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 FOUR

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 2.02 pm

Mr RON JAMES ALEXANDER
Former Chair, Methamphetamine Action Plan Taskforce, sworn and examined:

Professor DANIEL MICHAEL FATOVICH
Former Deputy Chair, Methamphetamine Action Plan Taskforce, sworn and examined:

The CHAIR: Welcome. Thank you very much for joining us today. My name is Alison Xamon and I am the Chair of this parliamentary inquiry. I just want to introduce you to the other people here: we have Hon Colin de Grussa; Hon Michael Mischin; Ms Lisa Penman, who is assisting us with this inquiry; Hon Samantha Rowe, who is the Deputy Chair of this inquiry; and Hon Aaron Stonehouse. Thanks very much for being here today. On behalf of the committee, I would like to welcome you. Today's hearing will be broadcast, so before we go live, I would like to remind both of you that if you have any private documents with you, make sure you keep them flat on the table so that they avoid the cameras.

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

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.

Mr Alexander: No objections.

The CHAIR: 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 that you do not cover them with papers or make noise near them. If you could, please also try to speak in turn so that it is 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 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 either of you like to make an opening statement to the committee?

Mr Alexander: Yes, I will start if you like. We had a very good task force, very experienced, with Daniel as chair and Professor Simon Lenton from Curtin University; Colleen Hayward, professor from Edith Cowan; Don Punch, MP for Bunbury—very experienced—and Michelle Fyfe, who was assistant Commissioner of Police and now heads St John Ambulance. We had a very good group backed up by the Public Sector Commission and Premiers. For a year, we went from north to south and east to west interviewing people, letting them tell us their stories, gathering information where we could,

listening to people in rehab, listening to people who are running rehab, listening to police and listening to other services—so we got a really good feel for things. Part of what we will deliver here today, too, are some of the universal questions we were asking, so you should have a list of those. I suspect that these are the questions you would expect that we would ask, and people were very forthcoming. We did find that a range of parents and people who have family members caught up in meth found it very cathartic to be able to talk to somebody. In some cases, people were saying that they had not been able to really talk to anyone to get their story across, so that was useful. If you have had the chance to have a read of our report or even a couple of the documents that we put in, we have a list of things that can be tightened up, because there are good things happening, and there are some suggestions about what else could happen. With programs, you find people have very good resources and you look at the resources and think how good they are. In education, for example, you then go and talk to people in education and in some of the different sectors, and they might say that in some given years they do not actually do any education on drugs and how to stay away because the government of the day's issue is bullying in schools, so they concentrate on that. We think that when we see great resources that they are being delivered; in fact, some are, some are not, so there are various stages of what is going to be delivered and what is not. We think it is very important that, particularly in the prevention side, there is some reporting on who is delivering what, and that is not the case at the moment.

The CHAIR: Do you want to make a statement?

Prof. Fatovich: Only to back up what Ron has just said. Also, we are grateful for the opportunity to speak on this. If I was going to say there was one main message, it is that methamphetamine use is a health and community issue, or a health and social issue. That was the recurring theme from all the community consultation and everybody we spoke to. That would be my one main message. There are other things that we can discuss that will probably come out, but that is my one main message.

The CHAIR: Can I start with the start. In the chair's introduction to the final report early on you say —

> Many policies we thought would protect us from harm are failing, some are even counter-productive.

Do you want to elaborate in particular on those points? What is it that we are doing now that is pointless and indeed harmful?

Mr Alexander: When I go and talk to people like Neil Morgan, who was Inspector of Custodial Services, and who I understood usually chatted to —

The CHAIR: Yes, we grabbed him before he retired!

Mr Alexander: Yes, he is a good man. He will be sorely missed. There are approximately 7 000 prisoners, 10 per cent of whom are women. Half of those prisoners have some form of mental illness, so there are 3 500. Some have depression from being locked up, but others have more severe anxiety. There are 10 per cent of those 3 500 who have severe mental illness, so in fact our prisons are our largest mental institutions. Most prisoners do not get assessed when they go into prison. Often there is not rehabilitation available. The government is making some efforts with Wandoo with the women's prison, and a men's prison is being constructed at the moment, particularly for drug users. But largely in the prisons, there is the opportunity for rehab and it is not happening. When you have 350 of those people with severe mental illness, it makes our prisons our largest mental institutions in the state.

[2.10 pm]

The CHAIR: You have just described a lost opportunity, which is different from the idea that we are doing something at the moment which is exacerbating the problem. That is what I was trying to unpick. Rather than looking at where we are failing, where I think we are going to have a very long list, what practices or approaches that we are taking at the moment to deal with illicit drug use, and specifically meth, are proving to be counterproductive?

