

THE STATE OF THE SECTOR:

PRE-AMALGAMATION EVALUATION OF THE WA ALCOHOL AND OTHER DRUG SECTOR

1. Background

The amalgamation of the Drug and Alcohol Office (DAO) and the Mental Health Commission (MHC), with a single chief executive, was announced by the WA Premier on 10 April 2013 as one of a number of changes to machinery of Government. The intent of the amalgamation was to:

enable better integration of the State's network of services relating to prevention, treatment, professional education and training and research activities in the drug and alcohol sector and its support for and delivery of mental health services.

The changes were identified as a response to the findings of the Stokes Report, with the intent being “to improve service delivery, streamline processes, ensure better transparency and bring greater efficiencies to many government operations,” and “ensuring better delivery of service to the public”.

WANADA has drawn on available data, feedback from the sector via surveys, and recent research and evaluations in an attempt to identify the state of the sector before the amalgamation of DAO and the MHC. This baseline “pre-amalgamation evaluation” will be compared with similar information in the years following the amalgamation to determine if the amalgamation has achieved its intent.

WANADA would hope that current good processes are at least maintained. In the areas identified as currently needing improvement WANADA has made recommendations that it feels will result in improved achievement of the machinery of government intent.

2. Executive Summary

Service delivery

A number of factors, beyond the amalgamation, will impact on service delivery. In relation to the current workforce the Western Australian alcohol and other drug sector is made up of well qualified staff who are satisfied with their roles. Nearly half of the current staff came to the sector from other sectors; do not intend to stay working in the sector for more than 5 years; and are over 45 years old. This suggests implications for the future service delivery, with a clear need for a focus on workforce planning. In future evaluations WANADA would like to see:

- The percentage of staff in the sector with formal qualifications at least maintained if not increased;
- Job satisfaction of the sector staff maintained as a minimum.

There are inadequate services to meet current demand, as highlighted in the *WA Mental Health, Alcohol and other Drug Services Plan 2015 – 2025 (10 Year Plan)*. If the expansion proposed in the 10 Year Plan is achieved, this will clearly impact on any service delivery improvements.

This State of the Sector report explores the sector staff's perception of changes impacting on their work. The report identifies that the current data collected through DAO does not enable adequate verification of staff experience. Changing drug use trends and issues presented by the consumers of the services need to be considered in any expansion of services, including those directed by the 10 Year Plan. The data collection system needs to be reviewed to support sector planning.

Waiting lists and waiting times are not currently uniformly collated, or able to be used as a measurement of demand. This would have benefits beyond informing any service delivery outcomes, including supporting referral and collaborations across sectors.

Streamlined processes and greater efficiencies

DAO have been providing a range of support services that potentially streamline processes.

- Alcohol and other drug service providers report a strong working relationship with DAO contract managers, indicating in general a respectful partnership that adds value to the services delivered. This needs to be at least maintained.
- Data management and support, on the other hand, has been identified by the sector as needing to be improved. Data management is key to being able to demonstrate the effectiveness and efficiency of the sector, and to demonstrate the intentions of the amalgamation.
- Professional development (workforce training) to the not-for-profit sector staff received good feedback and has been evaluated positively. DAO training participation rates by alcohol and other drug not-for-profit staff, and any form of

coordination of professional development has, however, been assessed by WANADA in this report as inadequate or not evident.

- The broader workforce development agenda, beyond the minimal impact that can be made by training, has evidently been achieved by DAO through training of professionals in other sectors. WANADA acknowledges the systemic value of capacity building for other sectors, however believes the approach taken by DAO could be improved for better capacity building. In addition organisation and systemic workforce development and planning needs to be prioritised and resourced. Which body (government or non-government) best placed to coordinate and deliver these broader initiatives needs to be identified.

Better integration

This report looks at collaborations between the alcohol and other drug sector and the mental health sector.

Stigma and discrimination is a key factor hindering the willingness of other sectors to work with alcohol and other drug consumers, in order to add to sustainable and improved outcomes for individuals, family members and the community.

