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 TWO

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 11.06 am

Dr NATHAN GIBSON
Chief Psychiatrist of Western Australia, sworn and examined:

The CHAIR: On behalf of the committee, I would like to welcome you to the committee. You do, of course, know me, Alison Xamon. I am chairing this inquiry. I would also like to introduce you to the other people who are here: my colleagues, Hon Colin de Grussa; Hon Michael Mischin; Ms Lisa Penman, who is assisting us; Hon Samantha Rowe, who is the deputy chair of this inquiry; and Hon Aaron Stonehouse. We are looking forward to hearing from you today. Today's hearing will be broadcast. Before we go live, I would just like to remind you that if you have any private documents with you, keep them flat on the desk to avoid the cameras. Please begin the broadcast. I now require you to take either the oath or the affirmation.

[Witness took the oath.]

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

Dr Gibson: Yes.

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, please quote the full title of any document you refer to during the course of this hearing for the record. Please be aware of the microphones and try to talk into them and ensure you do not cover them with papers or make noise near them. 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 proceedings, 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 Gibson: My opening statement would be that I have really put into the submission, in a fairly brief way, the key issues. The primary issue for me is the individuals with severe and enduring mental illness. I do not necessarily want to consider broader issues primarily, but to focus on that particular group, which is within my remit.

The CHAIR: Absolutely. Your submission refers to the 2010 SHIP study, which was a survey of people with psychotic illness in Australia. The study found that the drug most commonly used by people with psychotic illness was cannabis. Can you explain the link, if any, between cannabis and psychosis?

Dr Gibson: Probably the highest-use drug would be nicotine, of course, but we are not looking at that today. But it has its own issues. What was the question again, please?

The CHAIR: Could you please explain the link, if indeed there is any, between cannabis and psychosis? You are aware, of course, that this is a quite controversial debate.

Dr Gibson: Absolutely. There has been quite significant work done on this, but it remains variable in the findings. Certainly it is reasonable to say that some individuals have a predisposition to psychosis. For those individuals, cannabis is likely to be a potential trigger for them. If you are looking at, if you like, a toxic psychosis due to cannabis, you would have to smoke very large amounts of cannabis to cause that, and that is quite uncommon. In most cases, we are talking about individuals who have perhaps a genetic predisposition to psychosis and for whom a small to moderate, or even large, amount of cannabis can precipitate psychosis.

[11.10 am]

The CHAIR: Do you think that is many people that we are talking about—people who might have a genetic predisposition to this?

Dr Gibson: It is very hard to say. We look at parents, of course, and family members. The vast majority of people who turn up to mental health services do not necessarily have an overt family history of psychiatric illness, but when the studies are done to look at the heritability, certainly if you have a parent with a major mental illness like schizophrenia, you probably have something like a 12 per cent chance of getting that. I guess if you know that, and most people do not, you would be more ready to consider whether cannabis would be something you would use or not, although it is pretty hard for someone who is a teenager to conceptualise that.

The CHAIR: The study also suggested a large increase in the rates of illicit drug use by people with psychotic illness between 1998 and 2010. Can you comment on why you think this might have occurred?

Dr Gibson: There are a couple of potentials here. One is that people were more likely to admit to it as time goes on. That cannot be absolutely excluded in that process. There may have been cohort issues, particularly picking up different cohorts. Obviously this is not all people with psychosis—this is a sample study. So that may be an issue there. To be honest, I am not really sure why it has increased so much. There are some of those other confounders, but I do not think we really know.

The CHAIR: Meth did not seem to be widely used by the group that was surveyed back in 2010. Would you say that this has now changed? Is it your experience that many people who are now presenting with psychotic illness are using meth?

Dr Gibson: That is a very good point. If you look at the lifetime use of amphetamines, it was 40 per cent for those people with severe and enduring mental illness within the SHIP study, so that is quite significant. We actually looked at, in Graylands, in the early 2000s, the number of individuals who were abusing drugs or dependent on drugs in a cross-sectional view of the admissions. There were very low numbers of people that were using amphetamines or that admitted to using amphetamines. Again, this is people who are admitting rather than actual drug testing per se. From my experience, then up to now, there does appear to have been an increase in meth becoming a significant issue. Certainly if you talk to individuals within the emergency departments or on general wards, meth is a significant issue. We know that the community rates of amphetamines are not that much higher than they used to be, but the use of meth seems to have created a furore with regard to increased amounts of psychosis.

