EDUCATION AND HEALTH STANDING COMMITTEE

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

WRITTEN SUBMISSION

EXECUTIVE SUMMARY

The Western Australian Network for Alcohol and other Drugs (WANADA) is the peak body for the alcohol and other drug sector in Western Australia, offering advocacy and support to 90 member agencies, including metropolitan, regional, remote and indigenous organisations.

Sections (a) and (c) of the terms of reference are specific, whilst section (b) is broad, potentially covering a diverse range of issues. Given the format of the terms of reference and the short time-frame in which to complete the submission, WANADA has focused on addressing the major issues faced by the alcohol and other drug sector in Western Australia.

However, many important and pressing issues have been omitted from WANADA's submission as they are specific to particular alcohol and other drug services. WANADA has encouraged alcohol and other drug services to develop their own submission that are specific to their own organisation.

WANADA encourages the Education and Health Standing Committee to contact WANADA to discuss these issues further.

WA Parliament Education & Health Standing Committee Submission

"(1) To inquire into the adequacy and appropriateness of prevention and treatment services for alcohol and illicit drug problems in Western Australia, with particular reference to:

(a) the evidence base, content, implementation and resourcing (including teacher training) for health education and other interventions on alcohol and illicit drugs for school-aged students;

i. Alcohol and drug misuse in school-aged students – key statistics

- Fifty-eight percent of Western Australian school students aged 12 to 17 years in 2005 had never used an illegal drug (Miller & Lang, 2007);
- During 2005, 88% of Western Australian school students aged 12 to 17 years had consumed alcohol at some time in their life, 44% in the last month and 29% in the last week (Lang et al. 2007);
- In Western Australia, from 2002 to 2005, there was an increase in the proportion of 12 to 17 year olds who drank 'at risk' levels and this may be related to the significant increase in the 'at risk' drinking of 12 to 15 year old females (Lang, et al. 2007);
- During 2005, in Western Australia, 30% of female students who were current drinkers were classified at-risk when compared to male current drinkers (24%) (Miller & Land, 2007);
- In Western Australia, 2005 survey results reported that fewer 12 to 17 year olds had ever used cannabis (23% versus 31.5%), amphetamines (8.5% versus 13%), opiates (2% versus 3%) and inhalants (14.5% versus 18%) by comparison to 2002 (Miller & Lang, 2007);
- During 2005, 19% of Western Australian school students aged 12 to 17 years used cannabis in the last 12 months, which is higher than the national average of 14.2% (Miller & Lang, 2007);
- In Western Australia, non prescribed amphetamines were used by 5.5% of students aged 12 to 17 years in the last year, (Miller & Lang, 2007) which is the highest in Australia.

ii. Building Resilience in Young People - Issues

- By the end of secondary school, most young people will have experimented with alcohol and/or other drugs (ADCA, 2003). It is important to recognise this when implementing prevention programs;
- There are a number of 'risk' and 'protective' factors that led to substance misuse in young people. Risk factors include experiences of bullying; peer rejection; poor attachment to school; membership of a deviant peer group; inadequate behaviour management; and school failure (Meyer & Cahill, 2003). Protective factors include a sense of belonging; the presence of a pro-social peer group; required responsibility;

opportunities for success and recognition; and school norms against violence (ADCA, 2003);

- There needs to be a shift in the focus from the negative to the positive. Work towards supporting young people to be emotionally well-balanced, socially connected, and engaged in life, rather than focusing on negative outcomes such as harm related to illicit drug use;

- Previous class-room based drug education single session strategies worked at inciting fear into young people has only demonstrated limited effectiveness, and in some instances were counter-productive (ASCA, 2003). These models were not evidence base practice. Curriculum based drug education programs such as the SEDRA (Special drug education program) are more appropriate and should be complemented with increased funding for teacher training and classroom support.

iii. Parental Support – Issues

- Parents are the main influencers on a young person's life, especially between 9 -14. Therefore, resourcing and supporting parents, and families, to be positive role models and provide a supportive environment is essential in addressing issues of alcohol and drug use in young people;

- An identified risk factor that increases the risk of a young person's use of alcohol and other drugs is parenting style. Therefore, addressing issues such as attachment to family; parental harmony; parents who supervise and are involved with their children; and good inter-family communication (ADF, 2008) will decrease risks associated with young people and the use of Alcohol and Other Drugs.

