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 THREE

Members

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

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Hearing commenced at 1.20 pm

Ms JUANITA KOEIJERS
Project Lead, Alcohol and Other Drug Consumer and Community Coalition, sworn and examined:

Mr SHANNON DIXON
Chair, Alcohol and Other Drug Consumer and Community Coalition, sworn and examined:

The CHAIR: On behalf of the committee, I would like to welcome you to the hearing. I will quickly introduce the committee. My name is Hon Alison Xamon and I am the Chair of this inquiry. My colleagues are Hon Michael Mischin; Deputy Chair of the inquiry, Hon Samantha Rowe; and Hon Aaron Stonehouse. Unfortunately, Hon Colin de Grussa has been called away to another committee that is occurring at the same time, so he is unable to be here today. Today's hearing will be broadcast. Before we go live, I would like to remind you that if you have any private documents in front of you, keep them flat on the desk in order to avoid the cameras.

[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.

The WITNESSES: No.

The CHAIR: A transcript of your evidence will be provided to you. To assist the committee and Hansard could you please quote the full title of any document you refer to during the course of this hearing for the record and please be aware of the microphones and try to talk into them, ensuring that you do not cover them with papers or make noise near them. Also, 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 this 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 the 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?

Ms Koeijers: I will briefly. I want to commend the committee on the inquiry and for accepting a late submission from us.

The CHAIR: We would like to know little bit about your organisation. Could you please tell me how you came into existence and how many people are currently involved?

Ms Koeijers: As an association, we incorporated this time last year, during 2018. Prior to that, we had been operating as a transitional alcohol and other drug advisory group. That was on the back of a 2014 consultation into improving consumer engagement in the AOD sector. Basically, the Health

Consumers' Council picked up some funding on the back of that to progress guidelines to inform organisations on how to improve their consumer engagement.

The CHAIR: Are they still auspicing you or are you now completely independent?

Mr Dixon: We are in the form of establishing independence.

Ms Koeijers: We are now completely independent. We have just been given an establishment grant through the Mental Health Commission. We are not in an auspicing arrangement. Actually, we got a small grant to run consultations to write this submission, so we have, kind of, set up from then.

The CHAIR: Are you effectively now the AOD equivalent of COMHWA?

Ms Koeijers: Yes.

The CHAIR: Great. Thank you, I now have you contextualised.

Ms Koeijers: There is not another one of us in Australia. In Victoria, there is SHARC. There is an association of participating service users, but that is just for service users. We recognise family members and significant others as equals in our membership because we understand that drug-related harm does not happen in isolation.

The CHAIR: I want to refer to the consultation that you undertook and the findings in your submission. Your members reported that mental health services are still being denied or withdrawn from those who disclose drug use. Could you provide examples of how and when this has happened? This is something that we hear quite often, but it is not very often quantified or qualified.

Ms Koeijers: I do not think I would be able to provide you with exact examples or any organisations that people have commented on. We were just talking about this previously, what I do see is, after disclosures, the staff in one facility are unsure how to deal with an AOD disclosure and either want to handball or refer to appropriate treatment rather than utilise their own capacity there and then. The same with AOD services; perhaps, they are a little bit hesitant around mental health also.

The CHAIR: In the report, you said that members also report experiencing stigma from health professionals. Again, is it possible to give any examples of your members' experiences of this or even if you are able to speak more broadly? We are trying to tease out the issues of concern that you raised in your submission.

Ms Koeijers: Really, that is speaking to access. When you do not quite look right or sound right, it is a barrier to accessing health services in general. Maybe the reluctance to disclose is a fear of judgement. Health professionals are not getting the full picture.

Mr Dixon: There are a variety of assumptions. Some of our members have often referenced lack of referrals to other agencies based on the assumption that they are not seeking AOD-specific treatment but diversionary—people are pigeonholed, if I were to be broad.

The CHAIR: Could you explain that a little more fully?

Mr Dixon: Some of our member base have reflected being referred to one specific alternative approach instead of being educated on a range of things that potentially could be offered to them.

Hon MICHAEL MISCHIN: Could you give us some examples?

Mr Dixon: Specifically, pharmacotherapy, long-term treatment, one-on-one counselling—there are a range of community-based approaches, but often clients are not educated on the full extent of what there is that they could access.

