Western Australian Network of Alcohol & other Drug Agencies

# WANADA Submission to Interim Consultation Summary Report: Alcohol and Other Drug Services in the Kimberley

## About WANADA

WANADA is the peak body for the alcohol and other drug education, prevention, treatment and support sector in Western Australia. WANADA is an independent, membership-driven not-for-profit association.

WANADA is driven by the passion and hard work of its member agencies, which include community alcohol and other drug counselling; therapeutic communities; residential rehabilitation; intoxication management; harm reduction; peer based; prevention; and community development services.

## Introduction

WANADA supports the Mental Health Commissions approach of conducting community and service consultation prior to undertaking alcohol and other drug service planning and design in the Kimberley. As part of this process, WANADA welcomes the opportunity to provide feedback on the *Interim Consultation Summary Report on Alcohol and Other Drug Services in the Kimberley* (the Interim Report).

Identifying common themes from the consultation undertaken provides a sound basis for informing future service planning in the Kimberley. While the consultation appears to be comprised of limited participants, WANADA is concerned that the summary of the themes in the Interim Report appears to present a more negative perception of service operations than we believe is warranted.

While the perceptions of those consulted is valuable, it is important that these perceptions are evaluated alongside a critical evaluation of the current system and service environment. By analysing both peoples' perception, and the service system's operations, there is a need to identify:

- opportunities to introduce system or service improvements;
- examples of best practice that could be applied regionally or State-wide; and
- opportunities to improve stakeholder and community awareness of how the alcohol and other drug system, and specific services, operate.

WANADA has structured its response by focussing upon the principles and enablers sections of the Interim Report. Noting the recurrence of some themes throughout the Interim Report, WANADA's comments can be extrapolated to other sections. Opportunities to further refine the consultation, terminology and structure of the Interim Report have also been identified.

WANADA contributed to the service consultation and wishes to remain involved in any subsequent consultation or service planning, to provide systems input from a service sector perspective. We would welcome the opportunity to discuss or clarify any points raised within this submission.

## Consultation

Noting the focus of the Interim Report is to synthesise the participant's commentary across all consultations, it would be beneficial to provide further clarity about the nature of consultations undertaken. While organisations are listed, there is limited information regarding the number of participants present at the service provider workshops and the consumer and family forums. It is important that the number of

individual participants is provided, particularly as qualifiers of support (i.e. few, some, many, most) are quantified.

WANADA notes that consultation to support Kimberley service planning has been undertaken in an environment of significant community and service consultation activity, including the recent regional consultations associated with the Methamphetamine Action Plan Taskforce. WANADA recognises the difficulty that multiple rounds of consultation present for both community engagement and government processes, particularly when topics overlap. It is hoped that there is an opportunity for the Kimberley service review to be informed by the consultations conducted by the Taskforce.

## Terminology

Within the Interim Report, there are opportunities to clarify or amend language that will improve the document's communication of key concepts.

As a general comment WANADA recommends that 'alcohol and other drugs' is not abbreviated to 'AOD'. Acronyms such as these are less accessible to the community. Furthermore, the extended reference provides an opportunity to improve community awareness that alcohol is a drug, and not a usual commodity.

Noting the sensitivity of alcohol and other drug issues in the Kimberley, WANADA recommends that some phrases and comments are reviewed and reframed.

- The term 'negative stigma' (p.13) infers that positive stigma also occurs in association with alcohol and other drug use.
- There is a more comprehensive and appropriate definition of "recovery" as it applies in the alcohol and other drug area available through within the UK Drug Policy Commission Recovery Consensus Group report *A Vision of Recovery* (July 2008), which extensively outlines the features and process of recovery[1] in the alcohol and other drug sector.
- WANADA cautions against the use of terminology which is used predominantly in other sectors and is not as useful for alcohol and other drug consumers or sector development. "Lived experience" is one example of a term used within the mental health space, however has many issues and concerns for people who have experienced/are experiencing a range of issues associated with alcohol and other drug use, including people with alcohol and other drug dependence. For many alcohol and other drug consumers the term has been reported as being more disempowering than intended. A preferred term for the alcohol and other drug sector consumers is "having experiential knowledge" – which is seen as empowering, supports an appreciation of collective knowledge rather than individual perception/views. Within the alcohol and other drug sector, experiential knowledge is the preferred term to lived experience.
- WANADA cautions some language that could be perceived as unhelpful to readers. In particular: *once people are turned away or receive delayed treatment, you are no longer preventing alcohol and other drug use but rather encouraging it* (p.17). The wording risks confusing prevention activities and service access. Further, 'encourage' could be interpreted as inferring a causal and approbative relationship.

