ATODA
Alcohol Tobacco & Other Drug Association ACT

Minister Andrew Barr MLA
ACT Treasurer
budgetconsultation@act.gov.au

Submission to the ACT Budget 2016 – 2017 Consultation

Dear Minister Barr,

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 2016 - 2017. We note our request to ACT Treasury for an extension.

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.

The requests for funding in this submission are considered within the context of some increasing drug related harms, the challenging fiscal realities of the ACT economy and Canberra's ambitious social policy agenda. The priorities identified seek to have long-term benefits for individuals, families and communities of Canberra and are consider against the scientific evidence.

The harms from alcohol, tobacco and other drugs continue to impose heavy costs, in personal and financial terms, on individuals, families and the ACT community. The increasing in harms from crystal methamphetamines has provided additional challenges for the community and specialist drugs services.

The drug sector in the ACT (including treatment and harm reduction services, researchers, consumers, families and policy makers) continues to play a key role in reducing the harms associated with drug use, including methamphetamines.

The sector has proven efficient in reducing the demand for more expensive acute health and criminal justice services, improving the wellbeing of Canberrans and saving lives. Despite this, drug related health interventions receive less funding than criminal justice responses.

The sector has identified some areas where existing resources could be better allocated, don't exist, or where reform is not possible without an additional funding injection.

The process for developing this submission has included regular discussions with the sector and other stakeholders, and has been informed by a Strategic Brainstorming Forum held in October 2015. A number of initiatives to prevent and reduce ATOD related harms in the ACT are also included within this submission:

Please do not hesitate to contact us if we can provide any further information in support of this submission.

Sincerely,

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November 2015

Summary of funding priorities to prevent and reduce alcohol, tobacco and other drug related harm in the ACT (2016 - 2017)

Priority area	Initiative	Description	Funding
Specialist drug treatment and support	Recurrent investment in specialist drug services to create capacity to respond to increased demand and rising methamphetamine-related harms	To increase the capacity of all non-government specialist drug treatment and support services to: meet the 36% increase in demand (2010–2014); effectively respond to rising methamphetamine-related harms including treatment length and complexity; to reduce waiting times and increase aftercare.	$1.6 million per annum, recurrent
Preventing and reducing opioid related morbidity and mortality	Expanding Naloxone availability in the ACT	To recurrently fund the delivery and expansion of the ACT's effective and trailblazing take-home naloxone, which included education and training for at-risk groups, program to prevent and better respond to opioid overdoses.	$115,000 per annum, recurrent
Early intervention for methamphetamine and other drug problems	Implement a program of methamphetamine, alcohol and other drug training to build capacity in non-ATOD settings (e.g. domestic violence, care and protection, justice, homelessness, mental health) to provide	Capacity building is required for workers across a range of sectors that come into contact with people experiencing methamphetamine and other drug problems. This program would provide training to improve their capacity to provide screening, brief intervention and referrals utilising a validated, cross-cultural and easy to use	Recurrent per annum investment of $115,000 to fund: • A position responsible for identifying and responding to training needs and capacity building needs across various sectors, and sourcing, organizing and

	partnerships with specialist ATOD services	are relevant and specific to different contexts and workers needs (e.g. methamphetamine de-escalation techniques, working with intoxicated people)	specific training).
Preventing chronic disease and death amongst disadvantaged people who smoke	Subsidised Nicotine Replacement Therapy (NRT) for all specialist drug service clients who smoke	To embed and fund smoking treatment as routine care in all specialist drug services by providing subsidised full courses of Nicotine Replacement Therapy (not currently covered on the Pharmaceutical Benefits Scheme) to all clients who smoke according to best clinical practice, and accompanied by ongoing capacity building and evaluation.	ACT Health could do costing based on (a) numbers of all specialist drug services clients (b) a full course of 8-12 weeks of NRT (c) ongoing smoking treatment capacity building in services (d) evaluation and monitoring
	Fill a major policy gap in the ACT by identifying practical, evidence-based tobacco control strategies that will reduce smoking among disadvantaged sub-populations	To undertake a project that will review the tobacco control research evidence and current ACT practice and capacity to deliver activities to disadvantaged population groups. The project will result in practical impact-oriented recommendations for policy and practice that will seek to increase tailored smoking care activities to reduce unacceptably high smoking prevalence in disadvantaged sub-populations.	$130,000 (one-off estimate)
Fully fund 2012 ACT Election Commitments	Aboriginal and Torres Strait Islander tobacco control	To fully fund the Aboriginal and Torres Strait Islander Smoking Cessation Program as per the 2012 ACT Government election commitment.	$220,700 (total remaining funding to be committed)
Road Safety and impaired	Improve the ACT Alcohol	Two significant problems have emerged	• Minimal recurrent costs;

