Strengthening Specialist Alcohol and Other Drug Treatment and Support: Needs and Priorities for the ACT 2016 - 2017

An independent expert paper for the ACT Primary Health Network's Baseline Needs Assesssment

Alcohol Tobacco & Other Drug Association ACT

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ATODA Monograph Series, No.3

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ATODA

This monograph forms part of the Alcohol Tobacco and Other Drug Association ACT (ATODA) Monograph Series.

ATODA is the peak body for the alcohol, tobacco and other drug sector in the Australian Capital Territory (ACT). This includes both government and non-government services.

ATODA's vision is an ACT community and region with the lowest possible levels of alcohol, tobacco and other drug related harm, as a result of the alcohol, tobacco and other drug (and related) sectors' evidence-informed prevention, treatment and harm reduction policies and services. ATODA works collaboratively to provide expertise and leadership in the areas of social policy, sector and workforce development, research, coordination, partnerships, communication, education, information and resources. ATODA is an evidence-informed organisation.

The ways ATODA works, and the outcomes it strives to achieve, reflect its commitment to the values of population health, human rights, social justice and reconciliation between Aboriginal and Torres Strait Islander people and other Australians.

ATODA strives to achieve better interaction and integration between alcohol, tobacco and other drug researchers, policy workers, practitioners, consumers and their friends and families in the ACT and region. ATODA hopes this will:

- Improve health and social outcomes for individual clients and their families
- Enhance research utilisation in policy development and its implementation and evaluation
- Mobilise and support knowledge transfer and exchange
- Support demonstration of research and service impact
- Improve the quality of the sector's practice and services
- Improve the health and wellbeing of our community

ATODA has in-house—and a network of external—expertise in alcohol, tobacco and other drug research, policy, advocacy and capacity building, and a proven track record with engaging collaboratively and producing high-quality evidence-informed reports that provide practical expertise to inform policy and decision-making.

Monographs in the series are:

No 1. Reducing smoking in the ACT among Aboriginal and Torres Strait Islander women who are pregnant or who have young children

No 2. ACT Alcohol, Tobacco and Other Drug Workforce Qualification and Remuneration Profile 2014

We hope this monograph contributes to the sector, and is a useful resource towards our shared goal of a healthy, strong and supported community.

Carrie Fowlie
Executive Officer

Acknowledgments

We acknowledge the Traditional Owners and continuing custodians of the lands of the ACT and region, and we pay our respects to the Elders, their families and ancestors.

We are appreciative of the ACT Primary Health Network's (known as the Capital Health Network) engagement of ATODA in consultancy by commissioning this paper and for its collaborative approach throughout the process. ATODA is pleased to have been able to make a co-contribution to the costs of this paper and associated processes.

ATODA commends the Capital Health Network's:

- Commitment to consultation and engagement with the ACT AOD sector, including the consumer organisation and Aboriginal and Torres Strait Islander community-controlled services.
- Acknowledgement of the significant expertise, skills, workforce, capacity, infrastructure, evidence-base, data and systems in the ACT AOD sector.
- Commitment to building on the existing expertise and investment in ACT specialist AOD treatment and support services.

ATODA would also like to acknowledge and thank the following services and people for their contributions to this paper and its associated processes, particularly under such a tight timeframe:

- Executive Directors and workers from specialist AOD treatment and support services in the ACT
- AOD Policy Unit, ACT Health
- David McDonald, Social Research and Evaluation

The following ATODA staff are the primary authors of this paper:

- Anke van der Sterren
- Carrie Fowlie

Additional support was provided by the following ATODA staff:

- Asmara Jammali-Blasi
- Melanie Walker

We would also like to acknowledge the services and service users of specialist AOD services in the ACT who participated in the *Service Users' Satisfaction and Outcomes Survey* (SUSOS); the SUSOS has provided valuable data about the profile of people accessing specialist AOD treatment and support services in the ACT.

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List of acronyms

ACCHO	Aboriginal Community Controlled Health Organisation
ACT	Australian Capital Territory
AFSW	Aboriginal Family Support Worker
AMS	Aboriginal Medical Service
AOD	Alcohol and other drugs
AODTS-NMDS	Alcohol and Other Drug Treatment Services National Minimum Data Set
ATOD	Alcohol, tobacco and other drugs
ATODA	Alcohol Tobacco and Other Drug Association ACT
CBT	Cognitive behavioural therapies
DA-CCP	Drug and Alcohol Clinical Care Package
DASP	Drug and Alcohol Service Planning (Model)
eASSIST	electronic Alcohol, Smoking & Substance Involvement Screening Test
NIDAC	National Indigenous Drug and Alcohol Committee
NMDS	National Minimum Data Set
OMT	Opioid Maintenance Therapy
PBS	Pharmaceutical Benefits Scheme
PHN	Primary Health Networks
SUSOS	Service Users' Satisfaction and Outcomes Survey

Addendum

This paper was prepared in March 2016, in consultation with ACT specialist alcohol and other drug (AOD) services, ACT Health, AOD research expertise and the Capital Health Network (the ACT's Primary Health Network). The needs and priorities in this paper are the AOD treatment component of the Baseline Needs Assessment submitted by the Capital Health Network to the Australian Government Department of Health on 30 March 2016 as part of the 'Primary Health Network (PHN) Grant Programme'.

The paper was prepared within the specific context of informing the Capital Health Network's Baseline Needs Assessment submission and so the scope of the paper is framed according to the guidelines and other documentation made available by the Australian Government Department of Health up to March 2016. So, for instance, the guidelines from February 2016 clearly specified that the funding of Drug and Alcohol Treatment Activity under the PHN Grant Programme is for drug and alcohol treatment services across a range of possible service types. The paper, therefore, focuses on services that can be delivered through specialist drug and alcohol treatment services, and identifies a number of key areas of need for specialist drug treatment and support that require further investment and development in the ACT. These are detailed in sections 4 and 5 of this report, and are grouped under two priority areas:

1. Community based specialist AOD treatment and support.
2. Specialist AOD treatment for Aboriginal and Torres Strait Islander people.

As the Baseline Needs Assessment was specifically to inform new investment in specialist alcohol and drug services in the ACT, this paper, *Strengthening Specialist AOD Treatment and Support: Needs and Priorities for the ACT 2016–2017*, focuses on identifying priorities that would be in scope for investment from a new funding source such as this PHN Grant Programme. As has been noted in the main body of the paper, there are other priority needs in the AOD treatment sector. However, several of these are being progressed through other projects and processes (see section 3.3).

At the beginning of May 2016, following the submission of the Baseline Needs Assessment and its approval by the Australian Government Department of Health, the Capital Health Network was notified by the Australian Government Department of Health of its funding allocation to commission specialist AOD treatment in the ACT of $903,429 per year for three years (2016 – 2019), a proportion of which is to be specifically used for specialist AOD treatment for Aboriginal and Torres Strait Islander people.

This paper has subsequently been used as the basis of discussions with ACT specialist AOD services and other key stakeholders through a number of processes. One purpose of these processes was to confirm and verify the priorities identified in the paper. This was particularly important given the very short timelines prescribed by the Australian Government Department of Health.

The following processes were undertaken:

- On 20 April 2016, ATODA and ACT Health co-hosted a workshop, facilitated by Professor Alison Ritter, Drug Policy Modelling Program, National Drug and Alcohol Research Centre. The workshop discussed the *Drug and Alcohol Service Planning (DASP) Model,* the associated *DASP Decision Support Tool* and the *Drug and Alcohol Clinical Care and Prevention (DA-CCP) adaptation for Aboriginal and Torres Strait*

Islander people. The workshop was attended by ACT specialist AOD services and funding bodies (including the ACT, Murrumbidgee and South East NSW Primary Health Networks). Not only were participants informed about the potential uses of the model and tool, but they were able to consider and discuss its implications for planning and funding for specialist AOD services in the ACT through various processes and sources including Primary Health Networks, ACT Health and the Australian Government.

- On 27 April 2016, a bus tour for funding and policy agencies (including Primary Health Networks, ACT Health, the Australian Government Department of Health, and the Australian Government Department of Prime Minister and Cabinet) was held to provide an opportunity to visit all of the existing specialist AOD services to gain insight into the quality and diversity of services and interventions available in the ACT.

- On 29 April 2016, Aboriginal and Torres Strait Islander AOD workers were invited to a meeting to discuss the findings of this paper and how these resonated with their experiences.

Discussions held through the various processes detailed above affirmed and reinforced the needs and priorities identified in this paper.

On 3 May 2016, the Capital Health Network, in collaboration with ACT Health and ATODA, hosted a workshop to discuss identified priorities that could be included in the Capital Health Network's draft Drug and Alcohol Treatment Activity Work Plan 2016–2019.

The workshop included: discussion of the priorities identified in this needs assessment document; a presentation of additional data by ACT Health; a presentation on the amount of funding available through the Capital Health Network to commission AOD treatment including the quarantined amount for Aboriginal and Torres Strait Islander AOD treatment; funding principles; what could be realistically purchased with the available funding so as to maximise return for investment; and the Capital Health Network's commitment to a select tender process.

The two priorities confirmed at the workshop were:

1. Specialist AOD counselling
2. Specialist AOD treatment for Aboriginal and Torres Strait Islander people, including identified positions.

These two priorities were subsequently detailed in the Capital Health Network's draft Drug and Alcohol Treatment Activity Work Plan 2016–2019 submitted to the Australian Department of Health on 6 May 2016. Subsequently, the Capital Health Network's Work Plan was approved and is to form the basis of the purchasing of specialist AOD treatment and support services through the Capital Health Network commencing in July 2016.

It should be noted that the needs and priorities identified through this paper have also been used to inform ACT Government specialist AOD treatment funding and policy decisions throughout this time.

Amendments to this paper post 30 March 2016

Informed by these processes, a number of minor amendments have been made to the final version of this paper to improve clarity and make minor corrections. This has included for instance:

- Reordering of some sections of the paper to improve the logical sequence of information.
- Clarifying concepts—for example, as a result of information from the DASP Model workshop.
- Updating titles and improving the consistency of terminology—for example, early documentation associated with the Primary Health Network Grant Programme referred to the 'Regional Operational Plan'. This has subsequently become known as the Drug and Alcohol Treatment Activity Work Plan; to avoid confusion, this final paper uses the current title throughout.

It should also be noted that this paper was prepared in the context of data available up to 30 March 2016, and prior to information becoming available on the parameters and quantum of funding available through the Capital Health Network to commission specialist AOD treatment and support services in the ACT from 2016–2019.

May 2016

Executive Summary

On 6 December 2015 the Australian Government announced $241.5 million over 4 years in additional drug and alcohol treatment funding to be commissioned through the Primary Health Networks commencing 1 July 2016. This includes $78.6 million specifically for services for Aboriginal and Torres Strait Islander people.[1] As part of the process of allocating this money, the Australian Department of Health required a Baseline Needs Assessment and Drug and Alcohol Treatment Activity Plan from each of the funded Primary Health Networks.

In mid March 2016, the Capital Health Network, the ACT's Primary Health Network, asked ATODA to provide expert independent advice, including writing this paper that focussed on highlighting specialist alcohol and other drug (AOD) treatment and support needs and priorities for the ACT to inform its Baseline Needs Assessment and Drug and Alcohol Treatment Activity Plan 2016–2017 to 2018–2019. As part of this process, ATODA agreed to engage with all ACT specialist AOD treatment services funded by the ACT and/or Australian Government health departments and to work with ACT Health.

AOD use and treatment in the ACT

Data from the 2015 Service Users' Satisfaction and Outcomes Survey (SUSOS) shows that between 400 and 500 people access specialist AOD treatment and support services on any single day in the ACT. Around 25% of clients attending ACT AOD treatment and support services on the single census day of the SUSOS survey identified as being of Aboriginal and/or Torres Strait Islander descent; when only considering mainstream AOD services, 19.4% of clients identified as Aboriginal and/or Torres Strait Islander.[2]

The ACT Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS-NMDS) reports that there were 4,652 closed treatment episodes provided in the ACT in 2013–14 to an estimated 3,332 clients. Twelve per cent (12%) of AOD treatment episodes reported in the NMDS were delivered to Aboriginal and Torres Strait Islander people.[3]

NMDS data further shows that alcohol (47%) was the principal drug of concern in the ACT in 2013–14, followed by cannabis (18%), amphetamines (15%) and heroin (11%). Amphetamines as the principal drug of concern increased from 6% to 15% between 2009–10 and 2013–14.[3]

In the ACT, 'information and education only' was the most common main treatment type delivered (21%). 'Counselling' as the main treatment type has declined over the past five years from 30% of episodes in 2009–10 to 19% in 2013–14.[3] The ACT (at 19% in 2013–14) has provided proportionally fewer treatment episodes of 'counselling' compared to the national average (43% in 2013–14), and the lowest proportion compared to other jurisdictions (e.g. 35% in NSW, 56% in Victoria and 62% in Tasmania).[4]

High quality delivery of specialist AOD treatment and support

High quality specialist AOD treatment and support should be delivered according to established and documented best practice in the AOD treatment field. This includes, for example: conducting comprehensive AOD assessments that channel people into the appropriate treatment modalities; and developing, in collaboration with the service user, an individual AOD treatment plan that articulates the goals and outcomes of their treatment. In addition, best practice requires consumer participation in decision-making, and intensive and

on-going engagement by AOD treatment services so that individuals remain engaged with the service system, are able to maintain their treatment goals, and reduce relapse.

Regardless of the service context, specialist AOD treatment and support for Aboriginal and Torres Strait Islander people should be based on the best practice principles outlined above, and on adapting and delivering this in culturally safe ways.

Further, sufficient resourcing should be available to deliver the components of high quality and culturally safe care with both mainstream and Aboriginal and Torres Strait Islander-specific AOD services. Existing models, such as the *Drug and Alcohol Service Planning Tool* and the *Drug and Alcohol Clinical Care Package adaptation for Aboriginal and Torres Strait Islander people* can be used as an estimate for the resources required to deliver specific types of AOD care across a typical population.

Needs in specialist AOD treatment and support in the ACT

In the ACT, there has been a significant increase in demand for specialist AOD treatment and support services over the past five years. Analysis of data and reports from workers in the field point towards the specific needs within specialist AOD services, and the components that require further investment and development. There are, of course, other multiple points of need in the ACT specialist AOD treatment and support service system. However, the priorities identified in this paper do not include, and go beyond, a number of areas of established need that are already being progressed by other projects or processes (for example, an improved response to withdrawal management is being progressed through a Withdrawal Services Review and Redesign project, and the need for AOD residential rehabilitation for Aboriginal and Torres Strait Islander people is being progressed through the development of the Ngunnawal Bush Healing Farm).

The focus of additional specialist AOD treatment and support is, therefore, on capacity that can be built across, and that can benefit, the entire AOD service system in the priority areas of:

1. Community based specialist AOD treatment and support
2. Specialist AOD treatment for Aboriginal and Torres Strait Islander people

Priority 1—Community based specialist AOD treatment and support

Community based AOD treatment and support can be delivered along multiple stages of the treatment pathway, and can be described as requiring increased investment in the following components. Where relevant, the associated National Minimum Data Set treatment types that correspond with each component are listed in parenthesis.

1. Opportunistic assertive outreach to engage ‘hard to reach’ sub-populations to prevent and reduce AOD related harm and provide supported referrals to specialist AOD treatment services (information and education; support and case management).

2. Increased capacity for specialist AOD treatment and support services to provide immediate triage and brief intervention when clients initially contact the services (information and education; support and case management; counselling).

3. Increased capacity for specialist AOD treatment and support services to provide brief interventions and/or low intensity treatment to people on waiting lists for AOD treatment (information and education; support and case management; counselling).

4. Intensive structured non-residential specialist AOD treatment and support, particularly counselling (counselling; non-residential rehabilitation).

5. AOD specialist structured aftercare (information and education; support and case management; counselling).

6. Targeted service delivery projects that reduce AOD related harms and improve the quality of care embedded in existing specialist AOD treatment and support services:

    - Structured and formalised consumer and friend/family participation strategies
    - Hepatitis C treatment provided concurrently with AOD treatment
    - Opioid overdose education programs provided concurrently with AOD treatment
    - Methamphetamine specific programs.

Priority 2—Specialist AOD treatment for Aboriginal and Torres Strait Islander people

ATODA understands that the following ACT AOD Minimum Data Set treatment types are not sufficiently purchased specifically for Aboriginal and Torres Strait Islander people:[5]

- Comprehensive specialist AOD assessment
- Specialist AOD counselling
- Non-residential rehabilitation.

Hence the full range of ACT AOD Minimum Data Set treatment types are not currently, explicitly, sufficiently and specifically purchased for Aboriginal and Torres Strait Islander people. This means that the majority of ACT AOD Minimum Data Set treatment types specifically purchased for Aboriginal and Torres Strait Islander people are non-clinical. This creates a major inequity in the provision of high quality clinical AOD treatment for Aboriginal and Torres Strait Islander people in the ACT.

Furthermore, the quality of AOD drug treatment and support will be enhanced by the provision of external clinical and non-clinical specialist AOD supervision to the existing and future workforce providing services for Aboriginal and Torres Strait Islander people. Depending on the site of service delivery, this workforce may also require cultural supervision to enhance the delivery of culturally safe care.

Ensuring the cultural safety of *all* specialist AOD treatment settings in the ACT is a prioritised strategy. This strategy is about building workforce capacity to work with Aboriginal and Torres Strait Islander clients in mainstream settings via a range of measures. Only two mainstream agencies have identified Aboriginal and Torres Strait Islander (non-clinical) positions, but the remaining mainstream specialist AOD services do not have specifically identified positions, and do not currently receive Aboriginal and Torres Strait Islander specific AOD treatment funding.

The needs and priorities for culturally safe specialist AOD treatment types specifically for Aboriginal and Torres Strait Islander people in the ACT are:

1. Explicit and specific purchase and increased provision of:
    - Specialist AOD assessment
    - Specialist AOD counselling
    - Specialist AOD non-residential rehabilitation.

2. Aboriginal and Torres Strait Islander people seeking treatment from specialist AOD mainstream settings receive culturally safe care and support.

3. Targeted quality improvement—purchase of external AOD specific supervision for AOD workers providing treatment and support for Aboriginal and Torres Strait Islander people.

ACT Specialist AOD treatment funding principles

The report concludes with a final section that outlines the basic funding principles that should underlie the commissioning and funding of specialist AOD treatment and support services in the ACT. This includes:

- Commissioning should be based on the *Drug and Alcohol Service Planning (DASP) Model*, and the *Drug and Alcohol Clinical Care and Prevention (DA-CCP) adaptation for Aboriginal and Torres Strait Islander people.*
- The Primary Health Network commissioning process should be developed in partnership with AOD experts.
- The scope of the funding should focus on the provision of specialist AOD treatment and support, and build upon and leverage off the existing specialist AOD treatment and support services in the ACT.
- The Capital Health Network global commissioning framework must be complemented by AOD specific guidelines and criteria. This includes, for example:
    - Recognising that outcomes-commissioning is not effective for specialist AOD services
    - Utilising existing AOD sector guidelines for the commissioning of specialist AOD treatment for Aboriginal and Torres Strait Islander people
    - Moving towards a 3+1+1 (5) year model of funding contracts
    - Purchasing by and reporting to the ACT AOD Minimum Data Set (that feed into the National Minimum Data Set)
    - Providing funding investment that genuinely enables additional AOD treatment capacity
    - Including investment in AOD specific external specialist supervision for any positions that are funded
    - Funding independent external evaluations
    - Ensuring that funding does not replace costs that are normally the responsibility of the ACT or Commonwealth governments
    - Providing a standard 6–week period for response to the call for tender
    - Requiring clear articulation of the program logic in the tender process.

- The absence of particular services within the ACT boundaries should not be interpreted as ‘market failure’ and actions to address this absence should be negotiated with the ACT AOD sector; there is no treatment type that could not be delivered in the ACT by the existing AOD services.

Part A

Section 1: Introduction, Approach and Consultation

In March 2016, the ACT Primary Health Network (the Capital Health Network) commissioned the Alcohol Tobacco and Other Drug Association ACT (ATODA) to provide expert independent advice including writing this paper to inform the alcohol and other drug (AOD) treatment component of the Baseline Needs Assessment and the Drug and Alcohol Treatment Activity Work Plan[a] 2016–2017 to 2018–2019 to be submitted to the Australian Department of Health.

Part A (Sections 1 and 2) provides an introduction and background to people who access specialist AOD treatment and support services and the issues facing the services they access in the ACT. Section 1 details the scope and purpose of this document and the methods used to describe and identify the priority needs. Section 2 presents background information on the use of AOD in the ACT, and on the make up and utilisation of the specialist AOD treatment and support sector. The paper focuses on specialist AOD treatment and support services that support people with high levels of dependence and severity of substance use problems. Throughout Part A, data and information is presented for the treatment population and sector as a whole, but also specifically for Aboriginal and Torres Strait Islander people as an AOD treatment sub-population that requires specific services and investment.

These background sections contextualise the needs that have been identified and prioritised in Part B (Sections 3, 4 and 5). Section 3 identifies key components of specialist AOD treatment and support, and describes the treatment types where capacity needs to be built to better meet the needs of clients of these services. Sections 4 and 5 describe the components of community-based AOD treatment and support that require increased investment to enable the sector to provide optimal care and AOD treatment outcomes. Section 4 refers to the specialist AOD treatment and support sector generally, while Section 5 makes some additional, specific recommendations about investment for Aboriginal and Torres Strait Islander people.

