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

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

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
MONDAY, 15 APRIL 2019

SESSION THREE

Members

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

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Hearing commenced at 12.48 pm

Dr ANDREW ROBERTSON
Chief Health Officer, Assistant Director General, Public and Aboriginal Health, Department of Health, sworn and examined:

Dr HUI-MIN JESSAMINE SODERSTROM
Emergency Consultant, Clinical Toxicologist, Royal Perth Hospital, sworn and examined:

The CHAIR: My name is Hon Alison Xamon. I am the chair of this inquiry. Thank you very much for coming along today. I will just introduce the rest of the panel. I have here Hon Colin de Grussa; Hon Michael Mischin; M Lisa Penman, who is assisting with this inquiry; Hon Samantha Rowe, deputy chair; and Hon Aaron Stonehouse. I do want to welcome you and thank you for coming here today. Today's hearing will be broadcast, so before we go live I would like to remind you both that if you have any private documents with you, keep them flat on the desk to avoid the cameras. Can we please begin the broadcast?

I now require you to take either the oath or affirmation.

[Witnesses took the oath.]

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

The WITNESSES: Yes, we have.

The CHAIR: These proceedings are being recorded by Hansard and broadcast on the internet. Please note that this broadcast will also be available for viewing online after this hearing. Please advise the committee if you object to the broadcast being made available in this way. A transcript of your evidence will be provided to you. To assist the committee and Hansard, could you please quote the full title of any document you refer to during the course of this hearing for the record, and please be aware of the microphones and try to talk into them, ensure that you do not cover them with papers and make noise near them. Could you please ensure that you try to speak in turn, because it makes it easier for Hansard. I remind you that your transcript will be made public. If you wish to provide the committee with details of personal experiences during today's hearings, you should request that the evidence be taken in private session. If the committee grants your request, any public and media in attendance will be excluded from the hearing. Until such time as the transcript of your public evidence is finalised, it should not be made public. I advise you that publication or disclosure of the uncorrected transcript of evidence may constitute a contempt of Parliament and may mean that the material published or disclosed is not subject to parliamentary privilege.

Would you like to make an opening statement to the committee?

Dr Robertson: Yes, I would like to make a brief opening statement and then Dr Soderstrom, I believe, has an opening statement. Thank you for inviting me to the committee. As you are probably aware, most of the information on illicit drugs is managed by the Mental Health Commission, and I appreciate that they are probably coming to this committee on a separate occasion. My area that I am covering is really the regulatory aspects around the Department of Health and what their requirements are, so I can talk primarily to those areas and primarily to the illicit use of pharmaceutical drugs, which is probably our main area of involvement.

Dr Soderstrom: My name is Jess Soderstrom. I am an emergency physician at Royal Perth Hospital. I was asked to talk about the impact of illicit drug use on the emergency department. I have an opening statement. Are you happy for me to read that out?

The CHAIR: Yes.

Dr Soderstrom: I work in an inner-city emergency department that sees around 75 000 patients a year. About 10 per cent of these presentations relate to illicit drug use. These patients are sick. They represent about 17 per cent of our triage category 1 patients, which means that they need immediate attention. Can I paint you a picture, please, of what it is like in our ED? We have 29 cubicles in our emergency department. Picture a corridor with about eight cubicles. In each one of these cubicles is a patient that is sedated, with a single nurse looking after them. This peaceful scene only belies the fact that during that 10-hour shift, eight patients have been brought in, one after the other, either by paramedics or by the police. There is a man who was convinced that his mind was being read by his credit card strips and he was found at a petrol station throwing his credit cards around; a few patients running in and out of traffic, usually naked. One was convinced that Godzilla was chasing him. There was a young man who had jumped off a balcony several stories high, convinced there was a crocodile chasing him. There is a young lady cowering in the back of a paddy wagon, terrified, convinced that she had been fishing dead bodies out of the Swan River. I have not made any of these stories up. These are stories of patients who have come in through the ED.

[12.50 pm]

This is eight patients with drug-induced psychosis who now occupy a third of the cubicles in our ED, for an average of 11 hours. Each of them has a single nurse solely devoted to their care for their safety and close observation for aggression and violence. As each of these patients arrive, agitated, aggressive and very distressed, two-thirds of them will actually need a drip put in and intravenous sedation, and a third of them would need security assistance to actually physically restrain so that we can chemically sedate them. So the impact on our ED is significant, because a third of our beds have now been taken up by these drug-affected patients for an average of 11 hours, which means they are not available for us to review other patients.

The effect on patients is that they come in unwell, psychotic, and often physically injured during their meth-induced psychosis. If they are lucky, most of them will recover after a sleep. Only two per cent of them will go on to have ongoing psychosis that needs psychiatric admission. The impact on the other patients having to witness the violence and the aggression, when they are there seeking medical attention, is not pleasant. Our staff in the ED work in an environment where violence is now a given. It is not okay, and our security staff do an amazing job in trying to keep us safe. It is not uncommon for doctors and nurses to be kicked and punched, spat on, and held in a headlock during a shift. We have got aggression simulation training, and they all help to mitigate some of the risk, but it does not stop it. The knock-on effect to the other departments dealing with the ongoing effects of methamphetamines include persistent psychosis, traumas and infections. That cannot be underestimated. What I have described is really some of the effects of methamphetamines on an ED. Besides alcohol, methamphetamines would be the most common illicit drug use causing presentations to our ED. It comprises about 70 of all our illicit drug use presentations.

