PALMERSTON
ASSOCIATION INC
ABN 38 789 840 948

7th August, 2009

Dr Janet Woollard MLA
Member for Alfred Cove
Chairperson
Education and Health Standing Committee
Parliament House
PERTH WA 6000

Dear Janet

Inquiry into the Adequacy and Appropriateness of Prevention and Treatment Services for Alcohol and Illicit Drug Problems in WA:

Congratulations to you and your Committee on resolving to inquire into the adequacy and appropriateness of alcohol and illicit drug treatment services.

As the Chief Executive Officer of Palmerston Association and on behalf of the Board of the Organisation, I believe there needs to be an increased effort to provide a continuum of services and programs designed to meet the diversity of people with AOD problems. There also needs a robust and realistic government policy framework in which funding decisions are made.

WANADA, the AOD peak body, has prepared an extensive submission which has the support of its member organisations, of which Palmerston is one. WANADA's submission provides a comprehensive statistical overview of substance use in Western Australia and more than adequately addresses the terms of reference.

Since its inception almost 30 years ago, Palmerston Association has been leading the development of service delivery and shaping innovative responses to the challenges of AOD issues. It aims to remain so and has prepared the attached submission to assist the Committee in its deliberations.

Palmerston's submission is based on the views and observations of the managers of our service units. It also refers your Committee to the vexed policy question of pill testing in the current debate.

Furthermore, the submission incorporates some observations from our Comorbidity Improved Services initiative.

The Improved Services Initiative is one of a suite of programs funded by COAG under the National Mental Health Action Plan 2006 – 2011. The aim of this initiative is to build the capacity of non-government drug and alcohol treatment organisations to better identify and effectively treat people with co morbid drug and alcohol problems and mental illness, through a range of service improvement activities.

Palmerston Association strongly believes that any efforts to improve outcomes must take into account the co-occurrence of mental health and substance use problems.

I look forward to the deliberations of your Inquiry.

Yours sincerely

Sheila McHale
Chief Executive Officer
Palmerston Association Inc

ORGANISATIONAL INFORMATION - PALMERSTON ASSOCIATION

Background

Helping people whose lives are affected by drugs and alcohol.

Palmerston was established in 1980 as a research and rehabilitation service for illicit drug users. However in responding to changing community needs, we now service all forms of alcohol and substance abuse. The agency operates in the community and at its special purpose Therapeutic Community rehabilitation facility at Palmerston Farm in Wellard. Palmerston Association is one of the largest specialist non-government providers of alcohol and substance use education and counselling in Western Australia, operating from nine offices in Western Australia, including the South Metro Community Drug Service, Great Southern Community Drug Service Team (providing services in Albany, Katanning, Denmark, Mt Barker, Walpole and other outlying towns), Palmerston Perth and Palmerston Farm.

Organisational Objectives

Palmerston Association is a not for profit organisation involved in providing treatment and advocacy and community based services for individuals, families and members of the wider community dealing with addiction, primarily alcohol, illicit and licit drug abuse.

Core Services

The **Therapeutic Community** is a central initiative and offers a residential rehabilitation program for people over the age of 18 wishing to control their substance abuse issues.

All farm residents work each weekday morning with the aim of achieving a sustainable recovery from drug dependency:

The farm program is typically three months duration and aims to;

- self esteem
- develop work skills
- develop social skills and the ability to work productively in a social/team environment
- optimise health and reduce or eliminate chronic morbidity and improve general mood and well being.
- learn or develop appropriate skills for living and working in society
- improve specific issues like anger management, anxiety. impulse control
- improve attitudes to parenting, family work and recreation
- gain an increased enjoyment of the opportunities that life offers

All non residential branches offer the following core services:

- early intervention supporting individuals, families and the community to minimise drug use.
- counselling and group work for people experiencing alcohol or other drug problems
- provide family support for those experiencing difficulties with a family member's drug use.
- run groups specifically designed for women, men, young people, parents or families.
- provide education and training for other service providers, client groups, and the general community about preventing, avoiding or intervening in drug issues.
- provide support and consultation to local communities and organisations such as, community groups, other service providers and private enterprise.
- provide outreach counselling for youth affected by drug use.
- provide parenting skills for young mothers with drug problems

Transitional Housing:

The Farm also provides three beds for residents who have completed the basic program and who are judged likely to benefit from ongoing involvement in the Therapeutic Community. These residents provide mentoring to newer clients in the Community. The program seeks to engage these long stay residents in developing skills to permit employment and/or allows them to pursue further training off site. Residents will generally remain in the transitional program for six months or longer and some have gained admission to university course after completing this phase of their rehabilitation.