The CHAIR: This is by mental health services specifically that they are trying to access or health services more broadly? We are trying to get an understanding of where the principal blockages lie

within the system to people who are making presentations and potentially looking for appropriate supports, but are simply not being referred appropriately. What are the barriers to those referral pathways?

Ms Koeijers: GPs are often our first port of call. A GP, unfortunately, is given 15 minutes to have a consult and generally there will be other health presentations to work with. To have the broader mental health discussion alone, the drug and alcohol use discussion, is a big deal to have in 15 minutes. Also, whether that GP has enough awareness of the system and the services around him that could support a client, or his patient, to access what they need.

[1.30 pm]

The CHAIR: Are you finding that it is primary health that tends to be the main barrier to being able to get that early support and referral?

Ms Koeijers: That would be my understanding, yes.

The CHAIR: That is helpful. Also, we noted in your report your members reported preferring to access peer-based services over medical services but that they feel that those services are often undervalued and underutilised. I am hoping that you can expand more on that and on what you would like to see happen in terms of support for peer-based services.

Ms Koeijers: Peer workers, particularly, are just invaluable in the AOD space. If you are wanting to build a rapport with someone, to safely engage them with any course of treatment, it is the peers that can make that contact, and normalise their process and what is happening for them. It is really valuable—I mean, in partnership with counselling and any of the more formal therapists, but the peer workers essentially can speak the language that is real for people. I do not think it is capitalised on as far as improving engagement.

Mr Dixon: Often overcoming stigma and increasing therapeutic alliance, peer supporters can often build therapeutic rapport with anybody accessing services at a much faster rate than anybody else. Personally, I would love to see a lot more of it. Agencies, they do—they underutilise peer supported opportunities and training.

The CHAIR: Out of interest, in the same way that there is cert IV in peer support within mental health, do they have anything similar within AOD?

Mr Dixon: There is AOD cert IV.

Ms Koeijers: Not in peer work.

The CHAIR: Not in peer work, because there is a specific one in peer work for mental health.

Ms Koeijers: Yes.

The CHAIR: That is why I asked, because building up a workforce can be quite complex as well.

Ms Koeijers: Absolutely; and also integrating peer workers into the organisational structure, reporting and all of that kind of thing. There are quite a few workplace barriers, I think, as well.

The CHAIR: I want to tease out this issue of workforce development around peer work a little further. What work, if any, are you aware of—because this is the Mental Health Commission's role—are they doing to develop a peer workforce in AOD?

Mr Dixon: It is part of the 10-year plan, is it not?

The CHAIR: It is part of the 10-year plan, that is why I am asking: what work are you aware of that is occurring in this space, if any?

Ms Koeijers: Apart from increasing scholarship opportunities to the mental health peer work training —

The CHAIR: I suppose that is what I am asking. I am wondering where the training specific to AOD is actually coming through, or are you presuming that the cert IV in mental health peer work is intended to cover the lot?

Ms Koeijers: Yes. I believe it probably is—well, or that is how it is functioning right now. There is no AOD-specific training that I am aware of; there is only the cert IV in AOD.

Mr Dixon: I am not aware of any either.

The CHAIR: Do you think there is a need for that—a specific AOD cert IV, or do you think the current mental health cert IV is sufficient?

Ms Koeijers: I would always go for AOD-specific; it really strengthens the fact that substance use, or people who use drugs, experience problems, and there is a different language around engagement in that field that is not always covered off by mental health.

The CHAIR: So I am aware that within mental health and the development of a peer workforce there, that not everyone who is employed as a peer worker goes through the cert IV process, or needs to go through the cert IV process. I am thinking, for example, of the excellent training being undertaken for people with eating disorders, that do not go through the cert IV, but I would argue has probably the best peer work within the mental health space. Who is potentially undertaking a similar framework of workforce development for AOD peer workers?

Ms Koeijers: I would not know.

The CHAIR: Nobody? If nobody is the answer, that is what the committee needs to know.

Ms Koeijers: Yes.

The CHAIR: It sounds like that needs to occur.

Ms Koeijers: Some organisations are doing small amounts of work around training development, but it is internal.

The CHAIR: I presume they are just doing it for their own service delivery.

Ms Koeijers: It is internal; yes.

Mr Dixon: Those that I am aware of are internal; I am not aware of any service doing it for the sector as a whole.

The CHAIR: Are you aware whether peer workers are a required part of any service delivery funding arrangements?

Ms Koeijers: I am not aware.

Mr Dixon: No, I am not aware either. But in my previous statement, one could argue that internally training up your support workers would benefit the sector as a whole, being specific.