The collateral damage to the families of the patients involved is heartbreaking. For example, the scene of watching a parent of a young person intubated, on a ventilator, on Christmas Day, to prevent complications of stimulant drug use, is sad. I have not covered the effects of the use of other illicit drugs on the ED, including opioids, synthetic cathinones and the other diverted pharmaceuticals, like pregabalin.

Anecdotes make great stories, but data and research are key. We have been running the WA illicit substance evaluation project, or the WISE project, for the last two years at Royal Perth. For the first time, our treatment is focused not just on symptom control but also determining exactly what agents are causing our patients to become unwell. For the first time, we are able to correlate the patient's symptoms with their agent and their blood level. We have been able to quantify the effect of methamphetamines on the ED. We have also learnt that the patient's psychotic symptoms are actually not related to their meth levels but more likely to be due to their pattern of use, and sleep deprivation. We have been collaborating with the WA tox service, the EDs and the ChemCentre. The collaboration has worked very well to act as an early warning system. When there is a cluster of poisoning that has identified, we can quickly determine the causative agent and then put out a public health message. This has been demonstrated in the last couple of years with a recent NBOMe-5 fluoroamphetamine and hyoscine clusters.

[1.00 pm]

We also have a large case series of ecstasy, or MDMA, and synthetic cannabinoids in the study. We are looking to expand to opioid presentations as anecdotally this does seem to be an increasing problem, with an increasing amount of naloxone being required.

So the question is: is the toxicity from the opioids due to the type of opioids or is it the amount? This project has now evolved to develop into a clinical protocol and having a systemic approach to collecting blood from patients unwell from illicit drug use. We are in the process of expanding this project beyond Royal Perth to other metropolitan hospitals in WA and setting up a national registry to work out the pattern of poisonings around the country. This project is called EDNA—the Emerging Drug Network of Australia. We are using the infrastructure of the National Poisons Network and lessons learnt here in WA.

We have to move beyond anecdotes and use research to drive change. We have recently opened a six-bed unit in what is called the urgent care centre, dedicated to looking after these patients in an attempt to decongest our main ED floor. This has worked to improve the efficiency of our main ED, freeing up these beds to review other patients.

We are also incredibly fortunate in the ED at Royal Perth where we have psychiatry drug and alcohol staff embedded within our team. We see each presentation—each person who comes in with illicit drug use—as an opportunity for intervention. Our staff are quite proactive in terms of assisting the ED in assessing patients who have persistent psychosis and offering them drug rehab if they wish. We work well as a team, especially determining it as a medical cause or purely psychiatric cause for psychosis.

Collaboration with external agencies, like the ChemCentre, Peer Based Harm Reduction WA and the National Poisons Network have allowed us to expand beyond simply bandaiding the problem of illicit drug use. We are being proactive in working out what drugs are causing harm and causing presentations to an ED. This collaboration improves our capacity to disseminate this information to people on the ground. We recognise that this problem is bigger than just the ED. We represent only a very small subsection of a very large problem. The ultimate goal is working towards developing an early warning system of identifying clusters of poisonings and developing an efficient manner in terms of disseminating this information with the aim of reducing harm.

The CHAIR: Thank you, Dr Soderstrom. You have outlined a particularly dire situation. How long have you been working in this setting?

Dr Soderstrom: I have been an ED physician for 14 years.

The CHAIR: That is good. I am interested to know your observations as to what has significantly changed over the last few years. You have spoken a fair bit about meth. Could you maybe give the

committee your reflections on how meth itself has changed the landscape of drug-induced presentations.

Dr Soderstrom: I have been an ED consultant for 14 years but I have been working in ED for 20 years. The pattern has changed. When I first started working in the ED, opioids was by far the most common illicit drug presentation.

The CHAIR: Is that principally heroin?

Dr Soderstrom: Principally heroin. They were fairly straightforward because they come in sleepy. The art was then to give them enough naloxone to wake them up but not wake them up too much. Now what has changed is the degree of violence that is within the ED. We get relatively immune to it and we all develop our own coping mechanisms in terms of how you manage in a chaotic environment like that. Violence is now a given. We have to teach our junior medical staff in terms of how to cope with witnessing and seeing that violence within the ED, and protecting yourself in terms of how you prevent yourself from getting attacked during the normal course of a day. These patients do not mean to do it; they are unwell. The landscape has changed. It has become a lot more violent. It has become a lot more chaotic.

The CHAIR: The AMA has already said that acute psychosis is presenting a major safety issue for healthcare staff. What measures or protocols are in place to respond to those situations?