The commonwealth government's Improved Services Initiative funding (currently the Substance Misuse Service Delivery Grant Funds) provides a good example of resources contributing to the service effectiveness for co-occurring issues. While the commonwealth funding focus has changed, and its continuation is perpetually in doubt, the lessons learnt from this would contribute to the government's intent for the amalgamated DAO and MHC.

3. Recommendations

1. Planning needs to be informed by changing trends and increasing complexity that is expected to be addressed by alcohol and other drug services.
2. A means of monitoring collective waiting lists and/or times needs to be developed and implemented.
3. The sector data system including: the data collected; and how it is managed, used and supported needs to be reviewed, with improvements made to better meet the data needs of services.
4. A workforce training framework needs to be developed and implemented to ensure coordinated, appropriate training is available to the not-for-profit alcohol and other drug service sector.
5. Workforce planning strategies need to be prioritised to both overcome current workforce trends and support an expanded workforce needed as a result of the developments of the 10 Year Plan.
6. Capacity building training and support needs to be coordinated, developed and delivered to meet the needs of non-government services from other sectors.
7. Resources are needed to implement identified strategies aimed at addressing stigma and discrimination of alcohol and other drug users and family members. This includes the establishment of an alcohol and other drug systems advocacy consumer body.
8. Routine co-occurring mental health and alcohol and other drug service capability assessments (through independent DDCAT and DDCMHT reviews) needs to be resourced. These assessments would inform a comprehensive approach to the sectors' development in delivering services to people with co-occurring issues.

4. Service delivery

4.1 The workforce overview

The workplace development survey administered in 2014 by WANADA for staff of its member services provided a number of indicators.

WANADA estimates there are approximately 1,200 staff in the WA alcohol and other drug service sector. We received only 171 responses from staff (an estimate of 14.25%). As such the following figures are used only as indicators. The figures do, however, match well with WANADA's anecdotal assessment of the sector.

- 64.1% of respondents were from the metropolitan area. The Kimberley and Pilbara regions made up another 19.4% of respondents. The remaining 16.5% was made up of respondents from the Wheatbelt, South West, Midwest, Great Southern and Goldfields Regions.
- 9.36% of respondents identified as Aboriginal
- 40.29% are over 45 years old
- 75.44% are female
- 46.47% of staff came to their current role in the alcohol and other drug sector from a position outside of the sector.
- 28.82% came from another organisation in the sector
- 9.41% came from a position of volunteer within the sector
- 15.29% came following a student placement in the sector.
- Length of time staff have been employed either at the agency they are currently at or in the alcohol and other drug sector:

Time period	At current agency	In the AOD sector
Less than 1 year	13.53%	28.24%
1-2 years	15.88%	19.41%
2-5 years	24.71%	27.65%
5-10 years	20.59%	17.06%
More than 10 years	25.30%	7.65%

- 92.59% of respondents are satisfied with their current employment in the AOD sector
- Intentions to remain working in the AOD sector:

Time period	
Less than 1 year	2.96%
1-2 years	12.59%
2-5 years	28.89%
5-10 years	28.15%
More than 10 years	27.41%

- 56.36% have completed a formal university qualification
 - a further 5.45% are currently completing a formal university qualification
- 19.40% of respondents have completed a Community Services Training Package with an AOD specific unit or units of competency

As a brief summary: the Western Australian alcohol and other drug sector is made up of well qualified staff who are satisfied with their roles. Nearly half of the current staff came to the sector from other sectors; do not intend to stay working in the sector for more than 5 years; and are over 45 years old. This information both informs and identifies the need for a focus on workforce planning initiatives.

4.2 Demand for Services

The need for alcohol and other drug service provision has been determined through a national population planning process: the *National Drug and Alcohol Service Planning Model*. This has been adapted for Western Australia and used to inform service expansion needs as identified in the 10 Year Plan. The national planning Model used clearly shows the need for an expansion of services in all service areas in the WA alcohol and other drug sector. WANADA acknowledges that the Model provides a guideline only.

WANADA has identified two factors that could potentially inform demand considerations: changing trends and waiting lists or times.

4.3 Changing trends in consumer needs

The results of the alcohol and other drug worker survey administered in 2014 by WANADA indicates that 48% of workers have observed changes in the needs of their clients in the past 3 years.