## Structure

**Service taxonomy**

WANADA applauds the efforts of the document to maintain the structure of service types as presented in the *Western Australian Mental Health, Alcohol and other Drug Services Plan 2015 – 2025.* There is, however, confusion and overlap within the Interim Report in describing prevention; community support; community treatment; community bed-based; and hospital-based services within the document. This is of further concern where the "future services" are not presented within the Plan's taxonomy, despite all of the

[1] UK Drug Policy Commission Recovery Consensus Group (2008), A *vision of recovery*. http://www.ukdpc.org.uk/publication/recovery-consensus-group/ Accessed 24 August 2018.

identified future services fitting easily into this scheme. Clearer delineation of service needs within the taxonomy is required.

**System-wide reform initiatives**
WANADA notes that system-wide reform (as it is referred to in the *Western Australian Mental Health, Alcohol and other Drug Services Plan 2015 – 2025)* is not analysed in the document, despite the principles and enablers having a system focus and broader implications for service delivery in Western Australia.

WANADA recommends that systems initiatives are separated into another section within the Interim Report. Within this section, analysis could be provided about implications of many issues raised, and how these could be systemically addressed either within the Kimberley region or at a State level. For example, all initiatives will require support in the form of:

- co-production and co-design with consumers, family members and community;
- system integration and navigation, including capacity building (e.g. both service and cross-sector capacity building; targeted initiatives such as youth and fetal alcohol spectrum disorder (FASD); and
- workforce development (e.g. recruitment, training, retention and supervision and worker well-being to address issues such as translation of evidence informed practice and vicarious trauma).

A centre of capacity building and coordination would be ideally placed to support the coordination and delivery of these initiatives, by contributing to the alcohol and other drug service sector's quality and capacity, as well as systematically support the capacity of all relevant human services to address alcohol and other drug related issues.

A systems-wide reform initiatives section would also enable the Interim Report's consultation themes to be linked with existing system evaluations and recommendations, such as those contained within WANADA's *Comprehensive Alcohol and Other Drug Workforce in Western Australia: Full Report*, and WANADA's *2019-2020 Pre-Budget Submission: Building Capacity to Drive Positive Change*. This would enable consideration of cost-effective solutions that would address the issues identified within the Kimberley, and also realise systems improvements state-wide.

## Principles

1. **Community led, co-designed initiatives deliver better results for people with alcohol and other drug and mental health issues**
   The Interim Report states: *The majority of participants in consultations highlighted that locally led and co-designed services do not feature strongly in the current AOD service system.*

   WANADA suggests it would be useful to identify examples of locally led and co-designed alcohol and other drug services. WANADA is aware of several co-designed alcohol and other drug services and would be happy to discuss these with the Interim Report drafters.

   Regarding locally led initiatives, WANADA believes that at the very least the Aboriginal Community Controlled Organisations involved in alcohol and other drug service delivery should be considered examples. Liquor restrictions in the Kimberley and FASD awareness are additional examples of community led alcohol and other drug initiatives. The emphasis in the Interim Report of underachievement in this area unfortunately undermines the significance of community champions and community input that have led positive changes in the Kimberley region.

   Clarification of what is happening as a result of locally led initiatives and co-designed services would lead to a more refined principle – such as:

   > *Promoting the extent of, and achievements resulting from, locally led and co-designed alcohol and other drug initiatives and services supports community pride and ownership of contributing to positive change.*

   While the need to address alcohol and other drug and mental health issues as they co-occur is an important consideration, WANADA questions combining alcohol and other drug and mental health

within this principle. Efforts in locally led and co-designed initiatives and services are different across the two sectors, especially as much of the locally led initiatives are related to alcohol prevention and alcohol and other drug related issues.

2. **The alcohol and other drug service system needs to be underpinned by 'whole of family' approaches to services.**
   Not all services equally lend themselves to applying whole of family approaches. For example, sobering-up and other harm reduction services may have minimal opportunities to apply this principle, where residential services may be more able to incorporate these practices. WANADA is aware that the residential services in the Kimberly are inclusive of whole of family approaches.

   WANADA's understanding of family engagement in non-residential treatment services is that family members or people impacted by another person's alcohol and other drug use can access support independently and can be invited to participate with the substance user accessing treatment if it was approved by the consumer and identified as beneficial in improving outcomes. This inclusivity and flexibility is an important consideration.

   Prevention initiatives, such as FASD awareness, engage family members as appropriate. Community led initiatives such as restrictions similarly have not just family but a population health focus.

   The Interim Report's lack of acknowledgement of the services that apply this principle, and a focus on the lack of the universal application of this principle is unhelpful in understanding what improvements are indeed needed. A preferred principle would be to state the positive achievements of family and community engagement rather than presenting it as a complete gap.

