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

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

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
MONDAY, 15 APRIL 2019

SESSION FIVE

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 3.14 pm

Ms JILL RUNDLE
Chief Executive Officer, Western Australian Network of Alcohol and other Drug Agencies, affirmed and examined:

Mr ETHAN JAMES
Manager, Advocacy and Systems, Western Australian Network of Alcohol and other Drug Agencies, affirmed and examined:

The CHAIR: Hello. My name is Hon Alison Xamon. I am the Chair of the committee. I have already advised the committee that I know you both. I want to introduce the other people who are here. There is Hon Colin de Grussa; Hon Michael Mischin; Ms Lisa Penman, who is assisting the inquiry; Hon Samantha Rowe, who is the Deputy Chair of this inquiry; and Hon Aaron Stonehouse. On behalf of all of us, I would like to welcome you to today's hearing. Today's hearing will be broadcast. Before we go live, I would like to remind you that if any of the documents in front of you are private, keep them flat on the desk so that you avoid the cameras. Could we please begin the broadcast. I now require you to take either the oath or affirmation.

[Witnesses took the affirmation.]

The CHAIR: You both 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. 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 could you please be aware of the microphones and try to talk into them, and ensure that you do not cover them with any papers or make noise near them. Could you also please try to make sure you both speak one at a time. It makes it a lot easier for Hansard. I remind you that your transcript will be made public. If you wish to provide the committee with details of personal experiences during today's proceedings, you should request that the evidence be taken in private session. If the committee grants your request, any public and media in attendance will be excluded from the hearing. Until such time as the transcript of your public evidence is finalised it should not be made public. I advise you that publication or disclosure of the uncorrected transcript of evidence may constitute a contempt of Parliament and may mean that the material published or disclosed is not subject to parliamentary privilege. Would either of you like to make an opening statement to the committee?

Ms Rundle: Yes, I would. Thank you very much for the opportunity to present to this inquiry. Before I start, I would like to acknowledge the traditional owners of the land where we are meeting, the Whadjuk people of the Noongar nation, and pay respects to elders past, present and emerging.

A little bit about WANADA—WANADA is the peak body for the alcohol and other drug service sector in Western Australia. We are the peak body of the drug education, prevention, treatment and support services. We are an independent membership driven organisation, not-for-profit. Our member agencies include community alcohol and other drug counselling, therapeutic communities,

residential rehabilitation, intoxication management, harm reduction, peer-based prevention, and community development services. Our vision is for a human services sector that significantly improves the health and wellbeing of individuals, families and the community by addressing issues associated with alcohol and other drugs.

I would like to take this introductory opportunity also to talk about the complexity of substance use issues, and there is no single solution, I think it is fair to say. In terms of the health effects on individuals, there are psychological factors—addressing coping skills and resilience. There are biological factors—genetic factors, tolerance and breaking patterns of behaviour. There are social factors—many people experience issues with abuse and trauma; low socioeconomic status; and poor community connectedness. All of these contribute to the development and the maintenance of substance use disorders, or dependence or alcohol and other drug problems.

Just in terms of where we are at in Western Australia, the Western Australian government established an independent statutory body in 1974 to specifically address alcohol and other drug issues. This predates the introduction of the national drug strategy to reduce illicit harm, which was first established in 1985; so more than 10 years prior to the national drug strategy. It is great to see the national drug strategy and the three pillars. It is a strategy that covers both health and law enforcement. The three pillars of the harm minimisation strategy are harm reduction, demand reduction and supply reduction. It is important to note that the balance of funding across the three pillars is significantly out of kilter and imbalanced, with supply reduction receiving about 65 per cent of the funding, treatment about 30 per cent, and harm reduction very minimal—I do have more exact figures here—about two per cent. They were the 2010 calculations, and that was recorded in the "Parliamentary Joint Committee on Law Enforcement—Inquiry into crystal methamphetamine (ice): Final Report". I think we need to be addressing any issue across the range of strategic areas for a more balanced approach. That probably is a good start as an introduction, thank you.

[3.20 pm]

The CHAIR: Mr James, did you have something you want to say?

Mr James: Just shortly. Just of note is that with WA having a population that is approximately 11 per cent of the nation and a landmass of one-third of Australia, I think it is important to recognise that in an environment of fiscal constraint, consideration really should be given in regards to how we establish an effective, efficient and balanced system of services and responses that meets the needs of people across both metropolitan, regional, rural and remote areas. Realising this requires improved community education and awareness but also, particularly, sustained political leadership and support for the implementation of evidence-based practice over the long term. I think I will keep it at that.