The CHAIR: But we are trying to figure out if it is happening; and, from what you are saying, it is not really—not in a systemic way.

Mr Dixon: Not in a systemic way, no.

The CHAIR: Although you have also just said in your submission that that is the model of service delivery that most resonates with people seeking AOD services.

Ms Koeijers: Our demographic; absolutely.

The CHAIR: Social isolation seems to be one of the biggest issues for your members, a theme which has come through often in the course of this inquiry. What services can best address this and why are your members struggling to access those services?

Ms Koeijers: Social isolation is an interesting one. It can happen for a number of reasons: whether someone's drug or alcohol use has become problematic, whether they suffer from some social anxiety or whether their behaviours from their drug and alcohol use are not acceptable and that increases their social isolation. Currently, my understanding of social interventions are that they involve more education-based things like access to TAFE, access to volunteering opportunities and access to employment. There is nothing that really covers off the more human aspect of interaction than human relations—communication 101: Getting to know your local community. What are your shared spaces? Where do you meet and have a conversation with someone? How do you even do that? There are a few small organisations that do a little bit of this kind of work; no-one really focuses on it. I would think somewhere like the Lorikeet Centre offers a nice —

The CHAIR: Lorikeet is also primarily for people with mental health issues.

Ms Koeijers: That is right.

Mr Dixon: Correct; there is no AOD equivalent.

The CHAIR: And much older people, too, tend to populate Lorikeet.

Ms Koeijers: It can be. It really depends on how an organisation markets and who they get.

The CHAIR: Basically nowhere, is the answer to that question. There is not anywhere really that is providing that service around social isolation?

Mr Dixon: Not specifically.

The CHAIR: But that remains an ongoing problem?

Ms Koeijers: That is right. It is a really big issue, this one, because even when people access residential treatment, they are in there for a long time and then they might go into transitional housing. Outside the support that is organised through part of transitional housing, there is no real facilitation into the greater community. That is left up to the person really and maybe —

The CHAIR: Is that not part of some of the service delivery requirements —

Ms Koeijers: The care planning —

The CHAIR: — to actually look at appropriate transitional arrangements for people, particularly as they are leaving residential facilities.

Mr Dixon: There is the THASP—transitional housing and support program—which a lot of residential facilities have houses for, and there is an emphasis on nine months of ongoing referrals to community-based organisations. So trying to contact —

The CHAIR: Is that sufficient?

Mr Dixon: Yes, it is. It is an incredible program, and I think that it has had a great impact. But at the conclusion of the transition period, there is not very much in the way of AOD-specific engagement for an individual to go to in the community; there would just be the ongoing referrals to the transitional program, which may be other various community groups.

Ms Koeijers: Or back to counselling. There is not a great facilitation into the broader community; it is mainly treatment options.

Mr Dixon: There is a focus on ongoing treatment as opposed to community integration.

The CHAIR: Do you find that that gap means that people are more likely to relapse?

Ms Koeijers: Absolutely.

The CHAIR: And, so, what would a model to address that look like?

[1.40 pm]

Ms Koeijers: Something to be developed, I think.

Mr Dixon: I am not sure, but I would strongly advocate an increase in the transitional housing program. That in itself is quite simple.

The CHAIR: Can I just clarify what you mean by "increase"? You said it is nine months, so I do not know whether by "increase" you mean an increase in time, an increase in scope or an increase in availability.

Mr Dixon: We do not have any access to any sort of numbers, but roughly I think there is something like five or six agencies with transitional houses and probably 100 or so beds. In terms of beds in residential facilities and transitional housing, there is a massive difference.

The CHAIR: Okay, so people are leaving residential facilities without simply being able to access that particular program. So one of the things you are saying is: it needs to be expanded.

Mr Dixon: Correct, yes.

The CHAIR: Is it a particular problem in the regions? Where are the most obvious gaps in that program?

Mr Dixon: One could argue that it is an even larger issue in the regions because people are returning back to the same socioeconomic and cultural areas where their substance use first became problematic, so having a fresh, clean supported environment might be the difference of returning back to the same harms.

The CHAIR: Does your organisation have many regional members participating?

Ms Koeijers: We do. We had around 20 regional participants. We had two face-to-face consultations with around 30 people in each, and we created a survey that mirrored the consultation to send out to our regionals, so yes.