Dr Soderstrom: Everyone has to undergo mandatory training. There are systems in place where our staff are very good at recognising when a patient comes in acutely intoxicated, and we get security involved very, very early. Security is based in the ED. They have security cameras everywhere, so they are looking and they are patrolling the ED regularly. We have a code black whereby if we are feeling at risk, if you are working in the UCC, you all have a personal duress alarm. There are innumerable numbers of protocols to keep us safe as best as possible.

The CHAIR: We have just hear from Dr Nathan Gibson about the issues around people presenting at EDs. He was particularly looking at the issue of people who have serious and enduring mental illness, co-morbidity issues with AOD. He talked about the need to be able to change some of the infrastructure within our EDs to better accommodate people who are presenting with psychosis, which is effectively what we are talking about. Can you give us your thoughts on that and what you think a better physical structure in our ED might look like to better accommodate those needs?

Dr Soderstrom: We have done a bit of that work. A big problem of treating patients with meth-induced psychosis is that you can imagine that when someone is acutely psychotic, they are agitated and you are treating them in a place where there is a lot of activity. There are people going in and out and if you have ever been to the Royal Perth ED, it is quite small. There are people going in and out. There is a lot of activity. It is well recognised that if you are treating someone who is agitated, that is the worst environment you could be treating them in because they get stimulated, and if you are hearing things and seeing things and there are a lot of people traffic around in the ED, it is going to be distressing and very stimulating for them. We recognise that because they have taken up so much of our ED floor space and they are in there for 11 hours, on average. So what we have done, they built a special unit called the urgent care centre, which has six beds. That is a locked area whereby the acutely psychotic patients can be cohorted in that area. Rather than needing a one-to-one nurse, you have two nurses for a six-bed area. It is much quieter and it is separate from the main ED, where they can be cohorted.

The CHAIR: Can you tell me which hospitals have that particular set-up?

Dr Soderstrom: We have that at Royal Perth. The other hospitals have got similar but different. I think Charlies have a MHOA.

The CHAIR: Yes, although we have already heard that MHOAs are not appropriate places for people who have deep psychosis.

Dr Soderstrom: MHOAs are different. Looking at the MHOAs around the country, the aims of that are really like an acute psychiatric admission. For the acutely drug-affected patients, they may not be necessarily suitable because the majority of patients will recover after a sleep; only about two per cent of them need ongoing psychiatric care. I do not know if I have answered your question.

[1.10 pm]

The CHAIR: It sounds as though we do not necessarily have the facilities that we need in each hospital emergency department.

Dr Soderstrom: I do not think so, no.

The CHAIR: How does the situation compare with our regional hospitals as well?

Dr Soderstrom: —It is terrible. I work in Albany regional hospital and I work in a high-dependency unit there. I can only speak about Albany because that is where I work, but the situation is much worse. At Royal Perth, I am very privileged, because at any one time, if I have a patient who is aggressive, I have six burly security guards next to me, because I am going to be no good at holding anybody down. I have six burly security guards behind me who are well trained and able to protect me. We can physically restrain a patient, so we can chemically sedate them to keep them safe. At any one time, there are six helping us in the hospital. In Albany, there are two. When they are sedated, they get put in the high-dependency unit where there are two nurses. It is very unsafe. The security guards come from outside and they are not allowed to touch patients.

Hon MICHAEL MISCHIN: Why is that?

Hon COLIN de GRUSSA: They are not hospital employees?

Dr Soderstrom: They are not hospital employees; they are external security guards.

Hon COLIN de GRUSSA: So, as a consequence of that, they are therefore not allowed to interact with the patients?

Dr Soderstrom: Yes.

Hon SAMANTHA ROWE: And at Royal Perth, they are hospital employees?

Dr Soderstrom: They are hospital employees, yes.

The CHAIR: To the best of your knowledge, that is pretty much the situation in most regional hospitals?

Dr Soderstrom: I do not know. I cannot comment about the other hospitals, but I anticipate that it would be not dissimilar.

The CHAIR: According to the emergency department attendances report, around 15 per cent of people who attended for meth left either before they were seen or against medical advice. Could you give the committee some advice as to why this is likely to happen?

Dr Soderstrom: As to why they are discharged?

The CHAIR: Why they are either discharged prematurely or they just decide to leave.

Dr Soderstrom: When someone comes in with a drug-induced psychosis, as they wake up and emerge from the sedation, we have to make a decision then as to, when they wake up, whether or not they have capacity: are they still psychotic, has their psychosis resolved and do they have the capacity to make the decision to take their own discharge? It is a clinical decision at the time when we review the patients. Often patients may not actually want to be there and we have to make a decision there and then whether or not they have capacity and are safe to take their own discharge.

The CHAIR: The committee has taken evidence that one of the issues for people who are experiencing drug-induced psychosis going into medical departments is that they report that they feel stigma in their presentation. Is there any training or professional development which is being provided to staff in this regard? I recognise that staff are dealing under enormous pressure and it is very much a crisis-driven environment. I can imagine that if there is someone who is being aggressive, people are not going to feel predisposed to wanting to assist them, but if this is a barrier to them getting assistance —

Dr Soderstrom: To be very honest with you, all of us work in an emergency department with the patient's care utmost in our minds. Anyone who comes in, we will treat them. We will see anyone who comes in. We do not ever refuse anyone the right to be seen. When someone comes in aggressive, we have a lot of training in terms of verbal de-escalation. We talk them down. We give them options in terms of accepting treatment. It is a fine balance and a clinical judgement between giving patient care—we will treat anyone—and if someone is being particularly abusive, we will often give patient choices. It is part of our ED training whereby we do teach our junior medical staff in terms of treating people with respect and verbal de-escalation. All those things are a part of our medical training.

