

ACT Alcohol, Tobacco
and other Drug Strategy

2004 - 2008



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Foreward

Drug misuse causes harm across all income levels, cultural groups and ages. Despite existing efforts, and success in some areas, levels of drug use are still far too high.

The problematic use of drugs - including tobacco, alcohol, pharmaceutical products, inhalants, steroids, cannabis, heroin, and other illegal drugs, is one of the most significant social and public health issues facing Australia today.

This Government is not only concerned about injecting drug use and the more public face of the "illicit drug problem", but also with the harms inflicted by tobacco and alcohol – the legal drugs that cause more deaths and cost to the community than any of the illicit drugs.

The development of the ACT Alcohol, Tobacco and other Drug Strategy 2004-08 has been an opportunity to provide thoughtful, consultative policy development in an area traditionally fraught with difficulty.

The Strategy outlines actions that the Government will, in partnership with the community and non-government organisations, work to implement over the next four years.

I would like to thank members of the ACT Alcohol and other Drug Taskforce, their constituents and members of the public who contributed to the development of the ACT Alcohol, Tobacco and other Drug Strategy 2004-08.

The ACT Government is committed to reducing the harm associated with the misuse of alcohol and other drugs in the ACT community and I look forward to a better future for those affected by alcohol and other drug misuse.



Bill Wood
Acting Minister for Health

Introduction

Vision

The ACT Alcohol, Tobacco and other Drug Strategy 2004 forms part of a Whole of Government vision for the ACT as a strong, confident and prosperous community.

As detailed in the ACT Health Action Plan, the Government's vision is of a community that:

- Is inclusive of all Canberrans;
- Is prosperous, progressive, skilled and creative;
- Is cohesive, fair, tolerant and optimistic;
- Is committed to protecting the vulnerable and supporting those in need; and
- Gives its children every chance to realise their potential.

Background

The exact cause of harmful alcohol, tobacco and other drug use is not simply defined or explained. What is known, however, is that there is a broad range of complex factors that contribute to the harmful use of alcohol, tobacco and other drugs. Our understanding of these contributing factors assists us in targeting interventions that are intended to reduce the harms associated with such use. These include individual factors, environmental factors, and more broadly, societal factors. An approach that addresses all three of these elements is important to comprehensively address the harmful effects of drug use.

People use drugs for many reasons, be it to relax, to have fun or to be part of a group. Young people may experiment and take risks with drugs out of curiosity, while others may encounter pressure to enhance their appearance, status or sporting performance through drug use. Misuse by adults - especially parents - of tobacco, alcohol and other drugs can also influence young people's perceptions about the role of drugs in society.

While problems of this sort can arise in all social groups, people who experience social disadvantage may be at higher risk of problematic alcohol, tobacco and other drug use. Other issues, including mental health problems, physical health problems, family stress and breakdown, peer pressure, and cultural dislocation can also contribute to harmful drug use.

While we know that people use drugs for a variety of reasons, drug taking is not without risk and in certain situations can result in harmful effects to both individuals and the community. For example, most of the illnesses and premature deaths related to drug use (especially from cancers, heart disease and injury) result from the consumption of tobacco and alcohol. Older people who tend to have a higher rate of prescription use can encounter drug related problems with extended use of multiple medications, or when medication is combined with alcohol.

Alcohol, tobacco and other drug-related harm occur within a social context. Therefore consideration of the complex interrelationship of biological, psychological, cultural and social aspects of alcohol, tobacco and other drug use is important when planning and developing appropriate interventions that aim to promote the health and well-being of individuals and communities. Systems of prevention, control and management need to be utilised to minimise the net harm from alcohol, tobacco and other drugs in order to maximise the benefits for individuals and society.

The problematic use of legal and illegal drugs affects the ACT community and has significant social and economic costs for individuals, families and carers, businesses and local communities. The community as a whole bears the cost of harmful alcohol, tobacco and other drug use in the ACT.

Development of the Strategy

The ACT Government established an Alcohol Tobacco and other Drug Taskforce in August 2002 to make recommendations to Government about minimising the harms associated with substance use. Taskforce membership and Terms of Reference are detailed at Appendix 1 and Appendix 2.

In developing its recommendations, the Taskforce undertook a range of consultations with key stakeholders and the broader community through public consultations, one addressing Aboriginal and Torres Strait Islander issues and the other the community in general.

The Aboriginal and Torres Strait Islander forum recommended that a specific Aboriginal and Torres Strait Islander Strategy be developed to address the needs of this community more comprehensively. This Strategy includes a range of actions to address the needs of the Aboriginal and Torres Strait Islander people, and the Aboriginal and Torres Strait Strategy will build on these actions.

In December 2003, the Taskforce presented the Health Minister with a draft *ACT Alcohol and other Drug Strategy*. The draft strategy recommended the implementation of a range of actions over the next three years that cover the key areas of harm minimisation: supply reduction, demand reduction and harm reduction.

Following preliminary consideration of the draft Strategy, the Government announced in December 2003 that it had made available \$250,000 this financial year to support the implementation of a number of high priority actions identified in the draft Strategy. These actions included:

- Creating 100 additional subsidised places in the methadone and buprenorphine program;
- Establishing a trial of vending machines for dispensing needles and syringes in the ACT, which will provide 24 hour access to sterile injecting equipment;
- Increasing and improving support for peer based models of service delivery, support and advocacy, and community development;
- Strengthening training programs across the drug and alcohol sector; and
- Monitoring and evaluation of the Strategy.

Funding was also made available in the 2004/05 Budget to support the implementation of the following initiatives:

School Education Alcohol and Drug Program: to identify and implement school alcohol and drug education programs that have been successful in reducing drug use, delaying uptake of drugs and developing resilience in children and young people. Peer education, including mentoring programs will be introduced into ACT schools to prevent and address drug and alcohol problems.

Tobacco Compliance Program: to target the illegal supply of tobacco to minors. The initiative will test whether tobacco retailers are complying with the legislation.

Case Management: to strengthen and increase case management of clients with complex needs, particularly those utilising pharmacotherapy treatments and develop and implement a case management framework and protocols both within the alcohol and drug sector and across sectors (eg: between health, education, housing and corrections).

Dual Diagnosis: to engage two dual diagnosis outreach workers to work with Aboriginal and Torres Strait Islanders. The funds will enable an outreach service to be established to assist people who have both a mental illness and substance abuse problems.

Bush Healing Farm: to conduct a feasibility study into establishing a bush healing farm. The farm could target improved health outcomes for Aboriginals and Torres Strait Islanders by developing the most culturally appropriate prevention, education, rehabilitation and outreach programs to address drug and alcohol misuse within these local communities.

The Government has further considered the draft Strategy and received stakeholder feedback on the draft Strategy. The ACT Alcohol, Tobacco and other Drug Strategy 2004-2008 (the Strategy) has been finalised based on the draft Strategy and this feedback. The Strategy provides direction for decision-making to assist in reducing the harm associated with the misuse of alcohol and other drugs in the ACT community over the next four years.

Rationale for the Strategy

The ACT Alcohol, Tobacco and other Drug Strategy builds on the previous ACT Drug Strategy - *From Harm to Hope* (1999). The purpose of the Strategy is to provide a framework that offers direction for decision-making on issues associated with alcohol, tobacco and other drug use in our community. The Strategy provides a common vision for the ACT Community. It supports the development of a shared understanding of both the issues facing the ACT, including the changing needs of the population and those of the alcohol and other drug sector, and the directions identified to address these issues. This shared understanding will support the community in working together to address alcohol, tobacco and other drug issues in a co-ordinated and collaborative way.

Aims of the Strategy

The four main aims of the Strategy are 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 initiatives to ensure that issues associated with harmful alcohol, tobacco and other drug use are addressed in an effective way; and
- Implement the Strategy in a manner that respects, protects and promotes human rights.

Legal requirements of the Strategy

Human Rights

A human rights framework underpins the Strategy. This framework was identified by the ACT Alcohol and other Drug Taskforce, and will be further strengthened by the *Human Rights Act 2004*. It recognises basic principles such as:

- treating people with dignity and respect;
- empowering people to participate directly in decisions about their health and well being;
- self-determination in relation to their life choices;
- the right to informed consent and adequate and accurate information to support decision making;
- adopting strategies to improve self-esteem and self-worth;
- access to non-judgmental and non-discriminatory services;
- access to advocacy processes to protect rights in service delivery, basic consumer rights, etc; and
- respect for the right to privacy.

Principles of the Strategy

The Strategy is guided by the following principles:

Harm minimisation

Harm minimisation has formed the basis of Australia's approach to drug misuse since its inception in 1985 preventing and minimising harm caused by licit drugs, illicit drugs and other substances.

Harm minimisation is the basis for alcohol, tobacco and other drug policies and service provision in the ACT. Harm minimisation represents a 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.

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.

(Please refer to the Glossary section for a full articulation of harm minimisation.)

Applying evidence-based practice

The use of evidence-based practice, which has been developed from research, analysis and evaluation, supports the development of informed policy decisions that provide a framework for the implementation of effective interventions. New approaches to address drug related harm will integrate the best available evidence with professional, community and peer-based expertise.

While empirical evidence is the ideal, innovative responses may be required to address more complex situations or emerging trends where such evidence is less than comprehensive. Inquiry and openness to new options, balanced with rigour in the design and implementation of initiatives, may lead to more effective solutions for our community.

It is important that ongoing quality improvement includes evaluation of interventions, particularly those in the areas of prevention, treatment and law enforcement. Evaluations will inform future planning of service delivery and approaches to practice by taking into consideration the different needs and perspectives of consumers, carers, service providers and the community.

Strengthening partnerships, collaborations and ownership

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 through 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.

Recognition of social determinants of health and well-being

People's lifestyles and the conditions in which they live and work strongly influence their health and well-being. Wilkinson & Marmot (1998) identify a number of social factors that influence an individual's health and well-being. These factors have been published by the World Health Organisation and include the following:

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

In addition, this strategy recognises the following factors as contributing to a person's health and wellbeing:

- 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.

Harmful alcohol, tobacco and other drug use is closely associated with social and economic disadvantage, the response to which often lies beyond the health system and is typically beyond individual control. Important social and economic considerations such as cultural dislocation, comorbidity of mental health problems, physical health problems, housing, educational opportunities, living skills, income support and job security need to be incorporated into any effective intervention.

Interventions for 'drug problems', therefore need not only support and treat people who have developed harmful patterns of use but also address patterns of social deprivation. A holistic approach to addressing harmful drug use which goes beyond the focus of a specific treatment is more likely to achieve better outcomes.

The Strategy also recognises that factors such as race, gender and other social issues influence both people's experience of alcohol and other drug problems as well as the sort of responses that are most effective and appropriate in addressing these problems.

Increasing access to services

Outlining social justice principles that support equitable access to alcohol and other drug services is important in that it provides opportunities for both individuals and communities to consider the impact of harmful drug, alcohol and tobacco use. It also facilitates access to appropriate support and information needed to address these issues.

Recognition of the diverse needs of the community and the need to minimise potential barriers in accessing services are fundamental aspects of this approach. Through consideration of these issues, the community will receive appropriate support that is relevant and meaningful to their needs. For example, a person's age, race, ethnicity, mental ability, parental status, sexuality, Aboriginal or Torres Strait Islander heritage, gender, physical ability, financial resources, religion, geographic location or disability should not be a factor in equity of access to services. Equally services will at times need to respond differently to the needs of people with different backgrounds and experiences.

Access to alcohol, tobacco and other drug-related primary care, including generalist medical care similar to that available to the broader community, should also be available to people within the correctional system.

Furthermore, shared location of services, greater flexibility of type and delivery of services, as well as availability of culturally, age, and gender appropriate resources, should be considered in the development of services to ensure that the broad needs of clients are met.

Primary care providers, including those offering generalist medical care and community services, are critical in ensuring access to services. They have a defined role within the community that affords them knowledge about health and well being, and the opportunity to take a holistic approach to addressing harmful drug use.

Consumer involvement in the development, planning and evaluation of both current and future service delivery is imperative. This involvement will support the development of meaningful service delivery, which will result in greater access.

Investing wisely in the future

A broad spectrum of health interventions that adopt a comprehensive approach including health promotion, health information and education, prevention, early intervention, treatment and continuing care, is necessary to maximise health outcomes.

Workforce development of the alcohol and other drug sector is necessary as a long-term investment. Capacity building will enable the sector to further develop expertise, skills and competencies in order to provide professional leadership and quality services to the community. Investment in workforce development should also apply to the broader community sector, which makes a strong contribution to addressing harmful drug use in the community.

Physical infrastructure development is also essential to ensure quality services are provided to the community through appropriate, welcoming and well-maintained buildings.

Enhancing health promotion, early intervention and resilience building

Health promotion is a key element in reducing the harm associated with alcohol and other drug use.

Key objectives of health promotion in this are :

- Prevention or delay of the commencement of drug use;
- Reduction of problematic drug use;
- Awareness of potential drug related harm;
- Provision of information about the range of treatment and counseling services.

It is important that community education campaigns for health promotion and prevention are integrated, sustained and based on evidence – rather than perceptions – of effectiveness.

Schools in particular play a primary role in health promotion, early intervention and resilience building by imparting knowledge, skills and sound values about drug use. Schools can play a critical function in facilitating education about the use of drugs. Schools provide a good opportunity to care for and support the student who becomes involved with drugs and the family.

The risk of developing certain health conditions or behaviours is linked to risk factors throughout a person's life. By promoting protective factors the risk of a person developing harmful drug use is decreased. These factors include a sense of belonging or connectedness, self-efficacy, resilience, and capable and caring families and carers.

The influence of risk and protective factors is greatest in very early childhood and at key transition periods across the lifespan. These transition periods include events such as the birth of a child, preschool years, moving from primary to high school, graduating from high school and engaging in higher education, entering the workforce, and possible unemployment or retirement.

Early intervention within the continuum of prevention to treatment includes strategies for early detection of potentially harmful drug use. The most widely researched of brief intervention techniques involves assessing an individual's use of alcohol, tobacco and other drugs, and providing information and clear advice on reducing use and related harm. Opportunistic and early interventions promote self-efficacy and self help and can prevent the need for more intensive treatment in the future.

Using a quality framework

A quality framework refers to the provision of policies and services that are developed in accordance with the needs of the community. A quality framework embraces a continuous improvement approach to the delivery of services. It also requires an ongoing and continuous evaluation of services, such that each evaluation cycle improves the service being provided. A key component to this framework is the meaningful involvement of consumers in the evaluation process of service delivery.

A quality framework includes a collection of accurate information to enable planning and development as well as avoidance of inadequate or inappropriate pre-emptive actions. Maintenance of quality and the achievement of desired outcomes, will be facilitated by ongoing involvement of consumers and carers in the design, delivery and evaluation of initiatives.

