

# **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**

**TRANSCRIPT OF EVIDENCE TAKEN  
AT PERTH  
WEDNESDAY, 16 JUNE 2010**

### **SESSION TWO**

#### **Members**

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

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**Hearing commenced at 10.41 am**

**MCHALE, HON SHEILA**

**Chief Executive Officer, Palmerston Association Inc,  
examined:**

**DICKENS, MR BRAM**

**Manager, Palmerston Association Inc,  
examined:**

**The CHAIRMAN:** On behalf of the Education and Health Standing Committee, I thank you for your interest in and appearance before us today. The purpose of this hearing is to assist the committee in gathering evidence for its inquiry into the adequacy and appropriateness of prevention and treatment services for alcohol and illicit drug problems in Western Australia. You have been provided with a copy of the committee's specific terms of reference. I would like to introduce myself, Janet Woollard. Next to me on my left is Mr Peter Abetz, Mr Ian Blayney and Ms Lisa Baker. On my right we have our principal research officer Dr David Worth and Barbara and Darby from Hansard.

This committee is a committee of the Assembly. This hearing is a formal procedure of Parliament and therefore commands the same respect given to proceedings in the house. Even though the committee is not asking you to provide evidence on oath or affirmation, it is important that you understand that any deliberate misleading of the committee may be regarded as a contempt of Parliament. As this is a public hearing, Hansard is making a transcript of the proceedings for the public record. If you refer to any document or documents during your evidence, it would assist Hansard if you could provide the full title for the record. Before we proceed to the questions we have for you today, I need to ask you a series of questions. Have you completed the "Details of Witness" form?

**The Witnesses:** Yes.

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

**The Witnesses:** Yes.

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

**The Witnesses:** Yes.

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

**The Witnesses:** No.

**The CHAIRMAN:** I believe that you are going to make a PowerPoint presentation to us first. While you are making that presentation, are you happy to take interjections if members have questions, or would you rather that we waited until the very end before we asked questions?

**Ms McHale:** We are happy to do whatever the committee would like. We are happy to take questions. I have a few points that I would like to talk to, Madam Chairman, and then a very short video presentation; it is five minutes only. I am conscious of your time. We will probably need only half an hour, max.

**The CHAIRMAN:** Janet is fine. This is a friendly hearing. You are here to help us with this inquiry.

**Ms McHale:** Thank you, Janet. I thank the committee for setting up this inquiry into what we obviously think is a critical and very pervasive area of social problems in our community. I will not go over our submission; you have that. I just want to pick out a couple of key points and messages that we would like to leave with you and to help you work through them. Obviously the committee will have received hundreds of submissions and heard a lot of commentary. I will put the Palmerston Association in context. We are a drug and alcohol organisation that is celebrating its thirtieth year this year. We are one of the leading drug and alcohol organisations in Western Australia. We provide counselling services in the community and we also have a residential facility that is run broadly on therapeutic community models that is located just south of Perth. We operate in a harm minimisation context, although the “pharms” therapy, as we call them, is an abstinence-based therapeutic environment. The primary drug of concern that presents to Palmerston is alcohol. Close to about 45 per cent of our clients would say that alcohol was their primary drug of concern. It varies, but that is broadly the figure. That reflects not that Palmerston is an alcohol service provider but the pervasiveness of alcohol in our community, yet it is not the drug that gets the most public attention. We want to make the point very clearly that it is in fact alcohol that our clients predominantly present with. They are people of all ages, from young people through to older people.

