Dr Paul Kelly
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ACT Health
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cc: AODpolicy@act.gov.au

Submission to the Draft ACT Drug Strategy Action Plan

Dear Dr Kelly,

The Alcohol Tobacco and Other Drug Association ACT (ATODA) welcomes the opportunity to make a submission on the Draft ACT Drug Strategy Action Plan.

ATODA's vision is an ACT community with the lowest possible levels of alcohol, tobacco and other drug (ATOD) related harm, as a result of the ATOD and related sectors evidence-informed prevention, treatment and harm reduction policies and services.

ATODA works collaboratively to provide expertise and leadership in the areas of social policy, capacity building, sector and workforce development, research, coordination, partnerships, communication, education, information and resources.

ATODA is an evidence-informed organisation. The ways we work, and the outcomes we strive to achieve, reflect our commitment to the values of population health, human rights, social justice and reconciliation between Aboriginal and Torres Strait Islander people and other Australians. The mission of ATODA is to be the peak body representing and supporting the ATOD sector and community in the ACT.

This submission reflects feedback from stakeholder consultations held by ATODA on the draft Action Plan (with participation from the ATOD sector, allied services, peak organisations and consumer organisations), the body of work undertaken by ATODA since its establishment in 2010 and the evidence base of the ATOD field.

In the past the ACT Government has developed, implemented and evaluated good quality drug policy and we hope that this legacy can be extended into the new ACT Drug Strategy Action Plan. ATODA offers its specialist ATOD expertise, networks, support and commitment to ensure that this continues into the future in line with the feedback provided in this submission.

Please do not hesitate to contact us if we can clarify or discuss any components of this submission or the evidence to which it refers.

Kindest regards,

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30 March 2018

ATODA's Submission to the Draft ACT Drug Strategy Action Plan

This submission is divided into a number of sections with appendices and attachments:

1. Achievements of Previous ACT Alcohol, Tobacco and Other Drug Strategies
2. The Context of the Draft Drug Strategy Action Plan
3. Risks Associated with the Draft Drug Strategy Action Plan
4. Governance
5. Engagement Including Consumer Participation
6. Feedback on Specific Areas of the Draft Drug Strategy Action Plan
7. Proposed Priority Setting Criteria
8. Summary of Proposed Additional Actions

    - Appendices: A series of appendices (1 – 14) with detailed information on each of the proposed actions.

    - Attachments:
        - Letter to ACT Health regarding the request to reconvene the governance group prior to, and as part of, finalising the ACT Drug Strategy Action Plan (Attachment A); and
        - An excerpt of the priority actions of the Draft ACT Drug Strategy Action Plan (Attachment B) to provide additional context to ATODA's submission.

This submission has been developed following extensive consultation and input from the ACT alcohol, tobacco and other drug (ATOD) sector, including specialist alcohol and other drug (AOD) services and related health bodies. Input was received through three consultation meetings, and included settings priorities, and commenting on a submission draft.

1. Achievements of Previous ACT Alcohol, Tobacco and Other Drug Strategies

For close to two decades, the ACT has had a series of Alcohol, Tobacco and Other Drug Strategy documents; with implementation monitored and evaluated through the oversight of the Alcohol, Tobacco and Other Drug Strategy Evaluation Group – a body composed of both community and Government representatives. The group met bi-monthly and fulfilled a number of functions in relation to implementation of the Strategy actions, provision of advice to ACT Government and ACT Health, monitoring and evaluation, facilitation of linkages across policy areas, and consultation with the community and other stakeholders. The previous ACT ATOD Strategies have been acknowledged for their high quality. Among the key features that have been acclaimed are that the Strategies have:

- Articulated effectively with the National Drug Strategy and those of other Australian jurisdictions, facilitating interstate and national collaboration.
- Had a whole of government focus, with particular emphasis on the core roles of the health and justice sectors in both preventive and remedial services.
- Emphasised mutually respectful partnerships between the government sector and the not-for-profit community sector.
- Focused on all potentially harmful psychoactive substances, including alcohol, tobacco, pharmaceutical products and illicit drugs.
- Spelled out the governance and accountability arrangements for policy development, implementation and evaluation.
- Presented the broad principles underpinning action in this field, including:
    - The importance of the social determinants of risky behaviours;
    - The empirical evidence underpinning setting priorities for action;

  - Clear statements of actions to be taken in the preventive and remedial fields particularly in the health and justice sectors; and
  - Clear statements as to who is responsible for further policy development and implementation, along with accountability mechanisms to ensure high quality service delivery.

The Canberra community can be proud of the ACT Government and its ATOD sector for contributing to the development, implementation and evaluation of previous ACT ATOD Strategies based on research evidence, collaborative policy-making and evaluation. Some achievements have included:

- Maintenance of an ACT ATOD sector that is a strong, united and cohesive where non-government and government services work collaboratively to deliver evidence-informed and high quality services to the community.

- Establishment of strong partnerships across health, justice and community sectors to facilitate more coordinated responses to ATOD issues cross-sectorally and to provide sound outcomes for people engaged in services.

- Implementation of public health law reform including legislative amendments:
  - Of the legal thresholds that differentiate between personal use offences and trafficking offences for some drugs
  - To the Good Samaritan provisions of the Civil Law (Wrongs) Act 2002 (republished 15 August 2017) to protect people who respond in emergency overdose situations
  - To the infringement system for low income people including implementing community work and social development programs focussed in the alcohol, tobacco and other drug sector

- Implementation of service evaluations with alcohol, tobacco and other drug experts including for diversion, rehabilitation and withdrawal services

- Development and implementation of new ACT specific data and services mapping including:
  - Service User Satisfaction and Outcomes Survey
  - Workforce Remuneration and Qualification Survey
  - ACT Alcohol Tobacco and Other Drug Services Directory

- Maintenance of regular and coherent alcohol, tobacco and other drug-related governance, advisory and collaborative structures including:
  - Opioid Treatment Advisory Committee & NSP Advisory Committee
  - Aboriginal and Torres Strait Islander Tobacco Control Strategy Committee
  - Specialist AOD Executives Group & Workers Group
  - ATODA as the ACT sector's peak body

- Implementation of collective capacity building and pooled resourcing, such as the Qualification Strategy, workers and clients subsidised NRT

- Demonstration of leadership and innovation, including Australia's first peer based naloxone program

While there is still much work to be done, the ACT community can be satisfied that investments in ATOD policy and interventions is both an effective and a sound use of scarce public funding. It is with respect to this historical context of strong drug policy development,

implementation and evaluation in the ACT that the comments and feedback within this submission are made.

2. The Context of the Draft ACT Drug Strategy Action Plan

The consultation draft of the ACT Drug Strategy Action Plan (DSAP) is framed as being a document that guides implementation of the National Drug Strategy in the ACT, reflecting the statement in the National Drug Strategy document: 'It is expected that each jurisdiction will develop their own accompanying strategy action plan which details the local priorities and activities to be progressed during the Strategy lifespan'.[1] However, ATODA does not believe that it was ever intended that the states and territories would, as a consequence, not produce, promulgate and adhere to their own ATOD strategies, as seems to be the approach underpinning the DSAP.

The central problem with a very brief DSAP, in the absence of an ACT ATOD Strategy, is that the **National Drug Strategy document is not a valid or usable replacement for an ACT Drug Strategy**. It was drafted for national purposes, not to guide state and territory level actions in a specific manner. One consequence is that some aspects that are key to guiding ATOD policy work and program implementation in the ACT are missing. Some of the most problematic of these are as follows:

- The National Drug Strategy document is not a strategy in the normal sense of the term, as it does not include any clear statements of the outcomes that are expected to be achieved, and the steps to be used to attain those outcomes. Since the National Drug Strategy document does not include a statement of objectives, i.e. the outcomes that are expected to be achieved through its implementation, it is crucial that the ACT DSAP includes a clear statement along these lines. As mentioned below, the wording in the draft DSAP section headed 'Objectives' does not do this.[a]

- The National Drug Strategy document contains many descriptions of what are referred to as 'good practice', including the appendix of 'Examples of evidence-based and practice-informed approaches to harm minimisation'. These 'examples' operate in vacuums, however, as they are not tied to what the scientific literature tells us about the most efficacious and cost-effective interventions for achieving identified goals. **One of the strengths of previous ACT ATOD Strategies has been that they were firmly based on data about the extent and nature of the ATOD needs in the ACT, and the selected priority actions were those that science tells us are most apposite.** That evidence was documented in the Strategies. It will be essential that the ACT DSAP does something similar if its contents are to be credible with the ACT specialist ATOD sector, the Government, the community and the media.

- The current draft gives no indication as to the criteria used for including some actions in the priority list, but excluding others. Indeed, **most of the interventions that we know are most efficacious and cost-effective are omitted from the draft DSAP,** and some of those that are included are either ongoing interventions or those for which the evidence shows have less impact.[2,3,4]

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[a] The current wording of the Objectives is: "Progress towards achieving the following objectives will be monitored over the life of the ACT Drug Strategy Action Plan, drawing on available local and national data sources. The objectives mirror those of the National Drug Strategy, with evidence-based priority actions to be implemented with reference to local requirements and key stakeholders"

- The National Drug Strategy document continues to fail to address the important issue of attaining balance between the three pillars that compose the Australian definition of 'harm minimisation'. The National Drug Strategy fails to point out that two-thirds of the nation's drug budget goes to drug law enforcement with approximately 20% to treatment, 10% to prevention and a tiny 2% to harm reduction.[5] The ACT's drug budget is similar, in its distribution of funding, to the national one. In ATODA's view, **it is essential that the DSAP provide leadership and commence the process of attaining a balance of investment in the ATOD sector in the ACT that better reflects what we know about what works**.[6] This rebalance means progressively shifting resources from law enforcement to the areas and intervention types that are both efficacious and cost-effective.

Having an ACT DSAP that does not address the issues highlighted above, would mean that we will be operating largely in a drug policy vacuum with respect to what we are seeking to achieve, and with respect to why those things are important.

3. Risks Associated with the Draft ACT Drug Strategy Action Plan

The preamble of the draft DSAP states that it '… aims to be a single, unifying document provides an overarching framework for addressing the harms associated with alcohol, tobacco and other drugs in the ACT. In this way, the DSAP will support a comprehensive approach to preventing and minimising alcohol, tobacco and other drug-related harms, and facilitate coordination across policy and program areas.' The email with which the draft was provided to ATODA states that: the draft "… is intended to be a succinct, user-friendly document focusing on clearly articulated action items. Graphic design elements will be used to create an easily accessible document".[7] An outcome of this approach, a regrettable one in ATODA's view, is that **the draft Action Plan fails to deal with most of the highest priority actions needed, demonstrates little recognition of the existence and attainments of the ACT's specialist AOD service system and is too brief to do the job**.

ATODA perceives that the current management of ACT Health takes a different approach to the contents of health strategy documents than occurred in the past. The emphasis seems to be more on brevity and an engaging layout, rather than on dealing with the complexities inherent in the task. Whilst it could be that the minimalist approach evidenced in the draft DSAP is applicable in some highly constrained, narrow technical domains such as a disease-specific area with clearly understood and universally accepted intervention modalities, that is certainly not the case with respect to the alcohol, tobacco and other drug sector. This is of particular concern to ATODA, as it is occurring within a broader context of ACT Health internal realignments, whereby from September 2017 ACT Health's specialist Alcohol and Other Drug Policy Unit, and the expertise within it, was disbanded, with AOD policy and contract management functions split across health policy.

In contrast to many other sectors, the ATOD area is intensely ideological in nature. Despite having a strong evidence base to underpin the selection of effective interventions, this is frequently not possible owing to pressures from vested interests that have little or no regard for scientific evidence. Politics, religion, individual value systems, commercial interests, etc., are at play in the drug sector to a far greater degree than in many other sectors. The complexity of ATOD policy work was evident, for example, with industry groups in 2016 successfully opposing strategies to reduce alcohol availability, which resulted in the ACT Government committing to not pursuing the evidence-based strategy of reducing trading hours then or into the future.[8]

A direct consequence of the complexity of drug policy, ATODA suggests, is that ACT Health needs to take a different approach to the contents of the DSAP. It seems essential to us that

its final version deals with the areas that are most important and for which we have sound evidence for the efficacy and cost-effectiveness of interventions, on the one hand, and presents a convincing argument supporting the inclusion of some actions as priorities and the exclusion of others.

In ATODA's view, if this is not done, **ACT Health and the ACT Government will be exposing itself to considerable risk of well-founded criticism from diverse sectors including the media, opposition politicians, external lobby groups and the medical and population health professions.** ATODA is convinced that ACT Health will be able to mount a convincing argument as to why the final version of the DSAP is more comprehensive than this first draft, why it addresses the real priority actions for the ACT community, and justifies the inclusion/exclusion criteria applied.

4. Governance

ATODA notes that the Strategy states an expert Advisory Group will be *established* in relation to the DSAP. As far as ATODA is aware, the ACT ATOD Strategy Evaluation Group that has overseen the development, implementation, monitoring and evaluation of ACT ATOD Strategies for more than a decade, remains a current governance group (despite not being convened for over a year); and as a member of that group ATODA has not been informed otherwise by ACT Health. It is concerning to ATODA, and other stakeholders, that a new governance approach is proposed (especially when the existing approach has functioned well). Importantly, many of the stakeholders, including ATODA, who have participated in structures that informed the drafting of a number of the previous strategies, are available and ready to recommence engagement in drug policy governance in the ACT.

ATODA also notes that the draft DSAP proposes that the new governance group is convened only after the plan has been finalised with a focus on *implementation* rather than contributing to its development. We are concerned that the DSADP proposal contradicts the highly effective practice of the ACT ATOD Strategy Evaluation Group (mentioned above), which has had active involvement in the development of new and existing strategies. ATODA requests that ACT Health convene a governance group prior to the action plan being finalised, and seek its advice on the contents of the DSAP, its implementation modalities, and its governance.

ATODA highlighted these concerns related to the proposed governance of the DSAP in a letter to ACT Health dated 23 March 2018 titled "Request to convene the governance group prior to, and as part of, finalising the ACT Drug Strategy Action Plan". For a copy see Attachment A.

As per the previous ACT ATOD Strategy, ATODA also encourages the governance group to have the ability to establish necessary sub-groups / working groups to progress priority areas – for example the current running Needle and Syringe Program Advisory Group is a working group of the ACT ATOD Strategy Evaluation Group.

5. Engagement Including Consumer Participation

Previous ACT ATOD strategies have articulated a clear commitment to a whole-of-government and whole-of-community approach, where collaboration across various parts of government (e.g. Community Services Directorate, Education Directorate, Justice and Community Safety Directorate, etc), and the participation of community stakeholders has been key to achieving the outcomes of the strategy. Strong commitments have previously

been made to engaging a wide range of key stakeholders in policy development, implementation and evaluation, including a focus on consumer participation.