Context of the Strategy

The ACT Alcohol, Tobacco and other Drug Strategy 2004 has been developed in the context of the *National Drug Strategy 2004-2009*; the *National Tobacco Strategy 1999-2004*; the *National Alcohol Strategy 1999-2004*; the *National HIV Strategy 1999-2004*; the *National Hepatitis C Strategy 1999-2004*; and the ACT Government's policies in the areas of health; policing; justice and community safety; education youth and family services; and disability housing and community services.

National Drug Strategy 2004-2009

At a national level, the Ministerial Council on Drug Strategy (MCDS) endorsed the National Drug Strategy 2004-2009 in May 2004. The National Strategy outlines a coordinated approach to reducing problems associated with harmful drug use in Australia. It affirms Australia's commitment to harm minimisation as the main principle underpinning approaches to problematic drug use. Australia's obligations under international drug treaties and conventions are met through the National Strategy, and through Commonwealth and State and Territory legislation.

The ACT Alcohol, Tobacco and other Drug Strategy 2004 interprets the national agenda by continuing to approach the issues associated with harmful alcohol, tobacco and other drug use through applying the principles of harm minimisation, improving the evidence base that informs policy development and extending community partnerships beyond law enforcement and health.

National Tobacco Strategy 1999-2004

Australia has been active in implementing tobacco control strategies and first formalised its commitment to a comprehensive approach to tobacco control in the 1991 National Health Policy on Tobacco in Australia. Tobacco smoking, however, remains the single largest preventable cause of premature death and disease in Australia.

The *National Tobacco Strategy 1999-2004* recognises that future successful action in tobacco control hinges upon coordinated and comprehensive national action. The Strategy has expanded the range of initiatives previously implemented by Commonwealth, State and Territory governments and non-government organisations and linked with other relevant national strategic documents to ensure an integrated approach.

National Alcohol Strategy 2001-2004

The *National Alcohol Strategy 2001-2004* has been a collaborative effort between the Commonwealth and State and Territory governments, setting out a broad coordinated strategic approach to the reduction of alcohol-related harm in Australia. The *National Alcohol Strategy* has aimed to provide a comprehensive, evidence-based approach to reducing alcohol-related harm to Australian communities, families and individuals, whilst acknowledging the accumulation of evidence regarding the potential health benefits of low level alcohol consumption.

National HIV Strategy 1999-2004

Australia's comprehensive national approach to responding to HIV/AIDS has long been regarded as one of the best in the world. From the endorsement of the first National HIV/AIDS Strategy in 1989 through to the conclusion of the third *National HIV/AIDS Strategy* in 1999, Australia has recognised the need for coordinated action in response to HIV.

The *National HIV/AIDS Strategy 1999-2000 to 2003-2004* expresses a commitment by the nation to the pursuit of two goals, namely: to eliminate the transmission of HIV; and to minimise the personal and social impacts of HIV infection. The Strategy recognises the importance of establishing and maintaining operational links with other national population health strategies and is situated within a broader communicable diseases framework. It is the links between and the integration of these responses that will ensure both sustainability and maximum population health benefit.

National Hepatitis C Strategy 1999-2004

The *National Hepatitis C Resource Manual* states that current estimates suggest that there are over 200,000 Australians infected with Hepatitis C and that 11,000 new infections occur each year. Of these new infections, 90% result from the sharing or re-use of drug injecting equipment contaminated with infected blood.

The *National Hepatitis C Strategy 1999-2000 to 2003-2004* was launched in June 2000 and aimed to reduce the transmission of hepatitis C in Australia; and to minimise the personal and social impacts of hepatitis C infection. The Strategy established an important foundation for action—a partnership between people affected by hepatitis C, governments at all levels, and medical, scientific and health care professionals; and acknowledged the need to work in a collaborative, non-partisan manner with all members of the partnership.

Assessment of the ACT Drug Strategy 1999 – *From Harm to Hope*

The ACT Drug Strategy 1999 – From Harm to Hope, was launched in September 1999.

The specific goals of the strategy were to:

1. reduce the supply of harmful drugs;
2. reduce harmful drug using behaviour and use of harmful drugs;
3. reduce demand for alcohol and other drugs, especially among young people; and
4. minimise the harms to the individual and society associated with the use and misuse of alcohol and other drugs.

Over the period of the *ACT Drug Strategy 1999* indications are that harms associated with the use of tobacco, alcohol and cannabis were reduced. However, further effort is needed in terms of reducing demand and supply. Figures relating to high-risk injecting behaviours are relatively high and this is an issue that will be addressed through the Action Plan within this Strategy.

Daily usage of **tobacco** in the ACT declined from 26.5% in 1998 to 18.4% in 2001, however there are significant age specific variations; in particular, female teenagers in the ACT are more likely to smoke tobacco daily (31.6%) than their male counterparts (12.7%). In addition, ACT female teenagers are more likely to smoke daily than female teenagers nationally; 16.2 % and 14.1% respectively (*2001 National Drug Strategy Household Survey*).

In 2001, 9.6% of ACT residents consumed **alcohol** at risky to high-risk levels for long-term harm, which is comparable to the national figure of 9.9%. However, females in the ACT more commonly risked long term harm than ACT males; 11.6% and 7.5% respectively (*2001 National Drug Strategy Household Survey*).

The illicit trade in **pharmaceuticals** for non-medical use is sourced most frequently through forged prescriptions or from friends and relatives. According to the 2001 National Drug Strategy Household Survey, the rates of recent non-medicinal use of analgesics/pain killers (3.3%) and tranquillisers/sleeping pills (1.4%) were slightly higher in the ACT than across Australia generally (3.1%; 1.1%). It should be noted however that due to small sample sizes and low prevalence in the ACT, interpretation of these figures and any comparisons over time or between jurisdictions should be treated with caution (*2001 National Drug Strategy Household Survey*). In 2003, ACT Police advise the majority of forged prescriptions reported were for oxycodone and benzodiazepines.

Although **methadone** must be medically prescribed for treatment purposes, there is also an illicit trade. 2001 National Household Survey data does not record any use of methadone in the ACT for non-maintenance purposes, though 21% of injecting drug users nationally report they had illicitly obtained methadone syrup in the previous six months (*2003 Australian Drug Trends*).

Both nationally and in the ACT, recent use of **cannabis** decreased between 1998 and 2001. In 2001, recent use of cannabis was reported among 14.4% of people aged over 14 years in the ACT. Although this is higher than the national figure of 12.9%, its usage reduced significantly from 1998 (20.3%). Just over 34% of 14 to 24 year-old Canberrans had recently used cannabis, compared with a national figure for this age group of 27.8 %. After the Northern Territory (37%), this was the highest age group usage of cannabis in Australia (*2001 National Drug Strategy Household Survey*).

According to data collected through the Illicit Drug Reporting System (IDRS), the price of cannabis remained stable across Australia and all jurisdictions reported the perceived potency of cannabis as 'high'. Respondents to the survey reported cannabis was easy to obtain and hydroponic cannabis continued to dominate the market (*Australian Drug Trends 2003*).

Cannabis seizures in the ACT have remained relatively stable over the period 1997-2003. However, the average weight of seizures has been steadily increasing since 2000 (*ACT Drug Trends 2003*).

The IDRS reported **Cocaine** use had decreased in the ACT and was reported to be 'very difficult' to obtain (*Australian Drug Trends 2003*). This corresponds with data relating to cocaine seizures at the Australian border. During 2002-03, the Australian Customs Service made a record 422 detections of cocaine at the border, the highest number of detections to date. (*Australian Drug Trends 2003*).

The 2001 National Drug Strategy Household Survey states that, since 1998, use of **heroin** in the ACT has remained stable at around 0.4%. However, data obtained through the IDRS indicates that frequency of use has increased in both the ACT and South Australia and decreased in Queensland (*Australian Drug Trends 2003*).

Recent data from ACT Ambulance Service indicates a significant increase in the number of responses to heroin related overdoses in the ACT. Monthly heroin overdoses for the 2002-2003 financial year averaged 12.6 per month. Extrapolating the current trend for the 2003-2004 financial year indicates an estimated 288 overdoses for this financial year, up from 150 for the 2002-2003 financial year.

Heroin overdose rates fluctuate over time and relate to factors such as supply and purity of heroin. The ACT's harm minimisation approach recognises that it is necessary to provide a range of strategies to reduce the risk of heroin overdoses.

Data obtained through the IDRS indicated there had been an increase in the overall quantity of heroin seized in 2002. However, while the number of seizures during 2003 had remained stable, the weight of seizures had declined to levels experienced during 2001. (*ACT Drug Trends 2003*).

Recent use of **amphetamine type stimulants** increased in the ACT from 3.1% in 1998 to 4.5% in 2001 (*2001 National Drug Strategy Household Survey*). **Methamphetamine** (Speed, Base & Ice) is reported to be easy to obtain and while the use of Base had decreased in several jurisdictions, including the ACT, use of Ice had increased across Australia (*Australian Drug Trends 2003*).

While amphetamine seizures have remained relatively stable since 2000, there was an almost fourfold increase in the weight of amphetamine seized in 2001 and the weight of seizures has remained high in 2002 and 2003 (*ACT Drug Trends 2003*).

In 2001, use and availability of **ecstasy** increased from previous years. Recent use of ecstasy and designer drugs increased marginally across Australia from 2.4 % in 1998 to 2.9 % in 2001. Although ecstasy and designer drug use in the ACT was similar to the national figure in 1998, by 2001 it had increased significantly above the national average to 4.8% (*2001 National Drug Strategy Household Survey*).

In 2001, 1.1% of people over 14 years had recently used **hallucinogens**, a reduction from 3% in 1998. Use of hallucinogens is common among ACT injecting drug users with 72 % reporting they had swallowed hallucinogens at least once and 16% in the previous six months (*2001 National Drug Strategy Household Survey*).

Polydrug use is increasing within the Australian community. Although there has always been a high proportion of common usage of tobacco and alcohol, it is now much more common to combine use of tobacco, alcohol and cannabis with amphetamines, hallucinogens and ecstasy (*2001 National Drug Strategy Household Survey*).

High-risk injecting behaviour, such as sharing needles, sharing injecting equipment or injecting in non-sterile conditions, contributes significantly to the transmission of blood borne viruses associated with HIV, Hepatitis B and C, and other communicable diseases.

In 2001-2002, 12% of ACT injecting drug users reported sharing needles and 16% reported lending used needles. This was a slight reduction from the previous year from 15.2% and 16.2% respectively (*ACT Drug Trends 2003*).

New Hepatitis C infections increased from around 11,000 in 1997 to 16,000 in 2001, of which most (90%) occurred among injecting drug users. It is estimated that around 65% of injecting drug users carry the hepatitis C virus (*ACT Chief Health Officer's Report, 2003*).

In 2002, there were 233 notifications of Hepatitis C infection in the ACT, and 82 notifications of hepatitis B (*ACT Chief Health Officer's Report, 2003*). On average, 258 Hepatitis C antibody positive cases are reported annually in the ACT. It can be predicted that by the year 2008 an additional 1290 Hepatitis C antibody cases will be reported in the ACT (*Communicable Disease Control Unit, 2003*). Rates of Hepatitis C infection for 2000 in the ACT community (73 per 100,000) were lower than the Australian rate (90 per 100,000) (*ACT Chief Health Officer's Report, 2003*).

Anecdotal evidence suggests that harms associated with other **high-risk behaviours**, such as unsafe sex practices whilst under the influence of licit or illicit drugs or driving whilst under the influence of licit or illicit drugs, have significantly increased over recent years.

Analysis of alcohol and other drug services in the ACT

Alcohol and other drug services in the ACT focus principally on **harm reduction** and **treatment**.

Primary prevention

Primary prevention aims to prevent the onset of drug use most commonly through educational approaches, law enforcement and codes of practice. It also aims to address the common antecedents and social problems by reducing risk factors and boosting protective factors.

The ACT is involved in a range of Commonwealth and local health **educational and promotional initiatives** through mass media campaigns, school education programs and a range of other strategies as detailed in the ACT Health Action Plan. In 2004/05 Healthpact will award \$89,495 in grants and sponsorships to reinforce the Smokefree message. ACT Health maintains an ongoing contract with the Cancer Council ACT for Quitline services and the Health Promotion Unit manages the Youth Smoking Prevention Program, which targets youth with messages regarding not starting smoking and smoking cessation for those who already smoke. The Youth Smoking Prevention Program is a \$200,000 2 year program which will feature a mass media campaign and will involve the development of resources and ongoing work with schools and community organisations.

Schools play a primary role in health promotion, early intervention and resilience building by imparting knowledge, skills and sound values about drug use. Schools can play a critical role in facilitating **education about the use of drugs**. Schools provide a good opportunity to care for and support the student who becomes involved with drugs and the family.

Drug Education in ACT Schools in 2004 will involve training teachers in: Resilience Education and Drug Information (REDI), Principles for School Drug Information, the revised Rethinking Drinking resource, Cannabis and Consequences, and Monographs on Innovation and Good Practice in Drug Education.

Training will continue for schools in the Health Promoting Schools Model and secondary schools will be trained through the School Health and Alcohol Harm Reduction Project.

Notwithstanding the need to target early intervention strategies towards families/carers of children in schools, the onset of substance use can occur at anytime of a person's life, and affects carers who are children, partners and parents. This strategy focuses on early intervention strategies for young people, but also extends the focus of the early intervention strategies to target all types of carers across the lifespan to minimise the need for later crisis responses.

National and state protocols to conduct **safer dance parties** and prevent drug related problems among non-users and novice users were developed in 1997 that recommend adequate provision of water, ventilation, 'chill out' areas and information. These codes are implemented to different degrees in each jurisdiction.

ACT Policing focuses on **supply reduction**. In 2002-2003 ACT Policing mounted numerous operations investigating serious offences relating to the sale and supply of illicit drugs in the Territory. Following the heroin shortage that began in 2001, many of their investigations have been directed towards the large scale cultivation of cannabis. During this period, police investigations have also been increasingly targeted towards individuals and groups involved in the sale and supply of methamphetamines, and the distribution of other amphetamine type substances such as GHB (Gamma hydroxybutyrate) and MDMA (Ecstasy or 3,4-Methylenedioxymethamphetamine).

The ACT will continue to maintain and monitor a wide range of diversion programs that enable people to access treatment away from the criminal justice system, especially in the early stages of their drug use. Diversion schemes will include police early diversion, and both pre and post sentencing court diversion.

Legislative and regulatory measures restrict access (especially to minors) to tobacco, alcohol and other drugs. The relevant legislation in the ACT includes the *Tobacco Act 1927*, *Smoke-free Areas (Enclosed Public Places) Act 1994*, *Smoking (Prohibition in Enclosed Public Places) Act 2003*, *Liquor Licensing Act and Standards Manual*, *Drugs of Dependence Act 1989*, *Intoxicated Person's Care and Protection Act 1994*, and the *Supervising Injecting Place Trial Act 1999*. A new **National Tobacco Strategy** will provide a framework for tobacco control in the ACT. Possession and self-administration of small amounts of cannabis are decriminalised offences in the ACT.