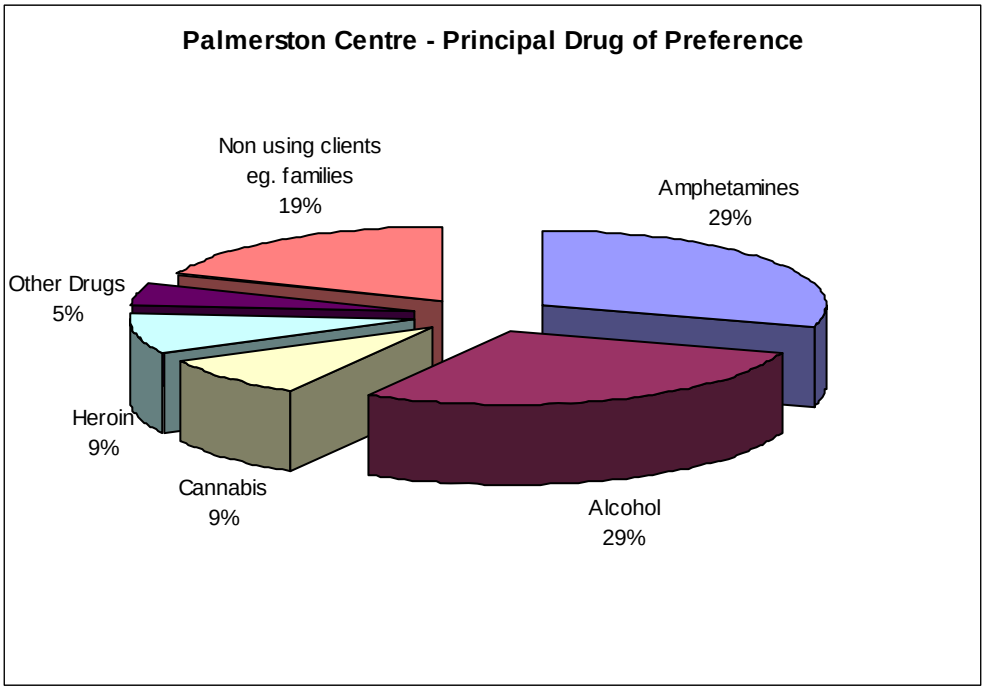
Profile of Clients and Principal Drug of Preference by Service Unit (2007-08)

Palmerston Perth (previously Palmerston Centre):

In the financial year ending June 2008 the Centre saw a total of 821 clients, an increase of 2% over the previous year and total contacts increased by 4% to 4,214.

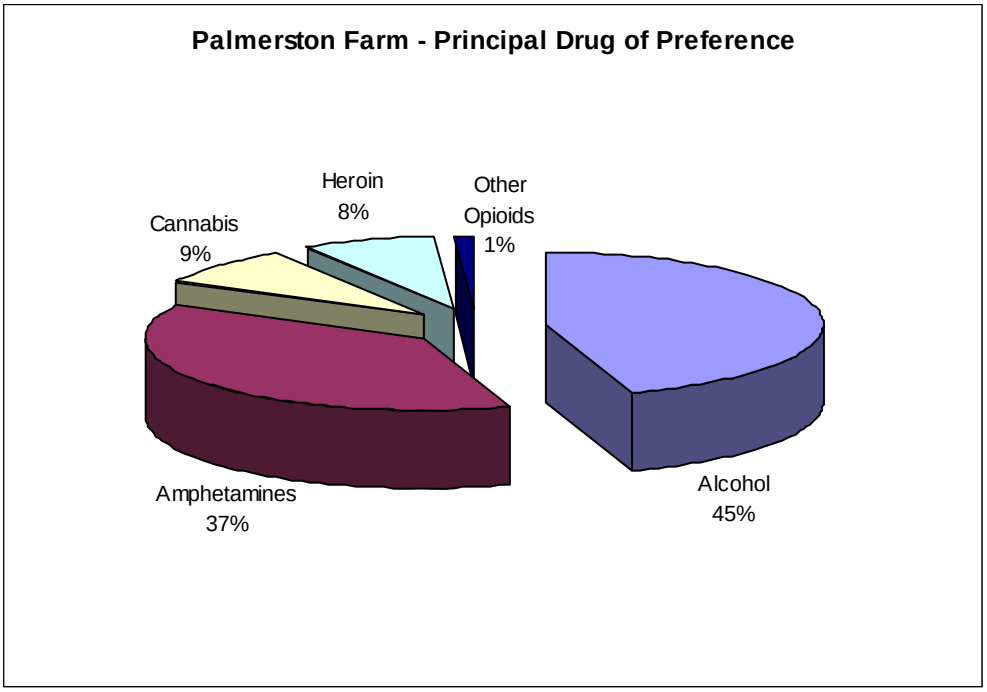
The principal drugs of presentation comprise amphetamines (29%), and alcohol (29%), Families and significant others accounted for 19% of people receiving treatment and reflects the Centre's increased focus on providing support to families of clients with drug problems.

37% of clients are in the 25 – 34 year age range and as such are largely people at the beginning of their drug taking existence where there is a realistic goal of achieving long term recovery before chronic health or mental problems have become irreversibly established.


Palmerston Centre - Principal Drug of Preference
Non using clients eg. families 19%
Amphetamines 29%
Other Drugs 5%
Heroin 9%
Cannabis 9%
Alcohol 29%

Palmerston Farm:

During the year, 91 people participated in the Farm Program. This is an increase of 17 from the previous year and is a consequence of significantly expanding residential capacity by a major capital works program which created 19 new male beds, a new kitchen dining hall and amenity space. Occupancy rate averaged 80% with the average length of stay being 77 days. Alcohol was identified by 45% of residents as their main drug of concern. This was closely followed by amphetamines (37%). Cannabis was identified by 9% and Heroin by 8% were other drugs of concern. For 1% drug problems related to such issues as diversion of prescription medication and other illicit drugs not fitting into previous categories).
64% of residents were male.



