

ACT Alcohol, Tobacco and Other Drug Strategy 2010-2014

June 2010

ACT ALCOHOL, TOBACCO AND OTHER DRUG STRATEGY 2010-2014

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FOREWORD

The Australian Capital Territory is a thriving and dynamic place. On virtually all measures our standard of living has improved. Canberrans are earning more, learning more and gaining in health and well-being. The ACT has a strong economic base, a highly educated and skilled workforce and continues to have the lowest unemployment levels in Australia. Most people in the ACT enjoy the benefits of good health; as a community we are generally very healthy and active and avoid risky behaviour.

The ACT Government has developed and implemented strategies to promote respect for human rights, social cohesion, social inclusion, equity of opportunity, access to justice, and physical safety. While the achievements are many, the Government has not lost its focus on those who continue to suffer disadvantage, including the long-term unemployed, people reliant on government support, the homeless, people with a disability or long-term illness, and people who are affected by the harms caused by alcohol and other drugs.

Despite some perceptions in the community that drug-related problems are caused primarily by illicit drugs, the drugs responsible for most harm are tobacco and alcohol. In addition to deaths and illnesses attributable to tobacco and alcohol, illicit drugs create their own harms through impacts including overdose deaths, criminal activity, drug-induced mental health disorders, and the transmission of HIV/AIDS, hepatitis C and other blood-borne viruses.

The ACT Government is aware that some issues impact men and women differently and that responses need to include consideration of the underlying causes of alcohol, tobacco and other drug use. Whilst some people use drugs to attain a pleasurable mood state, others use drugs as a response to social pressures or in response to pain, emotional distress, and dependence. The underlying causes of harmful drug use can include:

- experience of trauma and victimisation such as childhood sexual, physical and/or emotional abuse, partner violence, and other violent episodes
- marginalisation such as that experienced through social class, ethnicity, lifestyle choice, and gender
- social conditioning such as role modelling and cultural norms, and
- physical, mental or emotional ill-health.

To inform its focus on priority issues, population groups, interventions and practices, this ACT Alcohol, Tobacco and Other Drug Strategy 2010-2014 has drawn on the best and latest international and national research, combined with extensive consultation with key informants, including the ACT's highly experienced alcohol and other drug treatment and support services.

EXECUTIVE SUMMARY

Aim of the Strategy

The ACT Alcohol, Tobacco and Other Drug Strategy 2010-2014 aims to:

- improve the health and social well-being of individuals, consumers, families and carers, and the community in the ACT
- minimise the harm in our community from alcohol, tobacco and other drugs while recognising the individual needs of all citizens in the ACT
- develop evidence-based policies and initiatives to ensure that issues associated with harmful alcohol, tobacco and other drug use are addressed in an effective way, and
- implement the Strategy Action Plan in a manner that respects, protects and promotes human rights.

Guiding principles

The Strategy is guided by the following principles:

- harm minimisation, addressing all drugs, and implementing interventions across drug demand reduction, supply reduction and harm reduction
- applying evidence-informed policy
- enhancing health promotion, early intervention and resilience building
- recognition of social determinants of health and well-being
- increasing access to welcoming services, and
- strengthening partnerships, collaborations and ownership.

Focussing on drug type in the order of relative burden of harm

The title of the ACT Alcohol, Tobacco and Other Drug Strategy reflects the fact that alcohol and tobacco are the drugs that cause the most harm in Australian society. Together they account for 92% of Australian drug-related mortality, with other drugs – mostly illicit – accounting for only 8%. Of the overall burden of disease and injury nationally, tobacco accounts for 65% of the drug-related burden, alcohol 19% and illicit drugs 16%. In terms of the social costs of drug use nationally, tobacco accounts for 56%, alcohol 27% and illicit drugs 15%. Illicit drugs combined with alcohol account for a further 2%.

The Strategy reports in detail on the following areas, outlining a current assessment of the situation and challenges, identifying target populations and areas for further intervention, and where appropriate, describing drug availability:

- tobacco
- alcohol
- other drugs

- comorbidity
- consumer participation
- education, and
- workforce development.

Key Strategic Priorities

The ACT Alcohol, Tobacco and Other Drug Strategy 2010-2014 identifies a total of 66 key strategic priorities in the following eight categories:

- tobacco – five strategic priorities
- alcohol – twelve strategic priorities
- other drugs – nine strategic priorities
- comorbidity – two strategic priorities
- service system and consumer framework – sixteen strategic priorities
- education – eight strategic priorities
- workforce development – three strategic priorities, and
- research and surveillance – eleven strategic priorities.

Extent and nature of alcohol and other drug use and related harms

Below is an overview of the general extent and nature of alcohol and other drug use and related harms in the Territory that has informed the ACT Alcohol, Tobacco and Other Drug Strategy's key strategic priorities.

Trends

Nationally, daily smoking rates have fallen from one in four people in 1993 to one in six people in 2007. Amongst those still smoking in 2007, nearly one third had reduced their consumption. ACT figures show a trend of reduction in rates of smoking. The proportion of the ACT population aged 14 years and over who report smoking daily has reduced from 18.4% in 2001, and 16.17% in 2004 to 14.7% in 2007. Some 10% of female secondary school students report current tobacco use, as do 7.5% of the male students. Smoking rates among these students have fallen markedly in recent years.

Whilst one in five Australians aged 14 years or older consumed alcohol once a month or more at levels that placed them at risk of harm in the short term, half of all drinkers had undertaken at least some alcohol moderation behaviour, mostly for health reasons. In the ACT, consumption of alcohol at levels jeopardising health in the short term on one or more occasion yearly has decreased slightly from 39.1% in 2001 to 36.1% in 2007. The proportion reporting at least monthly consumption of alcohol at levels risking harm in the short term was 20.8% in 2004 and 21.1% in 2007.

On most indicators, the prevalence of harms related to psychoactive substances in the ACT are stable or falling. The only particularly problematic trend is the apparent shift among some people who use illicit drugs to more potent forms of amphetamines.

Drug use

Some 14.7% of ACT survey respondents aged 14 years or older reported smoking tobacco daily, a rate below the national prevalence of 16.6%. Whilst smoking rates in general population terms have fallen in recent years, there remain certain population groups requiring a priority focus. These population groups are:

- Aboriginal and Torres Strait Islander people, for whom smoking rates (41.1% in 2004-05) are far higher than in the general population
 - Although the rate of smoking is declining amongst Aboriginal and Torres Strait Islander secondary school students, these students were significantly more likely than students who were not Aboriginal and Torres Strait Islander people to report that they had smoked in 2005
 - Almost half (42.9%) of ACT resident Aboriginal and Torres Strait Islander women who gave birth during 2000-2004 reported that they smoked during pregnancy compared to 13.8% in the general population
- Adults in detention, for whom smoking rates are alarming (80% of women and 75% of men were current smokers according to the 2009 NSW Inmate Health Survey)
- Juveniles in detention, according to *The NSW Young People in Custody Health Survey*, commenced smoking at an average age of 12 years. Some 27% began smoking at ten years or younger
- People with mental illness smoke at a far higher rate than the general population. Smoking rates amongst people with mental illness are reported to be as low as 32% and as high as 88%
- People who use alcohol and/or other drugs smoke at far higher rates than the general population. Up to 95% of people undergoing alcohol and other drug treatment smoke. In the ACT 99% of Illicit Drug Reporting System participants (people who inject drugs) reported having ever smoked and also having recently smoked
- Women with low-to-middle incomes report higher rates of tobacco smoking than those with higher incomes. According to Australian Bureau Statistics' *National Health Survey 2004-05* unpublished data some 19.4% of women in the lowest and second-lowest of five household income brackets reported being current smokers. This compares with 8.5% of women in the highest bracket, and
- Men with low-to-middle incomes similarly reported higher rates of tobacco smoking than those with higher incomes. The 2004-05 *National Health Survey* found that the current smoking rate amongst professionals was 13% compared with 40% in 'labourers and related workers. Similarly, the Australian Bureau of Statistics found that 33% of men in the most disadvantaged areas reported daily smoking, compared with 16% in the most advantaged areas.

In 2007 some 88% of ACT survey respondents aged 14 years or older reported drinking alcohol, with 7% drinking daily and 10% drinking at levels that place them at risk of long-term alcohol-related harm. The national rates are 83%, 8% and 10% respectively.

The use of alcohol by some young people is concerning. In the ACT, over a 12 month period:

- 26% of 14-19 year olds risked short-term harm to their health from alcohol consumption (so-called “binge drinking”) on a monthly basis, and 7% risked long term harm
- 21% of those in the ACT aged 14 years and older reported drinking once a month or more at levels considered to be harmful in the short term, and
- alcohol (and for some, other drugs) is involved in a significant number of child protection cases. Data from NSW indicate that around half of the risk-of-harm reports made to Care and Protection Services (in NSW) involve parent/carer problematic use of alcohol and/or other drugs.

Some 14% of ACT survey respondents and 13% nationally aged 14 years or older reported using an illicit drug in the year before interview. Cannabis is the drug most frequently consumed, with 9% reporting recent use both in the ACT and nationally. In the ACT and nationally, a little over 2% report recent use of methamphetamine. Poly-drug use is the norm among people who inject illegal drugs and who use ‘ecstasy’ related drugs. On most indicators, the prevalence of harms related to psychoactive substances in the ACT is stable or falling. Heroin, ‘ecstasy’, cannabis and methamphetamine are said by users to be ‘easy’ to ‘very easy’ to obtain in the ACT, while cocaine availability remains low.

Drugs, crime and law enforcement

Over a 12 month period in 2008-09, a total of 1,023 people were taken into police custody in the ACT owing to intoxication.

Significant numbers of ACT residents report engaging in dangerous or otherwise problematic activities while under the influence of alcohol and/or other drugs. This includes the 16% of ACT residents who report driving a motor vehicle while under the influence of alcohol and the 6% who report going to work in that condition. In addition, 5% of ACT residents report driving under the influence of drugs other than alcohol and 2% report going to work in that condition. In the main, the male rates significantly exceed those of females.

In 2007-08, there were 423 arrests for drug offences (not including Simple Cannabis Offence Notices); on a per capita basis, this is 37% of the national rate. Of the total arrests (including Simple Cannabis Offence Notices) for all drugs, consumers (i.e. offenders not classified as providers) comprised 81%. Cannabis consumers comprised 60% of all ACT drug arrests in that year. Of the 104 inmates of the Alexander Maconochie Centre at 30 September 2009, only two had a drug offence as the most serious offence for which they had been incarcerated.

Drugs and health

Tobacco use is the largest single preventable cause of premature death and ill-health in Australia – accounting for an estimated 7.8% of the burden of disease on the population in 2003.

Alcohol is a major cause of deaths and hospital presentations. It is estimated that, over the 1992-2001 decade, alcohol caused the loss of 341 lives in the ACT. Of these, 82 deaths were from alcoholic liver cirrhosis, 54 from road crash injury, 33 from alcohol poisoning, 32 from suicide and 28 from other acute medical conditions.

Overdose is a major health threat to people who consume drugs. The ACT Ambulance Service attended 933 overdose incidents in 2009, with alcohol accounting for the majority (42%), and heroin for 13%. ACT rates of illicit drug-related hospital separations ('hospital separations' being a measure of hospital utilisation) are all far below those of Australia overall.

Hepatitis C is a blood borne virus with approximately 90% of new infections nationally being transmitted by shared injecting equipment. In the ACT in 2009 there were 7 incident cases (confirmed as 'new infections') and 158 unspecified cases (previously reported or of unknown duration) reported. The ACT rate of 45 per 100,000 population for unspecified cases is below the national rate of 51 per 100,000.

Comorbidity

There is an increasing awareness of the association between alcohol and other drug issues and mental illness. The National Centre for Education on Training and Addiction (NCETA) estimates that 50% to 75% of people with chronic alcohol and other drug problems experience an ongoing mental illness or disorder. Furthermore, within alcohol and other drug and mental health service settings, there is a shortfall in the proportion of staff within those settings with the expertise to treat comorbidity when compared with the proportion of clients with comorbidity issues.

Social inclusion

The Canberra Social Plan articulates a vision where all people reach their potential and make a contribution. An inclusive community supports this participation through a twin focus on building social cohesion and addressing disadvantage. Collaboration – including whole of government approaches, partnerships and access to integrated services – is the key to building an inclusive community and is reflected in the aims and guiding principles of The ACT Alcohol, Tobacco and Other Drug Strategy 2010-2014.

1. VISION

The ACT Government's vision is that Canberra will be recognised throughout the world as a truly sustainable and creative city; as a community that is socially inclusive – acknowledging and supporting those who are vulnerable and in need and enabling all to reach their full potential; as a centre of economic growth and innovation; as the proud capital of the nation and home of its pre-eminent cultural institutions, and as a place of great natural beauty.

The Canberra Plan: Towards Our Second Century articulates the vision through seven strategic themes that reflect the ACT Government's priorities.¹ The themes are:

- quality health care
- a fair and safe community
- excellent education, quality teaching and skills development
- a strong, dynamic economy
- a vibrant city and great neighbourhoods
- a sustainable future, and
- high-quality services.

2. AIMS

The ACT Alcohol, Tobacco and Other Drug Strategy 2010-2014 aims to:

- improve the health and social well-being of individuals, consumers, families and carers, and the community in the ACT
- minimise the harm in our community from alcohol, tobacco and other drugs while recognising the individual needs of all citizens in the ACT
- develop evidence-informed policies and initiatives to ensure that issues associated with harmful alcohol, tobacco and other drug use are addressed in an effective way, and
- implement the Strategy Action Plan in a manner that respects, protects and promotes human rights.

¹ Chief Minister's Department 2008, *The Canberra Plan: Towards our second century*, ACT Government: Canberra.

3. GUIDING PRINCIPLES

The ACT Alcohol, Tobacco and Other Drug Strategy 2010-2014 is guided by the following principles:

- harm minimisation
- applying evidence-informed practice
- enhancing health promotion, early intervention and resilience building
- recognition of social determinants of health and well-being
- increasing access to services, and
- strengthening partnerships, collaborations and ownership.

In recognising the social determinants of health and well-being, the Strategy recognises that people's lifestyles and the conditions in which they live and work strongly influence their health and well-being – including their use of alcohol, tobacco and other drugs. In work published by the World Health Organization, Wilkinson and Marmot² have identified a number of social factors that influence an individual's health and well-being. These social determinants are:

- addiction – the effects of alcohol and other drugs
- early life – the importance of ensuring a good environment in early childhood
- food – the need to ensure access to supplies of healthy food for everyone
- social exclusion – the dangers of social exclusion
- social support – the role of friendship and social cohesion
- stress – how the social and psychological environment affects health
- the social gradient – the need for policies to prevent people from falling into long-term disadvantage
- transport – the need for healthier transport systems
- unemployment – the problems of unemployment and job security, and
- work – the impact of work on health.

The Strategy also recognises the following factors as contributing to an individual's health and well-being:

- appropriate housing – access to appropriate, safe and affordable housing or shelter
- family relationships (parent/child and significant other), and
- greater empowerment of individuals/society as a whole.

2 Wilkinson, R & Marmot, M (Eds.) 2003, *Social determinants of health: the solid facts*. (2nd ed.). World Health Organisation, Denmark.

The Canberra Social Plan articulates a vision where all people reach their potential and make a contribution. An inclusive community supports this participation through a twin focus on building social cohesion and addressing disadvantage. Collaboration – including whole of government approaches, partnerships and access to integrated services – is the key to building an inclusive community and is reflected in the aims and guiding principles of The ACT Alcohol, Tobacco and Other Drug Strategy 2010-2014.

In acknowledging the special needs of young people, the Strategy is guided by the ACT Young People's Plan 2009-2014 and its vision that the ACT is child and youth friendly, supports all young people to reach their full potential, make valuable contributions and share the benefits of our community.

In addition, the Strategy recognises the importance of tailoring education and the provision of information generally in accordance with developmental stages and life milestones of particular population sub-groups (e.g. the transition from school/college to university) as well as where the population sub-groups are in terms of their drug use (e.g. pre experimental, experimental, regular, dependent, recovering/stabilising).

Mindful of the ACT's cultural and linguistic diversity, including the needs of people speaking English as a second language or not at all, the Strategy is guided by the principles of the ACT Multicultural Strategy – including a commitment to building a better future for all Canberrans, regardless of their cultural and linguistic background. This Strategy recognises that consideration of culture and background is fundamentally important when engaging with a diverse community. As such, it is acknowledged that a variety of stressors place priority groups such as refugee communities at greater risk of drug-related harms.

4. PRIORITY SETTING FRAMEWORK AND INTERVENTIONS LADDER

The strategic priorities identified in this strategy have been assessed according to The Basic Priority Rating model.³

The Basic Priority Rating model as described by authors Vilnius and Dandoy is a widely used tool for priority setting. People who use it identify empirical, usually quantitative, indicators on each of the criteria listed below. Weights are applied to each criterion according to its relative importance and a total score obtained for each area being considered. The Basic Priority Rating model takes into account the size and severity of the various problems that could be addressed, as well as the environmental factors that facilitate or impede effective and efficient intervention implementation.

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

McDonald, D 2004, *The ACT Alcohol, Tobacco and Other Drug Strategy 2004-2008 proposal for Further Developing Structures and Processes for Implementing the Strategy*, Social Research and Evaluation Pty Ltd: Canberra.

The criteria for priority-setting used in this approach are:

- the size of the problem, usually based on incidence or prevalence rates
- the seriousness of the problem, based on its urgency, severity, economic loss and impact on others
- the effectiveness of interventions available to address the problem, and
- other environmental factors including
 - propriety
 - economics
 - acceptability
 - legality of solutions, and
 - availability of resources.

This Strategy has been developed recognising that its health and other measures must strike a balance between determining healthy living conditions and protecting members of the public from harm caused by others. On one hand it is important to avoid coercion and the unnecessary restriction of freedom. On the other hand, health and other measures must address inequitable health outcomes for disadvantaged and vulnerable populations. Finding the right balance has and continues to need to be guided by the “intervention ladder”.⁴ For a full explanation of this model see Appendix One.

5. HARM MINIMISATION

Nationally, harm minimisation has formed the basis of the approach to problematic drug use since its adoption in 1985. Indicative of the success associated with harm minimisation, 2007 survey data⁵ suggests:

- whilst 44.6% of Australians aged 14 years or older had smoked 100 or more cigarettes at some time in their lives, 19.4% had smoked in the preceding 12 months
- whilst 82.9% of Australians aged 14 years or older had consumed alcohol in the preceding 12 months, the proportion of those reporting to consume alcohol daily fell significantly from 8.9% in 2004 to 8.1% in 2007, and
- whilst 38.1% of Australians aged 14 years or older had ever used an illicit drug, 13.4% (down from 15.3% in 2004) had used illicit drugs in the preceding 12 months. Most notable is the significant reduction in recent use of cannabis which dropped from 11.3% in 2004 to 9.1% in 2007.

4 Nuffield Council on Bioethics 2007, *Public health: ethical issues*, Nuffield Council on Bioethics: London.

5 Australian Institute of Health and Welfare 2008, *2007 National Drug Strategy household survey: State and Territory Supplement*, cat. No. PHE 102: AIHW, Canberra.

In the ACT, harm minimisation continues to be the basis for alcohol, tobacco and other drug policies and service provision. Harm minimisation represents a three-pillared philosophical and practical approach that aims to improve health, social and economic outcomes for the community and individuals by encompassing a wide range of approaches, including:

- **Supply-reduction** strategies designed to disrupt the production and supply of illicit drugs and to control and regulate licit substances
- **Demand-reduction** strategies designed to prevent the uptake of harmful drug use and treatment to reduce drug use, and
- **Harm-reduction** strategies designed to reduce drug-related harm to individuals and communities.

It is useful to be aware of the sources of drug-related harm. One useful approach is to consider two dimensions, one identifying the *types of harms* (e.g. health, social and economic functioning, safety and public order, criminal justice) and the other identifying *who bears the harm or risk* (e.g. people who use drugs, suppliers of drugs, intimates, employers, neighbourhoods, society, etc.) and the primary sources of harm (e.g. drug use, the legal status of drugs, and drug interventions including prevention, treatment and enforcement).⁶ In combination, these clarify thinking about the sources of drug-related harms and facilitate targeting the interventions.

The overarching test for any service or policy will be to ensure that each achieves the most benefit, and therefore the least net harm, to individuals and society.

6. PRESENT SITUATION

The title of the ACT Alcohol, Tobacco and Other Drug Strategy reflects the fact that alcohol and tobacco are the drugs that cause the most harm in Australian society. Together they account for 92% of Australian drug-related mortality, with other drugs (mostly illicit ones) accounting for only 8%. Of the overall burden of disease and injury nationally, tobacco accounts for 65% of the drug-related burden, alcohol 19% and illicit drugs 16%. In terms of the social costs, tobacco accounts for 56%, alcohol 27% and illicit drugs 15%. Illicit drugs combined with alcohol account for a further 2%.⁷

6 Adapted from MacCoun, RJ & Reuter, P 2001, *Drug war heresies: learning from other vices, times, and places*, Rand Studies in Policy Analysis, Cambridge University Press: Cambridge, UK, pp. 102-12.

7 Begg, S, Vos, T, Barker, B, Stevenson, C, Stanley, L & Lopez, AD 2007, *The burden of disease and injury in Australia 2003*, AIHW cat. no. PHE 82, Australian Institute of Health and Welfare, Canberra.

Collins, DJ & Lapsley, HM 2008, *The costs of tobacco, alcohol and illicit drug abuse to Australian society in 2004/05*, National Drug Strategy Monograph Series no. 64, Department of Health and Ageing, Canberra.

This section examines in turn the following categories:

- tobacco
- alcohol
- other drugs
- comorbidity
- consumer participation
- education, and
- workforce development.

Each category outlines a current assessment of the situation and challenges, identifies target populations or areas for further intervention, and where appropriate, describes drug availability.⁸

6.1 Tobacco

Current Assessment

The ACT has a relatively low level of daily smoking amongst adults at 14.7%, the lowest of all Australian states and territories.⁹

Reductions in smoking rates are attributed to a broad range of strategies including:

- the impact of new graphic health warnings on cigarette packaging in March 2006
- Commonwealth-funded national mass media campaigns over the past decade
- legislative amendments to increase bans, which in the ACT have resulted in
 - smoking bans in enclosed public spaces such as restaurants, pubs and nightclubs
 - a prohibition on vending machines distributing tobacco products
 - bans on smoking within all ACT Government schools and their grounds, and
 - bans on smoking other than in designated areas at the Canberra Stadium and Manuka Oval; and
- ACT Health funding provided to a range of sporting, arts, cultural and recreational organisations to promote smoke free messages. ACT Health has also funded a project to prevent uptake of smoking amongst 13-19 year olds

⁸ The prevalence rates presented in this Strategy are crude rates, not adjusted for the different age distributions of the various populations referred to, owing to the absence of the data needed to estimate age-adjusted prevalence rates. Nonetheless, in almost all cases, age-adjusted rates, if available, would be very similar to the crude rates presented.