The CHAIR: Do you have much Aboriginal engagement within your organisation

Ms Koeijers: It is limited. We are pretty new; we have about 170 members and we have some national interest as well.

The CHAIR: What is the sort of age, generally?

Ms Koeijers: We made our original membership process quite simple—that you agree to our purpose. We did not ask for many demographics because we did not want to be that off-putting. However, that is something we will revisit pretty soon. We need to know who our membership is.

The CHAIR: Even if it is done confidentially, I suppose. Requirements for national police clearances are increasing. In what areas of life in particular has this affected your members?

Mr Dixon: In terms of what were just talking about, opportunities for members to re-engage into the community and address social isolation—things like basic volunteering—that is something that a lot of members cannot access, even if it is just the Salvos. Convictions for drug-related offences can be a blockage to such things.

The CHAIR: How often would it be that someone has an offence merely for possessing and taking drugs, as opposed to other offences arising from drug-taking behaviour, such as property offences or maybe offences of the person—those sorts of things? How often would it be that someone ends up with a criminal record just because they use drugs and not because of any other related offences?

Ms Koeijers: I could not quote on the stats; I could only provide an educated guess around that, and that is not very many. Most people would accumulate other charges as well.

Mr Dixon: I would agree.

The CHAIR: Okay. Can I ask: one of the issues that keeps coming up in the course of these sorts of inquiries—it will probably be no surprise to you—is the suggestion that we should have mandatory treatment. Can I get your thoughts on that?

Ms Koeijers: Freedom is a basic human right. We always should step into any kind of compulsory treatment with real caution.

The CHAIR: That is interesting, because you are not saying it should never be considered.

Ms Koeijers: No. I visited a facility in New South Wales—a compulsory treatment facility in New South Wales. I do not think it is the best option.

Hon MICHAEL MISCHIN: Why is that?

Ms Koeijers: Particularly the processes—I actually consulted around this—by which family members can place a compulsory treatment order on someone are really damaging to their primary source of safety. People said, "If my family member put an order out on me for this compulsory treatment, I would likely never speak to them again."

The CHAIR: So, just to be clear, your primary concern about the use of compulsory treatment orders is the impact it has on primary relationships in terms of a breakdown in trust?

Ms Koeijers: A breakdown in trust and also you do not want to make any access to treatment a negative one. If you really want to genuinely support someone to make some changes in their life, or even to save their life, I understand that the argument for this is that it is a crisis intervention and you are likely saving someone's life in that time and space, and that is really valid.

Mr Dixon: There is often reference to therapeutic alliance or certain environments that are supportive to therapeutic intervention. There is a power imbalance at a facility that is mandated upon somebody and there can be a lack of investment in the therapeutic process from the individual, particularly if there is no ownership of the things being put in place.

Hon MICHAEL MISCHIN: In short, they do not want to do it.

Mr Dixon: Yes.

Hon MICHAEL MISCHIN: So they are not going to; they will just go through the motions until they get themselves out of the situation.

Mr Dixon: In so many words, I would agree with that—an understanding that what is being suggested to them is irrelevant to them specifically because there is no ownership.

Hon MICHAEL MISCHIN: Can I just explore a little of that, if I may? We have heard a fair bit of evidence about the sorts of things that will motivate people to seek to overcome their drug use, but I just want to understand what information you are drawing on. You have about 170 members. How many of those are actual drug users who identify that they have a problem, as opposed to simply advocacy on behalf of, say, decriminalisation or whatever it might be? Can you give us a breakdown of what your membership is?

Ms Koeijers: Not really. We —

Hon MICHAEL MISCHIN: Did you say you had families and the like as well?

Ms Koeijers: We do.

Hon MICHAEL MISCHIN: What proportion of these people —

Ms Koeijers: Exactly. That is why we are looking at making our membership application much more specific in terms of demographics. Initially we were not wanting to identify people from the outset, but it is actually really important.

Hon MICHAEL MISCHIN: What is it that the organisation is engaged in doing? You do not provide any services yourself; it is really as an advocacy group for people to say, "Well, we'd like this to happen."

Ms Koeijers: Yes, to promote the interests, welfare and education of those affected by alcohol and drug use. Essentially, what I hope we will be about is providing that space for people to start being able to voice what is happening for them across the drug and alcohol landscape, whether that is as a family member or someone who is experiencing problematic drug use, and access to services or lack of them. It is just to support a much broader community conversation around the reality of drug use in society. It has to happen.

