EDUCATION AND HEALTH STANDING COMMITTEE

AN INQUIRY INTO IMPROVING EDUCATIONAL OUTCOMES FOR WESTERN AUSTRALIANS OF ALL AGES

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
WEDNESDAY, 20 JUNE 2012

SESSION ONE

Members

Dr J.M. Woollard (Chairman)
Mr P.B. Watson (Deputy Chairman)
Dr G.G. Jacobs
Ms L.L. Baker
Mr P. Abetz

Hearing commenced at 9.38 am

GUARD, Mr NEIL
Executive Director, Drug and Alcohol Office,
7 Field Street,
Mt Lawley 6050, examined:

KIRBY, Mr GARY
Director, Prevention and Workforce Development, Drug and Alcohol Office,
7 Field Street,
Mt Lawley 6050, examined:

The CHAIR: On behalf of the Education and Health Standing Committee I would like to thank you for your interest and your appearance before us today. The purpose of this hearing is to assist the committee in gathering evidence for its inquiry into improving educational outcomes for Western Australians of all ages. At this stage I would like to introduce myself, Janet Woollard, and next to me very soon will be Peter Watson, then Graham Jacobs and Peter Abetz, and our secretariat Brian Gordon and Lucy Roberts, and from Hansard this morning we have Melissa Pilkington. The Education and Health Standing Committee is a committee of the Assembly of the Parliament of Western Australia. This hearing is a formal procedure of Parliament and therefore commands the same respect given to proceedings in the house. This is a public hearing and Hansard will be 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 to your submission and any questions we have for you today, I need to ask you: have you completed the "Details of Witness" form?

The Witnesses: Yes.

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

The Witnesses: Yes.

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

The Witnesses: Yes.

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

The Witnesses: No.

The CHAIR: Thank you very much. I know we have gone through those questions with you several times, but it is a formal requirement that we have to go through them.

Thank you very much for coming along today. You have had an opportunity to look at our terms of reference for this inquiry. Committee members were very pleased to see on Sunday the new campaign that is being launched, and we would like to congratulate you for your part in that. We think that that is just wonderful.

Mr Guard: Thank you; that was great.

The CHAIR: Would you like to maybe start with your, I guess, advice to us or recommendations to us to give us the background about where you fit in terms of our terms of reference? We then have some specific questions. If you do not discuss the Department of Health's model of care and FASD

and different things, then we will ask you questions about those, but we will give you an opportunity first, bearing in mind that you have seen our terms of reference, to give us a general overview.

Mr Guard: That is great; thank you for that opportunity, and thanks for the invitation to attend this morning in relation to your inquiry. Certainly, from having looked at the terms of reference of your inquiry, particularly in relation to the fifth term of reference, which relate to foetal alcohol syndrome prevalence, prevention, identification, funding and treatment, to improve educational, social and economic outcomes, but also I think the discussion could well be relevant in relation to the second term of reference relating to the factors influencing positive or negative childhood development from birth to year 12, so the link between the two of those. I will talk but interrupt if you want to as I go through this. I think the points you raised before about model of care and the DAO role within that, and what we are currently doing, is what I will intend to try to cover here, but interrupt on the way through if you want to do that.

Foetal alcohol spectrum disorder, or FASD, is an umbrella term and it is used to describe a range of disabilities and a continuum of effects that may arise from prenatal alcohol exposure. They include physical, cognitive, behavioural and learning disabilities with lifelong implications. FASD is not a clinical diagnosis in itself, but it represents a range of diagnoses that fall under the spectrum. These diagnoses are foetal alcohol syndrome or FAS, partial foetal alcohol syndrome or PFAS, alcohol-related neuro-developmental disorders or ARND, and alcohol-related birth defects or ARBD. FAS represents the most severe end of the diagnostic spectrum, and the intellectual impairment associated with FAS is permanent. Children with FAS and/or FASD are at increased risk of a broad range of developmental delays and disorders, growths, defects, abnormal structural development of the brain, abnormal brain function, behavioural problems and social skills deficits, hence the clear link with your term of reference 2. A pattern of drinking in which large quantities of alcohol are consumed in one sitting, commonly termed “binge drinking”, during pregnancy is certainly a risk factor for FAS and/or FASD. However, the relative risk of drinking during pregnancy or breastfeeding, compared to not drinking, has not been determined across a range of drinking levels and hence a safe or no-effect level has not been established. The latest NHMRC guidelines therefore now clearly recommend that drinking no alcohol during pregnancy is the safest option and there is no accurate information about prevalence of FASD in Western Australia or in Australia; the extent is still largely under-ascertained, but it is a whole-of-population issue, affecting Indigenous and non-Indigenous people. Broadly, the estimates vary—some of those that we have heard about—between 0.004 to 0.02 per 1 000 non-Indigenous, and 0.146 to 2.76 per 1 000 Indigenous. Fiona Stanley made the point at the launch on Sunday —

The CHAIR: Could you give us those statistics again?

Mr Guard: Where were these from?

Mr Kirby: That is from a range of different research available in Australia. The upper limits are to be found in the model of care, and it comes from a lot of research from around the place. Carol Bower was one of the first who started it, so the upper limits are the ones in Carol’s research. That is my understanding, but again, I would refer you back to the model of care. That is the data in the model of care. The 0.004 one is a lower limit that comes from some other research.