The CHAIR: Are people taught about issues of stigma in terms of people with drug and alcohol issues who are presenting as a barrier to them wanting to continue to seek help?

Dr Soderstrom: I can see why the patients would have a perception of stigma, but we teach all our staff, and if you have ever had the privilege of working in an ED, you will see that our staff treat everyone with respect.

Hon AARON STONEHOUSE: Just on the issue of stigma, I wonder, when you are treating someone presenting with some condition that may be linked to drug abuse, do you have difficulty with them being perhaps not forthcoming with information for fear of revealing their criminal activity, I suppose? Is the criminal nature of the substance they are taking sometimes a roadblock in treating them because they are not honest about what substance they have taken or what their habits might be?

Dr Soderstrom: It has to be said that, generally, when we have asked patients—I ask everybody—about their history of drug use, they are usually very forthcoming. I will always say to them, "We don't care." It is not relevant. It is not illegal to actually ingest drugs. We are not involved with the police, so we are not law enforcement. They are usually very forthcoming.

The CHAIR: But surely some people would be brought in by the police, so I would imagine in those scenarios, if they have been brought in by the police, they might be reluctant to relay to you the full extent of what it is they have been engaged in for fear of subsequent prosecution.

Dr Soderstrom: I think it depends. Often the police will bring people in for a welfare check. They have been contacted by members of the public because someone is behaving erratically. I think it depends on whether or not they are under arrest. Often when patients are brought in by the police, if they are not under arrest and they are just brought in for a welfare check, we do release the police so that we can then have a conversation with the patient without the police present. I think it depends on the scenario—if the scenario is that of the patient being under arrest or just brought in for a welfare check. Does that answer your question?

Hon MICHAEL MISCHIN: To what extent do people refuse continuing treatment and assistance who have manifested drug-based bad behaviour in the emergency department? Do many of them say, "Yes, now I see the consequences of my behaviour. How can you help me?" or do you find that most are quite happy to get the immediate treatment and then be on their way?

Dr Soderstrom: I have to say that the majority of patients are very happy to tell me what it is they have taken.

Hon MICHAEL MISCHIN: Yes, but the follow-up as opposed to what they have taken and actually get assistance to get off what they have been taking and to change their behaviour?

The CHAIR: So move beyond that deep crisis.

Dr Soderstrom: I do not have those numbers.

Hon MICHAEL MISCHIN: But, anecdotally, what is your sense of it?

Dr Soderstrom: I do not have those numbers in terms of the number of people we offer rehab and drug education to. The percentage of them who take us up on that, I do not have those numbers on me.

Hon MICHAEL MISCHIN: What is your sense of it?

Dr Soderstrom: To be really honest, I think the majority of them are quite happy continuing to use.

Hon MICHAEL MISCHIN: You still also have that cohort who discharge themselves on their own recognisance and those who do not hang around at all for treatment at some point, and then you have those who do go through that process that evening and being treated and sleeping it off. Okay; those are the ones you can comment on.

Dr Soderstrom: Yes.

[1.20 pm]

The CHAIR: So you would see a lot of the same people over and over again?

Dr Soderstrom: In terms of the number of re-presentations in the same patients, I would need to look that up. I do not have those numbers on me.

The CHAIR: Would we please be able to take that question on notice—that is, just as it pertains to Royal Perth. I would like the numbers of re-presentations of people who come in with AOD issues. For Hansard, that is question C1.

Can I just ask some questions in relation to emergency department attendance in relation to ecstasy? Can you provide the number of ED attendances relating to ecstasy for 2017–18? I am happy to take that on notice if you do not have those figures available, for you.

Dr Soderstrom: Can I take that on notice?

The CHAIR: Of course. That would be question C2. From your experience at RPH, what are the most common symptoms and diagnoses of people who are presenting—what are the problems that emerge if they are presenting, having taken ecstasy?

Dr Soderstrom: The most common symptoms are usually what we call sympathomimetic toxidrome—a big name—simply meaning that they come in agitated, having a fast heart rate. That is what I mean by a sympathomimetic toxidrome. They are agitated and a fast heart rate, and they can also have seizures—fits is the other word for seizures—and they can also come in hallucinating.

The CHAIR: Is it relatively common?

Dr Soderstrom: Ecstasy?

The CHAIR: Yes, and presentations at emergency departments as a result?

Dr Soderstrom: Yes, it is.

The CHAIR: Are most of these people arriving by ambulance? How are they making their way to the ED?

Dr Soderstrom: In particular with ecstasy?

The CHAIR: Yes.