The CHAIR: Thank you. Can I turn to your submission? Thank you very much for giving that. You say early on under "Leadership drives change" that there is evidence that community attitudes to drug use issues has shifted significantly away from a law enforcement response to more treatment. You quoted from the Australian Institute of Health and Welfare report "National Drugs Strategy Household Survey 2016". Having said that, I am questioning whether community attitudes have changed and whether there really is an appetite to look at different approaches to how we deal with the issue of drug misuse. Can you give some more thoughts around that issue?

Ms Rundle: Yes. I think the attitudes that have changed are more in line with what we hear and have seen in terms of recommendations in quotes around "We can't arrest our way out of drug issues." The attitudes are more around that we should stop spending money on law enforcement and start spending more money on treatment, harm reduction and prevention. That is the attitude,

as opposed to a shift in attitude, in relation to stigma and discrimination. I think there is obviously a conflict there in the shift in attitude.

The CHAIR: That was, effectively, where I was wanting to go with that because you do talk about stigma as being a huge issue and a barrier to people seeking help when they have reached a point where they feel that they need that. That is a recurrent theme in terms of the work that you are doing. I was hoping that you could elaborate a little bit on that, noting that stigma is also recognised within the 10-year services plan, so it has been recognised by government as being an ongoing problem as well. How do you propose that these issues get addressed? I was interested in having you unpick a little bit this idea that drug use is still highly stigmatised and yet this idea that people are open to, perhaps, changing the way we are dealing with and treating drug use.

Ms Rundle: We do need political leadership to address stigma and discrimination. I think we need government to support evidence-based approaches—that is, evidence-based prevention approaches, evidence-based treatment approaches and harm reduction approaches. They are cost efficient and effective, yet the focus on illicit drugs in particular being illegal has seen quite a push in regards to law enforcement. It is the leadership with the focus around law enforcement, which, I think, personally, contributes to stigma and discrimination. If there is increased community awareness about the reasons why people are in the circumstances that they are in and there is increased understanding that treatment is effective and that it is not just a criminal issue, I think we could shift stigma and discrimination. Many reports identify the need to address stigma and discrimination. I think it is a shift away from the individual and more of a systems approach to addressing stigma and discrimination. I know that there is some research—I am sorry I cannot quote the research—but I have seen research that says that the focus on the individual in regards to alcohol and other drugs only leads to further attitudes of stigma and discrimination. It is about lack of access. It is about supporting people to make the change when they do and yet it has that counter effect of reducing people's willingness to access treatment or services when they need it. I think it is reflected in a lot of policy across government, which clearly needs to be addressed. It is an issue that all government departments and agencies need to be—it is part of their business, whether we are talking about corrective services, whether we are talking child protection, homelessness et cetera. Alcohol and other drugs are a significant factor for all of those agencies so we need to get on board and have a united approach to addressing stigma and discrimination so we can tackle it as a whole-of-government and whole-of-community approach. It also, I think, is reflected in the funding shortfall that we see in alcohol and other drugs sector as well.

The CHAIR: WANADA recommends that legislation be reviewed to ensure that stigma and other barriers to service access are addressed. The example that you have given is one of Aboriginal people being less likely to be referred to drug diversion. I was hoping you could elaborate a little bit more on that and also, are you aware of any other legislative provisions that you think, effectively, promote stigma or are creating barriers?

Ms Rundle: I think in our submission we have called for a review of the diversion initiative so it can be more inclusive and to see more people referred to access treatment as a response to or instead of affecting a police record or criminal record of some sort or ending up in prison. There is a need for a review of the diversion to be more inclusive and support more people in that regard.

The CHAIR: Are you seeing people at the moment who are being turned away from those options who in your opinion would be prime to be able to pursue those?

Ms Rundle: I think the opportunities for diversion are not maximised.

Hon MICHAEL MISCHIN: Can I just ask a question on that? You mention about people being imprisoned. Are people imprisoned simply for possession of an illegal drug?

[3.30 pm]

Ms Rundle: I think many people are in prison for many reasons, and the reasons why they are in prison is as a result of their substance use, as well as —

Hon MICHAEL MISCHIN: That is a different question though, is it not?

Ms Rundle: — for their alcohol and other drug use or activities.

