EDUCATION AND HEALTH STANDING COMMITTEE

REVIEW OF WA'S CURRENT AND FUTURE HOSPITAL AND COMMUNITY HEALTH CARE SERVICES

INQUIRY INTO THE ADEQUACY AND APPROPRIATENESS OF PREVENTION AND TREATMENT SERVICES FOR ALCOHOL AND ILLICIT DRUG PROBLEMS IN WESTERN AUSTRALIA

TRANSCRIPT OF EVIDENCE TAKEN
AT KALGOORLIE
MONDAY, 14 SEPTEMBER 2009

SESSION SIX

Members

Dr J.M. Woollard (Chairman)
Ms L.L. Baker (Deputy Chairman)
Mr P.B. Watson
Mr I.C. Blayney
Mr P. Abetz

Hearing commenced at 4.33 pm

CLARK, MISS DEBORAH FAYE
Chairperson, Kalgoorlie Local Drug Action Group,
examined:

HUNT, MS ROSEMARY JUNE
Executive Manager, Centrecare,
examined:

The CHAIRMAN: On behalf of the Education and Health Standing Committee, thank you for your interest and your appearance before us today. The purpose of this hearing is to assist the committee in gathering evidence for its inquiries into the review of Western Australia's current and future hospital and community healthcare services and the adequacy and appropriateness of prevention and treatment services for alcohol and illicit drug problems in Western Australia. You have been provided with a copy of the committee's terms of reference. The Education and Health Standing Committee is a committee of the Legislative Assembly and this hearing is a formal procedure of Parliament and therefore commands the same respect given to proceedings in the house. Even though the committee is not asking you to provide evidence on oath or affirmation, it is important that you understand that any deliberate misleading of the committee may be regarded as a contempt of Parliament. As this is a public hearing, Hansard staff are making a transcript of the proceedings for the public record. If you refer to any document or documents during your evidence, it would assist Hansard if you could provide the full title for the record. Before we proceed to the questions we have for you today, I need to ask you a series of questions. Have you completed the "Details of Witness" form?

Miss Clark: Yes.

The CHAIRMAN: Do you understand the notes at the bottom of the form about giving evidence to a parliamentary committee?

Miss Clark: Yes.

The CHAIRMAN: Did you receive and read the information for witnesses briefing sheet provided with the "Details of Witness" form today?

Miss Clark: Yes.

The CHAIRMAN: Do you have any questions in relation to being a witness at today's hearing?

Miss Clark: No.

The CHAIRMAN: Deborah, we are looking for you to paint us a picture, looking at both the hospital and the community, of what facilities are available now, where there are gaps in those facilities and how those gaps can best be addressed both now and in view of changes to the population. What is needed now and what might be needed in five years' time if you can see any changes occurring?

Miss Clark: From a Local Drug Action Group perspective, we do not have a great deal to do with the hospital. We are a community group so we are made up of community volunteers. Our role in the community is to raise awareness about alcohol and other drug issues and to empower community members to be involved in various activities that may contribute to raising that awareness within the community about alcohol and other drug issues. We are not a treatment service. We have a prevention approach. We do not provide any services as such around alcohol

and other drug use. As I said, we do not have a great deal to do with the hospital. I do believe that our group is promoted within the hospital by way of flyer but we do not have any representatives from the hospital on our committee.

From a community perspective, for many years now our group has generally been made up of service providers. We struggle to attract community members to our group. They will often come for six or 12 months and then for various reasons—someone might be leaving town or whatever—we lose them from our group. It is generally a core group of service providers who have been with the group for quite some time. As a group we often work in conjunction with the National Drug Research Institute and Kalgoorlie Alcohol Action Project on activities designed to raise awareness about drinking alcohol, in particular, as well as alcohol and other drug issues.

