Mr Andrew Barr MLA
ACT Treasurer
Email: BudgetConsultation@act.gov.au

Submission to the ACT Budget 2021-22 Consultation

Dear Mr Barr MLA,

The Alcohol Tobacco and Other Drug Association ACT (ATODA) would like to thank the ACT Government for the opportunity to provide a submission to the public consultation for the ACT Budget 2021 – 2022.

ATODA is the peak body for the alcohol, tobacco and other drug sector in the ACT and seeks to promote health through preventing and reducing alcohol, tobacco and other drug related harms.

ATODA recognises the current post-COVID funding environment is tight. There is also an urgent need to meet the Government's election commitments to Alcohol and Other Drug (AOD) services and fund a reasonable portion of these in 2021-22. Early investment will position the sector to recruit new staff, increase and diversify services to meet current and future demand, and audit existing infrastructure to plan for much needed upgrades. Funding the final request will go a long way to addressing the largest modifiable contributor to ill health in the ACT population – tobacco consumption – and provide a saving of health and social costs conservatively estimated at $2.6 for every $1 invested in the first year.

Summary of costed funding priorities proposed

Priority area	Description	Costings
1. Meet Labor's election commitments	Conduct a comprehensive audit of residential rehabilitation infrastructure.	$400,000 (estimate)
2. Meet the Green's election commitments	Boost **funding by 50%** for specialist AOD treatment and harm reduction services to meet current demand and start scaling up to meet future demand.	$10m on top of estimated 2020-21 funding of $20m per annum
3. Preventing chronic disease and death	Upscale successful *"We Can Program"* and significantly reduce tobacco-associated disease burden among users of AOD specialist services.	$2m

We are happy for this submission to be made public. Please do not hesitate to contact ATODA if you have any queries or require further information in support of this submission.

Yours sincerely

Devin Bowles

Dr Devin Bowles

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

Submission to the ACT Budget Consultation 2021-22

Prioritising election commitments and sound investments

1. Introduction

ATODA leads and influences positive outcomes in policy, practice and research, as the peak body for the alcohol, tobacco and other drug sector in the ACT. ATODA welcomes the ACT Government's overall approach of taking 'a harm minimisation approach to drug and alcohol policy, treating drug use as a health issue rather than a criminal matter', and identifying this as the 'key value underpinning the ACT Drug Strategy Action Plan 2018-2021'.[1] We also welcome the funding and policy commitments made by Labor[1] and the Greens in their Policy Platform for the 10th Assembly[2] to increase support for alcohol and other drugs services over the current Assembly.

In Canberra, the alcohol, tobacco and other drug (ATOD) sector provides a wide variety of high-quality services to different client groups experiencing issues with alcohol, tobacco, or other drugs. The organisations providing services meet a series of quality activities that constitute a quality framework, for example meeting national accreditation standards as required, and employ staff who are required to obtain at least an AOD-specific Certificate IV. However, the sector is at capacity: current waiting times for some services are long, and service providers are often only able to provide low intensity treatment options to clients assessed as needing high intensity treatment. For more evidence on the essential role the AOD sector plays in minimising harm, the quality of the Canberra AOD sector, and how chronic underfunding means that it is unable to meet demand, please see Appendix 1. Current demand significantly outstrips capacity, and a significant boost in funding is needed.

We welcome the proposed Private Member's *Drugs of Dependence (Personal Use) Amendment Bill 2021* (hereafter referred to as 'the Bill') and its overall intent to decriminalise a range of illicit drugs. We also note the inclusion of AOD programs, policy and funding in the associated Inquiry's Terms of Reference. This is highly appropriate as decriminalisation will result in more people feeling comfortable to seek treatment for illicit drug use. However, this will also increase demand on an already overstretched service sector as people with long-standing AOD issues feel able to seek treatment.

2. This submission in context

The ACT Government has made several commitments to enhance AOD services in the current parliamentary period. These are articulated in Labor's Health Policy Position statement[1] and the Greens Policy Platform for the 10th Assembly.[2]

The commitments include:

- Renew residential rehabilitation infrastructure of NGO service providers (Labor).
- Consider expansion in provision of intensive non-residential rehabilitation supports (Labor).
- Introduce permanent pill testing at all ACT festivals (Labor), as well as other sites (Greens).
- Enhance drug diversion pathways for law enforcement (Greens).
- Construct and operate an Aboriginal Community Controlled drug and alcohol rehabilitation facility (Labor).
- Pilot a safe drug consumption site (Greens).

- Double funding for services to address drug and mental health co-morbidity (Greens).

The current funding environment is tight, and the government will need to be deliberate about how it finances its election commitments across the Legislative Assembly's term. However, given the context of substantial unmet demand for drug treatment and harm reduction, and its projected rise with decriminalisation, it is imperative that the government funds a significant portion of its AOD commitments in 2021-22. Early investment will position the sector to recruit new staff, increase services and diversify them to meet rising and evolving demands.