From WANADA's AOD Worker's Survey 2014 - sector workers most noted the following changing trend and issues consumers are presenting with:

- Increased housing and accommodation issues (noted by 17% of respondents)
- Increase in meth/amphetamine (ATS) use and associated harms (15.4%)
- More complex presentations in general (14.77%)
- Increase in mental health issues (12.5%)

While all of these areas have implications for the services provided by the sector, data routinely collected through the DAO warehoused data management system unfortunately falls short in both verifying the anecdotal experience of workers and in supporting planning to address the collective significant needs that consumers are presenting with.

In exploring the impact of methamphetamines, for example, data provided by DAO for the past 3 years¹ only goes some way to support the trend identified in relation to increased presentations of meth/amphetamine use and associated harms.

	2012/13	2013/14	2014 – end of Feb 2015
Number of open and opened treatment episodes	24,304	25,627	17,191
Primary drug of concern	35.42%	33.83%	32.28%
Alcohol			
Meth/amphetamines	18.11%	19.70%	21.65%
Opiates	17.07%	16.10%	17.43%
Cannabis	20.05%	19.96%	18.27%

The data provided by DAO on drug use is based on primary drug of concern.

With methamphetamines being a high profile concern for the community WANADA coordinated a snap-shot of methamphetamine use amongst consumers accessing the AOD sector (July 2015).

- Data was collected from 17 AOD services across WA, including 11 non-residential services and 6 residential services.
- Of the 884 clients who accessed the services throughout the data collection period, the survey was administered to 50% of clients (n=442).
- 72% of surveyed participants indicated that they had used Methamphetamine (Ice).
 - 34% indicated that they had used Methamphetamine (Ice) for more than 10 years
 - 19% had used the drug for 5-10 years
 - 16% had used for 2 – 5 years
 - 15% had used for 1-2 years
 - 16% had used for less than 1 year
 - 44% reported smoking as the most common means of administration
 - 42% reported injection
 - 23% were using daily
 - 31% were using weekly
 - 15% were using monthly
 - 31% were using less than monthly

Clearly, based on the data provided by DAO, the majority of consumers accessing alcohol and other drug treatment services who have used methamphetamine do not identify this substance as their primary drug of concern, however regular use may be impacting on the complexity of the consumers' issues. Data warehoused by DAO clearly does not represent drug use trends – and therefore does not provide adequate guidance for information, training and support needed by workers in the

¹ Drug and Alcohol Office 2015. *Information to support an evaluation of the amalgamation of the Mental Health Commission and the Drug and Alcohol Office – requested by the WA Network of Alcohol and other Drug Agencies.*

sector that in turn supports the consumers and family members accessing the services².

Ever changing drug trends and related issues that consumers are presenting with have implications for the knowledge and skills, and therefore training and information on evidence based practice, of the sector staff.

Recommendation 1:

Planning needs to be informed by changing trends and increasing complexity that is expected to be addressed by alcohol and other drug services.

4.4 Waiting lists or waiting times

Waiting list and times are often used to inform the need for resources in tertiary health setting. Wait times at alcohol and other drug services are often requested to inform referral options.

Waiting lists and times are only effective if the community (including referring professionals) are aware of where to go, or refer people to, when they have an alcohol and other drug related issue. Comments from the community are often made about the lack of awareness of where to go; and when they do have some awareness of services available the comments are often about the extent of the waiting times for individuals to access services.

A number of services implement waiting list strategies – prioritising, offering group brief intervention, etc. Most organisations, however, do not actively promote their services because the demand for their service is already more than capacity.

Waiting lists and time would give a clear indication of direct demand for services, can be used to inform referral, and could inform initiatives that promote the sector and inform the community of services that can be accessed to meet their needs. One would expect that once the services offered have expanded as per the 10 Year Plan that waiting lists and times are manageable and acceptable to an informed community.

Ways of determining waiting lists and times for not-for-profit alcohol and other drug residential services vary for different priority population groups and the methods used. A record of non-residential services' waiting lists and times is not maintained or available for analysis. Waiting lists and times is a good indicator of service demand, and there is currently no means of obtaining collective information identifying demand trends evident through waiting lists and times.

