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, 17 JUNE 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 10.46 am

Ms SUE JONES
Assistant Commissioner, Alcohol, Other Drugs and Prevention Services, Mental Health Commission, sworn and examined:

Mr DAVID AXWORTHY
Assistant Commissioner, Mental Health Commission, sworn and examined:

Mr GARY KIRBY
Director, Prevention Services, Mental Health Commission, sworn and examined:

Dr RICHARD O'REGAN
Director Clinical Services, Next Step, sworn and examined:

The CHAIR: Hello. On behalf of the committee, I would like to welcome you to the hearing. Before we move to the broadcast, I just wanted to introduce you to my parliamentary colleagues. We have Hon Colin de Grussa; Hon Michael Mischin; Hon Samantha Rowe, who is also the Deputy Chair of this inquiry; and Hon Aaron Stonehouse. I know most of you; my name is Hon Alison Xamon and I am the Chair of this inquiry. Today's hearing will be broadcast, so before we go live, I would like to remind you that if any of the documents in front of you are private, just make sure you keep them flat on the desk so that you can avoid the cameras. Please begin the broadcast.

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

[Witnesses took the affirmation.]

The CHAIR: You will all 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 used 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 and please be aware of the microphones and try to talk into them, ensuring that you do not cover them with papers or make noise near them. Also, because there is a number of you, for Hansard, could you please try to speak in turn. 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 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 any of you like to make an opening statement to the committee?

Mr Axworthy: I am happy to provide an broad overarching comment in terms of the broad policy framework in which the commission operates. I am sure the committee is aware, but I will just reiterate that the commonwealth government has its national drug strategy 2017–2026, which is

overseen by the MDAF, the Ministerial Drug and Alcohol Forum. Sitting in parallel to that at a state level is "The Western Australian Alcohol and Drug Interagency Strategy 2018–2022" that was recently released, which guides the policy setting in terms of WA for alcohol and other drugs. I guess sitting alongside that as a complementary piece is the plan, the "Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025", and its recent update that was published last month. Then more recently, the methamphetamine action plan and the various pieces of work and initiatives sitting underneath that. I know you have spoken with Mr Ron Alexander from the task force. The establishment of a committee of this shape, size and form was one of the recommendations coming out of the task force report.

The CHAIR: I am also aware that one of the things that the Mental Health Commission has responsibility for is the overall review of the Mental Health Act, which I imagine is probably underway, in order to meet the statutory provisions. One of the things that we need to unpick as a committee is the scope of interaction between the operation of the Mental Health Act and particularly people who are presenting at mental health services with drug induced psychosis. To the best of your knowledge, and I am aware that none of you are lawyers, can the Mental Health Act be used to detain people who are experiencing meth psychosis, where mental illness has not been proven; and, if so, under what circumstances and for how long? Because this is an issue which has arisen in the course of this inquiry. Is anyone able to answer that?

[10.50 am]

Mr Axworthy: What I will say, Chair, is that I understand that you had a similar question for the Chief Psychiatrist, and I think his advice was that there is some differing opinion in this space at the moment among clinicians. As a non-clinician and a-non lawyer, that is probably about as far as I am prepared to go in terms of providing an interpretation to the act.

The CHAIR: It is my understanding, though, Mr Axworthy, that the review of the act is likely to come under your department, within the Mental Health Commission. Is this an issue that is likely to be pursued as part of that statutory review?

Mr Axworthy: Absolutely. It has certainly been an issue that this committee has raised and that the Chief Psychiatrist has also raised. So that would clearly be something that would be looked at as part of that review.

Hon MICHAEL MISCHIN: Has any submission been made to the minister to seek legislative clarity of this issue?

Mr Axworthy: Not to my knowledge, no—not at this stage.

Hon MICHAEL MISCHIN: I am not suggesting that is necessarily your responsibility, but if there is some ambiguity about the legislation and it is so fundamental to the operation of the act, ought there not be some urgent steps to tweak the legislation to make it quite clear what the government's position is and what will work?

Mr Axworthy: My understanding, again as a non-clinician and a non-lawyer, is that in the situation of a meth-induced or a drug-induced psychosis, there is ability under the act to detain. The broader issue is at what stage beyond that initial psychotic state is the power of the act to detain for a longer period outside of that acute psychotic episode,

The CHAIR: One of the issues that has been brought to our attention is that there may indeed be capacity to detain someone immediately under psychosis, but at the moment there does not seem to be any capacity to detain people beyond that very immediate period. There seems to be some mixed views around that, so we are trying to get an understanding of what the limitations are currently under the Mental Health Act around that and what the practice is.

Dr O'Regan: What actually happens is a person presents in crisis, generally to an emergency department, and if they have a psychosis, the clinicians are not going to know that this is a meth-induced psychosis. All they are going to know is, hopefully if the family are there, they are going to have a bit of detail about what was going on, they are going to do their assessment of the person in terms of the mental health assessment, and they are going to know that this person potentially is unable to care for themselves, or at risk to themselves or others, and that is where the Mental Health Act is going to be enacted. Whether it is a substance use-induced psychosis or not, that generally comes back later. Quite often you cannot determine that the substance use necessarily is the cause of the psychosis. So invariably a person will be admitted to hospital, potentially under the act, but it will be a number of days before it becomes clear whether that psychosis settles down with the absence of the drug or whether it persists. It is quite often the case that the substance they have used is then going to be attributed to a percentage of that psychosis, but it is very unclear as to exactly what is going on. In my experience, most people who end up in hospital along those lines will have a degree of mental health problems anyway, and it is quite difficult in many instances to actually separate the substance use from the underlying condition. You never get anybody coming to hospital with a psychotic illness who has used meth who does not have other problems as well, and that is usually high anxiety, high depression, a lot of psycho-social issues, and potentially a history of psychosis that has never really been attributed clearly to drugs or not to drugs. So it is hard to tell.

The CHAIR: One of the things that the committee has received evidence of is the value of compulsory detox as opposed to compulsory treatment. Firstly, do you think there is any merit in that; and, secondly, how would that potentially be addressed legislatively?

Dr O'Regan: I think there is merit in it. Talking to some of the clinicians in the eastern states who participate in compulsory treatment, they have anecdotes where people's lives have literally been turned around. Every single case that I have heard of has been a person who has been affected by alcohol. Nobody has spoken to me ever of a situation, and I do not know of any areas where methamphetamine-induced psychosis or methamphetamine problems have led to compulsory treatment. Really, it is all about alcohol, unless you have evidence —

The CHAIR: We are talking about compulsory detox, and we have been told maybe 12 to 14 days being compulsorily detained in order to be able to detox that initial substance, particularly with meth, out of the system enough to be able to get some sort of cognitive understanding of the situation.

Dr O'Regan: I believe that if you can actually achieve that, that will put the person in a much better position to start making decisions about their own treatment and about engaging in a form of treatment. But if the question is what do I think about compulsory meth detoxification, I have never seen it and I have never heard of it being applied anywhere, so anything I say would be really conjecture and speculation.

