



To: AODpolicy@act.gov.au

Submission to the Draft ACT Drug Strategy Action Plan 2018 - 2021 (Public Consultation)

To whom it may concern,

The Alcohol Tobacco and Other Drug Association ACT (ATODA) welcomes the opportunity to make a submission on the public consultation on the Draft ACT Drug Strategy Action Plan 2018 - 2021.

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, consumer organisations and researchers), the body of work undertaken by ATODA since its establishment in 2010 and the evidence base of the ATOD field. It also builds on written submissions made to previous consultation versions of the draft Drug Strategy Action Plan (including the February 2018 draft).

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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ATODA Submission to the Draft ACT Drug Strategy Action Plan 2018 - 2021 (Public Consultation)

This submission is divided into a number of sections:

Section A: General comments on the introductory material

1. Consultations and context for this submission
2. Comments on the front material
3. Governance, monitoring and evaluation

Section B: General comments on priority actions

Section C: Comments on specialist alcohol and other drug treatment priority actions

Section D: Comments on other priority actions

1. Alcohol
2. Tobacco
3. Illegal drugs and non-medical use of pharmaceuticals
4. All drugs (excluding specialist AOD treatment dealt with through section C)
5. Emerging issues

Appendix: ATODA submission to the February 2018 draft Drug Strategy Action Plan (by invitation)

SECTION A: General comments on the introductory material

1. Consultations and context for this submission

This submission has been developed through extensive stakeholder consultations held by ATODA on the draft Drug Strategy Action Plan (DSAP) with participation from the ATOD sector, allied services, peak organisations, consumer organisations and researchers.

As a member of the ACT ATOD Strategy Evaluation Group since 2010, ATODA has also used its corporate knowledge of ACT AOD policy development, implementation, governance and evaluation to inform this submission.

This submission explicitly builds on the written submission ATODA made to the 'by invitation' consultation on the February 2018 version of the draft DSAP. Importantly, this submission made commentary in relation to:

- Achievements of Previous ACT Alcohol, Tobacco and Other Drug Strategies
- The Context of the Draft Drug Strategy Action Plan
- Risks Associated with the Draft Drug Strategy Action Plan
- Governance
- Engagement Including Consumer Participation
- Feedback on Specific Areas of the Draft Drug Strategy Action Plan
- Proposed Priority Setting Criteria
- Summary of Proposed 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 reduce the need to repeat the content and evidence presented in that submission here, we have appended it to this document for reference (see the appendix).

ATODA notes the extensive modifications made to the DSAP since the release of the earlier February 2018 draft, and is pleased to see incorporation of many of the recommendations made by stakeholders. The DSAP has been markedly improved in this short period of time.

This submission, therefore, seeks to further detail and clarify input from ATODA and stakeholders on outstanding issues, including those related to the statements of action (rather than re-hashing lengthy evidence summaries).

2. Comments on the front material

2.1 Introduction section

The introduction section states that:

'The Action Plan includes information on government commitments, current activities that are in their early stages and future intentions. It does not attempt to capture all routinely delivered services and activities such as continuing provision of key treatment services' (pg3).

ATODA urges that the next version explicitly identify the ongoing activities that are particularly important, that must not be scaled back or lost. This is particularly pertinent in a whole-of-government and whole-of-community strategy where corporate knowledge or history of AOD policy should not be assumed; and considering the extensive staff and structural changes within ACT Health in 2017 and 2018 and planned into 2019.

2.2 Guiding principles section

ATODA recommends that more attention be given, in preparing the next draft, to the topic of social determinants. The front material of this draft highlights the importance of social determinants which is pleasing:

‘Similarly important are the partnerships required in **responding to the social determinants of alcohol, tobacco and other drug problems**. This includes partnerships between government and non-government organisations in treatment and support services, primary health care (including General Practitioners), justice, child protection, road safety and education. It also includes partnerships with researchers, consumers and drug user organisations, families, Aboriginal and Torres Strait Islander communities, and other priority populations (see below).’ (p. 4, our emphasis).

Pages 4-5 discuss ‘Access and equity’, key factors in the social determinants approach to population health generally, and the AOD sector specifically.

On page 6, however, we read that social determinants are beyond the scope of the Action Plan:

‘It is also acknowledged that addressing social determinants of health such as discrimination, unemployment, homelessness, poverty and family breakdown can positively impact alcohol, tobacco and other drug related problems. **However, this is beyond the scope of the Action Plan.**’ (p. 6, our emphasis).

This is not acceptable in the context of the National Drug Strategy and ACT DSAP being whole-of-government and whole-of-community approaches. Treating the social determinants of AOD-related harms as out of scope of ACT Government action in this sector ignores the sources of AOD harms, and of what we know works to prevent and respond to such harms. It is also inconsistent with other ACT policies, including (we assume) the ACT Preventive Health and Wellbeing Plan.

ATODA is a signatory to community sector shared statement which outlines the community priorities for action during the 2016-2020 term of the ACT Government, which highlights the social determinant of health including related to housing, employment, transport, health and social services.¹

2.3 Coordination and collaboration section

This section would benefit from the inclusion of the ACT alcohol and other drug sector peak body (ATODA) as a key stakeholder with which the listed NGO organisations, ACT Government, Australian Government and Capital Health Network also collaborate.

2.4 Specific priority populations

This section reproduces, from the National Drug Strategy, a long list of what are characterised as 'specific priority populations'. In demographic terms, the list covers a large proportion of the ACT's population. It omits, however, most of the service users of the ACT's specialist AOD services. ATODA suggests that the next version of the DSAP identify the *specific population groups* in the ACT that will be given priority over the next three years, and maps these to the priority actions.

ATODA notes, for example, that women are not identified as a priority population in their own right within the DSAP. While women are rightly identified as a priority population as it relates to domestic and family violence in the DSAP, they are *only* referenced in that context. Whereas it is well established, and was for example a key topic of discussion at the 2017 ACT ATOD sector conference, the need to reduce barriers for women to access specialist AOD services (e.g. by increasing child and family inclusive practices including access to subsidised childcare).

[2.5 Objectives](#)

ATODA is pleased to see included, in this draft of the DSAP, a list of objectives (pp. 5-6). We note that these objectives are not necessarily expected to be attained over the three-year life of the Plan; this is implied in the statement that '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'. ATODA suggests that the next draft include a statement of the actual objectives of the Action Plan, specifying what is expected to be attained over its three-year life. At the 20 June 2018 AOD Stakeholder meeting convened by ACT Health, this was suggested as being in the form of Key Performance Indicators.

[2.6 Emerging issues section](#)

The third paragraph of this section of the draft DSAP states:

'Information sharing between ACT Government Directorates, and between jurisdictions, will be a key element in identifying and responding to emerging issues.'

ATODA suggests this be expanded to cover information sharing between government agencies and the non-government sector, including the representatives of people who use drugs, as this will be integral to identifying strategies focussing on emerging issues.

[2.7 Other priorities for the front material](#)

Re-establishing specialist drug policy functions in ACT Health:

In September 2017 ACT Health disbanded the specialist AOD Policy Unit. This has resulted in unintended consequences including related to loss of corporate knowledge and access to AOD specialist policy expertise.

It is essential that centralised AOD specialist policy expertise be re-established within ACT Health, particularly given the breadth of work required to implement this DSAP including actions across the health and criminal justice systems and working with diverse non-government stakeholders. A central unit will also aid with accountability and transparency.

Attaining balance across the three pillars:

As highlighted in ATODA's submission to the February 2018 version of the draft DSAP, the DSAP still fails 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.² 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.³ This rebalance means progressively shifting resources from law enforcement to the areas and intervention types that are both efficacious and cost-effective. This approach is also consistent with the ACT Government commitment to Justice Reinvestment.

Engagement including consumer participation:

As highlighted in the ATODA submission to the February 2018 version of the draft DSAP, we note this revised draft DSAP lacks focus on engagement of impacted communities, particularly consumer and family participation. 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.

3. Governance, monitoring and evaluation

3.1 National Governance

Given the alignment between the draft DSAP and the National Drug Strategy 2017 – 2026, it would be appropriate to reference the national governance mechanisms for drug policy on which the ACT is represented, including the National Drug Strategy Committee and the Ministerial Drug and Alcohol Forum. The ACT Alcohol Tobacco and Other Drug Strategy Evaluation Group has been integral in supporting non-government input to ACT Government representations in these forums and also in translating national priorities to the local context.

3.2 ACT Governance

The DSAP, under the Monitoring and Evaluation section, states:

"An expert Advisory Group will be established to provide expert advice on implementing the Action Plan, and developing an evaluation and monitoring framework to measure progress in meeting the Objectives."

It further states, under the Emerging Issues section, that:

"The Advisory Group will be co-chaired by ACT Health and the Justice and Community Safety Directorate, and include representatives from both ACT Government and relevant community and consumer organisations"

ATODA commends the ACT Government's commitment to the continuance of a formally constituted and whole-of-government, whole-of-community drug policy governance structure in the ACT that is directly linked with and explicitly articulated in the DSAP.

ATODA believes that the DSAP would be greatly strengthened by incorporating the Terms of Reference for the governance group within it; this is consistent with the approach taken with previous ACT ATOD strategies. This Group could be named the *ACT Drug Strategy Action Plan Evaluation and Advisory Group*.

Fortunately we are not working from scratch and there is significant documentation and experience from the current ACT ATOD Strategy Evaluation Group, which has been in place for over a decade. The current Terms of Reference for the ACT ATOD Strategy Evaluation Group and draft Terms of Reference developed as part of a previous consultation version of the draft ACT ATOD Strategy 2016-2020 provide an essential foundation to build upon.

Chairing and meeting frequency:

ATODA strongly supports the co-chairing arrangements between ACT Health (the organisation responsible for strategic policy and planning stewardship of the ACT's health system) and the Justice and Community Safety Directorate; this key partnership is consistent with the National Drug Strategy.

Consistent with the previous meeting frequency of the Group, ATODA recommends that the Group be convened bi-monthly to provide adequate input and oversight to the implementation of an annual workplan, the monitoring and evaluation framework (commissioned from monitoring and evaluation experts – see below), and annual evaluation reports. Frequent meetings are particularly important given the work in scope, and that the length of the DSAP is only three years.

Functions and responsibility:

ATODA supports the following functions and responsibility for the Group (including those which were developed by the Group):

- providing advice on the changing needs of the ACT community and the relative effectiveness of alternative investments and interventions across and within the three areas of harm minimisation – supply reduction, demand reduction and harm reduction;
- monitoring and evaluating the implementation of the ACT Drug Strategy Action Plan 2018-2021 in line with the monitoring and evaluation plan (commissioned from monitoring and evaluation experts);
- facilitating linkages with relevant local and national strategies;
- establishing and/or receiving regular advice from key committees and working groups including:
 - Opioid Treatment Advisory Committee
 - ACT Needle and Syringe Program Advisory Group
 - Specialist AOD Executives and Workers Groups (this is an additional suggested inclusion which captures publicly funded specialist alcohol and other drug services in the ACT);
- monitoring the regular updating of important local references including:
 - Extent and Nature of Drug Use and Harms in the ACT
 - ACT ATOD Workforce Qualification and Remuneration Profile - Specialist Alcohol and Other Drug Services

- ACT ATOD Service User Satisfaction and Outcomes Survey – Specialist Alcohol and Other Drug Services (this is an additional suggested inclusion which captures all people who access specialist alcohol and other drug services in the ACT regardless of public funding source)
- ACT Government Expenditure on Preventing and Responding to Drug Abuse; and
- Sources of Published Data on Drugs.

Name and membership:

ATODA suggests the following name for the group: the ACT Drug Strategy Action Plan Evaluation and Advisory Group as this reflects two of its key functions as described in the DSAP – evaluation and expert advice; and recommends maintaining the current arrangements of engaging relevant whole-of-government and whole-of-community stakeholders and functions.

ATODA believes this membership should, at a minimum, reflect the functions and stakeholder groups represented through the previous iteration of the ACT Drug Strategy Evaluation Group. Many of these stakeholders are available and ready to recommence engagement in ACT drug policy governance. ATODA notes and supports the current approach where non-government members of the Group have representative functions. As a member of the Group, ATODA's understanding of the current membership is:

- Aboriginal & Torres Strait Islander community (current member: Winnunga Nimmityjah Aboriginal Health and Community Services)
- Community sector peak (current member: ACT Council of Social Service)
- Primary Health Network (current member: Capital Health Network)
- ACT Health (co-chair) (note: following the ACT Health restructure this would be the organisation responsible for strategic policy and health system stewardship)
- ACT Health clinical operations that focuses on the operational delivery of health care services to the community (current member: Alcohol and Drug Service)
- Alcohol tobacco and other drug sector peak (current member: Alcohol Tobacco and Other Drug Association ACT)
- ACT Policing
- Chief Minister, Treasury and Economic Development Directorate
- Consumer representatives x 2 (current members: Canberra Alliance for Harm Minimisation and Advocacy and Health Care Consumers Association)
- Community Services Directorate
- Education and Training Directorate
- Justice and Community Safety Directorate (co-chair)
- Families, friends and carers (current member: Families and Friends for Drug Law Reform)
- Blood-borne virus and sexual health sector (current member: Hepatitis ACT)
- Mental health sector peak (current member: Mental Health Community Coalition ACT)
- Multicultural Women's Advocacy Group
- Ministerial Advisory Council on Women
- Pharmacy sector (current member: Pharmacy Guild of Australia – ACT Branch)
- Research advisor to the Group (current member: Social Research and Evaluation)
- Youth sector peak (current member: Youth Coalition of the ACT)

ATODA recommends the membership is expanded to include the domestic and family violence sector within the membership, for example through the peak body the Domestic

Violence Prevention Council. This is particularly important given the only health-specific initiative funded through the Safer Families Initiative is in relation to specialist alcohol and other drug services, and is for implementation during the life of the DSAP.

3.3 Monitoring and evaluation

ATODA is pleased to see a commitment to monitoring and evaluation in the DSAP, stating that “The Action Plan will be formally reviewed after three years”.

ATODA understands that the governance Group will be representative of the Plan’s diverse stakeholders (see previous section on governance), but its members will not be experts in monitoring and evaluation. For that reason, we suggest that the DSAP include a commitment to commissioning monitoring and evaluation specialists to develop a comprehensive monitoring and evaluation plan *as one of the Action Plan’s first actions*. It would be highly problematic if this activity were conducted at the end of the period of the Action Plan. Clearly, the monitoring and evaluation plan needs to be developed and funded at the beginning of the three-year life of the Action Plan, and implemented throughout it, with a summative evaluation at the end.

Section B: General comments on priority actions

This section provides general comments that relate to all priority actions within the DSAP as well as detailing a number of general new actions.