- Parents and family members of children with substance use issues need support to help them deal with a range of overwhelming emotions, how to cope with the behavioural disturbances associated with substance misuse, how to manage the psychological and health implications of a young person with problematic substance use, and how to manage the financial pressures that may result because of this substance misuse;

- To effectively reduce the number of young people becoming the next generation of drug affected clients then we need to treat the parents of children that are affected to reduce the flow-on effect that this has on each generation. As part of any drug education program whether in a school setting or community, promotion and education should also include the important fact that treatment works.

iv. Harm, Demand and Supply Reduction - Issues

- There has been confusion and therefore misinterpretation about what harm minimisation actually is. Harm minimisation is an umbrella term which covers a comprehensive approach to responding to alcohol and drugs. Under the umbrella of harm minimisation is:

  Demand Reduction: This can be described as reducing the demand for drugs by people not taking drugs in the first place (prevention) or by people reducing or stopping their alcohol and drug use through treatment programs;

Supply Reduction: This is about reducing the supply of drugs and falls under the responsibility of customs, police and the justice system;

Harm Reduction: This is about reducing the harms associated with alcohol and drug use. This includes treatment and rehabilitation programs as well as syringe exchange programs.

Public Health Awareness: This includes the containment of communicable and chronic disease perpetuated by alcohol and drug use, such as containing the spread of HIV/AIDS and Hepatitis C through health promotion and programs such as syringe exchange.

- Harm minimisation, in its various forms, has a significant role to play in health education in school-aged students. As previously mentioned, initiatives that build resilience in young people will give them the skills to make informed and confident decisions about alcohol and drug use, not only for themselves but also for their friends. This is a demand reduction tool, by giving young people the confidence and self-esteem not to follow peer pressure and take alcohol and other drugs;

- However, building resilience is also a harm reduction tool. Resilience can prevent young people moving from alcohol and other drug experimentation onto alcohol and other drug use and addiction. It will also give young people the skills to help and support their friends when they undertake risky behaviour.

v. Recommendations

a) School drug education programs need to be evidence based, relevant to young people's experience and developmentally appropriate. Young people need to be provided with clarified values, skills and confidence, building in young people the ability to resist alcohol and drug use;

b) As resilience is a long-term approach, programs need to be integrated into school curriculum, including into subjects that contribute to students academic achievement;

c) Resilience programs need to be integrated throughout the 'lifetime' of a young person's schooling, from pre-primary through to upper secondary school;

d) Alcohol and other drug prevention and intervention should become part of a school key performance indicators;

e) There is a need to deliver more intervention programs specifically targeting the support needs of family members of young substance misusers. These should include counselling and developing coping strategies for family members; financial management support; and providing information on issues of overdose, withdrawal, treatment and relapse;

f) Grandparents who have assumed the parenting role need additional support structures to address the grandparent's specific needs. This is a critical area research as there has been little research done into the needs of grandparents who are carers;

g) Specifically targeted prevention and early intervention programs need to be delivered to reach young people who are 'at risk', or do not engage, or are regularly truant from the education system.

(b) the evidence base, adequacy, accessibility and appropriateness of the broad range of services for treatment and support of people with alcohol and drug problems and their families, and the most appropriate ways to ensure integrated care;

CRIMINAL JUSTICE SYSTEM AND ALCOHOL AND OTHER DRUGS

i. Incidence of Alcohol and Drug Misuse and Treatment of Offenders – Key Statistics

