EDUCATION AND HEALTH STANDING COMMITTEE

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

TRANSCRIPT OF EVIDENCE TAKEN
AT PERTH
WEDNESDAY, 26 AUGUST 2009

SESSION FOUR

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 1.00 pm

GUARD, MR NEIL STUART
Executive Director, Drug and Alcohol Office,
examined:

BROWNE, MRS MYRA ANNE
Director, Police, Strategy and Information, Drug and Alcohol Office,
examined:

DILLON, MR ERIC
Director, Client Services, Drug and Alcohol Office,
examined:

The CHAIRMAN: On behalf of the Education and Health Standing Committee, I would like to 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 review of Western Australia's current and future hospital and community healthcare services. You have been provided with a copy of the committee's specific terms of reference.

The Education and Health Standing Committee is a committee of the Legislative Assembly of the Parliament of Western Australia. This hearing is a formal proceeding of the Parliament and therefore commands the same respect given to proceedings in the house itself. 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 your presentation and the questions that 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?

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: In which case, starting with Myra, would you please state the capacity in which you appear before the committee today.

Mrs Browne: I am here as Director, Policy, Strategy and Information of the Drug and Alcohol Office. That directorate covers policy, strategy, the Aboriginal area, research, evaluation and communication with the agencies. I am here in the capacity of being a senior manager of the Drug and Alcohol Office.

Mr Guard: I am the Executive Director of the Drug and Alcohol Office.

Mr Dillon: I am the Director, Client Services of the Drug and Alcohol Office. I primarily cover the management of the contracts for treatment agencies across the state—the Alcohol and Drug Information Service, Parent Drug Information Service and diversion services.

The CHAIRMAN: Thank you very much for coming along today. We are really hoping that you will start with the building blocks and explain how the service fits into the overall structure, including the hospital and community structures, and whether it is metropolitan based or WA based. If it is okay with you, we will interject as you go along.

Mr Guard: That is absolutely fine. Thank you for the invitation to attend today and present information and evidence on behalf of the Drug and Alcohol Office to your inquiry into hospital and healthcare services. My understanding is that the inquiry is looking to determine whether population needs should be taken into account in assessing, planning, implementing and evaluating services. In particular, from discussions, we understand that the committee is interested in DAO's perspective on the terms of reference in relation to compliance with the directions of the Reid review and the "WA Health Clinical Services Framework 2005-2015", plus our views on possible needs and gaps and, maybe ,options to fill those needs and gaps.

In taking into account what you said, in preparing for today we felt that perhaps a good approach was to give a presentation. We will present an overview and respond to any specifics that are not covered in that. We understand that we have until two o'clock, is that right?

The CHAIRMAN: Yes. However, there is no need for you to rush. If you do not complete your evidence, we will be more than happy to have you back another time. It really is important that we get the whole picture.

Mr Guard: We will launch into the presentation and, again, thank you very much for the opportunity to present today. I thought it would be useful to give the committee some brief contextual information about the extent and impact of alcohol and drug-related harms, both broadly and then specifically in the context of the health system. Clearly, problematic drug and alcohol use impacts, broadly, upon all Western Australians. It results in significant health, social and economic costs to the community. As you can see from the slide, the social cost of alcohol and drug use in 2004-05 was estimated at around $55.1 billion. Of that, alcohol contributed to around $15.3 billion and illicit drugs around $8.2 billion.

Alcohol and drug problems are also associated with a range of other issues, including mental health problems—co-occurring mental health and substance use conditions—blood borne viruses, road accidents, crime and violence, community protection concerns, suicide and homelessness. It impacts on so many different walks of life.

Alcohol specifically is the major drug of concern of the Western Australian community and regular drinking above the recommended health limits is having a significant impact on the WA health system. In Western Australia the total hospitalisation costs associated with alcohol were conservatively estimated at more than $33 million in 2006.

In looking at illicit drugs; generally, illicit drug use has been declining in Western Australia since 1988 to the extent that cannabis still remains the most widely used illicit drug. The prevalence of heroin use is remaining relatively low and stable and methamphetamine use is declining, but is still above the national level. In 2001 there was still a total of 4 605 other drug-related—that is, other than tobacco and alcohol—hospital admissions in Western Australia, resulting in something like 20 394 bed days of inpatient treatment at a cost of around $10 million. Again, it is a significant impact on our hospital system.

The CHAIRMAN: Have you done the bed days statistics yourself, because Access Economics do them. I was not expecting you to present those figures. Have those statistics been done within the department?

Mr Guard: They came from the health department statistics. We work very closely with the health department in analysing and collecting data and we make sure we use those statistics for planning purposes.

We have some issues around the fact that 80 per cent of clients in alcohol and drug treatment have a co-occurring mental health condition. Those with co-occurring problems are more likely to develop chronic and disabling conditions that lead to greater health service use in the longer term. We thought it would be useful to present some of that contextual information.

Mr P. ABETZ: What comes first—the chicken or the egg? Are mental health issues brought about by drug use or are you not sure?

Mr Guard: The reality is that there are links. I am not sure that it is possible to actually say which comes first. It would not be the same in every instance.

Looking at the approach: a lot of drug and alcohol issues involve a community-based approach. The preferred approach in Western Australia and, generally, in other jurisdictions is seeking to provide the appropriate supports and responses to the issues where they are arise, which is generally in the community and through local and accessible services.

[1.10 pm]

The primary benefits of that particular approach include reducing pressure on the tertiary hospital system by allowing people to receive community-based treatment and support or care in the most appropriate setting, and particularly so when that approach is underpinned and supported by sustained prevention and promotion programs to reduce the demand and the harmful use of alcohol and other drugs and, as a consequence, reduce the number of people entering the hospital system.