Hon MICHAEL MISCHIN: What has your membership told you about things like rehabilitation programs and how they might function? What are the elements of those sorts of programs to get people off, say, methamphetamine reliance or for any other sort of a drug, as to how these sorts of programs should be structured, or should there not be any programs—or what? What are they telling you?

Ms Koeijers: Are you speaking specifically about therapeutic communities or alternatives to therapy?

Hon MICHAEL MISCHIN: I am speaking about overcoming drug dependence. What triggers them to seek that sort of assistance, and what do they think is going to work as a means of relieving themselves of the dependence and the way that it is damaging their lives and the lives of their families?

[1.50 pm]

Ms Koeijers: It is such an individual thing where someone is, and it is usually when things have become vastly problematic that you kind of understand that there needs to be significant change, and then how you go about that is another question. If you are just looking to reduce your use in the short term or in the long term, you might not need such extensive help.

Hon MICHAEL MISCHIN: Do they have anything to say about how to best educate and discourage others from taking up drugs?

Ms Koeijers: We had a little bit of a conversation about that, particularly in relation to decriminalisation. It was interesting exploring that people did not see that the criminalisation of drugs reduced their decision to use. It was not a factor in their decision-making processes around using what they use—the drugs.

Hon MICHAEL MISCHIN: What did they say would, or do they not consider that they have got a problem, and that it is acceptable? How will they see discouraging young people—their kids, for example—from taking up drug use and experimentation?

Ms Koeijers: That was the other part of the same conversation. It is funny that the criminalisation of drugs was seen to be enticing to some, and that particularly young people are seeking to engage in risky behaviour. And actually, having it not deemed so bad or—it is such a naughty thing to do—essentially was taking it off their radar.

Hon MICHAEL MISCHIN: So not sending out a message that drug use is bad and anti-social, it ought to be just neutral about it?

Ms Koeijers: Neutral and informed. Yes, it makes it much less attractive.

Hon MICHAEL MISCHIN: Informed in what way? At the moment a kid might instinctively think, "That is against the law. I want to risk it and try it, just to see what it's like and be a bit of a rebel", but if there is no social comment on it as to it being neither good or bad, then what is the discouragement from trying it out —

Mr Dixon: Education on the risks involved?

Hon MICHAEL MISCHIN: Say, education, but educating them on what and how. What would influence them to not take drugs, when it is not socially stigmatised?

Ms Koeijers: If basic drug awareness was brought in much earlier and really around the physiological aspects, the negative physiological aspects of taking drugs—how it impairs your function, you know, your ability to communicate, and it if it is prolonged, there are some pretty unattractive things that you could throw into that education. It is also about allowing them to make an informed choice. I think people are concerned about their health and wellbeing these days.

Mr Dixon: A lack of the emphasis on some of the reasons that people may choose to use substances and the benefits that they might have in terms of addressing mental health and social isolation and anxiety. There is a reason that people do use, and there is not much education out there that I am aware of on expanding on that. If people were provided with an understanding of why people may use and alternative ways to gain those same benefits, they might have a bit more of a balanced perspective. An emphasis on self-regulating mental health and the benefits of such, alongside why people would use. Does that make sense?

The CHAIR: It does. Can I just go back to this issue of compulsory regimes, if that is okay, because part of the evidence that has been received by this committee is that we need to distinguish potentially between compulsory treatment and compulsory detox, particularly as it pertains to people who are living with meth addiction. It has been suggested that perhaps there is merit in looking at a 12 to 14-day—that sort of time frame—compulsory detox for someone who presents with severe meth induced psychosis, in order to be able to —

Mr Dixon: Stabilise.

The CHAIR: Stabilise, that is exactly right, and have enough time to get the meth out of the system, because the evidence we have received is that two or three days just does not even come close. What do you think about that sort of regime? It has been argued that it might actually get someone to a point of clarity, where they can then make a more informed decision about what they may want to do next.

Ms Koeijers: I do not know how much of that is just a difference of a word: compulsory treatment, compulsory detox.

The CHAIR: Treatment usually means three to six months, and that is expected to undertake a particular—that is a significant time frame and all the things that come with treatment, whereas a detox is just that.

Ms Koeijers: My understanding is that the compulsory treatment programs over east were not that long.

The CHAIR: Would you have the same concerns with the compulsory detox regime as you would with a compulsory treatment regime? Is that your advice to this committee?