⁹ Australian Institute of Health and Welfare 2008, *2007 National Drug Strategy Household Survey: State and Territory Supplement*, Cat. No. PHE 102. AIHW: Canberra.

who have left traditional school settings. ACT Health continues to fund the Quitline Program – a 24 hour phone line as well as cessation programs in schools and to those in the general community. During 2007-08, the Quitline Program received 1835 calls.¹⁰

Despite nicotine being reported as a principal drug of concern (i.e. the main drug as stated by the client that has lead to that client seeking alcohol and other drug treatment) in only 2% of all alcohol and other drug treatment episodes delivered nationally in 2007-2008, nicotine was the fourth most common drug of concern (i.e. reported by clients to be of concern in addition to the principal drug of concern) overall.¹¹

In a 2008 report focusing on women's health in the ACT, Maslen, using data from the Australian Bureau of Statistics National Health Survey 2004-05, describes tobacco smoking in the context of social determinants of health and wellbeing. Maslen associates increased prevalence of tobacco smoking with low autonomy, caring for families, low income, unemployment and poor mental health. Maslen notes:

*Tobacco smoking follows a socioeconomic gradient, with a greater prevalence of people with lower socioeconomic status smoking than higher status people. The importance of understanding 'unhealthy' behaviours as linked to socioeconomic factors is well illustrated in an assessment of the high prevalence of tobacco smoking amongst mothers with low incomes. Low income mothers isolated with young children were found to report above average rates of tobacco smoking. Smoking prevalence was attributed to the strains of caring responsibilities and material disadvantages...*¹²

Despite the decreasing prevalence of tobacco use, smoking remains the single greatest preventable cause of death and disease in Australia. Additionally, smoking is more common in certain sub-populations compared with the mainstream Australian population.

Drug Availability

A total of 372 retail tobacconists' licences were on issue at February 2010, a slight increase on the 351 licences that were on issue at the end of 2007.¹³

Tobacco is the second most accessible drug nationally with almost 50% of those aged 14 years or older reporting that tobacco was offered or available for consumption

10 ACT Cancer Council performance report 2008-09.

11 Australian Institute of Health and Welfare 2009, *Alcohol and other drug treatment services in Australia 2007-08: Findings from the National Minimum Data Set*. AIHW Drug Treatment Series No 9, Bulletin no. 65. Cat. no. AUS 107. AIHW: Canberra.

12 Maslen, S 2008, *Social determinants of women's health and wellbeing in the Australian Capital Territory*, Women's Centre for Health Matters Inc: Canberra.

13 Source: ACT Office of Regulatory Services, unpublished data.

within the last 12 months.¹⁴ Similarly, the ACT Secondary Student Drug and Health Risk Survey found that almost half (48.1%) of ACT Aboriginal and Torres Strait Islander secondary school students surveyed indicated that it would be ‘easy’ or ‘very easy’ for them to get someone to buy cigarettes for them.¹⁵

Target Populations for Further Intervention

In light of the challenges and opportunities in relation to tobacco and certain population groups, the following target populations are identified for priority focus. A detailed description of the target populations’ use of tobacco is provided at Appendix Two. The target populations are:

- Aboriginal and Torres Strait Islander people
- adults in detention
- juveniles in detention
- people with mental illness
- people who use or are recovering from harmful use of alcohol and/or other drugs
- women with low-to-middle incomes, and
- men with low-to-middle incomes.

6.2 Alcohol

Current Assessment

According to the *National Alcohol Strategy 2006-2009: Towards safer drinking cultures*¹⁶ alcohol is important to Australian employment, retail activity, export income and taxation revenue. Alcohol is also a drug traditionally and culturally significant to the ways in which many Australians celebrate, relax and socialise. The *2007 National Drug Strategy Household Survey* found that 83% of people aged 14 years or more drank alcohol in 2007.

For many Australians alcohol is a drug that can promote feelings of relaxation and euphoria. For others however, alcohol can lead to intoxication, dependence and a wide range of associated harms. Recent financial estimates suggest that alcohol costs

14 Australian Institute of Health and Welfare 2008, *2007 National Drug Strategy, Household Survey: first results*. Drug Statistics Series number 20. Cat. No. PHE 98, pg xi. AIHW: Canberra.

15 Population Health Research Centre, ACT Health 2007, *The Health of Aboriginal and Torres Strait Islander People in the ACT, 2000-2005*. Population Health Research Centre, ACT Health: Canberra.

16 *National Alcohol Strategy 2006 – 2009: Towards Safer Drinking Cultures*. Ministerial Council on Drug Strategy, Commonwealth of Australia: n.p.

the Australian economy some \$15.3 billion per annum in health and policing costs and lost productivity.¹⁷

According to the Australian Burden of Disease Study conducted by the School of Population Health at the University of Queensland and the Australian Institute of Health and Welfare¹⁸, alcohol dependence and harmful use is the seventh most prevalent health condition among Australians (4%).

The proportion of ACT residents who drink alcohol daily (6.6%) is similar to the national population (8.1%).¹⁹ The proportion drinking at levels that place them at risk of long-term alcohol-related harm (using the National Health and Medical Research Council's definition²⁰) is a little lower than the national proportion (9.9% cf. 10.3%). A lower proportion of ACT males drink at harmful levels than the national figure (8.6% cf. 10.2%), whereas among females the ACT and national figures are similar (11.1% cf. 10.5%).

Over a recent 12 month period, alcohol affected the ACT in the following ways:

- 15 deaths per year, on average, caused directly by alcohol²¹
- five road deaths per year, on average, caused by drivers affected by alcohol²²
- 293 ACT inpatient hospitalisations as a direct result of alcohol use²³
- 616 emergency department presentations for ACT residents²⁴
- 390 ambulance attendances per year for high level intoxication involving alcohol²⁵
- alcohol (and for some, other drugs) is involved in a significant number of child protection cases. Data from NSW indicate that around half of the risk-of-harm

17 Collins, DJ, & Lapsley, HM 2008, *The costs of Tobacco, Alcohol and Illicit Drug Abuse to Australian Society in 2004/05*. Commonwealth of Australia: Canberra.

18 Begg, S, Vos, T, Barker, B, Stevenson, C, Stanley, L, Lopez, AD 2007, *The burden of disease and injury in Australia 2003*. PHE 82. AIHW: Canberra.

19 Australian Institute of Health and Welfare 2008, *2007 National Drug Strategy household survey: State and Territory supplement*, cat. no. PHE 102, AIHW: Canberra.

20 National Health and Medical Research Council (Australia) 2001, *Australian alcohol guidelines: health risks and benefits*, National Health and Medical Research Council: Canberra.

21 Population Health Research Centre, ACT Health unpublished data.

22 Chikritzhs, T, Catalano, P, Stockwell, T, Donath, S, Ngo, H, Young, D, et al 2003, *Australian alcohol indicators: Patterns of alcohol use and related harms for Australian states and territories 1990-2001*, National Drug Research Institute and Turning Point Alcohol & Drug Centre, Melbourne.

23 Population Health Research Centre, ACT Health unpublished 2006-2007 data.

24 ACT Health unpublished EDIS data 2008-2009. This figure does not indicate the definitive number of alcohol-related presentations to the Emergency Department as a number of other presentations such as violent injury or accident diagnoses may be related to alcohol consumption and not recorded as such due to having an alternative primary diagnosis.

25 Source: ACT Health unpublished Ambulance Service Attendance 2009 data, February 2010.

reports made to Care and Protection Services (in NSW) involve parent/carer use of alcohol and other drugs.²⁶

- 26% of 14-19 year olds at risk of short term harm to their health from alcohol consumption on a monthly basis, and 7% at risk of long term harm²⁷
- 10% of those in the ACT aged 14 years and older reporting drinking at risky or at high risk levels in the long term²⁸
- 21% of those in the ACT aged 14 years and older reporting drinking once a month or more at levels considered to be harmful in the short term²⁹
- 2,261 people seeking drug treatment for problems involving alcohol³⁰
- 43 infringements for liquor licensing breaches³¹
- 324 identification documents (i.e. licences suspected to be fraudulently altered or belonging to another) confiscated and forwarded to the Office of Regulatory Services for investigation³²
- 63 cautions to underage person identified in licensed premises³³
- 1,523 drivers convicted of drink driving offences, and³⁴
- 1,023 people were lodged in custody for being intoxicated including 317 taken into police custody for their own protection and 650 for disorderly conduct.³⁵

The following key areas are now explored in more detail:

- Alcohol and policing
- Alcohol and violence

26 Estimation based on Department of Community Services, NSW figures in the absence of ACT data. Source is: Bruce Barbour, NSW Ombudsman letter to The Hon Jenny Macklin MP, Minister for Families, Housing, Community Services and Indigenous Affairs, dated 15 July 2008.

27 2007 National Drug Strategy Household Survey – ACT Confidentialised Unit Record File.

28 Australian Institute of Health and Welfare 2008. *2007 National Drug Strategy Household Survey: detailed findings*. Drug statistics series no. 22. Cat. no. PHE 107. AIHW: Canberra.

29 Ibid.

30 Australian Institute of Health and Welfare 2009, *Alcohol and drug treatment services in the Australian Capital Territory 2007-08: findings from the National Minimum Data Set*. Cat. No. HSW 76. AIHW: Canberra..

31 Office of Regulatory Services, ACT Department of Justice and Community Safety unpublished data 2007-2008.

32 Office of Regulatory Services, ACT Department of Justice and Community Safety unpublished data, 18 February 2009.

33 Ibid.

34 Department of Justice and Community Safety nd, *ACT criminal justice statistical profile*, 1 October 2008-31 August 2009, ACT Department of Justice and Community Safety: Canberra.

35 Australian Federal Police 2008, ACT Policing: submission to the Department of Justice and Community Safety Discussion Paper: Review of the Liquor Act 1975, ACT Policing: Canberra.

- Alcohol and regulation, and
- Alcohol and advertising.

Alcohol and policing

It has been estimated that nationally, approximately 62% of police time is spent in response to alcohol-related incidents. Alcohol is involved in 73% of assaults, 77% of street offences, 40% of domestic violence incidents and in approximately 90% of all late-night Police call-outs.³⁶

The ACT and Western Australia are the only two Australian jurisdictions not to have a zero blood alcohol concentration limit for novice (i.e. learner and provisional) drivers. There is considerable evidence to suggest that young and/or inexperienced drivers are more adversely affected by alcohol at lower levels than more mature drivers. Young drivers are over represented in alcohol related crashes in Australia and are more at risk because their driving skills are still developing and they need to exercise more conscious control over their driving.³⁷ There is also evidence to suggest that young novice drivers find it difficult to effectively monitor their alcohol consumption to stay below 0.02.³⁸

Alcohol and violence

There is a well-established link between violence and alcohol consumption. In 2001, an authoritative review of pharmacological, psychological, sociological, and epidemiological studies concluded that there is an indisputable causal link between alcohol consumption and violence in Australia.³⁹ A 1995 study estimated that, in Australia, 47% of all perpetrators, and 43% of all victims of assault, were intoxicated prior to the assault.⁴⁰

A 2003 Productivity Commission study estimated that, in Australia, alcohol is involved in 73% of assaults and 40% of domestic violence incidents.⁴¹ Another estimated that between 1993-94 and 2000-01, there were 21,487 hospitalisations in Australia of females for injuries

36 Doherty, SJ & Roche, AM 2003, *Alcohol and Licensed Premises: Best Practice in Policy, A Monograph for Police and Policy Makers*, Australasian Centre for Policing Research: Adelaide.

37 Chikritzhs, T, Catalano, P, Stockwell, T, Donath, S, Ngo, H, Young, D & Matthews, S 2003, *Australian Alcohol Indicators: Patterns of Alcohol Use and Related Harms for Australian States and Territories 1990-2001*, National Drug Research Institute and Turning Point Alcohol & Drug Centre: Melbourne.

38 Ibid.

39 Graham, K. & West, P 2001, *Alcohol and crime: examining the link*. Cited in: Heather, N, et. al. *International Handbook of Alcohol Dependence and Problems*. John Wiley & Sons: New York, Brisbane, Toronto.

40 English, DR., Holman, CDJ, Milne, E 1995, *The quantification of drug caused morbidity and mortality in Australia, 1995*, Commonwealth Department of Human Services and Health: Canberra.

41 Doherty, SJ & Roche, AM 2003, *Alcohol and Licensed Premises: Best Practice in Policy, A Monograph for Police and Policy Makers*, Australasian Centre for Policing Research: Adelaide.

from alcohol-related assaults.⁴² In 2005, the Steering Committee for the Review of Government Service Provision found that excessive alcohol was an important factor in 50% of cases of domestic physical and sexual violence.⁴³

It is well documented that in Australia there are many sexual assaults that occur each year following perpetrators spiking drinks with alcohol.⁴⁴ These sexual assaults are almost always against women who are voluntarily consuming drinks almost always bought by male friends or acquaintances, who do not inform the women that the drinks are double or triple 'shots' of spirits. They then sexually assault the women when the latter are so affected by alcohol that they are incapable of consenting to sex.⁴⁵

There is little robust ACT data on these general trends. However, national publications on alcohol consumption provide some assistance. The authors of a 2002 study⁴⁶ estimated rates of hospitalisations for injuries due to assaults caused by alcohol in Australia. To do so, they relied on data from hospital admission records and serious assaults reported to police in each Australian state and territory.

The authors estimated that in 1998 and 1999, some 62,534 alcohol-related assaults were reported to police, and that many assaults went unreported. Further, they estimated that 8,661 hospitalisations were due to assaults caused by alcohol consumption. They also estimated that 74% of the hospitalised individuals were male and that two-thirds were aged 15 to 34 years. The authors suggested that of all the states and territories, the ACT had the lowest estimated rate of alcohol-related assaults, causing hospitalisation at 1.4 per 10,000 persons.

The authors of the 2004 National Alcohol Indicators Bulletin⁴⁷ made estimations about causes of youth death due to 'risky/high-risk drinking'. Their estimations that bear on

42 Chikritzhs, T, Catalano, P, Stockwell, T, Donath, S, Ngo, H, Young, D & Matthews, S 2003, *Australian Alcohol Indicators: Patterns of Alcohol Use and Related Harms for Australian States and Territories 1990-2001*, National Drug Research Institute and Turning Point Alcohol & Drug Centre: Melbourne.

43 Steering Committee for the Review of Government Service Provision 2005, *Overcoming Indigenous Disadvantage Key Indicators 2005 Report*, Productivity Commission: Melbourne.

44 Moreton, R & Bedford, K 2002, *Spiked drinks: A focus group study of young women's perceptions of risk and behaviours*, Central Sydney Area Health Service: Sydney.

Taylor, N, Prichard, J, Charlton, K, 2004, *National Project on Drink Spiking: Investigating the nature and extent of drink spiking in Australia*, Commissioned by the Ministerial Council on Drug Strategy as a project under the cost shared funding arrangement, Prepared by the Australian Institute of Criminology: Canberra.

45 Taylor, N, Prichard, J, Charlton, K, 2004, *National Project on Drink Spiking: Investigating the nature and extent of drink spiking in Australia*, Commissioned by the Ministerial Council on Drug Strategy as a project under the cost shared funding arrangement, Prepared by the Australian Institute of Criminology: Canberra.

46 Matthews, S, Chikritzhs, T, Catalano, P, Stockwell, T, & Donath, S 2002, *Trends in Alcohol-Related Violence in Australia, 1991/92-1999/00*, National Alcohol Indicators Bulletin No. 5, National Drug Research Institute and Turning Point Alcohol & Drug Centre: Melbourne.

47 Chikritzhs, T & Pascal, R. 2004 *Trends in Youth Alcohol Consumption and Related Harms in Australian Jurisdictions, 1990-2002*, National Alcohol Indicators Bulletin No. 6, National Drug Research Institute: Perth, WA.

violence-induced death are twofold. First, suicide is the second most common cause of death due to risky/high-risk drinking among Australian youth. Second, for women, it is almost as common to die from assaults caused by risky/high risk drinking as from suicide. The Bulletin features only one ACT-specific statistic: the rate of alcohol-attributable deaths for 15–24 year old individuals over the years 1993 to 2002 inclusive was 0.6 per 10,000 persons. There is no breakdown of how many of these deaths involved suicide or assault.

Alcohol and regulation

The ACT had 606 liquor licences in operation at the end of 2007, a licence-to-population ratio similar to a decade earlier.

Underage drinking has been a problem in some licensed venues in the ACT. Between July 2004 and April 2007 there were 347 breaches identified by Office of Regulatory Services inspectors. Of these:

- 15% involved breaches of the underage drinking provisions in the Liquor Act
- 35% for non-compliance with licensing conditions, and
- 30% for non-compliance with the standards of the Liquor Licensing Standards Manual.⁴⁸

The ACT Government has recently completed a review of the *Liquor Act 1975* and the Liquor Bill 2010 is planned to be introduced into the Assembly in the June 2010 sittings. It has been proposed that new laws will make it an offence to:

- provide alcohol to an already intoxicated person by both patrons and employees on licensed premises
- abusing, threatening or intimidating an employee for refusing service of alcohol, and
- offering alcohol promotions which encourage rapid consumption of alcohol.

Key elements of the proposed ACT reform package include:

- risk based licensing fees
- dedicated ACT Policing liquor licensing teams
- the provision for lockouts at licensed premises if required
- the introduction of mandatory responsible service of alcohol training for all staff and security guards
- a requirement on licensees to provide, contribute towards, or otherwise identify transport options for patrons to get home safely after early morning trading
- new police powers including the power to impose an emergency 24 hour suspension of trade on the spot

48 Department of Justice and Community Safety 2007, *ACT Auditor-General's Office of Performance Audit Report, Regulation of ACT Liquor Licences*, pp. 42-43, Department of Justice and Community Safety: Canberra.

- public notification of liquor licensing applications with provision for members of the community to comment on prospective liquor licences
- new powers for the Commissioner for Fair Trading to impose and vary conditions on a licence at any time to protect the interests of the community
- new powers for the Commissioner for Fair Trading to refuse a licence application if it is not in the interests of the broader community, aimed at preventing the over representation of licensed premises in a single location, and
- the collection of wholesale alcohol data.

According to the *National Alcohol Strategy 2006-2009*⁴⁹, the absence of reliable alcohol consumption data is problematic. The *National Alcohol Strategy* notes:

While there are estimates of per capita alcohol consumption in Australia, there are no longer any accurate records of actual consumption since the collection of wholesale alcohol sales data ceased in some jurisdictions [including the ACT] in 1997.

The National Alcohol Indicators Project researchers⁵⁰ agreed, noting that alcohol wholesale sales data were “*essential for the evaluation of licensing restrictions in Indigenous communities...as well as for numerous local, regional and jurisdiction-wide monitoring exercises*”.

Alcohol wholesale sales data are understood to be important for a number of reasons. These include that alcohol wholesale sales data are:

- the most accurate estimate of true per capita alcohol consumption, as self-report data from surveys account for only between half and three-quarters of known alcoholic beverage sales⁵¹, and there is probably a systematic bias in the pattern of responses
- the only valid source of local level data on consumption levels and, very importantly, beverage mix (i.e. the proportion that is wine, beer, spirits, mixers, high and low alcohol beer, etc.). Local level data are crucial for making local policy decisions on matters such as liquor licensing. Although the ABS produces the *Apparent Consumption of Alcohol, Australia* report this does not aggregate the data to a jurisdictional level
- core data items for undertaking local, regional and Territory-wide evaluations – such as those measuring the effectiveness of any new alcohol management

49 Ministerial Council on Drug Strategy, Strategy Development Team 2006, *National Alcohol Strategy 2006-2009: Towards safer drinking cultures*, MCDS: Canberra.

50 Chikritzhs, T, Catalano, P, Stockwell, T, Donath, S, Ngo, H, Young, D & Matthews, S 2003, *Australian alcohol indicators, 1990-2001: patterns of alcohol use and related harms for Australian states and territories*, National Drug Research Institute, Curtin University of Technology: Perth, WA, p.4.

51 Ibid.

strategies such as ‘lock outs’ and the increased tax on pre-mixed spirits (alcopops)⁵²

- essential information in monitoring consumption trends
- a benchmark for gauging the accuracy of alcohol consumption surveys, and
- able to facilitate studies of the relationships between changes in the level of per capita consumption and both population health outcomes and social harms (e.g. alcohol related violence).⁵³

Alcohol and advertising

Other developments have occurred in parallel with a national decline in mean per capita alcohol consumption. These include: an increase in production of various alcohol product types (e.g. wine); the emergence of new types of products (e.g. alcopops) designed to appeal to specific sectors of the market; expanded outlet types (e.g. supermarkets); and more relaxed drinking laws (e.g. extended trading hours, together with more aggressive, creative and pervasive marketing). While mean consumption has decreased, sub-groups (e.g. young people, women) within the population drink more now than in previous generations and at riskier levels.

Very large amounts of money are spent on alcohol advertising in Australia, not only in measured forms (i.e. \$124 million in 2004 on television, magazines, radio and billboards⁵⁴) but also in unmeasured forms of promotion (i.e. branded materials, point-of-sale materials, giveaways, sponsorships and special events). Unmeasured promotion is said to cost two to three times that spent on measured forms.⁵⁵ While arguments are still proffered by commercial interest groups that advertising does not increase alcohol consumption *per se* but merely influences brand preference, the available evidence from consumer studies is clear that this is not the case. Advertising is a potent and effective means by which to influence drinking levels and especially so where younger people are concerned. In addition, the pervasiveness of alcohol advertising is likely to have a cumulative effect not only on the target audience, but also on others who may be incidentally exposed to it.

Gender stereotyping, sexual innuendo, Australian icons and quintessential images of mateship and larrikin behaviour are recurrent themes in many Australian alcohol commercials and these advertisements perpetuate male stereotypes of masculinity and/or women as the butt of the joke. Using persuasive themes and stereotypes, alcohol advertisements often mirror themes that appear in non-alcohol

52 Hall, W, Chikritzhs, T, d’Abbs, P, & Room, R 2008, Alcohol sales data are essential for good public policies towards alcohol, *MJA*, vol. 189, no. 4, p.188.

53 Ibid.

54 Nielsen Media Research in King, E, Taylor, J & Carrol, T 2005, *Australian alcohol beverage advertising in mainstream Australian media 2003 to 2005: Expenditure, exposure and related issues*. Australian Department of Health and Ageing: Canberra.

55 Jernigan, DH, Ostroff, J, & Ross, C 2005, Alcohol advertising and youth: a measured approach. *Journal of Public Health Policy*, 26(3), 312-325.

advertisements.⁵⁶ This has a normalising effect such that young people are already familiar with the themes when they first experience alcohol advertising. Moreover, those who do not yet drink show a strong preference for image advertisements and intention to drink in the future.⁵⁷ In the USA, monitoring of alcohol advertising has found that young people have been consistently exposed to more beer, spirits and alcohol advertisements compared to adults.⁵⁸

The price of alcohol beverages, particularly at the point of sale, has an impact on people's choice of beverage and quantity consumed. Low income earners, young people and marginalised groups are especially price sensitive consumers. Promotional activities, such as 'happy hour' and special price promotions, have been associated with increased consumption during the promotion period in licensed outlets internationally.⁵⁹ Similar discounted drinks promotions are widely available in licensed outlets across Australia, including the ACT.

Drug Availability

Liquor licences

At February 2010 there were 632 current liquor licences issued under the *ACT Liquor Act 1975*.⁶⁰ The number of licences on issue in effect has changed very little over the last decade.

Service of alcohol

'Responsible service of alcohol' or alcohol server training aims to provide those involved in serving alcohol with the knowledge and awareness with which to responsibly serve alcohol on licensed premises. The Australian experience of alcohol server training outcomes reflects that found overseas.⁶¹ That is, that the behavioural

56 Austin, EW & Hurst, SJ 2005, Targeting adolescents? The content and frequency of alcoholic and non-alcoholic beverage ads in video and magazine formats popular among adolescents. *Journal of Health Communication*, 10(8), 769-785.

