Report Prepared By
Dr E.B. Ritson,
Senior Consultant Psychiatrist,
Royal Edinburgh Hospital, Scotland
for the
Western Australian Alcohol
and
Drug Authority

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PREFACE

Organisation of the Report:

The report opens with comments on existing clinical services and then discusses each profession's contribution to these services. The Alcohol and Drug Authority's relationship with non-statutory services is briefly considered before going on to the educational, research, library and administrative divisions of the Authority. Existing services to non-metropolitan areas are discussed and limited to a consideration of Aboriginal substance abuse.

Finally, I have tried to identify some issues which will need to be addressed in the immediate future and recurrent themes which have been highlighted for me during my stay.

C O N T E N T S

INTRODUCTION:

It is hard to summarise four months of fascinating experience in a few paragraphs. But some recurrent themes stand out from reviewing my diaries and notes and recalling conversations with members of the Alcohol and Drug Authority, workers in other agencies and particularly meeting the clients and their families.

This is not a report in the conventional sense. I have not been conducting an enquiry or collecting evidence. I have simply been working with colleagues in the Authority, and what follows is therefore a series of impressions and reflections.

For a more systematic review, there is Dr Bewley's valuable report (1979) and which still contains much relevance to the present situation. I was struck by the congruence between his recommendations, the Director's own Directional Statement and my own impressions. Dr Bewley recommended greater priority for outpatient work, earlier intervention, improved liaison and an emphasis on training. These recommendations are not yet realised but they are certainly being actively pursued at present. His report, along with the annual reports of the Authority itself, and the Commonwealth report on Drug Problems in Australia (1977) form the backdrop against which my own impressionistic account can be viewed.

During my stay, I have had almost daily discussions with the Director about the pattern of services and the future of the organisation. The Authority is fortunate in having someone of his vision and experience and I have greatly valued his help throughout.

I should like to thank the Board and all the staff of the Authority for giving me the privilege of working with them and allowing me to become acquainted with what must be one of the friendliest and most beautiful cities in the world.

CLINICAL SERVICES

The debate which preceeded the formation of the Alcohol and Drug Authority was particularly concerned with the provision of services to socially deteriorated alcoholics who were often very publicly visible, made a lot of use of existing resources and were often in trouble with the police. This client group is therefore well represented amongst those attending the existing services. Present services within Perth are:-

Carrellis Centre:

This outpatient clinic provides an excellent service. Patients rarely have to wait long for an appointment and "walk-in" cases can usually be seen without much delay. The secretarial and reception services are good and skillfully manage difficult clients and phone calls. It would probably facilitate their work if the typing function was separated from reception and records and this should be readily achieved in Mount Lawley. This separation would also ensure a greater degree of confidentiality because discussion and dictation can take place at a distance from the area where outpatients check in at the reception desk.

Most patients are seen initially by a Social Worker and then by a Doctor. I personally like the modular organisation of the casenotes. However, the actual interviews

can be somewhat repetitious. The Social Worker usually leaves good notes for the guidance of the Doctor, who then concentrates on assessing the degree of physical dependence and conducts a physical examination. This is usually essential because the patient has not been examined by any other Doctor, prior to referral to the Centre.

It might help in the planning and management of the patient if a meeting between the Social Worker, Doctor and the patient could be routinely arranged at the end of the first visit. This would go some way to overcome the fragmentation of services which is liable to occur when each worker makes independent plans for the patient's future management. Many patients are then seen by the A.A. Counsellor who also provides excellent service and can often undertake a considerable amount of the patient's aftercare.

The A.A. Counsellor at the Centre serves an invaluable function. I was impressed by the way in which he introduced suitable patients to the fellowship of A.A. but also provided counselling and support of an individual nature without any insistance on A.A. membership. Trained counsellors (not necessarily with A.A. experience), could be utilised much more extensively within the Authority.

This would require the presence of an adequate training course (see later). It is also important that such counsellors receive payment commensurate with their skills and contribution and are encouraged to attend further training in more advanced counselling techniques.

Aston Hospital:

This unit provides an excellent detoxification service to alcohol dependents and a small number of drug addicts. The hospital emphasises the physical aspects of treatment but also prepares patients for changing their lifestyle. This preparatory phase is very important and will require careful consideration in the move to Mount Lawley (see later). It is important to avoid too rigid a demarcation between physical assessment and the more psychosocial aspects of rehabilitation.

Although detoxification is the main function of this facility, I was pleased to see that patients were sometimes admitted for other reasons such as a social crisis or for investigation of psychological or physical abnormality. It is important that the Authority retains some beds for this kind of client and avoids restricting its admission criteria too rigidly to those with the alcohol dependence syndrome.

Young drug addicts seem to manage quite well in Aston provided their numbers are kept to one or two at a time.

With larger numbers they become a distinctly disruptive influence. They also report being 'deterred' by the pervasive clinical atmosphere of the wards and would prefer a more 'domestic' setting. Hopefully, the non-statutory sector will agree on plans for a residential facility that would provide detoxification for young drug addicts in a setting where they feel more at ease.

I have stressed 'young' addicts because there is another probably larger group of older people who are dependent on tranquillizers and hypnotics. This group which evidence elsewhere suggests may grow in number can be treated alongside alcoholics in Aston. It is unfortunately very easy for patients to 'shop 'round' from one general practitioner to another, obtaining tranquillizers from each. The Alcohol and Drug Authority could participate in raising public awareness of the dangers of tranquillizer abuse and their addictive properties.

At present, plans for each patient are agreed at a weekly meeting attended by social work, nursing, O.T. and medical staff. Here decisions are made which form the foundation of subsequent care. A large number of patients need to be discussed at this time and I was impressed by the rapidity with which decisions were made. Given more time, it would be helpful in some cases to permit more detailed review of the different facets of each patient's problems with the additional option of having the patient attend the meeting.

There is, at present, a danger that the plans for patient and relatives become fragmented so that each profession - social work, psychology and medicine pursue their own policy for after-care without much co-ordination or opportunity to review progress. While the individual skills possessed by the different professions involved are undoubted the after-care programme lacks an integrative element.

