Maintaining and Strengthening Specialist Alcohol and Other Drug Services for the ACT Community Needs Assessment Analysis, 2022-2025

Alcohol Tobacco & Other Drug Association ACT

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Contents

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

This needs assessment is supported by funding from the Capital Health Network, the ACT's Primary Health Network. We appreciate the ongoing collaboration between the specialist Alcohol Tobacco and Other Drug (ATOD) sector and the Capital Health Network (CHN) which commenced in 2016 when the CHN commissioned ATODA to conduct a baseline assessment of specialist AOD service needs in the ACT.

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About ATODA

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

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

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

ATODA has an in-house network of internal and 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.

Introduction

The Capital Health Network (CHN) has commissioned ATODA to

- provide this needs assessment chapter, with a focus on promoting feedback from the ATOD sector to enrich its contents;
- provide updated demand and service modelling for the ACT using the Drug and Alcohol Service Planning Model (DASPM); and
- re-cost services currently funded by the CHN.

ATODA's commissioned work for this Needs Assessment is intended to inform advocacy for enhanced service provision and future service design, both by the CHN and other funders of AOD services in the Territory. It is based on a careful review of published literature which includes written evidence and oral testimony provided to the ACT Legislative Assembly's Inquiry into the Drugs of Dependence (Personal Use) Amendment Bill 2021. ACT data is included wherever available and only augmented by national data where this is lacking or where comparisons are necessary Feedback has been gathered from a wide variety of stakeholders in conformity with the needs assessment checklist provided by the Federal Department of Health.[1] Drafts were prepared by ATODA with assistance from executives of specialist AOD service organisations, but final editorial oversight rests with the CHN. Further detail on the methodology is given in Appendix 1. Data sources and acronyms are listed in Appendix 2.

As ATODA progresses work on the other two workstreams between September 2021 and March 2022, it will seek opportunities to further enrich the needs assessment information.

Table 0.1 – Checklist of key stakeholder engagement

Stakeholder area	**ACT specific stakeholder**	**Engaged**	**Input provided**
Local AOD treatment providers	ACT Health and/or Department of Health funded specialist AOD services (NGO & government) – see Appendix 3	Yes	Feedback given in workshop with Specialist AOD Executives on 30 August, and written feedback provided on drafts
Peer-based organisation	Canberra Alliance for Harm Minimisation and Advocacy	Yes	Verbal and written feedback provided
State/Territory government services related to AOD policy	ACT Health Directorate (particularly the AOD Policy Unit)	Yes	Feedback given in workshop at Specialist AOD Executives meeting on 30 August, and in writing
Key AOD researchers	David McDonald, Social Research and Evaluation and Anna Olsen, ANU	Yes	Reviewed first draft
Peak AOD Body	ATODA	Yes	Initial author
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)

1. Outcomes of the health needs analysis

Breadth of ATOD use and associated harms

Tobacco, alcohol and illicit drugs each contribute to avoidable ill-health and premature mortality. The Australian Institute of Health and Welfare (AIHW) calculates the contribution of leading risk factors for the burden of disease nationally, with periodic updates.

Table 1.1: Contribution of different drugs to total burden of disease, including year of source data

	ACT (2011)[2]	National (2015, 2018)
Tobacco	5.4%	8.6%[3]
Alcohol	4.2%	4.5%[3]
Illicit drugs (all)	2.2%	2.7%[4]

Tobacco

The ACT Government reported data from the AIHW's Australian Burden of Disease Study in 2011[2] indicating that tobacco use resulted in the highest burden of disease of any modifiable factor, exceeding combined dietary risks (5.1%) and high body mass index (4.5%). More recent ACT figures are not available, but a recently released summary national report,[3] states that of all the measured factors, tobacco use continues to result in the highest burden of disease (8.6% in 2018), and accounted for 13% of all deaths in Australia in 2018. ATODA has previously estimated that there are just under 29,000 smokers in the ACT. Of these, slightly under 4,000 attended an alcohol or other drug (AOD) specialist service in 2018-19, meaning that a substantial proportion of all the ACT's smokers attend AOD services.[5]

Alcohol

In 2011, alcohol use was the fourth greatest risk factor for the burden of disease in the ACT. In the ACT, alcohol is the leading risk factor for disease burden among 15–24 year-old males (11.4%) and females (4.0%). It is also the leading risk factor in 25–44 year-old males (10.2%) and females (2.8%)[6]. Around 80% of Australian adults consume alcohol.[7] In 2019, 20.7% of ACT residents aged 14 years and older engaged in risky drinking at least once a week[8], although this was the lowest rate recorded by the jurisdictions. Still, as in other jurisdictions, younger ages groups and males are more likely to report risky levels of alcohol use. Furthermore, the Alcohol and Other Drug Treatment Services National Minimum Data Set shows that alcohol was the principal drug of concern in 42% of recorded treatment episodes in the ACT.[9]

Illicit drugs

The disease burden from illicit drugs is not in the top five causes as shown in Table 1.1.[4] However, nationally illicit drugs are associated with around 11.5 million hospitalisations per year[10] and one-fifth of deaths reported to the Australian coronial system.[11] In 2019, 14.6% of ACT residents aged 14 years and older reported illicit use of any drug in the previous year, this was lower than the national figure of 16.4%.[12]

Social determinants of ATOD use

The burden of disease from ATOD is not evenly distributed across Australia. Some areas and populations experience worse outcomes due to factors such as higher levels of unemployment, lower educational attainment, and poorer access to, and use of, health services. For example, people living in the lowest socioeconomic areas of Australia were about 3.7 times as likely as those in the highest socioeconomic areas to smoke daily (19.0% compared with 5.1%). The association between socioeconomic status and ATOD harms has implications for a wealthy jurisdiction like the ACT. While lower than the national average, almost 10% of the ACT's population of approximately 432,000[13] live in households that are among Australia's most disadvantaged.[14] It is reasonable to assume that smoking rates in the Canberra community are highest among these disadvantaged households.

Demography of AOD service users

People may seek to access a range of AOD treatment and harm reduction program options to meet their personal goals for AOD use. This may include harm reduction measures that enable a person to reduce their risk of harm while continuing some drug use. At the 2018 ACT Service Users Satisfaction and Outcomes Survey (SUSOS) (see Appendix 4), 58.3% of public AOD service users were men, 39.8% were women and 1.3% were non-binary or self-described.[15] Analysis of closed treatment episodes for 2019-20 (see Appendix 5) indicated a similar breakdown, and these levels have been stable across previous SUSOS surveys in 2009, 2012, and 2015. SUSOS respondents varied in age from 15-71 years, with a mean age of 37.5 years. Over one in ten (10.7%) were aged 10-19 years.[15] Many service users come from disadvantaged backgrounds or priority population groups. For instance, 31% of those accessing an ACT AOD service identified as Aboriginal and/or Torres Strait Islander, and 9.7% identified as LGBTIQ+ (with an additional 4.2% indicating 'other' or 'prefer not to say).[15] Additionally, 13.3% indicated that they were from a culturally and linguistically diverse background, and 20.4% (SUSOS) identified as having a disability (compared with about 18% in the Australian population, noting that there has been no age adjustment in making this comparison)[16]. Most adults accessing AOD services (61.2%) were parents.

AOD services users, disadvantage and comorbidity

People seeking treatment and harm reduction from specialist AOD services are disproportionately disadvantaged across many variables. For example, there is a very high rate of smoking among Canberra's AOD service users – 76.9%[15] compared to 8.6% in the general population.[2] Similarly, use of one illicit drug is often associated with the use of additional illicit drugs. Comorbid risky drug use and mental health is an issue for several reasons, including shared risk factors. Analysis of treatment episodes provided in 2019-20 (see Appendix 5) indicates that cumulatively, about 7 out of every 10 clients have a mental health diagnosis.

Table 1.2: Demographic characteristics of service users in 2018 SUSOS[15]

Service users who self-identified as….	Proportion reported in 2018 SUSOS (%)	
	Overall	Range across services
Living alone	30.0	7.5 – 53.6
Unemployed (adults over age 18 years)	69.5	44.6 – 88.2

Homeless or at risk of homelessness	30.1	15.1 – 48.6
On the waiting list for Social Housing	22.4	11.1 – 35.1
Adults with Year 10 or lower as their highest level of education	49.9	23.5 – 71.9

Socioeconomic issues also compound health issues. Disadvantage is correlated with a wide range of health problems, including increased morbidity and higher mortality.

Over 30% of AOD service users in 2017 were homeless or at risk of homelessness[15]. It is positive to note the apparently high levels of accessing of AOD services in this group. However, in some instances there is anecdotal evidence of people, especially homeless men and women experiencing domestic violence, accessing rehabilitation facilities partly to have a place to sleep for the night. This speaks to the wider lack of emergency accommodation in the community. There is also considerable anecdotal evidence of high levels of trust by disadvantaged groups in the peak body for people who use drugs, the Canberra Alliance for Harm Minimisation and Advocacy (CAHMA), as evidenced by the organisation's ability to connect with AOD users during quarantine of public housing facilities throughout the second COVID-19 lockdown after the 12th of August 2021. There is also an opportunity for active outreach to these groups for AOD treatment after the lockdown.

Risk profiles of different drugs

Tobacco, alcohol and illicit drugs each have a different risk-profile. It is generally accepted that each cigarette smoked contributes to ill-health, and a dose/response relationship exists. Smoking rates increase with socio-economic disadvantage. Moderate alcohol consumption is widely accepted as normal practice in Australia, though the most recent National Health and Medical Research Council (NHMRC) advice indicates that all alcohol consumption is associated with some health risk. Nevertheless, the NHMRC advises that "to reduce the risk of harm from alcohol-related disease or injury, healthy men and women should drink no more than 10 standard drinks a week and no more than 4 standard drinks on any one day".[17] Risk of harm from tobacco, alcohol and other drugs also relates to a person's biological, mental, social, and economic risk and protective factors. Protective factors such as economic and social capital can reduce the likelihood of problematic drug use, and reduce some risks associated with a given level of drug use. Most people who use illicit drugs do not require treatment,[18] and risks vary by drug.

Reasons why many people do not seek treatment

The different levels of risk for a drug make determining the population who would benefit from treatment or harm reduction difficult to assess, as there is typically a subjective judgement about what level of risk requires treatment or harm reduction. This is complicated by the fact that some people who would benefit from treatment or harm reduction services do not want them. Reasons for this include:

- different appetites for risk or reward
- the stigma associated with illicit drug use or treatment, or alcohol treatment
- long waiting periods which often characterise the sector deterring treatment seeking.

The important point is that there remains a portion of people who use alcohol and other drugs who would and could benefit from treatment who do not seek it. Concerted public health efforts to encourage those who would benefit from treatment, harm reduction services or information to obtain it, similar to those which have occurred for HIV, could make a positive difference. This would have the effect of increasing demand on already over-taxed specialist services and would be most effective in conjunction with increases in sector funding and capacity.

The current ACT Legislative Assembly's Select Committee's Inquiry into the Drugs of Dependence (Personal Use) Amendment Bill 2021 (hereafter referred to as 'the Inquiry'), and potential passage of the associated Bill, will likely affect demand for AOD services. If passed, the Bill would partially decriminalise personal possession of small amounts of most or all illicit drugs. Passage of the Bill in its current form would be unlikely to increase drug use and might decrease problematic drug use in the medium or long term. However, in reducing barriers to treatment and harm reduction, most notably stigma, its passage would likely increase demand on specialist AOD services.[5] This effect would be magnified if, as some submissions to the Inquiry have advocated, treatment were made mandatory. However, research evidence shows that mandatory treatment is often ineffective, and that voluntary treatment is most effective.[19, 20] Voluntary treatment also reflects the rights of the person concerned and is consistent with best practice promoted by consumer groups.

2. Outcomes of the service needs analysis

Scene setting

Different levels of response to problematic ATOD use

The response to problematic ATOD use across Australia takes place at three main levels:[21]

- Primary prevention activities designed to limit uptake of ATOD use by new users, e.g., school programs.
- Secondary prevention activities designed to identify, and offer early intervention to, people who may be at risk of developing ATOD-related problems.
- Tertiary prevention designed to offer specialist treatment to people with moderate to severe ATOD-related problems and options to reduce harm from substance use.

Secondary prevention is often delivered by GPs and other health workers in primary health care settings, and by workers in a range of other health and community service delivery settings. Anecdotally, many GPs are not enthusiastic about treating AOD problems. Underlying factors may be that it is not their area of expertise and/or they do not make a special effort to meet that client group. This may be exacerbated in Canberra given the low rate of bulk billing generally, given that many people who use drugs cannot afford additional medical fees. AOD service providers report there are insufficient GPs who prescribe Opioid maintenance treatment (OMT), impeding access to treatment for consumers and leaving the system highly vulnerable, particularly as many of these practitioners may soon retire.

Opportunities for self-assessment and self-management are increasingly offered online. Brief interventions may also be conducted by staff of the ATOD sector as an adjunct to specialist work, or in settings where contact with service consumers is short-lived.