[11.00 am]

The CHAIR: I imagine that would be quite resource intensive as well. Is there anything in the current framework of services that you think would be equipped to provide such a regime, or is it the Mental Health Commission's view that we would have to look at funding an entirely new set of services in order to be able to provide such a regime?

Mr Axworthy: That would be the position of the commission at the moment. We do not have those services currently available and it would need a whole new model of service to be developed to put something of that type in place.

Hon COLIN de GRUSSA: More broadly on the detention discussion we were having before, do you understand that there is the capacity within the system at the moment—the hospital system, I guess—to be able to effect those sorts of detentions in every case, or would your view be that there needs to be more resources to allow that to happen, and is there perhaps a difference in the regional versus metro context as well?

Mr Axworthy: If you look at the information provided in the task force report—this is a question that was really fundamental to the work the task force did in terms of compulsory treatment—the task force was pretty clear that it did not think there was a need for compulsory treatment, but for that extended care type of approach. I think what the task force reported on was that there was very clear evidence from the families and individuals that they spoke to that they were looking for another option—not necessarily a process run by the police and not necessarily a form of detention within the health system through the Mental Health Act, but some other way in which people might be helped in that difficult period of time. I think the task force talks about that as a "safe place". That is obviously an interesting notion. It is very clear from the report that that is what they heard people wanted. Turning that into some kind of service response is going to be very difficult for the commission.

The CHAIR: Why will it be difficult?

Mr Axworthy: In terms of mapping out the key components around that and whether that needs to have some kind of compulsory component to it or not.

Hon MICHAEL MISCHIN: There may be competing interests involved, but, at the end of the day, you have to do something that is practical. What do you see as possibilities arising out of the task force's recommendations that can be implemented, whether with or without legislative change, that would be a model that you would recommend be attempted?

Mr Axworthy: One of the things we have done in terms of recommendation 29, which is the specific recommendation around safe places —

Hon MICHAEL MISCHIN: If you do not agree with the recommendations, whether tentatively or otherwise, then —

The CHAIR: As a public servant, feel free to say!

Hon MICHAEL MISCHIN: That would be useful, too. Recommendations are recommendations, but they may not be soundly based, from your experience.

Mr Axworthy: But I think what they point to is that there are individuals and families who do not feel that the current service system is supporting them in their times of real need. As a commission, we are very keen to try to resolve those specific issues that have been raised. In terms of that specific recommendation on safe places, the commission has been working very closely with the police and the mental health services in terms of developing and expanding the police co-response model. There has been some funding through the current budget process for further planning in that space to take that model forward, which will need to change and be reviewed in terms of its applicability to regional areas and to also include some specific alcohol and other drug service component to it. The other area in that space is that I think you have had previous evidence around the roles of the mental health observation areas that sit adjacent to EDs and their capacity to deal with individuals.

The CHAIR: And their limitations as well.

Mr Axworthy: That is right.

The CHAIR: Could you talk a little bit more about that?

Mr Axworthy: We have heard exactly the same response. At the moment, we are doing some internal work at the commission to look at maybe an alternative model of service, so that it is not necessarily the way in which the MHOAs are currently configured and providing their services, but to look at a broader model that might have some capacity to stabilise individuals who are coming in in a more distressed state.

The CHAIR: I note that Sweden has an interesting approach to emergency services in that they have a specialised emergency department for people with mental health issues and, in the same building but at a different entrance, they have a specialised emergency presentation for people with alcohol and other drug issues. Is this a model that the Mental Health Commission is aware of?

Mr Axworthy: I am not aware of the specifics of the Swedish model, but I do know that the emergency department at Royal Perth Hospital is looking at a number of innovative ways in which they can deal with the individuals who are presenting to them. They have established their own urgent care clinic, which sits adjacent to the ED, which is specifically run by specialist service staff in that space.

The CHAIR: So do you think there is merit in an emergency service somewhere, particularly within Perth, being able to have a place for specialised presentations in either mental health or alcohol and other drug presentations?

Mr Axworthy: I am very interested in that alternative model. I have been really keen to make sure that we see the relevant evidence that comes out of the trial at Royal Perth to make sure that it is actually providing the services that it was established to do and that it is doing it in an effective way.

The CHAIR: What is the time frame of that trial at RPH?

Mr Axworthy: The UCC has only been running for six months.

The CHAIR: And when is it being evaluated?

Dr O'Regan: I am not aware of when it will be evaluated.

Mr Axworthy: We can certainly find out that information.

The CHAIR: I will take that on notice as question A1. We will write to you, and if you can provide the information around the time frame for that trial and also when it is likely to be evaluated, that would be fantastic.

Mr Axworthy: My assumption is that it is a new service that has been established with an evaluation framework built around it.

The CHAIR: We would certainly hope so.

Mr Axworthy: We will get the information for you.

The CHAIR: Thank you.

Hon SAMANTHA ROWE: Can you talk us through the cannabis intervention sessions and what that typically looks like?

The CHAIR: We understand that the Mental Health Commission oversees the delivery of those.

Hon SAMANTHA ROWE: You oversee those, and the other drug intervention sessions. Is that right?

Mr Axworthy: The role of the commission in that space is that the commission purchases the services from the relevant non-government agency that provides those counselling services. I think they are sometimes provided through the community alcohol and drug services run by the commission. My understanding is that each individual who goes through the CIR process has access to one session. I think that is a 90-minute session.

Hon SAMANTHA ROWE: That is for cannabis, is it not?

Mr Axworthy: It is. Under the other diversion process, the ODIR—the other drug intervention requirement—it is three one-hour sessions, so there is some slight difference in the way in which both operate.

Hon SAMANTHA ROWE: What are the differences or what is the extra content, do you know?

Mr Kirby: They will be brief counselling sessions that will be available.

Hon SAMANTHA ROWE: In the other drug one?

Mr Kirby: That is correct, yes. If we can continue with cannabis intervention sessions, when somebody receives a CIR, they will get in contact with the alcohol and drug support line, and they will book a session for them with a service. The person then needs to attend the service for that particular session, which they have to complete.

Hon SAMANTHA ROWE: Do you know what is the cost per session?

Mr Kirby: It is no cost.

Mr Axworthy: No cost to the individual.

Mr Kirby: Sorry, no cost to the individual.

The CHAIR: What is the cost per session for the taxpayer, for the government?

Mr Kirby: I do not know that.

The CHAIR: Are you able to get that information and provide that to the committee?

Mr Axworthy: Sure.

The CHAIR: I note that as question on notice 2.

Hon SAMANTHA ROWE: Are the sessions individualised or is it a one-size-fits-all?