ATODA believes some modifications can be made across the priority actions to improve clarity, focus and structure. This includes:

- Adding a specific column to each action to document the specific priority population to which the action applies. The current approach is not effective as it is not sufficient to identify this in general terms (i.e. it applies to a population but not naming which). Nor should it appear within the National Drug Strategy pillar column (as it is not a pillar).
- Clarifying which of the two ACT Health organisations will be responsible as lead organisation following the ACT Health restructure in October 2018 (i.e. the organisation responsible for strategic policy and planning stewardship, or the one responsible for the delivery of clinical services).
- Strengthening many of the actions to move beyond relatively passive statements of 'explore', 'consider', 'undertake research'; to more specific statements of action related to implementation (including defining the focus of the action, and the mechanism to achieve it).

ATODA notes that actions in the DSAP have had extensive modifications since the release of the earlier February 2018 draft, and is pleased to see incorporation of many of the recommendations made by stakeholders. The DSAP has been markedly improved in this short period of time and the following recommendations will further improve the DSAP's next iteration.

General actions related to the implementation of the ACT Drug Strategy Action Plan

ATODA suggests adding three new Actions that are related to the implementation of the ACT Drug Strategy Action Plan:

Draft DSAP action	Suggested action	Proposed change and rationale	Further comments
New action	Convene the ACT Drug Strategy Action Plan Evaluation and Advisory Group bimonthly during the term of the ACT Drug Strategy Action Plan (2018 – 2021) to provide input and	Convening of the proposed governance group bi-monthly is necessary to provide adequate input and oversight to the implementation of an annual workplan, the monitoring and evaluation framework and annual	Refer to Section A, 3.2 of this submission for further details.

	oversight as detailed in the Group's Terms of Reference.	evaluation reports. Frequent meetings are particularly important given the work in scope, and that the length of the DSAP is only three years.	
New action	Commission monitoring and evaluation specialists, at the beginning of the three-year life of the Action Plan, to develop a comprehensive monitoring and evaluation plan with input from the ACT Drug Strategy Action Plan Evaluation and Advisory Group.	A monitoring and evaluation plan must be developed at the beginning of the 3-year Action Plan, and should be developed by expert evaluation specialists commissioned by ACT Health. Monitoring and evaluation should be implemented throughout the life of Action Plan, with a summative evaluation at the end of the three-year period.	Refer to Section A, 3.3 of this submission for further details.
New action	Re-establish a specialist AOD Policy Unit in the new organisation being established by ACT Health that will have responsibility for strategic policy and planning stewardship of the ACT's ATOD services within the ACT health system, the role of which includes centralised support to the DSAP and secretariat for the Evaluation and Advisory Group.	<p>In September 2017 ACT Health disbanded its specialist AOD Policy Unit. This has resulted in unintended consequences related to loss of corporate knowledge and access to AOD specialist policy expertise.</p> <p>It is essential that centralised AOD specialist policy expertise be re-established within ACT Health, particularly given the breadth of work across the health and criminal justice systems. A central unit will also aid with communication, accountability and transparency.</p>	

Section C: Comments on specialist alcohol and other drug treatment priority actions

This section provides general comments as well as detailing proposed changes and rationales for actions within the 'Treatment' section of the draft DSAP (currently actions 29 – 34).

For the purpose of the ATODA submission this has been elevated from the 'All drugs' section as a stand alone section in our submission given the detail and breadth of the commentary provided. We acknowledge, however, that for the revised DSAP this would be situated as a sub-heading within the 'All drugs' section (as is currently the case).

General comments:

ATODA proposes that the sub-heading of the section be updated to 'Specialist AOD treatment' to provide adequate clarity of scope and focus on the target of the actions described. Harm reduction strategies should be assumed within this phrasing, as essential components of any modern and evidence based AOD treatment program, policy and system (either as stand alone programs or integrated activities).⁴

ATODA suggests this section would benefit from some introductory information to help clarify the context in which the actions are to be implemented. This is consistent with the information provided at the commencement of a number of the other action areas within the draft DSAP. Information from some key data sources has been summarised below that may provide useful guidance in documenting this contextual information:

The ACT alcohol, tobacco and other drug sector is comprised of diverse services and programs; practitioners; people who use drugs and their families and friends; researchers; law enforcement and legal workers; policy workers and policy makers – with the specialist AOD treatment and harm reduction services being an integral part of the sector. This service system in the ACT is comprised of a diverse range of non-government and government services that work to prevent and reduce harms associated with ATOD use in the community. The ATOD sector is an evidence-informed, quality and data driven sector that is transparent and accountable to its service users, the broader public and its funding bodies. In the ACT, 10 services are funded by ACT Health to deliver various types of specialist drug treatment and support services. These services assist people to address their ATOD use and the consequences of such use through a wide range of treatment and support approaches including: harm reduction; information and education; withdrawal management; counselling; rehabilitation programs; and pharmacotherapy. Non-government and government agencies provide these interventions in both residential and non-residential settings.⁵

In the ACT there are 10 organisations publicly-funded (by ACT Health and/or Australian Government Department of Health and/or Prime Minister and Cabinet) to deliver specialist alcohol and other drug treatment, harm reduction and support services that deliver more than 34 programs. These are:

- Alcohol and Drug Services, ACT Health
- Canberra Alliance for Harm Minimisation and Advocacy
- Canberra Recovery Services, The Salvation Army
- CatholicCare Canberra & Goulburn
- Directions Health Services
- Gugan Gulwan Youth Aboriginal Corporation
- Karralika Programs Inc.
- Ted Noffs Foundation
- Toora Women Inc.
- Winnunga Nimmityjah Aboriginal Health and Community Services

These treatment and harm reduction services are supported by specialist AOD services provided by the peak body, the Alcohol Tobacco and Other Drug Association ACT (ATODA), which is also funded by ACT Health and the Australian Government Department of Health.

High quality specialist AOD treatment and support are delivered according to established and documented best practice in the AOD treatment field. This includes, for example: conducting comprehensive AOD assessments that channel people into the appropriate treatment modalities; and developing, in collaboration with the service user, an individual AOD treatment plan that articulates the goals and outcomes of their treatment. In addition, best practice requires consumer participation in decision-making, and intensive and on-going engagement by AOD treatment services so that individuals remain engaged with the service system, are able to maintain their treatment goals, and reduce relapse.⁶

Data from the 2015 ACT Service Users' Satisfaction and Outcomes Survey (SUSOS) shows that between 400 and 500 people access specialist AOD treatment and support services on any single day in the ACT. Around 25% of clients attending ACT AOD treatment and support services on the single census day of the SUSOS survey identified as being of Aboriginal and/or Torres Strait Islander descent; when only considering mainstream AOD services, 19.4% of clients identified as Aboriginal and/or Torres Strait Islander.⁷

The ACT Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTSNMDS) reports that there were 5,914 closed treatment episodes provided in the ACT in 2015-16 to an estimated 3,524 clients. This data is an underestimate of the total numbers of people accessing specialist AOD treatment services as not all services report to the AODTSNMDS.⁸

NMDS data further shows that alcohol (44%) was the principal drug of concern in the ACT, followed by amphetamines (24%), cannabis (17%) and heroin (9%). 'Information and education only' and 'assessment only' were the most common main treatment types delivered (24% respectively). This is followed by 'counselling' (20%), 'support and case management only' (12%), 'rehabilitation' (8%) and

‘withdrawal management’ (6%).⁹ Additionally, the 2017 National Opioid Pharmacotherapy Statistics show that up to 1,017 people were accessing pharmacotherapy treatment on a snapshot day in 2017 in the ACT.¹⁰

Comments on Treatment Actions:

ATODA is concerned that the existing action statements related to specialist AOD treatment and harm reduction are inadequate in specificity, clarity and breadth. There is greater opportunity to build on the activities and expertise of the sector by documenting policy guidance for innovations, growth and quality improvements lead by the sector over the next three years. As such, stakeholders from the sector have contributed significant time and expertise in re-drafting and proposing additional actions within the treatment section as outlined below.

Draft DSAP Action	Suggested Action	Proposed changes and rationale	Further comments
29. Drawing on specialist sector knowledge, identify options to expand alcohol and other drug services to meet the needs of a growing population, including outpatient withdrawal services, early interventions, and responses to the needs of priority populations.	See below	<p>Replace action 29 with 4 distinct and clear actions (Numbers 29.1 – 29.4 detailed below).</p> <p>The current draft of action 29 conflates a number of distinct areas of work. The 4 suggested actions better acknowledge the existing context and stakeholder groups involved in progressing each of the actions.</p>	See below
	29.1 Respond to the unmet demand for, and chronic underfunding of, specialist AOD services by ensuring there is a net increase in service places and capacity in the ACT.	The current specialist AOD service system is full and demand has been steadily increasing for several years. Concurrently there are development plans underway (e.g. the Drug and Alcohol Court), and it is essential that the existing capacity is not diverted or diminished.	The ‘alignment’ column in the DSAP should list the Commonwealth commissioned <i>New Horizons: The review of alcohol and other drug treatment services in Australia</i> . ¹²

Draft DSAP Action	Suggested Action	Proposed changes and rationale	Further comments
		<p>For further rationale see ATODA's submission to the Draft ACT Drug Strategy Action Plan (March 2018) and ATODA's Submission to the Supreme Court consultation concerning its document 'A Drug and Alcohol Court for the ACT: issues and draft proposals for consultation (October 2017).¹¹</p>	
	<p>29.2 Expand and embed AOD specialist treatment and harm reduction services into committed new ACT Health infrastructure (e.g. community health centres) to meet the needs of a growing population. This includes opioid substitution treatment (i.e. primary dosing point), needle and syringe programs and AOD therapeutic clinical spaces.</p>	<p>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 ACT Health planning for new ACT Health facilities in Civic, Weston Creek / Molonglo and North Canberra. The AOD specific elements of the planning process should involve service users and specialist AOD services.</p> <p>See Appendix 3 in ATODA's Submission to the Draft ACT Drug Strategy Action Plan (March 2018).</p>	<p>The 'alignment' column in the DSAP should list the Draft Territory Wide Health Services Framework.</p> <p>This action should be informed by the existing work within ACT Health to produce the Community Based Health Services Position Statement and the subsequent Community Based Health Service Planning Day (World Café) Draft Discussion Summary, March 2018. We note that this consultation was problematic, however, firm commitments were made through these processes to collaboratively plan for the services delivered through new</p>

Draft DSAP Action	Suggested Action	Proposed changes and rationale	Further comments
		ATODA notes that major opportunities were missed when AOD issues were not taken into consideration in the development of previous ACT Health infrastructure (e.g. not including primary dosing at Belconnen Health Centre as part of the planning process).	committed ACT Health infrastructure.
	29.3 Support the sustainable implementation of the new outpatient withdrawal services	<p>It is integral that the ACT Health commissioned and co-designed withdrawal services model report is released publicly to guide system improvement and funding allocation.</p> <p>A new program that provides non-residential withdrawal for people with low to moderate withdrawal symptoms and a confirmed place in a rehabilitation program in the ACT has now been established with Commonwealth funding.</p> <p>This program is funded until 2019 and addresses part of the identified outpatient withdrawal service gap.</p>	<p>The 'alignment' column in the DSAP should list the <i>Review and re-design of alcohol and other drug withdrawal services in the ACT</i>.</p> <p>ATODA urges the multiple funding bodies to consolidate resources and sustainably fund specialist AOD programs.</p>
	29.4 Undertake a policy process that documents and describes	Policy work is required to better define what is meant by early	The 'alignment' column in the DSAP should list the: <i>Early</i>

Draft DSAP Action	Suggested Action	Proposed changes and rationale	Further comments
	how AOD activities could be expanded in relation to early intervention, and use this to inform AOD specific input to the Early Intervention Strategy	<p>intervention in the context of specialist AOD services (and the appropriate activities in light of this within the ACT Government policy context). This is particularly pertinent in relation to the development of the Early Intervention Strategy (led by the Community Services Directorate) to ensure that ATOD sector input is conceptualised clearly and appropriately.</p> <p>This work should be undertaken with specialist AOD services with reference to the academic literature.¹³</p>	<i>Intervention Strategy and the Preventive Health and Wellbeing Plan.</i>
30. Working with Capital Health Network, increase the capacity of general practices to provide alcohol, tobacco and other drug screening, brief intervention, referrals and management, including use of prescription medications including opioid substitution treatment, naloxone, and medications for alcohol use disorders.	See below	<p>The current draft of action 30 conflates a number of distinct areas of work; and we suggest replacing it with two distinct actions (Numbers 30.1 – 30.2 detailed below).</p> <p>This screening, brief intervention and referral to treatment activity of general practitioners has been relocated as a new action in the Alcohol section with a rationale provided there (see new action in section D under subheading 1.f screening and assessment).</p>	See below

Draft DSAP Action	Suggested Action	Proposed changes and rationale	Further comments
		<p>This is distinct from the specialist AOD functions that may be undertaken by general practitioners (e.g. opioid substitution prescribing).</p> <p>Note that suggested actions related to naloxone (including GP provision) have been suggested under the opioid overdose section (see action 20.3).</p>	
	<p>30.1 Work with the Capital Health Network to develop AOD treatment HealthPathways, including those related to:</p> <ul style="list-style-type: none"> • Opioid pharmacotherapy prescribing • Opioid dependence and overdose • Alcohol dependence and withdrawal 	<p>The Capital Health Network is currently drafting AOD HealthPathways for the ACT through the activities of the 'HealthPathways AOD Pathways Working Group'. This will be the mechanism by which guidance on the management of AOD conditions within general practice can be provided.</p>	<p>The 'alignment' column in the DSAP should list the Capital Health Network's HealthPathways ACT and SNSW</p>
	<p>30.2 Develop and implement a pilot program that aims to increase the number of general practitioners who are opioid substitution treatment prescribers</p>	<p>The expansion of GP opioid prescribing numbers continues to be a drug policy priority for the ACT and has been the case for a number of years.</p> <p>Despite this problem being well known, it has not been progressed; therefore a specific</p>	<p>The 'alignment' column in the DSAP should list</p> <ul style="list-style-type: none"> • <i>Opioid Maintenance Treatment in the ACT: Local Policies and Procedures;</i> • <i>National Guidelines for Medication-Assisted Treatment of Opioid Dependence (April 2014)</i>¹⁴

Draft DSAP Action	Suggested Action	Proposed changes and rationale	Further comments
		<p>initiative is needed to increase the numbers of opioid substitution treatment prescribing GPs.</p> <p>The pilot program would need to include multiple strategies including potential GP incentives, systems of supports for new prescribing GPs (e.g. mentoring), increasing frequency of training, etc.</p>	
31. Collaborate with non-government organisations to implement the National Quality Framework for Drug and Alcohol Treatment Services and the National Treatment Framework.	See below	Replace action 31 with 2 distinct and clear actions (numbers 31.1 and 31.2 detailed below) that acknowledge the different timeframes and processes for each piece of contingent national work.	See below
	31.1. Work with ATODA to collaborate with specialist AOD services to develop jurisdictionally appropriate strategies to implement the <i>National Quality Framework for Drug and Alcohol Treatment Services</i> in the ACT, once it is promulgated.	<p>A number of shared quality improvement activities within NGO AOD services can currently be collectively defined and comprehensively documented as part of an ACT quality framework. ATODA has already undertaken substantial work in this area that can be built upon.</p> <p>See Appendix 7 in ATODA's Submission to the Draft ACT</p>	<p>The 'alignment' column in the DSAP should list the:</p> <ul style="list-style-type: none"> • National Quality Framework for Drug and Alcohol Treatment Services • Summary of quality strategies in specialist AOD services in the ACT¹⁵