In the ACT, most of the AOD work is done by specialist AOD services, which include withdrawal and residential rehabilitation, AOD assessment and brief interventions, and harm

reduction measures such as needle and syringe programs or pharmacotherapy. The ATOD treatment sector in the ACT delivers more than thirty programs across the main treatment types. A detailed description of these programs can be found in the ACT ATOD Services Online Directory at directory.atoda.org.au, and they are summarised in Appendix 6.

Tertiary treatment and harm reduction for moderate to severe ATOD-related problems are generally delivered through the specialist treatment sector. Residential treatment services are utilised by a proportion of consumers with more severe and complex care needs; this group also uses community-based treatment services. Specialist ATOD treatment is most suitable for individuals whose ATOD use has led them to experience significant impairment or distress. There are a relatively small number of GPs who provide pharmacotherapy for illicit drugs and/or overdose prevention programs using naloxone via the subsidised public Medicare scheme. The National Opioid Pharmacotherapy Statistics Annual Data (NOPSAD) 2020 report (Supplementary Table: S15) indicated there were 11 public prescribers, 49 private prescribers, one public/private prescriber, and 8 prescribers at the AMC on the census day.[22] AOD service providers and consumer groups report a structural vulnerability due to reliance on an insufficient number of GPs, the majority of whom work at the Interchange Co-operative Tuggeranong and Hobart Place in the city. This workforce is also aging.

Specialist AOD services

A key strength of the ATOD sector in the ACT is the integration of government and non-government services to collaboratively provide a wide range of evidence-based harm reduction and treatment interventions (see Appendix 7).[21] Key facts about the sector are:

- Nine of the ten specialist service providers are community organisations (NGOs) – see Appendix 4 for further detail.
- There are several specific treatment and program types that are only provided by non-government service providers. These are shaded in Figure A7.1, Appendix 7.
- The specialist ATOD service sector includes programs catering for the needs of specific populations, for example: youth; Aboriginal and Torres Strait Islander people; women; and families.

The ACT's population of approximately 432,000[13] benefits from ten specialist AOD service providers, which often operate from more than one site and offer several programs. The National Quality Framework for Drug and Alcohol Treatment Services sets a minimum benchmark for AOD treatment services including clinical governance.[23] The Framework has nine nationally agreed Guiding Principles which include statements of commitment that articulate key aspects required to improve quality in AOD treatment services. All specialist AOD service providers are accredited against the principles in the Framework,[23] except one service which is working towards accreditation.[24]

The specialist AOD service sector in the ACT is organised to help assist several priority populations, with some providers focusing all or some of their programs on: Aboriginal and Torres Strait Islander people, youth, women, and adults with children. While this is essential when tailoring best practice treatments to individuals accessing services, at times it complicates allocation of people to places, as some people are not eligible for various types of specialist treatment.

Quantity of treatment services provided

Appendix 8 summarises the availability of ATOD treatment services in the ACT by treatment type, providing detail on the number of providers. In 2019-20, 6,438 'closed' episodes of

alcohol and drug treatment were provided in the ACT.[25] A treatment episode is 'defined as the period of contact between a client and a treatment provider or team of treatment providers'[26] and it is closed when treatment ceases. AODTS-NMDS[27] and NOSPAD data,[22] and ATODA's latest SUSOS data[15] suggest 600–700 people access ACT specialist AOD services on any one day. Table 2.1 shows the steady upward trend over the past decade. The reduction in treatment episodes during the 2019-20 period is believed to relate to the disruption caused by the COVID-19 pandemic.

Table 2.1: Total treatment episodes, ACT (2010-2020, AODTS-NMDS)[25]

	10-11	11-12	12-13	13-14	14-15	15-16	16-17	17-18	18-19	19-20
Treatment Episodes	3,156	4,080	4,416	4,652	5,222	5,914	6,389	6,931	6,700	6,438

Treatment types

The National Minimum Data Set indicates alcohol has been the leading drug of concern every year in the past decade, with 42.2% of treatment being alcohol-related in 2019-20.[25] Methamphetamine overtook cannabis to become the second drug of concern in 2014-15, and by 2019-20, 23.2% of treatment in the ACT was for this drug compared to 11.2% for cannabis. This is notable because of the relatively low prevalence of methamphetamine use in the general population. Service providers report anecdotally that these high rates of treatment concern a relatively small number of people who use the drug and face significant health issues. National Drug Strategy Household Survey data (last survey in 2019[28]) indicated that cocaine use had almost doubled from 1.9% in 2016 to 3.5% by 2019,[28] replacing MDMA as the second most commonly used illicit drug. National data[29] indicates the highest rates of use among men in the 20-29 age group and service providers in the ACT report this too, as well as an increase in cocaine use in the past twelve months, albeit from a comparatively low base. They also report a small but growing use of heroin mixed with fentanyl, both intentionally and unintentionally, which is associated with a higher risk of overdose. Further detail on the principal drugs of concern in the ACT is provided at Appendix 10.

These changes in patients' reported principal drug of concern have ongoing implications for treatment, including changes in the treatment types and clinical expertise required for different substances. Although there is currently a lack of evidence-based pharmacotherapy for methamphetamine dependence, there is a strong evidence base for the effectiveness of behavioural interventions.[30] Beyond this, the range of treatment options for various drugs tends to overlap significantly, as Appendix 9 shows. Non-pharmacological therapies, which make up the bulk of treatment episodes, can be adapted to a wide range of drugs.

Figure 2.1: Main treatment types in the ACT, 2010-2020[25]

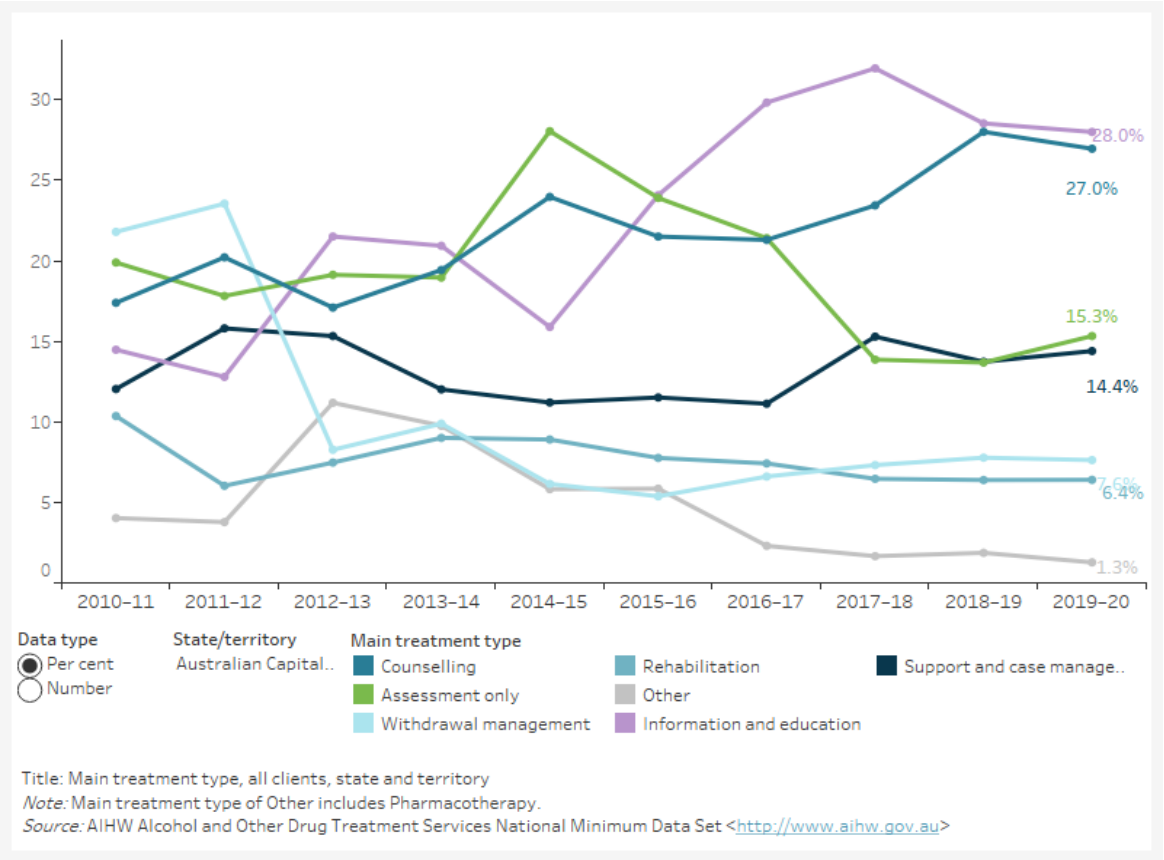


Figure 2.1 shows the type of treatment delivered to clients for their own drug use for different types of drugs over the past decade and is based on the analysis of AODTS-NMDS data.[9] Notable points are:

- the main treatment type was information and education (28.0%), closely followed by counselling (27.0%)
- the proportion of more intensive treatment options, such as residential rehabilitation and withdrawal management, declined as a proportion of the service mix between 2010-2016, and after that remained relatively constant
- less intensive options, including information and education and counselling, have almost doubled during the decade from 2010-2020
- counselling rates have risen from 22% in 2015-16 to 27% in 2019-20.[9]

The need for increased counselling services was highlighted in the CHN's 2016 Baseline Needs Assessment, and it is encouraging to see the rise in counselling rates which is likely to be partially due to the increased CHN investment in this area. It would likely have been even higher were it not for the impact of COVID-19 as shown by the trend line from 2016-17 to 2018-19. It is noteworthy that in 2019-20 roughly 85% of people who accessed AOD treatment services in the ACT accessed community based AOD treatment services, compared to about 15% who access residential withdrawal and rehabilitation services. It is likely that there had been latent demand for counselling services in the community for some time prior to the funding for additional places. There are few mechanisms to quantify latent demand for AOD services in the ACT, but when new services are made available, demand is consistently illustrated by high levels of service uptake. There is likely further latent demand

for counselling and a wide range of other AOD services that would be made apparent with increased treatment offerings.

Smoking cessation treatment typically occurs via specialist tobacco service providers, primary care providers, and/or AOD services. Treatment can include counselling, use of a quit line, nicotine replacement therapy (NRT) or other pharmacotherapy. This can be undertaken with or without the assistance of a GP, though some forms of pharmacotherapy either require a prescription or the cost may be reduced with a prescription.

Impact of COVID-19 lockdowns

Despite the COVID-19 lockdown period in the April – June quarter of 2019-20,[22] the number of opioid pharmacotherapy clients was practically identical compared to the previous year.[22] The distribution of sterile needles and syringes increased by 7% in 2020.[31] There was only a 4% percent decline in treatment episodes in 2019-20 compared to 2018-19 in the ACT[27] – see Appendix 11. This was largely accounted for by fewer counselling and information and education episodes. Rehabilitation episodes were 4% lower in 2019-20 than in 2018-19, in line with the general trend, and withdrawal episodes were 6% lower.[27] For comparison, NSW experienced a 15% fall in rehabilitation episodes, and withdrawal episodes fell 7% during the same period.[27] The relatively small impact on service delivery in the ACT during the pandemic speaks to the organisation, collaboration and commitment of the ACT specialist AOD sector. Innovative responses over the past 18 months include a **pharmacotherapy service and outreach COVID-19 testing and vaccination**.

Cross-border treatment

Cross-border treatment for AOD issues is more common than for many health conditions due to several factors including:

- many people will seek AOD treatment far from home due to stigma associated with AOD dependence and the desire for a change in environment or social circles.
- some forms of treatment have limited availability for some groups, requiring interstate travel. For instance, residential rehabilitation programs for young people are rare in Australia, and as one is offered in Canberra, young people travel interstate to Canberra for this treatment.
- Indigenous Canberrans cannot currently access a community-controlled rehabilitation facility in the ACT.

Harm reduction activities are often brief and often relatively frequent (e.g., procuring sterile injecting equipment), and are therefore less amenable to long distance access. Anecdotally, access to ACT harm reduction services by people from Queanbeyan, Goulburn and the surrounding area occurs.

Canberra's position as the major population centre in the local area means that people from nearby regional New South Wales access treatment in the ACT. ATODA analysed the data set of closed treatment episodes provided in 2019-20 by post code and found that 18.3% were provided to people whose home address was outside the ACT – see Appendix 5.

Data from the Network of Alcohol and other Drugs Agencies (NADA) database (NADAbase) has been requested and we expect to receive this in early November. Analysis will allow calculation of the total episodes of care provided by publicly funded non-government AOD service providers in New South Wales to people who reside in the ACT. Subtraction of this

figure from the number of episodes of care for people who travel the other way for treatment, will indicate the net flow of those seeking cross-border treatment. This calculation will not include people who reside in the ACT who attend AOD treatment in a state other than New South Wales or who attend a service not captured by NADAbase. NADAbase includes only data from NADA members, and therefore excludes all NSW government-provided alcohol and other drug services.