New legislation enacted in late 2003 provides for smoking to be prohibited in all enclosed public places, including restaurants and licensed premises with current exemptions phased out by 1 December 2006. This will ensure that employees and patrons are given effective protection from tobacco smoke. By establishing non-smoking as the social norm in hospitality venues, these arrangements may also have some impact on discouraging the uptake of smoking by young people. The deterrent role of legislation is only as successful as its application. In a 2002 NSW survey of 18-39 year olds, 54.4 per cent reported that on the last occasion of consuming alcohol at acute risk levels, the final place they had been drinking were licensed premises: hotels, registered clubs and nightclubs. Only 10 percent reported signs of intoxication being met with responsible service initiatives from licensed premise staff. Over half reported that they continued to be served alcohol. The ACT will mandate responsible serving of alcohol through amendments to the **Liquor Licensing Standards Manual**.

Secondary prevention

Secondary prevention aims to reduce problems among current drug users by for example information dissemination to drug users on drug related harm, self-help strategies to quit or reduce use, needle exchanges and safe injecting rooms.

The ACT offers a range of **information sources** to drug users including through general practitioners, community health centres, drug and alcohol service providers and specific sources geared to specific groups including Aboriginal and Torres Strait Islander youth and women. As part of its ongoing 'rave safe' campaign, South Australian authorities test party drugs for users without penalty to minimise the harm of unsafe use. Again in South Australia, an intervention aimed at reducing incidence of heroin overdose has been developed in the form of safer use messages on posters, booklets, postcards and fridge magnets. Needle and syringe exchange programs are also important points of contact to provide injecting drug users with information, education and referral.

The ACT is currently funding Toora Women Inc to complete a project Women and **Benzodiazepine** Use, Misuse and Dependency Research Project. The project will collect information from women about their patterns of use as well as the key services that they access for support with their health and related life issues.

The most common **self-help groups** are Alcoholics Anonymous (AA) and Narcotics Anonymous (NA). AA and NA use a psychological approach to withdrawal from drug dependence through a 12 step program leading to a goal of abstinence. These programs appear to be most successful as continuing after care treatment by providing accessible social supports to resist relapse. Literature on relapse suggests that a feature distinguishing those people who relapse from those who maintain change is their quality of life post change. This includes not only issues of non-drug using social support but also housing, employment and relationships.

Sobering up centres where intoxicated people can receive care and respite in a safe environment until the effects of the substances consumed have dissipated can also provide opportunities for brief interventions. Staff at sobering up centres should be able to recognise medical conditions requiring hospitalisation and behavioural conditions requiring police referral. The ACT is currently undertaking work to establish a sobering up centre at Ainslie Village with links to treatment, health and welfare services.

Since their introduction in 1987, **needle and syringe** programs have made a significant contribution to the prevention of the spread of Human Immunodeficiency Virus (HIV) and other blood borne viral infections. Provision of sterile injecting equipment has been an important part of Australia's success in containing the spread of HIV. By contrast, the prevalence of hepatitis C infection among the majority of injecting drug users in Australia is high. Some reasons for this disparity might be that hepatitis C is far more infectious than HIV and, because the virus has been established within the injecting drug population since the early 1970s, it is difficult to contain.

Popularity of needle and syringe programs among injecting drug users is not universal. A 2000 surveillance report from Sydney suggests limited use of needle and syringe programs by Indigenous injecting drug users and by those of non-English speaking background. Culturally appropriate programs supported by the relevant communities are vital to encouraging more widespread use.

During the financial year 2002-03, 393,883 needles were supplied through around 18 needle and syringe supply outlets and 27 pharmacies in the ACT. The ACT has a low rate of unsafe needle and syringe disposal: around 259,650 needles were returned to the primary outlets during 2002-03. The ACT has installed 'disposal safe' bins in inner-city locations and community health centres. Needle disposal bins are also provided in all public toilets. ACT "City Rangers" collect inappropriately discarded sharps on public land.

There is a proposal from the Commonwealth to provide injecting drug users with retractable needles and syringes, in addition to the usual supply of non-retractables, as a community safety measure to make disposal safer. On available information it appears the cost per retractable needle and syringe will be much higher than the cost of current equipment. To date, there is evidence of very low acceptance of these devices among injecting drug users. Anecdotal evidence from trials of retractable needles suggests that previous models were capable of being used more than once.

The Standing Committee on Health Report No. 5 – *access to needles and syringes by intravenous drug users* was tabled in the Legislative Assembly in August 2003. The Report gave particular regard to after-hours access; access in prisons and remand centres; and access for Aboriginal and Torres Strait Islander peoples. The Government response to the Standing Committee report detailed its commitment to progressing the implementation of a number of the report's recommendations, including establishing a trial of vending machines for dispensing needles and syringes in the ACT. The trial will provide 24 hour access to sterile injecting equipment across a range of sites in the ACT and will be implemented in 2004.

The Standing Committee Report also recommended that the Government adopt the policy of injecting equipment exchange in the **ACT corrections system**. The principle of harm minimisation in correctional facilities is supported. However, there are a range of issues that need to be considered in the development of an appropriate model such as duty of care issues for custodians and occupational health and safety issues for staff. Although the adult correctional facility environment has been identified as high risk in terms of blood borne viral infection due to the high rates of injecting, tattooing, unsafe sexual practice and the high prevalence of Hepatitis C in correctional facilities, the extent of these problems in some or all of the ACT facilities is unclear. The costs/benefits and feasibility of this issue will be examined further in conjunction with corrections officers, youth justice staff and relevant health experts.

An **injecting room** is a clinically supervised place where injecting drug users can inject drugs in sterile conditions, and can receive care where necessary. The supervised injecting place trial currently underway in Sydney will continue to be monitored. A Supervised Injecting Place trial in the ACT would be a significant investment and concerns have been raised in relation to the feasibility of conducting a trial in the ACT, in terms of its likely use and the cost effectiveness. However, the drug-scene is always changing and it is essential that governments maintain a flexible approach to issues affecting their communities. Continual monitoring of this issue will allow the ACT to revisit a proposed supervised injecting place trial if it is warranted.

Tertiary prevention

Tertiary prevention strategies provide safe withdrawal and treatment for problematic drug use including detoxification and pharmacological treatments in residential and non-residential settings. Residential treatment programs are often considered a primary means of intervention for long term drug users.

These programs appear to be more effective when a broad range of treatments and interventions are involved including counselling, life skills training and education, employment or recreation options. Anecdotal evidence suggests that many people desire additional activities to maintain high levels of motivation and interest.

Detoxification was defined in 1989 by Heather and Tebbutt as “ the process by which alcohol and drug dependent persons recover from intoxication in a supervised manner so that withdrawal symptoms are minimised”. Detoxification can be provided as an inpatient, outpatient or home-based services and may be medicated or non-medicated. Most of the available research on illicit drug detoxification relates to opioid dependence. The three key factors that appear to affect the outcome of detoxification are the individual's motivation, the choice of available methods and the reason for detoxification.

In the ACT there are three withdrawal services. All three adopt the philosophy of harm minimisation. Services include a non-medicated withdrawal service (Arcadia House), a medicated withdrawal service (ACT Alcohol and Drug Program) and a non-medicated service for young people aged 14 to 18 years (Ted Noffs Foundation). Withdrawal interventions include counselling, massage, herbal remedies and medications all of which are aimed at reducing the severity of physical and psychological symptoms of withdrawal. In the financial year 2002-2003, 363 clients were reported to have accessed non-medicated withdrawal through Arcadia House, 685 to medicated withdrawal through the ACT Alcohol and Drug Program and 122 young people had accessed non-medicated withdrawal through the Ted Noffs Foundation.

The medicated and non-medicated adult services currently differ in several ways. This includes the types of interventions offered as well as the costs to the client. Due to the nature of the interventions, the medicated service prioritises clients with more complex withdrawal needs such as people withdrawing from alcohol as opposed to those withdrawing from a range of illicit substances. Although withdrawal from a range of substances occurs in both services, the needs of the client are assessed according to the interventions available within the service.

There is a perception among drug dependent homeless people in the ACT that access to detoxification services is difficult and prohibitively expensive. In fact, medicated withdrawal is free and the adult non-medicated service is funded as a part cost recovery/fee paying service. Payment for the withdrawal service is based on a flat fee of \$100 irrespective of how long the client stays. Capacity to pay is determined on an individual basis and no client is refused accommodation exclusively on their ability to pay. However, low levels of cost recovery would have an impact on the financial capacity of the service's operation. This has the potential to form a barrier for clients wanting to access this service, which for the most part are clients dependent on heroin or other illicit substances.

There are some further structural barriers to people accessing services. People accessing services may also have to pay rent to retain their usual place of residence, and if they are parents, may not have appropriate care for their children for the duration of treatment.

It has been said, anecdotally, among injecting drug users in particular, that many would prefer to have access to both methods of withdrawal in a single service. Some claim that retention rates in current non-medicated services would be improved with some access to medicated withdrawal. Some drug users in the ACT also believe that current services do not have the same level of expertise necessary to successfully provide withdrawal services for poly drug users as they are for withdrawal from a single drug.

In Australia, pharmacotherapies are primarily used for withdrawal and maintenance of opiate and alcohol dependence: overseas amphetamine and cocaine substitution therapy has been used for some years. There are a number of pharmacotherapies for opiate dependence including **methadone, buprenorphine and naltrexone** that act as either agonists (produce opioid like effects) or antagonists (block the effect of opioids). The ACT currently has a methadone program, has introduced buprenorphine following recent clinical trials and intends to introduce naltrexone for withdrawal.

Methadone is a synthetic opioid agonist used as a treatment intervention for both withdrawal and maintenance. It is a potent drug and is not a cure for heroin dependence. Methadone is dispensed in syrup form to be drunk. Most people on methadone programs commit to attending daily for their dose, but under certain conditions some are allowed take-away doses. Doses in excess of 60mg a day are associated with better results, however, doses in excess of 120mg a day do not confer additional benefit. Although the effects of a methadone dose last much longer than heroin, a single dose being effective for about 24 hours, there is no 'high' experience from a dose. Withdrawal symptoms usually begin one to three days after the last dose, and peak around the sixth day. Side effects of taking methadone include sweating, constipation, irregular periods, lowered sex drive, skin rashes and itches and abdominal cramps. Prolonged use of methadone is not known to cause physical damage other than tooth decay because of reduced saliva production, the effects of which can be lessened by use of a new glucose free product, chewing sugarless gum and dental hygiene.

Methadone maintenance is associated with higher treatment retention rates, and reductions in illicit opioid use, criminal activity and mortality rate of users. Reduction in risk-related behaviours and improvements in physical and psychological health, social and occupational functioning are also demonstrated outcomes.

In the ACT, methadone and buprenorphine services are delivered to clients through several treatment “tiers” combining both public and community provision and these are outlined below:

Tier	Description
Tier 1	<ul style="list-style-type: none"> - ACT Health’s public clinic prescribing and dosing - treatment is free for the first six months - client then pays \$15 per week
Tier 2	<ul style="list-style-type: none"> - ACT Health’s public clinic prescribing and community pharmacist dosing - client pays \$15 per week to community pharmacist - ACT Health pays subsidy of \$20 per week for each client
Tier 3	<ul style="list-style-type: none"> - community GP prescribing and community pharmacist dosing - client pays \$15 per week to community pharmacist - ACT Health pays subsidy of \$20 per week for each client
Total of Subsidised Places	
Tier 4	<ul style="list-style-type: none"> - ACT Health’s public clinic/community GP prescribing and ACT Health’s public clinic/ community pharmacy dosing - client pays \$35 per week to ACT Health

Tiers 1, 2 and 3 are subsidised places and the cost to the ACT Government varies according to the mix of Tier 1, 2 and 3 clients.

It is recommended that people on methadone programs also receive counselling. One of the criticisms that some users have of the ACT program is that there is inadequate emphasis on treatment plans. Treatment plans are a detailed overview of the planned intervention that is jointly negotiated between the counsellor and the individual. Consideration is given to the person’s current circumstances, strengths and weaknesses, and the impact of intervention on their ability to meet goals. There is growing evidence of the importance of clearly developed treatment plans in achieving better therapeutic outcomes.

Buprenorphine is a partial agonist drug that is used for both maintenance and detoxification pharmacotherapy for people who are opioid dependent. It prevents withdrawal symptoms and has less euphoric effects than heroin or methadone. Withdrawal symptoms from buprenorphine are milder than symptoms associated with methadone withdrawal. The effects of buprenorphine last longer than methadone and the person can be dosed every second day. Buprenorphine is associated with higher treatment retention rates and reduced illicit opioid use.

Buprenorphine is taken in tablet form, placed under the tongue and allowed to dissolve. Chewing or swallowing the tablet will make it less effective. It dissolves within two to eight minutes after placing it under the tongue and effects begin within 30-60 minutes. Some pharmacists claim they will require higher subsidies to dispense buprenorphine than they do for methadone because of the time it takes to dissolve. Techniques such as crushing the tablet in a pill crusher prior to dosing the client can reduce this time.

Naltrexone is an opioid antagonist. It prevents relapse by blocking the effect of opiates. Naltrexone does not produce any euphoric effects or induce dependence and anecdotally, it is said to reduce cravings. Naltrexone tablets are taken orally, and daily doses are recommended but not necessary depending on the dose. Some of the reported side effects include insomnia, anxiety, abdominal cramps, constipation, diarrhoea, skin rashes and joint and muscle pain. The greatest risk associated with naltrexone is when heroin is used either after a naltrexone dose has been missed or if the person stops taking it altogether, because their tolerance to heroin has been reduced.

There has been much controversy about the effectiveness of naltrexone. There is evidence indicating a high incidence of overdose among people engaged in naltrexone programs. Over a short period of time tolerance levels to opioids can be rapidly reduced. People who are unaware of this reduced tolerance are at greater risk of overdose. Some research comparing naltrexone and methadone report that people treated with methadone remained in treatment longer than those with naltrexone.

It is worth noting that an evaluation from a trial in Western Australia indicated that the mortality figure for use of naltrexone for this treatment is higher than if the person had received no treatment at all. This result indicates the need for the service system to be in place for when the person ceases naltrexone. This may include that the person is given information to use less prior to ceasing the treatment and that follow up/engagement with further treatment post naltrexone should be considered as part of the continuum of care when planning the clients care.

Naltrexone has been available for use in opioid dependence since the late 1990's. While it was originally hailed as a major breakthrough, and its use flourished for the first years, enthusiasm was tempered by further studies and further experience by Alcohol and Drug Units.

Naltrexone use in the ACT is strictly in accordance with the national guidelines for such use, "*Clinical Guidelines and Procedures for the Use of Naltrexone in the Management of Opioid Dependence*".