Finally, Part C outlines some of the key funding principles and considerations that should be applied to the commissioning of specialist AOD treatment and support. This applies both in a general sense, but also to the new funding allocation by the Australian Government through the Primary Health Networks.

1.1 New additional Australian Government funding for Alcohol and Other Drug Treatment

On 6 December 2015 the Australian Government announced $241.5 million over 4 years in additional drug and alcohol treatment funding to be commissioned through the Primary Health Networks. The additional funding available to the Primary Health Networks from 1 July 2016 includes $78.6 million for specialist AOD services for Aboriginal and Torres Strait Islander people.[1]

The Australian (and ACT) AOD sector has welcomed this injection of funding. As demonstrated throughout this paper, people in the ACT region currently need increased options for access to specialist AOD services that provide treatment and support of sufficient duration and intensity.

[a] Early documentation associated with the Primary Health Network Grant Programme referred to the Drug and Alcohol Treatment Activity Work Plan as the Regional Operational Plan. This paper uses the current title.

This paper was developed when the detailed guidelines and the quantum of funds to be allocated to the ACT and region were unknown, including the quarantined funds for the provision of additional specialist AOD treatment and support for Aboriginal and Torres Strait Islander people. Guidance materials provided to all Primary Health Networks by the Department of Health in early March 2016 made it clear that the funding was for the commissioning of drug and alcohol treatment.[b]

1.2 Capital Health Network's Baseline Needs Assessment 2016–2017 and Drug and Alcohol Treatment Activity Plan 2016–2017 to 2018–2019

Primary Health Networks were required to submit a Baseline Needs Assessment, including an explicit and separate AOD treatment component, to the Australian Government Department of Health by 30 March 2016 and a Drug and Alcohol Treatment Activity Plan by 6 May 2016.

In February 2016, the Capital Health Network, ATODA and ACT Health agreed to work in collaboration to support the needs assessment, planning, commissioning, implementation and evaluation of the new AOD treatment investment in the ACT. The three parties agreed to a set of shared principles, including acknowledging and recognising:

- The importance of consultation and engagement with ACT specialist drug treatment and support services to shape AOD treatment investment.
- The existing and significant expertise, skills, workforce, capacity, infrastructure, evidence-base and data systems in the ACT (and Australian) AOD sector.
- That specialist drug services and primary care services are both important to preventing and reducing alcohol, tobacco and other drug related harms.
- The importance of building on the existing expertise and investment in ACT specialist drug treatment services.

In March 2016, the Capital Health Network asked ATODA to provide expert advice, including consulting with key stakeholders to develop an independent paper (this document) focussed on highlighting specialist AOD treatment and support needs and priorities for the ACT for its Baseline Needs Assessment, Drug and Alcohol Treatment Activity Work Plan and other subsequent commissioning activities. As part of this process, ATODA agreed to engage with all ACT specialist AOD treatment services funded by the ACT and/or Australian Government health departments and to work with ACT Health (particularly in its role as majority funder, in ACT AOD Policy and as custodian of the ACT AOD Minimum Data Set).

In acknowledgement of ATODA's expertise and leadership in the AOD sector, the Capital Health Network engaged ATODA in consultancy and commissioned this paper. ATODA is pleased to have been able to make a co-contribution to the costs of this paper and associated processes.

1.3 Purpose, scope and appropriate use of this document

A primary purpose of this paper has been to inform the Capital Health Network's Baseline Needs Assessment and Drug and Alcohol Treatment Activity Plan to:

- Obtain a comprehensive understanding of the needs of the ACT AOD specialist treatment population.
- Understand the current AOD specialist treatment and support services available in the ACT.

[b] Subsequent to the use of this paper to inform the Baseline Needs Assessment submitted by the Capital Health Network to the Australian Government Department of Health, further details about the grant were released (see Addendum).

- Analyse the needs and current service provision of existing specialist AOD treatment and support in the ACT.
- Set priorities in the context of limited resources for specialist AOD treatment and support services in the ACT.

The purpose of this paper is not primarily to identify service gaps, rather the focus is to enhance the effectiveness of the current investment in specialist AOD treatment and support in the ACT.

The appropriate use of this paper is:

- Use by the Capital Health Network for its Baseline Needs Assessment, including reporting to the Department of Health on 30 March 2016.
- Use by the Capital Health Network to develop, in ongoing consultation with stakeholders (see Appendix A), its Drug and Alcohol Treatment Activity Work Plan.
- To feedback to participating stakeholders on their input.
- To support a shared understanding of ACT AOD sector need and priorities at a set point in time for the primary purpose of informing the allocation of new and additional AOD treatment and support funding in 2016–2017 through the Capital Health Network and also to inform ACT Health's commissioning.
- To inform the development of the ACT AOD Treatment Services Plan in 2016–2017.
- To act as a basis for future needs assessment and priority setting work to inform the Capital Health Network tender process.

This paper does not detail the specific current investment in specialist AOD treatment and support in the ACT by either the Australian or the ACT Governments—this includes the Non-Government Organisation Treatment Grants Program, the Substance Misuse Service Delivery Grants Fund and the Indigenous Advancement Strategy.

This paper is an ATODA publication and may be updated and adapted in the future to support service planning in the ACT.

The final version of this paper is available freely on the ATODA, Capital Health Network and other websites.

Decisions made with regard to how the information in this paper is used—and any subsequent ACT AOD treatment funding processes—are the responsibility of the commissioners, not ATODA.

1.4 Framework used to develop this paper

This paper is based on the premise that the current infrastructure, investment and policy environment is in place within and for specialist AOD service provision in the ACT. If that were to change then these priorities would change. While this seems obvious, it is particularly pertinent for the ACT AOD sector, which is under considerable and ongoing uncertainty with regard to current and future funding arrangements. For example:

- ACT Health (the majority funder) is currently re-negotiating 3–year contracts.
- The Australian Government Department of Health has undertaken another 12–month contract extension for services currently funded under the Non-Government Organisation Treatment Grants Program and Substance Misuse Service Delivery Grants Fund.

Further, to-date specialist AOD services in the ACT have not been purchased using the *Drug and Alcohol Service Planning Model* (DASP Model) and *DASP Decision Support Tool*; these estimate the

resources required to deliver specific types of AOD treatment (see Section 3.1.1). This means that it is likely that the funding provided for the delivery of particular services may be less than the services actually cost. For further discussion of funding principles and issues see Section 6.

This paper utilises the Bradshaw approach to conceptualising need.[6] These are not types of need, rather they are different ways to describe, understand and find out what the needs are.

These areas of need and the data used to inform this needs assessment and priorities are:

- Normative needs are identified by experts in the field, in this case, workers, managers and peers in specialist AOD services in the ACT, ACT Health, ATODA and researchers. Using their broad knowledge—including knowledge of drug-related harms, treatment types, service utilisation, and resource allocation— the needs of people using AOD and the gaps in the ACT sector can be identified. This has then been reinforced by the strong evidence-base of the field.

- Felt needs are those of the public. These can be assessed through surveys but this has generally been found to be an unsatisfactory way of developing information about AOD treatment service needs, as well as being a very expensive undertaking. In the case of AOD, the major public survey is the National Drug Strategy Household Survey, which is referenced particularly with regard to the prevalence of AOD use.

- Expressed needs are those of the public revealed through patterns of service utilisation. These are sometimes referred to as felt needs converted into action, namely seeking services from service providers. In the case of specialist AOD treatment in the ACT, the National and ACT AOD Minimum Data Sets, the Service User Satisfaction and Outcomes Survey and targeted discussions with consumers have been used.

- Comparative needs become apparent in situations where different communities or population groups have similar characteristics, but one group receives a given level of services and the other does not. This draws attention to the misallocation of resources and distributional equity issues. In the case of specialist AOD treatment and support in the ACT, this is particularly the case for Aboriginal and Torres Strait Islander people.

1.5 Policy context

This paper is based within and informed by a comprehensive and well-established ACT and national alcohol, tobacco and other drug policy environment. The two primary policy documents are the *ACT Alcohol Tobacco and Other Drug Strategy*[7] and the *National Drug Strategy*,[8] both of which describe and define the broader policy context in which this paper is written.

1.6 Methodology

The methodology was constrained by the short time frame provided to undertake this important and high stakes piece of work for people with AOD problems and their families in the ACT region. This paper was first developed in order to meet the 30 March 2016 deadline given by the Australian Government Department of Health.

Fortunately the ACT has a well-established, known and sophisticated alcohol, tobacco and other drug sector. The field has a strong evidence base, and significant and ongoing work is routinely undertaken to understand and progress needs, priorities and opportunities for ongoing improvement.

The process for developing this document has been as follows:

- ATODA reviewed existing ACT AOD policy and priority documents (e.g. the *ACT Alcohol Tobacco and Other Drug Strategy*;[7] the report *Need to Expand AOD Rehabilitation Services in the ACT*;[9] multiple submissions to ACT Government such as budget submissions, etc.) which have been based on existing AOD specific expertise, knowledge and processes undertaken in the ACT over the past 5 years and into which various stakeholders have had an input.
- ATODA circulated a draft to all ACT Health and Australian Government Department of Health funded specialist AOD services, ACT Health and external expert AOD research stakeholders.
- ATODA convened a face-to-face meeting with ACT Health and Australian Government Department of Health funded specialist AOD services to obtain their input into the draft.
- ATODA met with ACT Health and made multiple data and other information requests.
- ATODA met with the ACT's drug user organisation.
- ATODA met individually with Aboriginal and Torres Strait Islander community controlled services funded by ACT Health to deliver specialist AOD services.
- ATODA met with the Capital Health Network multiple times.

Information from this process was used to identify and articulate the two priority areas and the strategies by which they could be progressed. This paper was provided to the Capital Health Network to for its Baseline Needs Assessment, submitted to the Australian Government Department of Health on 30 March 2016.

Section 2: Background and context of AOD use and treatment in the ACT

This section describes the context of AOD use in the ACT, in particular focusing on the population of people who are high-risk and/or dependent users of AOD who make up the potential treatment population for AOD specialist services. This section includes an overview of current specialist AOD treatment and support services in the ACT, and so provides the context for the discussion in following sections on the identified priorities within this sector.

Where available, data is separately reported for Aboriginal and Torres Strait Islander people accessing AOD specialist treatment and support services because of the identified and specific needs within this community. Aboriginal and Torres Strait Islander people have different patterns of AOD use than the general population—for instance, higher rates of smoking and lower rates of drinking overall. The evidence indicates that Aboriginal and Torres Strait Islander communities are disproportionately affected by AOD-related harm, and consequently particular consideration is needed to provide targeted specialist AOD treatment and support services tailored specifically for this population.

2.1 Data sources

In this section, two main ACT-specific data sources provide information on the sub-population of people who access specialist AOD treatment and support services in the ACT.

2.1.1 The ACT Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS-NMDS)

Almost all ACT specialist AOD treatment and support services currently report to the ACT Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS-NMDS). Other than episodes of care, this data set provides information on other aspects of specialist AOD treatment and support provision, including treatment types accessed and drugs of concern.

The AODTS-NMDS is an important data source for the sector, but should be used and interpreted in the context of other sources of data to build a picture of AOD treatment services usage. The following limitations of the AODTS-NMDS data set for the ACT should be noted:

- A small number of services either do not report to the AODTS-NMDS, or their data is not included in the ACT AODTS-NMDS collection submitted to the Australian Institute of Health and Welfare: [c]
    - One Aboriginal and Torres Strait Islander community-controlled service that receives specialist AOD funding does not contribute to the ACT AODTS-NMDS.
    - Episode data is not included in the ACT AODTS-NMDS reporting to Australian Institute of Health and Welfare for:
        - Gugan Gulwan Youth Aboriginal Corporation
        - Sobering Up Shelter, CatholicCare
        - SOLARIS Rehabilitation Program (based at the adult prison, the Alexander Maconochie Centre).

[c] Personal correspondence, AOD Policy Unit, ACT Health – 10 March 2016.

- Reporting to the ACT AODTS-NMDS only occurs for closed cases, and therefore does not represent the current treatment load and true demand on specialist AOD treatment and support services. In addition, it does not reflect the complexity experienced by people who present to services.

- Workers at AOD treatment and support services have noted limitations with coding in the reporting, particularly with the treatment types delivered. A number of issues have been noted, including differing interpretations of treatment types and treatment closure, and the complexity of coding where several treatment types are provided. The ACT AOD sector acknowledges that there are opportunities for improving this coding and is currently involved in a Data Outcomes Project that seeks to identify and progress these inconsistencies.

- There is a time-lag between services reporting to the ACT AODTS-NMDS and its analysis and publication as information that can be utilised to inform service delivery (e.g. 12–18 months). This points to the importance of other modes of information collection that involve maintaining strong relationships with services and engaging with consumers and families. Both have on-the-ground and real-time information about drug use– and service-utilisation–trends that can inform more responsive service-delivery.

- Aboriginal and Torres Strait Islander data is under-reported and this is likely to be due to services whose episode data is not included in the reporting to ACT Health or in the ACT AODTS-NMDS collection submitted by ACT Health to the Australian Institute of Health and Welfare (see above). In addition, Aboriginal and Torres Strait Islander status was 'not stated/inadequately described' for 6.5% of the total treatment episodes reported through this data set.[d]

It should be noted here that the collection of every person's Aboriginal and Torres Strait Islander status in ACT specialist AOD treatment and support services is essential. This data: supports appropriate planning and commissioning of services; measures the impact of services; monitors trends and changes; and supports access and referral to Aboriginal and Torres Strait Islander specific services.[10]

2.1.2 The Service Users' Satisfaction and Outcomes Survey

The Service Users' Satisfaction and Outcomes Survey (SUSOS) provides a snapshot profile of people who access all specialist AOD treatment and support services funded by ACT Health and/or the Australian Government Department of Health in the ACT on a single day (both Aboriginal and Torres Strait Islander-specific and mainstream services). The most recent survey was conducted in December 2015, and involved 469 people accessing ten specialist AOD services in the ACT. The survey is administered regularly by ATODA in collaboration with participating services.[2]

2.2 AOD use in the ACT

According to the latest National Drug Strategy Household Survey (NDSHS), the use of AOD in the ACT is consistent with patterns of use in Australia generally (Table 1). Table 2 presents data for AOD use among Aboriginal and Torres Strait Islander people in Australia. Because of the relatively small size of the Aboriginal and Torres Strait Islander population in the ACT, AOD use data reported in national surveys has a high margin of error. However, the proportions in the ACT are likely to be similar to the national data presented below.

[d] Personal correspondence, AOD Policy Unit, ACT Health – 10 March 2016.

Within the population, use of AOD occurs across a spectrum of levels of use and degrees of associated health and social harms. Some people represented in the data in Tables 1 and 2 are one-off, occasional and/or episodic users of AOD, while others are regular and dependent users of AOD. Only a small proportion of people who use AOD are impacted by significant levels of AOD-related harms, with some being impacted by multiple and complex health and social harms. Importantly, the data presented in Tables 1 and 2 does not specify the level of AOD use or the degree or severity of dependence, and thus does not reflect the degree of harm or service-need for individuals using AOD.

Table 1: Summary of recent drug use[a], people aged 14 years or older, ACT and Australia, 2013 (%)
Source: AIHW 2014[11]

Drug	ACT	Australia
Current smoker	12.2	15.8
Recent drinker	82.6	78.2
Illicit (excluding pharmaceuticals)		
Cannabis	10.1	10.2
Ecstasy	2.9	2.5
Meth/amphetamine[b]	2.2	2.1
Cocaine	2.8	2.1
Hallucinogens	*1.7	1.3
Inhalants	*1.1	0.8
Heroin	**0.3	0.1
Ketamine	**0.2	0.3
GHB	— —	*<0.1
Synthetic Cannabinoids	*0.8	1.2
New and Emerging Psychoactive Substances	**0.5	0.4
Injected drugs	**0.2	0.3
Any illicit[c] excluding pharmaceuticals	12.4	12.0
Pharmaceuticals		
Pain-killers/analgesics[b]	2.8	3.3
Tranquillisers/sleeping pills[b]	1.6	1.6
Steroids[b]	— —	*0.1
Methadone[d] or Buprenorphine	— —	0.2
Other opiates/opioids[b]	**0.4	0.4
Misuse of any pharmaceutical[b]	4.2	4.7
Illicit use of any drug[e]	15.3	15.0
None of the above	15.3	18.5

* Estimate has a relative standard error of 25% to 50% and should be used with caution.
** Estimate has a relative standard error greater than 50% and is considered too unreliable for general use.
(a) Used in the previous 12 months. For tobacco and alcohol, recent/current use means daily, weekly and less than weekly smokers and drinkers; (b) For non-medical purposes; (c) Illicit use of at least 1 of 12 drugs (excluding pharmaceuticals) in the previous 12 months in 2013; (d) Non-maintenance; (e) Used at least 1 of 17 illicit drugs in the previous 12 months in 2013.

Table 2: Summary of recent drug use, Australian Aboriginal and Torres Strait Islander people aged 15 years or older, Australia, 2013 (%)
Source: ABS 2013[12]

Drug	Australia[(a)]
Current smoker[(b)]	41.6
Recent drinker[(c)]	44.3
Illicit (excluding pharmaceuticals)	
Marijuana, hashish or cannabis resin	18.7
Amphetamines or speed	2.3
Kava	1.3
Other[(d)]	2.8
Pharmaceuticals	
Analgesics and sedatives for non-medical use	3.9

(a) Presented as a proportion of survey respondents; (b) Current use means daily, weekly and less than weekly smokers and drinkers; (c) Consumed alcohol in the last week; (d) Includes heroin, cocaine, petrol, LSD/synthetic hallucinogens, naturally occurring hallucinogens, ecstasy/designer drugs, methadone and other inhalants

2.3 Ways of describing and determining who needs AOD treatment

Only a relatively small proportion of people represented in Tables 1 and 2 could be described as having an AOD 'problem'. In the ACT, 'problematic' use of AOD can be described in multiple ways, including according to risk, having severe AOD problems, and/or experiencing a substance use disorder, using a number of tools and documents. For example:

- Screening for risk—the ACT eASSIST (electronic Alcohol, Smoking & Substance Involvement Screening Test) provides a questionnaire that screens for all levels of problem or risky substance use. People are classified as at 'low-', moderate-' or 'high-' risk of health and other problems from their current pattern of use. Someone at 'high' risk is experiencing health and other problems with increasing severity and is likely to be dependent on the substance(s) and warrant a referral to a specialist AOD treatment and support service.[13]

- 'Severe AOD problems' describes how ACT Health purchases specialist AOD treatment and support.[5]

- 'Substance use disorder'—people experiencing AOD problems can also be described by whether or not they have a 'diagnosable illness' for a 'substance use disorder' according to the DSM-5 (Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition) criteria. A clinical assessment of a 'substance use disorder' is based on criteria such as: the development of physical tolerance; dependence and withdrawal symptoms; control over use; negative impact of use on relationships and social functioning; and experience of craving. The DSM-5 measures the 'disorder' on a continuum from mild to severe to inform the AOD treatment and support required.[14]

People who would likely benefit from specialist AOD treatment and support are the subject of this paper and are, therefore, the population group for whom the interventions described in this paper are relevant. These people would likely screen as 'high-risk', many are likely to be 'dependent', and they could be described as having a substance use disorder.

However, many people who need and are suitable for treatment may not formally meet diagnostic criteria per se, and many people who do meet diagnostic criteria do not need specialist AOD

treatment and support. The determination of who needs AOD treatment is based largely on a comprehensive AOD assessment that is considered an essential element of treatment. Such an assessment:

> Involves detailed questioning and is a specialist function conducted to identify the type and severity of a specific problem in order to gather the detailed information needed to develop a comprehensive treatment plan that meets the individual needs of each service user. Assessment is arguably the single most important element of AOD treatment as it provides information for effective case formulation and treatment planning, case management and treatment monitoring, and can be an effective brief intervention in its own right.[e]

2.4 Prevalence of high-risk and dependent AOD use

Australia-wide there has been a long-term trend toward lower prevalence of illicit drug use. Although per-capita alcohol consumption is decreasing, the incidence of alcohol-related harms is increasing.[15] In contrast to most of the other illicit drugs, the prevalence of methamphetamine use is increasing, as are the proportions of people who use methamphetamine who are dependent, and the levels of methamphetamine-related harms generally.[16,17]

While there has been a trend towards lower prevalence of illicit drug use in the population generally, there has been an increase in the prevalence of people who are *dependent* on illicit drugs. This prevalence has been estimated specifically in relation to methamphetamine use in Australia between 2010 and 2013 (see Figure 1). This shows that 19% of people using methamphetamine in 2010 were classified as 'dependent users', and that this increased to 41% in 2013. Figure 1 shows that, nationally, the proportions of dependent users of methamphetamines has more than doubled.[18] There has consequently also been a corresponding increase in the potential demand for specialist AOD treatment and support services associated just with methamphetamine use (i.e. this demand has more than doubled in the three-year period, 2010–2013). This trend toward increased demand for specialist AOD treatment and support services associated with amphetamine use is consistent with observations in the ACT (see Section 2.8).

Projected models have identified an additional 200,000 to 500,000 people Australia-wide who need and would seek AOD treatment (over and above the 200,000 already in treatment) per year.[19] While this data is not specifically available for the ACT, the consistency in overall AOD use between the ACT and Australia-wide would suggest a similar increase in dependent users of AOD in the ACT and corresponding increases in demand for specialist AOD treatment and support services.