Funding of AOD services

Services in the ACT are provided at comparatively low or no cost to service users. The largest single funder of AOD services is the ACT Government which provides approximately $22 million annually for AOD services via the Health Directorate and Canberra Health Services. Current contracts end in June 2022 and there is a need to evaluate service delivery needs and costs. The contracts have not been properly re-costed for about a decade. The ACT Government also provides smaller amounts of funding for treatment provided to people with drug offences diverted to the treatment system via the Justice and Community Safety Directorate. Federal government funding is provided directly to services and via the CHN, as well as via other channels. Several community organisations use philanthropic funds to deliver AOD services, including The Salvation Army who currently fund 38 of the residential rehabilitation beds now available. Philanthropic funding has been especially affected by the COVID-19 pandemic. Many services rely on volunteer labour to support their community outreach, and several also charge modest service user fees towards consumer living expenses in rehabilitation programs. Collectively, these diverse funding sources make up a complex funding mosaic for the delivery of AOD services which is detailed in Appendix 12. Appendix 13 outlines the CHN's different funding streams for AOD services and Appendix 14 summarises the different programs currently funded.

It is important to note that most specialist AOD services are required to obtain funds from diverse, impermanent sources, and blend them together, to support the delivery of a coherent AOD intervention or program. Both Commonwealth sources and ACT Health are critical funding sources necessary to ensure programs are available to the community. There is a risk to the AOD service system when any stream of funding is reduced or ceased, as there are impacts not just on clients directly supported by that program but on the services provided by other providers that would need to adjust to accommodate a new client base. ATODA commends recent efforts to coordinate funding between funders. However, there is not yet infrastructure to coordinate optimally, and efforts rely on the personal motivation and networks of public servants.

The AOD workforce

ATODA conducts a Workforce Profile survey of individual workers and organisations providing AOD services every three years with funding from the ACT Government's Health Directorate (HD). Preliminary results from the 2021 survey[32] have been made available with the agreement of the HD, and are elaborated in Appendix 15. The AOD workforce is highly mixed in its education and background, but consistently dedicated and focused on reducing AOD harms. In 2021,[32] the specialist AOD workforce was estimated to be approximately 330, compared to about 300 in 2017.[33]

Table 2.2: Demographics of the AOD workforce compared to service users of specialist AOD services[15, 32]

Attribute		AOD Workforce	Service users
Gender	Man	31.9%	58.3%
	Woman	63.3%	39.8%
	Non-binary or self-described	1.1%	1.3%
Mean age		43.7 years	37.5 years
Aboriginal and/or Torres Strait Islander (mainstream services only)	Yes	2.7%	17.9%
	No	96.3%	80.3%
	Prefer not to say	1.1%	1.8%
Culturally and Linguistically Diverse background (other than being of Aboriginal and/or Torres Strait Islander background)*		32.4%	9.5%
Sexual orientation	Heterosexual/straight	80.6%	86.0%
	LGBTIQ	10.9%	9.7%
	Other	0.5%	1.6%
	Prefer not to say	7.0%	2.6%

* Note that being from a CALD background was measured differently in each survey: this table reports 'country of birth' for the Workforce Profile; and the response to the question 'Do you identify as being from a culturally and linguistically diverse background?' for the SUSOS.

A comparison of workforce composition against service user composition indicates:

1. A predominantly male client base (58.3%), but a predominantly female workforce (63.3%). This may have implications for the delivery of treatment and support within specific contexts; for example, it may impact on disclosures in the therapeutic context, or affect responses to specific issues such as domestic and family violence.
2. People identifying as Aboriginal and/or Torres Strait Islander make up about 18% of the service user group, compared to only 2.7% of workers responding to the survey. This is not sufficient to address the cultural security needs of Aboriginal and Torres Strait Islander people utilizing mainstream specialist AOD services. ACT specialist AOD services have recognized for many years the need to recruit workers to Aboriginal and Torres Strait Islander-specific positions but have often faced difficulties in attracting and retaining people to these positions.
3. The proportions of people identifying as LGBTIQ are approximately equal for these two groups. This is likely to contribute to responsive and supportive service environments for people who identify as LGBTIQ.

Around half the workforce identify as AOD workers (48%), including peer workers, with 79% reporting direct client contact for at least part of their role. The average time working in the ATOD sector was just over 7 years, and the average age was 43.7 years. Almost three in five (59.2%) workers possessed a bachelor qualification or higher.[33] The ACT AOD Qualifications Strategy mandates that specialist AOD services funded by the ACT

Government will require staff to have or obtain at least a Certificate IV in ATOD or addiction studies; or a health, social or behavioural science qualification plus the 'Alcohol and Other Drug Skill Set'.[34] Staff recruitment is identified as an issue by executives, especially for positions requiring specific and high-level AOD qualifications or expertise (counselling, nurses with dosing and inpatient withdrawal expertise, peer workers, AOD case managers).[33]

A recent National AOD Workforce Profile[35] and the most recent ACT AOD Workforce Profiles[32, 33] found that the AOD service workforce faces several challenges including:

23. Low wages for most of the workforce
24. Insecure and often short-term employment contracts associated with the patchwork nature of funding and often short-term funding contracts offered to providers
25. Stress, workload and the experience of difficult clients, particularly relative to poor remuneration, as likely contributors to workers leaving the workforce.

ATODA Service Directory

ATODA compiles summaries of ATOD programs in the ACT in the ACT Alcohol, Tobacco and Other Drug Services Online Directory at directory.atoda.org.au. This directory is designed for AOD workers, who report that they regularly consult the Directory when needing to refer a client to another service. It is updated regularly, and widely used by AOD workers. The directory is not designed for use by consumers or their families, who have few resources to navigate the AOD service system. This lack of information for consumers remains a weakness in the AOD service system.

Performance of services and demand

Outcomes for clients

The AOD sector in the ACT provides high quality evidence-informed services and treatment. The sector is cohesive and unified, working together across government and non-government services to provide the main AOD treatment types to those seeking support and treatment for AOD issues. ACT services deliver positive outcomes for people able to access services. In the 2018 SUSOS people accessing ACT AOD services reported: reduced substance use (75% of people receiving services); improved general health (81%); improved mental health (73%); and reduced experience of AOD related harms, including reduced involvement in crime (80%), and improved knowledge of preventing transmission of blood borne viruses (78%).[15] Overall, 92.4% of clients surveyed reported they were very or mostly satisfied with the service and similar rates were reported in previous surveys in 2015, 2012 and 2009 (Appendix 4).

Scan against other dimensions of performance

A brief scan of the ACT AOD Sector against the other performance indicators of the Australian Health Performance Framework[36] indicates:

- Safety: service providers have policies in place to ensure services are provided in ways that keep clients safe and uphold quality of care.
- Appropriateness: the wide variety of service types and of providers promotes the provision of care appropriate to the particular client, with all offered service types supported by the evidence; however, the system can be difficult to navigate for consumers and their families.

- Continuity of care: service providers have internal systems to follow up on clients and ensure they are progressing in their treatment, and not relapsing. Although anecdotally relationships with providers in allied sectors such as mental health, youth and housing are strong and promote cross-referral of clients, service providers also report that there is considerable scope to make these more systematic. Evidence from parents of people who use drugs who gave testimony to the Inquiry indicated that once in the AOD treatment system, people are helped with navigating the service system. However, they also testified that many people experience challenges knowing how to enter the system.
- Sustainability: supplementation of government funding with philanthropic funding and some use of voluntary labour by non-government providers, ensures that unit costs are generally low across services, but the lack of long-term government funding means service providers are unsure about their long-term viability. Service providers report that overall funding is stretched, often limiting the ability for pilot projects to be sustained. This inhibits innovation and sustainability of new services.

International studies of the cost-benefit or cost-effectiveness for individual AOD interventions also consistently show that AOD treatment and harm reduction services are a good investment.[37-42]

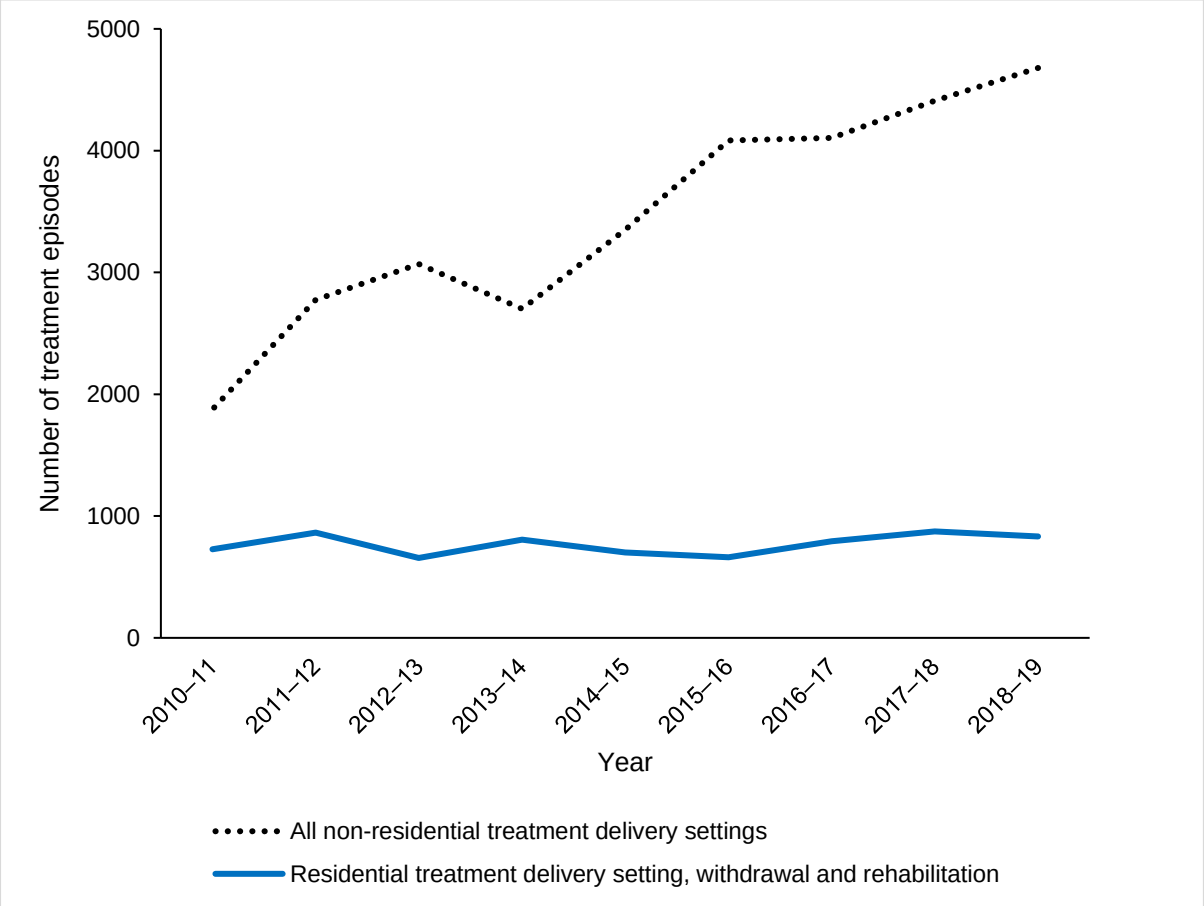
Waiting times and modelling of demand

The aim of the National Framework for Alcohol, Tobacco and Drug Treatment is that 'high quality …treatment … can be accessed when and where people need it'.[43] Circumstances for potential service users may change rapidly, so that they are unable or unwilling to take up a treatment place if there is a significant delay. In the SUSOS:[15]

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

ATODA's members frequently report long waits for community-based treatment and support services. Unfortunately, the SUSOS is not able to provide this data. Figure 2.2 provides an analysis of demand for services based on currently available data. It shows a picture of a growing client load and a sector trying to provide at least some help in the absence of commensurate funding. Further analysis is provided in Appendix 16.

Figure 2.2: Comparison of treatment episodes provided in residential and non-residential settings (AODTS-NMDS 2019)



Explanation of categories:

Residential treatment delivery setting, withdrawal and rehabilitation (solid line): only includes the treatment types 'withdrawal' and 'rehabilitation' delivered within residential treatment settings

All non-residential treatment delivery settings (dotted line): includes all treatment types delivered in all non-residential treatment delivery settings, including 'non-residential setting', 'home' and 'outreach' [note that 'other' has not been included]

National modelling commissioned by the Federal Government identified that there needs to be at least a doubling of AOD treatment capacity to meet current demand.[44] While this modelling is not specifically available for the ACT, the consistency in overall AOD use between the ACT and Australia-wide suggests it represents a reasonable estimate of overall unmet need in the ACT. This suggests, a **doubling of capacity for AOD services** is needed overall in the ACT, followed by annual increments in line with overall population increase.[44] It is not possible to extrapolate from the national data to the ACT to assess which *types* of services are needed in the ACT, however the next section uses other data sources to specify gaps more precisely. The DASP modelling exercise will provide more detailed information on met and unmet demand for AOD services.