Dr O'Regan: People come along. There is a core component to it, which will be education. These sessions will be run by counsellors. Then they will, I guess, take it in directions that they need to. Some people will come with instances where the discussion might go into their family of origin or into their past experience, relationships, anxiety, depression and these sorts of things. It may then lead to formal counselling over a longer period of time. There are core and non-core components, essentially.

The CHAIR: What if someone has just eaten a hash brownie at a party because they are trying to have a little bit of fun and they do not actually have a drug problem? How is that dealt with?

Dr O'Regan: Brief intervention might be education. It is highly likely that it will be some education about the harms of substance use and probably not much further than that.

The CHAIR: From a public health perspective, can you see any reason why we would want to treat recreational marijuana use in the terms in which I have described any differently from somebody who has turned up to a party and had two glasses of chardonnay?

[11.10 am]

Dr O'Regan: I am not quite sure what you are asking.

The CHAIR: From a public health perspective, is there merit in having someone who has eaten the hash brownie at a party treated differently from the same person who is at the same party who has had two glasses of chardonnay?

Dr O'Regan: Would we have anything concrete and necessary that that person needs to know or hear or would impact on their behaviour? Probably not, and no, I do not think so. In terms of the impact that you are going to have from what you have described, it would be minor.

Hon AARON STONEHOUSE: Is the goal abstinence from drugs or is it reducing problematic drug use?

Dr O'Regan: The goal is very much: what is the person's goal? The person's goal might be in relation to the law, their family, their job or their health. Some people come to us looking for abstinence definitely. Most people come looking for a reduction. A lot of people look for a reduction and to maintain what is called social drinking, within the case of drinking. Some people can achieve that; a lot of people who have had serious problems with drugs and alcohol cannot achieve that. There are a huge variety of goals.

Hon AARON STONEHOUSE: With the cannabis intervention notices, is the counselling around that aimed at reducing problematic use, or abstinence, or is it what you just described, sort of working with the client or the patient to find out what fits with them?

Dr O'Regan: Absolutely. I am not involved in cannabis interventions. However, it very much depends on what the person wants. Some people will come without any particular problems and they have been made to do this and they do not really want to do it and they will come along so they avoid further penalty, whereas some people come along and that will be, if you like, a stepping stone into a more significant engagement with us.

Hon AARON STONEHOUSE: Do you see that in any way inconsistent with the way police approach this or the justice system approaches this? It seems that the attitude of police or the justice system would be abstinence because it is illegal but then when you receive somebody on a cannabis intervention notice or you put them through a cannabis intervention session, abstinence is not necessarily the goal; you take into account all these other factors. Is that out of step with the way the justice system is approaching it—the health approach that you take in those counselling sessions?

Dr O'Regan: Well, it is, but in my opinion understandably so. They have their remit and their position and I and other healthcare workers have our remit and position. I do not think they are the same, clearly. Yes, it is different but I do not see an inconsistency in the fact that they have a particular point of view that stems from who they are and what they do.

Hon MICHAEL MISCHIN: More significantly, is there a conflict between the various aims that limits the ability to cooperate and integrate with the police and other service providers like the Department of Health and the like? Does that create issues; and, if so, what?

Dr O'Regan: I think there is a conflict between —

Hon MICHAEL MISCHIN: Objectives generally.

Dr O'Regan: I do, absolutely. But again, I think the conflict is entirely understandable from what people's purpose is. I happen to think that the purpose of intervening for a person in terms of their health and wellbeing and their social relationships and capacity to get employment and support their family, to my mind, are the important things. So, intervening with the person from a health and wellbeing perspective, to my mind, is clearly what I believe in rather than the existing punitive position we have.

Hon MICHAEL MISCHIN: One can understand each government organ has different means of getting to those different objectives and the like. Are there, I suppose, fatal, in a sense of policy achievement, inconsistencies or conflicts that need to be resolved between agencies in order that

you can do your job as well as allowing them to do their job—areas that we ought to be looking at perhaps to see whether some more alignment can be achieved?

Dr O'Regan: I do think there is a conflict, but I am not quite sure how to answer your question about what to do with that or where to take that conflict.

Hon MICHAEL MISCHIN: If you can identify the conflict, it would be a good start to help us out, where there are irreconcilable ones that are causing problems.

Dr O'Regan: On the one side, I suppose, you have a position whereby you cannot do that; it is against the law and there is a penalty for that. Therefore, we will apply that penalty. From my perspective, the conflict is in doing so, you make life more difficult for a person in terms of getting employment, or in their family—all those sorts of things that you have no doubt heard of. I think that is the conflict. They are at odds with it. The legal approach makes the social and health approach that much harder when you have to deal with the ramifications of the legal approach.

Hon MICHAEL MISCHIN: If there were no legal sanction or approach, and this comes back down to submissions we have received about decriminalisation—and we will not get into the argument about what that might mean, because it could mean different things to different people—what would encourage people to take advantage of the services that you offer were criminal elements or the police removed from the equation? Would you find people still coming to you or, in respect of the drugs at any rate, is a lot of it triggered as the gateway to you through the justice system and to what extent?

Dr O'Regan: Virtually all the people I have ever treated in 25 years have been voluntary and no legal issue specifically forced them to come and see me. Being a doctor, I deal mostly with alcohol, opioids and prescription drugs simply because there are things that doctors can do in that sphere, whereas cannabis, for example, generally is approached with a counselling type of approach. They do not tend to come to doctors. Most of the people that I have ever seen have come of their own volition. If it were a matter of reducing the legal sanctions against people, would people still come to me? Absolutely, because people come to me because of the things that I have mentioned before—family, employment, accommodation and personal health matters as well. It is not legal issues that make people come to see an addiction specialist such as myself.

Mr Kirby: It is probably fair to say—this is more Richard's field than my own—that people will attend treatment for a whole range of different reasons that they are coerced to do. In the case of the CIR that we are talking about, it brings people in contact with the treatment service that they might not otherwise have done. For some, they will simply expiate and that will be the end of it, but for others, as Richard has already explained, it can be the gateway for them into the treatment service that they might not have otherwise attended.

The CHAIR: Which is effectively the Portuguese model, but it is civilly constructed not via criminal penalty.

Mr Kirby: There are a range of those different models around the world. I am certainly aware that you have spoken with a number of people beforehand who have spoken more about those models.

I come back to that central point about coercion, that people will attend because their relationship is potentially going to fall apart; financially they are in trouble; employment wise, they are in trouble; and legally, it is perhaps another reason for them to come into contact with the treatment service, which brings them into contact with the health gains, the health benefits.

Hon MICHAEL MISCHIN: People do not seek treatment unless they have convinced themselves that they have a problem. That problem can manifest itself in a variety of ways, one of them being

suddenly your family is breaking up or your employer says you cannot do your job properly so you have to go or a police officer arrests you for something and you go to court.

[11.20 am]

Mr Kirby: That is the difficult web I think you are trying to investigate and look at.