Wherever possible, ATODA believes that the identification, development, implementation and evaluation of initiatives should be undertaken through a co-design process where key stakeholders are engaged in these processes. Co-design processes are purposefully and strategically: inclusive; respectful; participative; iterative; and outcomes focused.[9] Key stakeholders in the co-design of ATOD initiatives could include, but are not limited to: people who use ATOD; service users; families of people who use ATOD; AOD workers and specialist services; workers and services in other relevant sectors (e.g. justice, education, community services); and policy makers (including, across various directorates).

The successful use of co-design in the ATOD sector has been demonstrated through the *AOD Safer Families Program*, where people in the specialist AOD service system, DFV sector stakeholders, policy makers, AOD workers, and the consumer organisation came together during 2017 to design a program for improved responses for people accessing specialist AOD services who are experiencing or using domestic and family violence.[10] Likewise, a co-design approach was utilised in 2016 for the *Review and re-design of alcohol and other drug withdrawal services in the ACT* and the development of an associated systems level model of care.[11]

While the DSAP states that, 'actions are to be delivered in collaboration with relevant community and consumer organisations', little to no detail is provided on how this will be operationalised. A priority named in the National Drug Strategy is, 'Supporting Community Engagement in Identifying and Responding to Alcohol, Tobacco and Other Drug Issues'. In light of this, ATODA believes that the priority actions and the broader DSAP could better articulate and name the stakeholder groups and mechanisms for engagement, such that the DSAP better reflects the principle of whole-of-government, whole-of-community participation and benefit.

6. Feedback on Specific Areas of the Draft ACT Drug Strategy Action Plan

<u>The front material</u>

- The Draft draws attention, on page 3, to priority populations, stating that 'The Action Plan acknowledges the priority populations identified in the National Drug Strategy 2017-2016 (*sic*)'. ATODA supports this approach while noting, however, that the priority populations listed in the NDS document cover virtually the whole Australian population.

  We also draw attention to the valuable framing, promulgated by the independent think tank Australia 21, of people who use drugs as being a priority population in drug policy work:

  > *We … point out that people criminalised because of their drug use—stigmatised, discriminated against, imprisoned, unable to find housing or employment, etc.—should also be considered members of a priority population at high risk of experiencing disproportionate harms, and that drug law reform is a sensible, evidence-informed approach to assisting this priority population.*[12]

  ATODA urges people who use drugs to be a priority population in the DSAP.

- The first paragraph under the ‘Introduction’ subheading of the DSAP, reproducing the National Drug Strategy aim, omits the key word ‘cultural’ in relation to the types of harms the Strategy aims to prevent and minimise.

- The second paragraph under the ‘Introduction’ subheading of the DSAP has the potential to confuse readers. Since 1985 Australia has had a stable definition of the word ‘drug’, in the context of the National Drug Strategy and the state and territory drug strategies and action plans: ‘drug’ includes all psychoactive substances. However, this statement in the DSAP risks implying something different. One helpful way would be to quote the definition provided in the 2010-2015 National Drug Strategy document – “The term ‘drug’ includes alcohol, tobacco, illegal (also known as ‘illicit’) drugs, pharmaceuticals and other substances that alter brain function, resulting in changes in perception, mood, consciousness, cognition and behaviour”.[13]

- The draft DSAP states that it ‘Aligns with the ACT Government’s relevant policy and planning documents’. In ATODA’s view, it will be essential to include a list of these key documents and, in particular, to be explicit about how the Action Plan aligns with other policy proposed by ACT Health such as those articulated in the ACT Health Territory Wide Health Services Framework 2017-2027.[14] Likewise, it is necessary to be explicit about how the Action Plan aligns with the ATOD specific components of the Preventive Health Strategy, and other policies relevant to progressing the social determinants of health (i.e. those policies that seek to address ‘upstream’ determinants that impact on ATOD related harms).

- It also seems important, in this discussion of alignment, that the DSAP acknowledges the very large proportion of ATOD funding in the ACT that comes from the Commonwealth (both directly and via Primary Health Networks). The implications of this for coherent strategy development and implementation need to be spelled out. The additional priorities proposed later in this submission, particularly that which relate to technical planning between the ATOD sector, Commonwealth Government and ACT Government, could help to address this issue (See Appendix 6).

- ATODA notes that the ‘Guiding principles’ section is largely reproduced from the National Drug Strategy document and that the source should be acknowledged. ATODA notes and supports the addition of the important principle of access and equity. Additionally, there is an editorial amendment required at the end of the description of the access and equity principle in the dates for the National Drug Strategy.

Objectives and indicators

ATODA is concerned that the DSAP does not provide a statement of objectives, despite the subheading of objectives being present. Instead, five ‘measures of success’ are given under a separate sub-heading. They come verbatim from the National Drug Strategy document (page 40) where they are listed as ‘indicators’, not as ‘objectives’. As such, the DSAP would benefit from outlining a statement of objectives.

The ‘Measures of success’ listed in the DSAP are written like unquantified targets and ATODA urges ACT Health to think carefully about this part of the DSAP. **If the ACT Government adopts these ‘Measures of success’—things to be achieved over the three year life of the DSAP—they will not be achievable**. It will not be possible to identify

positive changes at the population level, over the three years, that can be confidently ascribed to implementing the 23 actions currently proposed in the draft DSAP. There are two reasons for this:

1) The 'Measures of success' have not been mapped to the proposed Actions. For example: it is not clear which of the listed actions will reduce arrestees' drug use over the three years; which of the indicators will cover exploring opportunities to introduce pill testing in the ACT; etc.

2) The information sources required to produce the data needed to monitor the outcomes of the DSAP:

   - One of the five 'measures of success' does not exist for the ACT:

     - The Drug Use Monitoring in Australia (DUMA) Project that would be the source of information nationally in relation to the measure 'Reduce arrestees' illicit drug use in the month before committing an offence for which charged', has never been conducted in the ACT and we are not aware of any plans for the Australian Criminal Intelligence Commission (ACIC) to expand it into this jurisdiction.

   - The information source related to drug-related burden of disease has limited use in monitoring the outcomes of the DSAP over the next 3-years:

     - The data in the latest Australian ATOD-related burden of disease and injury report (published on 29 March 2018) is from 2011, and of limited use as baseline data for assessing the current situation in the ACT.
     - So far as ATODA is aware, ATOD-related burden of disease data is not frequently published (e.g. once a decade), and when it is uses data that is several years old. Relevant ATOD-related burden of disease data is unlikely to be released during the 2018 – 2021 life of the DSAP. Further, previous ATOD-related burden of disease data has not been published at the ACT level, either in aggregate or disaggregated into the listed priority population groups and drug types.
     - While the recent burden of disease report provides data disaggregated for the ACT by drug types, it does not provide data on ATOD-related burden of disease by priority population group. Its utility as an information source to monitor outcomes of the DSAP in relation to priority population groups is, therefore, limited.

   - The remaining three indicators come from the National Drug Strategy Household Survey, which presents a number of challenges in regards to producing the data needed to monitor the outcomes of the DSAP including:

     - The potential that the timetable for data release does not match the 2018-2021 DSAP timeline.
     - The ACT sample size may not be large enough to have sufficient statistical power to provide valid data disaggregated by the listed population groups, drug types, etc. unless ACT Health pays for (as it has in the past) an increase to the ACT sample size for future waves of the National Drug Strategy Household Survey.

ATODA, therefore, believes the ACT Government should name indicators of success, specific to the individual actions articulated in the DSAP. Particularly, with reference to things that may indicate success in the relative short 3 year life of the DSAP (i.e. what achievable

steps along the way can demonstrate progress). Later in this submission, ATODA has proposed a series of additional actions for inclusion in the DSAP, and articulated both 'Indicators of progress in the life of the DSAP' as well as 'Longer term data sources'. ATODA has done this to model good practice and suggests that such an approach could be applied across all of the existing actions in the DSAP to ensure progress can be measured (see Attachment B for a list of proposed actions in the draft DSAP).

Examples of indicators for the actions written in the DSAP

Below, are examples of progress indicators that could apply to some of the existing proposed DSAP actions—for reference, see the excerpt of the Priority Actions from the Draft ACT Drug Strategy Action Plan in Attachment B. These are not exhaustive, and further progress indicators could be identified for these actions.

Action		**Indicators of Progress in Life of Drug Strategy Action Plan**
13.	Review and implement potential diversion strategies such as an ACT Drug and Alcohol Court.	Expand police diversion to include pre-charge diversion for low-level offences into specialist AOD services.
15.	Continue to support evidence-based prescription treatment programs such as naloxone and medicinal cannabis.	Education and training provided to General Practitioners on the prescription of naloxone; and on the prescription of medicinal cannabis.
20.	Develop and implement a local early warning system to monitor and respond to emerging drug trends and harms in order to make more timely use of data.	Implement and evaluate a fixed-site drug checking/pill testing

Comments on the priority actions

In developing this submission, ATODA has not taken the approach of reviewing the individual actions proposed in the draft DSAP – as this amount of work would be equivalent to a full re-drafting. However, a range of comments related to the actions as a whole include:

- ATODA believes the DSAP should include a statement describing the criteria or framework that have been applied to determine which actions are priorities—which actions are included and which are excluded. This will help the reader to understand the underpinning rationale. An example of such an approach is articulated later in this submission. A priority-setting framework was included in the previous ACT ATOD Strategy and this should be maintained in the DSAP.

- ATODA is concerned that there appears to little mention of the specialist AOD service system beyond the statement that precedes the actions: 'The ACT Government … will continue to invest in alcohol and other drug treatment and support services over the life of the Action Plan''. ATODA believes the DSAP should make explicit what actions will be implemented to fill the existing service gaps, and to respond to emerging service needs, over the next three years, particularly considering the acknowledged inadequate resourcing of the sector in relation to the level of demand for treatment and harm

reduction services. Some suggestions of actions and how this could be achieved are provided later in this submission.

We particularly draw attention to Appendix 7 (Strategic framework fit for purpose for specialist AOD health services) which highlights risks with the potentially blunt approach of the Territory-wide Health Services Framework if not appropriately adapted to the uniqueness and strengths of the ACT ATOD sector; and recommends strategies for how the Territory-wide Health Services Framework can be effectively utilised by having in place strategic ATOD specific elements that underpin it.

Further given, for example, that the Territory-wide Health Services Framework is in the first stage focussed on internally on ACT Health and is hospital-centric, in ATODA's view it is not acceptable for the DSAP to not include explicit and multiple actions related to the specialist AOD services system in the ACT – otherwise we fear that the drug treatment policy vacuum that has been in place since the beginning of 2017 will be maintained.

- ATODA is concerned that there is no mention of Aboriginal and Torres Strait Islander people within the DSAP actions, beyond a single action related to tobacco that states: 'Maintain a focus on Aboriginal & Torres Strait Islander smoking interventions'. ATODA believes the DSAP should make explicit what actions will be implemented over the next three years to address the disproportionate impact of ATOD related harms on Aboriginal and Torres Strait Islander people and the inadequate resourcing and availability of culturally secure ATOD services. These actions should be specifically consulted on with the Aboriginal and Torres Strait Islander community.

- With respect to the actions listed, the DSAP gives no indication that what is included are the actions that research evidence shows are most likely to produce the desired outcomes. For example, with respect to alcohol, reducing availability (especially trading hours and outlet density), and setting a floor price for alcohol beverages, are not mentioned, despite being among the most powerful and cost-effective interventions available for reducing alcohol-related harm. This applies also to alcohols impact on road traffic injuries, despite the newly released Australian Institute of Health and Welfare report on the impact of alcohol and illicit drug use on the burden of disease and injury in Australia identifying that alcohol use is responsible for around one-third of the burden of road traffic injuries.[15]

- ATODA notes priority actions are listed for alcohol, tobacco and 'all drugs', i.e. all psychoactive substances. ATODA believes that sections should be added explicitly stating the priority actions on illicit drugs and pharmaceutical products, particularly considering the burgeoning epidemic of opioid overdose morbidity and mortality.

7. Proposed Priority Setting Criteria

In preparing this submission, and consulting on the additional proposed actions articulated in later sections, ATODA utilised a criteria to determine and prioritise actions (and make decisions about what should be included or excluded); these priority setting criteria are presented in Box 1, below.

ATODA believes that it is necessary for the DSAP to use, and articulate criteria for priority setting and decision-making.

Box 1: Priority Setting Criteria

1. **Size**: the size of the problem to be addressed, usually based on data on incidence (number of new cases in a given time period) or prevalence (number of cases existing in a specified geographical area at a given point in time, or given time period).
2. **Seriousness**: the seriousness of the problem to be addressed, based on such factors as it its urgency, severity, actual or potential adverse economic impacts, actual or potential adverse impacts upon others, etc.
3. **Effectiveness of interventions**: the effectiveness of the interventions available to address the problem, i.e. the likelihood of attaining the intended outcomes.
4. **Feasibility**: the feasibility of implementing the activity and of producing good outcomes, taking into account the DSAP's time frame (three years initially), available resources (funds, expertise, time, physical infrastructure, governance, etc.) and environmental factors (such as: propriety, economics, acceptability, legality of solutions, availability of resources).
5. **Equity**: the likely results of the intervention in terms of improved equity outcomes and the disproportionate impacts on disadvantaged populations.

Source: adapted from Vilnius, D & Dandoy, S 1990, 'A priority rating system for public health programs', *Public Health Reports*, vol. 105, no. 5, pp.463-70.

8. Summary of Proposed Additional Actions

In collaboration with stakeholders, using the body of information and expertise available in the ACT ATOD sector as well as the evidence base of the field, ATODA has generated a number of actions that it proposes for inclusion in the DSAP. These have been assessed against the priority setting criteria listed above. Recommendations for indicators of achievement in the life of the DSAP, as well as longer term data sources, are also articulated for each action. A mixture of both process and outcome indicators have been suggested as examples (i.e. process indicators that are used to measure processes or activities to implement the actions in the 3 year life of the DSAP; and outcome indicators that measure medium term impacts of the implementation of the actions). This is similar to the approach established in the previous *ACT ATOD Strategy 2010-14*, which identified examples of indicators that could be used to evaluate the strategy.[16]

A summary of the actions are provided in Table 1 below; followed by more detailed descriptive documents that articulate the rationale and evidence for the actions proposed (as appendices). ATODA believes that such an approach, and articulation of evidence, should be incorporated for the range of actions articulated in the DSAP. Below ATODA is modelling good practice in drug policy.