The CHAIR: Is any data being collected in Western Australia regarding the number of people with comorbid severe mental illness and substance use disorders?

Dr Gibson: Not at the moment. At some point, I assume, the SHIP study will be done again. Vera Morgan and Assen Jablensky are from WA and were two lead authors in that study. There has been some work done in the north metro mental health service to replicate some of these post that SHIP study in 2010, but I think it is fairly clear that it is a major issue.

The CHAIR: Are you expecting it is going to be demonstrated that the landscape has shifted quite considerably as a result of meth?

Dr Gibson: I think so, but not necessarily, as I said, from a broader community use of the drug, but from the impact of the drug on mental health.

The CHAIR: Okay.

Hon MICHAEL MISCHIN: I will just ask a question. It is probably naive, but which comes first: the propensity to psychosis and the resorting to various drugs, or is it the other way around—that people try this stuff out and it triggers something that is latent in them? Is there a connection that we have not been able to ascertain yet?

Dr Gibson: Look, it is a bit unclear. It is a chicken and the egg question. It certainly is clear that for some people where psychosis is perhaps developing and they are at an early stage before it becomes really obvious, with the distress that they may be feeling, they may actually turn to drugs to actually try to dampen that down. We cannot underestimate that some people use drugs to try to deal with the symptoms that they are actually experiencing. Again, that often becomes the chicken and the egg. It is hard to say, from a broad community perspective, what the figures would be on that.

Hon MICHAEL MISCHIN: Just to develop that a little bit further, if someone with a mental health problem resorts to drugs as opposed to—I hesitate to use the term "normal"— someone who is not manifesting any sort of mental illness and chooses to take drugs as an experiment and then triggers some problem, is it some innate need in a person that turns them towards an addiction, whether it be alcohol, tobacco, drugs or some sort of substance abuse?

Dr Gibson: There are lots of drivers to the addiction. Obviously, the nature/nurture argument is there. There are probably three main groups, if you want to look at it that way. There are those people who have never used drugs and they experiment with drugs for the first time. Some of them will have a predisposition to psychosis; some of them will not.

Hon MICHAEL MISCHIN: "Predisposition" is the word that I was groping for, yes.

Dr Gibson: Then there is the group who may be developing early signs of mental illness. It is not yet diagnosed, but they are distressed and they potentially use drugs, but that may not be the majority of people who are developing mental illness. Then there is the third group of individuals who have well-established severe and enduring mental illness and, for various reasons, continue to use drugs. There are different phases in this process, I think.

Hon MICHAEL MISCHIN: One further question on that and then I will drop it. Thinking a little laterally in this, we talk about how drug abuse and substance abuse is a health problem and can give rise to mental health considerations, but where does it really sit? Is it a health issue? Is it more of a mental health issue? Is it more of a mainstream health issue? The connection with mental instability seems almost inevitable when you are abusing substances. Is it better dealt with within the mental health system with things like treatment detoxification and all the rest of it, or in the mainstream health system? Where do we primarily put the resources and where do we aim our educative and intervention processes? I suppose it is a question of emphasis as much as anything else. Do we treat it as a medical issue that someone is abusing alcohol, or do we treat it as a potential mental health issue in that a person has a predisposition to abuse alcohol and is doing so, which is giving rise to other health and mental problems?

Dr Gibson: That is a challenging question. It goes back a long, long time to Descartes and the mind–body split.

Hon MICHAEL MISCHIN: All right. That is probably for another day.

Dr Gibson: It is for another day, but I guess what I am saying is it is a wicked problem. What I would say is that if you attempt to silo these issues, that is when the problems arise. Does it sit within mental health? Does it sit within general health? Does it sit by itself? All aspects have to be involved in the care, because if you have a drug and alcohol problem, you may actually become homeless, your relationship might break down, you may become depressed. There may be a whole heap of sequelae that follow from your drug and alcohol problem.

