EDUCATION AND HEALTH STANDING COMMITTEE

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

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

TRANSCRIPT OF EVIDENCE TAKEN
AT ALBANY
FRIDAY, 11 SEPTEMBER 2009

SESSION SEVEN

Members

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

<028> N/F

Hearing commenced at 4.07 pm

LEEKONG, SUPERINTENDENT DENE
WA Police, Great Southern District Office,
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Albany 6330, examined:

TAYLOR, MR BRYAN
Palmerston-Great Southern Community Drug Service Team,
PO Box 5334,
Albany 6332, examined:

CANNON, MS MARCELLE
Manager, Mental Health, WA Country Health Service-Great Southern,
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MISSON, MS MELINDA JANE
Team Manager, GS Mental Health Service, WACHS,
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Albany 6331, 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 review of WA's current and future hospital and community healthcare services and 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. The Education and Health Standing 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 is making a transcript of the proceedings for the public record. If you refer to any document or documents during your evidence it would assist Hansard if you could provide the full title for the record. Before we proceed, 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 inquiry?

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: You are aware of the specific terms of reference for these reviews. Melinda and Marcelle, are you team presenting?

Ms Misson: Yes.

Ms Cannon: Yes.

The CHAIRMAN: We will probably make it so that you have between 10 and 15 minutes with the committee interjecting with questions and then we will maybe move on to Superintendent Leekong and then to Mr Bryan Taylor. If it is okay with everyone, we will stop as we go along so that we can clarify points as you bring them up.

Ms Cannon: I was not quite sure exactly what you might want in this section, so it is just talking about how we do work with drug and alcohol services currently. I guess we are trying to work within the policy direction, which is trying to build tighter working relationships between drug and alcohol services and specialist mental health services. We have Palmerston in the great southern, as well as Holyoake, that provide drug and alcohol services. In Narrogin, Holyoake is co-located with our Narrogin-based specialist mental health team.

The CHAIRMAN: Actually, I am going to interject. As you are giving your presentation, because you interact, Bryan, you may, if you would like, interject or flag some points when Melinda and Marcelle describe something to the committee; otherwise, as part of your presentation, you may need to go back to similar ground, so it would be much better if we can have this together.

Ms Cannon: Holyoake in Narrogin, and in covering the upper part of our region, attends our intake meetings and there is joint assessment and care planning for shared clients. We have consent forms that allow that sharing of information with Palmerston, and both of them are covered by a memorandum of understanding. We invest a lot of time in trying to work collaboratively on assessment and care planning for joint clients as well, so there are regular meetings and attempts to try to use as much of our resources effectively together. Melinda has probably taken a fairly strong role in that, so she might want to say a bit more.

Ms Misson: Yes. We have actually had a formal MOU—memorandum of understanding—with Palmerston for over a year now. As a result of that, one of the things that we had jointly decided was to do more interagency networking in the belief that if staff know each other then they are more likely to actually contact each other and do conjoint care planning. At the moment we are having interagency meetings every three to four months, and individual clinicians will actually liaise if we know that there is a Palmerston worker working with the client and the client will give us consent. Obviously, with some clients, consent can be an issue, but we do our very best to have that sort of shared agency model so that we actually do get a full range of comorbid service.

The CHAIRMAN: Under the MOU that you have with Palmerston, how are the funds made available? I know that you may not have had the opportunity to look at the submission that was made by Palmerston, but one of their comments was that diversion programs will not work if adequate resources are not available for treatment programs of diverted clients. Are you referring to funds from mental health services, Bryan, and how does that work? If you could explain it first, and then Melinda and Marcelle can maybe come back to that one.

Mr Taylor: I do not know whether I can explain it any better than they can. My understanding is that it is completely separate; the funding does not overlap at all.

The CHAIRMAN: Sorry; what you said about the funds in your submission is that diversion programs will not work if adequate resources are not available for treatment programs of diverted clients. Who are you referring to there?

Mr Taylor: That is referring to court diversion clients under the state diversion program, which is sort of a little —

The CHAIRMAN: Okay; that is fine. We can come back; sorry.

Ms Misson: I guess what we experience is that the gap is probably similar to the reports we have had from Palmerston that staff are experiencing; although we do our very best to work together, sometimes joint case management can be difficult with complex clients with multiple comorbidities. I think what we have tried to do very much is work a little along the lines of perhaps—are you familiar with the Strong Families process?

The CHAIRMAN: Lisa is; I am not.

Ms Misson: In the Strong Families process, there is an independent case manager who actually organises the meetings around it. We have tried to do something like that process but without the external case manager to organise, so sometimes it is actually difficult to resource the case management side of things and I think that is the potential where sometimes things can actually fall through the cracks a little.

The CHAIRMAN: So you are saying that you do not have a team manager for patient —

Ms Misson: We have a mental health case manager and Palmerston would have a drug and alcohol case manager. There is not actually an overall independent case manager for people with multiple complex comorbidities that may involve alcohol and drugs, mental health, child protection issues, domestic violence; there may actually be multiple complex issues.

The CHAIRMAN: Whereas in, say, other healthcare services, they have a multidisciplinary team, are you saying then that you do not have that multidisciplinary team that comes together to look at patients who have those comorbidities?