Table 1: Summary of Proposed Additional Actions, Outcomes, Indicators and Data Sources for the ACT Drug Strategy Action Plan

Appendix #	Area	Action	Outcome	Indicators	Longer term Data Sources
1	Opioid overdose	Develop and implement, as a matter of urgency, an ACT Opioid Overdose Reduction & Response Strategy, and supporting national initiatives.	Reduced opioid-related mortality and morbidity in the ACT	• ATOD sector, including people who use drugs, engaged in a co-design process toward the establishment of an ACT Opioid Overdose Reduction & Response Strategy. • Quality of process and progress on development and implementation of an ACT Opioid Overdose Reduction & Response Strategy. • Public release of the ACT Opioid Overdose Reduction and Response Strategy developed through the above processes. • Timely data on the incidence of opioid-related overdose and mortality in the ACT derived from ACT Health and coronial epidemiological data systems.	• Evaluation of the implementation and outcomes of an ACT Opioid Overdose Reduction and Response Strategy • Trends in the incidence of opioid-related overdose and mortality in the ACT
2	Drink- driving deterrence	Increase randomness and intensity of random breath testing (RBT).	Improved road safety through strengthening drink-driving deterrence.	• ACT Government and ACT Policing to create a new target within their service contract that related to random roadside breath testing rates (in addition to drivers self-report data). • ACT Policing resourced adequately to achieve the agreed target. • A progressive increase in the ratio of RBT tests per 100,000 licensed drivers. • Reduction in the quarterly fluctuations in positive breath tests, showing that testing is more random and less targeted.	• ACT road crash and serious injury road crash incidence data

Appendix #	Area	Action	Outcome	Indicators	Longer term Data Sources
3	Specialist AOD treatment and harm reduction services	Expand and embed AOD specialist treatment and support services into committed ACT Health infrastructure (e.g. community health centres), including opioid maintenance treatment, needle and syringe programs and AOD therapeutic clinical spaces.	Meet current and future demand for AOD treatment and support services in areas of significant population growth	• Quality of process and progress on inclusion of AOD-specific services within future ACT Health health-services infrastructure planning and development. • ATOD sector, including service consumers, engaged in co-design processes toward the establishment of expanded AOD specialist treatment and support services. • A new Primary Needle and Syringe Program is established and is operational in an under-serviced area of the ACT. • A new Opioid Maintenance Treatment tier one dosing point is established and is operational in the north of Canberra. • Clinical spaces specifically for the delivery of specialist AOD outreach interventions are planned for, established, and operational within, new and future ACT Health Community Centres. • Numbers of service consumers accessing these new sites: needle and syringe program, Opioid Maintenance Treatment program, and AOD therapeutic outreach interventions.	• National Opioid Pharmacotherapy Statistics Annual Data (NOPSAD) • Needle and Syringe Program National Data Source • Alcohol and Other Drug Treatment Service National Minimum Data Set • Service Level Reporting and Outcomes Measurement • Service User Satisfaction and Outcomes Survey
4	Drug diversion	Expand the ACT's existing Simple Cannabis Offence Notice (SCON) scheme to	Reduce the number of people, particularly young people, with criminal records.	• ACT Policing, ACT Health, ACT Justice and Community Safety Directorate to scope options for expanding the ACT's Simple Cannabis Offence Notice (SCON) scheme in consultation with other key stakeholders.	• Australian Bureau of Statistics Recorded Crime Offenders data • Australian Crime Commission Illicit Drug Data Report

Appendix #	Area	Action	Outcome	Indicators	Longer term Data Sources
		cover all illegal drugs (e.g. MDMA/ 'ecstasy').		• Based on the scoping exercise (above), commence processes to legislate the expansion of the ACT's Simple Cannabis Offence Notice (SCON) scheme to include all illicit drugs. • Numbers of people diverted through the SCON scheme from the criminal justice system into the specialist drug treatment system (depending of timing of expansion of the scheme).	• ACT Criminal Justice Statistical Profile • ACT Policing Annual Report
5	Specialist AOD withdrawal services	Establish a new specialist structured outpatient withdrawal program for people dependent on alcohol and other drugs.	Fill a major gap in the ACT's health service system by providing appropriate levels of support for withdrawal to be completed safely.	• ACT Health release of the 2016 report into the Review and Redesign of AOD Withdrawal Services in the ACT. • Quality of process and progress with funding bodies to fund the establishment of outpatient withdrawal services. • Depending on time of establishment: potential utilisation of Alcohol and Other Drug Treatment Service National Minimum Data Set and service reporting to determine number of participants, stakeholders involved, population served etc.	• Alcohol and Other Drug Treatment Service National Minimum Data Set • ACT ATOD Service User Satisfaction and Outcomes Survey • ACT ATOD Workforce Qualification and Remuneration Profile • Service level outcomes measures
6	Specialist AOD health services planning	ACT Health to collaborate with the Commonwealt h Government, State and	Increase the sustainability, viability and capacity of the ACT AOD treatment and	• ACT Health engages with ATODA and the ATOD sector to commence dialogue on approaches to technical AOD specific health service planning. • Quality of the process of, and progress on, ACT Health's participation in the	• Monitoring and evaluation activities to be confirmed

Appendix #	Area	Action	Outcome	Indicators	Longer term Data Sources
		Territory AOD Peaks Network and others to ensure the *Drug and Alcohol Service Planning Model (DASP)* informs joint planning and investment in, specialist AOD treatment and harm reduction services in the ACT and nationally.	support system to meet current and future needs	Commonwealth Government processes established to inform the use of the Drug and Alcohol Service Planning Model (DASP) in the joint planning of, and investment in, specialist AOD treatment and harm reduction services (including participation in a Working Group and Technical Group, as advised by the State and Territory AOD Peaks Network).	
7	Strategic framework fit for purpose for specialist AOD health services	Produce a strategic framework (and infrastructure) to guide the development and design of specialist AOD health care services across the	Consistent with ACT Health priorities, specialist AOD health care services across the Territory remain person centred, integrated, safe and effective with the	• ACT Health commits to a strategic framework (with infrastructure) to guide the development and design of specialist AOD health care services across the Territory over the next decade. • ACT Health engages with ATODA and the ATOD sector to commence dialogue on approaches to developing these frameworks and infrastructure (including enabling sector-led co-design processes). • Quality of the process of, and progress on, the development of a sector-driven co-	• All established AOD data sources (e.g. ATODS NMDS, Service User Satisfaction and Outcomes Survey, Workforce Profile) • Monitoring and reporting on implementation strategic framework

Appendix #	Area	Action	Outcome	Indicators	Longer term Data Sources
		Territory over the next decade, consistent with the ACT Health Territory Wide Health Services Framework 2017-2027.	appropriate infrastructure to meet the future health needs of the growing ACT and surrounding region.	design ACT AOD Treatment and Support Framework that reflects good practice across specialist AOD treatment providers. • Sector-driven and co-designed development of a document that collates and clinically endorses the current evidence based treatment and support approaches offered by the specialist ATOD sector in Australia, and maps the ACT against this. • Quality of the process of, and progress on, documenting and endorsing an agreed standard or approach to the monitoring and reporting of ATOD outcomes data, including deciding on indicators and data sources (a sector-driven and co-designed Specialist ACT AOD Outcomes Framework). • Quality of the process of, and progress on, development of a sector-driven and co-designed ACT ATOD Sector Quality Framework that builds on existing shared components within ACT Health contracts. • Quality of the process of, and progress on, development and implementation of a Sector-driven and co-designed ACT Workforce Development Strategy that is consistent with the National AOD Workforce Development Strategy.	elements including of ACT AOD Treatment and Support Framework; Specialist ACT AOD Outcomes Framework; and ACT Workforce Development Strategy.
8	Blood borne viruses	Integrate hepatitis C	Reduce the burden of	• Externally facilitated workshop held between specialist AOD services, blood–	• Chief Health Officers Report

Appendix #	Area	Action	Outcome	Indicators	Longer term Data Sources
		prevention, identification and treatment in specialist AOD settings.	disease from hepatitis C	borne virus services, researchers, consumers, and policy-workers to develop action plan related to hepatitis C identification, treatment and prevention in AOD settings and to respond to the specific needs of the diversity of people who use drugs within these settings. • Scoping of appropriate measures and tools for the collection of data by specialist AOD services on hepatitis C screening, referral and treatment activities provided to service consumers. • Establishment of a program of activities to implement the agreed action plan (above). • Improved capacity, including clinical capacity, within existing AOD treatment and support services to identify, treat and prevent hepatitis C, including through providing on site services, or facilitating links to off-site supports. • Specialist AOD services contribute to the target set in the Hepatitis B, Hepatitis C, HIV and Sexually Transmissible Infections ACT Statement of Priorities 2016 – 2020 to increase the number of people receiving antiviral treatment by 50% each year.	• Hepatitis C Annual Surveillance Reports • Viral Hepatitis Clinical Research Program: Monitoring Hepatitis C Treatment Uptake • Alcohol and Other Drug Treatment Services National Minimum Data Set • Service Level Reporting and Outcomes Measurement • Service User Satisfaction and Outcomes Survey • Potential additional data source depending on outcome of scoping exercise (see in examples of indicators)
9	Smoking cessation	Provide targeted, settings-based and intensive smoking	Reduced tobacco use and tobacco related harms among people	• ACT Health increases investment in subsidised NRT through the existing program offered in specialised AOD services, including investment in smoking	• Monitoring and evaluation data collected by the subsidised

Appendix #	Area	Action	Outcome	Indicators	Longer term Data Sources
		cessation support that includes subsidised nicotine replacement therapy.	who smoke from disadvantaged populations with very high smoking rates.	cessation for workers providing the program. • Establish a plan to engage other sectors representing services accessed by other disadvantaged population groups in the expansion of the existing subsidised NRT/smoking cessation support program. • Existing subsidised NRT/smoking cessation support program is expanded into other settings accessed by disadvantaged population groups (e.g. homelessness, mental health, etc)—with appropriate resourcing provided by ACT Health. • Increase in quality quit attempts made by people accessing targeted, settings-based and intensive smoking cessation support that includes subsidised nicotine replacement therapy. • Numbers of workers trained in providing smoking cessation support.	NRT/smoking cessation program • Service Users' Satisfaction and Outcomes Survey • Service level outcomes measures • ACT ATOD Workforce Qualification and Remuneration Profile
10	Infrastructure	Develop and implement an infrastructure plan, which includes grants, for specialist AOD services to address ageing and changing	Improved physical and information technology infrastructure for specialist alcohol and other drug services to enable services to better meet	• ACT Health funds an independent audit to identify and prioritise the infrastructure needs of existing specialist AOD services, including physical infrastructure and information technology. • Based on this audit, develop a ten-year infrastructure plan is co-designed with ACT Health and specialist AOD services. • ACT Health co-designs with specialist AOD services an infrastructure grants program that responds to the immediate	• Service Users' Satisfaction and Outcomes Survey • Workforce Remuneration and Qualification Survey (with added components) • Service level data collection (e.g. in-

Appendix #	Area	Action	Outcome	Indicators	Longer term Data Sources
		infrastructure needs.	the needs of, and improve outcomes for, service consumers.	needs identified in the audit, including guidelines and application processes. • Specialist AOD services apply for, and receive funding for infrastructure improvements, and make the identified improvements to infrastructure. • Service consumers, their families, and staff are engaged in the project design, prioritisation and implementation. • Improved service consumer and staff safety, improved amenity to enhance AOD outcomes, and ability for AOD services to expand delivery and reporting on services.	house satisfaction surveys) • Infrastructure plan implementation reporting including repeating an audit
11	Innovation	Establish and provide funding through an innovation fund for specialist AOD services to develop, implement and evaluate new AOD initiatives and service models.	Existing investment leveraged by enhancing the capacity of specialist AOD services to respond dynamically to identified, and changing, needs of service consumers and patterns of drug use through innovative service delivery responses.	• Based on the priorities identified in the ACT AOD Treatment and Support Framework (see appendix 5), ACT Health funds a sector-driven co-design process to establish an innovation fund for specialist AOD services, including guidelines and application processes. • Specialist AOD services, respond to needs of service consumers, identify appropriate innovative responses, and apply for funding from the innovation fund. • Specialist AOD services receive funding from the fund and develop, implement and evaluate new and innovative alcohol and other drug initiatives and models.	• ACT Alcohol Tobacco and Other Drug Services Directory • Service Users' Satisfaction and Outcomes Survey • National Minimum Data Set • Innovation program level evaluations

Appendix #	Area	Action	Outcome	Indicators	Longer term Data Sources
12	School drug education	Implement modern, evidence-informed school drug education programs in the ACT.	Prevent the uptake of drugs, delaying first use, and reducing drug use and harms amongst young people.	• ACT Health and the Education Directorate co-commission a review of the ACT school drug education programs, including the current extent and nature of these programs, and the degree to which they reflect contemporary good practice as evidenced from evaluation research. • Publicly release the review (above). • Based on the review and report (above), a commitment is made to the implementation of an evidenced-based school drug education program in the ACT.	• Reports available to the public demonstrating the implementation of evidence-informed school drug education programs, their effectiveness and cost-effectiveness • Data on drug use among school students
13	Data quality and capacity	Improve drug treatment data collection, management, analysis and utilisation by transferring responsibility to AODTS NMDS from ACT Health to the sector (through ATODA)	Enhanced capacity to collect and analyse data, improved data quality and timeliness, and more effective use of data in the ACT ATOD sector and the ACT community	• ACT ATOD sector engaged in the National AODTS NMDS Project. • Transfer of responsibility for the ACT AODTS NMDS from ACT Health to the sector (through ATODA). • Publication of initial ACT-specific reports from the NMDS.	• Improved ACT data quality in the AIHW's national data holdings • ACT-specific reports from the NMDS
14	Prison health services	Provide sterile injecting equipment for use by people	Protecting the health and well-being of the Alexander	• ACT Health and Justice and Community Safety Directorate, with other stakeholders, to review the implementation of, and revise, the	• Data on utilisation of an Needle and Syringe Program at

Appendix #	Area	Action	Outcome	Indicators	Longer term Data Sources
		detained in the Alexander Maconochie Centre	Maconochie Centre's detainees, staff and visitors, and the broader community	Strategic Framework for the Management of Blood-Borne Viruses in the Alexander Maconochie Centre 2013 – 2017. • The ACT Government publicly announce a strategy to implement the ACT Government policy on establishing a Needle and Syringe Program at the AMC • Implementation of the ACT Government policy.	the Alexander Maconochie Centre • Data on the prevalence and incidence of blood-borne viral infections among Alexander Maconochie Centre detainees

Appendix 1

Area: Opioid Overdose

Action: Develop and implement, as a matter of urgency, an ACT Opioid Overdose Reduction & Response Strategy, and supporting national initiatives.

Outcome: Reduced opioid-related mortality and morbidity in the ACT

Examples of Indicators of Progress in Life of Drug Strategy Action Plan:
- ATOD sector, including people who use drugs, engaged in a co-design process toward the establishment of an ACT Opioid Overdose Reduction & Response Strategy.
- Quality of process and progress on development and implementation of an ACT Opioid Overdose Reduction & Response Strategy.
- Public release of the ACT Opioid Overdose Reduction and Response Strategy developed through the above processes.
- Timely data on the incidence of opioid-related overdose and mortality in the ACT derived from ACT Health and coronial epidemiological data systems.