Draft DSAP Action	Suggested Action	Proposed changes and rationale	Further comments
		Drug Strategy Action Plan (March 2018).	
	31.2. Work with ATODA to collaborate with specialist ACT AOD services to provide input into the development the National AOD Treatment Framework, including the development of an ACT specific AOD Treatment Framework.	<p>The National AOD Treatment Framework will be developed over the life of the DSAP. As such, working with the peak ATODA to support input from specialist ACT AOD services into its development over the coming years will be necessary within this period. ATODA has already undertaken substantial work in this area that can be built upon.</p> <p>In any case, as the Framework will be nationally focused, an ACT specific treatment framework will be necessary to guide jurisdictional implementation, policy and planning that reflects consensus on common and good practice.</p> <p>See Appendix 7 in ATODA's Submission to the Draft ACT Drug Strategy Action Plan (March 2018).</p>	<p>The 'alignment' column in the DSAP should list:</p> <ul style="list-style-type: none"> • The specialist alcohol, tobacco and other drug sector: a description and examination of treatment and support approaches.¹⁶ • Service Users' Satisfaction and Outcomes Survey.¹⁷
32. Develop specialty service plans for ACT Health treatment	See below	Replace action 32 with four actions (numbers 32.1 – 32.4 detailed below) that more clearly	See below

Draft DSAP Action	Suggested Action	Proposed changes and rationale	Further comments
services and review/develop appropriate models of care.		define the scope and focus of related planning activities.	
	32.1 Develop specialty service plans for AOD treatment delivered by ACT Health and review / develop appropriate models of care in consultation with key stakeholders including service users, non-government specialist AOD services and independent clinical advisors.	There is a need to be clear that this action relates to ACT Government provided AOD services, and accurately reflects the two new organisations being developed by ACT Health which come into effect from 1 October 2018.	The 'alignment' column in the DSAP should also list the Specialty Services Plans, and the Territory Wide Health Services Framework.
	32.2 Work with ATODA to collaborate with specialist AOD services and other stakeholders to undertake technical, AOD specific, health service planning and infrastructure development to develop a 10 year plan.	<p>Focusing planning exclusively on ACT Health delivered AOD treatment alone as per the existing action 32 (in absence of the predominantly NGO components of the specialist AOD service system) is inappropriate. This action seeks to expand planning activities and resources to the whole specialist AOD sub-system.</p> <p>See the ATODA Submission to the Draft ACT Drug Strategy Action Plan (March 2018) and the State and Territory AOD Peaks advice on request to The Hon Greg Hunt MP, Minister for Health 16 March 2018.</p>	<p>The 'alignment' column in the DSAP should also list the:</p> <ul style="list-style-type: none"> • Drug and Alcohol Service Planning Model for Australia • Adapting the Drug and Alcohol Service Planning Model for Aboriginal and Torres Strait Islander people receiving alcohol, tobacco and other drug services: Components of care and a resource estimation tool.¹⁸ <p>Technical planning activities should seek to build on the knowledge, evidence and documentation of existing ACT AOD specialist treatment and harm reduction gaps (as identified throughout a number of</p>

Draft DSAP Action	Suggested Action	Proposed changes and rationale	Further comments
			<p>actions within the draft DSAP and suggested actions area); as well as identifying emerging gaps not yet being progressed, such as:</p> <ul style="list-style-type: none"> - Justice specific AOD services - Low threshold services (e.g. drop in, phone and online counselling services) - Intensive community based services
	<p>32.3 Ensure specialist AOD service provision is not interrupted by the ACT Health restructure and that NGO contracts are renewed for a minimum of three years from 1 July 2019 and managed by the new ACT Health organisation that will have responsibility for strategic policy and planning stewardship of the ACT's health system.</p>	<p>The ideal funding agreement would be rolling five year contracts, with the option of reviewing and amending at year three or four by both parties. At a minimum, all service delivery grants should relate to funding agreements of no less than three years. This has been the long standing practice of ACT Health with regards to purchasing specialist AOD services from non-government providers.</p>	<p>The 'alignment' column in the DSAP should also list the Specialist AOD Services Funding Principles in the ACT¹⁹</p> <p>ATODA notes that the last time ACT Health purchased additional services from new funding from the ACT Budget was in 2016 and this was purchased by full-time equivalent staff to ensure that genuine capacity was built within the sector. The Capital Health Network supported this approach when it commissioned specialist AOD services in 2017 and 2018.</p>
	<p>32.4 Relocate specialist AOD NGO contract management to</p>	<p>In September 2017 ACT Health split specialist AOD NGO</p>	

Draft DSAP Action	Suggested Action	Proposed changes and rationale	Further comments
	one place within the new ACT Health organisation with responsibility for strategic policy and planning stewardship of the ACT's ATOD services within the ACT health system.	<p>contract management across two areas of ACT Health.</p> <p>It would be beneficial to bring all specialist AOD NGO contracts back together to be managed within the same area of ACT Health. This better acknowledges that the specialist AOD services function as an integrated system delivering efficiencies and economies of scale via, for example, a shared workforce, clients and collective activities within the specialist AOD sector.</p>	
33. Investigate options to enhance treatment of comorbid alcohol and other drug and mental health conditions, including suicide prevention.	See below	<p>Replace action 33 with multiple clear and distinct actions (numbers 33.1 – 33.8 detailed below). This acknowledges the multiple comorbidities experienced by people accessing specialist AOD treatment and harm reduction services; and the unique opportunity in AOD settings to provide integrated and effective responses to these issues.</p> <p>The comorbidities of people who access specialist AOD services are well established and the</p>	See below

Draft DSAP Action	Suggested Action	Proposed changes and rationale	Further comments
		responses have evolved beyond referring to just 'mental health'.	
	33.1 Building on the existing mental health responses within specialist AOD services, co-design a new specialist service response for the treatment of concurrent and severe AOD and severe mental health issues.	Specialist AOD services, through the Commonwealth funded Improved Services Initiative, undertook multiple years of capacity building to improve and embed responses to people experiencing comorbid mental health issues in AOD settings (with a focus on mild-moderate mental health issues). These services have insights that are essential to understanding remaining gaps and co-designing responses to those with severe mental health issues in AOD settings	This action should be conceptualised in relation to the now lapsed ACT Comorbidity Strategy 2012-2014 with particular considerations to 'Level of Care Quadrants' – as there has been significant progress within specialist AOD services with regards to responding in integrated ways to people who present with severe AOD issues and mild to moderate mental health issues (e.g. anxiety and depression).
	33.2 Building on the existing suicide prevention responses within specialist AOD services, expand suicide prevention activities with a focus on comprehensive assessment, policy development, management of suicide risk and referral.	<p>Suicide prevention in AOD settings should be progressed through a distinct action to provide adequate focus to the well established relationship between AOD use, intoxication and suicide risk.</p> <p>These activities should focus on capacity building and leveraging existing services expertise.</p>	The National Drug and Alcohol Research Centre has produced a Suicide Assessment Kit specifically for AOD contexts.

Draft DSAP Action	Suggested Action	Proposed changes and rationale	Further comments
	33.3 Increase access to hepatitis C prevention, identification and treatment in specialist AOD settings.	<p>This action seeks to replace content from action 15 (in the blood borne infection section) to provide a specific action on hepatitis responses within AOD settings.</p> <p>Hepatitis C should be identified separately as the blood borne virus that results in the most significant burden of harm for people who use drugs.</p> <p>A distinct action on hepatitis C acknowledges the necessary role AOD settings should play in achieving hepatitis prevention and treatment targets (particularly those related to hepatitis C) because of access to affected communities.</p>	The 'alignment' column in the DSAP should list the Hepatitis B, Hepatitis C, HIV and Sexually Transmissible Infections ACT Statement of Priorities 2016-2020
	33.4 Increase access to hepatitis A and B vaccination, prevention, identification and treatment in specialist AOD settings.	This action seeks to distinguish the nature and diverse responses required to different blood borne viruses (rather than providing generic phrasing)	The 'alignment' column in the DSAP should list the Hepatitis B, Hepatitis C, HIV and Sexually Transmissible Infections ACT Statement of Priorities 2016-2020
	33.5 Expand initiatives to reduce tobacco smoking among people with unacceptably high smoking rates accessing specialist AOD services in the	This action responds to the unacceptably high rates of smoking among people who access AOD treatment and harm reduction services.	Refer to Table B in the report: Reducing smoking in the ACT among Aboriginal and Torres Strait Islander women who are

Draft DSAP Action	Suggested Action	Proposed changes and rationale	Further comments
	ACT by collaborating with ATODA and specialist AOD services to enhance capacity and expand access to all types of NRT and associated nicotine dependence treatment.	This acknowledges that offering nicotine dependence treatment alongside other drug treatment has been assessed to increase smoking cessation. Consequently, this action has been placed in the Specialist AOD treatment section, rather than the Tobacco section.	pregnant or who have young children. ²⁰
	33.6 Develop, implement and evaluate a specialist nicotine dependence treatment service for the ACT, in particular for disadvantaged hard-to-reach sub-populations with higher smoking rates.	The expert consensus is that disadvantaged hard-to-reach sub-populations with higher smoking rates require additional, and more sophisticated, targeted and sustained tobacco treatment strategies. The model of a specialist nicotine dependence treatment service should include specific strategies for targeting hard-to-reach sub-populations. The expertise of specialist AOD services should be leveraged as part of this initiative.	
	33.7 Prevent and respond to domestic and family violence by establishing new coordinated/integrated AOD and DFV interventions within specialist AOD services, while concurrently enhancing the	Replace action 37 (that stands alone) with a revised action for incorporating in the specialist AOD treatment and harm reduction section).	The 'alignment' column of the DSAP should list resources and processes co-design by the specialist AOD sector and ACT DFV sector, including: <ul style="list-style-type: none"> <i>Domestic and Family Violence Capability</i>

Draft DSAP Action	Suggested Action	Proposed changes and rationale	Further comments
	universal capacity of the service system including services, the workforce and service consumers, to respond well to DFV.	This acknowledges the context of the Safer Families Initiatives that provides AOD focused funding to increase “the capacity of specialist drug treatment services to deliver programs that integrate best practice in addressing family violence”. This recognises the “complex relationship between family violence and alcohol and other drug use, and seeks to enhance opportunities for early intervention with victims and perpetrators of family violence”. ²¹	<p><i>Assessment Tool: for AOD settings</i></p> <ul style="list-style-type: none"> • <i>Scope of Practice: for working with service consumers in AOD settings who experience or use DFV</i> • <i>Practice Guide: for responding to DFV in AOD settings</i> • <i>ACT AOD Safer Families Program 2017 – 2021: Design, model, implementation and evaluation framework</i>
	33.8 Implement a project that co-designs and costs an ACT specific model that increases specialist AOD services clients (e.g. tier 1 opioid substitution treatment and low threshold services) access to ongoing general practice and primary health care services.	<p>People accessing specialist AOD services have both poor health status and low access to general practitioners (due to cost barriers, stigma, etc).</p> <p>A resourced and specific body of work, that is documented, is needed to progress this long known area of need. Co-designed implementation strategies could include: a system model of care; funding additional GP capacity in existing specialist AOD primary health care services; training support and resourcing for private GPs; strategies to specifically facilitate</p>	<p>Targeted primary health care models have been shown to be successful (e.g. Kirketon Road Centre) with sufficient resources.</p> <p>This project would need to be conducted in partnership between the Capital Health Network, ACT Health, NGO AOD health services, and require specific technical input and expertise (e.g in health financing across the Territory and Commonwealth governments).</p>

Draft DSAP Action	Suggested Action	Proposed changes and rationale	Further comments
		linkages into general practices; etc.	
34. Support the development of a skilled and diverse alcohol, tobacco and other drug workforce.	<p>34. Work with ATODA to collaborate with specialist AOD services to support the further development of a skilled and diverse alcohol, tobacco and other drug workforce through:</p> <ul style="list-style-type: none"> Implementing strategies to support and expand the Aboriginal and Torres Strait Islander AOD workforce. Expanding the ACT AOD Qualification Strategy to meet the needs of a growing workforce, including tertiary qualification options. Co-designing ACT Specialist AOD Workforce Development Strategy 	<p>Reword action 34 to clarify more specific actions and priorities for implementing workforce development initiatives.</p> <p>The ACT ATOD Qualification and Remuneration Profile provides detailed data and information on the changing needs of the specialist AOD workforce which could inform the implementation of workforce development initiatives (including trends and achievements over nearly a decade).</p> <p>ATODA has already undertaken substantial work in this area that can be built upon.</p> <p>See Appendix 7 in ATODA's Submission to the Draft ACT Drug Strategy Action Plan (March 2018).</p>	<p>The 'alignment' column in the DSAP should list the ACT AOD Qualification Strategy;²² the ACT ATOD Workforce Qualification and Remuneration Profile;²³ and the National Alcohol and Other Drug Workforce Development Strategy 2015 – 2018.²⁴</p> <p>This action should engage the ACT ATOD Workers Group that develops and implements an annual workplan focussed on workforce development and capacity building.</p>
New action	Develop and implement an infrastructure plan, with funding, for specialist AOD services to	See Appendix 10 in ATODA's Submission to the Draft ACT	

Draft DSAP Action	Suggested Action	Proposed changes and rationale	Further comments
	address ageing and changing infrastructure needs.	Drug Strategy Action Plan (March 2018).	
New action	Establish and provide funding through an innovation fund for specialist AOD services to develop, implement and evaluate new AOD initiatives and service funding models.	See Appendix 11 in ATODA's Submission to the Draft ACT Drug Strategy Action Plan (March 2018).	
New action	Collaborate with Aboriginal and Torres Strait Islander services, mainstream specialist AOD services and other stakeholders to determine specialist AOD implementation priorities for Aboriginal and Torres Strait Islander people.	There is a need for increased specialist AOD treatment, harm reduction and support services specifically for Aboriginal and Torres Strait Islander people in the ACT. This need has been identified in both community based and residential settings.	<p>The 'alignment' column in the DSAP could reference:</p> <ul style="list-style-type: none"> • Adapting the Drug and Alcohol Service Planning Model for Aboriginal and Torres Strait Islander people receiving alcohol, tobacco and other drug services: Components of care and a resource estimation tool. • The multiple documents developed in advance of the establishment of the Ngunnawal Bush Healing Farm • Strengthening Specialist Alcohol and Other Drug Treatment and Support: Needs and Priorities for the ACT 2016–2017—An independent expert paper for the ACT Primary Health Network's Baseline Needs Assessment (which