Recommendation 2:

A means of monitoring collective waiting lists and/or times needs to be developed and implemented.

² Implications for data management are explored below under 5.2.

5. Streamlined processes and greater efficiencies

5.1 Services Provided by the Government Agency (DAO)

The amalgamation between DAO and the MHC came into effect on the 1 July 2015. The information in this section was obtained prior to the amalgamation and focuses on the services provided by DAO.

It is intended that a similar evaluation will be conducted at regular intervals (possibly related to the 10 Year Plan phases of 2017, 2020, 2025) to provide an indicator of the benefits to the alcohol and other drug sector resulting from the amalgamation.

5.2 Contract Management

A key indicator of the effectiveness of the partnership between government and not-for-profit services is the relationship services have with contract managers. This may be contingent on a range of factors such as the number of years the contract manager has been working with the service, through to the workload of the contract managers i.e. the average number of contracts or contract funds managed.

Feedback³ from Sector Managers regarding their relationship with DAO contract managers indicates:

Length of time working with current DAO contract manager

- 31.3% had been working with them less than 1 year;
- 43.8% had been working with them between 1 and 5 years; and
- 12.5% had been working with the same DAO contract manager for between 5 and 10 years

The quality of the relationship:

- 62.5% of respondents indicated the relationship was extremely good, and 18.7% rated the relationship was moderately good.
- 62.5% of respondents indicated that it was 'extremely likely' that the current contract manager adds value to the service they manage.
- 75% of respondents indicated that their relationship with their current DAO contract manager was "extremely respectful".

The number of treatment and support services contracts funded by DAO⁴ has minimally increased over the past years: 64 in 2012/13 growing to 66 in 2014/15.

³ From WANADA's AOD Manager's Survey 2014

⁴ Drug and Alcohol Office 2015. *Information to support an evaluation of the amalgamation of the Mental Health Commission and the Drug and Alcohol Office – requested by the WA Network of Alcohol and other Drug Agencies.*

WANADA was not able to determine the number of FTE contract staff at DAO to determine average number of contracts managed or information related to the average contract funds managed. As such WANADA is not able to determine if the quality of the relationship with contract managers is related to contract manager workload.

5.3 Data Management

While the data collected by the not-for-profit services belongs to the organisations, DAO have warehoused the data collected through the Systems and Information Management System (SIMS) by services that DAO fund. SIMS data includes the National Minimum Data Set requirements for alcohol and other drug services.

As stated above the usefulness of the data collected, in terms of informing practice, is unclear.

An independent consultant, Social Ventures Australia (SVA) undertook consultation in 2014/15 with the sector on behalf of WANADA and received feedback from WANADA members on the SIMS data management system. Most WANADA members think data collection system is poor and only use SIMS to “appease DAO”. They believe WANADA could play an important role in improvements.

A summary of data management issues provided by SVA includes:

- many respondents think that the data collected is poor and tools are primitive;
- most services use SIMS just for reporting to DAO and don’t use it for internal planning;
- 75% of survey respondents and the majority of interviewees did not think that the SIMS data set is adequate to serve the needs of the sector;
- some organisations have their own data systems and find it frustrating that the systems don’t integrate;
- many respondents didn’t feel like they really understood the capability of SIMS; and
- a couple of services were very positive about SIMS but they had worked hard with DAO to make SIMS work for their services.

Suggested improvements in the data management system were recorded:

Having access [to data] at a sector level would be useful for benchmarking, planning and shared learning.

We need to be able to analyse cost effectiveness of services across the sector.

It would be great if SIMS could integrate with our own systems.

We are not telling the full story of the sector through SIMS – there are many real outcomes achieved that are not reported – this needs to change.

Many sector service stakeholders saw a role for WANADA in these improvements:

WANADA should work with DAO to define what data needs to be collected by the sector to truly demonstrate outcomes achieved.

WANADA should advocate for better data processes.

There is a definite role for WANADA to work with DAO to improve collection, availability and analysis.

We all need to improve and demonstrate value for money so WANADA could support organisations to do this.

WANADA could help organisations figure out what data they need to collect and how to analyse it.