William Street Clinic:

The Clinic is very well organised and morale and enthusiasm was remarkably high in a service which is acknowledged to be extremely stressful and difficult to maintain. There is again the problem of overlap between Physician and Social Worker referred to above and joint discussion and planning is very important.

Methadone maintenance is only offered after a lot of thought. The strategy of submitting requests for maintenance to an independent Panel works well - and has the important function of distancing the personal Clinician from the decision and avoiding tedious and even violent arguments over the provision of drugs.

It is unfortunate that the public image of William Sreet is of "a methadone maintenance programme" because it is a resource for all individuals who abuse drugs (including those legally obtained) and a potential source of help to concerned family

members who wish information, advice, or counselling. The Authority should give some thought to counteringthis image and make it clear that if offers extensive help beyond methadone.

The Clinic is well situated and has a friendly atmosphere. It must be one of the cleanest and tidiest addiction Clinics anywhere. It is obviously inconveniently located for some patients who require to attend every day and I was pleased to learn that satellite dispensing Clinics are being established at other hospital pharmacies. Given sufficient consultation and support, there is no reason why daily supplies could not be given to patients of proven reliability at a range of hospital pharmacies. This already occurs outside the metropolitan area. I would personally see little advantage in making changes to the present criteria for dispensing methadone as there is little evidence that generosity in methadone provision improves either function or prognosis in the long term.

Quo Vadis Centre:

This facility is in a beautiful, but unfortunately rather remote setting. The staff had clearly been demoralised by the cutbacks of recent years and the outcome of the recent evaluation study. (They should not feel too cast down by the latter, because they are of course working with one of the most difficult groups of alcoholics, and as such, a high rate of recovery could not be anticipated).

The House is well managed by a supervisor, but the respective roles of nurses and programme assistants requires some clarification. In general, I felt that Quo Vadis was in a period of transition and looking for a clearer function in keeping with the other changes occurring in the Alcohol and Drug Authority. At present, it is often seen by others as a place where the cognitively impaired can rest and hopefully recover their function. The staff at Quo Vadis would like to have a more active rehabilitative function but lack the resources and in some cases, the experience to achieve this goal. Here again, distance is a problem because it is too far away from the Authority's other resources to obtain more than token assistance from them. Rehabilitation incorporates preparing the patient for a return to family and workplace - these are usually in Perth and too far for regular contact.

More use might be made of adult education, craft skills, employment counselling and similar resources in the environs of Quo Vadis itself. In general the Authority should try and utilise other agencies wherever possible, rather than feel it needs to provide every resource itself.

Ord Street Hospital:

The programme is concerned with providing the patients (principally alcoholic) with skills in self management. Full entry into the programme depends on the patient's capacity to "pass" an assessment procedure. Motivation is obviously an

important but largely immeasurable factor. A great deal of attention is given to psychological assessment, particularly of cognitive and learning capacity. The Psychologist co-ordinating the programme has made a determined effort to standardise the screening procedure to obtain a clear profile of the patients most likely to benefit from the treatment. This praiseworthy and all too rare effort now needs to be properly evaluated to discover if the clinical hunches about which patient fares best with what programme can be convincingly proved. In the meantime, it would be wrong to pay slavish alegiance to methods of unproven validity. The present approach represents a useful start in improving the criteria by which clinical judgements are made.

The programme booklets which guide each patient through the inpatient stay represent a great deal of thought and careful preparation. They are excellent and patients use them very well. I did wonder how the less literate would cope with some parts of the programme and the nurses would have to be ready to assist patients who fail to understand some of the literature provided.

Ord Street has the rare attribute of possessing a coherent treatment philosophy. Ideally this allows both patient and therapist to "know where they are" in the therapeutic plan. Unfortunately, some of the staff are inadequately trained for the task they have been set, and there is an urgent need for recently appointed staff to receive necessary training.

The very coherence of the treatment philosophy has the danger of becoming exclusive so that patients, or even staff with alternative perspectives, may find it difficult to fit in. Regular staff policy reviews and a willingness to experiment with different treatment approaches and different client groups should help to ensure that no such ossification occurs.

Ambulatory Treatment:

Many patients are offered regular outpatient consultations with a member of staff and regular medical reviews are common. I was unable to obtain statistics for non-attendance rates or the frequency of patient contact. The programme offered regular reunions of patients who had been in the Ord Street programme or at Quo Vadis. The Occupational Therapist has recently organised a 'retread group' for patients who have relapsed and feel they need to review their way of life and set new goals. Groups of this kind could be developed further as patients commonly need a chance to analyse relapses and learn to find new ways of coping with the inevitable setbacks they will encounter.

Some clients are offered more specialised interventions on an outpatient basis:-

Relative Groups:

I was impressed by the coherence of this group and the skilled way in which the Social Workers integrated information and self exploration within an intensive programme. The handbook which accompanies the course is excellent. My only concern here was

that the programme had insufficiently clear links with other parts of the service such as Ord Street Hospital or family therapy - so that a family might have contact with different aspects of the Authority without the insights of one being relayed to the other, thereby losing some of their value.

Family Therapy:

This programme is experimental and at present relatively staff intensive. At a later stage, it should be possible for two teams to operate independently allowing more families to receive therapy. The team show a high level of commitment to family therapy and is developing interesting and worthwhile techniques. It is important that the Authority encourages innovative work of this kind, particularly in an area where there is currently world-wide interest. Once the skills are clearly developed and possessed by all members of the team, this should be an important area for clinical evaluation and research.

Family therapy requires two rooms - one for the family and therapist and one for the team of observers. The sessions could also be used for teaching other staff members about family dynamics. It is essential that the audio visual equipment used in this process functions well, which is not the case at present.

The resource represented by the one-way screen at William Street and hopefully duplicated at Mount Lawley, could be used for other clinical purposes, particularly teaching and observing group process. Currently it is under-used.

Childrens' Group:

I was pleased that the programme acknowledges the stress imposed on children and provides a means of helping them gain both understanding and means of coping. Again, the team responsible is developing a booklet to accompany the course which should be extremely useful.