Mr Alexander: We do not put people in jail who abuse alcohol, yet we put people in jail who abuse other drugs. If those people are not harming anybody else, it is a fairly pointless exercise in putting them into a prison system which cannot help with their rehab and which in fact then adds to their own mental difficulties and does not help. That is a prime example. The education example is one, where there are good resources available. Some do it well, others do not, yet we do not record or know who is doing what. That is another one. We have Aboriginal people who are more susceptible to meth—in my understanding, they are twice as likely to fall foul of meth than the rest of the population—so there are some recommendations with regard to, as you would imagine, being culturally sensitive, but also having people of Aboriginal descent working in that area. We find that in regional Western Australia, it is like so many other things. It is like in education, where so often the young teachers go out to the remote areas and so get some of the hardest classes. In regional Western Australia, we believe there needs to be a case-based approach, because so many of our areas are different; it is not one-size-fits-all. In the wheatbelt, for example, there are something like 23 different shires. To have people who are on meth having to catch a bus to get to somewhere 100 kilometres away to seek some treatment is difficult. Then there is also the stigma of meth. Early intervention in meth is critical. The stigma that they get labelled with often prevents help-seeking behaviour. It is exacerbated in the country because of the fears of being recognised, but also providing services in Western Australia does need a case-based approach because, as I said, of the different nature of regional Western Australia and people being unable to access treatment.

The CHAIR: Recommendation 48 from your final report calls for a parliamentary inquiry into alternative methods of drug regulation and control. This committee is effectively conducting that inquiry and we are representative of five different political parties, so I think that is very useful. The taskforce did not recommend a particular alternative model, but are there any models that you found particularly interesting or that you think show early promise that this committee might want to consider?

Mr Alexander: Certainly. Daniel might like to have first go.

Prof. Fatovich: I would draw the committee's attention to the Global Commission on Drug Policy, which has produced a document called "Taking Control: Pathways to Drug Policies that Work". Again, the number one item is that you redefine the problem as a health and social issue, rather than a law enforcement issue. Once you accept that redefinition of the problem, the corollary of that is that you need to improve treatment services. As I am sure you are well aware, treatment services like rehabilitation are sorely lacking and are difficult to access and understand by people who are trying to get into the system.

The CHAIR: We heard from the police this morning, who were very strongly of the view that no models of decriminalisation should be entertained for any drugs. What would be your reflections on that particular position?

Mr Alexander: The so-called war on drugs has been an absolute failure, because drugs, and particularly meth, are now far more readily available than they were 10 years ago and they are 50 per cent cheaper. Despite all the best efforts of law enforcement agencies around the world, the drugs are more readily available and cheaper. So the supply is there. If it is one of our children or relations or work colleagues and they get up tomorrow morning, they can go and find it. When I sat

in rehab with people that had been using, many times over they said, "Ron, come for a walk with me and I'll find you three shots in 15 minutes, just walking."

The CHAIR: Yes; I noticed that in the report.

Mr Alexander: It is just freely available. Part of what we have written here is the conundrum and the paralysis that governments are facing. What they are facing is that the supply is out there—it is absolutely out there. Criminal harms come with only criminals being able to sell it. What we have constructed, worldwide, is a product which only criminals sell and which is easily found. Yet, we cannot expect governments to start selling that sort of drug. We have all probably had a look at the Portugal exercise and in some other countries where they are making efforts to take control of the supply. Now, that is fraught. That is one in which we end up all being paralysed. We know the current status quo cannot remain, where it is just so freely available, yet what is the next step in taking control of supply? I understand that in Portugal they have taken control of some of the supplies of some of the drugs, and when they get the money from that, they then provide better rehab and provide employers with a subsidy to take on people who have been using drugs to try to get them into regular work. We are not suggesting that we start experimenting on the Western Australian population, but we are extremely supportive of your committee looking at things around the world of people who have been brave enough to try something different. At the moment, what is happening is what some people call the definition of lunacy—we keep doing the same thing over and over again. We have people saying, "We're tough on drugs." Whoopee! We are tough on drugs, but they are more readily available, and nothing is changing.

The CHAIR: When you looked at a number of international jurisdictions, were there any that you looked at where you went, "This would not work within Western Australia. This is a no-go"? Have you got any advice for the committee, from your deliberations, about which ones are really not worthwhile investigating?

Mr Alexander: Which particular countries? We certainly think the Portugal one is —

The CHAIR: Are you saying that is worth investigating?

Mr Alexander: Absolutely.

The CHAIR: We are just interested in whether you saw any models that you thought would not translate well in Australia.

Mr Alexander: We looked at a range of models. For example, in America, about 11 different states have decriminalised or legalised marijuana in one sense or another. I think in Colorado it is in chocolate and biscuits and everywhere else. My understanding is that that policy has gone to hell, whereas other states in America have decriminalised it but not legalised it, so it is still difficult to get hold of. They are having some more success. I do not think anyone is suggesting that you are going to legalise a drug like meth.

The CHAIR: Oh, no; I have not heard anyone say that.

Mr Alexander: They have not, but the paralysis comes with it being so freely available. It is just such a paralysis for us all that we then leave it to criminals, who, as we know, get people into debt. People end up in servitude to criminals. You have people who can afford it paying thousands and thousands of dollars to get their people out of trouble. We have all the harms that come with a supplier, which causes extra difficulties other than the health and wellbeing of the user.