- In mid 2001 between 37% and 52% of offenders in Australia reported that their offending was attributable to their drug problem (Makkai & Payne, 2003);
- In relation to juvenile offenders, an Australian study indicated that the use of drugs exacerbated offending, with 35% of Indigenous and 29% of non Indigenous youths attributing their offending to their drug use (Commonwealth of Australia, 2008);
- In Australia, 71% of youths had used one type of drug (including alcohol) regularly in the six months prior to detention, and 29% more than one drug regularly (Prichard & Payne, 2003);
- During 2003-04 in Australia, it was estimated that 33% of young people in detention attributed their offending to drug and alcohol use (Prichard & Payne, 2003);
- An estimate of 91% of prisoners, in 2005, with alcohol and other drug problems do not have access to treatment and support in jail (budget submission presented by DCS and DAO 2006);
- An estimate of 50% of community based offenders/people on community orders that would benefit from alcohol and other drugs treatment and support do not currently have access (conservatively equating to 3500 people) (submission presented by DCS and DAO 2006);
- Of all women prisoners surveyed in 2003, 78% of respondents reported they had frequently used drugs and alcohol in the six months prior to their arrest (DCS, 2003);
- In 2007, 15% (the highest in the country) of East Perth detainees, who had illicitly used drugs in the past 12 months self-reported they had been turned away from treatment due to lack of places (Institute of Criminology, 2005);
- The total cost per prisoner per day in 2007 was $269 or $98,000 per year per prisoner (Productivity Commission 2009) as opposed to $98 per day from residential rehabilitation (Moore et al. 2007);
- 60% of females and 50% males in custody with and alcohol and other drug problems also have a mental health problem (Australian Government National Drug Strategy, 2008);
- Increase in prisoners has resulted in more services being delivered to involuntary clients and therefore less service delivery to voluntary clients and agencies are struggling to meet the demand of justice clients.

ii. Aboriginal Offenders and Alcohol and Other Drugs – Key Statistics

- It has been recognised that alcohol and other drug use is more than a symptom of Aboriginal incarceration, it is the principle cause (Pearson, 2007);
- Aboriginal adults are 13 times more likely to be imprisoned , however in 2007 in Western Australia, Aboriginal people were 21 times more likely to be in prison than non-Indigenous (ABS, 2007b);
- Approximately 70% to 80% of juveniles in detention in Western Australia are Aboriginal (ANCD, 2009);
- In Western Australia in 2003, between 17% and 26% of people dealt with by the courts were Aboriginal (ANCD, 2009);
- Aboriginal persons arrested by police increased from 20% in 1991 to 28.5% in 2003 (ANCD, 2009);
- Male prisoners are at increased risk of suicide and death from overdose in the period immediately following their release (Kariminia, Law et al. 2007); In WA, Aboriginal male ex-prisoners demonstrated higher mortality rates relative to non-Aboriginal male ex-prisoners (Hobbs et al, 2006);
- Female Aboriginal prisoners experience greater rates of mental health problems and substance misuse than male prisoners (Johnson 2004) and the rate of Aboriginal female incarceration increase by 343% between 1991 & 2005, despite the Royal Commission into Aboriginal Deaths in Custody recommending that 'imprisonment should be utilised only as a sanction of last resort' (Aboriginal and Torres Strait Islander Social Justice, 2005);
- 68% of Aboriginal adult police detainees tested positive to drugs and 63.8 self-reported that they had drunk alcohol within 48 hours before their arrest (Adam et al. 2007) and Aboriginal male offenders are more likely to be dependent on alcohol than non-Aboriginal male offenders (Putt et al, 2005);
- Aboriginal prisoners are twice as likely to reoffend within two years of being released (Willis, 2008);
- Aboriginal people who are incarcerated suffer from a loss of cultural identity and a disconnection from their family, which highlights the need for post-release programs focusing on reconnecting prisoners with family and community as a recidivism prevention strategy (NIDAC, 2009).

iii. Current Service Provision - Issues

- WANADA member agencies state that the workload associated with Department of Corrective Service clients is significantly higher than for clients in the general community with drug-related problems. WANADA is concerned that the Department of Corrective Service client workload is impacting on the availability of services to non-mandated clients. This must be a concern to State and Commonwealth agencies involved on funding alcohol and other drug services in Western Australia;
- Department of Corrective Services have cost shifted their responsibility for alcohol and other drug service to an already strained sector which is experiencing a reduction

in accessibility for community members due to the increase by Department of Corrective Services to provide a service to their clients. Alcohol and other drug agencies will have to reduce or cap the amount of Corrective Service clients they see. If the funding shortfall is not addressed, access to services is likely to decline further and the prospects of meeting the already significant and clearly demonstrated unmet need (see key statistics) will be negligible;