Mr Axworthy: I think that is right. Just to come back to your point earlier about potential conflict between different groups in this space, I think all the parties that we interact with on a regular basis recognise this is a very complicated area with a whole range of different and alternative approaches to it. Whilst at the extremes of that, there would potentially be some conflict, but the CIR and ODIR are operated by the police. I think the police are very keen to see those diversion processes expanded, because they recognise the value of having individuals go through those processes. I think, in the main, the conflict amongst service providers, even with different uniforms and different employers, is fairly minimal. I think everybody is trying to work towards some alternative approaches to go forward to try to make the best use of the resourcing that we have to provide the most effective services that we can.

Hon AARON STONEHOUSE: I want to talk a little bit about cannabis and its impact on mental health and how a different approach to cannabis regulation might impact some of your patients. We were talking to a previous witness about the idea that a lot of people using cannabis are self-medicating for some kind of mental disorder or some kind of physical ailment—managing pain perhaps. I was wondering whether you could reflect on your experience with patients self-medicating with cannabis, if you have had any experience there. I am also interested in what impact you think medicinal cannabis has had on mental health patients who do that and how recreational cannabis plays into that. Maybe you can tell us about your experience with patients using cannabis to self-medicate for anxiety or any other kind of disorder. Have you had any experience there?

Dr O'Regan: If I could start with medicinal cannabis, that is much easier because medicinal cannabis has only been available for a very short period of time. I have never come across any patient using medicinal cannabis; it is still an incredibly small number of people.

Hon AARON STONEHOUSE: Why do you think that is?

Dr O'Regan: It has only been around for a little while. I think there is still controversy over the value of medicinal cannabis. I happen to know that the pain specialists in Australia still do not recognise the evidence for medicinal cannabis in terms of treatment of pain. I do not think it has been promulgated. I think the people who are potentially promoting the use of medicinal cannabis in Australia are not pharmaceutical companies; it is generally small people with specialised interests in it—potentially opening up a clinic that relates to medicinal cannabis. That is why it has not got penetration, but, again, it is very early in the stage.

But to get back to the broader question of people self-medicating with cannabis, there is a degree to which the whole self-medication with a drug for a particular ailment, whether it be pain, anxiety, depression, loneliness or boredom, comes into it. But if you talk about people using substances to self-medicate, I think it also takes away, to some extent, from the fact that, with the medications that we are talking about—cannabis or opiates or alcohol, for example, or, indeed, methamphetamine—it is not just a self-medication scenario where a person uses that. If you adopt the position that it is self-medication, you forget that there are physiological changes that occur with the use of these compounds that result in tolerance and dependence such that to ascribe it to self-medication probably leaves out a large number of issues for why people are using that. I also think people get, to some extent, a little bit deluded into the idea of self-medication inasmuch as it is almost like a reasonable reason to use that, not forgetting that they happen to have grown up in

a milieu where people use drugs. Most people use drugs, certainly for the initial time, because it is enjoyable, and then it becomes something that starts to encroach and the people you deal with tend to narrow down to people who also use drugs. You then start to develop tolerance such that if you stop using that drug, it feels awful. But I think ascribing it to "I'm using it as self-medication" obviates or excludes some of those other issues.

Hon MICHAEL MISCHIN: Self-medication tends to suggest that there is some kind of clinical basis for it rather than necessarily a psychological one.

Dr O'Regan: Clinical? I think the two go together.

Hon MICHAEL MISCHIN: You are talking about self-medication as if it is an alternative or collateral to physician medication. It elevates its status. You may as well say that you self-medicate on Valium or alcohol.

Dr O'Regan: Yes.

Hon AARON STONEHOUSE: That is interesting. Can you talk a little bit about perhaps the impact on mental health, if you see one, for people who suffer, say, anxiety and then use cannabis to calm themselves down from their anxiety? What is the drawback there and what are the risks associated with that?

Dr O'Regan: The drawback is that, in the short term, it works. The drawback from that is a disinclination to take a medication that is prescribed. Typically, for example, the serotonin reuptake inhibitors Prozac or Aropax—a whole lot of medications—have unpleasant side-effects, they are very slow to work and most people do not like taking a pill, or multiple pills, on a regular basis. What we are offering as an incentive to improve "You'll get better if you do this; this is a medicated, safe way to address your issues" versus the one of smoking cannabis in the short term is very effective and probably has a degree of social aspect to it. Yes, there are people who are very socially isolated because of their drug use, but for a lot of people, their drug use is, if you like, almost like a club. What I mean by that is that there are a lot of social connections from that.

The downside, of course, from a medicinal point of view for anxiety or depression is that I am offering something that is slow to act, you have to take a pill, you have to come and see me, you have to adopt the mantle of sickness and you have to persist with the medication. Of course, with the medical model, we do not really offer those sorts of aspects of treatment; that is, a person trying to recover from drug use and improve their life needs something in their life to draw them away from the drug use, and we do not tend to do that. What I am talking about here is positive aspects in their life and their relationships and how they actually do something that makes them feel worthy and appreciated and being able to get by in life. The best drug treatment or the best counselling treatment in the world does not address those sorts of issues, and certainly not the medications that I have that might help a person with alcohol indulgence. Probably the best ones that we have are the ones that are used for opiate-replacement therapy for opiate dependence—so, methadone or buprenorphine—because they do tend to provide what the person requires.

The CHAIR: I have some questions I want to ask about service delivery. The committee has heard many times that the time required to recover, particularly from meth dependency, is between six months and up to four years. That is the sort of time frame that has been proposed to us. Do funding structures still revolve around three-month treatment periods?

Ms Jones: I do not think it is the funding structure. If we look at the Next Step clinical service down in East Perth, it has 17 beds down there. Clients come in as needed. They do tend to stay a little bit longer for meth withdrawal and other substances, but they also can have repeat admissions. They then get attached to the community drug service or their GP. That ongoing care, whilst, anecdotally,

it takes longer for people to recover from a methamphetamine addiction, can be quite community based rather than hospital based.

[11.30 am]

The CHAIR: We have heard evidence that people feel as though they are being required to leave services before they are ready and that this is hampering people's rehabilitation and recovery. Is there any move to change so that people can automatically stay longer if that is what they need? Of course, it costs money; we are not unaware of this.

Mr Axworthy: I think there are two elements there; one of which is the contractual terms around the funding relationship. It would be my understanding that if there were a specific circumstance when somebody needed to remain in a particular service for a longer period to ensure their recovery, that would be seen as a reasonable part of that service delivery.

The CHAIR: But that would be deemed to have to be a variation of the nature of that contractual relationship. Is that correct?

Mr Axworthy: My understanding is that it might sit outside the broad terms of the agreement. There would not necessarily have to be a variation. We manage the contracts with the providers quite closely, so that would be part of a normal discussion process with an individual agency.

The CHAIR: Rather than having to deal with that every time there is an individual who needs more than three months and, as I said, the evidence we are getting is that six months is considered to be the bare minimum, are there any moves to change the nature of those service contracts so that it is automatically a six-month amount that is made available?

