
Response to:

# **WESTERN AUSTRALIAN MENTAL HEALTH, ALCOHOL AND OTHER DRUG SERVICES** PLAN 2015 – 2025

Thank you for the opportunity to respond to the Western Australian Mental Health, Alcohol and other Drugs Services Plan 2015 – 2025 (the Plan).

WANADA wishes to acknowledge the Government's commitment to the Plan being based on the principle of a 'person centred' approach; taking into consideration the whole sector; and being informed by the evidence established in the national modelling tools, including the *National Drug and Alcohol Services Planning Model.*

WANADA applauds the key values of the Plan such as neutrality of service model, funder and provider. We agree, as stated in the consultation forums, that without neutrality in this regard the Plan would be disingenuous.

WANADA wishes to acknowledge the opportunity for the alcohol and other drug service sector to be involved in the consultation forums coordinated by the Mental Health Commission and the Drug and Alcohol Office. Given the limited participation places at the combined sectors consultation forums, some services were not able to be involved in forums relevant to the services they provide or have expertise in.

The consultation specifically for the alcohol and other drug sector on 12 March 2015, was welcomed. WANADA is supportive of the majority of the comments made by participants at this consultation session, specifically repeated comments on the need to maintain the strengths already evident in the alcohol and other drug sector.

To inform this written response WANADA has sought feedback from its members, requesting feedback specifically from organisation representatives working in, and with knowledge of, the Plan's priority areas. WANADA's response focusses specifically on issues related to the alcohol and other drug service sector.

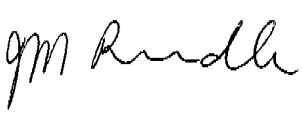
The response comments on the principles in the Plan and developments proposed under each of the priority sections, with a significant focus on systems improvement and supporting change.

In relation to providing feedback on the different priority areas, WANADA would like to highlight the difficulties of separating service delivery into categories. As an example, many community treatment services also have a mandate to coordinate local prevention, deliver harm reduction and other support services such as addressing personalised needs related to housing, employment and education. Integration across these categories is important to achieve the principles of the Plan.

To start this discussion WANADA feels it is important to highlight some significant achievements made to date in the alcohol and other drug sector.

WANADA would welcome the opportunity to meet and discuss this response further.

Yours sincerely



Jill Rundle
CEO

2 April 2015

## Significant Achievements of the Alcohol and Other Drug Sector

The Western Australian alcohol and other drug sector is seen as one of the most progressive in Australia. This is not on the basis of services funded, as there is clearly higher demand than the services are able to deliver. The kudos to the Western Australian alcohol and other drug services sector is founded on efficiency and effectiveness of innovations within systems developments and support.

Acknowledging there remains room for improvements, the significant systems development and support that has been achieved in the alcohol and other drug sector include:

- an established internationally recognised **accreditation scheme**, which has been developed in Western Australia by WANADA, implemented broadly by alcohol and other drug services in Western Australia and nationally, and has been developed and implemented with principles that encourage an evidence based practice approach based on continuous quality improvement;

- the establishment of a suite of **evidence based practice guidelines**, many of which have been brought together in Western Australia and which is drawn on nationally;

- dedicated **workforce training** to support sector induction and development of skills, as well as building the capacity of professionals across sectors in recognition that people with alcohol and other drug issues often have complex needs and are likely to access services in other sectors;

- dedicated **Aboriginal workforce development** and cultural awareness training has resulted in good representation of Aboriginal staff in the sector, supporting better access and outcomes for Aboriginal people through alcohol and other drug services;

- **capacity building initiatives specifically to address co-occurring alcohol and other drug and mental health issues**, including the assessment of organisation comorbidity capability and the identification of opportunities for improvement both on individual organisation and sector wide levels;

- **integration of, and community engagement in, prevention initiatives** at a local level, as well as a campaign approach. This is unique to Western Australia and has undoubtedly resulted in reduced problematic substance use issues and harm reduction activities;

- **collaboration between government and non-government treatment services** resulting in improved pathways or through-care of individuals to ensure better outcomes. Within this there is general respect for the diversity of services (from intoxication management, harm reduction through to counselling and intensive residential care) that is offered by the non-government sector – each service type has its place within the system.

- **a warehoused data management system** that enhances an appreciation of the outputs, and to some extent distal outcomes, delivered by the community treatment services throughout the state. This data enables a review of trends in drug use and specific issues that may impact on individuals (consumers and family members) impacted by alcohol and other drug use.

## Principles of the Plan

WANADA is disappointed that some of the principles are specific to either the mental health sector (for example principles 1, 3 and 5) or the alcohol and other drug sector (principle 6) rather than presenting shared principles that have guided the development of both sectors and will guide the implementation of the Plan.

WANADA believes that this has resulted in either:

- a duplication of principles (for example principles 5 and 6 could be seen as subsumed within principle 7 which presents a very similar principle albeit requiring clarification of the limitation of the state funded mental health services); or

- an imbalance of principle requirements (for example principle 1 proposes a practice orientation for mental health services where there is no equivalent principle for the alcohol and other drug services; and principle 3 rightly suggests a need for rebalancing the mental health sector without offering possibilities of improvement in rebalance for the alcohol and other drug sector).

A set of common (cross-sector) principles has been developed over more than 2 years by the WA Collaboration of Substance Use and Mental Health (WACSUMH) Executive for a collaborative care framework. The now six principles developed by the WACSUMH Executive:

- have been informed by consultation with cross-sector workers and consumers;

- are accompanied by definitions which provide some context and ensure against misinterpretation;

- have taken time and resources to develop, and have been extensively considered and refined over the years.

The six principles developed by WACSUMH include:

1. Engage in a person-centred holistic way that does no harm
2. Involve families and carers in treatment and support
3. Mental health, alcohol and drug problems are equal in importance and require a collaborative response
4. Respect Diversity and be socially inclusive
5. Cultural Diversity
6. Continuous improvement

The WACSUMH principles encompass many of the Plan principles, and would add important values such as respect, non-discrimination, cultural security, quality/improvement, and equitable importance of both alcohol and other drugs and mental health and the need to expect a significant likelihood of co-occurrence (informing service processes across the two sectors including partnership and collaboration).

WANADA acknowledges that the Plan principles also need to cover areas specific to building or expanding the mental health, alcohol and other drug service sectors as opposed to informing the underlying principles expected within service delivery.

What is missing from the Plan principles are what guides the rebalancing and expansions – for example evidence, being provider and service model neutral (emphasised in the consultations and based presumably on principles of efficiency and effectiveness), accessibility, etc.