Longer term Data Sources:
- Evaluation of the implementation and outcomes of an ACT Opioid Overdose Reduction and Response Strategy
- Trends in the incidence of opioid-related overdose and mortality in the ACT

Australia, in common with some other wealthy Western nations, is currently experiencing an epidemic of unintentional opioid-related deaths: 'In 2015, there were a total of 2,023 drug-related deaths in Australia. This has increased from 1,313 deaths in 2001'.[17] Unfortunately, in the absence of an ACT drug monitoring and early warning system, we do not have up-to-date quantification of the extent of the epidemic with in this jurisdiction. It is disgraceful that the most recent ACT data, published by the National Drug and Alcohol Research Centre (NDARC), are for the 2013 year.[18]

A study of opioid-related deaths using National Coronial Information System data, conducted by the ACT Health's former Alcohol and Drug Policy Unit as part of the evaluation of the ACT naloxone program, revealed that, in 2013 and 2014, there were 32 opioid-related deaths in the ACT, almost twice the number of deaths than occurred in motor vehicle crashes.[19] It is likely that the number has increased since then, and that the incidence is now as high, or higher, than during the previous opioid-related mortality epidemic of the late 1990s.

We know how to respond to the opioid overdose epidemic being experienced in the ACT and beyond. The key actions were documented during the previous epidemic and are being promulgated again during this one.[20] They include the following:
- Improve opioid prescribing, and establish a real-time monitoring system accessible by prescribers, dispensers and others;
- Improve medical and allied health professional interventions for pain management in the whole community, and respond better to the challenging pain management experiences of people who use opioids, either therapeutically or otherwise;
- Treat opioid use disorders by expanding the ACT's Opioid Maintenance Treatment program and implementing a heroin-assisted treatment program in the ACT or, as an interim measure, a hydromorphone-assisted treatment program;
- Reduce the frequency of drug overdoses by boosting peer education on preventive strategies;

- Undertake a feasibility study for a supervised injecting place, with the view to Potentially implementing one as per the Supervised Injecting Place Act;
- Establish drug checking services (including fixed site services);
- Improve the management of overdose by witnesses;
- Commission a study to investigate and report on the feasibility of establishing a supervised injecting place in Canberra under the ACT *Supervised Injecting Place Trial Act 1999*;
- etc.

In 2001 we were in the tragic situation of the Ministerial Council on Drug Strategy promulgating a National Heroin Overdose Strategy *after the heroin overdose epidemic had ended*, owing to the failure of the bureaucrats and politicians responsible to act in a timely manner. We must not see this repeated in the ACT now.

The DSAP should include, as a high and urgent priority, action to develop and implement, in conjunction with community stakeholders (including the representatives of people who use illicit drugs) an evidence-informed strategy to reduce the adverse impacts of opioids in the ACT.

Appendix 2

Area: Drink-driving deterrence

Action: Increase randomness and intensity of random breath testing (RBT).

Outcome: Improved road safety through strengthening drink-driving deterrence.

Examples of Indicators of Progress in Life of Drug Strategy Action Plan:

- ACT Government and ACT Policing to create a new target within their service contract that related to random roadside breath testing rates (in addition to drivers self-report data).
- ACT Policing resourced adequately to achieve the agreed target.
- A progressive increase in the ratio of RBT tests per 100,000 licensed drivers.
- Reduction in the quarterly fluctuations in positive breath tests, showing that testing is more random and less targeted.

Longer term Data Sources:

- ACT road crash and serious injury road crash incidence data

Although Australia's drink-driving motor vehicle crash, injury and death rate has fallen in recent decades, partly because of the implementation of random breath testing (RBT), alcohol continues to be a major risk factor for motor vehicle crashes with some 30% of crashes that result in death or serious injury nationally being alcohol-related.[21]

To be effective as a road safety intervention (rather than as a law enforcement intervention *per se*) RBT achieves its deterrent effects by being truly random and by being conducted with a high enough intensity that drivers perceive that there is a genuine likelihood of them being tested.[22] Recent research has demonstrated, however, that the intensity of testing in the ACT (an average of one test per three licensed drivers per annum) is well below that considered to be best practice, namely an average of one test per licensed driver per annum.[23]

RBT is highly cost-effective but, to attain its potential, needs to be implemented with a considerably higher level of intensity than is the case in the ACT at present.[24]

Furthermore, there is a widespread perception that RBT in Canberra is not implemented on a truly random basis. Rather, it is being implemented in a targeted manner, targeting particular locations, times of the day, days of the week, and driver populations. ACT Policing statistics tend to confirm this observation.[25] In so far as this is correct, it militates against attaining the deterrence objectives of RBT.

There is also concern that the number of RBTs conducted in the ACT has fallen substantially over the period that highly-targeted roadside oral fluid tests for three drugs have been implemented,[26] raising concerns that resources may be being diverted from an intervention that we know works (RBT) to one for which there is no evidence of effectiveness as a road safety initiative (roadside oral fluid testing).[27,28,29]

ACT Policing should be resourced adequately to keep up with the required volume of random breath testing to meet best practice, maximise the deterrent effect and maintain road safety.

RBT in the ACT needs to be implemented in a genuinely random way and testing rates need to triple to meet best practice standards (an average of one test per licenced driver should be conducted per year).

The DSAP could include initiatives that will create a new target in the contract between the ACT Government and ACT Policing that the latter implement an average of one random breath test per licensed driver per year, by a specified date, and markedly increase the proportion of breath tests that are random, rather than targeted.

Appendix 3

Area: Specialist AOD Treatment and Harm Reduction

Action: Expand and embed AOD specialist treatment and support services into committed ACT Health infrastructure (e.g. community health centres), including opioid maintenance treatment, needle and syringe programs and AOD therapeutic clinical spaces.

Outcome: Meet current and future demand for AOD treatment and support services in areas of significant population growth.

Examples of Indicators of Progress in Life of Drug Strategy Action Plan:
- Quality of process and progress on inclusion of AOD-specific services within future ACT Health health-services infrastructure planning and development.
- ATOD sector, including service consumers, engaged in co-design processes toward the establishment of expanded AOD specialist treatment and support services.
- A new Primary Needle and Syringe Program is established and is operational in an under-serviced area of the ACT.
- A new Opioid Maintenance Treatment tier one dosing point is established and is operational in the north of Canberra.
- Clinical spaces specifically for the delivery of specialist AOD outreach interventions are planned for, established, and operational within, new and future ACT Health Community Centres.
- Numbers of service consumers accessing these new sites: needle and syringe program, Opioid Maintenance Treatment program, and AOD therapeutic outreach interventions.

Longer term Data Sources:
- National Opioid Pharmacotherapy Statistics Annual Data (NOPSAD)
- Needle and Syringe Program National Data Source
- Alcohol and Other Drug Treatment Service National Minimum Data Set
- Service Level Reporting and Outcomes Measurement
- Service User Satisfaction and Outcomes Survey

There is a need to selectively expand locations for the provision of specialist AOD services in the ACT to meet demand in areas of significant population growth, and to do so as part of the ACT's overall health service planning. The total population in the ACT is projected to grow by 6 per cent from 2016 – 2020; however, this growth will be largely concentrated in two areas:

- Cotter-Namadgi: Projected population growth of 139% between 2015-2020. This will take the population from 3,707 in 2015 to 13,025 in 2020.
- North Canberra: Projected population growth of 24.6% in Gungahlin; 10% in North Canberra and 3.6% in Belconnen between 2015-2020. According to the 2016 Census Gungahlin was the second-fastest growing region in Australia, now home to 71,000 people, up from 47,000 in 2011.[30]

The ACT Government has made firm commitments to plan for this growth, particularly in the provision of health services and infrastructure.[31] Notably, commitments to health infrastructure within the two regions above include:

- Establishment of a nurse-led walk in centre for the Gungahlin community.
- Scoping work for the establishment of a new walk in centre in the Weston Creek region.[32]
- Planning for a new City Health Centre in Civic.[33]

Consistent with the Territory Wide Health Services Plan 2017-2027 and ACT Health's Quality Strategy, the community health centres provide safe and effective settings through which a range of specialist services can be delivered closer to peoples homes, including specialist AOD services.[34]

Unfortunately, planning for the provision of AOD services within ACT Health infrastructure has been overlooked in recent times; and facilities such as the new Sub-acute Hospital, Belconnen Health Centre and Gungahlin Health Centre were developed without due consideration to the need for, and appropriateness of, a range of specialist AOD services.

Three services, in particular, should be considered for inclusion in newly planned health infrastructure operated by ACT Health and delivered in partnership with the specialist AOD service system (government and non-government providers), including:

- Needle and syringe programs (particularly opportunities for expanding primary NSP services)
- Opioid Maintenance Treatment (particularly opportunities for providing tier one dosing on the northside of Canberra).
- Access to therapeutic AOD services through the provision of clinical spaces in which established AOD services could outreach to community health settings.

We note that a joint project was undertaken by ATODA and CAHMA in 2017 that sought to better understand the needs of people who use drugs and their experiences of the service system in the north of Canberra. This work can helpfully inform the further service development of going forward and has informed this submission.

Details for each of these priorities, and their appropriateness and need for inclusion in the committed health services infrastructure developments is expanded on below:

<u>Establish a new Primary Needle and Syringe Program site</u>

Over 80% of all newly acquired hepatitis C infections in Australia are associated with injecting (illicit) drug use, primarily as a result of using injecting equipment exposed to another person's blood.[35] Needle and syringe programs (NSPs) provide sterile injecting equipment, have been successfully managed and implemented in the ACT since 1989,[36] and have been cost-effective as one of Australia's public health approaches to preventing the spread of blood-borne viruses.[37] A primary NSP distributes a wide range of free specialist injecting equipment, along with broader health and social support services including education and referral to treatment.[38] NSPs are in a unique position to be a contact point for providing health and welfare services to a group of people who are often underserviced and experience poor general health and medical problems associated with injecting.[39,40]

There are currently two primary NSPs in Canberra, located in Civic and Phillip; while some sterile injecting equipment is available from secondary outlets located throughout the ACT, these outlets do not provide the full range of specialised equipment and targeted health and social support services. Consequently, a large proportion of people who inject drugs in the ACT are required to travel substantial distances to access these vital services – or may not access them at all.

Evidence shows that we are yet to achieve 'full coverage' of having all injections occurring with new, sterile equipment. A key factor associated with this is the location and geographical accessibility of services (combined with transport issues).[41]

An additional primary NSP outlet in an under-serviced area of the ACT (such as in north Canberra) would improve accessibility and the capacity of NSPs to meet anticipated future demand, contributing to the public health of Canberrans and the prevention of the spread of blood borne viruses.

Establish a new Opioid Maintenance Treatment tier one dosing point in the north of Canberra

Heroin, and opioid dependence in general, is a major area of focus for drug and alcohol treatment services because the harms, and economic and social costs, are disproportionate to the prevalence of use.[42]

Opioid Maintenance Treatment (OMT) includes the provision of a range of opioid-based pharmacotherapies used to treat opioid dependence, and is highly effective in:

- Bringing an end to, or significantly reducing, an individual's illicit opioid use;
- Reducing the risk of overdose;
- Reducing the transmission of blood-borne viruses; and,
- Improving general health and social functioning, including a reduction in crime."[43]

These objectives are achieved by engaging and retaining people dependent on opioids in treatment.

OMT is cost-effective and provides substantial social and economic benefits to the wider community. For example, both methadone and buprenorphine are highly cost-effective treatment programs, with the return on investment in methadone programs estimated to be between 2:1 and 38:1.[44]

People on OMT attend a dosing point regularly, sometimes daily, to take a supervised dose of medicine. The ACT OMT program operates on a tiered approach, whereby most clients must attend the public clinic operated by ACT Health at The Canberra Hospital, potentially for some months, prior to moving to community-based prescribing and dosing. This can result in an overwhelming impact on time and effort required to access treatment; in some cases up to a multiple hour round trip daily for those living far away from The Canberra Hospital.

Case study: Sarah

A single mother in her 20s, has two children under five and is accessing drug treatment as part of tier one OMT. She did not complete year 10, she has never been employed, has experienced repeated homelessness, is a Centrelink recipient, and does not have family and social supports (including access to child care) in Canberra. The only health and community service she accesses is through the OMT program. She is in poor health, particularly for her age, began using heroin in her teens, and after 10 years began treatment as part of the OMT program. She, and her two children, are required to attend The Canberra Hospital daily via public transport for her to receive her medication. They reside in Gungahlin in public housing, their house is a bus ride from the Gungahlin towncentre and it is a multiple hour round trip. The demands on her family to access treatment mean that she is not able to engage in education and training, and therefore her chances of reaching economic and social independence are limited. Currently, Sarah would have to choose between accessing drug treatment and engaging in employment / education / training. Sarah's chances of relapsing into heroin use, and potential overdose, are greatly increased if she ceases OMT.

According to 2016 National Opioid Pharmacotherapy Statistics, the ACT has the equal highest rate in the country of clients receiving opioid pharmacotherapy (26 per 100,000 population). Approximately 15% of people will be dosing at the primary clinic (the second highest proportion of public dosing in Australia, and almost double the national rate). We also have the highest ratio of clients to dosing points at 31.3 clients per dosing point (nearly 10 higher than the next nearest state).[45]

While a multi-pronged approach will be necessary, that includes the recruitment of more community based prescribers and dosing points, providing an additional location for the dosing of pharmacotherapy for tier 1 clients at a primary clinic willl respond to growing demand in the north of Canberra, reduce unacceptable access barriers and improve the equity and effectiveness of the ACT's OMT Program. Planning for the new Civic Health Centre would seem an appropriate setting in which to do this.

Provide clinical space in ACT Health Community Centres for the delivery of specialist AOD services

There are a number of psychosocial and therapeutic AOD interventions that can be safely and effectively delivered through outreach/in-reach approaches across Canberra. This includes: counselling, group programs, day rehabilitation programs, aftercare, peer based support groups and intensive AOD focused case management. However, the lack of affordable and safe clinical spaces to do so is a barrier to specialist ACT AOD services delivering interventions in a wide range of settings closer to people's homes.

The establishment of new ACT Health infrastructure, including those committed to in North Canberra and Weston Creek, provide a timely opportunity to plan for the provision of clinical space to allow a more agile delivery of a range of specialist AOD interventions.

Appendix 4

Area: Drug Diversion

Action: Expand the ACT's existing Simple Cannabis Offence Notice (SCON) scheme to cover all illegal drugs (e.g. MDMA/'ecstasy').

Outcome: Reduce the number of people, particularly young people, with criminal records.

