I ask the minister to consider the quite open-ended nature of this definition of a drug-dependent person, because I think this is one of the real difficulties associated with the legislation.

What I have sought to do by way of this amendment is delete lines 14 to 17 of clause 94 and reinstate the definition of "addiction" that we have been using and that the minister has claimed on a number of occasions today is working quite nicely under the current legislation. The bill would state that a drug-dependent person is a person who is addicted to drugs under the same definition as that found in the Drugs of Addiction Notification Regulations 1980.

Dr K.D. HAMES: The government will not support this amendment, which is not to say that the member does not have a very good point. The member uses interesting words when he talks about the difference between addiction and dependency. I would warn my patients who had been on morphine derivatives for chronic pain of the risk of addiction. Often they are a similar sort of patient to those discussed by the member for Mirrabooka— people who have a workers' compensation claim or a motor vehicle insurance claim. Those risks of addiction are very high. In fact, recently I have been arguing a bit with my own department about people who have acute cervical nerve compression injuries or an acute cervical disc prolapse. One patient at the time was a nurse who suffered a severe acute disc prolapse and was in severe pain who, in my view, should have been classed as urgent for immediate surgery. The risk of not doing so means that she will become a drug addict. "Addict" might

be regarded as a severe term, but once patients go on morphine for a sufficient time, it is an addictive drug. They become addicted to it. Sure, there is a physical habitual dependency that is part of it. That is similar to smoking; people are happy to suck on a straw sometimes just to have that physical thing of having something in their fingers and sticking it in their mouth. There is the comfort and the fear of not having it and what the pain will do. Again, all those things are critical.

What the member for Kwinana is saying is right: before, it was only those who were "addict addicts" running around getting drugs who would go on the list. If a doctor had a patient who had been treated with MS Contin for back pain for a considerable period of time and had become, in his view, addicted through his own prescription, he would be required to put his patient on the list. That might not have been the case before. The issue with such a case is the critical importance of that one doctor looking after that one patient. While that patient might be on the list, as long as she continues to see that doctor for her drug of addiction, even if it is prescribed by him for her pain, it is not a problem.

Mr R.H. Cook: That is right, yes.

Dr K.D. HAMES: It is on the patient record. He knows and he is not going to tell anybody else. It becomes an issue only because of that addiction that the doctor has probably created himself. I have done it lots of times. It is an awful thing when a person is in so much pain that they have to be given strong painkillers knowing the potential effects. I warn patients trying everything to avoid it, but sometimes, sadly, it is unavoidable. I need to know whether that patient will go shopping somewhere else. If the patient is addicted to the drug I have started him or her with, and then runs to see doctors down the road, I do not want those doctors to prescribe to the patient; otherwise, it will get out of control. Doctors must have control of a person who is on an addictive drug having his or her name down on the register so that those patients do not start shopping around for other doctors to get the same drugs.

Sometimes in the past when a patient was registered—some patients are already on the register, not all of them, but lots of them already are—the patient would come to see me and say that they are being seen by Dr Such and such for a long period of time and he is giving morphine even though they know it is addictive. They say that without it their life is not worth living anymore. I check and, yes, the name of the patient is there with the name of the doctor. I ring that doctor to ask whether it is true. Sometimes I have been caught because the doctor has not been available and I have given the patient something to see them over to the next working day when I expect the doctor to be there. I then call them up to check. Sometimes I find these doctors say, "Yes, that is my patient; yes, I'm happy for you to give them that and, yes, I should've given them enough to see them through." That is all sweet. That has happened lots of times as well, but these patients need to be on the register. That is why we will not accept the amendment.

Mr R.H. COOK: The minister has by his own arguments defined the very problem we are trying to resolve. He referred to a patient who is having essentially their addiction managed properly by a local doctor—the minister or whomever—and that he believes that that is the best way for that addiction to be managed. Why should the minister be compelled, therefore, because this person has a dependency as opposed to what might be described as a fully-fledged addiction, to then capture that person within this legislation? All we have at this stage is some poor soul with a bad back who the doctor has been managing with painkillers for a period of time. The patient has come to the doctor and said, "When I wake up in the morning, I really believe I need my painkillers more than just to meet my physical requirements. I'm starting to use these painkillers more and more to achieve the same result in terms of my bad back." Essentially, the doctor has created a drug-dependent person; but by this point the doctor may not want to declare the person on a register or put them at the mercy of this legislation. The doctor might be thinking that he needs to manage this person in a different way in order to treat their emerging drug dependence. Surely that was the minister's intention when he looked at this legislation, rather than sending that person off into the arms of this legislation, as rigid as it is and as long term as it is, yet the doctor is continuing to manage that patient.

