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, 18 MARCH 2019

SESSION ONE

Members

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

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Hearing commenced at 2.45 pm

Ms MARGARET DOHERTY
Convenor, Mental Health Matters 2, sworn and examined:

Mrs CAROLINE WADDINGTON
Steering Group Committee Member, Mental Health Matters 2, sworn and examined:

Ms VIRGINIA CATTERALL
Independent Consumer Representative, Mental Health Matters 2, sworn and examined:

The CHAIR: On behalf of the committee, I would very much like to welcome you and thank you for coming to the hearing today. We, of course, received your submission, so we are interested in hearing further from you. My name is Alison Xamon and I am the chair of this parliamentary inquiry. I would like to quickly introduce you to the other members here: Hon Colin de Grussa; Hon Aaron Stonehouse, who is the deputy chair of this inquiry; Ms Lisa Penman is one of the advisory officers to this inquiry; Hon Samantha Rowe; and Hon Michael Mischin.

Today's hearing is going to be broadcast. Before we go live, I would just like to remind all parties that if you do have any private documents, you need to keep them flat on the desk in order to avoid the cameras. If we could please begin the broadcast. I also add that if at any point during the proceedings you wish to go into private session, that is fine as well. You just need to request it and then we can make a determination about going into private session.

Could the witnesses please take the oath or affirmation.

[Witnesses took the affirmation.]

The CHAIR: Thank you. You will have all 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.

I understand that you have an opening statement that you have kindly also circulated to the committee. Would you like to commence with your opening statement?

[2.50 pm]

Ms Doherty: Thank you. Before I begin, I would like to acknowledge the traditional custodians of the land that we meet upon today, the Wadjuk people of the Noongar nation, and pay our respects to their elders past, present and those emerging. Mental Health Matters 2 started out nine years ago as a group of concerned citizens desperately seeking better outcomes for ourselves and family members or friends with ongoing experiences of co-occurring mental distress and alcohol and other drug use. Often, that also meant involvement with police, courts and detention. We did not foresee the journey we had ahead of us back then that has brought us here, and we would like to thank you for the invitation and the opportunity to meet with you today. We appreciate you taking the time to hear directly from people affected in this area.

I do not intend to repeat evidence or statistics that are already available in our brief submission. I would just like to make two points. Firstly, Mental Health Matters 2 and its steering group is made up of individuals who have personal experiences of mental distress, often alcohol and other drug use, some of whom have been to court and sometimes prison. It is also made up of family members and friends of people with those experiences, as well as individuals who work in services. We are not neatly compartmentalised into one of those three groups, so we bring a strong consumer and family/supporter lens to this very real issue. The strength of that is that we have different perspectives to draw on within our group.

While our lived and living experience is our primary reason for being in this area, people also bring their professional expertise to this work. Just as people are more than their role as politicians, individuals and families are greater than their experiences of mental distress and alcohol and other drug use. For example, within just our small steering group at the moment, for which lived experience is an essential criterion, we have people with professional backgrounds in academia; project management; stockbroking; small business ownership; community-based corrective services, including specialised family violence work; alcohol and other drug counselling; education; and peer work. In this small group, people hold qualifications in the humanities; commerce; criminology; mental health; alcohol and other drug work; and peer support. We have steering group members who have worked in helping people to transition from prison, as well as someone who has experienced being in prison and another whose family member with serious mental health and alcohol and other drugs issues is currently in remand. We bring all of those skills and knowledge to this table, as well as what we continue to learn from our life experiences in this area.

Secondly, Mental Health Matters 2 focusses on the situation for people and their families at what we call the pointy end. Individuals are likely to have diagnoses of serious mental illness such as schizophrenia as well as the more high prevalence diagnoses of anxiety and depression.

The co-occurrence of these with alcohol and other drug use has generally been a major contributor to their involvement with the criminal justice system. The evidence shows that co-occurring mental health and alcohol and other drug use is the expectation when people present to services, rather than the exception, and should be approached as such. Individuals and families are also not just trying to deal or live with these two fairly challenging health issues, but are often doing so while managing other life problems such as poverty or stretched incomes, unstable or unsafe accommodation, parenting or grand-parenting, and compromised physical health that the evidence shows comes with this package.

This is a group that is often given the label of complex needs, whereas in fact we believe the complexity belongs to the service systems and their lack of integration, not to the individual or the family. That label alone lends to the idea that we are in the too-hard basket and it can be part of the stigma which stops people seeking or getting the help they need. This discrimination is often compounded if the person has a criminal record.