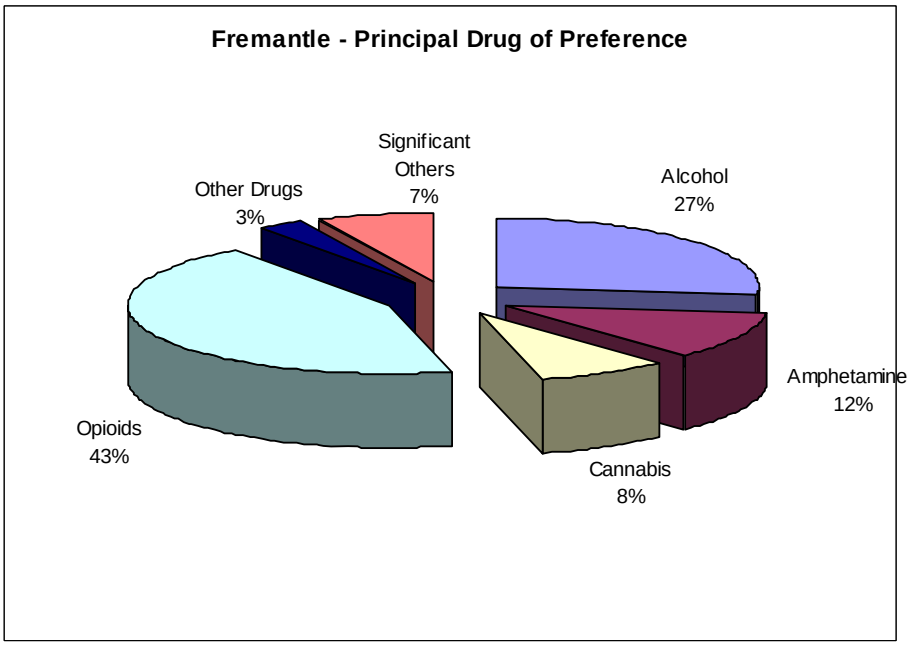
The Farm attemps to monitor long term outcomes and collects followup data on clients. Figures indicate that 30% of clients achieve long term abstinence and another 30% achieve reduced drug use and improved social functioning.

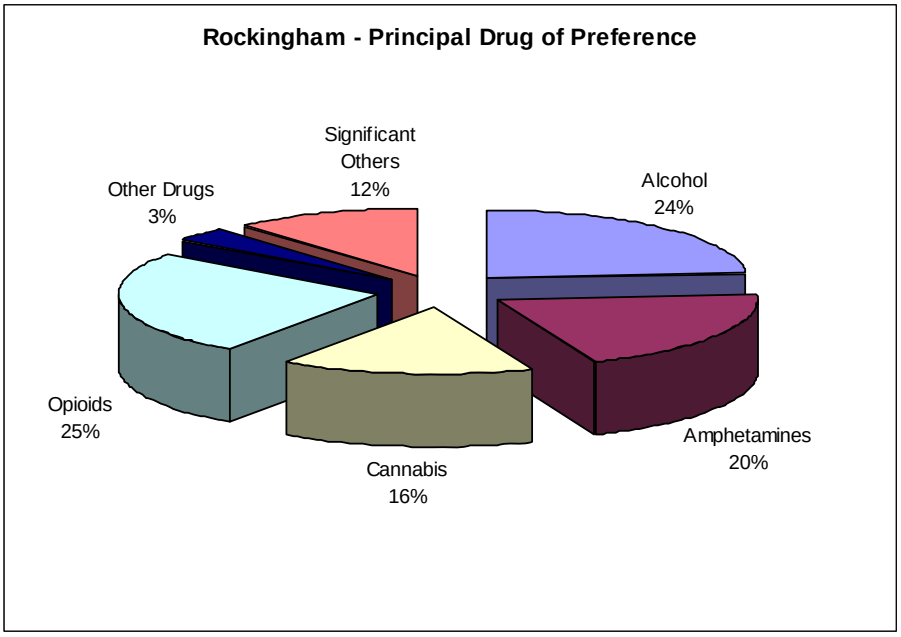
South Metro Community Drug Service:

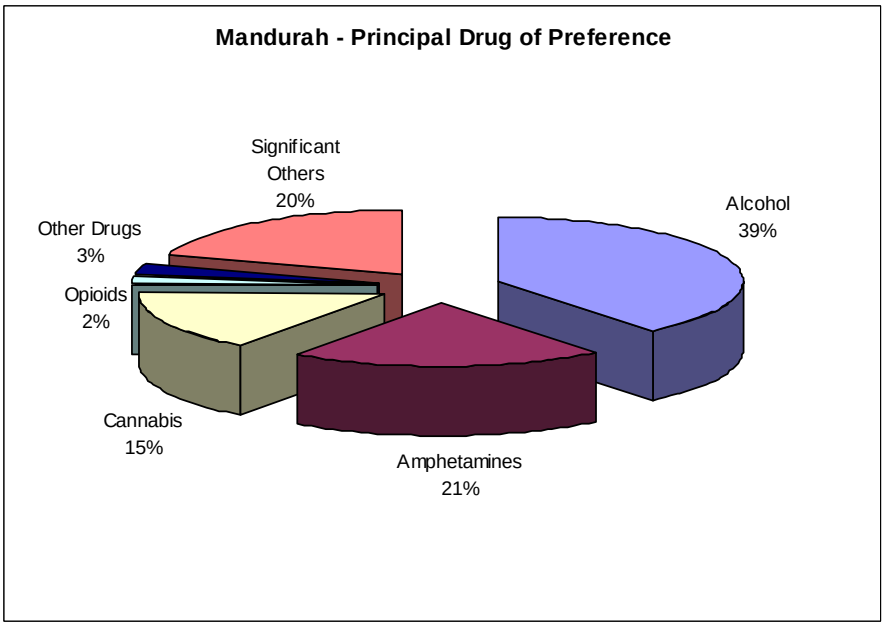
In Fremantle, 1186 clients were seen with 9711 occasions of service. The major illicit drugs of choice for clients were opioids (43%), alcohol (27%), amphetamines (12%) and cannabis (8%). The higher level of opiod abuse is a consequence of operating a methadone program in conjunction with Next Step at both Fremantle and Rockingham.