Mr Axworthy: I am not sure of any formal process at this stage, but I would certainly expect as part of the changing profile of individuals and the particular principal drug that they are seeking to withdraw from.

The CHAIR: We are talking principally about meth.

Mr Axworthy: That would have been a significant change over the last five to 10 years in terms of that profile. But as that profile has increased, I would expect there to be ongoing conversations between the providers and the contract managers and if there was a situation in which the majority of people needed longer treatment cycles, that would be part of an ongoing negotiation with that contractor.

The CHAIR: The other thing is that we have received evidence around the issue of regulation of providers. We are aware that at the moment, providers who are in receipt of government moneys are subject to some sort of oversight. I have a further question arising from this, but could you please give this committee some advice as to what that oversight looks like from the commission for those services that are in receipt of government moneys?

Mr Kirby: May I start off with the work that is being done nationally at the moment?

The CHAIR: Please.

Mr Kirby: The ministerial drug and alcohol forum set in place a project to tie in with the national quality framework. What that is seeking to do is to come up with a commonly agreed set of standards that provide a minimum standard by which all alcohol and other drug services should be able to meet. Without wanting to go into a whole heap of detail, there were some commonly agreed principles between the jurisdictions. That is now being worked through in terms of a range of different accreditation standards that meet those principles. Sometime later this year, my understanding is that that suite of standards that meet those standard principles will then be released. The agreement is that all government funded services should be able to meet those

standards as a minimum. In WA at the moment, all services that are funded by the Mental Health Commission or alcohol and other drug services have to be able to meet a minimum standard already, so it will be consistent with the national quality framework when it is introduced. I understand that the commonwealth-funded alcohol and other drug services are also moving towards that if they have not met it already, but that is around about where that stops at the moment.

The CHAIR: Ensuring a minimum standard, as you have said, applies only to services that are in receipt of some government moneys. What happens to ensure quality of service and, indeed, safety of service for those services who do not receive money? Are there any processes of regulation or oversight or even independent evaluation of effectiveness that is available?

Mr Kirby: My understanding is that there is no minimum standard that exists for those services that are not government funded in any jurisdiction throughout Australia. It is a common issue that the national quality framework was set up to start trying to work towards. My understanding from the commonwealth is that they regard that as being the jurisdictions of states and territories.

The CHAIR: Okay, so it is left up to each state to determine how they will undertake that evaluation. Are there any moves at this state level to address the concern of private providers who are not in receipt of government money who perhaps are potentially not meeting minimum standards?

Mr Kirby: Not that I am aware of.

The CHAIR: There are no moves on foot to address any concerns that might arise from that?

Mr Kirby: No.

The CHAIR: The committee has also heard conflicting evidence around how long people are typically needing to wait before they can get into residential rehabilitation. It is very difficult to try to get a firm number on this. I appreciate that we may have to take this on notice, in which case, we will. Otherwise, if you happen to have it in front of you, what is the average wait time for people to get into residential rehabilitation? As part of that are there differing wait times depending on whether you are in the regions or where you live? Are there also differing wait times depending on whether you have additional requirements such as if you have children?

Ms Jones: There are differing wait times, depending on accesses to different services. I think what is also quite important—sometimes this gets missed, particularly in the media—is that people also need to be worked up, ready to come into detox and rehab. I use the example that if you were going to go in and have an orthopaedic procedure, for example, you would not expect to immediately get in for that procedure, like the next day; you would have to go and see specialists and anaesthetists; you would have to have some tests. That seems to get missed for admissions into detox. You get clients, parents or families, who desperately want them to go in. They have to be ready to want to go as well. Usually, that means they have engaged with the community drug service team. They have had counselling. They have seen a doctor. They are starting to be prepped and be psychologically ready to enter detox. Sometimes, if people are not psychologically ready to go through that procedure, they end up just leaving. There will be a self-discharge because they are not prepped and ready for that. That is one thing we try to dispel a little bit of a myth around that instant access. On the other hand, some people when they contact the community drug service or the alcohol and drug support lines, they are ready and they want instant access then.

The CHAIR: We have heard evidence from those people.

Ms Jones: At that point, they might not be able to get instant access whether they have been held in an emergency department for a little while, perhaps cannot get a bed in Next Step or they might be referred to the GP. Sometimes in terms of education, even people in the health system, are not

that clear on what the pathways are for how to get in and out of services. Sometimes access to the AOD service is not that well understood. That sometimes also gets perpetuated in the media about not being able to get in. It is a bit more complicated than just not being able to get in.

The CHAIR: Surely you have time frames that are kept about when you have people waiting. Do you have those available here at the committee?

Ms Jones: No, we do not have them. We could —

The CHAIR: No worries. I will put that on notice as question on notice 3. I would like to have a breakdown of that please, looking at different regions as well as different types of services that might be available.

[11.40 am]

Ms Jones: Anecdotally, we can say two to three weeks as a ballpark.

The CHAIR: Okay, thank you.

Hon COLIN de GRUSSA: Just to put a regional context on some of those issues then, if you are seeking treatment and you are living in country WA, obviously away from a major centre, a lot of the actual services may well be in Perth, but the services to prepare you for that, what is their availability like in the regions? Would an ideal model have the service itself—the rehabilitation service or whatever you want to call it—actually located in the regions or perhaps centralise that but have the preparation done out there?

Ms Jones: I think a lot of the health services, and particularly obviously the country health services, are very much determined by their care closer to home. They want to have their services and they try to set up the hub-and-spoke model so people do not have to keep travelling up to Perth. I think what is quite interesting is that there is a mandated health policy around statewide detoxing that all health services are able and should be doing statewide detox. Again, I think it goes to education and training, often, with people knowing how to manage and care for people with alcohol and drug issues. I think we have eight specialists in Next Step—AOD specialists—but not broadly across the states to manage these issues.

Dr O'Regan: There are 7.3 FTE addiction specialists employed by Western Australia. They all work for Next Step, and it is all metro. We do not have any addiction specialists employed in WA hospitals, and in my mind it is a huge oversight where you have got multidisciplinary—you have got crisis with methamphetamine particularly, the other drug issues as well coming into hospitals. These are complex people with complex problems. You need a multidisciplinary team involved and we have no addiction medicine specialists having anything to do in any hospitals.

The CHAIR: It is quite extraordinary.

Dr O'Regan: It is. Western Australia is absolutely way behind the rest of Australia in this regard. I have been asked why that is the case and I cannot answer that. It is a historical issue. We have been looking at trying to do this. We have had moments when people have ducked into hospital. I was given a position of one day a week going to Joondalup Health Campus, working in the emergency department, in the wards and in the community mental health service up there. Having an addiction medicine specialist embedded into community mental health services, inpatient services and the hospital is the logical place to go. We are talking so much about having aspects of treating alcohol-and-drug individuals, but quite frankly addiction medicine specialists are not part of the conversation. We are too small. We are also potentially dying out in Western Australia because were not training enough people as well.