Our members and we have the same needs as other human beings. They include wanting to be connected to people whom we care about and who care about us, having enough money to have a life, having something meaningful to do, being safe, and being able to access services that see us as a whole rather than treating just a piece of us. So, rather than complex needs, our people generally have a number of unmet needs which require services to work together to address them. Giving someone a safe, secure and affordable place to live can be an effective alcohol and other drug intervention. We need to look beyond alcohol and other drug use or mental distress to what lies beneath.

The reason I emphasise this is the importance of looking at the subject of reducing harm from illicit drug use in a way that cuts across the siloed systems of service planning and delivery in Western Australia. The very way in which services for this group are designed and delivered contributes to the increase in harm felt in the community. In our world, an unfortunately common example is where people end up in a high-cost emergency department bed or, worse still, double-bunked in remand, when a lower cost, trauma-informed and personalised response in the community may well have met their need. The cost borne by the individual, family and community of this fragmented approach is significant in both financial and human terms. It is often laid bare in headlines and coroners' reports when it is, frankly, too late for the people who were often calling for help beforehand.

Many reviews and reports in this area use words like integration, collaboration, patient involvement and person-centred care. What we are keen to see and be part of is the translation of those aspirations into easily accessible, on-the-ground, safe and high-quality responses that are co-designed with people who use services and their families and friends, or led by that expertise.

At the moment Mental Health Matters 2 acts as the ambulance drivers at the bottom of the cliff. As we are unfunded and run on volunteer energy, people generally only get to us when they have exhausted all other options. This bouncing around the systems in itself causes harm, particularly for people who have already experienced trauma. We sometimes get referrals from caring practitioners who know that the person needs advocacy for a more comprehensive response, but it falls outside of the silo in which they work. We call these practitioners the angels in the system. We greatly appreciate their commitment to treating the whole person within systems which, frankly, do not seem to support them very well to do so. Because this is an issue that is very real for us and which affects most of us on a daily basis, we are keen to be of help in your inquiry.

The CHAIR: Thank you very much. If I refer to the submission you have given us, your submission does refer to people with multiple unmet needs who are often put in that too-hard basket, and you have referred to that again in your opening statement. We are curious to have you elaborate on that a little bit more. Amongst your members, which needs in particular do you typically see co-occurring?

Ms Doherty: We would typically see alcohol and other drug use—what I would call active alcohol and other drug use—and high levels of mental distress co-occurring. But they do not occur in isolation. Those would occur while people, as I said, are managing difficult housing, and they may be managing parenting stresses. There is a range of other life stresses and financial problems that they could also be dealing with.

The CHAIR: But for your members it is primarily the intersection between mental health and AOD and how those two are into playing between each other?

Ms Catterall: It could also be the judicial system as well. A lot of our members or our members' families have their loved ones going through the judicial system.

The CHAIR: So it is the complexity between the three?

Ms Catterall: Yes, there are three things, really, that potentially are happening.

The CHAIR: In your submission you did talk about people with co-occurring mental health and AOD issues often fall through the gaps of the siloed services. Of course, we keep getting told that these issues have been resolved and that there is not really such a problem with siloed services on the ground. Could you maybe respond to that and also provide some examples of how this has occurred in practice?

Ms Doherty: Sure. A common example that we would experience would be the inability to access services. I know there is a concept in the sector called "no wrong door", but our experience is that that no wrong door is firmly shut at four o'clock on a Friday afternoon and does not open again until Monday morning. That is if you can access the service.

I do not mean that flippantly but I do believe that there is great intent to improve this. But I think we have to be really careful to not confuse the rhetoric of it happening with the actuality of it happening, and that is where, I suppose, the power of lived experience comes into play because we are experiencing the gaps. An example I can think of most recently is someone who got discharged on a Friday afternoon from a public mental health locked ward to homelessness and was not getting paid until Monday. They ended up in remand nine days later.

[3.00 pm]

The CHAIR: In your experience, is this a situation that is aggravated by regional distance at all or is it a problem right across the state? Could you perhaps give a bit more information about that?

Ms Doherty: I think it depends sometimes on the individuals. In some regional areas, because people know each other and often when integration works and collaboration works, it is actually relationship based rather than system based. We want to make sure it is both. The people who work in services, some people will often go out of their way to try to get a good outcome for a person. If they move out of that role, then that whole system collapses because there is no embedding of the need of that integration.

The CHAIR: I want to see if I can elaborate and unpick that piece a bit because that is often part of the concern—is that in the regions, those services are not happening. Are you saying that in the regions where particular individuals are playing a key role, that service integration is working?

Ms Doherty: Is working.

The CHAIR: But that can be quite fragile.

Ms Doherty: It can be quite fragile for the very reason that it can disperse the minute that person goes into either a different role or leaves that area.