In Rockingham, 618 clients were seen with 4208 occasions of service. The major illicit drugs of choice for clients were opioids (25%), alcohol (24%), amphetamines (20%) and cannabis (16%).

In Mandurah, 574 clients were seen with 2015 occasions of service. The major drugs of choice for clients were alcohol (39%), amphetamines (21%) and cannabis (15%).


Fremantle - Principal Drug of Preference
Significant Others 7%
Other Drugs 3%
Alcohol 27%
Amphetamine 12%
Opioids 43%
Cannabis 8%

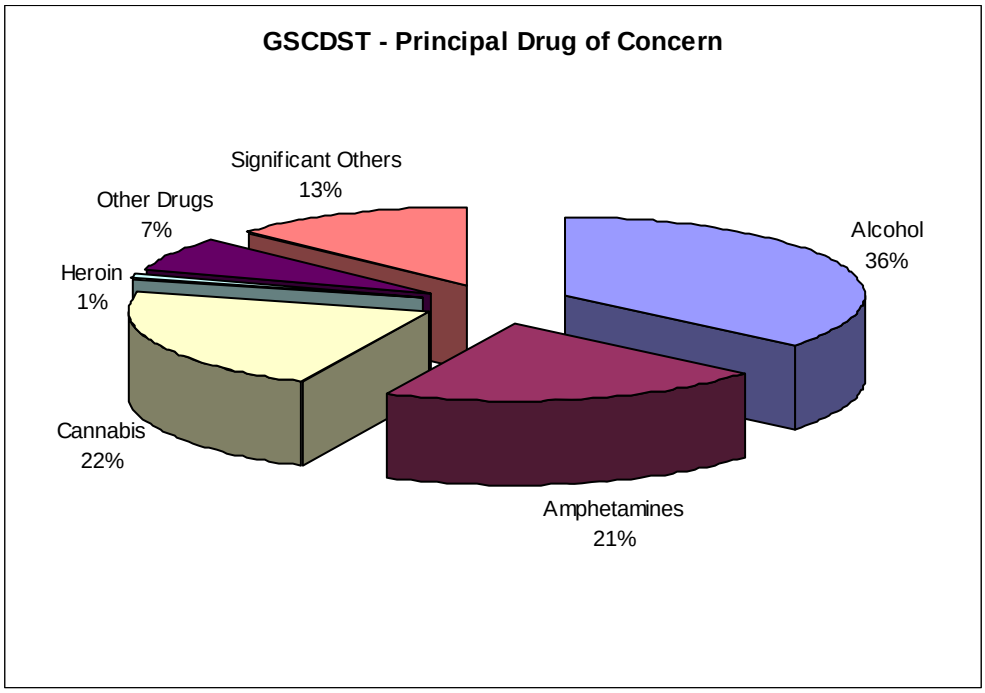

Rockingham - Principal Drug of Preference
Significant Others 12%
Other Drugs 3%
Alcohol 24%
Opioids 25%
Amphetamines 20%
Cannabis 16%


Mandurah - Principal Drug of Preference
Significant Others 20%
Other Drugs 3%
Alcohol 39%
Opioids 2%
Cannabis 15%
Amphetamines 21%

Great Southern Community Drug Service Team (GSCDST)

There were 644 clients registered in the year, an increase of 5% on the previous year, and a total of 6,669 contacts, an increase of 20%. It is of interest that while females make up 40% of registered clients, 55% of contacts were with female clients.

The principal reporting drugs were alcohol 36%, cannabis 22% and amphetamines 21%. Alcohol was the principal reporting drug for 41% of males but only 26% of females. Conversely, amphetamines were the drug of choice for 32% of females and 24% of males. The service continues to have a large Aboriginal client base making up 30% of our clients. In the past year 40% of clients completed their program, up from 28% last year.



Parliamentary Inquiry into the Adequacy and Appropriateness of Prevention and Treatment Services for Alcohol and Illicit Drug Problems in WA.

(A) SOCIAL AND OTHER DETERMINANTS OF DRUG USE

There are many complex reasons why individuals substance abuse. From Palmerston's experience, some of the common themes presented by our clients include:

- Post traumatic stress response or co-existing psychiatric disorders are the most common pre-disposing circumstances,
- Normal risk taking behaviour particularly in young people
- Social right of passage issues for certain groups or gatherings.
- Cultural celebrations to mark important occasions, etc
- Boredom
- Low Self esteem
- Flawed coping strategy to deal with issues such as abandonment, abuse (physical, verbal, sexual), grief and loss, loneliness,
- Family of origin dysfunction including long term multigenerational welfare dependency
- Lifestyle choices
- Personality identification (Above the law, an outsider, etc).

Effective prevention and treatment of comorbid mental health and substance use disorders requires a greater understanding of the causes and potential risk factors for its co-occurrence (Teeson, Degenhardt, Proudfoot, Hall, & Lynskey, 2005). Mueser, Drake, and Wallach (1998) propose that any perspective of co-morbidity should form part of a 'multiple risk factors' model, which would take account of common factors relating to socio-cultural, socio-economic, and skills deficits.

Therefore, adopting a 'multiple risks factors' model, it makes sense that service provision within the AOD sector be multi-faceted and take into account a multi-factorial approach around 'social and other determinants of drug use' and hence the alleviation of drug use problems.

The commitment to this reality will require the development of suitable facilities and organisational structures cable of delivering both drug intervention and psychiatric services from a common platform.

(B) EFFECTIVE PREVENTION STRATEGIES

NGO AOD Services are typically funded to provide direct clinical services to clients with little funding allocated to prevention work (at least through primary funding sources). This needs to be remedied, and should include community education and development work.