We note high levels of scrutiny on service delivery performance and funding in this area associated with the current Inquiry. Failure to follow through on its election commitments could leave the Government vulnerable to criticism. This is especially true in the context of the Bill and the potential partial decriminalisation of many illicit drugs. Without increased funding for AOD treatment and harm reduction, there is a risk that some people will not correctly understand decriminalisation to be a health measure.

3. ATODA's budget requests

Previous national research indicates that investment in the AOD sector would need to at least double to meet demand for treatment and harm reduction services.[3] This Budget submission has triaged possible investments in the AOD system and elevated those which are politically urgent and which provide a clear financial return on investment.

Modelling shows that AOD treatment and harm reduction services are a good investment. One analysis found that for every $1 invested in alcohol and other drug treatment, society gains $7.[4] Other studies have found similarly favourable cost-effective ratios across AOD treatment services and harm reduction programs.[5-7]

Funding the first two requests below will position the system to better address current demand as well as future increases in demand following decriminalisation of illicit drugs. The proposed 50% increment in funding for service provision this financial year will help prepare the AOD sector for the changes needed to meet future demand, allowing for recruitment and training of new staff, extension of existing programs. It will also enable the government's other most urgent AOD election commitments. Similarly, the proposed infrastructure audit will provide a comprehensive review of the condition of existing residential rehabilitation infrastructure and a costed plan to inform necessary upgrades.

Funding the third request will go a long way to addressing the largest modifiable contributor to ill health in the ACT population – tobacco consumption. It would upscale a proven program for helping people seeking help for alcohol and other drug use to quit smoking, yielding high medium-term impacts on the overall budget. It is a highly cost-effective approach to reducing direct and indirect disease impacts on people who smoke, their carers, and the broader social and health systems.

i) Fund Labor's election commitments

Several of Labor's election commitments for the 10th term of the Legislative Assembly should receive prioritised funding in 2021-22, rather than later years. This includes an infrastructure audit, an expansion of non-residential rehabilitation, and permanent pill testing at all major festivals as a prelude to permanent pill testing facilities.

Labor's commitment to 'work with (NGO service) providers… to consider ways to renew their residential rehabilitation infrastructure.' This commitment recognises that the buildings used for AOD residential rehabilitation treatment by many of the service providers are in a poor state of repair and/or not fit for purpose. Specifically, we recommend that an audit of treatment infrastructure is prioritised. This should include *all* the sites of AOD residential rehabilitation, not just those owned by the ACT Government. It should engage expertise in construction, clinical services and demographic modelling to recommend enhancements fit for current and projected future demand over a 20-year time horizon. Future-planning is important due to the longevity of built infrastructure. It should result in a costed plan for addressing gaps and implementing the upgrades to infrastructure recommended.

While built infrastructure deficits are being assessed, it is critical to fund other treatment modalities. Funding Labor's commitment to consider expansion of intensive non-residential rehabilitation supports will be critical given the limited availability of residential rehabilitation beds currently. Specialist AOD services report that they have reached full capacity for most residential programs and cannot offer further places for several weeks or months (see Appendix 1 for further detail).

An evaluation of pill testing at the 2019 Groovin the Moo festival found that it was well received, and impacted positively on patron knowledge, attitudes and behaviours.[8] After limited opportunities for major festivals due to COVID-19 and the bushfires, it is likely that the next festival season in the summer and autumn of 2021-22 will be a big one. There is the risk of a strong rebound effect in drug consumption in this context, so funding pill testing to occur will be especially important to protect the health of young people in the ACT. Continuing pill-testing at a growing range of festivals and other events in the next financial year will enhance the ACT's capacity for permanent pill testing infrastructure in subsequent years.

We also note and welcome progress on the following commitments and understand funding to progress these is in train as "new money", given stretched resources throughout the sector:

- Increase availability of opioid replacement treatment in the north of Canberra – including through ongoing operation of the new public Opioid Treatment Service (OTS) at the Belconnen Community Health Centre ($3m committed over 4 years).
- Feasibility of a simple offence notice for some drugs of dependency.
- Construction and operation of an Aboriginal Community-Controlled drug and alcohol rehabilitation facility.

Recommendation 1: Fund Labor's election commitments

1.1 Conduct a comprehensive audit of residential rehabilitation infrastructure to inform decision-making and planning to make it fit-for-purpose now and into the future. Estimated cost: **$400,000.**

1.2 Expand provision of intensive non-residential rehabilitation supports through additional funding.

1.3 Introduce permanent pill testing at all ACT festivals through additional funding.

ii) Fund the Green's election commitments

Several of the Green's election commitments should also be prioritised for funding in 2021-22. These include piloting a safe drug consumption site, enhancing drug diversion pathways for law enforcement, introducing permanent pill testing at all ACT festivals and other sites (discussed above), and beginning the four-year process of doubling funding to the AOD treatment sector.