From a Local Drug Action Group perspective, we do think that there is a severe lack of services here in Kalgoorlie. If people come to us requesting support or treatment, we will often refer them to the community-based service team based at Centrecare or to Bega, the Aboriginal medical service. Other than that, there are not many treatment services available. There are GPs and hospitals, obviously. By far, we think that the biggest need here in Kalgoorlie-Boulder would be for some sort of residential treatment service. At the moment the hospital does participate in detoxing clients if a GP is willing to oversee the detoxification. To my knowledge, there is no-one out at the hospital who does that.

The CHAIRMAN: Is that in the medical wards?

Miss Clark: Yes.

The CHAIRMAN: Is there an isolated room there?

Miss Clark: Not to my knowledge. I believe they are just in the ward. That is solely on the proviso that their GP is willing to oversee that. The GP has to come in and monitor and give meds and those sorts of things. People can detox here. At times—many times actually—through referral to the community drug service team, we have had people sent down to Perth for residential rehabilitation. Waiting lists are quite astronomical at times, always at least a couple of months.

The CHAIRMAN: Do you mean waiting lists when people arrive in Perth? Someone might want to give up but might have to wait two or three months before a place becomes available for them to go down to Perth to join a program.

Miss Clark: Yes. The CDS team would start the process. Assessment can generally be done over the telephone. We get an idea of what the waiting list is like. It is generally between eight to 10 weeks for the services down in Perth. Depending on what the client prefers, they would have a detox up here in the hospital if their GP could oversee that, otherwise we try to coordinate for that person to be detoxed at Next Step and then go into the treatment program.

Mr P. ABETZ: Does Next Step have massive waiting lists?

Miss Clark: Certainly with the detox part, yes. Sometimes it might be Next Step that we are waiting for more so than one of the treatment providers. That is by far the biggest need here. From there, generally the transition would be straight from Next Step into one of the residential rehabs, so there is no time between. Both Next Step and all of the rehabilitation centres down in Perth have been very good as far as assisting us to ensure a smooth transition for a client. The difficulty is the eight-week waiting period. I had a role in the community drug service team. Probably one in four will make it to rehab.

The CHAIRMAN: Is that because they have lost the urge to change their behaviour?

Miss Clark: So many things could happen in their lives because they lead quite hectic lifestyles. Nine weeks down the track is not a suitable time.

Mr P. ABETZ: It is an eternity away.

Miss Clark: Absolutely, certainly for a drug user. I also think some Indigenous-specific programs and services are required. We do see Indigenous clients through the community drug service team. We have a lot of trouble attracting Indigenous community members to our Local Drug Action Group. We do have one Aboriginal person on a Local Drug Action Group at present but they are a difficult bunch to try to attract to the group. We need services for Indigenous people, particularly more remote Indigenous people. If we were to look at the goldfields as a region rather than just Kalgoorlie-Boulder, it has extremely limited services. I understand that the majority of people would probably access support through their local health clinic, but that is about it. We support other Local Drug Action Groups. We have a bit to do with the Local Drug Action Group in Coolgardie and also the Local Drug Action Group in Laverton. We try to offer them as much support as we can and encourage them to link in with various activities.

The CHAIRMAN: Do you know what the major problems in Kalgoorlie are in relation to addictions? Do you have any idea what the percentage would be?

Miss Clark: I probably would not guess at percentages but I could certainly tell you the order of prevalence. Alcohol would definitely be number one while cannabis and amphetamines tend to fluctuate at two and three. There is quite a big gap between those three main drugs and then your opiates, hallucinogens and those sorts of drugs. There are pockets of areas that have issues around solvents and volatile substance use but in Kalgoorlie-Boulder itself and the region, alcohol would be number one.

The Sobering Up Centre and those sorts of things require more input, more money and building up. The Sobering Up Centre is fairly limited in how many people it can take. It is the only one in the community. We certainly have an issue with non-Indigenous intoxicated people in town. The Sobering Up Centre is not perhaps as useful for those types of clients.

Mr P. ABETZ: Is the Sobering Up Centre predominantly used by Indigenous people?