Ms Cannon: No; it is probably a bit of a separate process in that the Strong Families approach —

Ms L.L. BAKER: Perhaps you would just like to spend a couple of seconds on Strong Families so you can explain how that model works and then it will be clear to everyone.

Ms Misson: The Strong Families process actually works by having an independently funded person in the regional role of case manager who will actually manage multiple agencies' involvements in a client family of the Strong Families process. It came about as a result of the Gordon inquiry, from memory. It means that someone actually has the time and the resources to do multi-agency, multi-stakeholder meetings, which actually require a lot of preparation time and a lot of organising.

The CHAIRMAN: And you are saying that you do not have that person.

Ms Cannon: Because that is very specifically for child protection —

Ms Misson: It is for Strong Families; it is a very specific role. I think if we could have either the resources or something like that type of role for complex multiple comorbidities, it would be quite helpful; otherwise it falls to clinicians, whether they be in publicly funded mental health services or in the non-government sector, to do that coordination.

The CHAIRMAN: For that coordination for your region, would you need one full-time equivalent position or two? I do not know. What are your client members that fall within that comorbidity —

Ms Cannon: One FTE.

Ms Misson: In terms of the services, is there more that we would like to do as a mental health service in working with alcohol and drug comorbid clients? Absolutely. I think that the main issues are not motivation or intention; the main issues are actually resource issues. In terms of prioritising, as Marcelle mentioned in our first submission, the priority inevitably goes to psychiatric emergencies and crisis cases when we have to look at an appropriate allocation of resources. Often it is the continuing care-type clients, including stable comorbid clients, who have experienced cancelled appointments or lower priority in service provision.

The CHAIRMAN: What are you doing in terms of prevention? Are you involved in prevention in the area of alcohol and drug problems?

Ms Misson: There is nothing in terms of programs that we are involved with.

Ms Cannon: Not prevention. In our general assessment and care planning with people, some of the factors we work on for triggers for relapse would be around lifestyle behaviours like alcohol and drugs not being good things to be involved with for mental health, but in terms of population based or kind of more specific —
<029> D/4

[4.20 pm]

The CHAIRMAN: You are treatment oriented?

Ms Misson: Absolutely.

Mr P.B. WATSON: Where in the great southern is the prevention?

The CHAIRMAN: That is what I was going to ask Bryan next.

Ms L.L. BAKER: Can Holyoake not do prevention?

Mr P.B. WATSON: No. I am just saying Palmerston generally get people after they have been affected.

Mr Taylor: Yes. Clients tend to be those for whom prevention has not worked; it is as simple as that. And I think we need to differentiate between primary prevention and secondary and tertiary prevention. I am sure these guys do secondary and tertiary; they do not do much primary. We do a little bit of primary through our contract with DAO. I have had some issues with the Drug and Alcohol Office of the state health department. They do not ask prevention services to do treatment, so why are they asking treatment services to do primary prevention? I have a bit of an issue with that. We certainly lend ourselves to it and we work with the sentiments of what they are trying to do, but it seems to be just a bit of an add-on so that they —

The CHAIRMAN: But do you not think that if you are providing the treatment services, you are aware of the factors that lead them to the clients who need your services?

Mr Taylor: Absolutely!

The CHAIRMAN: And therefore you would be in a good position to develop those prevention programs to try to stop people needing your services.

Mr Taylor: Yes, I think there is a little bit of demarcation around that; you know, are we a treatment service or are we a preventive service? I acknowledge and accept what you say. Yes. I think, listening to myself talk, if we were going to do it effectively, we would be funded for a prevention purpose and a primary prevention officer and do it that way. But it just seems to be a bit of an add-on to what we do. Yes, it is consistent and we get some valuable lessons and some valuable insight to what is going on through being involved in those, but it does seem to be a little bit of a burden for the clinical staff sometimes.

Ms Cannon: It is a very different skill set as well. Population health—Sandra whom you met with—her team is actually skilled and resourced and that is their training qualifications, to look at population-based strategies around prevention and targeted ones as well. I have worked in both sectors so I know that a very different skill set is required and a different approach is used. My sense is that in population health some of their health promotion resources have been minimised and minimised that, I guess, when it comes down to someone with a crisis, acute hospitals and acute treatment becomes the focus when times are lean. So the health promotion and prevention stuff tends to be the bits that drop off because people do not tend to complain about it.

The CHAIRMAN: Maybe, Dene, could we come to you in terms of the problems in relation to alcohol and illicit drugs? What is the earliest age that you are coming across these problems? What are the main problems that you are coming across within this region?

Supt Leekong: Probably the alcohol and the drugs contribute straight to domestic violence. That is probably the first sign we get: domestic violence, antisocial behaviour.

The CHAIRMAN: In some other regional areas we have been told that five years ago, would have accounted for 97 per cent of domestic violence. That has maybe fallen down to 90 per cent because of the economy at the moment and other factors at home that might be leading to domestic violence. What would you say the figure is here?

Supt Leekong: It is 50.4 per cent.

Mr P.B. WATSON: The youngest offender is 12.

Ms L.L. BAKER: Page number?

Supt Leekong: I do not have a page number, sorry.

Mr P.B. WATSON: The youngest offender is 12; I have worked that out from the second page.