- In 2005 the Department of Corrective Services acknowledged that the service provision within the Department fell significantly short of meeting the needs of offenders with drug and alcohol issues, both in custody and in the community. Although this has changes for the better since then, there is still both insufficient access for clients and an insufficient range of services; in particular there is a paucity of Aboriginal, gender and juvenile specific services;

- Further to this, the Community Services sector is in the midst of a workforce crisis and without immediate increase in funding to services, workers will continue to leave the sector. In the past two years 253 staff left the sector (Alcohol and Other Drug, Mental Health, Women's Health and Domestic Violence), indicating better pay as the key factor for leaving and 123 workers resigned as a result of stress or burnout (Workforce in Crisis, 2008). This will add to the chronic short fall and reduce the availability of treatment and support.

- Treatment services for all offenders with alcohol and other drug problems is a crime prevention strategy as a portion of those not undergoing treatment who currently commit crimes on release, would not commit them if their alcohol and other drug problems were treated. In this regard, the cost of provided treatment services to all offenders with alcohol and other drug problems will be recouped by reduced prison numbers, policing and court costs. Additionally, there will be fewer victims of crime and more people being productive members of the community;

- Diversion programs are successful at addressing alcohol and other drug problems in offenders. However, the participation rate of Indigenous offenders is low. This is a result of numerous barriers presented to Indigenous offenders that exclude them from accessing diversion programs. These exclusions include: those who have been previously convicted of violent crime; those with alcohol related offences; those with co-existing mental illness and that an admission of guilt is a requirement.

iv. Recommendations

a) Redirect funding from the construction of new correctional facilities into treatment services, both inside and outside prison. This should include residential rehabilitation services, focusing on Aboriginal and rural and remote areas. Alternative models of incarceration should be considered that a low level drug rehabilitation community model. This is both a crime prevention and cost saving initiative, as money spent on delivering treatment services results in even greater cost savings from fewer prisoners, and lower policing and court costs;

b) Improve the transition of Aboriginal offenders back into their communities, through the provision of "throughcare" or a continuum of care, especially in remote settings (NIDAC, 2009).

c) Change the eligibility criteria for diversion programs in order to increase the participation rate for Indigenous offenders, having positive flow effects such as reduced recidivism and better social and economic outcomes (NIDAC, 2009);

d) Provide funding for and establish appropriate links between diversion programs and Aboriginal community controlled health services to address general health problems;

e) Increase the level of funding for alcohol and other drug, health and educational services for all of those on correctional services and develop Aboriginal specific programs;

f) Make life skills and rehabilitation programs, for example parenting programs, available to prisoners (Opening Doors Forum, 2009);

g) The funding model for Department of Corrective Service clients needs to be addressed so there is a fair distribution of funds to alcohol and other drug services so they can accommodate the increasing work load of Department of Corrective Service referred clients.

Section (b) cont.

QUALITY & ACCREDITATION

- In February 2005, the Western Australian Alcohol and Other Drug Sector Quality Framework Version 1 (QF) were established. This was the culmination of a number of year's discussion between the sector and the major funders on a way to entrench the concept of Continuous Quality Improvement (CQI) into the sector. The QF Peer Review process was agreed to and reporting on QF progression is now embedded in the reporting requirements of the major funders, including the Drug and Alcohol Office;

- WANADA is of the opinion that the sector, having embraced the QF, needed a QF option to get to accreditation, as accreditation is increasingly being required to by funders. This would involved developing a QF version 2, that would be more comprehensive and robust, allowing alcohol and other drug agencies to use the QF version 2 as a pathway to accreditation as opposed to adopting a non-specific accreditation model;

- WANADA has a number of concerns about alcohol and other drug agencies being required to adopt a one size fits all quality accreditation process. These include:

    - That it would not be sufficiently relevant to the specific needs of alcohol and other drug services. Many of the services are non-medical and have different requirements from more traditional health services;

    - That it would not be sufficiently relevant to the WA context, particularly the circumstances of Aboriginal, rural and remote services;

    - That it would not be flexible enough to accommodate the wide range of service types, sizes, locations and structures to be found in the WA alcohol and other drugs sector.