The CHAIR: In your experience—I recognise this is anecdotal—would you say that the situation is worse at the metropolitan area? Where are you seeing the obvious cracks in the system?

Ms Doherty: The metropolitan area has very obvious cracks. I would say that our experience and expertise is generally in the metropolitan area. Where I have seen successes in the regional area is where there has been strong advocacy generally from family members and they have known who to advocate with because they know the person in the regional area, because maybe their kids go to school together or there is a personal relationship involved, which plays a part.

The CHAIR: I want to pursue this issue of No Wrong Door a little bit more. You have talked about the problem with the lack of service delivery outside of set hours and particularly on the weekends. Has the issue of people being turned away because they are either not a mental health or not an AOD service provider, where people are presenting with both, is that still an ongoing concern because that certainly was a concern a decade ago?

Ms Doherty: Again, I think it depends. It sounds like an Irish answer, but it does depend. I think for people with higher prevalence disorders like anxiety and depression who present with maybe mild intoxication, then you may get entry. If you are talking about someone who is severely psychotic and extremely intoxicated, that is a different story.

The CHAIR: This committee is specifically looking at the issue of illicit drug taking as well. Would you have anything you would like to inform the committee about in relation to the intersection between the illegality of the substance that people are taking and how that may impact?

Ms Doherty: I am happy to hand to my colleagues on this, but I would say a primary message that we would say is that rather than the legality or illegality, it is actually more about the harm caused. Alcohol is illegal, but it can cause significant harm. That is probably the greatest burden of harm caused in the community. Caroline, did you want to speak to that? You do not need to.

Mrs Waddington: I will reflect on that.

The CHAIR: If at any point you wish to make some comment, you can do that.

Hon AARON STONEHOUSE: When talking about the illegality of illicit substances, can you speak about what impact that has on people seeking services? In your experience, is there a stigma perhaps attached to the use of these substances that is acting as a block to people seeking services?

Ms Catterall: Without a doubt. If you present to ED and somebody knows that you are under the influence of an illicit substance, particularly meth, for example, you will experience significant stigma.

Hon AARON STONEHOUSE: How does that affect the integration of services—the stigma attached to illicit substances? Do you find that that affects the ability of someone to be referred on to an appropriate service if they arrive at —

Ms Catterall: It probably depends on how you are presenting. If you are violent at that particular point in time, there will be security to strap you down, but in terms of getting referred to a bed or to a quiet area, that bed will be given to somebody that they view has a higher need than you.

Hon MICHAEL MISCHIN: That is not unusual. That is what emergency departments are meant to do, is it not, to triage on the basis of need?

Ms Catterall: Yes, but if you are dealing with a situation in which you have someone who is presenting with a psychosis and you cannot tell whether it is a drug-induced psychosis or a psychiatric-induced psychosis, that person should be treated anyway. The decision should not be made that, "Okay, it is drug-induced psychosis, we're going to ship him out."

The CHAIR: Are you then advising the committee that in your experience if someone is psychotic as a direct result of their drug taking, you believe that they receive a lesser treatment than if someone is presenting with psychosis that is deemed to be primarily due to mental health?

Ms Catterall: Yes, I absolutely believe that.

Hon MICHAEL MISCHIN: Do you have any evidence to support that?

Ms Catterall: I am sorry, I do not have any statistics; it is all qualitative information. Mental Health Matters 2 runs a Families 4 Families support group where we have a number of family members who come to our support group. A lot of them have loved ones who have a diagnosis of paranoid schizophrenia and who also have a dual diagnosis of drug use and they have experienced multiple episodes of psychosis presenting to ED and being turned away. I personally have been turned away at an ED.

Hon MICHAEL MISCHIN: What I was driving at was the triaging within the emergency department.

Ms Catterall: You would think so.

Hon MICHAEL MISCHIN: You are suggesting that there is a discrimination on the basis because someone has come in, they are violent, they are acting psychotically. They needed to be strapped down and restrained. I can understand until they have calmed down, it may be a little difficult to

treat them, so some resources would then go to others who may be in more immediate need who can be treated. I can understand that. You are suggesting that that is wrong or what? I am just confused as to how it is supposed to work.

Ms Doherty: First of all, it is about understanding that emergency departments are the very worst place to be if you are experiencing psychosis.

Hon MICHAEL MISCHIN: That is where people go.