57 Kelly, KJ & Edwards, RW 1998, Image advertisements for alcohol products: Is their appeal associated with adolescents' intention to consume alcohol? *Adolescence* 33(129), 47-59.

58 Center on Alcohol Marketing and Youth 2005, *Youth exposure to alcohol advertising in magazines, 2001 to 2004: Good news, bad news*. Center on Alcohol Marketing and Youth: Washington.

Center on Alcohol Marketing and Youth 2007, *Drowned out: Alcohol industry "responsibility" advertising on television, 2001-2005*. Center on Alcohol Marketing and Youth: Washington.

59 MCM 2004, *WTAG binge-drinking research. Report of research and consultation for Wine Intelligence*. MCM Research Ltd: Oxford.

Kuo, M, Wechsler, H, Greenberg, P & Lee, H 2003, The marketing of alcohol to college students: The role of low prices and special promotions. *American Journal of Preventive Medicine*, 25(3), 204-211.

60 ACT Office of Regulatory Services data

61 Loxley, W, Toumbourou, J & Stockwell, T 2004, *The prevention of substance use, risk and harm in Australia: A review of the evidence*., The National Drug Research Institute and the Centre for Adolescent Health, Ministerial Council on Drug Strategy, Commonwealth of Australia: Canberra.

change of server practices is less associated with particular training programs and more associated with the managerial support for responsible service practice and enforcement of alcohol service laws. Where there is motivated management support, the likelihood of positive outcomes is increased⁶² but this is rare because of the “highly competitive retail liquor industry where profitability is the dominant driving force and responsible beverage service is an impediment to that end”.⁶³ Where liquor licensing programs include a mandatory component of training, effective enforcement and a high level of perceived detection of infringements, results may be improved. The possibility of substantial financial penalty is a strong motivator and enforcement vehicle in ensuring that licensees improve server training and behaviour.

Target Populations for Further Intervention

There are important benefits of alcohol screening and brief interventions to reduce use amongst those who drink significant amounts of alcohol on individual occasions. It is these individuals who are more likely to become alcohol related casualties, including becoming victims of alcohol related driving deaths. Given these drinkers may not drink alcohol on a daily or even weekly basis, they are often not alcohol dependent and often do not seek treatment. Interventions to engage with these drinkers need to be opportunistic, assessing and providing them with feedback in a relatively short period of time in primary health care settings, hospital emergency departments, mental health services and in the criminal justice system.

In light of the challenges and opportunities in relation to alcohol and certain population groups, the target populations listed below are identified as needing a priority focus. A detailed description of these target populations’ use of alcohol is provided at Appendix Three. The target populations are:

- young people
- Aboriginal and Torres Strait Islander people
- people in detention
- people with mental illness, and
- people who use alcohol and/or other drugs.

62 Saltz, R 1987, The roles of bars and restaurants in preventing alcohol impaired driving: An evaluation of server intervention. *Evaluation and Health Professionals*, 10(1): 5-27.

63 National Drug Research Institute 2007, *Restriction on the Sale and Supply of Alcohol: Evidence and Outcomes*. NDRI, Curtin University: Perth.

6.3 Other Drugs

Current Assessment

Illicit drugs

Reflecting the use of illicit drugs nationally, reports⁶⁴ indicate that:

- almost two in every five Australians (38.1%) aged 14 years or older had used an illicit drug at some time in their lives
- more than one in seven (13.4%) had used illicit drugs in the previous 12 months, including 17% of 14-19 year olds
- the most commonly-reported illicit drug used in the previous 12 months was marijuana/cannabis (9.1% of people aged 14 years or older), followed by ecstasy (3.5%), pain killers/analgesics used for non-medical purposes (2.5%) and meth/amphetamine (which includes 'ice') (2.3%), and
- the most accessible illicit drugs are marijuana/cannabis and painkillers/analgesics with 17.1% and 15.4% of the population respectively being offered or having the opportunity to use these drugs for non-medical purposes in the preceding 12 months.

In the same period the proportion of Australians approving of the regular use of illicit drugs was generally low (10.4%). A similar proportion (13.3%) 'neither approved nor disapproved' of the illicit use of painkillers/analgesics. Of Australians aged 18 years or older, more than one in five persons (20.2%) who used an illicit drug in the previous month reported high or very high levels of psychological distress – more than twice the proportion (8.7%) of those who had not used an illicit drug in the same period.⁶⁵

The ACT mortality rate from opioids, 1.0 per 100,000, was one-third of the national rate in 2004, the most recent year for which ACT data are available.

Police and illicit drugs

For all drugs, the ACT arrest rate plus Simple Cannabis Offence Notice rate was 143 per 100,000, only 36% of the equivalent national rate of 392 per 100,000.

64 Australian Institute of Health and Welfare 2008, *2007 National Drug Strategy Household Survey: first results*. Drug Statistics Series number 20. Cat. no. PHE 98. AIHW: Canberra.

Australian Institute of Health and Welfare 2008, *Making progress: the health, development and wellbeing of Australian's children and young people*. Cat. No. PHE 104. AIHW: Canberra.

65 Australian Institute of Health and Welfare 2008. *2007 National Drug Strategy Household Survey: first results*. Drug Statistics Series number 20. Cat. no. PHE 98. AIHW: Canberra.

The Australian Crime Commission (ACC) provides data concerning drug-crime arrests.⁶⁶ Using data provided by the Australian Federal Police, ACC advised that in the ACT in 2007-08, 449 people classified as drug ‘consumers’ were arrested or issued with a Simple Cannabis Offence Notice, and 66 people classified as ‘providers’ were arrested, a total of 515 offenders. This figure means consumers comprised 87% of the ACT total, compared with the national figure of 81%. The proportion of ACT consumer arrests appears to be increasing – while the proportions for 2007-08 and 2006-07 were both 87%, in 2005-06 82% of the ACT total was classified as consumers and 77% in 2004-05.

Cannabis offences are the most frequent. In the ACT in 2007-08, 94% (93% in 2006-07 and 92% in 2005-06) of people arrested for a cannabis offence or issued with a Simple Cannabis Offence Notice were consumers, compared with 86% nationally. Cannabis consumers were 58% (60% in the previous year) of all illicit drug arrests and Simple Cannabis Offence Notices in the ACT, a proportion similar to the 59% nationally.

According to the Drug Policy Modelling Program, a collaboration between the National Drug and Alcohol Research Centre and other organisations including the Australian National University, the University of Queensland and Burnet Institute, in their 2010 submission as part of the consultation process for Australia’s National Drug Strategy it was indicated that:

[The Illicit Drug Data Report 2006 -2007] data show that [nationally] consumer arrests far outstrip provider arrests. Of all arrests in 2006-07, 81% were of consumers and 19% providers. Naturally the number of consumer arrests will be higher than provider arrests simply because many more people use drugs than engage in selling, manufacturing or distributing them. Therefore little can be said in itself about the relative proportions of 80:20 ... If we are in agreement [however] that the most important role for law enforcement is to reduce supplies of drugs (through apprehending dealers and producers) then we would expect increasing provider arrests as an overall proportion of all drug arrests.⁶⁷

Benzodiazepines and other forms of pharmaceutical drugs

In Australia, the most commonly misused pharmaceuticals include painkillers/analgesics, benzodiazepines, and narcotic analgesics.⁶⁸

In 2007 the Parliament of Victoria Drugs and Crime Prevention Committee held an Inquiry into the Misuse/Abuse of Benzodiazepines and other forms of Pharmaceutical

66 Australian Crime Commission 2008, *Illicit drug data report 2007-08*, Australian Crime Commission, Canberra.

67 Drug Policy Modelling Program 2010, *Submission Australia’s National Drug Strategy: Beyond 2009 Consultation Process*

68 Australian Institute of Health and Welfare 2005, *National Drug Strategy Household Survey: Detailed Findings*, AIHW: Canberra.

Drugs in Victoria.⁶⁹ The Committee's report focused on prescribed drugs broadly known as benzodiazepines and the narcotic analgesics (opioids). Their findings included that:

- Numerous problems can occur when pharmaceutical drugs such as benzodiazepines and narcotic analgesics are used for non-medical purposes. Even when used as prescribed and under the care of a medical practitioner these drugs can have adverse effects
- The misuse of benzodiazepines and prescribed opioids can also have an effect at a macro level, in terms of impacts on the health budget, such as through hospital admissions and ambulance call-outs, crime rates and other outcomes at a population level, and
- In recent decades there have been large increases in the supply of narcotic analgesics into the Australian community. Whilst recognising that much of this supply may be reflective of better pain management and other improvements in treatment for a range of conditions, it nevertheless also represents an increase in the total supply potentially available for diversion and non-medical use.

Homelessness

Almost 105,000 Australians were homeless on the night of the 2006 Census which included around 16,000 persons sleeping rough, almost 7,500 families with children and around 32,500 young people aged 12-24 years.⁷⁰ Of immense concern is the 2.6% of Australian children under the age of five who will sleep in crisis accommodation at some stage during any year.⁷¹ According to the 2006 Census data there were 42 homeless persons per 10,000 of the ACT population.

People who are homeless or at risk of homelessness reflect the make-up of our diverse community. Many people are dealing with multiple problems, and are likely to have different needs depending on their household type and whether they live in remote, rural or urban areas.⁷²

The risk of homelessness can be exacerbated by other personal factors such as mental health issues, problematic use of alcohol and/or other drugs, problem gambling, a history of physical or sexual abuse, limited life skills, and poor financial literacy. At

69 Drugs and Crime Prevention Committee 2007, *Inquiry into Misuse/Abuse of Benzodiazepines and other Pharmaceutical drugs*, Parliament of Victoria: Melbourne.

70 Australian National Council on Drugs 2009, http://www.hip.org.au/pdf/homelessness_factsheet.pdf

71 Australian Bureau of Statistics 2006, *Census of Population and Housing Australia* (data for children aged 0 to 4 years);

Australian Institute of Health and Welfare 2009, *Homeless People in SAAP, Supported Accommodation Assistance Program, National Data Collection annual report 2007-08*, series 13, Cat. No. HOU 191, AIHW: Canberra.

72 Homelessness Australia 2008, *Green Paper on Homelessness Roundtable: Report of Key Issues*, (unpublished).

times, government policies or procedures that respond to these factors may inadvertently increase the risk of homelessness.

Vulnerability to homelessness is also heightened during important life transitions such as going from school to work, leaving the child protection system, family breakdown, retirement, leaving prison, or relocating.

One in three clients of Supported Accommodation Assistance Program services experiences problems with their use of alcohol and/or other drugs. Of the 165,000 support periods provided by selected agencies in 2005-06, almost 10,000 people (some 6%) nominated problematic use of alcohol and/or other drugs as the main reason for seeking assistance.⁷³ In many cases, intensive and ongoing addiction impairs their health and ability to live independently.⁷⁴ A study exploring the use of alcohol and other drugs among young people who experienced homelessness found that they use considerably more drugs than their peers who have homes. The study also found that the longer a person was homeless, the more likely it was that they would have problems with alcohol and/or other substances.⁷⁵ Nationally, of the respondents to the 2007 Illicit Drug Reporting System (people who inject drugs), some 11% reported that they had no fixed address and a further 11% were residing in a boarding house or hostel.⁷⁶

Target Populations for Further Intervention

In light of the challenges and opportunities in relation to drugs (other than tobacco and alcohol) and certain population groups, the following target populations are identified as needing a priority focus. A detailed description of the target populations' use of these drugs is provided at Appendix Four. The target populations are:

- Aboriginal and Torres Strait Islander people
- people in detention
- people with mental illness, and
- people who use alcohol and other drugs.

73 Australian National Council on Drugs 2009, http://www.hip.org.au/pdf/homelessness_factsheet.pdf

74 Thomson Goodall Associates 2003, *People who are Assisted by SAAP Services and Require a High Level and Complexity of Service Provision: An Enhanced Assessment and Measurement Framework*, a report to the Department of Family and Community Services.

75 Mallett, S, Edwards, J, Keys, D, Myers, P, & Rosenthal, D 2003, *Disrupting Stereotypes: Young People, Drug Use and Homelessness*, Key Centre for Women's Health in Society, University of Melbourne: Melbourne.

76 Australian National Council on Drugs 2009, http://www.hip.org.au/pdf/homelessness_factsheet.pdf

6.4 Comorbidity

Current Assessment

It is estimated that 6,024 adults in the ACT will experience both an alcohol and/or other drug and a mental health problem in any 12 month period.⁷⁷

In this Strategy, ‘comorbidity’ refers to situations where people experience mental health problems and alcohol and other drug problems concurrently. That is:

Situations where people have problems related to both their use of substances (from hazardous through to harmful use and / or dependence) and to their mental health (problematic symptoms through to highly prevalent conditions, such as, depression and anxiety, to low prevalence disorders such as psychosis)⁷⁸

Only a portion of these people will access assistance from a mental health service or an alcohol and other drug service. Estimates of the portion of people registered with alcohol and other drug services who have a comorbid mental health problem varies from between 60% and 85%.⁷⁹ Data collected by ACT Health’s Mental Health ACT in 2008-2009 indicated that 64.7% (4,751) of their current clients, aged 16 to 64, had a definite history of problematic alcohol and/or other drug use.

Alternatively, people experiencing mental health and alcohol and other drug problems concurrently may also seek assistance from the following types of services:

- Self-help groups – these groups are often led by people who have experienced similar problems themselves
- On-line resources – this can include information as well as more interactive programs aimed to assist individuals to better understand and address problems
- General Practitioners – whose skills and experience in this area may span a continuum from being fairly generic to being highly specialised, and
- A broad range of other community based support services such as Youth Services and Family Support Services.

Research indicates that people who do experience comorbidity are more likely to experience problems relating to homelessness, family disruption, poorer social supports, and financial and legal issues. The tendency for alcohol and other drugs to

77 This estimate is based on figures provided in the National Survey of Mental Health and Wellbeing (2007), with extrapolation using ACT population data from the 2006 ABS Census

78 New South Wales Health 2009, *NSW Clinical Guidelines For the Care of Persons with Comorbid Mental Illness and Substance Use Disorders in Acute Care Settings*, Sydney, New South Wales.

79 ACT Health 2009, Unpublished Data. Alcohol and Other Drug Service Provider correspondence.

impair judgement and reduce impulse control also places people experiencing comorbid conditions at greater risk of self harm, including suicide.⁸⁰

Working with people experiencing comorbidities is core business of both mental health and alcohol and other drug services. Building the capacity of these services to better meet the needs of people experiencing comorbidities has been the focus of a number of initiatives in recent years including the following.

- The establishment of an ACT Comorbidity Strategic Working Group with the assistance of funding provided by the Australian Government Department of Health and Ageing *National Comorbidity Project's Improved Services Initiative*. The Group is drawn from a range of key stakeholders including non-government alcohol and other drug treatment services, the ACT Division of General Practice, Headspace ACT, ACT Health's Mental Health ACT, ACT Health's Alcohol and Drug Program (ADP), and the Youth Coalition of the ACT. Initiatives implemented with the support of this group include:
 - 50% of the alcohol and other drug sector currently annually map their comorbidity capacity through the Dual Diagnosis Capability in Addiction Treatment (DDCAT) Index
 - Implementation of mental health screening tool by alcohol and other drug services
 - Implementation of an annual Comorbidity Interagency Day
 - Six monthly mapping of the provision of services to people experiencing comorbidity
 - Establishment of a General Practice working group, and
 - Reviewing models of service delivery within some services to better support people experiencing comorbidity.

Both the Alcohol and Drug Program (ADP) and Mental Health ACT (the specialist alcohol and other drug and mental health services) each employ a full time staff member whose focus is comorbidity. The Alcohol and Drug Program (ADP) also has a part-time medical registrar training position. Clinicians from Mental Health ACT are offered the opportunity to undertake the NSW Institute of Psychiatry – Mental Illness and Substance Abuse Unit course and follow up two-week supernumerary placement with the Alcohol and Drug Program's Detoxification Unit, Opioid Treatment Service, Consultation Nurse and Counselling Team.

80 Commonwealth of Australia 2007. *Psycheck: Responding to mental health issues within alcohol and drug treatment*. Canberra.

6.5 Consumer Participation

Current Assessment

The Australian Injecting and Illicit Drug Users League (also known as 'AIVL') is the national peak organisation representing the state and territory drug user organisations and issues of national significance for people who use or have used illicit drugs. In the final report on the Treatment Service Users Project, focusing on consumer participation in drug treatment agencies, AIVL noted that:

There is a strong belief amongst some providers that consumers are not interested in taking part in consumer participation activities. Similarly some consumers expressed the view that other consumers are not interested in consumer participation. This contrasts sharply with reports from consumers themselves many of whom say they would be willing to take part in consumer participation activities.⁸¹

This AIVL finding highlights that considerable communication gaps currently exist between providers and consumers, and also that a potential opportunity exists to both close the gap and substantially increase the level of participation.

The Treatment Service Users Project report also refers to the *National Drug Strategy: Australia's Integrated Framework 2004-2009* and notes that Strategy's commitment to consumer participation through:

- *improved access to quality treatment – through the involvement of consumers and drug user organisations, and*
- *a coordinated, integrated approach – through commitment to partnership.*

Whilst the Treatment Service Users Project report acknowledges that the National Drug Strategy broadly identifies the issue of consumer participation, AIVL stresses that the Strategy does not outline a consumer participation framework or approach with which to guide and support its implementation within drug related services and programs. AIVL further highlights that:

consumer and carer participation can occur across many levels including:

- *participation in treatment and care*
- *employment of consumers by services as consultants and advocates*
- *participation in service delivery and evaluation*
- *participation in policy and planning*
- *participation in education and training, and*

81 Australian Injecting and Illicit Drug Users League (AIVL) 2008, *Treatment Service Users Project final report*, AIVL: Canberra.

- *participation in staff recruitment.*

The benefits and successful outcomes stemming from consumer participation in health services have been listed by the National Resource Centre for Consumer Participation in Health⁸² as follows:

- *improvements in the quality of health care*
- *improvements in health outcomes*
- *more appropriate public policy*
- *better use of public funds*
- *better understanding and targeting of consumer issues and needs*
- *increased consumer control over health and health services, and*
- *improved communication between service providers and consumers.*

Input from consumers, carers and representatives of community organisations is an essential component of policy development, planning and service delivery. Also, as a principle, consumers should be remunerated for their involvement in consumer participation activities. Both consumers and service providers require access to quality training programs if they are to capitalise upon the potential benefits and successful outcomes consumer participation has to offer.

In the ACT in 2009 ACT Health funded drug treatment and support services all implemented a client satisfaction survey and those services will be repeating a survey every 12 -18 months.

There is a need for ongoing monitoring and evaluation to shift from a culture of complaint and review to one of continuous improvement.

6.6 Education (including Community Education and School Drug Education)

Effective community education programs recognise the importance of tailoring the information to reflect the developmental stages and life milestones of particular population sub-groups (e.g. the transition from school/college to university) as well as where the population sub-groups are in terms of their drug use (e.g. pre experimental, experimental, regular, dependent, recovering/stabilising).

Current Assessment

Every chance to learn: Curriculum framework for ACT schools Preschool to year 10 is the new curriculum framework⁸³ used by all ACT government and non-government

⁸² NRCCPH cited in Australian Injecting and Illicit Drug Users League (AIVL) 2008, *Treatment Service Users Project final report*, AIVL: Canberra.

schools to plan what is taught in the school curriculum from preschool to year 10. The framework states clearly what is essential for all students to learn and what all students are expected to be able to do as a result of that learning. The curriculum framework has been sequenced in four bands of development related to ages and school years.

The essential learning achievement, ‘The Student Takes Action To Promote Health’, aims to develop students’ capacity to make decisions and act in ways that promote their health and that of others. Health is a multi-dimensional concept used to describe a person’s physical, emotional, mental, cognitive, social and spiritual well-being. The relevant essential learning in relation to drugs has been defined under this achievement area.

In addition to school drug education, community education is occurring across a range of government and non-government sectors both locally and nationally, particularly in the area of smoking prevention.

For example, the ACT is regularly included in mass media smoking prevention campaigns, funded by both the Commonwealth and NSW Health, which include extensive TV advertising. This is supported in the ACT by key non-government organisations such as the Cancer Council ACT, which provides local smoking prevention and cessation support.

ACT Health’s SmokeFree Sponsorships also play a significant role in community education, through the provision of funding for sporting, arts, community and recreational organisations on the ACT to support signage, resources and smoke-free policy development.

Target Areas for Further Intervention

Reflecting the challenges and opportunities for education (including community education and school drug education), alcohol and roadside drug testing are highlighted below for priority focus.

Alcohol

Community education is important to increasing community support for changes to laws and policies that will prevent or reduce the harm caused by alcohol. According to the findings from the *National Drug Household Survey*,⁸⁴ the community’s support for a range of measures increased between 2004 to 2007, as shown in Table 3 below:

83 ACT Department of Education and Training 2008, *Every chance to learn: Curriculum framework for ACT schools Preschool to year 10*, Act Department of Education and Training: Canberra.

84 Australian Institute of Health and Welfare 2008, *2007 National Drug Strategy household survey: first results*, cat. no. PHE 98, AIHW.

Table 3: Community Support for Alcohol Control Measures

Measure	2004	2007
Increasing the price of alcohol	20.9%	24.1%
Reducing the number of outlets that sell alcohol	28.5%	32.2%
Reducing trading hours for pubs and clubs	32.0%	38.9%

The measures included in Table 3 are known to have an effect on the level of alcohol consumption. Consumers, including those who drink heavily, respond to the price of alcohol by drinking more when prices are lowered and drinking less at elevated prices. Increased taxes and prices have been demonstrated to reduce alcohol-related problems. Studies have shown that reducing the hours and days of alcohol sale, reducing numbers of outlets that sell alcohol and other restrictions on access to alcohol are associated with reductions in both alcohol use and alcohol-related problems.⁸⁵

The National Preventative Health Taskforce⁸⁶ has highlighted that, in general, the measures that are most often called for by community members tend to be the least effective, while the most effective measures are the least popular. Following reviews of available research evidence, the Taskforce has listed interventions that are considered most effective:

- regulating physical availability – including sales bans, hours and days of sale restrictions, and server liability
- taxation and pricing
- drink-driving countermeasures – including sobriety checkpoints, random breath testing, lowered blood alcohol concentration limits for less-experienced drivers, and ignition interlocks, and
- treatment and early intervention – including brief interventions and alcohol problems treatment.

Roadside Drug Testing

Any introduction of roadside drug testing will require an extensive social marketing strategy utilising the internet, electronic and print media. There are a number of target audiences requiring different messages and different communication channels.

1. The community at large: most of these people do not use the targeted controlled drugs; the purpose would be to inform them about new legislation and to reinforce their continuing non-use of the target controlled drugs.

85 Babor, TF et al. 2003, Alcohol: No Ordinary Commodity. A summary of the book, *Addiction*, 98, 1343-1350.

86 National Preventative Health Taskforce, Alcohol Working Group 2008, *Preventing Alcohol-related Harm in Australia: a window of opportunity*, Technical Report No. 3, Australian Government Preventative Health Taskforce: Canberra.