ATODA supports the findings of the recent feasibility study into the establishment of a supervised drug consumption site. It is important to develop a model which matches the ACT's unique context, meeting drug user needs while optimising opportunities to connect to and layer on relevant services and ensuring value for money. ATODA notes the expense of a medicalised model and recommends a nurse- or peer-led model which emphasises the provision of other harm reduction services. Design should be largely consumer driven.

The ACT Government is currently trialling a Drug and Alcohol Sentencing List (DASL, or drug court). While formal evaluation is ongoing, anecdotal evidence suggests that it is successful in enhancing the lives of participants. Funding for participating AOD services expires at the end of this financial year. Funding should be urgently continued and expanded to consider the full costs of service delivery and unmet demand. Funding should also be allocated to the AOD sector for services that the recently establish Therapeutic Care Court will likely request.

Increasing funding will boost services at a time when there is already a significant gap between capacity and demand. This gap is demonstrated by long waiting times for many treatment services, and by national modelling which recommends a doubling of capacity.[3] It is critical that there is a significant boost in baseline funding levels for the AOD sector in the 2021-22 budget to support investment to enlarge the workforce, and to extend and diversify services.

Changes in policy likely to arise from the Bill will increase demand further as more people are diverted towards treatment by the police, and greater numbers of people feel comfortable to seek treatment. It is also important that the Government demonstrates visible commitment to a health-based approach to enhance interpretation of the Bill's intent.

Recommendation 2: Fund the Green's election commitments

2.1 Fund a nurse- or peer-led drug consumption site.

2.2 Urgently continue and expand funding for the Drug and Alcohol Sentencing list, budgeted appropriately for the true cost of service delivery, and fund AOD service participation in the Therapeutic Care Court.

2.3 Boost **funding by 50%** for specialist alcohol and other drug (AOD) treatment and harm reduction services above the 2020-2021 allocation to allow service providers to meet current demand and start scaling up to meet future demand. Each of the above recommendations can be funded from this pool of money. Additional monies can be disbursed through the Health Directorate's commissioning processes.

iii) Scale-up funding for AOD clients to quit smoking

Of all modifiable risk factors, tobacco use contributes the most burden of disease in Australia (9.3%).[9] The overall daily smoking rate in the ACT is 8.3% (aged 15 and over).[10] Using the latest available Australian Bureau of Statistics population figures,[11] this equates to an estimated 28,900 people who still smoke in the ACT, as shown in Table 1.

*Table 1. Prevalence of smoking in ACT**

Entity	Daily smoking prevalence* (%)	Population (million)*	Estimated number of smokers (000)
Australia	11.2	20.92	2,343
ACT	8.3	0.35	28.9

*Daily smoking prevalence of people aged 15 and over, 2019 figures (AIHW)[10]; Population data for people aged 15 and over, 30 September 2020[11]

The annual health and social cost of tobacco in 2015-16 in Australia was estimated at $136.9 billion dollars: $19.2 billion in tangible costs [a] and $117.7 billion in intangible costs[b].[12] Given that at that time there were about 2,433,000 smokers in Australia,[10] this equates to **$56,268 dollars per annum** per smoker.

Multiple levels of government have implemented legislation and regulation programs for tobacco cessation targeting the general population. While the *ACT Drug Strategy Action Plan 2018-2021* and the *Healthy Canberra ACT Preventive Health Plan 2020-2025* include the commitment to 'Further develop approaches to reduce smoking rates among high-risk population groups in the ACT', how this will be achieved has not been articulated. People in lower socio-economic groups, people dependant on alcohol and other drugs, Aboriginal and Torres Strait Islander people, and people with mental illness are harmed in especially high numbers.[9,13-15]

Users of AOD services have very high tobacco usage rates but are also serviced by a dedicated workforce with high capacity to provide support for tobacco cessation if funding is provided. Key facts are:

- 4,986 people[c] accessed alcohol and other drug treatment in the ACT in 2018-19.
- 76.9% of people accessing these AOD specialist services are smokers,[16] representing about 3,834 people in 2018-19.

The 'We CAN Program' is a small but successful intervention for this vulnerable target group, using best-practice nicotine dependence treatment. This includes vouchers for full courses of combination nicotine replacement therapy (NRT) complemented by specialist smoking cessation support[17] – see Appendix 2 for further detail on the Program.