Hon MICHAEL MISCHIN: I am not sure about that. That is what I am driving at. It is said that imprisonment of adults on illicit drug offences in WA increased almost 70 per cent between 2012 and 2017, but you are telling us that, rather than sending people to jail, there should be other programs. Surely whether someone is abusing legal drugs such as alcohol and commit an offence that is of such violence or such harm that it warrants imprisonment, their alcohol and drug use is irrelevant; the crime they are going to jail for is an offence of a different type. Are you saying that because they use drugs, they should be exempted from going to jail?

Ms Rundle: No.

Hon MICHAEL MISCHIN: I am just trying to understand how it all meshes together—that the risk of going to jail is somehow impeding people from seeking assistance. It is the crime they have committed that sends them to jail.

Ms Rundle: Indeed, and we are not saying that people who commit crimes should not be punished appropriately—absolutely. We are talking, however, about a significant number of people who are currently in our prisons who would benefit from alcohol and other drug treatment. Varied research indicates that 70 or 80 per cent of people in prison would benefit from alcohol and other drug treatment.

Hon MICHAEL MISCHIN: No, I think the figures are that there may be that number that have substance abuse problems of one sort or another, which may be causally connected to them ending up in prison. Sure enough, if you can catch them before they go to jail by some kind of a diversion process or whether they choose to seek assistance, they may not end up committing crimes. But that is different to saying that they are going to jail for drug use.

Ms Rundle: No. I think the issue is that we do not have enough services to meet demand. The "Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025" identified that for alcohol and other drug services, across all service types, we do not have nearly enough to meet demand. It is a half to a third, depending on the different service types. In terms of harm reduction, the figures they have in the 10-year plan show we need to build harm reduction from 5 000 hours to something like 258 000 hours by 2025. The gap is 5 000 to 258 000 hours in services needed to meet individuals' needs. While we do not have enough services to meet demand, people are involved in criminal activity or activity that inadvertently sees them ending up in prison. I am not saying that if they are involved in criminal activity, they should not receive imprisonment as appropriate, or punishment for that activity, but if we do not have enough services to meet demand, then we cannot effectively reduce the behaviours associated with their alcohol and other drug use.

Hon MICHAEL MISCHIN: I agree with that.

Hon AARON STONEHOUSE: I want to jump in on that line of questioning and maybe we can draw some distinctions with what we are talking about. We are talking about imprisoning people for drug use. I think we might all agree, perhaps, that someone committing a violent crime, whether under the influence or motivated by drug abuse, should be imprisoned for the safety of the community—there should be some kind of punishment or deterrent for people carrying out violent crime. I assume, but maybe you can clarify this for me, that your position would be that drug possession

or drug use should not be criminalised in itself; other violent activities that may be linked to that drug use should still be criminalised, but drug use or drug possession should not. Hon Michael Mischin said that very few people go to jail simply for drug possession. That is certainly true, but I wonder whether you would extend that to people who are perhaps in possession with a quantity sufficient to deal, or are in possession of a quantity of drugs that may make them declared a drug trafficker. Would you extend this advocacy for decriminalisation of drugs around the use and consumption to potential dealers and traffickers? It has been pointed out to me that peoples' drug habits have changed quite a lot. Some people are using quite a lot more. When it comes to meth, they are no longer using a point a week; they might be using a point a day in some cases. Somebody having 28 grams of meth—that is a lot of meth, but it might mostly be for personal consumption—may sell a little bit on the side as well, but they probably do not meet the definition of what a layperson understands as a drug trafficker, although they meet the definition of a trafficker under law. Would you extend decriminalisation to those kinds of people who might be captured by dealer and trafficker provisions?

Ms Rundle: I do not think the focus in our submission was around decriminalisation.

The CHAIR: No, it was not.

Ms Rundle: Our focus was that alcohol and other drug problems need to be seen as a health issue. By looking at it as a health issue, we can have more of a focus on prevention and we can have more of a focus on treatment and harm reduction. If we have enough services to address those issues, there will be less people likely to also be engaged in criminal activity, given, obviously, that some illicit drugs are illegal drugs. People are using a range of legal substances in an illegal way or in a way that is not fit for purpose. I guess that is one question I have of the committee: what is the scope of illicit drugs that you are talking about?