Miss Clark: Yes.

The CHAIRMAN: Welcome, Rosemary. On behalf of the Education and Health Standing Committee, thank you for your interest and your appearance before us today. The purpose of this hearing is to assist the committee in gathering evidence for its inquiries into the review of Western Australia's current and future hospital and community healthcare services and the adequacy and appropriateness of prevention and treatment services for alcohol and illicit drug problems in Western Australia. You have been provided with a copy of the committee's specific terms of reference. This committee is a committee of the Legislative Assembly and this hearing is a formal procedure of Parliament and therefore commands the same respect given to proceedings in the house. Even though the committee is not asking you to provide evidence on oath or affirmation, it is important that you understand that any deliberate misleading of the committee may be regarded as a contempt of Parliament. As this is a public hearing, Hansard staff are making a transcript of the proceedings for the public record. If you refer to any document or documents during your evidence, it would assist Hansard if you could provide the full title for the record. Before we proceed to the questions we have for you today, I need to ask you a series of questions. Have you completed the "Details of Witness" form?

Ms Hunt: Yes.

The CHAIRMAN: Do you understand the notes at the bottom of the form about giving evidence to a parliamentary committee?

Ms Hunt: Yes.

The CHAIRMAN: Did you receive and read the information for witnesses briefing sheet provided with the "Details of Witness" form today?

Ms Hunt: Yes.

The CHAIRMAN: Do you have any questions in relation to being a witness at today's hearing?

Ms Hunt: No.

The CHAIRMAN: Rosemary, you missed some of Deb's presentation. We are looking to see, with regard to hospital and community services and health care services in general, how those health care issues relate to problems with alcohol and illicit drug use and what problems there are at the moment in terms of alcohol and illicit drug use within the region. What are the gaps, how can the gaps be addressed and what planning needs to be done for the future, anticipating what problems are likely to develop in the future?

Ms Hunt: I will provide a couple of facts so you understand where I am coming from. Centrecare Goldfields includes Esperance; it goes down through the northern core to Laverton, right down to Esperance, Hopetoun and all that area. It covers quite a wide variety of population. Those groups all travel. Even though you might not be particularly interested in some of those areas, those populations tend to migrate through our land at one stage or another. As Deb said, the observation I would make is that alcohol would have to be the predominant causative agent of ill-health and social dysfunction that we see. You could bring an awful lot of money into those services and I do not know that you would ever really hit the nail on the head because it is just so inherent in the culture and in the lifestyles throughout this region. It is really bad.

Some of the gaps are related to the fact that you could invest a lot of money and you will not get to the bottom of it all. In the contracts that we service in this area, we cover all those areas but we also employ a variety of people. Those contracts talk about who we employ in those areas. We like to have Indigenous health workers or Indigenous people. If we could get qualified Indigenous counsellors, we would employ them as well.

The CHAIRMAN: What percentage of your staff are Indigenous and non-Indigenous?

Ms Hunt: We currently have seven or eight employees out of 50 who are Indigenous, not through lack of trying. We would take more. It is very, very difficult to get that group of people to engage in long-term study to get further qualifications. We do support Indigenous staff through the community drug service to continue their studies. We give them leave and we do all sorts of things, and so does the Drug and Alcohol Office. It contributes a substantial amount to staff. It is good that it does that but I feel a little like the horse has bolted. There are so many Indigenous kids going through the schools, even now as we speak, with terrible literacy and numeracy issues. They are our future in terms of health workers or Indigenous counsellors or leaders in their community. We are set up for failure unless we address that. It is like the horse has bolted.