The regulation of naltrexone in Australia, as detailed in the Clinical Guidelines, states that:

- Naltrexone hydrochloride (REVIA) is registered in Australia for use in relapse prevention for alcohol dependence and opioid dependence.
- Naltrexone is available on the Pharmaceutical Benefits Scheme for one indication, as an authority prescription for relapse prevention in the management of alcohol dependence.
- Naltrexone implants are not registered for use in Australia, and their use is experimental. Medical practitioners are advised not to use naltrexone implants, except in the context of clinical trials registered with the Therapeutic Goods Administration.
- Naltrexone is not registered in Australia for use in rapid detoxification.
- Naltrexone treatment is only appropriate for opioid users committed to long term abstinence.
- Naltrexone is available on private prescription for relapse prevention in opioid dependence.
- The effectiveness of naltrexone treatment for relapse prevention is limited. Published literature on naltrexone in relapse prevention generally shows: that only a small minority of opioid-dependent people seeks naltrexone treatment; and among those entering treatment there is a very high rate of dropping out.

The current state of the drug is that it is available in the ACT on private prescription for use in narcotic dependence, but has not been listed on the Pharmaceutical Benefits Scheme for this purpose making it quite an expensive option at around \$220 per month.

Naltrexone treatment is only appropriate for opioid users committed to long term abstinence.

There is no doubt that there are occasional patients who are suitable for naltrexone.

These principally:

- have stable employment
- have stable social parameters
- are able to meet the cost of the drug
- have a “significant other” who will ensure compliance of the drug (ie parent, partner etc)
- have no chronic pain issues which would contraindicate the use of naltrexone

Even amongst this group, only some will be suitable for the drug. A particular group which has been found in studies to be particularly suitable is impaired professionals (Doctors and Nurses) who have registration board issues contingent on the outcome of treatment.

During the 1990's the ACT had approximately a dozen patients on the drug, at this point in time the ACT Alcohol and Drug Program has only one. It is unknown if any ACT private GP's are using the drug for this purpose, but it is thought unlikely.

It is to be noted that ACT residents have naltrexone implants, having been inserted interstate. The long term efficacy of this treatment has not yet been systematically evaluated in the literature. It is also to be noted that the use of naltrexone for the purposes of “rapid detoxification” is not available in the ACT at this time.

Naltrexone is also used as an alcohol pharmacotherapy for which it has Pharmaceutical Benefit Scheme listing. Acamprosate is another **alcohol pharmacotherapy**. Zyban is a **tobacco phamacotherapy**.

The ACT Government is considering the possibility of subsidising **Nicotine Replacement Therapy** for Health Card holders.

Addressing the harm caused by drugs in the ACT

The management, control and prevention of drugs in the ACT are implemented through a range of methods and policies. Some drugs are controlled through regulation, licensing, or prescription, while others are controlled by laws that provide for criminal (or other) sanctions for possession, use, manufacture and trafficking. Prevention, control and management of drugs in the ACT requires the cooperation of a range of agencies, including the community sector, health, police, justice and community safety, education youth and family services; and disability housing and community services.

Although the joint aim of agencies is to minimise harm to individuals and the community, it needs to be acknowledged that agencies are shaped by particular philosophies and have differing functions to fulfil within the community. Through an understanding of these philosophies and the strengthening of communication between them, agencies are committed to achieving the best available outcomes for individuals and the community.

The ACT, in responding to the needs of individuals and the community in dealing with these issues, strives for responses that are holistic, respectful, rational and co-operative. The geographic size of the Territory supports the development of a whole of system/s approach. The ACT has developed innovative types of treatment and approaches in the past, such as The Opioid Program and the Karralika family-based rehabilitation program.

Community Sector

The community sector plays a vital role in the delivery of drug and alcohol related services to the ACT community. The ACT community currently has access to the following range of alcohol and other drug treatments and supports administered by both ACT Health and the community sector:

Non-Government Organisation	Services Provided
ACT Division of General Practice Pty Ltd	The Opiate Program (TOP) The program is a specialist drug and alcohol clinical service designed specifically to assist General Practitioners with the management of opiate, benzodiazepine and amphetamine dependent patients.
Alcohol & Drug Foundation ACT Inc (ADFFACT)	Karralika Residential Rehabilitation Program Residential rehabilitation for adults, including parents accompanied by children, who are recovering from or are currently undergoing treatment for alcohol and drug problems. Community Houses for Men & Women Supported accommodation for men and women for transitional purposes. Family Support Provision of a registered Child Care Centre at the Fadden site for parents accessing ADFFACT services with accompanying children
Canberra Alliance for Harm Minimisation & Advocacy (CAHMA)	Canberra Alliance for Harm Minimisation & Advocacy (CAHMA) - subcontract Provision of information, advice & referral about the range of services available to injecting drug users & users of other illicit drugs. Activities which facilitate the exchange of information & personal experiences, provide activities to meet common needs & provide social & practical support. Needle and Syringe outlet.

Non-Government Organisation	Services Provided
DIRECTIONS	<p><u>Primary Health Care Intervention</u> Assessment, development & monitoring of service and case management plans to support to access general community services. Information, advice and referral. Provide alcohol & drug education to colleges in the community.</p> <p><u>Arcadia House Withdrawal Centre</u> Provision of a residential non-medicated withdrawal program.</p> <p><u>Needle & Syringe Program (NSP)</u> Provision of a needle & syringe program through health services and pharmacies and a day program for injecting drug users.</p> <p><u>Life Skills Program</u> Provide opportunistic & crisis counselling to clients of needle & syringe outlets and at outreach points in the ACT. Provide opportunities for education, training and employment. Support injecting drug users to pursue detoxification and rehabilitation treatments.</p>
Gugan Gulwan Youth Aboriginal Corp	<p><u>Outreach Service</u> Provide Aboriginal & Torres Strait Islander young people access to information on education & health service resources relating to alcohol & drug use through provision of an outreach service including street based outreach and through forging links with mainstream services.</p> <p><u>Detox Support Service</u> Provide a support service for young aboriginal people accessing mainstream detox services.</p> <p><u>Elders Bus Tour - education</u> A bus tour appropriate service to educate elders about mainstream services available for their families.</p> <p><u>Cultural & Recreational Outings – for young people accessing the service</u> Provide outings with cultural significance, within the Canberra region Provide recreational outings including sport and camping activities</p>
Salvation Army Incorporated	<p><u>The Bridge Program</u> Provision of Alcohol & Drug Counselling services and rehabilitation program.</p> <p><u>The Oasis Bridge Program</u> Provision of Alcohol & Drug Counselling – individual, group and family counselling, life skills training and staff role modelling</p>
Toora Women Incorporated	<p><u>Women’s Information, Resources, Education on Drug Dependency (WIREDD)</u> Provides education resources & information to individuals and professionals on issues relevant to the field of women and drugs and dependency, with the aim of minimising the harm associated with dependencies.</p> <p><u>Before & After Supervised Withdrawal Support Service</u> A support service for women & women with children who are planning to attend and/or have completed a supervised withdrawal.</p> <p><u>Community House for Women</u> Supported accommodation for women for transitional purposes.</p>
Ted Noffs Foundation Inc	<p><u>Program for Adolescent Life Management & Aftercare (PALM)</u> Residential treatment and aftercare program for adolescent substance users aged 14–18 years. Family and carer support groups</p> <p><u>Adolescent Drug Withdrawal Unit</u> Provision of a residential non-medicated withdrawal service for adolescents aged 14–18 years.</p>
Winnunga Nimmityjah Aboriginal Health Service	<p><u>Detox (Withdrawal) Support Service</u> Provide a support service for young aboriginal people accessing mainstream detox (withdrawal) services.</p>

ACT Health

ACT Health provides a range of co-ordinated health and health care services designed to deliver improved health and community well-being for all. ACT Health is responsible for providing services to promote health, prevent illness and treat illness for the people of the Australian Capital Territory. Alcohol and other drug services provided by the ACT Alcohol and Drug Program include:

- Outpatient counselling
- Methadone and Buprenorphine treatment
- Withdrawal services
- Case management
- Needle & syringe outlets
- Health Promotion
- Alcohol & drug family skills education program

While the ACT has a high quality health system, there is room for improvement. The ACT Health Action Plan 2002 outlines a vision for Canberra where our citizens are “healthy individuals participating in a healthy community.” A number of priority actions have been identified in this plan to address problematic alcohol and other drug use.

ACT Health, in conjunction with the non-government sector participates in health promotion activities related to addressing and promoting awareness around alcohol and other drug use issues for example participation in National Campaigns such as Drug Action Week, National Alcohol Campaign, National Tobacco Campaign and Drug Overdose Day.

ACT Policing

ACT Policing is committed to the concept of harm minimisation. It recognises the limitations of an enforcement only approach and focuses on the need to utilise a number of approaches in order to minimise the actual and potential harm associated with alcohol and other drug use. ACT Policing have a strong commitment to working collaboratively with key stakeholders in the alcohol and other drug field. This approach is implemented through the following activities:

- Maintain a drug crime operations policy of targeting major manufacturers, suppliers and distributors of illicit drugs;
- Provision of early intervention and treatment options for people with drug and alcohol related problems through supporting alternatives to sentencing such as drug diversion and diversionary conferencing programs;
- Enforcing legislation to minimise alcohol related harm in the community, including traffic accidents and violence;
- Enforcing legislation prohibiting the sale of alcohol and tobacco to young people;
- Developing harm reduction policies to protect life; and
- Working collaboratively with other agencies to provide effective drug education to schools, colleges, and community groups.

Department of Justice and Community Safety

ACT Corrective Services provide a range of alcohol and other drug education programs at the Belconnen Remand Centre and the Periodic Detention Centre. These Programs aim to provide participants with information to assist them to change their alcohol and drug behaviours and to develop skills to enable them to lead a more satisfying and substance free lifestyle.

The Programs delivered are:

- Alcohol and other Drug Educational Program: One off 2 hr session
- Drug Awareness: 6 x 2 hr sessions
- Alcohol and other Drug Coping Skills Program: 15 x 2 hr session
- Counselling/Case Management – Belconnen Remand Centre, Symonston Temporary Remand Centre

In addition, all offenders who are supervised by the Probation and Parole Unit are referred for assessment and counselling/rehabilitation if alcohol and or other drug issues are assessed as a criminogenic risk factor.

Department of Education and Training (DET)

Consistent with the *ACT Drug Education Framework* ACT schools incorporate drug education strategies through a variety of programs and approaches that aim to develop student understanding of drugs and issues related to drug use. These programs are primarily based upon whole school approaches to health education through the Health and Physical Education (PE) curriculum as well as through specific drug education activities such as drug summits that involve the school community. Health forums and drug summits involve parents, teachers, students and community agencies in information sharing and discussion of drug issues.

DET has supported ACT government schools to develop whole school approaches to drug education that incorporate relevant student support mechanisms centred on building student resilience and optimism. The Health Promoting Schools model with training and support continues to be promoted to schools with an increasing number of schools becoming involved. A number of schools utilise a range of education materials developed by the Australian Government as well as link drug education topics with ACT initiatives such as the High School Exhibitions program.

DET specifically supports schools with the provision of drug and health education professional development for teachers. The Department supports and links ACT schools to develop consistent best practice drug education programs.

There are also a range of non-government family support services, working collaboratively with the government, operating across the ACT that provide support to parents experiencing drug and alcohol problems. Services include one-to-one home visiting, support groups, respite care, childcare for children at risk.

In the youth services area, youth centres and outreach services work with young people experiencing alcohol and drug problems. Services include one-to-one support, housing assistance, education support. This support is also provided to young people leaving Quamby and moving back into the community.

Department of Disability, Housing and Community Services

The Department of Disability, Housing and Community Services have recently addressed some of the financial barriers of public housing tenants needing to access long term residential rehabilitation services. In November 2003, the Government announced a series of reforms to the Public Housing Rental Assistance Program aimed at removing barriers to public housing and maintaining sustainable tenancies.

These reforms include:

- Removing the requirement for new public tenants to pay initial rent at the commencement of a tenancy when the costs of establishing their new home are quite high;
- Reducing the minimum rent for rent rebate purposes from \$20 to \$5; and
- Easing the rent payment burden for public housing tenants who go into residential rehabilitation.

Other ACT Government initiatives

A Whole of Government approach to addressing harmful use of legal and illegal drugs in the ACT is reflected in a range of ACT Government initiatives. A list of these initiatives and strategies can be found in Appendix 3.

This Strategy acknowledges that there are existing planning and policy frameworks for Aboriginal and Torres Strait Islander health issues, and this Strategy will work in collaboration with these frameworks to provide the best possible health outcomes for Aboriginal and Torres Strait Islander people in the ACT. These policies include the ACT Aboriginal and Torres Strait Islander Health Framework Agreement, the ACT Aboriginal and Torres Strait Islander Health Forum and the ACT Aboriginal and Torres Strait Islander Regional Health Plan.

Commonwealth Funding

The Commonwealth Government provides funding to ACT Health to purchase a range of drug and alcohol related services in the ACT. This funding is provided under the Council of Australian Governments National Illicit Drug Strategy and includes:

- Supporting Measures relating to Needle and Syringe Programs
- Police Early Intervention and Diversion Program
- Parent Education and Support Program

Supporting Measures relating to Needle and Syringe Programs

Two components make up this program:

1. diversification of the needle and syringe program: to increase the number of pharmacies and other outlets that distribute needles and syringes; and
2. day program for injecting drug users: to increase the capacity of injecting drug users to move away from drug use and to reintegrate into education, training, employment and family.

Police Early Intervention and Diversion Program

This program aims to divert alcohol and other drug offenders away from the criminal justice system and into education and treatment. Opportunities for diversion exist at community, pre-court, pre-sentencing and post-sentencing stages and includes four components:

- Simple Cannabis Offence Notice Scheme
- ACT Police early intervention and diversion program
- Court alcohol and drug assessment scheme
- Treatment assessment program under the *Drugs of Dependence Act 1989*

Parent Education and Support Program

This program aims to provide parents with the skills to handle drug-related issues in the family context. An important secondary objective is to enhance the capacity of community service providers to deliver targeted skills development to families who are affected by or vulnerable to the harms related to illicit drug use.

Action Plan

Each of the following actions detailed in this plan have been aligned against one of the three pillars of harm minimisation: supply reduction, demand reduction and harm reduction. Actions have also been grouped under the headings of:

- Regulatory Change;
- Monitoring;
- Health Sector Service Development;
- Cross Sector Service Development;
- Custodial Service Delivery;
- Aboriginal and Torres Strait Islander Service Development;
- Workforce Development; and
- Diversion.

Priority Actions have been bolded and listed at the start of each section.

The rationale for each action, examples of ways in which the implementation of the action may be evaluated and the lead agency responsible for implementation of each action has also been included.