The CHAIR: I can answer that, because it was canvassed in the course of the parliamentary debate. While it was recognised that there is a significant issue around the illicit use of licit drugs, which probably wants an inquiry unto itself, the scope of this committee is to look specifically at those drugs which are classified as illicit. Hopefully that helps to inform, but, of course, all these issues are enormously important and need to be canvassed as a whole. But we are specifically looking at the issues of whether different approaches need to be taken to illicit drugs.

Ms Rundle: Absolutely.

Hon MICHAEL MISCHIN: What is the position of WANADA about decriminalisation?

The CHAIR: I note from your submission that you quoted another report, but presumably you put it in because you agreed with it. I thought it was very interesting. You say —

> … decriminalised drug policies are demonstrated to have a positive impact on health outcomes for drug users, decriminalisation is not a "silver bullet". Reform to decriminalise drug use must occur in conjunction with investment in treatment services to ensure drug users are able to transition into treatment services without delay.

I thought that was a particularly interesting quote. Can I assume that WANADA is in complete agreement with that statement?

Ms Rundle: Absolutely; we are.

The CHAIR: Obviously, decriminalisation is one of the issues which this committee will be canvassing. Different illicit drugs, of course, at the moment are having different impacts. There has been considerable discussion about whether decriminalisation might be an appropriate response to marijuana, for example. There is then the concern about whether decriminalisation is an

appropriate response to meth. There are different drugs and different responses. We have heard from some AOD providers as well who also proffered their opinions. Do you have any views as to whether it is appropriate to have different legal responses to different types of drugs, depending on the nature of the harm?

Ms Rundle: In our submission, we quoted—as you will see—endless recommendations or statements from so many inquiries in this area. I think the biggest issue for the sector and the consumers or family members is that there are barriers to putting recommendations in place. We are not going to see decriminalisation effected unless there is community support for it and unless there is political will and leadership for it, in my opinion.

[3.40 pm]

The CHAIR: In your opinion, do think that is even a good thing to be working towards?

Ms Rundle: I think that we need to raise community awareness. We need to make sure that there are adequate treatment, prevention and harm-reduction services well in advance. But we have got such a long way to go. We would like to see recommendations from this inquiry that address the barriers to evidence-informed policy being implemented. So if there is going to be a recommendation for decriminalisation, for example, from yourselves, what will be the barriers and how do you propose overcoming it?

The CHAIR: And what do you think those barriers are going to be?

Ms Rundle: I think stigma and discrimination are significant barriers. I think political will and leadership. But, again, with community awareness, we need a lot more of a social-inclusion focus in regard to people with what we are seeing as primarily a public health issue, so that there are no barriers to accessing support from a range of areas and across sectors that are needed by people with alcohol and other drug problems. They do not occur in isolation. I would also like to raise the fact that of the number of people who use illicit drugs, not many of them actually end up with problems associated with that substance. We are seeing people across the spectrum for methamphetamines. Again, it was something like 70 per cent of people who use methamphetamines never develop problems associated with their use. They might use only once or they use so infrequently that it never becomes a problem. The alcohol and other drugs treatment sector focuses on people who have ended up with problems associated with alcohol and other drugs, but there are a lot of people who do not—just the same as 80 per cent of people use alcohol, but not all of that 80 per cent develop problems. So we are saying that with all substances, there are people who use it and do not have a problem with it, and then there are those people who do develop problems with it. This is the complexity that I initially spoke about in regard to the psychological, biological and also social issues that are impacting on people to develop and see the problems associated with alcohol and other drugs maintained without support. So we are saying that meeting the needs of people with problems associated with alcohol and drugs needs to be in place. But community awareness needs to be there. Before decriminalisation or that debate can happen within the community, and for politicians to lead this, I think we need to be clear on what the issue is.

Hon MICHAEL MISCHIN: Well, that is assuming that leading towards decriminalisation is a good idea. Can I just ask you, though: how do you see this decriminalisation working? Let us pick a couple of drugs: one is cannabis, one is methylamphetamine, and let us say heroin. How do you see it working when it is decriminalised? Where do I get my drugs from if I decide that I want to use some meth today, and it is decriminalised, so I can possess it? I can take it and I am not a criminal, but if I am trafficking in it and dealing with it, I am. How does it work? Where do I get my drugs from?

Ms Rundle: Again, WANADA's position is not promoting decriminalisation as a priority above adequate —

Hon MICHAEL MISCHIN: No, I am not saying it is a priority, but that is what you say is a key area.

The CHAIR: Let the witness finish.

Ms Rundle: — treatment, support, prevention and harm reduction. So I do not think you can just go, "Boom! Here it is. We will now decriminalise." We need so much in place before we can even have that debate.