Gaps in service coverage and systems

Gaps in current service coverage are identified in Appendix 6. They include drop-in, peer-based services for people who use drugs in the south of Canberra, expanding naloxone overdose prevention programs, increasing support and case management across sectors, withdrawal management in the sector, NRT counselling and subsidised access, and pill-testing facilities.

The submissions to the Inquiry, and testimonies from consumers and loved ones of people who use drugs, indicated the following major gaps in the current service system:

- Pre- and post-program supports – service providers are under-resourced to provide low-level support to clients prior to entry to more intensive programs, and to provide ongoing follow-up support after clients leave intensive interventions like rehabilitation care; innovation continues in this area but is constrained by under-resourcing
- Outreach treatment – structured and more intensive treatment provided in the community for those unable to attend rehabilitation facilities for personal reasons such as employment or childcare responsibilities and/or for whom outreach support is needed
    1) Provision of mental health and AOD treatment for consumers with high comorbidity. There is a need for to strengthen coordinated care for people with concurrent serious mental health conditions and severe AOD-related problems. Some Inquiry testimonies indicated that people with significant AOD issues are often turned away by mental health services. They also pointed to the need to strengthen coordination between the AOD and mental health sectors to foster access to integrated care.
    2) Equivalent access to best-practice AOD treatment and harm reduction for people in the AMC compared to the wider community should be provided; in particular a needle and syringe program needs to be provided to reduce the risk of preventable bloodborne disease infections,[45] and increased access to individual counselling services
    3) More support for families of people who seek AOD treatment. Currently there are limited dedicated programs for support to family members of people who use drugs outside of the Family Drug Support line which annually received about 460 calls from the ACT,[46] Karralika's dedicated Family Program, and Directions individual counselling and support and dedicated groups for family members/friends impacted by someone else's use. During the Inquiry this group reported there were limited services available to advise them how best to support their relative who is seeking AOD treatment, and how to maintain their own mental health.
    4) Subsidised tobacco cessation support for consumers of AOD services is limited to small programs and should be scaled up – see ATODA 2021-22 Budget submission for further detail[47]
    5) Navigating the system is difficult, especially for newcomers, and a portal providing integrated, simple advice to consumers is lacking
    6) Culturally secure services – Winnunga Nimmityjah's testimony highlighted the lack of a Culturally Controlled rehabilitation facility for Aboriginal and/or Torres Strait Islander people, although there is a Labor and Greens government commitment to build one.

Sectoral and systemic issues

Cooperation within the sector

The system is characterised by a high degree of cooperation between specialist AOD services, with cross-referral of clients for stepping up or stepping down care. Because the sector is so well-coordinated, all services are well used.

While the specialist AOD harm reduction and treatment services sit at the core of the AOD sector, they also rely on the capacities of other organisations and roles in the sector, including:

- research on service needs, support for advocacy to government on policy and funding and high quality training from the peak AOD organisation (ATODA)
- funding support informed by specialised AOD policy positions within the ACT Health Directorate
- AOD researchers who provide an external, informed source of advice on sector performance and opportunities for improvements, and
- clinicians with AOD specialities who provide specialist support for OMT.

Cooperation with allied sectors

AOD service providers also coordinate with allied services, including housing, homelessness, mental health, and domestic & family violence services, to ensure cross-referral of clients as appropriate. However, services report that there are also often insufficient places for mental health, housing and other support services for AOD clients and more work needs to be done on reducing stigma and addressing barriers to access in partnership with other sectors.

Submissions and testimony to the Inquiry generally indicated that cross-referral within the AOD sector works well due to connections across organisations. However, they also pointed to a need to strengthen coordinated care for people with concurrent serious mental health conditions and severe AOD-related problems, including via a 'no wrong door' policy and better coordination between the AOD and mental health sectors to foster access to integrated care.

Considerations for future funding choices

If in future funding for any service in the system ceases, system adjustment will be needed. This involves both clients missing out on services and changes to referral pathways. These system costs should make policy makers wary of withdrawing investment from existing services to invest in a new initiative. A clear implication is that the burden of evidence required to justify a new initiative should be set at a high level to avoid the risk of disrupting the system and counterbalance the negative impact of withdrawing investment in a particular area.

Adjustments for COVID-19

Concerted efforts were made by both the sector and the ACT Government to maintain access to treatment services during the COVID-19 pandemic. The ACT Government convened a whole of sector working group, including representation from all specialist service providers, to coordinate the sector response and provided an additional $518,000 to support alcohol and drug services to respond to the pandemic. This funding supported OMT medication supply, flexible response to demand pressures, innovation in essential services delivery, and provided AOD treatment staff with updated information on alcohol, drugs and COVID-19. ATODA updated the information in the Service Directory.[48]

The capacity of services was somewhat reduced by infection control and social distancing requirements during the ongoing COVID-19 pandemic period. Some services had to suspend in-person face-to-face services during the 2020 lockdown, but the majority of services were maintained with adjustments made for telehealth delivery, and face-to-face delivery maintained for those who required it. Anecdotal reports from services indicate that the clear majority of services have been maintained during the 2021 lockdown commencing on 12th August, though scale was sometimes reduced.

During the current lockdown, the ATOD sector has also played a prominent role in providing support to those with ATOD dependencies under quarantine in public housing developments. Peer workers have provided in-reach counselling and support to access basic services including food, and clinical services have provided to support pharmacotherapy.

The presence of structured, regular coordination and information sharing meetings at Service Executive and workers' levels assists with real-time decision-making on adjustments to services. Negative impacts such as disruptions to face to face services from prolonged lockdowns have been minimised by integrating learning from previous episodes.

3. Opportunities and priorities

Current CHN funding

The CHN currently funds a range of treatment programs and services. These were selected based on a baseline needs assessment conducted by ATODA and the CHN in consultation with all AOD service providers in 2016.

Opportunities for new investment

Priorities for new investment were identified for 2021 based on consultation with the sector, as well as review of all written submissions and oral testimony provided to the Inquiry. Those priorities appraised as having high urgency and importance are listed in Table 3.1. Ratings of 3 or 4 indicate high levels of importance and urgency; detailed explanation for the scoring is given in Appendix 17. The last column in the table outlines the gap to be addressed and some, but not necessarily all, written submissions to the Inquiry in which further information and evidence can be found. It also notes if an initiative requires legislative change, if there is a government policy commitment, and design considerations.

Each priority was also analysed against the Primary Health Network proscribed classification model for ATOD services (see Table A18.1, Appendix 18)[49] Any priority selected for new investment would need to be developed via a co-design process which includes consumers and all relevant service providers.

As noted above, if the Drugs and Dependence (Personal Use) Amendment Bill 2021 Bill is passed, it is likely that there will be increased rates of seeking treatment by those experiencing significant AOD dependence due to diminished stigma and perceived legal risk. This will place additional demand on an already overstretched ATOD sector.

Existing programs already address key service needs and consumer satisfaction levels are high. There are many existing programs that can be expanded without fear that the money will be under-utilised. These represent 'low hanging fruit' where investment in new capacity within existing services will yield positive outcomes.

Potential risks

The ACT has the substantial benefit of having all its ten providers providing high-quality, evidence-based care. When considering commissioning processes, it is also important to be wary of risks to quality from the entry of private, for-profit providers of AOD services into the service system. The Victorian Health Complaints Commissioner's review of private health service providers offering AOD rehabilitation and counselling services noted that, 'The unregulated nature of the private sector has allowed numerous operators to open AOD treatment services without the necessary competence, skills or experience to meet client needs or expectations'.[50] Commissioning processes should be wary of introducing the issues experienced in other jurisdictions associated with the presence of low-quality providers. The costs to the AOD system of even a single low-quality provider moving into the ACT would be substantial due the need for additional oversight and diminished cooperation.

The recommendations and opportunities below draw on and distil the planning, purchasing and resourcing principles outlined in the National Framework for Alcohol and Other Drug Treatment, 2019-29,[43] and the nine guiding principles of the National Quality Framework for drug and alcohol treatment services.[23]

Table 3.1 – Priorities for investment

Initiative	Importance	Urgency	Gap/issue (For more information see Inquiry submissions listed)
Treatment			
Intensive community-based outreach models targeted to where populations are located	3	3	Some populations are unable or unwilling to come into service provider facilities to receive treatment like day programs (ATODA, Directions submissions to the Inquiry)
Provision of intensive community-based care as alternative for people with complex needs	3	3	Some populations are unable to access treatment including rehabilitation in facilities due to barriers such as employment and childcare responsibilities (see ATODA, Directions, Karralika)
More capacity for intensive early intervention support & trauma-informed counselling to families and children	3	3	Families and children of people with severe AOD dependency face a lack of dedicated services to support early intervention with children and trauma-informed counselling (ATODA, Karralika, Toora)
Increase community-based withdrawal options, particularly for specific population groups	3	3	There is a lack of community-based withdrawal options for those unwilling or unable to use withdrawal facilities (ATODA, HCCA, Karralika, no. 18, Directions)
Increase government funding for residential rehabilitation service places	3	3	Many residential service places are funded by TSA, and there are often delays in accessing treatment due to capacity, discouraging treatment seeking (ATODA, several ATOD sector submissions)
Conduct infrastructure audit and fund upgrade of facilities delivering AOD services to meet current and projected demand	3	4	Many facilities have aging infrastructure needing modernisation. This increases ongoing costs such as heating and means work occurs in buildings that are not fit for purpose, reducing efficiency (ATODA, Gov't & Karralika, Directions; Labor election commitment to conduct infrastructure audit)
Fund an Aboriginal Community Controlled residential rehabilitation facility	3	3	This is lacking in the ACT (ATODA, Winnunga, Karralika, JRG; Joint Labor/Green commitment)
Building capacity & capability of specialist AOD services to respond to ancillary health and social needs within scope of practice—e.g., building on existing sector work to respond to DFV	4, 2	3	Social housing and mental health supports are especially important for many clients to have effective treatment and be able to obtain employment and other life goals (4); other supports are less important (2) (ATODA)

Initiative	Importance	Urgency	Gap/issue (For more information see Inquiry submissions listed)
Improving cultural security within specialist AOD services, including through funding and supporting Aboriginal AOD & liaison workers	2	3	Baseline capacity is already high as evidenced by the SUSOS, but there is potential to increase the Aboriginal workforce (ATODA)
Specialised support & intensive treatment for families at risk of interaction with child protection system due to AOD issues	3	3	Lack of specialised support and intensive treatment for families at risk of interaction with child protection system due to AOD issues. Children of people who use drugs are overrepresented in the child protection system and out of home care (ATODA, Karralika, CAHMA, Directions)
More robust pre- and post- program supports, including flexible options when wait lists are long	4	4	More robust pre- and post-program supports are needed to adapt to long waiting lists and reduce relapse. Given reduced intensity compared to many forms of treatment, they are a good investment (ATODA)
Increased diversion for low-level, non-violent offending associated with AOD use, including more places for and use of the Drug and Alcohol Sentencing List	3	3	There is scope for greater diversion for low-level, non-violent offending to avoid harms associated with engagement with the criminal justice system (ATODA, Karralika, Directions; this is an ACT Gov't issue (JaCS)
Further opportunities to provide in-reach across specialist AOD services	3	3	There are an increasing number of examples of successful in-reach across specialist AOD services, but more are needed to maximise collective impact and enhance coordination within the sector (ATODA)
Increase capability of AOD service users to provide treatment that integrates dependent children	3	3	Only Karralika and Toora have facilities which integrate dependent children, and these are oversubscribed (ATODA, Toora, Karralika, Directions)
Increasing mechanisms to improve cooperation, coordination and collaboration between AOD and MH sectors, with particular regard for people with concurrent complex AOD and MH issues	4	3	There is a lack of *a framework* to coordinate holistic care and integrated care models across AOD and mental health services and to co-design these with consumers (Directions, CAHMA, ATODA submission, family and GP testimonies, No. 6)
Strengthen cross-service coordination and develop an integrated model of care across AOD & allied sectors	3	3	Cross-sector coordination need strengthening to develop an integrated model of care. Anecdotal evidence from the AOD sector's COVID-19 response is that there are many people who will seek AOD treatment once they develop a relationship with an AOD service, so cross-service coordination and in-reach has capacity to increase the number of people who seek treatment (Toora Women, Salvation Army, Directions)