driving	Ignition Interlock Program to 1) provide a comprehensive financial assistance scheme and 2) provide immediate eligibility to install interlocks upon sentencing	through the implementation of the new ACT Alcohol Ignition Interlock Program. These can be addressed by aligning the program more closely with the evidence-base and with the practice of other jurisdictions (e.g. New South Wales).	estimates could be based on the number of concessions sought for mandatory interlocks since the beginning of the program • Policy change for immediate eligibility to install interlocks upon sentencing
Justice reform and drug (including methamphetamine) and alcohol-related offending	Swift, certain and fair alcohol and drug specific ACT pilot project	To reduce drug (including methamphetamine) and alcohol related offending by developing, implementing and evaluating a small multi-year ACT specific pilot project, utilising the principles and evaluation findings of alcohol and drug specific swift, certain and fair initiatives as a novel approach to sanctions.	Independent expertise in the area (e.g. RAND Canberra and RegNet, ANU) should be engaged and funded to undertake a process to develop the program model with stakeholders (e.g. Corrections, specialist drug treatment services, legal services, offenders) and to conduct the research evaluation, which should have controls and be developed prior to the project beginning and continue for the life of the project. ATODA can provide further support to develop specific costings for the research and evaluation component.
Reducing prisoner morbidity and mortality	Develop a business case to implement a 'Health	To reduce prisoner morbidity and mortality by developing, implementing and evaluating	e.g. • Consultant resources (e.g.

	specific Throughcare Program' at the AMC	comprehensive and resourced 'Health Throughcare Program' which would build on the success of the current Throughcare Program (largely focussed on the social determinants of health	$60,000) to develop the business case • ACT Health Policy staff resources • Establish a Working Group as a sub-group of the AMC Health Services and Advisory Group (which includes the NGO Health and community representatives)

PRIORITY: Specialist drug treatment and support

Initiative:	**Recurrent investment in specialist drug services to create capacity to respond to increased demand and rising methamphetamine-related harms**
Description:	To increase the capacity of all non-government specialist drug treatment and support services to: meet the 36% increase in demand (2010–2014); effectively respond to rising methamphetamine-related harms including treatment length and complexity; to reduce waiting times and increase aftercare.
Funding:	$1.6 million per annum, recurrent

There is growing public attention and concern about the impacts of methamphetamine and other drug related harms, and the resulting increased demand for ACT drug treatment and support services.

The population rate of recent[1] methamphetamine use is 2.1%, a figure essentially unchanged for the last 10 years.[2,3] This means a small but significant sub-group is at serious risk.[4] This has implications for the sorts of interventions needed and their priority. Instead of broad-based population wide strategies we need targeted strategies that provide treatment and better equip those who work on the frontline and come into contact with people affected by methamphetamine, including strategies specifically designed and delivered by Aboriginal and Torres Strait Islander community-controlled services.[5]

As a first priority, any new investment to address methamphetamine should build upon, and lever off of, ACT Health's current investment in specialist drug services.

The increasing methamphetamine-related harms are attributable to:

- A rapid and profound shift from the use of powder amphetamines to the more harmful crystalline methamphetamine form;[6]
- Increased purity but stable price;[7] and
- Increased frequency of use, which leads to a greater likelihood of producing dependence.[8]

This is reflected in treatment data, which shows that there has been a rise in people presenting to ACT specialist drug treatment services where amphetamines is a drug of concern.[9] This is occurring within a context of treatment services already being stretched beyond demand—episodes of care by non-government specialist drug treatment services have increased by 36% over 5 years (2010 –2014).[10]

ATODA has repeatedly advised the ACT Government that an appropriate response to the rising methamphetamine-related harms is through investing in specialist drug treatment and support services.[11,12]

In the 2015/16 ACT Budget, the Minister for Health Simon Corbell announced a one off $800,000 funding boost for specialist drug treatment and support services in the ACT.[13] While important and welcomed, this funding only goes part of the way to meeting treatment demand, expires on 30 June 2016 and represents half of what has been identified as needed. When announcing this funding, the Minister

acknowledged the necessity of increased funding to allow services to increase their capacity to treat patients and reduce waiting times.[14]

The fact that some Canberrans are waiting up to 2 months to access alcohol and drug treatment is unacceptable and perpetuates or prolongs crisis, risks and harms for people needing treatment, their families and the community.[15]

Research tells us that lengthy waiting lists for drug treatment are detrimental to people and that, wherever possible, we should have a treatment on demand model that can lead to the immediate reduction or elimination of drug use[16,17] and its associated harms.[18,19] One-off funding will not be able to meaningfully address this problem and ensure the viability of specialist drug services into the future.

ATODA therefore urges the ACT Government to make a recurrent investment of $1.6 million in all specialist drug services in order to genuinely create more capacity in the drug services system through a minimum allocation of one full-time equivalent staff member per service (i.e. $115,000). Additional funding for ongoing sector-wide capacity building and workforce development activities must complement this.

PRIORITY: Preventing and reducing opioid related morbidity and mortality

Initiative:	**Expanding Naloxone availability in the ACT**
Description:	To recurrently fund the delivery and expansion of the ACT's effective and trailblazing take-home naloxone, which included education and training for at-risk groups, program to prevent and better respond to opioid overdoses.
Funding:	$115,000 per annum, recurrent

- 18 Canberrans died from opioids (like heroin and oxycodone) in 2014, this is the highest in a decade.[20]
- Naloxone is a safe and effective medicine listed on the Pharmaceutical Benefit Scheme (PBS) whose only effect is to reverse an opioid overdose, thus potentially preventing these unnecessary deaths.