Hon AARON STONEHOUSE: I have a couple of lines of questioning. I will pick up on what you are talking about there—some of the harms related to the illicit drug trade. I wonder whether you can tell me about the experiences of some of the people you interviewed. Have you had experiences of drug users being subject to violent crime and not having a means of legal recourse, perhaps because

that violent crime is around their illicit drug use and they felt they could not go to the police to report violent crime because it is a result of their drug use or drug dealing?

[2.20 pm]

Mr Alexander: We heard a range of stories of people who got into debt, were threatened, and then got into prostitution, burglaries and assaults. I am sure you are aware of the stat that 85 per cent of assaults and burglaries in Western Australia are alcohol and drug-related.

Hon AARON STONEHOUSE: When you say they are alcohol and drug-related, you do not necessarily mean that they are under the influence when they commit those crimes, but they may have some link to somebody having to pay off a drug debt or having a drug debt extracted from them?

Mr Alexander: I think it is all of the above. The 85 per cent becomes all of the above.

Hon AARON STONEHOUSE: So it captures all of that activity?

Mr Alexander: It captures all of that, and so people actually end up in servitude to —

Hon AARON STONEHOUSE: If I owe money to Telstra, Telstra is not going to send somebody around to break my kneecaps.

The CHAIR: Well, we hope not.

Hon AARON STONEHOUSE: But if I owe money to my drug dealer, the only way for them to extract that debt from me might be through violence or coercion.

Mr Alexander: What we discovered—for all of us who have not been involved in these sorts of things before—is it is almost like you have your hand over your face, you are not looking to your left and there is a whole underworld going on there. There was a report in the press a few weeks ago that something like $27 million worth of meth is being sold a week, so that is a huge economy that is happening there. Then all the burglaries and assaults and everything that goes with it is all happening out there. We cannot stop it, because there is only one group of people who are supplying the drug. It is causing extra pain to people. Good luck to this committee in solving that conundrum.

Hon AARON STONEHOUSE: I am wondering what, in your view, drives people to a substance like meth as opposed to cannabis, cocaine or just regular old speed. Why are people going for methamphetamine in particular?

Mr Alexander: If you could imagine the most anxious moment you have ever had in your life and you are living that 24/7 and you have been living that for a couple of years, and then you take a shot of meth and it makes you feel strong and empowered and, in fact, better than you have ever felt before. When you were thinking of perhaps taking your own life, you can understand perhaps why some people do take it.

Hon AARON STONEHOUSE: I wonder whether there is anything to the argument that it is a more potent substance in smaller quantities compared to regular speed or cannabis or other substances?

Mr Alexander: I think it is like alcohol: some people like gin, some people like whiskey, and some people like beer. It has different effects on different people. With meth, we talk to all our young people, tell them how bad it is and that things will happen. Then they try some marijuana or something, they love it and they think that everyone has been telling them lies.

Prof. Fatovich: I think it would be fair to say that meth gives you a higher high than other stimulants like cocaine.

Hon AARON STONEHOUSE: A scenario has been put to me, and I am wondering whether you can clarify or debunk this for me. It has been put to me that some people may have used cannabis recreationally, but because that potentially stays in your system for weeks, it can easily be detected

by drug tests. For somebody doing fly in, fly out work, where they are regularly subjected to drug tests by their employer, cannabis is no longer a way of unwinding and recreating during their time back in Perth. They switch to a different substance like meth, which may only be in their system for a few days. It may be clear from their system, at least at detectable levels, by the time they have to go back to work and are drug tested again. Is that true? Does that happen?

Prof. Fatovich: That is a scenario that has been explained to me, yes.

Hon AARON STONEHOUSE: Is it accurate to say that—hopefully I am not taking too much of a leap here—

Mr Alexander: No. You are absolutely right. When we went to areas like Kalgoorlie and those sorts of places it is the drug of choice, because it goes through the system so quickly.

Hon AARON STONEHOUSE: I wonder whether the prohibition of cannabis is leading people to more potent substances like methamphetamine. Is the criminalisation of cannabis—which can be easily detected and, from a law-enforcement perspective, easily interdicted and detected because it is such a large bulky substance and it is easy to detect in your blood and urine—driving people to more potent substances in smaller quantities like meth, which are harder to detect and harder to interdict?

Mr Alexander: I would say that is a reasonable analysis. Also, cannabis—straight marijuana—is up to 25 times stronger than it was 10 years ago. It is now a far more potent drug. People would tell us it is a gateway to other drugs. Certainly, one of the benefits that people see of meth is the fact that it gives them a great high and it goes through their system very quickly.

Prof. Fatovich: I have a slightly different perspective. I think that can apply to some people, but there is a spectrum of use. Some people talk about the term “gateway”. That probably applies to some people, but for a lot of people it does not. There is a spectrum of use. There is a spectrum of approaches by people. People are not rational; some people just use what they can get their hands on. I do not think you can make it a black-and-white thing about cannabis.

Mr Alexander: I will make a point on the funding of government to the different areas of harm-prevention, education et cetera. All around the world, they put all the law-enforcement resources into stopping the drugs coming in, yet they are more readily available. There have been great efforts with seizures and all of those sorts of things, but it is not making any real difference. Certainly, it is the taskforce’s belief that new funds should be going towards education and harm prevention et cetera.