Supply Reduction:
actions to disrupt the production and supply of illicit drugs and to control and regulate licit substances

	Actions	Rationale	Evaluation <i>(examples of ways in which implementation of actions may be evaluated.)</i>	Lead Agency
1	<p>Regulatory Change</p> <p>Provide greater protection from environmental tobacco smoke exposure to those in public places.</p>	<p>The Tobacco Act 1927 regulates the sale and supply of tobacco products in the ACT and the Smoke-free Areas (Enclosed Public Places) Act 1994 prohibits or restricts smoking in enclosed public places. Smoking in ACT restaurants and licensed premises is to be phased out by 1 December 2006.</p> <ul style="list-style-type: none"> ▪ Consistent with Health Action Plan 	<p>Implement phase out exemptions from the Smoke-free Areas (Enclosed Public Places) Act 1994.</p>	ACT Health
2	<p>Provide additional resources to improve the enforcement of ACT laws that prohibit the sale of tobacco products to minors.</p>	<p>The program will provide increased capacity for education of businesses involved in the sale of tobacco products as well as the detection and enforcement of breaches of the Tobacco Act 1927. The effective enforcement of 'sales to minors' legislation is an important component of a comprehensive strategy designed to discourage the uptake of regular smoking by young people.</p>	<ul style="list-style-type: none"> ▪ Number of education sessions provided for businesses ▪ Number of breaches detected and enforced under the Tobacco Act 1927 	ACT Health
3	<p>Work with other Australian States/Territories and the Commonwealth to investigate possible options and implications of implementing anti-smoking advertisements in cinemas prior to screening movies that depict smoking.</p>	<p>While tobacco use in the overall population has continued to decline, studies of smoking in films over the past 15 years have shown a higher proportion of leading characters smoking when compared to the general population.</p> <p>Section 14 of the Tobacco Advertising Prohibition Act 1992, allows for the broadcast of a tobacco advertisements as an accidental or incidental accompaniment to the broadcast of other matter. "... Australians [continue to be] exposed to a very substantial amount "of messages and images that may persuade them to start smoking, or to continue smoking or to use, or continue using tobacco products."</p>	<p>A strategy developed based on research evidence supporting the effectiveness of anti-smoking health warnings in cinemas and the legal, administrative and funding issues of implementing such advertisements.</p>	ACT Health
4	<p>Review Liquor Licensing legislation and develop strategies for more effective enforcement of the legislation.</p>	<p>To ensure police have appropriate powers over licensed premises.</p> <ul style="list-style-type: none"> ▪ Consistent with Health Action Plan 	<p>Review of Liquor Licensing legislation completed.</p> <p>Strategies implemented to ensure more effective enforcement of legislation.</p>	JACS

**Supply Reduction:
actions to disrupt the production and supply of illicit drugs and to control and regulate licit substances**

	Actions	Rationale	Evaluation (examples of ways in which implementation of actions may be evaluated.)	Lead Agency
5	<p>Monitoring</p> <p>Support the development of appropriate national drug law enforcement performance indicators (include qualitative measures).</p>	<p>Various national and Commonwealth fora, including the Heads of Commonwealth Operational Law Enforcement Agencies, the Australasian Police Ministers' Council and the Police Commissioner's Conference have stressed the need for improved performance measurement concerning drug law enforcement.</p> <p>The NSW Bureau of Crime Statistics and Research <i>Crime and Justice Bulletin</i> states that it is impossible to tell whether the money invested in drug law enforcement in Australia is wisely spent, and that the quantitative measures (drugs seized, dealers arrested) fall short of what is required to determine this.</p> <p>The Australian Institute of Criminology is currently undertaking a project to review and assess current performance measurement systems in drug law enforcement across Australia. The AIC will then develop and trial some approaches that might help to address any identified gaps. This project is being funded under the auspices of the National Drug Law Enforcement Research Fund (NDLERF). Once a review is complete, ACT Policing will evaluate the performance measures and adopt them where appropriate.</p>	<p>Improved quantitative and qualitative national drug law enforcement performance indicators developed.</p>	AFP

Demand Reduction
actions to prevent the uptake of harmful drug use and treatment to reduce drug use

	Actions	Rationale	Evaluation <i>(examples of ways in which implementation of actions may be evaluated.)</i>	Lead Agency
6	<p><i>Health Sector Service Development</i></p> <p>Develop and implement home and outreach models of withdrawal services.</p>	<p>The complex needs of many people with alcohol and other drug problems requires a range of service delivery models to meet their needs.</p> <ul style="list-style-type: none"> ▪ Consistent with Health Action Plan. 	<ul style="list-style-type: none"> ▪ Service delivery model for home based withdrawal services developed and implemented. ▪ Number of people accessing home and outreach withdrawal services. 	ACT Health
7	<p><i>Early Intervention</i></p> <p>Identify and implement evidence based school education programs that are aimed at reducing drug use delaying uptake of drugs and developing resilience in school children, young people, families and communities.</p> <p>Promote the development of protective factors such as a sense of connectedness in school environments for young people and their families/carers.</p> <p>Strengthen and promote the Health Promoting Schools model across all ACT Schools through the delivery of parent/community based workshops on drug education.</p> <p>Adapt resources like the FAsT program for use within the Alcohol and other Drug sector to support family friendly service provision.</p>	<p>Consistent with the National School Drug Education Strategy and the Drug Education Project for School Communities in the ACT Strategic Plan.</p> <p>The Health Promoting Schools model encourages the involvement of families and carers and the active participation of students in the development of a health curriculum which promotes knowledge and the acquisition of lifelong health-related skills.</p> <p>The Families and Schools Together (FAST) program commenced operation at Melrose Primary School in March 2000.</p> <p>The program is a school based early intervention program for children and families. FAST targets the underlying causes of school failure, child abuse, substance abuse and juvenile crime. It requires the collaboration of schools, parents, family support and alcohol and drug agencies.</p>	<ul style="list-style-type: none"> ▪ Increase in number of participants (schools, students, teachers etc.) ▪ Increase in number of parent/community based workshops delivered. ▪ Resources like the FAsT program adapted for use within the alcohol and other drug sector. 	DET
8	<p>Introduce peer education/ mentoring programs into ACT Schools that prevent and address drug and alcohol problems.</p>	<p>Research suggests that people are more likely to hear and personalise messages, and thus to change their attitudes and behaviours, if they believe the messenger is similar to them and faces the same concerns and pressures. Numerous studies have demonstrated that peers influence young people's health behaviours. Peer education can support young people in developing positive group norms and in making healthy decisions.</p> <ul style="list-style-type: none"> ▪ Consistent with Health Action Plan. 	<ul style="list-style-type: none"> ▪ Increase in numbers of peer education/mentoring programs addressing drug and alcohol issues introduced into ACT schools. ▪ Increase in number of participants (schools, students, teachers etc.) ▪ Improved performance reported against indicators of effectiveness, eg: change in rates of binge drinking over time 	ACT Health

Demand Reduction (continued)
actions to prevent the uptake of harmful drug use and treatment to reduce drug use

	Actions	Rationale	Evaluation <i>(examples of ways in which implementation of actions may be evaluated.)</i>	Lead Agency
9	<p>Early Intervention</p> <p>Provide effective early intervention programs, with specific emphasis on early age development, youth, and families.</p>	<p>The ACT Children's Plan states that Government policies and services affecting children should be Family focused. The family's role in providing sound foundations for health and development needs to be supported.</p> <ul style="list-style-type: none"> ▪ Consistent with the ACT Children's Plan, Family Support program and Health Action Plan. 	<ul style="list-style-type: none"> ▪ Increase in number of early intervention programs provided ▪ Increase in number of participants (schools, families, communities etc.) ▪ Improved performance reported against indicators of effectiveness. eg: change in rates of binge drinking over time 	ACT Health
10	<p>Provide integrated family support programs that adopt a community development approach and address issues such as pre-natal support, early age development, youth and family issues for example Families First.</p>	<p>Families and friends can partner effectively with service providers and work together to reduce the likelihood of AOD use escalating to dependency if intervention is timely. Families and friends are in the best position to offer timely intervention but they need to be supported and skilled to act. Service providers must have the capacity to work with families and friends and strengthen relationships to benefit the AOD affected person.</p> <ul style="list-style-type: none"> ▪ Consistent with the ACT Children's Plan, Family Support Program and Health Action Plan. 	<p>Increase in number of prenatal services offered.</p> <p>Formal and informal links developed between the alcohol and drug sector agencies and family support sector agencies through network and forum activities.</p> <p>Increased referrals between the sector agencies.</p> <ul style="list-style-type: none"> ▪ Broader support network for families dealing with illicit drug use by a young family member ▪ Development of effective family relation skills i.e. communication, stress management ▪ Reduced personal and social disruption to the family members 	ACT Health
11	<p>Provide a range of family and carer oriented early intervention programs that build the capacity of families to address substance abuse issues.</p>	<p>The use and misuse of drugs is a health problem which needs to be addressed by all sections of the community. Parents/carers have prime responsibility for developing personal values, ethics and social behaviour in their children. The development of partnerships between students, teachers, parents/carers, the school and the wider community is integral to the successful development of school-based drug education programs.</p> <ul style="list-style-type: none"> ▪ Consistent with the ACT Children's Plan, Family Support Program and Health Action Plan. ▪ Consistent with the ACT Children's Plan and Family Support Program. 	<p>Increased number of family and carer oriented early intervention programs provided.</p>	ACT Health
12	<p>Establish an interdepartmental steering committee that will develop models of family support for 'at risk' children and families, and ensure that the committee has the capacity to make decisions and effect change.</p>	<ul style="list-style-type: none"> ▪ Consistent with the ACT Children's Plan and Family Support Program. 	<p>Interdepartmental steering committee established.</p>	ACT Health

Demand Reduction (continued)
actions to prevent the uptake of harmful drug use and treatment to reduce drug use

	Actions	Rationale	Evaluation (examples of ways in which implementation of actions may be evaluated.)	Lead Agency
13	<p>Early Intervention</p> <p>Implementation of health promotion initiatives that reinforce smoke free messages.</p>	<p>Discouraging the uptake of tobacco use is a key public health goal, especially given that the vast majority of people commence regular smoking while in their teens. Studies have found that the younger people are when they start to smoke, the less likely they are to quit and the more likely they are to become heavy smokers, suffer from smoking-related caused health problems and die prematurely.</p> <p>The Youth Smoking Prevention Program targets young people with messages regarding not starting smoking and smoking cessation. The Program is a 2 year program which will feature a mass media campaign and will involve the development of resources and ongoing work with schools and community organisations.</p> <p>Healthpact awards grants and sponsorships to reinforce the Smokefree message.</p> <p>ACT Health has an ongoing contract with the Cancer Council ACT for Quitline services.</p>	<p>Mass media campaign on Youth Smoking Prevention implemented. Increase in the number of schools, students and communities targeted as part of the Youth Smoking Prevention Program.</p> <p>Healthpact grants and sponsorships awarded reinforcing the Smokefree message.</p> <p>Reduction in uptake and cessation rates. (young people, male/female etc.)</p>	ACT Health
14	<p>Promote healthy lifestyles for all in the community through the introduction and acceptance of this strategy.</p>	<p>Ensuring the community is better informed about the consequences of alcohol, tobacco and other drugs misuse.</p> <ul style="list-style-type: none"> ▪ Consistent with Health Action Plan. 	ACT Alcohol, Tobacco and other Drug Strategy promoted to the ACT community.	ACT Health
15	<p>Health Sector Service Development</p> <p>Increase the number of subsidised pharmacotherapy places.</p>	<p>The ACT provides a mix of subsidised and non-subsidised pharmacotherapy places in the ACT.</p>	Increased the number of subsidised pharmacotherapy places.	ACT Health

Demand Reduction (continued)
actions to prevent the uptake of harmful drug use and treatment to reduce drug use

	Actions	Rationale	Evaluation <i>(examples of ways in which implementation of actions may be evaluated.)</i>	Lead Agency
16	<p>Health Sector Service Development</p> <p>Increase the number of community based pharmacotherapy places for both prescribing and dispensing pharmacotherapies and ensure seamless service provision between public and community streams of pharmacotherapy programs.</p>	<p>In the ACT, the prescribing and dispensing of pharmacotherapies is undertaken by the ACT Health's public clinic, community pharmacists and General Practitioners. The ACT Pharmacotherapy Program is structured in four tiers:</p> <p><u>Tier 1:</u> ACT Health's public clinic prescribes and doses</p> <p><u>Tier 2:</u> ACT Health's public clinic prescribes and community pharmacists dose</p> <p><u>Tier 3:</u> Community GPs prescribe and community pharmacists dose</p> <p><u>Tier 4:</u> ACT Health's public clinic/community GPs prescribe and ACT Health's public clinic/ community pharmacists dose.</p>	<ul style="list-style-type: none"> ▪ Survey completed of Pharmacotherapy clients to identify potential barriers for clients for moving between the ACT Health public clinic, general practitioners and community pharmacies. ▪ Quarterly reviews completed of actual and potential client transfers between tiers of the Pharmacotherapy Program. ▪ Implementation and evaluation of a trial aimed at improving client transfers between the public and community streams of the Pharmacotherapy Program. The trial will involve developing: <ul style="list-style-type: none"> • definitions and protocols for defining 'stable' clients; • procedures for transferring clients between streams and/or tiers • review procedures 	ACT Health
17	<p>Improve access to rehabilitation services in the ACT.</p>	<p>The demand for residential alcohol and drug rehabilitation programs in the ACT has been increasing over the last few years. Preliminary analysis of ACT data suggests that demand for residential rehabilitation programs rose by 9.2% between 2000-01 and 2001-02 and by a further 16% between 2001-02 and 2002-03.</p>	<ul style="list-style-type: none"> ▪ Increase in number of clients accessing rehabilitation programs. ▪ Increase the completion rates of those participating in rehabilitation programs. 	ACT Health
18	<p>Improve access to Hepatitis B vaccinations.</p>	<p>Hepatitis B is a serious viral disease that affects the liver. The most effective way of preventing the spread of hepatitis B is through vaccination. There is a high incidence of injecting drug users with Hepatitis C and it is important to guard against these people contracting Hepatitis B.</p>	<p>Number of Hepatitis B vaccinations provided.</p>	ACT Health
19	<p>Review the delineation between medical and non-medical withdrawal services to assess if this delineation is appropriate.</p>	<p>The main difference between the medical and non-medical services in the ACT is that one has a doctor available and medication may be prescribed as required during the withdrawal process. The other provides supported withdrawal from drugs and alcohol using natural therapies to alleviate symptoms.</p> <p>Medical Withdrawal services are provided only by ACT Health. Non-medical withdrawal services are provided for youth at Ted Noffs and for adults at Arcadia, Directions ACT Inc.</p>	<p>Delineation between medical and non-medical withdrawal services reviewed.</p>	ACT Health

Demand Reduction (continued)
actions to prevent the uptake of harmful drug use and treatment to reduce drug use