Mr Guard: The point that Fiona Stanley made on Sunday at the launch of our campaign was that this perception that it is more of an Indigenous Aboriginal issue than a non-Aboriginal issue is not the case. Given that there are significantly greater numbers in the non-Aboriginal population, when you apply these percentages to that population, the numbers of people potentially affected are significantly greater than they would be in the Aboriginal population.

What research has also found is that there is a lack of awareness of the harms associated with alcohol use in pregnancy and recent research that was used for the launch on Sunday suggests that only two out of three Australian women have heard about the potential effects of alcohol on the

foetus. The other part we know is that women believe that health professionals are the best source of information about alcohol use during pregnancy, which means they have a very key role to play. It is a concern that advice being provided is not always consistent with the NHMRC guidelines, and that some health professionals are not aware that the previous guidelines have changed to reflect the guidelines that are there today.

The CHAIR: In relation to those guidelines, when Brian and I were in Canada it was interesting to see that their alcohol guidelines now state two alcohol-free days a week, which was the standard maybe 20 years ago that patients with risk factors were being advised in relation to their alcohol, yet we have not brought that in with our guidelines.

Mr Kirby: In fact, they were the old NHMRC guidelines. These newer 2009 guidelines took a low-risk perspective, so the guideline that pertains to drinking at harmful levels that may pose the risk of harm in the long term is one that just talks about regularly drinking, so they shied away from nominating two days because of the individual variation that occurs within the population, but across the population they acknowledge that regular drinking in excess of two standard drinks per day —

Mr Guard: Which previously was higher.

Mr Kirby: Exactly. That poses an increased level of risk of harm. As you know, alcohol-caused cancers have a zero level of consumption, and they go up basically from zero consumption, whereas it is fair to say that the jury is still out on whether or not there is any cardiovascular benefit from any consumption of alcohol at all. That certainly was the evidence, but Tanya Chikritzhs of the National Drug Research Institute here has led some important international evidence that showed there were some methodological problems with all of that research, and so they do not know whether that protective effect actually exists or not.

The CHAIR: We were told that those two alcohol-free days were included particularly because of liver cirrhosis, and the opportunity to—I cannot say dry it out, but whatever the expression is—give it a rest for a couple of days. So they were in previously?

Mr Kirby: They were in previously, but they have chosen to take them away to try to encourage people to —

The CHAIR: Look at short-term harm and long-term harm.

Mr Kirby: Exactly.

Mr Guard: One of the good things is that consistency now, male and female, the same number applying to both, which is a lot easier for us to communicate now than it was before.

Mr Kirby: That was one of the important things; interestingly, after talking to the expert group, they were very mindful of the communication problems with the previous guidelines as well, so they were trying to bring together what the evidence told us with what the population can reasonably be expected to digest, and then work with, so they worked on the premise that if we simplify the thing then it is going to be much easier for the community to understand.

The CHAIR: To get the message out. Thank you.

Mr Guard: Specifically on the FASD model of care, the development of that model of care was led by the Department of Health and involved a multi-agency working group. It was published in March 2010 by the child and health network, and the model developed is for an across-government and sector approach, focusing on primary, secondary and tertiary care and prevention. It aligns with national directions, including the IGCD draft monograph, which is yet to be released as I understand it, but we are hoping it will be fairly soon, and the recommendations in that, which I also hope will be published fairly soon. It prioritises the use of prevention strategies to reduce the prevalence of FASD, recognising there is no cure to this avoidable condition.

The CHAIR: Just one moment, because you were very quick with that: the IGCD?

Mr Guard: Intergovernmental Committee on Drugs. This would have been work that commenced two or three years ago.

Mr Kirby: At least.

Mr Guard: At least two to three years ago. It developed a monograph, which has been going through the governmental processes, and I understand that it will shortly be signed off on by AHMAC and SCOH, and then it will be released.

The CHAIR: Again—AHMAC and SCOH?

Mr Guard: Australian Health Ministers' Advisory Council, which is effectively the DGs of Australian health, and the Standing Committee on Health, which will be the final ministerial council that will sign off on the release of that report, which is being presented to it.

The CHAIR: So this is for all states, not just WA?

Mr Guard: That is right. This is a piece of work that was an inter-jurisdictional piece of work, funded by the intergovernmental committee on drugs to pull together everything that was known at the time and a series of recommendations as to what the approach should be. I have certainly seen that draft and the multiple care recommendations are pretty consistent with the majority of the recommendations in the draft, but it has taken a while to get out, so hopefully it will be released fairly soon.

The CHAIR: The WA model of care has really set a precedent for the other states, then?

Mr Kirby: It goes much further. It makes some assumptions. I am aware of the recommendations in the monograph, and it is cautious around the prevention-related recommendations. The evidence is not strong and the reason it is not strong is that there is a lack of evidence. As you would have discovered, there is very little literature and very little evidence around the reasons for it. You have to be able to diagnose it first to be able to get some notion of prevalence so then you can have some basis upon which you can work out whether or not an intervention has made a difference or not. So you are caught in a catch 22 so you do not get the literature or evidence being developed until you have some notion of how widespread the problem of focus is. Until such time as you get some notion of that, you have very little idea about how much difference you have made with regard to the outcome. It is difficult. There is a lack of literature around and I believe there will be a lack of literature for a reasonable period of time. We were fairly fortunate in this state in that we have had the Telethon Institute and others engaged in the area for a while, doing a lot of research, and they were heavily involved along with a bundle of other people who are named in the model of care. That brought to the table a wealth of information that they had available to them, and there were some assumptions made, one of them being that we know that FASD is something that, once you have it, you have it for life. One of the best investments you can make is to try to prevent it in the first place. They were prepared to say, "What do we know from other related areas that we believe would make a difference and put that upfront?" There was also an acknowledgement that we are unlikely to be able to measure prevalence until we have a trained workforce that starts recognising it for what it is, so two of the important investments you need to make is prevention and then training your workforce to start recognising it and seeing it and referring people for diagnosis as you start developing that capability. The difficulty is what to do with it. Sorry; long-winded answer. To come back your question: was the model of care ahead of the game? I think the short answer is: yes, well and truly ahead of the game, but based on as good an evidence base as well as clinical experience as it could be.