To do the job properly and to effectively address alcohol and drug use and achieve sustainable reduction requires actions at national, state, regional and local levels and includes a comprehensive program of policy, education, social and structural strategies. The longer-term problems associated with drug and alcohol use and the consequent impact on the health and hospital sector highlights the importance of a comprehensive approach to restrict supply, prevent and delay use, and includes things like increasing the age of initiation and experimentation as part of that and reducing the number of people who become regular users and also encouraging current users to reduce or cease their alcohol and drug use. That comprehensive approach needs to look beyond the presenting condition and include a comprehensive range of strategies, including those that address the core determinants. A lot of our work is with other organisations that can help us to do that, including housing, employment, education, reconciliation and cultural healing. Very much, our approach is in tandem and in partnership with other organisations. It needs a long-term approach and, as I said, collaboration and partnership with the relevant stakeholders. It also needs a framework that ranges from population-based prevention approaches to targeted community-based interventions, right the way through to relevant and culturally appropriate rehabilitation services that can be implemented on an ongoing basis and address that continuum of care. For us, and for a lot of other services, the priority is the implementation of appropriate strategies to reduce that inequality in health status, in particular a focus on Aboriginal health and areas of disadvantage in health promotion, early intervention, patient-centred approaches to care and the development of relevant links to other government and other non-government services.

That broadly is the preferred approach, and the approach we consider. The evidence suggests it is the approach that is needed to effectively address alcohol and drug-related use and harm.

The member asked about the role of the Drug and Alcohol Office. DAO is the lead government agency responsible for alcohol and drug strategy policy and service provision in Western Australia. It was established as a statutory authority under the Alcohol and Drug Authority Act 1974. It has a dedicated focus on preventing and reducing alcohol-related harm and providing effective treatment, which is very much in line with the functions of the 1974 legislation. Our role around strategy,

policy and service provision is statewide. We fulfil that mission that I just outlined by either providing or contracting a statewide network of services that relate to prevention, treatment, professional education and training, and we also coordinate and collaborate with associated research activities. The range of things that DAO does and coordinates is pretty extensive on a statewide basis. One of the important things is that our unique position, being part of, but sitting slightly outside of, the Department of Health, enables that broad focus across the areas of alcohol and other drug use, but also gives us additional flexibility and the ability to respond fairly quickly, which is quite important in this particular area.

A very significant focus also of what we do, as I mentioned earlier, is that leading role in trying to drive the linkages and partnerships across and within the sectors. That is not just within Health, albeit the various sectors of WA Health are very important in terms of who we work and engage with, but also outside Health, with the Department for Child Protection, WA Police, the Department of Racing, Gaming and Liquor and community groups at a range of different levels. That is a little bit of an overview of our background. We are part of the broader Department of Health operations—WA Country Health Service, the area health services, women and children health services. We work very closely with those particular services. We are very closely aligned with and we closely comply with the WA Health clinical services framework, and we try to support that continuum of care for people through the provision of population, health and community-based support and treatment services to enable people to access the care in the most appropriate setting as far as possible close to where they live.

The CHAIRMAN: You said that you work with country and metropolitan area health services. Do you work with them on a regional basis in the country areas and on the level of the North Metropolitan Area Health Service and South Metropolitan Area Health Service?

Mr Guard: We have very close linkages in regional WA with WA Country Health Service, and each of their outposts. That would be across the state. Exactly how we work varies in the different regions, but it is clearly very closely aligned with them. A lot of what we do is community-based support, and they will provide some of that acute response and care when they need that too. In a number of the regions our community drug services are part of and owned by the WA Country Health Service.

Mr Dillon: That is in the Kimberley, Pilbara and Midwest-Gascoyne. Those three particular community drug service teams are operated by the WA Country Health Service. We fund other services in those regions that are non-government operated, but I think that illustrates the point that it is about partnering with those agencies that are able to deliver and is based on the range of agencies that are available in any particular region.

The CHAIRMAN: We were made aware this morning that regional funding is provided by the state through the WA Country Health Service and then there is the commonwealth funding and then the divisional funding. Do you tap into that commonwealth funding and the divisional funding? How do you work with the divisions?

Mr Guard: The divisions of general practice?

The CHAIRMAN: Yes.

Mr Guard: Very closely. We need to do more and to build stronger linkages with general practitioners and others, but we have applied quite a lot of effort to that. We are a conduit for some of the commonwealth funding. For example, with diversion programs we receive the commonwealth funding to run a number of alcohol and drug diversion programs, and we will use that to supplement activities of community drug service teams, which also provide that particular support. In other respects, we work closely alongside the commonwealth agencies providing funding for particular services so that is planned and coordinated between the state and the commonwealth. It is actually a very collaborative effort in terms of trying to plan where services are

needed, the design of those services to make sure that we avoid duplication as much as possible, and that we collectively fill the gaps as we see them and as they emerge.

The CHAIRMAN: Does commonwealth funding come directly to the DAO?

Mr Guard: The diversion funding is a good example. Public health outcome funding used to come directly to us. Under the new funding agreements we now get that through Treasury to the Department of Health and down to us. From this year, that is the route by which we will get that particular budget.

The CHAIRMAN: That is state funding. What about commonwealth funding such as the Indigenous federal funding?

Mr Dillon: Perhaps if I can comment, Neil. It is a mixed arrangement as some of the commonwealth funds are provided directly to DAO or through state Treasury as part of the health funding agreement, which then is channelled through the Drug and Alcohol Office to those agencies. Commonwealth agencies, though, also provide some funding directly to some of their agencies that deliver alcohol and drug services. It is a mixed arrangement, but we coordinate that through a partnership arrangement that we have with the primary commonwealth funders of alcohol and drug services. We meet on a regular basis with them and do some joint planning about where we need to target resources and who is best able to deliver them and how that funding should be channelled.

[1.20 pm]

The CHAIRMAN: I am just interested in whether we are getting our fair share of the pie in relation to drug and alcohol services in both the metropolitan area and regional areas.