Ms Koeijers: I would be hesitant around anything compulsory.

The CHAIR: We compulsorily detain people under the Mental Health Act now.

Ms Koeijers: Yes, I know. However, there is real need to address the safety of these people in that moment in time and how we go about doing that in a way that is humanitarian that does not drive them away from seeking help in the future, and that creates a positive experience around the purpose of them getting well. Like, that it is not a punishing or punitive action. This is: "Actually, we don't want you to die out here, and you're about to". How do you do a compulsory detox and frame it in that way, if it is compulsory.

Mr Dixon: I would be curious to know the direction or the impact that one would hope that would have on the community. In terms of voluntary detox, the relapse rates are very high. A lot of people would enter facilities and detox, physically addressing the dependency, but not so much addressing the emotional and psychological dependency that one could have and that can take months to years.

The CHAIR: Can I just ask, is that because there is a lack of services to help assist with whatever the social determinates are happening within someone's life that effectively are contributing to the addiction?

Mr Dixon: There are services out there to address those. Often it is a lack of understanding of dependency, and people enter short-term detox facilities thinking that it will be a one-stop shop, if I could use that language, not realising the extent that substance use integrates into people's personal lives. My thoughts on the compulsory detox would be that it would be an amazing opportunity for somebody to stabilise and possibly have an understanding of options that are out there, and significant reduction of risk to self and the community in that very moment, but in terms of long-term impact on somebody's substance use, I would be questionable how impactful that service would be.

Ms Koeijers: If more detox opportunities were to become available, the intake processes are—you cannot get into detox when you need it. It is about capitalising on momentum, when there has been a situation and you realise you are in crisis, and go, "Right, this needs to happen now". There is no way you are pretty much going to get into a service then and there.

The CHAIR: Can I pick up on that, because that was raised with the Mental Health Commission, and the Mental Health Commission's evidence to this committee was that any waiting list go into residential facilities is actually very small because there are necessary precursors to admission anyway, and that they would have to occur regardless. What are your reflections upon that?

Ms Koeijers: Are you talking access or entry into residential treatment or mental health services?

The CHAIR: Either really, if you are telling me that there are problems with both. I was specifically talking about residential facilities.

Ms Koeijers: Moving just back from that, detox is the first port of call for a residential treatment facility, so you cannot actually get into a residential without having detoxed somewhat, so some are embedding small low —

Mr Dixon: Low-medical detox facilities.

[2.00 pm]

Ms Koeijers: Yes, which is helpful, but the access to detox in general is just not —

Mr Dixon: My understanding is that there is a bottleneck before detox. So access, like the Mental Health Commission reported, is actually quite short to get into long-term residential facilities. So people can be approved a bed but then still need to go through the screening process of the detox facility, which can actually be quite tight.

The CHAIR: So when you are talking about the detox facility, you are specifically talking about Next Step, are you?

Mr Dixon: Yes.

Ms Koeijers: DAYS and Next Step, DAWN.

Mr Dixon: There are a couple of recently emerged low-medical detoxes, which are effectively not staffed by medical staff 24/7, so they cannot —

The CHAIR: Like who? Who is doing that?

Mr Dixon: There are a couple of services out there—DAWN, for instance.

The CHAIR: Okay.

Mr Dixon: DAWN would be classified as a low-medical detox. They have certain criteria around what they can detox from, and under what circumstances, and they would refer to Next Step if it was too complex.

The CHAIR: Okay. So, it is difficult getting into those first steps.

Mr Dixon: Effectively, people are sick enough for rehab but too sick for detox.

Ms Koeijers: Is that right—too sick for rehab?

Mr Dixon: No. They have been approved for a bed in residential but have been too unstable to go through detox.

The CHAIR: Too unstable to go through detox?

Mr Dixon: Yes.

Ms Koeijers: Wow!

The CHAIR: So what are they supposed to do?

Ms Koeijers: That is a very good question.

Mr Dixon: That is a good question. If somebody has suicidal ideation or unstable mental health —

The CHAIR: Okay. This is what I am trying to understand. It is the people who have comorbidity, is that what you are saying?

Mr Dixon: Correct. Sorry if I was not specific about that.

The CHAIR: I was just trying to figure out how someone could be too unwell. So we do not have the services to deal with comorbidity detox, apart from—I understand that certainly people can potentially be involuntarily detained under the Mental Health Act in Graylands and those sorts of services, but only for a few days.