The first of its kind in Australia, the ACT's trailblazing take-home naloxone program involves comprehensive opioid overdose management training and the prescription and supply of naloxone to eligible participants who are potential overdose victims. Administration of naloxone reverses the effects of an opioid overdose and the program empowers people who use opioids, and their friends and family, to safely respond to overdose and prevent death.[21]

The program has been overwhelmingly endorsed by an independent expert evaluation report that was launched by ACT Health Minister Simon Corbell on International Overdose Awareness Day, Monday 31 August 2015.[22] The independent evaluation showed that the program has been a great success with over 200 potential overdose witnesses trained, and program-issued naloxone used 57 times to resuscitate people.[23]

As part of the ACT Government Budget for 2015/16, $115,000 (one-off) was allocated to support a wider roll out of the naloxone program over a 12-month period. Within the Budget Papers it was stated that "The naloxone overdose management program is currently being evaluated and the Government will determine future funding for this initiative after considering the evaluation findings".[24]

As this evaluation report has now been released. The importance of making take-home naloxone programs widely available as core business for the health sector, particularly for specialist AOD services, in the ACT is clear. This is acutely pressing given the release of new data that reveals that twice as many Canberrans die from opioids than on our roads.[25] Within this context, it is essential that the ACT Government continue to show leadership in supporting evidence based policy approaches to responding to opioid overdose.

Current funding for the take-home naloxone program will cease on 30 June 2016. ATODA therefore calls on the ACT Government to support the continued delivery and expansion of Australia's first and highly effective take-home naloxone program through the provision of recurrent funding attached to two priorities:

- Funding to maintain the core delivery of the comprehensive opioid overdose management training and the prescription and supply of naloxone to eligible participants who are not health professionals, and
- Funding to co-ordinate systems reform, capacity building and policy development that are necessary to pursue an expanded roll out of opioid overdose management training and the prescription and supply of naloxone within priority settings. For example, the evaluation uncovered a number of local systems issues requiring attention in the consideration of expanding naloxone distribution in other settings[26] All suggestions present opportunities for the ACT to take a leading role in the development and practices of expanded naloxone availability and overdose prevention in the Territory and at a national level.

PRIORITY: Early intervention for methamphetamine and other drug problems

Initiative:	**Implement a program of methamphetamine, alcohol and other drug training to build capacity in non-ATOD settings (e.g. domestic violence, care and protection, justice, homelessness, mental health) to provide appropriate screening, brief intervention and to strengthen referrals and partnerships with specialist ATOD services**
Description:	• Capacity building is required for workers across a range of sectors that come into contact with people experiencing methamphetamine and other drug problems. • This program would provide training to improve their capacity to provide screening, brief intervention and referrals utilising a validated, cross-cultural and easy to use existing tool - the eASSIST. • It would also provide additional high-quality, evidence-based training in ATOD skills that are relevant and specific to different contexts and workers needs (e.g. methamphetamine de-escalation techniques, working with intoxicated people)
Funding:	Recurrent per annum investment of $115,000 to fund: • A position responsible for identifying and responding to training needs and capacity building needs across various sectors, and sourcing, organizing and evaluation this training • A pool of ACT training funding to provide ATOD specific training

Drug treatment resources are scare and under significant demand. ACT Health commissioned specialist drug services are for people with severe drug problems. Unnecessary referrals to the ATOD sector create further blockages in a system already unable to meet demand and can create delay in people accessing the help they need.

Not all people who use drugs will develop severe problems that require them to immediately access specialist drug services. Currently, there is a group of people using drugs who experience a range of moderate drug problems. They do not require immediate referral to drug treatment services, but they do require a degree of support to prevent their problems from escalating. This is particularly problematic for some people using crystal methamphetamine where the severity of the problems can escalate quickly relative to other drugs (e.g. alcohol, heroin, cannabis). Currently, people with moderate drug problems often don't get the support they need, when and where they need it, to prevent their problems from escalating.

Many people with moderate drug problems will already be accessing other parts of the service system (e.g. domestic violence, care and protection, justice, homelessness, mental health). This creates a unique opportunity for these parts of the service system to play a significant role in engaging with people to identify drug problems and provide appropriate screening, brief interventions, information and

referrals. This could prevent both the unnecessary referral of people into specialist drug services and the further escalation of moderate drug problems.

However currently, workers outside of specialist ATOD settings often lack the expertise to assess the severity of drug problems, or to provide advice and referrals commensurate to the level of the problem. Non-ATOD workers can effectively deliver screening, brief intervention and referrals with the right tools, training and support. The dramatic increase in harms from methamphetamines have brought the need for training and use of consistent evidence based tools to the fore.

In order to achieve this, workers outside of specialist ATOD settings need access to appropriate screening, brief intervention and referral tools, and to tailored, evidence-based and customised ATOD training.