On the other hand, you may have serious mental illness and drugs and alcohol exacerbate that. As well as that, you may get the physical problems associated with drugs and alcohol that we know so well. I guess my point is that I am not sure that it is helpful to try to silo it within one area or try to conceptualise it within one area. It is better to conceptualise it as a broad problem. We create these kind of silos and we try to fit people in, and that is part of the barrier for treatment.

[11.20 am]

Hon MICHAEL MISCHIN: Let us say that I go to you, as my general practitioner, and I reveal certain behaviours, such as I drink too much and from time to time I smoke cannabis, and albeit it is not a problem for me, I insist, I take some methylamphetamine, and I reveal the consequences that it is having on a life. Are you as a GP, in fact, equipped to give advice on the mental health consequences of that? Do you refer on me to someone else, and if I say, "No, I don't need a psychologist or a psychiatrist and I don't have a mental health problem", how do you deal with that? Is that not important for the treatment regime that we do by way of that early intervention, where we are saying that we ought to be doing more at that stage rather than at a later stage, and trying to eliminate the stigma and all that sort of stuff and actually properly deal with the problem at an earlier point? How do we deal we will that?

Dr Gibson: With deference to my GP colleagues, I think they can manage the early stage very well. It depends on the individual. As you pointed out, an individual may come with a multitude of things and it is the GP's role to work with that individual to prioritise the treatment for each of those things. What we do know is that the idea of saying, "You've got to stop your drugs and alcohol first before we treat your mental illness"—at times that happens within services—that is actually problematic. We actually need to try to treat them at the same time. Ken Minkoff in the United States, a psychiatrist who works in comorbidity, talks about the "welcoming service"—the service that says, "You're complex. You've got physical problems. You've got mental health problems. You've got alcohol and drug problems. You're the sort of person that we, as a tertiary service, want to see"; so, the idea is that we do not turn people away. At a GP level, I think that is the same as well. GPs are well-placed to see the person holistically. Of course, GPs are like any doctor. Some of them have more experience in alcohol and drugs than others. You cannot necessarily paint them all as the same group; they will be variably skilled, but the vast majority of GPs will be very competent to manage addictions. They do that with smoking on a regular basis.

The CHAIR: I want to pick up on this issue of integrated care, which is coming up a lot in our submissions and it was also in your submission. You note that the coordination of care between mental health and drug and alcohol services has been universally difficult to achieve in practice. Can you elaborate on why you think that is the case and perhaps give some examples?

Dr Gibson: I think the issue with bringing the services together is tricky, because how do you put them together? Do you put physical health with mental health? Do you put alcohol and drugs with physical? That is the thing. How do you configure them at a broader service level? In some ways, it does not matter how you configure them at a broader service level because it actually has to work at the ground level. The idea that you can have broader, overarching governance around alcohol and drugs and mental health together is a good idea, but it still has to translate to clinical on-the-

ground services. For example, what does that actually mean? Does it mean that when someone comes into the emergency department with a drug and alcohol problem, that the emergency department staff who see them, possibly the drug and alcohol staff and the mental health staff who see them, will be part of a team? That is variable—we get variable structures. Some of the bigger tertiary hospitals do have the resources and staff to do that. In some of the smaller hospitals it is more of a generalist model where the first person you see has to try to do all of that at the same time. It does depend on the structure within the service. It also depends on the training. For example, historically there has been this issue within mental health that if you are a drug and alcohol user, that is not real mental health; that is your own kind of issue and you need to deal with that. We have struggled hard to work with and change that culture so that when folk come in, they are seen and treated holistically. So it is cultural issues, it is structural issues which have been a barrier to this; and it is training issues as well.

The CHAIR: The no-wrong-door approach is not new; it is one that we have been trying to address in this state for several years now; in fact, it is enshrined within the 10-year plan. Clearly, the policy is not working. Do you think that there are different ways that we need to approach this to try to finally achieve that outcome—legislative requirements, for example?