The points that I want to raise with you are that currently the drug and alcohol sector is operating in a very uncertain environment. Three things highlight that. The first is the Council of Australian Governments reform. It is not clear in that debate where drug and alcohol fits. We think that it fits in primary health care but there has been very little debate. Compounded with that is Western Australia’s position at this stage. We are not sure whether it will sign the agreement. Secondly, the work of the Economic Audit Committee, which we support, adds another element of uncertainty around what parts of the human services sector will actually be contracted out, privatised or given over to the not-for-profit sector, and how that will actually play out. The third area, given the establishment of the mental health commission, is where drug and alcohol fits in the suite of service delivery. If it is going to fit within the mental health area under the mental health commission, ultimately, that is a decision for the government to make. If that is to happen, there must be a very strong focus and commitment to drug and alcohol so that it does not get lost in the more medical model of mental health. The psychosocial philosophy or context in which drug and alcohol services operate must be maintained. All of those things that are happening nationally and at a state level are quite exciting on the one hand but on the other hand they provide an uncertain environment in an environment that really needs to have some certainty.

**Mr P. ABETZ:** Is Palmerston an NGO, or is it fully government owned and funded?

**Ms McHale:** It is an independent organisation, but it is dependent on its funding from the federal and state governments. We do not do much fundraising. We do not do city to surf fun runs. Historically, we have relied on project funding and core funding from the Drug and Alcohol Office, through the Department of Health, and the federal government.

**The CHAIRMAN:** Is it 50–50?

**Ms McHale:** It varies but it is broadly around 60–40 or 55–45 federal government and state government funding, but it is only marginally more federal government funding than state government funding.

The second point that I want to make by way of introduction is to suggest that we need a major rethink of the drug strategy. I am not using the drug strategy to mean the government strategy but how we approach drugs and alcohol. We know that drug and alcohol issues pervade a range of social issues from child abuse, homelessness, employment and so on.

[10.45 am]

And yet it is still confined to the “drug problem”. So often people rely on the drug services to deal with it, so it ought not be confined to being a “drug problem” because along with that comes the associated stigma and societal condemnation about drug users. I am not talking about the criminality of drugs and suppliers; I am talking about those who are addicted or have been affected in many ways. We deal with not only the individual but also the family members.

**The CHAIRMAN:** How many family members? You talked about child abuse. How far down the family do you go?

**Ms McHale:** We deal with parents and children.

**The CHAIRMAN:** Ages?

**Ms McHale:** We have a number of programs that we will talk specifically about. In the Great Southern, through our parenting program, we deal with babies. We deal with the parents—mums predominantly—who come along with their babies, toddlers and primary school children. When Bram talks about the transformers program, we are talking about primary and early high school.

**Mr Dickens:** We work also with whole families. When we do that we bring children into the sessions wherever possible.

**The CHAIRMAN:** To date we have gathered minimal evidence in relation to children and alcohol and illicit drugs. I am particularly interested in that; it is an area that we need to get more information on, so we will be interested if you can elaborate more on that area, thank you.

**Ms McHale:** Okay. They are the broad environmental issues. We are working in an uncertain environment. There is nothing necessarily wrong with that, but we need to be aware that significant reforms have occurred since we put in a submission, almost a year ago now, that need to be understood. Our message is: let us try to work through those issues so we have clarity about where the drug and alcohol field will sit, and the imperative to see drug and alcohol in our community, not as a drug issue, but in the broader context. From there we need to design services around that and make sure other organisations such as child protection and corrective services are adequately equipped to deal with these issues within their own populations.

There are three or four specific areas I want to talk about. The first is the prison system; the second is the elderly and alcohol; and the third is children. We will finish with children and our DVD. With the prison system, I think our observations are that, first of all, the prevalence of drug and alcohol use among the prison population is high either prior to going into prison or even within prison. Therefore, there is a good population that we could be working with to deal with use and then the consequential criminal activities that come from that. Our observations are that there are insufficient supports within the prison system for people who have drug and alcohol issues.

**The CHAIRMAN:** Is that in WA or across Australia? Someone from corrective services will be giving evidence. You would obviously link with other non-government organisations in other states. Is it a similar picture or do you believe it might be worse in WA?