Prof. Fatovich: I want to add something about the Portugal model. Internationally, the Portugal model is considered best practice, but I think there are two things that people forget about in the Portugal model. First, it was very much a bipartisan approach. The other thing was that their key problem was heroin, not meth. Heroin is a different drug, for which there is a substitution therapy available, so there are some medical components to treatment that are attainable, whereas methamphetamine does not have a substitution-therapy approach available; that is why research is very important. What might work for one major drug problem will not necessarily work for a different kind of drug. To the best of my knowledge, there are few places around the world where methamphetamine is the principal problematic drug. Unfortunately, nobody has been able to work out an approach that is effective.

The CHAIR: Yet.

Prof. Fatovich: Yet, but there is the overriding principle that it is predominantly a health and social issue.

Hon MICHAEL MISCHIN: What exactly was the taskforce's remit? I was hoping that you might be able to assist us as to some of the solutions rather than to pose the problem, tell us that it is a difficult one to solve and hope that we would figure it out. It has been mentioned that we need to redefine drug abuse as a health and social issue rather than a law-enforcement issue, but I am not quite sure what that means. If we recognise that there is an element of physical and mental health that is inextricably bound up as either a cause or a symptom of substance abuse, whether it is methamphetamine, cannabis, alcohol or anything else, I could understand that. But I am not sure what is considered to be a way forward to deal with it. In fact, your report suggests that there is no solution that you have been able to come up with. You suggested the Portuguese model, but you also say that that does not necessarily work. Can you help us out here? I see that there is more than just simply redefining things. We have heard, and it seems that you acknowledge, that decriminalisation or legalisation of drugs across the board, or specific drugs, is not the answer. Yes, the so-called war on drugs has not been an outstanding success, but you are never going to compare it against what it might be like if these substances were readily, freely and commercially available in our communities, and people would be using them as a matter of course, like alcohol. I appreciate a little bit of guidance as to how we deal with the two elements not only of treatment and, broadly speaking, the delivery of programs, but the prevention side of it. How do we deal with it?

[2.30 pm]

Mr Alexander: We believe we gave a comprehensive approach with 57 different recommendations in all of the different areas—harm prevention, education et cetera.

The CHAIR: Services.

Mr Alexander: When we specifically come to supply, that becomes one where we felt it was better, rather than us suggesting decriminalisation or loosening up the supply, that we would not be experimenting on our population. We believe there should be a committee, as yours has been formed, to actually have a look at what works in other jurisdictions, because in Portugal, as Daniel was explaining, some drugs are made available and some drugs so then there is something that you can use instead of the drug to help them come down on, yet meth is not one of those.

Hon MICHAEL MISCHIN: No, and heroin does not appear to be as great a problem in Western Australia as methamphetamine and potentially cannabis.

Mr Alexander: No, that is right. In all the other areas we have made comprehensive recommendations about tightening up some of the good things that are happening in Western Australia but could be better if they were better monitored, and a whole range of recommendations. But when it comes to supply, that becomes an issue that we are not suggesting that the experiments occur on our population. We could make all sorts of suggestions like happening in some countries of it being supplied through medical practitioners and mental health institutions et cetera, but we would prefer to see that happening somewhere else and see what the outcomes of that were first before we tried it on Western Australia. But, clearly, one of the challenges around the world, which no-one has been to be able grab the nettle on, is how you de-stable a criminal model of them supplying it.

Hon MICHAEL MISCHIN: Just on that, because you were focusing on methamphetamine as a task force, are you for, against or noncommittal on the question of decriminalising small amounts for personal use?

Mr Alexander: My personal opinion is treat it like alcohol. Alcohol is another drug. If someone on alcohol punches someone or drives and hurts someone or commits some crime, then they are subject to the law. But if someone is taking marijuana or some other drug and they are not hurting anybody else, then what is the point of criminalising then, because you then put them into jail where

they do not get any treatment and are more likely to come to harm, so it does not seem to be a very sensible policy.

Hon MICHAEL MISCHIN: Okay, let us go back to that premise. You said you do not put people in jail for abusing alcohol; that is right. But we put people in jail for abusing drugs; that is not necessarily correct. Personal use, possession, does not inevitably or even commonly, it appears, result in a term of imprisonment. It is only as a consequence of their actions while under the influence of drugs or a motivation for obtaining drugs that seems to land people in trouble with the authorities that send them to jail. So, we are not sending users to jail. We are sending abusers to jail who commit other offences that warrant them going to jail, such as offences of violence, burglary et cetera. How does this decriminalisation work? Do you mean that if I want to go and get a dose of meth, I will go down to my local store and buy it? How does it work? Is it legalisation or decriminalisation, and how do you think that will work with dealing with the methamphetamine problem where people take it, do not know their limits, commit offences, end up in emergency wards in hospitals? I need some assistance here because we are looking at these alternatives. How do you see it working?

