EDUCATION AND HEALTH STANDING COMMITTEE

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 PERTH
WEDNESDAY, 25 AUGUST 2010

SESSION ONE

Members

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

Hearing commenced at 9.06 am

DAVENPORT, HON DR CHERYL
Chairperson, WA Network of Alcohol and Other Drug Agencies, examined:

RUNDLE, MS JILL
Executive Director, WA Network of Alcohol and Other Drug Agencies, examined:

FLUGGE, MR WAYNE GILBERT
Aboriginal Services Manager, WA Network of Alcohol and Other Drug Agencies, examined:

DAWS, MS CAROL
Board Member, WA Network of Alcohol and Other Drug Agencies, examined:

The CHAIRMAN: On behalf of the Education and Health Standing Committee, I 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 inquiry into 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. At this stage I will introduce myself, Janet Woollard, and Mr Peter Abetz. Also with us are Dr David Worth, Lucy Roberts, and Heather and Olivier from Hansard. This committee is a committee of the Assembly. This hearing is a formal procedure 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. This is a public hearing and Hansard will be making a transcript of the proceedings for the public record. If you refer to any 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?

The Witnesses: Yes.

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

The Witnesses: Yes.

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

The Witnesses: Yes.

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

The Witnesses: No.

The CHAIRMAN: Thank you. Just to give Peter some perspective, Cheryl, you were actually a member in the Council.

Dr Davenport: Yes, from 1989 to 2001.

The CHAIRMAN: I think I have bumped into you at different times at different rallies in Rockingham and other places.

Dr Davenport: Yes.

The CHAIRMAN: Joining us now at the table is Mr Peter Watson who is a country member so it is obviously —

Mr P. ABETZ: He has just flown in from Albany.

Mr P.B. WATSON: I flew in last night but I have just had one of those mornings where everything has gone wrong. I got in the lift and finished up in the basement—that topped it off!

The CHAIRMAN: You all have had an opportunity to look at the terms of reference for this inquiry. It is obviously a really important inquiry, given the problems with alcohol that we have not just in WA but throughout Australia and internationally. Hopefully, through this inquiry we can come up with some recommendations to government that may stop some of the problems, both the economic and social costs, that result from alcohol and illicit drug use. Who would like to go first? I might give each one of you five minutes because the committee would like to have time to ask you questions.

Dr Davenport: We thought that I would make an opening statement. Our submission came in in 2009—12 months ago—and we had at that stage an acting CEO; Jill was seconded elsewhere and she returned towards the end of last year. Things have moved on just a little in the past 12 months in relation to the submission we gave to you, particularly the actual accreditation and quality control mechanisms for services; it is not complete yet but it is certainly moving in the right direction in terms of both the state and commonwealth government. But we thought we would bring just a summary in relation to —

The CHAIRMAN: Thank you and we will accept that by way of supplementary information.

Dr Davenport: I might just make some opening remarks highlighting the major things. We thought that it would probably be better for you to ask us questions, which is why we brought a range of people, in particular, Wayne who manages our Aboriginal services, which I think might be of use.

I took over as chair towards the end of March this year. I am an independent chair; I have never actually worked or served on the board of any alcohol or drug agency in terms of providing services. I think that one of the positives of that is that I do not have a vested interest in any particular service providing or getting access to funding or anything like that. As I say to the board from time to time, I can ask both the difficult questions and the stupid ones because I do not know everything that needs to be done to actually manage a service.

[9.13 am]

Of course, WANADA is the peak organisation of Western Australia for 90 agencies of quite considerable size in some cases—like Cyrenian, Palmerston and the like—and also some very small agencies, which obviously take account of the geographic nature and diversity of the state. Our role is about both alcohol and drug issues. From WANADA's perspective, we see some obstacles that may well occur for this particular sector, with the move to the Mental Health Commission. There is certainly some innuendo around the sector to suggest that they want to bring alcohol and drug issues under that umbrella. One of the concerns that we have had in relation to that is that the non-government alcohol and drug sector has a psychosocial clinical approach to trying to rehabilitate, and also to prevent, alcohol and drug issues, as opposed to the mental health area, which has more of a psychiatric approach to these issues. Not every person who has an alcohol and drug problem has a mental health issue. In fact, we deal more with people who have depression, anxiety and issues of that nature, which are at the lower end of the scale—not without being serious in some instances, but certainly not having progressed to the schizophrenia and bipolar end of the scale. We would be really concerned if that emphasis on a psychosocial rehabilitation effort were to be prohibited by coming under the mental health umbrella. At the moment it is actually treated as comorbidity and there is interaction between both sides of the equation.