Hon MICHAEL MISCHIN: Well, I am just looking at attachment 2.

Ms Rundle: I think perhaps you are assuming that we have a strong position in regard to that. Our strong position is that this is a public health issue that requires adequate services to meet demand. That has to happen. If we are looking at recommendations of decriminalisation, for example, if that is one that you all put forward, before that can happen, we need a hell of a lot of things put in place first. We need adequate services to meet demand. I do not know how else to say it.

Hon MICHAEL MISCHIN: Well, I am sorry; I am looking at attachment 2 to your submission "Law Reform—WANADA's Position". It spends a lot of time telling us about —

> Given the current criminal penalties attached to illicit drug possession and use, the justice system has a significant and resource-intensive role in contributing to the State's current approach to harm minimisation.
>
> Imprisonments of adults on illicit drug offences in WA increased almost 70% between 2012 and 2017.

I do not know what the figures were, but let us assume that is right. But the evidence we received is that people do not tend to go to jail simply for use—only for possession with intent to sell or supply, or the supply of drugs or trafficking and the like. Then you go on about —

> Western Australia has one of the most punitive approaches to sentencing policy and practice. This approach is not as a result of public attitude, rather it is a function of political will.

So, it is the politicians' fault. Your submission continues —

> This underlines the importance of leadership from all sides of politics in refining the current sentencing arrangements to better reflect community attitudes to addressing drug use, acknowledge that drug dependence is a health issue, and to optimise access to alternatives to criminal penalties.

I have not seen anything in there saying that a precursor to any relief on the criminalisation of drug use or possession is contingent upon somehow reducing demand through other means. At the bottom you talk about diversion. You speak of it as a barrier, in fact, to service access. It seems to suggest that you get rid of the barrier, which is criminalisation, and then you can get access to services, because you talk about it and link it with stigma. Then you say —

> WANADA believes decriminalisation appropriately reflect —

I take it that should be "reflects" —

> drug use as being a complex health and social issue.

Your submission outlines that we have approached decriminalisation de facto in WA, but it is modest and so on. I am just trying to understand how you see the sequence of events working. I take it you are looking at decriminalisation as an end point now, rather than as a starting point.

Ms Rundle: I think our attachment 1 is, clearly, the health-focused approach.

Mr James: In terms of attachment 2, we are not technically arguing and/or trying to establish what that end point should be. But we are pointing out that in terms of under a decriminalising approach, de facto decriminalisation—diversion—does require a review to see whether it is properly optimised, so that people who would benefit from treatment are gaining access to treatment. In that regard, we are not saying what the end point should be, but we are suggesting that there are opportunities to optimise the current decriminalisation system within WA. We are not trying to say what the review should come out with as a recommendation, but we are saying that a review should be undertaken.

The CHAIR: I am just changing the subject. You talk about the need for a national quality safety framework. Can you provide an example of how a private provider might fall short of government standards? I am not asking you to give any specific examples of any providers you may be aware of, but if you could give the committee some advice as to what that might look like if they are falling short.

Ms Rundle: Yes, absolutely. All non-government organisations that are funded by both state and commonwealth governments are required either to have or to be working towards an accreditation—a set of standards.

The CHAIR: And as I understand it, that is the vast majority of services, is it not?

Ms Rundle: Yes, absolutely. There is no regulation, however, of services that are not funded by government.

The CHAIR: So what would be the sort of practices that might be undertaken by those services which would raise concerns?

[3.50 pm]

Ms Rundle: I think if there is no evident application of evidence-based practice, that would be of concern. As a part of any quality services, a requirement of services is to be meeting the health services code of practice and health workers code of practice and consumer rights charter, and services that are not funded by government—so, not accountable in that regard to a government body—may not be putting those in place. So, their practices may be in breach of accepted codes of conduct and human rights, effectively.

The CHAIR: Are there many services in Western Australia that you are aware of that currently receive no government funding at all?

Ms Rundle: There are a number and of those there are some that have engaged in a certification against a recognised standard, but there are some that have not. I think it is to support —

The CHAIR: Where is that standard? What is the standard?