Ms Doherty: That is where people go because they have no other option. If you are in a place that by the very nature of the place is making your illness worse or your health worse, I do not think you should be discriminated against on the basis of that. For people to be in emergency departments, which are very busy environments—people are coming in, trauma, road injuries, someone is actively voice hearing, they may or may not be intoxicated, they need a quiet space to be to kind of get a little bit of space in that psychosis to just settle. They are unlikely to get that. If they have a history of active drug use, what our members tell us regularly at meetings is that they do not feel they get the same treatment as some people. We do not have the evidence to say that X number of triages get knocked back; we can only go at this point on the anecdotal information of people who use services really regularly.

[3.10 pm]

Hon MICHAEL MISCHIN: This is where I find —

The CHAIR: I am aware that you wanted to produce some data in relation to this matter, though, so maybe if we just give an opportunity to hear that?

Hon MICHAEL MISCHIN: Yes, sure; that is fine. But this is where we are getting to something that I think is productive, that you say that in an emergency department, someone is picked up by the police, or they turn themselves in to an emergency department because they are acting psychotically and potentially harmful to themselves and others. You are saying an emergency department is not the place for them to be. They should be somewhere else that is quiet. What can you suggest ought to be established that can meet that particular need, not interfere with the work of an emergency department and deal with people who are needing equally, if not more, immediate medical attention? What are you suggesting is an alternative where they could go to? How do we deal with that particular issue?

Ms Doherty: I suppose it is about early intervention at the first possible opportunity, as distinct from early intervention in an age cohort. It is well evidenced that families will often be calling for help, saying, "This person is becoming unwell. We are really concerned if we don't get some support in", and that support could be an assertive outreach team to the house. That is a quiet place, familiar surroundings, food is available—you are not buying from a vending machine. If that assertive outreach team were to come to the person's house, that would deflect someone often from the journey to ED. There are some peer-led services, certainly in the United Kingdom, who offer crisis-type services that operate between say 9.00 pm and 2.00 am, and they just offer people a place to be. Psychosis is a human experience, which is very distressing to experience. You kind of want to be in the best possible environment if you are going to be experiencing that. We would say, have them tended to at home if at all possible, have a quiet area in an emergency department, given that we know —

The CHAIR: Such as a MHOA? Are you finding that the MHOAs are helpful or not?

Ms Doherty: MHOAs are one option. But actually just having that quiet space, because what we want to do is make sure that if that person has any physical health issues—post self-harming, suicidal ideation—actually, we are looking after that as well.

The CHAIR: I am just conscious again, you wanted to be able to give the committee some information.

Mrs Waddington: I did have a little bit on stigma. It is not necessarily at the emergency departments, but looking at a systemic review, health professionals generally have a negative attitude towards patients with AOD issues. That is actually from a journal review. They concluded that negative attitudes of health professionals towards patients with substance use disorders are common and contribute to suboptimal health care for these patients. And, of course, it is well known that stigma is also associated with social exclusion, which sets up that whole cycle of reusing, using, being socially isolated and what have you. Also, the exclusion means that people are less likely to engage in the broader community, which causes further health and social inequities and greater harms to the person. That is what we have on that.

Hon COLIN de GRUSSA: If we can just go back to the triage example you were talking about. Two things. The first point is: are you saying that people who are turning up at hospital are actually being turned away from the hospital, or just when they are triaged they are not given priority? The second point is: what does a hospital need; and, what facility does it need in order to better manage those patients when they come into the place so that they get some sort of treatment at least initially and then maybe can be referred on elsewhere?

Ms Doherty: As long as I remember your first question—you can remind me if I go off the point—the first thing would be, if you end up in an emergency department, often there is many hours' wait. For someone experiencing psychosis, they are just not able to wait for six hours to be seen in a busy waiting room where people are going in and out and where often as well if they experience paranoia as part of their psychosis, the security officers—we know they have a role in EDs, but that is quite confronting if you have paranoia around that. That is number one. They may well leave of their own accord. If they start to behave in what may be interpreted as an aggressive or an agitated way, they may be asked to leave or stand outside, in which case they just drift on down the road and walk away.

Hon COLIN de GRUSSA: In some respects, it is about the system, the triage system if you like, not actually being established or set up to manage mental health issues?

Ms Doherty: Yes. It is also about the availability of psych liaison nurses and to actually be assessed and triaged by someone who understands mental health. If there is not a psych liaison nurse available, is the person assessing really across the issue of mental health? It is the access to information on the person. My understanding is the access to PSOLIS, for example, the information system used to store mental health data in public hospitals, is only available to the psych liaison nurse at emergency departments and to the psych registrar. If they are not available or they are busy with other people —

The CHAIR: Or if the position does not exist and they do not have them.

Hon COLIN de GRUSSA: Yes, right. That is the other question I was asking.