Prof. Fatovich: That is not easy to define operationally, but nobody in the world is recommending that we, for want of a better term, legalise methamphetamine because it is a harmful substance. As a medical practitioner, I am never going to advocate for someone to use officially a harmful substance. The reality is when you talk to people, there are people who do not listen to doctors and other health professionals and choose to use. That is a pathway that a lot of people enjoy but sometimes lands them in trouble. I know that in the Portuguese model, they refer to what is called the Commissions for the Dissuasion of Drug Addiction. Basically, they are subject to civil penalties, rather than criminal penalties. So, that is something that is worth looking into, how they actually do that.

Hon MICHAEL MISCHIN: As the task force, did you examine any of those alternative models?

Mr Alexander: We looked at those but we felt that it needed people to go there, take more time, and look at it and speak with the people who were actually running those sorts of programs. We did not have the opportunity to go and visit or import those people to do that. We spoke to plenty of impressive people who were suggesting, as Daniel said, that it goes down that line. To be fair to Western Australian authorities, they have made a lot more efforts in the last seven or eight years not to just put small-time users into jail. That is a good policy road to be on.

Hon MICHAEL MISCHIN: On the subject of decriminalisation, rather than legalisation, there still has to be an illegal source for the drugs. Even if I happen to have a small quantity I purchased, I purchased it from someone who is a dealer and I purchased a drug that is prima facie illegal. That still creates a market for the underworld, does it not? It is not going to actually reduce the demand that is generating the supply. Perhaps not now, but if you have any thoughts on the subject that may be able to assist us on how such a scheme would work and whether the Portuguese model that was aimed at a different drug is really applicable to a drug that is completely different like methamphetamine. You may not have the time now—it does not even have to be on notice really—but I would appreciate some guidance on this.

Mr Alexander: The question is one that has been asked worldwide, as you know, because how do you get an alternative supply to the criminals when it's there and readily available. At some stage, some nation is going to try decriminalising it at the very least and supplying it to see if it is any better and there are less harms that arrive than just criminals selling it.

Hon COLIN de GRUSSA: I want to pick up on some of the questions that you made earlier about mental health in particular around this—I think what you said was because of the feeling people get or the high they get from meth, it was a way out of a mental hole that they had fallen into, I guess.

So, is it fair to say there is a cohort of users who are self-medicating using meth, rather than seeking treatment for their mental health issues; and, if so, what kind of proportion of the population would that be or proportion of the user base would that be roughly? Is it any different in regional areas in particular where access to those mental health services may not be as readily available?

Mr Alexander: What we are told is that there is roughly around 70 000 people who use meth. Some use it as heroin addicts and others do and manage it quite well, and that is about 85 per cent or thereabouts. Then there is about 15 per cent of users who get out of control; the longer they are on it, the more likely they are to get out of control, hence one of the good things is trying to get people to seek help early when they then have a chance. Also, we felt it would be good if the government and others could tell some of the good stories of where people have actually gone quite well getting off meth, because it would appear to us that it is somewhat of a myth that you have one shot of meth and you are hooked forever, because there are quite a lot of people who have been able to get their loved ones off methamphetamine, and then it becomes a lifelong issue in ensuring they do not get back on it. So, we tend to hear all the bad stories in the press, but we do not hear about enough of the good stories —

The CHAIR: The recovery stories.

Mr Alexander: That is right, and there is certainly a lot of those. But approximately 70 000 people, as we understand it.

[2.40 pm]

Hon COLIN de GRUSSA: And, of those, a proportion have mental health issues before they begin using it, or are using it as a treatment for their mental health issues?

Prof. Fatovich: Yes. There are some people with mental health problems who choose to self-medicate with drugs, for whatever reason, and then there are some people with mental health problems who are on regular treatment who decide to add in extra treatments themselves. I have never seen any figures quoted in relation to proportions, but, yes, that is what we are aware of.

Hon COLIN de GRUSSA: Do you think access to those services makes a difference to whether people use drugs?

Prof. Fatovich: I think as a general principle, yes. People find it hard to access services, and there are not enough services and there are not enough rehabilitation services.

Mr Alexander: Can I just say, one of the issues with all of that, too, is because, as we know, people love to blame governments for failures, but also, in dealing with people on meth, they do not always turn up on time at nine o'clock. They are hard to engage. So, the ones that tend to do better are those that have an advocate that is actually helping them along the way. That assistance is so important to them, and they have got to be pretty tenacious, because it is a rocky road in breakdowns and not turning up and failing and getting back on it again. The ones that do succeed usually have some tenacious people assisting them.

The CHAIR: Can I pick up on this a little bit, because we, of course, have been hearing from families who are calling for compulsory treatment, understandably—they are at the end of their tether, and these are people who they love and they want them to be well. You reflected this in your report as well. I want to know, firstly, what your views are on compulsory treatment, and, even though a call for it is coming from families, where have you landed as the task force around the issue of compulsory treatment?

Also, I am wondering if you could give the committee an indication about the government's recent announcement about trialling compulsory detox and how that differs from recommendation 29, which relates to crisis intervention facilities?