The eASSIST: an existing WHO evidence-based tool used in the ACT

The ACT is leading Australia in its implementation of the World Health Organisation's Alcohol, Smoking and Substance Involvement Screening Test (ASSIST). The ACT electronic version of the tool, eASSIST, is a validated, cross-cultural, electronic, screening instrument that assesses for all levels of problem or risky alcohol, tobacco and other drug (including methamphetamine) use change[27]. Encompassing screening, brief intervention and referral components, it represents a cost-effective tool that is wide-reaching and robust to change.[28] The ACT eASSIST includes Canberra-based referrals to better support treatment matching.

When trained in its use and application, any worker can deliver the screening component, and follow the prompts to provide brief interventions and referrals commensurate to the level of drug problems assessed through the screening process. When applied in service settings outside of ATOD, the eASSIST can support the early identification of issues surrounding use of tobacco, alcohol and other drugs, the extent of the problems surrounding their substance use, and consequently the appropriate supports and referrals that should be offered. In addition, the process of screening creates the opportunity to provide a brief intervention to educate clients about the risks of hazardous alcohol, tobacco or other drug use.

As a result of the broader implementation of the eASSIST, people with drug problems could be better matched to specialist ATOD services based on the identified risk and severity of issues. This is consistent with the continuum of care approach identified in, for example, the ACT Comorbidity Strategy.

ATOD training to provide appropriate brief interventions, support and referrals

The evidence for and value of building capacity outside specialist ATOD sector settings in screening, brief intervention and referral is clear, and there is a significant need to support this by providing diverse and regular ATOD training across various non-specialist ATOD sector workers, and at the same time providing ongoing up-skilling within the ATOD sector. Outside of the training provided for the ATOD sector, there is little to no ATOD training available in the ACT.

Diverse and regular ATOD training should be tailored according to the needs of different services, professional needs and contexts. (e.g. screening, building clinical expertise, working with intoxicated people, de-escalation techniques, brief

intervention skills). Such training would need to be offered across various non-specialist ATOD sectors and to a range of workers and professionals within those sectors (e.g. police, domestic violence, mental health, homelessness, youth, primary care, hospital, corrections).

At the same time, appropriate support to people who use drugs and their families is additionally built through ongoing up-skilling within the ATOD sector, particularly in response to emerging drug issues. For example, the recent trends in methamphetamine use and related harms require upskilling in methamphetamine withdrawal guidelines and de-escalation approaches.

What is required to support this process

In order to build capacity in ATOD across various sectors, recurrent funding is required for a position that would be responsible for identifying and responding to training needs, and sourcing and organizing this training. This position would require access to a specific funding pool to enable the delivery of high quality, evidence-based training tailored to the needs of workers and sectors. The ACT ATOD sector's qualification strategy policy is to source high quality industry specific training – this is all sourced from interstate. Sourcing interstate training adds to the cost of training and requires knowledge of what is of high quality and what will meet identified needs.

PRIORITY: Preventing chronic disease and death amongst disadvantaged people who smoke

Initiative:	**Subsidised Nicotine Replacement Therapy (NRT) for all specialist drug service clients who smoke**
Description:	To embed and fund smoking treatment as routine care in all specialist drug services by providing subsidised full courses of Nicotine Replacement Therapy (not currently covered on the Pharmaceutical Benefits Scheme) to all clients who smoke according to best clinical practice, and accompanied by ongoing capacity building and evaluation.
Funding:	ACT Health could do costing based on (a) numbers of all specialist drug services clients (b) a full course of 8-12 weeks of NRT (c) ongoing smoking treatment capacity building in services (d) evaluation and monitoring

- The ACT daily smoking rate is approximately 10%, whereas up to 100% of clients of specialist drug services smoke. This disparity is unacceptable.
- Tobacco smoking can kill between one-third to two-thirds of all persistent users.[29,30]
- Best practice smoking treatment should be funded and provided as routine care of specialist drug services in the ACT for all clients who smoke.

Smoking rates are unacceptably high among people accessing specialist drug services

People accessing specialist drug services have among the highest rates of smoking in the community, reportedly between 68–98% in various drug treatment contexts nationally,[31] including in the ACT.[32] The evidence suggests that people accessing opioid substitution therapy have among the highest smoking rates of people who use ATOD.[33] Anecdotally, workers from ACT specialist drug services report smoking rates among service users of between 80–100%.

Disadvantaged smokers want to and can quit, but need more intensive interventions to do so

The evidence is clear that people experiencing disadvantage are as motivated to quit (or reduce) smoking as those in the general population, and can have quit smoking rates equivalent to the general population when given access to appropriate intensive interventions.[34,35] Furthermore, there is evidence that smoking cessation improves abstinence outcomes from alcohol and other drugs.[36,37]

Nicotine replacement therapy (NRT) is an effective smoking cessation tool when offered according to best practice

NRT is known to be effective at supporting nicotine dependent people to quit or reduce their smoking;[38] using any form of NRT increases the chances of a successful quit attempt by 50 to 70%.[39] NRT is particularly useful for people with high levels of nicotine dependence;[40] a significant proportion of people who use

drugs have a high level of nicotine dependence [41] indicating that NRT with accompanying supports is an appropriate treatment option for smoking cessation for them.