Draft DSAP Action	Suggested Action	Proposed changes and rationale	Further comments
			specifically discussed specialist AOD responses for Aboriginal and Torres Strait Islander clients and workers in the ACT)
New action	Implement a sector-driven drug treatment data collection, management, analysis, utilisation quality improvement and capacity building program which includes transferring functions for the NGO elements of Alcohol and Other Drug Treatment Services National Minimum Data Set from ACT Health to the peak	<p>See appendix 13 in the ATODA Submission to the Draft ACT Drug Strategy Action Plan (March 2018).</p> <p>The recommended approach for the ACT is consistent with the approach taken by health departments in NSW and Queensland.</p> <p>There are significant data development priorities in the ACT and nationally (e.g. related to waiting lists).</p>	
New action	Strengthen specialist AOD service capacity to establish and utilise fit-for-purpose data management systems to undertake further outcomes measurement and benchmarking.	Specialist AOD services have increased their capacity significantly in recent years to undertake outcomes measurement and benchmarking. Opportunities exist to ensure that information management systems and processes are fit-for-purpose for AOD settings.	
New action	Monitor and learn from clinical trials and program evaluations undertaken in other jurisdiction	Research and trials are already underway nationally that may create implementation	

Draft DSAP Action	Suggested Action	Proposed changes and rationale	Further comments
	with a view to expanding the available substitution therapies in the ACT (e.g. hydromorphone assisted treatment, N-acetyl-cysteine).	opportunities for the ACT to be at the cutting edge of specialist AOD treatment responses.	
New action	Expand support available to families, friends and significant others through specialist AOD services for people who are: <ul style="list-style-type: none"> • Seeking AOD treatment as a family • Seeking support in relation to a loved ones drug use 	There are opportunities to expand options and increase effectiveness of AOD interventions for families.	
New action	Improve outcomes for children and remove barriers to treatment access for people, especially women, including by expanding appropriate and subsidised childcare support options.		
New action	Ensure the viability of ACT ATOD Services Directory to underpin and inform the National Drug and Alcohol Services Directory.		The 'alignment' column in the DSAP should list the: <ul style="list-style-type: none"> • National Drug and Alcohol Services Directory funded by the Commonwealth Government. • ACT Alcohol and Other Drug Services Directory (www.directory.atoda.org.au)

SECTION D: Other priority actions

The following sections provide suggestions and comments on the priority actions according to the following headings:

1. Alcohol
2. Tobacco
3. Illegal drugs and non-medical use of pharmaceuticals
4. All drugs (excluding specialist AOD treatment dealt with through section C)
5. Emerging issues

For each suggested action, information on the proposed change, rationale and further information is provided (where relevant).

1. Alcohol

This section provides general comments as well as detailing proposed changes and rationales for actions within the 'Alcohol' section of the draft DSAP (currently actions 1 – 8).

General comments:

This section is significantly hindered by its lack of focus on alcohol supply measures (such as through restricting trading hours). This is in spite of the evidence that shows that alcohol supply measures are among the most effective ways of reducing alcohol-related harm. Further, greater success will be achieved by simultaneously acting across all three pillars of harm minimisation (demand reduction, supply reduction and harm reduction).

Comments on the introduction:

The introduction could be updated and strengthened with contemporary and local alcohol data such as is summarised in the recently released Chief Health Officer's Report 2018.²⁵

1.a. Sub-heading: Build community knowledge and change acceptability of use

Draft DSAP Action	Suggested Action	Proposed changes and rationale	Further comments
<p>1. Conduct evidence-informed alcohol public education and social marketing campaigns, including those that aim to:</p> <ul style="list-style-type: none"> • increase public knowledge of links between alcohol use and chronic disease, including cancer and cardiovascular disease; • increase public knowledge of safe drinking guidelines; • Increase the knowledge of young people, including school students, of the short and long-term harms of risky drinking, and also of issues relating to secondary supply of alcohol to peers. 	<p>1. Conduct three distinct, evidence-informed and health-led social marketing campaigns that aim to:</p> <ul style="list-style-type: none"> • increase public knowledge of links between alcohol use and chronic disease, including cancer and cardiovascular disease; • increase public knowledge of safe drinking guidelines; • Increase the knowledge of young people, including school students, of the short and long-term harms of risky drinking, and also of issues relating to secondary supply of alcohol to peers. 	<p>Reword action 1 to clarify that each campaign is distinct with its own audience and stakeholder groups that would need to be engaged.</p> <p>The health led focus of the campaigns should be made more explicit.</p>	<p>To support this action, the ACT should look into drafting policy that focuses on ensuring alcohol public health information is not connected to the alcohol industry.</p> <p>Such a policy should include the following points (taken from a similar policy developed by the Health Service Executive, Ireland):²⁶</p> <ul style="list-style-type: none"> • public health information on alcohol must be impartial, authoritative and provided by expert sources; • information programs should be supported by clinical experts, are evidence-based, have clear behaviour-change objectives, and their impact is measured and evaluated; • public health information and advice should be formally separated from the alcohol industry, as promoting health and wellbeing and increasing industry profits are not coherent are incompatible strategic objectives;

Draft DSAP Action	Suggested Action	Proposed changes and rationale	Further comments
			<ul style="list-style-type: none"> Government services, divisions, or staff in the course of their work for the government will not take part in campaigns, programs or initiatives that are funded, or co-funded, directly or indirectly, by alcohol manufacturers and distributors or their related Social Aspect Public Relations Organisations (SAPROS). <p>This should link with the 2017-18 ACT Budget commitment to use fees for certain off-licensed venues to fund an education campaign to better inform Canberrans about the safe and responsible consumption of alcohol.²⁷</p>

1.b. Sub-heading: Restrictions on promotion

Draft DSAP Action	Suggested Action	Proposed changes and rationale	Further comments
2. Explore options to reduce alcohol promotion and use in	2. Commence actions and policy work to reduce alcohol promotion and use in ACT	Reword action 2 to provide greater specificity of the contexts in which alcohol promotion will be addressed.	Examples of programs and policy work to reduce alcohol promotion in sports settings include:

Draft DSAP Action	Suggested Action	Proposed changes and rationale	Further comments
ACT sports and other community settings.	sports and other community settings, including prohibiting alcohol and licensed premise sponsorship of ACT junior sports teams, isolating alcohol in supermarkets, and prohibiting alcohol promotions within a defined radius of a school.		<ul style="list-style-type: none"> • 'End alcohol advertising in sport' campaign²⁸ • 'Sample alcohol policy' developed by the WA Department of Local Government, Sport and Cultural Industries.²⁹ • Good Sports Program³⁰
3. Consider options to reduce promotion of alcohol on government premises, consistent with preventive health commitments.	3. Implement strategies to prohibit the promotion of alcohol on government-owned property and assets, including all transport and transport infrastructure and sporting grounds.	Reword action 3 to provide greater specificity of the contexts in which alcohol promotion will be addressed on government property.	

1.c. Sub-heading: Price mechanisms

Draft DSAP Action	Suggested Action	Proposed changes and rationale	Further comments
4. Explore the option of introducing a minimum price per standard drink of alcohol.	4. Undertake a policy process to describe options to implement an appropriate minimum unit price per standard drink of alcohol for the ACT, with sufficient consideration to the	Reword action 4 to clarify a policy process is required with sufficient consideration to potential negative unintended consequences.	The policy process should monitor and be informed by minimum floor price policy implementation and key learnings in the Northern Territory (and progress in other jurisdictions including Scotland and Canada).

	complexity and potential for negative unintended consequences based on race, poverty or social exclusion.		
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1.d. Sub-heading: Supporting research and building and sharing evidence

Draft DSAP Action	Suggested Action	Proposed changes and rationale	Further comments
<p>5. Undertake research to inform public health responses on contextual and individual factors that influence risky drinking and alcohol-related harms, including:</p> <ul style="list-style-type: none"> • links between alcohol use and domestic and family violence; • the impact of enforcement measures on risky drinking; • evidence-informed options for further reducing road safety risk caused by drink-driving; • exposure of young people and risky drinkers to alcohol advertising in ACT public spaces. 	<p>5. Develop ACT specific and focused policy options for the implementation of activities that positively influence contextual and individual factors related to risky drinking and alcohol related harms (including improved data collection and reporting) with a focus on:</p> <ul style="list-style-type: none"> • links between alcohol use and domestic and family violence; • the impact of enforcement measures on risky drinking. 	<p>Reword action 5 as these do not need to be new pieces of research work, as the evidence for each of these is already established in the literature.</p> <p>Instead these should be the subject of the implementation of good public health practice to: scope the evidence and the context; develop appropriate response options (policy and/or program); put these forward for consideration and debate; refine and implement them; and monitor and evaluate these responses.</p> <p>Some dot points should be removed to reduce duplication (i.e. road safety addressed through action 6; and young people and advertising addressed through action 2).</p>	

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1.e Sub-heading: Safe transport

ATODA proposes that this sub-heading is changed from 'safe transport and sobering up services' to just 'safe transport' as there are no actions listed related to sobering up services in the DSAP.

Draft DSAP Action	Suggested Action	Proposed changes and rationale	Further comments
6. Continue work to reduce alcohol-impaired driving, including random breath testing and the ACT alcohol interlock program, taking into consideration findings from evaluations of relevant programs.	6. Continue to work to reduce alcohol-impaired driving by increasing targets for the randomness and intensity of random breath testing (RBT) and continue to implement supported findings from the independent evaluation of the ACT Alcohol Interlock Program.	<p>Reword action 6 to further clarify the focus of activities related to random breath testing. In the ACT, the intensity of RBT is well below what is considered to be best practice.</p> <p>See appendix 2 in ATODAs submission to the Draft ACT Drug Strategy Action Plan (30 March 2018).</p> <p>Also, wording in relation to the implementation of the alcohol interlock program evaluation findings was stronger in the February 2018 draft DSAP, we suggest this wording is used.</p>	

1.f Sub-heading: Screening and assessment

ATODA proposes that this sub-heading is changed from 'screening, assessment and treatment' to just 'screening and assessment' to reflect the relocation of actions related to alcohol treatment into the section entitled 'Specialist AOD treatment'.

Draft DSAP Action	Suggested Action	Proposed changes and rationale	Further comments
<p>7. Implement appropriate actions at territory level to support the national Fetal Alcohol Spectrum Disorder (FASD) Strategic Action Plan (when finalised).</p>			<p>ATODA notes the absence of disability in the DSAP, including screening and specific responses for AOD-related disabilities.</p> <p>FASD is only one type of AOD-related disability, with others including alcohol related and hypoxic brain injuries from overdose.</p> <p>Progress has been made in specialist AOD treatment settings, and other settings, to progress AOD-specific responses to disability.</p> <p>Disability warrants further consideration and articulation in the DSAP, including the interrelationships with the Disability Justice Strategy that the Justice and Community Safety Directorate is developing.</p>
<p>New action</p>	<p>Work with the Capital Health Network to increase the capacity of general practices to provide alcohol, tobacco and other drug screening, brief intervention and referral to specialist AOD treatment.</p>	<p>This action has been separated out from action 30 to acknowledge the specific activity of Screening, Brief Intervention and Referral to Treatment (SBIRT) that should be undertaken in general practice settings.</p>	<p>This action should build on activities to date in the ACT to embed evidence based ATOD screening practices in a range of settings, including linking with national resources such as the World Health Organisation and</p>

Draft DSAP Action	Suggested Action	Proposed changes and rationale	Further comments
		The placement of this action within the Alcohol section recognises that this response should occur across the whole population (i.e. the majority of Canberrans are classified as current drinkers, many of whom would attend a GP, and screening through GPs provides an effective setting in which to reach a large proportion of this population).	DASSA Collaborating Centre ASSIST work.

1.g Sub-heading: Age restrictions

Draft DSAP Action	Suggested Action	Proposed changes and rationale	Further comments
8. Explore measures to reduce secondary supply of alcohol to minors, including by family members and over-age friends.	8. Identify and implement measures to reduce secondary supply of alcohol to minors, including by family members and over-age friends.	Reword action 8 to clarify an implementation focus.	The new Australian evidence supporting action is compelling. ³¹

2. Tobacco

This section provides general comments as well as detailing proposed changes and rationales for actions within the 'Tobacco' section of the draft DSAP (currently actions 9 – 13).

General comments:

ATODA assumes that prevention strategies associated with tobacco use will be covered in the *ACT Preventive Health and Wellbeing Plan*. We, therefore, assume that the DSAP will focus on nicotine dependence treatment and regulation. As such, this section should provide greater clarity and focus specifically around the strategies required to achieve even lower smoking rates in the ACT; that is, maintaining population-wide interventions such as regulation, while at the same time strengthening nicotine dependence treatments that have been demonstrated to be effective among particular population groups with high smoking prevalence.

Comments on the introduction:

The introduction currently covers the morbidity and mortality resulting from tobacco smoking, but it does not include more detailed ACT-specific epidemiological data and articulation of the specific priority populations relevant to the ACT. Inclusion of this will contextualise the actions needed in tobacco control that are particular for the ACT context.

The dot points below provide guidance on the types of data and information that could be included.

- The current daily smoking rate in the ACT is 10%, and is the lowest rate in Australia³²
- However, the smoking rates among certain disadvantaged sub-populations in the ACT are much higher. This includes:
 - People who use AOD – a 2015 survey of people accessing specialist AOD services in the ACT found that 82% self-identified as smokers³³
 - Prisoners (84% of ACT prisoners on entry to prison in 2015 self-identified as smokers)³⁴
 - Aboriginal and Torres Strait Islander people (ACT—36% age-standardised daily smoking rate, aged 18 and over).³⁵
 - People experiencing homelessness (77%—Melbourne 1995 – 96);³⁶
 - People who reported having been diagnosed or treated for mental illness in the past year (26%—national survey 2016)^{37,38}
 - People who are socio-economically disadvantaged (21% among people living in areas of Australia with more disadvantage)³⁹
- Within these disadvantaged sub-populations are further sub-groups with relatively high levels of smoking. For example, young women and their partners/families who are disadvantaged are more likely to be smokers than more advantaged young women; they are, therefore, also more likely to continue smoking during pregnancy. The interaction with health services that comes with pregnancy and

post-partum care provide opportune moments to assist pregnant women and new mothers, and their partners and families, with smoking cessation.⁴⁰

- All of these sub-populations face a range of barriers that inhibit their access to nicotine dependence treatments that have proven successful with other smokers in the general ACT community. The expert consensus is that 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.