The CHAIRMAN: Why do you think it would be lost? Is that not possibly a failing, in that mental health has very much focused on the acute occurrence rather than looking at that —

Dr Davenport: It does become acute and the lower end of the scale gets lost; that is what we are fearful of because we have a very small budget by comparison with what the mental health area has.

Ms Daws: There is probably less degree of flexibility with the medical model than there is with psychosocial model. A psychosocial model can be inclusive of a number of other factors that may not be included in the medical model per se.

Mr P. ABETZ: Do you think mental health is going to go more down the direction of the medical model? Because with my experience of working with people—not directly in mental health, but more sort of pastoral care type of situations—my impression was that mental health is moving away significantly from just the medical model—give them the tablets to fix that depression or whatever—and to embrace the social issues and all of that.

Dr Davenport: I think that is certainly being looked at, but we are also conscious that we do not want to be subsumed into just a psychiatric approach to the issues, because so many of these people are young and you do not want to them to have that stigma attached at such an early age so that they are prohibited, in some instances because of their personalities, from recovering. That is one of the pitfalls that we see in that approach. I am not saying that that is going to happen, but certainly the early discussions that we have had with ministers suggest to us that that might be the case.

The CHAIRMAN: With "suggest", I need more from you in terms of that, because you are saying and the discussions you have had with —

Dr Davenport: We have had an ongoing series of meetings with both the Drug and Alcohol Office and the minister over the past 12 months. Certainly, in the last meeting that we had with the minister we got that sense, and we also know that the acting head of the Drug and Alcohol Office has actually been seconded to mental health, which would suggest to us that he is possibly doing the legwork to prepare to bring it under that umbrella.

Mr P. ABETZ: One of the concerns I have about the Drug and Alcohol Office and the way it operates, is that it is actually an entity on its own. Charles Gairdner and Royal Perth have a real problem in terms of getting people with drug and alcohol issues into the Drug and Alcohol Office program, because if they cannot tick all the boxes of not having any mental issues, no seizures, all these things, they cannot access that facility. Therefore, these people are stuck in the general hospital which creates a whole issue. To me, there needs to be a much more holistic approach to this whole drug and alcohol mental health thing, rather than compartmentalising it, which seems to be happening. The difficulty that medical students or interns have, we have been told, is that they get very minimal training in the drug and alcohol field because Next Step does not take interns any more. Therefore, WA-trained doctors are probably the poorest trained in the country in terms of drug and alcohol issues, which is really quite disappointing. They are the issues we are really looking at and wanting to try and get to the bottom of.

[9.20 am]

Ms Daws: I can respond to that. I think they are really valid points. We would really holus-bolus support interns being available to the Drug and Alcohol Office because we think it is imperative that they have that in their training—number one. I guess, though, there is a two-sided approach to the comment about drug and alcohol being isolated. From our perspective, we get concerned that the money will get subsumed into the mental health system. We all know that the mental health system is a bottomless pit, and if you take that money away from drug and alcohol, where it is safe at the moment, all of the agencies that are funded through that will be incredibly nervous about what kind of percentage of money we would get back from that. I would say minimal, given that mental health and health services generally just suck money like it is going out of fashion—if you will excuse my comments on that.

Mr P. ABETZ: Yes, I understand what you are saying.

Ms Daws: So, we are saying from our perspective we get really concerned about that money going in there and then we do not see it again in drug and alcohol. So that is kind of one concern. I do not agree with your comment about people not being able to get in through the system. We have worked really, really hard in the drug and alcohol sector to make our services open to people with mental health problems. We have had a huge amount of money from the federal government to —

The CHAIRMAN: Is Cyrenian House where Next Step is run then?

Ms Daws: No. Cyrenian House is a non-government agency that runs a residential service and an integrated community drug service with Next Step; and also a women and children's program. We have a full array of services. We take all people with mental health problems. Clearly we cannot have somebody in our treatment centre whose mental health issues are to the extent where they need to be hospitalised. That is a whole different ball game, but we certainly do take people.

Mr P. ABETZ: Yes, sure.

The CHAIRMAN: Carol, I think what Peter was saying was not necessarily a lack of places for mental health; it is the fact that people who are being admitted into hospitals at the moment now who may want to undergo counselling because they appreciate they have an alcohol problem and there are no places for them at Next Step.

Ms Daws: Next Step is only one small bit.

The CHAIRMAN: That is right, it is only one small part. But the committee has heard from emergency department doctors that people with alcohol problems are staying in hospital for a few days and then they are going out, and at the stage where they want to make a change, there is nothing available for them.

Ms Daws: I would say that is more about places being available across the board.

Dr Davenport: It is about a coordinated approach.

The CHAIRMAN: Yes, I agree with you there.

Ms Daws: Because if our services are full, we cannot fit people in where we do not have the space.

Mr P. ABETZ: That is right.

Ms Daws: We would be happy to take more if we were funded for more.