NRT efficacy is improved by good clinical and public health practice that includes:

- Providing 8–12 weeks worth of NRT as a course[42]
- Using combination therapy that combines patches with an intermittent form of NRT (e.g. gum, strips, inhalator, lozenges, spray)[43]
- Offering comprehensive multi-session support from a health professional or other trained advisor alongside NRT (e.g. an ATOD worker, pharmacist, Quitline).[44,45]

Access to best practice provision of NRT is limited for clients of specialist drug services

Clients of specialist drug services have limited access to NRT delivered according to best practice, largely due to cost and lower levels of contact with general health services. Cost has been identified by ATOD workers as the most significant barrier to smoking cessation. The Pharmaceutical Benefits Scheme only subsidises the patches-form of NRT.[46] Other intermittent forms of NRT (e.g. gum, lozenges, spray, strips) are not subsidised, and are only available over-the-counter at pharmacies and some supermarkets making them unaffordable for many people who smoke. In addition, many people accessing ATOD services have low levels of contact with general health services, and so have low access to prescriptions for NRT patches and smoking cessation advice from a GP.

Limited subsidised NRT available

Inpatients of ACT Health's specialist drug services in the ACT have some access to NRT on discharge;[47] this is limited to a prescription for three days worth of NRT, in line with their other prescriptions[48,49]. This is inconsistent with good clinical practice that recommends 8–12 weeks worth of NRT, and it does not acknowledge that lack of access to affordable combination NRT (i.e. patches combined with an intermittent form) is a significant barrier for clients of specialist drug services. The specialist drug NGO services are currently participating in the We CAN Program,[50] which is providing up to 270 full courses of NRT over 3 years. However this program is not available to all clients and is not able to meet demand.

What is needed:

- Subsidised full course of NRT for all clients who access specialist drug services
- On-going smoking treatment capacity building with specialist drug services, including training, and access to specialist expertise and support
- Integrated and on-going evaluation of smoking treatment activities

Initiative:	**Fill a major policy gap in the ACT by identifying practical, evidence-based tobacco control strategies that will reduce smoking among disadvantaged sub-populations**
Description:	To undertake a project that will review the tobacco control research evidence and current ACT practice and capacity to deliver activities to disadvantaged population groups. The project will result in practical impact-oriented recommendations for policy and practice that will seek to increase tailored smoking care activities to reduce unacceptably high smoking prevalence in disadvantaged sub-populations.
Funding:	$130,000 (one-off estimate)

- Of the more than 35,000 Canberrans who smoke, between 33-66% of them will die because of tobacco-related illnesses.[51]
- Up to 85% of disadvantaged people accessing the service system smoke.
- Disadvantaged people can and want to quit smoking at the same rate as the general population and can do so with the right support.
- Most services don't provide tailored smoking cessation care, however many of them could.

The ACT tobacco policy context

Tobacco policy responsibility is split across multiple areas of ACT Health (e.g. Health Protection, Health Promotion, Chronic Disease, Aboriginal and Torres Strait Islander Health). This has meant that some tobacco control activities have had strong support (e.g. population level activities like smokefree areas and a sub-population initiative through the Aboriginal and Torres Strait Islander Tobacco Control Strategy); however others (i.e. smoking and disadvantage) have had insufficient attention. This has created a serious gap and means that scarce tobacco policy and practice resources may not be accurately prioritised and smoking care not getting to the people who need it most. By engaging an external tobacco expert to undertake an ACT tobacco control policy and practice review project, the multiple stakeholders will have a clear understanding of the current tobacco control landscape and the policy and practice options moving forward.

Smoking and disadvantage

While the smoking rate in the ACT is the lowest in the country (approximately 10%)[52], there are still sub-populations of the ACT community that have disproportionately higher smoking rates, and impacts from tobacco-related harms. This includes: people who use drugs (85%); people experiencing homelessness (77%); people living with psychosis (66%) or mental illness (32%); prisoners (74%); and Aboriginal and Torres Strait Islander people (48%).[53] These sub-populations face a range of barriers that inhibit their access to smoking cessation treatments that have proven successful with other smokers in the general ACT community.

The evidence is clear that people experiencing disadvantage are as motivated to quit (or reduce) smoking as those in the general population, and can have quit smoking rates equivalent to the general population when given access to

appropriate intensive interventions[54,55]. Disadvantaged sub-populations are not responding equally to population level policy levers and mass media campaigns that have been successful at lowering the smoking rate in Australia generally. The social context in which smoking occurs is extremely complex and thus requires more complex, sophisticated and sustained responses targeted at those people who most need them.

The expert consensus is that, rather than focusing on legislative measures, disadvantaged hard-to-reach sub-populations with higher smoking rates require additional more intensive strategies to access the treatment tools that are known to help people to quit—e.g. counselling, smoking cessation medications and behavioural interventions[56,57]. Furthermore, evidence shows that it is the quality of the support received while making a quit attempt that is more likely to result in maintaining smoking abstinence, as opposed to the number of times somebody tries to quit. It is, therefore, important to ensure that *every* quit attempt by members of our community who are still smoking is well supported by best practice smoking cessation supports[58].