[9.55 am]

Mr Guard: Just following on from what Gary said, the Drug and Alcohol Office we primarily see our role in leading the development and implementation of the primary prevention strategies. The

aim of those strategies is to reduce the incidence of FASD at a couple of levels: one, by targeting women of child-bearing age, and the second by targeting the general population through broader alcohol harm reduction strategies. "Primary prevention" in that definition includes strategies to try to change individual behaviour, community attitudes and the systems that support the current drinking culture and environment that we have in Western Australia. The model of care made five recommendations, and I will cover those for you, unless you do not need to. First —

> Provide public education and community action to support responses to alcohol-related problems

It proposed those be achieved through coordinated community action; social marketing campaigns; targeted social marketing to females of child-bearing years, including pregnant women and their partners; access to pre-conception information to women of childbearing age; school education addressing alcohol use and pregnancy; culturally appropriate and acceptable strategies; and strategies in conjunction with relevant Aboriginal organisations in the broader Aboriginal community. That was the first recommendation and it has been a key area of focus for us.

The CHAIR: Were you given additional money? I mean, the launch on Sunday was just wonderful. Was there, obviously —

Mr Guard: No, the Drug and Alcohol Office has found that within its existing budget. I will talk a bit about that in a second. But we were determined to make this happen, largely because it is a very important area for our work, but we were keen that it was not painted as an Aboriginal issue too. Last year, we had through Closing the Gap funding been able to launch our Strong Spirit Strong Future campaign, but wanted to make sure that we both address mainstream and Aboriginal populations, so we were very, very keen to make that happen.

The second recommendation in the model of care is —

> Prevent harmful alcohol consumption through responsible supply and service of alcohol

That is proposed to be achieved through enforcing laws, responsible alcohol service and enforcement of liquor licensing laws; managing outlet density; managing outlet trading hours to prevent and reduce harmful drinking; taxation of alcohol on a volumetric basis and applying effective tax differentials; progressively eliminating alcohol advertising and price discounting; health warnings on alcohol labels, including warning about drinking during pregnancy; developing and implementing local alcohol management plans in communities; and managing access and supply of alcohol in unlicensed settings. So, a series of actions were proposed under that recommendation and a number of those —

The CHAIR: In relation to that recommendation, the Minister for Racing and Gaming said in Parliament, probably about six weeks ago, that he would review the Liquor Control Act. Have you been approached yet to be involved in that review?

Mr Guard: No, but I am aware of it. I am certainly aware of it and representatives from the Department of Racing, Gaming and Liquor advised us of what the minister has said as well. So, we are certainly getting our thinking together about how we will pull together, from the Drug and Alcohol Office perspective, what we believe those changes should be.

The third recommendation in the model of care is —

> Reduce harmful alcohol consumption by youth by addressing risk factors and promoting protective factors and resilience

Some of the channels there are around school organisation and behaviour management, health promotion in schools, and managing access to alcohol by young people in private settings and encouraging adult supervision. So, three specific strategies there.

The fourth recommendation in the model of care is —

> Promote healthy behaviour practices and pre-conception care for females of child bearing years including promotion of abstinence from alcohol prior to pregnancy

Proposed initiatives include establishing protocols for health professionals to advise females of child-bearing years about the risks, routinely screening all women of child-bearing age, increasing use of brief interventions to address high-risk alcohol use and referral to drug and alcohol services as appropriate there.

Finally, the fifth recommendation is "Reduce unplanned pregnancy". Proposed initiatives include promoting the use of brief interventions by health professionals which promote consistent use of contraception in women of child-bearing age, particularly women with harmful patterns of drinking and alcohol dependence; developing strategies to promote the use of contraception and to improve the consistency of contraceptive use, including contraception prior to discharge from hospital postnatally; educating and enlisting men as partners in family planning—we also tried in the campaign at the weekend to get that message out as well around the support that would be useful for women trying to abstain during pregnancy; developing strategies to promote communication between partners about the use of contraception; implementing evidence-based primary and secondary school drug and sex education; and increasing the availability of relevant culturally appropriate courses, such as Nuts and Bolts, Core of Life and Mooditj.

So there are five key recommendations and a number of sub-strategies, and we are picking up a number of those as we go through.

The CHAIR: In relation to recommendation 5, one of the things that was put to us when we went on our trip to the north west by Aboriginal women was that there needed to be almost—maybe the committee members can help me with what it was called. But they suggested almost like a respite centre in some of the towns, so that if someone was living in an environment where alcohol was a big problem —

Mr P.B. WATSON: It was like a hostel.

The CHAIR: Like a hostel or something in the town where if someone is pregnant, they are living in an area where alcohol abuse, stay away—was the expression you used "stay away"? This was put to us by some Aboriginal women. There is nowhere there.

Mr Guard: Nowhere to escape.