2. People who currently use the targeted controlled drugs: it is unlikely that new legislative provisions will affect their drug use and so messages should focus on any risk to road safety that research evidence shows is linked to their drug use, e.g. do not drive soon after using the drugs in question. The social marketing campaign for this target group will need to address the community at large through mass media, and include components targeted specifically at people who use the drugs in question. While peer education approaches would be part of the mix, it needs to be noted that most of the users of the targeted controlled drugs are not in touch with any helping services or with drug user organisations, primarily because they perceive themselves as experiencing little harm associated with their drug use and may have observed little harm linked to drug use among their peers.
3. People who currently use medicines capable of causing impairment: messages should focus on any risk to road safety that research evidence shows is linked to their use of medicines. Messages should include the types of medicines that are capable of causing impairment, the relationship between dose and impairment, how to recognise impairment, and where to go for help or to access further information.
4. Passengers and potential passengers in motor vehicles driven by somebody who has recently used one of the targeted drugs.

6.7 Workforce Development

This sub-section is informed by the work of the National Centre for Education on Training and Addiction which asserts that the alcohol and other drug field has experienced substantial changes that have major implications for the alcohol and other drug workforce. Having substantial impacts are:

- changing patterns in the use of alcohol and other drugs
- the increase in poly-drug use
- increased awareness of comorbidity
- expanding knowledge base
- improved treatment protocols, and
- the growing focus on evidence based practice.

This document adopts The National Centre for Education on Training and Addiction's definition of 'workforce development', subsequently endorsed by the Intergovernmental Committee on Drugs and adopted in other jurisdictions. Workforce development is defined as:

a multi-faceted approach which addresses the range of factors impacting on the ability of the workforce to function with maximum effectiveness in responding to alcohol and other drug related problems. Workforce development should have a systems focus. Unlike traditional approaches, this is broad and comprehensive, targeting individual, organisational and

*structural factors, rather than just addressing education and training of individual mainstream workers.*⁸⁷

This definition of workforce development within the alcohol and other drug field adopts a ‘systems’ approach. Accordingly, whilst the value of education and training is acknowledged, more attention needs to be given to the organisational context in which workers operate and the wider systems at large which may ultimately determine whether specific policies or practices can be put in place.

Underscoring the need for a systems approach to alcohol and other drug workforce development is the complex nature of alcohol and other drug related problems which rarely present in isolation from associated and equally complex issues. This interrelationship requires a holistic response from not only dedicated alcohol and other drug services but also from neighbouring systems such as:

- health
- human services
- law enforcement/criminal justice
- housing
- employment
- mental health
- disability services
- education, and
- childcare and child safety.

Current Assessment

There is an ongoing focus on workforce development in the ACT. Key achievements over the past three years in the alcohol and other drug sector include:

- establishment of the Alcohol and Other Drug Sector e-Bulletin
- establishment of an ACT Alcohol and Other Drug Sector website⁸⁸
- development and ongoing (i.e. 12 – 18 monthly) enhancement of a comprehensive directory of alcohol and other drug services, and communication and dissemination of it to the community, all health and medical services, justice services, housing services, employment services, welfare services, and social and family services
- worker participation on guided bus tours of ACT comorbidity related services

87 NCETA 2002 submission to IGCD.

88 <http://www.aodsector.org.au>

- the conduct of a Service User Satisfaction Survey in the ACT's alcohol and other drug agencies on 19 November 2009, and commitment for ongoing Survey repeats (i.e. 12 – 18 monthly)
- planning and implementation of a sector conference during Drug Action Weeks in 2008 and 2009
- the 2005 establishment of the ACT Alcohol and Other Drug Executive Directors' Group as a forum for the Executive Directors' contribution to broad policy direction within the sector
- the 2007 establishment of the ACT Alcohol and Other Drug Workers' Group as a forum for alcohol and other drug services' representatives to contribute to sector development
- commitment from all the major ACT alcohol and other drug treatment services to undertake full formal accreditation
- completion of an ACT alcohol and other drug workforce profile in 2006⁸⁹,
- completion of an ACT alcohol and other drug Workforce Qualification and Remuneration Profile in 2009, and commitment for ongoing (i.e. 12 – 18 monthly) updates to this resource
- recurrent funding since 2007 towards costs for non-government alcohol and other drug workers to undertake units in the Certificate IV in Alcohol and Other Drug Work, and
- agreement by all non-government operated alcohol and other drug programs funded by ACT Health on a Minimum Qualifications Strategy which is reflected in funding agreements.

Target Areas for Development

Reflecting on the challenges and opportunities in relation to workforce development, comorbidity is seen as a priority. Within alcohol and other drug and mental health service settings, there is an imbalance between the proportion of clients with comorbidity issues, and the proportion of staff within those settings with the expertise to treat comorbidity.

The association between alcohol and other drug issues and mental illness presents certain challenges for ongoing workforce development within the alcohol and other drug and mental health sectors. Establishing appropriate information sharing protocols is widely recognised as a particular challenge in relation to models of shared care. On this matter, Kavanagh has highlighted:⁹⁰

it is very difficult to have sufficiently close communication to make shared case management by AOD and MH [mental health] services practical in more than a very few cases. It is also too expensive to have a lot of people involved;

89 <http://www.health.act.gov.au/c/health?a=sendfile&ft=p&fid=1157081240&sid=>

90 Kavanagh, D 2007, cited in Mundy, J 2008, Dual Diagnosis: Where to from here? *Of Substance*, vol. 6, no. 3, July 2008: p. 18.

most of the people that are seen by a MH or AOD service don't fulfil priority service criteria for the companion service; and the services have very different emphases and modes of operation. So in many cases, attempts to refer for joint management are almost bound to fail.

In the ACT working with people with comorbidities is considered core business of both mental health and alcohol and other drug services. The key elements to success are considered to be partnership, consultation and supervision, reciprocal rotations and placements, workforce education and training and strong leadership.

7. EVALUATION OF PREVIOUS STRATEGY

The ACT Government has significantly increased funding to the alcohol and other drug sector over the past four years. In December 2007, the ACT Government committed \$10.8 million to the establishment of an Aboriginal and Torres Strait Islander people's residential rehabilitation facility. Other new ACT Government recurrent funding announced over the past four years includes:

- \$50,000 for a dedicated detox program for women and women with children on dedicated weeks throughout the year
- \$60,000 for vending machines for dispensing needle syringes in the ACT to give the community 24 hour access to sterile injecting equipment
- \$100,000 to create 100 additional subsidised places in the methadone and buprenorphine program for heroin dependent people
- \$150,000 for a peer education program for school age children and young people
- \$75,000 for expanding support for peer based models of service delivery, support and advocacy, and community development
- \$15,000 for monitoring and evaluating the ACT Alcohol, Tobacco and Other Drug Strategy 2004-2008, and
- \$140,000 and \$170,000 to employ comorbidity and detoxification support workers at Gugan Gulwan Youth Aboriginal Corporation and Winnunga Nimmityjah Aboriginal Health Service.

Of the 68 actions identified in the *Strategy 2004-2008*, 91% were either fully or partially implemented. The breakdown is:

- 60% (41 of 68) were fully implemented
- 31% (21 of 68) were partially implemented, and
- 9% (6 of 68) were not implemented.

At the mid term evaluation of the Strategy, the areas of alcohol, primary care and corrections were highlighted as areas requiring a stronger focus. Directions ACT was subsequently successful in early 2008 in securing Australian Government funding to establish a primary clinic at Directions ACT's Woden premises. The ACT

Government and the Australian Government also committed funding in 2008 to increasing beds through the establishment of a therapeutic community in the Alexander Maconochie Centre. In 2008 the ACT Department of Justice and Community Safety also announced a review of the *ACT Liquor Act 1975*.

External evaluations undertaken included:

- *ACT Syringe Vending Machines Trial 2005-2006*
- *Evaluation of Centacare Sobering-up Shelter (2006)*, and
- *External Review of the ACT Alcohol and Drug Service System (2007)*.

Provision of ACT Alcohol and Other Drug treatment and support services

The provision of ACT alcohol and other drug treatment and support services is summarised as follows:⁹¹

- Despite similar demographics, historically the ACT has had a treatment rate per 100,000 population twice the national rate. In 2006-07, the ACT had a treatment rate of 1,267 per 100,000 compared to the national rate of 669 per 100,000 population.
- The proportion of episodes provided by treatment type has varied over time in the ACT. For example, while the proportion of counselling episodes rose from 16% in 2006-07 to 21% in 2007-08, the proportion of assessment only episodes fell from 36% to 19% over the same period.
- The ACT was well above the 2007-08 national level for people with opioids as a principal drug of concern (at 24% compared to 14% nationally). Heroin followed alcohol as the second most common drug of concern in the ACT (at 20% compared to the national figure of 11%).
- The ACT Health Alcohol and Drug Program's Opioid Treatment Service provides pharmacotherapy services to 817 people, with:
 - 482 people (59%) receiving pharmacotherapy prescriptions from the Alcohol and Drug Program
 - 201 people (25%) receiving pharmacotherapy medication at the Alcohol and Drug Program
 - 288 people (35%) receiving pharmacotherapy prescriptions from 26 general practitioners operating from 14 general practices
 - 569 people (70%) receiving pharmacotherapy receiving pharmacotherapy medication in 28 community pharmacies, and
 - 45 people were receiving opioid treatment in the Alexander Maconochie Centre.⁹²

91 Source: ACT Health, Alcohol and Drug Program unpublished data , February 2010.

Australian Institute of Health and Welfare 2009, *Alcohol and other drug treatment services in the Australian Capital Territory 2007-08 Findings from the National Minimum Data Set (NMDS)*, Cat. No. HSW 76, AIHW: Canberra.

- Nationally the second most common drug of concern was cannabis. The ACT had proportionally fewer episodes for cannabis (14%) in 2007-08 than the national figure of 22%.⁹³
- This Strategy also recognises the provision and effectiveness of support systems for people with alcohol and/or other drug problems by self-help groups including Narcotics Anonymous (NA) and Alcoholics Anonymous (AA).

External review of the ACT Alcohol and Other Drug service system

External consultants Siggins Miller completed a review of the ACT alcohol and other drug service system in 2007. The review highlighted as priority areas:

- integrated service delivery from residential detoxification and rehabilitation services to community-based aftercare (including relapse prevention)
- improved workforce capacity
- enhanced service delivery capacity for Aboriginal and Torres Strait Islander people
- improved cooperation between law enforcement bodies and agencies in the health and social services sectors
- establishment of a GP led expanded and enhanced community-based team to provide pharmacotherapy services
- provision of short-term residential rehabilitation, and
- revision of service provision arrangements for ACT withdrawal services – subsequently clinically reviewed leading to recommendations that
 - the Alcohol and Drug Program Withdrawal Unit’s role be expanded to also cater for people admitted to the Canberra Hospital with complex alcohol and other drug problems (e.g. overdose), and
 - client movement from the Alcohol and Drug Program Withdrawal Unit to Directions ACT’s Arcadia House be facilitated as appropriate.

Evaluation of drug policies and services

In accordance with the *Adult Corrections Health Services Plan 2008-2012*,⁹⁴ a full and comprehensive evaluation of drug policies and services and their subsequent effects on the prisoners and staff within the Alexander Maconochie Centre will be completed by December 2010.

92 Ibid.

93 Australian Institute of Health and Welfare 2009, *Alcohol and other drug treatment services in the Australian Capital Territory: Findings from the national minimum data set (NMDS)*, Cat. No. HSW 76, Canberra: AIHW.

94 ACT Health 2008, *Adult Corrections Health Services Plan 2008-2012*, ACT Health: Canberra.

ACT Needle and Syringe Program coverage

The ACT Needle and Syringe Program provides a range of services that includes the distribution of sterile injecting equipment, education and information to help reduce the harms associated with drug use, disposal services for used injecting equipment, and referral to drug treatment services, medical care, legal services and psycho-social supports. The Program also provides safe sex information and resources. Whilst the ACT Needle and Syringe Program is comprehensive in terms of type and amount of injecting equipment distributed through a range of outlets and service modalities, coverage can be enhanced to address existing gaps

A needle and syringe program coverage calculator was utilised to estimate the coverage of the needle and syringe program in the ACT. The device used was devised and published by Harm Reduction Works, a web site developed for the UK National Treatment Agency for Substance Misuse, a component of the UK National health Service.⁹⁵

In consultation with key alcohol and other drug experts in the ACT including the consumer group Canberra Alliance for Harm Minimisation and Advocacy, and informed by the *Return on Investment 2: evaluating the cost effectiveness of needle and syringe programs in Australia*⁹⁶ report, the coverage calculator estimated that the ACT Needle and Syringe Program coverage is 57%. In other words there is a new syringe available for every estimated 1.77 injections in the ACT.

Drug-related Expenditures by Governments

The use of drugs can impose heavy costs, in personal and financial terms, on individuals, families and the ACT community. In a study commissioned and published by the Commonwealth Government, Collins and Lapsley⁹⁷ estimated that the total social costs of problematic drug use in Australia in 2004-05 were \$55,173 million. Adjusting for the size of the ACT population, that represents total ACT social costs of \$883 million or \$2,565 per capita for that year.

Preventing and responding to drug use accounts for a significant amount of the ACT Government's (and other governments') budget outlays. These outlays occur across many agencies including, in the ACT, the health, criminal justice, education and social welfare sectors, among others. The work of Collins and Lapsley mentioned above shows that the States and Territories expended at least \$3,733 million on drug use in the 2004-05 year which, adjusted to the size of the ACT population, would be \$59.7 million in ACT Government expenditures. The same source shows that 85% of

95 http://www.harmreductionworks.org.uk/5_web/coverage_calculator/index.php

96 National Centre in HIV Epidemiology and Clinical Research 2009, *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.

97 Collins, DJ & Lapsley, HM 2008, *The costs of tobacco, alcohol and illicit drug abuse to Australian society in 2004/05*, National Drug Strategy Monograph Series no. 64, Department of Health and Ageing: Canberra.

the State/Territory expenditures on drug use were made in preventing and responding to crime, 12% in health and 3% in other areas of government. Applying these proportions to the estimated ACT total drug use expenditure shows \$51 million of ACT Government outlays on drug-related crime, \$7.2million in health and \$1.8 million in other sectors of government. Nationally, policing accounts for 77% of State/Territory drug-related crime expenditures or 66% of total State/Territory expenditures on drug use.

An overview of government expenditures on drug use in the European Union nations has also highlighted the concentration of expenditures in the criminal justice system: *“Just a few categories of spending account for most of the total...law enforcement appears to account for more than 50% in a number of countries (Austria, Belgium, France, the Netherlands, Spain, Sweden and the United Kingdom)”*.⁹⁸

The present estimate of ACT Government expenditure on drug use of \$59.7 million in 2004-05 is just 6.5% of the estimated social costs of drug use in the ACT. This accords with the observation that *“In the countries for which results are already available, the [government] drug budget on average represents only about 5% of the social costs of drugs use”*.⁹⁹

8. POLICY AND STRATEGY

This section outlines the Strategy’s policy context and guiding principles, notes the areas in which key strategic priorities have been identified, and details the rationale for the Strategy’s focus on specific areas.

8.1 Policy Context

The Strategy is implemented within a national policy context composed of:

- The National Drug Strategy, Australia’s Integrated Framework
- National Drug Strategy Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003-2009
- Fourth National Mental Health Plan (2009)
- National Corrections Drug Strategy 2006-2009
- The National Road Safety Strategy 2001-2010 and its annual Action Plans
- The National Alcohol Strategy: Towards Safer Drinking Cultures

98 Ballotta, D & Bergeron, H 2006, What drug policies cost. Does Europe know how much it is spending to face the drugs phenomenon?, *Addiction*, vol. 101, no. 3, pp. 339-40.

99 Single, E, Collins, D, Easton, B, Harwood, H, Lapsley, H, Kopp, P & Wilson, E 2003, *International guidelines for estimating the costs of substance abuse*, 2nd edn, World Health Organization: Geneva.

- National Tobacco Strategy 2004-2009
- The Sixth National HIV Strategy
- The First National Hepatitis B Strategy
- The Second National Sexually Transmissible Infections Strategy
- The Third National Hepatitis C Virus (HCV) Strategy
- The Third National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy
- The National Cannabis Strategy 2006-2009, and
- The National Amphetamine-Type Stimulants Strategy.

The local policy context includes:

- Adult Corrections Health Services Plan 2008-2012
- Building a Strong Foundation – A Framework for Promoting Mental Health and Wellbeing 2009-2014
- Chronic Disease Strategy 2008-2011
- HIV/AIDS, Hepatitis C, Sexually Transmissible Infections Strategic Framework for the ACT 2007-2012
- The ACT Primary Health Care Strategy 2006-2009
- Managing the Risk of Suicide – A Suicide Prevention Strategy for the ACT 2009-2014, and
- Mental Health Services Plan 2008-2011.

8.2 Guiding Principles

The ACT Alcohol, Tobacco and Other Drug Strategy 2010-2014 is guided by the following principles:

- harm minimisation, addressing all drugs, and implementing interventions across drug demand reduction, supply reduction and harm reduction
- applying evidence-informed practice
- enhancing health promotion, early intervention and resilience building
- recognition of social determinants of health and well-being
- increasing access to welcoming services, and
- strengthening partnerships, collaborations and ownership.

8.3 Key Strategic Priorities

The Strategy's key strategic priorities are documented in the Strategy Action Plan and have been grouped under the following headings:

- Tobacco
- Alcohol
- Other Drugs
- Comorbidity
- Service System, Consumer Framework, Diversion and Police
- Education (Including Community Education and School Drug Education)
- Workforce Development, and
- Research and Surveillance.

The order in which this Strategy and the Strategy Action Plan documents the drug categories reflects the extent of harms associated with their use. Tobacco accounts for 75% of Australian drug-related mortality and is addressed first. Alcohol is documented next, accounting for 17% of Australian drug-related mortality. Other drugs follow, reflecting that their use accounts for 8% of Australian drug-related mortality.¹⁰⁰

8.4 Rationale for the Focus Areas for Strategic Investment

The rationale for the Strategy's focus on specific areas and the determination of key strategic priorities, based on seven phases of an intervention continuum model, are described below.

Many interventions are available for preventing problematic drug use and dealing with its adverse consequences.¹⁰¹ A useful way of thinking about these is in terms of an intervention continuum that draws attention to the population groups targeted at the various stages.

Prevention programs may be usefully characterised as universal, selective or indicated.¹⁰² *Universal preventive measures* are those aimed at a whole population as the potential benefits outweigh the potential risks for everyone. This is the area informed by recent scholarship on the social determinants of health and well-being.¹⁰³

100 Begg, S, Vos, T, Barker, B, Stevenson, C, Stanley, L & Lopez, AD 2007, *The burden of disease and injury in Australia 2003*, AIHW cat. no. PHE 82, Australian Institute of Health and Welfare: Canberra.

101 Ritter, A & McDonald, D 2005, *Drug policy interventions: a comprehensive list and a review of classification schemes*, Drug Policy Modelling Project Monograph Series no. 2, Turning Point Alcohol and Drug Centre: Fitzroy, Vic.

102 Gordon, RS, Jr. 1983, An operational classification of disease prevention, *Public Health Reports*, vol. 98, pp. 107-9.

103 Marmot, MG & Wilkinson, RG (eds) 2006, *Social determinants of health*, 2nd edn, Oxford University Press: Oxford.

Selective preventive measures are those targeting people who are members of a population subgroup at elevated risk of developing the problems that the intervention is intended to prevent. *Indicated preventive measures* target people who have risk factors that place them at particularly high risk for developing the condition of concern.

The continuum then addresses treatment and maintenance.¹⁰⁴ *Treatment* commences with case identification and then moves to the provision of standard treatments for known disorders. Following treatment come two categories of *maintenance*, namely compliance with long-term treatment with the goal of reducing the likelihood of relapse, and after care, including rehabilitation. A comprehensive drug strategy will include investment in all seven phases of the intervention continuum.

8.4.1 Tobacco

Interventions addressing tobacco are a high priority within the Strategy. This is because the prevalence of tobacco use remains high in the ACT (47,000 ACT residents are daily smokers), as it does in other jurisdictions, and because smoking rates are particularly elevated in some identified population groups. The seriousness of smoking – in terms of the personal costs, health care costs and lost productivity costs to individuals, families and the community – is substantially higher than for any other drug category addressed in the Strategy.

Unlike some other areas of drug strategy, the evidence base covering the effectiveness of interventions addressing tobacco is particularly strong. The community at large, as well as the ACT and Commonwealth Governments, are supportive of evidence-based initiatives addressing tobacco. Furthermore, the seriousness of the problem, combined with the effectiveness and cost effectiveness of interventions to address it, lead to the conclusion that strong, intrusive interventions are justified. These interventions include guiding choice through disincentives such as higher taxation, and restricting choice through creating smoke-free areas to reduce the impact of second-hand environmental smoke.

Recent research has suggested that interventions focusing on the population at large are effective with respect to those population groups which have elevated levels of smoking prevalence. In other words, this area of health promotion does not appear to increase socio-economic differentials in the prevalence of tobacco use, as has been feared in the past.

Substantial beneficial impacts are derived from both supply reduction and demand reduction initiatives on tobacco. High levels of tax on tobacco products, graphic health warnings and hard-hitting mass media campaigns are initiatives that have been developed and implemented at the national level and which have proven effectiveness and cost-effectiveness. Interventions that fall within the jurisdiction of the ACT Government that are known to be effective include mandating smoke-free areas and

104 Mrazek, PJ & Haggerty, RJ (eds) 1994, *Reducing risks for mental disorders: frontiers for prevention intervention research*, National Academy Press: Washington DC.

prohibiting point of sale promotions of tobacco products. The promotion of nicotine replacement therapy is a key demand reduction strategy.

Harm reduction strategies relating to tobacco are contested and are awaiting the further development of an evidence base. A harm reduction approach, as it relates to tobacco control, aims to encourage tobacco smokers to “move down the risk continuum by choosing safer alternatives to smoking, without demanding abstinence.”¹⁰⁵

The ACT Government continues to support Commonwealth initiatives in the areas of taxation, graphic health warnings and hard-hitting mass media campaigns.

8.4.2 Alcohol

Interventions addressing alcohol are a high priority within the Strategy. This reflects the high prevalence of drinking at levels that are harmful and/or hazardous and likely to have adverse consequences in the short term and/or the long term. Furthermore, the Strategy recognises the emerging evidence about the importance of particular patterns of drinking (as well as levels of drinking) that is illustrated through recognition of drinking significant amounts of alcohol on individual occasions. This understanding underlies the Strategy’s focus on both a broad, population health approach and targeting particular population groups whose patterns of drinking are problematic. An emerging body of research evidence is challenging existing understandings about the protective effect of low levels of alcohol consumption with respect to some types of disease. This reinforces the public health message that no one should consume alcoholic beverages simply or primarily for the purpose of obtaining health benefits.

The seriousness of the impact of alcohol use in the ACT is highlighted by the fact that it is second only to tobacco use, among all the drugs consumed, in terms of its adverse impacts in terms of both personal costs and financial costs to the Territory. The effectiveness and cost-effectiveness of some interventions addressing alcohol have been established, with some of the most effective interventions (such as increasing the cost of alcoholic beverages through taxation) being less popular with the public, and some of the least effective interventions (such as alcohol education programs) being the most popular. The Strategy addresses this conundrum, acknowledging the need for a balance between promoting the most effective interventions as well as those which will have most support from key stakeholders but for which the evidence base is limited.