Mr P. ABETZ: One of the difficulties we have been told by the Drug and Alcohol Office facility in Moore Street is that often the beds are not full but the hospital cannot tick all the boxes. And basically they are saying if we could tick all the boxes, they actually do not need to go there any more; they could actually go back home or into more supported accommodation; they do not actually need that kind of facility.

Ms Daws: Okay; point taken.

Mr P. ABETZ: That is one of the issues we are sort of looking at.

Ms Daws: But that is just detox.

Mr P. ABETZ: Yes; sure.

Ms Daws: And we all know that detox is only one small part of a rehabilitation process.

Mr P. ABETZ: Sure.

Ms Rundle: In fact this is another point of difference between the mental health sector and the alcohol and drug sector. The mental health sector is primarily government; whereas in the alcohol and drug sector we are primarily non-government. And Next Step is the —

Ms Daws: It is the government detox.

Ms Rundle: It is the government service, and they are not members of WANADA, and as such we are not representing their issues.

Mr P. ABETZ: Sure; I appreciate that.

Ms Rundle: And I think we have similar experiences in terms of referring people for detox from the centre's services as well.

Mr P.B. WATSON: You keep saying that detox is one bit and this is another bit. What is the major bit?

Ms Daws: I think withdrawing somebody from drug use is only that much—a small part—of dealing with someone. There is preventative, clearly; there is a whole load, I mean this report —

Mr P.B. WATSON: Is that not the major part of any organisation—prevention?

Dr Davenport: We would like it to be.

Ms Daws: It is the major part of drug and alcohol issues, but it is not the major of all. I am a service delivery organisation.

Mr P.B. WATSON: So, you get the end result.

Ms Daws: I do deal with them, obviously, when we get people in. We deal with families and there are preventative issues in there obviously if one person in a family has a drug problem. If you can work with the parents and family and friends and so forth you can, hopefully, prevent some of those things being replicated. In our case, and in many of the agencies, we also work with mums with kids. So we are trying to prevent second generational, third generational issues with drug use.

Mr P.B. WATSON: Assuming you get the end result, do you think we as a society are doing enough for prevention?

Ms Daws: Do I think you are doing enough?

Mr P.B. WATSON: No, government or whichever government is in; are we doing enough for prevention because we are putting all this money into the end result?

Ms Rundle: I do not think there is a lot of money going into the end result either.

Ms Daws: No.

Mr P.B. WATSON: No, there is money going into the end result, but in my opinion I do not think there is enough going into the prevention of it. What is your opinion on that?

Ms Rundle: I think that there could always be more money spent on prevention.

Ms Daws: No doubt.

Ms Rundle: I also think there could be more money spent on treatment. I think the school drug education program is a great example of an evidence-based prevention working with school-age children. In their program, however, it is always up to the school community to decide whether or not to participate, and that is part of the frustration, I think.

Dr Davenport: I can just add to that as well. We are currently in negotiations with the Drug and Alcohol Office in relation to a draft set—it is in draft form at the moment—of guidelines to actually deliver services better. What we keep noticing is that they want clinical outcomes. Now, prevention is not always a clinical outcome. There is rigidity that does not give you the flexibility to actually be able to put that kind of emphasis on prevention as much as agencies would like to do, I think.

Mr P.B. WATSON: Carol, you were saying before that you go in with the families and try to help, but we have come back from the Kimberley and up there they desperately want it to be brought in at a younger age, because we have lost a generation that we are never going to get back. It is the same in Albany in our Nyoongah community—it is not only up north. Should we not be going into the schools and preschools and getting education in there. Because—I keep using the reference—my

granddaughter came home and said to me, "Do you smoke, papa?" and I said, "No." She said, "It kills you." So, just getting those little things into your kids' heads at a younger age.

Ms Daws: Appropriate education for those children.

Mr P.B. WATSON: Appropriate education; yes I know. I think she just took it on.

Ms Daws: I do not think we are talking about drug use for kindergarten children, but we might be talking about resilience and building self-esteem and dealing with peer pressure and all those sorts of things.

Mr P.B. WATSON: Yes, because with alcohol, which we found is the worst drug, parents are role models.

Ms Rundle: There was a research report released yesterday actually, commissioned by the Alcohol Education and Rehabilitation Foundation, and they were saying that it is actually costing us something like $36 billion a year in social costs. I agree but there is a school drug education program that is resilience based, that is evidence based and that is developmental, so that across the 12 years —

Mr P.B. WATSON: Is there one for alcohol too, Jill?