Mr Dillon: If I may comment on that, in terms of the funds that are provided for treatment, and just to give some context to what is provided, in 2008-09 approximately $51 million was provided to treatment agencies.

The CHAIRMAN: Was that from the state government or the commonwealth?

Mr Dillon: I can give you the breakdown. Of that $51 million, approximately $31.5 million was provided by the state, and the balance of about $19.8 million was provided by the commonwealth. So more funding is provided by the state than by the commonwealth—that is just a matter of fact at this point in time—although the commonwealth has been gradually increasing the amount of funding that it has been providing to this part of the health system.

Mr P. ABETZ: That is all channelled through DAO, and you use some of that for your own services, and you then pass some of it on to the NGOs?

Mr Guard: No. Not all of that is channelled through DAO. Some of that is channelled through DAO. Some of it comes now from the commonwealth to the state, and we get it through Treasury, to Health and to us, but the commonwealth also makes a direct investment in some of the services itself, outside its relationship with DAO. So the figure that Eric has given of the $51 million is the combined total, and some of that comes through us and some of that is direct .

The CHAIRMAN: Earlier you gave us some bed numbers and the cost per hospital admission. Has that been broken down further into the cost per metropolitan bed use and cost per regional bed use? It is just that we hear a lot, particularly from our regional members, about how suicide rates are higher and mental health problems are higher in regional areas, so I am wondering whether you have any statistics to show that there is a greater need for services in particular regions.

Mrs Browne: I do not think the hospitalisation data will totally give you that, because that is the data in hospitals.

The CHAIRMAN: So it is mainly metropolitan, is it?

Mr Guard: No. It would include other services.

Mr Dillon: Can I add that most of our services are not provided on an inpatient basis. Most of our services are outpatient-related. There are some detoxification services that we provide that are done on an inpatient basis, and there are some residential rehabilitation services that are also provided on an inpatient basis. We try to provide as many services as possible in the community and not on an inpatient basis, because it is very expensive to provide beds and to provide that type of service, and it is not required by everyone. The vast majority of people are able to receive the sorts of services that we provide on an outpatient basis.

The CHAIRMAN: I was thinking of the statistics that Neil gave in terms of the cost to WA.

Mr Dillon: The bed numbers.

The CHAIRMAN: Yes. For that figure of $33 million that you gave us, where did those statistics come from?

Mr Guard: The $33 million would have been from economic analysis studies. I can give you the references to that.

Mr Dillon: That is taken from the value of the contracts in any given period. The period that I was quoting was 2008-09. That was for the entirety of our services. It was not just for residential services. It was for outpatients as well.

The CHAIRMAN: That was the cost per alcohol or drug-related incident in our tertiary hospitals —

Mr Guard: The $33 million was the total hospitalisation costs associated with alcohol—the estimate in 2006. I do not have the reference on the slide. but I can give you that reference number. I am pretty sure we have covered it in one of the other documents that we have provided.

The CHAIRMAN: This morning we heard from Kim Snowball from Country Health Services, and he gave us a lovely picture of regional health services. He was saying that for accidents and emergencies, the number of admissions in regional areas was on a par with the number of admissions for our tertiary and secondary hospitals in the metropolitan area. For the cost of admissions for drug and alcohol services, it is mainly metropolitan, or is it fifty-fifty? If there was some way in which you could give us that further breakdown I would be very interested in that.

Mr Dillon: We do not have those figures here, but we will take that on notice and we will come back to you with an answer on that.

To get back to the slide, in terms of the specific questions about the Reid review and the clinical services framework, our activities and our approach do align very clearly with the objectives and the recommendations of those particular reports, and we are making progress. While I do not think the Drug and Alcohol Office was specifically mentioned in those reviews, the direction in which we have been going and are continuing to go is very clearly aligned with that, and we are making good progress towards recommendations in terms of cooperation and improved interface between non-government and government agencies, general practice networks and the organisations. That applies equally to our focus on the priority target groups, such as mental health, alcohol and drug issues, child maternal health, and Indigenous people. So when I went through those things and had a look at the particular recommendations in those frameworks, we are very closely aligned even though not specifically mentioned within them. When you look at the key priorities for DAO, they are outlined in the drug and alcohol strategy, and they will be again in the new drug and alcohol strategy when that is released for consultation. All the supporting frameworks are consistent with the WA Health vision and the objectives outlined in those reviews. So they include a priority focus on prevention and early and brief intervention; building and improving the linkages and pathways between services; supporting a highly-skilled and dedicated workforce; providing community-based integrated treatment and support in appropriate settings; and developing culturally-secure services. That is also very consistent with those particular reviews.

The CHAIRMAN: In looking at your work, it was interesting to hear in a presentation that over 50 per cent of the support that is being given in the mental health area now is done through non-government organisations and community groups. What would be the proportion in relation to —

Mr Guard: The funding for treatment services?

The CHAIRMAN: Yes.

Mr Guard: About 70 per cent of our funding of treatment services will be to non-government organisations and community-based organisations.

The CHAIRMAN: Could we have a list of that?

Mr Guard: Absolutely.

Mr Dillon: We fund 34 entities and 52 services. That is because some entities provide more than one particular service.

The CHAIRMAN: It would be lovely to have that list, if you could provide that as supplementary information.

Mr Dillon: Yes.