## Monitoring the Plan

WANADA hopes that the items under **"What we hope to achieve"** in the Plan inform key performance indicators, with a benchmark established before the Plan is implemented to enable effective monitoring and review for improvements.

It would also be of use to monitor any changes in the statistics presented in **"the need for change"** to determine the effectiveness of the Plan. Other relevant statistics would include the social costs of alcohol and other drugs and mental health on: police interventions, emergency departments, child protection, and corrective services.

WANADA feels that the potential cost savings from effective prevention, intervention, treatment and support across government would provide a valid justification for resources needed to meet alcohol and other drugs and mental health service demand.

## Prevention and Promotion

- The Prevention and Promotion section of the Plan provides minimal details of a diverse approach that may be considered, for example the Plan:
    - is not inclusive of family involvement for alcohol and other drug prevention;
    - minimally refers to foetal alcohol spectrum disorder;
    - does not identify tertiary prevention initiatives such as needle and syringe programs or bloodborne virus specific initiatives; and
    - does not identify specific concerns such as meth/amphetamine approaches in recognition of different approaches needed for diverse concerns.

- The development of a comprehensive prevention plan is a priority, including primary, secondary and tertiary prevention planning and performance indicators.

  There is significant research in this area in the alcohol and other drug sector with a dedicated national research centre in Western Australia focused on prevention – the National Drug Research Institute (NDRI). WANADA recommends NDRI are engaged to support the development of a comprehensive prevention plan.

- There is a need for a diversity of evidence based prevention models – including state social marketing campaigns; targeted campaigns for specific population groups; a comprehensive and compulsory school based education program from Kindergarten to Year 12 (K-12); locally developed and relevant prevention initiatives; family and community engagement; etc.

- There are workforce development/capacity building implications for prevention – for example school based education programs would be less effective without: in-house school support for students who may have alcohol and other drug/mental health issues; resources to develop and maintain referrals and partnerships; and clear guidelines on the extent of each partners' remit so that overlap and duplication of resources is avoided.

- There is a need for recognition of the diversity of approaches currently supported through community services, and the value this adds to a comprehensive prevention and promotion initiative.

- The integration of community treatment and prevention needs to be strengthened to reduce duplication, cater for community expectations, and ensure effectiveness.

- There is a need for recognition of the additional considerations for prevention when it challenges the agendas of industries (such as alcohol, tobacco and pharmaceutical industries).

- Physical health and life expectancy gaps are evident for people with alcohol and other drug dependence, not just mental illness as implied in the Plan. This is supported by research:

  > *The widest gap in life expectancy was seen in people with alcohol and drug disorders, and this gap of more than 20 years was maintained throughout the period of study. As we assigned a principal psychiatric diagnosis for each patient in this study, the category for alcohol and drug disorders did not include patients with another psychiatric diagnosis and a comorbid substance use disorder but only those with a primary diagnosis of a substance use disorder. Substance misuse is a well established risk factor for cardiovascular disease and many cancers, so it is not surprising that the majority of excess mortality was attributable to heart disease, cancer, and liver disease.*[1]

- Monitoring effectiveness of prevention initiatives needs to be adequately funded, incorporated in planning processes and inform development.

[1] Lawrence D, Hancock KJ, Kisely S. The gap in life expectancy from preventable physical illness in psychiatric patients in Western Australia: retrospective analysis of population based registers. British Medical Journal: BMJ 2013;346:f2539 doi: 10.1136/bmj.f2539; p4)

## Community Support Services

- A diversity of alcohol and other drug harm-reduction services need to be supported.

  The Plan identifies expansion of services with existing service models such as Transitional Housing and Support Programs (actions 7.6.6; 7.6.7; 7.6.11; 7.6.14) and Sobering-Up Services (action 7.6.8). This suggests the Plan is pre-empting service models, which is counter to statements in the Plan (p 11) and comments reinforced in the consultation forums.

  WANADA is concerned that the Plan is pre-empting and limiting future community support service planning rather than focusing on evidenced community need. Consumer participation in the development of expanded community support services is essential.

  Alcohol and other drug harm reduction services can be broader than those currently provided in Western Australia (e.g. needle and syringe programs, sobering-up centres, overdose prevention). Many more examples of evidence based harm reduction initiatives are provided nationally and internationally, and yet the Plan does not present as being open to considering these options.

  The extent of harm reduction services needs to take into consideration the additional alcohol and other drug support requirements of other sectors. For example (and there are many such examples) alcohol and other drug related behaviour management support for regional, rural and remote people accessing health services through patient assisted travel – who otherwise may be evicted from accommodation and unable to continue accessing vital health services.

- There is a need for recognition that personalised support (to meet personal goals such as housing, employment, education, parenting, relationship development, financial management, and anger management - to name but a few) are currently provided in the alcohol and other drug sector, linked with community support and treatment services. (Action 7.6.10). The Plan does not acknowledge that alcohol and other drug services typically address the social determinants of health as part of treatment and support.

  Lack of acknowledgement that these support services are provided by non-government alcohol and other drug services is a long standing misconception across government. It has, however, always been recognised in the service sector that addressing alcohol and other drug issues is more effective and sustainable when the complexity of issues that consumers may present with are equally addressed.

  Addressing these issues and measuring improvements is embedded in assessment tools (which identify any issues with employment, housing/accommodation, etc.), and pre and post service "outcome" measures (which support the identification of improvements in, for example, physical health, mental health/emotional well-being, relationships and personal support as well as alcohol and other drug reduction and confidence to maintain any reduction). These or similar assessment and outcome measures have been in place in the alcohol and other drug service sector for nearly twenty years, and are not just collected for statistical purposes. They are generally used to inform the holistic service provided.

- The engagement of welfare workers to address personalised needs has long been an approach identified as needed or adopted in the alcohol and other drug sector. Engagement of peer support workers requires specific consideration in the alcohol and other drug sector context. Many alcohol and other drug services have concerns with peer support being a workforce model. WANADA has concerns that a peer worker model is prioritised as an approach when personalised support can be achieved in a variety of ways (Action 7.6.10).

  WANADA believes that additional resources to address personalised support will reduce waiting lists at community treatment services.

- The linkages between community treatment, community bed-based and support services including personalised support, needs to be strengthened to reduce duplication and enhance effectiveness. As mentioned above these often occur within a single service.

- There are no community support services identified specifically for people involved in the criminal justice system. To achieve the principle of "same access and quality of care" for this population group WANADA believes identified action needs to be specified in each priority area.

- Some of the "actions" in the community support services area do not provide any guidance as to what will actually be done.

    - Action 7.6.4 (2017) talks about "exploring" how youth friendly places can be established, but makes no commitment to doing more than exploring. Resources are not committed to supporting this in further phases of the Plan.