**Ms McHale:** I think as a broad generalisation it is probably not dissimilar. There are programs we are aware of in Queensland that perhaps we might want to have a look at. However, what we have here in WA is a high Indigenous population and, after the Northern Territory, we have the highest rate of Indigenous men and women in our prison system.

**The CHAIRMAN:** Would you by way of supplementary information be able to provide us with more information about the programs you just referred to in Queensland?

**Ms McHale:** I will commit to doing that. I have been made aware of them only in the past 48 hours or so. I cannot give the name of the program but let me try to get back to you.

**The CHAIRMAN:** We are quite happy if it takes you a bit of time to get hold of those.

**Ms McHale:** We think we could be doing a lot more. There is lost opportunity to work with a population that we know has high alcohol and drug use and dependency. From our observations it is not seen as core business of corrective services. To give an example from Albany, the Albany prison wanted to work with Palmerston to provide some counselling, but it did not have any money for us to do that and we did not have any additional staff to be able to do it. We would love to work with the Albany prison. They have identified it as a need but do not have the additional resources. We could not do it for nothing, unfortunately. We will look to find money so that we can do it. The message we want to give is that there is a population we know of, and we could be doing a lot more certainly in the post-prison time in particular. I understand the first two weeks of coming out of prison is the most vulnerable time, yet we do not have specific programs that can target that period.

**The CHAIRMAN:** It is not just Albany. When I visit the Broome prison I was told that a vast majority of the Indigenous prisoners were there because of alcohol-related offences. If you believe there is a gap for those services, by way of supplementary information, we would appreciate what you can provide as a result of your looking at that program in Queensland and at what can be done here. It does not have to be in two weeks; the committee is not planning on tabling its report until the end of November. If by the end of August you could put to the committee a submission on how you would see Palmerston working with those prisoners when they are discharged to hopefully prevent them from —

**Mr P. ABETZ:** Even in prison.

**The CHAIRMAN:** Both in prison and on discharge to try to help them. You could have a bit of extra time in putting that together. It is obviously something you are thinking about, and we are interested in it because we are looking at where there might be gaps in treatment services and how those gaps could be filled. We would be very interested.

**Ms McHale:** I will move on to the next point. This might be a bit left field but I will share my thoughts with you. It relates to alcohol and the elderly. I know we are focused on young people and alcohol, and rightly so. I want to raise with the committee an issue that has not really had much attention; that is, the increased use of alcohol in particular, and possibly even prescription medication, among the elderly. It is an area I have an interest in and awareness of, having been a former Minister for Seniors. I think it is an area that has received little attention; yet it worries me that it is a social issue that we are not actually focussing on. From my reading of material, particularly coming out of the UK, there is an emerging awareness of alcohol use among the elderly.

**The CHAIRMAN:** Alcohol use or abuse?

**Ms McHale:** Overuse. I suppose we tend to try not to use “abuse” for a range of reasons. There is different research on the effectiveness and positive outcomes of alcohol. For instance, whether a glass of red wine a day is good or bad for the cardiovascular system has been disputed significantly in recent months.

[11.00 am]

If you now look at the material that is coming out in the media, the PR material coming out of DOHA is really focusing very much on alcohol is not good for you, and it can, in fact, be carcinogenic. We are living in an environment now whereby we used to think, a couple of years ago, that a glass of red was good for us, but now we do not know whether it is good for us. With the elderly there are a number of different groups. There are those who were early onset drinkers and have survived excessive alcohol use but have now aged; they are older, but they have had a drink problem in earlier years. There are those who are more late onset drinkers who are using the alcohol to deal with trauma in their lives, whether it is the loss of a loved one—say their husband or wife has died after 30 years—and they are using it to cope with loneliness or pain. Particularly for prescribed medication there is the possibility that we might be seeing an increasing social problem

around the use of prescription medication and the elderly. The third category I have seen in the literature is about the intermittent, or the binge drinking, elderly. Really, I do not have the answers to that. We do not do any work with—well, we have, but as a core business we do not do any work with the elderly. Is that fair to say?