According to the Alcohol and Other Drugs Council of Australia, Co morbidity Policy Paper (2008) prevention aims to interrupt the development of the full picture of co-morbidity disorders and to prevent complications, for example of liver disease and neurological damage.

It went on to say that the prevention of co-morbidity and the provision of treatment and rehabilitation are major challenges for health and human service systems. This should be a high priority for government and for non-government agencies.

These statements are strongly supported by Palmerston, however we would note that a strong evidence base as to what strategies will work is yet to be established and many preventative programs are offered with little evidence of their long term efficacy and with little effort to ensure longitudinal follow up to evaluate outcomes over decade or longer periods of time .

Other important prevention strategies that Palmerston is involved with include:

- Local drug action groups (LDAGS).
- Regarding drug education in schools, Palmerston has been advised by DAO that schools receive funding to provide drug education in-house. Some schools do this well, others not at all. We would strongly advise a more flexible approach that would allow us to present programs in school environments when so requested and that this not be processed as a criticism of existing drug programs delivered by the education department.
- Community development aims to educate the public to help manage issues associated with drug use. This includes presentations to organisations (in the work place) around the impact of substance use on the individual.

The Great Southern Community Drug Service Team (GSCDST) role is to support DAO in their public campaigns such as Rethink Drink. It is our view that integrating prevention work with treatment delivery is more appropriate and cost effective when delivered as part of the activities of CDST. This is particularly the case in relation to both drug related harm and alcohol misuse and binge consumption by young adolescents particularly the emerging trends for young girls to consume excessive amounts of high alcohol drinks.

(C) THE ROLE OF LEGISLATION AND LAW ENFORCEMENT

As indicated through such programs as pre-sentencing opportunity (POP), Cannabis cautioning, Supervised Treatment Intervention Regimes and Drug Court it is clear that there is a place for legislation, law enforcement and drug and alcohol services to work closely and collaboratively in order to address the 'multiple risk factors' around the use of illicit substances. Policies addressing drug supply and demand need to be reinforced

Palmerston believes it is important to view drug use as both a health and behavioural/social issue.

The WA Diversion Programs are running very successfully in Albany. Client numbers are increasing every year and have been since its inception in 2005. A State wide evaluation undertaken in 2007 reported reduced recidivism rates, reduced drug use and an improvement in mental and physical health. Unfortunately increased funding as yet has not been made available to the Great Southern CDST and we are currently working way beyond our capacity to service the needs of the client and the Court. Diversion is a program that is working well but to be fully effective needs adequate resources to deal with court client that have been diverted. If this program is not funded adequately or supported properly, it will fail to achieve its full potential. The following data illustrates the increase in demand.

Great Southern CDST – Increase in Diversion Clients:

Over the last three years, the number of clients referred to the Great Southern office of Palmerston Association for court diversion counselling has increased significantly:

January – June 2006	25
July- December 2008	52
January – June 2009	68

Clearly the demand has more than doubled over the three years due to the growing interest and the success of the programs and support of the current Albany based Magistrate who is also committed to the Diversion Program.

Consequent to this increase the number of contacts per client has dropped to manage the increased throughput. The office has seen a dramatic decrease in the ratio of contacts per client:

July – December 2008 the average was 7.5 per person;
January – June 2009 the average is 5 per client.

Given that the more time spent with a client the better the therapeutic outcome if the current trend continues the pressure on staff resources will increase and the positive therapeutic outcomes (success of the program) will be jeopardised.

The Cannabis Infringement Scheme has also worked successfully in diverting offenders from the criminal justice system despite limited application by the Police. There is a growing view worldwide that a total prohibition policy framework has failed to prevent drug abuse and schemes like the Cannabis Infringement Scheme are better suited to optimal community outcomes providing they are properly resourced to succeed.

(D) MENTAL, PHYSICAL, FAMILY AND ECONOMIC CONSEQUENCES OF DRUG USE

Just as there are complex reasons why people use illicit drugs, so too are the consequences of drug use complex and wide ranging including:

- People often self medicate such conditions as depression, anxiety and impulsiveness and anger issues
- Personality disorders including severe psychiatric disorders such as bi-polar disorders and schizophrenia are seen particularly with cannabis use in young people although a direct cause and effect relationship has not yet been established beyond any doubt.
- **Physical consequences such as** liver damage, brain (cognitive) impairment, needle use leading to blood borne virus infection and vein damage even limb gangrene can occur.
- Physical harm due to behaviour, (swimming while intoxicated, violent traffic accidents
- **Family**: impact on children: physical and emotional, Domestic Violence, family breakdown, financial distress and homelessness.
- **Economic:** Hospital care resulting from use, drugs in the work place: lost work hours. Long term care of permanently incapacitated.

Palmerston's Great Southern Community Drug Service Team commits significant resources to supporting families who are affected by and who play a significant part in the client's rehabilitation. The role and effort of these families is often unacknowledged and unsupported, particularly in co-morbid presentations. More could be done on a systemic level to improve outcomes.

Palmerston Albany has employed two nurses to help to deal with and treat the physical consequences of drug use. We have recently undertaken a program that aimed to increase the capacity of the Agency to deal with Co-Morbid clients. This was a difficult project to undertake with not enough direction or information gathered in terms of what really works for clients. The relationship with Mental Health staff is problematic and needs re-conceptualising in terms of GP's being the gatekeepers for referrals rather than Drug staff being able to refer directly.

More work needs to be undertaken to improve the interface between mental health services and AOD industry. The work of the Improved Services Initiative Consortium is an important project in this regard and needs ongoing support.