Ms Rundle: But the schools do not always choose to do that. The alcohol and drug sector contributes to that by either supporting the training of the teachers or supporting the school counsellors or pastors, or whatever, the school psychs. They attend things like leavers, give leavers talks or ball talks or if they are doing *Anna's Story* or relevant literature or other curricular activities related, then alcohol and drug services often go in and contribute that. I think it is important. There are also examples where a school will not participate in the SDERA program but they will get someone they know who used to use drugs or a bikie and talk, as an example, which is not always evidence based. They do not provide the opportunity for their teachers to go and get the training. I think that we would certainly like to see more incentives for schools to participate in the SDERA program as a prevention initiative; and also make those links with the alcohol and drug services so that they can link in if there are at-risk children, or parents for that matter.

The CHAIRMAN: Can I ask about that link, because, Cheryl, in your opening statements you said that WANADA covers 95 per cent, in the submission that you gave?

Dr Davenport: Ninety—we have 90 affiliated agencies.

The CHAIRMAN: Ninety affiliated agencies.

Dr Davenport: Yes, across the state.

The CHAIRMAN: The submission that you put in last year was excellent in terms of the breakdown into areas and the recommendations that you made. What was not in the submission and maybe we could ask you to provide by way of supplementary information is that we are noticing, again, particularly from our trip to the Kimberley, that there are gaps.

Dr Davenport: We know there are gaps.

[9.30 am]

The CHAIRMAN: We came across children lying in the gutters whose mother was oblivious because of alcohol intoxication. We also saw four and five-year-olds walking the streets. There are big problems. We do not have a clear picture. We are getting from DAO what they can tell us, which is where. It would be really useful to know who is attached to you and where they are attached to you. Maybe you could send a circular to each of the agencies affiliated with you to ask where they think the gaps are in the services they provide. We need where those gaps are so we can make recommendations in terms of where the gaps are—for example, we know there is a service here that is running really well; it does this, this and this. But it is north metro and we have not got anything in the regional areas like this or in the south metro like this.

Mr P.B. WATSON: Are you talking about service gaps or geographic gaps?

The CHAIRMAN: It covers both.

Ms Rundle: There is a national process happening at the moment to look at population and service needs —

The CHAIRMAN: We have to report by November, so we cannot wait for that!

Ms Rundle: There is a range of services that can be offered or need to be available to people with drug and alcohol problems, from detox to whether it is outpatients or residential through to therapeutic community in terms of nine months' intensive support. Then, after that of course, there is after-care and halfway houses and a whole range of things. Drug problems are not fixed overnight. It is an ongoing issue where there is relapse, just the same as there is relapse from diabetes or a range of other things. In terms of the health issue, it is a long-term treatment approach. There is not equitable access to all of those services throughout the state. We would certainly like to see some planning processes in place to make sure that that is the case. I know there are a couple of residential services up in the Kimberley—you mentioned the Kimberley—that have a lot of Aboriginal people participating. There are no residential services in the South West. There is no residential service in the Goldfields. There is infrastructure in the Goldfields but no funding to support that happening, for example. There are funding issues. The sector is minimally funded to provide treatment.

Mr P. ABETZ: Can you give us some indication of how much government funding WANADA affiliated organisations receive in terms of percentage of their budgets or in total dollar values at all? Does anybody have that information?

Ms Daws: I know how much we get. I do not know how much —

Mr P. ABETZ: Would most get a quarter of their funding from government, or less?

Ms Rundle: It is probably about 50–50 state and commonwealth. In the state it is about $50 million for drug and alcohol —

Dr Davenport: Which is 10 per cent of the mental health budget.

Ms Rundle: That is not all, obviously. There is the administration processes and DAO within that $50 million. It is very limited. When you are talking about running a residential service, you are talking about an enormous expense not just in the infrastructure. I know that the commonwealth have funded a residential service to be established in the Pilbara.

Ms Daws: If you add families in there as well, then you are talking more. It is a lot different running a service for individual adults than it is for, say, running it for adolescents or running it for parents with kids.

Ms Rundle: And also Aboriginal people with complex needs—they need more intensive services.

Mr P.B. WATSON: That is what I want to ask Wayne: do you think we put too much emphasis on up north and forget that we have probably got more Nyoongahs from Geraldton through to Albany than there are people up north? Do you think we are missing out down south?

Mr Flugge: We are certainly missing out down south and out in the Goldfields, without doubt. The Kimberley still needs a lot of support as well, and the Pilbara—which is going to get a residential service soon—but yes, sending people up north from down south to rehabilitation services up there—all Aboriginal people are not the same; we are very different from each other.

Mr P.B. WATSON: We have young Aboriginal boys coming down to the academy in Albany. We have had a couple of cultural issues in the town —

Mr Flugge: It is a foreign town.

Mr P.B. WATSON: The Nyoongah community are not quite happy with them being in the town. It is very hard to get that mix of what is best for all Indigenous people. As you say —

Dr Davenport: One size does not fit all, which we have actually been saying for so long. It is not just in the Indigenous sector, it is right across the board with these kinds of services. You have got diversity, cultural differences and how you ensure that cultural appropriateness.