Ms Doherty: Or if, as we have heard in the past, it is a small regional country hospital, where there are two nurses on at night, and if someone knocks on the door in an aggressive way, their response is to ring the police, because that is their only response. They have another group of patients that they have to safeguard. But it is not a great response if you are the person knocking at the door or the family member of the person who needs help. That was your first question, today.

Hon COLIN de GRUSSA: You more or less answered both, really.

Ms Doherty: Did I? Okay.

Hon COLIN de GRUSSA: You did, yes.

Hon SAMANTHA ROWE: Can I just clarify, Margaret, that it really sounds like emergency is just not the place?

Ms Doherty: Absolutely, yes.

Hon SAMANTHA ROWE: It is not the answer.

Ms Doherty: Yes. What I would say on that is that often it is the family members or the support people around the person who can see those early signs, or the person themselves. That is the early intervention that is critical in this space. But if you have not got a workforce that is co-occurring, capable and competent, you might not be screening for those behaviours or those needs.

The CHAIR: Before we move on to the other elements of your report, it would be said that in terms of that intervention to come to the home, that has existed in the past in various forms, I am thinking of the psychiatric emergency team and the Mental Health Emergency Response Line, for example. In your experience, they have not quite filled the brief. Have you had concerns about that?

Ms Doherty: We have had significant concerns and voiced them voraciously over the years. One is that the Mental Health Emergency Response Line is not a response service; it is a telephone triage service. They hand the call on, as my understanding is, to the local team, who then re-triages. They decide whether this is still a priority one emergency, or whatever the service language is around that. They may well ring the person or the family again and double triage. I think one way to deal with that is to actually be able to have whoever is answering the phone in the first place direct the team, in terms of the priority of triage. Second of all, for many of our members, staff—psychiatric mental health nurses—simply will not come to their premises without a police presence. That can be really problematic. I understand people's need for security and safety in their work—that is not an issue—but the issue is actually trying to get both parties there at the same time. You will understand that this rarely happens on Monday at noon. It generally happens on the weekends, at the times when those services are stretched. We know that there is some really good work being done with the call response team and we would say that that needs to be expanded.

The CHAIR: This is the co-response team between the police and the Mental Health Commission?

[3.20 pm]

Ms Doherty: Yes, the police initiative. There are three initiatives, as I understand it, under that initiative. One is the clinician sits in the back of the car, so if the team goes to the house, there is a police presence. Sometimes the police presence can calm the person down; at other times, it can actually be not helpful. But they are there should things kick off. They can often deal with that situation in the home with a referral to perhaps the person's case manager to be seen first thing or to be contacted the next day. So that is where you divert from emergency departments, and that, frankly, is a much more cost-effective way of diverting as well. They also have someone available at the operations centre, so if a call comes in, that person, that clinician, has access to the PSOLIS database and they can check if this is someone known to mental health services or can give some advice to police on how to operate. Also, my understanding is, because I do not work for either the police or the co-response team, the officers who are on there are volunteers, which is fabulous, and the nurses who are part of that program have volunteered to be part of that. That says something about their commitment in this space. I applaud them for that. They also have a mental health nurse at the lock-up, which one would have presumed would have been there, but clearly was not, and so it meant that anyone going into lock-up was not being screened for mental health.

The CHAIR: And they are now?

Ms Doherty: They are now between certain times. It is still not comprehensive, but at least there is some coverage there.

The CHAIR: Can I now go back to your submission. Your submission refers to the use of illicit drugs when people are in prison. What are your members' experiences of accessing drug treatment services when they are in prison?

Ms Doherty: I think when we talk about prison, there are a number of groups that I would talk about. One is remand. The chances of getting a program when you are on remand is zippo, so that is not going to happen, frankly. You would be fairly fortunate if you got perhaps a brief intervention, one-hour or two-hour program. I do not even know if they even run them anymore. But you are not going to get anything comprehensive and, more importantly, you do not seem to be getting the information that says, "If you get out of here next week and you really want to do something about your drug and alcohol abuse that may have contributed to you being here"—even if the only motivator is to be seen to be doing it for a court appearance, it is still a motivator—"Here's some information about services that are available in your area." That would be really helpful. For people who have longer sentences, what we have found, again from anecdotal evidence, is that people with diagnoses of serious mental illness do not get to access those programs in prison because they are basically run in group sessions and they may not be assessed as suitable.

The CHAIR: So, these are people who have a drug problem but are not able to access it?

Ms Doherty: Yes.

The CHAIR: What would be the grounds on which they would be deemed to be unsuitable? Is it because they have the co-occurring mental health issue as well?

Ms Doherty: Yes.

The CHAIR: What is your members' experiences of accessing mental health services in prison?