Evaluation of the pilot We CAN Program (July 2015-March 2017) demonstrated that it successfully facilitates access to best practice nicotine dependence treatment and support for people utilizing specialist AOD services. Many service users who presented to the pharmacy to purchase NRT accessed sufficient NRT to make a quality quit attempt. 100% of

[a] Tangible costs of premature mortality include: the present value of lost expected lifetime labour in paid employment; costs to employers of workplace disruption; the lifetime value of lost labour in the household; and a net cost saving of avoided lifetime medical expenditure by government.[12]
[b] Intangible costs include the value of life lost, pain and suffering, both from premature mortality and from the lost quality of life of those experiencing smoking attributable ill-health.[12]
[c] Based on data from the Alcohol and Other Drug Treatment Services National Minimum Dataset[23] and the National Opioid Pharmacotherapy Statistics.[24] This figure includes people accessing all tiers of opioid maintenance therapy but excludes those accessing needle and syringe programs (whose numbers are not counted due to maintaining confidentiality).

these participating clients also received smoking cessation support from a specialist AOD treatment and support worker, complemented by support when attending the pharmacy.

In 2020-2021 the 'We CAN Program' received $50,000 of funding, which was sufficient to supply 100 vouchers. Each voucher equated to one course of NRT and cost $300. Feedback from service providers was that clients continued to report high satisfaction rates with the program and that a high proportion made quality quit attempts.

Evidence shows that providing full financial interventions to smokers (such as the We CAN Program) will increase the proportion of smokers who attempt to quit, use smoking cessation treatments, and succeed in quitting[18] Using data from rigorous studies and systematic reviews, we can calculate that, on average, an additional 4.05 per 100 motivated smokers are likely to quit when accessing combination NRT (i.e., patches and an intermittent form of NRT such as gum, lozenges or spray).[d19-21]

With current funding, **only about 3% of smokers** accessing AOD treatment in the ACT can be offered a voucher for free NRT through the We CAN Program. Funding limitations also mean that they are limited to a single voucher. This successful program can be upscaled to reach the full cohort of smokers who access AOD specialist services annually, and provide multiple courses of NRT where required. The skilled workforce of AOD service providers can be leveraged to provide complementary support to their clients along with vouchers. The estimated health and social savings from people who quit will be over $5.28 million in the calendar year following cessation, based on the following conservative assumptions:

- 2,316 (60.41% of 3,834)[e] smokers accessing specialist AOD services in the ACT will make quit attempts (i.e., present their NRT vouchers to a pharmacy)
- Based on a quit rate of 4.05% (see above), around 94 extra people would be expected to quit by accessing the We CAN Program annually.

There are positive relationships between supported quit attempts (like those made in the Program) and future attempts at quitting. Smoking cessation also helps cessation of other drug use, which further leverages the investment. Perhaps most importantly, public health benefits should last well beyond the first year as many who have quit will continue not to smoke. Overall, the **return on investment is likely to be over $2.6 for every $1 invested** in the first year, with substantial additional returns in subsequent years.

[d] These proportions have been calculated using the following data: between 3% and 5% of smokers will quit on their own;[19] using any forms of NRT (on their own) will increase quitting rates by between 50% and 60%;[20] and using combination NRT (patches with an intermittent form of NRT) will further increase quit rates by between 15% to 36%.[21]

[e] 60.41% of people accessing specialist AOD services reported that they were motivated to quit smoking in the 2018 Service Users Satisfaction and Outcomes Survey (SUSOS).[16]

Table 2 - Budget for upscaling We CAN Program for smoking cessation

Item	Unit cost ($)	Number of smokers	Vouchers / person	Cost (000$)
Vouchers	300	3,834	1.4	1,610
Training (specialist, 3 day)	2,100	20	-	42
Training (basic, 1 day)	100	50		5
Project Manager	110,000	1	-	110
Community of Practice and Consultation meetings	1,000	8	-	8
Project development and management fee, overheads, etc	133,000	-	-	125
Evaluation	-	-	-	100
TOTAL				**2,000**

Recommendation 3: Investing in helping people quit smoking

Provide **$2m** of funding to upscale the successful *"We Can Program"* and significantly reduce the tobacco-associated disease burden among users of AOD specialist services.

4. About ATODA

ATODA is the peak body for the alcohol, tobacco and other drug (ATOD) sector in the ACT. Its purpose is to lead and influence positive outcomes in policy, practice and research by providing collaborative leadership for intersectoral action on the social determinants of harmful drug use, and on societal responses to drug use and to people who use drugs.

ATODA's vision is a healthy, well and safe ACT community with the lowest possible levels of alcohol, tobacco and other drug related harms. Underpinning ATODA's work is a commitment to health equity, the social and cultural determinants of health, and the values of collaboration, participation, diversity, respect for human rights, social justice and reconciliation between Aboriginal and Torres Strait Islander people and other Australians.

ATODA represents the ACT's specialist alcohol and other drug (AOD) treatment organisations, both NGOs and the ACT Government specialist treatment service. Membership also includes distinguished drug academics with expertise in the criminal justice system and the health effects of drug use; the group representing families and friends who have lost loved ones to drugs; and the organisation which advocates for people who use drugs in the ACT.