The CHAIR: There is nowhere for them to go during their pregnancy where they are in that safe environment. We were told that there is nothing currently there. Have you —

Mr Guard: I have not heard of anything currently there along that line either.

The CHAIR: Is that something that maybe you could take into consideration in terms of the work that you are doing in this area? Because possibly there needs to be some funding for a "stay away" place. In the metropolitan area we have respite centres for women who are the victims of —

Mr Kirby: Domestic violence?

Mr P.B. WATSON: They are all full, too.

The CHAIR: Yes, we need more.

But why not have somewhere in identified areas where if you fear that it is difficult for someone to lay off the alcohol because they live in an environment where alcohol is, you know, it is party night seven nights of the week, then should we have some kind of shelter or away place where women can go during their pregnancy to protect them?

Mr Guard: Can I take that away and think about it? It is not currently on the radar for the planning for the Drug and Alcohol Office to be doing that, but I totally support what you are saying in terms of the need for an environment that assists and encourages that to happen. We certainly would advocate for a comprehensive approach which includes design, education and a whole range of

strategies that also enable separation. If the environment is partly causing the drinking and the problem, then actually creating an environment where that is not supported and encouraged absolutely has to be part of the approach.

Mr Kirby: That was certainly something that the model of care group was acutely aware of. We cannot expect women who are pregnant to not drink at harmful levels—and in this case if you follow the NHMRC guideline, the recommendation is not all—if you are in an environment that sets you up for that. So you need a systemic approach and hence the first couple of recommendations are about setting up an environment that is about low-risk drinking and supports low-risk drinking and discourages harmful drinking. So it is not about, "Don't drink at all", because, again, the low-risk drinking guidelines make it quite clear that for other people, those who are not pregnant and are not kids, it is fine for them to drink, but to drink at low-risk levels. So we need a community out there and we need community settings out there and a policy out there that supports low-risk drinking and discourages harmful drinking. People will often ask me, "Isn't that one and the same thing?" I say, "No, they're actually quite subtly different." There's some quite clear things you can do to stop harmful drinking in the community and there are some other things you can do that will just promote low-risk drinking, and you need both.

Mr P.B. WATSON: Most of them do not realise they are pregnant and the damage is done. We went to Roebourne and we were talking to one of the ladies there and she said that when they actually explain to the mother that their child will be disadvantaged at school and everything like that, a lot of them change their ideas. But a lot of that time it is too late, because they have already had the child. I do not know what the answer is, but if we can push the message, "This will damage your child at school; this will stop your child going forward", if we angle it that way. But, as I said, if they are pregnant before they realise they are drinking too much —

Mr Guard: It is exactly why the campaign, for example, that we have launched on the weekend is targeting women of child-bearing age rather than specifically those that are pregnant. You are right, too, that we need to think of the ways to get the message across. I think it is Steve from NDRI who often talks about if you are to explain to people alcohol consumption could make a difference between a B grade and a C grade or a D grade, put it in terms that will resonate with some people, that it can make —

Mr P.B. WATSON: Or it will affect their sport, because they love sport so much.

Mr Kirby: The model of care group, again, were really clear about that; that it is about taking a future focus and it is what difference can we make now. So you cannot affect what has happened already, in terms of even alcohol consumption during the pregnancy to that date. It is really important for us to get the information across and get those environments supportive of people drinking at low-risk levels and in, this case, not at all for a pregnant woman. So it becomes really important now that they are informed and they are supported to start drinking at low-risk levels or to not drink. Similarly, this is one pregnancy, there may well be another pregnancy that will follow and another. It was really interesting that amongst a lot of the midwives and other groups that were also involved in the model of care, they were very quick to jump on the notion that this is one pregnancy, but there are often more pregnancies that follow, so if you can prevent it happening in future pregnancies, terrific. It was very clear amongst the group that it be future-focused; it starts from wherever we get the opportunity to intervene, do it from there forward. It is not about blaming somebody or shaming somebody about what has happened in the past.

Dr G.G. JACOBS: Neil and Gary, in the model of care recommendation 2 about preventing irresponsible drinking, talking about accessibility, availability, in parts of my electorate there is the issue of availability. Wine casks are being sold over the back fence at a hotel at six o'clock in the morning. When the voluntary accord of which the hoteliers are about 10, nine of them say, "We'll be part of this", there is one rogue not part of this—in fact, what we have in parts of the goldfields is this 6.00 am opening and selling takeaways. When the local member, who is me, says, "I don't

think we should sell these before 12 midday", I have been told that there will be riots in the street. It is about the 4.5-litre $9.50 Stanley blue box down at the Richardson Park, with particularly Indigenous folk, exposing all those women who, as Peter says, some of them do not even know they are pregnant. So now the minister has called for a review because the police have put in a submission to the director about takeaways. When do you get involved? Obviously Barry Sargeant will look at these submissions and other people can make submissions; in fact, I presented a petition last year from 40 Aboriginal people that said, "This is enough. It is not about prohibition, but do not sell it to the community before 12 midday and do not sell it to them after eight at night". Would you get involved in that process? What are the communications so that when Barry Sargeant goes there, do you have a role to play and how will you be engaged in that now?