Ms Doherty: I think again we have to make a distinction between people who have high prevalence disorders, like anxiety and depression, and people with more serious-end diagnoses. So, theoretically, people with serious-end diagnoses are cared for by the comorbidity team, which is a nurse-led team in most prisons with in-reach psychiatric help.

The CHAIR: You say "in theory".

Ms Doherty: Yes, in theory.

The CHAIR: So what is happening in practice?

Ms Doherty: In practice what happens is, if someone goes in on a Friday afternoon, straight from court, and they are on medication, it is extremely difficult for a family member to get that message into the prison. If the person is extremely unwell—we certainly have had anecdotal evidence of someone in the screening process denying their mental distress because they were concerned that that would make them appear more vulnerable in the prison population, which, unfortunately, we know may well be the case. So, it relies on self-reporting. Their GP or their community mental health person may be totally unaware that they are going through a court process, so it is generally the family member trying to get that information into the prison.

The remand centre will not take your phone call if the person is not already there, and then they probably will not take your phone call, so unless you know to send a fax through so that there is something in writing, pointed to the deputy superintendent—but you only know that if you have had to do it before and learn the hard way. That is not available anywhere for people to be made aware of that. So what can happen then is that people are without medications—that might be heart medication as well as neuroleptic medication—and it may not be picked up. It would be

wonderful if there were a seamless system there. The biggest challenge, of course, which comes down to how systems talk to each other, is that we go from the mental health system and the health system to a system that is actually run by the Department of Corrective Services, so three different health systems. I am not sure that they talk to each other really well or really often.

Hon COLIN de GRUSSA: I was going to ask that question: do they talk to each other or we do not know?

Ms Doherty: Well, I think it depends again on people to lift the phone to say, "Listen, my client, I'm aware they're in court today and they have just been remanded"—but how would they know that—"and I am aware they're coming your way." But it is generally the family member or the supporter who will be that person. But it takes a lot to do that when you are also managing the distress of seeing someone that you know who is extremely unwell going into a place that you know is not geared up to helping them.

The CHAIR: When they are in the prison system itself, how integrated are the mental health and AOD systems? What you have just described to me is not a particularly integrated approach. Are there programs that are working? Are there particular prisons that might be doing it better than others?

Ms Doherty: Did you want to answer?

Ms Catterall: I have lived experience of being incarcerated. It was some time ago. I had a dual diagnosis of mental health issues and AOD issues, and none of those needs were met whatsoever. I was not given any assistance with any kind of detox and I was not given any access to mental health antidepressants. I eventually got some antidepressants at some point, but I did not get the full range of the medication needs that I had. I will qualify that and say that that was a prison in Victoria, but I do believe, from what we have heard—we do not have any statistics—that that is still occurring in Western Australia.

Hon MICHAEL MISCHIN: How long ago was this?

Ms Catterall: Eight years.

Ms Doherty: I suppose in terms of the statistics that we do know, we have the Inspector of Custodial Services' report on prisoner access to mental health, in which he said that not everyone gets referred and of those who are referred, I think it was a third who are seen. But we know the problem is that there are 30 beds at the Frankland Centre and it operates primarily, at this point, looking from the outside in, as an emergency department for prisons. So people become very unwell in prison, they are transferred, if they are fortunate, to the Frankland Centre, who do really good work to stabilise them and work with them. Then, depending on how many magistrate hospital orders are made in a week, they may end up having to go back to prison prematurely where the whole cycle begins again. One of the curiosities that we have is that we are aware that work was done on a justice health project and we are wondering where that is sitting right now. We understand that it is with government, but we would be really curious about what recommendations are there and what government is planning to do with that report.

[3.30 pm]

The CHAIR: In your experience, when people are finally leaving the prison system, how good is the support upon their exit from prison?

Ms Doherty: Again, I think, distinguishing between those groups who are under the care of the comorbidity teams, this is where we have to look at the large picture. If the person does not have accommodation, then they cannot get referred to a community mental health service because they

do not have an address. If they do have an address, then that transfer can take, because the community mental health service has to make an assessment as to whether they take them on et cetera—and given how stretched many of them, that can be difficult—so that can be two to three weeks. So there is the gap. People are often making their way back into the judicial system again in that gap.

One piece of good news in that area, because I do not want to sound all doom and gloom, is the prison transition team, which started, I think, in February 2018 perhaps, or 2017—I am not sure which. It identifies, from the psychiatrists who work in the prison, people who are due to come out in the next three to six months and starts working with them. It does some really good work in that area, so it can do the assessments when someone is still inside and pass on that information if there is an address, which is a big if at the moment. If there is an address, they can pass it on to the relevant community mental health team. However, depending on the nature of a person's unwellness, if that person experiences paranoia, that often means they are very reluctant to sign forms. So if they do not give permission for the team to work with them, the team cannot work with them at the moment.