(E) THE ROLES OF INDIVIDUALS, FAMILIES AND COMMUNITY GROUPS

Family members are significantly and adversely affected by drug and alcohol abuse within their families. These adverse effects include:

- family disharmony
- family violence
- parental conflict
- parental separation and loss
- inconsistent and ambivalent parenting

Many of the children in these families subsequently demonstrate negative effects of these experiences compared with children who have not been exposed to such trauma. These problems include:

- higher levels of behavioural disturbance
- anti-social behaviour (conduct disorder)
- emotional difficulties
- school problems
- 'precocious maturity'
- and a more difficult transition from childhood through adolescence

Throw into the above mix a mental illness as well and those negative outcomes for individuals and families increase enormously.

Family members can be highly instrumental in getting resistant substance users into treatment. If family members are involved in treatment, both the family members and the users tend to have better outcomes. If we develop services for family members in their own right, these are often very effective and family members show improved physical and psychological symptoms and better coping skills with more social support then being available.

As Miller & Wilbourne (2002) concluded in their major review: *'Attention to the person's social context and support system is prominent among several of the most supported approaches'* (p. 276).

"Recent literature and reports from alcohol and other drug (AOD) workers, indicate that people with comorbidity (co-occurring disorders/dual diagnosis) are perceived to be time consuming, difficult to manage and to adhere poorly to treatment regimens, (reference to NADA/MHCC material IWW), highly mobile (homelessness is common), lacking in social supports, emotionally labile and at high risk of more severe psychiatric symptoms. They are believed to relapse more often and to be readmitted to emergency departments and hospitals more frequently than either mental health or drug and alcohol problems alone. (Sitharthan et al: 1999)

There is a body of literature describing the optimal configuration of mental health and drug and alcohol services with carer and consumer input (Cupitt et al: 1999) and there is research to show the cost-effectiveness of treating the disorders concurrently. (Bradley and Toohey:1999).

We consider it is absolutely imperative that funds need to be invested in prevention, primary health care, treatment, rehabilitation and recovery for co-occurring disorders. In addition there needs to be significant structural reform to remove long standing structural impediments in managing co-morbidity: specifically

1. low prioritisation of mental health, drug and alcohol services and of programs to integrate these services,
2. lack of knowledge, skills and confidence in front-line workers to manage people with co-occurring disorders; and
3. the administrative complexity of servicing the problems by disparate groups of skilled workers often operating in stand alone facilities.

(F) EARLY INTERVENTION

Given the complex and multi-factored natured of co morbidity the literature is clear and universal about the importance of early detection of this condition in people who present to AOD services.

Routine screening for co-occurring disorders needs to occur at the initial point-of-contact, in both AOD (for MH disorders) and MH (for AOD use) sectors and services/agencies.

Each service/agency should have a preferred suite of tools for the detection of co-occurring disorders, and policies.

Each sector and service/agency should be familiar with and supportive of its opposite sector's screening tools.

Early collaboration and joint assessment and shared cross sector work is crucial in ensuring that this client group does not continue to 'fall in the gaps between services' or experience what the literature refers to as the 'ping pong' effect. National and state level attention has been drawn to the issue of co morbidity with significant investment in such national projects as the Co morbidity Improved Services Initiative. This level of commitment at the very least should be continued.

We believe that primary prevention and school drug education are effective to a point. The application of school-based drug education could be enhanced if our organisation was able to gain entry to schools when requested by school personnel. Clients presenting to our services are those for whom prevention 'hasn't worked'. They are most often acutely aware of the harms associated with drug use.

(G) FORMAL AND INFORMAL TREATMENT PROGRAMS, INCLUDING ISSUES OF ACCESS, COST-EFFECTIVENESS, AND POSITIVE AND UNINTENDED OUTCOMES OF SUCH PROGRAMS

Drake, O'Neal, and Wallach (2008) reviewed 45 controlled studies of psychosocial interventions for people with co-morbidity/dual diagnosis:

Three types of interventions (group counselling, contingency management, and residential dual diagnosis treatment) showed consistent positive effects on substance use disorder.

The other reviewed interventions (individual counselling, family intervention, case management, intensive community rehabilitation, and legal/mandated intervention) had significant impacts on other areas of concern (thus case management enhanced community tenure, and legal/mandated interventions increased treatment participation and effectiveness.

Successful treatment in this setting is premised on evidence-based practices of *inclusion*, *responsiveness* (early and personal, difficult in remote settings), *'non-judgementally' and tolerance* (to facilitate the healing process), *outreach* (essential and often difficult) and pragmatism. Punitive responses to so called 'non-compliance' is most often unhelpful.

We also recognise that it is unhelpful to differentiate between psycho-active drugs. Alcohol, illicit drugs, *prescription* and 'diverted' prescription are identified as 'drugs of concern' in this client group. (side effects and problems arising from prescribed drug-use are often the most difficult to address due to their pre-eminence in the dominant medical model. 'Pathologising' of substance-use is unhelpful.

Effective models of practice include community reinforcement, psycho-social counselling, mindfulness and holistic health.

An example of a good treatment model is the YAP program.

The YAP program provides practical support as well as evidence based clinical interventions for a multi-generational, predominantly aboriginal client group in a friendly and accessible manner. The program is able to work with multiple issues either within the agency or through a shared care model with other services, including Strong Families program.

Our target group are parents with AOD problems, their children and other family members in Katanning, Mt. Barker and Albany. The client group, in addition to their AOD problems, may also experience domestic violence, poverty and mental health conditions, as well as child welfare issues. The client group is typically reluctant and/or unable to access assistance before accessing our program.