Mr Guard: Broadly, in terms of our investment, the DAO budget is around $50 million in 2008-09. If you look at the breakdown broadly between prevention activity and the treatment and support focus, currently it would be—the administrative costs have been appropriately apportioned across these as well—around $6 million in the prevention area and about $44 million in the treatment and support area. As I said, a significant proportion of that is community-based. So about 80 per cent of those funds would be directed to community-based treatment and prevention initiatives, and a significant proportion of that—around 70 per cent of the treatment funding—is directed to non-government organisations. So that is a snapshot breakdown of how the money will be generally apportioned. In terms of indicators of success there, prevention is clearly a high priority for us. The reality is that investment in sustained prevention and promotion programs can significantly reduce the trends of chronic disease and reduce the number of people entering the health system. So that is a high priority for us. A whole-of-population approach does have a flow-on effect into the broader community and it really is effective in terms of reaching a greater number of people when it is coupled with specific and targeted interventions. We monitor ongoing progress through a range of mechanisms. They would include national and state surveys—for example, the National Drug Strategy Household Survey and the Australian School Students' Alcohol and Drug Survey—as well as other relevant health, ambulance and police data, and calls to our own alcohol and drug information services. So we have a range of different mechanisms to continually monitor what is happening out there and the developing trends.

[1.30 pm]

The CHAIRMAN: Are you saying that you are collecting the data from those occupation groups or are you using the data that is collected by them?

Mr Guard: We use the data that is collected. Some of it we collect ourselves and some of it we are provided from national surveys and we are able to analyse that at a state level, as we are currently doing with —

Mrs Browne: The national drug strategy?

Mr Guard: Yes, the national drug strategy and the Australian school students survey data. Some of it is collected by other bodies but we have access to it. When we are looking at trends in, for example, heroin and other use, we collect information from a range of different sources including ambulance data, hospital data and others, to give us a picture of what is happening out there. We do a lot of that. All those mechanisms generally show us a consistent downward trend in illicit drug use in particular. We also evaluate our public education campaigns. You can see on the power point

slide some of the top line results from the public education campaigns that were conducted last year. For example, the awareness levels around the rethinkdrink campaign—which is all about trying to change community tolerance of drunken behaviour and which is a bit of a call to action around that—are 75 per cent, of which 63 per cent of those are able to recall the key messages of that campaign. We are starting to have some impact with that campaign. In the drug aware area, there is a 48 per cent awareness rate. That campaign does not use television; it uses radio and other interactive media to engage younger people. Of that group, 99 per cent are able to correctly recall the key messages; that is, around 48 per cent of the total cycle are correctly recalling the messages, which is pretty reasonable too.

We are also getting some good data from the work we are doing to try to support communities. I will present some of that data a bit later on as an example of other areas of work that we do.

The CHAIRMAN: And that would involve the volunteers. How do the volunteer groups help in both the —

Mr Guard: Things like local drug action groups and others?

The CHAIRMAN: Yes.

Mr Guard: There is a statewide network of local drug action groups, the executive office of which is located right next to the drug and alcohol office building. We receive and pass regular information to and from those groups. They are actually a very good conduit for information on what is going on at community level and on some of the needs at community level. They are a very strong point of consultation for us on a range of different things that we do. The other thing that is not mentioned on this slide is the work in the prevention that we do in liquor licensing. One of the key areas there is the significant support to the executive director, public health, in relation to looking at liquor licensing applications from the public health perspective. We are able to challenge them when necessary. In 2008-09 we were successful in that, of the 48 interventions lodged, 30 were either fully or partially successful. That is really, really good in making sure that the public health perspective is taken into account when looking at liquor license applications.

The CHAIRMAN: Given your involvement in the liquor licensing process, I had—again as a local member—a phone call last week from someone who wanted to set up a new liquor outlet very near to an existing outlet in the community. I know that some professional groups, such as the pharmacists, have a boundary, but that there does not seem to be any boundary in WA in terms of how many outlets can be within that —

Mr Guard: Yes; we know that with density there is no particular rule.

The CHAIRMAN: No; but is —

Mr Guard: But there is a limit.

The CHAIRMAN: Are there any such guidelines in other states or —

Mr Guard: No, not really: I mean, it is one of those areas that has been highlighted through a number of reviews, including the ministerial council, as one that needs some research. There are clear links—well, links—between the numbers of outlets and their hours of trading and others in a particular locality. There are suggestions that research needs to happen in that particular area.

The CHAIRMAN: At a local or national level? Is it a national question that is coming up?

Mr Guard: It is a recommendation that will be, I think, included in a report from the ministerial council on drug strategy to the Council of Australian Governments; namely, that this is one of the options that needs to be thought about. It has arisen as a result of state input into the development of that particular report. It is one of the areas that we absolutely think needs more work to help us to better define the key drivers of alcohol related harm and the types of things that could be done to reduce that harm. But we have a very active role in this particular area.

Mr P. ABETZ: I see that. I think that part of the issue with pharmacies is that that arrangement is under constant pressure from whatever it is that the commonwealth competition body is called that tries to deregulate the economy and make everything market driven. There is constant pressure, but the pharmacists have been able to resist that pressure on the basis of providing a health service and all that sort of thing. But from that quarter there would also be significant resistance to the so-called free-market economic-rationalist philosophy that states the more competition there is the better; however, I think that we would need to balance that against the social costs and unfortunately these people think purely in economic terms rather than social terms.

Mr Guard: Yes. The liquor act in Western Australia does have that. One of the criteria that needs to be considered is that of public health issues. Equally, weight is applied to the interests of the licensees as well as to public health. It is a delicate balance. However, it gives us the ability to intervene and to submit or to oppose an application every now and again. The data suggests that when we oppose an application we are pretty successful.

The CHAIRMAN: You have the community programs up on the screen now and you have mentioned Fitzroy Crossing and Halls Creek. Other than the legal restrictions that we now have, is there anything else? I mean, where to next? Mr Abetz and I both attended a presentation by June Oscar —

Mr Guard: June Oscar; I was with her yesterday.

The CHAIRMAN: It was an excellent presentation. She said that the measures that have been introduced have had a very good effect, but she said it is only a start. Where do you see that you can help those communities? What advice or support can you give them?