Dr Soderstrom: If you are needing to know specific numbers —

The CHAIR: No—would you say anecdotally —

Dr Soderstrom: It is a mixture of ambulances and being brought in by friends. The different cohort of patients are the ones who use party drugs versus meth—it is different. The ones that use party drugs, we often see them, like, in music festivals—we know that we often get clusters of them during music festivals.

The CHAIR: That was my next question, actually.

Dr Soderstrom: And, variably, they are brought in either by friends or by ambulance, depending.

The CHAIR: When they are presenting, is it because of the effects of the drug itself or because of the behaviours which have emerged from the taking of the drug, such as excessive physical activity, excessive drinking of water or dehydration? I am trying to get an idea of how much of the problem is the actual drug itself or how much of it is the behaviours which emerge as a result of that drug taking.

Dr Soderstrom: I am not quite sure of your question. Can you repeat that?

The CHAIR: If I take ecstasy, and just sit down in a chair and take ecstasy, then that will have some sort of physiological response. But if I take ecstasy and go out and dance my little heart out and do not have anything to drink, for example—I do not have any fluids—then that means that I will potentially experience a whole bunch of different physiological responses. The purpose of me asking the question is I am interested in exploring this idea to which education at music festivals, for example, might play a role in being able to assist young people who are going to take drugs to take them more safely or whether the drug itself is inherently dangerous and cannot be taken safely.

Dr Soderstrom: That is a difficult question.

The CHAIR: It is the one this committee has to grapple with.

Dr Soderstrom: The reason why I say it is difficult is that we are in the process of publishing a paper from our WISE study on a series of MDMA patients. What is interesting is that people do not just take MDMA.

The CHAIR: So it is the poly-drug use that is the issue?

Dr Soderstrom: Yes. What we are finding is that people do not just have MDMA in their blood; they have MDMA, they have amphetamines, they have other things in their blood that is just not MDMA. The number of people who actually just have pure MDMA is relatively small.

The CHAIR: Can I ask is that because they are actually taking multiple drugs or is it because of the nature of MDMA, being an illicit drug that is produced god knows where by god knows who, means that you have no idea what is in it?

Dr Soderstrom: I do not know. I cannot answer that question because all I can tell you is that the patients that are coming into the hospital who are sick. When we analyse their blood, they have not just MDMA in their blood; there is MDMA, there is often amphetamines—there are other things in their blood that is not just MDMA.

The CHAIR: Is any data being kept by anyone to track—for those people who are presenting in emergency departments, ostensibly because they have taken MDMA—how they got to that point, whether it is as a result of deliberate poly-drug use or because there have been problems with a particular batch of MDMA?

Dr Soderstrom: No.

The CHAIR: That would be useful information, certainly, would it not?

Dr Soderstrom: Yes, it would be. Really, up until our project had been running for the last couple of years, we had no idea what people were taking; we had no idea what was making them sick.

The CHAIR: Who do you think would be best placed to be able to start collating that data?

Dr Soderstrom: In terms of what drugs are causing—well, we are doing that now. My aim is that this project that we are running at Royal Perth, we are actually expanding to all the other metro hospitals in WA, with the view to actually seeing what illicit drugs are causing harm. We know that people come in sick, but until now we had no idea what it is that they have actually taken. We are starting that now.

The CHAIR: Starting it now?

Dr Soderstrom: Yes.

The CHAIR: Can I ask, to what degree is cocaine a problem?

Dr Soderstrom: It is not a huge problem.

The CHAIR: Do you have many presentations of cocaine overdose?

Dr Soderstrom: Very occasionally; maybe one or two a year, if that.

The CHAIR: What sort of demographic of person tends to present after having taken an excess of cocaine?

Dr Soderstrom: That I cannot tell you, because it is very infrequent that we are seeing cocaine in the cohort of people that are coming through Royal Perth. Two-thirds of them are primarily methamphetamine—that is by far our biggest. Cocaine is very occasional.

The CHAIR: What about synthetic drugs?

Dr Soderstrom: Synthetic cathinones—again, they are small numbers. The data is there; it is just in the process of being analysed at the moment in terms of other synthetic cathinones and cannabinoids.

The CHAIR: I actually wanted to ask specifically about cannabis as well. Do you have presentations of people who have overdosed on cannabis or who are presenting with psychosis as a result of cannabis use?

Dr Soderstrom: Yes, we do.

The CHAIR: Because this committee has also had evidence tended that cannabis is safe. Feel free if you wish to speak.

Dr Soderstrom: I disagree with that.

Dr Robertson: Yes, and I disagree with that as well.

The CHAIR: Would you like to elaborate, please? I am happy to hear from both of you on this.

Dr Soderstrom: Cannabis has changed. From cannabis of old, when we were kids, and cannabis of now, the ratio of THC to cannabidiols has changed , so that the THC levels now, with their different breeding that they are doing, is much higher. I do not think it is safe, especially in the young adult group with a predisposition to psychosis.

The CHAIR: But we have no idea of predicting who is likely to have a predisposition to psychosis, do we?

Dr Soderstrom: No, we do not. There are studies that have been done in Dunedin, and the like, whereby cannabis has well and truly been associated with a higher incidence of early onset of

schizophrenia, especially when it is used in a younger age group. Do I think cannabis is safe? No, I do not.