Appendix 1 - State of ACT alcohol and other drug service system

1. State of the Sector

A 2018 survey found that 600-700 people access specialist AOD services each day in the ACT. These service users experience high levels of socio-economic disadvantage: nearly one-third were homeless or at risk of homelessness; 70% were unemployed or not working; and half had year 10 or less as their highest level of education.[16]

The alcohol, tobacco and other drug treatment sector in the ACT delivers more than thirty programs across the main treatment types. A description of these programs can be found in the ACT Alcohol, Tobacco and Other Drug Services Online Directory at www.directory.atoda.org.au. A key strength of the alcohol, tobacco and other drug sector is the integration of government and non-government services to collaboratively provide a wide range of legally-permitted evidence-based harm reduction and treatment interventions.[22] Key facts about the sector are:

- Nine of the ten specialist service providers are community organisations (NGOs).
- There are several specific treatment and program types that are only provided by non-government service providers.
- The specialist alcohol, tobacco and other drug service sector includes programs catering for the needs of specific populations, for example: youth; Aboriginal and Torres Strait Islander people; women; families; and peers.
- Services are typically funded by a blend of ACT Government, federal (directly from the Commonwealth and through the Capital Health Network) and philanthropic sources.

2. Treatment and harm reduction in the ACT delivers positive outcomes and high levels of client satisfaction

The AOD sector in the ACT provides high quality evidence-informed harm reduction and treatment despite limited resources and high demand. The sector is cohesive and unified, working together across government and non-government services to provide the main AOD treatment types to those seeking support and treatment for AOD issues. The specialist AOD workers in these services are highly qualified in their fields of expertise and are committed to positive therapeutic and other outcomes for service users.

ACT treatment and harm reduction services deliver positive outcomes for people able to access services. In a 2018 survey, people accessing ACT AOD services reported: reduced substance use (75% of people receiving services); improved general health (81%); improved mental health (73%); and reduced experience of AOD related harms, including reduced involvement in crime (80%), and improved knowledge of preventing transmission of blood borne viruses (78%).[16]

3. Drug treatment works, but the ACT service system is full

Despite the above strengths, the specialist AOD service system in the ACT is constrained by chronic, long-term underfunding. The compounding effect of several years of resourcing below demonstrated community demand without cost benchmarking has resulted in a critical undersupply of AOD treatment capacity.

The organisations delivering treatment and harm reduction services have achieved substantial increases in treatment episodes delivered over many years as the sector struggles to achieve maximum efficiency from funding available. However increased

demand means individuals accessing community-based services often receive a lower treatment 'dose' (e.g., of counselling duration or frequency) resulting in sub-optimal outcomes. Many specialist AOD programs have substantial and unacceptable waiting times or contact lists, particularly for residential rehabilitation, day programs, residential withdrawal and counselling.

Service providers continue to work hard in partnership with government agencies to provide timely and quality AOD services to also address additional demand arising from ACT Government flagship priorities. These priorities include:

- the ACT Drug and Alcohol Sentencing List
- ACT Policing's new community policing model
- Reducing Recidivism by 25% by 2025
- Safer Families Initiative
- Therapeutic Care Court
- Reintegration Centre.

Additional funding for AOD specialist services is required to ensure their success.

4. We need to double drug treatment places to meet demand

National modelling commissioned by the Federal Government identified that an additional 200,000 to 500,000 people Australia-wide needed and would seek AOD treatment (over and above the 200,000 already in treatment) per year.[3] While this modelling is not specifically available for the ACT, the consistency in overall AOD use between the ACT and Australia-wide suggests it represents a fair estimate of unmet need in the ACT. Based on the lower estimate, a **doubling of capacity for AOD services** is needed, followed by annual increments in line with overall population increase.

Existing national datasets show that more than 5,000 closed treatment episodes for AOD treatment and harm reduction were provided in 2019-20, and 600–700 people access ACT specialist AOD services on any one day.[16,23,24] In the SUSOS:

- Around three-quarters of service users accessing residential AOD services also reported having to wait to access the AOD service they were in at the time.
- 45% of these reporting waiting between 3 and 8 weeks.
- 41% reported waiting for more than 8 weeks.[16]