Mr P. ABETZ: Wayne, could you develop that a bit further for us in terms of the Aboriginal side?

Mr Flugge: In terms of?

Mr P. ABETZ: What do you see as the shortfalls in servicing the Aboriginal Indigenous community throughout WA? Where are the big holes in terms of services that are not being provided and that you believe are desperately needed? What could we as a government do better in terms of funding organisations that service the Aboriginal community? What sort of services should be provided?

Mr Flugge: Certainly in terms of rehabilitation, there needs to be a facility in the Goldfields. There certainly needs to be one in the South West, if not the Great Southern, and probably the Mid West. The Mid West are Yamatji people, the Goldfields are Wongi, and we are all Nyoongah down south. Even within the Nyoongah community we are very fragmented and it is very clan-based. We have one Aboriginal Alcohol and Drug Service in the metropolitan area. That is clearly not enough. If there are family conflicts and issues within management by the clients outside, they will not access that service. Whether or not they would access —

Mr P.B. WATSON: What is the answer, Wayne? I have faced this for 10 years since I have been in this job. We get a group or a family coming in but the other people do not do it. If you bring someone from outside who is Indigenous, they will not deal with them because they are from another family. What is the answer? What we have got to try to do is get them all together. We have even looked at putting half and half. When we had the Southern Aboriginal Corporation we tried to make sure it was balanced, and it never was because one family always differed. Have you got an answer?

Mr Flugge: I think if the services that are available within the towns and the regions are very culturally secure, it does not matter who is managing those services. If the Aboriginal people believe that yes, that is a service that we are comfortable with, they will access that service. By "culturally secure" I mean, generally speaking Aboriginal folk will not come to a service. They would rather the service provider provide that service in their town and do that outreach work, like a locum doctor. That is a far better approach for Aboriginal people than having, say, an Aboriginal medical service—let us say it is SAC or whatever in Albany—a particular group will come and access that but the outlying folk who are not part of the group that are running it —

The CHAIRMAN: Wayne, what was the name of that service that you first-off mentioned; and then I am back to you, Peter?

Mr P.B. WATSON: Remember when we were over east there was an Aboriginal Indigenous doctor who had this service where they made everything cultural. There was Aboriginal music in the background and Aboriginal drawings around the place. Who was that? He was very successful. He got Medicare to bulk-bill.

The CHAIRMAN: I think he was from Alice Springs.

Mr P.B. WATSON: He did everything culturally sensitive.

The CHAIRMAN: I want to join with Peter in that—when you say make the service culturally sensitive —

Mr Flugge: "Culturally secure".

[9.40 am]

The CHAIRMAN: Sorry, culturally secure. I want from you as a group what is missing. You are saying that we do not have services and there should be services in the Kimberley, in the Goldfields, in the South West and other places. The word "services" means something different to every person sitting around this table today. We need to know from you—we will be happy to accept that by way of supplementary information—what you mean when you say, "We need services and outreach facilities." We need a full description of how you see those services being organised and provided to the community. We are happy for you to tell us now what you think should go into that type of service or for you to have a little more time to think about that and provide the detail by way of supplementary information.

Mr Flugge: We need rehabilitation centres in the Goldfields, the Great Southern or South West and the Mid West.

The CHAIRMAN: Again, what do you mean when you say "rehabilitation centres"?

Mr Flugge: A residential therapeutic community.

The CHAIRMAN: Residential—okay. But again —

Ms Daws: A residential therapeutic community.

The CHAIRMAN: Sorry, I want you to go that step further —

Mr Flugge: Similar to Ngnowar-Aerwah and Milliya Rumurra up in the Kimberley.

Dr Davenport: Can I just stop you there to say it is all very well for you to say you want all that information from us, but the kind of pressure it puts on the non-government sector to provide that information is massive, because we do not have the staff to do the work. Essentially, that kind of work will take Wayne away from the other work that he currently has to do to manage across the state. We find that happening all the time. I want to home in here on the fact that those people who provide services in this sector—the non-government sector—are paid 30 per cent below the wage that a government employee or an employee in a not-for-profit organisation receives. That is the kind of stuff that we are up against.

The CHAIRMAN: But Cheryl, you know—you were in Parliament before and —

Dr Davenport: I know it.

The CHAIRMAN: —you know that if you do not do that work and give that work to us as a committee —

Dr Davenport: I agree. What I am saying to you is —

The CHAIRMAN: —nothing is going to happen.

Dr Davenport: —this should not be forgotten; that is, the fact that the pressure that actually puts on these organisations —

Mr P.B. WATSON: Cheryl, could we just get Wayne to speak to five major dot points and we can work from there?