	Actions	Rationale	Evaluation <i>(examples of ways in which implementation of actions may be evaluated.)</i>	Lead Agency
20	<p>Health Sector Service Development</p> <p>Provide supervised withdrawal services for women, women with children and families with children.</p>	<p>The ACT Select Committee on the Status of Women reported that the interests of women and their children are not being well-served when mothers feel unable to present for residential treatment due to the fear of losing their family. While other non-residential drug treatment options are available, these were not considered to provide the same level of care, support and structure that many women with substance abuse issues require.</p> <p>Consistent with the Government Response to the Select Committee on the Status of Women.</p>	<p>Information collected and analysed from withdrawal services about the number of women who are primary or secondary carers and are currently accessing services.</p> <p>Information collected and analysed about the number of women whose primary caring role has created a barrier for them in accessing services.</p>	ACT Health
21	<p>Establish Benzodiazepine withdrawal and reduction programs that target women.</p>	<p>The Select Committee on the Status of Women reported that misuse of benzodiazepines such as Valium or Serapax are a key health concern for many women. The committee heard that mis-prescription and inadequate patient follow-up can lead to addiction and misuse.</p> <ul style="list-style-type: none"> ▪ Consistent with Health Action Plan. ▪ Consistent with the Government Response to the Select Committee on the Status of Women 	<ul style="list-style-type: none"> ▪ Number of benzodiazepine withdrawal and reduction programs targeting women established. ▪ Number of women commencing programs and percentage completing programs. ▪ Needs assessment completed of services providing support to women withdrawing and reducing Benzodiazepine use. ▪ Increase in the number of training programs provided and persons trained. 	ACT Health
22	<p>Develop protocols between withdrawal services and residential rehabilitation services that support clients in moving between these agencies with little disruption to their treatment.</p>	<p>The complex needs of many people with alcohol and other drug problems requires a range of services and sectors to collaboratively work together for the best outcome for the client.</p> <p>Drug use is not merely a matter of physical dependency.</p> <p>Physical withdrawal from a substance does not equate to rehabilitation.</p> <ul style="list-style-type: none"> ▪ Consistent with Health Action Plan. 	<p>Protocols between withdrawal services and residential rehabilitation services developed.</p>	ACT Health

**Harm Reduction:
actions to reduce drug-related harm to individuals and communities**

	Actions	Rationale	Evaluation <i>(examples of ways in which implementation of actions may be evaluated.)</i>	Lead Agency
23	<p>Regulatory Change</p> <p>Continue to support the creation of Alcohol Free Zones as appropriate.</p>	<p>Alcohol misuse is recognized under the National Drug Strategic Framework as one of the most significant causes of drug related harm in Australia and second only to tobacco as a preventable cause of death and hospitalisation.</p> <ul style="list-style-type: none"> ▪ Consistent with Health Action Plan. 	<p>Increase in the number of alcohol free zones.</p>	<p>ACT Health JACS</p>
24	<p>Consider the implications of decriminalising possession of small quantities of drugs for personal use.</p>	<p>A combination of strategies, including legal initiatives and community education and development are needed to reduce the harms associated with drug misuse.</p>	<p>Decriminalised possession of small quantities of drugs for personal use examined.</p>	<p>ACT Health JACS</p>
25	<p>Eliminate inconsistencies between existing laws and evaluate new legislation for consistency with harm minimization.</p>	<p>Harm minimisation is the basis for alcohol, tobacco and other drug policies and service provision in the ACT.</p>	<p>Number of pieces of legislation evaluated for consistency to harm minimization.</p>	<p>JACS</p>
26	<p>Review the Periodic Detention legislation and other legislation to identify barriers for offenders with alcohol and other drug use issues in completing their Periodic Detention Orders and other orders.</p>	<p>Issues for an offender with an alcohol or other drug misuse issue are complex. Drug & alcohol intervention considers the stages of change process & relapse prevention models. Alcohol or drug use while on an order may lead to breach action & re-sentencing without the scope to consider the complexity of treatment. In relation to Periodic Detention & Community Service orders people are not accepted under the influence of drugs or alcohol because of the danger they present to themselves or others while performing community service work.</p>	<p>Legislation to be reviewed and the issue of alcohol and drug interventions and closer partnerships with ADP to be considered.</p>	<p>JACS</p>
27	<p>Reduce retail outlet advertising of tobacco.</p>	<p>Tobacco smoking is the single largest preventable cause of premature death and disease in Australia.</p> <ul style="list-style-type: none"> ▪ Consistent with Health Action Plan. 	<p>Reduction in retail outlet advertising of tobacco.</p>	<p>ACT Health</p>
28	<p>Examine the feasibility of legislative change to remove self-administration of illicit substances as a criminal offence and remove legal restrictions on the distribution of clean injecting equipment between peers.</p>	<p>Under the <i>Drugs of Dependence Act 1989</i>, it is a criminal offence to possess or self-administer a drug of dependence. Research suggests that people are more likely to change their attitudes and behaviours, if they believe the messenger is similar to them and faces the same concerns and pressures. Peer education can support people in making healthy decisions.</p>	<ul style="list-style-type: none"> ▪ Feasibility of legislative change to remove self-administration of illicit substances as a criminal offence examined ▪ Feasibility of removal of legal restrictions on the distribution of clean injecting equipment between peers examined. 	<p>ACT Health</p>

**Harm Reduction:
actions to reduce drug-related harm to individuals and communities**

	Actions	Rationale	Evaluation (examples of ways in which implementation of actions may be evaluated.)	
29	<p>Regulatory Change</p> <p>Effect legislative and cultural change, and undertake community education on harmful patterns of alcohol consumption and the way drugs (including tobacco) are portrayed in the community.</p>	<p>Alcohol misuse is recognized under the National Drug Strategic Framework as one of the most significant causes of drug related harm in Australia and second only to tobacco as a preventable cause of death and hospitalisation.</p> <p>Tobacco smoking is the single largest preventable cause of premature death and disease in Australia.</p> <ul style="list-style-type: none"> ▪ Consistent with Health Action Plan. 	<p>Legislative and cultural change implemented.</p>	ACT Health
30	<p>Health Sector Service Development</p> <p>Establish a trial of vending machines for dispensing needles and syringes in the ACT to provide 24hr anonymous access to clean injecting equipment.</p>	<p>The ACT already has a comprehensive needle and syringe program in place. Needles and syringes are already provided free of charge weekdays from many community health centres and are able to be purchased from many local pharmacies. The ACT does not have twenty-four hour access to needle and syringes. Large parts of Tuggeranong, Gungahlin and inner-Belconnen have no after hours access and only limited access on weekends.</p> <p>Consistent with the Government response to the Select Committee report on the access of needles and syringes in ACT.</p>	<ul style="list-style-type: none"> ▪ Trial completed of vending machines for dispensing needles and syringes in the ACT established. ▪ Trial evaluated to assess: <ul style="list-style-type: none"> ▪ Increased no. of syringes distributed throughout the ACT ▪ Rate of appropriately/inappropriately discarded injecting equipment ▪ time of day/week people access needles & syringes ▪ reason/frequency of sharing needles ▪ appropriateness of location of machines ▪ pricing (barrier to access) 	ACT Health
31	<p>Provide access to needles and syringes in all hospitals, health centres and a range of participating pharmacies and develop a strategy to encourage pharmacy participation in Needle and Syringe Programs.</p>	<p>Access to sterile injecting equipment through needle and syringe programs is recognised as one of the most cost-effective public health interventions developed over the last twenty years. The spread of location within the community of hospitals, health centres and community pharmacies, coupled with a variety opening hours, would allow these facilities to play an important role in the program.</p>	<ul style="list-style-type: none"> ▪ Increased number and proportion of hospitals, health centres and pharmacies participating in the Needle and Syringe Program. ▪ Increased number of needles and syringes provided by ACT hospitals, health centres and pharmacies. 	ACT Health

Harm Reduction (continued):
actions to reduce drug-related harm to individuals and communities

	Actions	Rationale	Evaluation (examples of ways in which implementation of actions may be evaluated.)	Lead Agency
32	<p>Health Sector Service Development</p> <p>Establish a sobering up facility in the ACT.</p>	<p>While it is not a criminal offence to be intoxicated in the ACT, the <i>Intoxicated Persons Care and Protection Act 1994</i> provides for people to be taken into protective custody if they are: disorderly; behaving in a manner likely to cause injury to themselves or to others; or they are incapable of protecting themselves from physical harm. Current practice is that people who are assessed as meeting these criteria are held in the City Watchhouse, as there is currently no sobering up facility in the ACT.</p> <p>Consistent with the <i>Intoxicated Persons (Care and Protection) Act 1994</i></p>	<ul style="list-style-type: none"> ▪ Sobering up facility established in the ACT ▪ Pilot implemented and evaluated. 	ACT Health
33	<p>Develop a model that improves general primary healthcare services for those with drug and alcohol problems.</p>	<p>To assist general practitioners and other primary health care workers manage the complex health requirements of their clients.</p>	<p>Improved general primary healthcare services for those with drug and alcohol problems.</p>	ACT Health
34	<p>Support agencies to develop and implement client feedback processes within services.</p>	<p>Client feedback is essential to maintaining and improving services.</p>	<p>Number and types of client feedback mechanisms utilised by agencies.</p> <p>Improvements implemented as a result of client feedback.</p>	ACT Health
35	<p>Contribute to national programs that address community attitudes about alcohol.</p>	<p>Alcohol misuse is recognized under the National Drug Strategic Framework as one of the most significant causes of drug related harm in Australia and second only to tobacco as a preventable cause of death and hospitalisation.</p> <ul style="list-style-type: none"> ▪ Consistent with Health Action Plan. 	<p>Number of national programs that address community attitudes about alcohol contributed to</p>	ACT Health
36	<p>Influence and challenge community attitudes towards people who use drugs, to reduce the stigmatisation of drug users.</p>	<p>The stigma that some people in the community associate with drug use can limit access or a willingness to use services.</p>	<ul style="list-style-type: none"> ▪ Number of activities incorporated into Drug Action Week ▪ Number of activities incorporated into National Overdose Day 	ACT Health
37	<p>Address financial and other barriers to access General Practice medical services.</p>	<p>To assist clients with drug and alcohol issues access the most appropriate services.</p> <ul style="list-style-type: none"> ▪ Consistent with Health Action Plan. 	<p>Financial and other barriers to access General Practice medical services identified.</p>	ACT Health
38	<p>Work with GPs and the Youth Sector to ensure that a comprehensive understanding of the multiple issues facing young people with depression is understood and this knowledge is incorporated into the provision of appropriate interventions.</p>	<p>Effective case management and staff skilling can contribute to appropriate interventions across services.</p> <ul style="list-style-type: none"> ▪ Consistent with Health Action Plan. 	<p>Greater understanding of general practitioners and youth workers of the multiple issues facing young people with depression.</p>	ACT Health OCYFS

**Harm Reduction (continued):
actions to reduce drug-related harm to individuals and communities**

	Actions	Rationale	Evaluation (examples of ways in which implementation of actions may be evaluated.)	Lead Agency
39	<p><i>Health Sector Service Development</i></p> <p>Increase and improve support for peer-based models of service delivery, support, advocacy and community development.</p>	<p>Peer-based service employees can provide empathy and understanding to their clients as they have often shared similar experiences.</p>	<p>Expansion of peer based services. Increased number of clients accessing peer based services.</p>	ACT Health
40	<p>In line with the ACT Health Research Strategy, support researchers to seek funding to participate in a clinical research trial of hydromorphone in the ACT and support the participation of the ACT in the trial.</p>	<p>The progression of a hydromorphone trial would expand the range of possible treatments available to opioid-dependent persons.</p>	<p>Feasibility study for a clinical trial of hydromorphone conducted.</p>	ACT Health
41	<p>Establish continuous quality improvement processes within the alcohol and other drug sector.</p>	<p>Standardised and continuous quality improvement processes will ensure objectivity in the assessment and improvement of services.</p>	<p>Continuous quality improvement processes established.</p>	ACT Health
42	<p>Strengthen the research capacity in the ACT by developing strategic partnerships, with drug and alcohol research institutes in other jurisdictions.</p>	<p>To support the development of informed policy decisions that provide a framework for the implementation of effective interventions.</p>	<p>Strategic partnerships with drug and alcohol research institutes developed.</p>	ACT Health
43	<p>Monitor and evaluate the Strategy through the establishment of an evaluation and monitoring group including both community and Government representatives.</p>	<p>Evaluations inform future planning of service delivery and approaches to practice by taking into consideration the different needs and perspectives of consumers, carers, service providers and the community.</p>	<p>Evaluation Group established.</p>	ACT Health
44	<p>Concrete actions for addressing the gaps in responses and services for illicit users with mental health issues.</p>	<p>Dual diagnosis issues are becoming increasingly pressing in the alcohol and other drug treatment sector as shifts in drug consumption patterns over the last three years have markedly altered the type of challenging behaviour people living with a dual diagnosis present to services.</p>	<p>Actions for addressing gaps in responses and services for illicit drug users with mental illness identified.</p>	ACT Health

Harm Reduction (continued):
actions to reduce drug-related harm to individuals and communities

	Actions	Rationale	Evaluation <i>(examples of ways in which implementation of actions may be evaluated.)</i>	Lead Agency
45	<p>Health Sector Service Development</p> <p>Investigate the feasibility of a Supervised Injecting Place trial in the ACT and, on the basis of the findings, make recommendations as to the implementation of a scientific trial.</p>	<p>A Supervised Injecting Place trial aims to:</p> <ul style="list-style-type: none"> ▪ improve health outcomes by decreasing the transmission of blood borne viruses through providing a clean environment with access to sterile injecting equipment ▪ reduce the risk of overdose deaths and the cost of ambulance call outs by providing a supervised injecting environment ▪ improve access to primary health care and treatment options for IDUs ▪ reduce litter of injecting equipment, ▪ reduce the public nuisance associated with street injecting and overdosing ▪ Consistent with Health Action Plan. <p>To improve service links and allow staff to take a more proactive role in recommending treatment options.</p>	<p>Feasibility of a supervised injecting place trial in the ACT investigated.</p>	ACT Health
46	<p>Establish a database of best practice for drug and alcohol prevention and treatment services.</p>	<p>Program evaluations would allow services to develop future programs that are evidence based.</p>	<p>Utilise existing resources such as NDARC/ADCA.</p> <p>Provide training in accessing appropriate information and research.</p>	ACT Health
47	<p>Commit resources to allow drug and alcohol services to undertake independent evaluations.</p>	<p>A rigorous trial would test if prescribed heroin will help people who have not found other treatments to be of value, attract people into treatment and provide an easier drug to withdraw from for those who wish to become drug-free. It also has the potential to improve community safety and reduce crime by undermining the black market trade in heroin.</p> <ul style="list-style-type: none"> ▪ Consistent with Health Action Plan. 	<p>Resources allocated to drug and alcohol services to undertake independent evaluations.</p>	ACT Health
48	<p>Continue to lobby the Commonwealth to establish a heroin trial in the ACT.</p>	<p>Instances of lobbying undertaken.</p>		ACT Health

Harm Reduction (continued):
actions to reduce drug-related harm to individuals and communities