Dr Gibson: There is a great article from the National Institute for Health and Care Excellence in the UK. I think it is about 2005—I would have to get you the reference. It looks at how do you change clinician's behaviour. There are a whole range of things. In short, it essentially says that education is fantastic but it is not enough. You actually need leadership support to do that and other things like ongoing professional support. Resources are some of those things as well too. There are a range of things that would have to happen. For example, if you train up mental health clinicians in drug and alcohol and then send them back to the same culture as they were in before, they are going to do one of two things. They are either going to go and work in a drug and alcohol service or they are going to drift away from their drug and alcohol training back to the culture. It is about local cultures and leadership. Leadership is about that issue of when people come in through the front door, they do not fall outside the catchment criteria. Whilst for mental health services there are no catchment criteria, people with drug and alcohol issues can be treated, and it is in the plan, as you say, but there is a process whereby people still tend to be siloed at that clinical level. How do we change that? It is with education and with through work with the leadership, and there is some resource implication at a service level as well.

Things have been tried; for example, having a service that can provide capacity building for mental health services, which was the joint services development unit that was at Graylands several years ago. It worked okay but it just did not get traction. Having an individual with drug and alcohol training sitting in a mental health service can be helpful, but they can become isolated if they are the only one within the service. You really need a cohort of individuals across the service, leadership actually supporting that, and a process whereby people are given time and resources to actually do that work, as well as the mental health assessment, because doing a proper drug and alcohol assessment takes time. When there is a squeeze on time, what goes first? It is the things that you feel less comfortable with, which is probably the drug and alcohol thing for mental health workers. It is about structure, leadership, training and, to some extent, resources too.

The CHAIR: Your submission recommends that decriminalising possession of small amounts of drugs for personal use could reduce harms to people with co-occurring mental health illness and substance-use disorder. One of the things I want clarify with you is, were you were talking about any particular types of drugs which would be useful for this or were you referring to marijuana, meth or heroine? Is it effectively any drug that you were referring to?

[11.30 am]

Dr Gibson: Obviously cannabis is the highest use drug, but I was referring to all drugs. Again, obviously this is a broader public policy issue. My focus is on the benefit for those individuals with severe and enduring mental illness

The CHAIR: Your submission went on to talk about the harm that these people with co-occurring mental health and substance use disorders have when they encounter the criminal justice system. Can you elaborate on what those harms are?

Dr Gibson: There are many harms and they are well defined. People do not engage with treatment services, they do not take their medication, they have an increased likelihood of relapse and they are more likely to be made inpatients than other people. They have increased rates of homelessness, poor physical health, poor social outcomes broadly, increased risks of harm from suicide, increased risk of violence both to and from the person, and increased risks of engagement with the criminal justice system. There are a whole range of poor outcomes that occur with comorbid drug and alcohol use.

The CHAIR: The committee has just heard from WA police that they are of the view that police drug diversion programs are a more appropriate option than decriminalising possession. Does this type of intervention, which involves avoiding prosecution by attending one to three education sessions, tend to work for the people whom we are talking about here; those people with comorbidity of severe and enduring mental illness and AOD issues?

Dr Gibson: The Drug Court's process is separate from what might be a mental health court process. My experience really is with the mental health court process, which has been very helpful at assisting people to stay out of the criminal justice system and have good outcomes. I really could not comment on the diversion.

The CHAIR: For clarification, the police were particularly talking about the cannabis intervention requirements, which are a mechanism by which people are diverted through to an education system. The question was effectively: are those sorts of measures going to work for the sorts of people that you are talking about?

Dr Gibson: It is variable. Unless those measures are supported by an intensive mental health structure, they are unlikely to work. It is just like, let us say, general anti-smoking campaigns do not tend to work for the mental health cohort; you actually need to tailor that. It is about some issues which are perhaps different for the individuals with severe and enduring mental illness. Individuals with severe and enduring mental illness may struggle with the understanding of the link between their drugs and their illness. I know anyone in the general population can also have that issue; they may not see that link. That issue of perhaps lack of insight into the triggers for their relapse can be a significant issue for individuals with severe and enduring mental illness. Any standard program which relies on people going through a standard phase of change process or gives them the choice of criminal justice or another option, individuals with mental illness, I am sure, would choose the other option, but the issue is whether they could sustain that without the broader support that they may need to manage their mental illness. I guess mental illness can—not always—reduce capacity. It can reduce an individual's ability to be able to manage their lives.