Mr Guard: We are actively involved in each of those communities that you have mentioned—Fitzroy Crossing, Halls Creek and Oombulgurri. In fact one of the representative managers in our office chairs the alcohol management committees in each of those communities. He flies up and chairs those particular committees. We are very close to June and the team around there. We certainly see liquor restrictions as a start along the lines that June has outlined. They buy some space. They buy a window of opportunity for the community to get itself back together. But other things need to happen as well if you are going to make a sustainable difference. Part of the role that we play is to engage other organisations, both government and non-government agencies, to try to do what we can to fill some of the gaps. We see it, as they see it, as a start point. It does need the rest of the cavalry to come on board afterwards to work with those communities to build on the foundation created by breaking the cycle.

The CHAIRMAN: I think that there are many people who agree. We would like to come on board and give some support, but he question is: how can we do that?

Mr Guard: Yes; June was very clear both in that presentation and again yesterday in a meeting I was at, that—I think she was talking about the Fitzroy Futures Forum—at a community level, they are very clear about what needs to happen now to start to build on those foundations. They are looking at engaging with that particular forum and for the people involved to take a lead by pushing what the community thinks needs to happen and the government's response to that. I think that is a very important mechanism and we should not waste any opportunity to tap into the mechanisms already in place that will give us that groundswell. It is early days in Halls Creek. We are only 2.5 months in and the early signs are similar; that is, we would hope that the success that was achieved in Fitzroy Crossing will be mirrored in Halls Creek. However, from our perspective, we are finding increasing demand for additional treatment services in Fitzroy Crossing. That increase in demand was not immediate, but now we are getting it we are looking at how we can respond to that particular need as well. However, that has been driven by the community saying that it is ready for it and that it needs it now. The community programs area is very important to what we do. In the treatment area: the number of treatment episodes has generally been increasing since 2005-06—

particularly in relation to substances of significant concern such as alcohol, cannabis and amphetamines.

Mr P. ABETZ: This is alcohol and illicit drugs is it?

Mr Guard: Yes—specific treatment episodes. The data for 2008-09 indicates about 21 000 open episodes, 16 914 closed episodes and 4 579 people still in treatment. In terms of success, around about 71 per cent of those episodes were, based on this data, completed successfully or the person is still engaged in treatment. The ability to keep people engaged in treatment is one of the prerequisites for good outcomes from this particular piece. That compares well with what you would see interstate and internationally, based on the data that we have.

The CHAIRMAN: And is this both alcohol and drugs?

Mrs Browne: Yes.

Mr Guard: Yes.

[1.40 pm]

Mr P. ABETZ: What proportion of those still in treatment would be the methadone people?

Mrs Browne: About half of them maybe. I am not certain.

Mr Guard: We can find out for you.

Mr P. ABETZ: Very roughly; I was just wondering.

Mr Guard: We can check that and come back again.

Mrs Browne: Obviously, it would be only the people in pharmacotherapy within Next Step—in community pharmacotherapy, not the ones who are engaged with general practitioners. They are not shown in this data.

Mr P. ABETZ: So the ones who go to their local pharmacy under supervision of their GP are not shown here at all.

Mrs Browne: No. They are not in the treatment episodes. This is services—funded services.

Mr P. ABETZ: There must be a massive number of methadone patients out there then.

Mrs Browne: Yes—so I might be wrong in saying 2 000.

Mr P. ABETZ: Yes. I would be interested to find out.

The CHAIRMAN: What are your key performance indicators for success?

Mr Guard: In terms of those reported in the annual report now?

The CHAIRMAN: Yes.

Mr Guard: Looking at trends, it is the trends in illicit drug and alcohol use compared with the trends nationally. Our indicator is around the gap between where we are in Western Australia, and our target is to narrow that gap, because certainly in some of the areas we are slightly higher than the national average. Given that a lot of that survey information is available only every three years, the proxy in between includes some of those data around the success of our prevention campaign work in terms of awareness.

The CHAIRMAN: But how do you measure success?

Mr Guard: The campaign work?

The CHAIRMAN: What is success?

Mrs Browne: Success for treatment is the completion, so we are trying to reduce the unplanned exits for people who just leave.

The CHAIRMAN: So if someone is booked in for 12 sessions, they complete 12 sessions.

Mrs Browne: Yes, that is the plan, and it may be a longer-term plan or a short plan. But retention in treatment and length of treatment and people completing are seen as a very successful measure through the effectiveness literature, so reducing unplanned exits is a good thing to do. So getting people into treatment and getting people out and dry is a success.

The CHAIRMAN: I know that when the cannabis legislation was introduced, there were great hopes that people were going to go along to the cannabis information sessions. I believe that in the first year there was more of an uptake of those sessions than in the second year. However, you said earlier that one of the major higher-use drugs is cannabis.

Mr Guard: It has declined significantly from wherever it was, but, yes, it still is the most significant in terms of illicit drugs.

The CHAIRMAN: I think that maybe that decline is because it is linked with the cessation of smoking.

Mr Guard: I think there are some links between the two, yes.

The CHAIRMAN: Under those information sessions, it was just one or two sessions. What other programs do you have? As cannabis is still a key drug that is being used in the community, outside the CIS and the infringement legislation, who runs cannabis cessation programs and how many visits would be optimal? The reason I am interested in this, and we are interested in this, is that that legislation could possibly come back to Parliament again this year. I know that the funding previously was going to be for one session. We both come from a behavioural background, and we know that if someone is not ready for change, they could go along to an information session, but it would go in this ear and out the other ear. Who is running your cannabis withdrawal or cessation programs, and what would you see as being useful? From the data and from the programs that you have run in the past, how many treatment sessions are necessary for something like that for it to be effective?