	Actions	Rationale	Evaluation (examples of ways in which implementation of actions may be evaluated.)	Lead Agency
49	<p><i>Health Sector Service Development</i></p> <p>Conduct research on alcohol and other drug use issues for women and women with children.</p>	<p>There is little research on women and dependency and consequently women with complex needs are often inadequately diagnosed.</p> <ul style="list-style-type: none"> ▪ Consistent with the report of the Select Committee on the Status of Women which identified there are specific problems confronting women in relation to the misuse of drugs and alcohol. ▪ Consistent with the Family Support Program and Health Action Plan. 	<p>Research on alcohol and other drug issues for women and women with children undertaken.</p>	ACT Health
50	<p><i>Cross Sector Service Development</i></p> <p>Service providers to develop and implement carers policies in line with the ACT Carers Policy released in December 2003.</p>	<p>The ACT Government's Caring for Carer's Policy 2003 states that: it is desirable that carers are informed about their rights and responsibilities upon first contact with services. This might involve the development of formal statements outlining carer's rights and responsibilities covering all aspects of involvement with the service.</p>	<p>Carers policy developed and implemented by service providers in the ACT alcohol and drug sector.</p>	ACT Health
51	<p>Establish trial employment programs for people currently in treatment for drug and alcohol problems (including people on substitution treatment (eg methadone). These employment programs should include traineeships, training, and volunteering opportunities.</p>	<p>People with drug and alcohol problems often require assistance to gain training, qualifications and work experience that may lead to sustainable employment and increase their engagement and participation in the community.</p>	<ul style="list-style-type: none"> ▪ Number of employment programs trialled ▪ Percentage of people completing programs started. 	ACT Health

Harm Reduction (continued):
actions to reduce drug-related harm to individuals and communities

	Actions	Rationale	Evaluation (examples of ways in which implementation of actions may be evaluated.)	Lead Agency
	Cross Sector Service Development			
52	Improve the mentoring/ counselling/support service dealing with drug and related issues for consumers and carers.	Mentoring and supporting consumers and carers builds relationships and trust across sectors.	Number of mentoring/counselling/support services provided.	ACT Health
53	Strengthen and increase case management services for clients with complex needs , (particularly those clients utilising pharmacotherapy treatments) and develop and implement a case management framework and protocols both within the alcohol and drug sector and across sectors (eg between health, education, housing and corrections).	To deliver the best outcomes for clients, a range of services and sectors need to work together collaboratively and have a clear understanding of the framework they are working in and their role within it. Protocols between services are a fundamental component of this approach.	Case management services strengthened and increased. Case management framework and protocols both within the alcohol and drug sector and across sectors developed and implemented. Case management plans are designed and implemented in consultation with appropriate agencies.	ACT Health
54	Alcohol and Other Drug Services will provide referrals for families to appropriate education in the community.	Most families have influence over the drug user. This influence may be strengthened, when the family understand the process, & accepts support itself. <ul style="list-style-type: none"> Consistent with the ACT Children's Plan and Family Support Program. 	Number of referrals to appropriate education services in the community provided to families.	ACT Health
55	Provide outreach support to crisis accommodation services so that the drug and alcohol needs of their clients are addressed.	Improving liaison and referral services between agencies will strengthen links and provide more complete services to clients with drug and alcohol issues.	Outreach support services increased.	ACT Health
56	Support the integration and development of partnerships between mental health, education, older person's mental health, drug and alcohol, and disability and housing agencies.	The complex needs of many people with alcohol and other drug problems requires a range of services and sectors to collaboratively work together for the best outcome for the client. <ul style="list-style-type: none"> In November 2003, the Government announced a series of reforms to the Public Housing Rental Assistance Program aimed at removing barriers to public housing and maintaining sustainable tenancies. 	Partnerships between mental health, education, older person's mental health, drug and alcohol and disability and housing agencies developed.	ACT Health
57	Address financial barriers for clients in accessing services, including the development of a policy on fees, and the issue of public housing tenants needing to access long-term residential services.		Rent payment burden eased for public housing tenants going into residential rehabilitation. Financial barriers for clients accessing alcohol and drug services addressed. <ul style="list-style-type: none"> Fees mapped across alcohol and drug sector Analysis of financial barriers completed and options for improvement identified 	DHCS ACT Health
58	Provide interpreting services and resources in community languages, and support agencies to ensure that staffing of services reflects the communities they serve.	Improving cultural awareness in the broader Australian community to ensure appropriate services are provided. <ul style="list-style-type: none"> Consistent with Health Action Plan. 	Translation and interpreting of pamphlets/information for current services.	CMD

**Harm Reduction:
actions to reduce drug-related harm to individuals and communities**

	Actions	Rationale	Evaluation <i>(examples of ways in which implementation of actions may be evaluated.)</i>	Lead Agency
59	<p>Workforce Development</p> <p>Develop and resource an ACT workforce development strategy, and develop a change management/ implementation plan to accompany this strategy:</p> <p>Strategy to include:</p> <ul style="list-style-type: none"> ▪ Provide training (for Police, frontline health workers including Accident & Emergency staff and Alcohol and other Drug workers) and capacity building strategies regarding the increasing trend of methamphetamine and other Amphetamine Type Stimulants use & other emerging trends. ▪ Develop a model for the ACT that utilises peer educators in alcohol and other drug sector workforce development (including strategies for peers educating each other and educating workers). ▪ Resource the Coalition of Alcohol and other Drug Agencies of the ACT (CADA ACT) to provide for sector development training and continue to develop partnerships across alcohol and other drug agencies. ▪ Support human service agencies through the provision of training and sector development strategies to respond appropriately to alcohol and other drug related issues, including working with clients who have complex needs such as dual diagnosis/co-morbidity (both mental health and alcohol and other drug) issues. These strategies will address barriers to services for the clients. 	<p>Workforce development of the alcohol and other drug and community sectors is a necessary long-term investment. Capacity building will enable the sectors to further develop expertise, skills and competencies in order to provide professional leadership and quality services to the community.</p> <p>One of the most pressing issues facing the sectors is the capacity for agencies to attract and retain qualified staff. Workforce development has been recognized as a national concern and has been identified by the Intergovernmental Committee on Drugs as a priority area for development.</p> <ul style="list-style-type: none"> ▪ Consistent with Health Action Plan 	<p>Evaluation <i>(examples of ways in which implementation of actions may be evaluated.)</i></p> <ul style="list-style-type: none"> ▪ Development and delivery of a workforce development strategy that incorporates findings from other ACT, state/territory and national workforce development studies and strategies. ▪ Model for peer educators developed ▪ Demonstrated consultation and liaison with ACT alcohol and other drug and community sector agencies, and representative bodies from other state and territory jurisdictions. ▪ Improved access to training for workforce. ▪ Monitoring of ongoing effectiveness of the strategy. 	ACT Health
60	<p>Implement the findings of the National Evaluation of Pharmacotherapies for Opiate Dependence (NEPOD) and disseminate resources to carers, consumers and workers.</p>	<p>The National Evaluation of Pharmacotherapies for Opiate Dependence (NEPOD) project aims to develop and implement a range of effective, evidence-based, best practice treatment options for people who are dependent on opioids. The NEPOD dissemination and implementation strategy aims to ensure that accurate information about the nature, costs and effectiveness of the evaluated pharmacotherapies is made available.</p> <ul style="list-style-type: none"> ▪ Consistent with Health Action Plan. 	<p>National Evaluation of Pharmacotherapies for Opiate Dependence (NEPOD) findings implemented and resources disseminated to target groups.</p>	ACT Health

**Harm Reduction:
actions to reduce drug-related harm to individuals and communities**

	Actions	Rationale	Evaluation <i>(examples of ways in which implementation of actions may be evaluated.)</i>	Lead Agency
61	<p>Aboriginal and Torres Strait Islander Service Development</p> <p>Establish an Aboriginal and Torres Strait Islander bush healing farm, and investigate the possibility of a funding partnership arrangement with Mental Health ACT.</p>	<p>Aboriginal and Torres Strait Islander people in the ACT have identified that they require a system wide approach that promotes complete primary care rather than the compartmentalisation of health and community services which can be characteristic of mainstream services.</p> <p>A bush healing farm could target improved health outcomes for Aboriginals and Torres Strait Islanders by developing culturally appropriate prevention, education, rehabilitation and outreach programs to address drug and alcohol abuse within these local communities.</p>	<p>Feasibility study completed into establishing a bush healing farm.</p>	<p>ACT Health</p>
62	<p>Increase services for Aboriginal and Torres Strait Islanders with alcohol and other drug problems including the provision of professional development for Aboriginal and Torres Strait Islander services.</p>	<p>Aboriginal and Torres Strait Islander people in the ACT have identified that there is a need to improve the attitudes of the people who work in mainstream services. Aboriginal people need a system wide approach that promotes complete primary care rather than the compartmentalisation of health and community services characteristic of mainstream programs. There was also a need highlighted to strengthen partnerships between Aboriginal and non-Aboriginal services.</p>	<p>Actions to be further developed through the Aboriginal and Torres Strait Islander Strategy.</p>	<p>ACT Health</p>

**Harm Reduction:
actions to reduce drug-related harm to individuals and communities**

	Actions	Rationale	Evaluation (examples of ways in which implementation of actions may be evaluated.)	Lead Agency
63	<p>Aboriginal and Torres Strait Islander Service Development</p> <p>Address barriers for Aboriginal and Torres Strait Islander people in accessing mainstream services through providing culturally sensitive services that are developed in collaboration with the Aboriginal and Torres Strait Islander communities.</p> <ul style="list-style-type: none"> ▪ Establish an outreach service to assist people who have both a mental illness and substance abuse problems. ▪ Establish an Aboriginal and Torres Strait Islander Youth Detoxification Support Service to improve Aboriginal and Torres Strait Islander young peoples' access to mainstream detoxification (withdrawal) services. ▪ Improve access to pharmacotherapies for young Aboriginal and Torres Strait Islander people. 	<p>Aboriginal and Torres Strait Islander people in the ACT have identified that there is a need to improve the attitudes of the people who work in mainstream services. Aboriginal people need a system wide approach that promotes complete primary care rather than the compartmentalisation of health and community services characteristic of mainstream programs. There was also a need highlighted to strengthen partnerships between Aboriginal and non-Aboriginal services.</p> <p>Aboriginal and Torres Strait Islander people in the ACT have identified that few Aboriginal people access mainstream detoxification (withdrawal) services and those that do often leave early.</p> <p>In the ACT, the prescribing and dispensing of pharmacotherapies is undertaken by the ACT Health's public clinic, community pharmacists and General Practitioners.</p> <ul style="list-style-type: none"> ▪ Consistent with Health Action Plan. <p>Consistent with Action 14</p>	<p>Increased number of Aboriginal and Torres Strait Islander people with a mental illness and substance abuse problems accessing outreach services.</p> <p>Aboriginal and Torres Strait Islander Youth Detoxification Support Service established.</p> <p>Increased number of Aboriginal and Torres Strait Islander people accessing and completing detoxification (withdrawal).</p> <p>Development of a service model for the delivery of home detoxification services.</p> <p>Survey completed of Pharmacotherapy clients to identify potential barriers for clients for moving between the ACT Health public clinic, general practitioners and community pharmacies.</p> <p>Quarterly reviews completed of actual and potential client transfers between tiers of the Pharmacotherapy Program.</p> <p>Implementation and evaluation of a trial aimed at improving client transfers between the public and community streams of the Pharmacotherapy Program. The trial will involve developing:</p> <ul style="list-style-type: none"> ▪ definitions and protocols for defining 'stable' clients; ▪ procedures for transferring clients between streams and/or tiers ▪ review procedures 	ACT Health

**Harm Reduction:
actions to reduce drug-related harm to individuals and communities**

	Actions	Rationale	Evaluation <i>(examples of ways in which implementation of actions may be evaluated.)</i>	Lead Agency
64	<p><i>Diversion</i></p> <p>Expansion of the Diversion Program to increase the number and proportion of those with alcohol and drug problems being diverted from the court system into treatment where appropriate.</p>	<p>The ACT Police Early Intervention (PIED) and the Court Alcohol and Drug Assessment Scheme (CADAS) provide early intervention in the criminal justice process and opportunities for individuals to be assessed with a view to treatment, rather than progress through the criminal justice system.</p> <p>For example, in 2003 there were 250 Diversions through Court Alcohol and Drug Assessment (CADAS) and 174 from January to April 2004.</p> <p>Over the past three years, of those diverted, over 80 have been male and 91% have been in the age group 15-44. During 2002-03 an average of 16% of diversion clients identified themselves as being of Aboriginal or Torres Strait Islander origin. (13.8 times the rate that ACT residents identified themselves as of Aboriginal or Torres Strait Islander origin in the 2001 Australian Census.)</p> <p>Provision of a consistent approach in the development and implementation of treatment goals.</p>	<p>Evaluation completed of the Police Early Intervention Program (PIED) and the Court Alcohol and Drug Assessment Scheme (CADAS) in conjunction with the Territory Reference Group and recommendations implemented.</p> <p>Consideration will have been given to:</p> <ul style="list-style-type: none"> ▪ opportunities to improve systems and processes ▪ service gaps ▪ expansion of the scope of the Diversion Program to include alcohol ▪ incentives and opportunities for those working in the Police Early Intervention Program (PIED) and Court Alcohol and Drug Assessment Scheme (CADAS) to implement strategies to increase 'take up' of the program within the police and court systems 	ACT Health
65	<p>Continue to involve alcohol and other drug workers where appropriate in criminal matters, where alcohol and other drugs are involved, including GP's and primary health care providers.</p>		<p>Non-government registered treatment providers to work with ACT Health's Diversion Assessment Team and the Territory Reference Group to:</p> <ul style="list-style-type: none"> ▪ develop protocols for referral to providers according to identified client needs and treatment provided ▪ monitor treatment and referral patterns ▪ enhance communication/consultation strategies for working with magistrates ▪ contribute to the overall evaluation of the Diversion program 	ACT Health