Many organisations collect additional data to support operations and most think they need more analytical/data resources and skills.

WANADA has often requested collective data to inform initiatives, on behalf of or at the request of members. This may involve getting permission from the organisations who own the data. The requests to DAO have often been protracted, and consequently cannot always be relied on to inform time limited planning processes.

Along with the responsibility of warehousing, DAO are required to address any data issues including providing support related to SIMS needed by sector services. WANADA's AOD CEO/Managers' Survey 2014 sought feedback on DAO's data management support offered.

- 25% of respondents indicated the DAO data management systems is not relevant to them (i.e. they are not funded by DAO)
- Of those that use SIMS, data management support was called on at least fortnightly or more frequently by 50% of respondents.
- Of those that use SIMS, 25% rated the support they received as less than worthwhile, which is of concern.

The data collected by DAO does not cover the whole of the sector. This feedback on data management support provided by DAO indicates that support is clearly necessary, however there is room for improvements in regards to the support provided.

Recommendation 3:

The sector data system including: the data collected; and how it is managed, used and supported needs to be reviewed, with improvements made to better meet the data needs of services.

5.4 Training offered by DAO

DAO's workforce development branch identifies as a key provider of training to the staff in the alcohol and other drug sector and other sectors working with people impacted by alcohol and other drugs.

Numbers of participants and training provided by DAO to the 'non-government' alcohol and other drug sector staff was received from DAO⁵.

	2013/14	2014 - end Feb 2015
NGO AOD staff attending DAO training:	338	216
Number of DAO events open to NGO AOD staff:	119	52
KPIs of training events provided by DAO accessible to NGO AOD staff:		
Usefulness	82.0%	90.0%
Knowledge	75.5%	79.5%
Confidence	74.1%	76.4%
Competence	69.4%	71.3%

These figures show an average of:

- 2.8 non-government alcohol and other drug service staff attended each event that was open to them and provided by DAO in 2013/14;
- 4.2 non-government alcohol and other drug service staff attended each event that was open to them and provided by DAO in 2014/15 to the end of February.

WANADA is aware that there are some training event provided by DAO specifically targeting alcohol and other drug service staff, such as sector induction training. Conceivably, therefore, there would be events that have not attracted any non-government sector staff. This raises concerns about the relevance of the training provided by DAO to meet the needs of the non-government sector services' staff.

The KPI's do not provide any indication of the impact that the training has had on sustained practice.

As shown below in 5.6 the number of staff from other sectors accessing DAO training has been 1,006 in 2013/14 and 826 to the end of February 2014/15. This raises a further concern about the priority DAO have given to training for the not-for-profit alcohol and other drug sector.

Feedback provided to WANADA clearly indicates staff are accessing professional development training outside of that provided by DAO. WANADA is not aware of any extensive coordination of training undertaken that would ensure against duplication of the training provided and inform training gaps.

WANADA's Manager's Survey 2014 indicated:

- 87.5% see training as adding value to the service provision of their organisation

⁵ Drug and Alcohol Office 2015. *Information to support an evaluation of the amalgamation of the Mental Health Commission and the Drug and Alcohol Office – requested by the WA Network of Alcohol and other Drug Agencies.*

- 86.67% of respondents indicated it was important that training accessed by their staff was accredited.

Other than the DAO Aboriginal Program courses, the training provided by DAO is not accredited. Feedback from the sector on the courses offered by DAO under the Aboriginal Program is positive and it is generally acknowledged this Program has contributed to a sound Aboriginal workforce in the alcohol and other drug sector.

Recommendation 4:

A workforce training framework needs to be developed and implemented to ensure coordinated, appropriate training is available to the not-for-profit alcohol and other drug service sector.

5.5 Workforce Planning

Feedback provided through WANADA's AOD Worker's Survey 2014 indicates 61.81% of respondents have or are completing a formal university qualification (mostly in psychology, social work, counselling, or related degree with addiction/alcohol and other drug units). A further 19.40% have completed a Community Services Training Package with an alcohol and other drug specific unit or units of competency.

- 53.94% of respondents indicated their formal qualification did better than moderately prepare them for their AOD role.

There would clearly be an advantage in the sector informing the curriculum of relevant courses.