- **Recommendations**

    - WANADA recommends that the Western Australian government support and fund the development of the QF version 2, to become a nationally recognised quality accreditation process, as well as a Continuous Quality Improvement process for those alcohol and other drug agencies not needing to or wanting to become fully accredited;

    - WANADA recommends that the funding for the QF version 2 go beyond the initial development and be supported through subsequent years to be disseminated and implementation within the alcohol and other drug sector;

    - Adequate funding must be provided to alcohol and other drug agencies so they can engage in, and work towards gaining Quality Accreditation. The responsibility should not be on not-for-profit alcohol and other drug agencies to shoulder the on-going costs associated with meeting the quality requirements of governments.

Section (b) cont.

SERVICES CATERING FOR FAMILIES

i. Alcohol and other drugs and families – key statistics

- International household survey suggests that approximately 10 per cent of children live in households affected by parental alcohol and other drug misuse (Dawe, 2007);
- In Western Australia, the Department for Child Protection has found that of 175 cases studied in 2003, drug and alcohol use was a contributing factor in 57% of protection orders (Leek et al, 2004);
- It is estimated that 13.2% of children under 12 years of age in Australia are exposed to binge drinking by at least one adult in the household, 2.3% are exposed to at least one daily cannabis user and 0.8% exposed to a methamphetamine user who uses on at least a monthly basis (Dawe, 2007);
- Problematic drug and alcohol use can have a negative effect on family relationships, impacting on the physical and mental health of family members and placing significant financial pressure on the family unit (Frye, 2008);
- Due to the stigma associated with drug use and difficulties associated with access, families of drug users often make only limited use of social support and treatment services (Frye, 2008).

ii. Alcohol and Other Drugs and Families - Issues

- Research evidence highlights the importance of intervention that address the many aspects of family lives rather than single issues;
- The complex nature of family interaction combined with alcohol and drug misuse requires intense resource allocations placing the burden on alcohol and other drug services in regard to addition staffing and training to deliver service to families.

iii. Recommendations

- Funding needs to be provided to services so all family members who need it, can receive treatment in their own right regardless of the treatment status of the family member affect by substance misuse;
- There is no single model that can be adopted uniformly across services. Alcohol and other drug services need to be funded and supported to deliver a broad and diverse range of interventions that responded to the need of the family;
- There needs to be a broader range of treatment programs to manage parental alcohol and other drug and mental health issues;
- Treatment services need to target parents' capacity to seek and sustain support systems in their family and social networks. Parents also need support in addressing unemployment and homelessness as these increase alcohol and other drug misuse, whilst employment and stable housing reduce alcohol and other drug misuse;

- Partner violence often co-occurs with substance misuse. Treatment services need additional support to screen for the occurrence of family violence and provide services such as shelter and ‘safe houses’.

Section (b) cont

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COMORBIDITY – ALCOHOL AND OTHER DRUGS AND MENTAL HEALTH

i. Alcohol and other Drugs and Mental Health – Key Statistics

- It is estimated that between 30% and 50% of those with a mental health disorder(s) experience a substance use disorder (WADS, 2009)
- During 2007, almost one in 10 (9.9%) people aged 18 years and over reported high or very high levels of psychological distress (NDSHS, 2007);
- During 2007, Australians aged 18 and over who consumed alcohol at a high-risk level (15.3%) were twice as likely as low-risk drinkers (8.5%) to experience high or very high levels of psychological distress (NDSHS, 2007);
- In 2007, use of any illicit drug in the last month (including cannabis) was associated with high or very high levels of psychological distress for Australians aged 18 years and over (NDSHS, 2007);
- From 2001 to 2005, the proportion of people in Western Australia who had a drug and/or alcohol use problem and committed suicide increased from 31.7% to 36.1% (WA Suicide Prevention Strategy 2008-2013).

ii. Consumer and careers perspective - Issues

- Research indicates people with 'comorbidity' experience higher rates of homelessness, social isolation, infections and physical health problems, suicidal behaviour, violence, antisocial behaviour and incarceration and these issues need to be addressed through responsive community based services;
- Service access and applicability need to be augmented, particularly in rural and remote areas and for specific populations (e.g. Aboriginal, CALD and clients involved in the justice system). Increased involvement of consumers and carers in planning, development, review and evaluation of services is essential to ensure services are meeting the needs of the community in relation to comorbidity.