    - Action 7.6.5 (2017) is about developing an accommodation strategy. No definitive action beyond the strategy is identified.

    - Action 7.6.6 is an action that just identifies the continuation of an existing service. Should there be concern from services if all of the existing services are not mentioned in the Plan?

- Dedicated alcohol and other drug programs for people in crisis accommodation have previously been funded but has since been discontinued. To ensure the sustainability of services WANADA hopes that the issues that resulted in the defunding are reviewed, and risk of this happening again mitigated.

**As a clarification:** the figures presented in action 7.6.2 are not consistent with the figures provided in the matrix. The hours of service currently identified for community support are 859,000, while the action indicates a doubling of service hours from 440,000 hours to 880,000 hours.

## Community Treatment Services

- Pharmacotherapies, as implied in the name of the approach, sees improved outcomes when co-therapeutic approaches are linked and coordinated. Collaboration support needs to be beyond prescribers and dispensers of the medication, and yet this is not evident in the Plan.

  > *Pharmacotherapies for opioid dependence should be part of a comprehensive treatment program, with access to counselling and other ancillary services available to all individuals.*[2]

  WANADA believes that the Plan does not adequately speak to the parallel growth required across the co-therapy spectrum for people on pharmacotherapy treatment.

  Similarly the through-care planning (for example from detoxification, to residential, community treatment, post residential/treatment support or additional harm reduction and support services) is not evident in the Plan. For sustainability of outcomes, and effectiveness generally, WANADA believes that expanding entry point services (such as detoxification or pharmacotherapy) is ineffective unless the parallel or through-care services are equitably expanded or in place to meet the expected new levels of demand.

- WANADA supports the expansion of alcohol and other drug community treatment services throughout the state.

  Expansion needs are evident. Within this a diversity of services needs to be considered and supported to meet demand. 'One size does not fit all' is a shared sentiment between services in the alcohol and other drug sector. Support for this position is demonstrated through: the strong partnerships formed between services including between services operating from different models and philosophies (such as between abstinence based services and harm reduction services); and general respect within the sector recognising each service's position within the continuum of care.

  A diversity of services is needed to meet the diversity of needs that consumers, family members and communities present with. WANADA sees the focus on expansion of one service model (such as the integrated service model of the Community Alcohol and other Drug Services), as presented in the Plan, as pre-emptive and disingenuous in planning for appropriate services to meet the community's needs. This focus is evident in actions: 8.6.3 and 8.6.10.

- A review of the delineation of what is necessarily provided by government services is essential as this Plan goes forward.

  WANADA welcomes the intent of rebalancing the mental health sector. It is acknowledged that the balance between high end medical services and community services in the alcohol and other drug sector is preferable than for the mental health sector. WANADA believes this Plan does not, however, adequately question or support a review of rebalancing opportunities in the alcohol and other drug sector.

  WANADA supports the integration of medical and psychosocial treatment and support. This is, however, often confused in the example of the existing "integrated alcohol and other drug services" where the focus is on the integration of 'government' and 'non-government' services. Even within the existing integrated services, government and non-government collocated organisations both provide psychosocial treatment and support. Clear delineation of roles between what is ideally provided by government vs non-government organisations is not evident. WANADA believes the current "integration" between government and non-government services has resulted in undermining the capacity of non-government organisations, and does not prioritise an individualised approach for best consumer outcomes.

[2] National Drug Strategy. *National Pharmacotherapy Policy: for people dependent on opioids.* January 2007. P 7.

A number of non-government community alcohol and other drug treatment services provide medical support, employing doctors, nurses, clinical psychologists. As such it is clearly not a government organisation's unique mandate to provide medical services.

Concerns with the different organisation cultures between government and non-government services involved in the integrated services is frequently reported to WANADA – by service representatives, staff and consumers. While pre-emptive, the expansion of the current government and non-government alcohol and other drug integration model as demonstrated in the Plan has also not considered these barriers to efficiency and effectiveness.

There are examples in the alcohol and other drug sector of other integration models. These wholly non-government integrated services equally provide medical and psychosocial support, and include programs to address consumer needs including: primary health; mental health; domestic violence; homelessness; family and child protection; employment; etc.

These alternative models of integration prioritise the holistic needs of the individual; and enables the non-government organisations to seek funding from across government agencies to value add to the overall service that is provided to alcohol and other drug consumers.

The model of "integration" proposed in the specific actions in the Plan needs to be reviewed for efficiency and effectiveness to best meet individual needs rather than pre-empting the existing model.

Consumer participation (including family participation) in the development of expanded community treatment services is essential.

- WANADA supports the expanded engagement of GPs (actions 8.6.12 and 8.6.14).

  A number of strategies have been trialled in the alcohol and other drug sector to support increased engagement. WANADA sees that there is a need to review existing and past strategies, including identifying the reasons for the evident barriers to engagement such as stigma and discrimination. Past strategies have been effective, for example building knowledge and skills of GPs through a targeted professional development program, leading more GPs to develop an interest in taking up addictions specialty. Existing strategies are clearly not effective enough based on the limited and aging population of addiction specialists.

  Access to alcohol and other drug medical specialists is particularly limited in most regions, and needs to be a priority.

  WANADA's research on stigma and discrimination, specifically by GPs needs to inform these actions. This creates not just a barrier to GPs developing alcohol and other drug specialty but also impacts on access to primary health care for alcohol and other drug consumers.

**As a clarification:** It appears action 8.6.1 relates only to mental health when comparing the figures in the matrix. For monitoring purposes it would be of use to ensure actions specific to a sector are stated.

While related to the mental health sector, action 8.6.2 suggests a pre-determination of provider (government/public mental health).

Why is a police co-response (action 8.6.5) only related to the mental health sector when more than 70% of police activity is related to alcohol and other drug related issues?

## Community Bed Based Services

- There is no specific recognition of therapeutic communities within the community bed based services section of the Plan. WANADA feels this is an oversight.

  Within the residential rehabilitation approach in the alcohol and other drug sector therapeutic communities need to be recognised as services that, by the nature of the model, incorporate a significant focus on addressing individualised needs and personalised support, with services developed on principles of co-planning, co-designing, co-delivery and co-reviewing.

  There are economies of scale that need be taken into consideration for therapeutic communities to operate – for example informing a minimum bed capacity for optimum application of the model and effectiveness. Length of these intensive programs, informed by research evidence, is also a consideration to ensure the sustainability of outcomes.

  Therapeutic communities offer an alternative bed based service to residential rehabilitation services, complementing the suite of options that need to be made available to meet the diverse needs of the consumers and community.