[e] This definition of 'assessment' comes from a forthcoming paper that describes and examines the treatment and support approaches in the specialist AOD sector; it is being prepared by 360Edge and the Alcohol Tobacco and Other Drug Association (ATODA). Once published, this paper will be available on the ATODA website: www.atoda.org.au

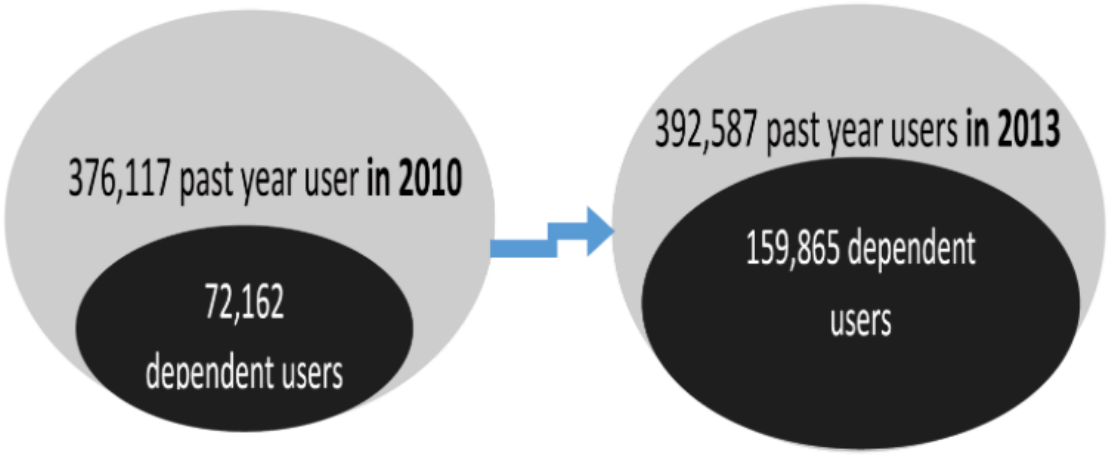

Figure 1: Changes in the proportions of people who are dependent on methamphetamine over 3 years

Sources: Graphic from Dietze 2016;[18] data of 'past year users' figures derived from the NDSHS and ABS population estimates for the most recent year; 'dependent users' estimates based on Degenhardt et al 2016.[16]

2.5 Profile of people accessing ACT specialist AOD services

In December 2015, a total of 469 people completed the most recent Service Users' Satisfaction and Outcomes Survey (SUSOS), and provided a snapshot profile of people who accessed all ten specialist AOD treatment and support services in the ACT on a single day (both Aboriginal and Torres Strait Islander-specific and mainstream services). This profile is shown in Table 3.

Notable in this data is that:

- Two-thirds of the treatment population are male (65.8%).
- Most (73.9%) are in the 20–49 year old age bracket.
- Most (73.5%) are unemployed.
- About 46% of respondents are either homeless or at risk of homelessness, including 18.6% who have no fixed place to live.
- 38% have children.[f]

This data is consistent with that reported in the 2013–14 ACT Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS-NMDS), which reports males as making up 67% of clients who were receiving treatment for their own drug use in specialist AOD treatment and support services in the ACT.[3]

[f] Including respondents who were parents in both categories, i.e. parents who had 'children living with them' and 'children not living with them'.

Table 3: Profile of people accessing specialist AOD treatment and support services in the ACT on a single day (December 2015)
Source: ATODA 2016[2]

Item	Proportion of respondents*
Gender	
Male	65.8
Female	34.0
Age groups	
Under 20 years old	10.1
20–49 years old	73.9
Over 50 years old	15.9
Aboriginal and/or Torres Strait Islander descent	
Accessing all specialist AOD services	25.1
Accessing mainstream AOD services	19.4
Current employment status	
Employed full-time	11.9
Employed part-time	8.7
Unemployed	73.5
Volunteer or unpaid work	5.8
Currently studying	
Yes, full time	5.0
Yes, part time	11.2
No	83.8
Current housing situation	
Settled/permanent accommodation	54.4
Residential treatment program	15.9
Other temporary accommodation	11.1
No fixed place of living	18.6
Parent	
Children living with them	17.1
Children not living with them	27.4

* Proportions of respondents who answered each question (i.e. missing responses are excluded)

2.5.1 Profile of Aboriginal and Torres Strait Islander people accessing ACT specialist AOD services

Aboriginal and Torres Strait Islander people are a sub-set of the SUSOS data reported in Table 3, and so several aspects of the demographic profile are likely to be similar for this sub-population.[g]

According to the ACT AODTS-NMDS in 2013–2014, 12% of AOD treatment episodes in the ACT were delivered to Aboriginal and Torres Strait Islander people.[h] A comparison of data from the AODTS-NMDS and the SUSOS, clearly shows the likely level of under-reporting of Aboriginal and Torres Strait Islander status in the AODTS-NMDS. As shown in Table 3, the SUSOS (2015) found that 25% of clients of all ACT AOD treatment and support services reported being of Aboriginal and/or Torres Strait Islander descent. When only considering mainstream AOD treatment and support services, 19.4% of clients reported being of Aboriginal and Torres Strait Islander descent. The limitations of the AODTS-NMDS are discussed in Section 2.1.1.

[g] An example of where the demographic profiles may be dissimilar is for 'age'. As the age profile of the Aboriginal and Torres Strait Islander population is younger than the general Australian population, the profile of Aboriginal and Torres Strait Islander people utilising specialist AOD treatment and support services is also likely to be younger.
[h] Personal correspondence, AOD Policy Unit, ACT Health—18 March 2016.

2.6 Complex needs of people accessing ACT specialist AOD treatment and support services

Within the ACT and Australian AOD sector, the needs of existing clients are a necessary focus due to the significant and multiple burdens of harm experienced. These may include:

- Overdose
- Various physical health problems, including blood borne virus infection (especially hepatitis C)
- Accidents and injury
- Mental health problems, particularly anxiety and depression
- Family relationship difficulties, including with children
- Financial problems
- Cognitive impairment
- Homelessness
- Un- or under-employment
- Involvement in the criminal justice system
- Contact with the child protection system
- Being a victim and/or perpetrator of crime.

People accessing specialist AOD services generally have multiple and complex needs over and above their AOD use. The profile in Table 3, for example, shows that issues such as unemployment, homelessness, and parental relationships are applicable for many clients of AOD services, and add complexity to the support that clients require. Some of these needs can be directly dealt with in the context of the specialist AOD treatment services, but many require referral to, or support from, social/welfare services or other types of services (e.g. dental services, legal services).

The burdens of harm and needs of people accessing specialist AOD treatment and support services can change significantly with changes in drug use trends. So for example, harms from overdose and blood borne virus infection may be of greater concern when opioids are the drugs of choice, while cognitive impairment may be of greater concern when methamphetamines are more frequently used. When resourced appropriately, specialist AOD treatment and support services have shown they have the capacity to adapt existing treatment approaches and respond to these changing trends in drug use and drug-related harms.[20]

It should be noted that while these AOD-related harms affect all people accessing specialist AOD services, it is well recognised that Aboriginal and Torres Strait Islander people experience a disproportionate burden of multiple and complex AOD-related harms. This has implications for resourcing directed towards Aboriginal and Torres Strait Islander people currently using and who may want to use specialist AOD treatment and support services (see Section 5).[21]

While there are complex and competing burdens of harm experienced by people accessing specialist AOD treatment and support services, there are a number of clear priority needs that affect people across the entire sector, regardless of the treatment type that they are accessing. These priority needs are:

- Hepatitis C in particular, but also other blood borne viruses
- Opioid-related overdose
- Specific harms related to methamphetamine use.

These needs, including the rationale behind the necessity to address these, are described further in Section 4.6.

2.7 Specialist AOD services in the ACT

In the ACT there are 10 publicly–funded (ACT Health and/or Australian Government Department of Health) specialist AOD services that deliver more than 30 programs, these are:

- Alcohol and Drug Services, ACT Health
- Canberra Alliance for Harm Minimisation and Advocacy
- Canberra Recovery Services (The Salvation Army)
- Directions
- Gugan Gulwan Youth Aboriginal Corporation
- Karralika Programs
- Sobering Up Shelter, CatholicCare
- Ted Noffs Foundation
- Toora Women
- Winnunga Nimmityjah Aboriginal Health Service.

These services collaborate to generate a six monthly profile and service map that is publicly available at www.directory.atoda.org.au. A summary of these services, their programs and the treatment types provided are shown in Appendix B.

2.7.1 Specialist AOD services in the ACT for Aboriginal and Torres Strait Islander people

In the ACT, Aboriginal and Torres Strait Islander people who use AOD can access specialist AOD treatment and support through Aboriginal and Torres Strait Islander-specific (including community-controlled) organisations and programs, as well as through mainstream services.

In the ACT there are four non-government services or programs that deliver (or are soon to deliver) specialist AOD treatment and support types specifically for Aboriginal and Torres Strait Islander people. Other than the Ngunnawal Bush Healing Farm that is currently in development, this list of Aboriginal and Torres Strait Islander services has been compiled from information in the ACT ATOD Services Directory; further information about each of these services is available at www.directory.atoda.org.au. The associated National Minimum Data Set treatment types that correspond with each component are listed in parenthesis.

1. Aboriginal Community Controlled Health Organisation (ACCHO) or Aboriginal Medical Service (AMS) that provides primary health care but also provides some specialist AOD services for Aboriginal and Torres Strait Islander people (Winnunga Nimmityjah Aboriginal Health Service) (pharmacotherapy, information and education, support and case management).

2. Youth Aboriginal Community Controlled organisation but also provides some specialist non-clinical AOD services for Aboriginal and Torres Strait Islander people (Gugan Gulwan Youth Aboriginal Corporation) (information and education, support and case management).

3. Aboriginal Community Controlled Health Organisation (ACCHO) lead agency in partnership with a mainstream specialist AOD treatment service (model of care, including the possible partnership approach, under development—Ngunnawal Bush Healing Farm)[i] (residential rehabilitation).

[i] At the time of publication of this paper, this is the proposed model from ACT Health for the Ngunnawal Bush Healing Farm.

4. Mainstream specialist non-government drug service that is controlled by consumers—people who use/have used drugs—and provides non-clinical services (The Connection) (information and education, support and case management).

Furthermore, the ACT Government specialist AOD treatment service (Alcohol and Drug Services, ACT Health) employs an Aboriginal Liaison Officer who provides non-clinical support to Aboriginal and Torres Strait Islander clients, including assisting with case management, support, referral, advocacy, and negotiating and developing appropriate and achievable AOD treatment plans.[22]

2.7.2 AOD specialist workforce

The specialist AOD workforce in the ACT is mapped and profiled through the *ACT Alcohol, Tobacco and Other Drug Workforce Qualification and Remuneration Profile*. This profile is undertaken regularly and is used to monitor trends in the ACT AOD workforce. The most recent profile (2014) has estimated an ACT specialist alcohol, tobacco and other drug workforce of 245 workers. Aboriginal and Torres Strait Islander people make up approximately 5% of this workforce, with most of these workers based at Aboriginal and Torres Strait Islander community controlled services (points 1 and 2 in Section 2.7.1, above), and employed in non-clinical positions.[23]

Two mainstream agencies have identified Aboriginal and Torres Strait Islander (non-clinical) positions,[j] but the remaining mainstream specialist AOD services do not have specifically identified positions, and do not currently receive Aboriginal and Torres Strait Islander specific AOD treatment funding. However, they do deliver AOD treatment types for Aboriginal and Torres Strait Islander people who access their services.

2.7.3 ACT AOD treatment types

In the ACT, the agreed AOD Minimum Data Set treatment types used and reported against by ACT Health and Australian Government Department of Health funded specialist AOD agencies are:

- Information and education
- Assessment only
- Withdrawal management
- Rehabilitation
- Counselling
- Pharmacotherapy
- Support and case management.

All of these treatment types are available in the ACT. However, the extent to which they are available, and the sub-populations to which they are available varies. ACT Health purchases specialist AOD services according to these treatment types. As this is the standard used by the ACT sector, these descriptions are used throughout this paper. The ACT-specific AOD Minimum Data Set dictionary describes and explains these treatment types and this is replicated in Appendix C. It should be noted that some specialist AOD treatment services deliver programs that are beyond the treatment types articulated in the Minimum Data Set (e.g. Sobering Up Shelter, see Section 2.1.1).

[j] The Connection, and Alcohol and Drug Services, ACT Health

Counselling in specialist AOD treatment and support services

One of these treatment types—counselling—deserves particular description because it is central to clinical service delivery in specialist AOD treatment and support, and can be poorly defined and understood. 'Counselling' in this context has a very particular definition that is articulated in the service contracts between ACT Health and specialist AOD services.[k] The definition prescribes that an AOD counselling service includes access to tertiary qualified counsellors (e.g. registered Clinical Psychologists and/or Social Workers) who are able to offer cognitive behaviour therapy and family therapy (where relevant), and access to AOD workers who are able to:

- Provide comprehensive ATOD assessments, basic mental health screening and brief interventions and suicide risk assessments.
- Manage intoxicated clients.
- Use motivational interviewing as the primary counselling approach.
- Use relapse prevention on an individual or group basis and the primary ATOD intervention.
- Understand the ATOD sector including treatment pathways and make referrals to specialist mental health and other services.

An additional complexity is that 'counselling' when it is coded by specialist AOD treatment and support services for the NMDS refers to counselling that is provided in the *non-residential* service context. Counselling that is offered as part of residential rehabilitation is included in the NMDS coding of 'rehabilitation'.

2.8 Service usage

Using data from the Service Users' Satisfaction and Outcomes Survey (SUSOS), it is estimated that 400–500 people access specialist AOD services on any single day in the ACT (see section 2.5).[2] While indicative of the daily workload of the ten ACT specialist AOD services, this figure does not equate to annual treatment episodes. This information is obtained from the ACT AODTS-NMDS to which almost all ACT specialist AOD services currently report. The limitations of this data set are discussed in Section 2.1.1.

ACT AODTS-NMDS data show that there were 4,652 closed treatment episodes provided in specialist AOD treatment and support services in the ACT in 2013–14 to an estimated 3,332 clients. Over the five-year period to 2013–14, there has been a steady increase in the number of treatment episodes provided across services in the ACT—from 3,750 to 4,652, an increase of 24%. In non-government specialist AOD treatment and support services alone, there was a 36% increase in service demand between 2010 and 2014.[24,l]

Table 4 shows the principal drugs of concern for treatment episodes provided to clients for their own drug use in 2013–14 (as opposed to episodes provided for someone else's drug use). Importantly, the proportion of treatment episodes involving heroin was higher than the national average (7%), and amphetamines as the principal drug of concern increased from 6% to 15% between 2009–10 and 2013–14.[3]

[k] Personal communication, AOD Policy Unit, ACT Health—31 March 2016

[l] Analysis of data from the Service Users' Satisfaction Survey (2012) and the Service Users' Satisfaction and Outcomes Survey (2015) also shows a 36% increase in the numbers of people completing the survey in all (government and non-government) specialist AOD treatment and support services in a single day (from 346 in 2012 to 469 in 2015).[2]

Table 4: Proportions of treatment episodes of principal drugs of concern in the ACT (2013–14)
Source: AIHW 2015[3]

Principal drug of concern	Proportion of treatment episodes
Alcohol	47%
Cannabis	18%
Amphetamines	15%
Heroin	11%

In the ACT, 'information and education only' was the most common main treatment type delivered (21% of episodes), followed by 'assessment only' (19%), 'counselling' (19%), and 'support and case management only' (12%). In the five year period to 2013–14, 'information and education only' increased in the ACT from 11% to 21% of treatment episodes.[3]

Conversely, 'counselling' as the main treatment type has declined over the past five years, from 30% of episodes in 2009–10 to 19% in 2013–14. Compared to the national averages over the past five years, the ACT has provided proportionally fewer episodes of 'counselling'. In 2013–14, for example, 'counselling' was provided in 43% of treatment episodes nationally, compared to 19% in the ACT.[3] Further, in 2013–14 the ACT had the lowest proportion of episodes of 'counselling' (as a proportion of main treatment types) of any jurisdiction—for example, 19% in the ACT, compared to 35% in NSW, 56% in Victoria and 62% in Tasmania.[4] Importantly, 'counselling', as reported in this data set, refers to counselling offered outside the residential rehabilitation context (see Section 2.7.3).

2.8.1 Service usage by Aboriginal and Torres Strait Islander people

As reported in Section 2.5, 25% of people who completed the SUSOS (2015) identified as being of Aboriginal and/or Torres Strait Islander descent. When Aboriginal and Torres Strait Islander community-controlled services are excluded, the SUSOS data shows that 19.4% of people attending mainstream specialist AOD services identified as Aboriginal and/or Torres Strait Islander.[2] The current level of presentations by Aboriginal and Torres Strait Islander people to ACT mainstream specialist AOD treatment and support services is expected given the high level of AOD-related harms experienced by the Aboriginal and Torres Strait Islander community.

The limitations of the NMDS data (see Section 2.1.1) mean that the treatment types for Aboriginal and Torres Strait Islander people accessing Aboriginal and Torres Strait islander-specific services cannot be specifically articulated. However, in discussion with ACT Health about the types of services that they purchase from Aboriginal and Torres Strait Islander-specific organisations, it is known that specialist AOD assessment, counselling and non-residential rehabilitation are not specifically and explicitly purchased.[m] Aboriginal and Torres Strait Islander people wishing to access these drug treatment service types must currently do so through the mainstream specialist AOD services.

2.8.2 Catchment and boundary considerations

It is impossible to discuss AOD treatment and support service delivery, needs and priorities in the ACT without considering cross-border issues.

[m] Residential rehabilitation specifically for Aboriginal and Torres Strait Islander people is in the process of being established at a purpose-built facility, the Ngunnawal Bush Healing Farm.

Across Australia, Primary Health Network boundaries do not match the reality of how specialist AOD treatment and support services are organised, delivered and to whom. While the ACT is fortunate in some ways that its boundary matches that of the Capital Health Network, the reality is that people from beyond the borders of the ACT regularly access specialist AOD treatment and support services (in particular, for example, from Queanbeyan, Yass, Goulburn, Cooma and the South Coast). Many of these local communities have little (if any) local choice of specialist AOD treatment services, and so the population potentially serviced by ACT specialist AOD treatment and support services is 580,000 (rather than the 380,000 population of the ACT). ATODA is collaborating with ACT Health to undertake an analysis of specialist AOD treatment and support cross-border issues, including a postcode data analysis, which will be available in 2016–2017.

Secondly, the nature of utilisation of specialist AOD treatment and support services across Australia requires flexibility in client access across Primary Health Network, state and territory boundaries. Several factors will impact on the choices that people make about where they access specialist AOD treatment and support: shame and stigma associated with AOD treatment; wanting to remove yourself from an environment where your network may be using AOD; and access to different modalities of AOD treatment not available in their local area (e.g. residential care that accepts parents with children).

Clearly, although ACT residents are given priority of access to ACT AOD treatment and support services, access is not just limited to ACT residents. Similarly, ACT residents are able to access specialist AOD treatment and support services in other jurisdictions. This is an important and inherent strength of the Australian specialist AOD treatment and support service system.

Furthermore, Aboriginal and Torres Strait Islander community-controlled services report high mobility of Aboriginal and Torres Strait Islander people across the NSW-ACT border. Visiting the ACT for brief or extended periods to maintain family and work connections contributes to this high mobility, as well as specifically visiting the ACT to access services (including specialist AOD treatment and support) that are not available elsewhere. This is clearly demonstrated by the work of the ACT's Aboriginal and Torres Strait Islander community controlled health service; of the 4,437 individual clients in 2014–15, 19% lived in NSW and 2% were either residents of other jurisdictions or the information was not recorded.[25]

2.9 Unmet demand for specialist AOD treatment and support

The relatively recent, quick and building changes in demand for specialist AOD treatment and support have resulted in multiple problems within the ACT specialist AOD service system, such as:

- Barriers to entry into AOD treatment due to, for example, insufficient treatment places and resulting lengthy waiting lists.
- Inability to provide optimal levels of care for an at risk population, their families and the wider community.
- Insufficient funding and planning across the AOD service system.

This has exacerbated and brought to the fore other systems problems, such as an inability to swiftly provide AOD treatment places to people involved in the criminal justice and child protection systems. Based on current trends (in the ACT and nationally) it can be expected that demand for AOD treatment and support will not abate.

In response to this crisis in Australia, the *New Horizons: Review of the Alcohol and Other Drug Treatment Services in Australia* report recommended that **treatment places need to double in response to current unmet demand**.[19] Like elsewhere in the country, the ACT needs further

treatment places to meet the increased demand that is being placed on specialist AOD treatment and support services.

The needs of ACT specialist AOD treatment and support services to develop capacity to meet the identified unmet demand and are explored in Part B.

Part B

Section 3: Using good practice in specialist AOD treatment and support to deliver quality services and meet demand

This section provides an overview of the needs and priorities of existing specialist AOD treatment and support services in the ACT to deliver quality services and meet the unmet demand. Articulating these needs and priorities requires first examining the components that should be present in an optimal specialist AOD service system, and how these should be resourced. Effective specialist AOD treatment and support interventions have extensive Australian and international evidence. Studies show that elements of best-practice and effective AOD treatment for Aboriginal and Torres Strait Islander people are the same as effective treatment to other Australians, when delivered in a culturally safe ways.[26]

3.1 Good practice in specialist AOD treatment and support

A high quality AOD treatment and support sector is acknowledged to adopt a number of key elements:[27]

- The sector should provide a range of specialist AOD treatment and support options and settings to select from and to which clients can be matched to ensure the most effective treatment. High quality outcomes among clients are determined by accessibility of these treatment options.