iv. Service Providers - Issues

- People with comorbidty are more time consuming, difficult to manage, are less likely to adhere to time regimes, are highly mobile, at greater risk of more severe psychiatric conditions and have fewer social supports. Consequently, compared to single issue non complex clients, they are less likely to be able to access treatment;
- Research indicates that treating people concurrently for alcohol and other drug and mental health issues much more cost effective (Bradley & Toohey, 1999);
- WANADA applauds the Commonwealth Government's focus on building the alcohol and other drug sector's capacity to respond to service users, their families and the community through the Improved Services Initiative. However this funding needs to go beyond 2010;

- There has been no suggested funding approach to increase service levels in response to any increased demand arising from increased public awareness of changes to comorbidity capacity;

- Expanded and quality referral pathways between alcohol and other drug and mental health government and non-government services need to be supported;

- Memorandums of Understanding (MOU's) between alcohols and other drug and mental health agencies need to be developed that work 'at ground level'. MOU's that are only implemented at high levels will not equate to improved service delivery.

v. Government Policy - Issues

- There is an inconsistency in legislation boundaries across sectors (ie. health, policing, justice, NGO accountability), often with the consumer falling through the gaps;

- There is a need for increased communication both 'top down' and 'bottom up' to ensure that initiatives are meeting the community's needs in relation to alcohol and other drug and mental health responses;

- Imperative that a 'one size fits all' approach is discouraged. Community diversity must be acknowledged for effective responses to both mental health and alcohol and drug issues.

vi. Recommendations

a) There needs to be a continued funding focus on supporting people with a lifelong mental health 'diagnosis' or low prevalence mental health diagnosis (e.g. schizophrenia). There is also a need for additional funding to support service provision for people who are not considered to have a serious mental illness, yet where there is a high prevalence (e.g. depression, anxiety etc);

b) Memorandums of Understanding and referral pathways between alcohol and other drug and mental health service provider's needs to be supported at all levels of service delivery. This includes from 'top down' to 'bottom-up';

c) The Western Australian Government should acknowledge and support the excellent work that has been achieved through the Commonwealth Government Improved Services Initiative by further supporting and expanding this project;

d) There needs to be joint alcohol and other drug and mental health funding put aside to address the increased demand on alcohol and other drug services to support and treat people with comorbidity;

e) Additional training and closer links with GP's regarding the treatment and ongoing support for people with depression and/or anxiety as these are usually the first line prescribers of antidepressants and antipsychotics but not the first point of contact for mental health or alcohol and other drugs.

(c) the adequacy of the current education and training of medical and allied health professionals in the alcohol and drug field.

REMUNERATION AND RETENTION

i. Remuneration and Retention – Key Statistics

- The percentage of Alcohol and other Drug, Family and Domestic Violence, Mental Health and Women's Health sectors workforce holding post school qualifications was 85%, which was more than double that of the total Western Australian workforce. Nearly 45% of the sector workforce posses a tertiary degree or higher qualification (Workforce in Crisis, 2007);

- On average, non-government workers get paid 30 per cent less than government workers who are doing the same or similar jobs (Workforce in Crisis, 2007);

- For the past three years, there has been a downward trend in enrolment numbers for all social work courses in Western Australia. In 2008, enrolment numbers decreased by 28% (Workforce in Crisis, 2007);

- There are declining numbers of TEE students enrolling in social work courses. This may indicate that:

  a) youth are not attracted to the Community Service Sector and/or,
  b) there is a general lack of awareness in youth about the sector and/or,
  c) students recognise that remuneration as a qualified social worker may not be sufficient to support the debt associated with study.