Mr Dillon: Just to refer back to the current cannabis scheme, whereby a cannabis education session is provided, that is a single session, as you are probably aware, and the uptake of those sessions is not high, and has diminished over the life of that scheme. The detail of the new scheme is yet to be agreed, but with both the current scheme and the proposed scheme, and if we assume, for example, that the new scheme might be just a single intervention, there was always an intention that those who went to those would receive an opportunity to continue in treatment if they were willing to do that and if it was deemed appropriate, depending on the amount of cannabis they were using and any other problems that were arising from that. There is not a prescribed amount of treatment that is deemed appropriate.

The CHAIRMAN: There are not programs in other countries that are currently up and running and that have a 60 or 70 per cent success rate from —

Mr Dillon: Not really. The treatment really needs to be tailored to the individual. So for one user with a certain level and frequency of utilisation, anything from one session to just a few sessions might be fine. For someone with a more ingrained use, and perhaps they are using other drugs as well, they may need to be engaged for a longer period. So it is too difficult to say that everyone should get five sessions, because for some that might be more than is really needed and for others that might not be enough.

The CHAIRMAN: If an amendment to the legislation were to come before the Parliament, it might be more efficient or effective if a sum of money were made available to DAO or to a group for cannabis education, and then that was used on, I guess, a client basis as to how effective you think it might be with particular patients, rather than so much money per patient.

Mr Dillon: Yes. I think what we have to do first of all is create the circumstances in which there is treatment readily available within a short time frame for people who are in that scheme, because they have only so long to deal with the infringement notice that they have been given, and usually

that is in the vicinity of 28 days. So the service has to have the capacity to be able to bring those people on board and give them their introductory session, if you like. The proposal at the moment—but that is yet to go through the course of parliamentary and government approval—is that the intervention, rather than just being an education session per se, would be more of an intervention. So it would involve an assessment of their level of drug use and the issues that it was creating for them personally and for their families, looking at any other drugs that they might be using as well, beginning a counselling process with them and giving them some strategies about how to address their drug use, and then, where it seems appropriate, encouraging them to stay on with the service and get some further help if they are willing to do that and if that seems appropriate in their circumstances.

Outside of that scheme, though, the vast majority of people who are receiving help for their cannabis use are already engaging with the community drug service teams and other agencies as well, and are engaged on a whole range of programs. Some of those would be in group format, and some of those would be on an individual face-to-face basis and would involve a variable number of sessions for each person. So there is a lot of that work already going on outside that specific scheme, which is for people who have been apprehended by the police with a small amount of cannabis and have chosen to accept a caution in that instance and engage with a treatment agency. I think it is important to differentiate those. That is meant to be an early intervention approach to avoiding further contact with the criminal justice system and introducing them to engagement with a treatment agency so that they can explore their drug use and —

The CHAIRMAN: Make them aware of what is available.

Mr Dillon: That is right; and then uptake some further treatment if that is necessary.

The CHAIRMAN: Other than the cannabis legislation, which I am hoping will come back sooner rather than later with amendments, what other legislation is there that you are involved in that covers drug and alcohol use and that might need to be reviewed in the future to possibly try to cut back on the problems associated with drugs and alcohol?

Mr Guard: Clearly, we have the Cannabis Control Act, which is the one that is going to come back in, but associated with that and the amendments that are proposed is the Misuse of Drugs Act. That will need to be amended to give effect to any change that you have there. Then you have the Young Offenders Act and the Liquor Control Act. So that is again a very important framework, and we talked a little bit earlier on about the liquor licensing work we do, so that one is relevant to our work.

[1.50 pm]

The Poisons Act is equally around volatile substances and some of the other areas there. They would be the top ones. The other ones that I think we should look at engaging were things like the new Public Health Act. That probably provides some opportunities there to engage local governments and others in what they can do to improve the health act, particularly associated with alcohol and drugs. That one might be relevant to us as well. But those that I have outlined are the current ones on the table that are particularly relevant to our work.

I am conscious of the time. In terms of what is making a difference: evidence clearly indicates that investing in early life stage programs and prevention programs has the potential to make a very significant difference. We provide a range of prevention and early intervention programs and services that are all about preventing and delaying the onset of alcohol and drug use, and supporting improvements to environments. As you would know from the tobacco area, if you can change the environment to create a supportive environment it also encourages people to cut down or reduce, in terms of risky alcohol use in particular. Enhancing attitudes and skills, and supporting initiatives to discourage the inappropriate supply of drugs and alcohol.

Examples of the pieces that DAO particularly is involved with are prevention and education campaigns. I have mentioned the "Rethink Drink" campaign that has focused on community attitudes to alcohol, in trying to change those; the "Drug Aware" campaign, which is focussing on preventing illicit drug use and the illicit drug problems. Prevention oriented partnerships are another part of what we do very well, including engaging with other government human services agencies—the police; Racing, Gaming and Liquor; Department of Indigenous Affairs; Department for Child Protection; Department of Health; and a whole range of non-government organisations and community groups. We fund the School Drug Education and Road Aware program to provide education, training and support for schools and teachers to facilitate drug education as a component of the health and phys. ed. curriculum. We also support, as I mentioned before, a statewide network of local drug action groups that deliver prevention activities and education for young people and support for families.

In terms of early intervention, especially prior to the onset of drug and alcohol dependence, that is very, very important. There are examples again of what we do there. The Alcohol and Drug Information Service and Parent Drug Information Service, both of which are housed at the Drug and Alcohol Office, provide a statewide 24-hour telephone service across Western Australia that offers alcohol and drug information and opportunistic brief interventions. Together in 2008-09 they serviced around 21 500 calls. It is a pretty significant service that provides a statewide information response and brief intervention response. We have the WA Diversion Program, the illicit drug diversion, and then, increasingly, as I said, in recent years we have played a more proactive role in supporting community action, which I think makes a big deal of difference. It is something that we are getting increasing demand to do. We try our best to stretch what we do to respond to all those community requests.