- Level of dependence (and associated harms) will determine the type of AOD treatment that should be offered; so, people with severe levels of dependence/high-risk use will require more intensive interventions compared to clients with lower levels of dependence/lower risk use.

- AOD treatment interventions should be based on the outcomes of a comprehensive AOD assessment, and be guided by an individual AOD treatment plan, developed collaboratively between the service user and the treatment service staff.

- Intensive and on-going engagement by AOD treatment services with people using AOD is necessary for high quality outcomes:

    - Adequate time needs to be allocated to enable a person to gain the benefits they need from treatment.
    - On their own, short-term contact through withdrawal and education will have limited impact; treatment outcomes are maximised when these are used in conjunction with longer-term intensive AOD treatment interventions.
    - Aftercare is essential and has been shown to reduce the frequency of relapse.
    - The quality of the therapeutic relationship between the person and the professional with whom they interact is critical to good treatment outcomes.

- AOD treatment is potentially effective even when other social and welfare issues have not yet been addressed.

- AOD treatment is more likely to be successful where people are motivated to undertake treatment.

- Consumer participation in specialist AOD treatment and support services is acknowledged to improve experiences within services for consumers and their families and friends. Furthermore, it is a right and ethical imperative for consumers to participate in decision-making about their own treatment.[28]

An ideal pathway of AOD treatment involves being provided with an assessment that channels a person into the appropriate modalities of care according to the needs of the individual (e.g. withdrawal management, residential or non-residential rehabilitation, counselling, pharmacotherapy).

An assessment should result in an individual AOD treatment plan that articulates the goals of the individual and how they are to be supported to achieve their goals and outcomes; this plan can be modified during the treatment process. Throughout all stages of AOD treatment (and indeed pre and post), active engagement with AOD treatment services—information and education, including with a focus on harm reduction—should also be provided. Best outcomes are achieved when people are transitioned from intensive AOD treatment into aftercare that continues to actively support them (e.g. through less intensive counselling) to sustain their treatment gains, including reducing relapse.

Specialist AOD clinicians provide both intensive and brief therapies (e.g. counselling) in the ACT and Australian AOD sector. Evidence-based psychological therapies for adults with AOD problems are provided in the ACT, with cognitive behavioural therapies (CBT) being a primary approach.

In the specialist AOD field,[29] CBT interventions commonly draw on a relapse prevention approach and focus on the cognitive, emotional and situational triggers for AOD use and teach skills and strategies for alternative ways of coping. These include:

- Identification of internal and external triggers to use
- Self-monitoring to identify craving
- Coping with craving skills training
- Coping skills training (both cognitive and affective e.g. anger management, managing negative thoughts, decision making, problem solving)
- Motivational interventions (e.g. Motivational Enhancement Therapy)
- Contingency management
- Substance refusal skills training
- Social skills training
- Increasing non-using related activity.

3.1.1 Adequate funding of best practice AOD treatment and support

Australia's first Drug and Alcohol Service Planning Model (DASP Model) identifies the type of treatment (termed 'care') required by drug type and age group, and the components of that treatment (termed 'care package'). Elements of the care required—including staffing—are costed, and this can be used to estimate the resources required to deliver that care across a typical population of 100,000 people. The accompanying DASP Decision Support Tool can be used to estimate the resources required to deliver appropriate and adequate AOD treatment and support to a population (see also section 6.1).

The DASP Model was formerly known as the Drug and Alcohol Clinical Care and Prevention (DA-CCP) planning tool. The model and planning tool has been adapted into a tool for use in relation to resourcing of care packages for AOD treatment for Aboriginal and Torres Strait Islander people—the *DA-CCP adaptation for Aboriginal and Torres Strait Islander people*. This will be discussed further in section 3.2.3 (see also section 6.1).

The DASP Model and the DA-CCP adaption for Aboriginal and Torres Strait Islander people are not available in the public domain. However, leading up to the release of the final version of this paper,

ATODA hosted a workshop with ACT specialist AOD treatment and support services, ACT Health and Primary Health Networks to learn about the Drug and Alcohol Service Planning (DASP) Model and the DA-CCP adaption. Attendees at the workshop were given a sense of the components of the model, how it was developed, and its implications for planning for specialist alcohol and drug services in the ACT.

3.2 Good practice in specialist AOD treatment and support for Aboriginal and Torres Strait Islander people

Regardless of the service context, specialist AOD treatment and support for Aboriginal and Torres Strait Islander people should be based on three principles:

- Providing high quality AOD treatment according to best practice
- Adapting and delivering this in culturally safe ways
- Sufficient resources to deliver the components of high quality and culturally safe care.

Furthermore, decisions about the allocation of AOD resources for Aboriginal and Torres Strait Islander people should involve Aboriginal and Torres Strait Islander people centrally in the planning, development, implementation and evaluation of strategies, and funding models should support this delivery of high-quality AOD treatment in settings that are appropriate and culturally safe (see also Section 6).

3.2.1 High quality AOD treatment according to best practice

Each of the components articulated in Section 3.1 are equally relevant to the provision of best practice, high quality treatment and support for Aboriginal and Torres Strait Islander people who use AOD.[27] These components should be available to Aboriginal and Torres Strait Islander people across the specialist AOD treatment and support system regardless of setting—that is, in both the Aboriginal and Torres Strait Islander community controlled and mainstream service settings.

3.2.2 Culturally safe practice in specialist AOD treatment and support

Studies of Aboriginal and Torres Strait Islander people who use drugs have found that they want access to a range of specialist AOD treatment and support services,[30] and this is the basis of good practice in AOD service delivery for Aboriginal and Torres Strait Islander people.[31] For the majority of Aboriginal and Torres Strait Islander people who use AOD, there is a preference to access Aboriginal and Torres Strait Islander community controlled services for all or some of their AOD treatment and/or health care.[32] Research shows that community controlled organisations improve access to services, make service delivery more appropriate for people with complex needs, and improve outcomes.[31]

However, there are a variety of reasons why some Aboriginal and Torres Strait Islander people who use AOD may want to preferentially access mainstream services for all or some of their AOD treatment. Studies report, for example, that some Aboriginal and Torres Strait Islander people using AOD may feel ashamed that in accessing community controlled services they will be seen by family and friends, and that they have concerns in relation to possible breaches of confidentiality and discrimination from the community.[33]

Ensuring that a mix of culturally safe AOD treatment and support services is available to Aboriginal and Torres Strait Islander people who use AOD is, therefore, critical to meeting AOD treatment needs within the Aboriginal and Torres Strait Islander community. Clearly, Aboriginal and Torres Strait

Islander community controlled services have a prominent role in this mix, but there is also a role for mainstream specialist AOD treatment and support services.

As detailed in Section 2, the SUSOS data shows that 19.4% of people currently attending mainstream specialist AOD services identified as Aboriginal and/or Torres Strait Islander.[2] Mainstream specialist AOD treatment and support services in the ACT have expressed commitment to adapting their practice and programs to meet the needs of this client group through developing culturally safe practice.

However, mainstream specialist AOD services in the ACT have reportedly found it challenging to provide treatment options that are sufficiently appealing to Aboriginal and Torres Strait Islander clients, to both attract and retain clients within their programs. Clearly a high number of Aboriginal and Torres Strait Islander clients are accessing mainstream specialist AOD treatment and support services, but workers in both mainstream and community controlled services report that there are still significant cultural and other barriers for Aboriginal and Torres Strait Islander people in engaging with these mainstream services. Consequently numbers of potential service users are disengaging from mainstream services without having their AOD treatment and support needs met. There is therefore demonstrable room for improvement in enhancing the cultural safety of mainstream specialist AOD treatment and support services.

The employment of Aboriginal and Torres Strait Islander workers within both community controlled and mainstream services is acknowledged to improve the cultural safety and accessibility of these services for Aboriginal and Torres Strait Islander clients. However, some mainstream specialist AOD treatment and support services have, to date, found this challenging. According to the most recent ACT ATOD Workforce Qualification and Remuneration Profile 2014, there are seven Aboriginal and/or Torres Strait Islander workers employed in mainstream specialist AOD services in the ACT, with only two of these positions identified as being Aboriginal and Torres Strait Islander-specific. Some AOD services have one or more Aboriginal and Torres Strait Islander workers, while some have none.[23]

3.2.3 Sufficient resourcing to specialist AOD treatment and support services for Aboriginal and Torres Strait Islander people

An equitable distribution of AOD treatment care and an equal standard of AOD treatment infrastructure for Aboriginal and Torres Strait Islander people should not be measured in terms of formal equality—that is that the same per capita resources are allocated to Aboriginal and Torres Strait Islander as are allocated to other Australians for specialist AOD treatment. It should be expected (and planned for) that:

- Given the significant and long term under-investment in Aboriginal and Torres Strait Islander specific AOD treatment additional and sustained funding is required.

- Given the greater burden of harm of alcohol, tobacco and other drugs experienced by Aboriginal and Torres Strait Islander people, greater per capita resources are required.

- Given the greater complexity and need for holistic care to be wrapped around AOD treatment, that each episode of care requires additional resources for delivery (including additional staff time, number of staff, complexity, cultural considerations, social supports).

The *National Aboriginal and Torres Strait Islander Peoples' Drug Strategy 2014–2019* advocates that available resources should be provided in a well-targeted manner to support sustainability and evidence-informed results, and that both short-term and long-term funding should be coordinated across funding sources.[34]

Two documents are useful in guiding how resourcing to AOD treatment and support for Aboriginal and Torres Strait Islander people can be directed: the *DA-CCP adaptation for Aboriginal and Torres Strait Islander people*; and principles articulated by the National Indigenous Drug and Alcohol Committee (NIDAC).

Drug and Alcohol Clinical Care Package adaptation for Aboriginal and Torres Strait Islander people

The *Drug and Alcohol Clinical Care and Prevention (DA-CCP) adaptation for Aboriginal and Torres Strait Islander people*[n] can provide detailed advice on the resources required for appropriate and evidence-based clinical care for Aboriginal and Torres Strait Islander people including costings. The adaptation considers additional elements of Aboriginal culture and wellbeing (e.g. spirituality, connection to country, and family and kinship ties), as well as the consequences of social and economic inequalities and cultural dislocation (e.g. social disadvantage, discrimination, grief and trauma). Examples of further elements that are costed into some of the care packages include: providing transport; additional time and flexibility to address complex issues; incorporating cultural elements into treatment; additional on-going care and follow up; return to country/community activities; and additional staffing requirements to deliver these.[o] Bearing in mind these additional elements, the implications for AOD treatment planning and funding are that services cost significantly more.

The level of care described in the care packages apply to all Aboriginal and Torres Strait Islander people receiving AOD treatment and support. The *DA-CCP adaptation* should, therefore, be the basis of purchasing, planning and implementing AOD treatment for all Aboriginal and Torres Strait Islander people regardless of the AOD treatment setting that they access (i.e. Aboriginal and Torres Strait Islander community controlled or mainstream). The focus is not on the setting in which the care package is delivered, but rather on adequately resourcing a high quality care package that includes best practice AOD treatment and support and additional cultural safety components.

Principles from the National Indigenous Drug and Alcohol Committee (NIDAC)

In 2013 the National Indigenous Drug and Alcohol Committee (NIDAC) developed a position statement on principles for funding AOD interventions and services for Aboriginal and Torres Strait Islander People.[35] A key principle, that funding for AOD interventions for Aboriginal and Torres Strait Islander people should be quarantined from mainstream funding, has been addressed in the proposed funding allocation through the Primary Health Networks. However, there are further funding principles that should be considered.

Where possible, the provision of Aboriginal and Torres Strait Islander specific AOD interventions should be prioritised to sit with Aboriginal and Torres Strait Islander community controlled organisations, and where this is not possible there should be mechanisms in place to build the capacity of these organisations to provide these AOD services.

Ensuring access to culturally safe high-quality AOD treatment through the Aboriginal and Torres Strait Islander community controlled services is vital to improving outcomes for Aboriginal and Torres Strait Islander people who use AOD. To support the capacity building of local Aboriginal and Torres Strait Islander community controlled services to provide a full range of specialist AOD treatment

[n] ACT Health is the custodian of the *Drug and Alcohol Clinical Care Package (DA-CCP) adaptation for Aboriginal and Torres Strait Islander people* in the ACT.
[o] The *DA-CCP adaptation for Aboriginal and Torres Strait Islander people* is not publicly available, but information about the packages and tool was presented at the workshop facilitated by ATODA on 20 April 2016.

service types, it is crucial to prioritise adequate resourcing, targeted quality improvement measures and broadening of current scope to ensure high quality service delivery (see section 5).[35]

However, even with additional resourcing, the Aboriginal and Torres Strait Islander community controlled services may still not be able to meet the full level of demand from the Aboriginal and Torres Strait Islander community, or may not be able to provide the full range of services required by the community. Mainstream specialist AOD treatment services are crucial to the mix of service types that should be available to Aboriginal and Torres Strait Islander people in the ACT. However, the development of Aboriginal and Torres Strait Islander specific AOD interventions in mainstream services should be undertaken in partnership with Aboriginal and Torres Strait Islander community controlled services to build capacity in Aboriginal and Torres Strait Islander services. Likewise, collaborations between mainstream specialist AOD treatment and support services and the Aboriginal and Torres Strait Islander community controlled services will enhance the cultural safety of existing mainstream services.

3.2.4 Aboriginal and Torres Strait Islander ownership of solutions

The *National Aboriginal and Torres Strait Islander Peoples' Drug Strategy 2014–2019* clearly stipulates that a key principle guiding the implementation of the strategy is Aboriginal and Torres Strait Islander ownership of solutions from inception and planning, through to implementation and provision, and monitoring and evaluation. Such engagement should be meaningful and genuine, and Aboriginal and Torres Strait Islander organisations should be empowered to participate in and lead the decision-making that affects their lives.[34]

Similarly, this principle should be applied in the provision of additional funding for specialist AOD treatment and support in the ACT through the Primary Health Networks and other funding bodies.

Progress in line with the priority areas identified in this section should therefore be actioned through a process that involves Aboriginal and Torres Strait Islander community controlled organisations in the planning, development, implementation and evaluation of initiatives, and determining the settings and delivery modes that are likely to result in greatest benefit for Aboriginal and Torres Strait Islander people in the ACT.

3.3 Needs in specialist AOD treatment and support in the ACT

As presented in Section 2.8, there has been a significant increase in demand in the ACT for specialist AOD treatment and support services over the past five years. Analysis of data and reports from workers in the field point towards the specific needs within specialist AOD service services, and the components that require further investment.

Analysis of the AODTS-NMDS data shows that the ACT has more 'assessments only' (19%) than the national average (16%), and that the highest proportion of 'assessment only' is occurring within residential settings.[3] The AODTS-NMDS data also shows that compared to other jurisdictions, the ACT provides 27% fewer counselling episodes of care than the national average (i.e. in 2013–14, 19% of treatment episodes in the ACT compared to 43% nationally). Furthermore, consistent with AODTS–NMDS data, ACT Health modelling utilising the DASP Decision Support Tool shows that the ACT has less resourcing capacity to offer 'care packages' that include more intensive AOD treatment outside the residential setting (including for example, counselling and support & case management).[p]

[p] Personal correspondence, AOD Policy Unit, ACT Health, March 2016.

These data and modelling sources show service use trends that indicate multiple barriers and needs for improvements within the system. In particular, they show the lack of capacity in existing specialist AOD treatment and support services in the ACT to provide:

- Immediate triage and brief intervention when clients make initial contact, including screening and treatment matching.
- Brief interventions and low intensity treatment (e.g. counselling) to people on waiting lists for AOD treatment.
- Intensive structured non-residential specialist AOD treatment and support, particularly counselling.

Further analysis shows that 75% of 'information and education' and 'support and case management' are not done in outreach settings in the ACT.[3] This highlights the need to increase opportunistic assertive outreach to engage 'hard to reach' sub-populations to prevent and reduce AOD related harm and provide supported referrals to specialist AOD treatment. This is particularly important given people cannot access treatment on demand in the ACT though they may want to and / or need specialist AOD interventions.

Data and modelling from the NMDS and DA-CCP are consistent with reports from workers in specialist AOD services in the ACT. One of their frustrations consistently reported to ATODA is the feeling that they lack the resources to offer more intensive support outside of the residential rehabilitation service context that is of adequate intensity to meet client needs. In practice this boils down to clients potentially having less positive and less impactful treatment outcomes than they might have otherwise. Such 'treatment failure' is usually unfairly attributed to the 'failings' of the individual client, rather than to the failure of the system to adequately meet their needs.

Meeting these needs involves going beyond screening, assessment and brief interventions to be able to provide a spectrum of treatment options outside the residential setting. In particular, this refers to being able to provide a range of low to high intensity counselling to people who do not wish to access, or are otherwise ineligible for, residential rehabilitation services. This is applicable across the continuum of treatment and support, including while people are on waiting lists for AOD treatment, while they are receiving intensive AOD treatment, and when they are receiving specialist structured AOD aftercare.

Both the data and the needs articulated by specialist AOD workers, therefore, identify the limited resources to provide adequate (in terms of intensity) non-residential, community-based AOD treatment and support as a universal gap across the system. This type of support is characterised by being non-bed and non-hospital based, and could range from intensive to less intensive depending on the stage of AOD treatment for the individual. It is important to note that community based, non-residential treatment services are cost-effective, although residential services are indicated for some particularly high-risk and complex needs clients.[36,37]

There are, of course, other multiple points of need in the ACT specialist AOD treatment and support service system. The recommendations for enhancing the effectiveness of current investment contained in this document are not inclusive of initiatives to address established areas of need in service delivery that are currently being progressed by other projects/processes; for example:

- Review and re-design of drug and alcohol withdrawal management services in the ACT
- Aboriginal and Torres Strait Islander AOD Residential Rehabilitation—the Ngunnawal Bush Healing Farm
- Additional Addiction Medicine Specialist services for people on Opioid Maintenance Therapy through ACT Community Health Centres.

These needs represent specific points in the service system and currently have processes and resources behind them to progress to the next stage of development.

However, additional treatment capacity will be built across the *entire* AOD treatment and support service system if investment is made to increase the delivery of non-residential, community-based AOD treatment and support. This paper, therefore, focuses on articulating the needs within this area exclusively. This area of need and priority applies to both 'mainstream' specialist AOD treatment and support services (see Section 4) and to specialist AOD treatment for Aboriginal and Torres Strait Islander people (see Section 5).

3.4 Additional needs in specialist AOD treatment and support in the ACT for Aboriginal and Torres Strait Islander people

Aboriginal and Torres Strait Islander people are accessing specialist AOD treatment and support throughout the service sector (i.e. through both Aboriginal and Torres Strait Islander and mainstream services). Therefore, the service needs identified in the Section 3.3 are equally relevant to *all* specialist AOD treatment and support services in the ACT.

Further, ATODA understands that no explicit and specific Aboriginal and Torres Strait Islander funding is allocated to the following AOD treatment types:[5]

- Comprehensive specialist AOD assessment
- Specialist AOD counselling
- Non-residential rehabilitation.

It is, therefore, clear that there are particular treatment types for Aboriginal and Torres Strait Islander-specific AOD service delivery that require additional investment and development.

Section 4: Priority 1—Community based specialist AOD treatment and support

As described in section 3.3, a priority need identified in the specialist AOD system in the ACT is for community based specialist AOD treatment and support. Community based AOD treatment and support can be delivered along multiple stages of the treatment pathway, and can be described as requiring increased investment in the following components:

1. Opportunistic assertive outreach to engage 'hard to reach' sub-populations to prevent and reduce AOD related harm and provide supported referrals to specialist AOD treatment services.

2. Increased capacity for specialist AOD treatment and support services to provide immediate triage and brief intervention when clients initially contact the services.

3. Increased capacity for specialist AOD treatment and support services to provide brief interventions and/or low intensity care to people on waiting lists for AOD treatment.

4. Intensive structured non-residential specialist AOD treatment and support, particularly counselling.

5. AOD specialist structured aftercare.

6. Targeted service delivery projects that reduce AOD related harms and improve the quality of care embedded in existing specialist AOD treatment and support services:

    - Structured and formalised consumer and friend/family participation strategies
    - Hepatitis C treatment provided concurrently with AOD treatment
    - Opioid overdose education programs provided concurrently with AOD treatment
    - Methamphetamine specific programs.

These components of community-based AOD treatment and support require increased investment to enable the specialist AOD service system to provide optimal care and AOD treatment outcomes. This section describes each of these components, the rationale for their needs, and maps each against the relevant ACT AOD Minimum Data Set treatment types: information and education; support and case management; counselling; and rehabilitation (non-residential) (see Appendix C for a description of ACT AOD Minimum Data Set classifications).

4.1 Opportunistic assertive outreach to engage 'hard to reach' sub-populations

Among people who are using AOD in the ACT there are 'hard-to-reach', diverse and clinical sub-populations of people who:

- Are using AOD in high risk ways and who may be dependent
- May or may not be in AOD treatment (at all or sufficiently)
- Could benefit from specialist AOD interventions (i.e. harm reduction) while they continue to use AOD
- Would likely be eligible for AOD treatment upon assessment
- May benefit from supported referrals into AOD treatment (e.g. via peer workers)
- May not be engaged with other parts of the health system (e.g. GPs), however may use a high level of services (e.g. ambulance, emergency, crisis).