The seriousness of alcohol-related problems, the level of prevalence of such problems and the availability of effective interventions justify the implementation of initiatives that are high on the intervention ladder. These interventions include the elimination of choice, for example, legislating zero blood alcohol concentration limits among novice drivers and bus drivers, as well as significant restrictions on choice, such as restricted liquor trading hours.

105 Swenor et al. cited in Topp, L, Smoking: A case for harm reduction. *Of Substance*, vol. 6, no. 3, July 2008: p. 8.

The international body of research evidence concerning alcohol shows that the following policy options stand out as best practices:¹⁰⁶

- minimum legal purchase age
- government monopoly of retail sales
- restrictions on hours or days of sale
- outlet density restrictions
- alcohol taxes
- sobriety check-points¹⁰⁷
- lowered blood alcohol concentration limits
- administrative licensee suspension, and
- graduated licensing for novice drivers.

Some of these interventions fall within the jurisdiction of the ACT Government, while others are matters for the Commonwealth which the ACT supports through Commonwealth/State/Territory policy bodies. It should be noticed that interventions not listed here, including alcohol education programs, have not been shown to be as effective and cost-effective as those listed. This does not mean, however, that they have no place in a comprehensive strategy. It simply means that only limited evidence exists as to their usefulness in achieving the goals of this Strategy.

8.4.3 Other Drugs

The strategic priorities in these areas reflect the potential interactions that exist between different types of drugs, and between the impacts of drug use in terms of mental illness and other adverse health and social consequences. The evidence base for interventions in this area is not as strong as for tobacco and alcohol, reflecting the complexities involved in the interactions between drug types and consequences, and the limited amount of research into the efficacy, effectiveness and cost-effectiveness of interventions in these areas.

With respect to poly-drug use, the bodies of evidence relating to the individual drug types involved (e.g., alcohol, tobacco, illicit drugs, pharmaceutical products, inhalants, etc.) are drawn upon. Poly-drug use presents significant challenges to treatment agencies. Too many of these agencies place insufficient attention on poly-

106 Alcohol & Public Policy Group 2003, *Alcohol: No Ordinary Commodity: a summary of the book, Addiction*, vol. 98, pp. 1343-50.

107 'Sobriety check-points' are places where police stop motor vehicles and breath test drivers whom they believe are intoxicated. This approach is to be contrasted with what we call 'random breath testing' (RBT), whereby the driver of every vehicle that is stopped by police is breath tested. The evidence is that the RBT approach is more effective as a general deterrent because it significantly increases the perception of and reality of likelihood of detection, compared with the use of sobriety check-points.

drug use, particularly considering the high levels of tobacco use among people with problems of dependence or harmful use of alcohol and illicit drugs, and the prevalence of problematic alcohol use among people who use illicit drugs. A reasonably strong information base is available as to the epidemiology of comorbidity, but the evidence about successful interventions in this area is far thinner. Intervention research – especially covering treatment – is a priority and the Commonwealth has an important role in promoting and funding such research. The current Commonwealth-funded Comorbidity Initiative provides a conducive environment to doing so.

Increasing concern is emerging, both in Australia and abroad, that problems relating to the use of prescribed pharmaceuticals are becoming more prominent and that this trend may accelerate in the future. This is a particular concern in the USA where the over-prescription of benzodiazepines and narcotic analgesics is said to be becoming a more serious problem than the use of illicit drugs, at the population level. Little intervention research has been published in this area.

‘Doctor shopping’, especially for narcotic analgesics and benzodiazepines, has long been recognised as a problem in Australia and only a weak evidence base exists covering interventions addressing this issue.

The prevalence of problems linked to poly-drug use, comorbidity, and the inappropriate use of pharmaceutical products, as well as the seriousness of their impacts, explains the Strategy giving prominence to this area. A further justification is the limited attention given to it in the past. The relative inadequacy of the evidence base concerning interventions, however, implies that caution is needed in selecting particularly intrusive interventions.

8.4.4 Comorbidity

Given 75% of adult mental health and substance use disorders begin in childhood or adolescents,¹⁰⁸ and adolescence is a time of increased experimentation with alcohol and other drugs, young people are a priority population for investment, particularly in terms of prevention and early intervention.

In the ACT, most young people who experience mild to moderate alcohol and other drug or mental health problems do not present to either mental health or alcohol and other drug services. Typically they seek help from general practitioners, youth workers and from teachers, counsellors and other support workers in schools. This creates many challenges in terms of ensuring people with comorbidities are systematically identified through the use of screening tools, and ensuring workers and practitioners have the knowledge and skills necessary to identify and respond appropriately.

108 Commonwealth of Australia 2009. State of Australia’s Young People: A Report on the social, economic, health and family lives of young people. Department of Education, Employment and Work Relations. Canberra.

To provide integrated assessment, treatment and care for both young people and adults, effective partnerships need to be in place amongst Alcohol and Drug Program (ADP) and Mental Health ACT, ACT Health, consumers, carers, general practitioners and community based service providers. Outcomes and service quality for clients with a comorbidity need to be monitored and regularly reviewed.

8.4.4 Service System and Consumer Framework

The ACT's alcohol and other drug services comprise a service system that addresses all drugs, both licit and illicit, and a range of population groups. It does so through demand reduction, supply reduction and harm reduction interventions. The approach taken in the Strategy is to see the service system as a whole, made up of a number of inter-relating components. These components include the community at large, the workers and management of specialist alcohol and other drug agencies, and the workers and management in other related sectors and mainstream agencies. This section of the Strategy addresses the service system as a whole and focuses on particular components that warrant special attention.

8.4.5 Education

Community education, including school drug education programs, can be characterised as 'popular but not proven' as to their effectiveness and cost-effectiveness in the real world. Evidence exists that certain types of school drug education programs can produce unintended adverse consequences in terms of drug use and related harms. This can flow from non-users being encouraged to try drugs or from interventions that bring together students with problematic drug use in ways that exacerbate their drug use and related patterns of harm.

With regard to school drug education, the key issues include the content of the programs, the method of delivery and the specific target groups. ACT policy reflects the evidence base that it is preferable to focus school drug education programs on the whole school community rather than on particularly groups (especially current drug users) within it. The evidence also points to the value of having school drug education programs delivered by members of the school community as an integral part of the school's regular program of activities, rather than being delivered by outside, specialist drug educators.

At the same time, it is acknowledged that some young people who use drugs in a harmful or potentially harmful manner, and are not closely engaged as members of the school community, have special needs that can be addressed through programs quite separate from those undertaken within the schools. These targeted programs are in direct contrast to the more broadly based approaches advocated for implementation within the school communities. Peer-based drug education initiatives are favoured among disengaged youth, although little research has been undertaken as to their effectiveness. Nonetheless, the evidence base for the effectiveness of peer education more broadly is strong enough to justify the development and implementation of peer education among young people who are disengaged from the school community.

9. LEGAL FRAMEWORK

The legislative context in which the Territory's harm minimisation approach operates is documented at Appendix 5.

10. GOVERNANCE, MONITORING AND EVALUATION

This Strategy's implementation is 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's oversight is facilitated through bi-monthly meetings and annual evaluation reports addressing both:

- the changing needs of the ACT community and the relative effectiveness of alternative investments and intervention across the three areas of harm minimisation, and
- implementation of individual action items in the Strategy Action Plan.

This Strategy involves a number of ACT Government and non-government agencies, including those in the health, education and law enforcement areas. It is important to continue to foster partnerships that enable the development of a shared vision and which support a coordinated approach to address alcohol, tobacco and other drug issues in an integrated way. Bringing members of the community together to develop a common understanding of harmful drug use acknowledges that the answer to complex social issues does not lie exclusively with any one section of the community. Only continued cooperation between government and non-government agencies, consumers, carers and other community groups, will achieve cooperative planning between providers, funding agencies and other key stakeholders and ensure that service development and delivery meet the needs of individuals and communities.

10.1 Alcohol, Tobacco and Other Drug Strategy Evaluation Group Membership

The Alcohol, Tobacco and Other Drug Strategy Evaluation Group is to be established with a membership representing relevant stakeholders including:

- Aboriginal & Torres Strait Islander community
- ACT Council of Social Services
- ACT Division of General Practice
- ACT Health
- Alcohol, Tobacco and Other Drug Association of the ACT
- Australian Federal Police
- Chief Minister's Department

- Consumer representative
- Department of Disability, Housing and Community Services
- Department of Education and Training
- Department of Justice and Community Safety
- Families and Friends for Drug Law Reform
- Hepatitis Resource Centre
- Mental Health Community Coalition
- Multicultural Women’s Advocacy Group
- Ministerial Advisory Council on Women
- Pharmacy Guild
- Research adviser to the Group, and
- Youth Coalition of the ACT.

10.2 Alcohol, Tobacco and Other Drug Strategy Evaluation Group Terms of Reference

The Alcohol, Tobacco and Other Drug Strategy Evaluation Group will operate in accordance with the following terms of reference:

- Provide advice to ACT Health on the changing needs of the ACT community and the relative effectiveness of alternative investments and intervention across the three areas of harm minimisation – supply reduction, demand reduction and harm reduction
- Monitor and evaluate the implementation of the ACT Alcohol, Tobacco and Other Drug Strategy 2010-2014
- Facilitate linkages between the ACT Alcohol, Tobacco and Other Drug Strategy 2010-2014 and other relevant ACT and National Strategies including
 - *The National Drug Strategy: Australia’s Integrated Framework 2004-2009*
 - *The National Drug Strategy Aboriginal & Torres Strait Islander Peoples’ Complementary Action Plan 2003-2009*, and
 - their replacements
- Seek advice from key committees and working groups responsible for progressing implementation of priority actions including
 - Opioid Treatment Advisory Committee (provides a mechanism for consumer involvement in policy development across both public and community streams of the pharmacotherapy program)

- Territory Reference Group (provides advice on the implementation of the Council of Australian Governments Diversion Initiative in the ACT)
 - a gay, lesbian, bi-sexual, sex and gender diverse community (GBLT) reference group, and
 - research bodies or teams undertaking research projects of relevance
- Working groups and areas responsible for implementation of actions identified within the ACT Strategy will provide regular written and verbal reports to the Evaluation Group as required
 - Performance reporting data from ACT Health's Alcohol and Drug Program (ADP) and each of the alcohol and other drug services funded by ACT Health will be provided to the Group by way of annual evaluation reports
 - Consult with the community, clients, service providers and other key stakeholders as required
 - Adopt a model for public, private and community providers to work as equal partners to develop an integrated policy and management approach that allows for collaboration in the collection of performance data and long term planning for public/private/non-government and acute/and non-acute services and funding sources
 - Improve equity and access to a variety of treatment service options that can help address the impact of alcohol and other drug use, and allocate expenditure to alcohol and other drug services in proportion to the burden of illness and demand for services
 - Monitor those initiatives already implemented and enable the regular updating of important local references including
 - *Extent and Nature of Drug Use and Harms in the ACT 2008*
 - *Workforce Profile - ACT Alcohol and Other Drug Sector 2006*
 - *ACT Government Expenditure on Preventing and Responding to Drug Abuse 2006*), and
 - *Sources of Published Data on Drugs 2006*
 - Be convened and chaired by ACT Health and meet at least quarterly
 - The Group will be guided by an annual workplan
 - To assist the Group to monitor and evaluate the implementation of the Strategy, evaluation protocols will be developed for each of the Strategy's actions items being implemented
 - The Group will report to ACT Health and ACT Health will report to the Government on the implementation of the Strategy, and

- Contribute to the development of the next ACT Alcohol, Tobacco and Other Drug Strategy.

10.3 Alcohol and Other Drug Treatment and Support Services

Alcohol, Tobacco and Other Drug Association of the ACT

The Alcohol, Tobacco and Other Drug Association of the ACT is not for profit and is the peak body representing alcohol, tobacco and other drug services in the Australian Capital Territory; and provides leadership, representation, advocacy and information. The Association:

- coordinates, supports and assists organisations and individuals to provide services for the relief of suffering from alcohol, tobacco and other drug use disorders in the Australian Capital Territory and surrounding region
- coordinates, supports and assists organisations and individuals to provide services that prevent and reduce the harms associated with alcohol, tobacco and other drugs in the ACT
- facilitates the development and operation of partnerships, collaborations and networking with key stakeholders to support joint action aiming to assist organisations and individuals to provide services for the prevention and relief of suffering from alcohol, tobacco and other drug use disorders in the Australian Capital Territory region
- engages in, promotes, develops and supports inclusive and evidence-informed decision-making, research and policy development; capacity building, sector and workforce development; advocacy and representation, and
- promotes the development and use of evidence-informed alcohol, tobacco and other drug related information, resources, policy and practice to key stakeholders.

Alcohol and Other Drug Workers' Group

The Alcohol and Other Drug Workers' Group provides a monthly forum for workers from alcohol and other drug treatment and support services to meet and progress workforce development initiatives and build capacity within the sector.

Alcohol and Other Drug Workers' Group – Membership

The Alcohol and Other Drug Workers' Group receives secretariat and project management support from the Alcohol, Tobacco and Other Drug Association of the ACT and the Group's membership is drawn from the following organisations:

- ACT Health, Alcohol and Drug Program
- ACT Health, Alcohol and Other Drug Policy Unit

- Catholic Care
- Directions ACT
- Gugan Gulwan Youth Aboriginal Corporation
- Ted Noffs Foundation
- The Alcohol and Drug Foundation of the ACT (ADFACT)
- The Canberra Alliance for Harm Minimisation and Advocacy (CAHMA)
- The Salvation Army - The Bridge Program
- The Salvation Army - Canberra Recovery Services
- Toora Women Incorporated, and
- Winnunga Nimmityjah Aboriginal Health Service.

11. STRATEGY ACTION PLAN

Priority actions have been bolded and the listed at the start of each section. Examples of ways in which the implementation of the actions may be evaluated and the lead agency responsible for implementation of each action has also been included.

	Actions	Rationale	Evaluation <i>(examples of ways in which implementation of actions may be evaluated.)</i>	Lead Agency
Tobacco				
1.	<p>Improve access to a range of smoking reduction and cessation programs including:</p> <ul style="list-style-type: none"> • information and education • counselling, and • nicotine replacement therapy, <p>for target populations including:</p> <ul style="list-style-type: none"> • young people and adults in detention • people with alcohol and other drug and/or mental health issues • workers in the community sector particularly those working in alcohol and other drug and mental health services and programs, and • ACT Health employees. 	Harm Reduction	<p>Increase in uptake rates of smoking reduction and cessation programs for target populations</p> <ul style="list-style-type: none"> • Number of calls to Quitline • Participation in smoking reduction and cessation programs. <p>Increase in number of smoking reduction and cessation programs offering free nicotine replacement therapy for target populations.</p> <p>Number of clients and workers of alcohol and other drug and mental health services supported to reduce or cease smoking.</p> <p>Decrease in smoking rates for target populations.</p>	ACT Health
2.	Evaluate effectiveness of indoor smoking restrictions in the Alexander Maconochie Centre and the uptake of smoking reduction and cessation programs.	Harm Reduction	<p>Smoking restrictions evaluated including:</p> <ul style="list-style-type: none"> • opportunities to improve compliance investigated 	ACT Health DJACS

Actions		Rationale	Evaluation <i>(examples of ways in which implementation of actions may be evaluated.)</i>	Lead Agency
			<ul style="list-style-type: none"> opportunities to expand restrictions to other areas within the prison investigated. <p>Increase in uptake rates of smoking reduction and cessation programs.</p> <p>Decrease in smoking rates.</p>	
3.	Investigate opportunities for partnerships with industry to implement smoking bans and improve access to and uptake of smoking reduction and cessation programs (e.g. the construction industry).	Harm Reduction	<p>Partnerships between Government and industry established.</p> <p>Increase in uptake rates of smoking reduction and cessation programs.</p> <p>Decrease in smoking rates.</p> <p>Learnings from pilot programs such as the ACT Alcohol and Other Drug Sector's Smokefree workplace initiatives shared with those working in other industries.</p>	ACT Health
4.	Work with members of the Aboriginal and Torres Strait Islander community to implement the ACT Aboriginal and Torres Strait Islander Tobacco Control Strategy to prevent and reduce smoking.	Harm Reduction	<p>Increase in uptake rates of smoking reduction and cessation programs.</p> <p>Decrease in smoking rates.</p>	ACT Health
5.	Explore regulatory and non-regulatory options for reducing exposure of children to tobacco smoke in motor	Harm Reduction	Options investigated and relevant restrictions progressed.	ACT Health

	Actions	Rationale	Evaluation <i>(examples of ways in which implementation of actions may be evaluated.)</i>	Lead Agency
	vehicles.			
Alcohol				
6.	ACT Policing to work with ACT Health to implement the Alcohol Early Intervention Pilot Program in the ACT.	Harm Reduction	Alcohol Early Intervention Pilot Program implemented. External evaluation of Alcohol Early Intervention Pilot Program implemented.	ACT Policing ACT Health
7.	Implement the outcomes of the Review of the Road Transport (Alcohol and Drugs) Act 1977.	Harm Reduction	Changes implemented relating to the Review of the <i>Road Transport (Alcohol and Drugs) Act 1977</i> .	TaMS
8.	Extend the zero blood alcohol concentration limit to novice drivers (i.e. L-platers and P-platers) and drivers of public vehicles.	Supply Reduction	Zero blood alcohol concentration limit extended to include novice drivers (i.e. L-platers and P-platers) and drivers of public vehicles.	TaMS
9.	As a road safety initiative, ACT Policing will continue breath testing of motorists in the ACT. This will be undertaken via random breath testing, targeted campaigns, and specific intelligence-led targeting of drink drivers.	Harm Reduction	Reduction in the proportion of persons who self-report to driving while suspecting they are over the prescribed alcohol limit. Number of drivers breath tested per annum. Number of drivers per annum detected over the recommended BAC. Number of repeat offenders detected per annum.	ACT Policing

Actions		Rationale	Evaluation <i>(examples of ways in which implementation of actions may be evaluated.)</i>	Lead Agency
10.	<p>Implement the outcomes of the Review of the <i>Liquor Act 1975</i> to:</p> <ul style="list-style-type: none"> • reduce anti-social behaviour in and close to licensed premises • ensure immediate and meaningful consequences to licensees for breaches, and • ensure that those associated with the most harm pay a commensurate licensing fee. 	Harm Reduction	<p>Number of people being issued with infringement notices for consuming alcohol in a public place or being detained in the Watch House for being intoxicated.</p> <p>Increase in percentage of intoxicated people who have been apprehended by ACT Policing being referred to the Sobering-up facility.</p> <p>Number & type of breaches detected and penalties issued.</p>	<p>DJACS</p> <p>ACT Policing</p>
11.	Implement recommendations arising from the review of drink driving laws in the ACT.	Harm Reduction	Changes implemented.	TaMS
12.	Implement mandatory training in the responsible service of alcohol for staff and management of licensed venues and ensure that breaches result in immediate and meaningful consequences for licensees and managers.	Supply Reduction	<p>Mandatory training requirements for staff and management established that recognise the different needs across different types of outlets.</p> <p>Mandatory training requirements include a mandatory refresher requirement.</p> <p>Number of breaches regarding those not having undertaken required training and practices in breach of requirements (e.g. serving intoxicated people) detected and penalties issued.</p>	DJACS
13.	Reduce young people's exposure to alcohol advertising by working with the Australian Government and other state	Demand Reduction	Reduction in exposure of people younger than 18 years to alcohol promotions (e.g. bill board	DJACS

Actions		Rationale	Evaluation <i>(examples of ways in which implementation of actions may be evaluated.)</i>	Lead Agency
	and territory governments to ensure alcohol products are not targeted at people younger than 18 years.		advertising, event sponsorship, sale of alcohol beverages such as milkshakes, display and promotion of alcohol in general area of supermarkets).	
14.	Reduce community exposure to alcohol related promotions that normalise problematic drinking in social situations and promote excessive consumption of alcohol.	Harm Reduction	Implement ban on promotions in licensed premises that encourage rapid and/or excessive consumption of alcohol.	DJACS
15.	Support the development of a National Drug Strategy Diversion Initiative that includes alcohol.	Harm Reduction	Alcohol included within scope of the National Drug Strategy Diversion Initiative.	ACT Health
16.	Improve access to alcohol and other drug services for vulnerable populations at health care centres ensuring the culture at these centres is holistic and inclusive of vulnerable populations.	Harm Reduction	Feasibility of co-locating both government and non-government alcohol and other drug treatment and support staff at health care centres as part of primary care teams investigated. Requirements in terms of capacity building and workforce development of the ACT alcohol and other drug sector identified and addressed including ensuring workers are able to work effectively with young people aged 12 -25 years.	ACT Health
17.	Investigate the feasibility of establishing a sobering-up facility for people younger than 18 years of age.	Harm Reduction	Feasibility investigated.	ACT Health

Actions	Rationale	Evaluation <i>(examples of ways in which implementation of actions may be evaluated.)</i>	Lead Agency	
Other Drugs				
18.	Implement national clinical guidelines for the management of drug use during pregnancy, birth and the early years of the newborn.	Demand Reduction	Guidelines implemented across alcohol and other drug treatment and support sector. Requirements in terms of capacity building and workforce development of the ACT alcohol and other drug sector identified and addressed.	ACT Health
19.	Expand the range of health services authorised to dispense needle and syringe equipment (e.g. mental health services).	Harm Reduction	Increase in number and type of needle and syringe outlets. Requirements in terms of capacity building and workforce development of the ACT alcohol and other drug sector identified and addressed.	ACT Health
20.	Investigate the feasibility of utilising new service delivery models, to overcome some of the barriers for people experiencing difficulties accessing needles and syringes, such as the provision of peer based services to enhance coverage for all people in the ACT who inject drugs (e.g. outreach, foot patrols, peer workers providing NSP services in Community Health Centres and Indigenous specific initiatives).	Harm Reduction	Feasibility of new service delivery models investigated.	ACT Health
21.	Increase the number of subsidised pharmacy places to allow additional clients of the Opiate Replacement Maintenance Program to transfer to community	Harm Reduction	Increase in the number of subsidised places to enable more people to dose in community pharmacies and receive their script from a general practitioner working in the community	ACT Health

Actions		Rationale	Evaluation <i>(examples of ways in which implementation of actions may be evaluated.)</i>	Lead Agency
	pharmacies.		rather than from ACT Health's Alcohol and Drug Program. Opioid Treatment Advisory Committee (OTAC) to monitor the effective implementation of the ACT Opioid Maintenance Treatment Guidelines. This in part will occur through the committee monitoring performance against the indicators outlined in the Evaluation section of the Guidelines.	
22.	Improve access to hepatitis C treatment for people who inject drugs.	Harm Reduction	Increased number of people who inject drugs completing treatment for hepatitis C. Expanded access to treatment by increasing the number of setting from which treatment is offered and the modes of delivery.	ACT Health
23.	Investigate the feasibility of expanding Mental Health ACT's Better Health Outcomes Program to those working with clients with complex alcohol and other drug problems.	Harm Reduction	Feasibility determined of expanding the ACT's Better Health Outcomes Program (e.g. including establishing service funding agreements between ACT Health and GP practices, creating capacity for greater professional support from the Alcohol and Drug Program to assist practices to take on clients with more complex needs). Enhancing training provided for pharmacists, general practitioners and practice nurses	ACT Health