Prof. Fatovich: In relation to compulsory treatment, when you look at the evidence, and there have been studies done worldwide, and I fully understand the rationale for that, which we all do —

The CHAIR: All parents would.

Prof. Fatovich: —there is no evidence that there is any difference at 12 months between compulsory treatment and voluntary treatment. We also understand, though, that in the acute crisis phase, when somebody is at risk to themselves or others, or some acute need for respite, in whatever fashion that may manifest, there is already a mechanism in the current Metal Health Act that is applied where people can be detained involuntarily for their own safety or the safety of others.

The CHAIR: We heard from Dr Gibson this morning, who indicated that there are different interpretations of the provisions under the Mental Health Act as to whether people can detain, even if there is a degree of psychosis, where there is no clear diagnosis of a mental health issue. It would appear that there are concerns that there are limitations under the Mental Health Act pertaining to be able to detain people.

Prof. Fatovich: I can only describe my experience, where I work in the emergency department, and it is not uncommon for people to be detained under the Mental Health Act, as required, according to the situation in circumstances as you described. So there is already a mechanism in place to keep people safe. But that does not change the outcome 12 months later in terms of the proportion who are abstinent. At 12 months, whether there is compulsory or voluntary treatment, around only 10 per cent of people are abstinent.

Hon MICHAEL MISCHIN: How long does a treatment program have to be, in your experience, to have a better than even chance of a good effect?

The CHAIR: A lifetime effect.

Prof. Fatovich: For methamphetamine, a long time. I would not like to define a specific time frame—a long time.

The CHAIR: We were told up to four years.

Prof. Fatovich: It can be up to years.

Hon MICHAEL MISCHIN: I am sorry about this, but if I can just pick up on that point. Is there some evidence to support the view that you can have a methylamphetamine habit in the same way as someone can be a functioning alcoholic?

Prof. Fatovich: There are some people who can remain reasonably functional when they are using illicit drugs, including methamphetamine.

The CHAIR: We have had evidence of that.

Prof. Fatovich: But it depends on how much they use. Some people use infrequently; some people use very frequently. If you are using more than weekly, that is when you start really getting into functional problems.

Mr Alexander: Going back to the question, we did hear from a lot of, particularly parents, the need for what they would term a halfway house—that was not prison and was not a mental institution. They are saying they get ping-ponged around. They go to a mental health institution and they say, "We don't take people on drugs here; you need to go to emergency", and then emergency get them, and if they cause some trouble, they end up in jail. So they are looking for something other than those two areas where they could have their loved one in a stable frame of mind where they could make a decision. When I first started in this gig, I was initially horrified that you could not get into rehab for at least two weeks. I thought that was pretty poor.

The CHAIR: It is worse now.

Mr Alexander: Yes. When I spoke to people who were running rehabs, they would say, "We've got to triage these people because if they don't really want to get stuck into their rehab—if they are forced into rehab—they take drugs with them, and then they ruin other people's rehabs inside." So when you actually stop and listen to people who are working in them, there is a very good reason that they do not just throw them straight into Palmerston or wherever it might be, because —

Hon MICHAEL MISCHIN: It may do more harm.

Mr Alexander: Exactly. You hear from different people who are absolutely sure that unless someone has decided they want to, it is not going to work.

The CHAIR: Hon Aaron Stonehouse has some further questions.

Hon AARON STONEHOUSE: Thank you, Chair. I was just wondering about law enforcement's efforts to curb drug use, I think you might have mentioned it earlier, but I have heard people talk about how the aim of law enforcement should be to limit supply, because if there is less supply of drugs, people will be exposed to them less often, and that would reduce harm. I wonder if you might be able to tell me if there are any unintended consequences of targeting supply. I think of things like perhaps increased risk for people in drug dealing, which means increased prices. Of course, if people are addicted to a substance, the demand is going to be inelastic of the price of the drug, I imagine, to some extent. Have you identified or witnessed any unintended consequences of tackling supply in the illicit drug trade?

Mr Alexander: I think history is a great teacher. When you go back to the prohibition days in America, they could not stop the supply—as much as they were tough on it and all those sorts of things, they could not stop it. Quite clearly, around the world, they cannot stop the supply. So, it is only guesswork, but if they were successful in stopping the supply, what would happen? One would imagine the price would go up and all those sorts of things. It has been proved very clearly that the best law enforcement agencies around the world cannot stop it, and it is becoming more readily available. That is just the fact of the matter.

Prof. Fatovich: In terms of unintended consequences, once supply is restricted, the price goes up. The use of drugs is very price sensitive, and people tend to use what is available and cheaper.

Hon AARON STONEHOUSE: Okay. So you do see a change in behaviour due to the price?

Prof. Fatovich: Yes. It is definitely price sensitive, which reflects availability. If something has become very pricey, people tend to migrate to a different drug.

Hon AARON STONEHOUSE: Substance substitution, for example?

Prof. Fatovich: Yes, even though sometimes it is a totally irrational substitution, from a stimulant to a depressant, but people will tend to use what is available.