**Mr Dickens:** That is correct. We have been asked, on occasions, to provide education to groups of elderly people when issues such as Sheila has described have arisen, such as in a nursing home for example, where a number are drinking heavily and it is not being seen by that population as a significant problem, but it is causing problems.

**Ms McHale:** I am really flagging it not as your most top number one priority, but I think if we are taking a holistic approach, it is a great opportunity for me to put it to the committee that I think there is a social problem there that needs either further research or attention. Again, we would be very happy to work with whomever to look at that.

That then brings me to the other end of the population spectrum, which is young children. Having talked about the elderly and the importance of looking at that, this is an area that concerns me greatly and where we have done some work with children. What we are talking about here, though, are the children of users, as opposed to children as users themselves. I suppose it comes back to my earlier remarks about seeing drug and alcohol in a broader context.

There is obviously value in dealing with the users—the parents—but unless you deal with the whole family, we, again, are missing out on an opportunity to prevent the cycle of alcohol and drug use in later life amongst the children. We have been working with children on two programs that we would like to talk about. The first one is the Transformers program. That is, essentially, working with primary and early high school children of users to try to give them coping mechanisms so that they do not necessarily get into the cycle of use. I would like Bram to talk in greater detail about Transformers.

**Mr Dickens:** The Transformers program came about because we observed, over a number of years, that we were working with young adults—as in late teens, early 20s—who had very poor interpersonal skills and very low self-esteem. What we observed—these are our own observations; they have not necessarily come from an evidence base at this stage—was that they had, from a very young age, and had actually had modelled from a very young age, the use of substances to manage difficult situations. That led us to inquire along the lines of what if we were able to get to young people before they actually started using substances and provide them with a range of skills that they could use to address some of the more difficult issues they might encounter in their lives; the normal range of difficult issues, I mean. We thought along those lines because we observed that the clients we were seeing, the young adults I have described, were actually being modelled for the use of substances to address difficulties. From there we developed the Transformers program, as Sheila has described, which is a group aimed to increase two key areas: firstly, self-esteem; and, secondly, interpersonal skills or communication skills. We focused on interpersonal skills and we worked with small groups. We worked with the schools and we got very small groups of children identified as at risk of being drug users in the future because of their family backgrounds. We worked with them in small groups to teach them those skills. We looked at two age groups—really the late primary and the early high school—because we felt there was a significant difference. We did identify an evidence base that indicated that improving those two areas of self-esteem and interpersonal skills would actually be a protective factor against drug use in the future. That was funded through a state government proceeds of crime grant, and we got very good outcomes from those groups. I must say, it is a challenging area to work in because you have to work with schools and families, and the children themselves are difficult to work with.

**The CHAIRMAN:** How were they identified at the schools for you; through the school nurse?

**Mr Dickens:** The school nurse, school counsellor or pastor would identify them as a child at risk and refer them to the group. We were networking with the schools to set that up.

**The CHAIRMAN:** One of the things that the committee is interested in is meeting with some young people. What approaches did you use with those children to get them to open up? Have you done the work personally, or do you have facilitators who go into the schools for you?

**Mr Dickens:** The work was done by a council of educators skilled in group work, particularly skilled in working with young people. They would have a range of interventions they would use to teach these skills.

**Ms McHale:** They are our staff.

**Mr Dickens:** Our staff did it, yes. We developed the program ourselves and tried various methods and researched various methods for working with young people. We used a lot of art, for example; that worked really well. A lot of art therapy works very well with young people.

**Mr I.C. BLAYNEY:** In that case, the Privacy Act does not sort of interfere there, does it? You said they were identified by staff at the schools, and then I assume they are offered your program.

**Mr Dickens:** Yes, but with the permission of the parents. We have the appropriate forms developed to account for that, yes.