The CHAIRMAN: What about the attendances at our emergency departments because of illicit drugs; what is happening in that area? What are you suggesting?

Mr Guard: In terms of the relationship? You would know that after the amphetamine summit in 2007 there were dedicated AOD nurse positions established in the three main tertiary hospital EDs. They now play a very proactive role working with people who are admitted. In those circumstances, and where they can, actually doing some counselling and work direct with those people, but also referring them to other services where they can make that happen. That has been in place now for probably the last 12 months. From the feedback we are getting, it is proving very successful, including follow-ups with people who they were not there with at the time but whose telephone numbers have been taken, or who have been given an opportunity to call for further advice and information. I think that is something that we need to properly evaluate and learn from as an approach. But a lot of the work that we are doing is actually around trying to prevent that.

The CHAIRMAN: Maybe before we move on to that: previously I asked whether you might be able to give the statistics in terms of the community area and the regional area. Now I am wondering whether we can go a bit further than that, particularly in the metropolitan area, because if that model is effective, if we know the number of admissions in some of our secondary hospitals, maybe we should be looking —

Mr Guard: Are you talking about ED?

The CHAIRMAN: In that ED setting —

Mr Guard: So ED admissions that are alcohol and drug related?

The CHAIRMAN: That is right. If we know that in a particular socioeconomic area, where there is a secondary hospital, there are a large number of admissions to the accident emergency department because of alcohol and drugs, then maybe something that we as a committee should be recommending to the government is that they also introduce the same specialist —

Mr Guard: Type of mechanisms?

The CHAIRMAN: Yes; the same mechanisms. Is it possible to not only have those figures for regional and for metropolitan but for that breakdown in the metropolitan area so that we can see whether there are some areas where alcohol and drug problems are more prevalent than in other areas?

Mr Guard: The data you are talking about, I think, is certainly obtainable. We use it when we are working with—it is one of the key information sources that we would use when we are working with communities to understand the extent of the issues and the extent of the problems as part of the data that we would collect. A good example I was going to move on to was the Fitzroy one. This is 12 months on from the introduction of the restrictions there. The reduction that was achieved in alcohol-related ED presentations is pretty astounding. A 36 per cent reduction has been achieved in a 12-month period. We are able to collect that data and are able to use that as a tracking data to see the success of some of the things that we are doing. This was a really good case study of one where we have been actively involved as the Drug and Alcohol Office, along with a range of other players—I do not take all the credit for it—but put in place an evaluation framework that has given us this. Reductions in ED presentations—we have not seen a flow-off flow to other hospital EDs from the community. Reduction in suicides, ambulance call-outs, violence and abuse towards staff, and reduction in cases of attempted self-harm—there is some great data there. The health staff locally reported that shift from an acute response to a long-term response. Generally, the clients are more compliant. Fewer drunk teenagers, healthier newborns.

AOD services now, as I said a bit earlier on, is starting to notice an increase in requests for treatment assistance, which is a good outcome for us. There is increased demand there but it is people coming back and saying, "I would like some support." It is a great case study. The reality is, on the back of Fitzroy's experience, Oombulgurri's experience and Halls Creek's experience we are getting a lot more communities putting their hands up now. We have the same type of assistance. The teams work in with a number of communities running alcohol management strategies and plans, regionally and also community-based. It is a great success story in terms of the way this part of our work operates. As you said, ED data is available because we use it for these types of things. That is your example—alcohol-related admissions department presentations; the line down the middle being the date that the restrictions were implemented. You see a consistent downward trend there.

Community-based treatment—this is the next thing. We have talked about prevention and early intervention. Community-based treatment equally makes a big difference. The range of treatment services provided and funded by DAO is deliberately diverse to enable people to choose and to meet the needs of the various population groups and subgroups that have got alcohol and other drug problems. The examples range from withdrawal, detoxification, residential organisations, supported accommodation, sobering-up centres, outpatient services, pharmacotherapies and telephone counselling. It is a diverse range because there is no "one size fits all". It is around meeting the needs of individuals and meeting the needs of communities.

Significantly, as Eric mentioned a bit earlier on, the community drug services and the community drug services teams. They now represent a key primary network of treatment services in Western Australia. They provide a range of non-residential counselling, case management and support services. They have been progressively expanded wherever possible in recent years to have that community-based response. They offer a holistic response, which is very important. It is not just treating the alcohol and drug-specific issue, but they might provide referral and support for a range of other health issues including blood-borne viruses, sexually transmitted infections. They do a lot more work than a specific AOD focus.

The CHAIRMAN: Do you have statistics in terms of adult programs and programs for children; for what programs you run?

[2.00 pm]

Mr Guard: You mean numbers?

The CHAIRMAN: Yes.

Mr Guard: In that different range that I have just mentioned, we do have. We have reports from every agency about the numbers of treatment episodes and age groupings, too.

The CHAIRMAN: Could we have that by way of supplementary information?

Mr Guard: Yes. There are seven community drug services teams operating in regional and remote Western Australia and four community drug services teams in the metropolitan area. In the metropolitan area we have spent a significant effort in recent years trying to integrate government and non-government services in the metropolitan area, very successfully. The aim there was to try to provide access to a more effective and comprehensive range of AOD treatment and prevention services and to extend the availability where there was significant demand. So it does make a big difference. It has been an area of focus for us. Equally, those services of recent years have also been formalising arrangement under memoranda of understand with mental health services and also with child protection services. So that close collaborative working relationship has been a key area of focus for us, and that one also is an area that works very well.