Ms Rundle: WANADA has a standard. It is currently called the "Standard on Culturally Secure Practice". It is under review at the moment, but it is a certification standard that falls under the joint accreditation system of Australia–New Zealand, but there are a number of standards across Australia that different alcohol and other drug services are certified against. So, the National Quality Framework is establishing a list of accepted standards and I guess, in that sense, it would make the job of any regulatory body of organisations that are not funded by government easier because it is, "You need to be certified against a recognised standard." That is a systems management standard as well is what I understand will be the requirement; the National Quality Framework process is still underway.

The CHAIR: During the course of receiving submissions, we have received submissions that have been calling for compulsory treatment, particularly from families who are often desperate. Does WANADA have a position on the value of compulsory treatment or where it would fit within an overall landscape of service delivery?

Ms Rundle: WANADA did do a submission to—I think it was the previous government undertook a review or looked at mandatory treatment as an option. WANADA received feedback from hundreds of consumers, service users, as well as the service sector, and the majority of people felt that it was an expensive option that was not cost-efficient at a time when we have inadequate voluntary services to meet demand. So, where is our priority here? Because if you do not have enough services to meet people voluntarily accessing—even though diversion is not necessarily voluntary, but you are offered a choice so in that sense it is still a voluntary program. If we do not have enough voluntary services and you push for mandatory treatment, it is pushing money or expending money at the treatment end that does not necessarily meet community need.

The CHAIR: How large is the shortfall in terms of access to treatment and residential beds?

Ms Rundle: I think residential beds is—I do not have those figures, but it would be in the 10-year "WA Mental Health Alcohol and Other Drug Services Plan 2015–2025". I think it is about a third of the services needed to meet demand at 2015. There has been some investment by governments since the release of the plan in regards to beds, but there is still a significant shortfall. So, prevention in terms of hours needs to go from 66 000 hours to 208 000 hours so about a third or more. Harm reduction, as I said before, from 5 000 to 250 000. I do not even know what percentage that would be—thousands! Community diversion needs to be increased from 50 000 to 163 000 hours. So, we are at about a third for diversion. In terms of non-residential community treatment, it needs to go from 565 000 hours to 2 060 000 hours, so we are at about a third, a quarter. In terms of low-med withdrawal beds, we have got 14, which needs to increase to 52. Quite complex withdrawal, again, from 22 to 98. Residential rehabilitation beds we have 344 beds and it needs to increase to 772.

The CHAIR: I am just confirming that is right across the board. That includes alcohol, does it not?

Ms Rundle: Yes.

The CHAIR: Also, use of illicit drugs. It is, basically, all areas of problematic drug use.

Ms Rundle: We do not have enough services to meet demand.

The CHAIR: Are there particular areas that are particularly bad? I am thinking of specific cultural groups or actual regions.

Ms Rundle: Yes.

The CHAIR: There are particular areas. Could you say where the biggest problems lie, please?

Ms Rundle: Certainly the WANADA board is supportive of priority given to Aboriginal and Torres Strait Islander people access to services and a range of service choice including Aboriginal-specific service provision provided by Aboriginal community-controlled health organisations or Aboriginal community-controlled organisations so that there is that choice of Aboriginal-specific as well as dedicated services delivered by mainstream services and culturally secure services. So, I think certainly the WANADA board is offering a priority to ensuring there is adequate services to meet the demands of Aboriginal and Torres Strait Islander people in Western Australia.

The CHAIR: So the committee has heard, of course, about problems trying to deliver integrated treatment and care for people who have co-occurring mental health and substance use disorders. I was wondering whether you could comment on as to how common comorbidity is amongst the consumers you are interacting with?

Ms Rundle: That our sector would be interacting with—and I am sorry; I do not have the figures. However, the not-for-profit alcohol and other drug services did receive commonwealth funding over a number of years to support the increased capability of those services to better meet the needs of those people with co-occurring alcohol and other drug and mental health conditions. So, I think, in general, while I have seen some figures recently about 60 per cent of people accessing the alcohol and other drug services also having co-occurring mental health conditions. So, it is seen as what is expected as opposed to the exception. I think, also, however, there are a lot of people accessing alcohol and other drug services that have housing and homeless issues, family domestic violence issues, child protection issues, involvement with the justice system et cetera. So, we are dealing with the range of issues, then I think there needs to be a recognition of the co-occurring complexity of the people who are accessing alcohol and other drug services.

The CHAIR: So to what degree will interaction with the justice system perhaps aggravate efforts to try to address their drug use issues or does it have no impact at all?