[1.30 pm]

The CHAIR: Did you want to elaborate?

Dr Robertson: For all of those reasons, particularly the psychosis, I think we are actually seeing its impact on other systems as well. We have certainly seen the increase in road accidents, which have been significant, particularly in the US and Canada, where, obviously, there is a bit of a natural experiment going on with the use of recreational cannabis. I think we are starting to see its impact on other body systems as well. I think, for all of those reasons, the legalisation of recreational cannabis would pose a major risk to health if it was done so.

Hon MICHAEL MISCHIN: You mentioned poly-drug use. Do you find it combined with cannabis very often, or does it tend to be a standalone issue where it comes to admission to an emergency department?

Dr Soderstrom: It is not generally a standalone. People do use —

Hon MICHAEL MISCHIN: With other things.

Dr Soderstrom: Yes—with other things.

Hon MICHAEL MISCHIN: I have a couple of questions regarding your opening statement, Dr Soderstrom. It is really me; I just do not understand what you are driving at. Can I refer you to page 2—the sixth paragraph down? You commence by telling us about how you tried to ascertain what drugs have caused patients to become unwell and correlating patient systems with the agent and the blood level. Then you go on to talk about the relationship between meth levels and illness. The next paragraph says —

> The collaboration with the WA Toxicology service, the Emergency Departments and the Chemistry Centre has also worked well to act as an early warning system where a cluster of poisonings is identified, the causative agent can be quickly determined and a public health message placed.

Over the page in the second last paragraph your final sentence picks up on that theme, I think —

> The ultimate goal is working towards an early warning system of identifying clusters of poisonings and developing an efficient manner of disseminating this information with the aim of reducing harm.

Can you explain what you mean by that? I take it by poisonings you mean people who have been found to have ingested a variety of drugs, but what is the early warning system and public health message you are talking about there? How will that help rather than working out how to treat the particular patient that you have and developing systems to deal with violent consequences of that illness? What sort of public health message are you talking about, what sort of early warning system, and how do they relate to the problems you are facing?

Dr Soderstrom: Do you want me to talk about the meth levels first?

Hon MICHAEL MISCHIN: Sure, whichever way is the best way of making the point.

Dr Soderstrom: This project only was possible with the collaboration with the chemistry centre. They have basically been doing our blood levels pro bono, so they have not charged us for it. That is the only way this project has even started. What we have learnt —

Hon MICHAEL MISCHIN: Just on that point, I take it that is because there is nothing budgeted for that particular project and that particular investigation?

Dr Soderstrom: No.

Hon MICHAEL MISCHIN: That is not the reason, or that is the reason they are doing it pro bono?

Dr Soderstrom: Sorry. Repeat the question, please.

Hon MICHAEL MISCHIN: You said they are doing it pro bono so that you could do —

Dr Soderstrom: They are covering the costs. The chemistry centre is covering the costs for us. That is the only way that the project has actually happened.

Hon MICHAEL MISCHIN: Right.

Dr Soderstrom: We are doing it because we are interested.

Hon MICHAEL MISCHIN: And they help.

Dr Soderstrom: The chemistry centre is assisting us with the analysis of the blood. There is no money budgeted for it per se. We have actually been able to measure what meth levels are causing people to become sick. Our initial hypothesis was that people came in sick and they were psychotic probably because their meth levels were really high. That was our hypothesis. But, in fact, their meth levels are half of what roadside testing is. I am going to make the very bad assumption that if you are driving a car on meth you should not be psychotic and hopefully reasonable at driving your car. The police seizures and police roadside testing—their meth levels are about 0.2 milligrams per litre. The meth levels for all our profoundly psychotic patients coming through the ED is 0.1. So that is half. That brings a hypothesis that may be it is actually not the—we then looked at more the patterns of use. People, when on meth, do not sleep—and they do not sleep for a number of days. Anyone that does not sleep for a number of days will become psychotic. What is interesting is that once they have a sleep, most of them recover. Only about two per cent go on to have ongoing psychosis.

Hon MICHAEL MISCHIN: So, in a sense, having a drunk tank for druggies is a way of going about it—someplace where people can sleep off the problem?

Dr Soderstrom: But they do need some chemical assistance because they are —

The CHAIR: To calm the brain, effectively.

Dr Soderstrom: Yes.

The CHAIR: Dr Robertson, can I just —

Hon MICHAEL MISCHIN: Sorry. Sorry about that, but you were going to get onto —

Dr Soderstrom: Yes. I am going to go onto the early warning system. One of the lovely side effects of this project was that it acted as—when we had clusters of poisonings—as an example, the Vic Park cluster, where we had the eight poisoned backpackers, and we also had a cluster of poisonings with what we now know as N-BOMe and 5-FU—fluoroamphetamines. We had a cluster of three or four people coming in to the different EDs really sick. If I just go to the N-BOMe and 5-FU, we had a cluster of people coming in from different parties and they were very unwell. We had five or six of them come into the ED at one time. They actually needed intubation and were on a ventilator, because they were—what happens is that they basically get overheated. Their body overheats because of the effect of the drugs. Because of the collaboration with the ChemCentre we could say, "Can you look at this, because we have got a cluster now of five or six people who are critically unwell. Will you tell us what is causing it?" They could do it within 24 hours and say to us, "Okay, it is N-BOMe and 5-fluoroamphetamines. Working then with the police at that time, they could assist us in terms of putting out a public health message saying that if you see this pill, do not take it because it is very bad for you and it makes you sick. That is what I mean by an early warning system, but that was just in its infancy. It was very much just by the nature of the collaboration with the ChemCentre that we have got started. What I want to do is actually formalise that so it is a bit more of a robust way of us being able to notify people when there is a cluster. With the hyoscine case, we