The CHAIR: can I just confirm. My understanding is that it is beyond the power of the Mental Health Commission to compel the health department to have that level of specialty within their service delivery. That is correct, is it?

Ms Jones: Yes. There is also the issue, particularly in the regional areas I think, of accessing services and the stigma around accessing services. If you live in a small country town, you will know your GP very well. Do you actually want to if you have a Valium addiction or some alcohol addiction? The issue of stigma is really alive and well. You have only got a look at the newspapers that still talk about "addicts". It is really quite a punitive and very negative terminology, so people can often be hesitant to access services, particularly locally, because they feel stigmatised.

The CHAIR: I am aware we are almost at time. Hon Samantha Rowe has some questions we are keen to get answers to.

Hon SAMANTHA ROWE: If I can go back, if you do not mind, to the drug intervention sessions. Are there cases in which a person may attend, say, one of the other drug intervention sessions, but they do not complete the entire three sessions? Does that happen?

Mr Axworthy: I do not have the numbers.

Hon SAMANTHA ROWE: Is it something we can get information or data on?

Mr Axworthy: Sure, we can take that on notice.

The CHAIR: Can we have that as question 4 on notice, thank you very much.

Mr Axworthy: That is the number that do not successfully complete the three counselling sessions.

Hon SAMANTHA ROWE: That is right. They might just go to the first one and then they do not complete the other two sessions—the three in total.

I also want to find out in relation to the intervention sessions how you measure whether those sessions are having any impact on the drug taking behaviour. Is it something that you have been able to measure?

Dr O'Regan: I do not have anything to do with that, so I cannot answer that question directly, I am sorry.

Mr Axworthy: There would be some element that you would look at of recidivism and there would be some data around people who would receive another charge, a later charge, if where talking about the CIR.

The CHAIR: The police have previously supplied that.

Mr Axworthy: I was about to say that the police are the group that would need to provide that information.

The CHAIR: But otherwise is no independent data kept about actual drug usage as opposed to not being able to avoid getting pinged by the police.

Mr Axworthy: I think there would be a couple of practical administrative issues there. I suspect, but I am not aware, that there would be some kind of evaluation immediately post–your third session that is, "How have you gone? Has it worked? Does it change your attitude or behaviours going forward?" There would be an issue about following as people up six months later—just keeping in touch with people and being able to understand where they are and what they were doing. I think we would be happy to take on notice trying to find any evaluative work that has been done on that immediate post–third session.

Ms Jones: But it would be a therapeutic relationship between the counsellor and the client in terms of the outcomes.

Mr Axworthy: And any evaluation would probably be the responsibility of the police, given its their scheme.

The CHAIR: We will have that as question on notice 5.

Mr Axworthy: Will provide you with a broad overview of the evaluation processes associated with the CIR and the ODIR post-session.

Hon SAMANTHA ROWE: If the commission were going to review the intervention sessions, is there anything that you might do to improve those sessions or any changes you might do to those intervention sessions?

Mr Axworthy: My understanding of the information that the police have provided is that at the moment—I am going to get the phrasing right: is it the expiate rates?

Mr Kirby: Very good!

Mr Axworthy: The expiate rates are actually as one would expect. I guess the broader issue from the commission's perspective would be to make sure that the opportunity to undertake those diversionary activities was increased. At the moment I think the police have made it clear that they view that as a very effective mechanism—a way of diverting people out of the criminal justice system. At the moment there are a couple of issues in terms of the rates there, one of which is around education for the police about what this service, or the diversion system, does. The other is the capacity of the system to provide additional counselling sessions. I think rather than focusing on how the individual sessions run, it would be making sure that there are more of those available across the system to take more referrals in from the police.

The CHAIR: Can I ask the a little bit about its investment in prevention? The committee has heard that there has been very little increase in prevention investment since the release of the 10-year plan, despite the fact that the 10-year plan, which is an excellent plan by the way, makes it very clear that we need to significantly increase our investment in this space. Why have we not done that? I am asking because the money has not kept pace with what was anticipated in the plan. Are you able to give a reason for why that is the case?

Mr Axworthy: I think there are a couple of elements to that, one of which is that the government has recently, with the release of the sustainable health review, recognised that as a target.

The CHAIR: It is a bit of a no-brainer, really, is it not?

[11.50 am]

Mr Axworthy: I think that has been formally recognised as a target for the sustainable health review across all prevention services. So, we think it is a restatement from the government of their commitment to that target.

The CHAIR: A restatement yes, because of course, that statement was made in 2015 and it is now 2019, and so four years later we have not seen that investment.

Mr Kirby: Again, it is restating what is within the prevention plan that was recently released as a compliment to the services plan; there is certainly strong evidence around the effectiveness of that prevention effort that has gone in and some of the other prospective prevention effort that you do in terms of both preventing and reducing use and related harm, which is often something that is overlooked in terms of the harms that you can therefore prevent occurring as well. It is a matter of investment.

The CHAIR: And you have not had that yet.

Mr Kirby: Certainly, the budgets that we have had to work with, no.

The CHAIR: I know the 2018 prevention plan has focused on reporting and monitoring. What types of data collection requirements are you building into prevention contracts?

Mr Kirby: Depends on the contract and what its purpose would be, and then it is a matter of then —

The CHAIR: Could you give an example, particularly as it pertains to alcohol and other drug issues, rather than mental health because I know you are dealing with both sides of this?

Mr Kirby: Yes. Let us have a look at some of the school drug education.

The CHAIR: Please.

Mr Kirby: The sort of indicators that we would be asking them to report on would be going to the amount of service that is actually being provided in the way of contacts with schools, numbers of teachers trained. It will be also then periodically looking towards combining that with some—sorry, I am jumping between two things. Back to the indicators. So, we would be looking at the number of teachers trained, the number of parents who are also included within the parent education sessions that are done, the number of school policies that are developed. So, they are some of the impact indicators that you would be seeking to see, rather than typically what people would think of in terms of the outcomes, what is happening behaviourally, because it exists within the system. So there is a whole bunch of things that, for example, impact upon the alcohol and other drug use of people, in this case school-age students, as well. We will then compare that often to a lot of the prevalence data, which you would be aware of, that we collect on a triennial basis and look at where that is going as well. There is the contract-related work and then the other work that we will do as well. Then some of the others focus more on the harm reduction. So, we will again have a look at—they will be large-impact things, so things that the service can have an impact on. It is the contacts they are having, the number of sessions that they are running, and starting to collect that information because the behavioural outcomes that you would be looking to achieve would be again affected by a whole range of things within the system.

The CHAIR: Often when we talk about prevention, we are talking about schools for obvious reasons because you are getting people, hopefully, as young as possible and you have got a captive audience if you like. I would be interested to know a bit about the prevention programs you have for adults, because I am thinking of entire adult population groups that might be at risk of taking up harmful illicit drug use. Could you give an example of the sorts of programs that you think are effective there in terms of prevention?