Creating a better understanding of disadvantage, smoking and required ACT specific initiatives

What is not well understood in the ACT context is how we can best support people from disadvantaged sub-populations to make high quality quit attempts and to sustain and maintain smoking abstinence. The following questions require further investigation to inform innovative clinical and public health policy and practice that target disadvantaged smokers in the ACT:

- At which points in the current health and social care systems do people who smoke and who are from disadvantaged groups receive smoking cessation advice and treatment, and quit maintenance support? What are the current strengths and gaps in the system?
- At which points in the current health and social care systems could this advice, treatment and maintenance support be most effectively offered?
    - What service delivery environments, programs, policies and expertise in the current system could be utilised and built upon?
    - What is needed to deliver and achieve this support, and what capacity needs to be built across the system?
- What are best-practice and innovative programs, activities and policies that have been implemented elsewhere that could inform initiatives in the ACT?
- How can system-wide change be most practically and effectively achieved to increase the provision of and access to smoking cessation advice and quit maintenance support for smokers from disadvantaged sub-populations?

Investigation of these questions utilising a knowledge translation framework will enable knowledge input from across the health and community sectors resulting in the development of practical impact-oriented recommendations for system-wide policy and practice improvement, and ultimately health improvement for these sub-populations. The process and resulting recommendations could inform the revision of the ACT Government's *Future Directions for tobacco reduction in the ACT* that is due for review in 2016.

PRIORITY: Fully fund 2012 ACT Election Commitments

A number of alcohol, tobacco and other drug initiatives were committed to at the 2012 ACT Election. ATODA acknowledges these commitments and subsequent funding to prevent and reduce alcohol, tobacco and other drug related harms. ATODA calls on the ACT Government to fulfil its remaining commitments in the next and final ACT Budget before the 2016 Election.

Initiative:	**Aboriginal and Torres Strait Islander tobacco control**
Description:	To fully fund the Aboriginal and Torres Strait Islander smoking cessation program as per the 2012 ACT Government election commitment.
Funding:	$220,700 (estimate total remaining funding to be committed)

ATODA welcomes the ACT Government allocation of $212,000 in the 2015-16 Budget to the Aboriginal and Torres Strait Islander smoking cessation, an amount equivalent to its 2012 Election commitment for that financial year. The ACT Government stated that evaluation of the program outcomes in 2015-16 would inform future funding decisions.[59] ATODA understands that the evaluation of the *ACT Aboriginal and Torres Strait Islander Tobacco Control Strategy* has been completed and found the initiative to be overall successful and for the strategy itself to be renewed.

Further, in March 2015 the *Reducing smoking in the ACT among Aboriginal and Torres Strait Islander women who are pregnant or who have young children* report identified significant achievements with regards to smoking cessation amongst Aboriginal and Torres Strait Islander community-controlled services and that these should be strengthened into the future.[60]

ATODA calls on the ACT Government to fully fund the Aboriginal and Torres Strait Islander smoking cessation program in the next financial year to the level consistent with the 2012 ACT Government election commitment, as described in the table below.

	2013-14	2014-15	2015-16	2016-17	Total	Difference
Funding committed through the ACT Budget	$200,000	$204,000	$212,000	$0	$616,000	$220,700
2012 Election Commitment	$200,000	$206,000	$212,200	$218,500	$836,700	

PRIORITY: Road Safety and impaired driving

Initiative:	Improve the ACT Alcohol Ignition Interlock Program to 1) provide a comprehensive financial assistance scheme and 2) provide immediate eligibility to install interlocks upon sentencing
Description:	Two significant problems have emerged through the implementation of the new ACT Alcohol Ignition Interlock Program. These can be addressed by aligning the program more closely with the evidence-base and with the practice of other jurisdictions (e.g. New South Wales).
Funding:	• Minimal recurrent costs; estimates could be based on the number of concessions sought for mandatory interlocks since the beginning of the program[61] • Policy change for immediate eligibility to install interlocks upon sentencing

The ACT Government should be commended for seeking to enhance road safety through implementing an Alcohol Ignition Interlock Program as a new sentencing option. However two problems have been identified that are reducing the program's effectiveness. These problems and suggested solutions are described below.

1. Implement a comprehensive financial assistance program consistent with those already available in the ACT and comparable to NSW

The cost of the ACT's Alcohol Ignition Interlock Program is regressive – meaning that it disproportionately impacts people on low incomes. The program can cost up to $10,744.70.[62] Therefore if someone on a low income is mandated to have an interlock and cannot afford it they may never be able to get their licence back. This is inequitable, disproportionate and inconsistent with other jurisdictions, such as NSW.

In order to address this, the ACT Government could adopt a comprehensive financial assistance scheme for the ACT Alcohol Ignition Interlock Program that maintains the existing concession of 35% for low-income participants, is consistent with the ACT Government *Infringement Notice Management Plans*[63] and is comparable with the NSW Alcohol Interlock Financial Assistance program.[64] In the ACT it could include:

- Payment plan options – providing the ability to pay the cost of the interlock device in installments
- Access to Work and Development Programs – providing the possibility to pay off the cost of the interlock device via working for nominated community organisations, or completion of:
    - Educational, vocational or life skills courses
    - Financial or other counseling
    - Treatment for a physical or mental illness, disorder or disability
    - Alcohol and other drug treatment

- Mentoring

- Provide financial assistance ranging from partial assistance to the full amount owing to an interlock service provider.