The most appropriate specialist AOD intervention for these 'hard-to-reach' at-risk sub-populations may be interventions and types of engagement that reduce AOD related harms and provide supported referrals to specialist AOD treatment and support services.

Drugs and drug use are facts of life that cannot be eliminated, however the harms associated with them can be substantially reduced. Harm reduction is one of the three pillars of the Australian and ACT drug strategies. Harm reduction refers to policies, programs and practices that aim to reduce the harms associated with the use of psychoactive drugs by people unable or unwilling to stop. The defining features are the focus on the reduction of harm (rather than on the elimination of drug use itself) and the focus on people who continue to use drugs.[38]

Harm reduction strategies are essential components of any modern and evidence based AOD treatment program, policy and system.[39] Harm reduction strategies have a strong evidence base and are cost effective.[40,41] While the ACT has a strong foundation of harm reduction services, there are limited modalities, sub-populations and geographic areas reached. People who use drugs engage well with harm reduction interventions delivered using peer-based approaches.[42]

The priority areas of need with regard to specialist AOD harm reduction reported by workers and people who use drugs accessing peer based services, which are also consistent with the evidence are:

- Blood borne virus prevention and supported engagement with treatment (e.g. hepatitis C)
- Overdose education, prevention and management (e.g. opioids)
- Peer education models and programs
- Peer treatment support (e.g. initial and ongoing engagement in treatment)
- Adapting harm reduction practices and information to specific needs (e.g. people who use methamphetamine).

The appropriate ACT AOD Minimum Data Set treatment types for this need are:

- Information and education
- Support and case management.

4.2 Immediate triage and brief interventions at initial contact

Often people contact specialist ACT AOD treatment and support services for help following a crisis (e.g. involvement of police or child protection, overdose, loss of employment). An optimal response at this point is to engage sufficiently with the person making contact to triage them to a particular service type, and, where that service type is not immediately available, offer a brief intervention, including a commitment to re-engage (e.g. next day follow up).

However, such is the demand for specialist AOD treatment and support services, that many people who are dependent and/or high-risk who seek formal specialist AOD treatment either cannot reach the service, or cannot be offered sufficient AOD treatment options to meet their needs. Examples of the barriers experienced could include:

- An individual (or friend or family member) calls a specialist AOD service seeking treatment and is put through to an answering machine
- An individual is able to be assessed but there are no places available suitable for their treatment needs
- There can be up to a 2–month wait for residential services and/or no current counselling places available.

In addition to reflecting the increased overall demand for specialist AOD treatment and support services, such barriers are symptoms of limited capacity within AOD services, including: staff resources and skills; distribution of resources to programs and services that best meet current needs; and flexibility to respond to client needs. The dangers are that people seeking AOD treatment and support either get no services or can only be offered sub-optimal treatment (e.g. once a month rather than daily) and that does not meet their needs.

It is well accepted that, if people who need AOD treatment do not get a specialist AOD response when they seek it, they may not re-engage for significant periods of time and may remain at high risk.[43] Specialist AOD workers have reported having to spread their resources so thinly that optimal treatment cannot be provided to meet client needs.

Ultimately, these system problems may then translate to poorer client treatment outcomes, perpetuated or prolonged crises as well as increases in the risk of harms for at-risk populations, their families and the wider community.[44]

The appropriate ACT AOD Minimum Data Set treatment types for this need are:

- Information and education
- Support and case management
- Counselling.

4.3 Brief interventions and low intensity treatment to people on waiting lists

Research and clinical experience show that there is a 'treatment window' during which a person seeking AOD treatment can be assisted. If some kind of immediate AOD specific support is not given at that time, the person (and their friends/family) will remain at high-risk[43] and may not engage with specialist AOD treatment and support services again for a prolonged period of time. Proper resourcing for managing people on waiting lists, including providing low threshold interventions (e.g. counselling), is a key element of funding for specialised AOD treatment and support services.[45]

Evidence supports the key relationships that exist between reducing treatment queues and waiting times, and increasing service levels and treatment capacity. Both of these factors will enhance the resulting beneficial impact of treatment.[46]

There is a small window of opportunity to respond to treatment needs and this drives the requirement for a 'treatment on demand' model that can lead to the immediate reduction or elimination of drug use and its associated harms. Such strategies involve implementation of cost effective, low intensity front line activities such as specialist AOD crisis support, brief interventions and low intensity counselling that are attached to broader more intensive treatment provision. For this to occur, greater resource investment is required in line with wider public health and AOD treatment planning processes, including greater accountability and consideration of clinical needs and urgency for treatment.

Treatment required at this stage of the client pathway does not necessarily need to be intensive but does require structured, reliable, consistently available opportunistic AOD specific interventions that are located at the front end of the specialist AOD service system.

The appropriate ACT AOD Minimum Data Set treatment types for this need are:

- Information and education
- Support and case management
- Counselling.

4.4 Intensive structured non-residential specialist AOD treatment

In Australia, accepted primary objectives of AOD treatment are:

- To reduce the client's level of substance use
- To reduce the client's experience of AOD - related harm
- To improve the client's health and wellbeing.[47]

Achieving these objectives is closely associated with ongoing AOD treatment exposure, and is largely associated with more positive outcomes and sustained reductions in AOD related harms and use. Long-term treatment success is more common with longer treatment duration and associated with the more intensive structured treatment modalities (e.g. medium to high intensity counselling, day programs).[48]

As discussed previously, ACT specialist AOD services are not able to meet demand for entry into treatment, this problem is then compounded when an individual is engaged in (non-residential) AOD treatment as there are insufficient resources to provide the frequency and length of care needed (e.g. medium to high intensity counselling).

Structured therapeutic non-residential and outpatient services are recognised as an integral component of specialist AOD treatment and support services that should be offered for people with a substance use disorder, including as identified through the DASP Model.[49]

The increased pressure on AOD treatment and support services (particularly residential services) and resulting waiting lists in the ACT has been compounded by a lack of non-residential therapeutic services such as counselling and day programs. These programs provide complementary AOD treatment options for people unsuitable for, or unable or not wanting to access, residential treatment (e.g. due to work or family commitments). They can also relieve some of the burden and subsequent waiting lists for residential AOD treatment services.

Structured non-residential therapeutic services provide AOD treatment and support to people without the need for bed-based infrastructure, and for many people, participation in these non-residential programs is at least as effective as residential treatment. Furthermore, non-residential therapeutic programs enable people to remain at home and engaged with family and work or study commitments.

It is well established in the ACT that there is a need for more structured, therapeutic, non-residential and outpatient treatment options, particularly medium to high intensity counselling.[3,9,50,q]

The appropriate ACT AOD Minimum Data Set treatment types for this need are:

- Counselling
- Rehabilitation (non-residential).

4.5 AOD specialist structured aftercare

AOD treatment aftercare (which can also be described as continuing care) is recognised as an integral component of AOD treatment. Aftercare occurs following an intensive phase of AOD treatment that can be residential or non-residential (e.g. residential rehabilitation, day program, intensive counselling support). AOD treatment in aftercare may involve, for example 1 or 2 counselling sessions per week over several weeks or months and regular planned participation in

[q] Based on analysis of DA-CCP modelling for the ACT; personal communication, AOD Policy Unit, ACT Health—20 June 2016.

support groups. The evidence is accumulating that low intensity continuing care contacts, such as regular text messages, can be effective.[51]

Aftercare recognises that best practice in AOD treatment requires ongoing support of clients to enable maintenance of treatment gains, including preventing relapse, and to promote re-engagement with the treatment system when needed (i.e. stepped care).[52,53,54] To be most effective, aftercare should be structured and embedded within, and delivered according to, individual treatment plans.

AOD dependence is a health condition that is chronic and relapsing. The need for ongoing care and treatment for this health condition is similar to other chronic conditions such as diabetes, asthma and hypertension; and it can also be managed effectively.[55] The chronic nature of AOD dependence means that relapse is likely and should be planned for within:

- Individual treatment plans
- AOD treatment services
- Planning and purchasing in the AOD treatment system.

When relapse occurs it is often characterised as 'treatment failure'; this is inappropriate and stigmatising. A more appropriate description of relapse is that symptoms of AOD dependence reoccur, and consequently treatment needs to be re-instated, adjusted or a different modality applied.

The objectives of AOD treatment are generally achievable while the individual is engaged with intensive AOD treatment. However, these treatment gains can diminish over time, and particularly where contact with AOD treatment supports are not sustained.

Aftercare needs vary according to the individual and the substance(s) of concern. For example, with regard to people dependent on methamphetamine:

- There is evidence of prolonged withdrawal symptoms and longer-term effects on neurocognitive impairment, thus highlighting the significant need for continuing care and aftercare supports for this client group.[56]

- The Australian Methamphetamine Treatment Evaluation Study (MATES) found that methamphetamine treatment entrants showed sustained reductions in methamphetamine use and related harms after drug treatment, but these positive outcomes were largely due to ongoing treatment exposure.[48]

The overall effectiveness of AOD treatment outcomes may be improved with increased investment of resources for structured and dedicated programs to clients following intensive (residential or non-residential) AOD treatment. The modality, intensity, frequency and length of AOD treatment aftercare provided can be linked with sustaining AOD treatment outcomes and would need to be individually determined, based on an extension of the existing AOD treatment plan.

In the ACT there is little resourcing to provide effective structured AOD treatment specific aftercare programs. For example, in the 2010-2013 ACT Health contracts for AOD treatment, services were only required/resourced to provide one phone call within 3 months post intensive treatment.

The appropriate ACT Minimum Data Set treatment types for this need are:

- Information and education
- Support and case management
- Counselling.

4.6 Targeted Service Delivery Projects

The provision of high quality AOD treatment and client outcomes can be strengthened through the delivery of targeted projects that specifically seek to improve the overall quality of service delivery within ACT specialist AOD treatment and support services. Such targeted quality-improvement service delivery projects are required in the AOD field because:

- The AOD field has a strong, continuously and significantly evolving evidence base that needs to be translated into practice.

- The nature of drugs and their patterns of use and harms are constantly in flux which may require modified clinical responses (e.g. responding to the specific challenges resulting from an increase in methamphetamine use).

- External (e.g. government, sector) quality improvement priorities are identified that require implementation.

- As discussed previously, it is well established that in the ACT (and Australia) there is significant and ongoing demand on scarce specialist AOD treatment and support resources. This means that undertaking meaningful, sufficient and timely quality improvement projects (particularly larger projects related to revising clinical care practices) requires provision of additional and specific resources to do so.

When sufficient and specific quality improvement funding and supports are in place, ACT specialist AOD services have repeatedly demonstrated that they are well placed to effectively respond to new and fluctuating drug trends and harms in the ACT community and to adapt their clinical practices to new evidence.[57]

The Australian Government has recognised this capacity and ongoing need in the Australian (and ACT) AOD sector since 2007 when it first allocated specific funding through the Improved Services Initiative. This initial and specific funding injection, for example, enabled services to implement projects to embed mental health as core business and routine care in AOD treatment and support.

Four priority areas have been identified as targeted service delivery projects to improve the quality of AOD treatment and support in the ACT:

- Structured and formalised consumer and friend/family participation strategies.
- Hepatitis C treatment provided concurrently with AOD treatment and support.
- Opioid overdose education programs provided concurrently with AOD treatment and support.
- Methamphetamine specific programs.

These priority areas have been selected on the following criteria:[r]

- Significant burden of harm experienced by the existing AOD treatment population.
- Expressed need and priority of the ACT AOD sector.
- ACT and Australian Government policy priorities.

[r] Based on the criteria listed, smoking cessation and reduction activities should also be listed. However, smoking cessation is currently being addressed through other tobacco management activities within ACT AOD services, including: formalising smoking cessation within assessment processes; implementing smoke-free policies; supporting smoking cessation training; and providing subsidised nicotine replacement therapy (see: www.atoda.org.au/projects/tobacco/; and www.atoda.org.au/activities/we-can-project-communities-accessing-all-types-of-nicotine-replacement-therapy/). Smoking cessation as a targeted service delivery project may be a future area of need.

- Capitalising on increased access to subsidised medicines through the Pharmaceutical Benefits Scheme (PBS) and new scheduling arrangements.
- Evidence for the need and effectiveness of the intervention.
- Ability for a project to be implemented within a 12 month funding period.

Specialist AOD treatment services would need to adapt their clinical practices in order to implement these quality improvement projects, which would need to include an evaluation component.

4.6.1 Structured and formalised consumer and friend/family participation strategies

All specialist AOD treatment and support services should have structured and formalised strategies in place to improve consumer and friend/family participation. Treatment experiences are improved when clients of specialist AOD treatment and support services and their friends/family experience enhanced participation in their care and the design, delivery and evaluation of programs.

A 2014 report prepared for the Australian National Council on Drugs on consumer participation in the AOD sector recorded the agreement of key stakeholders that:[28]

- Consumers are entitled to participate in decision-making about their own treatment and how their AOD treatment and support services operate.

- There is an ethical obligation for managers of specialist AOD treatment and support services to facilitate meaningful participation.

- Other benefits from consumer participation programs include:
    - Improved service user satisfaction with services
    - Positively changing the nature of service provision for consumers
    - Facilitating retention in treatment
    - Improving participation in peer-based roles that make direct contributions to service delivery
    - Improving clarity of information to service users about the services and service delivery
    - Eliciting critical feedback about the service beyond standard satisfaction surveys.

- Although there is a lack of evidence from studies, it is likely that well-designed and implemented consumer participation should contribute to positive client outcomes.

- There is a potential role for drug users consumer advocacy organisations in supporting consumer representatives to engage in participatory activities in specialist AOD treatment and support services. The ACT peer-based drug user group is not currently funded to engage in this type of activity.

4.6.2 Hepatitis C treatment provided concurrently with AOD treatment

All people who access ACT AOD treatment services should be offered hepatitis (and other blood borne virus) screening, testing, vaccinations and treatment as part of routine care and their AOD treatment plan. Targeted and resourced service delivery projects can enable this to occur in the ACT.

This is necessary because:

- Hepatitis C is the most significant contributor for illicit drugs use-related mortality.[58]

- At the end of 2014, there were 230,470 people living with chronic hepatitis C infection in Australia; however, it is estimated that one in six people with hepatitis C are undiagnosed.[59]

- In 2014, 27% of notified cases of newly acquired hepatitis C infection were diagnosed in the Aboriginal and Torres Strait Islander population.[60]

- In the ACT in 2014, a total of 174 cases of newly acquired hepatitis C were reported; this figure has remained approximately stable over the past ten years.[61]

- 82% of newly diagnosed hepatitis C infections (that have an exposure-category recorded) are attributable to injecting drug use.[61]

- People who use injecting drugs are also at greater risk of acquiring hepatitis B, a vaccine-preventable disease.[62]

- People who use drugs (particularly people who inject drugs) have previously had a low uptake of hepatitis C treatment; however uptake can be relatively high when offered alongside and within AOD treatment settings and treatment plans.[63]

- The hepatitis C treatment landscape has recently changed significantly with the availability of Pharmaceutical Benefits Scheme subsidised new medicines.

- The new medications are highly effective, with a cure rate greater than 90 per cent.[64]

- Unlike previous treatments for hepatitis C, these new medicines are well tolerated, have fewer side effects and treatment duration is generally between 8–12 weeks.[64]

- There are no access restrictions applied to people who inject drugs as they are a priority population for hepatitis C treatment.

- On 1 March 2016, General Practitioners in the community became eligible to prescribe these medicines under the General Schedule (Section 85) in consultation with a specialist experienced in the treatment of hepatitis C.[65]

- People accessing specialist AOD treatment and support services should be offered hepatitis B vaccination.

- In the ACT, hepatitis C treatment is not generally provided as routine care as part of AOD treatment.

- However, Australian AOD treatment settings and services have been demonstrated to be able and effective at implementing hepatitis C treatment as part of AOD treatment.[66]

4.6.3 Opioid overdose education programs provided concurrently with AOD treatment

All people who access ACT AOD treatment and support services with opioids as a drug of concern should be offered opioid overdose prevention and management training and naloxone, including as part of their AOD treatment plan. Targeted and resourced service delivery projects can enable this to occur in the ACT.

A significant proportion of people utilising AOD treatment and support in the ACT are accessing treatment for opioids. According to 2014 data from the NMDS, heroin is the principle drug of

concern for 11% of people accessing specialist AOD treatment and support services in the ACT, and up to 93% of these people are injecting as their method of use.[3,67] However, the ACT AODTS-NMDS does not capture people who are accessing some other service types (e.g. the Needle and Syringe Program). A snapshot survey found that 923 people accessed the ACT's OMT program on a single day in June 2014.[s] Further, for the ATODA SUSOS, 80 people completed a survey at one of the primary NSP sites.[2] Data from the 2014 annual NSP survey conducted by the Kirby Institute shows that heroin was the most recent drug injected by 44% of people using a primary NSP in the ACT.[68]

One of the most challenging areas to manage within the AOD sector includes the risks associated with opioid overdose.[69] An opioid overdose prevention and management training program can assist clients of specialist AOD treatment and support services who have histories of opioid use to increase their knowledge and skills to prevent and manage overdose.

This priority should be addressed because:

- 18 Canberrans died from opioids (e.g. heroin and oxycodone) in 2014; this is the highest number in a decade.[70]
- Multiple data sources tell us that we are on an upward trajectory for a heroin 'epidemic' in Australia.[t]
- Naloxone is a safe and effective medicine the only effect of which is to reverse an opioid overdose, thus potentially preventing unnecessary deaths.
- Naloxone has recently received a dual listing on the Pharmaceutical Benefit Scheme (PBS) of schedule 3 (pharmacy only) and schedule 4 (prescription only).
- The first of its kind in Australia, the ACT's trailblazing take-home naloxone program involves comprehensive opioid overdose management training and the prescription and supply of naloxone to eligible participants who are potential overdose victims.[71]
- The program has been overwhelmingly endorsed by an independent expert evaluation report—launched by ACT Health Minister Simon Corbell—which showed that the program has been a great success with over 200 potential overdose witnesses trained, and program-issued naloxone used 57 times to resuscitate people.[70]
- The evaluation report recommended making overdose prevention and management (including take-home naloxone) programs core business for ACT specialist AOD services. This is acutely pressing given the release of new data that reveals that twice as many Canberrans die from opioids than on our roads.[70]

4.6.4 Methamphetamine specific programs

There are increased methamphetamine presentations across specialist AOD treatment and support services, and some treatment/clinical approaches need to be adapted in order to better manage and provide support to people presenting with methamphetamine-related issues. Targeted and

[s] Personal communication, AOD Policy Unit, ACT Health—31 August 2015.

[t] By the time drug-trend data is published, it reflects the situation that was observed within services and on the streets one to two years earlier. Through their on-the-ground work and preliminary analyses of data, AOD workers and researchers have been observing a gradual increase in heroin use that is not yet observed in the published data. These observations have been reported and discussed within the sector, at sector workshops and conferences, and in the media (for example: 7:30 Report, ABC *Heroin: a new drug epidemic with an old drug*. Broadcast 27/1/16).

resourced service delivery projects can enable this to occur in the ACT. Such projects can ensure that clients of specialist drug treatment and support services who have histories of methamphetamine use have access to tailored approaches to address issues specific to methamphetamine use (e.g. longer and more sustained withdrawal, cognitive impairment).

Addressing this priority is necessary because:

- In the ACT, methamphetamine was reported as a drug of concern for 11 per cent of treatment episodes in 2013–14, an increase from 6.45 per cent in 2012–13.[u]

- As drug use patterns change, permanently or temporarily, treatment and support services can and need to be able to adapt to this changing environment.

- Recent studies have demonstrated marked increases in methamphetamine use in Australia nationally, and at the regional level, and have shown that a surprisingly high proportion of methamphetamine users appear to be dependent upon the drug.[16,17]

- A small but significant sub-group is at serious risk.[72] Despite stability in prevalence of use, it is clear that there has been increasing harm across the country and in the ACT.

- Research shows that methamphetamine is typically used concurrently with other drugs, so it is also important to consider the number of treatment episodes where methamphetamine was identified as an issue (even when other principal drugs of concern are identified).

- When both principal and additional drugs are considered, amphetamines are estimated to account for 29% of all drug treatment episodes in 2013-14 in the ACT.[24]

- Non-completion of treatment and relapse risk are high among this group. In addition to the acute withdrawal period there is a sub-acute withdrawal period among heavily dependent methamphetamine users that can last months to years after abstinence.

- Given the long post-acute withdrawal phase, and the reported relapse rate (up to 80%) among this group after one year, post-withdrawal linkages are crucial. Not all dependent methamphetamine users need long-term or intensive residential treatment, but some form of long-term support is required to achieve better outcomes. Linkages may include residential and non-residential rehabilitation as well as outpatient counselling and other forms of treatment and support, such as peer support services.

- There is a need to adapt current treatment approaches including: adopting new screening tools; managing longer and more sustained withdrawal while in treatment; modifying therapies to take account of methamphetamine-related cognitive impairment; managing challenges in treating clients with severe depressant and stimulant problems in the same program; and a need for longer treatment programs and sustained intensive aftercare.[v]

[u] Personal correspondence, AOD Policy Unit, ACT Health, 18 March 2016.

[v] These adaptations to current treatment approaches in response to the rise in methamphetamine presentations were raised and discussed at the accredited methamphetamine training facilitated by ATODA in June to August 2015, and delivered to 25% of the workforce based in ACT Health funded or delivered specialist drug treatment and support services.