General Hospital Consultations:

Professor E.G. Saint has pioneered a consultation service within the Sir Charles Gairdner Hospital where he currently operates from a base within the extended care clinic. These services require to be expanded so that hospital staff can obtain help in recognising and in many cases, managing early cases of alcohol and drug misuse. (The reasons for this are set out in Appendix 1). This hospital has, in principle, welcomed the concept of extending our services. We should also ensure that the Authority is credited with this service and records and statistics are kept by the Authority.

At a later stage, I would envisage clinics being established in the outpatient department of this hospital. It would take referrals from general practitioners and hospital staff. Location within a non-stigmatising setting would make it easier for patients to attend at an earlier stage in their "illness" when the prospects for cure are much better. At a still later stage, we would hope to see a small inpatient facility within one of the teaching hospitals. This would be an ideal location for teaching medical students and nurses. The initial service would require at least two-thirds of one consultant's time, plus the assistance of one registrar who

could be one of the trainees working within the Alcohol and Drug Authority. (I would however, like to see some of the medical officers of the Authority having sessions attached to this service if they wished more variety in their clinical work). A Social Worker and half time Nurse (Charge nurse grade) would also be required. These would not necessarily represent additional posts, but could be achieved by relocation of staff consequent on the Mount Lawley move. Hopefully, a part-time receptionist will be provided initially by the hospitals concerned. However, good communication is an essential component at any service of this kind and I imagine it would soon require the assistance of one full-time Secretary.

Alcoholism Programmes in Employment:

The Authority provides counselling support to INDRAD's outreach programme. This is a development which should facilitate early recognition of alcohol problems and has proved very effective in many countries. It should therefore represent a significant growth area and is very much in accord with the current philosophy of the Authority. It is however, essential that the package which INDRAD presents to raise industry's awareness of alcohol problems, is capable of 'delivering the goods' in terms of counselling services. At present, this component is under-staffed and under-financed for the task ahead. If the service to industry is going to grow, which is highly desirable, then there seem to be two possible approaches to the dilemma of service provision. One is to increase the funding to the Authority so that the

Authority's staff can develop this programme further, or a separate non-statutory agency should be established to take on the task. In either case, one would hope that industry itself could be persuaded to contribute to the financing of a programme which is very much in their own interests.

PROFESSIONAL GROUPS WITHIN A.D.A.:

Social Work:

The Authority provides an admirable range of social work services. In common with other departments within the Authority, it lacks a career structure and there is little chance of offering financial reward for learning new skills or adopting new responsibilities.

Facilities for regular supervision should be developed within the service and recognition given to the time involved in this task. If the Alcohol and Drug Authority assumes responsibility for more counselling within employment programmes, then expansion of social work will be necessary. It seems likely that a Senior Social Worker will be given the task of providing supervision and support to the Field Officers; specific sessions should be allocated to this. Liaison with statutory and non-statutory agencies is an important part of the service which is only now being pursued energetically: more communication between agencies would be helpful. If it is important, for clients to be clear about the expectations they have of the Authority, then the same is true of agencies. I often felt that referrals could be avoided if consultation had taken place between the agencies involved. We should try to avoid duplicating the work of other social work agencies - and there seems to be a general need for some co-ordination of social work services throughout the city. Even the planned listing of each agency with details of its activities would be helpful.

Occupational Therapy:

The present occupational therapy (O.T.) services are insufficient. There is also no proper space allocated to O.T. in the present buildings. This should be improved in Mount Lawley. O.T. can provide skills training, and an opportunity for the patients to try out new approaches to familiar situations (See Appendix 2). In the longer term, it should also give patients a chance to try out alternative pursuits, other than drinking. O.T. should also be involved in assessment for employment and domestic skills. To provide an effective service, the present complement should be increased by at least one basic grade worker. Craft and trade workers employed by the Alcohol and Drug Authority should be linked to occupational therapy as part of a co-ordinated retraining programme.

Medical Staff:

The medical officers provide an excellent service. They concentrate principally on the physical aspects of the patient's condition but are clearly well aware of the psychosocial dimensions. Most provide a specialist rather than a general practitioner function. It is again a pity that there is so little opportunity for professional advancement within the career structure of the Authority and this may deter some younger doctors from entering the service. The offer of training posts to other branches of medicine such as general practice and psychiatry is a promising model and one would hope to see more movement between the Alcohol and Drug Authority and other branches of medicine. There is a tendency for the present doctors to specialise within one part of the Authority. I think it would be preferrable to offer rotation to all aspects of the Authority, including liaison hospital and community work. This is particularly true for the trainees and an example of the range of

experiences which should be available to a psychiatric trainee is shown in Appendix 3.

Nurses:

Nurses are the largest professional group within the Authority. They engage in a number of very different activities and it is possible that some Nurses will have a definite preference for one or other of these. Amongst the distinct activities are:-

a) Detoxification nursing;
b) Assessing and motivating patients in the early stages of treatment;
c) Supervising and monitoring methadone maintenance;
d) Group work with patients;
e) Counselling;
f) Skills training, including relaxation, training and B.S.M. techniques;
g) Teaching: patients and their families;
: other nurses (in-service);
h) Consultation with colleagues in other hospitals;
i) Administration.

All of these activities involve human relations skills which are the essence of good nursing, but some of the activities call upon a predominant clinical interest while others need educational, psychological or organisational skills. Basic training does not prepare nurses for many of these tasks and we currently provide insufficient in-service training, particularly for B.S.M. nurses. Nurses should also be encouraged to attend relevant courses outwith the Authority and we should devise some means of providing financial rewards for those nurses who enhance their skills and bring them

back to the Authority. It should be possible for a Nurse to be promoted to senior positions while retaining clinical responsibility without the need to enter administration for which he or she may be ill suited.

I am reluctant to add to the long list of Nurse responsibilities but the component of community nursing is poorly developed. Hopefully the move to Mount Lawley will release some nursing posts and I would hope some of these could be used to form a community nursing division. I am not suggesting that we try to provide a community nursing service to all drug and alcohol dependents, but that a team of nurses work to promote the skills of existing community nursing services. It is, for instance, quite possible to detoxify the majority of alcoholics in their own homes provided some nursing supervision and support is at hand. Although the community nurses would be principally engaged in consultation and education, they would probably require to provide some services - perhaps to the Authority's own outpatients initially.