2. Need for immediate eligibility to install interlocks upon sentencing[65]

Following a conviction for a drink drive offence, a person should be immediately eligible to participate (i.e. drive legally) in the ACT Alcohol Ignition Interlock Program. Under the current ACT program, a probationary licence with a mandatory interlock condition cannot be issued until half of the disqualification period has been served.[66]

The evidence indicates that, for maximum benefit, participation in an interlock program should be available as soon as possible after a drink driving conviction. Requiring a period of license suspension prior to interlock eligibility may contribute to our inability to place the interlocks onto the vehicles of the most persistent drink drivers.[67] Offenders who participate in an interlock program have 50% to 75% lower recidivism rates while on the interlock program than similar offenders whose licenses have been suspended (and therefore should not be driving at all).[68]

It may seem counter-intuitive to allow high range and repeat offenders to drive with an interlock as soon as possible after a conviction, and this may challenge the beliefs of many in the community. However the evidence supports that there are greater benefits to immediately installing interlocks compared with suspending licences;[69] "an early interlock installation must not be viewed as a reduction in punishment, but as a punishment that enhances public safety, even though driving is permitted."[70]

ATODA acknowledges the contributions of Street Law to this submission.

PRIORITY: Justice reform and drug (including methamphetamine) and alcohol-related offending

Initiative:	**Swift, certain and fair alcohol and drug specific ACT pilot project**
Description:	To reduce drug (including methamphetamine) and alcohol related offending by developing, implementing and evaluating a small multi-year ACT specific pilot project, utilising the principles and evaluation findings of alcohol and drug specific swift, certain and fair initiatives as a novel approach to sanctions.
Funding:	Independent expertise in the area (e.g. RAND Canberra and RegNet, ANU) should be engaged and funded to undertake a process to develop the program model with stakeholders (e.g. Corrections, specialist drug treatment services, legal services, offenders) and to conduct the research evaluation, which should have controls and be developed prior to the project beginning and continue for the life of the project. ATODA can provide further support to develop specific costings for the research and evaluation component.

Drug and alcohol related and offending

Drug and alcohol use is one major contributor to reoffending among prisoners. Australian research indicates that a history of drug use is associated with an increased likelihood of being re-incarcerated within months of leaving prison.[71] In the ACT, approximately two-thirds (67%) of prisoners in the Alexander Maconochie Centre have a history of injecting drug use and 79% reported being under the influence of drugs at the time of committing their most recent offence.[72]

A report by the National Drug and Alcohol Research Centre undertaken for the Australian National Council on Drugs has emphasised Australia's correction systems overemphasis on supply reduction measures at the expense of demand and harm reduction measures.[73] This means that many prisoners are not receiving evidence-based treatments for their alcohol and other drug problems.

Treatment can be effective at addressing problematic alcohol and other drug use, reducing offending behaviour, and diverting offenders from prison. It has also been shown to be less expensive than incarceration for some populations.[74]

Need for novel approaches to alcohol and drug related offending

The ACT (and Australian) prison populations are growing at unprecedented rates. Last year's ACT Budget allocation to expand the AMC is an unfortunate testament to this problem. This coupled with the difficult economic times the ACT faces means, more than ever, we have a responsibility to explore evidence based and cost-effective alternative options to punishment.

The ACT is engaged in significant policy work to engage in this problem including responding to the findings from ACT Legislative Assembly's Inquiry into Sentencing and developing Justice Reform and Justice Reinvestment strategies.

Supervision-orientated alcohol and drug programs overseas have been found to be successful in improving public health outcomes, reducing participant alcohol and drug use, reducing road crashes and domestic violence, and having high participant program compliance. These programs have utilised the criminological theory and are developing an evidence base for sanctions that are swift, certain and fair.
Most notable of them are the South Dakota 24/7 Program (focused on drink driving) and the Hawaii's Opportunity with Probation Enforcement (HOPE) program (focused on drug related offending).

In July 2013 and March 2015, ATODA invited Professor Beau Kilmer from RAND to do a roundtable and public lectures to explore the criminological theory and evidence base for sanctions that are swift, certain and fair with a particular focus on its application to drink driving. Further, the ACT Justice and Community Safety Directorate commissioned a paper by University of Canberra Associate Professor Lorana Bartels on swift, certain and fair approaches and invited, in August 2015, Judge Alm from the Hawaii's Opportunity with Probation Enforcement (HOPE) program to visit Canberra. ATODA notes that a key message from Justice Alm in general, and to the Justice Reform Strategy specifically, was that specialist drug treatment and support services are a core and integral part of the program.