Supt Leekong: Yes, it affects 50.4 per cent. We attended 633 family violence incidents this calendar year, and 50.4 per cent involved alcohol and/or drugs.

The CHAIRMAN: But has the change in economics, do you think, influenced the cause?

Supt Leekong: No. I think the trouble is we have gone from probably a cultural position where we did not deal with domestic violence very well and record it very well, and now because we are capturing so much of it, of course the percentage is dropping because we have got a bigger—we call it net widening. We are capturing a lot more data, so we expect that that figure will drop down.

The CHAIRMAN: Do you think that the advertising that we have had on domestic violence, encouraging people to speak up about the domestic violence, has led to both more people reporting it but a lessening of domestic violence within the community? What influence do you think that that campaign has had?

Supt Leekong: Internally in the police department we have had a huge cultural shift to actually intervening into domestic violence, whereas before we would probably push it off and decide to try to arrest the main perpetrator. Now we are actually intervening, taking out police orders, 24-hour police orders, moving the main trouble person away, and engaging government agencies. What that means for us is we are spending a lot more time doing domestic violence and we are capturing a lot more data. So we are getting more calls because the victims see that we are actually engaging now, so they know when we do come, we are going to do something. So we are getting more complaints. So probably, I had a look at the data this morning, and we have got the same amount of domestic violence this year as we did last year to this date.

Mr P.B. WATSON: The VROs on the spot; does that help?

Supt Leekong: We do not actually use VROs on the spot very much; we use police orders—24-hour police orders, 72-hour police orders—where they have to be displaced from their residence and we try to engage refuges. We cannot obviously leave the perpetrator in the streets; we have got to try to get them to a refuge as well.

The CHAIRMAN: The rates of hospitalisation due to alcohol are significantly higher here than elsewhere. If you listed the drugs, would you list alcohol as the biggest problem?

Supt Leekong: Yes, definitely alcohol is the biggest one.

Mr P.B. WATSON: By far.

The CHAIRMAN: And then?

Supt Leekong: Yes. I would have to check the data, but undoubtedly I could say it is cannabis.

The CHAIRMAN: And then?

Supt Leekong: Then working through the powders—I am sure Bryan would have better information than I have—but ecstasy, amphetamine; we do not see much heroin; we do not see much cocaine here; we do not see much ice, I do not believe. So it is mainly down in the ecstasy and amphetamine, but Bryan would certainly have better data probably than I would at the moment.

The CHAIRMAN: When you come across the drug and alcohol-related problems—you have talked about the ones that are caused by domestic violence—you would use a refuge. What other mechanisms then do you use to help those people? Obviously one is referral to Palmerston.

Mr P.B. WATSON: Not directly for us, no. If we engage domestic violence, then we normally end up —

Mr Taylor: No, I am thinking now of alcohol —

Supt Leekong: The normal alcohol —

The CHAIRMAN: When you come across someone for an alcohol or drug-related problem that you have —

Mr P.B. WATSON: A lot of those ones at Palmerston get it from the magistrate, do they not?

Mr Taylor: The diversion program is effectively only for illicit drugs through the courts, so people who find themselves in front of court and —

The CHAIRMAN: I see; it cannot be for direct from the police, then?

Mr Taylor: No, it cannot be for alcohol. This is a glitch, if you like, and it is being discussed ad nauseam with your federal counterparts. It is a problem for us on lots of levels. Anyway, the court can refer to what is known as the formal diversion programs—there is a couple of them—for illicit drugs, or if you can make an association between their illicit drug use and their offending, it does not have to be direct as long as they are co-occurring, if you like. If it is an illicit drug, they can be referred to the diversion program; otherwise they are simply referred on court-based programs if it is alcohol-related offending.

The CHAIRMAN: So they can be referred?

Mr Taylor: They can but it is just a general program; it is not a target program. It is just the general court process. They put them on an order, and that order might include a counselling or treatment for their alcohol problem, but it is not the diversion program. It is not set up formally like the illicit drug diversion program.

The CHAIRMAN: So if alcohol is a big problem, what services are there down here—Alcoholics Anonymous? What is there for people who have alcohol problems?

Mr Taylor: Yes, there is an Alcoholics Anonymous. Consistently in the time I have been there, alcohol is always rated as the principal presenting drug and the principal problematic drug as well. So it is the most common one, it is the most common-causing problem. Typically it is around 35 to 40 per cent, and has been for a long time; and then cannabis and amphetamines tend to fluctuate around the 20 per cent mark each. It is about 70 per cent through those three substances. The amphetamine seems to be sort of more acute-type problems. And the family violence and those sorts of things we see as a direct association, violence and aggression, with amphetamine use and with alcohol particularly; they go hand in hand.
<030> R/F

[4.30 pm]

The CHAIRMAN: Bryan, could you describe the services that Palmerston offers? Then I will come to you, Dene, and ask about your experience with alcohol accords—you will be aware of

different accords introduced in different regions—and what form those accords took within this region, and if they have not been used, what might be useful in targeting alcohol problems within the region.