Hon MICHAEL MISCHIN: How do you overcome that?

Ms Doherty: My way of overcoming that is that I think you have to try it a lot of different ways. People feel paranoid when they are scared, so you have to maybe put that conversation in a relationship with someone whom they feel safe around. So it might not be this stranger from this team coming in and asking that question; it might need to be asked by someone who has been treating them for a number of years. Secondly, perhaps there is a possibility of doing a paper transfer. The person might not be willing to give you the information, given that they have been in the mental health system for a long time and they are currently being cared for, but there is a reasonable predictable trajectory that they will continue to need that care. So instead of taking verbal input, the person could just flag it. I would just point out the significant problem in that plan is the address.

Hon MICHAEL MISCHIN: That is a significant problem as well in what you were suggesting earlier about early active intervention. It is all very well if someone has a family that is noticing problems or a person is sufficiently self-aware to know that they are going to have an episode, but if they are either not self-aware, in denial or do not have people who are able to alert the authorities, then you still have them being picked up after having committed an offence of some sort. They are taken to an emergency department and have to be dealt with there, while potentially being violent, disruptive and interfering in the operations of the emergency department. So early intervention is not an answer in that. There has to be some other strategy.

Ms Doherty: I think providing safe, affordable, secure housing is a definite answer to that. We can look at the 50 Lives 50 Homes project, which has been running out of Perth for a little while now and has just had an evaluation of its work conducted by the Centre for Social Impact at UWA. It has some really good evidence there that actually putting someone in a house and adopting a housing-first model—where you do not expect them to be ready for tenancy but you give them the tenancy and wrap the services around them to help them maintain the tenancy—means that what you lose from your budget in emergency departments and with policing is spent differently, and I think probably it is spent more humanely.

The CHAIR: You refer to the Portuguese model in your submission. You would be aware that that is something this committee is also looking at. Do you think this type of model is better suited for people with multiple unmet needs than the current approach within Western Australia?

Ms Doherty: Yes, we do.

The CHAIR: Could you elaborate on that a little bit more? Of course, the approach looks at treating drug problems from a health perspective, rather than through the criminal justice system. I am curious to know what that would mean to you.

Ms Doherty: If the majority of drugs were to be decriminalised for personal use—let me just be very clear that I am not talking about trafficking or manufacturing, but for personal use—people would then be able to access, hopefully, those drugs through a practitioner. It may be that those drugs are available on prescription and you provide points of purchase for those drugs, which can also provide education around using those drugs and using them safely. A criminal record for drug use is a very real obstacle when you are looking for employment or when you are trying to travel overseas or when you are doing lots of things that we all want to do in our lives. Even if you got it when you were 19 and a bit daft, perhaps—not all 19-year-olds are daft, but maybe we did silly things when we were young—that follows you. It also allows drug use to be seen through the health lens. It is a health issue. It is not a willpower issue. It is not a moral issue. It should not be a justice issue. It is a health issue.

The CHAIR: We have heard evidence that some drugs perhaps would be well-suited to this. What you just described is effectively a pharmaceutical-based approach. But we have also heard evidence that some drugs are so dangerous that they should never be made legal—that they should remain illegal, but simply that the use of them should not be made illegal. Do you have any reflections on that and the severity of harm of any particular types of drugs?

Ms Doherty: I think when we look at the severity of harm, alcohol is up there with number one. I will just put that one on the table. In terms of illegal drugs, we have had this conversation among ourselves, particularly around meth, given the focus on meth and given that it potentially invokes such an intense and violent response, which often happens within family homes—families are often on the front face of that response. What we have come to is a space where there are still mixed views about it. I certainly do not think we have fixed on a position, but it is around the harm done and it is around trying to intervene way before people get to that stage of using. It is looking at the activators for their drug use. It is about providing safe and stable accommodation, something meaningful to do during the day and a decent income to live on—those sorts of things. We are still debating it. There are people who say, “Okay, let’s keep the drug illegal, but decriminalise the use of the drug for personal use”, as you said. I think that has merit. But, as I said, we have not come to an agreed position on that yet.

Hon MICHAEL MISCHIN: Which ones? You said the majority should be decriminalised for personal use. Presumably, there is a minority of drugs that you feel —

Ms Doherty: Minority of one, which would be methamphetamine.

Hon MICHAEL MISCHIN: That is methamphetamine, and presumably analogues of that that are equally harmful.

Ms Doherty: Yes.