Actions		Rationale	Evaluation <i>(examples of ways in which implementation of actions may be evaluated.)</i>	Lead Agency
			working with clients with more complex needs.	
24.	<p>Investigate the feasibility of strengthening transition support residential drug treatment programs for people experiencing withdrawal or detoxification, including those:</p> <ul style="list-style-type: none"> • continuing on opioid maintenance treatment programs, and • choosing to cease opioid maintenance treatment over time. 	Harm Reduction	<p>Investigation completed.</p> <p>Investigation informed by the findings from the Clinical Review of ACT Adult Detoxification Services.</p>	ACT Health
25.	ACT Policing will continue to target manufacturers and distributors of illicit drugs to reduce and disrupt illicit drug supply.	Supply Reduction	Increase in number of arrests of drug providers.	ACT Policing
26.	ACT Government will work with other stakeholder agencies with a view to reforming legislation that improves law enforcement capability in targeting manufacturers and distributors of illicit drugs to reduce and disrupt illicit drug supply.	Supply Reduction	Legislation reviewed and prospectively reformed to enable an increase in the number of arrests of drug providers	<p>DJACS</p> <p>ACT Policing</p>
Comorbidity				
27.	Alcohol and other drug and mental health services systematically screen and assess for concurrent alcohol and other drug and mental health problems both on admission and throughout the period the client remains with the service.	Harm reduction	<p>Review completed of screening and assessment tools and improvements made where necessary.</p> <p>Mental Health ACT and the Alcohol and Drug Program (ADP) establish ACT Clinical Guidelines for the Care of Persons in Acute</p>	ACT Health

Actions	Rationale	Evaluation <i>(examples of ways in which implementation of actions may be evaluated.)</i>	Lead Agency
		<p>Care Settings, similar to the <i>NSW Clinical Guidelines - For the Care of Persons with Comorbid Mental Illness and Substance Use Disorders in Acute Care Settings</i>. (These Guidelines will also articulate options for working with clients who may be intoxicated when they present to services.)</p> <p>Requirements in terms of capacity building and workforce development of the ACT alcohol and other drug and mental health sectors identified and addressed.</p> <p>Outcomes and service quality for clients with a comorbidity are monitored and regularly reviewed in conjunction with consumers and carers.</p>	
<p>28. General practitioners, community based service providers and practitioners from the ACT Health's Alcohol and Drug Program and ACT Health's Mental Health ACT to introduce mechanisms for facilitating the provision of integrated assessment, treatment and care.</p>	<p>Harm reduction</p>	<p>Memorandums of Understanding are reviewed and established where necessary to ensure that they clearly articulate:</p> <ul style="list-style-type: none"> • the obligation for each service to screen and assess for concurrent alcohol and other drug and mental health problems both on admission and throughout the period the client remains with the service • protocols for Mental Health ACT and 	<p>ACT Health</p>

Actions	Rationale	Evaluation <i>(examples of ways in which implementation of actions may be evaluated.)</i>	Lead Agency
		<p>the Alcohol and Drug Program (ADP) to provide</p> <ul style="list-style-type: none"> ○ consultation/liaison support and joint management for services working with clients experiencing moderate problems relating to mental illness or alcohol and other drug problems ○ actively referral for clients with severe mental illness or alcohol and other drug problems ○ follow-up of clients at key service transition points, including those being discharged from inpatient services and those moving between services. <p>Outcomes and service quality for clients with comorbidities are monitored and regularly reviewed.</p>	
Service System and Consumer Participation			
<p>29. Corrections Health Program, ACT Health to ensure clients admitted to the Alexander Maconochie Centre and the Bimberi Youth Justice Centre:</p> <ul style="list-style-type: none"> • are screened on admission for concurrent 	Harm Reduction	<p>Changes implemented.</p> <p>Detainees access health care within 24 hours of admission into the facility including being able to access opioid maintenance treatment within</p>	ACT Health

Actions	Rationale	Evaluation <i>(examples of ways in which implementation of actions may be evaluated.)</i>	Lead Agency
<p>mental health and alcohol and other drug problems</p> <ul style="list-style-type: none"> • have the opportunity to identify alcohol and other drug and mental health services that they have had contact with in the community that may be advised of the client’s admission and offered the opportunity to provide support to these clients whilst in detention • obtain consultation/liaison support to assist the Corrections Health Program to manage detainees with a suspected moderate mental illness and/or moderate alcohol and other drug problem, and • are referred on for joint management of a severe mental illness and/or severe alcohol and other drug problem. 		<p>24 hours.</p> <p>Corrections custodial staff complete some basic training in assessment of health and mental health needs and referral pathways.</p>	
<p>30. Ensure prisoners and other detainees, both adult and young people, are able to access the same community-based alcohol and other drug programs and other services where appropriate (e.g. Canberra Rape Crisis Centre) in detention and when they leave detention.</p>	<p>Harm Reduction</p>	<p>Increased uptake of alcohol and other drug services by individuals pre-detention, during detention and post-detention.</p> <p>100% of sentenced detainees (adult and young people) possess a throughcare/ aftercare plan prior to their release from detention.</p> <p>A holistic approach is adopted to the planning and delivery of services by ACT Health and ACT alcohol and other drug treatment and</p>	<p>ACT Health</p> <p>DJACS</p>

	Actions	Rationale	Evaluation <i>(examples of ways in which implementation of actions may be evaluated.)</i>	Lead Agency
			support services in partnership with other relevant Government and community organisations.	
31.	In collaboration with the Advisory Board, continue to progress the establishment and operation of the Aboriginal and Torres Strait Islander residential rehabilitation service.	Harm Reduction	Residential rehabilitation service established and in operation. Occasions of service delivery and treatment outcomes. Occasions of support to Aboriginal and Torres Strait Islander people at risk of involvement in alcohol-related violence.	ACT Health
32.	Implement ACT Alcohol and Other Drug and Mental Health Comorbidity Strategy in accordance with the Mental Health Services Plan 2009-2014.	Harm Reduction	ACT-wide Integrated Comorbidity Strategy implemented that articulates: <ul style="list-style-type: none"> • agreed roles of both the alcohol and other drug services and mental health services when engaging with clients presenting • areas where investment is required in workforce development and information management initiatives • opportunities to strengthen existing MOUs, protocols, policies and procedures and develop new ones where required (e.g. in relation to information sharing and provision for more 	ACT Health

	Actions	Rationale	Evaluation <i>(examples of ways in which implementation of actions may be evaluated.)</i>	Lead Agency
			<p>integrated service provision to clients</p> <ul style="list-style-type: none"> • holistic approaches necessary to prevent developing alcohol and other drug and mental health problems, and • opportunities for improving investments in research and development. 	
33.	Develop a specific policy framework to support consumer participation in drug treatment and support services provided by both ACT Health and community organisations in addition to policies relating to consumer participation in general health settings.	Harm Reduction	<p>Policy framework developed.</p> <p>Review findings from the 2009 Alcohol and Other Drug Services Consumer Participation Survey to inform the development of the consumer participation framework and regularly conduct a consumer survey (i.e. 12 – 18 months).</p> <p>ACT Health’s Alcohol and Drug Program (ADP) and all community organisations funded by ACT Health to provide drug treatment and support services to report routinely against agreed indicators in the policy framework and to make this information available to consumers.</p> <p>Consultation undertaken with key peak bodies and sectors such as the Youth Coalition and the youth sector to progress the youth participation component.</p>	ACT Health

	Actions	Rationale	Evaluation <i>(examples of ways in which implementation of actions may be evaluated.)</i>	Lead Agency
			Requirements in terms of capacity building and workforce development of the ACT alcohol and other drug sector identified and addressed.	
34.	Ensure all ACT Health funded drug treatment services are formally accredited.	Demand Reduction	100% of drug treatment services funded by ACT Health are formally accredited.	ACT Health
35.	<p>Expand access to tertiary level services provided by the Alcohol and Drug Program (ADP) to both clients and workers in the health and community services sector by:</p> <ul style="list-style-type: none"> • expanding the role of ten bed withdrawal unit to include those with other complex alcohol and other drug problems and increase admissions from four to seven days per week • enhancing access to consultation/liaison advice for staff working in hospitals as well as workers in the health and community sectors more broadly • establishing a walk-in outpatient clinic • increasing participation in community-based multidisciplinary teams with GPs, pharmacists and the relevant non-government alcohol and other drug services • enhanced access to services including counselling services on an inpatient, outpatient and outreach basis including to those under 18 years of age, and • enhanced access to screening, vaccinations, 	Demand Reduction	<p>Initiatives listed implemented along with relevant capacity building and workforce development (e.g. development of workers' skills to work effectively with young people).</p> <p>Increased uptake of training provided for pharmacists, general practitioners and practice nurses working with clients with more complex needs.</p> <p>New ACT Opiate Replacement Maintenance Guidelines implemented.</p> <p>Increased uptake of Alcohol and Drug Program (ADP) services by priority populations (e.g. people from culturally and linguistically diverse backgrounds, refugees, women, Aboriginal and Torres Strait Islander peoples, young people and people experiencing homelessness).</p> <p>ACT-wide Integrated Comorbidity Strategy implemented.</p>	ACT Health

Actions	Rationale	Evaluation <i>(examples of ways in which implementation of actions may be evaluated.)</i>	Lead Agency
<p>information and education, counselling and treatment in relation to hepatitis A, B and C, other blood borne viruses, mental health services and sexual health care.</p>		<p>Improved access to treatment and support programs for those experiencing:</p> <ul style="list-style-type: none"> • anxiety • sleep disorders and pain • mood disorders • depression • post traumatic stress disorders, and • problematic benzodiazepines and opioid analgesic use, dependency and withdrawal. 	
<p>36. Provide better access to drug counselling, withdrawal, rehabilitation and relapse prevention services in collaboration with mainstream health services by:</p> <ul style="list-style-type: none"> • alcohol and other drug treatment and support services working in partnership with a broad range of community based primary health care services provided at <ul style="list-style-type: none"> ○ youth services ○ health centres, and ○ walk-in centres, and focus on whole of person care • improving access to screening, vaccinations, information and education, counselling and 	<p>Harm Reduction</p>	<p>Increased uptake of drug treatment services by priority populations (e.g. people from culturally and linguistically diverse backgrounds, refugees, women, Aboriginal and Torres Strait Islander peoples).</p> <p>Increased uptake of drug treatment services by people with poly-drug use problems.</p> <p>Support GPs to maintain their S100 hepatitis C prescriber status.</p> <p>Stronger linkages developed between alcohol and other drug, mental health and other services (e.g. housing and homelessness) in order to</p>	<p>ACT Health</p>

Actions	Rationale	Evaluation <i>(examples of ways in which implementation of actions may be evaluated.)</i>	Lead Agency
<p>treatment in relation to hepatitis A, B and C, blood borne viruses, mental health services and sexual health care</p> <ul style="list-style-type: none"> • ensuring those on opioid maintenance treatment, including those who choose to cease opioid maintenance treatment over time, and those requiring shorter term programs have access to rehabilitation and other treatment services, and • ensuring drug treatment and support services utilise common screening, assessment and outcome measurement. 		<p>provide more holistic care.</p> <p>Increased capacity for peer services to provide information, education and peer support for current or past drug users, in relation to hepatitis A, B, C, and HIV prevention and treatment.</p> <p>Enhanced access to services for priority populations (e.g. people from culturally and linguistically diverse backgrounds, women, Aboriginal and Torres Strait Islander peoples).</p> <p>Clinical reviews of counselling and rehabilitation services completed and supported recommendations implemented. (Clinical reviews will consider opportunities for services to become more family inclusive, recognise where a collaborative approach across agencies is required, and investigate opportunities to expand services for those on opioid maintenance treatment (including those who choose to cease opioid maintenance treatment over time).</p> <p>Improved access to treatment and support programs for those experiencing:</p> <ul style="list-style-type: none"> • anxiety 	

Actions	Rationale	Evaluation <i>(examples of ways in which implementation of actions may be evaluated.)</i>	Lead Agency
		<ul style="list-style-type: none"> • sleep disorders and pain, and • problematic benzodiazepines and opioid analgesic use, dependency and withdrawal. <p>Investigation completed by ACT Health with the ACT alcohol and other drug sector to identify appropriate shared screening, assessment and outcome measurement tools and data bases.</p> <p>Requirements in terms of capacity building and workforce development of the ACT alcohol and other drug sector identified and addressed.</p>	
<p>37. Promote access to online and telephone based information, education and counselling interventions to targeted populations such as young people as well as the general population.</p>	<p>Demand Reduction</p>	<p>Review the findings from the Department of Health and Ageing's <i>Online Drug and Alcohol Services Project</i>.</p> <p>Relevant programs promoted locally.</p> <p>Increase ACT uptake of on-line and telephone screening and counselling.</p> <p>Monitor, via survey, the uptake of screening and counselling opportunities by priority populations (e.g. people from culturally and linguistically diverse backgrounds, women, Aboriginal and Torres Strait Islander peoples).</p>	<p>ACT Health</p>

	Actions	Rationale	Evaluation <i>(examples of ways in which implementation of actions may be evaluated.)</i>	Lead Agency
			Review completed of findings from evaluation of MoodGYM..	
38.	Enhance capacity for Gugan Gulwan to: <ul style="list-style-type: none"> • meet increasing demand • pursue opportunities for the operation of a night-time outreach service, and • further enhance staff knowledge and skills. 	Demand Reduction	Increased funding and resources for Gugan Gulwan Youth Aboriginal Corporation. Occasions of support to Aboriginal and Torres Strait Islander people at risk of involvement in alcohol-related violence.	ACT Health
39.	Profile the ACT alcohol and other drug workforce every 12 – 18 months to monitor changes such as those relating to qualifications and remuneration and implement required enhancements.	Demand Reduction	Profile completed every 12 – 18 months and enhancements made.	ACT Health
40.	Alcohol and other drug services to formalise partnership arrangements with the new ACT Aboriginal and Torres Strait Islander residential rehabilitation service to ensure, upon completion, clients have access to culturally appropriate community liaison, care coordination and relapse prevention services.	Demand Reduction	Formal partnerships established.	ACT Health
41.	Strengthen access to health services and support provided for Aboriginal and Torres Strait Islander people who are: <ul style="list-style-type: none"> • in detention and after they leave detention • residents, and their families, of the Aboriginal and Torres Strait Islander residential drug 	Demand Reduction	Increased uptake of health and support services provided by Aboriginal and Torres Strait Islander community controlled organisations to people in detention and those in and discharged from residential rehabilitation.	ACT Health

	Actions	Rationale	Evaluation <i>(examples of ways in which implementation of actions may be evaluated.)</i>	Lead Agency
	rehabilitation program, and <ul style="list-style-type: none"> • pursue opportunities for the operation of a night-time outreach service. 		Occasions of support to Aboriginal and Torres Strait Islander people at risk of involvement in alcohol-related violence.	
42.	Work with ACT Policing, ACT Corrective Services, Corrections Health, DHCS and ACT Health to review and expand the investment and effectiveness of diversion programs.	Demand Reduction	Increased uptake of diversion programs. Increased effectiveness of diversion programs. Partnerships and strategies developed to promote the uptake of evidence-based diversionary initiatives.	ACT Health DJACS DHCS
43.	Maintain effective protocols for meeting the special needs of detainees who are intoxicated and/ or drug dependent in the Police Watch House and review access for detainees to prescribed medication (e.g. methadone).	Harm Reduction	Effective Police Watch House protocols meeting the special needs of detainees who are intoxicated and/or drug dependent maintained. Review access for detainees to prescribed medication (e.g. methadone).	ACT Policing
44.	Ensure the new model to progress the principles of the ACT Government's Caring for Carers Policy recognises: <ul style="list-style-type: none"> • the special needs of grandparents who have a significant caring role for grandchildren as a result of parental use of alcohol and other drugs, • the special needs of children and young people affected by parental use of alcohol and other drugs, and 	Demand Reduction	Special needs of each of the target groups are recognised in implementation of the ACT Government's Caring for Carers Policy through, for example: <ul style="list-style-type: none"> • needs assessment • identification of best practice and opportunities for collaborative efforts with Mental Health ACT's COPMI program (children of 	DHCS

Actions	Rationale	Evaluation <i>(examples of ways in which implementation of actions may be evaluated.)</i>	Lead Agency
<ul style="list-style-type: none"> the special needs of young people effected by their siblings' use of alcohol and other drugs. 		<p>parents with a mental illness)</p> <ul style="list-style-type: none"> training and education information and resources networking and sharing information access to area expertise stakeholder consultation service delivery development coordination; and monitoring and evaluation. <p>Capacity and linkages enhanced with existing carer services such as CYCLOPS and Carers ACT to work with this target group, their families, and alcohol and other drug services.</p>	
Education			
<p>45. ACT Department of Education and Training to be guided by:</p> <ul style="list-style-type: none"> alcohol and other drug education programs that have demonstrated reduced or delayed uptake of drugs, and ACT Secondary Student Drug and Health Risk Survey results 	Demand Reduction	<p>School curricula drug education evaluation processes guided by programs that have demonstrated reduced or delayed uptake of drugs and the ACT Secondary Student Drug and Health Risk Survey results.</p> <p>A database of evaluated and effective alcohol and other drug education programs compiled.</p>	ACT DET

	Actions	Rationale	Evaluation <i>(examples of ways in which implementation of actions may be evaluated.)</i>	Lead Agency
	to inform the development and implementation of curriculum drug education programs in schools.			
46.	Investigate the feasibility of developing and implementing a peer education program informed by evidence for young people at risk who are not engaged with the formal education system.	Harm Reduction	<p>Program developed, implemented and evaluated.</p> <p>Monitor program effectiveness for priority populations (e.g. people from culturally and linguistically diverse backgrounds, women, Aboriginal and Torres Strait Islander peoples).</p>	ACT Health
47.	Work with people from culturally and linguistically diverse backgrounds and refugees and the services who work with these people to identify their needs in relation to alcohol and other drug issues, and develop appropriate strategies to address them.	Harm Reduction	<p>Improved access to interpreter services and written information in different languages in relation to alcohol and other drug prevention and treatment services. (Where relevant, this work will be undertaken in collaboration with Mental Health ACT's Transcultural Mental Health Liaison and Community Development Officer.)</p> <p>Youth-specific resources developed in partnership with young people from culturally and linguistically diverse backgrounds and refugees.</p> <p>Capacity building and workforce development requirements of the ACT alcohol and other drug sector identified and addressed.</p>	ACT Health

Actions		Rationale	Evaluation <i>(examples of ways in which implementation of actions may be evaluated.)</i>	Lead Agency
48.	Investigate the feasibility of developing and implementing a social marketing strategy to accompany the introduction of roadside drug testing.	Harm Reduction	<p>Program developed, implemented and evaluated.</p> <p>Program targeted towards specific populations. (e.g. young people, those who regularly take medication etc).</p>	ACT Health
49.	Expand and improve the quality of drug related community education campaigns and programs offered to target groups.	Harm Reduction	<p>Community Education programs developed, implemented and evaluated for (and in partnership with):</p> <ul style="list-style-type: none"> • the general population, and • targeted populations including young people; the gay, lesbian, bi-sexual, sex and gender diverse communities; people for whom English is a second language; multi-cultural communities; and people experiencing, or at risk of experiencing alcohol and other drug and mental health problems currently, <p>using targeted approaches including:</p> <ul style="list-style-type: none"> • the life stages • the stages of drug use, and • settings, including educational institutions, the workplace (e.g. sex workers, community sector, government sector employees), 	ACT Health

Actions	Rationale	Evaluation <i>(examples of ways in which implementation of actions may be evaluated.)</i>	Lead Agency
		<p>in relation to:</p> <ul style="list-style-type: none"> • effective policy measures for reducing drug related harm (e.g. impact of taxation and pricing on alcohol related harm) • awareness of harm to others of second-hand tobacco smoke • consequences and dangers of poly-drug use (illicit and licit drugs including alcohol and dangers such as loss of inhibitions, unsafe sex, dangerous driving and violence) • revised Alcohol Guidelines for Low Risk Drinking • hosting safe parties • secondary supply of alcohol and tobacco to minors • dangers of using psychostimulants • influencing and challenging community attitudes towards people who use drugs, to reduce the stigma associated with the use of drugs • reducing the incidence of sexually transmitted infections/blood borne 	

	Actions	Rationale	Evaluation <i>(examples of ways in which implementation of actions may be evaluated.)</i>	Lead Agency
			viruses <ul style="list-style-type: none"> • promote healthy activities (e.g. workplace fitness activities), and • health promotion messages advocating safer and healthier use of alcohol. Capacity building and workforce development requirements of the ACT alcohol and other drug sector identified and addressed.	
50.	Increase and improve support for peer-based models of service delivery, support, advocacy and community development.	Harm Reduction	Expansion of peer based services. Increased number of clients accessing peer based services. Improve access to peer support programs for those accessing hepatitis C treatment.	ACT Health
51.	Enhance workforce development programs offered for workers of ACT Government and community agencies whose clients are experiencing, or at risk of experiencing alcohol and other drug problems (including those working in areas relating to children, youth and families; education settings; and other related community-based services).	Harm Reduction	Workforce development programs enhanced and implemented and evaluated.	ACT Health
52.	Expand on the work undertaken by the Office for Children, Youth and Family Support to formalise relationships with alcohol and other drug services by further developing protocols to:	Harm Reduction	Protocol developed and implemented. Office for Children, Youth and Family Support input to alcohol and other drug services'	ACT Health DHCS

Actions	Rationale	Evaluation <i>(examples of ways in which implementation of actions may be evaluated.)</i>	Lead Agency
<ul style="list-style-type: none"> • improve knowledge and understanding of respective services and priorities • provide guidance and commitment to a way of collaborative working, and • maximise opportunities for cross agency training. 		<p>education units and training materials relating to Early Intervention and Care and Protection matters.</p> <p>AOD services' input to Office for Children, Youth and Family Support education units and training materials relating to alcohol and other drug matters.</p>	
Workforce Development			
<p>53. Develop and implement a workforce development strategy for the ACT alcohol and other drug treatment and support services, including:</p> <ul style="list-style-type: none"> • the continuation of support for a strong, stable and flexible workforce to meet the needs of people who use alcohol and other drugs and their families • increased capacity to attract and retain a highly skilled specialist alcohol and other drug treatment and support workforce • increased capacity for generalist health and welfare workers to identify and respond to alcohol and other drug problems and related harm, and apply evidence-informed interventions, and • the continuation of support for the attainment 	Demand Reduction	<p>Recurrent funding allocated to support Alcohol and Other Drug Workers' Group.</p> <p>Complete an ACT Alcohol and Other Drug Workforce Remuneration and Qualification Profile each 12 – 18 months.</p> <p>Ongoing refinement and implementation of the ACT Alcohol and Other Drug Minimum Qualifications Strategy in accordance with ACT Health funding agreements with treatment and support services.</p> <p>Competitive employment conditions, incentives and benefits implemented in both Government and non-government agencies.</p> <p>Capacity created for transfer between the Government and non-government agencies</p>	ACT Health