**Harm Reduction:
actions to reduce drug-related harm to individuals and communities**

	Actions	Rationale	Evaluation <i>(examples of ways in which implementation of actions may be evaluated.)</i>	Lead Agency
66	<p>Custodial Service Delivery</p> <p>Provide full access to health services and treatments that are available to the community to prisoners, detainees, and remandees.</p>	<p>The Draft Standard Guidelines for Corrections in Australia 2003 (revised) states that every prisoner is to have access to evidence-based health services provided by a competent, registered health professional who will provide a standard of health services comparable to that of the general community. Restrictions on a person's liberty should not necessarily restrict their access to continuity of treatment options.</p> <ul style="list-style-type: none"> ▪ Consistent with Health Action Plan. 	<p>Case plans to be developed by ACT Corrective Services in consultation with health providers to ensure continuity of treatment.</p>	JACS
67	<p>Support community corrections, ACT Corrective Services programs staff and custodial officers to work in conjunction with other government and non-government agencies and clients to achieve outcomes that address the offenders assessed needs. For example community corrections officers refer to a range of services in the community.</p>	<ul style="list-style-type: none"> ▪ Maximising brokerage options for case management. <p>Increasing the range of interventions offered to address responsibility issues.</p> <p>Utilise available resources within the community to facilitate compliance with conditions of orders and support and encourage contact between offenders and the community.</p> <p>Support a through care approach to offender management.</p> <ul style="list-style-type: none"> ▪ Consistent with Family Support Program 	<p>Increased utilization of a broader range of services.</p> <p>Decrease in offending behaviour.</p> <p>Increased awareness of services offered in the community.</p> <p>Periodic review of case management plans to ensure appropriate community resources are being utilized.</p>	JACS
68	<p>Increase the programs available and improve access to current programs for young women in Quamby, women in the Belconnen Remand Centre (BRC) and the Temporary Remand Centre (TRC).</p>	<p>Recognition of the importance of a holistic approach to women's wellbeing and recognition of the particular life experiences of women in the correctional and youth justice systems which often includes alcohol and other drug misuse.</p> <p>Recognition of the importance of programs and services, including legal, health, alcohol and drug, mental health, and life skills programs, that are designed to meet the specific needs of women and young women and which are based on current best practice, nationally and internationally.</p>	<p>Review completed of current alcohol and drug programs to ensure appropriateness for women offenders.</p> <p>The development and delivery of alcohol and drug programs for women in BRC and STRC which will include: Alcohol and Drug Education Program; and Alcohol and Drug Awareness Program.</p>	JACS

Appendices

Appendix 1: Membership of the ACT Alcohol and other Drug Taskforce

Dr Tony Sherbon	Chief Executive, ACT Health (Taskforce chair)
Mr John Murray	Australian Federal Police
Ms Jenny Kitchin	Department of Education, Youth and Family Services – Manager of Community Partnerships and School Development
Ms Ronia McDade	Department of Justice and Community Safety – Manager of Community Corrections
Ms Audrey Ngingali Kinnear	Healing and Reconciliation Consultant and Community Advocate
Ms Annie Madden	Executive Officer, Australian IV League
Ms Sally Pink	Director, Alcohol and Drug Program, Community Health
Mr Ivor Shaw	Director, Ted Noffs Canberra
Captain David Pullen	Oasis Bridge Program, Salvation Army
Mr Rollo Brett	Co-ordinator of Samaritan House, St Vincent de Paul Society
Ms Robyn Davies	RN and PhD student at the National Centre for Epidemiology and Population Health the Australian National University and researcher at ACT Division of General Practice
Dr Paul Dugdale	Chief Health Officer of the ACT
Dr Clare Willington	Adviser on General Practice to the ACT Health.
Ms Marilyn Graeme	Youth Coalition of the ACT and Director of Lowana Young Women's Refuge
Ms Jacqui Pearce	Toora Women's Refuge, and Chair of Ministerial Advisory Council on Women
Mr Brian McConnell	Family and Friends of Drug Law Reform
Ms Colleen Duff	Australian Nursing Federation
Ms Margaret Morton	Carers ACT
Dr Gabriele Bammer	National Centre for Epidemiology and Population Health, The Australian National University.
Ms Wendy Macken	DIRECTIONS ACT

Appendix 2: Terms of Reference of the ACT Alcohol and other Drug Taskforce

The ACT Alcohol and other Drug Taskforce is a cross-sectoral Ministerial advisory group responsible for making recommendations to Government on ways to minimise alcohol and other drug (drug) related harm in the ACT.

The Terms of Reference for the Taskforce are to:

- Inquire into the level, nature and impact of harm related to the intentional and unintentional use of both licit and illicit drug in the ACT; and
- Develop the future Drug Strategy for the ACT.

The Taskforce will undertake this role with particular reference to:

- Prevention, early intervention and education, especially for youth;
- At risk and marginalised groups including women, youth, people from non English speaking backgrounds and indigenous people;
- Improving links and pathways to treatment and utilisation of data including links across Government and to existing working groups and committees, including those that have already been convened to oversee specific projects;
- Opportunities to improve service provision that can be implemented immediately and within existing budgets;
- National initiatives, policy or funding opportunities;
- The regional role of the ACT;
- Consumer involvement;
- Evidence based best practice in service provision and
- Gaps in alcohol and other drug service provision in the ACT; and
- The role of the criminal justice system in minimising alcohol and drug related harm.

The main elements of the work program for the Taskforce will include:

- Consolidating existing data on ACT drug use and need;
- Collecting additional data, where warranted, on ACT drug use and need; and
- Developing the ACT Drug Strategy.

Appendix 3: Other Government strategies that relate to this Strategy

The ACT Government strategies and policies that relate to this strategy are listed below:

- ACT Aboriginal and Torres Strait Islander Regional Health Plan 2000-2004
- ACT Community Crime Prevention Strategy
- ACT Health Action Plan 2002
- ACT Mental Health Strategy and Action Plan
- ACT Multicultural Framework 2001-2005
- ACT Policing Drug Strategy
- ACT Sexual Health and Blood Borne Diseases Strategic Plan 1998-2000 (to be updated)
- ACT Women's Action Plan (draft)
- ACT Young People's Framework
- Canberra Social Plan
- Caring for Carer's Policy 2003
- Drug Education Framework for ACT Government Schools 1999

The National strategies that relate to this strategy are listed below:

- National Drug Strategy 2004-2009
- National Tobacco Strategy 1999-2004
- National Alcohol Strategy 2001-2004
- National HIV/AIDS Strategy 1999-2004
- National Hepatitis C Action Plan 1999-2004

Glossary

Blood-borne virus: A virus that can be transmitted from an infected person to another person by blood-to-blood contact, including through the sharing of injecting equipment [National Drug Strategic Framework (NDSF): p.45].

Carers: As defined for this Strategy, carers are family members or friends that provide care to people that have a substance abuse problem or a dual diagnosis/ co morbidity involving mental illness and substance abuse

Detoxification (Withdrawal): The means by which a drug dependent person may withdraw from the effects of a drug [NDSF: p.46]. The symptoms that can occur when a person using a drug over a prolonged period reduces or ceases use are known as withdrawal symptoms [NDSF: p.49].

Drug: A substance that produces a psychoactive effect. This includes tobacco, alcohol, pharmaceutical drugs, image and performance enhancing substances and illicit drugs. It also includes substances such as kava and inhalants [NDSF: p.45].

Drug dependence: Drug dependence is characterized by a strong desire to use a drug. Among the indicators of dependence are impaired control over drug use, a higher priority given to drug use than to other activities and obligations, increased tolerance, physical withdrawal symptoms, and repeated drug use to suppress withdrawal [NDSF: p.46].

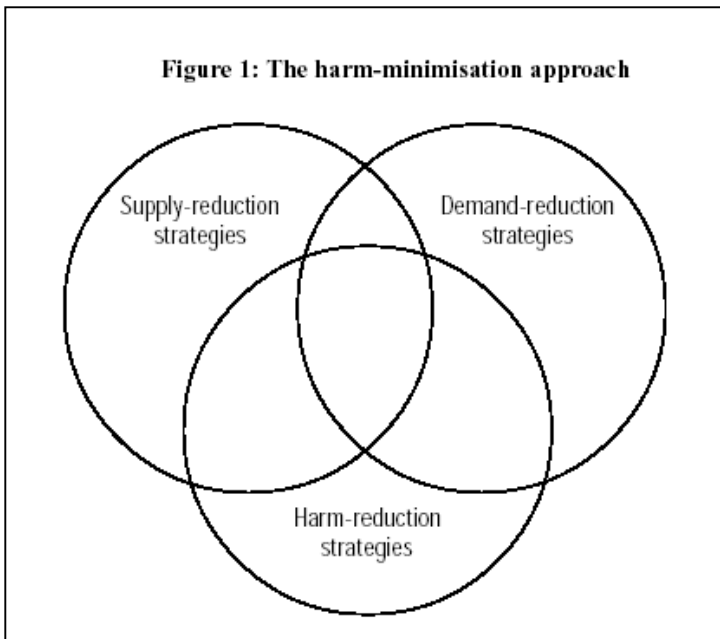
Dual Diagnosis/Co morbidity: Individuals with co-existing mental health and alcohol and other drug issues.

Early intervention: Early intervention describes practices designed to minimise the progression of a person at risk towards harmful drug use behaviours. It can include interventions early in a child's development to address specific risk factors that are associated with harmful drug use later in life, or it can include interventions early in a person's period of drug use to minimise the risk of their drug use behaviors becoming increasingly harmful.

Evidence-based best-practice: Evidence-based practice is based on rigorous research and evaluation, including assessment of the cost-effectiveness of interventions. Best-practice takes account of the preferences of individual clients, their families and the wider community [NDSF: p.18] and, on the evidence available, promotes the best intervention to produce improved outcomes for an identified issue [NDSF: p.35].

Harmful or problematic drug use: A pattern of drug use that has adverse social, physical, psychological, legal or other consequences for a person using drugs or people living with, or otherwise affected by the actions of, a person using drugs [NDSF: p.46].

Harm minimisation: Harm minimisation has been the key principle underpinning Australia's *Drug Strategy* since 1985 and was identified by Professors Single and Rohl as one of the features contributing to the success of the *National Drug Strategy*. Harm minimisation refers to policies and programs aimed at reducing drug-related harm. Harm minimisation aims to improve health, social and economic outcomes for both the community and the individual and encompasses a wide range of integrated approaches. These approaches are defined by the United Nations International Drug Control Programme, 2000, in their publication *Demand reduction: a glossary of terms*.



The following outlines these definitions:

Supply-reduction: "A broad term used for a range of activities designed to stop the production, manufacture and distribution of illicit drugs. Production can be curtailed through crop eradication or through large programmes of alternative development. Production (illicit manufacture) is attacked directly through the suppression of illicit laboratories and / or the control of pre-cursor chemicals, while distribution is reduced through police and customs and in some countries by military operations. Supply control is a term often used to cover police and customs activities."

Demand reduction: "International drug control conventions use this term in relation to the aim of reducing consumer demand for controlled substances. Demand reduction strategies contrast with approaches which aim to reduce supply of drugs though in practice demand and supply reduction can be complementary. The success of demand reduction is conventionally measured by a reduction in the prevalence of use, i.e. by more abstinence, and hence is separate and distinct from harm reduction.

Demand reduction is a broad term used for a range of policies and programmes, which seek a reduction of desire and of preparedness to obtain and use illegal drugs. Demand for drugs may be reduced through prevention and education programmes to dissuade users or potential users from experimenting with illegal drugs and/or continuing to use them; drug substitution programmes (e.g. methadone); treatment programmes mainly aimed at facilitating abstinence, reduction in frequency or amount of use; court diversion programmes offering education or treatment as alternatives to imprisonment; broad social policies to mitigate factors contributing to drug use such as unemployment, homelessness and truancy.'

Harm reduction: "In the context of alcohol or other drugs, harm reduction refers to policies or programmes that focus directly on reducing the harm resulting from the use of alcohol or other drugs, both to the individual and the larger community. The term is used particularly for policies or programmes that aim to reduce the harm without necessarily requiring abstinence. Some harm reduction strategies designed to achieve safer drug use may, however, precede subsequent efforts to achieve total abstinence. Examples of harm reduction include needle/syringe exchanges to reduce rates of needle sharing among injecting drug users, and the use of shatterproof glassware to reduce glass injuries in pub brawls. Harm reduction strategies can be distinguished from supply and demand reduction strategies."

Both licit and illicit drugs are the focus of Australia's harm-minimisation strategy. Harm minimisation includes preventing anticipated harm as well as reducing actual harm. Harm minimisation is therefore consistent with a comprehensive approach to drug-related harm, involving a balance between demand-reduction, supply-reduction and harm-reduction strategies.

A comprehensive harm-minimisation approach must take into account three interacting components: the individuals and communities involved; their social, cultural, physical and economic environment; and the drug itself. Approaches will vary according to population group, time and locality. For example, strategies for reducing harm to under-age drinkers will be entirely different from strategies targeting older smokers. Similarly, different strategies may be required for people who inject drugs in rural Queensland and people who inject drugs in metropolitan Sydney.

Governments do not condone illegal risk behaviours such as injecting drug use, but they do acknowledge that these behaviours occur. They have a responsibility to develop and implement public health and law-enforcement measures designed to reduce the harm that such behaviours can cause, both to individuals and to the community. In these circumstances harm-reduction strategies specifically target the individual using drugs and promote initiatives that benefit the wider community. For example, drink driving was identified as a serious drug-related harm and changes to legislation and law-enforcement practices were introduced. These harm-reduction strategies aimed to reduce harm associated with drink driving. Similarly, while the practice of injecting drug use continues, the provision of sterile injecting equipment through needle and syringe exchange programs is an important harm-reduction strategy for preventing the spread of blood-borne viruses such as HIV and hepatitis C.

Illicit drug: A drug whose production, sale or possession is prohibited. 'Illegal drug' is an alternative term [NDSF: p.47].

Licit drug: A drug whose production, sale or possession is not prohibited. 'Legal drug' is an alternative term [NDSF: p.47].

Net harm: A net harm approach to policy and intervention development is one, which takes into account both the anticipated positive and negative consequences of interventions, and weighs one against the other. It includes looking broadly to identify the consequences of one intervention for other interventions. If the likely impact of an intervention is limited to shifting the burden of harm from one sector to another (especially from the general community to drug users) this should be made explicit in the planning process and judgements made, based upon a net harm analysis, as to the appropriateness of proceeding [David McDonald].

Pharmacotherapies: Pharmaceutical drugs that either: substitute for a similar type of drug used in maintenance therapy; assist in the management of withdrawal symptoms; or, assist in the maintenance of abstinence after detoxification by either blocking the desired effects of a drug or by producing adverse affects such as nausea if drugs are taken.

Prevention: Preventing harmful drug use and preventing drug related harm including preventing or delaying the commencement of drug use [NDSF: p.49].

Psychoactive effects: Effects that alter mental processes such as mood, cognition, or thinking [NDSF: p.49].

Rehabilitate/Rehabilitation: Rehabilitation is a process, not an event and refers to the period following a decision by the individual to reduce harm associated with their substance use. This period can begin with withdrawal from the substance, but can also include commencement on a pharmacotherapy. Rehabilitation interventions include withdrawal, attendance at a support group (eg Relapse Prevention, Alcoholics Anonymous), residential rehabilitation or a pharmacotherapy (ie methadone or buprenorphine).

Withdrawal (Detoxification): The means by which a drug dependent person may withdraw from the effects of a drug [NDSF: p.46]. The symptoms that can occur when a person using a drug over a prolonged period reduces or ceases use are known as withdrawal symptoms [NDSF: p.49].

User Friendly Services: Services that are accessible and which are provided in a non-judgemental, appropriate, professional manner and that have appropriate mechanisms for client input and feedback and where peer-based service delivery models are valued.

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