Mr Taylor: I will take it back a little bit. The community drug service teams came about as a government initiative when they devolved the old Alcohol and Drug Authority. If I can put it rather simply, I think that it was seen that the capacity was limited for government to deliver those sorts of services, particularly in the area of harm reduction. It was called "Pretender" and the ADA role was tendered out originally to about 12 drug service teams in a combination of metro and regional teams. The original requirement from us was community development practices, primary prevention-type initiatives, client services, counselling and that sort of stuff, and supporting education initiatives as well. We worked with three pillars or three domains. That was some time back, and it has changed quite a bit throughout the state, in fact. We have a number of programs. We have counselling programs that include families, Indigenous and young people, and various other things. The youth assistance program, which is mainly based in Mt Barker and Katanning, is basically for parents with drug-related problems who have young children. It tends to concentrate on Indigenous people mostly, because of the location and the nature of the work. It is very effective, and it is just a case of being there and doing stuff with people—role modelling. At Katanning they have a garden and that sort of thing, and they will grow some produce and encourage the families to come along and cook it, eat it and share the meal.

Mr P.B. WATSON: Is that run by wadjalas?

Mr Taylor: Yes; we are running that and most of us are. Sam Williams has a big part of it and he is our Indigenous counsellor.

Mr P.B. WATSON: The reason they are doing that is that it attaches no stigma to the young mothers in the Nyoongah community?

Mr Taylor: Yes. That is a complicated question with Indigenous health, and a lot of them prefer to be there with white workers as they think there will be different confidentiality arrangements, rather than the information coming back to their own community. We did a bit of a thumbnail sketch for our Indigenous clients and asked, "Would you prefer a Nyoongah—an Indigenous counsellor—non-Indigenous, or you don't mind?" There was about a third in each domain. Indigenous people made the comment that for some issues they would like to see a white person, for other issues a Nyoongah person, and sometimes they did not mind, and so on and so forth. I think that is a fair representation amongst the clients that we see; sometimes they will ask for an Indigenous counsellor, but not always.

We do the diversion program, which is a significant component of what we do. That basically means having an assessment officer in the court to take the referrals from the court, provide an assessment, and enter them into a treatment plan through the pathways with the other services. We catch them, if you like, straight from the court under the program and try to identify any needs they have with other services and facilitate those.

The CHAIRMAN: I notice in your submission a comment that treatment in prisons can reduce recidivism.

Mr Taylor: We have done some programs in the prison in the past in collaboration with the Department of Corrective Services.

The CHAIRMAN: But you are not funded for that?

Mr Taylor: No, we were never funded. We were paid contractually for the ones that we did, but it was never an ongoing funding arrangement, which is a bit sad. The Strong Families coordinator is located at our office and we use that model quite a bit. We think it is an effective case management model. It has some limitations.

The CHAIRMAN: We have not finished with the prisons yet.

Mr Taylor: We have a big shortfall in prison programs. I am speaking specifically for our regional setting here—we have a prison in the region—and there are some real opportunities, we think, to work with offenders prior to release; perhaps a model by which we work with them six or eight weeks prior to release and then perhaps six or eight weeks post-release, and a family-inclusive type model would be very effective. That is sort of what we set up, and what we are practising by the by anyway, but they would not fund it, so we have let it slip.

The CHAIRMAN: For Melinda and Marcelle, we are hoping to get some statistics from our earlier hearings in relation to the number of people within prisons who have a mental illness.

Ms Misson: Can I speak as a private citizen for a moment without my WACHS hat on?

The CHAIRMAN: Yes.

Ms Misson: I was a prison counsellor and treatment coordinator in the metro system as well as down here at Albany. My understanding at the moment is that the only program they were running down here was medium intensity. Was it Moving on from Dependencies?

Mr Taylor: Moving on was rated as high intensity. They did a couple but, effectively, they have not done any for a couple of years. The only program I am aware of is the occasional and violent offenders treatment program.

Ms Misson: Based on my personal, professional experience in the prison system, there are significant comorbidities with alcohol and other drugs, offending behaviour and mental health. Those are three comorbidities occurring together. In terms of the programs, it is definitely a resource-effective way to ensure that you are getting groups of offenders who have been identified as having this as an issue through a process and giving them an opportunity to work on their issues.

The CHAIRMAN: What would you suggest as a model for the prison environment?

Ms Misson: I did not think there was a problem with the Moving on from Dependencies program, to be quite honest.

Mr Taylor: No.

Ms Misson: I think most of the problems were around resourcing, from my recollection.

Mr Taylor: I would agree with that. The programs themselves were not too bad. They probably needed a little bit of tweaking, and so on, but they had enough flexibility in them that we could deliver them effectively. There was Moving on from Dependencies, and what was the other one?

Ms Misson: MOFD and there was the low-intensity program, and I cannot recall the name.

Mr Taylor: There were two or three. We thought they were very effective. We also had one of our counsellors doing this model, the connections, that I spoke about—six weeks prior to release and six weeks after release—which was particularly effective.

The CHAIRMAN: You found that it was effective in keeping people from becoming repeat offenders and going back to prison?

Mr Taylor: Again, it was very hard to research real outcomes, but our appreciation of it was that the time between offences for offenders who participated in the program got longer and the offences got less serious, and some of them did not re-offend in the time of the review. On those measures, we thought it was very good.

The CHAIRMAN: Dene, can we ask for your comments on that issue because you are aware of who goes into prison. My own local police stations know from the crime statistics on the incidence of crime in the area who is out of prison at different times.