Initiative	Importance	Urgency	Gap/issue (For more information see Inquiry submissions listed)
Harm reduction			
Increased capacity to provide ongoing crisis supports/accommodation for clients who are intoxicated or in crisis	3	3	There is a lack of crisis supports and accommodation for clients who are intoxicated or in crisis. Some specialist AOD services have given up seeking crisis accommodation through OneLink because of a perception that they are virtually never able to provide crisis accommodation for someone with AOD issues. Overall housing stocks are quite low, and while the most recent ACT Budget committed substantial new housing investment, as of 4 October 2021, there were 2,965 households on the ACT's social housing waiting list[51] (ATODA)
Treatment with Injectable Opioids as a prescription option for medical practitioners in ACT	3	3*	Treatment with Injectable Opioids is not currently available; would likely require new legislation; opportunity to learn from Sydney trial of hydromorphone (ATODA, FFDLR, CAHMA, ADF)
Trialling of evidence-based stimulant treatment pharmacotherapy programs	3	3*	Stimulant treatment pharmacotherapy programs are not available; trials would likely require new legislation; opportunity to link with trials in other jurisdictions (ATODA, FFDLR, Directions, no.18, ACEM)
Expanding access to a Needle and Syringe Program	3	3	Needle and Syringe Program needs to be extended to reach all vulnerable populations. The most recent ACT Budget included additional funding for this, and the degree of need beyond that is not yet known (ATODA, Directions)
Introduce Needle & Syringe Program in the AMC	4	3	There is no Needle and Syringe Program in the AMC; currently opposed by the Corrective Services Union. The affected population includes those in the prison and those who are at greater risk of infectious disease from former prisoners because of a lack of NSP (ATODA, Karralika, ACTCOSS, ADF, JRG, Burnet Institute, Directions)
Introduce supervised drug consumption facility	3	3	The ACT lacks a supervised drug consumption facility. Introducing a supervised drug consumption facility would reduce risk of overdose deaths for injecting drug users (ATODA, CAHMA, ADF, no 18, Burnet Institute, Uniting, Directions; Green election commitment)

Initiative	Importance	Urgency	Gap/issue (For more information see Inquiry submissions listed)
Boost number of medical practitioners routinely prescribing naloxone	3	3	There are an insufficient number of medical practitioners routinely prescribing naloxone, meaning that current service levels are brittle and could be severely damaged by a small number of providers retiring. The low number of medical practitioners may also impede treatment due to limited availability and convenience (Directions, ATODA)
Boost number of medical practitioners registered as OST prescribers	3	4	There are an insufficient number of aging prescribers leaving the system highly vulnerable (ATODA)
Providing access to a choice of pharmacotherapies to people in custody	2	3	Currently prisoners in the AMC do not have the full range of choice of pharmacotherapy for OMT as experienced in the broader community; incarceration should not impede healthcare (ATODA)
Fixed site pill/drug checking	3	3	There is currently no permanent drug checking facility in the ACT. Drug checking allows users to monitor contamination and reduce risks as demonstrated by the festival pilot (ATODA, Directions; Labor and Green election commitment)
Other			
Develop a resource for consumers to understand services available, based on ATODA Directory	3	4	Consumers entering system lack a resource to understand the services available (raised by multiple submissions and testimonies from families); a solution could be based on the ATODA Service Directory
Increase services to support family members of people who use drugs, including improved online/phone advice, support groups and individual counselling	3	3	There is a lack of services to support family members of people who use drugs. FFDLR have no funding and there are no other services, besides a small program in Directions that serves this community. Family Drug Support line is funded privately (ATODA, FFDLR, Directions, ADF, FDS)

Recommendations for future CHN funding

- Keep funding existing services to avoid putting vital services and consumers at risk
- Promote increased flexibility and innovation in service delivery[5]
- If additional funding is available, consider priorities that are both urgent and important
- Develop new investment ideas via a co-design process with relevant actors in the sector and in consultation with consumers, seeking opportunities for enhancing partnerships across existing actors and linkages with allied sectors where appropriate
- Ensure funding decisions are informed by review of the evidence from other jurisdictions and internationally
- Consider data from the updated DASP(M) modelling when available to inform funding choices and modelling of updated service costs
- Develop clear measures to include people who use drugs in the development and monitoring of policy.

Program design principles

- Ensure adequate funds (at least 10%) are put aside for monitoring to adjust programs to better meet client needs, for external evaluation, promoting engagement of users and service providers
- Promote collection of data which feeds into the collection of the NMDS
- Ensure contract periods align with funding contract periods provided to CHN by the Commonwealth.

Over time, CHN should move to contract lengths which contribute to the longer-term viability of services and support long-term service planning:

  - 5 years (for long-established AOD programs) or
  - 3+2 (for newly established AOD programs).

This would assist services to attract and retain staff with longer or permanent contracts and promote more informed planning, leading to efficiencies.

Opportunities for the CHN and other funders

There are several opportunities for the CHN and other funders of AOD services in the Territory:

- Promote new models of operational collaboration where appropriate across AOD sector actors and with allied organisations and primary care networks[5]
- Develop a shared outcomes framework, which references national treatment and quality frameworks,[23, 43] including and promote alignment with strategic objectives of the successor to the DSAP
- Promote joint planning to contribute to overall strategic objectives for the Territory, consistent with the guiding principles of ‘collaboration and partnerships’ and ‘planning and engagement’ outlined in the National Quality Framework.[23]

Data collection

CHN’s service and demand modelling and updated costing of services projects will provide important new insights into the ATOD sector in the ACT. Currently, CHN-funded programs are required to provide data to the Alcohol and Other Drug Treatment Services National Minimum Data Set, but service providers are not required to complete the additional six

fields requested by the ACT Health Directorate.[26] This should also be required by CHN, to allow gathering of consistent information about the clients and activities of ATOD treatment services 'that will be used to inform planning and policy developments designed to reduce drug-related harm'.[26]

AODTS-MDS raw data collected in the ACT is currently only available to the individual service producing the data and the Health Directorate. An overall analysis of the data is not available to service providers or consumers. Government funders should consider providing modest funding to ATODA to support services in monitoring the outcomes of funding and analysing the data to provide regular insights into service provision in the territory and support tracking of trends in drug use.

List of Appendices

Appendix 1 – Methodology

ATODA reviewed relevant Australian Government and other publications for key information on the ACT's population and baseline health characteristics and habits, where applicable. ATODA also reviewed previous AOD needs assessments by the CHN, including the baseline conducted in 2016, the comprehensive needs assessment conducted in 2018, and updates in 2019 and 2020.

Where ACT-specific data were not available and appropriate, ATODA used national or international data where appropriate. Academic literature was interrogated to help assess appropriateness.

ATODA has also drawn extensively on its own data holdings. This includes four successive reports measuring service users' satisfaction and outcomes spanning nine years. The most recent of these is the 2018 version of the Service User Satisfaction and Outcomes Survey (SUSOS). The SUSOS is an Australia-first, single day snapshot of all service users accessing a specialist AOD service in the ACT.

This needs assessment also includes three reports spanning seven years of the Workforce Profile. This includes, most recently, preliminary results from the 2021 Profile. This data set contains information about the qualifications and other characteristics of the ACT AOD workforce.

On 11 February 2021, Mr. Michael Pettersson, MLA, presented to the Legislative Assembly a Private Member's Bill which, if passed, would decriminalize personal possession of small amounts of a wide range of illicit drugs in the ACT. The ACT Legislative Assembly took steps to examine the Bill and related issues in the alcohol and other drug sector. This included a Legislative Assembly Select Committee Inquiry into the Drugs of Dependence (Personal Use) Amendment Bill 2021. Its Terms of Reference included under item e) an examination of current strengths and weaknesses in the alcohol and other drug service sector; current and future demands; and recommending services, referral pathways and funding models that will better meet people's needs.

ATODA undertook an extensive consultation process with its members, open to all the specialist AOD providers in the ACT and representatives of allied sectors (including ACTCOSS, ACT Shelter and the Mental Health Community Coalition). This included the drafting of an initial set of consultation papers prior to a half-day session on 31 March 2021 designed to elicit ideas and establish priorities for new funding requests and the submission more broadly. The event was facilitated by a specialist external consultant.

Based on these deliberations, ATODA developed an initial draft of its submission to the Inquiry. Comment was sought from ATODA's members through three iterations of the document, each of which refined and strengthened ATODA's understanding of the AOD sector in the ACT and its strengths, weaknesses, and current and future demands. The final 42-page document was submitted to the Select Committee in June 2021.

The Inquiry elicited 59 publicly available submissions as of 15 July 2021, with a volume of roughly 1000 pages. Those making submissions include specialist alcohol and other drug services, families of people who use drugs, police, medical bodies, and advocates for and against drug law reform. Most of those making submissions were from the ACT. The publicly available submissions to this Inquiry may be the most comprehensive record of views on the health and other needs of people who use drugs in the ACT.

ATODA reviewed the submissions to the Inquiry to inform this needs assessment. Weight was given to those making submissions from within the ACT or about experiences in the ACT. The content of submissions was assessed for its relevance to this needs assessment whether it was stated as addressing matter e) of the Inquiry: 'issues specific to the drug rehabilitation and service sector (covering alcohol and other drug services) including:

i) identifying current strengths and weaknesses in the sector;

ii) assessing current and future demands; and

iii) recommending services, referral pathways and funding models that will better meet people's needs'.

For instance, some submissions from parents of people who use drugs are ostensibly about whether drugs should be 31ecriminalized, but also provide detail about the experiences they and their children have had seeking and accessing health services.

The Committee also held public hearings on four days. ATODA participated as a witness on one day and watched live, broadcast, or recorded versions of the hearings in their entirety.

Both ATODA's own consultation process with its members and allied organisations for the Inquiry and its review of all submissions to the Inquiry informed the draft needs assessment document. This was distributed to all specialist AOD organisations in the ACT to provide comment. Particular attention was paid to the list of necessary services and their classifications by urgency and importance.

Appendix 2 – Sources of data consulted and acronyms

During the Needs Assessment, published ACT AOD related information from health, social and criminal justice data were reviewed including:

- ACT AOD Service Users Satisfaction and Outcomes Survey (SUSOS)
- ACT AOD Treatment Services Minimum Data Set (AODTS-MDS)
- AOD Treatment Services National Minimum Data Set (AODTS-NMDS)
- ACT AOD Workforce Profile
- ACT Criminal Justice Statistical Profile
- ACT Prisoner Health Surveys
- Australia Secondary Schools Alcohol and Drug Surveys (ASSAD)
- Ecstasy and Related Drugs Reporting System (EDRS)
- Illicit Drug Reporting System (IDRS)
- National Drug Strategy Household Survey (NDSHS)
- National Opioid Pharmacotherapy Statistics Annual Data (NOPSAD)
- Needle Syringe Program National Minimum Data Collection (NSP NMDC)
- National Notifiable Disease Data Systems
- Drug Related Deaths and Coronial Data Systems
- ACT Ambulance and Hospital Data

All (59) written submissions and oral testimony made to the ACT Legislative Assembly Select Committee Inquiry into the Drugs of Dependence (Personal Use) Amendment Bill 2021. These formed the main content for identifying the priorities for new investment listed in Section 4 and determining their urgency and importance.

Acronyms

The acronyms for data sources are used widely in the report. Acronyms and contractions for AOD service providers are given in Appendix 3. Additional acronyms used are:

- Alcohol and Other Drugs (AOD)
- Alcohol, Tobacco and Other Drugs (ATOD)
- Alcohol Tobacco and Other Drug Association ACT (ATODA)
- Alexander Maconochie Centre (AMC)
- Australasian College for Emergency Medicine
- Australian Institute of Health and Welfare (AIHW)
- Capital Health Network (CHN)
- Client Satisfaction Questionnaire (CSQ-8)
- Department of Health (DoH)
- Drug and Alcohol Sentencing List (DASL)
- Drug and Alcohol Service Planning (Model) (DASP)
- electronic Alcohol, Smoking & Substance Involvement Screening Test (eASSIST)
- Family and Friends for Drug Law Reform (FFDLR)
- General Practitioner (GP)
- Health Care Consumers' Association ACT (HCCA)
- Mental Health (MH)
- National Health & Medical Research Council (NHMRC)
- National Minimum Data Set (NMDS)
- Needle Syringe Program National Minimum Data Collection (NSP NMDC)
- Nicotine Replacement Therapy (NRT)
- Opioid Management Therapy (OST)
- Pharmaceutical Benefits Scheme (PBS)
- Primary Health Network (PHN)
- Service Users' Satisfaction and Outcomes Survey (SUSOS)

Appendix 3 – Specialist AOD service providers in the ACT

In the ACT there are 10 publicly funded specialist AOD services that deliver more than 30 programs. These are:

- Alcohol and Drug Services, ACT Health (ADS)
- Canberra Alliance for Harm Minimisation and Advocacy (CAHMA)
- Canberra Recovery Services (The Salvation Army (TSA))
- CatholicCare, Goulburn & Canberra (CatholicCare)
- Directions Health Services (Directions)
- Gugan Gulwan Youth Aboriginal Corporation
- Karralika Programs Inc. (Karralika)
- Ted Noffs Foundation (Ted Noffs)
- Toora Women Inc. (Toora)
- Winnunga Nimmityjah Aboriginal Health and Community Services (Winnunga Nimmityjah).

These services collaborate to generate a regularly updated profile and service map that is publicly available at directory.atoda.org.au.

The shortened forms of their names are used often in the main body of the report.