Hon AARON STONEHOUSE: What about some of the, maybe, indirect unintended consequences? If previously someone was spending 30 per cent of their pay cheque to service their drug habit and now they are spending 70 per cent of their pay cheque to service their drug habit, what kind of social cost does that have when people become more desperate due to an increase in price of their drug of choice? Do you make any observations there?

Mr Alexander: All of the harms that come with people not having enough money and then they try to steal it or earn it in other ways, that is all there. But also some of the people we have spoken to who are professors in universities and who are international experts on drugs tell us that when you solve the methylamphetamine issue, the next new one will be just on the horizon and that will come in as well, so when you come up with different recommendations, make sure that they are able to be switched to the next exercise that is on the horizon.

[2.50 pm]

The CHAIR: You went around the community, including to a number of the regions. Can you briefly outline the differences that you saw in some of the regions, in particular around the issue of meth?

Mr Alexander: We also had a preliminary document to the main report, which is called "Methamphetamine Action Plan Taskforce: What the Taskforce Heard".

Hon MICHAEL MISCHIN: We have that. It is dated June 2018.

Mr Alexander: That is the one.

The CHAIR: We have that. We have already reviewed that.

Mr Alexander: That is handy. What did you find? In places like Broome, they were having a little more success because there was one highway in.

The CHAIR: So they were having success because they were able to limit supply; is that what you are saying?

Mr Alexander: Correct. I got asked to go up to Exmouth. They had some particular issues. I am not allowed to mention that particular agency so maybe I will leave that story away. I do not think I can talk about the one I was going to suggest on an open mic.

The CHAIR: That is okay. We are still interested to get a general idea about the sorts of differences between Broome, Kalgoorlie, Albany and Geraldton, for example, just generally speaking.

Mr Alexander: When I spoke to the people from the Royal Flying Doctor Service, they said that, at any given time, up to four of their 16 aircraft are out of action flying in people who are high on meth. What they require, then, is a doctor to be on board, a police officer and a nurse. So you have two pilots. Geraldton was one of the main destinations where they were transferring people from.

The CHAIR: If you had to summarise where in the regions you think we have the highest level of need, where would you say it is?

Mr Alexander: Regional Western Australia—places like Geraldton and Albany. A range of them are there. Aboriginal communities in particular. We interviewed a range of Aboriginal women who have been in rehabilitation successfully for 12 months. Their children had been taken away because they were unable to care for them. They get the children back and then they go back into the same environment and it starts all over again. That was one of the distressing areas. We went to the Turner River rehabilitation centre, which is 40 minutes' drive out of South Hedland. That has been very successful. They had a range of people there who seemed to be doing particularly well. As Daniel said, it seems the success rate is something like 10, 12 per cent a year. There are different rehabs who are claiming 70 and 90 per cent, which are somewhat doubtful. In regional Western Australia, some of the issues are —

The CHAIR: Can I just go back to that last point. You said some of them are claiming to be 70 to 90 per cent. I am aware of some services that receive no government funding that have not been able to write any independent evidence to the success of their programs or otherwise, but they have made some pretty large claims. Do you think that there is a need to look at regulation of these types of services?

Mr Alexander: Absolutely. One of our recommendations is that if people are going to set up where they are taking on people who are in a bad way, they have to be able to show some credentials and a successful and safe operation, just like something like a childcare facility; they are required to do that.

The CHAIR: Did your inquiry find that some of those services might actually be creating harm?

Mr Alexander: It has been suggested to us that that is the case. In some of them, there have been objections and stories to that effect, yes.

The CHAIR: One of the things I wanted to ask as well is about the issue of appropriate services for people from CALD backgrounds and also Aboriginal services as well. Did you find that there were an insufficient number of culturally appropriate services available?

Mr Alexander: There are a lot of good services available and there are some gaps. We made some particular references to Aboriginal people being engaged culturally —

The CHAIR: And also CALD.

Mr Alexander: Yes, and CALD—how that works, and also having Aboriginal people and CALD people involved and employed working in those services. We also found that some peer support was quite successful. Some of the particularly successful rehabs had recovered or recovering drug users working in those and, in the right circumstances, relating to the people who were coming in. It was quite successful as well.

The CHAIR: I have attempted to try to unpick waiting list times in questions in Parliament. I inevitably get the response that there are not really any waiting lists and that people are being able to access services within a reasonable time frame and it is not really a problem. I am curious to know: would that reflect your observation?

Mr Alexander: I am sorry, but it is one of those answers—all of the above, because there are all those good things happening but there are also people who struggle to get into a rehab. They struggle for a lot of reasons. A lot of people want to get into rehab but also, as I mentioned earlier, some people on rehab are not exactly citizens who are lining up or going to turn up on time and do all the right things. Their rehab becomes problematical and they become annoying and distressing and disruptive in those sorts of things so they get turfed out. People in rehab who are experienced and well trained understand those sorts of things, so that is part of what happens. Again, having been in government, I know how easy it is to criticise government and think government can make it all work. There are a lot of good things happening out there; there really are. There are a lot of good things that are listed to be happening that are not necessarily happening and need to be monitored more closely, and there are also some gaps.