Some of the other gaps between illicit drug substance and substance misuse and abuse, including alcohol, is the mental health problem that that causes. In Kalgoorlie we have the hospital inpatient mental health unit and we also have the community mental health unit. We also have our community mental health unit that we run at Centrecare. We provide a lot of psychological support and teach social skills. There is still a bit of a gap between clients who, as Deb said, are very inebriated or affected by substance misuse. We can get them to the hospital when they are in an acute situation. We do not have a GP. I am a nurse but we do not have a nurse employed as such. Our capacity to deal with the acute clients or those who are at the mental health abuse acute stage or substance abuse acute stage of unwellness need to go to the hospital. The hospital's capacity to deal with those clients is limited by where we can locate them. There is a bit of a gap in the follow up. Community mental health has a set boundary that they can go to and we do also but we seem to have a bit of a gap there. I think that is mostly in those acute people that do not really fit in the hospital.

The CHAIRMAN: Does that not come under community and mental health services?

Ms Hunt: Its capacity to deal with clients after hours is quite limited. Clients will get discharged from the health service and we might take them and they might come to us in a bad state and we

will put them into the system in the hospital. There are very few GPs who will take on any form of drying out. The hospital will not really book the clients in. There are limited services for those clients if they want to withdraw from substances anyway. If they suffer an acute crisis during that withdrawal period and they are not in the hospital and it is after hours or on a weekend, community mental health is not available.

The CHAIRMAN: Does community and mental health services only come in on a crisis situation? Does it generally not have care of patients with alcohol problems?

Miss Clark: It may have ongoing contact.

The CHAIRMAN: From another mental illness.

Miss Clark: There is no actual crisis service. There have been times when people have presented at Centrecare in an acute psychotic state. We have gone through our processes and taken them to the hospital and they still have not been admitted. That could be for a variety of reasons. It may be that there is no bed space or that person may have been assessed as being okay. Because Centrecare is not a crisis service and our capacity is limited in how often we can see a client—they may need to be seen once a day for the next week or so until that crisis is over—there is no service in the community at present that provides that. We will do the best we can to contact that person each day but that will involve phone calls and a client session.

Mr P. ABETZ: That points to the need for a residential rehabilitation facility in the area.

Ms Hunt: It needs to be able to cater for Indigenous and non-Indigenous clients.

The CHAIRMAN: How many people might you see in a day or a week?

Ms Hunt: Maybe 25 to 30 clients a week.

Mr P. ABETZ: How does Centrecare operate here in Kalgoorlie? Is it basically a counselling type service for people with issues with drugs and alcohol or is it wider than that?

Ms Hunt: It is much wider than that. We run nearly 50 programs. The streams traditionally all hold similar attributes. There will be counselling. We like to keep that around the 30 per cent mark because that is not as preventive or proactive as we would like. It is more for acute stuff. We provide one-on-one counselling, group sessions, education, information, stakeholder education and networking and community support. They run through various streams. We have family relationships, which covers domestic violence, child sexual assault and all of the things that are coloured by alcohol and illicit substance misuse. We have mandated violence groups as well that are court ordered for people to attend group counselling and one-on-one counselling.

The CHAIRMAN: Would you have a summary of the services that you provide?

Ms Hunt: We do. It is quite huge.

The CHAIRMAN: Could you provide that by way of supplementary information?

Ms Hunt: Yes.

The CHAIRMAN: What ages are you seeing?

Ms Hunt: There is no limit. Certain contracts talk about ages. If someone does not fit into that contract, we find something else and make sure we fit them into that. We have highly specialised counsellors who deal with areas such as child sexual health. I think that goes through to 18 years of age, at which stage they would fall into another program.

The CHAIRMAN: And as young as?

Ms Hunt: I think it is three or five. We would not leave them out. We would have them in another program once they got out of that age group. That is for the perpetrators, the survivors and/or their family and significant others who have been influenced by that.

The CHAIRMAN: How many children would you see either on a weekly or monthly basis?

Ms Hunt: If you did not count Deb's youth services, if you just stuck to family relationship services, anywhere between five and 15 in a week.

The CHAIRMAN: Deb, how many children would you see under 18 for youth services?

Miss Clark: Our age bracket is 12 to 18. During the school term, we would average five kids a day at our youth facility. During the school holidays we probably average 18 to 20.