Ms Rundle: Absolutely.

Mr Flugge: I think that another area in which we really fail Aboriginal people is when they are drinking and there is family violence—generally speaking, it is the male partner—they are locked in jail; they are taken away from the family and that just creates more family problems. Jailing Aboriginal folk is not the answer; it just creates more problems than what it is worth. We need some sort of timeout facility where they can get their drug and alcohol counselling, their family counselling, their marriage counselling and all of that—

Mr P.B. WATSON: Like up at Wyndham?

Mr Flugge: —somewhere their partner can come to see them; their children can come to see them.

Mr P.B. WATSON: There is something at seven mile in Wyndham. Have you heard of that facility?

Mr Flugge: That is a therapeutic community.

Mr P.B. WATSON: Is that where they dry out and the families come and —

Mr Flugge: That is correct.

The CHAIRMAN: They spend three to six months there, I think.

Mr Flugge: It is similar. It is family-orientated, very much like Carol's; that is, families can come in. It is a shared program—if you like. Another frustrating thing is that when the person who has the problem goes away from the community, the partner and the children fret and there is a disintegration of the family. To make the program work better, they have the whole family go to the community where the person is seeking and getting treatment.

Ms Daws: Just to add to that cultural security thing: the issue around Aboriginal staffing is a really good point. Clearly, Aboriginal people like to have Aboriginal staff. A lot of agencies have both Aboriginal and non-Aboriginal staff, but funding wise tend to get funded for one Aboriginal worker. That is just not appropriate. Aboriginal workers do not need to be on their own. We need to have several Aboriginal workers in one organisation, because that is what cultural security is about. It is not about saying here is the token Aboriginal person and —

Mr P.B. WATSON: That is a very, very good point.

Ms Daws: —we will stick them in and they can do that. I just thought I would add that.

Ms Rundle: Can I also add that there is a massive overrepresentation of Aboriginal people in prisons and in the corrective services sector as well, and that there is a totally unmet need for alcohol and drug treatment for the people in prison, particularly Aboriginal people. Aboriginal people are underrepresented, even in the diversion programs offered through commonwealth funding; that is, Aboriginal participation, especially in the metropolitan region is not happening. We have certainly put it in a submission and I am happy to table that document as well.

In terms of what can be done, I think we need to address Aboriginal and community corrections in particular so that these people will not—it can break down recidivism. Again, it needs to be culturally secure, but with a particular focus on Aboriginal people involved in corrective services.

The CHAIRMAN: We are happy to accept by way of supplementary information whatever document it is that you are trying to provide.

Ms Rundle: Yes.

The CHAIRMAN: I would like to come back to the prison issue, but Lisa may want to go first.

Ms L.L. BAKER: Yes; I have a little cluster of things that I want to ask about. Picking up on your comment, Jill, do you have an estimated number of drug and alcohol instances in prisoners that you would be able to tell us about—in the Western Australian prison system?

Ms Rundle: It is in this report, Lisa. But some research indicates that 80 per cent of people in prison or involved in the corrective services' system have alcohol and drug problems. It may not be —

Ms L.L. BAKER: In Western Australia?

Ms Rundle: In Western Australia.

Ms L.L. BAKER: Thank you.

Ms Rundle: It may not be that high; I think Corrective Services is talking about something above 60 per cent. But in terms of the services that are actually provided, it comes nowhere near providing a service to that number of people. These are people who without treatment and support will

reoffend and then our prison numbers will go up and up, which is ridiculous in terms of why we focus—anyway, that is our bias; we need treatment.

Ms L.L. BAKER: The WANADA pre-budget submission touches on the offenders issue and community services. It would be good to have a look at the pre-budget submission that you did for the committee. Finally, I wanted to pull back from the level of service delivery to ask you more of an ideological question about policy direction. It is a question that I have been asking everyone. The two areas that I am interested in are the currently fairly conflicting areas of a drug-free society versus harm minimisation and the ensuing around-the-world debate emerging on those two theories. I do not mind who comments, but I wondered if you would like to make some comments about those two theoretical paradigms and your view of them and how effective they are.

Dr Davenport: I think that I will leave that one to Jill or to Carol.

Ms Daws: I have to say that they are not necessarily mutually exclusive. When people talk about harm minimisation they think that that is completely in opposition to the drug-free position; whereas it is more on a spectrum. I just think people do not quite understand. Yes, there are some people who need to be drug free. There is no question that some people get to that point in their drug use at which unfortunately, or fortunately—depending on the way you look at it, it is not a good thing for them to drink or to take drugs. But at every point along that spectrum, you have to understand that you are addressing reducing the harm. I think Peter made a comment about a lost generation. I would really hate to think that we have written off a generation and have said, "I am sorry; we cannot help you anymore." I would not like to see it like that. I think there is always hope.