- WANADA supports an expansion of beds made available in residential settings and providing equitable access to people from throughout the state (as per actions 9.6.3; 9.6.5; 9.6.10). As above WANADA urges the government to take into considerations the requirements of enabling these to operate as therapeutic community services.

  Access barriers are not limited to geographic location. For example:

  - There are currently no residential service in Western Australia available to people on pharmacotherapies, or wishing this intensive support to reduce or detox from pharmacotherapies.

  - WANADA supports the establishment of an Aboriginal specific residential service in the metropolitan/southwest of the state (action 9.6.4) to ensure access options are available to Aboriginal and Torres Strait Islander people in this region.

  - Alcohol and other drug community bed based services for young people are limited. Expanding access to bed based services for young people is essential. (action 9.6.7)

- WANADA supports the expansion of low medical withdrawal services to reduce the need for, and complement, high medical withdrawal services (actions 9.6.8; 9.6.11). It is a concern that home based withdrawal is not considered in the actions of this section of the Plan.

- Integration/collaboration between community bed based services and community treatment and support services is needed, supported with adequate resources to ensure seamless ongoing support.

  There is an increase in alcohol and other drug concerns for the aging population. Improved integration and collaboration between aged care and alcohol and other drug community treatment is needed and not currently addressed in the Plan for alcohol and other drug issues only mental health (actions 9.6.2 and 9.6.9).

**As a clarification:** For monitoring purposes action 9.6.1 is not clear in terms of whether these existing commitments are in the alcohol and other drug or mental health sector.

## Hospital Based Services

- Alcohol and other drugs community support services are currently provided in acute mental health hospital settings, including Graylands Hospital. With the closure of the Graylands Hospital WANADA believes it is vital to ensure this community support is not disrupted for the consumers, and the service is supported to continue.

- WANADA is supportive of the expansion of alcohol and other drug emergency department consultation and liaison services (actions 10.6.7; 10.6.13; 10.6.18). WANADA believes that collaboration and partnership development needs to be an essential component of the service model, to enable appropriate discharge planning and communications with services.

- WANADA is supportive of the provision of a range of inpatient withdrawal services, specifically the expansion of complex withdrawal provision in hospitals, supported by transport initiatives, consultation and liaison to support transition to further care, and telehealth links for small hospitals.

  Access to hospital based detoxification services in the regions through publically funded hospitals needs to be assured, again with improvements in discharge planning and communications with referring services. Strategies to support appropriate workforce development initiatives for hospital staff also needs consideration.

- WANADA is supportive of medical inpatient withdrawal services provided at residential rehabilitation services to promote transition and throughcare to continuing care.

- Action 10.6.11 pre-empts the service provider of inpatient withdrawal services (Next Step). Any expansion of high medical withdrawal needs to be based on current actual capacity and coordinated to ensure transition/ongoing support can be coordinated to meet any increase in demand of throughcare services.

- Culturally security of high and complex medical withdrawal services needs to be assured to achieve equitable access to these services by Aboriginal people.

## Specialised State-wide Services

- At the alcohol and other drug consultation forum on 12 March participants were informed that this section is only relevant to mental health.

  WANADA appreciates that many of the specialised state-wide services in the alcohol and other drug sector are covered under community treatment and support sections of the plan. There needs, however, to be recognition of state-wide support that enhances alcohol and other drug service access and local provision. Current examples of state-wide services in the alcohol and other drug sector include:

  - A rural in-reach service, which enable telephone counselling, information and support, workforce development of regional rural and remote staff and networking.

  - The current metropolitan residential service, including the youth residential, accept referrals from across the state due to limited service options in the regions. Even with expanded services in the regions, it needs to be acknowledged that a significant number of alcohol and other drug consumers seek treatment outside of their normal place of residence. This supports confidentiality and meets their need to remove themselves from local environment, personal triggers and influences.

  - Coordinated interpreter/translation services for transcultural consumers and people who are deaf and hard of hearing (including families and communities) accessing alcohol and other drug services.

  - Coordinated childcare support for consumers (including family members) with under school aged children, and who are accessing alcohol and other drug services.

  - A postal needle and syringe harm reduction service is coordinated to provide state-wide support. Pharmacists, hospitals and vending machines only offer a limited range of equipment, and this gap is currently met through a postal service. It does not, however, offer the range of complementary services such as education and information, access to appropriate clinical support, etc.

  These and other state-wide initiatives in the alcohol and other drug sector need to be supported and expanded to meet demand requirements. These services support knowledge of available local services, assist in reducing barriers to cross-sector service access, and contribute to the reduction of fear due to stigma and discrimination.

## Forensic Services

- WANADA is concerned that the overview in this section of the Plan does not make reference to the prevalence of alcohol and other drug issues experienced by people involved in the criminal justice system. People with co-occurring (alcohol and other drug and mental health) concerns are only identified as a particular population group rather than alcohol and other drug issues being a legitimate concern in its own right. A very small sample of the available research statistics include:

  *Alcohol use has been linked to criminal behaviour (Marteau 2008).The prisoner population is characterised by very high rates of high-risk drinking (Butler & Milner 2003; Victorian Department of Justice 2003; Hockings et al. 2002).*[3]

  *Smoking prevalence is higher among prisoners than in the non-incarcerated adult population.* [4]

  *Most prisoners have used illicit drugs at some time in their life, with two-thirds regularly using drugs at the time of incarceration.*[5]

  *Over half of the prisoners surveyed in the four-state Bloodborne Virus Surveys reported injecting drug use in the previous months —New South Wales (69%), Queensland (61%), Western Australia (62%) and Tasmania (54%). Indigenous prisoners reported injecting drug use at a slightly higher rate than non-Indigenous prisoners (64% vs 58%) (Butler et al. 2005).*[6]

  *It is estimated that between 37% and 52% of offenders in Australia report that their offending is attributed to their drug problem (NCDS, 2006).*[7]

  *In relation to young people in custody, an Australian study indicated that the misuse of drugs exacerbated offending. With 35% of Aboriginal and 29% of non-Aboriginal youths attributed their offending to their drug use.* [8]

  *Of the almost 6,000 persons who consented to a urinalysis as part of the Drug Use Monitoring in Australia program 2009–10, two-thirds (66%) tested positive to at least one illicit drug type. Of these, 30% tested positive to multiple drug.* [9]

  *Almost half (45%) of the detainees confirmed that their substance use had contributed to their current offences (Sweeney & Payne 2011).* [10]

  A Forensicare review in 2008 suggest that for prisoners and offenders appearing before the courts in Western Australian more than 80% had *'substance abuse' issues.*[11]

  *Of the factors associated with recidivism, the three strongest relationships were with age, prior prison admission, and problematic substance use. Over half of sentenced prisoners released in 2008/9 and 2009/10 were identified as having highly problematic substance use.* [12]

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[3] AIHW (2009) *Bulletin 75: From corrections to community: a set of indicators of the health of Australia's prisoners,* p.11.