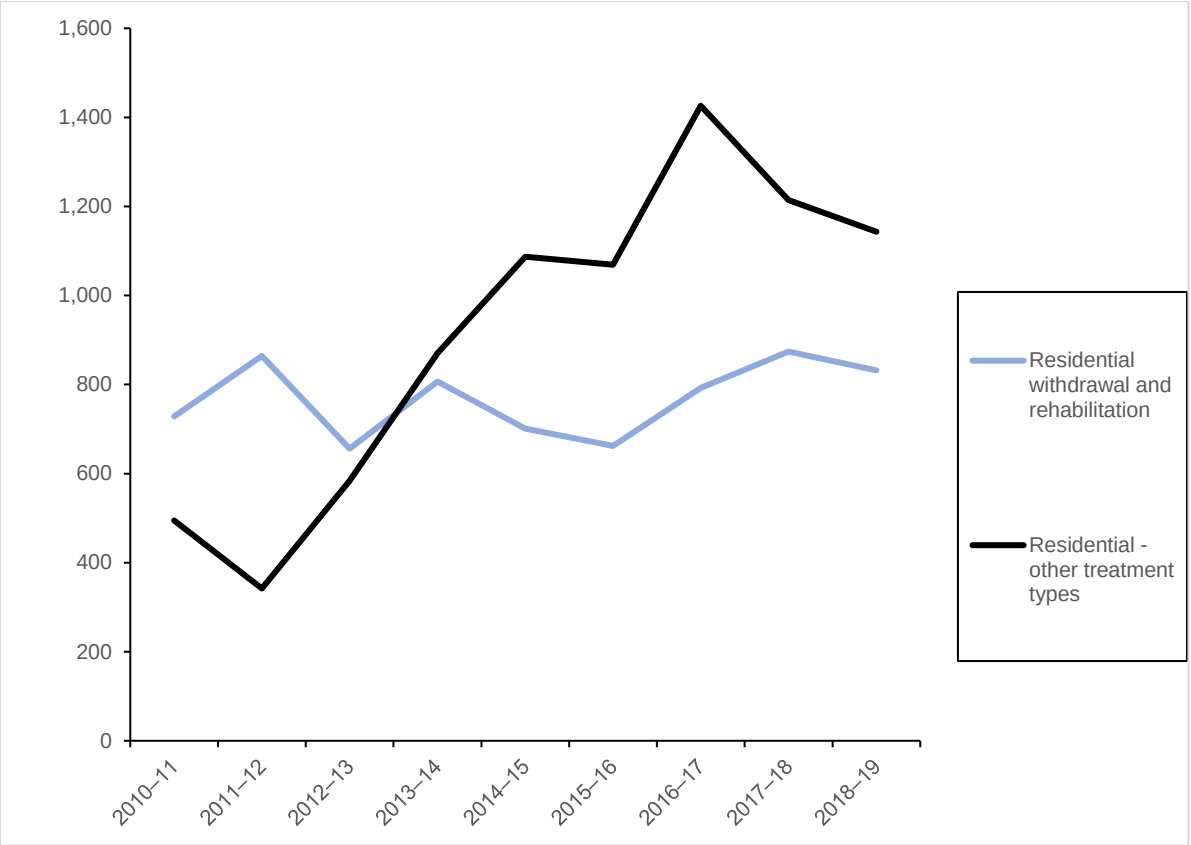
ATODA's members also report long waits for community-based treatment and support services. Specialist AOD services report (through regular monthly meetings) that they have reached full capacity for most residential programs and cannot offer further places for several weeks or months. This does not even account for people who never approach a service due to knowledge of waiting times or other access issues.

The increasing demand for ACT specialist AOD services over time can be illustrated through an analysis of the annually reported data to the AOD Treatment Services National Minimum Data Set (AODTS-NMDS).[25] Residential treatment beds have not meaningfully increased in number over the past decade, and consequently data on 'withdrawal' and 'rehabilitation' offered in residential settings has remained stable—as shown by the flat trend line, Figure 1.

However, the increase in demand for residential services is clearly illustrated by the data for other treatment types delivered within these residential service settings which has increased over time. Largely these treatment episodes represent people who are trying to access residential withdrawal or rehabilitation, but for whom there is no place. These two lines paint

a vivid picture of a sector struggling to provide at least some help to a growing client load in the absence of commensurate funding.