Section 5: Priority 2—Specialist AOD treatment for Aboriginal and Torres Strait Islander people

The second priority need identified in the specialist AOD services in the ACT is for increased specialist AOD treatment and targeted quality improvement activities specifically for Aboriginal and Torres Strait Islander people. This second priority area is in addition, in tandem to, and builds upon, the first priority (as described in Section 4).

The needs and priorities for culturally safe specialist AOD treatment types specifically for Aboriginal and Torres Strait Islander people in the ACT are:

1. Explicit and specific purchase and increased provision of:
   - Specialist AOD assessment
   - Specialist AOD counselling
   - Specialist AOD non-residential rehabilitation.
2. Aboriginal and Torres Strait Islander people seeking treatment from specialist AOD mainstream settings receive culturally safe care and support.
3. Targeted quality improvement— purchase of specific and external AOD specific supervision for AOD workers providing treatment and support for Aboriginal and Torres Strait Islander people.

These components of specialist AOD treatment require increased investment to enable the specialist AOD treatment and support system to provide optimal care and AOD treatment outcomes for Aboriginal and Torres Strait Islander people. This section describes each of these components, the rationale for their needs and maps each against the relevant ACT AOD Minimum Data Set treatment types: assessment, counselling, and rehabilitation (non-residential).

5.1 Culturally safe specialist AOD treatment types specifically for Aboriginal and Torres Strait Islander people in the ACT

As outlined in in Section 3, Aboriginal and Torres Strait Islander people are accessing specialist AOD treatment and support through both Aboriginal and Torres Strait Islander community controlled and mainstream services. Therefore, the service needs identified in the Section 3.1 are equally relevant to *all* specialist AOD treatment and support services in the ACT. If we consider what AOD treatment and support services are specifically purchased and delivered for Aboriginal and Torres Strait Islander people, it is clear that there are particular ACT AOD Minimum Data Set treatment types that require additional investment.

ATODA understands that the following ACT AOD Minimum Data Set treatment types are not explicitly and specifically purchased for Aboriginal and Torres Strait Islander people:[5]

- Comprehensive specialist AOD assessment
- Specialist AOD counselling
- Non-residential rehabilitation.

Hence the full range of ACT AOD Minimum Data Set treatment types are not currently explicitly and specifically purchased for Aboriginal and Torres Strait Islander people. This means that the majority of ACT AOD Minimum Data Set treatment types specifically purchased for Aboriginal and Torres Strait Islander people are non-clinical. This creates a major inequity in the provision of high quality clinical AOD treatment for Aboriginal and Torres Strait Islander people in the ACT.

As described earlier in this paper, these ACT AOD Minimum Data Set treatment types (e.g.

counselling, non-residential rehabilitation) are in high demand in the ACT by both Aboriginal and Torres Strait Islander people and others wanting AOD treatment.

While it is important to purchase all ACT AOD Minimum Data Set treatment types specifically for Aboriginal and Torres Strait Islander people, the simple provision of additional funding for services will not achieve this. If a service provider does not currently provide these treatment types then specialist AOD treatment infrastructure will need to be established and further developed over time. This includes, for example: tertiary qualified counsellors (e.g. psychologists) with AOD specific training and external AOD supervision; and AOD clinical models of care.

As previously stated, where possible, the provision of Aboriginal and Torres Strait Islander specific AOD interventions should be prioritised to sit with Aboriginal and Torres Strait Islander community controlled organisations, and where this is not possible there should be mechanisms in place to build the capacity of community controlled organisations to provide these AOD services.

As highlighted in Section 3.2.3, it should also be noted that there are additional costs associated with providing the AOD care required by Aboriginal and Torres Strait Islander clients (as articulated in the DA-CCP adaptation for Aboriginal and Torres Strait Islander people). The costs are demonstrably greater because of the need to include additional elements, such as more intensive follow-up, better engagement with families, transport and return to country activities.[w]

5.1.1 Explicit purchase and provision of increased comprehensive specialist AOD assessment specifically for Aboriginal and Torres Strait Islander people

The National Indigenous Drug and Alcohol Committee (NIDAC) identified that high quality AOD treatment should be based on the outcomes of a comprehensive AOD assessment, and be guided by an individual AOD treatment plan, developed collaboratively between the client and the treatment staff.[31]

In an AOD treatment service, assessment is a specialist activity that involves detailed appraisal of a person's AOD use, patterns and treatment history plus some level of screening for other important issues, such as psychological distress, that may affect AOD treatment outcomes. A client cannot have an AOD treatment plan unless they have undergone a specialist AOD assessment (see Section 2.3 and 3.1).

Comprehensive specialist AOD assessment is not currently explicitly purchased specifically for Aboriginal and Torres Strait Islander people. Such purchasing would require consideration of costing of additional cultural components as articulated in the *DA-CCP adaptation* (see section 3.2.3).

The appropriate ACT AOD Minimum Data Set treatment type for this need is:

- Assessment only.

5.1.2 Explicit purchase and provision of increased specialist AOD counselling specifically for Aboriginal and Torres Strait Islander people

The information below builds on the definition of 'counselling' provided in section 2.7.3, the description of counselling in evidence-based practice in section 3.1, and on the interventions discussed in sections 4.2, 4.3, 4.4 and 4.5.

[w] Personal communication with ACT Health, March 2016 as informed by Gomez *et al* 2014.[21]

Intensive and brief evidence-based psychological therapies for adults with AOD problems are provided by specialist AOD clinicians in the ACT, with cognitive behavioural therapies (CBT) being a primary approach.

Aboriginal counsellors have found CBT to be very useful for their Aboriginal clients and for themselves. When Aboriginal counsellors were asked about the utility of CBT with Aboriginal and Torres Strait Islander clients, they reported the positive aspects of CBT to be: its adaptability; pragmatic here-and-now approach; capacity for low intensity interventions, safe containing structure, promotion of self-agency, and valuable techniques. When practiced, they reported that CBT enhanced their clients' well-being, their own clinical skills, and their own well-being, and it reduced burnout. CBT could be even more useful with Aboriginal and Torres Strait Islander people if adapted to fit different social and cultural contexts.[73]

Specialist AOD counselling is not currently explicitly purchased specifically for Aboriginal and Torres Strait Islander people, this purchasing would require consideration of costing of additional cultural components as articulated in the *DA-CCP adaptation* (see section 3.2.3).

The appropriate ACT AOD Minimum Data Set treatment type for this need is:

- Counselling

5.1.3 Explicit purchase and provision of increased specialist AOD non-residential rehabilitation specifically for Aboriginal and Torres Strait Islander people

The information below builds on section 4.4.

Structured therapeutic non-residential services are recognised as an integral component of specialist AOD treatment and support services that should be offers for people with severe AOD problems, including as identified in the Aboriginal and Torres Strait Islander adaptation of the Drug and Alcohol Clinical Care Package.[x]

One evaluation found the viability of, and demand for, evidence-based non-residential treatment for Aboriginal and Torres Strait Islander clients with alcohol problems. A strength of note made in the evaluation of the program was with the therapist position was designated for a qualified psychologist or social worker experienced in working with AOD clients, and the inclusion of an Aboriginal Family Support Worker (AFSW).[74]

It has been long established that AOD non-residential rehabilitation services have been missing from the suite of specialist AOD interventions provided for Aboriginal and Torres Strait Islander people.[75] This remains the case in the ACT. Purchasing of non-residential rehabilitation services specifically for Aboriginal and Torres Strait Islander people would require consideration of costing of additional cultural components as articulated in the *DA-CCP adaptation* (see section 3.2.3).

The appropriate ACT AOD Minimum Data Set treatment type for this need is:

- Rehabilitation (non-residential)

[x] Personal communication with ACT Health, March 2016 as informed by Gomez *et al* 2014.[21]

5.2 Aboriginal and Torres Strait Islander people seeking treatment from specialist AOD mainstream settings receive culturally safe care and support

As detailed in Section 2, the SUSOS data shows that 19.4% of people attending mainstream specialist AOD services identified as Aboriginal and/or Torres Strait Islander.[2] Given that specialist AOD treatment and support services are in high demand and it is known that demand by Aboriginal and Torres Strait Islander people is not met, this number could potentially increase significantly.

Consequently, ensuring the cultural safety of *all* specialist AOD treatment settings in the ACT is a prioritised strategy. This strategy is about building workforce and service capacity to work with Aboriginal and Torres Strait Islander clients in mainstream settings via a range of measures.

As mentioned in Section 2, according to the most recent ACT ATOD Workforce Profile, two mainstream agencies have identified Aboriginal and Torres Strait Islander (non-clinical) positions, but the remaining mainstream specialist AOD services do not have specifically identified positions, and do not currently receive Aboriginal and Torres Strait Islander specific AOD treatment funding.[23] On the face of it, this number of workers is unlikely to address the needs of Aboriginal and Torres Strait Islander clients accessing specialist mainstream AOD services, and clearly the AOD sector needs and wants a plan for improving recruitment, retention and development of a specialist Aboriginal and Torres Strait Islander AOD workforce. Such a plan should consider appropriate targets for Aboriginal and Torres Strait Islander AOD workers and how to best support them.

The responsibility for establishing and meeting those targets should be shared across at least three areas:

1. ACT and Australian Governments AOD policy contexts (e.g. workforce development and qualification strategies through the ACT Alcohol Tobacco and Other Drug Strategy and the National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework).

2. Mainstream AOD organisations to implement internal workforce development strategies as per their Reconciliation Plans and Strategic Plans within existing resources.

3. Specifically funded Aboriginal and Torres Strait Islander identified positions whose role it is to deliver, and support the delivery of, culturally safe specialist AOD treatment and support within mainstream settings (e.g. such as the work undertaken by an Aboriginal Liaison Officer).

The first two strategies can be addressed through other, or existing, mechanisms. The third strategy requires further investment in the ACT AOD sector. In order to progress this strategy a range of options and projects could be considered in this context, including:

- Ensuring that there are adequate supports for Aboriginal and Torres Strait Islander workers to reduce isolation within mainstream services. For example this could include a minimum of two workers employed at an organisation to enable adequate support, and investing in a peer network to support Aboriginal and Torres Strait Islander AOD workers across organisations.

- Implementing innovative approaches or interagency strategies that could enable Aboriginal and Torres Strait Islander AOD workers to support clients within specialist mainstream AOD organisations. For example this could include:

- Specialist mainstream AOD services purchasing the expertise of AOD workers from Aboriginal and Torres Strait Islander community controlled services to provide in-reach services to their organisation, or
- A small team of Aboriginal and Torres Strait Islander identified AOD workers could be established to work across existing mainstream specialist AOD services to provide cultural support to Aboriginal and Torres Strait Islander clients and mainstream case managers. Such positions could perform functions encompassing:
    - Working with and supporting Aboriginal and Torres Strait Islander clients with case management, support, referral and advocacy when accessing AOD sector services, including assistance to negotiate and develop appropriate and achievable treatment plans with these services, and
    - Providing support and education to mainstream specialist AOD services to provide appropriate care for Aboriginal and Torres Strait Islander clients (e.g. conducting education, and developing and delivering health promotion activities.

Such prospective activities could be supported by complementary initiatives undertaken within the existing capacity of mainstream specialist AOD services. For example, this could be achieved through the establishment and implementation of employment targets for Aboriginal and Torres Strait Islander staff in mainstream specialist AOD treatment and support services.

5.3 Targeted quality improvement—purchase and provision of increased AOD specific and external supervision

All positions with direct client contact (both clinical and non-clinical) within specialist AOD treatment and support services should have explicit and funded AOD specific external supervision that is appropriate to the position (i.e. non-clinical AOD specific external supervision for non-clinical staff, and clinical AOD specific external supervision for clinical staff).

External AOD specific supervision for clinical and non-clinical for AOD workers is known to improve the quality of service provision in a complex and challenging service environment.[76]

Such supervision provides direction, clarity, and focus for AOD workers, and enables them to debrief and seek advice about difficult practice situations. Supervision is a vital ingredient for worker retention, stress reduction, reduced absenteeism and professional development. External supervision is necessary to ensure separation from line management/administrative supervision. Only one-third of current AOD clinical workers in the ACT have reported receiving clinical supervision.[23]

Where the capacity of services to deliver specialist AOD treatment and support is increased through the employment of specialist AOD workers undertaking clinical or non-clinical activities, contract conditions (with attached funding) should stipulate the provision of appropriate external AOD specific supervision to these positions. This applies equally to AOD clinical and non-clinical workers in Aboriginal and Torres Strait Islander-specific and mainstream AOD service contexts.

The specific funding and access to infrastructure (e.g. external specialist AOD supervisors) has not always been readily available within the ACT AOD sector. Services whose core and sole focus is the provision of specialist AOD services may have built greater infrastructure and have developed their experience in providing access to specialist external AOD supervision for their staff - whereas organisations whose primary focus is broader than specialist AOD treatment and support may not have. This means that AOD specific quality improvement strategies need to be funded in order to

establish, and build over time, the capacity, infrastructure and practice related to AOD specific external supervision.

Aboriginal and Torres Strait Islander specific AOD supervision tools and resources could be utilised to underpin this work. For example *Our Healing Ways: Putting Wisdom into Practice*, an AOD and mental health specific supervision tool developed in Victoria, is a collection of practice wisdom from a culturally appropriate and relevant perspective.[77]

The existing workforce of non-clinical specialist AOD workers in Aboriginal and Torres Strait Islander services also require external non-clinical AOD supervision.

All services funded to deliver specialist AOD treatment would provide line management/administrative supervision. However, the supervisee and clinical/external supervisor discuss clinical and professional issues as they relate to the professional growth of the supervisee. The ultimate long-term objective is to provide efficient and effective services to clients.

In addition, AOD workers who work particularly with Aboriginal and Torres Strait Islander people may, depending on their service context and/or Aboriginal and/or Torres Strait Islander background, require external *cultural* supervision to support them in their roles. Similar to specialist AOD supervision, cultural supervision can provide workers with opportunities to debrief and seek advice and strategies to manage complex and challenging practice situations.

Accordingly:

- An Aboriginal and Torres Strait Islander AOD worker in an Aboriginal and Torres Strait Islander community controlled service in a non-clinical role needs non-clinical AOD specific and external supervision.

- An Aboriginal and Torres Strait Islander AOD worker in an Aboriginal and Torres Strait Islander community controlled service in a clinical role needs clinical AOD specific and external supervision.

- An Aboriginal and Torres Strait Islander AOD worker in an identified position in a mainstream AOD treatment service needs (a) cultural supervision and (b) AOD specific and external supervision (either clinical or non-clinical, depending on the position).

- A non-Aboriginal and Torres Strait Islander worker based in an Aboriginal and Torres Strait Islander community controlled service who provides AOD treatment and/or support needs: (a) external cultural supervision; and (b) AOD specific and external supervision (either clinical or non-clinical, depending on the position).

Any resource allocations should enable structured supervision to be focused, paid for and factored into personal development plans for staff. The requirement for cultural as well as AOD-specific supervision needs to be noted and factored into resource allocations, and service and system planning.

Part C

Section 6: ACT specialist AOD treatment funding principles and key issues

This section outlines some key funding principles and considerations that should be applied in the commissioning of specialist AOD treatment generally by Primary Health Networks, and specifically by the Capital Health Network and applicable more broadly (e.g. to other ACT funding processes). These principles are applied in the context of existing standard and established practices and mechanism already in use in the ACT. This includes for example: how AOD services are purchased by ACT Health; reporting data to the ACT NMDS; and the profiling of workforce and consumer needs and issues through the Alcohol, Tobacco and Other Drug Workforce Qualification and Remuneration Profile and the Service Users' Satisfaction and Outcomes Survey.

6.1 Commissioning should be based on the Drug and Alcohol Service Planning (DASP) Model and the Drug and Alcohol Clinical Care and Prevention (DA-CCP) adaptation for Aboriginal and Torres Strait Islander people

As described in section 3.1.1, the *Drug and Alcohol Service Planning Model (DASP Model)* and the accompanying *DASP Decision Support Tool* can be utilised as a resource estimation tool. They identify the type of treatment (termed 'care') required by drug type and age group, the components of that treatment (termed 'care package'), and estimate the resources required to deliver these components across a typical population of 100,000 people over the course of a year.

The model and planning tool have been adapted into a tool for use in relation to resourcing of care packages specifically for AOD treatment for Aboriginal and Torres Strait Islander people—the *Drug and Alcohol Clinical Care and Prevention (DA-CCP) adaptation for Aboriginal and Torres Strait Islander people* (see section 3.2.3). ACT Health is the custodian of the DASP and the DA-CCP adaptation for Aboriginal and Torres Strait Islander people in the ACT. The adaptation considers the additional elements of care associated with providing AOD treatment for Aboriginal and Torres Strait Islander people that is appropriate for them, underpinned by Aboriginal and Torres Strait Islander culture and delivered in settings that are culturally secure. These elements are then costed into some of the care packages to more accurately reflect the actual (significantly higher) cost of AOD service delivery to Aboriginal and Torres Strait Islander people.

Specialist AOD services in the ACT do not have access to the DASP or DA-CCP adaptation, but have been briefed on their content at a workshop facilitated by ATODA and ACT Health on 20 April 2016.

The DASP and DA-CCP adaptation present an important opportunity to look at the existing investment in specialist AOD services in the ACT and to then systematically plan (over the longer term) what additional investments are required and where. We note, for example that Western Australia and Queensland have taken this approach and are using these resource planning tools in AOD services planning.

6.2 Primary Health Network commissioning processes to be developed in partnership with AOD experts

Primary Health Networks are experts in primary care. AOD treatment is beyond primary care and, by extension, beyond the current expertise of the Primary Health Networks.

In acknowledgement of this the Capital Health Network, ACT Health (particularly the AOD Policy Unit) and ATODA are working in collaboration to support the needs assessment, planning, commissioning, implementation and evaluation of the Australian Government's new AOD treatment investment in the ACT. Shared initial principles include:[78]

- The importance of consultation and engagement with ACT specialist drug treatment services.
- The significant expertise, skills, workforce, capacity, infrastructure, evidence-base and data systems in the ACT (and Australian) AOD sector.
- The importance of building on the existing expertise and investment in ACT specialist drug treatment services.

While these are important first steps, significant considerations need to be made and relationships built throughout the commissioning stages and over the long term – particularly with regard to securing appropriate AOD expertise with ACT service system knowledge on any funding assessment panels.

It is noted that AOD expertise is not currently within the scope of the Capital Health Network's governance and advisory structures. ATODA recommends that the existing infrastructure and resources of the ACT (and national) AOD sector are utilised and built upon rather than these being duplicated through the Capital Health Network's broader and primary health care focused mechanisms.

6.3 Scope of funding: AOD treatment

Given the specialised nature of AOD treatment and the size of the new investment through the Capital Health Network relative to the current investment in ACT specialist AOD treatment and support services, the funding should primarily focus on:

- Building upon and leveraging the existing specialist ACT AOD services firstly within the ACT (i.e. the ACT Primary Health Network boundary) and secondly within the region or catchment area.
- Being for the provision of AOD treatment.

In December 2015, the Capital Health Network issued public statements with regard to this new funding.[79] It is important to state that:

- While this funding was announced as part of the Australian Government response to crystal methamphetamine ('ice'), to be effective in practice it must be conceptualised, articulated and utilised in specialist AOD treatment—as distinct from establishing specific methamphetamine treatment services. This is consistent with the March 2016 guidance materials provided by the Australian Government Department of Health.[80]

- Most people who use methamphetamines are poly drug users. For example as demonstrated through the findings of the 2013 National Drug Strategy Household Survey which found 60% of recent illicit drug users had used at least one other illicit drug[11] and the

2013–14 AODTS-NMDS, which found 63% of persons who identified methamphetamine as their principle drug of concern also identified at least one other drug of concern.[3]

- Overall there are not specific AOD treatments for crystal methamphetamine, rather nationally within AOD treatment there are adapted practices (e.g. longer withdrawal) but the AOD treatment types remain the same (e.g. counselling, rehabilitation). Even where some jurisdictions (not the ACT) have established specific treatment programs these utilise the same treatment types (e.g. pharmacotherapy (trial phase), assessment) and evidence base (e.g. Cognitive Behavioural Therapy).

6.4 The Capital Health Network global commissioning framework must be complemented by AOD specific guidelines and criteria

ATODA understands that the Australian Government has provided core funding to the Primary Health Networks to establish themselves as—and to be ongoing—commissioning agencies. ATODA believes that 100% of new ACT AOD treatment funding should be allocated to specialist AOD services for treatment and quality improvement (including the proportion of funding allocated for services to Aboriginal and Torres Strait Islander communities).

Australia's AOD treatment system is unusual in that while specialist services are provided separately from generalist services, a large majority of this specialist treatment is provided by non-government organisations, as distinct from hospital based or private practice specialists (e.g. as is the case for inpatient mental health services). This is the case in the ACT where 90% of specialist AOD agencies are non-government.

Specialist AOD services have significant expertise in engaging this diverse and highly stigmatised population who are often excluded from other types of health and welfare systems because of their AOD use.

The 2013–14 AODTS-NMDS shows that nationally the primary referral pathway into specialist drug treatment for clients receiving treatment for their own drug use is via self-referral (42%), followed by referral by a 'health care service' (26%).[y,81]

AOD treatment is often provided, for example, by a non-government organisation by a multi-disciplinary team (including AOD workers, psychologists, social workers and nurses).