Psychologists:

The psychology services are well developed and represent a major influence on the Ord Street programme. I was impressed by the care given to assessing and testing patients. The Psychologists also offer behavioural techniques to patients and devote a considerable amount of time to teaching. As their time is very limited, I wondered if some of the testing could be computerised and as much use as possible made of self completion tasks which could be supervised by less skilled staff. (These developments are, I know, already envisaged).

Psychologists will also have a major role in developing self help manuals (see later). Those which have already been prepared for the present inpatient programme are a useful model for the future.

Clinical research is an invaluable part of any Psychologist's contribution to the team and it would be good to see more liaison between them and the research division on the design and monitoring of new developments.

I strongly agree with the principles proposed in the Authority's submission to the Select Committee 1983. The non-statutory sector provides a range of services, many of which are directed toward the more socially damaged, often homeless alcoholic, or drug dependent. We must be careful not to replicate services provided by this sector and should endeavour to influence standards and patterns of care within this sector as far as possible. Clearly, the Alcohol and Drug Authority might expect to have most influence on those programmes which it funds, either totally or partially. In seeking funding, voluntary agencies should be required to demonstrate that they have identified a client group in need and provide a description of the way in which they intend to meet this need. Some details of the qualifications and levels of staffing should also be provided. The Alcohol and Drug Authority has a right to obtain annual feedback from the agency, including a proper statistical account of their activities. An element of evaluation should be part of each proposal for funding. Essentially, voluntary agencies should demonstrate greater accountability for the public funds which they receive.

Voluntary services at present compete for funds from several sources and in some cases, may also have to compete for clients. This entrepreneurial approach has some benefits, for instance, in fostering innovation and motivation. It is however, potentially wasteful of scarce financial and professional resources. I suspect that the non-statutory sector would be better served if they could agree to form a council incorporating the diverse interests in the alcohol and drug field and require this Council to then negotiate for funds on behalf of its constituents. Such an arrangement would hopefully lead to a more co-ordinated pattern of services and more relevant funding. It might also limit wasteful repetition and competition.

EDUCATION

The Authority is already giving greater priority to its educational task and this is likely to become increasingly important in the future. There are many different aspects to alcohol and drug education:-

1. Education of identified patients and relatives:

   This is the responsibility of the clinical team but the education division should provide them with resources and information about new techniques and materials.

2. In-service training:

   This needs to be given greater priority. At its simplest there should be regular clinical meetings and opportunities to review existing practices. There should also be properly organised induction courses for new staff and multidisciplinary study days within the service which will help existing staff share ideas and refurbish old skills and develop others.

   Staff should be regularly informed of courses elsewhere in Western Australia and encouraged to attend where relevant.

3. Professional training:

   There is an urgent need for training courses for professionals (such as nurses and social workers) in all aspects of substance abuse. Some may be quite specific, e.g., course on detoxification provided for hospital nurses.

4. Counsellor training:

Although Holyoake Institute provides some training courses, in particular techniques for helping dependents and co-dependents, this is not a sufficient basis for the training of alcohol counsellors in the city. A counsellor training course should be established which would provide knowledge about all aspects of alcohol problems and a range of skills in counselling problem drinkers and their families. The course should provide an element of continuing supervision for all counsellors and this should continue after the course is completed.

5. Basic Professional Training:

The Authority should try and influence current teaching about alcohol and drug misuse in all basic training courses for social work, nurse and medical students. The education division should again provide support material for these courses.

6. Public Education and Self Help:

The Authority can not give a priority to every aspect of education, and in this sphere, it will hopefully work in co-operation with the Health Education Council, Road Safety, Department of Aboriginal Affairs and similar bodies who are already concerned with public information. We should concentrate on providing factual material and negotiate presentation with other bodies.

Self help techniques are very far advanced in Western Australia (e.g., migraine, hypertension). The Alcohol and Drug Authority should capitalise on the presence of several experts in this field and develop self help manuals for those who misuse alcohol and tranquillizers. Such manuals would be a useful resource, both for the general public and frontline professionals such as General Practitioners who can offer the manual to patients/clients with identified problems.

RESEARCH

I was impressed by the quality and quantity of the work undertaken by this division. It is an extremely useful resource which will presumably be able to attract further funding from other research foundations. It is unfortunate that one of its most valuable evaluation studies was modified to meet the requirements of the Director of the agency concerned and this resulted in a flaw in the overall design. I think this points to the difficulty of evaluation - it is not enough simply to design a project - it must be developed with the continuous involvement of the clinical staff concerned so that they have a sense of participation and ownership of any results that arise. Regular meetings between research and clinical staff would be useful so that the two activities have ample opportunity for mutual understanding. For the same reasons, research staff should have links with the educational and policy making aspects of the Authority. The analysis of the impact of 'Swan Light' is a good example of using a simple research design to answer a question in which there will be world-wide interest with important implications for future policy.

There is a surprising amount of research within Western Australia into alcohol problems, most of it is of a clinical nature. The Authority is well placed to convene a regular meeting of alcohol and drug abuse researchers in the State. There should also be regular feedback about recent developments to other members of the Alcohol and Drug Authority.

LIBRARY

This is an invaluable resource. It is unfortunate that clinical staff are mostly somewhat further away from Salvatori House and this may contribute to their using it less than the research staff.

Ideally, the library should be very accessible to all staff.

I liked the idea of a regular newsletter emmanating from the library. It might include other pieces of information such as lectures, meetings of interest, notes about new staff, latest statistics and research notes. A Committee representing each professional group could be responsible for the publication with the Librarian as Editor.

ADMINISTRATION

I was extremely impressed by the skill and thoughtfulness of the administration. It is a pity that they can not be accommodated within Mount Lawley, but should be as near as possible to minimise any split between 'management' and clinical staff.

The advent of a Statistician should improve the data collection and monitoring of drug and alcohol problems. The Medical Officer in Charge, together with social work staff, already contributed enormously to providing clear information about patterns of attendance and drug usage at William Street.