[4] Ibid, p. 12.

[5] AIHW (2006) *Towards a national prisoner health information system*.

[6] AIHW (2009) *Bulletin 75: From corrections to community: a set of indicators of the health of Australia's prisoners,* p.11.

[7] WA Department of Corrective Services (2010) *Offender Drug and Alcohol Strategy 2010 – 2014.*

[8] Prichard and Payne (2005) cited in Department of Corrective Services (2010) *Offender Drug and Alcohol Strategy 2010 – 2014*, http://goo.gl/fEVWt. Page 5.

[9] AIHW (2013) *The health of Australia's prisoners 2012,* Cat. no. PHE 170. Canberra: AIHW

[10] Ibid.

[11] Forensicare (2008) *Western Australian State Forensic Mental Health Services Review* 2008, p 9.

[12] Office of the Inspector of Custodial Services (2014, September) *Recidivism rates and the impact of treatment programs*, p. 7.

In WA the increasing influence of meth/amphetamine use is also highlighted in the prison population, as it is in the general population. The 2010 prison entrants BBV survey of those who have injected drugs reported amphetamine as the last drug injected by 75% of respondents. This is significant compared with 39% in Victoria and 33% in the Northern Territory. [13]

- WANADA is also concerned that current prison alcohol and other drug services are not acknowledged in the Plan, including: Drug and Alcohol Throughcare Services; the Pathways Program; Residential throughcare assessment provided by community services, and Corrections provided alcohol and other drug services. All of these services need to be expanded to meet need.

- WANADA believes alcohol and other drug service provision in prisons needs to expand, including the provision of service options that are evidence based and proven to be effective nationally and internationally – ranging from harm reduction services through to in-prison therapeutic communities.

- Planning for prison alcohol and other drug services is dependent on:

    - routine assessment of all prisoners to identify treatment and support needs and to ensure appropriate treatment matching;

    - useful data collection that can accurately identify service demand (for in-prison services and post release treatment and support) and enable evaluation that would inform service practice and continuous quality improvement.

- Improved access to alcohol and other drug treatment and support services are vital to reducing prison populations and recidivism.

- Enhancing alcohol and other drug diversion is only a component of the suite of services needed to reduce prison entry. All diversion services need to ensure cultural security to ensure access and specifically reduce prison entry by Aboriginal people.

  Evaluation of current diversion needs to inform future planning and expansion. Statistics on prison numbers would suggest diversion could play a more significant role in reducing prison entry.

[13] Butler, T, Lim D, & Callander D. (2011) *National Prison Entrants' Bloodborne Virus and Risk Behaviour Survey Report 2004, 2007, and 2010.* Kirby Institute (University of New South Wales) and National Drug Research Institute (Curtin University).

## System Improvement and Supporting Change

The Plan and the amalgamation of the Drug and Alcohol Office and the Mental Health Commission are intended to affect change in efficiency and outcomes for consumers.

WANADA recognised that system improvements and initiatives are essential for the achievement of the Plan's vision, aims and actions. Unfortunately this section of the plan is not cohesive, strategic or comprehensive enough to inform the infrastructure or the support required to ensure this reform or the actions are achieved.

### Recovery Oriented practice and supporting consumer voice

WANADA agrees that systems support requirements are needed for this area of work. WANADA is, however, concerned that the distinct differences between the mental health and alcohol and other drug sectors is not adequately appreciated or demonstrated in the Plan.

- **Recovery** oriented practice (as presented in the national mental health framework) and support for consumer voice are important for both the mental health and alcohol and other drug sectors. WANADA is concerned that the relevant elements under this focus area are not extended to the alcohol and other drug actions simply because of language barriers.

  "Abstinence" and "recovery" are terms that have been used interchangeably in relation to alcohol and other drugs for over 100 years. Even more recent literature from America indicates abstinence is the means to achieving recovery.[14] Either way recovery requires abstinence. There are many consumers of the alcohol and other drug sector who are extremely proud of their personal recovery – i.e. abstinence. The achievement of abstinence has been, for many people, the stepping stone to improved quality of life and wellbeing.

  Alcohol and other drug consumers can, however, improve their quality of life and well-being without abstinence. This is a goal of many community treatment and support services recognising many consumers are not striving for abstinence. WANADA is concerned that the achievements of those that attain, or strive for, abstinence are not minimised with the broader definition of recovery presented by the mental health sector.

  Both sectors bring a history of the use of language. This needs to be respected. While the two service sectors can have an appreciation of what is intended by the use of the term in the Plan, the core understanding of recovery from the perspective of consumers from both sectors needs to be taken into consideration and prioritised.

  Prioritising consumer perspective is consistent with the Plan's intent to support '**autonomy, self-determination and choice**' and '**co-designing and individualised plans'**. The achievement of this intent will require a particular cultural shift in all sectors that work with and support people with issues related to alcohol and other drugs, including: primary health; child protection; corrective services; mental health; homelessness; employment; etc. Many of these agencies/sector impose/require abstinence – not the broader understanding of recovery.

- **Stigma and discrimination** is significant for alcohol and other drug consumers, family members impacted by another's alcohol and other drug use, communities (particularly small and remote communities) impacted by alcohol and other drugs, and workers in the alcohol and other drug sector.

[14] El-Guebaly, Nady. 2012. The Meanings of Recovery From Addiction: Evolution and Promises. American Society of Addictions Medicine; Addict Med, Vol 6, No. 1.

The World Health Organisation states that illicit drug dependence is the most stigmatised health condition in the world; dependence on alcohol is ranked as the fourth most stigmatised condition. [15] With all of the media moral panic related to meth/amphetamines, stigma for people who identify meth/amphetamine as their principle drug or are dependent on this drug is undoubtedly currently significant.

WANADA has lead research into stigma and discrimination. As expected stigma and discrimination has many negative impacts, the most concerning is the reduced access to essential services – housing, primary and tertiary health, and mental health services. The WANADA research focused on the attitudes and practices of general practitioners and mental health sector workers, being the two main service areas identified by consumers as discriminating.

Starting from such a low base there is a lot to be done to support equitable social inclusion of people with problems associated with alcohol and other drugs. This needs to be a dedicated initiative, not something that is taken off the shelf from the mental health sector. The fundamental difference for alcohol and other drug consumers is the community judgement of their dependence as being a choice; and for illicit drug consumers their behaviour is essentially illegal.