Actions	Rationale	Evaluation <i>(examples of ways in which implementation of actions may be evaluated.)</i>	Lead Agency
<p>of quality standards for funded alcohol and other drug treatment and support services and alcohol and other drug workers.</p>		<p>without loss of continuity of entitlements (e.g. secondments).</p> <p>Funds designated for medical specialist training in the addictions linked to the availability of medical specialist positions in this field.</p> <p>Recruitment strategies implemented, including national and international advertising and joint initiatives with tertiary education institutions.</p> <p>Clinical supervision arrangements strengthened for staff of alcohol and other drug services following review of clinical supervision guidelines for those working in the alcohol and other drug sector.</p> <p>Additional training and development opportunities for the alcohol and other drug workforce in the areas of:</p> <ul style="list-style-type: none"> • adolescent health and wellbeing • Aboriginal and Torres Strait Islander cultural awareness • working with people from culturally and linguistically diverse communities • gender sensitivity/awareness • counselling 	

Actions	Rationale	Evaluation <i>(examples of ways in which implementation of actions may be evaluated.)</i>	Lead Agency
		<ul style="list-style-type: none"> • case management, and • comorbidity. <p>Commence a program that allows clinicians from the Alcohol and Drug Program (ADP) to undertake core units from the Certificate IV in Mental Health and a two-week placement in Mental Health ACT.</p> <p>Continue similar program already in operation for clinicians from Mental Health ACT.</p> <p>Commence co-morbidity workforce development initiatives that allow employees in the ACT alcohol and other drug and mental health government and non-government sectors to have reciprocal rotations and placements, participate in joint workforce development initiatives, and investigate feasibility and merit of establishing information sharing protocols.</p>	
54. Enhance comorbidity bus tours to become an integral component of inductions for staff entering the ACT alcohol and other drug and mental health sectors.	Harm Reduction	Participation in comorbidity bus tours built into induction programs for staff of alcohol and other drug and mental health services.	ACT Health
55. Improve access to opportunistic smoking and alcohol related interventions for priority populations (e.g. when a health crisis occurs such as when a child suffers an asthma attack) by providing GPs and other	Harm Reduction	Uptake of training programs offered in opportunistic interventions by: <ul style="list-style-type: none"> • GPs 	ACT Health

Actions		Rationale	Evaluation <i>(examples of ways in which implementation of actions may be evaluated.)</i>	Lead Agency
	health and community workers with timely access to resources, training and specialist advice.		<ul style="list-style-type: none"> workers in health and community centres, and workers in hospitals. <p>Increase in uptake rates of smoking cessation and reduction programs.</p> <p>Decrease in smoking rates.</p> <p>Increase in the level of consultation advice and training (including in relation to underlying causes and impact for men and women) provided by ACT Health's Alcohol and Drug Program (ADP), and other alcohol and other drug services to general practitioners and other health and community services workers.</p>	
Research and Surveillance				
56.	Implement research to review and strengthen current benzodiazepine and narcotics agreements utilised between general practitioners and clients.	Demand Reduction	Research implemented.	ACT Health
57.	Implement a full and comprehensive evaluation of drug policies and services and their subsequent effects on prisoners and staff within the Alexander Maconochie Centre.	Harm Reduction	<p>Evaluation completed and to include:</p> <ul style="list-style-type: none"> referral pathways throughcare related to screening, education and treatment for blood borne 	<p>ACT Health</p> <p>DJACS</p>

	Actions	Rationale	Evaluation <i>(examples of ways in which implementation of actions may be evaluated.)</i>	Lead Agency
			viruses and sexually transmitted infections, and drug treatment, and <ul style="list-style-type: none"> • consideration of priority populations such as young people (e.g. 18 – 25 years). Recommendations implemented.	
58.	Implement a full and comprehensive evaluation of proposed drug policies and services and their subsequent effects on young people and staff within Bimberi.	Harm Reduction	Evaluation completed and to include: <ul style="list-style-type: none"> • referral pathways, and • throughcare related to screening, education and treatment for blood borne viruses and sexually transmitted infections, and drug treatment. Recommendations implemented.	ACT Health DHCS
59.	Implement a local warning system and advocate for a national (capable of providing information with both strategic and immediate value) and contribute to the systems' development and implementation in collaboration with relevant organisations including consumer and community groups, police, ambulance, and health services.	Harm Reduction	Early warning system developed and implemented for: <ul style="list-style-type: none"> • supply of illicit drugs (e.g. Illicit Drug Reporting System type data) • problematic use of licit and illicit drugs (e.g. ambulance call-outs for overdose). Support provided for peer-based drug users organisations to be provided with increased capacity to participate in this early warning	ACT Health

	Actions	Rationale	Evaluation <i>(examples of ways in which implementation of actions may be evaluated.)</i>	Lead Agency
			system.	
60.	Seek permission from the federal government for the necessary drug importation to progress a clinical trial of diacetylmorphine prescription for people who are severely addicted to heroin and to advocate nationally for clinical trials of hydromorphone.	Demand Reduction	Approval for importation and conduct of program sought. Clinical trial of hydromorphone progressed.	ACT Health
61.	Improve the level and type of information collected in relation to the transmission of blood borne viruses for priority populations.	Harm Reduction	Expanded surveillance and publication of transmission rates of blood borne viruses for priority populations (e.g. prisoners and injecting drug users). Gender disaggregated data and analysis.	ACT Health
62.	Advocate for research that may determine whether there may be delays experienced by people with hepatitis C in efficiently metabolising alcohol due to decreased hepatic function.	Harm Reduction	Research completed. Findings from research inform road safety messages for people with hepatitis C.	ACT Health
63.	Establish a working group of representatives from organisations including ACT Ambulance Service, Office of Regulatory Services, ACT Policing and ACT Health in order that relevant information (including ‘last drinks’ data) be shared and analysed in order to: <ul style="list-style-type: none"> • identify venues and practices associated with disproportionate numbers of problems • recognise and promote successful practices and 	Harm Reduction	Working group meets regularly (i.e. quarterly or biannually) or as required. ‘Last drinks’ and other relevant data analysed.	DJACS ACT Policing ACT Health

	Actions	Rationale	Evaluation <i>(examples of ways in which implementation of actions may be evaluated.)</i>	Lead Agency
	strategies identified as leading to improved outcomes, and <ul style="list-style-type: none"> • inform operational decision making. 			
64.	Commission research to position the levels of drug use within the ACT gay, lesbian, bi-sexual, sex and gender diverse communities.	Harm Reduction	Research completed.	ACT Health
65.	Resume the collection of wholesale alcohol sales data to ensure the availability of local level data to inform local policy decisions on matters such as liquor licensing.	Supply Reduction	Collection of wholesale alcohol sales data resumed.	DJACS
66.	Collaborate with the Drug Policy Modelling Program (DPMP) to develop an ACT model of the service systems that focuses on the intersections between Health, Police, DHCS and ACT Corrective Services.	Demand Reduction	ACT Health, ACT Policing and DJACS, DHCS participation on a model development advisory group in collaboration with relevant consumer groups and the community sector. Development of an ACT model of the service system.	ACT Health DJACS ACT Policing DHCS

APPENDIX ONE – INTERVENTIONS LADDER

This Strategy has been developed recognising that its health and other measures must strike a balance between fostering healthy living conditions and protecting members of the public from harm caused by others. On one hand it is important to avoid coercion and the unnecessary restriction of freedom. On the other hand, health and other measures must address inequitable health outcomes for disadvantaged and vulnerable populations. Finding the right balance has been guided by the “intervention ladder”.¹⁰⁹

Lord Krebs, chairperson of the Nuffield Council on Bioethics’ that developed the concept of the “intervention ladder”,¹¹⁰ wrote:

The “intervention ladder” is a tool that enables one to rank public-health measures according to their coerciveness or intrusiveness. The higher up the ladder an intervention ranks, the stronger the need for justification and sound evidence for implementation. An example of a measure at the top of the ladder is that of compulsory quarantine or isolation in the event of an outbreak of infectious disease; both clearly involve a significant infringement of liberty. We suggest that these measures may be ethically justified where the harm to others can be significantly reduced.

The Nuffield Council on Bioethics¹¹¹ summarises the ladder’s purpose and ascending degrees of intervention as follows:

To assist in thinking about the acceptability and justification of different policy initiatives to improve public health we have devised what we call the ‘intervention ladder’ The first and least-intrusive step on the ladder is to do nothing, or at most monitor the situation. The most intrusive is to legislate in such a way as to restrict freedoms significantly, either for some groups of the population or the population as a whole, in order to achieve gains in population health. The higher the rung on the ladder at which the policy maker intervenes, the stronger the justification has to be. A more intrusive policy initiative is likely to be publicly acceptable only if it is clear that it will produce the desired effect and that this can be weighed against the loss of liberty that will result.

The range of options available to government and policy makers can be thought of as a ladder of interventions, with progressive steps from individual freedom and responsibility towards state intervention as one moves up the ladder. In considering which ‘rung’ is appropriate for a particular public health goal, the benefits to individuals and society should be weighed against the erosion of individual freedom.

109 Nuffield Council on Bioethics 2007, *Public health: ethical issues*, Nuffield Council on Bioethics: London.

110 Krebs, J 2008, The importance of public-health ethics, *Bulletin of the World Health Organization* 86 (8) August 2008, p. 579.

111 Nuffield Council on Bioethics 2007, *Public health: ethical issues*, Nuffield Council on Bioethics: London. Retrieved September 2008, <http://www.nuffieldbioethics.org/go/ourwork/publichealth/introduction.html>

Economic costs and benefits would need to be taken into account alongside health and societal benefits. The ladder of possible policy action is as follows:

- ***Eliminate choice.*** Regulate in such a way as to entirely eliminate choice, for example through compulsory isolation of patients with infectious diseases.
 - ***Restrict choice.*** Regulate in such a way as to restrict the options available to people with the aim of protecting them, for example removing unhealthy ingredients from foods, or unhealthy foods from shops or restaurants.
 - ***Guide choice through disincentives.*** Fiscal and other disincentives can be put in place to influence people not to pursue certain activities, for example through taxes on cigarettes, or by discouraging the use of cars in inner cities through charging schemes or limitations of parking spaces.
 - ***Guide choices through incentives.*** Regulations can be offered that guide choices by fiscal and other incentives, for example offering tax-breaks for the purchase of bicycles that are used as a means of travelling to work.
 - ***Guide choices through changing the default policy.*** For example, in a restaurant, instead of providing chips as a standard side dish (with healthier options available), menus could be changed to provide a more healthy option as standard (with chips as an option available).
 - ***Enable choice.*** Enable individuals to change their behaviours, for example by offering participation in an NHS 'stop smoking' programme, building cycle lanes, or providing free fruit in schools.
 - ***Provide information.*** Inform and educate the public, for example as part of campaigns to encourage people to walk more or eat five portions of fruit and vegetables per day.
 - ***Do nothing or simply monitor the current situation.***
-

APPENDIX TWO – TOBACCO & TARGET POPULATIONS FOR FURTHER INTERVENTION

In relation to tobacco, the following population groups are identified for priority focus for intervention and their use of this drug is described.

- Aboriginal and Torres Strait Islander people
- Adults in detention
- Juveniles in detention
- People with mental illness
- People who use alcohol and other drugs
- Women with low-to-middle incomes, and
- Men with low-to-middle incomes.

Aboriginal and Torres Strait Islander people

Although decreasing, smoking rates of 41.1% among ACT resident Aboriginal and Torres Strait Islander people in 2004-05 remain far higher than in the general population.

Similarly, although the rate of smoking is declining amongst Aboriginal and Torres Strait Islander secondary school students, these students were significantly more likely than students who were not Aboriginal and Torres Strait Islander people to report that they had smoked in 2005.¹¹²

Almost half (42.9%) of ACT resident Aboriginal and Torres Strait Islander women who gave birth during 2000-04 reported that they smoked during pregnancy compared to 13.8% in the general population. Seven in ten Aboriginal and Torres Strait Islander women who smoked during pregnancy reported that they smoked ten or more cigarettes per day (70.9%). Two thirds of Aboriginal and Torres Strait Islander women aged less than 20 years who gave birth during 2000-04 reported that they had smoked during pregnancy. This reduced to four in ten women aged over 20 years.

Adults in detention

In detention, 80% of women and 75% of men were current smokers according to the 2009 NSW Inmate Health Survey.¹¹³ Approximately 96% of these smokers consumed mainly hand rolled cigarettes which have higher nicotine and tar content than factory-made cigarettes and are more likely to be smoked without filters.

112 Population Health Research Centre, ACT Health 2007, *The Health of Aboriginal and Torres Strait Islander People in the ACT, 2000-2005*, Population Health Research Centre, ACT Health: Canberra.

113 Indig, D, Topp, L, Ross, B, Mamoon, H, Border, B, Kumar, S. and McNamara, M 2010, *2009 NSW Inmate Health Survey: Key Findings Report*. Justice Health. Sydney.

Some 53% of female smokers and 48% of male smokers reported consuming more tobacco whilst in prison than they did whilst in the community. The survey reported that 4% of women and 6% of men did not smoke in the twelve months prior to imprisonment but currently smoked.

In 2009, 74% of current women smokers and 89% of men wanted to quit smoking, with 46% of current women smokers and 58% of men attempting to stop smoking in the past twelve months. Some 52% of women and 57% of men reported attempting in the previous twelve months to reduce the amount smoked each day in order to reduce the harm associated with smoking. In addition, 33% of women and 49% of men had unsuccessfully attempted to stop smoking in the previous year.

Some 37% of women and 30% of men stated that they had felt the negative health effects of other people's cigarette smoke in the past twelve months. Nearly all (93% of men; 93% of women) Survey respondents believe that non-smokers should not be forced to share a cell with a current smoker. Only 18% of women and 24% of men agreed that smoking should be allowed in enclosed public areas of prison.

A 1996 survey in NSW correctional centres highlighted an alarming rate of reported current smoking amongst Aboriginal and Torres Strait people in detention. The survey found that Aboriginal and non-Aboriginal inmates reported similar levels of having ever used tobacco (83 vs. 81%); however Aboriginal and Torres Strait Islander people reported higher current use than people of non-Aboriginal and Torres Strait Islander descent (78% vs. 69%).¹¹⁴ A later 2001 survey in NSW correctional centres also found high rates of current tobacco use amongst Aboriginal and Torres Strait Islander people in detention (82% vs. 77% of people of non-Aboriginal and Torres Strait Islander descent).¹¹⁵

The ACT's Alexander Maconochie Centre, which opened in March 2009 does not permit prisoners to smoke inside, in either the cells block or cottage accommodation. When not confined to their cells, prisoners may smoke in designated areas outdoors. In the first three months after the AMC was opened to prisoners, prisoners who smoked were provided with nicotine lozenges free of charge to assist them to make the transition to the AMC environment and smoking rules. Prisoners are now able to purchase nicotine lozenges through the prisoner 'buy-ups' process.

Juveniles in detention

The NSW Young People in Custody Health Survey conducted in NSW juvenile detention centres found that the average age for commencing smoking was twelve years for both young men and young women. Some 27% (57) of young people in custody surveyed began smoking at ten years of age or younger.¹¹⁶ When combined with data from a similar 2003 survey of young offenders in non-custodial (i.e. on community orders) settings, the surveys found that

114 Butler, T, Levy, M, Dolan, K, Kaldor, J, Drug use and its correlates in an Australian prisoner population. *Addiction Research and Theory*; 1606-6359; 11 (2) April 2003; 89-101.

115 Butler, T, Milner, L 2003, *The 2001 New South Wales Inmate Health Survey*. NSW Corrections Health Service: Sydney.

116 Allerton, M, Kenny, D, Champion, U and Butler, T 2003, *NSW Young People in custody Health Survey: a summary of some key findings*. <http://www.justicehealth.nsw.gov.au/pubs/YPiCHS.pdf>

more than 80% of juvenile offenders in the community were current tobacco smokers and the average age at which they had started smoking was 12 years.¹¹⁷

Despite tobacco use being illegal in juvenile detention, the NSW Young People in Custody Health Survey found that 58% (127) of young people reported they were current smokers (57% of males and 67% of females). Some of 91% of current smokers did so on a weekly or more frequent basis (93% of males and 75% of females), with 68% (86) of current smokers reporting that they smoked daily. Ninety-two percent of both young men and young women reported currently smoking ten or fewer cigarettes on the days that they smoked.

Some 6% of young people reported that they had received help or treatment from a GP, counsellor or nurse to quit smoking since being admitted to custody. In contrast, 30% (38) of young people felt that they required assistance to quit smoking.¹¹⁸

People with mental illness

While smoking rates in the general population have fallen, according to SANE Australia¹¹⁹ around 32% of people with mental illness continue to smoke. It should be noted that this figure is disputed by some researchers. Other sources report that smoking rates amongst people with psychotic disorders are as high as 70-88%.¹²⁰

A recent University of Melbourne study¹²¹ involving 280 clients of a Victorian psychiatric support service found that 62% of those surveyed were current smokers. The study also found:

- smokers with a mental illness consumed on average 22 cigarettes per day, 50% more than smokers in the general population
- some smokers with a mental illness consumed up to 80 cigarettes per day
- 74% expressed a desire to reduce their consumption, and
- 59% of those surveyed expressed a desire to quit smoking.

The study's author also highlighted that:

Smoking compounds many of the health problems already experienced by people with mental illnesses. Combined with drug therapies that often make them overweight, they are at even greater risk of diabetes, heart attacks and strokes if they smoke. The biggest cause of death among people with mental illness is not suicide, it is cardiovascular disease.

117 Australian Institute of Health and Welfare 2008, *Australia's Health 2008*. Cat. no. AUS 99: AIHW: Canberra.

118 2003 *NSW Young People in Custody Health Survey. Key Findings Report*. NSW Department of Juvenile Justice: NSW ISBN: 0 7347 6518 5.

119 SANE Australia, retrieved February 2010, http://www.sane.org/factsheets/smoking_and_mental_illness.html

120 Baker, A. et al. Where there's smoke, there's fire: high prevalence of smoking among some sub- populations and recommendations for intervention. *Drug Alcohol Rev* 2006;25:85-96.

121 Moeller-Saxone, K 2008, Cigarette smoking and interest in quitting among consumers at a Psychiatric Disability Rehabilitation and Support Service in Victoria, *Australian and New Zealand Journal of Public Health*, Vol. 32, no. 5, October 2008, pp. 479-481.

People who use alcohol and other drugs

Up to 95% of people undergoing alcohol and other drug treatment smoke.¹²² Smokers with severe alcohol dependence smoke more cigarettes daily¹²³ and smoke sooner after waking than less severely dependent drinkers. Although there are less data available, a clear link has also been established between nicotine use and other substance use.¹²⁴ Findings from the 2008 Illicit Drug Reporting System included that 94% of participants (people who inject drugs) nationally reported to have smoked in the preceding six months whilst 90% reported being daily smokers.¹²⁵ In the ACT, 99% of Illicit Drug Reporting System participants reported having ever smoked and also having recently smoked.¹²⁶

Women with low-to-middle incomes

ACT women smoke at lower rates¹²⁷ than women nationally, with 14.6% reporting daily smoking in 2007, compared with the national figure of 16.6%. Despite this relatively favourable comparison, certain sub-populations of ACT women smoke at higher rates than the Territory average.

Women with low-to-middle incomes report higher rates of tobacco smoking than those with higher incomes. Data from the Australian Bureau Statistics' National Health Survey 2004-05 reveal that some 19.4% of women in the lowest and second-lowest of five household income brackets reported being current smokers. This compared with 8.5% of women in the highest bracket.¹²⁸

Indicating the generally positive social and emotional wellbeing of ACT women, most experience low (56%) or moderate (29%) levels of psychological distress. Of the 15% of women reporting high or very high levels of psychological distress (not necessarily an

122 Richter, K, Good and bad times for treating cigarette smoking in drug treatment. *Journal of Psychoactive Drugs*, Vol 38, no.3, pg 311-316.

Kerle, C & Jago, A 2005, *A Non Smoking Policy in a 15 Bed Detoxification Unit*, Australian Resource Centre for Healthcare Innovation. Retrieved September 2008, http://www.archi.net.au/e-library_administration/baxter05/effectiveness_of_health_care/non_smoking

123 Bowman, J & Walsh, R, Smoking intervention within alcohol and other drug treatment services: a selective review with suggestions for practical management. *Drug and Alcohol Review* 2003, Vol 22, pg 73-82.

Walsh, R, Bowman, J, Tzelepis, F & Lecantheiniais, C, Smoking cessation interventions in Australian drug treatment agencies; a national survey of attitudes and practices. *Drug and Alcohol Review* 2005 Vol 24, pg 235-244.

124 Ritcher, K & Arnsted, J, A rationale and model for addressing tobacco dependence in substance abuse treatment. *Substance Abuse Treatment Prevention & Policy* 2006, Vol 1, pg 23.

125 Stafford, J, Sindicich, N, & Burns, L 2008, *Australian Drug Trends 2008: Findings from the Illicit Drug Reporting System*, Australian Drug Trends Series No. 19, NDARC, Sydney.

126 Cassar, J, Stafford, J & Burns, L 2008, *ACT Drug Trends 2008: Findings from the Illicit Drug Reporting System*, Australian Drug Trends Series No. 21, NDARC: Sydney.

127 Australian Institute of Health and Welfare 2008, *2007 National Drug Strategy household survey: State and Territory Supplement*, cat. No. PHE 102, Canberra: AIHW.

128 Maslen, S 2008, *Social determinants of women's health and wellbeing in the Australian Capital Territory*, Women's Centre for Health Matters Inc: Canberra.

indicator of mental illness), 27% reported being current smokers. Similarly, 20% of women with diagnosed mental and behavioural health conditions reported smoking.

Men with low-to-middle incomes

Since 1945, when 72% of Australian men smoked, the national rate of daily smoking amongst males aged 14 years and older has steadily declined to 18% in 2007. In the ACT the 2007 rate was lower at 14.8%.¹²⁹ A slightly higher percentage of Australian men than women smoke overall. This is true of all age groups except those 14-19 years of age.¹³⁰ The highest rates of daily smoking among Australian men were in the 18-24 years age group. Smoking rates are higher among manual and factory workers than among office workers and professionals. This disparity was identified in the 2004-05 National Health Survey which found that the current smoking rate amongst professionals was 13% whereas 40% of 'labourers and related workers' smoked daily.¹³¹ Similarly, the Australian Bureau of Statistics¹³² found that 33% of men in the most disadvantaged areas reported daily smoking, compared with 16% in the most advantaged areas.

129 Australian Institute of Health and Welfare 2008, *2007 National Drug Strategy household survey: State and Territory Supplement*, cat. No. PHE 102, Canberra: AIHW.

130 Quit South Australia 2008, Men, Women & Smoking, Information Sheet, available at: http://www.quitsa.org.au/cms_resources/documents/infosheet_men_women_smoking.pdf

131 Cancer Council NSW 2008, *Smoking in Australia – Statistics*, available at: <http://www.cancercouncil.com.au/editorial.asp?pageid=371>

132 Australian Bureau of Statistics 2006, *Tobacco Smoking in Australia: A Snapshot, 2004-05*, available at: <http://www.abs.gov.au/AUSSTATS/abs@.nsf/mf/4831.0.55.001?OpenDocument>

APPENDIX THREE – ALCOHOL & TARGET POPULATIONS FOR FURTHER INTERVENTION

In relation to alcohol, the following population groups are identified for priority focus for intervention and their use of this drug is described.

- Young people
- Aboriginal and Torres Strait Islander people
- People in detention
- People with mental illness,
- People who use alcohol and other drugs.

Young people

Overall, 30% of male ACT secondary school students and 23% of female ACT students reported drinking alcohol in the week prior to the 2005 Secondary School Students' Survey. These results constitute a significantly lower proportion than reported in the previous (2002) survey.