had the eight patients going to all the different EDs around Perth because there were so many of them. But what we did was that through the poisons centre we could coordinate sampling from all of those patients from the different EDs and bring them all to us, get that to the ChemCentre and work out what it was that was making them sick. We had clinical data to work out what each patient looks like. Does that make sense?

Hon MICHAEL MISCHIN: It does, but I —

The CHAIR: We have to finish up soon.

Hon MICHAEL MISCHIN: I understand that.

The CHAIR: I have got a line of questioning.

Hon MICHAEL MISCHIN: All right.

The CHAIR: I have got a line of questioning for you, Dr Robertson. Could you please provide us with an overview generally of the public health messages which are currently being employed by the health department to reduce harms from illicit drug use—the ones that the department is overseeing?

Dr Robertson: There are a number of measures in place. As you are probably aware, within the Department of Health, within our medicines and poisons branch we manage schedule 8 drugs and stimulants and we obviously —

[1.40 pm]

The CHAIR: Can I interrupt you there. The interest of this committee is particularly on illicit drugs. We are deliberately not looking at the illicit use of licit drugs; instead, we are looking at drugs which are currently deemed to be illegal. If we could focus particularly on those measures. I am aware that there is a lot of work happening in the other areas as well.

Dr Robertson: For illicit drugs, we have a limited role. I suppose one thing is Project STOP, which you all will have had some experience with if you have ever tried to buy ephedrine or pseudoephedrine from a chemist and you have been asked for your driver's licence.

The CHAIR: Again, that is a project around licit drugs because —

Dr Robertson: No. The reason behind Project STOP is because pseudoephedrine is used in the manufacture of an illicit drug.

The CHAIR: One of the things that this committee is trying to look at is the degree to which various public health measures are being employed to ensure harm minimisation for illicit drugs and the degree to which the fact that it is effectively illegal to be undertaking the consumption of those drugs is impacting on our capacity to keep people safe. We are interested, for example, in looking at the sorts of issues such as the use of naloxone and whether there is a place for drug-injecting rooms—all those sorts of measures. That is why I am specifically interested in what the health department is currently doing—working with organisations or providing it themselves—in services to facilitate the safer use of illicit drugs, and also what gaps you see that would be useful to contemplate in Western Australia.

Dr Robertson: Now that I am slightly clearer on what you are after, probably the two major areas are our needle and syringe programs. Through our sexual health and bloodborne virus area, we manage, fund and coordinate a statewide needle and syringe program, and that obviously is used largely as a public health measure to reduce the transmission of bloodborne viruses. Our focus is more around preventing bloodborne virus transmission.

The CHAIR: Can I confirm, though, that is not available in the prison system, is it?

Dr Robertson: That is correct.

The CHAIR: In your opinion, as an expert in this area, do you think that should be available in our prisons?

Dr Robertson: I think it certainly should be explored as a possibility. It has been explored in a number of other countries.

The CHAIR: Has that been successful or has there been an increase in violence pertaining to inappropriate syringe use, which I assume is the primary reason why people might object to it?

Dr Robertson: My understanding is that each of the models is a bit different for service delivery. But it is in 13 countries, and I would have to check as to what issues they have had with it, but they have certainly continued with those programs. My understanding is that they have certainly had a significant impact on reducing bloodborne virus transmission in those prisons.

The CHAIR: Is that principally hep C?

Dr Robertson: It is principally hep C, but also HIV.

The CHAIR: Please keep going.

Dr Robertson: Currently, we provide a number. There are needle and syringe exchange programs at fixed sites. There are some outreach and mobile services and they are primarily one-for-one transfer. There are pharmacy-based needle and syringe programs. They are primarily on a commercial basis so people can get them from pharmacies. Health services will provide them, particularly in regional hospitals through public health units and community health centres. Then there are needle and syringe vending and dispensing machines. They are either very low cost or free. They are the main programs that are available. To give you an idea of the scale of that, between 2000 and 2009, we invested $12.9 million into those, which is believed to have resulted in a saving of approximately $124 million in healthcare costs.

The CHAIR: Is that because there is a significant correlation between rolling out those programs and a reduction in bloodborne viruses?

Dr Robertson: Yes, that is correct.

Hon MICHAEL MISCHIN: How do you ascertain that?