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SERVICES IN NON-METROPOLITAN AREAS:

Organising a service for a sparsely populated area which is larger than the whole of Europe presents formidable problems. Nurses and Social Workers in rural areas are necessarily very independent and the Alcohol and Drug Authority's main role should be to provide them with basic skills and knowledge in dealing with most alcohol and drug problems. Training courses (e.g., on detoxification), information leaflets on specific topics (see Appendix 4) and self-help manuals for clients could all be provided by the Authority. Specialist facilities in Perth are of little relevance to their clients because although in-patient treatment can usually be arranged if requested, the crucial after-care phase inevitably places responsibility back in the home community.

I realise I have only seen a small fraction of the State but even these visits have impressed me by the diversity of character and life-style within the State. Thus for example, an approach which seems correct for Kalgoorlie would be misplaced in Albany. Fortunately, the Field Development Officer's encyclopaediac knowledge of the State helps the Authority recognise this local diversity.

I was impressed by the work of the field officers which is often conducted in difficult conditions. The Authority's premises in Kalgoorlie for instance, are totally inadequate for a counselling and information service. Despite these conditions, the field officer there has been able to recruit and give some training to a group of eight volunteers who now help with the service. This innovation could be developed elsewhere and the Authority could provide staff and material for volunteer training courses throughout the State. Voluntary counsellors could be recruited and trained from amongst this number. If we wish to develop our use of volunteers we will need to establish procedures for their recruitment, selection and subsequent supervision.

Some areas have a predominantly transient population; this applies as much to Nurses and Social Workers as to others. This suggests that training courses will have to be repeated quite frequently because

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the population tends to move on after two or three years.

Field officers can feel very isolated or unsupported. The following measures might help: greater role clarity agreed with the Alcohol and Drug Authority; regular supervision from Senior Social Workers within the Authority; an opportunity to meet together at least twice yearly to compare notes and discuss problems. The Aboriginal Workers attached to the field officers have similar needs for training and support. Field Officers might be encouraged to take the initiative in forming professional counsellors support groups in their own areas. These would be regular meetings of Social Workers and other counsellors at which they could share issues and concerns. Devices of this kind would go some way to reducing the risk of staff burnout in these areas.

The Field Officers have a multiplicity of tasks, including acting as a:-

1. Resource for information and advice about substance abuse;
2. Monitoring local needs and issues aided by the committee;
3. Direct counselling;
4. Developing the skills of primary level workers;
5. Stimulating interest in education and prevention in consultation with the committee;
6. Establishing working links between workers with a common involvement with substance abusers;
7. Liaison with Aboriginal services;
8. Recruiting and training volunteers;
9. Acting as link between the Authority and the community (2-way-process);
10. Assisting in managing resources such as halfway houses.

Inevitably, the emphasis placed on each item varies from place to place. It would be helpful if the Field Officers could be given clearer roles and this topic might usefully form the basis of one of their joint conferences.

I visited halfway houses at Rosella and Prospect Lodge. These form a useful resource. Ideally, they should be sufficiently small to retain a domestic atmosphere, approximately 8 residents and should give residents some involvement in decision making. The aim should be to enhance self respect and self confidence. Re-entry in always a difficult stage and volunteers could be particularly valuable in providing support at this time.

A.A. was a prominent influence in both houses and is of course one of the more important resources throughout the State. It would be helpful if A.A. could keep the Authority up to date with their membership throughout the rural areas.

Regional Committees

I found the committees very varied and they have developed in a rather haphazard way. All contain A.A. members, plus other interested citizens. Some act principally as a management committee for the halfway house while others have much broader concerns. There will always be a need for a house management committee, but there is also a need for a group with a much broader function. This would include being a support and stimulus to the field officer; identifying local needs; being an advocate for alcohol and drug awareness in the community, fund raising and liaising with other agencies, including the Authority itself, and trying to create a co-ordinated response to alcohol problems in their community.

I was surprised to find little co-ordination or direction in social planning at a local level. Although it is obviously outside the remit of the Authority, it would be helpful if such groups concerned with the social environment existed. This would give the Alcohol and Drug Committee a setting within a more general framework.

Industry's Contribution

The towns are often dominated by a single industry, mining or fishing for example. There was surprisingly little evidence that these industries had any clear policy about the hazards of alcohol abuse and yet its contribution to accidents and poor quality work must be enormous. The Authority should encourage these industries to implement policies about alcohol and employment and show more concern for health and safety at work.
In some areas, a single company virtually 'owns' a town and their responsibility in these circumstances seems particularly clear cut. As a starting point, the Authority could ask these firms to inform us about the regulations which currently exist relating to drinking at or prior to work.

ABORIGINALS AND ALCOHOL PROBLEMS:

"We are as sure of nothing so much of that we know least about" Montaigne.

It seems presumptuous to comment on a culture whose acquaintance I have met only fleetingly and of which real knowledge is probably accorded only after a lifetime of closeness and understanding. Nonetheless, Social Workers, Police, Doctors and Aboriginals themselves all impress any visitor of the urgency and the tragedy of alcohol misuse in their culture.

Despite the frequent references to the problem in the press and media, and the presence of several articles and reports on the theme; little factual evidence exists about the nature of Aboriginal drinking habits. There are a number of reasons for this, including; difficulty in reaching a clearly defined sample; doubts about the meaning of the term 'Aboriginal'; and extreme tribal variations throughout the State. The situation is further complicated by the erosion of traditional tribal ways and the increasing integration of Aboriginals into the predominant culture. As a consequence, there are three broad groups to be considered - those who live within the tribal homelands who are mostly located furthest away from the city; those who are sometimes termed "fringe dwellers" and lead an uneasy existance on the edge of small towns and villages rarely working and subsisting on social security; and finally, those who while remaining identifiably Aboriginal, have integrated their lifestyle within the Caucasian urban majority. Excessive drinking seems to cause most concern and is most publicly evident amongst the fringe dwellers, but higher visibility does not necessarily mean that this represents the area where the problem is most prevalent or serious.

The Aboriginals are unusual in having no tradition of drug or alcohol use, and therefore, have evolved no laws to govern their use in everyday life. This is in contrast to many African cultures who have had alcohol for thousands of years and have developed sets of rules which surround village drinking, often prohibiting young people from drinking and restricting the amounts that women are allowed to drink.