Examples of Indicators of Progress in Life of Drug Strategy Action Plan:

- ACT Policing, ACT Health, ACT Justice and Community Safety Directorate to scope options for expanding the ACT's Simple Cannabis Offence Notice (SCON) scheme in consultation with other key stakeholders.
- Based on the scoping exercise (above), commence processes to legislate the expansion of the ACT's Simple Cannabis Offence Notice (SCON) scheme to include all illicit drugs.
- Numbers of people diverted through the SCON scheme from the criminal justice system into the specialist drug treatment system (depending of timing of expansion of the scheme).

Longer term Data Sources:

- Australian Bureau of Statistics Recorded Crime Offenders data
- Australian Criminal Intelligence Commission Illicit Drug Data Report
- ACT Criminal Justice Statistical Profile

The ACT's Simple Cannabis Offence Notice (SCON) scheme was established through legislation in 1989, with some modifications introduced subsequently. It empowers members of ACT Policing, when they detect a minor cannabis offence, to divert the alleged offender away from the criminal justice system by issuing a Simple Cannabis Offence Notice, which requires the person to pay a $100 fine. If that fine is paid within the specified time period, the person does not have to attend court and does not attain a criminal record because of the offence. In this respect, the SCONs operates similarly to traffic infringement notices.

In recent years the number of people arrested for minor drug offences, such as consuming drugs or possessing small quantities for their personal use, has increased dramatically. Specifically, over the eight years from 2008-09 to 2016-17, the annual number of people arrested for drug offences in the ACT has increased by 75%, from 239 to 418.[46] A large proportion of this increase has been arrests for minor consumer-type methamphetamine ('ice') offences, despite the fact that governments have broadly acknowledged that 'We cannot arrest our way out of drug problems'.

A consequence of the high numbers of arrests for drugs other than cannabis is that very large numbers of Canberrans, particularly young people, are getting criminal records for what the community acknowledges as being minor offences. These criminal records work against their life opportunities for many years later.

The Simple Cannabis Offence Notice scheme, along with other drug diversion initiatives implemented in the ACT, was evaluated by external experts in 2014.[47] That evaluation noted the benefits the ACT had derived, over the years, from its operation.

As its name indicates, the Simple Cannabis Offence Notice scheme applies only to minor cannabis offences. People detected committing minor offences such as **consuming** 'ecstasy' (MDMA), 'ice' (methamphetamine), cocaine, opioids, etc. are not eligible for this type of diversion. Accordingly, substantial benefits would be gained by people who use

drugs, their families, and the broader ACT community, if the SCON provisions were expanded to cover *all* illicit drugs, not only cannabis. This would reflect the realities of drug use in the ACT, including the fact that a high proportion of the people who use drugs are poly-drug users.

Extending the SCON scheme to cover all drugs will provide increased opportunities for frontline members of ACT Policing, who are in contact with people who use drugs, to divert them away from the criminal justice system and, where warranted, into the ACT's drug treatment services. It would not entail any increase in funding; indeed, it could create significant savings in the criminal justice system.

Appendix 5

Area: Specialist AOD Withdrawal Services

Action: Establish a new specialist structured outpatient withdrawal program for people dependent on alcohol and other drugs.

Outcome: A major gap in the ACT's health service system by providing appropriate levels of support for withdrawal to be completed safely is filled.

Examples of Indicators of Progress in Life of Drug Strategy Action Plan:
- ACT Health release of the 2016 report into the Review and Redesign of AOD Withdrawal Services in the ACT.
- Quality of process and progress with funding bodies to fund the establishment of outpatient withdrawal services.
- Depending on time of establishment: potential utilisation of Alcohol and Other Drug Treatment Service National Minimum Data Set and service reporting to determine number of participants, stakeholders involved, population served etc.

Longer term Data Sources:
- Alcohol and Other Drug Treatment Service National Minimum Data Set
- ACT ATOD Service User Satisfaction and Outcomes Survey
- ACT ATOD Workforce Qualification and Remuneration Profile
- Service level outcomes measures

The ACT is the only jurisdiction in Australia that does not have a structured outpatient withdrawal program as part of its alcohol and other drug treatment services system. In other jurisdictions such as Victoria, outpatient withdrawal can represent as much as 42% of all withdrawal episodes; compared to the 0% delivered in the ACT.[48] The availability of bed based-only AOD withdrawal care represents a major gap in service delivery in the ACT.

In 2016, ACT Health funded an independent review and systems level re-design of AOD withdrawal management services. This process collaboratively worked with all government and non-government specialist AOD services, policy makers, service consumers and allied stakeholders (e.g. GPs with AOD expertise) to co-design a new evidence based AOD withdrawal services system. [49] At the final stakeholder forum in December 2016 there was unanimous agreement on the outpatient withdrawal program approach and its need for establishment as a matter of priority. Disappointingly, the report on the review and re-design of the ACT withdrawal system has yet to be publicly released or responded to by ACT Health, despite being submitted in December 2016.

Evidence demonstrates that outpatient withdrawal services are a critical component in providing a suite of AOD withdrawal services, are more cost-effective than bed-based services, and are safe or more appropriate for a range of service users (e.g. women with children, people with other caring responsibilities, employed people, etc.). [50] Many potential services users are able to undertake a formal, structured withdrawal program, supported by specialised staff, in non-residential settings such as their home or in a dedicated outpatient day service.[51] Additionally, barriers to access and bottlenecks in AOD treatment pathways currently experienced in the ACT would be mitigated by access to outpatient withdrawal services, increasing throughput at a service system level with minimal additional investment (e.g. for some Aboriginal and Torres Strait Islander people).

Outpatient withdrawal services are cheaper than bed-based withdrawal and can be as effective for some people without requiring an expensive inpatient admission. As such, the establishment of an outpatient withdrawal service is consistent with the Parliamentary Agreement for the 9th Legislative Assembly for the ACT particularly related to increasing the provision of outpatient, community based and nursing services. [52] It is also consistent with ACT Health policy priorities, including those articulated in the Territory-wide Health Services Framework, and the subsequent realignment of Canberra Hospital and Health Services, related to the more efficient use of bed-based services.[53,54]

Appendix 6

Area: Specialist AOD health services planning

Action: ACT Health to collaborate with the Commonwealth Government, State and Territory AOD Peaks Network and others to ensure the *Drug and Alcohol Service Planning Model (DASP)* informs joint planning and investment in, specialist AOD treatment and harm reduction services in the ACT and nationally.

Outcome: Increase the sustainability, viability and capacity of the ACT AOD treatment and support system to meet current and future needs

Examples of Indicators of Progress in Life of Drug Strategy Action Plan:

- ACT Health engages with ATODA and the ATOD sector to commence dialogue on approaches to technical AOD specific health service planning.
- Quality of the process of, and progress on, ACT Health's participation in the Commonwealth Government processes established to inform the use of the Drug and Alcohol Service Planning Model (DASP) in the joint planning of, and investment in, specialist AOD treatment and harm reduction services (including participation in a Working Group and Technical Group, as advised by the State and Territory AOD Peaks Network).

Longer term Data Sources:

- Monitoring and evaluation activities to be confirmed

The specialist AOD service system in the ACT and nationally has been chronically underfunded. We know that nationally drug treatment places need to at least double to meet demand.[55] The Commonwealth Government commissioned *New Horizons Report* estimated that approximately 200,000 people receive AOD treatment in any one year in Australia. At the same time, modelled projections of the unmet demand for AOD treatment (that is the number of people in any one year who need and would seek treatment) are conservatively estimated to be between 200,000 and 500,000 people over and above those in treatment in any one year.[56]

The State and Territory Alcohol and Other Drug Peaks Network (the Network) is liaising with the Commonwealth Government to progress evidence informed planning and investment in specialist AOD services. The Network believes there is an opportunity for the Commonwealth to provide leadership in working with States and Territories to ensure *The Drug and Alcohol Service Planning Model (DASP)*[57] informs joint planning and investment in specialist AOD treatment and harm reduction services to meet demand. This includes proposing the establishment of two key working groups:

1. <u>Specialist AOD Treatment and Harm Reduction Services Working Group</u>

Purpose: Advise the National Drug Strategy Committee on planning and investment in specialist AOD treatment and harm reduction services to meet demand across Australia. This work would complement the national treatment and quality frameworks being developed under the Council Of Australian Governments' *National Ice Action Strategy (2015).*

Membership: Representation could be invited from: Australian Government Department of Health; State and Territory health departments (2 representatives); and the State and Territory Alcohol and Other Drug Peaks Network (2 representatives)

Responsibilities: To establish a long-term plan for joint investment in specialist AOD treatment and harm reduction services that is informed by the *Drug and Alcohol Service Planning Model (DASP)*[58], clarifies government roles and improves planning across the sector so that communities have access to the types of services they need.

2. Drug and Alcohol Service Planning Model (DASP) Technical Group

Purpose: Provide epidemiological and clinical advice in relation to use of the *Drug and Alcohol Service Planning Model (DASP)*[59] by the Specialist AOD Treatment and Harm Reduction Services Working Group.

Membership: Representation could be invited from: Australian Government Department of Health; State and Territory health departments (2 representatives); and the State and Territory Alcohol and Other Drug Peaks Network (2 representatives) and experts in modelling and epidemiology (2, including previous chair of the DACCP working group).

Responsibilities: To provide advice to jurisdictions on the application of the DASP model and to ensure the currency of data relevant to the delivery of services.

About the Drug and Alcohol Service Planning Model

The *Drug and Alcohol Service Planning Model* (DASP) identifies the type of treatment (termed 'care') required by drug type and age group, and the components of that treatment (termed 'care package'). Elements of the care required—including staffing—are costed, and this can be used to estimate the resources required to deliver that care across a typical population of 100,000 people. The accompanying DASP Decision Support Tool can be used to estimate the resources required to deliver appropriate and adequate AOD treatment and support to a population. There are five essential components: the epidemiology; severity distribution; treatment rate; care packages; and resource estimation. The model and planning tool has been adapted into a tool for use in relation to resourcing of care packages for AOD treatment for Aboriginal and Torres Strait Islander people—the *DA-CCP adaptation for Aboriginal and Torres Strait Islander people*[60].

Additionally, the Commonwealth-funded *New Horizons: the review of alcohol and other drug treatment services in Australia* provides useful guidance to underpin technical planning activities for AOD treatment and support services. Further excerpts from this review are provided below.

Excerpts related to strategic and technical planning for specialist AOD services from the 'New Horizons' Report[61]

There is no consistent approach to AOD treatment planning. In Australia each state and territory assumes responsibility for treatment planning in its own jurisdiction. There is no national strategic plan. There is limited technical planning (Chapter 9). Planning would help direct resources and services to the areas of highest need. There is a lack of clarity about the respective roles and responsibilities of the Commonwealth and state/territory governments (Chapter 12). Commonwealth and state/territory governments operate independently of one another, yet in many cases they provide financial support for the same organisations. The majority of organisations funded by the Commonwealth also receive state/territory funding; although 30% of the organisations funded under NGOTGP were funded only by the Commonwealth, as were 31% of the organisations funded under the SMSDGF Priority 1 (Chapter 5). There is no evidence that the Commonwealth's investment is out of step with the states/territories in terms of the types of treatment it purchases. The treatment service types supported by Commonwealth funds (largely counselling and residential rehabilitation) are also supported by state/territory funds. Priority

areas and significant service gaps that we have identified (Chapter 8) include: alcohol treatment; population groups with high need (including young people; Aboriginal and Torres Strait Islander people; families, parents/carers with children, and women; individuals with co-morbid AOD and mental health problems; and those from culturally and linguistically diverse backgrounds); and specific service types (residential rehabilitation; residential withdrawal; pharmacotherapies; counselling and other outpatient services). This list is largely inclusive of all population groups and all service types, which reinforces the evidence on unmet demand for specialist AOD treatment…

…Instead of making an a priori decision, the Commonwealth could engage in the longer-term process of strategic and technical planning (Chapter 13). Planning processes enable purchasing decisions to be grounded in data on need and demand and focus the Commonwealth's effort in those areas that emerge as highest need. In the immediate 2015 grant round, a rapid consultation process could be undertaken (Chapter 16) with submissions from states/territories and input from an expert panel (inclusive of service providers and consumers) to establish the specific priority areas for Commonwealth funding (for treatment service types and for capacity building). These actions would both articulate with and commence the longer-term path to establish a strategic plan and engage with states/territories in technical planning into the future…

…As referred to above, we draw a distinction between strategic and technical planning, and delineate the Commonwealth as responsible for strategic planning (in concert with states/territories) and the states/territories responsible for technical planning (in concert with the Commonwealth). To achieve meaningful change across policy and practice, planning should be a partnership between the Commonwealth and the states/territories, which incorporates the interests of both parties and includes real engagement of service providers and current and prospective clients (Chapter 9). In the longer-term, a nationally endorsed ten-year AOD Treatment Strategic Plan would specify the roles and responsibilities of each funder (state/territory and Commonwealth) and identify the priority service types, population groups and locations for funding (Chapter 13). Under this option, the Commonwealth would fulfil its responsibilities in providing leadership in planning and setting national priorities. The development of a Strategic Plan would lay the foundation for future comprehensive technical planning built from solid data. We have found that there is a current lack of needs-based planning data (notably the current treatment investment mix and impacts of capacity building). The collection, collation and analysis of planning data will provide a foundation for technical planning into the future….

…We want to reinforce that how these activities are undertaken is as important as what is actually undertaken (Chapter 11). Throughout planning, purchasing and accountability, the development and maintenance of collaborative respectful partnerships needs to be kept in mind. This applies equally to the Commonwealth and to states/territories – that is planning, purchasing and accountability by the two levels of government needs to be engaging of the other level of government. Further, meaningful input from service providers and consumers is crucial; to enable processes that are grounded in the realities of service delivery and account for local context, and to ensure provider support for real change and development in the sector. Investment of resources in building these working relationships is required. This would include bolstering the resources available to the InterGovernmental Committee on Drugs by increasing the frequency of meetings and improving the communications (assuming that this is the body where a partnership between the Commonwealth and states/territories is best formulated and sustained); establishing mechanisms to consult and coordinate with the NGO treatment sector; and establishing mechanisms to consult with current and prospective clients of AOD treatment. It is possible to establish these mechanisms for the short-term (focussed on the next Commonwealth funding round for the NGOTGP and SMSDGF), although achieving value for money and improving health outcomes for people with AOD problems in the long-term will require sustained partnership mechanisms and ongoing attention to managing relationships (Chapter 16).

Appendix 7

Area: Strategic framework fit for purpose for specialist AOD health services

Action: Produce a strategic framework (and infrastructure) to guide the development and design of specialist AOD health care services across the Territory over the next decade, consistent with the ACT Health Territory Wide Health Services Framework 2017-2027.

Outcome: Consistent with ACT Health priorities, specialist AOD health care services across the Territory remain person centred, integrated, safe and effective with the appropriate infrastructure to meet the future health needs of the growing ACT and surrounding region.