The program objectives are to reduce the prevalence of harmful alcohol and drug use, and address gaps in services for the client group through case management (counselling,

medical treatment and welfare referrals as appropriate and follow up support to a client group).

The primary methods are outreach counselling with home visits supported by a weekly playgroup. The program provides a wide variety of care such as advocacy, counselling, parenting support, education and information, with blood borne virus testing and treatment when appropriate. The playgroup gives parents an opportunity to interact with each other, develop parenting and home making skills in a non threatening environment, learn craft activities and see the nurse or counsellor. The children engage in active play, help with the cooking and have fun.

Since July 2004, 140 adults and 53 children have been registered to the program. There have been a total of 5000 individual and group contacts in this period. 80% of our clients are Aboriginal.

(H) OUTSTANDING NEEDS AND GAPS IN SERVICES AND HOW TO RESPOND TO THEM

The literature clearly indicates the necessity for consistent, sustainable and excellent cross sector/ cross agency collaboration when working with this co-morbid client group. Such collaborations should exist in the general course of business in the AOD sector in any case but should be even more enhanced when working with this client group. Our observations include the following.

- Relationships with cross-sector 'opposite' services/agencies are inconsistent at-best (and non-existent at-worst), which is where the Improved Services Initiative has attempted to intervene (via capacity building and cross-sectoral linkages/partnerships between sectors) but limited by its finite contract period (3 years) and lack of top-level (or executive level) authority:

- Strategies to improve cross-sector collaboration would include: regular formal and informal contacts between workers, cross-agency protocols (such as in Local Service Agreements, or LSA's), enhanced referral mechanisms, reciprocal worker placements, routinely providing services from the opposite agency, reciprocal training, and mechanisms for AOD workers to access authorized MH practitioners.

- Inconsistent levels and standards of education and/or training, both across and between agencies and clinicians, in matters of capability in managing/treating co-occurring disorders:

- Minimum standards of drug agency and clinician co-occurring disorders capability need to be developed and agreed to for both MH & AOD service systems with mutual respect for each others' contribution.

- Development and/or endorsement and promotion of tools for agencies and clinicians to self-evaluate their co-occurring disorders capability (e.g. Annual assessment via the DDxCAT).

- Some inconsistencies in the delivery of treatment for co-occurring disorders, even when treatment modalities and/or manuals are promoted and 'roll-outs' attempted (e.g. PsyCheck):

- Development and 'roll-out' of practical, clinician-oriented co morbidity specific treatment manuals, which are designed and aligned to our local systems and workforces. Such manuals should cover fundamental and ideal/best practices around detection/screening, assessment, treatment, shared-care/case management, referral, and follow-up protocols.

- Support and endorsement of aligned policy directions (i.e. policy development in consultation with state dual diagnosis planning group).

- Support reciprocal training initiatives from both AOD and MH workforce development to ensure mutual respect and non-competitive interactions in the interest of optimal outcomes for the client group.

Our metropolitan services are currently experiencing long wait lists. This is a worrying trend with potential significant consequences for clients.

Support for prisoners with AOD issues:

The lack of effective prison programs is a significant state-wide issue, particularly in the great southern region when inmates from the Albany prison return to the local community. Improved community health could be greatly enhanced with effective programs that engage inmates and their families prior to and beyond their release from prison.

Relationships with local Councils could be strengthened and improved through the appointment of a community development officer with an increased focus on community welfare needs.

Other pressure points include:

- Increased funding for the diversion program.
- More funding to service the great southern region effectively.
- Long term intervention as opposed to short term responses.
- More education around police referrals into cannabis education sessions.
- Less metro-centric approaches to funding and training.
- Increased funding for programs such as YAP which are proving successful.
- Better and more vigorous evaluation of programs which may not be working so well combined with a willingness to terminate programs that are not delivering value for resources invested.
- Low NGO remuneration levels create difficulties in attracting and keeping staff.
- Increase training for staff to meet the needs of complex clients, including the cost of training is not funded and creates difficulties in releasing staff in the face of long waitlists
- Increased community expectations of agencies to achieve better outcomes:
- Increasing administrative costs related to the need to provide frequent reports to a variety of funders increases costs and reduces clinical outputs. .
- Requirement to negotiate contracts or MOU's: leading to increased referrals, and longer waitlists.
- Agencies operating above capacity creating problems with space for clinical service delivery.
- An urgent need to respond to the needs of homeless clients.

- Adequate resources to provide out reach programs where clinical efficiencies are greatest.

(I) ACTIVITIES UNDERTAKEN IN OTHER JURISDICTIONS THAT MIGHT HELP IMPROVE THE COST EFFECTIVENESS OF ALCOHOL AND DRUG SERVICES IN WA.

We do not wish to address this point.

(J) LOCAL, STATE, AND FEDERAL GOVERNMENT RESOURCE ALLOCATION

We consider it appropriate to appoint dual diagnosis specific officers (or at-least assigning partial JDF role/remits) to delegated workers as key contact workers in both the AOD and MH sectors. The allocation should ensure ongoing funding for co- morbidity project offices with the WA GP networks.

These 'delegated' workers could:

- Implement QI activities, evaluating and developing service delivery ,
- Serve as the resource person providing additional capacity for other workers in the agency.
- Provide directly, or link other workers to dual diagnosis-oriented training/workforce development opportunities and/or clinical supervision.