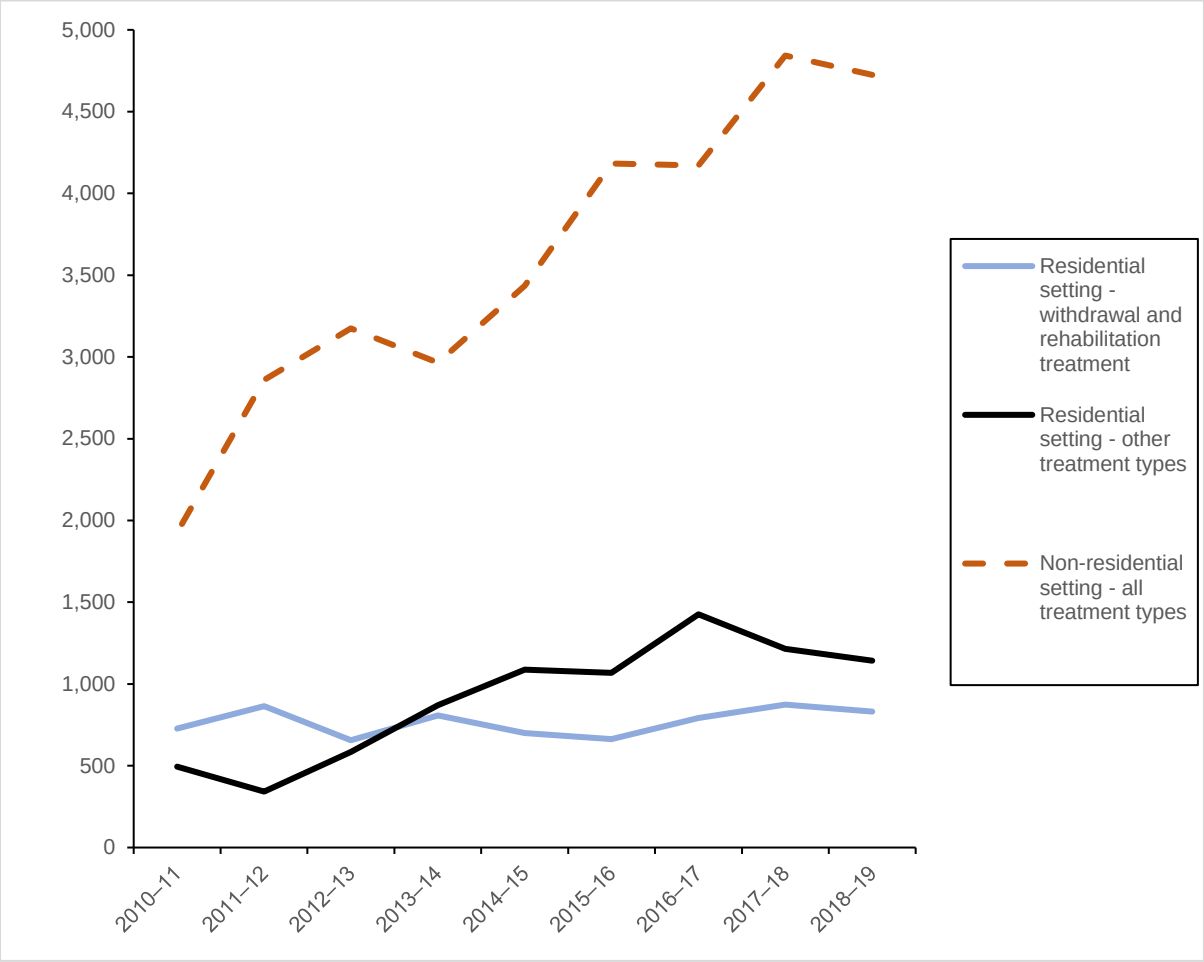
Figure 1: Treatment episodes provided in residential settings in ACT specialist AOD services—annual comparison of residential withdrawal and rehabilitation with other treatment types (2010-11 to 2018-19) Source: AODTS-NMDS 2019*[25]



*Includes: counselling only; other, including pharmacotherapy; support and case management only; information and education only; assessment only.

Similarly, the capacity crisis also exists in non-residential programs, such as counselling, day programs, and peer support. This is illustrated by data from the AODTS-NMDS (Figure 2). Although there has been some additional investment (for example through the Capital Health Network from mid-2017), there has been a consistent increase in demand for treatment provided in non-residential settings—a 38% increase between 2014-15 and 2018-19.

Figure 2: Comparison of treatment episodes provided in residential and non-residential settings in ACT specialist alcohol and other services—annual comparison of residential withdrawal and rehabilitation, residential other treatment types, and non-residential all treatment types^ (2010-11 to 2018-19) Source: AODTS-NMDS 2019*[25]



* Includes: counselling only; other, including pharmacotherapy; support and case management only; information and education only; assessment only.

^ Includes: withdrawal; counselling only; rehabilitation; other, including pharmacotherapy; support and case management only; information and education only; assessment only.

5. Alignment with other processes

Lastly, we note the importance of aligning enhanced investment in the sector with other related processes including the commissioning process for Health Directorate contracts, Territory-wide Health Service Planning by the Health Directorate, and evaluation of the ACT Drug Strategy Action Plan, 2018-2021, and formulation of its successor.

Appendix 2 – Background information on the We CAN Program

The We CAN Program—**C**ommunities **A**ccessing all-types of **N**icotine replacement therapy —aims to reduce smoking among people utilizing specialist AOD non-government organisations in the ACT by providing free access to 8 – 12 weeks-worth of any types of NRT through vouchers redeemable at partnering community pharmacies, complemented by smoking cessation advice and support.