Dr Robertson: It is by looking at the trends based on what we would have expected particularly in new HIV and hep C infections and the costs that are associated with treating both of those illnesses. They obviously require the use of expensive medications and a lot of medical care. Over that period, it is estimated—I am only talking across Australia now—that the NSP has probably averted around 32 000 new HIV infections and approximately 96 000 new hep C infections across Australia over a 10-year period.

The CHAIR: What about the use of naloxone?

Dr Robertson: As you are probably aware, naloxone was down registered.

The CHAIR: I am particularly interested in the degree to which naloxone might be able to be utilised by trained peers, for example. Is that something that is potentially able to be pursued?

Dr Robertson: We are certainly doing some work with that.

The CHAIR: Fantastic.

Dr Soderstrom: There is a lot of work in that area, so a lot of peer support organisations provide naloxone and training for peers. A naloxone program has been rolled out to the EDs, so patients who come in with opiates and need naloxone are offered naloxone to go home with.

Dr Robertson: Certainly, we are moving to extending the supply to drug and alcohol treatment sites as well. We have done some work around peer-to-peer models.

The CHAIR: What do you think of the use of injecting rooms?

Dr Robertson: We are aware that they have worked quite well in both New South Wales and more recently in Victoria.

The CHAIR: Can I just be clear: when you say "worked well", is the criteria you are using is reduction in deaths? What criteria are you applying when you talk about something working well?

Dr Robertson: That is a very good question. It is primarily a reduction in deaths —

The CHAIR: So it is about saving lives.

Dr Robertson: Yes, it is about saving lives, particularly overdoses; yes.

The CHAIR: To the best of your knowledge, does it assist with reducing use or is it just about ensuring that people who are using are less likely to die?

Dr Robertson: That is a good question. It is certainly about reducing deaths.

The CHAIR: I suppose I am curious to know whether it can also potentially be a site for intervention for people and whether there is any evidence to indicate that that occurs. Having said that, I have to say that saving lives is, in itself, a good starting point! I am very supportive of that.

Dr Robertson: I think there are a couple of other things from it. If you look at the Kings Cross medical injecting room, the figures there were around 5 900 overdoses were prevented, and 70 per cent had never accessed local health services prior to going there. Probably more than 12 000 referrals were made to external health and social welfare services.

The CHAIR: So it did actually serve as a first contact for many people.

Dr Robertson: That is correct, yes.

The CHAIR: We have to wrap up, but I have one more question. Of course, quite a lot of emphasis has been placed on public health measures to deal with issues of heroin. It has been around for a long time. What do you think would be some first strategies that we would want to look at from a public health perspective to deal with meth? If you got to rule the world and call the shots—this question is to both of you—what is the first thing you would do?

Dr Soderstrom: I would love for it to disappear.

The CHAIR: I would like to confirm that there has not been anyone who has given evidence who has said anything other than that. It is quite pernicious, wicked and other words that are bandied about—a scourge. We are looking at solutions.

Dr Robertson: I think prevention of supply is always going to be the ultimate aim.

The CHAIR: That is a law and order issue.

Dr Robertson: That is right. From a public health point of view, I think addressing some of the considerations as to availability and why people are actually taking it, what are some of those things, which probably fall more into the mental health arena.

The CHAIR: Do you think then that the fact that it is illegal might serve as a barrier to people being able to immediately get the assistance they require?

Dr Robertson: I do not think legalising it would actually make it —

The CHAIR: There are other things; you do not have to legalise anything, but the fact that people are then caught up in the justice system, which is where they first go, do you think that assists or hinders being able to deal with the issue?

Hon MICHAEL MISCHIN: Are you able to comment on that?

The CHAIR: Yes, I am only interested in your opinion.

Dr Soderstrom: It has to be said, I think that on the whole people are fairly open with their use. The experience I have had with the patients that I see, most of them are very open about their use. The difficulty is really the lack of effective treatment programs for them, because it is complex. We well know that people who chronically use meth, we have MRI studies that they have holes, like UBOs, on their brains. We also know that the part of the brain it affects is quieter and is suppressed. It affects the prefrontal cortex, and that part is suppressed. That part does not reactivate again for at least 12 months of them having to be clean. When you have a drug that affects someone's prefrontal cortex, which affects your executive functioning to work out, "Is this the right or the wrong thing to do?", if that part of the brain is actually suppressed for 12 months after they have been clean, it is understandable why it is actually so difficult for people to get off it.

The CHAIR: Do you support compulsory treatment?

Dr Soderstrom: I do not know. I think with any drug and alcohol issues, it works a lot better if the patients actually want to change.

The CHAIR: Okay. Unfortunately, I have to end there because we have run out of time. I want to thank you both for attending today. A transcript of this hearing will be forwarded to you for correction. If you believe that any correction should be made because of typographical or transcription errors, please indicate these corrections on the transcript. Errors of fact or substance must be corrected in a formal letter to the committee. When you receive your transcript of evidence, the committee will also advise you when you provide your answers to questions that have been taken on notice. If you want to provide additional information or elaborate on particular points, you may provide supplementary evidence for the committee's consideration when you return your corrected transcript of evidence. Thank you both for coming here today. It is much appreciated. You do a great job, and you do a hard job, so thank you. We recognise that.

Hearing concluded at 1.53 pm

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