**The CHAIRMAN:** Is the aim of that program to help those children develop self-esteem and coping mechanisms so that when we are in a difficult situation —

**Mr Dickens:** They do not turn to drugs, yes.

**Ms McHale:** That was based on earlier exposure to, as you say, young adults. We had learnt from the users themselves that that was their almost automatic or learnt response to difficult situations.

**Mr Dickens:** Yes, that is what was modelled in the home. One of the spin-offs we found from the program was that it encouraged more families to come seeking assistance from us as a family, so that was one of the findings.

**The CHAIRMAN:** Can I ask about younger children, because I actually, during a visit to child development services, saw a child whose mother had difficulties with both alcohol and drugs. I had an opportunity to chat to her and she told me how her child is having behavioural problems and she has social problems and she is working with a social worker and a speech therapist and this therapist—several different therapists—to try to assist those children. When you come in contact with these families who have young children, is there an automatic referral to a community health nurse or child development services?

**Mr Dickens:** It is not automatic but it often occurs, if, during the assessment process, we consider that necessary.

**The CHAIRMAN:** Then who does it go to?

**Mr Dickens:** It will depend on what we observe. In the extreme cases it might go to youth mental health services. We might manage it through the GP—we try to use the GP networks as much as we can because they are very effective.

**The CHAIRMAN:** If it was a two-year-old child, who would the referral be to?

**Mr Dickens:** It would go back to the GP, I imagine.

**The CHAIRMAN:** If, again, between now and when you put in your transcript, or even at a later date, if you have an opportunity to discuss the issue of those younger children with the staff who work for Palmerston, then we would be interested in, for the different age groups, who the referrals go to. We obviously want to look again and see if there are gaps, and are the referrals going to the right places and that they are being picked up and acted on.

**Mr Dickens:** The other area I should mention is child protection. We have actually built very strong relationship with the Department for Child Protection over the past two years, so the referrals will also go there when we have concerns.

**Ms McHale:** Without being able to give you the evidence, Janet, I would say there are huge gaps.

**The CHAIRMAN:** Help us identify them, Sheila.

**Ms McHale:** The message that keeps coming back is that many of these families do not go anywhere near services—do not even come to drug services—because of the stigma. We only see a very small percentage, I would say, of users with kids. It is partly because they think the kids are going to get taken away from them, and so that is a double barrier to them coming and seeking care for themselves, and, therefore, for their families. That is just part of the complexity of working in this field. Maybe the next bit of the five-minute presentation might help you a little bit. It is anecdotal, but it really sheets home the importance of having services that work not just on the adult user, but providing a suite of services around the family. That is what we are trying to do in the Great Southern with our YAP program.

**Ms L.L. BAKER:** Is that the therapeutic communities model?

**Ms McHale:** No; our therapeutic community does not have the capacity to take parents with children—we do not have facilities for children. If somebody wants to come into our therapeutic community, they have to have arrangements for their kids or not have kids, or they are estranged from their kids or their kids are in care.

**The CHAIRMAN:** Do you have any programs specific to Indigenous people?

**Ms McHale:** We have dedicated beds for Indigenous clients at the farm, at our therapeutic community. The YAP that the DVD is about—it is five minutes long—is used predominantly by Indigenous mothers in the Great Southern. We think that this is a great program. We are having it independently evaluated by the National Drug Research Institute, so that we can confirm or otherwise what we think about this program. But it is based on principles that we need to work with the whole family, we need to support the parent in better parenting, and we also have the opportunity to observe the children of the users so that we see it as a holistic program. We also engage other support workers that we can—Aboriginal health workers and speech therapists—and we bring them into the service. But we only deal with about 30 parents on this program in Mt Barker and Katanning. We would like to replicate this program in other areas of the state.

**The CHAIRMAN:** Across the state?

**Ms McHale:** Across the state, yes. I will show you the five-minute video. We will stop after five minutes. We will stop when the police car comes, although it is a very supportive police officer. It was made by us, so it is not a professional video.