Hon MICHAEL MISCHIN: So opiates, cannabis and others ought to be simply dealt with under pharmaceutical control?

Ms Doherty: I think so, yes—decriminalised for personal use.

The CHAIR: A bit of a live discussion is this issue of mandatory treatment or mandatory detox—the committee is clearly distinguishing between the two—as often parents are at the pointy end of this. Could you give the committee your thoughts on whether mandatory treatment or mandatory detox are options which should be contemplated by government?

Ms Doherty: Again, it is a vexed issue.

The CHAIR: I am interested to hear the complexities.

Ms Doherty: There is, I suppose, the individual rights perspective, which says I can do what I want to do; I need to take the consequences of that. But, unfortunately, the consequences often ripple out into the people around the person and the community. Then there is probably a view as well—I would call it perhaps an uneducated view—that says that if this person goes into detox and treatment, in 28 days it will be sorted, done, because that is what you see on TV. I think often the call for compulsory treatment comes from a very real place of anguish and pain and a space of, "This is going to end really badly, and we want to have some intervention beforehand." There is not a great evidence base at this point of time for compulsory treatment, so if we were to go down that track in this state, I think we would have to do so with a view to add into that evidence base. I think we would have to make sure that if there was compulsory detox, that what we are not actually doing is clearing the person's system in order to set them up for potential overdose.

The CHAIR: Could you elaborate on that a little more?

Ms Doherty: If a person is detoxed and their system is okay, they are feeling better and they go back out into the community and back into the same stressors that they left, without any other support, and they use the same amount—potential overdose.

[3.40 pm]

The CHAIR: You are suggesting if there were to be compulsory detox, it would still need to require ongoing assistance after that. What I am not clear is whether you are suggesting that any of the additional assistance beyond that would have a compulsory element.

Ms Doherty: Again, we have not come to an agreed position on this because within our group we have lots of variants in opinion, but certainly among the discussion has been the need for anyone—this is not a light option, number one; this is an option that you only use as a very last ditch effort in someone's treatment. Secondly of all, if you are going to take away people's rights, you have to make sure there is very, very good safeguarding around that. We have lessons to learn from how the Mental Health Act is applied. We need to make sure that there is access to advocacy et cetera. If we are going to detain people for a length of time, we would suggest that there needs to be an equivalent wraparound package of support that comes with that so that we do not inadvertently set that person up for failure by sending them back into the community with no stable housing and an appointment for a clinic in two weeks' time. In the New South Wales model, my understanding is there has been extremely assertive community follow-up. That contributed to some of the success in one of their pilots.

Hon MICHAEL MISCHIN: Is there any compulsion in the New South Wales model? Plainly, if you leave it to people's own devices and they are not keen to go through the process of changing their lifestyle, you need some stick as well as some carrot. How is it done? How do you suggest it be approached? What is needed as a minimum?

Ms Doherty: I think it is really difficult. When I attended some forums on this when it was being discussed, probably 18 months ago, even within the consumer body there were various quite differing opinions. One was "minimum" and the other person saying "need three to six months". I think it settled on "keep the minimum amount"; keep the compulsory amount minimal but make sure there are very, very clear supports around that. I do not mean to draw too long a bow, but to some degree we do a bit of a compulsory detox—certainly detox; not treatment—when people enter the criminal justice system as a result sometimes of the offending that occurs when they are

violent. I am not suggesting that as an option; I am just saying that is already there. That is not a nice way to detox and it is not a healthy way to detox.

The CHAIR: Unfortunately, we have run out of time, which is a shame because I think that there is still lots more that we would love to unpick.

Ms Catterall: Ms Xamon, could I just clarify something. I just wanted to clarify when I was last incarcerated—did I say it was eight years or 18 years?

Hon MICHAEL MISCHIN: Eight.

Ms Catterall: It was actually 18; my apologies. It is a big difference! I am just a bit nervous.

The CHAIR: That is absolutely fine. On that, I might just give the overview of what happens with the transcript. I do really want to thank you for attending today. It is very much appreciated. We are able to end the broadcast here at that point, if you wish.

A transcript of this hearing will be forwarded to you for correction. If you believe that any correction should be made because of typographical or transcription errors, please indicate these corrections on the transcript, but errors of fact or substance must be corrected in a formal letter to the committee; there is the opportunity to do that.

I am going to remind you that your transcript is going to be made public, but 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. If you want to provide additional information or elaborate on particular points, you may provide supplementary evidence for the committee's consideration when you return your corrected transcript of evidence. We are still keen to be able to hear from you, if you have further evidence that you feel would be helpful for the committee's deliberations. I want to thank you again for your time. It is much appreciated.

Hearing concluded at 3.44 pm

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