Supt Leekong: The crime rate has increased, yes. WA Police has a statewide initiative called PPO—priority prolific offenders. They are the main people we target in our volume crimes—

burglary, some drug offences and other bits and pieces. The only way we can get a judicial hold on them is when they are on bail. We put tight bail conditions on them—curfew and checks—and the magistrate also puts alcohol limits on them and geographic boundaries they cannot penetrate. We do checks, depending on the conditions. We have had a very high success rate, unfortunately, in putting them back into remand. Once we do that, our crime figures drop.

Ms L.L. BAKER: Is this an appropriate time to ask you to explain STIR?

Mr Taylor: STIR is our program. It is one of the former diversion programs.

Ms L.L. BAKER: It is in the police submission.

Supt Leekong: I was giving the agency a bit of positive comment.

Ms L.L. BAKER: It says that the magistrate has been highly successfully with her intervention programs and refers to STIR.
<031> N/F

[4.40 pm]

Mr Taylor: There are three drug diversion programs, effectively: YPOP is the youth pre-sentence opportunity program; POP is the pre-sentence opportunity program for adults; and the STIR program is the supervised treatment intervention regime, which is quite a stringent process. I will give you the brochures later. We think they are working and are very effective. There are sorts of counselling modules attached to the various programs. Our magistrate has a hair-trigger for referring to reparative-type interventions and therapeutic jurisprudence and those sorts of things. The STIR program is, we think, very successful and we have had some really good results with that. Basically, it has the counselling component and the urinalysis component to benchmark where they are going and those sorts of things. It is fairly intensive. We do have a number of people who commit to it and then find that it is more challenging than it would have been just to get their penalty, so they can voluntarily opt out and get their penalty when they wish to. It has coerced, if you like, some people into treatment for a long time who would not otherwise be there for three or four months, so that seems to be working very well and also for, I think, the likes of those Dene was talking about—the offenders who are committing multiple offences.

The CHAIRMAN: We will move back to Dene for a while to talk about accords.

Supt Leekong: The liquor accords are obviously a non-binding agreement; they do not have legislative power.

The CHAIRMAN: But I have been informed that with the various measures within an accord, you can approach liquor licensing and have any accord restrictions put on a licensee or included within the guidelines for a licence.

Supt Leekong: All the accord members have to agree to those conditions and I am not aware of any accord of such a form that has been registered with the director. Therefore, accords really are, I suppose, an agreement amongst licensed premises to come to meetings and, obviously, be updated on some of the issues that we are facing and they are facing, and provide education and increase awareness. It is a forum for us to also remind them of underage drinking and the responsible service of alcohol and to try to elicit from them any issues that they might have, such as a problem person who goes to one licensed premises and once he is banned from there, unfortunately, he will walk into another licensed premises. Whether you can ban them from all licensed premises is a bit of a touchy subject; obviously, that is a bit of a breach of human ,rights I believe, so that is not really done in that forum. Informally, we have used the liquor accords quite well; we have not had a licensee really be obstructionist with us at all. We have used it quite a few times when we have a risk incident, like a funeral perhaps, which has the ability to draw into a very small contained area a lot of people with a violent background and who consume a large amount of alcohol. So, through

that, the licensees have modified to low alcohol, shut at a certain time and have no takeaways, and it has worked pretty well for us actually, so we are pretty pleased with it so far.

The CHAIRMAN: Within the area, alcohol is the number one problem. How has the police department managed those problems within this region? How could you have managed it better?

Supt Leekong: We are a very reactive, I suppose, police force in that criterion. We respond to, obviously, complaints and that is where we get most of our contact. Proactively, we have started to put some science around our licensed premises. I think there are 313 licensed premises throughout the district and that ranges from distilleries to wholesalers to bowling clubs. What we have tried to do is rate them on their propensity for risk; in other words, the wholesaler is probably not going to be a high-risk premises for us —

Ms L.L. BAKER: Bowling clubs.

Mr Taylor: You will be surprised when I get to that bit.

Ms L.L. BAKER: No, I would not.

Mr Taylor: We rank them according to their risk and some of the complaints we get and we are also using some intelligence. Every time we get a drink-driver, we ask him the place of the last drink—the bowling club does come up—and that allows us to obviously go back and apply some science around where we are deploying our people to see whether we walk through the licensed premises, talk to the licensee and then, unfortunately, enforce through liquor infringements or capturing drink-drivers as they leave. They are some of the things that we are doing proactively.

The CHAIRMAN: I was looking at those statistics. There are 300 licensed premises and 52 000 people. I had read that number as 5 200 so I was thinking it was 1 to 20—I had my statistics slightly out there!

Mr Taylor: There are quite a few wineries as well in the district, yes.

Mr P.B. WATSON: Dene, do you think that the football clubs now training the bar staff in responsible drinking and all that sort of stuff has been successful?

Supt Leekong: I think it has, yes. It has certainly raised the awareness with the bar staff and the licensees. I think the minimum infringement that we can hand out is about $500 now and that is to the barperson who serves and one for the licensee, so that is quite a financial impact on them.

Mr P.B. WATSON: You will notice that one of our locals who got caught just recently had some underage drinkers there.

Supt Leekong: Yes, I know the venue.