In the past 12 months WANADA has supported a considerable number of student placements, using a developed supervision and support model. This has resulted in the engagement of approximately 60 undergraduate and 10 post-graduate students from social work, allied health, health promotion, health sciences, para-medical science, public health, pharmacy, medicine, etc. enrolled in courses at UWA, ECU, Curtin and Notre Dame Universities. These student placements has provided increased awareness of the expectations of graduates that may look for careers in the AOD sector. It has also raised awareness of potential career options in the sector.

In addition the network of state and territory alcohol and other peaks have provided significant input into the Community Services and Health Industry Skills Council alcohol and other drug relevant units, informing the curriculum. This has been led by the jurisdictions peaks who have a higher percentage of TAFE qualified staff in their sector.

WANADA is not aware of the impact of any workforce planning efforts undertaken by DAO that has supported the not-for-profit services, and feels that this responsibility is therefore best placed with WANADA.

Recommendation 5:

Workforce planning strategies need to be prioritised to both overcome current workforce trends and support an expanded workforce needed as a result of the developments of the 10 Year Plan.

5.6 Capacity building of other sectors

DAO has run a number of training events for staff of other sectors⁶.

	2013/14	2014 - end Feb 2015
Number of staff from other sectors attending training provided by DAO:		
Corrections	220	222
Child Protection	54	160
Mental Health	291	223
Police	320	104
Other – tertiary sector	121	117
Total	1,006	826
Number of training events provided by DAO specifically offered to staff of other sectors:		
Corrections	12	11
Child Protection	4	3
Mental Health	22	14
Police	13	4
Other – tertiary sector	5	4
Total	56	36
KPIs of training events provided by DAO accessible to NGO AOD staff:		
Usefulness	84.0%	87.8%
Knowledge	79.5%	80.8%
Confidence	72.4%	70.3%
Competence	70.7%	69.8%

Training to other sector staff is welcomed as a cross-sector capacity building initiative. WANADA recognised that DAO has a clear role in offering this training, specifically to government workers. Networking opportunities with the not-for-profit services (which make up the majority of alcohol and other drug services) are not made available through this training, and yet would support more effective referral and shared care.

⁶ Drug and Alcohol Office 2015. *Information to support an evaluation of the amalgamation of the Mental Health Commission and the Drug and Alcohol Office – requested by the WA Network of Alcohol and other Drug Agencies.*

Alcohol and other drug capacity building training and support is also needed for non-government staff from other sectors, including but not limited to: domestic violence, emergency relief, housing and homeless and youth services; and workplaces generally. Currently there appears to be limited resources dedicated to supporting this capacity building. WANADA would be best placed to coordinate this support.

Recommendation 6:

Capacity building training and support needs to be coordinated, developed and delivered to meet the needs of non-government services from other sectors.

6. Better integration

While alcohol and other drug issues are common experiences of consumers accessing most human services, the alcohol and other drug sector has worked at developing and improving cross-sector collaboration.

WANADA's survey questions to alcohol and other drug sector managers focused on two significant collaboration areas: mental health and primary health⁷. This decision was informed by research undertaken by WANADA on stigma and discrimination of alcohol and other drug users, family members and workers. Stigma and discrimination from these two sectors was highlighted as particularly significant.

*Consumers felt that the majority of the barriers to treatment and support they had experienced existed at the systemic and organisational level, but were exacerbated by interpersonal discrimination on the part of service providers. Service providers could shift the blame to organisational policies or systemic restrictions. The example of mental health services requiring consumers to be sober before assessment was cited here by a number of consumers. Consumers felt that this constituted discrimination on the part of service providers in mental health services, who used organisational policy as an excuse not to assess them.*⁸

*"Junkies don't qualify [for mental health services]." – Female consumer"*⁹

*Unanimously, sector workers and consumers felt that stigma surrounding drug and alcohol dependency and issues related to problematic use of these substances is based on a lack of understanding and empathy at all levels.*¹⁰

⁷ WANADA is focusing only on collaborations between the alcohol and other drug and mental health sectors in this report.