- There has been a gradual decline in enrolments for TAFE Community Service Worker courses in Western Australia. Regional enrolments at TAFE and University Community Service Workers (CSW) courses have fallen by an average of 7% per year since 2004. Metropolitan enrolments in Community Service Workers courses at TAFE and University have fallen by an average of 4.5% per year since 2003 (Workforce in Crisis, 2007).

ii. Accessibility of Training and Support - Issues

- There is a lack of accessibility to training and support as for Alcohol and Other Drug, Family and Domestic Violence, Mental Health and Women's Health sector workers. Alongside of the provision of training, both financial and backfill support was required to help them participate in training. Lack of support was found to be a major issue for rural, regional and remote workers in accessing training opportunities (Workforce in Crisis, 2007);

- There are problems with staff backfill in the Community Service Sector. A declining workforce has made it extremely difficult for agencies to find temporary staff to relieve workers so that they can attend training. Although agencies commonly incorporate the cost of back fill into tender applications, the reality is that there is often no-one available to undertake the work.

iii. Provision of Training and Support - Issues

- Across the Alcohol and other Drug, Family and Domestic Violence, Mental Health and Women's Health sectors in the past 12 months, 60% of survey respondents had been provided with internal training and support; 49% had received internal supervision; 50% had undertaken external training and 38% had received professional development opportunities.

    - There was feeling that Aboriginal workers are excluded from jobs by unrealistic selection criteria. People skills were perceived as more important than technical skills which could often be acquired by on the job training. Advocating for realistic career opportunities for Aborigines that provide career development would mitigate this (Opening Doors Forum, 2009);

    - There is a need for universities and other educational institutions to consult with the alcohol and other drug sector regarding any course development. This will ensure that courses are delivering training that is relevant to the alcohol and other drug sector and will practically prepare students to work in the field;

    - To apply for positions in the public service people are now required to access and lodge application packages via the internet. This disadvantages Aboriginal and remote area applicants, who have not had access to the requisite types of skills support to develop the means to do this, and frequently internet access to remote areas is unreliable.

vii. Recommendations

a) WANADA strongly recommends that medical and allied health professionals *must* have training and achieved some basic competencies or skills in working with people who use substances as part of their core training;

b) Mandatory cultural safety training at all alcohol and other drug agencies (Opening Doors Forum, 2009);

c) Funders to support models for on the job training for Indigenous workers to respond to alcohol and other drug and mental health issues (Opening Doors Forum, 2009);

d) Educational institutions need to consult with Aboriginal people and the alcohol and other drug sector when developing specific alcohol and other drug course as well as all health and health related courses;

e) A 30 per cent increase to all non-government organisations to directly support an increase in staff wages and on-costs.

d) Other Issues

(a) the evidence base, content, implementation and resourcing (including teacher training) for health education and other interventions on alcohol and illicit drugs for school-aged students

- In (a) above, WANADA strongly recommends that the inquiry expand its focus on health education and other interventions to include licit drugs as well as illicit drugs.

DRINKING CULTURE NEEDS TO BE ADDRESSED

i. Drinking Culture - Key statistics

- In Western Australia in 2007, of those aged 14 years and over, 9.8% reported drinking alcohol on a daily basis and 46.9% on a weekly basis, which is higher than the national figures of 8.1% and 41.3% respectively (AIHW, 2008);
- In Western Australia in 2007, 37.1% of those aged 14 years and over reported drinking alcohol at risky or high risk levels in the short term and 11.5% in the long term, which is above the national average of 34.6% and 10.3% respectively (AIHW, 2008)
- Between 1990/91 and 2004/05, there was an increase in per capita alcohol consumption of 34% among people aged 15 years and over in Western Australia (Xiao et al, 2008);
- Total alcohol related hospitalisation costs were estimated at $33 million in Western Australia in 2006 (Xiao et al, 2008);
- During 2005, alcohol use was associated with 11,878 hospitalisations in Western Australia (Xiao et al, 2008);
- During 2007, 10.0% of 14 to 19 year olds, 21.2% of people in their twenties and 11.9% of people in their thirties drank at risky or high risk levels in Western Australia (NDSHS, 2007);
- The estimated total social cost of alcohol use in Australia was $15.3 billion in 2004/05 (Collins & Lapsley, 2008);
- In 2007, for Australians aged 14 years and over it was estimated that there were 4.4 million victims of verbal abuse, 2.3 million 'put in fear' and 775,000 were physically abused as result of a person's alcohol use (NDSHS, 2007)

ii. Drinking Culture – Key Issues

- Alcohol is deeply entrenched in Australian society, and there are substantial economic interests in their production and distribution. However, alcohol abuse has caused substantial health and social harm to the drinker and to others;
- The World Health Organisation finds that alcohol is the third most important avoidable cause of death and disability in developed societies like Australia;

iii. Recommendations

a) Public policies should aim to reduce the harms of drinking. In some areas, Australian governments have led the world in doing so in issues such as drink driving and reduced taxes on low-alcohol beer. However, in other areas Australian governments have lagged behind.