Ms Hunt: We have discos and things like that where up to 50 children come.

Mr P.B. WATSON: Are these referred or do people drop in?

Miss Clark: Some of them are referred. The child sexual assault and counselling programs are referred but we have a youth drop-in centre.

The CHAIRMAN: You are not treating?

Miss Clark: Young people who come to the centre can access a counsellor. Each afternoon we have a life skills workshop. That may take only 15 or 20 minutes. We might talk about alcohol and other drugs, anger or communication. They engage in that.

The CHAIRMAN: Is that for all people affected by alcohol or other issues?

Miss Clark: It is for those who are classed as at risk. We would not turn anyone away who came in. At the moment 95 per cent of the kids who are utilising the centre are Indigenous. There is a bit of a misconception out there that is a service for Indigenous kids. That has been the case for a little while through no advertising of our own. We have tried to advertise the opposite. It is possibly due to the location. It is in Boulder, one of the lower socioeconomic suburbs of Kalgoorlie. They would all be classed as at risk. We often have kids who lob at the youth facility with not many clothes on, they do not know where mum and dad are, they have not had anything to eat that day and very few of them actively attend school. We try to have strong working relationships with the education department, youth pathways and those sorts of groups to ensure, where possible, kids will go to school. A huge portion come into the at-risk category because they are Aboriginal and because they are from low socioeconomic families, dysfunctional families, where there is a lot of alcohol and other drug use and violence.

[5.00 pm]

Mr P.B. WATSON: Rosemary, what is the youngest age group you work with?

Ms Hunt: We do not see children under five that often. In youth services, the average spread would be between five and 18 years old.

Mr P.B. WATSON: What about babies who have been affected by drugs?

Ms Hunt: We do not tend to see those children ourselves. They are often picked up by the ward where they have been delivered and they will be followed up by a child health nurse, a community health nurse or a paediatrician, more often than by us. We are seeing in the older group the long-term effect of foetal alcohol syndrome, which has increased. That has probably been picked up long after it was occurring. We are seeing those kids now. They are disengaged and are not functioning at school, even if the home is a functioning environment. A lot of them were dysfunctional anyway. They are not coping at home and they are living on the streets for four or five nights at a time. The family will not know where they are.

The CHAIRMAN: Are they children with foetal alcohol syndrome disorder?

Ms Hunt: Yes. If we were able to engage with them and tick a few boxes, they would fit in that spectrum.

Miss Clark: There are probably some young parents of those children who themselves have foetal alcohol syndrome spectrum disorder. They are now having their own children while continuing to drink. There is now a second generation.

The CHAIRMAN: Are numbers plateauing, escalating or decreasing?

Ms Hunt: I think it is getting worse, but that is just my personal impression. From a professional observation, I would say that the numbers are increasing. We are not necessarily seeing them engage in the services, but if you were to drive around the towns in the evening to the areas where they hang out, you can see that their numbers are definitely increasing.

The CHAIRMAN: Do you have statistics on the service provision for clients from one and two years ago?

Ms Hunt: Yes.

The CHAIRMAN: Could you tell us whether there were 1 500 this year and how many there were last year and the year before?

Ms Hunt: Do you mean the clients that we were servicing or clients who had particular problems? We collect a range of data on a variety of presentations and then on postcodes and age groups.

The CHAIRMAN: Could you send us some of those statistics for the past three years so that we can see the trend?

Mr P. ABETZ: That will be only the trend of what Centrecare has handled, which does not necessarily reflect what is happening in the community. My guess is that the Centrecare services are fully taxed and that a lot of other people who would benefit from accessing your services do not access them. Is that right?

Ms Hunt: That would be true. I do not think there are enough FTEs.

The CHAIRMAN: Even if that is not filling the gap, it will show that there is an increase in the pattern, which can be used to demonstrate that Centrecare requires more resources. You have already said on record that you do not think that is touching the surface in terms of the number of people among all age groups who need assistance.