The national average age at which males self-report to have first drunk a full glass of alcohol was 16 years, whereas for females it was 17.1 years.¹³³

According to *Victoria's Alcohol Action Plan 2008-2013: Restoring the balance*.¹³⁴

Evidence increasingly suggests that risky drinking during adolescence can impair healthy brain development including long-term memory and learning problems. This in turn can impair social development, leading to poorer performance at school and an increased risk of social and psychological problems.

When considering what constitutes risky alcohol consumption for adolescents, a cautious approach is necessary if applying 'risky drinking' levels that are developed using guidelines for low-risk drinking levels for adults. In contrast to adults, young people are generally smaller and have developing brains. As such, this Strategy recognises that there is no reliable evidence available on which to base recommendations for low-risk alcohol consumption for young people.

It is also important to note that young people can suffer the consequences of other people's drinking. For example, 7% of the 14-19 year old respondents to the 2007 National Drug Strategy Household Survey reported being the victims of alcohol-related physical abuse in

133 Australian Institute of Health and Welfare 2008, *2007 National Drug Strategy Household Survey: Detailed findings*. AIHW Cat. No. PHE 107, AIHW: Canberra.

134 http://www.health.vic.gov.au/drugservices/pubs/action_plan.htm

the year prior to interview, and 28% reported being the victims of alcohol-related verbal abuse.¹³⁵

Aboriginal and Torres Strait Islander people

According to *Victoria's Alcohol Action Plan 2008-2013: Restoring the balance*¹³⁶ Aboriginal and Torres Strait Islander people are less likely to consume alcohol than non-Indigenous Australians, but those Aboriginal and Torres Strait Islander people who do consume alcohol are more likely to do so at high to very high levels, and are more likely to drink at levels risking alcohol-related harm in the short term (sometimes referred to as 'binge drinking'). The National Health Survey 2001 found that 42% of Aboriginal and Torres Strait Islander adults compared with 62% of non-Aboriginal and Torres Strait Islander adults were likely to drink in the seven days prior to the survey. The Survey also found that, of those who did consume alcohol, Aboriginal and Torres Strait Islander adults were more likely to drink at risky or high-risk levels (29% cf. 17%).

Victoria's Alcohol Action Plan 2008-2013: Restoring the balance also highlights that Aboriginal and Torres Strait Islander people

experience significantly higher rates of alcohol-related harm such as alcohol cardiomyopathy (disease of the heart muscle), alcohol gastritis and alcoholic liver cirrhosis, traumatic injuries, road crashes, suicide and violent death. In addition, public drinking by Aboriginal and Torres Strait Islander people is a factor that contributes to the greater likelihood of arrest or detention for public drunkenness and alcohol-related violence than that experienced by non- Aboriginal and Torres Strait Islander Australians

and that Aboriginal and Torres Strait Islander women

identify alcohol as a major cause of violence and chaos within their lives. Indigenous women are five times more likely to call police to attend a family violence incident and 16 times more likely to seek support from the integrated family violence services system than non-Indigenous women.

In the ACT in 2007-08, 11% of closed treatment episodes (that is a period of contact, with defined dates of commencement and cessation, between a client and a treatment provider in which there is no change in main treatment type of the principle drug of concern, and there has not been a non-planned absence of contact for greater than three months) for people seeking alcohol and other drug treatment involved clients who identified as Aboriginal or Torres Strait Islander people. It should be noted that in 2007-08 approximately 8% of treatment episodes did not record the client's Indigenous status.¹³⁷

135 Ibid.

136 http://www.health.vic.gov.au/drugservices/pubs/action_plan.htm

137 Australian Institute of Health and Welfare 2009, *Alcohol and other drug treatment services in the Australian Capital Territory 2007-08: findings from the National Minimum Data Set (NMDS)*, Cat. no. HSW 76, AIHW, Canberra.

ACT Health unpublished AOD treatment data 2005-2007.

People in detention

According to the NSW Health Inmate Survey¹³⁸, alcohol consumption varies with socio-economic status. Those from disadvantaged groups are more likely to consume hazardous and harmful quantities of alcohol; this is particularly true for men.

The 2009 NSW Health Inmate Survey used the World Health Organisation's Alcohol Use Disorders Identification Test (AUDIT) as the means for assessing risky alcohol consumption in the 12 months prior to imprisonment. According to the Survey report¹³⁹ more women than men reported being non-drinkers (33% cf. 17%). Of particular concern is that 40% of women and 63% of men reported consuming alcohol in the 'hazardous' or 'harmful' range in the twelve months prior to imprisonment. In addition, 60% of women and 53% of men reported that a partner or other family member had an alcohol problem. Alcohol problems amongst the parents of both male and female prisoners were also commonly reported.

Of the young people in detention surveyed in the 2003 NSW Young People in Custody Health Survey, almost all had consumed alcohol at least once and most (85% of males, 100% of females) had been drunk on at least one occasion. Some 32% of males and 44% of females reported being drunk at least weekly in the 12 months prior to detention. Males reported hazardous or harmful drinking at lower rates than females (21% cf. 56%).¹⁴⁰

People with mental illness

According to *Victoria's Alcohol Action Plan 2008-2013: Restoring the balance* the problematic consumption of alcohol is closely associated with a number of mental health conditions. These include schizophrenia, anxiety, bipolar depression, and social phobias. The Plan also highlights that

*many people with depression and anxiety experience a range of co-occurring alcohol problems, and do so at higher rates than the general community (up to one in five people with an anxiety disorder also has a substance use disorder). Studies have found that alcohol abuse is associated with worse outcomes in terms of self-harm, suicide risk, social functioning and health care use for people who are also depressed.*¹⁴¹

ACT women with diagnosed mental and behavioural health conditions reported a higher rate of 'risky' or 'high risk' alcohol consumption (14%) than the ACT average for women (12%).¹⁴²

138 Indig, D, Topp, L, Ross, B, Mamoon, H, Border, B, Kumar, S. and McNamara, M 2010, *2009 NSW Inmate Health Survey: Key Findings Report*. Justice Health. Sydney.

139 Ibid.

140 *2003 NSW Young People in Custody Health Survey. Key Findings Report*. NSW Department of Juvenile Justice: NSW, ISBN: 0 7347 6518 5.

141 Victorian Government 2008, *Victoria's Alcohol Action Plan 2008-2013 'Restoring the Balance'*, Victorian Government: Melbourne.

142 Maslen, S 2008, *Social determinants of women's health and wellbeing in the Australian Capital Territory*, Women's Centre for Health Matters Inc: Canberra.

People who use alcohol and other drugs

Alcohol is the primary drug of concern for people accessing alcohol and other drug treatment both nationally and in the ACT.¹⁴³ Clients in 49% of the 3,738 reported closed treatment episodes (for people seeking treatment for their own drug use in the ACT) nominated alcohol as their principal drug of concern. This number increases to 62% when alcohol being nominated as another drug of concern by clients is considered. Alcohol was the principal drug of concern for all age groups. In the closed treatment episodes where alcohol was identified as a problem:

- 72% were provided to male clients
- the median age of persons receiving treatment was 35 years
- 24% of closed treatment episodes provided withdrawal management only, and
- 33% of closed treatment episodes provided counselling.

People who experience problems related to their use of alcohol are often reluctant to enter treatment. They may lack insight into the negative consequences of their alcohol use, and they may be in a state of denial about their level of alcohol use. Alcohol consumption is widely accepted in the Australian community and drinking to intoxication is often regarded as a 'part of growing up'. Furthermore, alcohol is understood by many in the community to be a substance somehow different from "drugs". This Strategy acknowledges that alcohol, whilst licit, is a drug and consistently refers to it as such. Those who drink in a 'risky' or 'high risk' manner may not drink alcohol on a daily or even weekly basis and hence may not be alcohol dependent. All of these factors mean that the majority of people who drink at risky or high-risk levels are unlikely to approach drug treatment services about their drinking. Therefore, interventions to address risky and high risk drinking need to be opportunistic and suitable for delivery in contexts where screening can be undertaken to identify people who practice risky or high risk drinking.

143 Australian Institute of Health and Welfare 2009, *Alcohol and other drug treatment services in the Australian Capital Territory 2007-08: Findings from the National Minimum Data Set*. Cat. no. HSW 76, 2005-06. AIHW: Canberra.

APPENDIX FOUR – OTHER DRUGS & TARGET POPULATIONS FOR FURTHER INTERVENTION

In relation to drugs other than tobacco and alcohol the following population groups are identified for priority focus for intervention and their use of these drugs is described.

- Aboriginal and Torres Strait Islander people
- People in detention
- People with mental illness, and
- People who use alcohol and other drugs

Aboriginal and Torres Strait Islander people

According to an Australian Institute of Health and Welfare report¹⁴⁴, Aboriginal and Torres Strait Islander peoples reported using illicit drugs in the previous 12 months at almost twice the rate reported by non-Indigenous Australians (28% cf. 15%). Amongst Aboriginal and Torres Strait Islander peoples:

- rates of substance use in men exceeded those for women
 - 54% of men have ever used an illicit substance
 - 45% of women have ever used an illicit substance
 - 32% of men have used an illicit substance recently (in the previous 12 months), and
 - 25% of women have recently used an illicit substance
- recent substance use was highest in those aged 25-34 years
- cannabis was the most commonly used illicit substance
 - 43% reported ever using cannabis, and
 - 23% reported using cannabis recently
- amphetamines was the next most commonly used illicit substance
 - 15% having ever used amphetamines, and
 - 7% having recently used amphetamines.

The greatest amount of burden of disease and injury nationally among young Aboriginal and Torres Strait Islander people can be attributed to alcohol and other drugs. The consequences are more serious with poly-drug use. The Australian Institute of Health and Welfare report included:

Indigenous young people aged 18-34 years who had recently used illicit substance were around twice as likely as those who had never used substances to regularly smoke (66% compared with 34%) and to binge drink on a weekly basis (28%

144 Pink, B & Allbon, P 2008, *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples: 2008*. ABS & AIHW: Canberra.

compared with 13%). They were also less likely to report being in excellent or very good health (41% compared with 58%).

People in detention

A report on the drug use of those arrested by police¹⁴⁵ found that poly-drug use is of concern, with almost half of the detainees found to be dependent on alcohol were also dependent on an illicit drug (49%). The prevalence of illicit drug use is decreasing and the prevalence of alcohol use has been stable in recent years. Another concern is injecting. Of those arrestees who self-reported using amphetamines/speed over the previous 12 months, 49% reported they always injected the drug.

Of the young people in detention surveyed in the 2003 NSW Young People in Custody Health Survey,¹⁴⁶ 26% of males and 53% of females used two or more illicit substances at least weekly prior to detention. Some 16% of males and 53% of females had injected drugs in the 12 months prior. Of those reporting to have used heroin, 47% reported injecting. This figure was lower for those reporting to have used amphetamines (35% injecting) and cocaine (32% injecting).

People with mental illness

Where there exists a co-occurrence of one or more alcohol and other drug disorders with one or more mental health disorders (including mood, anxiety or psychotic disorders), terms including 'comorbidity', 'dual diagnosis', and 'co-existing alcohol and other drug and mental health conditions' are often used. This Strategy uses the term 'comorbidity'.

In 2004, the National Centre for Education and Training on Addiction reported high rates of comorbidity. Comorbidity was highlighted as common, complex, often leading to poor outcomes and high drop-out rates with standard treatments, often involving multiple services, and is best approached through integrated and comprehensive treatment.¹⁴⁷

Determining the prevalence of illicit drug use by people experiencing mental illness is difficult as rates vary according to various sub-populations. National Centre for Education and Training on Addiction¹⁴⁸ reports that:

Overall, the 12 month prevalence of a substance use disorder together with a mental disorder is estimated to be 10% of the general population (ABS, 1998; Jablenski et al., 2000), and lifetime prevalence 20-30% (Todd, 2002). The evidence also suggests that for most people with mental health disorders, between 30 and 50% experience substance use disorder.

145 Gaffney, A, Jones, W, Sweeney, J & Payne, J 2010, *Drug use monitoring in Australia: 2008 annual report on drug use among police detainees*. Monitoring Reports 09. Australian Institute of Criminology: Canberra.

146 2003 NSW Young People in Custody Health Survey. *Key Findings Report*. NSW Department of Juvenile Justice: NSW, ISBN: 0 7347 6518 5.

147 National Centre for Education and Training on Addiction (NCETA) Consortium 2004, *Alcohol and Other Drugs: A Handbook for Health Professionals*. Australian Government, Department of Health and Ageing: Canberra.

148 Ibid.

The National Survey of Mental Health and Well Being¹⁴⁹ was conducted in 1997 to gather baseline information about the prevalence of mental illness in the Australian population. The survey, the most recent of its type, found:

- 18% of respondents met the criteria for a mental health disorder in the preceding 12 months
- prevalence of mental health problems decreased with age, with the highest prevalence (27%) amongst those aged 18-24 years, reflecting the relatively higher rate of alcohol and other drug disorders amongst young adults¹⁵⁰
- 46% of females with a substance use disorder met criteria for an anxiety or affective disorder, and 18% met criteria for both an anxiety and an affective disorder, and
- 25% of men with a substance use disorder met the criteria for another mental disorder, with 10% meeting criteria for both an affective and an anxiety disorder.¹⁵¹

People who use alcohol and other drugs

Heroin use has increased among people who regularly inject drugs in larger capital cities in Australia, while crystal methamphetamine ('crystal' or 'ice') use appears to have either stabilised or reduced among both people who inject and people who regularly use ecstasy.¹⁵²

Data from the Illicit Drug Reporting System,¹⁵³ which includes surveys with injecting drug users in each Australian state and territory, indicates that significant proportions of the sample had used pharmaceutical drugs illicitly over the previous six months. These drugs included methadone, buprenorphine, morphine, oxycodone and benzodiazepines.

In 2008, 66% of the Illicit Drug Reporting System sample from the ACT reported using benzodiazepines in the previous six months on a median of 120 days, an increase from the 2007 median of 48 days. Some 55% reported using prescribed benzodiazepines and 47% reporting using illicitly obtained benzodiazepines.

Some 35% of the ACT 2008 sample reported using illicit morphine in the previous six months, down from 53 % in 2007; and 12 % reported using licit morphine during this period.

Since 2005, Illicit Drug Reporting System interviewees have been asked specifically about the use of oxycodone. In 2008 the ACT sample reported an illicit oxycodone use of 27% and a licit use of 6% within the past six months.

149 Henderson et al. cited in Topp, L 2007, Comorbidity: A chance for change, *Of Substance*, vol. 5, no. 1.

150 Topp, L 2007, Comorbidity: A chance for change, *Of Substance*, vol. 5, no. 1.

151 Andrews, G, Hall, W, Teesson, M & Henderson, S 1999, *The Mental Health of Australians*, Mental Health Branch, Commonwealth Department of Health and Aged Care: Canberra.

152 Mundy, J 2008, Drug Use Snapshot: The 2007 IDRS and EDRS Findings, *Of Substance* vol 6, no 1, January 2008, pp. 20-21.

153 Cassar, J, Stafford, J & Burns, L 2009, ACT Drug Trends 2008: *Findings from the Illicit Drug Reporting System (IDRS)*, Australian Drug Trends Series No. 21, NDARC: Sydney.

Data from the 2008 Ecstasy and Related Drugs Reporting System¹⁵⁴ indicated that 21% of the ACT sample reported illicit use of benzodiazepines (the use of someone else's prescription) over the previous six months and 12 % reported licit use (use of their own prescription).

The Misuse/Abuse of Benzodiazepines and other forms of Pharmaceutical Drugs in Victoria report¹⁵⁵ included that:

*In terms of drug deaths, benzodiazepines are present in about half to two-thirds, depending on the type of drug death, not because they themselves are so dangerous that by themselves they cause people to die but they are often misused with other drugs and they add to the effects of other drugs, whether they be prescription drugs such as antidepressants, or people who choose to use heroin.*¹⁵⁶

It was also reported that most users of heroin also use benzodiazepines and prescription opioids. Heroin users are about 13 times more likely to die in any one year than their age-mates who do not use heroin,¹⁵⁷ with annual mortality rates of between 1–3%.¹⁵⁸ Furthermore, most heroin-related overdose deaths are associated with poly-drug use; that is, alcohol and/or a number of other drugs used in combination. In support of the association between poly-drug use and heroin-related deaths, the Victorian Report noted that benzodiazepines were detected in 71% of heroin related deaths, and morphine in 16% of heroin related deaths, in Victoria in 2001.¹⁵⁹

154 Rowe, P & Burns, L. 2009, *ACT Trends in Ecstasy and Related Drug Markets 2008, Findings from the Ecstasy and Related Drugs Reporting System (ERDS)*, Australian Drug Trends Series No. 30. National Drug and Alcohol Research Centre, UNSW.

155 Drugs and Crime Prevention Committee 2007, *Inquiry into Misuse/Abuse of Benzodiazepines and other Pharmaceutical drugs*. Parliament of Victoria: Melbourne.

156 Professor Olaf Drummer, Head (Forensic and Scientific Services), Victorian Institute of Forensic Medicine, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into the Misuse/Abuse of Benzodiazepines and Other Forms of Pharmaceutical Drugs in Victoria, Public Hearings, Melbourne, 13 July 2006.

157 English, DR. et al. 1995, *The quantification of drug caused morbidity and mortality in Australia*, Commonwealth Department of Human Services and Health: Canberra.

158 Darke, S & Zador, D 1996, Fatal heroin "overdose": A review, *Addiction*, vol. 91, pp.1765–1772.

159 Wallington, J, Gerostamoulos, J., & Drummer, OH 2002, *Heroin Deaths in Victoria: 2001*. Victorian Institute of Forensic Medicine & Department of Forensic Medicine, Monash University: Melbourne.

APPENDIX FIVE – LEGAL FRAMEWORK

The legislative context in which the Territory's harm minimisation approach operates includes the following elements.

ACT Legislation

- Age of Majority Act 1974
- Children and Young People Act 2008
- Criminal Code 2002
- Discrimination Act 1991
- Drugs of Dependence Act 1989
- Health Act 1993
- Health Professionals Act 2004
- Health Records (Privacy and Access) Act 1997
- Human Rights Act 2004
- Human Rights Commission Act 2005
- Intoxicated People (Care and Protection) Act 1994
- Liquor Act 1975
- Magistrates Court (Liquor Infringement Notices) Regulation 2008
- Medical Treatment Act 1994
- Medicines, Poisons and Therapeutic Goods Act 2008
- Mental Health (Treatment and Care) Act 1994
- Occupational Health and Safety Act 1989
- Public Health Act 1997
- Road Transport (Alcohol and Drugs) Act 1977
- Smoking (Prohibition in Enclosed Public Places) Act 2003, and
- Tobacco Act 1927.

Commonwealth Legislation

- Age Discrimination Act 2004
 - Criminal Code Act 1995
 - Disability Discrimination Act 1992
 - Freedom of Information Act 1982
 - Human Rights and Equal Opportunity Commission Act 1986
 - National Health Act 1953
-

- Privacy Act 1988
- Privacy Amendment (Private Sector) Act 2000, and
- Racial Discrimination Act 1975.

Three pieces of legislation relating to alcohol, tobacco and other drugs are the focus of separate reviews.

Tobacco

On 27 August 2008 The Tobacco Amendment Bill 2008 was passed providing for the transitioning of a ban on point of sale displays. Point of sale displays ended for most tobacco licensees on 31 December 2009. For tobacco licensees whose main business is the retail sale of tobacco products, point of sale displays will end on 31 December 2010.

The ACT Government is investigating legislation a ban on smoking in cars where children are present, restricting smoking near building entrances, outdoor dining and drinking areas and at underage functions.

The Australian Government's National Preventative Health Taskforce has identified that restricting tobacco packaging by prohibiting brand imagery, colours, corporate logos and trademarks (i.e. 'plain packaging') would reduce its appeal and perceptions about the likely enjoyment and desirability of smoking. Requiring cigarettes to be sold in plain packaging would reinforce the idea that cigarettes are not an ordinary consumer item. Plain packaging would also reduce the potential for cigarettes to be used to signify status and would increase the salience of health warnings (as research has shown that plain packaging improves recollection of health warnings).¹⁶⁰

There is considerable public support for the full range of measures in place to reduce problems associated with the use of tobacco.¹⁶¹ Support is greatest for stricter enforcement of law (90%) against, and stricter penalties (87.5%) for, selling or supplying to minors; and banning smoking in the workplace (82%) and at pubs/clubs (77%). Of all reduction measures surveyed, increasing tax to discourage smoking was least popular yet still supported by 65.7% of Australians.

Alcohol

In March 2008 the ACT Department of Justice and Community Safety released a public discussion paper to inform that Department's review of liquor licensing laws contained in the *ACT Liquor Act 1975*.

Consideration of amendments to the Liquor Act is an important element of a broader integrated approach to preventing and reducing alcohol related harm in accordance with the aims of the *National Alcohol Strategy 2006-2009*, to:

160 National Preventative Health Taskforce, Tobacco Working Group 2008, Tobacco Control in Australia: making smoking history, Technical Report No. 2, Australian Government Preventative Health Taskforce: Canberra.

161 Australian Institute of Health and Welfare 2008, *2007 National Drug Strategy, Household Survey: first results*. Drug Statistics Series number 20. Cat. No. PHE 98, pg xi. AIHW: Canberra.

- reduce the incidence of intoxication among drinkers
- enhance public safety and amenity at times and in places where alcohol is consumed
- improve health outcomes among all individuals and communities affected by alcohol consumption, and
- facilitate safer and healthier drinking cultures by developing community understanding about the special properties of alcohol and through regulation of its availability.

The ACT Government has recently completed the review of the *Liquor Act 1975* and the Liquor Bill 2010 is planned to be introduced into the Assembly in mid 2010. It has been proposed that new laws will make it an offence to:

- provide alcohol to an already intoxicated person by both patrons and employees on licensed premises
- abuse, threaten or intimidate an employee for refusing service of alcohol, and
- offer alcohol promotions which encourage rapid consumption of alcohol.

Key elements of the proposed ACT reform package include:

- risk based licensing fees
- dedicated ACT Policing liquor licensing teams
- the provision for lockouts at licensed premises if required
- the introduction of mandatory responsible service of alcohol training for all staff and security guards
- a requirement on licensees to provide, contribute towards, or otherwise identify transport options for patrons to get home safely after early morning trading
- new police powers including the power to impose an emergency 24 hour suspension of trade on the spot
- public notification of liquor licensing applications with provision for members of the community to comment on prospective liquor licences
- new powers for the Commissioner for Fair Trading to impose and vary conditions on a licence at any time to protect the interests of the community
- new powers for the Commissioner for Fair Trading to refuse a licence application if it is not in the interests of the broader community, aimed at preventing the over representation of licensed premises in a single location, and
- the collection of wholesale alcohol data.

Road Safety

In 2008 the ACT Government announced a review of the *Road Transport (Alcohol and Drugs) Act 1977*, which sets the law relating to alcohol and other drug driving.

A discussion paper outlining key issues covered by the review was developed. The paper focussed on:

- drugs and driving
-

- improving detection of drink driving
- interventions to prevent drink driving
- blood alcohol concentration limits
- penalties for drink driving
- alcohol interlocks, and
- granting restricted licences to drink drivers.

Amendments to the Road Transport (Alcohol and Drugs) Act 1977, covering the drink-driving reforms are expected to be introduced into the Legislative Assembly in mid 2010.