The CHAIR: Is it your observation that people who have severe and enduring mental illness are least likely to succeed in these traditional diversionary programs and more likely to end up in the justice system?

Dr Gibson: I think that is right. It is not to say that people should not be given the opportunity to do these, of course, but individuals with mental illness as a group, not as individuals, are less likely to be able to sustain those kinds of programs.

The CHAIR: As a health professional, would you consider that the types of diversionary programs that the police currently undertake would be considered to be health interventions?

Dr Gibson: Because I am not fully aware of all the details about those programs, it would be very hard for me to comment on that. For me, it is not about saying it is a good or bad program. I guess what I would be saying is that if it is a generic program for the community, then individuals with mental health issues who need to access that really do need associated intensive mental health support as well through those kinds of programs.

The CHAIR: Your position as Chief Psychiatrist is the position that has ultimate statutory responsibility for people who are detained under the Mental Health Act. I have previously been made aware of concerns by senior mental health practitioners that when people turn up to, particularly, Graylands suffering from extreme psychosis that has been caused by drug use, that they are not able to be detained for long enough to be able to ensure that that psychosis is appropriately dealt with, and so are prematurely released and that that can result in ongoing harm to both them and potentially the community. Do you have any reflections on the limitations of the Mental Health Act at the moment as it pertains to people who fall into that category?

Dr Gibson: I do, not so much directly relating to the Mental Health Act per se, but more the management of that particular group, which is the issue. I have had a number of clinicians also approach me about individuals with drug-induced psychosis who appear to be falling through the gaps and ending up in the criminal justice system, particularly the group who are difficult to engage with or with challenging behaviours and aggressive behaviours. The issue here, I think, is that, number one, where you have someone with a very severe and enduring mental illness with longstanding issues with capacity, it is very easy to say the Mental Health Act applies. Where you have someone who becomes fully well between episodes of psychosis, it is much more of a challenge. I am not sure that legislation can actually really solve that problem with regard to that group. I think there is an issue around working with clinicians because there are variable views among clinicians as to how they manage that group under the act. There are some clinicians who will take a very strong view that because, for example, someone who might be using drugs intermittently and becoming intermittently psychotic, it is a chronic problem and they may make a submission to the Mental Health Tribunal for someone to be on a community treatment order long term. The tribunal then has to decide whether they will allow that person to be kept. It may get to a point where the person is well enough for the tribunal to take them off the order. There are other clinicians who have a different view, who believe that they do not have the grounds to push those issues. It is often about clinician perception of how far they can push the act, and then it is about the Mental Health Tribunal, who decides whether someone stays under the act or not, making that decision.

The CHAIR: Dr Gibson, to the best of your knowledge, do you know of people who have been admitted to Graylands with drug-induced psychosis who have not been diagnosed as having a mental health issue and hence have been prematurely released and that that has then gone on to cause harm?

Dr Gibson: I am aware of two groups of individuals: one where there is significant debate amongst psychiatrists whether someone has schizophrenia or drug-induced psychosis. That can be problematic for care because if somebody believes that someone has schizophrenia, that is a more longstanding approach; whereas if someone —

The CHAIR: Surely they can be detained under the Mental Health Act.

Dr Gibson: They can, but the issue is differences of opinion around diagnosis. Then there is the other group that you are referring to, where the individuals have been seen as perhaps not having a substantial mental illness and, really, then it becomes their responsibility for themselves, and so they are discharged.

The CHAIR: Do you think there is a role for the law to be changed, not necessarily the Mental Health Act but at least some sort of legislative provision, whereby people who are deemed to have a psychosis as a direct result of drug use but no co-morbid mental health issues can still be involuntarily detained in order to address their psychosis?

[11.40 am]

Dr Gibson: There are two things. If someone is psychotic from drug intoxication, within a day or whatever their psychosis should be resolved. The drug-induced psychosis that I am talking about is someone who over days to perhaps a couple of weeks remains psychotic, even when the drug is out of their system. It is important to make the differentiation between those two groups. The individual who is actively psychotic when they are methed up—when they have a whole heap of meth in their system—can be managed under duty of care really and that is what they are managed under. Those individuals who remain psychotic, even after the meth is out of their system for, say, five, six or seven days —

The CHAIR: We have heard up to two weeks.