Examples of Indicators of Progress in Life of Drug Strategy Action Plan:

- ACT Health commits to a strategic framework (with infrastructure) to guide the development and design of specialist AOD health care services across the Territory over the next decade.
- ACT Health engages with ATODA and the ATOD sector to commence dialogue on approaches to developing these frameworks and infrastructure (including enabling sector-led co-design processes).
- Quality of the process of, and progress on, the development of a sector-driven co-design ACT AOD Treatment and Support Framework that reflects good practice across specialist AOD treatment providers.
- Sector-driven and co-designed development of a document that collates and clinically endorses the current evidence based treatment and support approaches offered by the specialist ATOD sector in Australia, and maps the ACT against this.
- Quality of the process of, and progress on, documenting and endorsing an agreed standard or approach to the monitoring and reporting of ATOD outcomes data, including deciding on indicators and data sources (a sector-driven and co-designed Specialist ACT AOD Outcomes Framework).
- Quality of the process of, and progress on, development of a sector-driven and co-designed ACT ATOD Sector Quality Framework that builds on existing shared components within ACT Health contracts.
- Quality of the process of, and progress on, development and implementation of a Sector-driven and co-designed ACT Workforce Development Strategy that is consistent with the National AOD Workforce Development Strategy.

Longer term Data Sources:

- All established AOD data sources (e.g. ATODS NMDS, Service User Satisfaction and Outcomes Survey, Workforce Profile)
- Monitoring and reporting on implementation strategic framework elements including of ACT AOD Treatment and Support Framework; Specialist ACT AOD Outcomes Framework; and ACT Workforce Development Strategy.

The ACT ATOD sector has within it a service system that is a high demand, evidence-informed, specialist component of the broader health system. AOD treatment is also a good investment. For every $1 invested in alcohol or drug treatment, society gains $7.[62] The savings that accrue to governments from AOD treatment occur largely through direct savings in future health care costs, reduced demands on the criminal justice system, and productivity gains. The well-being gained for individuals and families is immense, as clients reduce the harms from alcohol or drug use and achieve personal, social, and economic goals.[63]

Consistent with other areas of health, however, the specialist AOD service system is facing growing demand, increasing expectations of quality, increasing complexity, workforce growth and advances in interventions as well as communication systems and technologies.

The ACT Government, in partnership with the sector, has a critical role to play in planning for the delivery of specialist AOD treatment and support services. The ACT Health Territory-wide Health Services Framework outlines a bold 10-year vision to support planning across the health system as a whole.[64] To date many of the activities have focused on internal reforms to ACT Health services, notably a focus on the governance of The Canberra Hospital and those services delivered by ACT Health (particularly those connected to the hospital). It is unlikely that NGO stakeholders will be adequately planned for through these processes within the three years period of the DSAP. Further NGO and other stakeholders have expressed concern to ACT Health with regards to its processes to date regarding the ACT Health Territory-wide Health Services Framework and other multiple and concurrent reforms.

This is concerning for several reasons including because **hospital based AOD services reflect a minority (and expensive) component of the sector as a whole and the AOD sector is in the unique position in the ACT health system of being predominantly delivered by NGOs** (e.g. in ACT 38 of the 41 specialist AOD programs are delivered in community settings; and of these, 34 are non-government organisation delivered)[65].

As such, a positioning of hospital-based services (e.g. Addiction Medicine Specialists) and/or the ACT Health AOD service provider at the center - or as the leader of specialist AOD service system (i.e. treatment) planning - is inappropriate, presents potential and unnecessary conflicts and is not fit for purpose for the ACT ATOD sector.

The blunt approach of the Territory-wide Health Services Framework conflicts and risk undermining with the existing infrastructure and context the ACT AOD sector has developed over the past 10 years – which has a proud and demonstrated history of co-design and collaborative planning between government and non-government providers, the peak, service consumers, researchers and the ACT Government. Potential unintended consequences could include:

- Focus on government planning for government delivered services – lack of equivalence for whole of AOD service system planning that incorporates NGOs
- An inversed approach (spending more time planning for a relatively small and expensive component of the AOD service system)
- Focus on highest threshold and highest cost services first – this is in contradiction with the principle of AOD service provision that seeks to implement the lowest threshold service first, and only escalate when required (e.g. stepped care)
- Splintering a system that, up to this point, already has integrated care pathways across hospital and community based settings and strong partnerships between NGOs and government providers.

As such, the ACT ATOD sector, in implementing the Territory Wide Health Services Framework will need a consultative approach that is sector-driven, fit for purpose, efficient, evidence-informed, appropriate and co-designed. The development of a number of elements (as outlined below) reflect such an approach for the sector and provide a strengthened framework for the sector. Importantly, the proposed elements will complement and inform the sector and ACT Government (and other funders) in a range of reform and policy processes, namely:

- Engagement of the ACT Government in the implementation of technical planning tools (see Appendix 6, Specialist AOD Health Service Planning),
- Implementation of the Territory-Wide Health Services Framework within the specialist AOD service system as a whole
- Pending NGO procurement process (to be undertaken in 2019)
- Decision making and priority setting required to meet existing and future demand for services (to mitigate against impacts of population increases, growing demand and changing drug trends) (see Appendix 3 Specialist AOD Treatment and Harm Reduction)

The sector-driven elements of an overarching framework are summarised below. Their development could occur through a staged approach, leveraging off existing infrastructure and expertise, and produced relatively rapidly to meet the needs and timelines of related policy processes (if existing work and expertise for example through ATODA was effectively mobilised).

<u>Specialist ACT AOD Treatment and Support Framework</u>

Consistent with frameworks, plans or specifications in Victoria, Queensland, South Australia, New South Wales and Western Australia, the development of an ACT AOD Treatment and Support Framework could reflect a consensus across specialist AOD treatment providers (both NGO and government) on common and good practice, by describing:

- Specialist AOD treatment and support service delivery in the ACT.
- Missions, aims, objectives, values and understandings
- Specifications of service components
- A range of options for investment decisions and priority setting for all levels of Government and NGO stakeholders based on the optimal mix of services required for the ACT.
- Mechanisms to operationalise the Territory Wide Health Services Framework.

ATODA has already undertaken some work in this area that should be built upon. Future processes should be lead by ATODA as the organisation in the ACT with a strong track-record in undertaking co-design, and evidence and consensus based drug policy.

<u>A Description and Examination of AOD Treatment and Support Approaches</u>

A collation and clinical endorsement of current evidence based treatment and support approaches offered by the specialist ATOD sector in Australia (and a mapping of the ACT against this). This could define the specialist and unique role of the ATOD sector, delineate roles and scopes of practice, detail the diverse capabilities of services and programs in the sector, and document best practice for interventions.

ATODA has also already undertaken substantial work in this area that should be built upon. Future processes should be lead by ATODA as the organisation in the ACT with a strong track-record in undertaking co-design, and evidence and consensus based drug policy.

<u>Specialist ACT AOD Outcomes Framework</u>

Although the collation and utilisation of outcomes data has been integrated into the ACT AOD service system for some time, there is an opportunity to document and reach endorsement of an agreed standard or approach to the monitoring and reporting of outcomes (mapped to domains); and the potential indicators and data sources for doing so.

ATODA has again already undertaken some work in this area that should be built upon. Future processes should be lead by ATODA as the organisation in the ACT with a strong track-record in undertaking co-design, and evidence and consensus based drug policy.

<u>ACT ATOD Sector Quality Framework</u>

To date, a number of shared items with NGO AOD services have acted collectively defined and quality framework (many of which are reflected in across ACT Health service funding agreements) however these elements need to be strengthened and more comprehensively documented.

There are opportunities; however, the look at the work being led by the Commonwealth in relation to a Quality Framework for AOD services across Australia; and develop a framework that translates (and more importantly, exceeds this) within an ACT context.

Some examples of the components that constitute elements of a quality framework for the delivery of AOD services include:

- Report on the data elements specified in the ACT Minimum Data Set for Alcohol and Other Drug Treatment Services Data Dictionary and Collection Guidelines.
- Maintain accreditation.
- All staff providing specialist AOD counselling are required to have accreditation/registration in a directly relevant clinical field, i.e. psychologist, social worker, clinical psychologist or be eligible for full membership of a counselling professional accreditation body (e.g. Australian Counselling Association or the Psychotherapy and Counselling Federation of Australia). Those staff providing specialist alcohol and other drug counselling are also to have completed AOD-specific training equivalent to at least the four core competencies of Certificate IV in Alcohol and Other Drug Work. They are to receive regular access to clinical supervision from a practitioner with specialist expertise in drug counselling.
- Develop and document detailed program level models of care (a model of care template to be provided by ACT Health).
- Ensure and provide evidence that clinical policies and program materials are peer reviewed by an external person with specialist expertise in drug treatment.
- Provide evidence of progress towards implementing routine access to opioid overdose training and naloxone for clients with a history of opioid use (to be administered to them in an emergency during their stay in the rehabilitation program and to take with them when they leave the program); and access to screening, testing and treatment for blood borne viruses (BBVs) (e.g. hepatitis B, hepatitis C and HIV) and sexually transmitted infections (STIs).
- Comply with the ACT Alcohol and Other Drug Qualifications Strategy.
- Ensure robust feedback and complaints processes are in place and promoted to service users including internal processes and external processes such as the right to lodge complaints with the Health Services Commissioner
- Report on contracted outcomes using validated measures: (a) reductions in severity of dependence, amount and/or frequency of drug use, harmful drug use and related behaviours; and (b) improvements in mental health, physical health and social and emotional wellbeing; and functioning.
- Undertake an external evaluation of one or more program elements over the life of the contract.
- Participate in the ACT Alcohol and Other Drug Sector Workforce and Remuneration Profile (one profile to be undertaken during the life of the 3 year Agreement).
- Participate in the ACT Service User Satisfaction and Outcomes Survey (one survey will be undertaken during the life of the 3 year Agreement).

- Participate in sector governance.
- Ensure internal alcohol, tobacco and other drug (ATOD) policies and practices are consistent with relevant ATOD policies, strategies and guidelines.
- Continue to develop the cultural sensitivity and safety of programs including with a focus on Aboriginal and Torres Strait Islander people and gender responsive practice.
- Provide information for prospective clients, family members/friends and referrers via your website, clear promotional brochures and the 6 monthly updates required for the ACT Alcohol and Other Drug Services Directory.
- Drug treatment services will not provide information and education directly to school students (P-10).

ATODA has again already undertaken substantial work in this area that should be built upon. Future processes should be lead by ATODA as the organisation in the ACT with a strong track-record in undertaking co-design, and evidence and consensus based drug policy.

<u>ACT AOD Workforce Development Strategy</u>

Consistent with the National AOD Workforce Development Strategy, a locally informed strategy that operationalises the national strategy at a local level could help to ensure the specialist workforce exists to meet demand and builds on the established workforce development strategies and policies already in place.

Finally, again, ATODA has already undertaken work in this area that should be built upon. Future processes should be lead by ATODA as the organisation in the ACT with a strong track-record in undertaking co-design, and evidence and consensus based drug policy.

Appendix 8

Area: Blood borne viruses

Action: Integrate hepatitis C prevention, identification and treatment in specialist AOD settings.

Outcome: Reduce the burden of disease from hepatitis C

Examples of Indicators of Progress in Life of Drug Strategy Action Plan:

- Externally facilitated workshop held between specialist AOD services, blood–borne virus services, researchers, consumers, and policy-workers to develop action plan related to hepatitis C identification, treatment and prevention in AOD settings and to respond to the specific needs of the diversity of people who use drugs within these settings.
- Scoping of appropriate measures and tools for the collection of data by specialist AOD services on hepatitis C screening, referral and treatment activities provided to service consumers.
- Establishment of a program of activities to implement the agreed action plan (above).
- Improved capacity, including clinical capacity, within existing AOD treatment and support services to identify, treat and prevent hepatitis C, including through providing on site services, or facilitating links to off-site supports.
- Specialist AOD services contribute to the target set in the *Hepatitis B, Hepatitis C, HIV and Sexually Transmissible Infections ACT Statement of Priorities 2016 – 2020* to increase the number of people receiving antiviral treatment by 50% each year.

Longer term Data Sources:

- Chief Health Officers Report
- Hepatitis C Annual Surveillance Reports
- Viral Hepatitis Clinical Research Program: Monitoring Hepatitis C Treatment Uptake
- Alcohol and Other Drug Treatment Services National Minimum Data Set
- Service Level Reporting and Outcomes Measurement
- Service User Satisfaction and Outcomes Survey
- Potential additional data source depending on outcome of scoping exercise (see above)

Hepatitis C is a blood-borne viral infection of the liver. Chronic hepatitis C infection can result in progressive liver inflammation (viral hepatitis), which may progress to scarring (fibrosis and cirrhosis). If left untreated, inflammation can lead to mild, moderate, or serious liver disease and in some cases, liver cancer and liver failure. Hepatitis C is preventable and treatable, yet is one of the most commonly notified diseases in Australia.[66] Over 80% of all newly acquired hepatitis C infections in Australia are associated with injecting (illicit) drug use.[67] The number of people accessing AOD treatment or support services living with hepatitis C is known to be high.

From March 2016, a new generation of direct-acting antiviral (DAA) medications became available, through the Pharmaceutical Benefits Scheme (PBS), to all Australians living with hepatitis C. These medicines can be prescribed by a General Practitioner, are more effective, easier to take and have fewer side-effects than previous medications making Australia a world leader in the management and treatment of hepatitis C.[68] In support of universal access, these treatments are provided without restrictions based on a person's stage of liver disease or current injecting behaviours.[69]

While uptake of the new treatment was promising in early months, data suggests that treatment uptake has slowed significantly since that point. For example, in 2016, hepatitis C

treatment uptake was high nationally and locally (with 21.2% of those living with chronic hepatitis C in the ACT taking up treatment).[70] However, these trends have not been maintained and fewer than half as many people are now accessing the new treatments, which could potentially undermine Australian governments commitment to eliminate hepatitis C in Australia by 2030. [71]

Urgent action is needed to identify and engage the thousands of Canberrans living with chronic hepatitis C in treatment (particularly as 20% of people living with hepatitis C remain undiagnosed)[72]; while consolidating our evidence based harm reduction efforts to prevent new infections.