Dr K.D. HAMES: There are three components I will address. One, I am not sending the patient anywhere; in fact, I am only trying to make sure the patient stays where they are —

Mr R.H. Cook: You're making decisions about their civil liberties!

Dr K.D. HAMES: There are three things, I said, not one, that are involved in the legislation. The second is the definition we have in the bill. It is not just someone who may be addicted to some degree to the drugs that a doctor is prescribing. The bill states that a drug-dependent person is a person —

> who has acquired, as a result of repeated administration of drugs of addiction ... an overpowering desire for the continued administration ...

A doctor does not need to register that person unless they fit that description—that is, someone who has reached the stage where they have an overpowering desire.

The third point is that not all doctors do the right thing. This legislation encourages doctors to do the right thing. Some doctors who have treated patients in the long term, in my view, do not spend enough time or give enough care and attention to the needs of the patient with a problem, particularly, say, those who have a back injury, to avoid their becoming addicts. I have seen patients who, in my view, have been prescribed reckless amounts of drugs by other doctors in managing their conditions, and who have been happy to continue prescribing that drug at a level I believe is in excess. This bill will require these doctors to register a person who they believe has reached a stage at which they are likely to get drugs from other sources. Again, I refer to someone who is severely addicted to a drug, with an overpowering desire for the continued administration, and who therefore is likely to be shopping around for alternative services.

Mr R.H. COOK: Let me be clear. This is not about a piece of legislation to control doctors. This is a piece of legislation to control patients.

Dr K.D. Hames: That was the second point; I added a third.

Mr R.H. COOK: The minister is making decisions on behalf of a patient that will impact on their civil liberties because it will restrict the sort of things they can do.

Dr K.D. Hames: In what sense does the member mean that it will impact on their civil rights?

Mr R.H. COOK: I know it is not harsh.

Dr K.D. Hames: In what sense will it impact on their civil rights?

Mr R.H. COOK: Because the patient will go to another doctor, and that doctor will say that the system has decided that the patient is not in a position to make this decision. I do not ramp that up as being —

Dr K.D. Hames: I do not understand.

Mr R.H. COOK: We are making decisions about the freedoms that a person enjoys.

Dr K.D. Hames: Please explain.

Mr R.H. COOK: There are so many similarities!

We are making decisions about the freedom of this person to access health services. Whether we like it or not, and we can dress this up how we like, but we are making decisions around those issues. Let me be clear about this. This is not about controlling the doctor. I hope other forms of legislation and regulations ensure that doctors do not behave in an unethical or illegal manner in treating their patients. This is around a particular patient, and this is not about whether a doctor believes that the patient will go off and doctor shop. This is simply a definition around that person's drug dependence. The definition the minister has provided is so far at the lower end in terms of a hurdle—for want of a better description—for that patient to get over in the way he or she has been using that drug or wants to use that drug. The minister is essentially capturing a whole new part of the community with this definition. The minister has said to us on a number of occasions that this is not about extending the legislation, but about maintaining a current system that the minister claims is working well. Why are we broadening the definition to capture more people with this legislation?

Dr K.D. HAMES: As I said, I do not believe the definition is all that different. I think the definitions could have easily been reversed and we would have been arguing the same about the change from the old to the new. The Department of Health authorises doctors of patients who need chronic pain management with drugs of addiction to provide those drugs of addiction, and it will authorise only one doctor. People can still get MS Contin and might be able to jag an injection of pethidine somewhere, but to get the regular prescription of the MS Contin they require for their chronic back pain management, the department might authorise either one doctor or one practice so that other doctors within that practice can regularly prescribe that medication. When the member for Kwinana says these people will lose their civil liberties, I fail to see what civil liberty they will lose. What liberty allows a person to get medication that is under restricted access wherever and however they like? I know the member is probably not suggesting that, but I do not see what civil liberty they will lose. They are on that list because they are addicted and because they are registered as someone who needs that medication regularly, so their doctor is authorised to give it, or they are trying to get it elsewhere in other versions or in other components.