Dr Gibson: Yes, up to two weeks, certainly. In my mind, the Mental Health Act still allows them to be kept as involuntary patients for the duration that they still meet the criteria. The question is: how many episodes of psychosis do you need before someone will say you need a longer-term focus on the Mental Health Act—is it two; is it three? That is where the debate is and I am not sure that legislation can actually flesh that out. I think that is a broader cultural discussion within the mental health sector.

The CHAIR: Dr Gibson, what is your view of compulsory treatment of people with AOD issues?

Dr Gibson: There are two components. One is I am aware that compulsory treatment, potentially, could be very expensive for a very small number of people. The issue there is a public health issue. Do you spend a lot of money on a small number of people or use that money for other individuals with drug and alcohol issues? I am absolutely aware of carers' and parents' views on this, that they are very keen to have legislation. I am also aware that probably for that small number of people who might fall under that addiction mandatory treatment legislation, they may in fact benefit. I think it is a difficult problem and a broader issue. Do I agree that it may be useful in certain circumstances? Yes. Is it a good issue for the community to decide? That is a community question about whether that money will be spent for that small group of people or the same amount of money spent for a large group of people.

The CHAIR: Talking about carers and families, the committee heard from Mental Health Matters 2, who gave evidence that emergency departments can be very challenging environments for people who are experiencing psychosis. Would you agree with that statement?

Dr Gibson: That is a dorothy dixer. Yes, it is a challenge. Look, it is challenging for both the staff in the emergency department and for families and the consumers who come into emergency departments as well.

The CHAIR: What are the alternative options? What would you consider would be the best-case scenario?

Dr Gibson: Again, there are two scenarios. One where someone is very psychotic and highly aggressive. It is very difficult to see anything other than an emergency department that is going to be useful. Again, police cells for people who are actively psychotic is not the place to be. Where there are issues of drug-induced psychoses, I am firmly of the view that we need to provide greater resource to our acute community mental health services. We have seen really quite an expansion of mental health services over many years. I am concerned that there has been less of a focus on acute community mental health services, because I go to community mental health services and I see the increasing numbers of referrals they are getting without the commensurate increase in resources. If you are looking to divert from EDs, community mental health services are very helpful. The NGO sector is helpful, but they will not deal with the very acutely unwell folk—nor should they.

The CHAIR: No. Well, they are not equipped to do that.

Dr Gibson: They can certainly support in many ways and divert from EDs in other ways, but for people who are extremely unwell with drug-induced psychosis—if they are so unwell, they have to come to an ED, really.

The CHAIR: Yet we hear in evidence that it is also a terrible place for them to be.

Dr Gibson: Sure. Again, that is about the cultures. It is that idea that five to eight per cent of people who come to our EDs have drug and alcohol and mental health issues combined. It is quite a large number. It is one in 20 to one in 12 people who come in through the door. On some days in EDs, it seems like much more than that. I do not think that we can say that they are an outlier group; they are a key mainstream group that needs to be addressed. Again, it is a question of: there is a group needing services, there is our acute services both in ED and in the community, and how do our acute services address the needs for that?

You are probably well aware that there was a national round table at the end of last year run by the College of Emergency Medicine and supported by the College of Psychiatrists looking at mental health in emergency departments. They put out a communiqué with several points. It is worthwhile this group having a look at that, if you have not already had a look at that. I was very pleased to see the College of Emergency Medicine taking a lead to say that it supports the quality treatment of individuals with mental health issues, including drug and alcohol issues, within emergency departments. That is not to say that diversion should not occur for a range of people. The issue is how do we make our emergency departments more welcoming places, to use Ken Minkoff's term. I do not think the idea is creating some sort of extra, siloed place where people go. Part of the stigma also I think relates to mental illness is stigmatised, but individuals who have drug issues associated with mental illness are doubly stigmatised.