2.a. Sub-heading: Targeted approaches to priority populations

Draft DSAP action	Suggested action	Proposed change and rationale	Further comments
9. Further develop approaches to reduce smoking rates among high-risk population groups identified in the current National Tobacco Strategy, including Aboriginal and Torres Strait Islander Peoples.	See below	Replace action 9 with two actions that focuses on strengthening smoking cessation interventions among particular population groups with high smoking prevalence.	See below
	9.1 Building on work already undertaken, implement tobacco management capacity building in community-based settings accessed by disadvantaged people (e.g. homelessness services, mental health services, etc).	While disadvantaged people who smoke require access to targeted nicotine dependence treatment, such treatment cannot be offered in isolation from comprehensive tobacco management activities (e.g. smoke-free policies; adequate signage; workforce training; referral to nicotine dependence treatment; etc). Many community-based settings currently accessed by disadvantaged people who smoke need to build capacity in	

Draft DSAP action	Suggested action	Proposed change and rationale	Further comments
		<p>tobacco management, including referral mechanisms into the specialist nicotine dependence treatment service proposed in action 33.6 (see 'Specialist AOD treatment' section).</p> <p>The Workplace Tobacco Management Project and Under10% Project provide a model for how the program of work suggested in this action could be undertaken and are ACT specific.⁴¹</p> <p>People who use AOD are also a priority population, and nicotine dependence treatment delivered within the setting of specialist AOD services is included at action 33.5 (see 'Specialist AOD treatment' section).</p>	
	<p>9.2 Work with the Aboriginal and Torres Strait Islander community-controlled sector to identify and implement existing and further activities in nicotine dependence treatment and tobacco management.</p>	<p>As a priority high-risk population group for tobacco smoking, the ACT Aboriginal and Torres Strait Islander community should determine further support needed in nicotine dependence and tobacco management.</p> <p>We note that in the February 2018 Draft DSAP this was an</p>	<p>The 'alignment' column in the DSAP should list the ACT Aboriginal and Torres Strait Islander Tobacco Control Strategy (2010/11 – 2013/14); The ACT Aboriginal and Torres Strait Islander Tobacco Control Strategy Evaluation; and the</p>

Draft DSAP action	Suggested action	Proposed change and rationale	Further comments
		<p>action in its own right, and we suggest that is maintained.</p> <p>Note that the ACT Aboriginal and Torres Strait Islander Tobacco Control Strategy (2010/11 – 2013/14) has lapsed.⁴² This strategy was evaluated (The ACT Aboriginal and Torres Strait Islander Tobacco Control Strategy Evaluation), and had its own governance group, the 'ACT Health Aboriginal and Torres Strait Islander Tobacco Control Strategy Steering Group'.</p>	Commonwealth's Tackling Indigenous Smoking program.

2.b. Sub-heading: 'Regulatory responses'

ATODA proposes that this sub-heading is changed from 'safer settings' to 'Regulatory responses' to reflect the nature of the activities.

Draft DSAP action	Suggested action	Proposed change and rationale	Further comments
11. Consider the need for additional smoke-free areas, including smoke-free correctional facilities.	11. With reference to international best practice in tobacco control, conduct a comprehensive assessment of tobacco regulation in the ACT to identify where improved regulation is required; and utilising this, develop and	<p>Replace action 11 with a more specific action with a focus on tobacco regulation for the entire community.</p> <p>The Future directions for tobacco reduction in the ACT 2013 – 2016 has now lapsed. Policy guidance in relation to tobacco</p>	Change sub-heading to 'Regulatory responses'

Draft DSAP action	Suggested action	Proposed change and rationale	Further comments
	implement a plan of work to be carried out in the life of the DSAP for the formulation of policy options, proposal of legislative action, and, where possible, the enactment of regulatory responses (for example, additional smokefree areas, raising the legal purchase age for tobacco, strengthening controls on the sale of tobacco, etc).	control and legislation will be necessary in absence of a documented strategy. Action 13 (regarding raising the legal purchasing age for tobacco) has been incorporated into this action as part of the program of regulatory work to be undertaken. Incorporate smoke-free correctional facilities more specifically into an overall plan for alcohol, tobacco and blood borne virus issues in the AMC (in action 16 in the 'Illegal drugs and non-medical use of pharmaceuticals' section).	
12. Continue to enforce tobacco and smoke-free legislation in the ACT.	12. Continue to enforce existing tobacco and smoke-free legislation in the ACT.	Add 'existing' to differentiate it from new activity suggested above.	Place under sub-heading of 'Regulatory responses'

2.c. Sub-heading: 'Access restrictions'

Draft DSAP action	Suggested action	Proposed change and rationale	Further comments
13. Conduct research into the potential impact of raising the legal purchase age for tobacco.	Delete	Delete this action and include it under Action 11 above.	

		<p>This is not a research activity, as the impact on raising the legal purchase age is known. What is needed is a policy process to scope the evidence and context, and develop and consider policy responses to identified issues.</p>	
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3. Illegal drugs and non-medical use of pharmaceuticals

This section provides general comments as well as detailing proposed changes and rationales for actions within the 'Illegal drugs and non-medical use of pharmaceuticals' section of the draft DSAP, for the sub-sections 'Safe injecting and prevention of blood borne virus infections' and 'Overdose prevention' (currently actions 14 – 20).

General comments:

ATODA is not commenting on actions in this section that are specifically related to law enforcement (actions 21 – 26), except to reiterate the comments in the introductory section of this submission that the balance of investment in the ATOD sector should reflect the evidence for what works; this means a shifting of resources from law enforcement to the areas and intervention types that are both efficacious and cost-effective, particularly ATOD treatment and harm reduction.

ATODA notes that the earlier draft of the DSAP (February 2018) included an action on medicinal cannabis, and that the 2018 Chief Health Officer's Report 2018 discusses and reports on medicinal cannabis under the heading 'reducing harm from illicit drugs'.

ATODA has long supported a compassionate approach to people where cannabis has been identified to palliate symptoms of serious illness (e.g. HIV) or the adverse side-effects of their treatment (e.g. cancer). Such an approach would require the ACT to exempt defined groups from prosecution for the cultivation, possession and use of cannabis – which is an illicit drug policy issue and warrants a specific action in the DSAP.

However ATODA understands that the current ACT medicinal cannabis scheme relates only to prescribed products, and therefore at this point in the scheme's development has nothing to do with illicit drug policy.

Comments on the introduction:

ATODA suggests the following changes to the introductory statements of this section:

- The text of this introduction should be consistent with that found in the Chief Health Officer's 2018 report, including:
 - 'In the ACT, illicit drug use contributes to 2.2% of the total burden of disease and injury' (p. 40)
 - 'Canberra has the lowest use of illicit drugs. In 2016, 12.9% of Canberrans aged 14 years and older reported illicit use of any drug in the previous year. This was the lowest figure reported by any state or territory and almost half the figure reported in 1998 (23.9%)' (p. 40). This is in contrast with the current wording in the draft DSAP: '*In the ACT rates of illicit drug use are similar to national rates*'.

- We do not understand why the last sentence of the introduction is restricted to treatment only. Perhaps what is intended is ‘Harm reduction strategies, education, and supporting mechanisms to address social determinants of health are essential components of modern, evidence-informed ATOD programs, systems and policies, including those addressing illicit drug-related harms’, or similar.
- Include data on the opioid overdose epidemic, including trend data.

3.a. Sub-heading: Safer injecting and prevention of blood borne infections

Draft DSAP action	Suggested action	Proposed change and rationale	Further comments
14. Maintain and improve access to sterile injecting equipment and sharps disposal.	14. Maintain and improve access to sterile injecting equipment and sharps disposal, including by: <ul style="list-style-type: none"> • expanding modalities of availability (e.g. outreach, foot patrols, vending machines) • planning for and embedding NSPs into new committed ACT Health infrastructure (e.g. community health centres) • providing NSPs in locations with expanding populations and AOD needs (e.g. a primary NSP in northern Canberra). 	<p>Improved access to sterile injecting equipment can be achieved through expanding modalities including outreach.</p> <p>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 (see also action 29.2 in the ‘Specialist AOD treatment’ section).</p> <p>For a full rationale, see Appendix 3 in ATODA’s previous Submission to the Draft ACT Drug Strategy Action Plan (30 March 2018).</p>	This action to be implemented with advice from the ACT Needle and Syringe Program Advisory Group.
15. Increase access to prevention,	Action replaced in a different section.	This action has been replaced by actions 33.3 and 33.4 (in the	

Draft DSAP action	Suggested action	Proposed change and rationale	Further comments
screening, testing, vaccination and treatment for blood borne infections among people who use drugs, including in treatment settings.		'Specialist AOD treatment' section) to provide specific actions on hepatitis responses within AOD settings.	
16. Develop a plan during 2018 to address alcohol, drug and blood borne viruses issues in the ACT adult prison (Alexander Maconochie Centre).	16. Develop a specific 3-year plan during 2018 to address alcohol, tobacco, other drug and blood borne viruses issues in the ACT adult prison (Alexander Maconochie Centre), with a particular focus on providing access to equivalent health services and interventions as those available in the general community (e.g. access to hepatitis C treatment, access to sterile injecting equipment, expanded smoke-free regulation).	<p>An overall plan covering ATOD and BBV will provide a comprehensive approach within the setting of the ACT adult prison; the plan includes tobacco (instead of at action 11) to enable the progression of smoke-free regulation in the broader context of tobacco management in the prison environment.</p> <p>The ACT has an existing strategic framework for addressing blood borne viruses, the Strategic Framework for the Management of Blood-Borne Viruses in the Alexander Maconochie Centre 2013 – 2017 that can form the basis of an ATOD and BBV plan.</p> <p>For further rationale, see Appendix 14 in ATODA's previous Submission to the Draft</p>	<p>Recommend a working group of the DSAP governance group is established to lead the development of this plan and report through the DSAP governance group.</p> <p>The 'alignment' column of the DSAP should include the Strategic Framework for the Management of Blood-Borne Viruses in the Alexander Maconochie Centre 2013 – 2017.</p>

Draft DSAP action	Suggested action	Proposed change and rationale	Further comments
		ACT Drug Strategy Action Plan (30 March 2018).	

3.b. Sub-heading: Overdose prevention

Draft DSAP action	Suggested action	Proposed change and rationale	Further comments
17. Monitor implementation of medically supervised drug consumption facilities (injecting centres) in other jurisdictions to inform consideration of a potential ACT facility.	17. Commission a scoping study to investigate and report on the feasibility, need, effectiveness and appropriateness of establishing a medically supervised drug consumption facility (supervised injecting place) in the ACT context.	<p>Replace action 17 with a new action that better acknowledges that there is enough internationally published evidence and national policy experience to undertake this scoping exercise with consideration of the local ACT drug and policy context.</p> <p>Suggest this action is moved from 'safer injecting and prevention of blood borne infections' to 'overdose prevention' as that is aligned with the primary purpose of the intervention.</p>	<p>Advice from the ACT Drug Strategy Action Plan Evaluation and Advisory Group on how to approach this piece of work could be particularly useful.</p> <p>Refer to the ACT Supervised Injecting Place Trial Act 1999, demonstrating that the facilitating legislative framework is already in place.</p>
19. Explore further opportunities to expand on pill testing at events and/or at	See below	Replace action 19 with two distinct actions (numbers 19.1 – 19.2) to include a public alert system.	

Draft DSAP action	Suggested action	Proposed change and rationale	Further comments
fixed locations in the ACT.	19.1 Implement and independently evaluate regular pill testing/drug checking services at events and at fixed locations in the ACT.	Scaling up of drug checking services, building on the successful trial of pill testing in the ACT by the STA-SAFE consortium, and the international evidence, is an essential part of a package of harm reduction measures, and as part of drug early warning systems.	The 'alignment' column of the DSAP should include the Report on the ACT GTM Pill Testing Pilot: a Harm Reduction Service. Prepared by the Safety Testing Advisory Service At Festivals and Events (STA-SAFE) Consortium, June, 2018. ⁴³
	19.2 Establish a system of public alerts from the Chief Health Officer on the findings of pill testing/drug checking, including alerts developed with and targeted to reach affected populations.	To reduce drug-related harm, surveillance information from drug checking should be transmitted to the affected public in a timely and targeted manner.	Refer to the lessons from the British Columbia Drug Overdose & Alert Partnership. ⁴⁴
20. Explore further options to prevent and reduce harms from overdose, particularly opioid overdose, and including increased provision of naloxone.	See below	Replace action 20 with three actions (numbers 20.1 – 20.3) that relate to opioid overdose prevention in specific settings and/or with specific sub-populations.	
	20.1 Enhance the delivery of the current peer-based opioid overdose program to people at risk of overdose by enhancing access to both prescribed naloxone (schedule 4) and subsidised over-the-counter naloxone (schedule	There is a need for targeted approaches to improve access to naloxone while national supply issues are being sorted out. Affordability and lack of access to a GP (for a prescription) are	

Draft DSAP action	Suggested action	Proposed change and rationale	Further comments
	3)—for people who do not have access to a general practitioner.	currently the major barriers for many people to accessing naloxone for overdose prevention.	
	20.2 Undertake a multi-year clinical policy development and capacity building project to embed opioid overdose education, including access to naloxone, within specialist AOD settings.	Specialist AOD treatment services are an ideal setting to provide naloxone and overdose prevention education to people at risk of overdose. This project will require significant clinical policy and procedure development within specialist AOD treatment services, as well as training and capacity building for staff.	
	20.3 Work with the Capital Health Network, and other stakeholders to increase capacity in general practice to implement opioid overdose prevention strategies, including delivering brief interventions and naloxone prescriptions to people receiving prescribed opioid medications.	People who are receiving prescribed opioid medications through their GPs are a specific sub-population at risk of opioid overdose. GPs require increased training and capacity to implement opioid overdose prevention strategies with these specific patients.	Refer also to action 30.1 that relates to the development of AOD HealthPathways with the Capital Health Network.
New action	Using a co-design process, including with people at risk of opioid overdose and families, develop and implement an ACT Opioid Overdose Prevention and Response Strategy.	A coordinated and evidence informed strategy to reduce the adverse impacts of opioids in the ACT is urgently needed to	An ACT Opioid Overdose Prevention and Response Strategy will include the actions proposed above (as actions that are known to be needed), as well

Draft DSAP action	Suggested action	Proposed change and rationale	Further comments
		<p>enable a timely response to the opioid overdose epidemic.</p> <p>For a full rationale, see Appendix 1 in ATODA's previous Submission to the Draft ACT Drug Strategy Action Plan (30 March 2018).</p>	<p>as further actions as per the list provided in Appendix 1 in ATODA's previous Submission to the Draft ACT Drug Strategy Action Plan (30 March 2018).</p>

4. All drugs (excluding specialist AOD treatment)

This section provides general comments as well as detailing proposed changes and rationales for actions within the 'All drugs' section of the draft DSAP, excluding the sub-section on 'Specialist AOD treatment' (formerly just 'Treatment'). All actions related to 'Specialist AOD treatment' have been moved up to Section C to reflect the relative importance of ATODA's feedback on specialist AOD treatment actions. Actions 27, 28, 35, 36 and 37 are dealt with in this section below.