[11.15 am]

[A five-minute video was shown.]

**Ms McHale:** We bring the police in as well so that they get a positive model of the police, because most of them react very badly to the police. There were just a few messages in that five minutes that I think are really important and hopefully underpin what we have been saying about working with users and their kids. It is an exciting project. It is funded through bits and pieces that we can cobble together. We never know from one year to the next whether the funding will be there.

**The CHAIRMAN:** Why is it mainly in southern WA? Why does Palmerston mainly operate in the south?

**Ms McHale:** That is an interesting question. I suppose, in a way, that is where the money has been available. Palmerston started off, as a lot of organisations do, as a small group of people, including George Davies, who wanted to set up a residential facility for heroin users. Thirty years ago it was primarily heroin. They got together, they got money from the state government and they started the therapeutic community as a farm. As years have gone by, government policies have come and gone. Drug and alcohol funding is often subject to whether there has been a spate of heroin overdoses, particularly in middle-class families, and then the policy changes—it goes off the radar again and

something else happens and it becomes flavour of the social policy month. There has been the development of community drug teams. We ended up in Albany because funding was provided for the development of community drug teams.

**The CHAIRMAN:** Are there other agencies down south or up north that are doing similar work?

**Ms McHale:** We are the major drug and alcohol service in the Great Southern, but we have nothing north of Palmerston Street, Northbridge. That is the question I keep asking as CEO.

**The CHAIRMAN:** Are there services operating north?

**Ms McHale:** Yes, there are other services.

**The CHAIRMAN:** Such as?

**Ms McHale:** Communicare and Mission Australia. The government runs community services in Geraldton and Broome because of the difficulties of getting not-for-profit organisations to operate there. There is also Centacare and St John of God. We just have not secured funding to provide services in those other parts of the state. We have the Fremantle–Rockingham–Mandurah area and the Great Southern—we have been able to expand into Denmark, Mt Barker and Katanning. There are other towns in the Great Southern that we would like to support. I think there is a great need out in the Goldfields. I would like to see how we could use some of what we have learnt in the Great Southern in the Goldfields and elsewhere.

**The CHAIRMAN:** How many staff do you currently have and how many of your staff would be acting in the counselling capacity mode? What is the make-up of administration versus hands-on.

**Ms McHale:** We have 68 full-time equivalents. We have about 85 staff. We are lean and mean. Most of those would be counsellor educators. Maybe seven or eight would be clerical staff. By far the majority are out there working either in group work, in individual counselling or in diversion programs with the court system. We have the federal project around mental health co-morbidity, so mental health issues and drug and alcohol issues. All that funding comes to an end at the end of this year. Most of those staff would be working directly with clients.

**The CHAIRMAN:** What about the social impact, particularly of alcohol, at the moment? From your clientele and your knowledge in the area, do you think that things are getting better or worse with both the social and the economic costs resulting from —

**Ms McHale:** I would say that from our experience it is getting worse. From my experience as a former Minister for Community Development I know all too well the impact on children and about children coming into care. You can see the dramatic increase in the number of children coming into care. About 70 per cent of those were coming in primarily because of drug use and alcohol. There are domestic violence, employment and housing issues as well as all the physiological affects of alcohol on the health system.

**The CHAIRMAN:** Do you mean loss of employment and inability to get housing? Could you just clarify what you meant by employment and housing?

**Ms McHale:** People who are not able to sustain a job or keep a job down because of alcohol abuse—not turning up for work, not being able to concentrate and short-term memory loss. Then, of course, if you look at the resources industry, which has a no-use tolerance, if anybody is tested and they have alcohol or particularly cannabis in their urine, they are off the mine site and they lose their job. Children are coming into care through domestic violence or alcohol-fuelled violence and also psychotic episodes through other drug use. Bram, you might want to add to that in terms of the social and economic consequences of alcohol.