The CHAIR: In terms of mental health observation areas, MHOAs, what do you think about the idea of those spaces being utilised by people presenting in EDs who are psychotic, because of course you have the dilemma whereby you want to keep those people away from the general population because it is distressing for everyone, but they also may end up causing distress for people who may be in a MHOA for suicidality or those sorts of issues as well? Where do we land?

Dr Gibson: There are three models at the moment. One is the psychiatric emergency service, which is a full-on closed authorised mental health unit that could deal with people who were very aggressive. We do not have many of them in WA. Fiona Stanley kind of has one of those, but that is really the only place. There are others in Brisbane, Sydney, Melbourne et cetera. We also have the new services, which are set up within Royal Perth and will come to other hospitals, which focus on people who are drug addicted. They seem to be working reasonably well. But the MHOAs are not for the group who are severely unwell; they are designed to be a low stimulus environment for people who are severely distressed and stressed maybe with depression, suicidality, anxiety or

possibly some psychosis, but they are not staffed, nor structured physically or otherwise, to be there to deal with people who are highly aggressive. That is really important.

The CHAIR: Just confirming that MHOAs are not the solution to this particular group of people with ED presentations, and we need to have that third option, but we currently do not have widespread investment in that option in our hospitals.

Dr Gibson: That is right.

The CHAIR: You referred to the Inspector of Custodial Services' finding that 61 per cent of prisoner referrals do not result in a placement at the Frankland Centre. What is typically happening to those prisoners who cannot access a secure mental health bed and what are the impacts on them?

Dr Gibson: It is not to say that they are not getting access to mental health services; there are still nurses and doctors who see those people within the prisons, but they are not in the right place. If they have been put on a form, they have usually been put on a form by a psychiatrist in the prison. Even though the forms are to see a psychiatrist, if the psychiatrist does the form, the psychiatrist is saying that person needs to be in hospital. WA has virtually the lowest number of forensic beds per capita.

The CHAIR: And it has not risen in many, many years.

Dr Gibson: That is right. I am very pleased to see the subacute units being developed at both Casuarina and Bandyup. I think that is a fantastic move. I know there has been some work put into funding increased transition work from prisons to prevent people falling through the gaps, but we still need extra forensic beds at the moment and that is a problem.

The CHAIR: What do you think in the meantime? Apart from the additional facilities that have been made available at those two prisons, what do you think can happen in the other prison settings until such time as we have additional forensic beds finally brought on board?

[11.50 am]

Dr Gibson: As a short-term solution, greater access to specialist mental health services. For example, some prisons will have sessional psychiatrists, they may have a psychiatric liaison nurse Monday to Friday, but not at other times. That depends on the prison, of course. Greater across-the-board, around-the-clock access to specialist mental health services, not only nurses, but also increased numbers of psychiatrists. The reason I say that is not just to increase the number of psychiatrists. I think that when someone is very, very unwell, a psychiatrist is more likely to be able to negotiate the transfer of that person, to provide specialist medication in a way that is actually going to benefit that person, and to also negotiate around the placement of that person. As you know, at times in the prison we see individuals with psychosis getting stuck in management cells, which are essentially isolation cells. Again, prisons are stuck for options; I understand that, but that can be quite traumatic.

The CHAIR: Particularly for juveniles in Banksia Hill. I have seen that.

Dr Gibson: Yes.

Hon MICHAEL MISCHIN: Page 3 of your submission proposes "Redefinition as a health and social issue" and reads —

> The decriminalisation of the possession of small quantities of any illicit drug for personal use would reduce the harms caused to individuals with severe mental illness by involvement in the criminal justice system.

How do you see that working? Are you talking about a decriminalisation for that relatively small cohort who have severe mental illness, or are you talking about decriminalisation generally across the population? If you are talking about the former, are you looking at some kind of prescriptive element—doctors prescribing small amounts of their addictive drug in order to control their use and allow them to function—or how do you see this operating? You mentioned the balancing exercise between investing vast sums of money for a small group of people. Here we are talking about changing policy and laws that are designed to discourage the use of illicit substances in order to accommodate a smaller group of people. Perhaps if you could explain what you mean and how it is meant to operate.