Appendix 4 – Satisfaction and self-reported outcomes for service users of specialist alcohol and other drug treatment and support services in the ACT

All ten of the specialist alcohol and other drug (AOD) treatment and support services in the Australian Capital Territory (ACT) participated in the 2018 Service Users' Satisfaction and Outcomes Survey (SUSOS). This one-of-a-kind (in Australia) three-yearly state- and territory-level survey of service user satisfaction informs improvements in quality and responsiveness in specialist AOD services.

The fourth SUSOS, conducted in 2018,[15] provides an overall picture of service user demographics, experiences of accessing AOD services, perspectives of quality, and self-reported outcomes. The AOD services include withdrawal, treatment, and harm reduction services, offered in a range of settings: residential and non-residential; Aboriginal and Torres Strait Islander and mainstream; and government and non-government.

ACT specialist AOD services are in increasingly high demand

1. A total of 621 people completed the Survey in 2018—a 32% increase in response compared to 2015 (n=469).
2. It can be estimated that on any single day between 600 and 700 people access specialist AOD treatment in the ACT.

Characteristics of service users may inform need for specific service responses

The SUSOS reports on several important characteristics of the AOD service user population that may have specific socio-economic, cultural and/or service response needs. Responding most effectively to these groups to maximise service accessibility and program effectiveness may require specifically tailored responses across a range of areas, for example: staff mix and training; program structure; service environment; and referral responses. The data shows variations across specialist AOD services for many of these characteristics (Table A4.1).

Method

The SUSOS was conducted as a census survey on a single day in twenty-five programs across the ten participating specialist AOD services. Service users who agreed to participate received $25 reimbursement for completing a pen-and-paper questionnaire. While many questions were the same or comparable to earlier Surveys (2009, 2012 and 2015), there were some revisions, including new questions. The SUSOS includes the Client Satisfaction Questionnaire (CSQ-8) and specific questions relevant to the ACT AOD context. The project was approved by the ACT Health Human Research Ethics Committee (ETHLR.12.107, amendments approved 19 November 2018).

Table A4.1: Demographic characteristics of service users in 2018 SUSOS

Service users who self-identified as….		Proportion reported in 2018 SUSOS (%)	
		Overall	Range across services
Female		39.8	0.0 – 100.0
Aboriginal and/or Torres Strait Islander	All services	31.0	0.0 – 90.0
	Mainstream services only	17.9	0.0 – 32.1
Lesbian, gay, bisexual or queer		9.7	5.9 – 21.5
Having a physical or intellectual disability		20.4	0.0 – 34.6
Living alone		30.0	7.5 – 53.6
Unemployed (adults over age 18 years)		69.5	44.6 – 88.2
Homeless or at risk of homelessness		30.1	15.1 – 48.6
On the waiting list for Social Housing		22.4	11.1 – 35.1
Adults with Year 10 or lower as their highest level of education		49.9	23.5 – 71.9

Overall satisfaction levels and patterns

Embedded in the SUSOS is the CSQ-8, a validated instrument that produces a composite index of satisfaction derived from eight scale items.[52] CSQ-8 scores range from 8 (low satisfaction) to 32 (high satisfaction), with a mid-point of 20. Satisfaction levels have remained high and generally stable over the years, as measured by the CSQ-8 and illustrated through two specific questions (Table A4.2).

Table A4.2: Satisfaction levels and patterns in each year of the Survey

Satisfaction item	**Year of Survey**			
	2009	**2012**	**2015**	**2018**
Mean overall satisfaction score (CSQ-8)	26.2	27.1	26.9	27.3
How satisfied are you with the service you have received? (% answering ‘very satisfied’ or ‘mostly satisfied’)	90%	92%	90.4%	92.4%
If you were to seek help again, would you come back to this service? (% answering ‘yes, definitely’ or ‘yes, generally’)	91%	94%	93.1%	93.1%

In 2018, high satisfaction scores were related to the following variables (among others):

- Convenience of the location and opening hours, and ease of getting appointments.
- Being asked to provide feedback on the service or treatment received.

- Being in settled/permanent accommodation versus having no fixed place of living
- Having adequate input into their own treatment, and a treatment plan that reflects their goals and needs.
- Positive attitudes towards staff and the service generally (for example on measures of trust, safety, adequate support, being treated with respect, etc)
- Positive self-reported service user outcomes (see examples of measures below).

Self-reported service user outcomes

High levels of positive outcomes (i.e., respondents 'agreed' or 'strongly agreed' with the statements) were reported under each of the widely accepted objectives of AOD treatment (Table A4.3).[53] The CSQ-8 has been used under licence from the copyright owner, C. Clifford Attkisson, PhD.

Many services are also able to provide some level of ancillary support or referral (e.g., housing, financial management, legal assistance). Considering these activities are beyond the primary remit of most AOD services, service users reported reasonable levels of positive self-reported outcomes for these ancillary activities (between 46%–60%).

Table A4.3: Self-reported outcomes against the widely-accepted objectives of AOD treatment

Widely-accepted objectives of AOD treatment	Outcome measured in the 2018 SUSOS	Proportion of respondents who 'agreed' or 'strongly agreed'
To reduce the service user's level of substance use	'Your drug use has reduced'	75.3%
To reduce the service user's experience of AOD-related harm	'You are less involved in crime'	80.4%
	'Your knowledge of preventing transmission of blood borne viruses has improved'	77.9%
	'You have a better understanding of the harms and risks associated with your alcohol and other drug use'	85.4%
	'You have used some of the skills and strategies to keep you safer when using AOD'	84.2%
	'You have developed skills and strategies for reducing the harms from using AOD'	80.8%
To improve the service user's health and wellbeing	'Your general health and well-being has improved'	80.7%
	'Your mental health has improved'	73.4%
	'Your family, parenting and/or other relationships have improved'	65.0%

Appendix 5 – Analysis of data from the ACT Minimum Data Set

The ACT Health Directorate provided ATODA with deidentified data on closed treatment episodes from the ACT Alcohol and Other Drug Treatment Services Minimum Data Set (AODTS-MDS). A treatment episode for alcohol and other drug is defined as 'the period of contact between a client and a treatment provider or team of treatment providers'.[26] It must have a 'defined date of commencement and date of cessation.'

Client-level data was not available. The data file provided for analysis was specific to the 2019-20 collection year and included the following eight data elements–a mix of NMDS and ACT Minimum Data Collection elements.

NMDS elements

1. Sex
2. Indigenous status
3. Treatment delivery setting
4. Primary drug of concern (PDC)
5. Main treatment type (MTT)
6. Postcode

ACT MDS elements

7. Previous AOD treatment received
8. Mental health (MH) – question: *'Have you been diagnosed with a mental illness'?*

The data was provided with the following provisions:

- Data would only be reported in aggregate and no details which could enable identification should be published
- Cell sizes equal or less than five should not be published
- The data file was only to be used for this report and is not for external circulation.

The data was analysed using statistics software by ATODA. Validation checks were made for the calculations in all tables presented below.

Gender

ACT AODTS-MDS data shows that 61.1% of episodes of care were provided to males and 38.9% to females. Fewer than 5 people were reported as 'other'; this is likely to be lower than the actual figure and may reflect how the question is asked (options given are 'male', 'female', 'other'), and/or the assumptions made by staff about service users when collecting the data. Data from the Service Users' Satisfaction and Outcomes Survey (SUSOS) shows that 1.3% of service users self-identified as 'non-binary' or 'self-described' (although note that this refers to persons, not 'episodes of care').

Indigenous status

ACT AODTS-MDS data shows that 13.0% of the episodes of care provided were to people who identified themselves as of either 'Aboriginal only', 'Torres Strait Islander only' or both 'Aboriginal and Torres Strait Islander' origin (Table A5.1). This is lower than the SUSOS figure of 17.9% of people who accessed mainstream AOD services identifying themselves as of Aboriginal and/or Torres Strait Islander origin (although this refers to persons, not 'episodes of care'). Note that AOD services are also provided by Winnunga Nimmityjah Aboriginal Health and Community Services and Gugan Gulwan Youth Aboriginal Corporation, but these do not report through the NMDS reporting system.

Table A5.1: Episodes of care by Aboriginal and/or Torres Strait Islander status (ACT, 2019-20) (Source: ACT AODTS-MDS, 2019-20)

Aboriginal and/or Torres Strait Islander status	Frequency	Proportion
Aboriginal, but not Torres Strait Islander origin	784	12.2
Torres Strait islander but not Aboriginal origin	14	0.2
Both Aboriginal and Torres Strait Islander origin	37	0.6
Neither Aboriginal nor Torres Strait Islander origin	5340	82.9
Not stated/inadequately described	263	4.1
Total	*6438*	*100.0*

Primary drug of concern

ACT AODTS-MDS data shows that alcohol is, by far, the most reported primary drug of concern at 41.3% of episodes of care (Table A5.2). This is followed by amphetamines (22.7%), cannabis (10.9%) and heroin (9.7%).

Table A5.2: Episodes of care by primary drug of concern (Source: ACT AODTS-MDS, 2019-20)

Primary drug of concern	Frequency	Proportion
Codeine	10	0.2
Heroin	626	9.9
Methadone	155	2.5
Oxycodone	18	0.3
Other opioids and other analgesics*	333	5.3
Alcohol	2657	42.2
Benzodiazepines	60	1.0
Other sedatives and hypnotics	10	0.2
Amphetamines	1462	23.2
Ecstasy	55	0.9
Cocaine	111	1.8
Nicotine	56	0.9
Cannabis	702	11.2
Other*	40	0.6
Total	*6295*	*100.0*

* Due to small numbers (<10) ‘other opioids’ and ‘other analgesics’ have been combined, and also includes the analgesics categories ‘morphine’ and ‘buprenorphine’. The category ‘other’ also includes: ‘other stimulants and hallucinogens’, ‘volatile solvents’ and ‘not stated’.

Treatment type and treatment setting

'Counselling' and 'Information and education' each account for over one quarter of the main treatment types of the treatment episodes (27.0% and 28.0% respectively). Close to sixty percent of treatment episodes were in non-residential treatment facilities (57.3%), with 25.3% in outreach settings (Tables A5.3 and A5.4).

Table A5.3: Proportion of closed episodes of care by main treatment type (ACT, 2019-20) (Source: ACT AODTS-MDS, 2019-20)

Main treatment type	Frequency	Proportion (%)
Withdrawal management (detoxification)	491	7.6
Counselling	1741	27.0
Rehabilitation	414	6.4
Pharmacotherapy	78	1.2
Support and case management	920	14.3
Information and education	1803	28.0
Assessment only and other*	991	15.4
Total	6438	100.0

* The category 'other' has been combined with 'assessment only' to obscure a small number in that category.

Table A5.4: Proportion of closed episodes of care by treatment delivery setting (ACT, 2019-20) (Source: ACT AODTS-MDS, 2019-20)

Treatment delivery setting	Frequency	Proportion (%)
Non-residential treatment facility	3691	57.3
Residential treatment facility	990	15.4
Home	97	1.5
Outreach setting	1627	25.3
Other	33	0.5
Total	6438	100.0

Postcode

The data collected in the ACT AODTS-MDS enables an analysis of postcodes associated with each treatment episode. An analysis of access to AOD treatment must consider, where possible, interstate access to this treatment. Many service users report preferring accessing AOD treatment away from their home due to the stigma associated with problematic AOD use and treatment-seeking. In the ACT context, interstate access to AOD treatment is also important for the following reasons:

(1) Canberra is the regional centre for health care (including AOD treatment) for south-eastern NSW, and there are several treatment types (e.g. residential rehabilitation, in-patient withdrawal) that are not available elsewhere in the regional area.
(2) There are several unique programs in the ACT that are designed for specific population groups, for example, a women's-only service, and a unique residential rehabilitation program for families.
(3) Two AOD services are national organisations that refer people between programs—including from interstate—according to need and availability.

There is some complexity in the analysis of postcodes in this data as there are two postcodes (2618 and 2620) that are shared across the ACT and NSW, and it is not possible to accurately determine the state/territory of people who indicated 'no fixed address'. For each of these categories, frequencies have been estimated using the respective proportions from the 2018 Service Users' Satisfaction and Outcomes Survey (SUSOS). About 80% of treatment episodes in the ACT in 2019-20 were for people with ACT postcodes (and a number in the shared postcodes and with 'no fixed address'—see notes below the Table). Seventeen percent (17%) came from NSW and 1.3% from other states/territories (Table A5.5).

Within NSW, the highest numbers come from the Illawarra & Southeast region (n=411, 6.4% of total episodes) and the Riverina region (n=112, 1.7%). These regions border the ACT and include regional centres such as Merimbula, Bateman's Bay, Nowra, Wollongong, Young, Albury and Wagga Wagga. Figure A5.1 shows this concentration, with the shaded postcodes indicating those where 10 or more episodes of care were reported.