b) Building the capacity of communities to prevent both the uptake and establishment of alcohol misuse maximise the effectiveness of more intensive intervention approaches. There are a range of options available that fit within community development approaches and modes and these might typically include:

- Liquor restrictions
- By-laws in aboriginal communities
- Youth-focused activities
- Better play areas for children
- Parenting programs
- Alcohol and drug free community events and gatherings
- Education programs about a range of AOD related issues

Section (d) cont.

ADDRESSING 'RED TAPE'

i. Move from short-term to long-term funding – Issues

- Currently, the majority of government funding is only for a 1 to 3 year period. This does not allow organisations to forward plan; allow successful project to continue; provide adequate project set-up time and does not provide staff with job security.

ii. 'One size does not fit all' - Issues

- Traditionally there has been a 'one size fits all' approach to funding non-government alcohol and other drug agencies. This has limited and often detrimental effects on efficiency and effectiveness of the alcohol and other sector. Government needs to recognise the diversity of the needs of the alcohol and other drug sector in Western Australia, specifically the geographical locations, diverse needs of the consumers, the different types of service models, the size of organisations and the discrepancy of skill sets managers/alcohol and other drug workers have between these organisations. The needs of a Sobering up Shelter in the Kimberley differ greatly to those of a large non-residential service in the Perth metro area and imposing the same reporting requirements on all agencies across the sector impacts negatively on the efficiency and effectiveness of the sector.

iii. Acknowledging the value of local and community knowledge in service delivery and design - Issues

- Stronger acknowledgement of the value of local and community knowledge in the design and delivery of services would limit the detrimental impact of one-size-fits-all approaches to the provision of government funded services within the alcohol and other drug sector in Western Australia. Specifically in the rural and remote locations, alcohol and other drug services are in the best position to design, deliver and adapt services according to client and community needs. It is essential that government recognise the importance of local knowledge and the appropriateness of service delivery in a local context. An agency delivering a service in the Kimberley has an excellent appreciation of the needs of the community it is delivering to. However, quite often, agencies are dictated to from government departments who have constructed their view of remote Australia from a distance.

iv. Services having to absorb additional cost/time/staffing requirements for funding - Issues

- In the Kimberley and Pilbara the costs of housing has increased astronomically, without commensurate means to compensate for this in funding. Government does provide housing for government employees which non-government employees cannot access;

- The low pay, high stress and heavy workloads are creating a high turnover in agencies. This produces a loss of knowledge as people leave, but also resources invested in their training and development are lost too. The recruitment process is labour intensive, diverting valuable time and resources away from more productive work dealing with clients and issues.

v. Recommendations

1) WANADA strongly recommends that funding to alcohol and other drug agencies from 1 to 3 year to 4 to 10 years;

2) WANADA recommends that funding for alcohol and other drug agencies and subsequent reporting requirements should fit the needs of the agency, not the agency fitting the needs of government funding and reporting requirements. Appropriate levels of funding for core and capital costs need to be provided to support agencies to deliver the best possible service to clients. This funding needs to recognise the tyranny of distance for rural and remote services and high cost of maintenance of buildings for residential services;

3) WANADA recommends that government needs to consult with rural and remote alcohol and other drug agencies when designing funding opportunities and developing funding outcomes and reporting requirements. WANADA recommends that funding requirements should remain 'open', to allow alcohol and other drug agencies to adapt and change to the changing needs of the communities they are operating in;

4) Currently, funding requirements do not provide alcohol and other drug agencies with the ability to adapt to the changing needs of their consumers. WANADA recommends that government funding and reporting requirements become less onerous and embrace services ability to change to the need of their services;

5) Government needs to provide additional housing in rural and remote areas that is accessible to non-government employees;

6) Government needs to adequately fund costs associated with recruitment of new employees in alcohol and other drug agencies due to high staff turn-over.

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