- The alcohol and other drug sector has for a long time been incorporating the employment of people with **lived experience**. There are examples of community alcohol and other drug treatment services where 50% or more of the staff have this experience. In general these staff are not engaged as peer workers, but are required to have a period of time since service participation and to attain appropriate tertiary qualifications.

  The alcohol and other drug sector also has a dedicated peer based service. Staff of a peer based service are employed in specific job roles that do not in themselves identify them as peers – for example CEO, manager, outreach worker etc.

  With stigma and discrimination concerns, as raised above, people with lived experience do not typically want to be perpetually identified as peers, and to have this on the resumes for future work or career development. Also there are risk factors in having "peer workers" triggered by talking about their past experience as a part of their work role. Empowering people to come from a broader base than their own experience, achieved through tertiary education and qualifications, helps reduce some of these risks.

  As quoted by a CEO of an alcohol and other drug service:

  > *Employing staff with a lived experience may be a desirable criteria, but not essential. Employing people within job titles that identify them as peers might offer some hope to consumers of the service, however it puts too much pressure on these workers as role models. What worked for them might not work for others. Overemphasising this peer status also potentially minimises the impact that people without this lived experience bring. We find a mix of experiences from staff is preferable, and all are equally employed based on their qualifications attained… All staff have to demonstrate empathy, non-judgement and respect for the consumers. Let's face it, many heroin users judge meth users pretty harshly, and many drug users, let alone community members, judge solvent users.*

[15] Kelly JF, Westerhoff, CM. Does it matter how we refer to individuals with substance-related conditions? A randomized study of two commonly used terms. International Journal of Drug Policy. 2010; 21(3): 202–207.

Over time the alcohol and other drug sector has come to recognise the peer lived experience as a desirable quality alongside relevant qualifications. The involvement of peers in the workforce, including peer support workers, needs different considerations between the two sectors (action 13.9.5.1).

- WANADA believes **consumer (systems level) advocacy** is another area that needs to be developed specifically for the alcohol and other drug sector. This is not a current strength within the alcohol and other drug sector and cannot be achieved in an ad-hoc way or by mirroring what is done in mental health.

  Any systems consumer advocacy in the alcohol and other drug sector needs to support skills and capacity building of consumers (consistent with actions 13.7.5.20 and 13.7.5.4) , support organisation development to enable consumer advocacy influence, and support development of the broader system to again support consumer advocacy influence. Policies across sectors impacts on alcohol and other drug consumers, often in a negative way directly or inadvertently. This three pronged approach is consistent with capacity building principles and has been proven effective for consumer advocacy in other sectors - such as in the developmental disability sector.

  WANADA believes a distinct sector approach is warranted based on the extent of stigma and discrimination of the alcohol and other drug consumers; the politicisation of alcohol and other drug issues; the influence of powerful industries, such as the alcohol, pharmaceutical and testing industry, that impact on the community culture of alcohol and other drug use; and the polarised community attitude towards alcohol and other drug use where it is often seen as a criminal rather than a health issue.

**Culturally competent service development and delivery**

WANADA applauds the Plan for emphasising the need for the mental health and alcohol and other drug services to be responsive to **Aboriginal cultural requirements** to address the evident imbalances in issues and concerns related to these two sectors.

- WANADA acknowledges the shaming statistics of the impact of alcohol and other drugs on Aboriginal people, and the need for alternative approaches to support improved access and engagement with alcohol and other drug services.

  The Western Australian alcohol and other drug sector has developed a set of internationally recognised accreditation standards – the Standard on Culturally Secure Practice – that supports a continuous quality improvement approach to meeting the treatment and support needs of the community, including Aboriginal members of the community. Achieving quality accreditation has become increasingly important for services in the alcohol and other drug services to secure funding from state and commonwealth governments. WANADA would welcome mental health services, particularly as they increasingly work with people with co-occurring alcohol and other drug issues, adopting this accreditation Standard or taking on board the principles related to continuous improvement for cultural security embedded in the Standard. These principles inform consumer rights and responsibilities; consumer focused practice; evidence based practice; the organisation's staff development and support; and well as the organisation's governance and management.

  **Workforce strategies**, to increase the Aboriginal workforce participation, have developed considerably in the alcohol and other drug sector, significantly supported by the Aboriginal Program within the Drug and Alcohol Office. WANADA is concerned to ensure that these strategies are at least maintained if not increased for the benefit of the consumers of the alcohol and other drug sector, and not reduced through a focus on lifting the mental health sector responses.

Without any matrix indicating increased hours for this strategy in the Plan it will be difficult to monitor any expansion of effort let alone the achievement of desired outcomes. WANADA would like to suggest indicators include:

- Increased engagement of an Aboriginal workforce in both sectors and across the range of service areas;
- Participation of all non-Aboriginal staff in both sectors in current cultural awareness/competencies development courses (as per action 13.9.5.1 a);
- Increased Aboriginal access to services across both sectors, again across all service areas;
- Improved completion rates and outcomes of Aboriginal people engaged in services across the two sectors.

- WANADA acknowledges the underrepresentation of people from culturally and linguistically diverse (CaLD) backgrounds and the barriers to access.

  A culturally appropriate coordinated interpreter service is made available to alcohol and other drug services through WANADA.

**Youth specific mental health services**

Youth specific alcohol and other drug services do not get specific mention in this section of the Plan despite a need for increased dedicated services. Youth services have been covered in community treatment, support, bed-based and specialised services, etc.

As with the Aboriginal and CaLD focus above, there is a requirement to specifically consider enhancing alcohol and other drug services to be relevant to young people.

**Responding effectively to co-occurring problems**

- Determining the capacity of non-government alcohol and other drug services to better meet the needs of people **with co-occurring alcohol and other drug and mental health problems** has been supported with a validated assessment tool - the Dual Diagnosis Capability in Addiction Treatment (DDCAT). This assessment tool has been used by a significant number of non-government alcohol and other drug services in Western Australia, and the assessment tool is now incorporated into the WANADA Standard on Culturally Secure Practice.

  There is a mental health equivalent tool – the Dual Diagnosis in Mental Health Treatment (DDCMHT).

  WANADA believes it would require minimal resources to see all government and non-government alcohol and other drug and mental health services independently assessed for co-occurring capability by a qualified auditor. This independent assessment would:

  - Inform organisations of continuous improvement opportunities to achieve desired capabilities to address co-occurring issues;
  - Identify collective barriers to capabilities to address co-occurring issues and inform systems strategies (such as workforce development) to support sector improvements;
  - Set a benchmark of capabilities to enable the identification of required/desired future capability levels.
  - Support future planning of dedicated co-occurring services.

  These assessment tools would provide the evidence that is currently missing in informing development in this area.