Mr P.B. WATSON: It was not in that context. I was saying —

Ms Daws: I know, but I just thought I would mention it because it would be dreadful to think of a generation as a hopeless case. I do not believe there is a hopeless case. I think there is always support and treatment that people might need, even if it is just about keeping them safe while they are using. I think we need to be mindful, whatever approach we take, that there are personal choices or situations that people are in, in which it might seem that they should do what we want to do, but the reality is they are doing what they are doing and we need to keep them safe anyway, because that is part of our role in society—to give people equal opportunity and to support them. It is a terrible thing to debate, because it is not an either-or situation, but a spectrum. At one end, extreme harm minimisation may be seen as total abstinence; that is, if people do not use any drugs they are not going to be harmed. But the other end is people using and being given the opportunity to address anything that may cause harm in their lives.

[9.50 am]

Ms Rundle: A key difference, however, is that zero tolerance makes drug and alcohol a criminal issue; whereas harm minimisation sees it as a health issue.

Ms Daws: I am suggesting the full spectrum as opposed to —

Ms Rundle: Yes, but if there were a single focus on only zero tolerance, it would be just a punitive approach.

Ms Daws: Absolutely, and it is a health issue.

The CHAIRMAN: Because of time, if there are two parts to members' questions, ask both parts together. We get one question each now because of time.

Mr P.B. WATSON: I am taking one of Lisa's questions. On the dry-out centres —

Mr Flugge: Sobering-up shelters.

Mr P.B. WATSON: Yes. We saw people being picked up at night, do you think they are successful?

Mr Flugge: I think that they serve a very good purpose, probably more so when there are activities on in town and people come in from outlying areas and become intoxicated and have nowhere to stay. It is far better to have a facility they can access. One criticism I have about sobering-up shelters is that they do not take women or fathers with children. That is a huge area in which I think we fail as a community by not providing some sort of support when there is domestic violence or whatever at home. If the mum is intoxicated she cannot go to a women's refuge and if she has children she cannot go to a sobering-up shelter.

Mr P.B. WATSON: She is on the street.

Mr Flugge: She either has to go back home where the issue is or be on the street.

Ms Rundle: With the kids.

Mr Flugge: With the children in tow, yes.

Mr P.B. WATSON: My second question is: do you people address the alcohol problem with the white people in the community such as the fly in, fly outs? Some of the mining companies put an esky on the bus from the mine site to the airport. I have been at Karratha where I have seen them. I think Qantas has now stopped alcohol on flights. Is that an issue for you guys?

Ms Daws: It is a fascinating issue. It is interesting; I was on a plane last night. The air hostess always comes back and asks everyone who drinks, "Would you like another wine?" I do not drink, but she does not ask me if I want another drink. It is a huge issue around drinking. I would like to see more non-government involvement in providing more of a service to those mine sites around education, information and support services for people in that role.

Ms Rundle: They could provide policy development and providing employee assistance support. I think 70 per cent of EAP access is alcohol and drug related. The drug and alcohol sector are the specialists in this area; yet we are not necessarily consulted in that process. We would certainly like to see more support from the mining industry or industries generally.

Ms Daws: It is a culture issue. In Australia it is, "You're a good bloke because you drink." It requires an enormous amount of effort to change that culture. In fact, there is something wrong with you if you do not drink. Alcohol permeates every aspect of life. I do not want to sound paranoid because I am not an anti-alcohol person, but certainly it requires a huge culture shift, somewhat similar to what mental health did with normalising, if you like, mental illness. It did that really well. I think we need to do something about changing the view that alcohol has to go with everything.

Mr P. ABETZ: Following on from Lisa's question about harm minimisation and abstinence. I think everyone would agree that in an ideal world people would be drug free or moving towards living a drug-free life, obviously. Often they are people in lower socio-economic situations, so they would not be spending money on drugs and alcohol, but on food and health and all that sort of thing. That would definitely be the preferred direction to move in. I wonder about the approach taken in Sweden in recent years of not putting people into prison for drug and alcohol–type offences, but requiring that they go into compulsory rehab. That is showing extremely positive results, despite the fact that it is often considered that forcing people into rehab does not work. However, Sweden's statistics show that forced rehabilitation is more successful by a few per cent than voluntary rehab. Rather than go to prison they go into rehab and if they do the right thing there and stay drug free et cetera their conviction is removed from their record. It really gives people an opportunity to step up to the mark. Are you familiar with that?

Ms Rundle: I think therapeutic communities as an option to prison is a very sound idea. There are examples of that in New South Wales, Victoria and New Zealand.

Ms Daws: They have prison therapeutic communities.