Dr Gibson: Sure. Look, it is a challenging issue, because, again, I am focusing on those with severe enduring mental illness, and I appreciate that that is then hard to apply across a broader public paradigm. Again, I am not necessarily stating that it has to be done one way or the other. I guess the statement we were making was that if there are novel strategies that can prevent those individuals from falling into the criminal justice system, they will inevitably get better care within the health system. I have not actually gone through a process of saying we have to use one model or another. I think that is a broader debate than my submission, really. I am not trying to throw something out there that is impossible. I guess I am stating the obvious, and wanting to challenge the opportunity to develop new models that might suit that smaller cohort.

The CHAIR: What you are talking about has been an issue which has been brought up in research time and time again. Do you think that the community is ready to look at a shift in thinking around this? It appears that one of the barriers to any reform in this space is our very traditional approach to illicit drug use, in seeing it primarily as a law and order issue.

Dr Gibson: Yes. I guess I refer back to the joint position statement of the Royal Australasian College of Physicians and the Royal Australian and New Zealand College of Psychiatrists who, in some ways, whilst they represent two medical colleges, would be taking into consideration broader community values as well. They have clearly made the statement that we have to redefine illicit drugs primarily as a health and social issue. It is probably not for me to state whether the community is ready for this or not. All I can state is that from a broader medical perspective, I think there is very strong pressure from these two groups to actually challenge where we are as a society on dealing with this issue.

Hon MICHAEL MISCHIN: Redefining illicit drugs primarily as a health and social issue is one thing, but that is not necessarily the same as decriminalising the possession and misuse of certain drugs across the board, no more than removing any restriction and regulation over the availability of prescription drugs. A broadening of emphasis is one thing, but decriminalisation seems to be a very broad policy statement. There would be nothing to discourage people—young or old—from using small amounts of any sort of a drug to experiment with or for their own purposes, in order to accommodate the problem of those who have a severe mental health issue. Perhaps what you are trying to drive at is that there ought to be some facility for earlier intervention and recognition of the problem that does not necessarily criminalise someone but encourages a diversion into access to health and mental health services.

Dr Gibson: I am not sure that the issue of not providing a barrier for young people to experiment is implied by that, because I think the whole idea of a health issue is that it is not seen as something that is to be encouraged. Cigarettes are quite different, but it is the same sort of thing. The whole focus on cigarettes has been trying to work with a whole range of people to try and prevent them from starting to use cigarettes, and so taking a health focus is about a public health focus, to try and

prevent people from using them. It is taking a different tack to actually prevent them from using them.

Hon MICHAEL MISCHIN: Yes, but there are also distinctions. Probably a better parallel would be access to alcohol rather than cigarettes. Cigarettes do not tend to trigger psychosis, and people as a rule do not commit crimes to get money to buy cigarettes; nor do cigarettes cause people to drive dangerously. Alcohol, on the other hand, which is a legal drug—a legal intoxicant—can be abused; there is regulation around that. It is not criminal, but there are restrictions around it. I am just focusing on your bald statement that the decriminalisation of possession of small quantities of any illicit drug for personal use would reduce the harms caused to individuals with severe mental illness by involvement of the criminal justice system. It just seemed something a bit more than nuanced, because we are looking at a relatively small number of people with complex reasons to use these drugs and the effects of these drugs on them. But to remove any restrictions upon access to or use of them seems to put an encouragement, or at least remove any barrier to anyone trying it, like they do with alcohol.

Dr Gibson: Yes, and I think that is a broader public policy issue. I think it is a clear statement that if individuals with severe enduring mental illness did not have to go through the criminal justice process, they would have better outcomes in this. That is really what I am trying to say.

Hon MICHAEL MISCHIN: It is a question of identifying those people early and finding some way of diverting them from the criminal justice system to get help.

Dr Gibson: There may be many ways to skin a cat. My focus is on that group.

The CHAIR: Thank you, Dr Gibson. Unfortunately, we have run out of time, so we might have to wrap it up there. I would like to thank you for attending today. Please end the broadcast.

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, and errors of fact or substance must be corrected in a formal letter to the committee. 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 very much for your attendance today.

Hearing adjourned at 12.00 pm

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