Our own services, the specialist services, equally we think make a difference, such as Next Step, which is the government's own specialist medical drug and alcohol service, and its purpose is to provide that leadership and excellence in clinical care and professional training and research. It is staffed by addiction and medicine consultants, nurses, clinical psychologists, pharmacists and social workers. It receives referrals from primary care, from the hospitals, from mental services and from the non-government sector, and actually works very cooperatively with the non-government sector. The clinical services also include outpatient clinics across the Perth metropolitan area, as part of that integration with the non-government sector agencies. An inpatient withdrawal service and a pharmacy support our professionals on clinical management of alcohol and drug use through a 24 hours, seven days a week clinical advisory service. So it is a significant component of the overall treatment response that we have in Western Australia as well.

Workforce development is a significant part of what we do. It does make a clear different. We provide clear, significant workforce support and development support, both to the drug and alcohol sector and to other human services agencies and the broader community, to basically try to expand access to professional education and training, workforce organisation support and resource development in the alcohol and drug area. Next Step also offers clinical training and placement for undergraduate and postgraduate health professionals. One of our most significant programs now is culturally secure workforce and organisational development programs for human services agencies, to respond effectively to Aboriginal people. That involves policy advice, professional education and training, including the fact that we are a nationally recognised RTO, and we also provide strategic support and planning for treatment and prevention programs.

The CHAIRMAN: RTO?

Mr Guard: Registered training organisation; I am sorry. That in particular has been recognised nationally for its leadership role in building national capacity through an Indigenous workforce development training qualification, and we have had commonwealth government funding to do that, and we have just been successful in obtaining commonwealth government funding for the next three years to build on the certificate 3 program and actual development a certificate 4 program, which will include an additional focus on mental health, alcohol and other drug support. That has really been good. It is state based but providing national support focus as well.

Mrs Browne: They fund us so that we can present it national. We have partners in other jurisdictions.

Mr Guard: In particular, in South Australia.

The CHAIRMAN: So you are basically preparing a program that can be rolled out in other states.

Mr Guard: Yes.

In terms of our approach to service planning, it is basically achieved through monitoring, evaluation and research. I talked about the monitoring of prevalence, emerging trends and issues through the national data, plus DUMA, plus police and hospital data; evaluation of the programs and initiatives that we are involved with or we fund; a leadership role in policy and strategy, and that includes at the national level national drug strategy intergovernmental committee and ministerial council and also through the WA drug and alcohol strategy. It is through partnerships and collaboration, and we talked a little bit about some of those partnerships that we have there as well. Heavy involvement: we get a lot of information through regional planning, and we work very, very closely with other regions. It is through local and regional alcohol and drug management plans, certainly in consultation with local service providers in the community. As I also said, consultation forms a huge part of what we do, and we do work and consult very closely with communities. Fitzroy was a great example of our drug and alcohol strategy. It is a really good example of how we consulted already, and we will be doing it again. We also consult on the development of programs in our campaigns, because clearly if you are going to make them work, you need to make sure you consult properly with the group you are targeting with those campaign activities. It is a comprehensive approach and it does involve a lot of identification of the needs, looking at prevalence data and close working relationships with a range of different partners, including communities, in doing that.

Some examples of where we are doing that now are across the metropolitan area in conjunction with Palmerston, Cyrenian and Holyoake, which is not included on there, but planning and looking at the service development needs of the metropolitan area. In Carnarvon we have actually received funding to do a scoping study about what residential services they may need there, and that is in consultation with the community. In Port Hedland in conjunction with OATSIH, we area looking at the scoping of a residential rehabilitation service up in Carnarvon. In the Kimberley we have done a lot of consultation of what the needs are for a comprehensive approach to addressing alcohol and other drug harms in the Kimberley region, and that is prevention through to treatments and health services. So it is a key function of what we do. I think we are well placed to do it, because of that to a great extent.

Finally, the last couple, you will be please to hear, are addressing the needs and gaps. I was asked to give some early thoughts as to what we saw as the key needs and gaps that need to be addressed. A lot of this will be covered in our other submissions to the other inquiry, so I am not going to go into the detail here. We will cover that in depth as to what we think needs to happen. But effectively, I have been trying to summarise the sort of top five here. We think there is a real need for increased prevention activity and sustained prevention activity at a broad, population-based level, with additional targeted interventions for the at-risk populations. We think we need to do more in the area of developing and prioritising early and brief intervention strategies, so intervening early before problems become entrenched, particularly for younger people. Doing what we can to continue to build the capacity of treatment options; including those in regions and including those is some of the remote areas of the regions as well, and part of that is building the capacity of the workforce in those particular areas to appropriately respond to drug issues. Improving the capacity of specialist workers working closely with primary health care providers and Aboriginal workers, so care is a focus; building on the work we are already doing but continuing to build the capacity there, and building equally on the work we have been doing with the mental health division about improved case management for people with co-occurring mental health and AOD issues. We are working very, very well with the mental health division. We have actually identified through a recent workshop the chief priorities for the next couple of years, which the AOD sector and mental health sector will be working collaboratively on. They will be some top line issues and some of the areas which we think are very, very important. That is more or less it.

The CHAIRMAN: Maybe one of the things you have not addressed, which maybe you could do next time or you could provide us by way of supplementary information, is the role that you may play in relation to prisons, because there is a big problem there. We have been looking at the lack of support for patients who have mental illnesses in prisons, so we are very interested in what support you are currently giving, or might be able to give, to prisoners who have drug and alcohol problems. Because of the time —

Mr Guard: Yes, I am sorry about that.

The CHAIRMAN: No, we should not have asked so many questions, but it has been very good.

Thank you very much for you 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, we are looking forward to addition information that will elaborate on particular points, and this will come in a supplementary submission for the committee's consideration when you return your transcript. If there is some of the supplementary information we have asked for, I appreciate that you may not be able to get back to us within the 10 days that you have to return the transcript, so if it takes a bit longer, that would be fine, as long as you have checked the transcript and returned it within the first 10 days. Once again, thank you very much for coming along today. We look forward to your continued input.

Mr Guard: Thank you very much indeed.

Hearing concluded at 2.08 pm