4.a. Sub-heading: Build community knowledge and change acceptability of use

Draft DSAP action	Suggested action	Proposed change and rationale	Further comments
27. Implement evidence-informed programs in community settings such as schools, sporting clubs and workplaces, to prevent and reduce harms of alcohol, tobacco and other drugs.	27. Commission a review of the ACT school drug education programs—for public release—including: the current extent and nature of these programs, and the degree to which they reflect contemporary good practice (as evidenced from the evaluation research); based on the review's findings develop and implement modern, evidence-informed school drug education programs in the ACT.	Replace this action with more specific settings-based actions. For a rationale for this action, refer to Appendix 12 in ATODA's Submission to the Draft ACT Drug Strategy Action Plan (March 2018).	See below
28. Explore options for development of an education program regarding the content of seized drugs, and how some of these drugs are manufactured.		ATODA has sought advice from stakeholders and does not understand what this action means and is therefore unable to provide comment.	

4.b. Sub-heading: Alcohol and other drug diversion

ATODA proposes that this sub-heading is changed from 'Diversion from the criminal justice system' to 'Alcohol and other drug diversion' to provide more accurate phrasing in relation to the actions that follow (i.e to cover diversion from criminal justice system into AOD treatment; diversion from prison into AOD treatment; diversion from criminal justice system into civil penalties).

Draft DSAP Action	Suggested Action	Proposed changes and rationale	Further comments
35. Implement an ACT Drug and Alcohol Court within the term of the ninth Assembly.	35. Implement an ACT Drug and Alcohol Court within the term of the ninth Assembly, including increases to required specialist AOD treatment capacity.	Reword action 35 to incorporate adequate specialist AOD treatment capacity as an inherent component of ACT Drug and Alcohol Court implementation.	See ATODA's Submission to the Supreme Court consultation concerning its document 'A Drug and Alcohol Court for the ACT: issues and draft proposals for consultation (October 2017). ⁴⁵
36. Explore ways to increase diversion options available in the ACT, including supporting all specialist alcohol and other drug treatment services to become Community Work and Social Development Order Program providers.	36. Increase access to police and court diversion programs in the ACT, including increasing the number of diversions for: <ul style="list-style-type: none"> • Simple Cannabis Offence Notices • Court Alcohol and Drug Assessment Service • Illicit Drug Diversion 	Reword action 36 to remove reference to Community Work and Social Development Order Programs (neither of which are diversion; and both of which have already been implemented in specialist AOD services). Increasing access to existing police and court diversion services in the ACT will minimise the risk of people who use drugs receiving criminal convictions for minor drug offences, and assist them to overcome their problematic drug use through specialist drug education and treatment.	The 'alignment' column in the DSAP should list the Evaluation of Australian Capital Territory drug diversion programs
New action	Expand the ACT's existing Simple Cannabis Offence Notice	See appendix 4 in the ATODA Submission to the Draft ACT	

Draft DSAP Action	Suggested Action	Proposed changes and rationale	Further comments
	(SCON) scheme to cover all illegal drugs (e.g. MDMA/‘ecstasy’).	Drug Strategy Action Plan (March 2018). Expanding the SCON scheme would reduce the number of people, particularly young people, with criminal records.	

4.c. Sub-heading: Domestic and family violence

Draft DSAP Action	Suggested Action	Proposed changes and rationale	Further comments
37. Integrate more effective responses within AOD services for people who either experience domestic and family violence or are at risk of using it.	Replaced by action 33.7.	This action has been moved and replaced with action 33.7 to reflect that it relates specifically to ‘Specialist AOD treatment’.	

5. Emerging issues

This section provides proposed changes and rationales for action 39 within the 'Emerging issues' section of the draft DSAP.

5.a. Sub-heading: Monitor emerging drug issues

Draft DSAP action	Suggested action	Proposed change and rationale	Further comments
39. Refer to learnings from National Pilots and explore the implementation of a local early warning system to ensure timely use of data to monitor and respond to emerging drug trends and harms.	39. Implement systems, similar to those used in other jurisdictions but adapted to the ACT's circumstances that will enable the ACT to anticipate, understand and effectively respond to emerging issues.	Much experience has been gained, in both Australia and abroad, on how to do this. The rapid changes that occur in the types of drugs available in Canberra's drug markets, and in the population groups using them, highlights the need for an effective health- (not police-) driven early warning system.	The 'alignment' column of the draft DSAP should list reporting systems including Illicit Drug Reporting System, Ecstasy and Related Drugs Reporting System, Australian Needle and Syringe Program Survey & Illicit Drug Data Report.

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- ¹ ACTCOSS, 'Community Shared Statement for 2016 ACT Election, viewed online August 2018, <https://www.actcoss.org.au/sites/default/files/public/publications/2016-community-shared-statement-act-election.pdf>
- ² A Ritter, R McLeod & M Shanahan, Government drug policy expenditure in Australia - 2009/10, with addendum dated 20 August 2013, *DPMP Monograph Series no. 24*, National Drug and Alcohol Research Centre, Sydney, 2013.
- ³ D McDonald, 'Australian governments' spending on preventing and responding to drug abuse should target the main sources of drug-related harm and the most cost-effective interventions', *Drug and Alcohol Review*, vol. 30, no. 1, pp. 96-100, 2011
- ⁴ Alcohol Tobacco and Other Drug Association ACT (ATODA), 'Strengthening Specialist Alcohol and Other Drug Treatment and Support: Needs and Priorities for the ACT 2016–2017—An independent expert paper for the ACT Primary Health Network's Baseline Needs Assessment'. *ATODA Monograph Series, No.3.*, Alcohol Tobacco and Other Drug Association ACT (ATODA), Canberra, 2016
- ⁵ 360Edge & Alcohol Tobacco and Other Drug Association ACT (ATODA), 'The specialist alcohol, tobacco and other drug sector: a description and examination of treatment and support approaches', *ATODA Monograph Series, No.5*, ATODA, Canberra, 2017.
- ⁶ Ibid
- ⁷ Alcohol Tobacco and Other Drug Association ACT (ATODA), 'Service Users' Satisfaction and Outcomes Survey 2015: a census of people accessing specialist alcohol and other drug services in the ACT', *ATODA Monograph Series, No.4.*, ATODA, Canberra, 2016.
- ⁸ Alcohol Tobacco and Other Drug Association ACT (ATODA), 'Alcohol and Other Drug Treatment Services in the ACT: 2015-16', *ATODA Monograph Series, No.7*, ATODA, Canberra, 2018.
- ⁹ Australian Institute of Health and Welfare (AIHW), *2015-16 Alcohol and Other Drug Treatment Services National Minimum Data Set data cubes*, viewed between June and August 2017, <http://www.aihw.gov.au/alcohol-and-other-drugs/data/>. [At time of report publication, available at <https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/aodts-2015-16-key-findings/contents/aodts-dynamic-data-displays>"]
- ¹⁰ Australian Institute of Health and Welfare (AIHW), *National Opioid Pharmacotherapy Statistics Annual Data (NOPSAD) collection*, AIHW, 2017, viewed January 2018, <https://www.aihw.gov.au/about-our-data/our-data-collections/nopsad-collection>.
- ¹¹ Alcohol Tobacco and Other Drug Association ACT (ATODA), Submission to the Supreme Court consultation concerning its document 'A Drug and Alcohol Court for the ACT: issues and draft proposals for consultation', October 2017, http://www.atoda.org.au/wp-content/uploads/2018/03/ATODA_submission-SupremeCourt_DAC_IssuesPaper_Final_241017_1.pdf
- ¹² 9 Ritter, A., Berends, L., Chalmers, J., Hull, P., Lancaster, K., Gomez, M. *New Horizons: The review of alcohol and other drug treatment services in Australia*, Drug Policy Modelling Program, National Drug and Alcohol Research Centre, UNSW, Sydney New South Wales, 2014.
- ¹³ JB, Conigrave, KM, Latt, N, Nutt, DJ, Marshall, J, Ling, W & Higuchi, S (eds) 2016, *Addiction medicine*, 2nd edn, Oxford Specialist Handbooks, Oxford University Press.
- ¹⁴ L Gowing, R Ali, A Dunlop, M Farrell, N Lintzeris, *National Guidelines for Medication-Assisted Treatment of Opioid Dependence*, Commonwealth of Australia, Canberra, 2014, <http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/Publishing.nsf/content/ng-mat-op-dep>
- ¹⁵ Alcohol Tobacco and Other Drug Association ACT (ATODA), website, viewed August 2018, www.atoda.org.au
- ¹⁶ 360Edge and Alcohol Tobacco and Other Drug Association ACT (ATODA), The specialist alcohol, tobacco and other drug sector: a description and examination of treatment and support approaches. *ATODA Monograph Series, No.5*, ATODA, Canberra, 2017.

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- ¹⁷ Alcohol Tobacco and Other Drug Association ACT (ATODA), 'Service Users' Satisfaction and Outcomes Survey 2015: a census of people accessing specialist alcohol and other drug services in the ACT', *ATODA Monograph Series, No.4.*, ATODA, Canberra, 2016.
- ¹⁸ Gomez, M., Ritter, A., Gray, D., Gilchrist, D., Harrison, K., Freeburn, B., & Wilson, S., *Adapting the Drug and Alcohol Service Planning Model for Aboriginal and Torres Strait Islander people receiving alcohol, tobacco and other drug services: Components of care and a resource estimation tool*. ACT Health, Canberra, 2014,
<https://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/DASPM%20Aboriginal%20care%20and%20resource%20estimation%20FINAL%20REPORT.pdf>
- ¹⁹ Alcohol Tobacco and Other Drug Association ACT (ATODA), website, viewed August 2018, www.atoda.org.au
- ²⁰ A van der Sterren & C Fowle, 'Reducing smoking in the ACT among Aboriginal and Torres Strait Islander women who are pregnant or who have young children'. *ATODA Monograph Series, No.1.* Alcohol Tobacco and Other Drug Association ACT (ATODA), Canberra, 2015.
- ²¹ Chief Minister, Treasury and Economic Sustainability Directorate, '2016-17 Budget Funding to Address Family Violence' webpage, viewed August 2018, <https://apps.treasury.act.gov.au/budget/budget-2016-2017/budget-booklets/safer-families/funding-to-address-family-violence>
- ²² Alcohol Tobacco and Other Drug Association ACT (ATODA), 'ACT AOD Qualification Strategy' webpage, viewed August 2018, <http://www.atoda.org.au/projects/qs/>
- ²³ Alcohol Tobacco and Other Drug Association ACT (ATODA), 'ACT ATOD Workforce Qualification and Remuneration Profiling Project' webpage, viewed August 2018, <http://www.atoda.org.au/projects/workforce-profile/>
- ²⁴ Intergovernmental Committee on Drugs, *National AOD Drugs Workforce Development Strategy 2015 -18, Canberra, 2015*, [http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/Publishing.nsf/content/C8000B21B6941A46CA257EAC001D266E/\\$File/National%20Alcohol%20and%20Other%20Drug%20Workforce%20Development%20Strategy%202015-2018.pdf](http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/Publishing.nsf/content/C8000B21B6941A46CA257EAC001D266E/$File/National%20Alcohol%20and%20Other%20Drug%20Workforce%20Development%20Strategy%202015-2018.pdf)
- ²⁵ ACT Health, Healthy Canberra, *Australian Capital Territory Chief Health Officer's Report 2018*, ACT Government, Canberra, 2018.
- ²⁶ HSE Health and Wellbeing Alcohol Misuse Group, *HSE Policy on Public Health Information Initiatives related to Alcohol*, HSE, Dublin, 2017, <http://www.lenus.ie/hse/handle/10147/621145>.
- ²⁷ Chief Minister, Treasury and Economic Sustainability Directorate, 'ACT Budget to support a safe and vibrant nightlife in CBR' webpage, viewed August 2018, www.cmtedd.act.gov.au/open_government/inform/act_government_media_releases/gordon-ramsay-mla-media-releases/2017/act-budget-to-support-a-safe-and-vibrant-nightlife-in-cbr
- ²⁸ Foundation for Alcohol Research & Education, End alcohol advertising in sport, Policy Document, viewed August 2018, www.endalcoholadvertisinginsport.org.au/wp-content/uploads/2018/05/POLICY-DOCUMENT.pdf
- ²⁹ Government of Western Australia, Department of Local Government, Sport and Cultural Industries, *Sample alcohol policy*, viewed August 2018, www.dsr.wa.gov.au/support-and-advice/safety-and-integrity-in-sport/alcohol-and-sport/sample-alcohol-policy
- ³⁰ Alcohol and Drug Foundation, Good Sports, website, viewed August 2018, adf.org.au/programs/good-sports/
- ³¹ Mattick, RP *et al.*, 'Association of parental supply of alcohol with adolescent drinking, alcohol-related harms, and alcohol use disorder symptoms: a prospective cohort study', *The Lancet Public Health*, vol. 3, no. 2, pp. e64-e71, 2018.
- ³² ACT Health, Healthy Canberra, *Australian Capital Territory Chief Health Officer's Report 2018*, ACT Government, Canberra, 2018.
- ³³ Alcohol Tobacco and Other Drug Association ACT (ATODA), 'Service Users' Satisfaction and Outcomes Survey 2015: a census of people accessing specialist alcohol and other drug services in the ACT', *ATODA Monograph Series, No.4.*, ATODA, Canberra, 2016.
- ³⁴ Australian Institute of Health and Welfare. *The health of Australia's prisoners 2015*. Cat. No. PHE 207, AIHW, Canberra, 2015
- ³⁵ Australian Bureau of Statistics, *National Aboriginal and Torres Strait Islander Social Survey, Australia, 2014 – 15*, 'Table 23.3 Health risk factor indicators, by state/territory and remoteness area, persons aged 18 years and over—2014 – 15, Proportion of persons', data cube: Excel spreadsheet, cat. no. 4714.0, viewed 7 March 2018, www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4714.02014-15?OpenDocument

-
- ³⁶ Australian National Preventive Health Agency, *Smoking and Disadvantage. Evidence Brief*, Cancer Council Victoria for the Australian National Preventive Health Agency, Canberra, 2013
- ³⁷ V Morgan, A Waterreus, A Mackinnon, JJ McGrath, V Carr et al. *People living with psychotic illness 2010. Report on the second Australian national survey*, DO556, Department of Health and Ageing, Canberra, 2011 Canberra
- ³⁸ Australian Bureau of Statistics, *National Survey of Mental Health and Wellbeing: Summary of Results, 2007*. Cat no.4326.0, ABS, Canberra, 2008
- ³⁹ Australian Bureau of Statistics, *National Health Survey: First Results, 2014 – 15*, Cat no. 4364.0.55.001, ABS, Canberra
- ⁴⁰ A van der Sterren & C Fowle, 'Reducing smoking in the ACT among Aboriginal and Torres Strait Islander women who are pregnant or who have young children'. *ATODA Monograph Series*, No.1. Alcohol Tobacco and Other Drug Association ACT (ATODA), Canberra, 2015.
- ⁴¹ Alcohol Tobacco and Other Drug Association ACT (ATODA), 'Workplace Tobacco Management Project', webpage, viewed August 2018, <http://www.atoda.org.au/projects/tobacco/>
- ⁴² ACT Health, *ACT Aboriginal and Torres Strait Islander Tobacco Control Strategy*, ACT Health, Canberra, 2010, <https://www.health.act.gov.au/sites/default/files/Aboriginal%20and%20Torres%20Strait%20Islander%20Tobacco%20Control%20Strategy%2C%202010-%202014.pdf>
- ⁴³ T Makkai, M Macleod, G Vumbaca, P Hill, D Caldicott, M Noffs, S Tzanetis, F Hansen, *Report on Canberra GTM Harm Reduction Service*, Harm Reduction Australia, 2018, viewed 2 August 2018, <http://www.harmreductionaustralia.org.au/wp-content/uploads/2018/06/Pill-Testing-Pilot-ACT-June-2018-Final-Report.pdf>.
- ⁴⁴ J Buxton, 'Drug Overdose & Alert Partnership: Collaboration and data sharing in an opioid overdose crisis', presentation at the Drugs Research Network Scotland & Glasgow Caledonian University, June 18, 2018, viewed 2 August 2018, https://drns.ac.uk/files/2018/06/Jane_Buxton_Collaboration.pdf.
- ⁴⁵ Alcohol Tobacco and Other Drug Association ACT (ATODA), submission to the Supreme Court consultation concerning its document 'A Drug and Alcohol Court for the ACT: issues and draft proposals for consultation', October 2017, http://www.atoda.org.au/wp-content/uploads/2018/03/ATODA_submission-SupremeCourt_DAC_IssuesPaper_Final_241017_1.pdf.