Translating the evidence base to the ACT context

It is important to recognise that the criminal justice context in the ACT (and Australia) differs markedly from that in the United States (US) where much of the evidence supporting swift, certain and fair initiatives derives. Consequently, it is imperative that what is meant by swift, certain and fair be clearly articulated for the ACT context so that all stakeholders are working with the same understanding of what may be, and may not be, part of an ACT swift, certain and fair pilot project. However there are particularly opportunities that exist in the ACT to be capitalised upon, including engaging the expertise of RAND who evaluated the South Dakota 24/7 program and have opened an office in Canberra, and of the Regulatory Institutions Network (RegNet) at The Australian National University.

It is unlikely that the design of swift, certain and fair initiatives in the US can be translated directly into the ACT context. Regardless, conceptualising swift, certain and fair as a methodology remains appropriate for piloting.

We note that at the Australasian Professional Society on Alcohol & other Drugs (APSAD) Conference in November 2015, Professor Beau Kilmer in his keynote suggested that small pilots with controls could be conducted, for example initially with a small group of offenders (e.g. 50) and involving two staff.

PRIORITY: Reducing prisoner morbidity and mortality

Initiative:	**Develop a business case to implement a 'Health specific Throughcare Program' at the AMC**
Description:	To reduce prisoner morbidity and mortality by developing, implementing and evaluating comprehensive and resourced 'Health Throughcare Program' which would build on the success of the current Throughcare Program (largely focussed on the social determinants of health
Funding:	• Consultant resources (e.g. $60,000) to develop the business case • ACT Health Policy staff resources • Establish a Working Group as a sub-group of the AMC Health Services and Advisory Group (which includes the NGO Health and community representatives)

The ACT Government should be commended for establishing the Throughcare Program at the adult prison, the AMC. The recent presentation by Corrective Services Executive Director Bernadette Mitcherson at the recent National Complex Needs Conference, highlighted the program's achievements and was noted by many participants.

The Throughcare program seeks to address the many challenges detainees experience re-entering the community and is focused on reducing recidivism. The program identifies support needs across the areas of housing, income, and basic life skills and then works intensively with former detainees to reintegrate back into the community. We acknowledge the increased investment in the 2014-15 Budget of $2.176m over two years to extend the Throughcare program.

Although the current AMC Throughcare program broadly includes health in its remit, its primary focus is on the social determinants of health (e.g. housing, income). This foundation is essential in order to meaningfully address the specific, complex and clinical health needs (e.g. hepatitis treatment, opioid maintenance therapy, diabetes, smoking cessation, opioid overdose prevention) of detainees.

It is well established that when people enter prison they have very poor and complex health needs, particularly related to Aboriginal Health, mental health, blood-borne viruses and alcohol tobacco and other drugs. For example, two-thirds (67%) of prisoners in the AMC have a history of injecting drug use and 79% reported being under the influence of drugs at the time of committing their most recent offence.[75]

An example of a need for improved health-specific throughcare is demonstrated by the fact that drug overdose remains a leading cause of death among recently released prisoners in Australia, with the greatest risk of death in the weeks immediately following release.[76]

At June 2015 there were 106 detainees on opioid maintenance therapy (OMT),[77] which was approximately one-third of all detainees. Both retention on OMT and the provision of take-home naloxone as part of health exit packs on release protects against drug related deaths post release. However in the ACT, no data is kept on

OMT clients who come and go from the AMC[78] and take-home naloxone is not provided directly upon release.

As such, a body of work should be undertaken to look at how the clinical health (including NGO health) services of detainees can be strengthened both within their own right and as part of the ACT's Throughcare initiatives.

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> *…provided with 7 days of NRT upon discharge and followed up by the relevant community team/GP/pharmacist within 7 days. Continued support should be offered to patients in the community following discharge from hospital which includes access to NRT, psychological and/or behavioural interventions*

Regardless of whether 3 or 7 days worth of NRT are provided, this is still inconsistent with good practice.

[50] The We CAN Program supports equity in access to NRT and a more consistent clinical approach to smoking cessation for disadvantaged Canberrans. It is based on the recognition of ATOD services as equal partners in addressing tobacco related harm, and is also being delivered in partnership with community pharmacies. It includes an external evaluation and research component. Service users of ATOD NGOs are screened by workers for nicotine dependence and, if eligible, are offered the option of participating in the Program. The worker provides the service user with 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 ATOD 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 with ATOD services and pharmacies. The Program is delivered where people are already accessing support and services (e.g. ATOD

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[62] The following table outlines what ATODA and Street Law understand are the minimum and maximum costs for those involved in the mandatory Alcohol Ignition Interlock Program entitled to the current 35% concession.

	Minimum costs	Maximum costs
Fine	$0	$4,200
Court costs	$75	$75
Drug and Alcohol Awareness Course	$180	$230
Probationary Licence	$194.70 (no concession available)	$194.70 (no concession available)
Interlock	$780 ($1200 minus 35%)	$6,045
Total	$1,229.70	$10,744.70

Note: Interlock costs are approximately $1,200 for the minimum six-month interlock period. If subject to interlock for a longer period, costs are approximately $1,800 per annum for monthly servicing of the device, up to maximum of a 5-year disqualification period. Hence total maximum costs with concession are the first six months ($780) plus costs for 4.5 years ($1,170 per annum [$1,800 x 0.35] x 4.5 = $5,265).
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