Ms Rundle: I think there is a need for looking at the diversion initiative to better support a treatment focus for people engaged in the criminal justice system. We are not talking about the range of people who are involved in the justice system. We are talking about people who are in need of treatment services. So, I think that is the focus. That where there is a need for treatment; we need to have enough services to meet demand from wherever they come from, whichever sector, they are primarily engaged in. There is a need for capacity building across all sectors—mental health, health et cetera. I think improved capacity for those services to engage in brief intervention, early intervention, referral, supporting referral processes, and systems navigation is important. It is everybody's business, as is mental health everybody's business. We need to be able to support systems navigation of anybody who accesses whichever service, recognising that the alcohol and drug service sector is a specialist sector that can both support the capacity of other service sectors, as well as address the specific needs when their problems are entrenched.

[4.00 pm]

The CHAIR: Turning to harm-reduction measures, one of the things that the committee is also looking at is the various measures that can potentially be adopted when it comes to the use of illicit drugs. Are there any particular harm-reduction measures that are currently operating that you think need to continue, and also any that you think potentially should be contemplated; and what are they?

Ms Rundle: We have got a long way to go, as those figures from the Western Australian Mental Health, Alcohol and Other Drug Services Plan indicate, from 5 000 hours to 258 000 hours. We clearly have needle and syringe exchange programs.

The CHAIR: We have heard evidence that perhaps it would be useful to have those programs extended into our prisons. Do you have any comment about that?

Ms Rundle: WANADA would be supportive of those programs being extended into the prison. I think there is evidence to back up their value, absolutely.

The CHAIR: Any other particular harm-reduction measures?

Ms Rundle: It is interesting. In terms of harm reduction, the three pillars—harm reduction, demand reduction and supply reduction—even the police for that matter, or law enforcement, are engaged in harm-reduction initiatives in terms of roadside testing and those sorts of things, which ultimately will reduce the harm to individuals, as well as anyone else on the road. There is a range of harm-reduction initiatives, not just in health but across many sectors. I think there could be increased

harm-reduction initiatives in health, in emergency departments, in mental health services. I do not think that WA is in a position where we could have safe injecting rooms or those sorts of things.

The CHAIR: Why do you say that?

Ms Rundle: At the moment, simply because of the population size. There is no real location. If it is evidence-based, and if it fits with the context of Western Australia, then WANADA would definitely be supportive of it.

The CHAIR: We heard evidence this morning from the police that they would never contemplate pill testing regimes, for example, and also they indicated a desire to continue on with sniffer dogs and those sorts of measures. Do you have any comments in relation to the effectiveness of those approaches or do you think perhaps a different approach should be considered?

Ms Rundle: I think the focus on pill testing has been around festivals —

The CHAIR: Specifically around festivals, yes.

Ms Rundle: — and pills as opposed to powders. I think we have certainly heard some evidence that where people have access to be able to test what substance they are about to use, it results in less harm. But, again, I think there needs to be a lot of understanding of the context of what we are talking about here. We have also heard that when people do undertake tests of the substances that they are about to use, and if they are find that they are not what they thought they had purchased or intended to purchase, they are less likely to take them. Yet this is a lot of anecdotal evidence as well as feedback that we have heard.

The CHAIR: Do you have any comments about the use of sniffer dogs?

Ms Rundle: I think we had an example in Western Australia a few years ago where the young girl saw barriers where she might potentially get into trouble for the substances that she had, and she took them. So it is not a harm-reduction strategy as such. We need to focus on harm reduction as a priority, and we need to identify the value of harm reduction. I think it is a very cost efficient and an effective overall strategy. For every dollar spent, $27 is saved in harm reduction. We have seen some fantastic initiatives in terms of even the needle and syringe exchanges, which have placed Australia in the leading role internationally in reducing HIV/AIDS. It would be great for community awareness, again, and political leadership, to take on board the evidence base behind any initiative, instead of making decisions based on polarised views and moralising around substances. We need to be saving lives and reducing harm as much as possible, and focusing on the public health of the community.

The CHAIR: In the police submission to this inquiry, they asserted that by keeping drugs illegal, they believe that is helping to keep consumption down, because a certain percentage of people will never take particular drugs because they fear the legal consequences. So they were asserting that the police were therefore playing a positive role in reducing demand. Do you have any thoughts in relation to that assertion by the police?