Currently there is little or no funding from Local Government directed at these goals and State funding has remained static for a number of years with the percentage of total funding coming from federal sources increasing every year. Changes to tied funding programs may lead to state funding being diminished if programs are considered politically unnecessary

(K) CONSIDERATIONS FOR FUTURE GOVERNMENT INVESTMENT

Collaborative and 'action' oriented strategic planning process, involving (both Government and NGO) AOD and MH planning and funding bodies, that focuses on the following:

- Implementing a broad spread of strategies towards actionable and sustained system change.
- Continuous review and addressing of systemic barriers to change.
- Effecting change to service delivery as an incremental process, which will require sustained commitment from leadership, as well as 'buy-in' from all of the stakeholders whose input is necessary to achieve systems change.
- Ongoing research/investigation into the prevalence of co-occurring disorders, and identification of best practice responses.
- Responding to population increases, particularly in the southern corridor.
- Improving access to services in regional areas including the Kimberley and other mining and resource rich regions in the east and north of the state.

- Responding to changing drug trends in a timely manner.
- Increasing support for programs in the Justice system.

Other Funding Issues:

We receive funding from many different sources. The management of these funds is becoming very resource intense with various compliance reporting requirements.

The West Australian Government (through DAO) provide core funding for the organisation and services and these funds need to be acquitted against the service, but there is no consideration of the ancillary and necessary resource requirements such as the corporate and resource teams which underpin service delivery.

Even though an administration component of the funding is allocated for this purpose within our Organisation's financial statement, it is not officially recognised by our major stakeholders as a funding component. Examples include:

With respect to the Integrated Service (SMCDS), handling of client files has dramatically changed to meet the needs of the integrated service but Palmerston has not received an increase in funding to meet the needs of the service in relation to the increased administrative workload.

Palmerston Farm. We received initial funding of $224,000 to allocate 6 beds for aboriginal clients at the Farm. However, the association financial costs to the organisation to recruit Aboriginal Workers, provide the required support for these workers and the infrastructure required to meet the special cultural needs of Aboriginal clients has not been considered. Even though we receive small grants to deliver specific projects, without their combined funding it would be impossible to deliver the project on the grant alone.

We receive approx $120,000 to run the YAP program, however without the support of other funders, this program could not operate ie. payment of wages, rent, resources and other associated expenses far exceed the notional funds for the YAP program.

COMPLYING WITH QUALITY STANDARDS AND LEGISLATION:

A funding body expects Quality Standards and Best Practice to be adhered to. However, funding is not allocated to assist in the resources required do this.

There are several acts that we are required to comply with including:

- Occupational Health and Safety Act
- Carers Act
- Food Act

The resources needed to meet legislative requirements are costly to any organisation and specific funding is not provided. Therefore it puts additional pressure on organisations in their efforts to comply with the various acts.

For the effective delivery of treatment services the infrastructure, finances and resources required to effectively manage an organisation to deliver the services and comply with contractual requirements, need to be acknowledged and a business component built into funding agreements.

CONCLUSION

I. Diversion programs will not work if adequate resources (funds) are not available for treatment programs of diverted clients

II. Treatment in prisons can reduce recidivism - this needs prison policy makers to recognise the cost benefits to them of this process

III. Co-morbidy is common in our client base - management needs to develop suitable multidisciplinary facilities to provide treatment and prevent ping-pong clients

IV. Homelessness is a major but still hidden issue for our clients

V. Quality assurance and other regulatory demands impose significant and rising costs on agencies and lead to reductions in 'clinical outputs' for all agencies - this needs to be recognised and no one is saying programs need not be accountable.

VI. The salary differentials between the Public and Not for Profit sectors needs to be addressed, along with the perceived differences in accountability measures (the NFP sector is subject to rigorous accountability which should be replicated in the Public Sector.

On Site Ecstasy Pill Testing

Recently the Board of Palmerston Association considered the complex and controversial subject of Ecstasy pill testing as an important harm minimization initiative.

The Board decided that the issues involved were complex including issues relating to legal and legislative matters that were beyond the capacity of an organisation like Palmerston to determine it therefore resolved that it would not be a service it would offer in its own right but it should bring that to the notice of the Parliamentary Inquiry for its deliberation as a potentially important harm reduction strategy. The Board requests that the Parliamentary Inquiry Standing Committee explore whether there has been any new research which may advance the debate on the efficacy of drug testing.

In its deliberations, the Standing Committee may wish to note that the Australian Council on Drug Strategy and the Intergovernmental Committee on Drugs have previously rejected pill testing as an appropriate harm minimisation practice.

There are broadly three methods of testing to draw conclusions about the content of ecstasy pills:

1. Analytical laboratory based testing using referenced methodologies. (with established accuracy of results).
2. Pill identification – using surrogate measures such as weighing, measuring, noting branding and colouring of pills and comparing them with previously analysed pills with known content (not a highly reliable methodology).
3. Point of Care pill testing – using testing kits supplied at venues which rely on fluid reagents that change colour in response to the presence of certain chemicals especially toxic chemicals that may be present as adulterants (there are well documented problems associated with the use of testing kits of this sort including price, reliability and valild interpretation of results.

To be useful testing really needs to be available in real time suggesting that option three is the only practical option in a community setting

In its research, the Committee may come to the view that this is a complex issue with significant legal and ethical ramifications, some of the legal issues being:

- Legal liability of tester for the results (especially if wrong)
- Implications of being in possession of an illicit drug for the purposes of testing
- Whether possession of kit is an offence
- The role of the Police in tolerating the use of kits
- Who would provide the testing kits and personnel
- How would results be promulgated to potential drug users

Nevertheless any measures that <u>may</u> reduce the existing levels of harm associated with the use of ecstasy warrant consideration.

References: On site Ecstasy pill testing – a consideration of the issues from a policing perspective; Roger Nicholas, Australian Centre for Policing Research September 2006.