Mr Kirby: Certainly some of the work that would be done with regard —

The CHAIR: Also just we just heard from the Public Health Association of Australia as well, who have been quite critical of other programs in other jurisdictions that have not been helpful, for example. They have deemed to be counterproductive, so we are conscious of that. I interrupted you; sorry, Mr Kirby.

Mr Kirby: It is quite all right. It depends upon the target groups that we are interested in. You have mentioned those that are adult related, and where the harm is that we might be interested in and focusing upon or some of the drug use behaviour that we are interested in focusing upon. So, let us use an example of drug use at night-time venues and entertainment events, music festivals et cetera; there would be some quite targeted work that you would want to do about that that might be education-focused in terms of alerting people to the harms they might face if they are involved in any alcohol and other drug use. There is then some work that you want to do around

the environment that is there. Let us use the music festival as an example. What are some of the harms and what is it that you can do organisationally within the place in terms of chill-out areas? What do we know might make a difference in terms of reducing harm? There is the awareness work that we will do with people attending. There are some of the environmental things. How can we make the place somewhere that is going to be safer and optimise health and safety for people attending the event? Then working with the actual staff there in terms of getting training for them et cetera. That is the sort of work we do around that. Then it is about working with local governments because they are the groups that administer or make the sites available. So, it is about working with that system and working with both some awareness work with patrons, but also some of the other work that is going to make the place a safer setting for them to attend. Then there is some other work that we would do, for example, there is some work that we are doing in the methamphetamine space around peer education. So, working with a particular provider —

The CHAIR: Is that via Peer Based Harm Reduction, who are doing excellent work?

Mr Kirby: It might be with them, but there is some other providers obviously out there that have contact with the target groups of interest. So, it might be people who are at risk of methamphetamine use or methamphetamine users. So, how is it that we can get information to them, both in terms of making safer decisions for themselves and decisions that are going to put them into a position that they are going to be able to prevent harm occurring to them, as well as working with other areas that might be able to make their settings safer for them as well. I am aware of certainly some of the criticisms around some of the prevention efforts that have gone on, and it is largely about poor targeting. So, it is going universal or going population-wide for a selective group.

The CHAIR: Actually, yes, that was the essence of the criticism that was put.

Mr Kirby: It is fair to say all of the clinicians work—and certainly what we would work with in terms of any groups that we contract as well, it is about working with them to help them understand what is the target and what does the evidence tell us can be the most effective ways for us to be able to ways for us to prevent harm in relation to that particular group? There are some cases, for example, alcohol use, where you would pursue a universal strategy. Alcohol use in pregnancy is a good example of it—women of childbearing age. But then when we start talking about methamphetamine use, it is a very much smaller group of the population or even those at risk. So, it is finding those groups and then being to be able to talk to them, because talking universally is not only potentially a poor use of the government funding, but it also potentially has some unintended consequences, which is the thing that we really want to principally avoid, about causing problems that might not have otherwise existed. It is about being quite targeted with your work, being quite clear about what the outcomes and the impacts that you want, and then going towards that contracting of it.

The CHAIR: One of the things you just spoke about then was the issue of pill testing, and that is something that has been raised with the committee in a number of submissions, and in the public hearings as well. Has the commission been approached, or has the commission ever investigated the possibility of pill-testing regimes within Western Australia?

[12 noon]

Mr Kirby: We have looked at drug checking. To some extent it has been done —

The CHAIR: At festivals?

Mr Kirby: We are aware of the trials that have gone on in the ACT, and some of the other international literature that is out there around drug checking, and to some extent there has been

some pill testing that has gone on, but we have tended not to focus so much on that as an activity, more so reframing it in terms of, how do you make for safer settings? In the case of music festivals, what is it that you can do at a music festival to optimise the health and safety for patrons attending?

The CHAIR: Have you ever been approached by service providers or concerned interest groups to look at providing pill-testing facilities at music festivals?

Mr Kirby: It is fair to say that there have been groups out there that have called for it. There are certainly a couple of national groups that I am aware of that have called for it, but, to my knowledge, none here to date that have asked for it. I can go back and check.

Ms Jones: We have got a workforce development representative that actually sits on the jurisdictional group that looks at this, but that is really the extent of our involvement.

The CHAIR: Does the commission have a view or any concerns about home testing pill kits—the basic reagent testing that you can buy online?

Mr Kirby: My understanding of the literature is that there are problems, because the reagents will only, by its own nature, be testing for the presence of whatever the reagents are testing for. So, if it is a couple of substances that it is testing for, if it is present, it will show a colour. All it is telling you is that those reagents that it is looking for are present. It provides you with no information about what else is in there, or how pure the substance is that it is in there as well. So there are some limitations, obviously, and some potential problems in terms of inferences that people may make. Basically, it does not tell you what you have not tested for, and it can only be a couple of things.

The CHAIR: Would it be true to characterise that the commission would be concerned about individuals relying on those online reagent tests to try to ensure that their drugs are safe?

Mr Kirby: It would be a very useful thing for people to understand its limitations.

Dr O'Regan: I just want to point out that there is the actual pill testing for the chemical, whether it is harmful, and what the concentration is and so forth, but the whole issue of drug checking is that you are sitting down with a health professional who knows a thing or two about substance use. That is probably going to have more impact on the individual than I would have thought the pill testing. It is like having a home pregnancy kit, I guess, and doing that at home.

The CHAIR: Although they can be relatively reliable.

Dr O'Regan: I am not even talking about the reliability of it, but I think it is a really good idea to have a talk with somebody about what your antenatal healthcare needs are, rather than just go ahead and have the baby. I am just pointing out that what is being promoted with this whole issue of pill testing at a festival is a lot more than just pill testing. I think that gets swamped in the media and in discussions on that one aspect of it, without having a look at the whole thing, and some of the things that Gary was talking about that are festival safety issues, about water and safe spots and police and ambos and that sort of thing.

Mr Kirby: If I can pick up on that, I have seen certainly in a lot of the reporting around it that there is an emphasis on just that as an initiative, and a suggestion that it is going to be a silver bullet. Hence the urging to reframe the question. The reframing has to be: how do we make music festivals a place that can optimise the health and safety of patrons? And there is more than just that that you would do. There is a whole suite of things that should be done that optimise that health and safety for the patrons that are attending.

The CHAIR: With a targeted audience.

Mr Kirby: Yes.

The CHAIR: Can I also ask some questions about drug injection rooms as well: we do not currently have drug injecting facilities here within Western Australia. Is this something that the Mental Health Commission is looking at, or has been approached to look at in any way?

Ms Jones: No, I think our involvement has just been with the health programs around needle and syringe hep C reduction. That is really our involvement there, and it is really more of a health issue, in terms of their responsibility for the needle and syringe programs.