Mr Dixon: In some cases, some clients —

The CHAIR: Not always.

Mr Dixon: Not always.

The CHAIR: I mean, we are talking psychosis, not depression, and certainly not suicidality. So that is where the gap is. That is helpful.

Mr Dixon: Yes. I mean, how many beds are there at Next Step? There are 15 or so. That is the extent of the state's medical detox capacity. So there is quite a backlog.

Ms Koeijers: Where I am going with the detox and the compulsory is if we can improve our access to detox in general for the general public, so they are coming in willingly, they can jump in when

and where they think they need it, and that ought to stabilise them. Rather than create an opportunity for a small number of the population and make it compulsory, I think that would be more proactive, and that making detox more readily available across the board and in general would be more helpful than a small compulsory detox program.

The CHAIR: The committee has also received evidence about the need for better regulation of private rehabilitation providers, particularly those who are not in receipt of government money but, of course, are not subject to any independent evaluation. Do any of your members have any reflections on that particular issue, or is there no problem?

Ms Koeijers: The reflections I have heard are that people get really attached to the place that they got well at. So, wherever they sought treatment, whatever quality treatment they got there, they are still fairly attached to the place that they went to because —

The CHAIR: Because they got well.

Ms Koeijers: They got well—they felt that it saved their lives at that moment. There are, however, a variety of treatment options out there. Some may be better or worse or safer than others. People just do not know what is available when they are given the first option by chance—whoever they happen to see, whatever networks they know, wherever they have been recommended to by family and friends—so they can end up in one line of treatment without fully understanding what may be available.

The CHAIR: Is there a problem with the need to regulate private providers?

Ms Koeijers: Yes.

The CHAIR: There is a need to do that?

Ms Koeijers: Yes.

The CHAIR: Can I also ask: pill testing and related services at festivals, is this something that your members are supportive of?

Ms Koeijers: Yes, absolutely.

The CHAIR: Could you tell me, in your view, what sort of regime of pill testing at festivals is likely to be the most effective at engaging your members?

Mr Dixon: Can you elaborate on that?

The CHAIR: What would a good pill-testing regime at a festival look like, that is going to be attractive to your members to use? What would be the characteristics of that?

Ms Koeijers: Use our peer workers and other health professionals in tandem; so for safe places, no police presence, no sniffer dogs.

Hon SAMANTHA ROWE: No police at all?

Ms Koeijers: If police are there, or officials, that might be a crowd-control issue, but not visibly in uniform around a potentially safe space.

Mr Dixon: Also, educational and transparent results, not just specifically with someone engaging with the pill testing, but also having the ability to be transparent with one individual who has, say, a problematic result. So the entire festival could engage in harm minimisation by not actually engaging with the pill testing, if someone was to present with something that was problematic, by actually advertising that at the festival.

The CHAIR: I am curious. How is that actually advertised? Is it put up on a screen or something to say, “By the way, don’t take the pink pills with the bunny on it”?

Mr Dixon: In so many words, yes, on a board, and that would educate the majority. The social word gets around quite quickly, particularly at a festival, and that would equip people with the education of what not to get their hands on.

The CHAIR: We do not have as strong a festival culture over here on the west coast as on the east coast. How much of a demand do you think there is, nevertheless, for pill-testing regimes at the few festivals we have here?

Mr Dixon: In Western Australia?

The CHAIR: In Western Australia, because we are only here from Western Australia, so it is all we are looking at.

Ms Koeijers: I would still think there is value in promoting it, just because it is a beautiful community education platform, and you are talking about educating our young people in safe drug use practice, which this population is obviously engaging in. There is over 50 per cent disclosure that, yes, they do take pills at festivals, so I would expect in reality it is much higher, so how do we capitalise on this opportunity to educate our young people and keep them safe.

The CHAIR: The argument that is put against this is that it is actually sending the entire wrong message, and that in essence it is almost giving de facto approval to people engaging in drug use. What would be your response to that criticism?

Ms Koeijers: I do understand this, and thankfully I am not a parent! It is a really difficult space. Drug use has been a part of our collective human experience since the beginning. The Bible tells plenty of stories of drunkenness and debauchery if you want to go that far back, and even as far back as some traditional medicine texts, particularly one for a herbal remedy. Really, what I am saying is that excess has been described in human culture for a very, very long time. People have a propensity to take mind and mood-altering substances for a variety of reasons. If we can encourage a broader conversation around the risks and the safety, I think it would be more helpful in addressing the stigma.