The Program is managed by the Alcohol Tobacco and Other Drug Association ACT (ATODA), is funded by ACT Health, and is implemented in partnership with specialist AOD non-government organisations and community pharmacies. The Program was initiated by the ACT ATOD Workers' Group, has been endorsed by the Executive Directors of AOD services, and receives widespread support from front-line AOD workers.

Program description and rationale

- Provides a program to people accessing specialist AOD services who have very high smoking rates:
    - 77% of people who access specialist AOD services in the ACT report being smokers.[16]
    - people experiencing disadvantage often want to quit (or reduce) smoking and can often do so with the right support.
- Enables delivery of best practice nicotine dependence treatment.[20,21,26,27]
    - NRT is an effective tool to aid smoking cessation and reduction.
    - Service users can access best practice nicotine dependence treatment:
        - full courses of NRT
        - combination therapy that combines patches with an intermittent form of NRT (e.g., gum, inhalator, lozenges, spray)
        - complemented by specialist smoking cessation support.
- Provides access to free NRT for a disadvantaged and hard-to-reach target population:
    - for most of this service user group, only NRT patches are available on prescription
    - intermittent forms of NRT are largely un-affordable (as they are not available on PBS)[f]
    - low levels of contact with general health services means low access to scripts for NRT patches
    - cost has been identified by AOD workers as a significant barrier to smoking cessation
    - there are better smoking cessation outcomes when NRT is provided free of charge.
- Implemented as part of routine AOD treatment and support:
    - integrating nicotine dependence treatment into AOD treatment and support has been found to increase smoking cessation,[28] and improve AOD treatment outcomes for service users.[29,30] Most of the residential AOD treatment sites are required to be completely smoke free; providing NRT is critical in these contexts.

[f] NRT gum and lozenges have been listed on the Pharmaceutical Benefits Scheme from 1 February 2019 but are restricted to Aboriginal and Torres Strait Islander people, are only to be used independently of patches (i.e., not for combination therapy), and only for 12 weeks per year. (https://www.pbs.gov.au/publication/schedule/2021/05/2021-05-01-general-schedule-volume-1.pdf Accessed 28/5/21).

    - service users of AOD NGOs are screened and assessed by workers to require smoking cessation support.
    - service users receive ongoing smoking cessation advice throughout their treatment and support.
- Leverages and enhances specialist AOD services' treatment and support expertise and organisational tobacco management policies:
    - all participating services have a tobacco management policy and other workplace supports in place.
- Leverages on existing smoking cessation training and resources through ACT community pharmacies:
    - most community pharmacies in the ACT have been involved in the Pharmacy Guild ACT Smoking Cessation Project, thereby receiving training and resources to support people who want to cease/reduce smoking.
    - many community pharmacists are keen to engage further with people using AOD and with specialist AOD services.

Monitoring data from We CAN Program pilot phase

The We CAN program, which is still operational, was initially tested with a pilot. The following is operational data from the We CAN Program during a 20-month pilot phase (July 2015 – March 2017) in seven specialist AOD services in the ACT.[17] In the 20-month period:

- 325 vouchers were distributed to service users:
    - 59% of vouchers were given to men; 38% to women
    - the average age of service users was 34 years
    - 14.5% were given to Aboriginal and/or Torres Strait Islander service users.
- 82% of vouchers were presented at the pharmacy (representing potential quit attempts).
- At least 28 people made more than one quit attempt (i.e., received more than one voucher).
- Many service users who presented to the pharmacy to purchase NRT accessed sufficient NRT to make a quality quit attempt as demonstrated by:
    - Multiple visits to pharmacies to purchase NRT—average of 2.57 times per voucher.
    - Purchasing a full course of NRT—40% of vouchers were completely, or almost completely expended (i.e., at least $250 of NRT was purchased).
    - Purchasing combination NRT—81% of vouchers were used to purchase a combination of patches and intermittent forms of NRT.
- 100% of these participating clients also received smoking cessation support from a specialist AOD treatment and support worker, complemented by support when attending the pharmacy.
- Feedback from AOD workers, pharmacies, and clients has been extremely positive, with the Program working effectively to support quit attempts.

The We CAN Program has been successful at facilitating access to best practice nicotine dependence treatment and support for people utilizing specialist AOD services.

Monitoring data from phase two (March 2017 to August 2018)

Between February 2017 and 30 March 2018, operational data shows that:

- A total of 278 vouchers were issued (271 to service users and 7 as NGO vouchers)
- Of the 271 vouchers issued to service users, 83.8% were presented to the pharmacies (i.e., 83.8% of people continue with their quit attempt).

- Of the vouchers presented to the pharmacies, an average of $239.14 (79.7% of the total value of the $300 vouchers) is expended on NRT per voucher.
- 46.6% (109 of 234) of vouchers presented to the pharmacies are expended to a value of $280 or more.

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