Therefore the Capital Health Network will need to approach this funding differently to other areas it may work with in the health field; for example the process for the AOD sector should be different to that being utilised in relation to mental health.

6.4.1 Concerns with 'outcomes-based commissioning' in the AOD sector

ATODA understands that the Australian Government Department of Health and the Primary Health Networks are developing an overarching commissioning framework and released a related discussion paper in December 2015.[82] While we see the value of having a consistent national framework this will need to be able to be adapted and interpreted for the different types of services funded through the Primary Health Networks. The New Horizons report found that there is a significant relationship between funding processes and AOD treatment outcomes.[19] In the case of AOD there are particular considerations that need to be accommodated. For example:

[y] Where a 'health care service' refers to: 'medical practitioner', 'hospital', 'mental health care service', and 'other health care service'.

Outcomes-commissioning is not effective for specialist AOD services

ATODA acknowledges that outcomes commissioning may be appropriate for some health matters, however the evidence shows that it is not effective for the complex area of specialist AOD services (see for example the results of the pilot payment by outcomes program in the UK).[83]

Differentiating between outcomes in treatment and outcomes commissioning

While outcomes commissioning may not be effective for specialist AOD treatment, utilising outcomes tools and frameworks within the delivery of specialist AOD services is. Through the Australian Government investment in the Improved Services Initiative and the Substance Misuse Service Delivery Grants Fund considerable work has been done within the specialist AOD service system to embed evidence-based outcomes measures and data management systems to support them.[84]

6.4.2 Existing, specific AOD sector guidelines should be used for commissioning of specialist AOD treatment with Aboriginal and Torres Strait Islander communities and services

The funding of AOD treatment specifically for Aboriginal and Torres Strait Islander people in the ACT should be consistent with the National Indigenous Drug and Alcohol Committee's (NIDAC) recommendations,[35] including:

- Consult with Aboriginal and Torres Strait Islander communities to determine what specialist AOD services are needed to meet the communities' needs.
- Quarantine funding for AOD interventions/services for Aboriginal and Torres Strait Islander people from mainstream funding.
- Prioritise the provision of Aboriginal and Torres Strait Islander specific AOD interventions by Aboriginal and Torres Strait Islander community controlled organisations.
- Where Aboriginal and Torres Strait Islander community controlled organisations are not in a position to provide specialist AOD treatment services, non-Aboriginal and Torres Strait Islander specialist AOD treatment organisations should be required to demonstrate how services will be provided in partnership with Aboriginal community controlled organisations and detail the process for transfer of funded services over to the Aboriginal community controlled organisations within an identified timeframe.
- Support the capacity building of local Aboriginal and Torres Strait Islander community controlled services to enable them to provide specialist AOD treatment services at a local level.

6.4.3 Length of AOD treatment contracts

According to a recent comprehensive national review of AOD treatment services in Australia:

> For core AOD treatment, which by its very nature needs to be long-standing, agencies require secure funding to make a commitment to enduring effective service provision and continuous quality improvement.[19]

The review highlights the significant administrative burden for services in responding to regular competitive tendering processes, which can often divert limited resources from service provision. This requirement is particularly burdensome for small non-government organisations. Short contractual timeframes can also make strategic planning problematic and contribute to difficulties in attracting and retaining skilled staff, with resultant implications for ongoing training costs, program continuity and client outcomes.

A separate recent national review of the Aboriginal and Torres Strait Islander-specific AOD treatment service sector also highlighted challenges associated with short-term funding and the burden of reporting. It similarly concluded that:

> …in the interests of more effective service provision, pressing for longer-term funding with decreased reliance on small grants should be a priority.[85]

As a result of the above-mentioned factors, a number of jurisdictional governments are moving towards longer-term contracts for AOD treatment and support services.

ACT Health and Australian Government contracts have been for 3 years (noting the current Australian Government Department of Health contracts have been extended for another 12 months).

ACT Health, the Capital Health Network and the Australian Government Department of Health should move towards implementing three year contracts for AOD treatment services, which can be rolled over for one year at a time for five years in total (a 3+1+1 model), conditional on funded agencies meeting performance measures—and as per the recommendation in the national review.[19]

6.4.4 Purchasing by and reporting to ACT AOD Minimum Data Set Treatment Types

The ACT Minimum Data Set (which feeds into the National Minimum Data Set) is the ongoing mandatory data collection system in the ACT (and the national version across Australia).

In the ACT the majority funder, ACT Health, purchases services aligned to AOD treatment types as described in the ACT AOD Minimum Data Set dictionary. Any new AOD treatment funding to be commissioned through the Capital Health Network should be consistent with this approach. All funding commissioned should have to comply with reporting requirements of the ACT Minimum Data Set.

6.4.5 Minimum investment in order to genuinely enable additional AOD treatment capacity

The majority of AOD treatment resources are allocated to staffing. In order to genuinely create more AOD treatment capacity in the ACT a minimum allocation of one full-time equivalent staff member (or approximately $115,000) per organisation/service is required. This standard was set in consultation with specialist AOD services in 2015 and is the standard applied by ACT Health in its allocation of additional specialist AOD service funding in 2015–2016.

6.4.6 AOD specific external supervision

Any positions funded with direct client contact (both clinical and non-clinical) should explicitly describe and cost AOD specific external supervision that is appropriate to the position (i.e. non-clinical AOD specific external supervision for non-clinical staff, etc).

6.4.7 Funded external independent evaluations

Any new programs or initiatives funded by the Capital Health Network should include an explicitly funded external independent evaluation component—both of funded programs and of the ACT AOD treatment commissioning process through the Capital Health Network.

6.4.8 Care taken not to cost shift

The AOD specialist drug treatment funding being distributed through the Primary Health Networks is to be used for the provision of new or additional services, and should not be used to resource programs that would otherwise be funded by the ACT or Commonwealth government. Collaboration between the Capital Health Network and ACT Health should mitigate that service duplication and cost shifting does not occur. Where funding to government services using the Primary Health Network funding is being considered, the government service should specifically demonstrate how the proposed program is out of scope for other government funding. This is consistent with the principles outlined in the drug and alcohol treatment services annexure to the PHN Programme Guidelines.[1]

6.4.9 Length of tender process

The tender process undertaken by the Capital Health Network should be consistent with the standard length of engagement with community organisations in the ACT. The ACT Government's guidelines on community engagement state that, "a minimum of six weeks is recommended" to allow enough time for organisations to participate.[86]

6.4.10 Articulation of program logic

The tendering process should include the specific articulation of the program logic of the activities to be commissioned; that is, articulating what the program is, what it expects to do, and how success will be measured. It provides a useful roadmap for the project by identifying and linking the assumptions, inputs, activities with program outputs and outcomes.[87,88]

6.5 Clear articulation of how 'market failure' is determined within the ACT AOD sector and the actions taken if identified

The current ACT and Australian AOD treatment service intake boundaries may not necessarily align with the Primary Health Network boundaries. In addition, not all local areas can support the provision of all specialist AOD treatment types. A historic response to this has been to develop specialist drug services which provide state/territory wide or cross-region services. This has occurred most commonly with residential rehabilitation services.

It is critical that there is acknowledgement that 'market failure' in the AOD sector should not be determined solely on the basis of what services exist within the Primary Health Network boundaries.

The policy that Primary Health Networks do not provide specialist AOD treatment and direct care should be maintained in cases of 'market failure'. The articulation of what constitutes market failure within the AOD sector should be negotiated with the AOD sector.

ATODA cannot identify any AOD treatment type that the AOD sector could not deliver in the ACT.

Local partnerships/collaborations between the state/territory AOD peak (e.g. ATODA in the ACT), the Primary Health Networks (e.g. Capital Health Network) and the state/territory health officials (e.g. ACT Health AOD Policy Unit) are well-placed to provide advice on current service provision and will enable a broader understanding of the AOD service system, the limitations within particular regions and facilitate collaboration (e.g. across jurisdictions or two or more Primary Health Networks).

Appendix A: Checklist of key stakeholder engagement

(as per guidelines provided by the Australian Government Department of Health)[89]

The checklist below confirms that in the process of writing this paper all the key elements of the needs assessment checklist provided by the Australian Government Department of Health have commenced. It is noted that while engagement has begun, ATODA believes that no ACT stakeholders would see the level of engagement so far as sufficient. This is because of the limited timelines. However, ATODA notes that the Capital Health Network committed to engaging with the stakeholders listed below in subsequent processes.

Stakeholder area	**ACT specific stakeholder**	**Engaged**	**Input provided to this paper**
State/Territory government services related to drug and alcohol	ACT Health (particularly the AOD Policy Unit)	Yes	Yes
Peak AOD Body	ATODA	Yes	Yes (author of this paper)
Drug User Organisation	Canberra Alliance for Harm Minimisation and Advocacy (CAHMA)	Yes	Yes
Local AOD treatment providers	All ACT Health and/or Department of Health funded specialist AOD services (NGO and government)	Yes	Yes
Aboriginal Community Controlled Organisations	• Winnunga Nimmityjah Aboriginal Health Service • Gugan Gulwan Youth Aboriginal Corporation	Yes	Initial meeting has taken place. ATODA recommends an additional process is undertaken specifically with regards to discussing commissioning for *Priority 2 – specialist AOD treatment for Aboriginal and Torres Strait Islander people in the ACT.*
Consult with key AOD researchers	Social Research and Evaluation	Yes	Yes
Other essential elements			
Consolidate a list of AOD treatment needs		Yes (as per this paper)	
Prioritise the list of treatment needs with strong justification		Yes (as per this paper)	

Appendix B: ACT ATOD services quick reference guide: by service name

(Source: ACT ATOD Services Directory version 13, November 2015)[90]

This list is a snapshot of ACT alcohol, tobacco and other drug services by service type. It lists the service name, description, and phone number. Services are listed alphabetically.

Information was collected from the Directory version 13 (www.directory.atoda.org.au) in November 2015.

Alcohol and Drug Services, ACT Health

Aboriginal and Torres Strait Islander Liaison Officer	Provides support to Aboriginal and/or Torres Strait Islander people to access and participate in ATOD services.
Consultation and Liaison and Comorbidity Service	Provides consultation and liaison support, assessment information and referrals for people in The Canberra Hospital who are experiencing ATOD issues. The Comorbidity Officer works specifically with people experiencing comorbid ATOD and mental health issues.
Counselling and Treatment Service	Provides ATOD counselling for adults, young people, family members and carers including a range of therapeutic and education groups
Inpatient Withdrawal Unit	Provides up to 7 days of medicated residential inpatient support for people experiencing withdrawal from ATOD.
Integrated Multi-agencies for Parents and Children Together (IMPACT)	Provides ATOD counselling for adults, young people, family members and carers including a range of therapeutic and education groups
Opioid Treatment Services	Provides opioid substitution treatment and coordinated care by working with other health and pharmacotherapy services.
Police and Court Drug Diversion Service	Provides programs that aim to divert people apprehended for ATOD use or ATOD related offences from the judicial system into the health system.

Canberra Alliance for Harm Minimisation and Advocacy (CAHMA)

Canberra Alliance for Harm Minimisation and Advocacy (CAHMA)	A peer based users group run by and for past or current illicit/injecting drug users, their families and friends.
The Connection	Provides a peer based support and education service for Aboriginal and/or Torres Strait Islander and other people. The Connection service aims to reduce the harms associated with alcohol & other drugs, with a focus on illicit and/or injecting drug use.

CatholicCare Canberra and Goulburn

Sobering Up Shelter	Provides overnight support, care and monitoring for people over the age of 18 who are intoxicated from alcohol and other drugs.

Directions

Althea Wellness Centre	Provides primary health care for people impacted by ATOD issues.
Arcadia House	Provides 7 days of non-medicated residential support for people experiencing withdrawal from ATOD; a 12-week transition program (incorporating residential and day program elements); and an 8-week non-residential day program.
Needle and Syringe Program (NSP): Pharmacy	Pharmacy NSPs are community retail pharmacies that distribute a range of injecting equipment. Pharmacy NSPs may supply injecting equipment and disposal containers free of charge for either sale or distribution to NSP clients.
Needle and Syringe Program (NSP): Primary	Pharmacy NSPs are community retail pharmacies that distribute a range of injecting equipment. Pharmacy NSPs may supply injecting equipment and disposal containers free of charge for either sale or distribution to NSP clients.
Needle and Syringe Program (NSP): Secondary	Secondary NSPs operate within an existing health or community service and may provide the same range of services as primary NSPs but typically have a limited capacity to deliver services in addition to injecting equipment and disposal facilities.
Needle and Syringe Program (NSP): Syringe Vending Machines	Syringe Vending Machines (SVMs) are self-contained units that dispense injecting equipment mostly for a small fee. SVMs operate after NSP service hours or provide 24-hour access to injecting equipment.
Support and Self Help Groups	Provides ATOD counselling for adults, young people, family members and carers including a range of therapeutic and education groups
Treatment and Support	Provides assessment, counselling, case management and support services for individuals, their partner, families and friends impacted by ATOD.

Gugan Gulwan Youth Aboriginal Corporation

Drug and Alcohol Program	Provides ATOD information, support, advocacy, case management and court support for young Aboriginal and Torres Strait Islander people aged 12 – 25 years.

Karralika Programs Inc.

Alcohol and Drug Driving Awareness - including Sober Driver Program and REVERSED	Provides education programs for people who have been charged with or are facing charges for drink/drug-driving offences. The programs specifically cater for drug driving offenders, mid to high range alcohol and repeat offenders.
Karralika Family Program	Provides up to 12 months of residential rehabilitation within a therapeutic community setting for adults with ATOD problems with accompanying children up to the age of 12.
Karralika Therapeutic Community Adult Program	Provides up to 12 months of residential rehabilitation within a therapeutic community setting for single adults and couples with ATOD problems.

Karuna Short Stay Program	Provides 8 weeks of residential rehabilitation within a therapeutic community setting for single adults and couples with ATOD issues.
Nexus Program	Provides a men's aftercare program for men experiencing ATOD problems.
Solaris Therapeutic Community	Provides a therapeutic community approach for adult males in the Alexander Maconochie Centre (AMC) with moderate to severe alcohol and other drug dependence.

Ted Noffs Foundation

Adolescent Drug Withdrawal Unit - ADWU	Provides up to 14 days of non-medicated residential support for young people aged 13 – 18 years experiencing withdrawal from ATOD.
Community Outreach Outclient Program – COOP	Provides support to young people aged 12 – 18 years who are experiencing ATOD issues in the community, and who do not want or need residential rehabilitation services.
Continuing Adolescent Life Management (CALM)	Provides up to three years of aftercare for young people leaving the PALM program.
Program for Adolescent Life Management (PALM)	Provides up to 3 months residential rehabilitation for young people aged between 13 – 18 years experiencing ATOD issues.

The Salvation Army

Canberra Recovery Services (Bridge Program)	Provides a residential rehabilitation program for people experiencing ATOD and/or gambling dependencies.

Toora Women Inc.

Lesley's Place Drug and Alcohol Residential and Outreach Service	Provides supported accommodation for up to three months and outreach support for women experiencing ATOD problems and women with accompanying children.
Marzenna Drug and Alcohol Residential Service	Provides medium to long-term supported accommodation for up to 12 months for women experiencing ATOD problems and accompanying children.
Women's Information Resource, Education on Drugs and Dependency (WIREDD)	Provides an 8-week ATOD day program including information, education, counselling and resources to women to minimise the harms associated with ATOD and other dependency.

Winnunga Nimmityjah Aboriginal Health Service

Alcohol, Tobacco and Other Drug Services	Aboriginal and Torres Strait Islander community-controlled primary healthcare including drug and alcohol clinical and non-clinical services.

Appendix C: AODTS—NMDS main treatment types for alcohol and other drugs

(Excerpt from: ACT Health 2015, pp.34–35)[91]

Main treatment type for alcohol and other drugs

Definition

The main activity determined at assessment by the treatment provider to treat the client's alcohol and/or drug problem for the principal drug of concern.

Classification

1	Withdrawal management (detoxification)
2	Counselling
3	Rehabilitation
4	Pharmacotherapy
5	Support and case management only
6	Information and education only
7	Assessment only
8	Other

Missing values

Missing values are not permitted for this data item.

Guide for use and validation checks

- If *Main treatment type* is coded 5 (Support and case management only), 6 (Information and education only) or 7 (Assessment only), then *Other treatment type* 1–4 must be blank.
- If *Main treatment type* is coded 1 (Withdrawal management (detoxification)), 3 (Rehabilitation) or 4 (Pharmacotherapy), then *Client type* must not be coded 2 (Other's alcohol or other drug use).
- If *Main treatment type* is coded to 4 (Pharmacotherapy), an *Other treatment type* must be reported.
- If pharmacotherapy is the main treatment type coded as 8 (Other), then an (additional) 'other treatment type' must be recorded.
- A single client record cannot have the same *Main treatment type* code recorded more than once, with the exception of code 8 (Other).
- The AIHW will continue to monitor *Main treatment type* 'Assessment only' duration and provide information to the jurisdictions on: episode duration of 30-89 days, and 90 days or longer. The AIHW has added validation checks for 'Assessment only' episodes greater than six months.
- The *Main treatment type* is the principal focus of a single treatment episode, as judged by the treatment provider, for the principal drug of concern. Consequently, each treatment episode will only have one main treatment type.
- For brief interventions, the main treatment type may apply to as few as one contact between the client and agency staff.

- Code 1 (Withdrawal management (detoxification)): refers to any form of withdrawal management, including medicated and non-medicated, in any delivery setting.
- Code 2 (Counselling): refers to any method of individual or group counselling directed towards identified problems with alcohol and/or other drug use or dependency. This code excludes counselling activity that is part of a rehabilitation program as defined in code 3.
- Code 3 (Rehabilitation): refers to an intensive treatment program that integrates a range of services and therapeutic activities that may include counselling, behavioural treatment approaches, recreational activities, social and community living skills, group work and relapse prevention. Rehabilitation treatment can provide a high level of support (i.e. up to 24 hours a day) and tends towards a medium to longer-term duration. Rehabilitation activities can occur in residential or non-residential settings. Counselling that is included within an overall rehabilitation program should be coded to code 3 for Rehabilitation, not to code 2 as a separate treatment episode for Counselling.
- Code 4 (Pharmacotherapy): refers to pharmacotherapies that include those used as maintenance therapies (e.g. naltrexone, buprenorphine, and methadone treatment) and those used as relapse prevention. Use code 1 (withdrawal management) where a pharmacotherapy is used solely for withdrawal. Note collection exclusions: excludes treatment episodes for clients who are on an opioid pharmacotherapy program and are not receiving any other form of treatment.
- Code 5 (Support and case management only): refers to when there is no treatment provided to the client other than support and case management (e.g. treatment provided through youth alcohol and other drug outreach services). This choice only applies where support and case management treatment is recorded as individual client data and the treatment activity is not included in any other category.
- Code 6 (Information and education only): refers to when there is no treatment provided to the client other than information and education. It is noted that, in general, service contacts would include a component of information and education.
- Code 7 (Assessment only): refers to when there is no treatment provided to the client other than assessment. It is noted that, in general, service contacts would include an assessment component.
- Code 8 (Other): refers to other main treatment types such as nicotine replacement therapy or outdoor therapy.

WHY IS THIS DATA ITEM COLLECTED?

This data item is collected to explore the types of treatments being accessed by clients. Main treatment type is then analysed with reference to other dataset variables.

References

[1] The Australian Government Department of Health. (2016). 'Annexure A2—Drug and Alcohol Treatment Services'. Annexure to *Primary Health Network. Grant Programme Guidelines—February 2016.* Canberra: Department of Health. Accessed 21 June 2016 at: www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Program_Guidelines

[2] Alcohol Tobacco and Other Drug Association ACT (ATODA). (2016). 'Service Users' Satisfaction and Outcomes Survey 2015: a census of people accessing specialist alcohol and other drug services in the ACT'. *ATODA Monograph Series,* No.4. Canberra: ATODA. Available at: www.atoda.org.au

[3] Australian Institute of Health and Welfare (AIHW). (2015). 'Alcohol and other drug treatment services in Australia 2013–14: state and territory summaries'. *Drug treatment series* no. 25. Cat. no. HSE 158. Canberra: AIHW.

[4] ACT Health. (2016). 'AOD Treatment Services Plan'. Presentation delivered by ACT Health on 3 May 2016 to a meeting of ACT specialist AOD treatment and support services, ACT's Primary Health Network, ACT Health and ATODA.

[5] ACT Government, Procurement and Capital Works. 'Contracts Search'; Accessed 21 June 2016 at: www.procurement.act.gov.au/contracts/contracts_register/contracts_register_functionality/contracts-search

[6] Bradshaw, J. (1972). 'The concept of social need', *New Society*, 19(496):640-3.

[7] ACT Health. (2010). *ACT Alcohol, Tobacco and Other Drug Strategy 2010–2014*. Canberra: ACT Health. Accessed 21 June 2016 at: www.health.act.gov.au/datapublications/reports/alcohol-tobacco-and-other-drugs

[8] Ministerial Council on Drug Strategy. (2011). *National Drug Strategy 2010–2015. A framework for action on alcohol, tobacco and other drugs*. Canberra:Department of Health and Ageing. Accessed 21 June 2016 at: www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/nds2015

[9] McQueen, R. & Biven, A. (2012). *Review of the Need to Expand Drug and Alcohol Rehabilitation Services in the ACT*. Commissioned by the Alcohol and Other Drug Policy Unit, Health Directorate—ACT.