[10.10 am]

Mr Guard: Within the Liquor Control Act, the executive director of public health has the ability to make submissions for interventions. One of the roles that the Drug and Alcohol Office plays is support for the Executive Director of Public Health in pulling together the information for those submissions and supporting the EDPH with those interventions. I think in your particular instance this time, for whatever reason—I do not know what that one would be—the EDPH was not part of that original submission by the police. But certainly a fair amount of the data in that report is health-related data that we have supplied to accompany that report already. But the decision on that will be with the director general of liquor licensing, who has obviously now issued the show cause notice out there and will consider whatever they get back as a result of that. That is the normal process in those particular cases. For examples like Fitzroy Crossing and Halls Creek, the Executive Director of Public Health certainly made a submission alongside police in those particular instances, and we were a strong support for the EDPH in those; similarly in other parts across the state. I am not clear why we are not on this one—not specifically in this one—but certainly the data was included, and police used that within their particular report to the director.

Dr G.G. JACOBS: So they got the data from you?

Mr Guard: They got some of the data from us. They asked for data, and we made that data available to them.

Mr Kirby: You are quite right in terms of drawing the link between harmful consumption and availability. Price is also —

Mr Guard: Availability, access, affordability, advertising are all —

Dr G.G. JACOBS: All the things we did with our committee —

Mr Guard: —factors that encourage —

Mr Kirby: And they will impact upon harmful consumption. In this case, harmful consumption, in this context, is about not drinking at all. So they are the same sorts of levers that you have available to you to effect harmful consumption. The NHMRC guidelines, I think, are a great framework to work within. If you want to reduce harmful consumption in amongst whatever the target group is—in this case, pregnant women—then it is important for us to be aware of what those levers are to reduce harmful consumption. We know availability and price are important. I think, Graham, you were just alluding to the ads we have seen in some papers for 10 litres of cask wine available for, I think it was $20, which equates to 20 cents a standard drink. You cannot buy water for that price in some places.

Mr P. ABETZ: The wine equalisation tax system really needs to be thrown out; volumetric taxing is the way to go.

Mr Kirby: Certainly the Henry tax review went to that.

Mr Guard: I have said in a number of presentations that the reality is that alcohol is available more hours of the day, more days of the week, more weeks of the year than it has ever been, and in such a

great variety of products that target every market now that we really should not be surprised that alcohol-related harms have increased.

Mr Kirby: Can I add one other thing to the question I think you were asking, Graham, about the review of the Liquor Control Act? As Neil said, we are yet to be advised as to —

Mr Guard: Formally.

Mr Kirby: — what form it is going to take, and, therefore, what contribution, and on what basis we can make that contribution to whatever form the review might take.

The CHAIR: As a separate body I would hope you would look at the act as a whole and you would go through each section of that act and you would make recommendations as to improvements for each section of that act.

Mr Guard: We will do a thorough review and we will certainly make our views known about the changes we believe should be considered as part of that review.

Mr Kirby: It just depends on what grounds the review will take place.

The CHAIR: I hope the terms of reference are going to be wide enough that the review is actually a proper review then.

Before we move back to Strong Spirit Strong Future, which we discussed with you previously—you said you would give some consideration to—comments that have come to the committee in terms of an away place or respite centre. I appreciate very much that you are both here today, but you are here today wearing your departmental hats. I appreciate it may be difficult to get back to us comments in a supplementary submission in relation to that, but we really need to discuss that with someone, if not yourself. Maybe if you are not able to give us back by way of supplementary information how it could work, maybe you are able to think about how this might work and tell us the people to talk to and provide it by way of supplementary information. I just realised that it is —

Mr Guard: Which might be the better approach. As I think you know, the Drug and Alcohol Office has that responsibility for some of the statewide planning, but we do it in conjunction with the other human services agencies. As part of the way we operate, we have a drug and alcohol strategic senior officers group that includes representatives from the 14 key human services agencies in government. I am quite happy, for example, to take what you have just spoken to us about to that group and say this is something that has been proposed through this particular process and what does the group think about it —

The CHAIR: Wonderful.

Mr Guard: — and who might take carriage of going away and thinking about what might be done in that respect, and then give you a call or provide something back to you on that.

The CHAIR: We would really appreciate that.

Mr Kirby: May I ask one question? When the women were telling you about the need for this, was it in a domestic violence context?

The CHAIR: No, this was purely in an alcohol context. This was, alcohol was at home, alcohol was in the immediate environment, and it is very difficult to cut back on alcohol when you are living with alcohol seven days and seven nights a week.

Mr Kirby: So how could they —

The CHAIR: They wanted somewhere—they called it an away place—like a respite centre, where, as soon as they knew they were pregnant, they could go and live.

Mr Kirby: So how could they get an environment that would support low-risk consumption?

The CHAIR: Yes; where could they go to and who would support them during their pregnancy so that the baby was not being harmed.

Mr Kirby: That gives us a focus for the literature that might be around that we can provide that evidence back for you.

Mr P. ABETZ: The challenge would be to keep them there and for them to stay there for the length of time. How do I put it? All people who have an alcohol problem want to be good most of the time but not all the time, so they will go there for a week or two, but then they will go back, have a binge drink, feel guilty, they will come back, and the damage is done to the child. That is my concern with that model.

Mr P.B. WATSON: We have to start somewhere.

Mr P. ABETZ: Yes. I think at the community level, if we can reduce the drinking at that level, that is probably the most effective.

Mr Guard: That is right. That is why we try to address it on the two levels—with the whole of community as well as the targeted group.

The CHAIR: No stone left unturned.

Mr Guard: The point you raised though is something that gets raised every now and again by people who have entered a treatment option for their alcohol and other drug issue. That may well have been at least partly caused by the environment they were living in beforehand, and for a number of people it is a concern to me that when they go through that treatment program they will then go back to that same environment without the change. That is partly why, even now, we are working through what we are calling a transitional housing accommodation support program as an addendum to a residential treatment program; it is to try to effect a change to that environment when somebody has completed that treatment and then gone back.