**Mr Dickens:** First, in terms of the discussion we were having earlier, from observing the statistics over the years, what I have noticed is that illicit drugs come and go depending on various factors, but alcohol is always a consistently big customer for us, so there is that to consider. That has not reduced in my time with Palmerston, which is almost 10 years. I do not have much more to add

about the social and economic costs. We see it in our family work particularly. Our philosophy is to work and engage with families, first by supporting them and secondly because it is a really effective way of addressing drug use problems. We see the impact of alcohol on families and family dynamics. The dynamics I am talking about would be with the young people. There is evidence of the intergenerational impact of alcohol. Alcohol is so acceptable and in such obvious supply—it is so easy to access. They are two of the key factors behind it. It is the breakdown of the family. I do not want to sound too dramatic, but that is what we see. We see this particular drug get into families and it can actually break up families. That is a significant problem that we see. Then there are all the compounding problems that come with that—children acting out, relationship issues with the parents, increased housing because you have to house two people, and so on. It escalates into a significant problem. It is often alcohol based. We are not always talking about people who are using illicit drugs.

**Mr P. ABETZ:** Sheila, you mentioned earlier that some funding was coming to a close at the end of the year or something like that. Government funds are often very short term. To what extent does that really hinder ongoing work in your sector? Perhaps you can comment on the sector, if you know for others, but certainly for Palmerston: to what extent is it an ongoing issue that you are never quite sure which programs can continue because funding might be cut and governments often look to fund new things rather than provide ongoing funding?

**Ms McHale:** As a CEO, that is the number one thing that gives me greatest concern. We work on the basis that funding will continue. You have to; otherwise, you may as well close. But that is an assumption rather than a fact. We have funding on a three-year basis. We have had some of our funding for 10 years and it has been evaluated for the first time; that is federal funding and not state funding. It is of great concern because we do not know whether a program will continue. As Bram said, some drugs come into fashion and affect policy, so other programs that are important may get de-funded. It always creates a certain tension, but we work on the basis that, unfortunately, the drug problem will continue. It might change characteristics, but there will always be a need. The message that I would like to leave is that it ought not to be so subject to public outrage. It ought to be seen as a social problem like any other illness or social problem and funded. It should not be so vulnerable to the flavour of the day. Is that a fair comment?

[11.30 am]

**Mr Dickens:** Yes.

**The CHAIRMAN:** If the government were to make more funding available, what new initiatives would you like to see introduced to limit the impact of alcohol consumption?

**Ms McHale:** I would focus more on families and children and the social policy that allows that to happen. If we do not work with kids as well as the users in that context, we take them away from the thing that is absolutely critically important to them and helps them in their recovery. This goes to the whole debate about child neglect and abuse and the point at which kids are taken away from their parents because of their drug use. That is a very vexed question. Drug users view their children as the most important aspect of their life or the most positive thing they have ever done in their life. Equally, we must work with the children to make sure that they are physically well. We spend a lot of time cooking and making sure people are fed. We also work on the users' parenting skills. Hopefully we can stop the next generation of users. Bram is working very much at the coalface. He might have something to add that might be something different.

**Mr Dickens:** I agree with what you said. If you look at the community drug service teams, which provide services across the state, their overall philosophy is to provide treatment and work with the community to engender a community response. We see that in the YAP program. In some of the bigger metropolitan areas, the demand for outpatient services has pushed the emphasis more on treatment and so we have shifted a little bit away from what I view as equally valuable, which is working with the community on a preventative focus. The Transformers program I described is one

example of that. If we turned our thinking that way we could come up with many more. We often discuss this in the sector. Alcohol advertising comes through—it is huge and effective. That is really what we need to address. We must educate in some effective way. I do not think that we are really achieving that because alcohol is still such a popular drug and the risks seem to be little known in the community. That is what I have observed and what my peers have fed back to me.