- **Trauma informed care and practice** is not only a requirement in mental health services. Alcohol and other drug use and resultant problems are often identified as linked to trauma. Many alcohol and other drug community treatment services incorporate the principles and guidelines of trauma informed care and practice.

  WANADA believes this is an area of legitimate integration across community sectors (not just alcohol and other drug and mental health).

**System integration and Navigation**

- WANADA supports the Plan's recognition that new and effective ways are needed for the alcohol and other drug and mental health sectors to work together. Improved coordination, **systems integration and navigation** is needed for improved consumer outcomes.

  WANADA assumes that there is a background paper specifically dedicated to this section. With limited detail in the Plan it is difficult to assess the rationale for the prioritisation presented.

  WANADA agrees that systems integration requires:
  - **Clarity about roles and responsibilities** (shared or otherwise). WANADA believes that current cultural differences between the alcohol and other drug and mental health sectors, and between government and non-government sectors needs to be acknowledged, with strategies identified to build on shared values if success and efficiency is to be achieved in systems integration.

    Clear delineation of roles and responsibilities will only enhance referral, appropriate service matching, shared care and throughcare to address the complexities and multiple co-occurring issues that consumers may present with.

  - Initiatives to **assist people to navigate the system of services**. This has been an under-resourced area in the alcohol and other drug sector for some time, with the sector requesting resources to engage welfare workers to assist in navigation. The community support services section of the Plan identified the need of personalised support programs (WANADA has made comment to this –see above). Navigation support needs to take into consideration the extent of stigma and discrimination barriers, and may require more than mentor or peer support in navigation.

    Navigation support *into* the alcohol and other drug sector is of particular need given the diversity of community alcohol and other drug treatment and support services and the lack of understanding by professionals across sectors of what the diversity of services offer (as identified in the background under 13.7.4).

    - The **helplines** through Alcohol and other Drug Information Service (ADIS), the Parent Drug information Service (PDIS), and the Clinical Advisory Service (CAS) are invaluable supports for community members and health professionals (CAS is restricted to health clinicians only). These supports and others could be more proactively promoted

    - WANADA acknowledges that the **online service** provided through the Green Book directory of community services only part of what can be provided. WANADA has been looking at other models of community service directories, including an example used by community services in Queensland that facilitates link between services and referral pathways. WANADA has also been working with Medicare Locals to support improved referral pathways from primary health.

The Green Book enables WANADA to promote the service sector, especially as it is linked to a blog site that has discussion on a range of community interest topic. The Green Book Blog will grow, is targeted to the general community, and has received over 4000 readers since being launched in June 2014.

Actions 13.7.5.3 and 13.7.5.8 are for the establishment of an online system and service directory. WANADA believes that enhancing existing systems would be preferable and more cost efficient than creating new systems.

- WANADA has already made comment on **peer support workers** (see in this response Community Support Services p 6; Systems Improvement and Supporting Change: Lived Experience pages 16 - 17)**.** It is enough to say that peer support workers in the alcohol and other drug sector have different considerations to these workers in mental health.

- WANADA supports, as previously discussed, systems navigation/ **community coordination.** Resources to support this are not evident in the Plan, and yet are essential to see this change support strategy enabling the efficiency and effectiveness of planned expansion across all service streams.

  The actions 13.7.5.1; 13.7.5.9 and 13.7.5.10 are to complement current programs such as Partners in Recovery. Partners in Recovery required considerable resources, and it is WANADA's understanding that the ongoing funding for this program is not necessarily assured.

Requiring commissioned services to develop coordinated service transition strategies (as per actions 13.7.3.3 and 13.7.3.5) lacks recognition of the ongoing resources required not just in developing these collaborations but also in maintaining them. Without evident resources considered in the Plan, WANADA believes this requirement is hollow and unrealistic in practice.

- **Clarity around accountability**. Without more background details WANADA assumes this is related to the identification of, and demonstration of outcomes.

  The current outcome measures of the alcohol and other drug sector focus on distal outcomes – for example consumer identified improvements in physical health; mental health/emotional wellbeing; and relationships and support networks; as well as reduced alcohol and other drug use and improved confidence to maintain any reduction.

  Satisfaction with the service provided is also an outcome measure. There are, however, examples of very sophisticated feedback informed practice tools that can actively inform the individualised service provided; be used to inform workforce developments (through supervision through to informing personal development); organisation developments as the collective needs of consumers are better identified and the capability of the organisation to meet these needs can be developed; etc. Feedback informed practice tools support the determination of the consumer's view on whether their individual needs have been met and provide feedback on the therapeutic alliance established between themselves and the worker.

  Therapeutic alliance is the most significant indicator for success in the treatment and support of people with alcohol and other drug problems. Together with distal outcomes related to the social determinants of health, relationship measures need to be prioritised. In WANADA's view this will enable services to demonstrate meaningful outcomes that sit

comfortably with the principles of this Plan – primarily that a person-centred service has been provided.

WANADA has concerns with what might be meant by **sharing information.** There are already issues with sharing information between medical and psychosocial services within integrated services – in that pharmacotherapy services are often jeopardised if consumers are working through continued illicit drug use in co-therapy.

Illicit drug use involves illegal behaviour. Sharing this information in an environment of heightened stigma and discrimination is likely to impact on the services provided. These concerns have implications for action 13.7.5.7. As such WANADA believes there is increased considerations related to privacy for consumers of the alcohol and other drug sector.

- In relation to the establishment of standardised "**models of service**" for the service streams WANADA is concerned that the full range of evidence based service models will not be considered in this approach (action 13.7.3.2). WANADA believes that in the alcohol and other drug service sector any standardising of a model is counter to ensuring the diversity of person-centred approaches, needed to meet the diversity of needs.

**Organisation effectiveness and efficiency**

- In relation to **safety and quality assurance mechanisms**, WANADA has undertaken a significant amount of work in supporting continuous quality improvement and accreditation of community alcohol and other drug treatment and support services.

  The Standard on Culturally Secure Practice (alcohol and other drug sector) was developed by WANADA following extensive consultation with Western Australian and other state and territory alcohol and other drug services. The Standard is independently audited under a Joint Accreditation Systems of Australia and New Zealand (JAS-ANZ) scheme that falls under ISO.

- In the application of the accreditation tool organisations are required to meet 80% of essential criteria to achieve accreditation, and 80% of the good practice criteria to achieve this additional recognition. Also as a continuous quality improvement focused process the Standard supports individual organisations to set their own **benchmarks of quality and responsiveness**. WANADA believes that government directives of benchmarks are ineffective - supporting the achievement of benchmarks as a checklist rather than supporting a culture of continuous improvement.