The CHAIR: I have two things I would like you think about when you are doing the review. Something else that was brought to our attention was the fact that we had legislation—I cannot think of the legislation we had—whereby if a child is assaulted there is mandatory reporting, and that is dealt with under legislation. There is nothing in any legislation that says that if someone is drinking at harmful levels someone will step in. I think Peter brought to the committee's attention some work that has been done in Norway where actually rather than someone coming and saying, "Where can I go and stay during my pregnancy to protect my baby?", I think Peter brought to the committee some work done in one of the Scandinavian countries, whereby if someone is pregnant and drinking at harmful levels they are actually taken—it is both in Scandinavian countries and in America—away from that situation to protect, I guess —

Mr P. ABETZ: Protective custody.

Mr Guard: The person is taken?

The CHAIR: They are looking at the rights of the child. I cannot remember which —

Mr P. ABETZ: They go into a secure facility where they have to remain until the child is born, and no alcohol is allowed into that facility. Basically, they put them in a secure set-up where they cannot drink. It would need a fairly major change in public perception.

Mr P.B. WATSON: Imagine doing that up north, saying, "We're going to put you in there while you're having your baby."

The CHAIR: We are not suggesting a mandated treatment centre like they may have in America, but we are asking whether there should be shelters where those people—who you have got your message over to, hopefully, with you campaign in relation to the harm from alcohol—could go. Where can they go?

We might now move on because of time; we wanted to discuss Strong Spirit Strong Future.

Mr Guard: We have talked about the model of care and the role we primarily think we are playing in relation to that. I will talk specifically now about some of the Drug and Alcohol Office initiatives, which are the ones that were mentioned to me.

In line with the mandate of the Drug and Alcohol Office, we are doing a range of FASD or alcohol in pregnancy initiatives that include social marketing and other prevention activities. We are continuing to focus on treatment and support, and on education and workforce development.

I will take the prevention pieces first. As you are aware, we have recently launched two campaigns aimed at addressing alcohol use in pregnancy. One of those is the Alcohol. Think Again alcohol in pregnancy campaign, which is the one that was launched on Sunday; the other one is Strong Spirit Strong Future, promoting healthy women and pregnancies campaign. The first of those—the alcohol in pregnancy campaign—was launched on Sunday, targeting women at child-bearing years, primarily women in the 25 to 35 age group but not exclusively in that age group. The communication key messages there are: when pregnant reducing your alcohol intake, with abstinence as the primary goal; not drinking or a reduction in intake will support the health of pregnancy and the baby; not drinking alcohol during pregnancy is the safest option; the risk for the foetus increases with an increasing amount and increasing frequency of consumption; there is risk even when a woman is not drunk; alcohol consumption is related to both short-term and long-term negative effects for the pregnancy and the foetus; and we are trying to challenge the belief, also, that a couple of drinks every now and again might be okay. The campaign includes TV advertising and a range of online strategies and resource distribution to health professionals. The spend this year for development and scheduling of that campaign was around $530 000, with $350 000 of that towards the scheduling, which will be over a six-week period, to try to maximise the exposure we get over that period. I think it will be four weeks on and two weeks off.

Mr Kirby: Two on, one off —

Mr Guard: That is that one. We hope to be able to repeat that again, building on that, in the next year.

The CHAIR: In relation to those timings, as a committee we have also noticed that prior to Easter, Christmas, Father's Day, Mother's Day, you know the two weeks prior —

Mr P.B. WATSON: Grand Final.

Mr P. ABETZ: Any excuse —

The CHAIR: Two weeks prior to those days —

Mr P.B. WATSON: The day after Australia Day.

The CHAIR: — the advertising is at a blitz.

Mr Guard: Alcohol advertising?

The CHAIR: Yes. If you have not already, could you please re-look at your times with those significant days, to make sure that your weeks off are not the week before when the market is being deluged with the —

Mr P.B. WATSON: Maybe *The Age* will not have it, because it will be all the mining stuff—Gina Rinehart!

The CHAIR: We are looking at WA!

Mr Guard: So look at the scheduling around significant events when alcohol is heavily promoted?

The CHAIR: Yes.

Mr P.B. WATSON: Then again, you could get lost in that, but if you put it on alone, it might stand out.

Mr Kirby: We are certainly conscious of just that, too, Peter, that pre-Christmas is not an optimal time to be there because there is just so much going on; people are starting to be here, there and everywhere, and so your effectiveness, in terms of your spend, is not very good at that point. I take your point about why we want to be there, but the cost effectiveness just is not there. It is not a good time to be there, and similarly just after it, into January, you will notice we are not there very much either. The reason is that most people are away, and so they are not big media consumers at that stage so it is difficult to get them. We will pick those times that we know we are going to be most cost-effective.

[10.25 am]

The CHAIR: But maybe one of your adverts, two weeks before Christmas, might be—just watch what is advertised for the next two weeks and count. You might run a competition to count how many times you see discounts here, there and everywhere. It might just be a case of being a bit more creative.