3. **Alcohol and other drug use cannot be understood without holistic consideration of other social issues and adverse life experiences**
   Harmful alcohol and other drug use may be caused by social issues and adverse life experiences. Harmful use can also contribute to, or cause these additional issues. Consequently, causal analysis is unhelpful. It is suffice to say co-occurrence is the norm rather than the exception, and services across the human services sectors must collaborate to address the range of social and health determinants.

   WANADA understands that co-occurring issues are screened, assessed for and addressed (internally at services or through shared care/care coordination) at alcohol and other drug services in the Kimberley and throughout the State. Without minimising the impact of trauma, grief and suicide rates in the Kimberley region, it is also important to address family and domestic violence, homelessness, long-term unemployment, poor general health etc. WANADA believes all determinants should be equally addressed, rather than have some factors (i.e. mental health issues) emphasised above other determinants.

   WANADA agrees that the role of alcohol and other drug services (from harm reduction to treatment) is to provide services along the continuum of psycho-social support and treatment. There is a need for all service types to be better resourced and evaluated to inform outcome and impact improvements.

4. **Integration and collaboration are key**
   Addressing the harms associated with alcohol and other drug use requires the combined efforts of people, communities, services, industry and government. An underpinning requirement for cross-sector collaboration and integration is the capacity of other sector services to play their role. This requires workers in all human services to: address any negative attitudes of alcohol and other drug consumers (reducing stigma and discrimination); feel confident to ask basic questions about alcohol and other drug use; provide evidence informed information; have the confidence to undertake brief/early intervention; refer as necessary to specialist treatment services; and accept referrals from

alcohol and other drug treatment services and agree on care coordination approaches to meet co-occurring and complex needs of individuals.

WANADA agrees that sometimes formalised care coordination processes may be needed, however informal process are also valuable. For both, alcohol and other drug specialist service-lead capacity building is required and needs resourcing for an improved systems approach.

5. **Culturally secure services are vital to community engagement and positive treatment outcomes**
   WANADA welcomes the acknowledgement of examples of cultural competence and the willingness of services to share culturally secure approaches. WANADA also agree there is a need to increase Aboriginal staff at alcohol and other drug services.

6. **Alcohol and policy reform is needed**
   WANADA agrees with, and evidence supports, a whole of population approach such as region-wide restrictions, particularly when they are combined with a suite of reform initiatives such as alcohol management plans and adequate services across the spectrum of service types to meed diverse needs.

   WANADA is aware that region-wide restrictions are also being considered in the Pilbara, and significant alcohol reform is being adopted in the Northern Territory. The focus on population health, as opposed to the potential vilification of individual community members through standalone initiatives such as a banned drinker register, is what is needed.

## Enablers

1. **A 'no wrong door' approach is required across the alcohol and other drug and mental health service system**
   Please refer to WANADA's comments above, under the principle for integration and collaboration.

2. **Building and retaining a capable workforce in the region**
   WANADA agrees with the descriptor under this enabler. There is a need to acknowledge the significant role the MHC Aboriginal Workforce Development Program has played to support this, and the need to expand these efforts rather than the current approach to reducing this workforce development initiative.

3. **The alcohol and other drug service system needs a greater focus on community awareness and education**
   WANADA agrees with the overriding premise of this enabler, however cautions the singular emphasis on methamphetamine. While acknowledging the community's stress related to the impact of methamphetamine, community awareness and education regarding alcohol and tobacco need to be prioritised for greater impact and population health and wellbeing.

4. **Doing the basics better**
   As addressed above - WANADA is supportive of the emphasis that this enabler offers.

5. **Removing the negative stigma around alcohol and other drugs and mental health**
   WANADA is of the view, supported by research, that addressing stigma associated with alcohol and other drug use requires a very different approach to addressing stigma in mental health. As such it is not beneficial to group these issues together.

   Addressing stigma in alcohol and other drugs needs to be a priority given injecting drug use is the most, and alcohol dependence is the fourth most stigmatised social and health issue according to the World Health Organisation.[2] An interdependent approach to addressing alcohol and other drug

[2] 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.

stigma has been identified as the most effective – and fits very well with the premise of the principles and enablers offered in this Interim Report.

6. **Information sharing between services is a barrier to service integration and collaboration**
   Unfortunately this statement is presented as a barrier rather than an enabler. WANADA considers the principles of care coordination and cross-sector collaboration to require effective information sharing. As such a more appropriate enabler would be to expand on the first “no-wrong door” enabler with resourced care coordination and system navigation.