Miss Clark: It is difficult to ascertain that data because of the transient nature of the community. At this time last year the housing market was going through the roof. A lot of people were moving into town and very few rentals were available. Then the economic crisis occurred and a lot of jobs in the nickel industry were lost. The nature of the community will affect our figures. It might be that 200 more people accessed the community drug service team for support but the issues had not changed a great deal or the issue may have changed from one drug to another. It depends, because it is a unique community.

The CHAIRMAN: How do the alcohol and illicit drug problems in the area affect or influence the prostitution rates in the area?

Ms Hunt: I think they get good business because of the destruction of the social fabric. Men are often up here on their own for a long time. They do not have anything to distract them between shifts. They may only have two days off and there is a culture of getting smashed during those two days and people think that the best way to have fun is to take drugs and drink alcohol, apparently. The men have high hormonal activity and they tend to egg each other on. Eventually, not only the sex industry gets busy, but also there are a lot of one-night stands. A lot of women present at the crisis centre and to us who believe that their drink has been spiked or they have been taken advantage of whilst inebriated. That statistic will rise. Unless the police talk to the committee, it will be hard to say whether they are seeing an increase in those types of reports because it is not necessarily an increase in the activity alone. Certainly, we are seeing an increase. We work reasonably closely with the sex workers and make counselling available for them. We also work with the women's health centre and talk to them about a variety of issues. They are very busy.

The CHAIRMAN: We have heard that there has been an escalation in sexually transmitted diseases such as chlamydia, HIV and gonorrhoea.

Ms Hunt: In other areas those things are being done, but not here.

Mr P. ABETZ: Kimberley and Kalgoorlie seem to be the hot spots.

The CHAIRMAN: Is someone who is attached to the community drug services team able to refer people to get a check for HIV and sexually transmitted diseases? How does that work?

Miss Clark: We would refer them to Population Health, which has a blood-borne virus and STI centre. People can get free checks from either of those places. As far as drug use among the sex workers is concerned, Magenta and similar agencies provide support through the sex workers support projects. Most of the brothels and houses are fairly clean in terms of drug use. There is not that much drug use among the girls but we have heard that a lot of private houses have opened up in the past 12 months and it is possible that more drug use goes on in those places.

Mr P. ABETZ: Magenta claims that. I have actually visited the madams in Kalgoorlie and they assured me that probably 80 to 90 per cent of the prostitutes are drug addicts, and that is why they do that work.

The CHAIRMAN: Peter went to visit the madams to do some research for a bill that is coming before Parliament. That was part of his research in his parliamentary capacity.

Mr P.B. WATSON: I have not visited them!

Mr P. ABETZ: The madams told me that business is very difficult at the moment because—interestingly enough—there was so much immorality that men are not having to go to the brothel to pay for sex; they can pick up someone from a pub and get sex for free.

Ms Hunt: We are seeing that.

Mr P. ABETZ: Their said that if it were not for the tourist tours that they conduct, the brothels would not be able to keep their doors open.

Mr P.B. WATSON: Is binge drinking a problem?

Miss Clark: It is a huge problem.

Ms Hunt: Even among nine and 11-year-olds.

The CHAIRMAN: Where are the nine-year-olds getting alcohol from?

Ms Hunt: That is a good question. Often it is from the older sibling.

The CHAIRMAN: Are they getting alcohol for providing sex?

Miss Clark: That does not happen here so much.

The CHAIRMAN: Children are receiving alcohol and cigarettes for providing sex.

Ms Hunt: It is definitely happening out in the lands. The girls and young boys will tell you that is happening.

Miss Clark: And for petrol, paint or glue.

Mr P. ABETZ: When I was running a rehabilitation group in Perth, we had a support group for recovering addicts and also for the parents of the kids on drugs. One of the frustrations of the parents was that there seemed to be a lack of police action. They followed their kids and knew where the kids got the drugs from but when they gave that information to the police, the police did not act on it. Is that an issue in Kalgoorlie? I can ask that because the police officer is not here at the moment.