The CHAIRMAN: You mentioned alcohol, cannabis and amphetamines and other drugs. The cannabis legislation was introduced in 2004 and I am sure Bryan is well aware that the review of that cannabis legislation made recommendations to decrease the number of plants or the licence. Another recommendation was that people either paid a fee or attended a cannabis information session. We know that people have not gone along to those cannabis information sessions. In relation to the problems we have with cannabis, what do you feel would be a good step to take—obviously, we all would like to see people not take up cannabis—in measures to help prevent the take up and for treatment?

Supt Leekong: Our role is really enforcement and disruption so we target these drug dealers, I suppose. We try to get into the mid-level drug dealer area because taking out a 16-year-old kid with a joint is not really a good use of our resources, so we are trying to target the mid-level. Cannabis, as you know, can be grown anywhere. We have had to target forestry areas up towards Walpole. It is very hard to cut the supply down. Our main role is to disrupt—take the supply out and make it hard to get hold of. It is very hard to take out cannabis—extremely hard. It can be grown in your backyard, so that is a difficult one for us. When we move into the powders, it is a very covert

environment; we have to use very technical means to try to get to the mid-level dealers. Therefore, our main role is disruption and enforcement.

The CHAIRMAN: In relation to the covert, Peter, did we not introduce legislation a few years ago that allows police to go undercover in different areas? Was that also in relation to drugs? Does that get used here? Do you have police going in undercover?

Supt Leekong: We have the power to buy drugs but not to sell drugs. Some eastern states have legislation that gives police the power to sell, which gives them better penetration. If you are not going to sell drugs, you probably do not get into some of these areas that we need to get into.

Mr P.B. WATSON: Would the police be happy to have legislation like that brought in?

Supt Leekong: It is a very contentious issue because it has a lot of problems over east; it has probably driven some corruption issues so that the outcomes might not be worth the risks. But we are a very corruption-resilient police force. I believe, so it is probably a different ball game for us.

The CHAIRMAN: Bryan, working in the area that you do, what would you see as maybe being a couple of key things that could be done to help address, firstly, the alcohol problems; secondly, cannabis; and, thirdly, illicit drugs? It is all right; we will give you a minute to think about this.

Mr P.B. WATSON: Then you will go straight to be the boss of Palmerston!
<032> N/G

[4.50 pm]

Mr Taylor: Can I duck that completely and just touch on something for a second that was covered before? There are two other diversion programs for illicit drugs, if you like. One is the mandatory education session cannabis infringement notice—CIN—program. We thought that worked particularly well for the people who got a ticket from the police and who chose the education session. It makes sense though; they were motivated, did not want a criminal record and were happy to participate. Therefore, those ones who actually came through our door we thought they were very successful. We sense a distinct reluctance on the part of police to issue infringements. We think that it looks like the discretion was quite remote—it was almost a fixed option to charge people. It did not happen all the time, but we were told that we were one of the most prolific infringement regions and I think we got 17 for the year, so that sort of told us that if we were one of the best, there was something about the system that was not getting enough people through. With absolute respect, the police have certain criteria when they can and cannot issue an infringement and I am sure that they would say those conditions existed most of the time. At the end of the day, we thought it was particularly effective. Those people who are not going to be compliant or who are not going to do anything will not do anything whether they go to court or go to an education session. The opportunity to not get a criminal record is significant because that plays out as a significant harm for so many people, so that motivated people to attend. The other one was the all drug diversion program, which no-one seems to know about. That was a more intensive program for when police encountered offenders with illicit drugs other than cannabis, so up to two grams I think of heroin or whatever and then they had an intensive treatment regime. We thought that worked particularly well for the one, two or three cases I think that we actually got. I know that there was some resistance for that among the police. It just did not seem to get utilised despite the potential that it had, so that seems to have faded away and no-one seems to know about it or talk about it.

I do not know the short answer to the alcohol problem and the illicit drug problem. I think it is a problem that alcohol is not seen as a problematic substance, culturally and for whatever reasons. It is a tragedy that we have to even use the term “alcohol and other drugs” so that people draw the association between them. I think we need —

The CHAIRMAN: What about other countries that have a higher age before —

Mr Taylor: Of alcohol consumption?

The CHAIRMAN: Yes.

Mr Taylor: I was on the voice committee, which was an advisory committee to the minister. The research says that the drinking age of 21 does reduce problems; that is fairly universal and fairly accepted, but it does create a few on the way through. The Mediterranean model is where young people are introduced to alcohol at any early age at the family table or whatever with diluted wine and so on. There is a lot of perceived merit to that model.

The CHAIRMAN: Have you looked at the statistics on diseases from that model?

Mr Taylor: I have seen a bit on it, but versus the alternative —

The CHAIRMAN: There are a great deal of statistics that show the —

Mr Taylor: I saw that, but the alternative is horrendous binge drinking in both Europe and places where there is a 21-year drinking age, such as the United States of America. It seems to be that when there is no exposure to alcohol in a quite prohibitive sort of background or when there is unlimited exposure to alcohol, a lot of binge drinking goes on. I think a nice balance between those two approaches would be interesting. I think the small-bar licences that the Liquor Licensing Act moved to is perhaps going to bring some of these issues to the forefront. Certainly, I would like to see big-ticket items such as alcohol in sports sponsorship done away with. I think that would be a huge and better investment than a lot of the primary prevention programs that go on. It is worth looking at the 21 drinking age simply because the research says that the problems are reduced —

Mr P.B. WATSON: What about binge drinking?

