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'.[i] 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.[ii]

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.[iii] 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.[iv] 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.[v]

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.[vi] 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.[vii]

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.[viii]

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.[ix] 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,[x] 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).[xi,xii,xiii]

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.[xiv]

The ACT Government has made firm commitments to plan for this growth, particularly in the provision of health services and infrastructure.[xv] 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.[xvi]
- Planning for a new City Health Centre in Civic.[xvii]

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.[xviii]

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.[xix] Needle and syringe programs (NSPs) provide sterile injecting equipment, have been successfully managed and implemented in the ACT since 1989,[xx] and have been cost-effective as one of Australia's public health approaches to preventing the spread of blood-borne viruses.[xxi] 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.[xxii] 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.[xxiii,xxiv]

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).[xxv]

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.[xxvi]

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."[xxvii]

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.[xxviii]

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).[xxix]

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.[xxx] 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.[xxxi] 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.[xxxii] 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. [xxxiii] 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.). [xxxiv] 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.[xxxv] 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. [xxxvi] 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.[xxxvii,xxxviii]

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.[xxxix] 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.[xl]

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)*[xli] 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. Specialist AOD Treatment and Harm Reduction Services Working Group

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)*[xlii], 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)*[xliii] 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*[xliv].

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[xlv]

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.[xlvi] 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.[xlvii]

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.[xlviii] 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)[xlix].

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).

Specialist ACT AOD Treatment and Support Framework

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.

A Description and Examination of AOD Treatment and Support Approaches

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.

Specialist ACT AOD Outcomes Framework

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.

ACT ATOD Sector Quality Framework

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.

ACT AOD Workforce Development Strategy

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.[i] Over 80% of all newly acquired hepatitis C infections in Australia are associated with injecting (illicit) drug use.[ii] 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.[iii] In support of universal access, these treatments are provided without restrictions based on a person's stage of liver disease or current injecting behaviours.[iii]

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).[liv] 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. [lv]

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) [lvi]; 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.[lvii]

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.[lviii]

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.[lix]

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%),[lx] 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.[lxi]

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.[lxii,lxiii] 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.[lxiv,lxv]

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).[lxvi,lxvii]

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.[lxviii]

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.[lxix]

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,[lxx] and to improve drug treatment outcomes.[lxxi,lxxii]

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);[lxxiii]
- 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.[1,lxxiv,lxxv] However, this initiative currently reaches only a small proportion of the

[1] 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.[lxxvi] 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.[lxxvii] 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".[lxxviii]

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.[lxxix,lxxx,lxxxi]

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,[lxxxii,lxxxiii] 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[lxxxiv]
- 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'[lxxxv]
- Preventure, a selective personality-targeted prevention program[lxxxvi]
- School Health and Alcohol Harm Reduction Project (SHAHRP), 'a curriculum programme with an explicit harm minimization goal'[lxxxvii]

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

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

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...' [lxxxviii]

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)[lxxxix] 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.[xc]

> 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.[xci]

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.[xcii] 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.[xciii]

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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