**APPENDIX: ATODA submission to the February 2018 draft
Drug Strategy Action Plan (by invitation)**



Dr Paul Kelly
Chief Health Officer & Deputy Director General
ACT Health
paul.kelly@act.gov.au
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,

A handwritten signature in black ink, appearing to read 'Carrie Fowlie', written in a cursive style.

Carrie Fowlie
Chief Executive Officer
Alcohol Tobacco and Other Drug Association ACT (ATODA)
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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}

^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

The front material

- 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 alcohol's 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 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	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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.	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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-served 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. 	<ul style="list-style-type: none"> • 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.	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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').		<ul style="list-style-type: none"> 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). 	<ul style="list-style-type: none"> 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.	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> 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 Commonwealth Government, State and	Increase the sustainability, viability and capacity of the ACT AOD treatment and	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 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 <i>Drug and Alcohol Service Planning Model (DASP)</i> 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	<ul style="list-style-type: none"> • 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- 	<ul style="list-style-type: none"> • 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.	<p>design ACT AOD Treatment and Support Framework that reflects good practice across specialist AOD treatment providers.</p> <ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Externally facilitated workshop held between specialist AOD services, blood– 	<ul style="list-style-type: none"> • 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	<p>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.</p> <ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • ACT Health increases investment in subsidised NRT through the existing program offered in specialised AOD services, including investment in smoking 	<ul style="list-style-type: none"> • 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.	<p>cessation for workers providing the program.</p> <ul style="list-style-type: none"> 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. 	<p>NRT/smoking cessation program</p> <ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 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.	<p>needs identified in the audit, including guidelines and application processes.</p> <ul style="list-style-type: none"> • 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. 	<p>house satisfaction surveys)</p> <ul style="list-style-type: none"> • 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.	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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.	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • ACT Health and Justice and Community Safety Directorate, with other stakeholders, to review the implementation of, and revise, the 	<ul style="list-style-type: none"> • 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	<p>Strategic Framework for the Management of Blood-Borne Viruses in the Alexander Maconochie Centre 2013 – 2017.</p> <ul style="list-style-type: none"> • 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. 	<p>the Alexander Maconochie Centre</p> <ul style="list-style-type: none"> • 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:

Establish a new Primary Needle and Syringe Program site

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 underserved 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 will 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. 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)*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' Report⁶¹

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).

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.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 subsidised 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 adolescence¹⁰⁰
- 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 program¹⁰²
- 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

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...' 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 as 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.

- ¹ Ministerial Drug and Alcohol Forum (Australia), *National Drug Strategy 2017-2026*, Department of Health, Canberra, 2017.
- ² T Babor, JP Caulkins, G Edwards, B Fischer, DR Foxcroft, K Humphreys, IS Obot, J Rehm, P Reuter, R Room, I Rossow & J Strang, *Drug policy and the public good*, Oxford University Press, Oxford, 2010
- ³ TF Babor, R Caetano, S Casswell, G Edwards, N Giesbrecht, K Graham, JW Grube, L Hill, H Holder, R Homel, M Livingston, E Osterberg, J Rehm, R Room & I Rossow, *Alcohol: no ordinary commodity - research and public policy*, 2nd edn, OUP, Oxford, 2011.
- ⁴ MAR Kleiman, JP Caulkins & A Hawken, A, *Drugs and drug policy: what everyone needs to know*, Oxford University Press, Oxford, 2011.
- ⁵ A Ritter, R McLeod & M Shanahan, *Government drug policy expenditure in Australia - 2009/10, with addendum dated 20 August 2013*, DPMP Monograph Series no. 24, National Drug and Alcohol Research Centre, Sydney, 2013.
- ⁶ D McDonald, 'Australian governments' spending on preventing and responding to drug abuse should target the main sources of drug-related harm and the most cost-effective interventions', *Drug and Alcohol Review*, vol. 30, no. 1, pp. 96-100, 2011
- ⁷ P Dugdale, email, 2 February 2018.
- ⁸ See multiple media and other public domain references
- ⁹ NSW Council of Social Services (NCOSS), *Principles of Co-design*, NCOSS, Woolloomooloo, 2017, <https://www.ncoss.org.au/sites/default/files/public/resources/Codesign%20principles.pdf>
- ¹⁰ Alcohol Tobacco and Other Drug Association ACT (ATODA), *ACT Alcohol and Other Drug Safer Families Program 2017 – 2021: Design, Model, Implementation Plan and Evaluation Framework*, ATODA, Canberra, 2017, <http://www.atoda.org.au>
- ¹¹ Alcohol Tobacco and Other Drug Association ACT, *Review and re-design of alcohol and other drug withdrawal services in the ACT*, website, viewed 18 March 2018, www.atoda.org.au/policy/withdrawal-review/
- ¹² D McDonald, *Can we impact positively on apparently intractable social problems through improved social policy to address the currently illegal drugs?*, Roundtable on The Social Impact of Australian Drug Laws March 2018, background paper, Australia21, Canberra, 2018, pp. 12-13.
- ¹³ Ministerial Council on Drug Strategy, *National Drug Strategy 2010 – 2015. A framework for action on alcohol, tobacco and other drugs*, Department of Health, Canberra, [2011].
- ¹⁴ ACT Health, *ACT Health Territory Wide Health Services Framework 2017-2027*, ACT Government, Canberra, 2017.
- ¹⁵ Australian Institute of Health and Welfare, *Impact of alcohol and illicit drug use on the burden of disease and injury in Australia: Australian Burden of Disease Study 2011*, AIHW, Canberra, 2018
- ¹⁶ ACT Health, *ACT Alcohol, Tobacco and Other Drug Strategy 2010 – 2014*. ACT Government, Canberra, 2010.
- ¹⁷ Penington Institute, *Australia's Annual Overdose Report 2017*, A Penington Institute report, Penington Institute, Melbourne, 2017, p. 2.
- ¹⁸ A Roxburgh & L Burns, *Accidental drug-induced deaths due to opioids in Australia, 2013*, National Drug and Alcohol Research Centre, Sydney, 2017.
- ¹⁹ A Olsen, D McDonald, S Lenton & P Dietze., *Independent evaluation of the 'Implementing Expanded Naloxone Availability in the ACT (I-ENAACT) Program, 2011-2014; final report*, ACT Health, Canberra, 2015.
- ²⁰ e.g. National Drug Strategy (Australia), *National Heroin Overdose Strategy*, Dept. of Health and Aged Care, Canberra, 2001; RP Ogeil, et al., 'Pharmaceutical opioid overdose deaths and the presence of witnesses', *Int J Drug Policy*, vol. 55, 2018, pp. 8-13; US Centers for Disease Control and Prevention <https://www.cdc.gov/drugoverdose/prevention/index.html> ; WD Hall, 'How can we reduce heroin "overdose" deaths? [editorial]', *Medical Journal of Australia*, vol. 164, no. 4, 1996, pp. 197-8.
- ²¹ Standing Committee on Transport, *National Road Safety Strategy 2011–2020*, Commonwealth Department of Infrastructure and Transport, [Canberra], 2011.
- ²² R Homel, *Policing and punishing the drinking driver: a study of general and specific deterrence*, Research in Criminology, Springer-Verlag, New York, 1988.
- ²³ J Ferris, et al., *A national examination of random breath testing and alcohol-related traffic crash rates (2000-2015)*, Foundation for Alcohol Research and Education, Canberra, 2015.
- ²⁴ L Cobiac, et al., 'Cost-effectiveness of interventions to prevent alcohol-related disease and injury in Australia', *Addiction*, vol. 104, no. 10, 2009, pp. 1646-55.
- ²⁵ ACT Government, Justice and Community Safety Directorate, *ACT criminal justice statistical profile*, ACT Department of Justice and Community Safety, bi-annually.
- ²⁶ ACT Government, Justice and Community Safety Directorate, *ACT criminal justice statistical profile*.
- ²⁷ A Wodak & D McDonald, *What would effective, fair and just drug-driving laws look like?*, The Conversation, 26 February, 2016, <https://theconversation.com/what-would-effective-fair-and-just-drug-driving-laws-look-like-55379>.
- ²⁸ JA Quilter & L McNamara, "'Zero tolerance" drug driving laws in Australia: a gap between rationale and form?', *International Journal for Crime, Justice and Social Democracy*, vol. 6, no. 3, 2017, pp. 47-71.
- ²⁹ M Kemp, 'Random breath testing for alcohol more important than drug testing of motorists, Centre for Automotive Safety Research report finds', *The Advertiser*, 20 October 2014.

- ³⁰ Australian Bureau of Statistics, *Australian Capital Territory Records the Nations Largest Population Growth*, media release, ABS, Canberra, 27 June 2017, <http://www.abs.gov.au/ausstats/abs@.nsf/lookup/Media%20Release8>
- ³¹ ACT Health, website, viewed 19 March 2018, <http://www.health.act.gov.au/public-information/consumers/health-infrastructure-program>
- ³² M Fitzharris MLA, *New Walk in Centre to provide better healthcare in our suburbs*, media release, ACT Government, Canberra, 31 May 2017, https://www.cmtedd.act.gov.au/open_government/inform/act_government_media_releases/meegan-fitzharris-mla-media-releases/2017/new-walk-in-centres-to-provide-better-health-care-in-our-suburbs
- ³³ ACT Government, *Australian Capital Territory Infrastructure Plan Update 2016-17*, Chief Minister, Treasury and Economic Development Directorate, Canberra, 2017, https://apps.treasury.act.gov.au/___data/assets/pdf_file/0004/1034482/Infrastructure-Plan-Update-2016-17.pdf
- ³⁴ ACT Health, *ACT Health Territory Wide Health Services Framework 2017-2027*, ACT Government, Canberra, 2017.
- ³⁵ Victorian Department of Human Services, *National Needle and Syringe Programs Strategic Framework 2010-2014*, Commonwealth of Australia, Canberra, 2010.
- ³⁶ Alcohol Tobacco and Other Drug Association ACT, *Implementing a needle and syringe program in the Alexander Maconochie Centre: ATODA submission to the ACT Government on the Moore Report consultation*, ATODA, Canberra, 2011.
- ³⁷ National Centre in HIV Epidemiology and Clinical Research, *Return on investment 2: evaluating the cost-effectiveness of needle and syringe programs in Australia*, National Centre in HIV Epidemiology and Clinical Research, The University of New South Wales, Sydney, 2009.
- ³⁸ Victorian Department of Human Services, *National Needle and Syringe Programs Strategic Framework 2010-2014*, Commonwealth of Australia, Canberra, 2010.
- ³⁹ Australian National Council on Drugs, *ANCD Position Paper Needle and Syringe Programs*, ANCD, Canberra, October 2013, http://www.atoda.org.au/wp-content/uploads/pp_NSPs1.pdf
- ⁴⁰ Victorian Department of Human Services, *National Needle and Syringe Programs Strategic Framework 2010-2014*, Commonwealth of Australia, Canberra, 2010.
- ⁴¹ Australian National Council on Drugs, *ANCD Position Paper Needle and Syringe Programs*, ANCD, Canberra, October 2013, http://www.atoda.org.au/wp-content/uploads/pp_NSPs1.pdf
- ⁴² L Gowing, R Ali, A Dunlop, M Farrell & N Lintzeris, *National Guidelines for Medication-Assisted Treatment of Opioid Dependence*, Commonwealth of Australia, Canberra, 2014.
- ⁴³ Intergovernmental Committee on Drugs (IGCD), *National Pharmacotherapy Policy for people dependent on opioids*, IGCD, Canberra, 2007
- ⁴⁴ R Mattick, E Digiusto, C.M. Doran, S O'Brien, M Shanahan, J Kimber, N Henderson, C Breen, J Shearer, J Gates, A Shakeshaft & NEPOD Trial Investigators, *National Evaluation of Pharmacotherapies for Opioid Dependence: report of results and recommendations*, National Drug and Alcohol Research Centre, Sydney, 2001
- ⁴⁵ Australian Institute of Health and Welfare, Supplementary Tables, *National opioid pharmacotherapy statistics (NOPSAD) 2016*, AIHW, Australian Government, Canberra, 2017.
- ⁴⁶ Australian Bureau of Statistics, *Recorded crime, offenders, 2016-17*, cat. no. 4519.0, Australian Bureau of Statistics, Canberra, data cubes Table 14, www.abs.gov.au/ausstats/abs@.nsf/mf/4519.0 2018.
- ⁴⁷ Hughes, C, Shanahan, M, Ritter, A, McDonald, D & Gray-Weale, F, *Evaluation of Australian Capital Territory drug diversion programs*, DPMP Monograph Series no. 25, Drug Policy Modelling Program, National Drug and Alcohol Research Centre, The University of New South Wales, Sydney, 2014.
- ⁴⁸ Australian Institute of Health and Welfare, *Alcohol and other drug treatment services in Australia 2014-15*, AIHW, Australian Government, Canberra, 2016.
- ⁴⁹ Alcohol Tobacco and Other Drug Association ACT, *Review and re-design of alcohol and other drug withdrawal services in the ACT*, webpage, viewed 16 March 2018, <http://www.atoda.org.au/policy/withdrawal-review/>
- ⁵⁰ L Jenner, *Forum 3: ACT Alcohol and other drug withdrawal services review and re-design project*, presentation, University House, Australian National University, Canberra, 8 December 2016.
- ⁵¹ L Berends, 'Pathways of care', in P Haber, C Day & MP Farrell (eds), *Addiction medicine: principles and practice*, IP Communications, Melbourne, pp. 64-73.
- ⁵² A Barr, S Rattenbury & C Le Couteur, *Parliamentary agreement for the 9th Legislative Assembly for the Australian Capital Territory*, Chief Minister, Treasury and Economic Development Directorate, Canberra, 2016.
- ⁵³ N Feely, personal communication from ACT Health, email received 8 December 2017.
- ⁵⁴ ACT Health, *ACT Health Territory Wide Health Services Framework 2017-2027*, ACT Government, Canberra, 2017.
- ⁵⁵ A Ritter, L Berends, J Chalmers, P Hull, K Lancaster, M Gomez, *New Horizons: The review of alcohol and other drug treatment services in Australia*, National Drug and Alcohol Research Centre, UNSW, Sydney, 2014.
- ⁵⁶ Ritter et al., *New Horizons: The review of alcohol and other drug treatment services in Australia*.
- ⁵⁷ NSW Ministry of Health, *Drug and Alcohol Service Planning Model for Australia. Population-based planning for Drug and Alcohol Service Development*, NSW Ministry of Health, North Sydney, 2013, http://parlinfo.aph.gov.au/parlInfo/download/publications/tables/papers/5766a0ce-dbc0-405d-9118-3335bb8b2617/upload_pdf/ATT%20B%20-%20Technical%20Manual_Final_V4.15_2013_4%20final.pdf;fileType=application%2Fpdf#search=%22publications/tables/papers/5766a0ce-dbc0-405d-9118-3335bb8b2617%22