Mr Guard: You do have to be creative in what you do. Talking about what you just said then, when I was at Healthway, we ran a cinema ad about smoking when we knew the film included significant episodes of smoking. Presumably, actors had been paid to do it as part of the product placement. An ad was run at the beginning before the film that raised that with the audience—that in the film they would see a lot of smoking and, just to let you know, it has been paid for by industry. When they did the evaluation afterwards, it had so significantly raised the issue at the beginning of the film that people came out of the cinema having counted the number of times people in the film had been smoking. It is quite interesting that little tricks like that can completely change —

Mr P.B. WATSON: In the old films, everyone smoked.

Mr Guard: We can change the way people look at it by raising it. In some of our online strategies we try to tease that out as well.

The second campaign is the Strong Spirit Strong Future promoting healthy women and pregnancies. That project targets Aboriginal women, families and communities. It aims to improve awareness among Aboriginal people, families and communities in metro, regional and remote Western Australia about the harms associated with alcohol use in pregnancy to prevent the occurrence of FASD. It includes the development of culturally secure resources, community awareness campaigns and activities, and workforce development activities. The development of the whole thing is being overseen and continues to be overseen by an Aboriginal advisory group and a patron who provide cultural knowledge and wisdom, content, expertise and community linkages, which is really important. This is funded through the COAG National Partnership Agreement for Indigenous Early Childhood Development. We have received $2.23 million over four and a bit years to do that. This year we have spent on that campaign around $489 000, and we are hopeful to have at least that amount, if not a little bit more, in the next year to repeat and build on it. The media part of that campaign includes a television advertisement and three radio advertisements, featuring Mary G, and they are being aired in the metropolitan and regional areas of WA. The first phase of the campaign was launched on FASD Awareness Day in September 2011 at a cost of $190 000, and the second phase is planned for late August and September this year. To support the campaign we also offered some small grants to regional areas to enable them to localise some of the resources and engage in community-based initiatives to support it. Approximately $150 000 in 2010–11 and nearly $60 000 in 2011–12 was offered through those grants. Another part of that campaign is around culturally secure resources. Those that have been developed include a number of posters on the role of the family and community in supporting women's healthy choices in pregnancy, a community brochure and a publication targeting young Aboriginal people to address risk behaviour resulting from alcohol use.

The third component of that work is workforce development, which aims to provide health workers with skills in and knowledge of screenings, brief interventions and referral pathways. That is currently being rolled out statewide. Since January 2011, a total of 22 workforce development events have been delivered to approximately 1 000 participants, and a presentation is also planned for the Aboriginal Maternal and Child Health Conference at the end of this month. The workforce development initiatives also include the development of —

The CHAIR: Which conference was that?

Mr Guard: The Aboriginal Maternal and Child Health Conference.

The CHAIR: Which is where?

Mr Kirby: It is here. That is my understanding.

The CHAIR: Could you get some information on that? I would be very interested if we could get that.

Mr Guard: Yes, I will send that through. So, they are the parties—the development of a flip chart for health workers that will promote the NHMRC guidelines. So that is what we have been doing in the prevention space there. But the second area of the Drug and Alcohol Office involvement is in relation to treatment and support, which is another key role that the Drug and Alcohol Office plays. As you know, we fund or contract a network of treatment and support services across Western Australia. All of those attempt to engage with women and pregnant women, or women of child-bearing age. In this year we will be spending just over $50 million on treatment services generally across the state, which obviously provide access to this particular group. The five integrated drug and alcohol services in the metropolitan area allocate pregnant women a category 1 status, so that makes them the highest priority to receive services. Then there are a number of specialist services in the area that we also provide funding and support to, and those would include the WA Women and Newborn Drug and Alcohol Service, which is located at King Edward Memorial Hospital. That is a specialist service dedicated to pregnant women with drug or alcohol problems, and it encourages effective antenatal care. So we fund that or provide some support to that one. There is the Saranna program of the Cyrenian therapeutic community, which is a residential drug and alcohol service that specifically targets women with dependent children in their care, and it works on a therapeutic community model and addresses parenting issues and children's needs, along with providing drug and alcohol treatment. Then there is the PEPISU program of women's health and family service, which is a non-residential treatment service running counselling, support and outreach services for women who are pregnant and/or parenting and have problematic drug and alcohol use. Then there is a further one that I just thought I would mention, which is the Attach program, which is delivered through UnitingCare West, that provides in-home counselling for parents with drug and alcohol problems who have got children up to six years of age. In the current year, we have provided funding of around $410 000 to that service. So they are the areas that we are primarily focusing on at the Drug and Alcohol Office. We have upped our work in that area certainly over the last two to three years—linked to them as our FASD model of care work, but because we also saw this as a priority for action. Clearly, alongside that, there are a range of other FASD initiatives which we are aware are being implemented in Western Australia, and those would include organisations such as the Telethon Institute for Child Health Research. They are developing a screening diagnostic instrument for Australia, and alcohol and pregnancy and FASD resources for health professionals. You have got the National Drug Research Institute at Curtin, where they are implementing a national Indigenous FASD resource project that aims to develop templates that can be used in the production of culturally secure and appropriate resources to assist health professionals in Aboriginal and Torres Strait healthcare settings across Australia. There is the George Institute and Nindilingarri Cultural Health Services through the Lililwan project. They are addressing FASD through awareness, prevention, diagnosis and support. There is OVAHS—Ord Valley Aboriginal Health Service—in the Kimberley as well. They are implementing a variety of initiatives to try and raise

awareness and education within their local area. And the final one I was just going to mention was the South West Women's Health, which, through a small grant from FARE—the Foundation for Alcohol Research and Education—produce the localised alcohol and pregnancy television advertisement as well. There are a range of other organisations that we know are also doing work in this area.