The CHAIRMAN: Have you heard that in Kalgoorlie people are aware of who might be dealing and it is not followed up by the police? Are there concerns that the police are not following that up? Have people put their concerns to you that the police are not following up those issues?

Mr P. ABETZ: I preface that with the comment that part of the police service—the higher echelons of the police service—have issued a statement saying that they are only after the big dealers and not the little dealers and therefore the police should not waste their time on that. What extent is that influencing the drug scene here?

Ms Hunt: From my experience, there is a reasonable amount of comment or vitriol around the inaction of the police force when it is notified of the dealers around town, particularly regarding youth who are being supplied with drugs as the precursor to sex. It gets very cloudy and very difficult. Some of the sorts of comments that I have heard immediately following those sorts of statements are, "If I were to take this any further, the next time I visit that community, I may well leave the town with a spear in my back." We want Indigenous workers to go to the Indigenous areas and be of country. There are a whole heap of cultural complications that occur when a culturally appropriate worker is sent out into the environment and comes back and tells us what is happening but says that if he did anything about it, the next time he headed out there, well, there would not be a next time because it would not be safe to do that. That probably limits the number of people who would give us that feedback. What we hear is maybe third or fourth-hand. Therefore, the veracity of that data has not been tested, but the fear of the workers is very real. I have lived in country towns for nearly all my life and I have not been in one town where that sort of statement has not been made. I do not know whether that is fair or unfair or whether it is just small-town talk, but that comment is made quite often. What I have learned from the youth who have come for counselling, particularly young girls who are enticed to offer sex for drugs, is that a lot of the deals are done quite openly. Health providers in the area, particularly pharmacists, would go to a local hotel to watch what is happening with the drug deals. They have said that they can sit in a hotel and see it happen. They will issue a prescription—I am talking about prescribed medications in particular—and the pharmacist will go to the hotel and have a few quiet beers, only to see them being on-sold.

The CHAIRMAN: So the person who got the drugs from the pharmacist went to the hotel and sold the pain relief drugs?

Miss Clark: There is quite a big black market in prescription medicines.

Ms Hunt: It is well known drugs are being used to tip the bar staff. Instead of money, packets of drugs are being handed over the counter to the bar staff. It seems to me that it is occurring quite openly.

Miss Clark: A lot occurs in licensed premises. There would not be a licensed premise in Kalgoorlie where drug dealing does not occur, particularly on a Friday or Saturday night.

Ms Hunt: We are not seeing that because we are not there. This is not information we could say with 100 per cent certainty that it is going on, but it is so widely spoken about that one wonders whether where there is smoke there might be fire.

Miss Clark: The police, at their discretion, can issue a cannabis infringement notice for people caught with small amounts of cannabis. For four years the police have had the option of issuing a CIN to people who have been found to have small amounts of cannabis. I was working in the diversion programs at Centrecare for most of that time and we were lucky to have received 10 referrals in that entire time. I understand that it was at the discretion of the police officer to do that. The feedback from the people who went to the cannabis education session was mostly positive. They found it useful and they learnt something from the sessions. That was brought in partly to reduce the time spent dealing with those sorts of matters in the courts but it was never utilised, which was disappointing.

The CHAIRMAN: If there is anything that you would like to bring to our attention, please do so by a way of supplementary information. Thank you for your evidence before the committee today. A transcript of this hearing will be forwarded to you for the correction of minor errors. Any such corrections must be made and the transcript returned within 10 days from the date of the letter attached to the transcript. If the transcript is not returned within this period, it will be deemed to be correct. New material cannot be added via these corrections and the sense of your evidence cannot be altered. Should you wish to provide additional information or elaborate on particular points, please include a supplementary submission for the committee's consideration when you return your corrected transcript. Thank you very much for coming.

Hearing concluded at 5.15 pm