- ⁵⁸ NSW Ministry of Health, *Drug and Alcohol Service Planning Model for Australia. Population-based planning for Drug and Alcohol Service Development*
- ⁵⁹ NSW Ministry of Health, *Drug and Alcohol Service Planning Model for Australia. Population-based planning for Drug and Alcohol Service Development*
- ⁶⁰ Ritter et al., *New Horizons: The review of alcohol and other drug treatment services in Australia*.
- ⁶¹ Ritter et al., *New Horizons: The review of alcohol and other drug treatment services in Australia*.
- ⁶² S Ettner et al., Benefit-cost in the California treatment outcome project: does substance abuse treatment "pay for itself"? *Health Services Research*, vol. 41, no.1, pp. 192-213, 2016 cited in A Ritter, L Berends, J Chalmers, P Hull, K Lancaster & M Gomez, *New Horizons: The review of alcohol and other drug treatment services in Australia*, Drug Policy Modelling Program, National Drug and Alcohol Research Centre, UNSW, Sydney, 2014.
- ⁶³ Ritter et al., *New Horizons: The review of alcohol and other drug treatment services in Australia*.
- ⁶⁴ ACT Health, *ACT Health Territory Wide Health Services Framework 2017-2027*, ACT Government, Canberra, 2017.
- ⁶⁵ Alcohol Tobacco and Other Drug Association ACT, *ACT Alcohol, Tobacco and Other Drug Services Directory v15*, website, viewed 19 March 2018, www.directory.atoda.org.au
- ⁶⁶ Hepatitis ACT, *Hepatitis C*, webpage, viewed 19 March 2018, <http://hepatitisact.com.au/about-hepatitis/hepatitis-c/>
- ⁶⁷ Victorian Department of Human Services, *National Needle and Syringe Programs Strategic Framework 2010-2014*, Commonwealth of Australia, Canberra, 2010.
- ⁶⁸ NSW Users and Aids Association (NUAA), *Hepatitis C Treatment and Support*, website, viewed 19 March 2018, <https://nuaa.org.au/treatment-access/hepatitis-c-treatment-support/>
- ⁶⁹ The Kirby Institute, *Monitoring hepatitis C treatment uptake in Australia (Issue 7)*, The Kirby Institute, UNSW Sydney, Sydney, NSW, July 2017
- ⁷⁰ J MacLachlan, L Thomas, B Cowie * N Allard, *Hepatitis C Mapping Project: Estimates of geographic diversity in chronic hepatitis C prevalence, diagnosis, monitoring and treatment – National Report 2016*, Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine (ASHM), Darlinghurst, New South Wales, 2018.
- ⁷¹ L Metherell, *Hepatitis C drugs not being accessed by thousands of Australians with the disease*, media release, Hepatitis Australia, Canberra, 12 February 2018.
- ⁷² S McGregor, H McManus & R Gray, *HIV, viral hepatitis and sexually transmissible infections in Australia Annual Surveillance Report 2016*, The Kirby Institute, UNSW Sydney, Sydney, NSW, 2016.
- ⁷³ Australian Society for HIV, Viral Hepatitis and Sexual Health Medicine (ASHM), *Hepatitis C in Drug and Alcohol Settings Education Program*, training flyer, viewed 19 March 2018, http://www.hnecphn.com.au/media/14054/hepatitis-c-in-drug-and-alcohol-settings-education_flyer_newcastleapril2.pdf
- ⁷⁴ Alcohol Tobacco and Other Drug Association ACT, *Service Users' Satisfaction and Outcomes Survey 2015: a census of people accessing specialist alcohol and other drug services in the ACT, ATODA Monograph Series, No.4*, ATODA, Canberra, 2016.
- ⁷⁵ ACT Health, *Hepatitis B, Hepatitis C, HIV and Sexually Transmissible Infections. ACT Statement of Priorities 2016 – 2020*. ACT Government, Canberra, 2016.
- ⁷⁶ ACT Health, *Healthy Canberra*, Australian Capital Territory Chief Health Officer's Report 2016, ACT Government, Canberra, 2016.
- ⁷⁷ Alcohol Tobacco and Other Drug Association ACT, *Service Users' Satisfaction and Outcomes Survey 2015: a census of people accessing specialist alcohol and other drug services in the ACT*.
- ⁷⁸ C Cookson, J Strang, E Ratschen, G Sutherland, E Finch & A McNeill, 'Smoking and its treatment in addiction services: clients' and staff behaviour and attitudes', *BMC Health Services Research*, vol. 14, pp304, 2014.
- ⁷⁹ M Khara and C Okoli, 'The tobacco-dependence clinic: intensive tobacco-dependence treatment in an addiction services outpatient setting', *The American Journal on Addictions*; vol 20, no1., pp.45–55, 2010.
- ⁸⁰ C Carlsten, A Halperin, J Crouch & W Burke, 'Personalised medicine and tobacco-related health disparities: is there a role for genetics?', *Annals of Family Medicine*, vol. 9, no.4, 2011
- ⁸¹ K Mikhailovich & P Morrison, 'An evaluation of a smoking cessation program for special populations in Australia', *Journal of Smoking Cessation*, vol. 3, no.1, pp.50–56, 2008.
- ⁸² LF Stead, R Perera, C Bullen, D Mant, J Hartmann-Boyce, K Cahill & T Lancaster, 'Nicotine replacement therapy for smoking cessation'. *Cochrane Database of Systematic Reviews* DOI: 10.1002/14651858.CD000146.pub4, 2012.
- ⁸³ Zwar et al, *Supporting smoking cessation: a guide for health professionals*, The Royal Australian College of General Practitioners, Melbourne, 2014.
- ⁸⁴ Pharmaceutical Benefits Scheme, 'PBS Schedule search for nicotine', viewed 23 March 2018, www.pbs.gov.au/pbs/search?term=nicotine&analyse=false&search-type=medicines
- ⁸⁵ A Ellerman, C Ford & S Stillman, 'Smoking Cessation' in MM Scollo and MH Winstanley (eds), *Tobacco in Australia: Facts and issues*. Cancer Council Victoria, 2016 (updated by E Greenhalgh)
- ⁸⁶ D Apollonio, R Philipps & L Bero L, 'Interventions for tobacco use cessation in people in treatment for or recovery from substance use disorders', *Cochrane Database of Systematic Reviews*, Issue. 11. Art. No.:CD010274, DOI:10.1002/14651858.CD010274.pub2., 2016
- ⁸⁷ JJ Prochaska, K Delucchi, K. & SM Hall, 'A meta-analysis of smoking cessation interventions with individuals in substance abuse treatment or recovery'. *Journal of Consulting and Clinical Psychology*, vol. 72, pp.1144–56, 2004.

- ⁸⁸ SL Thurgood, A McNeill & D Clark-Carter, 'A systematic review of smoking cessation interventions for adults in substance abuse treatment or recovery'. *Nicotine & Tobacco Research*, vol. 1-10. doi:10.1093/ntr/ntv127, 2015
- ⁸⁹ Apollonio et al, 'Interventions for tobacco use cessation in people in treatment for or recovery from substance use disorders'.
- ⁹⁰ ATODA, 'Workplace Tobacco Management' webpage, viewed 18 May 2017, <http://www.atoda.org.au/projects/tobacco/>
- ⁹¹ Alcohol Tobacco and Other Drug Association ACT, unpublished data, (ATODA), 2018
- ⁹² Victoria State Government Department of Health and Human Services, *2016 – 17 Alcohol and Other Drug Facilities Renewal Grants. Guidelines*, 2016, viewed 26 March 2018, <https://www2.health.vic.gov.au/alcohol-and-drugs/funding-and-reporting-aod-services/renewal-grants>
- ⁹³ Ministerial Drug and Alcohol Forum (Australia), *National Drug Strategy 2017-2026*.
- ⁹⁴ Australian Government Department of Social Services, *Community Capacity Building grant funding. Fact sheet*, 2014, viewed 27 March 2018, www.dss.gov.au/sites/default/files/documents/06_2015/communitycapacitybuilding_fact.pdf
- ⁹⁵ F Faggiano, et al., 'Universal school-based prevention for illicit drug use', *Cochrane Database Syst Rev*, no. 12, 2014, p. CD003020.
- ⁹⁶ T Babor, et al., *Drug policy and the public good*, Oxford University Press, Oxford, 2010.
- ⁹⁷ TF Babor, et al., *Alcohol: no ordinary commodity - research and public policy*, 2nd edn, OUP, Oxford, 2010.
- ⁹⁸ NK Lee, et al., *Alcohol education for Australian schools: a review of the evidence*, National Centre for Education and Training on Addiction., Adelaide, 2014.
- ⁹⁹ M Teesson, NC Newton & EL Barrett, 'Australian school-based prevention programs for alcohol and other drugs: a systematic review', *Drug Alcohol Rev*, vol. 31, no. 6, 2012, pp. 731-6.
- ¹⁰⁰ L Vogl, et al., *Climate Schools: universal computer-based programs to prevent alcohol and other drug use in adolescence*, Technical Report no. 321, National Drug & Alcohol Research Centre, UNSW, Sydney, 2012.
- ¹⁰¹ R Midford, et al., 'Alcohol prevention for school students: results from a 1-year follow up of a cluster-randomised controlled trial of harm minimisation school drug education', *Drugs: education, prevention and policy*, vol. online ahead of print, 2017.
- ¹⁰² NC Newton, et al., 'The long-term effectiveness of a selective, personality-targeted prevention program in reducing alcohol use and related harms: a cluster randomized controlled trial', *Journal of Child Psychology and Psychiatry*, vol. 57, no. 9, 2016, pp. 1056-65.
- ¹⁰³ N McBride, et al., 'Harm minimization in school drug education: final results of the School Health and Alcohol Harm Reduction Project (SHAHRP)', *Addiction*, vol. 99, no. 3, 2004, pp. 278-91.
- ¹⁰⁴ Australian Institute of Health and Welfare, *Alcohol and other drug treatment services in Australia 2015–16*, AIHW, Canberra, 2017, p. 2.
- ¹⁰⁵ Australian Institute of Health and Welfare, *Alcohol and other drug treatment services in Australia 2015-16: state and territory summaries*, Drug Treatment Series No. 29, cat no. HSE 187, AIHW, Canberra, [2017].
- ¹⁰⁶ ACT Human Rights Commission, *Review of the opioid replacement treatment program at the Alexander Maconochie Centre: report of the ACT Health Services Commissioner, March 2018*, the author, Canberra, 2018.
- ¹⁰⁷ *Canberra Times*, 15 March 2018.
- ¹⁰⁸ M Moore & M Walker, *Balancing access and safety: meeting the challenge of blood borne viruses in prison; Report for the ACT Government into implementation of a Needle and Syringe Program at the Alexander Maconochie Centre*, Public Health Association of Australia, Canberra, 2011.
- ¹⁰⁹ B Harkness, et al., 'Why is there still hepatitis C transmission in Australian prisons? A case report', *Harm Reduction Journal*, vol. 14, no. 1, 2017, pp. 75.

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
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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,



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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.

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

*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. <i>Develop interventions for groups with entrenched smoking behaviours as identified in the National Tobacco Strategy 2012-2018</i>	ACT Health		D, H, P
6. <i>Maintain a focus on Aboriginal & Torres Strait Islander smoking interventions</i>	ACT Health		D, H, P
7. <i>Finalise evaluation of relevant programs relating to smoking, including the Smoking in Pregnancy program</i>	ACT Health		D, H, P
8. <i>Consider the need for additional smoke-free areas.</i>	ACT Health		H
9. <i>Support enforcement of tobacco and smoke-free legislation in the ACT</i>	Access Canberra		H
10. <i>Consider emerging issues in tobacco control and respond as required</i>	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. <i>Develop and implement an ACT Drug Driving Strategy</i>	JaCSD	ACT Health, ACT Policing	D, H
12. <i>ACT Government will focus on raising public awareness about roadside drug testing and the known effects of drugs on the driving task.</i>	JaCSD		H
13. <i>Review and implement potential diversion strategies such as an ACT Drug and Alcohol Court</i>	JaCSD	ACT Health, ACT Policing	D, S, H
14. <i>Increase the capacity of specialist alcohol and other drug treatment services to deliver programs that integrate best practice in domestic and family violence prevention</i>	ACT Health	CSD	H, P
15. <i>Continue to support evidence-based prescription treatment programs such as naloxone and medicinal cannabis</i>	ACT Health		D, H
16. <i>Develop the Drugs and Poisons Information System to introduce online approvals and a remote access portal</i>	ACT Health		S, H
17. <i>Support all specialist alcohol and other drug treatment services to become Community Work and Social Development Order Program providers</i>	JaCSD		H, P

18. <i>Provide training and capacity building initiatives for alcohol, tobacco and other drugs in areas such as domestic and family violence services</i>	<i>ACT Health</i>		<i>H, P</i>
19. <i>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</i>	<i>ACT Education Directorate</i>	<i>ACT Health</i>	<i>D, P</i>
20. <i>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</i>	<i>ACT Health</i>	<i>JaCSD ACT Policing</i>	<i>S, H</i>
21. <i>Continue to explore opportunities to introduce harm reduction measures (including pill testing).</i>	<i>ACT Health</i>	<i>ACT Policing</i>	<i>H</i>
22. <i>Reduce blood-borne viral infections due to injecting drug use</i>	<i>ACT Health</i>		<i>D, H, P</i>
23. <i>Consider emerging issues in drug control and respond as required"</i>	<i>ACT Health</i>	<i>ACT Policing</i>	<i>D, H, P</i>