Table A5.5: Proportion of closed episodes of care for the ACT, NSW and other states/territories (ACT, 2019-20) (Source: ACT AODTS-MDS, 2019-20)

State/Territory	Area	Frequency	Proportion (%)	Frequency	Proportion (%)
ACT	ACT-Belconnen	1113	17.3	5146	79.9
	ACT-North Canberra	1049	16.3		
	ACT-South Canberra	361	5.6		
	ACT-Gungahlin & Hall	521	8.1		
	ACT-Jerrabomberra & Majura	72	1.1		
	ACT-Tuggeranong	1090	16.9		
	ACT-Weston Creek & Molonglo Valley	311	4.8		
	ACT-Woden Valley	419	6.5		
	ACT-Shared postcodes 2618 and 2620*	146	2.3		
	ACT-No fixed address †	64	1.0		
NSW	NSW-shared postcodes 2618 and 2620*	371	5.8	1090	17.0
	NSW-Illawarra & South East NSW	411	6.4		
	NSW-Riverina	112	1.7		
	NSW-Central & Northern Sydney	47	0.7		
	NSW-Southern & South Western Sydney	43	0.7		
	NSW-Western NSW	24	0.4		
	NSW-Western Sydney & Blue Mountains	18	0.3		
	NSW-Hunter & Central Coast	21	0.3		
	NSW-North Coast & Mid North Coast	16	0.2		
	NSW-New England	10	0.2		
	NSW-No fixed address†	17	0.3		
Other states/ territories	States and Territories other than NSW, including those with 'no fixed address'†	80	1.3	80	1.3
Unknown/Not stated/inadequately described		122	1.9	122	1.9
Total		6438	100.0	6438	100.0

Notes about data calculations

* Postcodes 2618 and 2620 are shared across the ACT and NSW borders. In order to estimate the total proportions of closed episodes of care attributable to the ACT and NSW from these postcodes, the following assumptions and calculations were used.

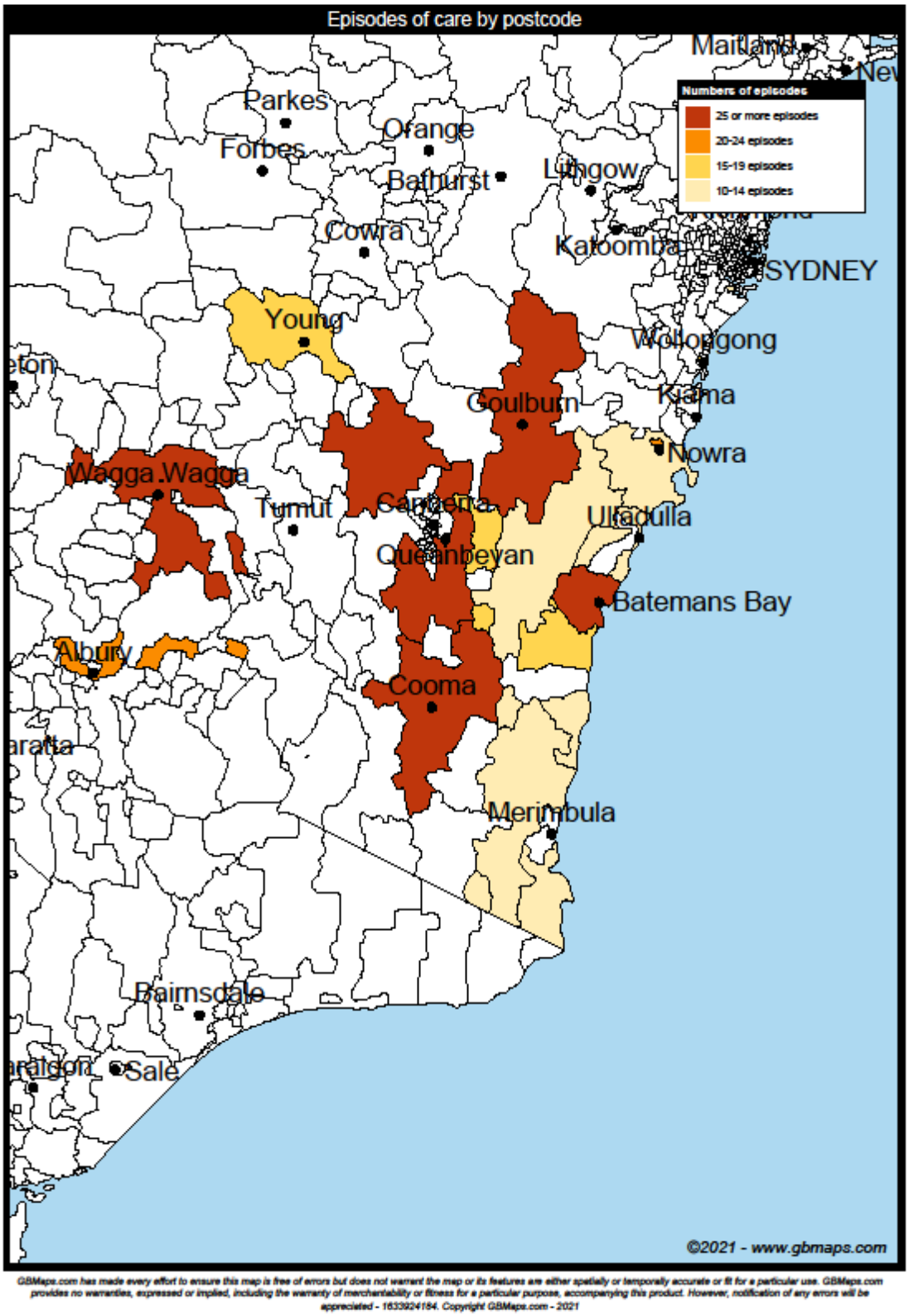
Assumptions: All episodes reported in the MDS dataset for postcode 2618 were in non-residential treatment or outreach settings. As the postcode is largely rural with main settlements, other than Hall (ACT), located further away from the ACT, it was assumed that all episodes could be attributed to the ACT. Data from the 2018 Service Users' Satisfaction and Outcomes Survey (SUSOS—see below) could not be used here due to low reporting numbers. For postcode 2620, several large settlements/towns (e.g. Queanbeyan) are located immediately over the ACT/NSW border—the assumption that 'non-residential treatment' and 'outreach' are indicative of being resident in the ACT does not hold. Therefore, an alternative data source has been used. The SUSOS data, found that approximately one in four service users in postcode 2620 were from the ACT, and approximately three in four were from NSW. Assuming that the proportions of service users is broadly equivalent to the proportions of episodes, the calculated proportions could be used to estimate relative proportions of MDS episodes for NSW and ACT.

Calculations

In the MDS data, about 500 episodes were recorded for postcode 2620. Using the assumption above, 133 episodes—could be estimated to have occurred for residents of the ACT, and 371 episodes for residents of NSW. In the MDS data, 13 episodes were from postcode 2618. Using the assumption above, all 13 (100%) have been attributed to the ACT. In total for postcodes 2618 and 2620, therefore, there were 146 episodes for the ACT and 371 episodes for NSW.

† Similarly, to calculate the proportions of episodes for 'no fixed address', the relative proportions reported in the 2018 SUSOS were used: about three in four for the ACT; and about one in five for NSW. Assuming that the proportions of service users is broadly equivalent to the proportions of episodes, these proportions were applied to the MDS data to calculate estimations for each jurisdictional region.

Figure A5.1: Map of ACT and surrounding NSW region showing postcodes with ten or more episodes (ACT, 2019-20) (Source: ACT AODTS-MDS, 2019-20)



Treatment setting by location

Of episodes of care for people from outside the ACT, nearly one in three (29.8%) were for treatment in a residential facility. This compares to about one in eight (12.3%) for episodes for people from within the ACT (Table A5.6). More than one-third (35.3%) of episodes within residential treatment facilities were for people from outside the ACT (Table A5.7).

Table A5.6: Proportions of episodes of care for service users of ACT AOD services from within and outside the ACT, by treatment setting* (Source: ACT AODTS-MDS, 2019-20)

Location‡	Treatment setting		
	Non-residential treatment facility, Home, Outreach and Other†	Residential treatment facility	Total
ACT	87.7	12.3	100.0
Outside ACT (NSW & other states/territories)	70.2	29.8	100.0
Not stated/inadequately described/unknown	92.6	7.4	100.0
Total	84.6	15.4	100.0

Table A5.7: Proportions of episodes of care for service users of ACT AOD services accessing various treatment settings, by postcode region* (Source: ACT AODTS-MDS, 2019-20)

Location‡	Treatment setting		
	Non-residential treatment facility, Home, Outreach and Other†	Residential treatment facility	Total
ACT	82.9	63.8	79.9
Outside ACT (NSW & other states/territories)	15.1	35.3	18.2
Not stated/inadequately described/unknown	2.1	0.9	1.9
Total	100.0	100.0	100.00

* Refers to postcode of the client's last known home address at the commencement of the treatment episode.

† 'Non-residential treatment facility', 'Home', 'Outreach' and 'Other' have been amalgamated to reflect any treatment that is not undertaken in a 'residential' facility.

‡ Shared postcodes 2618 and 2620 and figures for 'no fixed address' have been proportionately allocated to the ACT and Outside ACT using relative proportions from the 2018 Service Users' Satisfaction and Outcomes Survey (SUSOS)—see notes at Table A5.3 for details of how these proportions have been used.

Location by gender and Aboriginal and/or Torres Strait Islander status

Around three-quarters of episodes for both males (77.4%) and females (75.5%) were recorded for postcodes within the ACT. As seen in Table A5.8, overall 61.1% of treatment episodes were recorded for men and 38.9% for women, and this proportionate split is the same for treatment episodes for people from the ACT (i.e. 61.7% for males and 38.3% for women). However, the gender balance is more even among those coming from interstate—56:44 for NSW (excluding the immediate cross-border region); and 52:48 for other states/territories. Further, the proportion is reversed for treatment episodes where people reported having 'no fixed address'; women made up nearly two-thirds (64.3%) of treatment episodes for people reporting 'no fixed address'.

Table A5.8: Proportions of episodes of care for male and female service users of ACT AOD services, by postcode region* (Source: ACT AODTS-MDS, 2019-20)

Postcode region (n)	Gender†		Total
	Male	Female	
ACT (n=4935)	61.7	38.3	100
ACT/NSW cross border (n=517) ‡	69.1	30.9	100
Rest of NSW (n=702)	56.3	43.7	100
Other (n=77)	51.9	48.1	100
No fixed address (n=84)	35.7	64.3	100
Unknown or not stated/inadequately described (n=121)	54.5	45.5	100
Total	61.1	38.9	100

* Refers to postcode of the client's last known home address at the commencement of the treatment episode.
† 'Other' as a gender category has been excluded from the analysis due to small numbers.
‡ The ACT/NSW cross border region includes, among others, the towns/settlements of: Googong; Michelago; Oaks Estate; Queanbeyan; Royalla; and Tharwa.

Table A5.9 shows that a greater relative proportion of Aboriginal and Torres Strait Islander people are represented in the treatment episodes of people coming from the ACT/NSW cross border region (postcodes 2618 and 2620) and from interstate (the rest of NSW and other states/territories). Five or fewer episodes were for Aboriginal and/or Torres Strait Islander people coming from other states/territories. Aboriginal and Torres Strait Islander people made up 16.4% of treatment episodes from the ACT/NSW border region and 18.5% of those from interstate.

Table A5.9: Proportions of episodes of care by Aboriginal and/or Torres Strait Islander origin, by postcode region* (Source: ACT AODTS-MDS, 2019-20)

Postcode region (n)	Aboriginal and/or Torres Strait Islander origin			Total
	Aboriginal and/or Torres Strait Islander origin	Neither Aboriginal nor Torres Strait Islander origin	Not stated/ inadequately described	
ACT (n=4936)	11.6	84.2	4.2	100
ACT/NSW cross border (n=517)	16.4	79.7	3.9	100
Rest of NSW and other states and territories (n=779) †	18.5	77.3	4.2	100
No fixed address (n=84)	11.9	88.1	0.0	100
Unknown or not stated/inadequately described (n=122)	18.9	78.7	2.5	100
Total	13.0	82.9	4.1	100

* Refers to postcode of the client's last known home address at the commencement of the treatment episode.

† The rest of NSW and other states and territories have been placed in a single category due to small numbers.

Mental health (diagnosed with a mental illness)

Table A5.10 indicates that at least 39.6% of the treatment episodes were provided to clients who had been previously diagnosed with a mental illness. In 42.9% of episodes of care provided, the response to this question was not stated or inadequately described. It is probably reasonable to assume that proportions of mental illness prevalence are found within this group as within the wider group as a conservative estimate. Assuming this, a total of about 69% of clients have a mental health diagnosis. For comparison, the most recent ABS National Health Survey estimated there were 4.8 million Australians (20.1%) with a mental or behavioural condition in 2017–18. This figure may also be an undercount as clients accessing AOD services are often from disadvantaged backgrounds and may therefore have lower access to mental health diagnosis than the general population.