No such tradition exists here. The Aboriginals do however, have a tradition of sharing their goods within the extended family and this habit has unfortunately also been adopted for alcohol with the result that alcohol misuse seems to be less an individual problem than one of an extended family or a total community. This makes it difficult to think in terms of treating an individual in isolation when the pressures on him to return to drinking are so strong. Workers in rehabilitation centres spoke to me of the frustration of trying to treat a man when family members hover around the outside of the 'dry' house encouraging him to drink. The abscence of alcohol problems in the traditional culture also means that tribal law and for that matter, native healers, appear to have no particular remedies for alcohol problems, although the laws do have punishments for misdemeanours, committees under the influence of alcohol.

Although a lot is written about Aboriginal drinking in Australia (1), I could not find any factually adequate surveys in this State. There is the study of Professor Max Kamien(2) in Bourke, New South Wales in which he reported that more than half the men were heavy drinkers, consuming over 80 grams of pure alcohol per day. It is interesting that in his study, only three percent of the women were found to be very heavy drinkers and he reports 71% of the women have been abstainers. This doesn't accord with the descriptions given to me in Western Australia and either habits have changed or we are dealing with a very different population.

When I discussed this with Professor Kamien, he explained that abstinence rates for women vary markedly from one community to another. He also added that in some districts, a matriarchal society is established, taking over the roles normally occupied by sober men. In these situations the abstinence rate tends to be quite high. This opinion once more, underlines the significance of the family and perhaps the woman within the family in influencing a communities drinking habits.

(1) Alcohol Problems of Aboriginals 1977. House of Representatives Standing Committee on Aboriginal Affairs.

(2) Kamien, M. Medical J. of Australia (1975) 291-298.

Prevention/Availability:

Aboriginals have of course the same basic right of access to alcohol as any other group. Nonetheless, if certain communities have chosen to "go dry", then such a decision should be respected and local licensing authorities should ensure that alcohol is not introduced in areas where the majority of the community say it is not wanted. Paradoxically, there are problems in making alcohol inaccessible to a community which wishes to drink, because in these circumstances, the residents are forced to drive considerable distances to obtain alcohol and this encourages drinking and driving, a problem which is, for instance, very evident on the fringe of Perth at Cullacabardee.

Education:

Special skills would obviously be required in reaching the Aboriginal population and traditional health education methods are probably inappropriate. Some of the Health Workers did however suggest the value of video films which could be shown, but a great deal of advice would have to be taken from the indigenous population about striking the right chord in films of this kind. Others have suggested that methods such as street theatre or integrating pieces about alcohol within a corroboree would be helpful. It is interesting that some of the folk groups which are Aboriginal have developed "anti alcohol" songs. Ideas of this kind could be promoted and developed further and the Authority might have some role in providing the material and also using its extensive linkage throughout the remoter regions of the State as a means of distributing both materials and ideas. This network has been developed to an impressive degree by the Project and Development Co-ordinator, but could be further enhanced if he were given such materials.

In-Service Training:

The Aboriginal Health Workers who currently work alongside the Authority's Field Officers, already make great contributions to both the service and education. They would probably benefit from further training as this would increase their confidence in working with others, particularly in meeting with other professionals in hospital and social work departments.

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It would be helpful if they could have a regular in-service meeting at which they could share common problems and also get a sense of identity which may help them to overcome some of the feelings of isolation which they feel. Not only do some experience geographic isolation, but also isolation within their community and in their meetings with other professionals. The Alcohol and Drug Authority should also seize any opportunity to provide further educational input to the Aboriginal Medical Service to ensure that alcohol problems are taken into account when community plans for Aboriginals are being developed; for instance, concern for the provision of alternatives, problems about siting of liquor outlets and an awareness that alcohol is more likely to cause public problems if drinking takes place in the open and that the hazards of alcohol are greatly enhanced by driving or operating machinery.

A great deal of thought would have to be given to the role of alcohol policy for the Aboriginal community. At present, their drinking has an "all or none" quality about it. The simplest message therefore, would be one of abstinence and it is interesting that a Christian religion, Revival, which seems to be increasing in numbers in the Aboriginal community, contains a commitment to a life of tee-totalism An alternative strategy would be to think in terms of a generation which is trying to develop acceptable rules, governing its use of alcohol and that they will progress through this into a pattern which is less damaging. This is, for instance, the situation which occurred in Finland during the first half of this century and has been reported by Sulkunen in his concept of the 'wet' and the 'dry' generations succeeding each other. *Sulkunen 1979.

Treatment:

I have already referred to the difficulties of trying to treat the individual in isolation from his or her extended family. I think there is scope for developing family methods of treatment here, although I have not had any opportunity for exploring how feasible this would be.

* Sulkunen, P.
Abstainers in Finland 1946-1976: A study in social and cultural transition: Helsinki:
Finnish Institute of Alcohol Studies 133, 1979.

Given the available resources, ideally, the worker would hope to influence the attitude and behaviour of the whole extended family who would then thereafter impose their own controls on its more deviant members. The difficulty of treating individuals on their own has led me to have some doubts about the concept of rehabilitation houses placed some distance away from home. While they are doubtless quite effective in the short-term, these achievements are quickly redressed by the drinking which attends on the homecoming.

The concept of encouraging Aboriginals to develop abstinent work places on larger stations may be more appropriate and in these circumstances, there would be no plan to return "home", but rather the treatment would represent a geographic move, accompanied by a change of lifestyle for the whole extended family.

Alcoholics Anonymous seems to have a considerable appeal for certain Aboriginals and the "Twelve Steps" have been translated into terms which are more meaningful for the Aboriginal. The religious dimension of A.A. may well provide a sense of purpose and belonging which is absent in many Aboriginal lives. As mentioned above, religious conversion often leads to whole extended families becoming abstinent. It is noteworthy that Kamien, in his community study, found four males and four females who had all been severe alcoholics and were now tee-total (duration 3-45 years). Seven of this group had stoped after "an almost instantaneous religious conversion" resulting from listening to a visiting evangalist.