Mr Taylor: That is a really a tough one. It is so endemic that unless there is a personalised exposure to a problem with that, people will binge drink until they or someone they know gets hurt. That seems to be the way it operates all too often. I would like to think that education in schools and school models would be effective, but I do not know how effective they would be. School education is a little quixotic because it seems that there is a bunch of students who will be resilient anyway and there is a bunch of students who will not be resilient and who will make some bad choices. Prevention just works with a few in the margins, that is —

The CHAIRMAN: With school education, Dene, what age did Constable Care cover in the schools? I believe that was a very successful program.

Supt Leekong: It is currently moving through this district now or next month. It is targeting primary schools mainly, not really up in to high school.

The CHAIRMAN: Do the police do anything in the high schools?

Supt Leekong: We used to have the GURD program —

The CHAIRMAN: That is right—"drug" around the other way.

Supt Leekong: That has gone off the books for us. We used to have officers co-located in high schools and that has gone off the books, as well.

The CHAIRMAN: Is it all because of lack of funding that you have had to take them out?

Supt Leekong: Probably limited resources and I suppose we needed to use them effectively in other areas. We would like to be in an educational role, but it is probably still a bit difficult in this district with the finite resources that we have.

The CHAIRMAN: What about Bryan's suggestion for restricting alcohol at sporting events? I will ask you the same question next, ladies.

Supt Leekong: It is very topical and we asked that question of our liquor enforcement division before I came to this forum. I could not make a comment on that; it is still being worked on corporately so it would not be appropriate for me to make any comment on that. What I can say though is that we do target those sorts of events from our enforcement position; we look at the

trading permits and the licences they have. We try to obviously walk through some of these venues and obviously then target the drink drivers who leave. As I said to Mr Watson just before we started the session, the grand final season is upon us. Anecdotally, we targeted the Gnowangerup grand final I think it was and we did not get one drink driver so obviously the message —

Mr P.B. WATSON: You sounded disappointed.

Supt Leekong: I am a bit. The message is getting through. It would be nice to get one just for the stats.

Ms Cannon: Did you target the mad Mondays?

Supt Leekong: We do target a few of those, yes.

The CHAIRMAN: Is your division actually looking at this issue of alcohol restrictions in sports advertising? You said that you cannot make a comment on that, is that because you need to have the policy first? Is the policy being reviewed at this point in time?

Supt Leekong: I believe it is a whole-of-government approach and we are one portion of that. It would be inappropriate for me to comment on a policy that is probably in draft form, yes.

The CHAIRMAN: Right. Melinda and Marcelle, do you think alcohol restrictions at sporting events would be a good measure?

Ms Misson: I am in Bryan's camp actually. I think this is about cultural change more than anything else and I really think that while alcohol is seen as not being a drug and as being acceptable that it will make things hard going.

Ms Cannon: I think when you look at what is successful in bringing about changes, it is those multilayered strategies—it cannot be just one strategy at all.

The CHAIRMAN: But I am saying, do you think it would be useful as part of a wider approach?

Ms Misson: I have not seen any statistics. Do you have any statistics; has it been done overseas?

The CHAIRMAN: I guess the only thing that we have to look at is tobacco advertising. Tobacco restrictions have been very successful. Bearing that in mind, do you think that alcohol restrictions would be successful?

Ms Misson: I have heard Professor Mike Daube speak on this sort of issue and it has always struck me as somewhat anachronistic that we have people playing sport that is funded by something like alcohol that is not actually healthful or health promoting. I really do not know. I have not seen any evidence so I really do not know how to answer that.

Mr P.B. WATSON: I have never heard of anywhere that it has been banned.

Ms Cannon: I think the only way I could sort of comment is if you look at the same sort of thing when you look at strategies that have been effective in other areas, it is that sort of thing that does work as long as it is in combination, in tandem, with other strategies.

The CHAIRMAN: I will finish in a moment, unless there is something that someone wanted to flag.
<033> R/F

[5.00 pm]

Ms Misson: Yes, we did, actually, in reading the outline of the issues that the committee is looking at—that is, education of professionals. One of the things that we notice as a service is that there is not consistent and predictable training of staff at a tertiary level in what sort of comorbid models—if, indeed, they come with any—to practice. It would be extremely helpful to know that at that tertiary education level, whether it be at university or through the various TAFE courses that often feed into a lot of community-level alcohol and mental health workers, there would be the inclusion of comorbid drug and alcohol and mental health treatment frameworks that are consistent,

predictable, evidence-based, best practice and based on a what-works framework and that we consistently knew that people coming through that system would end up with. We know, invariably, that most people in mental health are going to have heard about cognitive behavioural therapy by the time they come to us. It would be really great to know that people are going to come with that sort of a model about stage of change and motivational interviewing and then be able to develop a plan as a result of using those processes with a client.

The CHAIRMAN: Would you recommend that that type of information be included within the curriculum for all health professionals?

Ms Misson: It would be incredibly helpful because these are now the same frameworks that are transferring over to chronic health frameworks, and they work not only in mental health and alcohol issues, but also with other health issues. If we knew that people were coming through the education process in preparation for these jobs with these frameworks, it would mean that we had a good baseline to start with and then we could just teach them how to put those into practice effectively in a specialist area.