The CHAIR: Wonderful. Thank you for that.

Mr P. ABETZ: Just a quick question: "I think they would be culturally secure." What does that mean? Are they culturally sensitive? I have not heard that term. You have used that a couple of times.

Mr Guard: It would include exactly what you said, so culturally informed by the Aboriginal community, developed in conjunction with the Aboriginal community, sensitive to the needs of that Aboriginal community and appropriate for the Aboriginal community.

Mr P. ABETZ: So it takes in all of that.

Mr Guard: Yes. Certainly, that is why with the Strong Spirit Strong Future project, we have made sure that that he has been advised by an Aboriginal advisory group to ensure that we hit the mark with it.

Dr G.G. JACOBS: Neil, in your earlier comments—I know this is difficult, and there is the problem that the work has not been done. I do not know how you do this study. This FASD is not a—you intimated that it is dose-related: the more you drink, the more severe you will have this condition in your baby; the more you drink —

Mr Guard: It is high risk.

Dr G.G. JACOBS: — the more likely you are to have a baby that has got FASD or FAS. How do we deal with that problem? We take almost the precautionary principle by saying, "Just don't drink." I have tried in other forums to try to get a handle on this, because with a lot of other things in medicine, you actually can determine a risk, and you can tell people the risk, and you can also somehow put a handle on how much drinking, how much effect, how much cause.

Mr Guard: Yes. An absolute key message in the campaign at the weekend was that there is no level of alcohol consumption that has been proven to be safe, and there is no time for alcohol consumption during pregnancy that has been proven to be safe. It would vary so significantly that it is almost impossible to predict that. So the message is that the only safe option, or the safest option, is not to drink during pregnancy. If you have not spoken to Carol already, I would suggest that Carol Bowers would be a better person to talk to about that. My naive understanding of it is that we just need more evidence across time to start getting a better understanding of this, and, for a whole range of different reasons, that body of literature just does not exist yet.

[10.35 am]

Mr P. ABETZ: And it would be very difficult to do, because who is keen to do a trial where you feed women X amount of alcohol per day and see what the impact is on their child? I mean, it would be pretty hard to get that past this committee!

Mr Kirby: Therefore, it is going to be time precious. It will only be over time that we start to really get that body of knowledge, and it will always be retrospective.

The CHAIR: I have one last quick question and then I have to sum up. You mentioned the Lililwan project and the work with the George Institute. Dr James Fitzpatrick came and gave a presentation to the committee on the work that is being done there, and the diagnostic tool and the allied health professional approach. Again, when Brian and I went to the FASD conference in Canada, we were told that there are 30 diagnostic clinics across Canada. One is being established in Sydney, and then if we can get one in WA, it would be the second. Was DAO involved with the actual diagnosis?

Where they had a speech therapist and an occupational therapist, was there someone from DAO as part of that team?

Mr Kirby: No. In Perth, the diagnostic work is bringing together a bundle of child health experts to then be able to look at the child and make an assessment in terms of where they think the problems are. So this is not an area that we are involved in.

The CHAIR: I was just wondering maybe, because of the family background, whether someone was involved to then try and give some support.

Mr Kirby: My understanding of the way that process works, again fairly naively, through the model of care group, was that you will get this group of experts that will make the assessment, and it will be multidisciplinary, and then they will pull in other people. So I would imagine that if we would be involved, that is where we would get involved. Can I just make one other point? The campaign that we launched on Sunday came out of the work of Dr Kathryn France. She did this as part of her doctoral thesis, in terms of actually getting together women of childbearing years and pregnant women and doing all the formative work—so doing the qualitative work and the quantitative work—to work up towards the concept, which we joined in at that stage, to take that concept and work with Kathryn and Professor Donovan to develop up the campaign and go forward from there. It would be remiss of us not to acknowledge Kathryn's contribution to that.

Mr Guard: That was a very significant research project.

The CHAIR: Was she not at ECU to begin with?

Mr Kirby: She is still at Edith Cowan University. She is also connected to TICHR as well—the Telethon Institute. So again you can probably make best contact with her, if you wanted to, through the Telethon Institute.

The CHAIR: We were very pleased to be able to congratulate you here today, so maybe we should send her a congratulatory card as well.

Mr Kirby: That would be terrific if you would.

The CHAIR: That is a wonderful initiative that you have taken on.

Mr Guard: And she was delighted to see it come to fruition as well, which is great.

Mr Kirby: You mentioned someone doing a doctoral thesis, and actually seeing it occur in the community is wonderful.

The CHAIR: Thank you both for your appearance before the committee today. A transcript of this hearing will be forwarded to you for correction of minor errors. Any such corrections must be made and the transcript returned within 10 days from the date of the letter attached to it. 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, please include a supplementary submission for the committee's consideration when you return your corrected transcript of evidence. We very much look forward to a response from you when you have had an opportunity to meet with—I cannot remember the name of the team.

Mr Guard: The drug and alcohol strategic senior officers group, or DASOG, as it is commonly known.

The CHAIR: Once you have had an opportunity to meet with the drug and alcohol senior project officers group, we would very much appreciate a response, if something like that could be done, as to the best way of doing that so we could maybe then make a recommendation to government as part of our report on this area.

Mr Guard: I should inform you that I will be away as of Sunday, so I will be on leave in the UK, but I am quite confident that Gary can read through the transcript and provide any feedback if necessary.

The CHAIR: Thank you very much. Thank you both.

Hearing concluded at 10.41 am