Because of the risk of hepatitis C transmission via injecting, and the stigma and discrimination experienced by people living with hepatitis C, specialist AOD services provide an appropriate and necessary setting for the prevention, identification and treatment of hepatitis C. This includes access to a large cohort of people living with and/or at risk of acquiring hepatitis C (and other blood borne viruses) that may not otherwise be accessing health services. This could include, for example, providing on-site services, or facilitating links to off-site supports (e.g. in primary care) for:

- Screening
- Liver disease assessment
- Engagement of affected communities
- Prevention with Education and the Provision of Sterile Injecting Equipment (including peer based approaches)
- Treatment with new DAAs (e.g. through liver clinics in specialist AOD services)
- Patient monitoring and post-treatment support.[73]

Importantly, this work could build on the existing blood borne virus education and prevention activities already embedded across specialist AOD services; 89.9% of service users of specialist AOD services in the ACT already report improved knowledge of prevention of blood borne virus transmission as an outcome of attending a treatment and support service.[74]

Providing both capacity building support to, and clinical capacity within, existing AOD treatment and support services is needed to identify, treat and prevent hepatitis C in the ACT and maintain improvements in treatment uptake.

In addition, capacity needs to be built within current data collection systems (e.g. AOD Treatment Services National Minimum Data Set) to capture the screening, treatment and referral activities undertaken by specialist AOD services. This could potentially be adapted to used to measure activities against the target of the *Hepatitis B, Hepatitis C, HIV and Sexually Transmissible Infections ACT Statement of Priorities 2016 – 2020* to increase the number of people receiving antiviral treatment by 50% each year.[75]

Appendix 9

Area: Smoking cessation

Action: Provide targeted, settings-based and intensive smoking cessation support that includes subsidised nicotine replacement therapy.

Outcome: Reduced tobacco use and tobacco related harms among people who smoke from disadvantaged populations with very high smoking rates.

Examples of Indicators of Progress in Life of Drug Strategy Action Plan:

- ACT Health increases investment in subsidised NRT through the existing program offered in specialised AOD services, including investment in smoking cessation for workers providing the program.
- Establish a plan to engage other sectors representing services accessed by other disadvantaged population groups in the expansion of the existing subsidised NRT/smoking cessation support program.
- Existing subsidised NRT/smoking cessation support program is expanded into other settings accessed by disadvantaged population groups (e.g. homelessness, mental health, etc)—with appropriate resourcing provided by ACT Health.
- Increase in quality quit attempts made by people accessing targeted, settings-based and intensive smoking cessation support that includes subsidised nicotine replacement therapy.
- Numbers of workers trained in providing smoking cessation support.

Longer term Data Sources:

- Monitoring and evaluation data collected by the subsidised NRT/smoking cessation program
- Service Users' Satisfaction and Outcomes Survey
- Service level data collection (e.g. recorded smoking status)
- ACT ATOD Workforce Qualification and Remuneration Profile

While the smoking rate in the ACT is the lowest in the Australia (approximately 10%),[76] there are still sub-populations of the ACT community that have disproportionately higher smoking rates, and impacts from tobacco-related harms, including: people who use AOD; people experiencing homelessness; people living with mental illness; prisoners; Aboriginal and Torres Strait Islander people. For example, in a 2015 single-day census, 82% of people accessing specialist AOD services in the ACT self-identified as smokers.[77]

Standard public health approaches are insufficient to reduce smoking among disadvantaged populations, and these sub-populations are neglected in tobacco control, despite showing willingness to make quit smoking attempts when given access to appropriate intensive interventions.[78,79] The expert consensus is that, rather than focusing on legislative measures, disadvantaged hard-to-reach sub-populations with higher smoking rates require additional more sophisticated, targeted and sustained strategies to access the treatment tools that are known to help people to engage in quality quit attempts.[80,81]

Widely accepted smoking cessation clinical guidelines recommend that, where smokers are not able to quit or reduce their smoking unassisted, pharmacotherapies (including NRT) are an effective (and cost-effective) tool, in combination with intensive and targeted support from a health worker trained in smoking cessation. NRT should be provided according to best practice: 8-12 weeks-worth as a full course, and as a combination of patches with intermittent forms of NRT (e.g. gum, inhalator, lozenges, spray).[82,83]

Access to effective NRT treatment complemented by smoking cessation support from a trained worker is, however, unaffordable and inaccessible to most disadvantaged people who smoke. The Pharmaceutical Benefits Scheme only provides for patches for smoking cessation and only with a prescription; other forms of NRT are only available by private purchase and are prohibitively expensive.[84]

Many disadvantaged groups, including people accessing specialist AOD services, have low levels of contact with general health services, and so have low access to prescriptions for NRT patches and smoking cessation advice. Offering disadvantaged people who smoke free-NRT, particularly when supported by smoking cessation advice from a trained worker, has been shown to increase smoking cessation rates.[85]

A settings-based approach, that provides intensive and targeted smoking cessation support to disadvantaged people who smoke where they access other services, is the most effective and efficient way to reach these populations. Providing effective smoking cessation support in settings can leverage off the existing treatment and support services, enhance treatment outcomes across the board, and requires comparatively minimal investment in additional smoking cessation training for health professionals and community workers (e.g. AOD workers, pharmacists, general practitioners, youth workers, etc).

Further, in some treatment settings, smoking cessation support enhances other health outcomes. For example, offering targeted smoking cessation treatment alongside other drug treatment (e.g. Opioid Maintenance Treatment, residential rehabilitation, counselling) has been assessed to both increase smoking cessation,[86] and to improve drug treatment outcomes.[87,88]

Evidence and practice experience support the provision of a program that specifically targets disadvantaged people who smoke to make quality quit attempts by:

- Taking a settings-based approach, offering intensive cessation support where disadvantaged smokers are accessing other services;
- Leveraging existing treatment and support structures, enabling the delivery of targeted best practice smoking cessation treatment as part of routine treatment and support (for example, as part of AOD treatment);[89]
- Leveraging existing worker expertise, augmented by an investment in smoking cessation training; and
- Providing disadvantaged people who smoke with access to subsidised courses of combination NRT.

A current ACT program for service consumers accessing specialist non-government AOD services has been successful at supporting quality quit attempts by providing access to subsidized NRT, complemented by smoking cessation advice from trained AOD workers and pharmacists.[b,90,91] However, this initiative currently reaches only a small proportion of the

[b] The We CAN Program supports equity in access to NRT and a more consistent clinical approach to smoking cessation for disadvantaged Canberrans. Service users of AOD NGOs are screened by workers for nicotine dependence and, if eligible, are offered the option of receiving a voucher that enables him/her to access 8–12 weeks-worth (a full course) of all-types of NRT over multiple visits to a local community pharmacy. The service user receives smoking cessation advice from both the AOD worker and from the pharmacy, including on the most appropriate NRT for their needs. The We CAN Program leverages off existing programs and processes that have developed tobacco management capacity within AOD services and pharmacies. The Program is delivered where people are already accessing support and services (e.g. AOD services, pharmacies), and by people who are already skilled (or who can be easily up-skilled) to provide smoking cessation advice and support (i.e. AOD workers, pharmacists).

people access specialist AOD services, who continue to smoke and who experience socio-economic and other disadvantage.

To increase smoking cessation and health outcomes for disadvantaged people who smoke, this existing program should be initially expanded throughout to all specialist AOD programs, and then extended to other disadvantaged priority population groups (e.g. mental health service clients, people in homelessness programs, etc.). A scale-up of this nature would need to be carefully developed, implemented and evaluated to maximise its impact and cost-effectiveness, particularly in settings where workers do not currently provide therapeutic interventions.

Appendix 10

Area: Infrastructure improvement

Action: Develop and implement an infrastructure plan, which includes grants, for specialist AOD services to address ageing and changing infrastructure needs.

Outcome: Improved physical and information technology infrastructure for specialist alcohol and other drug services to enable services to better meet the needs of, and improve outcomes for, service consumers.

Examples of Indicators of Progress in Life of Drug Strategy Action Plan:

- ACT Health funds an independent audit to identify and prioritise the infrastructure needs of existing specialist AOD services, including physical infrastructure and information technology.
- Based on this audit, develop a ten-year infrastructure plan is co-designed with ACT Health and specialist AOD services.
- ACT Health co-designs with specialist AOD services an infrastructure grants program that responds to the immediate needs identified in the audit, including guidelines and application processes.
- Specialist AOD services apply for, and receive funding for infrastructure improvements, and make the identified improvements to infrastructure.
- Service consumers, their families, and staff are engaged in the project design, prioritisation and implementation.
- Improved service consumer and staff safety, improved amenity to enhance AOD outcomes, and ability for AOD services to expand delivery and reporting on services.

Longer term Data Sources:

- Service Users' Satisfaction and Outcomes Survey
- Workforce Remuneration and Qualification Survey (with added components)
- Service level data collection (e.g. in-house satisfaction surveys)
- Infrastructure plan implementation reporting including repeating an audit

Existing infrastructure of specialist AOD services in the ACT is ageing and some is not fit for purpose. ACT Health has invested in and is committed to updating the building and IT infrastructure of *government* services, but has not directed funds or policy work towards improving *non-government* AOD services.

Funding is needed to update facilities, and thereby improve treatment outcomes, as follows:

- Upgrade poor quality, aged buildings that now require significant on-going and wasteful maintenance
- Improve work health and safety conditions for service consumers and staff (including for example, ligature risks, gender safety needs, swipe card access, degraded structures)
- Remove barriers to access for people with a disability
- Meet contemporary practice and improve treatment outcomes. Many AOD services are located in converted residences, and are therefore not fit for purpose to meet contemporary drug treatment practice. For example, buildings require improvement to:
    - Reduce restrictive or inappropriate environments
    - Reduce suicide risk
    - Improve access for family (including children) and friends involvement in AOD treatment

    - Address service fragmentation
    - Create client spaces that improve physical and mental wellbeing
    - Provide adaptable spaces to support various treatment activities, and that respond to changing patterns of drug use and treatment needs
- Improve responsiveness to coexisting issues, for example changes to waiting spaces and bathrooms to better support people who have experienced domestic and family violence, including sexual assault
- Improve data collection and monitoring of AOD programs by up-dating information technology hardware

These and other issues have also been identified by the Victorian Government and addressed through Facilities Renewal Grants offered by the Victorian Department of Health and Human Services.[92] A similar grants program could be offered in the ACT, and could respond to needs identified through an audit of capital infrastructure and conditions in specialist AOD services, with a specific focus on non-government services. Service consumers, their families, and staff should be involved in the identification of priorities, design and implementation of infrastructure improvement projects.

While a grants program will meet immediate needs in the next three years, such an infrastructure audit should be tied to a ten-year service infrastructure planning and implementation process.

Appendix 11

Area: Innovation

Action: Establish and provide funding through an innovation fund for specialist AOD services to develop, implement and evaluate new AOD initiatives and service models.

Outcome: Leverage existing investment by enhancing the capacity of specialist AOD services to respond dynamically to identified, and changing, needs of service consumers and patterns of drug use through innovative service delivery responses.

Examples of Indicators of Progress in Life of Drug Strategy Action Plan:

- Based on the priorities identified in the ACT AOD Treatment and Support Framework (see appendix 5), ACT Health funds a sector-driven co-design process to establish an innovation fund for specialist AOD services, including guidelines and application processes.
- Specialist AOD services, respond to needs of service consumers, identify appropriate innovative responses, and apply for funding from the innovation fund.
- Specialist AOD services receive funding from the fund and develop, implement and evaluate new and innovative alcohol and other drug initiatives and models.

Longer term Data Sources:

- ACT Alcohol Tobacco and Other Drug Services Directory
- Service Users' Satisfaction and Outcomes Survey
- National Minimum Data Set
- Innovation program level evaluations

The National Drug Strategy 2017 – 2026 advocates the development of new and innovative responses to reduce alcohol, tobacco and other drug problems.[93] Resourcing specialist AOD services to identify issues and respond with innovative initiatives and models will enable them to:

- Build their capacity to improve treatment outcomes for AOD service consumers
- Have greater agility to respond to emerging drug trends and changing priorities
- Test new treatment approaches and ways of working with specific populations
- Develop collaborative relationships to enhance access to complementary services and approaches
- Build on the evidence-base for what works in specialist AOD treatment
- Adapt the evidence-base to be fit for purpose for the specific needs and context of the ACT.

One mechanism for resourcing these responses is an innovation fund accessed through a grant process. Similar processes have been specifically used to "address local needs and create partnerships that lead to better services being delivered where the need is greatest" by giving services the "scope and flexibility to be responsive, innovative and creative in meeting the needs of, and achieving better outcomes".[94]

In order to contribute to building the evidence-base in specialist AOD treatment, funded programs should have a clearly articulated program logic and outcomes, and monitoring and evaluation framework.

Appendix 12

Area: School drug education

Action: Implement modern, evidence-informed school drug education programs in the ACT.

Outcome: Prevent the uptake of drugs, delaying first use, and reducing drug use and harms amongst young people.

Examples of Indicators of Progress in Life of Drug Strategy Action Plan:

- ACT Health and the Education Directorate co-commission a review of the ACT school drug education programs, including the current extent and nature of these programs, and the degree to which they reflect contemporary good practice as evidenced from evaluation research.
- Publicly release the review (above).
- Based on the review and report (above), a commitment is made to the implementation of an evidenced-based school drug education program in the ACT.

Longer term Data Sources:

- Reports available to the public demonstrating the implementation of evidence-informed school drug education programs, their effectiveness and cost-effectiveness
- Data on drug use among school students

School-based drug education programs generally fall into the category of 'popular but not proven': 'What is popular is not proven; what is proven is not popular'. Considerable dissolution has been expressed, over the years, about the efficacy and real-world effectiveness of school drug education programs, with the best designed and implemented showing only small effect sizes, low cost-effectiveness and low cost-benefit.[95,96,97]

In recent years, however, Australian researchers have demonstrated that innovative approaches to school drug education that better reflect the nature of Australia's National Drug Strategy rather than the cultures of other nations, can be both efficacious and cost-effective. This has been demonstrated by recent reviews conducted by Australian scholars,[98,99] and by the excellent documentation at the NDS Positive Choices website https://positivechoices.org.au/teachers/drug-prevention-what-works.

Among the new, strongly evidence-informed school drug education programs that should be progressively replacing the relatively ineffective approaches taken in the past are the following:

- Climate Schools, a universal computer-based program to prevent alcohol and other drug use in adolescence[100]
- The Drug Education in Victorian Schools (DEVS) program addressing all drugs with a focus on minimising harm 'and employed participatory, critical-thinking and skill-focussed pedagogy'[101]
- Preventure, a selective personality-targeted prevention program[102]
- School Health and Alcohol Harm Reduction Project (SHAHRP), 'a curriculum programme with an explicit harm minimization goal'[103]

The extent and nature of school drug education initiatives in the ACT, and the degree to which they reflect what has recently been learned about efficacy and cost-effectiveness in school drug education warrants closer attention.

The DSAP could include the commissioning of an expert review of the ACT school drug education programs with the goal of ensuring that 1) they reflect contemporary findings from evaluation research as to which programs are most efficacious and cost-effective and 2) the programs are being implemented with a high degree of fidelity and are hence likely to attain the positive outcomes revealed from implementation research.