Ms Rundle: I think there is evidence in regard to prevention activities, but it is not about the illegality or otherwise, or police activities or otherwise. I think there is sound evidence that good information and appropriate information from school drug education, or whatever, is effective in delaying the uptake and preventing the use of substances. I think, once again, we need data to demonstrate the value of any of these initiatives. Is it this initiative, or do we have strong prevention campaigns or community engagement that is actually preventing the uptake of substances? We are seeing a decline in terms of numbers of people using illicit drugs.

The CHAIR: It is interesting you say that, because that would not be the public perception. I think there is a public perception that we are seeing increased use. Would you say that is because of the

specific way in which meth presents—the public face of meth? I am curious about why you think that public perception may have come about, if, indeed, you are correct that drug use is going down.

Ms Rundle: We can certainly take it on notice to provide you with some of the statistics in regard to the reduction in illegal substances.

The CHAIR: I would appreciate you being able to take that on notice. Thank you.

Hon MICHAEL MISCHIN: We have heard evidence, though, that in terms of some drugs, such as meth, there may not have been an increase over the years, although emergency departments would say different, but notwithstanding that it may be only a reduction in the amount, if what you are saying is correct, the incidences of people turning up to emergency departments and engaging in violent behaviour that endangers themselves and their treating physicians and staff, and other patients, is on the increase.

The CHAIR: Certainly the level of purity has been reported as being significantly higher.

Hon MICHAEL MISCHIN: But you are saying that overall, drug use is going down.

Ms Rundle: The number of people who are using is reducing. The alcohol and other drug household surveys indicate—they only do it every three years, but they review it annually—that the number of people who have used particular illicit substances has reduced. But that does not talk to the quantity that the individuals that are using it are using, and it does not talk to the increase in purity, and it also does not talk to the mode of use, whether it is injecting or other ways in terms of methamphetamine. I know WA has a particularly high rate of injecting methamphetamine, and the purity is high. I think there is a range of issues; it is not so black and white.

[4.10 pm]

The CHAIR: I am also aware that illicit use of licit drugs such as opioids is on the increase as well so it may be that, collectively, there is just as much drug use as there always has been but the face of the types of drugs that are principally being taken is changing. Would that be a fair thing to say or not?

Ms Rundle: Based on psychological factors, biological factors and social factors, there is a cohort of people who will have issues around that, and without addressing them as part of a prevention campaign, that is not going to shift. There will always be a cohort of people. As I said before, of people using a substance, only a small percentage, or 30 per cent or whatever per cent of people using methamphetamine, may end up with trouble—that is, using on a regular basis. We are only talking about a small percentage of people who end up with a problem. Without addressing those psychological issues and other social factors et cetera and behavioural factors, we have to do that for those individuals who end up with problems. Also, we are aware that early intervention—as I said, this is everybody's business—around methamphetamine, people can use for up to five years before they develop a problem associated with methamphetamine use. If there is any sort of positive intervention along the way, they are likely to access treatment after three years so it is two years of less problematic use. If we do not address this, after five years, they will be wanting to access treatment or they will find themselves in a situation in which the behaviour is causing harm more broadly. With alcohol, it is something like 18 years. With early intervention, we can reduce the number of years of harmful alcohol use. It is not just one substance; it is any substance if there is early intervention. I think we need to be looking at prevention to address those issues as well.

Hon MICHAEL MISCHIN: Just on that subject of early intervention, much of that will occur with people who do not recognise they have a problem until they cross paths with the police and come to their notice for one reason or other, and that is what diversion services are meant to be for. If there is no criminalisation of the possession of these substances, there is little incentive to think

they have a problem. We will be looking at that element. That ties in with a small percentage of people with a problem, until they get to the point when even they have to recognise it. Looking at page 16 of your submission, you make reference to a document. I was wondering if it was possible to get a copy of that. I refer to footnote 52. It ties in with the proposition that —

> where criminal penalties are removed, replaced with civil penalties, or replaced with administrative penalties, which have been assessed as having a number of positive outcomes.

You cite a document—"Decriminalisation of Drug Use and Possession in Australia: A Briefing Note". Given that there is no reference to be able to get it, I presume it is something that has been provided to WANADA.

Ms Rundle: We will take that on notice to provide that.

The CHAIR: That is question on notice E2.

Thank you both for attending today. 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. When you receive your transcript of evidence, the committee will also advise you when to provide your answers to the questions that have been taken on notice. If you want to provide additional information or to elaborate on particular points, you may provide supplementary evidence for the committee's consideration when you return your corrected transcript of evidence. Thank you to both of you for coming along today. It is much appreciated.

Hearing concluded at 4.15 pm

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