Ms L.L. BAKER: Even just having unity in language would be helpful.

Ms Cannon: We looked at undergraduate programs from the chronic disease self-management model, and they do not actually deliver that skill. They deliver how to be an expert and how to tell people what to do, and we know that does not work.

Ms L.L. BAKER: Good suggestion!

Mr Taylor: Can I put a counterpoint to that? I agree with the sentiments behind it. We are a little bit de-credentialised, I think. I am a little avoidant of that because we would miss out on some very passionate and some very good people doing low-level, very basic and fundamental work, which I think is the strength of our work. As clinicians, we are up the ladder and there are a hierarchy of skill sets and those sorts of things, but I think there is always a place for people without credentials, certainly in our service. It is very difficult and they are often hard to manage, and it is great when they have both—a bit of experience and compassion, as well as the skill set. But we would not not employ someone simply because they did not have a degree of formal education around what they are doing. I know they are not saying that.

The CHAIRMAN: People within your area can be taught motivational interviewing skills and about the stages of change and how to use those in helping people to break the pattern of bad behaviours. I think Melinda and Marcelle want to give everyone that baseline, and you could easily give that baseline to people who were coming in to help you in a voluntary capacity.

Mr Taylor: I think with that baseline you can get that information out to families, peers and young people so that they start understanding concepts around the stages of change and those sorts of things. You can talk to them responsibly and share with them. That is where the power comes from. We are with them for an hour, maybe two hours, a week, and their friends and family are with them for 50, 60 or 100 hours a week—whatever it is—and if they have a good sense about it, they can move that along. We find we have good people who can operate compassionately.

The CHAIRMAN: Dene, the people on either side of you are talking about targeting people when they are ready to change their behaviour rather than spending a lot of time with someone who is not ready to change their behaviour and maybe at that point giving them information but trying to find the right point to begin a program to have an effect and help someone change their behaviour.

Ms Misson: It is also about the effective use of resources, because if you know at what stage of change a person is at, you can make sure, number one, that you are giving them the right information and the right resources; and, number two, that you are not pushing them off by trying to force them into a process that is likely to be unhelpful unless they are motivated to undertake it.

The CHAIRMAN: Dene, would you like to make a closing statement? I have given everyone else the opportunity, but I have not give you an opportunity for that final say.

Supt Leekong: The only point I want to close on relates to a classic example for us. When we have a young juvenile of maybe 16 who is street drinking or binge drinking, or whatever, we might give him a liquor caution, if we do not want to use a liquor infringement because of his age and his ability to pay it. If we had found him with cannabis, he would have been diverted through our drug system. However, we do not have any way of diverting youth with alcohol. It is at that point, when we come in contact with juveniles, that we need to be able to move them somewhere. The other point that we come into contact with them is in the lockup. They get asked a series of questions before they go into the cells, obviously to evaluate the risk. One of the questions we ask is whether they are under the influence of alcohol or drugs. I have dip-tested Albany and no-one presented with a "yes" to that question; however, in other areas the response has been as high as 90 per cent. At that point it would be good to have access to DCP or someone to take that juvenile and talk with him. When they are released, they go back to the environment from which they came, so it would be good at that point to co-work with someone to put them somewhere. It has been done a bit in the remote communities—Warburton and those areas—but probably not in Albany or anywhere else. That is something I alluded to in my submission.

The CHAIRMAN: Thank you for that. Having included that in your submission, and particularly having Melissa, Marcelle and Bryan here, I hope they will take up on your recommendation in this area and they will make sure that an application is made to try to get some additional support for this area. As you say, it could be very useful not just here, but throughout regional and metropolitan WA. Thank you for that.

Supt Leekong: Definitely.

Mr Taylor: Can I raise something here? I am not sure if the committee is aware, but there was a program down here with the police some years back. The juvenile action group co-located a civilian youth worker with a police officer, which is exactly the sort of stuff that Dene is talking about—a diversion thing where they could choose to talk to the copper or the youth worker. It was hugely effective and it was an award-winning program. I thought that was a wonderful initiative. It was very difficult to co-locate a civilian in a police establishment and those sorts of things, but they overcame the issues down here and that was a very effective program.

I would quickly like to add a point about school drug education. I do not know if the committee is familiar with Professor Ballard's "Principles for Drug Education in Schools". Professor Ballard has written 12 principles of drug education in schools, and one of the challenges is embedding drug education in schools.

The CHAIRMAN: You might like to send the committee a copy of that, because I have not come across it.

Mr Taylor: Certainly. If I can use the correlation with the Dr YES program—youth education sessions—which does not seem to be consistent with the principles of best practice in drug education, that is the sort of thing we are up against. It is very hard for us to get into schools because we need to be compliant, but there does not seem to be much consistency around that.

The CHAIRMAN: Thank you very much 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 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 by these corrections and the sense of your evidence cannot be altered. Should you wish to provide additional information or elaborate on particular points, in addition to the points we have asked for additional information on, please include a supplementary submission for the committee's consideration when you return your corrected transcript.

Once again, thank you very much for coming along today.

Hearing concluded at 5.08 pm