OTHER SUBSTANCE ABUSE:

It was impossible to gauge the extent to which other forms of illicit and licit drug misuse had gained a hold on the Aboriginal population. One exception was concern about petrol sniffing which is apparently extremely prevalent in some communities. Nurses working in these communities need guidelines for dealing with the medical consequences of this practice. No demonstrably effective preventive approach exists although reducing availability, developing alternative leisure activities and education have all been attempted (see Petrol Sniffing amongst Aboriginals: Western Desert project, Morice, R.; Swift, H.; Brady, M.; Flinders University, 1981).

PRIORITIES FOR THE FUTURE:

For historical reasons, the Alcohol and Drug Authority, since its inception, has devoted a lot of its resources to treating the more socially deteriorated advanced cases of alcoholism. A number of non-statutory agencies now also cater for this group. The Authority should therefore feel able to shift the emphasis of its own clinical services toward early intervention. This seems to afford the best prospect for minimising harm and will hopefully demonstrate to front-line agencies such as General Practitioners, hospital Doctors and Social Workers, that there are techniques which they can use effectively that are neither time consuming nor elaborate. (Appendices 1 and 5 provide background evidence for this belief). This change in emphasis is of course exactly in accord with the Alcohol and Drug Authority's Directional Statement (1981). The hospital based programme and the industrial counselling service discussed earlier are both examples of this new direction.

In the following section, I briefly explore some developments which are either in hand or need to be considered by the Authority. Following this, there is a concluding section which attempts to identify some recurrent issues which seemed important during my stay at the Alcohol and Drug Authority.

MOUNT LAWLEY:

The move to Mt. Lawley should facilitate the growth of a more integrated clinical programme than exists at present. The location is not ideal; it would have been better nearer the city centre and close to a general hospital. It is also unfortunate that it is adjacent to A.C.R.A.H's house which caters for a group of chronic alcoholics who continue drinking. Their presence has created in residents' eyes, a misleading stereotype of the alcoholic and the neighbourhood is understandably concerned about adding to this group in the area. It will be essential to keep the neighbourhood associations informed of our plans and this is already happening. At a later date, it may be wise to establish a formal link with the neighbourhood association which will hopefully become a source of support to the institution as its place becomes established and anxieties allayed.

Mount Lawley will combine outpatient assessment, detoxification and a daycare programme. It will be the main locus for individual and group follow-up, family therapy and relatives meetings. At present, there is a tendency to plan the move as if Aston and Ord Street Hospitals were transferring their programmes and cohabiting rather than merging. I think the staff have to think of a unified unit, hopefully under the guidance of a single Clinical Director (see later). It should be easy for patients to move from one part of the programme to another without feeling that they are entering a new domaine.

A great deal of thought needs to be given to the patient's transition from detoxification to day treatment. The concept of providing a buffer zone where the patient waits for psychological

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detoxification to occur is going to be difficult to manage and I wonder if such delay is fully justified.

Emphasis on a day programme requires the Alcohol and Drug Authority to consider where to accommodate patients, who, for various reasons, cannot stay at home. Hopefully, the non-statutory sector can be encouraged to accommodate this group but it will require very careful and regular liaison between the care staff of that facility and the staff of Mount Lawley and both will have to agree on a range of management and clinical issues.

These changes are major issues which are bound to cause anxiety while the established order changes and is replaced by an unpredictable future. Regular staff meetings involving all grades and professions should be held during this transition period. They should be concerned with communication and regular feedback about developments, but they should also give every team member a chance of explaining their inevitable anxieties and contributing ideas to the proposed plan.

It is unfortunate that the Administration, Research and Education divisions will remain removed from the Authority's main clinical resource. Such separation suggests they are separate enterprises whereas they should be mutually dependent. Separation from the library is particularly undesirable. It seems that the best we can hope for will be for these facilities to be as near as local Government planning constraints will allow.

DETOXIFICATION FOR DRUG ADDICTS:

Both the non-statutory sector and drug users themselves indicate that there is a need for a residential detoxification facility that is less 'clinical' than Aston. This house would provide support, possibly provided by ex-addict counsellors, medication with nursing supervision and medical cover as necessary. It would act as a resource for all the statutory and non-statutory agencies in this field and be closely linked with further rehabilitation programmes. A clear management structure would be necessary for this service and I think the voluntary bodies who are most concerned about the need should provide a clear proposal about the membership, structure and function of this organisation and clarify whether a totally new body is envisaged or whether an existing organisation is willing to take primary responsibility for the project. The Alcohol and Drug Authority should be closely involved with this new proposal and might well second staff for its clinical component.

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COMMUNITY LIAISON:

As the Alcohol and Drug Authority shifts its focus toward prevention and early detection, linkages with other community agencies will become increasingly important. The model of liaison and early intervention envisaged for hospitals could be transferred to Health Centres, Community Nurses and Social Work agencies. The Authority could experiment with the creation of a community alcohol team in an identified district of Perth. The team would contain social worker, community nurse with the support of a doctor and psychologist. They would work with the existing agencies in that area, and enable them to work more effectively with alcohol and drug problems. (See Shaw, S.; Cartwright, A.; Spratley, T.; Harwin, J. 1978. Responding do drinking problems, Croom Helm).

EMPLOYMENT:

Unemployment is now common amongst young people and of course alcoholics and drug addicts are both particularly likely to lose their jobs in times of recession. Rehabilitation is much more effective if it can involve a return to employment and repeated 'failures' in job interviews can be the kind of demoralising experience which precipitates relapse. The Alcohol and Drug Authority does not give sufficient attention to helping patients with employment advice. A number of strategies could be considered:-

1. Interview skills training - currently available in Ord Street;

2. The 'Retread' Group could focus on techniques for job interviews;

3. The Authority should establish links with employment agencies.

To a certain extent, each of these activities already takes place, but could be given more prominence and co-ordinated perhaps by the Occupational Therapist. Even so, it is likely that many will remain unemployed and the Authority might consider generating its own employment schemes. A small but effective model for this exists in 'Squirrel Nutkin'. New sources of funding are available to encourage self help work schemes. This is an area which we should explore further. I understand that the State will be producing a report on community based employment schemes which should be of interest to the Authority.