Mr R.H. COOK: We are not under instructions to filibuster; we have a genuine desire to come to grips with this legislation. Although we are referring to clauses that we will be discussing shortly, the minister has come back to the notion of a doctor having a reasonable suspicion that a patient will doctor shop. There is no reference to that in this legislation. There is simply a broad definition of drug dependence. In relation to that, subsequent clauses

have implications for the people who fall within that broad definition. The point we are discussing here is the issue of dependence and the way the minister has cast the definition of dependence. I notice in the Diagnostic and Statistical Manual of Mental Disorders that there are seven particular points around what are described as criteria for substance dependence. It contains a great deal of detail, which I could quote but it is fairly lengthy. It clearly describes someone who is dependent on a particular substance and has an increasing intention to take more of it. In that definition, the minister has essentially brought into the net this new group of people. The DSM uses the example of a chain-smoker or someone who has built up a maladaptive pattern of substance use, leading to clinically significant impairment or distress. It seems to me we are trying to define a group of people who are not simply struggling to deal with their prescriptions. This legislation seems to try to capture people who are looking to abuse a system in a way for which it was not intended. The minister has described doctor shopping and the selling of prescription drugs and so forth. It is still a mystery to us why the minister has sought to deliberately use the language of "dependency" upon a drug as opposed to an "addiction", which, as we have seen from the previous regulations, is a much more specific description and covers a higher level of abuse. Perhaps the minister can provide us with an explanation that will satisfy people. Why has the minister dropped the language around "addiction" and decided to use "dependence" if he was not intending to capture a new group of people under this legislation?

Mr M.P. MURRAY: I would like to follow the line of the member for Kwinana's argument and refer to basics, as the minister did earlier when he spoke about people with a back injury who have become drug dependent because a drug has been over-administered over time. The person is sent home and very quickly ends up going back to their doctor for the drug. I have heard, especially in the mining game, people say, "Oh, the doctor said he has taken me off the painkiller or whatever too quickly and I have become dependent on that and need to be weaned off over a period." That would put that person very close to having their name on the register. I am not saying whether they would; I am not sure, but because they have become dependent due to a back injury —

Dr K.D. Hames: If the doctor's belief is that the person has an overpowering desire to continue a drug, it would not be the case because that person would have been put on and taken off the drug and it should not have been done so quickly; they should have been weaned off. That might be the case, but that does not mean he has an overpowering desire, so the doctor would not need to put him on the register.

Mr M.P. MURRAY: There is another part to it; I am not trying to be silly about this. If that person went to another doctor in another town because he had to move there, would the new doctor pick up the phone, as the minister said he would, and ring the other doctor or would he say, "This bloke's doctor shopping; we'd better put him on the list."?

Dr K.D. Hames: No; he should ring the other doctor, but, alternatively, he would ring to see whether he was on the register and he would not be.

Mr M.P. MURRAY: He could be, under this legislation.

Dr K.D. Hames: No; that doctor would need to have the view that the person had an overwhelming addiction. I do not think that would be the case.

Mr M.P. MURRAY: The concern here is about how wide the net will be cast and how people could be caught unwittingly. If their name is put on the register, they would have to go through a process to get their name taken off the register, and that is of huge concern to me.

Dr K.D. Hames: The definition is there for a purpose.

Amendment put and negatived.

Clause put and passed.

Clauses 95 and 96 put and passed.

Clause 97: Practitioner to inform CEO of drug dependent status of patient —

Mr R.H. COOK: I have been advised to speak for approximately a minute and a half.

Several members interjected.

Mr R.H. COOK: If someone could take a point of order, I suspect that would solve the problem!

Mr Acting Speaker (Mr I.M. Britza), obviously you sense a desire from people in the chamber to spend some time discussing this clause. It is certainly a clause that gives us a great deal of concern and goes to the heart of the issue of a doctor's right to manage their patient in the way that they see fit, consistent with their ethics and their codes and in a manner that does no harm. It is the doctor, we contend, who is in the best position—I get the impression no-one is paying any attention to me!

Several members interjected.

Debate adjourned, pursuant to standing orders.