Appendix 13

Area: Data quality and capacity

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Action: Improve drug treatment data collection, management, analysis and utilisation by transferring responsibility to AODTS NMDS from ACT Health to the sector (through ATODA)

Outcome: Enhanced capacity to collect and analyse data, improved data quality and timeliness, and more effective use of data in the ACT ATOD sector and the ACT community

Examples of Indicators of Progress in Life of Drug Strategy Action Plan:

- ACT ATOD sector engaged in the National AODTS NMDS Project.
- Transfer of responsibility for the ACT AODTS NMDS from ACT Health to the sector (through ATODA).
- Publication of initial ACT-specific reports from the NMDS.

Longer term Data Sources:

- Improved ACT data quality in the AIHW's national data holdings
- ACT-specific reports from the NMDS

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AIHW explains that:

> 'Information on publicly funded AOD treatment services in Australia, and the people and drugs treated, are collected through the Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS NMDS). The AODTS NMDS is 1 of several NMDSs that collect data under the 2012 National Healthcare Agreement to inform policy and help improve service delivery...' [104]

In the ACT, ATOD treatment services have, for many years, applied considerable amount of resources to collecting data for the NMDS and transmitting it to ACT Health for collation and on forwarding to AIHW. AIHW is responsible for analysing and reporting on those data. Considerable delays—some years—exist between when data are submitted by the AOD agencies and when AIHW publishes it. AIHW publishes state and territory summaries, but they are very brief (the ACT is most recent one is only four pages in length)[105] and not useful as information to underpin policy work and evaluation. To date, the resources (money and data management and analysis expertise) necessary to make effective and timely use of the data collected by the treatment agencies have not been present in the ACT.

In other jurisdictions, in recent years responsibility for managing the state/territory AODTS NMDS has been transferred from the government health agencies to the state/territory AOD peak bodies, along with the funds that they need to implement the initiative effectively. This is the situation at present in New South Wales and Queensland. In those jurisdictions the health departments, the ATOD treatment agencies and AIHW have all found the new arrangements to be effective and, indeed, to have produced better outcomes than were observed previously. Leveraging off this success, the State and Territory AOD Peaks Network are also now leading a National Project to develop and implement nationally consistent infrastructure (e.g. training, support) to support the consistently high quality collection and reporting of the AODTS NMDS.

Were ATODA to become responsible for managing the NMDS for the ACT, we expect that the following outcomes would be realised:

- Enhanced capacity to use high quality treatment agency-level data in policy work

- Enhance capacity for treatment agencies and ACT Health to respond to public, media and Ministerial requests for information on treatment service delivery
- Enhanced quality of NMDS data through ATODA's capacity to engage continually and intensely with data providers
- Capacity building within individual agencies and across the sector with respect to data collection, management and utilisation
- Detailed analysis and reporting of NMDS data at the ACT level, with contents that reflect the information needs of key local stakeholders
- Potential for the ACT ATOD treatment service information system to expand its contents, including potentially covering client treatment outcomes.

The DSAP could usefully include is one of its priorities transferring of responsibilities for the NMDS from ACT Health to ATODA, along with the necessary resources for the systems enhancement and ongoing implementation.

Appendix 14

Area: Prison health services

Action: Provide sterile injecting equipment for use by people detained in the Alexander Maconochie Centre

Outcome: Protecting the health and well-being of the Alexander Maconochie Centre's detainees, staff and visitors, and the broader community

Examples of Indicators of Progress in Life of Drug Strategy Action Plan:

- ACT Health and Justice and Community Safety Directorate, with other stakeholders, to review the implementation of, and revise, the *Strategic Framework for the Management of Blood-Borne Viruses in the Alexander Maconochie Centre 2013 – 2017*.
- The ACT Government publicly announce a strategy to implement the ACT Government policy on establishing a Needle and Syringe Program at the AMC
- Implementation of the ACT Government policy.

Longer term Data Sources:

- Data on utilisation of an Needle and Syringe Program at the Alexander Maconochie Centre
- Data on the prevalence and incidence of blood-borne viral infections among Alexander Maconochie Centre detainees

The ACT Government has a clear policy to establish a needle syringe program (NSP) at the Alexander Maconochie Centre (AMC). This policy was reconfirmed as recently as this month in response to a report of the ACT Health Services Commissioner, Karen Toohey.[106]

> Corrections Minister Shane Rattenbury said a NSP would improve the health services available to prisoners.
>
> "A needle and syringe program would provide a considerable boost to harm reduction strategies at the AMC and deliver the same level of health service available to the rest of the community," he said.[107]

Commissioner Toohey had recommended (at page 6 of her report):

> That the Justice and Community Safety Directorate, Corrective Services and ACT Health undertake further work to progress the implementation of the ACT Government policy of a needle syringe program in the AMC, consistent with services available in the ACT community, to reduce risks of blood borne virus transmission.

ATODA does not need to rehearse the arguments in favour of an NSP at the AMC. This has been thoroughly documented, along with the range of viable models for implementing such a service.[108] What needs to be emphasised, however, is that the ACT Government is seriously in breach of its duty of care towards the AMC's detainees, staff and visitors, along with the community at large, by failing to provide this strongly evidence-informed public health intervention at the prison.

The international community is also acutely aware of the failure to implement this policy through the recent publication of an article in the prestigious international, refereed *Harm Reduction Journal*, written by ACT Health staff: 'Why is there still hepatitis C transmission in

Australian prisons? A case report'. The case report in question relates to an AMC detainee, with the authors highlighting that:

> We report a case of re-infection of hepatitis C in a prisoner treated with a direct-acting antiviral. What makes this case so remarkable is that it was entirely predictable and preventable … Hepatitis C infection will continue to test both the strengths and the weaknesses in the relationship between health and corrective services in Australia. Nothing less than full implementation of all harm minimisation modalities will be necessary to eliminate the clinical and public health risks of hepatitis C infection, both in prison and by extension into the general community.[109]

ATODA urges that action on implementing the ACT Government's policy on establishing an NSP at the AMC be a priority within the new Action Plan. Further delay is not acceptable.

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Attachment A: Letter to ACT Health regarding the request to reconvene the governance group prior to, and as part of, finalising the ACT Drug Strategy Action Plan

Dr Paul Kelly
Chief Health Officer & Deputy Director General
ACT Health
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cc: Non-government members of the ACT ATOD Strategy Evaluation Group (ACT Council of Social Services, Canberra Alliance for Harm Minimisation and Advocacy, Families and Friends for Drug Law Reform, Health Care Consumers Association, Hepatitis ACT, Mental Health Community Coalition, Pharmacy Guild ACT Branch, Youth Coalition of the ACT)
cc: ACT ATOD Strategy Evaluation Group Secretariat (AODpolicy@act.gov.au; Kathy.dennis@act.gov.au)

Request to convene the governance group prior to, and as part of, finalising the ACT Drug Strategy Action Plan

Dear Dr Kelly

Thank you for recently disseminating a Draft ACT Drug Strategy Action Plan for comment and for extending the submission deadline to 30 March 2017.

ATODA is working with stakeholders to make a full submission, however following multiple consultations to date, believes it is important to make an early submission specifically with regards to the matter of when the new governance group for the ACT Drug Strategy Action Plan will first be convened.

ATODA's consultations have included participation from the ATOD sector, allied services, peak organisations and consumer organisations. Stakeholders have been very interested in the draft plan and have expressed the importance of an appropriate whole-of –government and -community governance mechanism for the ACT Drug Strategy Action Plan - similar in function and membership to that which was convened under previous ACT Alcohol Tobacco and Other Drug strategies.

ATODA notes that the draft ACT Drug Strategy Action Plan proposes that the new governance group is convened only after the plan has been finalised. We are concerned that this proposal contradicts the highly effective practice of the ACT ATOD Strategy Evaluation Group, which has - for over a decade - been actively involved in the monitoring, evaluation, and, especially, the development of new and existing strategies. Stakeholders are concerned that the draft Action Plan currently focuses on advising about the *implementation* of the Plan, rather than contributing to its development.

As you can see, we have included the NGO members of the ACT ATOD Strategy Evaluation Group in this correspondence. As far as ATODA is aware, this group remains a current

governance group and as a member of that group ATODA has not been informed otherwise by ACT Health.

We request that ACT Health convene the new ACT Drug Strategy Action Plan governance group prior to the action plan being finalised, and seek its advice on the contents of the Strategy Action Plan, its implementation modalities, and its governance.

This approach is consistent with that which ACT Health took at the end of 2017 with regards reconvening the Opioid Treatment Advisory Committee and then subsequently adopting the National Guidelines for Medication-Assisted Treatment of Opioid Dependence and the development of the local procedures documentation.

As expressed to in the draft Strategy Action Plan; the actions that compose a response to drug use and harms are complex and require inter-governmental and whole-of-community engagement and responses. ATODA maintains the belief that good policy-making must involve a broader array of stakeholders; and in turn, that increases the need for consultation, trust and negotiation, rather than top down decision-making. This approach is consistent with *The Social Compact: A relationship framework between the ACT Government and community sector.* ATODA believes that principles of good governance and decision-making should be apparent through all components of drug policy and strategy making, starting with issue identification, through to policy analysis, consultation, decision making, implementation and all the way to evaluation (Althaus, Bridgman, & Davis 2018, *The Australian Policy Handbook*, 6th edn).

Importantly, the ACT Government has a strong legacy of good quality drug policy governance (attached to strategies) from which to draw; and many of the stakeholders, including ATODA, who have participated in structures that informed the drafting of a number of the previous strategies are available and ready to recommence engagement in drug policy governance in the ACT.

Kindest regards,

Carrie Fowlie
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23 March 2018

Attachment B:
Excerpt of the Priority Actions of the Draft ACT Drug Strategy Action Plan (From the Consultation Draft Circulated by ACT Health February 2018).

The following excerpt of the Priority Actions of the Draft ACT Drug Strategy Action Plan are listed to provide additional context to ATODA's submission; this should be read as actions *in addition* to those proposed by ATODA; and the actions are referenced in the body of ATODA's submission.

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Priority Actions

ACT Government-led priority actions have been developed for implementation under the *ACT Drug Strategy Action Plan* over three years. The actions, to be delivered in collaboration with relevant community and consumer organisations, align with the evidence-based and practice-informed approaches to harm minimisation outlined in the National Drug Strategy.

The ACT Government remains committed to minimising harm through the delivery of high quality, person-centred services, and will continue to invest in alcohol and other drug treatment and support services over the life of the Action Plan.

Alcohol

Interventions addressing alcohol are a high priority. Alcohol is a major contributor to death, disease, crime and violence, social problems, health and emergency service utilisation, and use of police resources. The following actions have been prioritised with the aim of reducing alcohol-related harm.

Action	Lead Directorate	Secondary Directorate/s	Relevant NDS Pillar*
1. *Prevent and reduce the exposure of children and young people to alcohol promotion and marketing*	*Justice and Community Safety Directorate (JaCSD)*	*ACT Health*	*D, H, P*
2. *Implement supported findings from the independent evaluation of the ACT alcohol ignition interlock program for high range and repeat drink driving offences*	*JaCSD*		*H, P*
3. *Implement evidence-based public education campaigns*	*ACT Health, JaCSD*		*D*
4. *Consider emerging issues in alcohol control and respond as required*	*JaCSD*	*ACT Health*	*H*

**National Drug Strategy Pillars are Demand Reduction (D), Supply Reduction (S) and Harm Reduction (H). The Strategy also focuses on specific priority populations (P).*

Tobacco

Tobacco smoking remains a leading cause of preventable death and disease in Australia. Smoking is responsible for the deaths of up to two-thirds of Australian smokers aged 45 years and over, and is a primary risk factor for various cancers, respiratory and cardiovascular disease, and other related illnesses. Passive exposure to tobacco smoke can also cause a range of adverse health effects including lung cancer and heart disease.

Action	Lead Directorate	Secondary Directorate/s	Relevant NDS Pillar
5. *Develop interventions for groups with entrenched smoking behaviours as identified in the National Tobacco Strategy 2012-2018*	*ACT Health*		*D, H, P*
6. *Maintain a focus on Aboriginal & Torres Strait Islander smoking interventions*	*ACT Health*		*D, H, P*
7. *Finalise evaluation of relevant programs relating to smoking, including the Smoking in Pregnancy program*	*ACT Health*		*D, H, P*
8. *Consider the need for additional smoke-free areas.*	*ACT Health*		*H*
9. *Support enforcement of tobacco and smoke-free legislation in the ACT*	*Access Canberra*		*H*
10. *Consider emerging issues in tobacco control and respond as required*	*ACT Health*		*D, H, P*

All drugs

ACT rates of illicit drug use are similar to national rates. Demand for alcohol and other drug treatment is at least double the available places. Many people who attend alcohol and drug treatment also have co-occurring mental health disorders, poorer physical health and more severe drug use. Harm reduction strategies, education and supporting mechanisms to address social determinants are essential components of a modern, evidence-based drug treatment program, system or policy.

Action	Lead Directorate	Secondary Directorate/s	Relevant NDS Pillar
11. *Develop and implement an ACT Drug Driving Strategy*	*JaCSD*	*ACT Health, ACT Policing*	*D, H*
12. *ACT Government will focus on raising public awareness about roadside drug testing and the known effects of drugs on the driving task.*	*JaCSD*		*H*
13. *Review and implement potential diversion strategies such as an ACT Drug and Alcohol Court*	*JaCSD*	*ACT Health, ACT Policing*	*D, S, H*
14. *Increase the capacity of specialist alcohol and other drug treatment services to deliver programs that integrate best practice in domestic and family violence prevention*	*ACT Health*	*CSD*	*H, P*
15. *Continue to support evidence-based prescription treatment programs such as naloxone and medicinal cannabis*	*ACT Health*		*D, H*
16. *Develop the Drugs and Poisons Information System to introduce online approvals and a remote access portal*	*ACT Health*		*S, H*
17. *Support all specialist alcohol and other drug treatment services to become Community Work and Social Development Order Program providers*	*JaCSD*		*H, P*

18. *Provide training and capacity building initiatives for alcohol, tobacco and other drugs in areas such as domestic and family violence services*	*ACT Health*		*H, P*
19. *Implement evidence-informed education programs that increase the awareness of the harms of alcohol, tobacco and other drugs in areas such as schools, sporting clubs and workplaces*	*ACT Education Directorate*	*ACT Health*	*D, P*
20. *Develop and implement a local early warning system to monitor and respond to emerging drug trends and harms in order to make more timely use of data*	*ACT Health*	*JaCSD* *ACT Policing*	*S, H*
21. *Continue to explore opportunities to introduce harm reduction measures (including pill testing).*	*ACT Health*	*ACT Policing*	*H*
22. *Reduce blood-borne viral infections due to injecting drug use*	*ACT Health*		*D, H, P*
23. *Consider emerging issues in drug control and respond as required"*	*ACT Health*	*ACT Policing*	*D, H, P*