[2.10 pm]

Mr Dixon: Just in relation to the pill testing, there is no guarantee that anybody is not going to have a reaction to any substance used, so although pill testing in itself can minimise harm, it will never eradicate it. Somebody can have something tested and there can be duplicates—there can be a range of things. One person's reaction to a certain substance might be completely different to somebody else's, based on their physiological response. It is simply providing informed consent. Pill testing is definitely not saying that substance use is free from harm. If it is educated as such, I do not think it could ever be taken as being a green light from any sort of authority, but as a strong warning of its risks.

The CHAIR: I am going to bounce back to the issue of meth rehabilitation. One of the concerns that has been raised with us is that the current three-month cycle of funding for services, particularly residential, is just not sufficient. The evidence we have had is that people need up to four years to be able to fully recover from meth addiction. Has it been the experience of your members that the amount of time available to them within residential facilities is simply inadequate to be able to give them the support they need, or is that not reported so much as an issue?

Ms Koeijers: I know people are able to advocate for longer stays.

The CHAIR: To the best of your knowledge, when people advocate for those longer stays, are they generally being granted?

Ms Koeijers: Yes.

The CHAIR: They are. Thank you. So it is not a systemic problem and that services are going, "Look, I'm only getting funded for this bed for three months, so I'm really, really sorry but you're going to have to go"? Is it your understanding that if people need to stay longer, they are generally able to?

Ms Koeijers: That is my general understanding.

Mr Dixon: There is also a preference on transition for the benefit of the client and not staying within the residential facility. There can be like a deficit to their recovery, so to speak. With therapeutic community models, there is also a staged approach. The latter part of their treatment is focused on transition, so that could be extended. There is obviously an emphasis on making beds available for people, but from my experience and understanding, there is no limit on it.

The CHAIR: So the main blockage, then, is early on in trying to get that detox, and then when they are leaving, they are not necessarily getting the full range of social supports they require in order to be able to successfully transition into the community.

Mr Dixon: My knowledge base there is from not-for-profit, non-government-based residential rehabs or therapeutic communities. The private sector that you were referring to before would be a little different.

The CHAIR: With these questions, I am really focusing on the ones that we know are regulated within a government system.

Mr Dixon: Yes. The issue with those would be the financial burden to the individual going through and not having the ability to stay long term. There would be a number of things that would dramatically shorten their treatment.

The CHAIR: I am conscious of the time; we have only a couple of minutes left. One thing I wanted to do was to basically hand it to you and say: what would be your top priorities for law reform for this committee to contemplate?

Ms Koeijers: Law reform? Certainly, just increasing services within justice themselves—increasing the quality of the services—before tackling anything like decriminalisation, even though I am personally supportive of that. We have a captive population of people experiencing the greatest burden of harms. Justice services could do a lot to improve outcomes for these people.

The CHAIR: When you say "justice services", I do not know whether you are talking about services within the prison system itself or whether you are talking about justice services in terms of diversionary programs or courts. What are you talking about when you say "justice services"?

Ms Koeijers: I am talking both, but primarily within the prison system itself. Certainly, the diversion program.

Mr Dixon: The court-appointed treatment services. Things like the Drug Court are effective.

The CHAIR: So you do not think there is enough emphasis at that level? Would that be the first area of law reform that you would consider?

Ms Koeijers: Within the prison system?

The CHAIR: I am asking you; it is your evidence.

Ms Koeijers: Without having to shift any money around, if you are going to fund law enforcement to the level they are being funded, they need to improve their services to people in-house, not just in targeting drug supply.

Mr Dixon: So education on identification and early intervention?

Ms Koeijers: Within the prison system?

Mr Dixon: Within enforcement.

Ms Koeijers: The provision of services to the prison populations, outside of Pathways or bloodborne viruses. Yourself?

Mr Dixon: I am not sure right now.

Ms Koeijers: It is a tough question.

The CHAIR: That is okay. I would like to thank you for attending today. Please end the broadcast. A transcript of this hearing will be forwarded to you for correction. If you believe that any 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. If you want to provide additional information—when you have had a chance to think about it, you may go, "I wish I had said this"—or if you want to elaborate on particular points, you may provide supplementary evidence for the committee's consideration when you return your corrected transcript of evidence.

Mr Dixon: That would be nice.

The CHAIR: Thank you very much.

Hearing concluded at 2.17 pm

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