**The CHAIRMAN:** What have your counsellors said about the availability and access of alcohol? Is that discussed during their sessions? What impact does that have on your clients?

**Mr Dickens:** It is certainly discussed. We work with our clients to develop strategies to counter that. It is really difficult when a client turns on a television or sees a billboard because it is there. We certainly try. Ironically, it is easier to come up with strategies for illicit drugs than it is for alcohol, because alcohol is so much there in the community.

**The CHAIRMAN:** Is Palmerston involved in the Albany accord?

**Mr Dickens:** I suspect we are.

**Ms McHale:** I cannot answer that question.

**The CHAIRMAN:** Maybe you could let us know later. Because you mentioned advertising, I do not know whether you are aware of the fact that Healthway—it has done a very good job over the past 20 years in terms of helping to cut back the number of people who smoke—is now trying to decrease the prevalence of alcohol advertising. Lots of groups are very unhappy about any cutbacks in sponsorship and funding for advertising. What are your comments on that? Does alcohol advertising have a powerful effect on all ages? Let us look at sport, for instance. What do you think about advertising at sporting venues?

**Ms McHale:** We know from the evidence that relates to smoking that those strategies have worked however unpopular they were at the time. We are dealing with huge lobby groups. I think you have to look at the evidence as to what works. When you are dealing with such costs to the community, it is imperative that we look at what works. Even though we get into arguments about individual choice and rights and so on, the evidence about what works and the costs are overwhelming.

**The CHAIRMAN:** Would you support a reduction in the advertising of alcohol at sporting venues? Last week I decided to go to the movie theatre early. Normally I just go when the movie starts, but I had heard about alcohol advertising at cinemas. Cinemas attract young people.

**Ms McHale:** If we are serious we have to look at that as a response. I am conscious that a lot of sporting groups allow that sponsorship.

**The CHAIRMAN:** That is what they said about tobacco.

**Mr I.C. BLAYNEY:** There is a difference between a name on a banner at a sports oval and the effect that has on someone who has a drinking problem versus what we used to see from the tobacco companies. I do not necessarily accept that we can just pick up the research that relates to tobacco and directly transfer it to alcohol. I think they are quite different issues.

**Mr Dickens:** The biggest impact in this discussion is the impact on young people and on setting up drinking behaviour. Effort should be aimed there, because that is where we could make the best improvements.

**Mr P. ABETZ:** No level of smoking is good for a person so the message is not to smoke whereas the message with alcohol is that a little bit is not so bad. That is the subtle difference.

**Mr I.C. BLAYNEY:** If a person has a cigarette, he is the same person after he has that cigarette whereas a drinker who has beer or two becomes a different person after those couple of beers.

**Mr Dickens:** But they do both lead to chronic illness.

**The CHAIRMAN:** Given that more than 60 people work in your counselling area, we would appreciate it if you could provide us any comments about access, availability and advertising at a later date. We would like the benefit of their experience.

**Ms McHale:** I think we probably rely on people like NDRI and the National Alliance to address those issues as well. We are happy to provide a comment.

**The CHAIRMAN:** Is there anything you would like to add before I close?

**Mr Dickens:** No, I think I have said enough.

**Ms McHale:** No.

**The CHAIRMAN:** Thank you very much for your evidence before the committee today. A transcript of this hearing will be forwarded to you for the correction of minor errors. Any such corrections must be made and the transcript returned within 10 days from the date of the letter attached to the transcript. If the transcript is not returned within this period, it will be deemed to be correct. New material cannot be added by these corrections and the sense of the evidence cannot be altered. Should you wish to provide additional information or elaborate on points, please include a supplementary submission for the committee's consideration when you return your corrected transcript of evidence—or as we have discussed today at a later date, because you may have to do further research into the Queensland model and the different approaches that could be taken in WA to address those gaps. Thank you both for coming along this morning.

**Hearing concluded at 11.40 am**