⁸ Colmar Brunton Social Research, 2014. WANADA Research to inform strategies to reduce AOD related stigma: AOD Service Consumers and Workers Qualitative Report. P 10.

⁹ Ibid

¹⁰ Colmar Brunton Social Research, 2014. WANADA Research to inform strategies to reduce AOD related stigma: AOD Service Consumers and Workers Qualitative Report. 929.

Addressing stigma and discrimination and consumer involvement are essential to inform cross-sector collaborations. An action plan to address stigma and discrimination issues, based on research and extensive consultation with sector consumers¹¹, was provided by WANADA to DAO in June 2015. The action plan was reliant on the establishment of an alcohol and other drug systems advocacy consumer body. WANADA understands DAO developed business cases for these initiatives.

Recommendation 7:

Resources are needed to implement identified strategies aimed at addressing stigma and discrimination of alcohol and other drug users and family members. This includes the establishment of an alcohol and other drug systems advocacy consumer body.

6.1 Collaboration with mental health services

Feedback via WANADA Managers' Survey 2014 indicates:

- 86% of respondents had contact with the Mental Health services;
- 58% on average had monthly or more frequent contact with Mental Health Services;
- 47% of respondents had initiated contact with Mental Health services, 7% indicated that Mental Health services had initiated contact with AOD services; and
- More than half (53%) believed their engagement with mental health services had been worthwhile.

The main challenges, highlighted in the feedback, to collaboration with mental health services included:

- the lack of understanding from staff from both sectors regarding the other's role;
- wait times; and
- unwillingness of mental health services to undertake appropriate assessments of AOD consumers.

Suggestions made for reducing these difficulties focused on improving the liaison between these two sectors through enhancing understanding and focusing on the respective strengths of each sector.

Many not-for-profit alcohol and other drug services have received and/or have benefited from Commonwealth funding to support them to build their capacity to better meet the needs of people with co-occurring alcohol and other drug and mental health issues.

The Improved Services Initiative (ISI) funding (2008 – 2011) resulted in 10 lead organisations and over 20 consortium member services supported in WA. All

services involved were required to undertake an assessment using the Dual Diagnosis Capability in Addiction Treatment (DDCAT). Drawing heavily on the DDCAT findings the impact of the ISI supported initiatives in WA was evaluated by WANADA¹².

- In 2008, the participating organisations assessed themselves as dual diagnosis capable against 6% of the DDCAT index items.
- In 2009, participating organisations assessed themselves as dual diagnosis capable against 46% of index items.
- In 2010, participating organisations assessed themselves as dual diagnosis capable against 70% of index items.

These improvements in services' capability are significant. Being able to demonstrate that changes implemented at the service level resulted in improvements not only motivated the sector, but informed planning beyond the ISI funding. The evaluation of ISI continues to provide the basis for WANADA's position on cross-sector collaboration between the alcohol and other drug and mental health sectors.

WANADA's position is that:

- dedicated capacity building resources are needed to improve the capability of services;
- a validated assessment tool (such as the DDCAT and the mental health service equivalent DDCMHT) are important tools to inform capacity building priorities and to demonstrate the effectiveness of services in meeting consumer needs; and
- the assessment tools would be improved with independent audit.

Recommendation 8:

Routine co-occurring mental health and alcohol and other drug service capability assessments (through independent DDCAT and DDCMHT reviews) needs to be resourced. These assessments would inform a comprehensive approach to the sectors' development in delivering services to people with co-occurring issues.

7. Conclusion

The stated intent of the amalgamation of DAO and the MHC was to improve:

- service delivery;
- streamline processes and efficiencies; and
- integration.

This State of the Sector report has been informed by available data, feedback from the sector via surveys, and recent research and evaluations – all gathered prior to the amalgamation. As such it provides a baseline “pre-amalgamation evaluation”

¹² WANADA 2011, Review of the Impact of the AOD Improved Services Initiative in Western Australia.

that can now be compared with similar information in the years to come, enabling an assessment of whether the amalgamation intent has been achieved.

There are many strengths in the alcohol and other drug sector. WANADA would hope that current good processes are at least maintained. Eight recommendations have also been made related to areas identified by the sector as currently needing improvement, and which will support the achievement of the amalgamation intent.