[10] Australian Institute of Health and Welfare (AIHW). (n.d.) *One Simple Question Could help you Close the Gap.* AIHW: Canberra. Accessed 21 June 2016 from: www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=6442471394

[11] Australian Institute of Health and Welfare (AIHW). (2014). *National Drug Strategy Household Survey detailed report 2013.* Drug statistics series no. 28. Cat. no. PHE 183. Canberra: AIHW.

[12] Australian Bureau of Statistics (ABS). (2013). *Australian Aboriginal and Torres Strait Islander Health Survey: First Results, Australia 2012-13*. Report number: 4727.0.55.001. Canberra: ABS.

[13] Alcohol Tobacco and Other Drug Association (ATODA). *ACT electronic Alcohol, Smoking & Substance Involvement Screening Test [ACT eASSIST]*. Canberra:ATODA. Accessed 21 June 2016 at www.act-eassist.org.au

[14] American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders. 5th ed.* Washington, DC: American Psychiatric Association.

[15] Livingston, M. (2013). 'Alcohol-fuelled violence on the rise despite falling consumption', *The Conversation*, 26 February 2013. Accessed 8 August at https://theconversation.com/alcohol-fuelled-violence-on-the-rise-despite-falling-consumption-9892

[16] Degenhardt, L., Larney, S., Chan, G., Dobbins, T., Weier, M., Roxburgh, A., Hall, W.D. & McKetin, R. (2016). 'Estimating the number of regular and dependent methamphetamine users in Australia, 2002–2014', *Medical Journal of Australia*, 204(4):153.

[17] Lai, F.Y., O'Brien, J., Thai, P.K., Hall, W.D. & Mueller, J.F. (2016). 'Trends in methamphetamine residues in wastewater in metropolitan and regional cities in south-east Queensland, 2009-2015', *Medical Journal of Australia*, 204(4):151-2.

[18] Dietze, P. (2016). 'Current drug trends and responses'. Presentation given at the Parliamentary Drug Summit 2016. Accessed 21 March 2016 at www.drugpolicyreform.com.au

[19] Ritter, A., Berends, L., Chalmers, J., Hull, P., Lancaster, K., Gomez, M. (2014) *New Horizons: The review of alcohol and other drug treatment services in Australia*, Drug Policy Modelling Program, National Drug and Alcohol Research Centre, UNSW, Sydney New South Wales.

[20] Alcohol Tobacco and Other Drug Association ACT (ATODA). (2015). *Provision of Accredited Methamphetamine ("Ice") Training with specialist drug services and Aboriginal and Torres Strait Islander Community Information*. Final Report (unpublished).

[21] Gomez, M., Ritter, A., Gray, D., Gilchrist, D., Harrison, K., Freeburn, B., & Wilson, S. (2014). *Draft Adapting the Drug and Alcohol Service Planning Model for Aboriginal and Torres Strait Islander people receiving alcohol, tobacco and other drug services: Components of care and a resource estimation tool*. Canberra: ACT Health.

[22] ACT Health. 'Health Liaison Officers, Aboriginal & Torres Strait Islander Health Portal'. Accessed 21 June 2016 at: www.health.act.gov.au/our-services/aboriginal-torres-strait-islander-health/health-liaison-officers

[23] Alcohol Tobacco and Other Drug Association ACT (ATODA). (2015). 'ACT Alcohol, Tobacco and Other Drug Workforce Qualification and Remuneration Profile 2014'. *ATODA Monograph Series,* No.2. Canberra: Alcohol Tobacco and Other Drug Association ACT (ATODA).

[24] Alcohol Tobacco and Other Drug Association ACT (ATODA). (2015). *Funding required for non-government specialist drug treatment and support services to effectively respond to a 36% increase in demand and rising methamphetamine-related harms.* May 2015. Accessed 1 April 2016 at http://www.atoda.org.au/wp-content/uploads/ATODA_Paper_NGO_drug_treatment_demand_and_methamphetamine_harms_Final_0515.pdf

[25] Winnunga Nimmityjah Aboriginal Health Service. (2015). *2014–2015 Annual Report*. Winnunga Nimmityjah Aboriginal Health Service: Canberra.

[26] Gray, D. & Wilkes, E. (2010). *Reducing alcohol and other drug related harm*. Resources sheet no 3. Closing the Gap Clearinghouse. Australian Institute of Health and Welfare: Canberra. Accessed 21 June 2016 at: www.aihw.gov.au/uploadedFiles/ClosingTheGap/Content/Publications/2010/ctgc-rs03.pdf

[27] Stokes, J.(ed). (2014). *Alcohol and other drug treatment for Aboriginal and Torres Strait Islander peoples*. Canberra: Australian National Council on Drugs.

[28] McDonald, D. (2014). *Consumer participation in the Australian alcohol and other drug sector*. Roundtable report and background paper prepared for the Australian National Council on Drugs. Canberra: Australian National Council on Drugs.

[29] Marlatt, G.A. & Gordon, J.R. (1985). *Relapse Prevention: Maintenance Strategies in the Treatment of Addictive Behaviours*. New York: Guilford Press.

[30] van der Sterren, A. and Anderson, I. (2002). *Building responses to blood-borne virus infection among Kooris using injecting drugs—Improving the link between policy and service delivery*. Discussion Paper No.7, Melbourne: Victorian Aboriginal Health Service Co-operative Ltd and VicHealth Koori Health Research & Community Development Unit.

[31] National Indigenous Drug and Alcohol Committee. (2014). *Alcohol and other drug treatment for Aboriginal and Torres Strait Islander peoples.* Canberra: Australian National Council on Drugs.

[32] See for example: Dance, P., Tongs, J., Guthrie, J., McDonald, D., D'Souza, R., Cubillo, C., Bammer, G. (2004). '*I want to be heard*': *an analysis of needs of Aboriginal and Torres Strait Islander*

illegal drug users in the ACT and region for treatment and other services. Canberra: National Centre for Epidemiology and Population Health, Australian National University.

[33] Mapfumo, L., Waples-Crowe, P., Ware, J. (2010). *Action Research - Addressing HIV risks related to injecting drug use in Victorian Aboriginal Communities*, A report for the Victorian Department of Health. Melbourne: Anex and the Victorian Aboriginal Community Controlled Health Organisation Inc (VACCHO).

[34] Intergovernmental Committee on Drugs. (2015). *National Aboriginal and Torres Strait Islander Peoples' Drug Strategy 2014–2019*. A sub-strategy of the National Drug Strategy 2010–2015. Canberra: Intergovernmental Committee on Drugs.

[35] National Indigenous Drug and Alcohol Committee (NIDAC). (2013). *Funding of Alcohol and Other Drug Interventions and Services for Aboriginal and Torres Strait Islander People*. Position Statement issued by NIDAC, August 2013.

[36] Belenko, S., Patapis, N. & French, M.T. (2005). *The economic benefits of drug treatment: a critical review of the evidence for policy makers*. Philadelphia, PA: Treatment Research Institute, University of Pennsylvania.

[37] Department for Work and Pensions, United Kingdom. (2015). *Understanding the costs and savings to public services of different treatment pathways for clients dependent on opiates*, DWP ad hoc research report no. 17. London: Department for Work and Pensions.

[38] Harm Reduction International (2016). *What is harm reduction? A position statement from Harm Reduction International*. Accessed 21 June 2016 at: www.hri.global/what-is-harm-reduction

[39] United Nations Office on Drugs and Crime (n.d.) *Reducing the harm of drug use and dependence*. Accessed 21 June 2016 at: www.unodc.org/ddt-training/treatment/VOLUME%20D/Topic%204/1.VolD_Topic4_Harm_Reduction.pdf

[40] Ritter, A. & Cameron, J. (2006). 'A review of the efficacy and effectiveness of harm reduction strategies for alcohol, tobacco and illicit drugs', *Drug & Alcohol Review*, 25(6):611-24.

[41] Wilson, D.P., Donald, B., Shattock, A.J., Wilson, D. & Fraser-Hurt, N. (2014). 'The cost-effectiveness of harm reduction', *International Journal of Drug Policy*, 26(Suppl 1):S5-11.

[42] Penn, R., Mukkath, S., Henschell, C., Andrews, J., Danis, C., Thorpe, M., Thompson, M., Gao, Y., Miller, C. & Strike, C. (2011). *Shifting Roles: Peer Harm Reduction Work at Regent Park Community Health Centre.* Toronto: Centre for Addiction and Mental Health.

[43] Peles, E., Schreiber, S. & Adelson, M. (2013). 'Opiate-dependent patients on a waiting list for methadone maintenance treatment are at high risk for mortality until treatment entry', *Journal of Addiction Medicine*, (7)3:177-82.

[44] Chun, J., Guydish, J., Silber, E., & Gleghorn, A. (2009). 'Drug treatment outcomes for persons on waiting lists'. *American Journal of Drug and Alcohol Abuse.* 34(5): 526-533.

[45] Effective Interventions Unit. (n.d.), *Integrated care for drug users: principles and practice*. Accessed 21 March 2016 from: www.sehd.scot.nhs.uk/publications/icdu/icdu.pdf. Edinburgh: Effective Interventions Unit, Substance Misuse Division, Scottish Executive.

[46] Kaplan, E. & Johri, M. (2000). 'Treatment on demand; an operational model'. *Health Care Management Science*, 3:171-193.

[47] McBean, R., Hipper, L., Tatow, D.,Buckley, J., Podevin, K. and Fewings, E. (2015). *Queensland Alcohol and Other Drug Treatment Service Delivery Framework.* Accessed 1 April 2016 at: dovetail.org.au/media/103784/qldaodtreatmentframework_march2015finalpdf.pdf

[48] McKetin, R., Najman, J.M., Baker, A., Lubman, D.I., Dawe, S., Ali, R., Lee, N.K., Mattick, R.P., & Mamun, A. (2012). 'Evaluating the impact of community-based treatment options on methamphetamine use: findings from the Methamphetamine Treatment Evaluation Study (MATES)'. *Addiction*, 107(11):1998-2008.

[49] Ritter, A. (n.d.). *Population planning for alcohol and other drug services: the national Drug and Alcohol Clinical Care & Prevention (DA-CCP) Project* [powerpoint slides]. Sydney: National Drug and Alcohol Research Centre. Accessed 21 June 2016 at: ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/Session%20Four%20-%20Alison%20Ritter.pdf

[50] Alcohol Tobacco and Other Drug Association ACT (ATODA). (2014). *Submission to the ACT Budget Consultation 2015–16*. Dated 27 October 2014.

[51] Gustafson, D.H., McTavish, F.M., Chih, M-Y., Atwood, A.K., Johnson, R.A., Boyle, M.G., Levy, M.S., Driscoll, H., Chisholm, S.M., Dillenburg, L., Isham, A. & Shah, D. (2014), 'A smartphone application to support recovery from alcoholism: a randomized clinical trial', *JAMA Psychiatry*, 71(5):566-72.

[52] Friedrich, R.M. & Kus, R.J. (1991). 'Cognitive impairments in early sobriety: nursing interventions'. *Archives of psychiatric nursing*, 5(2):105-12.

[53] Blodgett, J.C., Maisel, N.C., Fuh, I.L., Wilbourne, P.L. & Finney, J.W. (2014). 'How effective is continuing care for substance use disorders? A meta-analytic review'. *Journal of Substance Abuse Treatment*, 46(2):87-97.

[54] Brown, C.H., Bennett, M.E., Li, L. & Bellack, A.S. (2011). 'Predictors of initiation and engagement in substance abuse treatment among individuals with co-occurring serious mental illness and substance use disorders'. *Addictive Behaviors*, 36(5):439-47.

[55] National Institute on Drug Abuse. (2012). *Principles of Drug Addiction Treatment: A Research-Based Guide (Third Edition)*. National Institute on Drug Abuse, National Institutes of Health, US Department of Health and Human Services. Accessed 21 June 2016 at: www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/acknowledgments

[56] LeeJenn Health Consultants. (2014). *Methamphetamine step-up step-down withdrawal model evaluation Final Report.* Melbourne: UnitingCare ReGen.

[57] Hoffman, K. A., Green, C. A., Ford, J. H., Wisdom, J. P., Gustafson, D. H., & McCarty, D. (2012). 'Improving quality of care in substance abuse treatment using five key process improvement principles'. *The Journal of Behavioral Health Services & Research*, 39(3):234–244.

[58] Begg, S., Vos, T., Barker, B., Stevenson, C., Stanley, L. & Lopez, A.D. (2007), *The burden of disease and injury in Australia 2003*, PHE 82. Australian Institute of Health and Welfare, Canberra.

[59] Razavi, H., Waked, I., Sarrazin, C., Myers, R.P., Idilman, R., Calinas, F., Vogel, W. *et al.* (2014) 'The present and future disease burden of hepatitis C virus (HCV) infection with today's treatment paradigm', *Journal of Viral Hepatitis*, 21, (Suppl. 1):34–59.

[60] The Kirby Institute. (2015). *Bloodborne viral and sexually transmitted infections in Aboriginal and Torres Strait Islander people: Surveillance and Evaluation Report 2015.* Sydney: The Kirby Institute, University of New South Wales.

[61] The Kirby Institute. (2015). *HIV, viral hepatitis and sexually transmissible infections in Australia Annual Surveillance Report 2015*. Sydney: The Kirby Institute, University of New South Wales.

[62] Department of Health. (2014). *Second National Hepatitis B Strategy 2014–2017*. Canberra: Commonwealth of Australia.

[63] Alavi, M., Grebely, J., Micallef, M., Dunlop, A.J., Balcomb, A.C., Day, C.A., Treloar, C., Bath, N., Haber, P.S., Dore, G.J. (2013). 'Assessment and treatment of hepatitis C virus infection among people who inject drugs in the opioid substitution setting: ETHOS study'. *Clinical Infectious Diseases*, 57(Suppl 2):S62–9. Available at: kirby.unsw.edu.au/projects/ethos-cohort-enhanced-treatment-hepatitis-c-opioid-substitution-settings

[64] Hepatitis ACT. (2016). *Hepatitis Australia Fact Sheet: Accessing new treatments for hepatitis C*. Accessed 21 June 2016 at: hepatitisact.com.au/hepatitis-australia-fact-sheet-accessing-new-treatments-for-hepatitis-c/

[65] The Australian Government Department of Health. (2016). *Hep C Medicines The Facts: Fact Sheet for Community Based Prescribers.* Canberra: Department of Health. Accessed 21 June 2016 at www.pbs.gov.au/browse/publications

[66] Wade, A.J., Macdonald, D.M., Doyle, J.S., Gordon, A., Roberts, S.K., Thompson, A.J. & Hellard, M.E. (2015). 'The Cascade of Care for an Australian Community-Based Hepatitis C Treatment Service'*. PLoS One,* 10(11):e0142770.

[67] Australian Institute of Health and Welfare. (2015). 'Alcohol and other drugs (AODTS-NMDS) data cubes—Closed treatment episodes for clients own drug use by principal drug of concern 2013–14'. *Alcohol and other drugs data*. Accessed 5 April 2016 at www.aihw.gov.au/alcohol-and-other-drug-treatment-services-data (since superceded by 2014–15 data cubes)

[68] Iversen, J. & Maher, L. (2015). *Australian NSP Survey. Prevalence of HIV, HCV and injecting and sexual behavior among Needle and Syringe Program attendees. 20 Year National Data Report 1995–2014.* Sydney: The Kirby Institute, University of New South Wales.

[69] Dietze, P., Cogger, S., Malandkar, D., Olsen, A. & Lenton, S. (2015). *Knowledge of naloxone and take-home naloxone programs among a sample of people who inject drugs in Australia*. Sydney: National Drug and Alcohol Research Centre, University of New South Wales.

[70] Olsen, A., McDonald, D., Lenton, S. & Dietze, P. (2015) *Independent evaluation of the 'Implementing Expanded Naloxone Availability in the ACT (I-ENAACT) Program', 2011-2014; final report*. Melbourne: Centre for Research Into Injecting Drug Use. Accessed 10 August 2016 from www.atoda.org.au/wp-content/uploads/Naloxone-Evaluation-Report-FINAL_August-2015_BI.pdf

[71] Alcohol Tobacco and Other Drug Association ACT (ATODA) *Expanding Naloxone Availability in the ACT* [webpage]. Accessed 10 August 2016 at: www.atoda.org.au/policy/naloxone/

[72] Dietze, P. (2014). *News: 'Ice Epidemic?' How increased purity of crystal meth explains Victoria's rising methamphetamine related harms.* Victoria: Burnet Institute. Accessed 21 June 2016 at: www.burnet.edu.au/news/436_ice_epidemic_how_increased_purity_of_crystal_meth_explains_victoria_s_rising_methamphetamine_related_harms

[73] Bennett-Levy, J., Wilson, S., Nelson, J., Stirling, J., Ryan, K., Rotumah, D., Budden, W. & Beale, D. (2014), 'Can CBT Be Effective for Aboriginal Australians? Perspectives of Aboriginal Practitioners Trained in CBT'. *Australian Psychologist*, 49:1–7.

[74] D'Abbs, P., Togni, S., Rosewarne, C., Boffa, J. (2013). 'The Grog Mob: lessons from an evaluation of a multi-disciplinary alcohol intervention for Aboriginal clients'. *Australian and New Zealand Journal of Public Health*, 37(5):450–6.

[75] Brady, M., Dawe, S. & Richmond, R.L. (1998). 'Expanding knowledge among Aboriginal service providers on treatment options for excessive alcohol use'. *Drug & Alcohol Review*17: 69–76.

[76] Roche, A.M. & Pidd, K. (2010). *Alcohol & Other Drugs Workforce Development Issues and Imperatives: Setting the Scene*. Adelaide: National Centre for Education and Training on Addiction (NCETA), Flinders University.

[77] Victorian Dual Diagnosis Initiative: Education and Training Unit. (2012). *Our Healing Ways. Putting Wisdom into Practice. Working with co-existing mental health and drug and alcohol issues Aboriginal Way*. Melbourne:Victorian Dual Diagnosis Initiative: Education and Training Unit auspiced by St Vincent's Hospital.

[78] Capital Health Network, ATODA, ACT Health. *Joint Communiqué No. 1 for ACT Specialist Drug Treatment Services.* 18 February 2016. Accessed 21 June 2016 at: www.atoda.org.au/wp-content/uploads/ACT-Specialist-Drug-Treatment-Services_Joint-Communique_No.-13.pdf

[79] Capital Health Network. (2015). *Capital Health Network: Leading ice treatment services in the ACT* [webpage]. Dated 7 December 2015. Accessed 21 June 2016 at www.chnact.org.au/capital-health-network-leading-ice-treatment-services-act

[80] Australian Department of Health. (2016). *Primary Health Networks. Grant Programme Guidelines.* February 2016—Version 1.2. Canberra: Department of Health. Accessed 15 July from: www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Program_Guidelines

[81] Australian Institute of Health and Welfare. (2015). *Alcohol and other drug treatment services in Australia 2013–14*. Drug treatment series no. 25. Cat. no. HSE 158. Canberra: AIHW.

[82] The Australian Government Department of Health. (2015). *PHN Commissioning: Procuring Services and Shaping Supply*. Discussion paper, December 2015. Canberra: Department of Health.

[83] Mason, T., Sutton, M., Whittaker, W., McSweeney, T., Millar, T., Donmall, M., Jones, A. & Pierce, M. (2015). 'The impact of paying treatment providers for outcome: difference-in-differences analysis of the 'payment by results for drugs recovery' pilot'. *Addiction*, 110(7):1120–1128.

[84] McDonald, D. (2015), *Evaluation of AOD peak bodies' roles in building capacity in the Australian non-government alcohol and other drugs sector: final report*. Wamboin, NSW:Social Research & Evaluation.

[85] Gray, D., Stearne, A., Bonson, M., Wilkes, E., Butt, J. and Wilson, M. (2014). *Review of the Aboriginal and Torres Strait Islander Alcohol, Tobacco and Other Drugs Treatment Service Sector: Harnessing Good Intentions* (Revised Version). Perth, WA: National Drug Research Institute, Curtin University.

[86] ACT Government, (2011), *Engaging Canberrans. A guide to community engagement*. Canberra: ACT Government. Accessed 21 June 2016 at: www.timetotalk.act.gov.au/guide-to-engagement/

[87] Pacific Research and Evaluation Associates. (2010). 'Program logic', *Community Sustainability Engagement Evaluation Toolbox* [website]. Accessed 21 June 2016 at: evaluationtoolbox.net.au/index.php?option=com_content&view=article&id=30&Itemid=136

[88] Better Evaluation. 'Develop Programme Theory', *Better Evaluation. Sharing information to improve evaluation* [website]. Accessed 21 June 2016 at: betterevaluation.org/plan/define/develop_logic_model

[89] The Australian Government Department of Health. (2016). *Needs Assessment Toolkit. Supporting Primary Health Networks in conducting regional drug and alcohol treatment needs assessments.* Unpublished document, 29 February 2016.

[90] Alcohol Tobacco and Other Drug Association ACT (ATODA). (2013). *ACT Alcohol, Tobacco and Other Drug Services Online Directory* [website]. Version 13 updated on 12/15. Canberra: ATODA. Accessed 21 June 2016 at: directory.atoda.org.au

[91]Alcohol and Other Drug Policy Unit, ACT Health. (2015). *Data Dictionary and Collection Guidelines: ACT Minimum Data Set for Alcohol and Other Drug Treatment Services.* Version 3, 24 June 2015. Canberra: ACT Health.

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Alcohol Tobacco & Other Drug Association ACT