- The alcohol and other drug sector has access to a suite of **evidence based** practice research and guidelines developed in Western Australia, nationally and internationally. These include guidelines for working with consumers with co-occurring alcohol and other drug and mental health issues specifically for use by alcohol and other drug services. WANADA has developed a clearinghouse (AOD Knowledgebase) and is currently reviewing this to ensure ease of access to relevant evidence based practice research and guidelines for sector members.

  A national review of a quality framework, undertaken by Turning Point from Victoria, identified a potential gap in relation to evidence based practice being the monitoring of the application of guidelines. For the alcohol and other drug sector this is the next development needed in this area. As the majority of alcohol and other drug services are non-government WANADA believes this development is best driven by WANADA and the sector services.

- WANADA has identified a need to review **data and outcomes** measures and management. Comments have already been made in relation to outcomes (see in this response Systems Improvement and Supporting Change: Clarity and Accountability p 20)

  While WANADA believes the current data base warehoused by the Drug and Alcohol Office (SIMS) needs to be reviewed, the data management system already enables alcohol and other drug treatment services to demonstrate outputs such as length of stay, number of episodes and rates of planned completions, etc.

- This response has already talked of privacy issues and concerns related to shared information (see in this response Systems Improvement and Supporting Change: Sharing Information p 21).

**Workforce**

- Workforce planning **(building the capacity across the specialist workforce)** will require significant focus to support the identified expansion of services in the Plan.

  WANADA acknowledges that capacity (Tier 1 knowledge, screening skills) are required across sectors, including police, education, corrections, pharmacy and emergency departments as identified in Figure 20 (page 83 of the Plan), and also primary health, child protection, crisis accommodation and homelessness, domestic violence, emergency relief services. Building the capacity of these sectors needs to include awareness of referral processes and pathways. These are frontline services that need referral options, for example to progress screening to assessment.

  Capacity building to Tier 1, 2 and 3 needs to be supported by cross-sector networking i.e. with the majority service providers, being the non-government services. WANADA believes that cross-sector capacity building could be better coordinated and delivered, and falls within the mandate of the non-government alcohol and other drug sector.

  On a regional level this could be led by local specialist services. In the alcohol and other drug sector this is the case in the Kimberley – where capacity building across sector is undertaken with dedicated funding for the Kimberley Community Alcohol and other Drug Service. This model is not replicated in other regions.

  Tier 3 capacity building of corrections and general mental health and alcohol and other drug services (as identified in the Plan) is also relevant to general practice and child protection.

  WANADA believes it would be of benefit to assess the preferred provider of workforce development to all Tiers. In New South Wales, for example, the primary training provider for the alcohol and other drug sector is the peak body, the Network of Alcohol and other Drug Services (NADA). The Western Australian Association for Mental Health (WAAMH) also delivers significant workforce training to the mental health sector.

  There is significant research in workforce development in the alcohol and other drug sector with a dedicated national research centre in South Australia focused on this area. Training is an essential but only one element of effective learning.

  As the National Centre for Education and Training in Addictions asserts:

*[A] broader approach to workforce development involves a wide range of individual, organisational and systemic factors that can impact on the ability of the workforce to effectively and efficiently respond to AOD issues*[16]

While WA has a strong capacity in training, it is weak in the corresponding organisation and systems development and particularly where organisations are supported more directly to meet their own learning needs. All areas of workforce development need to be applied and complement each other.

More can be done to ensure a comprehensive workforce development approach (actions 13.9.5.1 and 13.9.5.3). As the peak organisation of the majority of service providers in Western Australia, WANADA believes it could make a significant difference to the comprehensiveness, effectiveness and efficiency of WA's workforce development effort.

- The Plan does not adequately speak to **alternative workforce planning** initiatives including both attracting workers into the sectors and ensuring students are appropriately work ready and confident to enter the sector.

  This year WANADA will have supported approximately 60 student placement in the alcohol and other drug sector. WANADA already supports students from all of the universities engaged in allied health, dietetics, physical health, health promotion, paramedics, medicine, pharmacy, social work. Feedback from students involved has indicated that while they may not have previously considered working in this field they would consider the alcohol and other drug sector as a future work option. Students report being more confident in working with people with alcohol and other drug issues as a result of their placement. Whether they end up working directly in this field or not, their placements have supported a capacity building to whichever field they may choose (action 13.9.5.2).

  Alcohol and other drug services also directly take students, typically from social work and psychology courses. The sector has a strong culture of engaging and supporting students.

  WANADA, and the other state and territory alcohol and other drug peak bodies, has provided extensive feedback to the Community Services & Health Industry Skills Council: Industry Qualifications Training Packages relevant to the alcohol and other drug sector, ensuring the courses are relevant for work readiness. Costs now requirements for these courses may impact on numbers of students participating, however fees would be more palatable if work readiness is assured.

  The alcohol and other drug sector already employ staff from overseas, and WANADA's e-newsletter and website have supported this through its 'jobs available' section. The sector has identified a need for WANADA to coordinate such initiatives to minimise a duplicated burden.

  Workforce planning is a particular issue for services in the regions. WANADA has piloted a secondment pool for regional, rural and remote services to particularly cover annual and long-service leave, and between recruitment. The pilot has seen one secondment staff member employed by the organisation, even though this was not the intent. WANADA is currently developing the processes to support an expansion of this initiative.

  An umbrella employee assistance program is also coordinated by WANADA, as an initiative to support staff retention. As a state wide umbrella service WANADA has been able negotiate cost efficient services that also meet the needs of regional, rural and remote services – through

[16] Roche, A. M., Pidd, K. (2010). Alcohol & Other Drugs Workforce Development Issues and Imperatives: Setting the Scene. National Centre for Education and Training on Addiction (NCETA), Flinders University, Adelaide. P 2.

telephone and video call contacts, as well as making cultural security a requirement of the provider.

There are numerous initiatives that contribute to effective and efficient workforce planning. WANADA feels that the Plan does not take into consideration what is currently in development, and is limited in its vision to address this significant issue.

**Information and Communication Technology**

- Privacy and confidentiality of information has particular considerations for people involved in the alcohol and other drug sector given a significant number (as illicit drug users) are involved in illegal behaviour. Sector and consumer input are required to ensure privacy and confidentiality issues are adequately considered in the development of processes that enhance information sharing.

- The alcohol and other drug sector currently has access to a rural in-reach service. This provides ITC supported counselling and support for consumers, families and communities as well as access to training. There is no need to reinvent these processes (action 13.10.3.1).

**Capital Infrastructure**

WANADA supports the identified need to enhance capital infrastructure to support service access and the sustainability of services.