PENAL POLICY:

Alcohol abuse makes a major contribution to police work and as many as two-thirds of prisoners will be found to have alcohol related problems. The Alcohol and Drug Authority will need to examine a number of issues relating to crime and drunkenness. Facilities for habitual drunken offenders are deficient at present and the State could invite the Authority along with the police, judiciary and the Department of Corrections to examine means of diverting this group from the penal system into a detoxification/rehabilitation network. Those alcoholics convicted of more serious crimes will have to be dealt with by the judiciary but more use could be made of probation with a condition of treatment in circumstances where the need for rehabilitation outweighs any necessity for exemplary punishment. Drunk driving offenders are of course a further group where a condition of alcohol education and counselling could be demanded of those who are repeated offenders or have exceptionally high blood alcohol levels at the time of arrest.

There are many complex issues in this field and the Authority might best take a catalytic role in bringing together judiciary, magistrates, law enforcement, prisons and probation and relevant non-statutory agencies to examine the problems posed by rehabilitation of the alcoholic offenders.

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CONCLUDING THEMES

Prevention:

Primary prevention should be one of the Alcohol and Drug Authority's main concerns. We know that availability of drugs and alcohol is a key factor in determining levels of consumption and that the penalty for increased consumption is increased harm. The Alcohol and Drug Authority must therefore be consulted on issues which are known to affect availability. These are as wide ranging as the prescribing habits of General Practitioners, the price of wine or the criteria adopted in opening a new liquor store. Research and statistics should be used to monitor changing trends, habits and new developments. The advocacy role of the Authority in advising on preventive strategies is most important.

Consideration should be given to expanding the research and statistics division so that it can provide adequate data on trends in consumption, harm and use of services. At present, the Authority often has to advise Government from an inadequate data base.

The Commonwealth Government report of 1977[1], for instance, sensibly recommended that each State "continually monitor the levels and patterns of alcohol consumption and formally advise their respective Goverments, before each budget, of the health considerations to be taken into account when examining excise and other revenue from alcohol".

1. Drug Problems in Australia. Report of the Senate Standing Committee on Social Welfare 1977; Australian Government Publishing Service, Canberra.

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Education :

Education is naturally linked with prevention and the Alcohol and Drug Authority should certainly contribute toward public education as much as it's limited resources will allow. At this point however, I think the Authority's educational priority should be in providing training courses for its own staff and other professionals. Counsellor training is another priority referred to earlier.

Career Structure:

Improved training should enhance the status and career prospects of the Alcohol and Drug Authority's staff. In several cases, I have been struck by the rather truncated career structures available to professional staff working with the Alcohol and Drug Authority. This is largely a consequence of being a small organisation which restricts the number of rungs available on the promotion ladder. It would be well worth exploring ways of breaking away from traditional Government service gradings which have been designed for larger departments. If such liberation could be achieved, then the acquisition of additional skills and responsibilities could be rewarded. This would be an incentive to staff recruitment and we could achieve greater comparability with other organisations without losing the beauty of smallness which is shown in the generally good morale which permeates the Alcohol and Drug Authority.

Linkages:

Communication is almost always a problem in any organisation. Within Perth, poor communication between agencies and even within the Alcohol and Drug Authority is a source of much confusion and wasteful duplication. The move to Mount Lawley should go a long way to improving links between the services currently offered by Carrellis, Ord Street and Aston. It will also be essential to maintain good records of clinical contacts at General Hospitals, Industry contacts and in the community. These should be integrated within a single uniform records system within the Alcohol and Drug Authority.

Sharing of professional experience and views is another important part of communication. As currently designed it is quite possible for a group of workers within the Authority to be unaware of colleagues' clinical activities in another building. Even before the move which will not in any case involve William Street and Quo Vadis, we should arrange regular clinical meetings for staff. The Thursday Case Conference is one step in this direction, but could be developed further. All clinical staff should be kept informed about the Alcohol and Drug Authority's research and educational activities, either at occasional Conferences or by means of the newsletter described earlier. Ideally, both strategies should be adopted.

The services of the Authority would benefit from the appointment of a Direcror or Clinical Services who could co-ordinate plans both at the level of an individual patient and in a more general way. He or she should have specialist experience in substance abuse - and should have a prior background in Psychiatry or General Medicine.

During my time with the Authority, I was consulted from time to time as a Psychiatrist about patients' mental health problems. These requests were episodic and would not require more than one session weekly. Hopefully these purely psychiatric requests can be dealt with

by the 'Psychiatric Trainee' in future. It would be beneficial to have some established consultant link between the Alcohol and Drug Authority and the Mental Health Services.

Links between the Authority and other agencies are a more complex problem. The voluntary organisations Liaison Social Worker is certainly working toward improving these links and the creation of a council of voluntary agencies would also help foster mutual awareness and co-operation.

I was surprised at the paucity of letters and records which the clinic receives about referrals from hospitals, and particularly General Practitioners. If the quality of information flow could be improved, then there would be less duplication of investigations and a clearer picture of which had already been offered to the patient.

The dearth of clinical information from other agencies is potentially dangerous where an important medical fact for instance about drugs which have been prescribed is not available.

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THE MERITS OF A SINGLE AUTHORITY:

One clear impression is of the good sense Western Australia has shown in establishing an Alcohol and Drug Authority. In so doing, the State has recognised the diversity and complexity of the issues involved. These can not be constrained within for example, the health field, but flow over into social policy, economics, education, licencing policy, penal and law enforcement. I was impressed by the benefits of gathering expertise within a single Authority which could then act as a resource for advice and as an advocate for client groups who are notoriously disadvantaged.

The Authority should be a key resource for the State in formulating an alcohol policy. The need for a coherent drug and alcohol strategy has been emphasised by the Commonwealth Senate Standing Committee on Social Welfare, 1977 and is very much in accord with the recommendations of the World Health Assembly.

One disadvantage of the title and terms of reference is that it may encourage the belief that the Authority will be ready to meet all the identified needs of alcoholics and drug dependents in the State. This is clearly unrealistic but it is important that Government acknowleges the limitations of a very small team, otherwise it will always remain vulnerable to the inevitable view that insufficient services are being provided. The Director's own policy statement and the Authority's submission to the Select Committee are both very clear about the point that the Alcohol and Drug Authority can only provide structure and stimulus to the development of a pattern of responses which must be the responsibility of the total community.