The CHAIR: Does the taskforce have the opportunity to speak to people who are currently in prison or who have recently come out of prison to ask them about their experiences of trying to address meth use?

Mr Alexander: Yes, we had the opportunity to talk to some people. I can recall one particular one in Kalgoorlie who was in prison and his father paid for high level rehab while he was in prison and had a particularly successful result.

The CHAIR: How did that happen? How was that delivered in prison?

Mr Alexander: I was just listening to the young man who was there in Kalgoorlie to say it. I cannot tell exactly the delivery, how it worked, but the father was able to arrange the rehab in prison and the son had a particularly good result from that.

The CHAIR: I am just curious. I have never heard of anything like that—that people have been able to get any sort of independent health or mental health or AOD services or dental health.

Mr Alexander: That is one story out of Kalgoorlie.

Hon MICHAEL MISCHIN: Was that independent assistance or did he just arrange something with the prison services? Did you get any further detail?

Mr Alexander: I honestly cannot go to the detail, other than the father arranged it and it was successful. That was it. Clearly, in our report, we are aspirational in regards to including people on remand and that they should be assessed and, if they want any rehabilitation, they should have had

the opportunity to do it. From what I understand, prisons are pretty crammed. When I speak to Neil Morgan, the Inspector of Custodial Services, the rehab is just not available.

The CHAIR: We have had evidence given in public hearing that remand prisoners are not being assessed at all. It strikes me as a lost opportunity.

I am conscious of time; we are rapidly running out of time. Your recommendations are considerable and multifaceted, which is good; it is what we want from a task force. What do you consider to be the single most important recommendation that has arisen from your report? If there is one thing you are hoping could be enacted, what would it be?

[3.00 pm]

Mr Alexander: I would wish your committee great success, because I think it is a wonderful opportunity —

Hon MICHAEL MISCHIN: So do I!

Mr Alexander: It is a wonderful opportunity and I hope you get the opportunity to travel to Portugal and others, because I know when you are in government and go overseas, everyone thinks it is a junket.

The CHAIR: They do.

Mr Alexander: My view of the world is that if you do not go overseas and look at some of these things, that would be a great miss, because there is an opportunity to look at that.

Hon MICHAEL MISCHIN: Well, your wish has come true; we will be going there shortly.

The CHAIR: But, presumably, you do not just wish that this committee travel. Presumably, you are hoping that the committee will travel for the purposes of achieving a particular —

Mr Alexander: I would like to see the issue of supply solved, and that almost might require a miracle, but it requires people to be brave. I know someone close to Daniel made the comment that sometimes governments know what to do, but they do not know how to do it and get re-elected.

The CHAIR: On that note, I want to ask: do you really believe that WA is ready to have an intelligent and informed and compassionate discussion about the value of decriminalisation, because we still hear all too often that anything that is moving away from a tough-on-crime approach means that we will be looking at hell in a handbasket?

Mr Alexander: No; you are hearing what we are hearing. When you read the information from the Global Commission on Drug Policy, and when you listen to what happens in other countries, I believe Western Australia is way behind in its view of doing something different and being a little bit brave. The moment someone suggests, for example, syringes in prison, I can tell you everyone —

The CHAIR: People lose their minds.

Mr Alexander: Exactly. A lot of the hierarchy in Justice will tell you that it is a no-brainer—that there should be a needle exchange, that no-one has been stabbed with a needle or anything else. But the unions do not want it. I believe, and in my foreword in the report I made the comment, that I would like to see this as the start of a serious conversation about what to do. But we are very conservative. We get the press quickly coming on board and saying the sky is going to fall in if you have a needle exchange or something like that. It requires people to be brave. This continual mantra of "we are tough on drugs" is just a failing strategy. We need new strategies. We like to think the report was comprehensive, but the one thing that we certainly did recommend was the way forward was supply. We wish you every good fortune on that, because the status quo is disastrous.

Hon SAMANTHA ROWE: It is not working, is it?

Mr Alexander: It is not.

Prof. Fatovich: No. Can I just add that everyone says let us go hard on drugs. I argue we need to go hard on health, which fits in with my opening comment: it is a health and social issue. Repeatedly through the task force, we heard all about the social determinants of health that drives drug use through the community. It is a social disease; it is not the disease of an individual's choice.

The CHAIR: On that note, we have run out of time. I want to thank you both for attending today. It is much appreciated. A transcript of this hearing will be forwarded to you for correction. If you believe that any corrections should be made 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. 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 so much for coming today. It is great that you were able to do so much of that work in your final report, because it is helpful.

Mr Alexander: I am sure Daniel and I really appreciate the opportunity.

Prof. Fatovich: We are very grateful.

Mr Alexander: Can I just say that we have had a very, very good group and I am sure they would all say that if you need any help or you want any discussions, or if we can help you in any way, we would certainly make ourselves available, because we have got good experience. We certainly have a good view of what is happening around Western Australia and it is probably a bit hard to convey it all in an hour.

The CHAIR: But you did it in a comprehensive report.

Mr Alexander: We wish you fair winds.

The CHAIR: Thank you.

Hearing concluded at 3.04 pm

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