The CHAIR: My understanding was, looking beyond the needle exchange programs, and actually looking at purpose-built facility for the purpose of injecting safely and learning how to inject safely, and potentially also with a smoking room as well for taking illicit drugs. Mr O'Regan, do you have some thoughts about that, and whether there would be merit in looking at something like that in Western Australia?

Dr O'Regan: When I look at the outcomes from the Sydney injecting service, which I think is 15, 16 or 17 years into its operations —

The CHAIR: Yes, it is well-established.

Dr O'Regan: They talk about, I think it is in the tens of thousands of people who have had overdoses that they have treated. It is a huge number. I cannot remember what the number is. The other outcome from that is the number of people who have been recommended to treatment, and the number of people who have actually been able to sit down with somebody who knows a thing or two about safer injecting and safer drug use. My view on safe injecting is that it is an opportunity where you either have people using without any influence or intervention whatsoever, and they are going to do what they are going to do, or do they do what they are going to do with some opportunity to have a discussion with somebody who might be able to get them on to a track that they could benefit from. I am talking about a health and wellbeing track. My opinion is that I am absolutely in favour of anything that provides me with an opportunity to have a positive impact on somebody's health and wellbeing.

The CHAIR: Okay, so this is something that you think would be worthwhile investigating further within Western Australia, is it?

Dr O'Regan: Without doubt—I am fully supportive of it.

The CHAIR: I have also noticed that there are other harm-minimisation measures—harm-reduction measures—in other jurisdictions, such as, for example, in Switzerland, the prescribed heroin trials. Would you have any thoughts on that?

Dr O'Regan: I have been prescribing a heroin substitute for 25 years.

The CHAIR: Are you talking about methadone?

Dr O'Regan: In terms of methadone, and they are not that far away from each other. There is a psychological jump from giving somebody methadone to giving somebody injectable heroin and, quite frankly, I am not 100 per cent sure that the Australian population is ready for an injectable heroin treatment program. Do I think there would be some benefits for people who do not do well in our current methadone or Suboxone treatment program? Yes I do. I think there would be a small percentage of people that would benefit from that.

The CHAIR: Can I ask you about that? When you are talking a small percentage, I am aware that the numbers, particularly in Switzerland, that we are talking about a really small. Would you be able to even give a ballpark figure of the sorts of numbers people that you speculate might be captured or might need such a trial?

[12.10 pm]

Dr O'Regan: I can, actually, because it is the number of people that I treat who disappear from treatment, who do not come in, who will not come to appointments, who do not like methadone or the alternative, Suboxone. I would put that at around about 10 per cent of the people that we treat.

The CHAIR: Which is how many people? In numbers, what would that be?

Dr O'Regan: We have about 4 000 people in Western Australia on alternative pharmacotherapy, so that is methadone or Suboxone. I would guesstimate that there would be around about 10 per cent of people who do dreadfully on methadone for a range of reasons. Is 10 per cent 40?

The CHAIR: That is one per cent—400 is 10 per cent.

Dr O'Regan: Four hundred—it is perhaps as many as that.

The CHAIR: Can I ask, though, are they people that would potentially engage with a prescription heroin trial because they just do not like methadone, or is it likely that a number of those people just do not want to engage with health services? Even if you had a heroin prescription service, they would not be engaging anyway.

Dr O'Regan: I totally agree with that. Either way, the 4 000 people that we reach—there is probably a lot more that we do not reach who are, as you say, not interested in coming to treatment services whatsoever and they will deal with their problems in whatever way that they choose to, independent of treatment services. I think it would be a percentage of that 10 per cent who do not do well on treatment who might then be interested in prescription heroin. I really think that prescription heroin—I would say do not spend too much time thinking about that. I just do not think that is the answer. I do not think that is going to serve a lot of people. I do not think we are ready for it and I do not think we need it. I would be saying, "Can we please look at how we can get more people in WA and Australia involved in the provision of pharmacotherapy?" We struggle all the time to get practitioners involved in the provision of that treatment.

The CHAIR: How do you do that?

Dr O'Regan: By tearing our hair out.

The CHAIR: I do not want to put that forward as a recommendation.

Dr O'Regan: We offer training on a regular basis—perhaps every six weeks we might run a training program. We might get one or two GPs. Most GPs do not want to do it. They are already very busy. They see what we do in methadone and Suboxone as a difficult job with difficult people and, quite frankly, it is just not attractive. In the type of medicine that is practised in Australia where it is fairly brisk, doing addiction medicine is very hard. Having said that, we have about 150 GPs who, for whatever reason, have elected to do that. How do we get more people involved? That is a much more interesting question and a much more practical question. If I had the capacity to do that, we would have a lot more impact on opiate use in WA than a heroin trial, without any doubt. And it would be much cheaper.

The CHAIR: What is the average that people will be on a methadone program for?

Dr O'Regan: If I had my way with people and I could say, "Definitely do this. You really need to be on treatment until things in your life change. Generally speaking, I am thinking 12 months to 24 months." Most people leave treatment far too early because they get jack of it, something else comes up, they move and it is difficult to get to a pharmacy or they move and there is no prescriber nearby. The average is less than a year.

Hon COLIN de GRUSSA: You talked earlier about the number of addiction medicine specialists that are available and we were just talking a little bit about that then. Is the limitation there getting

people into that field of medicine at the start and rather than GPs themselves, getting specialists into that field? How do you address that problem as opposed to training GPs? Is it a resource issue?

Dr O'Regan: Absolutely. It is a resource issue. We have 1.6 FTE training in WA at the moment.

Hon COLIN de GRUSSA: So there are not enough training places available?

Dr O'Regan: Not enough training—I would love more capacity to train more individuals. To invite someone to do some training with us, and they have to have a pre-existing specialty—for example, general practice or a physician—and at the end of it there is no job for them. If I do not have the capacity—I have just had a doctor complete training who did not have a position to go to who is now going to leave the state. Half the people who work as addiction specialists in WA are over 60. They will be retired in the next three to five years and I have 1.6 training at the moment. The sums are that the minimal specialists that we have in Western Australia are dwindling and the replacement is not catching up with the already low amounts that we have.

The CHAIR: I do believe it has been raised in Parliament already as a concern—the number of addiction specialists.

I am aware that we have now run out of time. I very much want to thank you for coming along today. That has been very helpful. Thank you for attending today. The transcript of this hearing will be forwarded to you for correction. If you believe that any corrections should be made because of typographical or transcription errors, please indicate these corrections on the transcript. Errors of fact or substance must be corrected in a formal letter to the committee. We have got a number of questions on notice that we will give you as well. When you receive your transcript of evidence that will also have the advice as to when to provide the answers to questions taken on notice. If you want to provide additional information or elaborate on particular points, you may provide supplementary evidence for the committee's consideration when you return your completed transcript of evidence. Thank you very much.

Hearing concluded at 12.16 pm

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