Ms Rundle: Therapeutic communities as an alternative to prison would certainly be supported by WANADA.

The CHAIRMAN: Do you have the names of the ones you mentioned in New South Wales and Victoria?

Ms Daws: Jill is referring to therapeutic communities in a prison setting. That is one option, but I think a preferable option is, which is what you are talking about, is to say to people that, rather than sending them to prison and their getting a criminal record, because it is a social crime in a sense, it would be far better for those people to have the option of going into treatment. In fact, nobody gets up one morning and says, "It's a nice day, I might stop using drugs today." Any incentive to get someone in there is perfect.

Ms L.L. BAKER: How much funding comes from the Department of Corrective Services to the alcohol and drug NGOs?

Ms Rundle: For community corrections—nothing.

Ms L.L. BAKER: What percentage of clients do you take from that sector?

Dr Davenport: We take all that comes.

Ms Rundle: A lot of services have now capped it because it impacts on the culture of the organisation. It is anywhere between 10 and 30 per cent, but an average of about 20-something per cent.

Ms L.L. BAKER: Which are not funded?

Ms Rundle: They are not funded. This displaces people who want to voluntarily participate in treatment. As a result of not being able to access services, obviously, they may get involved in criminal activity and end up in the system. It is something we really need to be looking at in terms of funding and supporting. It impacts on staff morale because, yes mandated treatment does work and is effective, but there needs to be proper assessment and referral. At the moment there is not that process. Unfortunately, we are getting people who are not willing to or not at a stage where they are motivated to change their behaviour. That impacts on the morale of staff who are seeing people who are not willing to participate in treatment effectively, or they do not show up, so it is ineffective use of our resources as well. Yes, we would certainly like to see Corrective Services put in some resources to support that development and to support the sector to meet their clients' needs.

Mr Flugge: I was just going to add that most Aboriginal people who have a drug conviction and go to court, plead guilty rather than do a diversion program or voluntary drug–rehabilitation program. They would rather cop a fine or go to jail. What we need to do is take that aspect away and say, "No you must do a rehabilitation program." It is a mindset within the Aboriginal community that we have to start changing rather than giving a person an option when in 99 per cent of the cases the option will be, "I'll take the easy way, which is to plead guilty."

The CHAIRMAN: Can I ask by way of supplementary information for a copy of your pre-budget submission, which you mentioned earlier.

Do you believe that the social impact of alcohol has got worse or better over the past 10 years or stayed the same? If money were available, what one new initiative should the government consider to limit the impact of alcohol consumption? Has it got worse or better or stayed the same, and what is one new initiative?

[10.00 am]

Ms Rundle: Just in terms of the way it is being used more by young people I think it is a concern for society. In terms of one initiative to—sorry?

The CHAIRMAN: To limit the impact of alcohol consumption.

Ms Daws: One would be very difficult to pull out.

The CHAIRMAN: Very quickly, one each, but you have to keep it down.

Ms Daws: I think one thing that we should stop doing is separating alcohol from drugs all the time. Alcohol and drugs are one major concern. I think governments like to say, "We will have an amphetamine summit or an alcohol thing." I think, "Why would you have a drug summit?" Alcohol is a drug, is a drug, is a drug. I think that probably needs to have more attention paid to it. When you say "drug-free", as you were talking about before, were you referring to alcohol as well? It is interesting.

Mr Flugge: I think from my perspective the compulsory sale of low-strength alcohol after midnight in all pubs and clubs.

The CHAIRMAN: Well done.

Ms Rundle: I think that for the alcohol industry, there needs to be stronger regulation of their advertising—a whole range of processes, really. We need to change the culture, and I think the culture needs to be changed from young people as well. So advertising and the whole range of how the alcohol industry sells these products—volumetric tax and so on, but not just one.

Dr Davenport: In terms of actually nailing these issues, there has got to be a coordinated approach. It cannot just be the alcohol and drug sector fighting this alone. It is so connected with homelessness, with self-esteem of young people, health, education and the whole bit. If you have got low self-esteem you are more likely to become involved in these areas. I have been banging on about social justice issues and a whole coordinated and collaborative approach for so many years I have lost count. From my perspective you are never going to fix this without a coordinated approach that sees governments actually working with the community rather than being punitive towards it. A lot of the stuff that we find is that one size will fit all because that is the way it is and that is the way you want it. It cannot be like that any more, not if you really are wanting to actually have success and to reduce those numbers. WA has got the highest use of both alcohol and drugs in the country. That has to say something.

The CHAIRMAN: I would like to thank you all for your evidence before the committee today. A transcript of this hearing will be forwarded to you for 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 of evidence. It may well be that when we get back the supplementary information we may write you with some further questions. But, once again, thank you all very much for coming this morning.

Hearing concluded at 10.03 am