Table A5.10: Episodes of care where service users reported diagnosis with a mental illness (ACT, 2019-20) (Source: ACT AODTS-MDS, 2019-20)

Data Domains in ACT AODTS-MDS	Frequency	Proportion (%)
Diagnosed three months ago or less	126	2.0
Diagnosed more than three months ago but less than or equal to twelve months ago	147	2.4
Diagnosed more than twelve months ago	2191	35.2
Never been diagnosed	1095	17.6
Not stated/inadequately described	2674	42.9
Total	6233	100.0

Appendix 6 – ATOD service types, by availability, in the ACT

The three-fold categorisation of service types and most of the individual types listed are derived from the National framework for alcohol, tobacco and other drug treatment, 2019-2029.[43] In Table A5.1, the types listed in italics are based on investigation of the ACT ATOD sector published by ATODA in 2017.[21] These are used in the ATODA online Directory and include a few additional types of treatment. The data in the table is taken from the ACT Government's submission to the Inquiry,[24] augmented by the ATODA Directory (italicised).[48]

Table A6.1: ATOD service types, by availability, in the ACT

Service type	Offered in ACT (Y/N) and provider(s)	Priority populations	Geographic coverage	Expansion required (Y/N) with explanation
Interventions to Reduce Harm				
Sobering Up Shelters	Y – CatholicCare (five beds)	People over age of 18	Campbell, Inner North	N
Needle and Syringe Programs (NSPs)	Y – '*2x primary (dedicated) services and outreach:* Directions, several secondary sites (including Hepatitis ACT) 1 syringe disposal service (multiple sites), also community pharmacies and Vending Machines	People who inject drugs	Dispersed (north and south)	Y - a NSP is urgently required in the AMC (Justice Reform Group submission); increasing availability of NSPs is also needed in the broader community
Drop-in services	Y – 5: CAHMA, The Salvation Army (TSA), Toora, Gugan Gulwan, Ted Noffs	Men, Women*, Youth & Indigenous people, with AOD issues	Dispersed, but peer-run centre in Belconnen only	Y – for people in the South, absence of peer-run drop-in centre; women with AOD issues and their children
Peer support and self-help	Y – CAHMA and the Connection** (Indigenous people), Youth (Ted Noffs), Women (Toora Women), Directions, Gugan Gulwan (Indigenous Youth)	Men, Women, Youth, Indigenous people	Dispersed, but peer-run centre for adults only in Belconnen	Y – as for drop-in services Limited access of peer groups to AMC
Overdose intervention (naloxone)	Y – CAHMA in collaboration with Directions and ADS, (interventions at multiple sites)	People who inject drugs	Dispersed	Y – recent review showed that almost all people who inject drugs knew about naloxone, but many did not consistently have it with them; additional outreach and distribution could help increase use

Service type	Offered in ACT (Y/N) and provider(s)	Priority populations	Geographic coverage	Expansion required (Y/N) with explanation
Family support	Y – 24-7 national helpline accessible, Karralika delivers a dedicated program for families; Toora supports women and children in their residential support programs; CAHMA, Directions delivers dedicated counselling and group programs for family members	Parents & carers of people with AOD issues Adults with AOD issues with children Children of adults with AOD issues	Dispersed	Y – there is little Canberra-specific support to families and carers not mediated by people who use drugs; additional capacity needed to support parents (counselling, training) and to integrate family support in to care programs (e.g., counselling for children of people who use drugs)
Screening & Brief Intervention	Y – Screening and brief intervention take place in primary care, such as GP services, hospitals and emergency departments and drop-in services All non-government specialist services provide	Men, Women, Youth, Indigenous people	Dispersed	N
Outreach AOD services	Y – Directions, various sites, Ted Noffs programs for 12 to 25 include mentoring, counselling and assistance, Toora extends outreach supports to all women accessing their services, CAHMA barbecues	Adults who use drugs Youth AMC (but limited)	Dispersed	Y Expansion is especially required for AMC where limited programs: Solaris (run by Karralika) provides limited AOD services for males; Pathways from Prison (Toora Women) for women is limited to info and education; Directions delivers harm reduction groups and individual counselling for women and men in the AMC. Recent evidence from the COVID-19 response indicates that there are many people who would use AOD services if they had a trusted relationship with them.
Safe-injection site	N	People who inject drugs	Co-locate with existing health facility	Y – ACT Gov't feasibility study concluded it would be expected to reduce overdose risks & encourage treatment seeking
Treatment interventions				
Assessment	Y – all specialist AOD services	People who inject or	Dispersed	N

Service type	Offered in ACT (Y/N) and provider(s)	Priority populations	Geographic coverage	Expansion required (Y/N) with explanation
		otherwise use drugs		
Consultation Liaison	Consultation and Liaison and Comorbidity Service, ADS (CHS)	People	Canberra Hospital, Woden	Y – lacking for Calvary hospital
Support and case management	Y – 15 programs by ADS and various non-government providers	Men, Women, Youth, Indigenous people	Dispersed	Y – there are many opportunities to increase collaboration between AOD service providers and other health and community services
Withdrawal management	Y – Four residential programs including: one medicated (ADS, 10 beds), three not medicated (Ted Noffs, Directions, Toora) Non-residential and home withdrawal program run by Karralika	Men, women, youth Youth	Dispersed, limited community outreach programs	Y – need to maintain and expand programs in the community
AOD primary care	Y – Directions, Winnunga Nimmityjah	People, Indigenous people	Dispersed	N
Day Program	Y – ADS***, Toora, Directions, TSA	Men, women	Dispersed	N
Psychosocial counselling	Y – Directions, ADS, Karralika, Toora Women, Catholic Care	Men, Women, Youth, Indigenous people with AOD issues	Dispersed	N
Rehabilitation	Y - '4 residential services, 8 programs (104 beds***): CRS, Directions Ted Noffs, Karralika Toora (x 2 facilities) Two non-residential services by Directions	Men, Women, Youth with AOD issues	Dispersed	Y - need for Aboriginal Community Controlled residential rehabilitation facility; only three residential settings (Karralika & Toora x2) have facilities for children to stay with parents
OMT	ADS (hospital based OPT), Directions,	People who inject drugs	Dispersed	Y– OPT prescribing options are limited. Hydromorphone-assisted treatment should be considered[54] to reach some

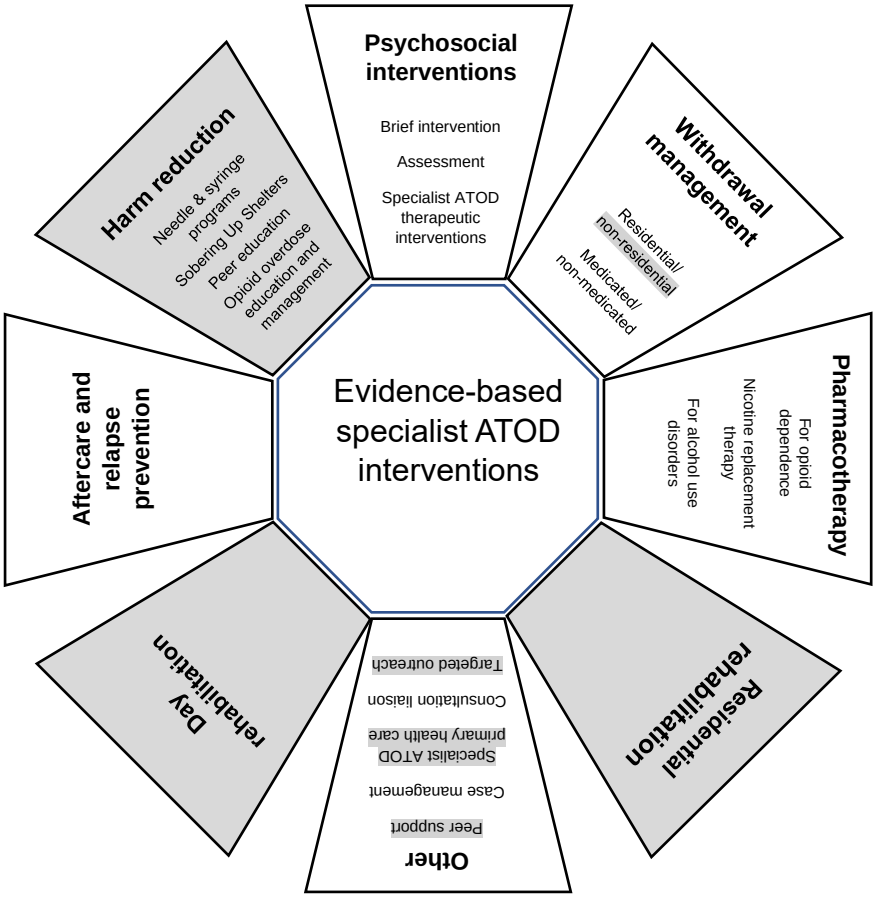
Service type	Offered in ACT (Y/N) and provider(s)	Priority populations	Geographic coverage	Expansion required (Y/N) with explanation
	Karralika (support & case management) 70 Prescribing GPs,[24] however most are private and do not prescribe to more than 5 clients			long-term opioid users (ATODA, FFDLR submission)
Alcohol and NRT prescribing	In specialist and primary care, e.g., Directions; ATODA runs 'We Can' program providing NRT to 8 AOD service sites	Adults with alcohol or drug dependence	Dispersed	Y – Need to expand free access to NRT and counselling for AOD service users
Pill testing	N	People who use illicit drugs		Y – Evaluation of trials conducted in Canberra have shown that pill testing works as intended
Heroin Assisted Therapy (HAT)	N	Adults with heroin dependence		Y – None currently in Canberra despite a strong evidence-base
Stimulant Replacement Therapy	N	Adults with alcohol or drug dependence		Evidence-base for this treatment is currently mixed

* Most AOD programs accept adults irrespective of their gender or sexual orientation and have diversity policies which promote gender inclusivity. Toora Women Inc. focuses its services on women. Toora Women Inc. and Karralika Programs Inc. provide services to adults with AOD issues in environments that can also accommodate their children.
** CAHMA operates a culture-specific peer-based ATOD program for Indigenous and Torres Strait Islander people - the Connection.
***38 of the 48 beds at TSA's residential facility at Canberra Recovery Services are funded by TSA as at Aug 16, 2021. The other 10 are funded by the DASL (5) and ACT Health (5). A further 11 beds are available in transitional houses but are currently unused due to lack of funding. TSA also funds a day program in Civic.

Appendix 7 – Evidence-based specialist ATOD interventions delivered in the ACT

Figure A7.1 shows types of treatment and harm reduction services delivered by government and/or non-government services in the ACT. Shading is used to highlight those intervention types offered only by non-government services. It is based on mapping and review of the ATOD sector in the ACT conducted by 360Edge and commissioned by ATODA in 2017.[21]

Figure A7.1: Evidence-based specialist ATOD interventions delivered in the ACT by government and/or non-government services



Note: Several interventions may incorporate the use of other intervention types. For example, 'case management' may include the use of various types of psychosocial interventions such as assessment and specific psychosocial therapies.

Appendix 8 – Availability of AOD services by treatment type

Table A8.1 shows availability of AOD services by treatment type. It is adapted from the ACT Government's submission to the Select Committee Inquiry, Drugs of Dependence (Personal Use) Amendment Bill (2021).[24]

Table A8.1: Availability of AOD services by treatment type[24]

Service element	Available in ACT?	Number of providers	Funding
Interventions to Reduce Harm			
Sobering Up Shelters	Yes	One (five beds)	ACT Government
Needle and Syringe Programs (NSPs)	Yes	2 primary (dedicated services) NSP outreach to various sites 9 secondary outlets 31 pharmacies 6 syringe vending machines 1 syringe disposal service (multiple sites)	ACT Government
Drop-in services	Yes	5 (with different target groups, including 2 youth-focused)	ACT Government
Peer support	Yes	4 government-funded; other self-funding organisations	ACT Government, CHN, Self-funded
Overdose prevention (naloxone)	Yes	2 main programs with interventions at multiple sites	ACT Government, Commonwealth Government
Family support	Yes	7 programs	ACT Government, Commonwealth Government, CHN
Less intensive treatment options			
Screening & Brief Intervention	Yes	3 programs Screening and brief intervention take place in primary care, such as general practice services, hospitals and emergency departments and drop-in services	ACT Government, Commonwealth Government
Less intensive treatment options			
Assessment	Yes	All AOD treatment services	ACT Government
Consultation Liaison	Yes	1	
Case management and Care cooperation	Yes	15 programs	ACT Government, CHN
Intensive treatment interventions			

Withdrawal management	Yes	Four programs including: One residential medicated service (10 beds) 2 residential non-medicated services 1 non-residential medicated service	ACT Government and CHN
Psychosocial counselling	Yes	6 programs	ACT Government CHN
Rehabilitation	Yes	Four residential services, 8 programs (104 beds*) Two non-residential services	ACT Government & self-funding
Pharmacotherapy	Yes	69 prescribers[22] 40 dosing points sites -One hospital-based opioid pharmacotherapy service (2 locations) -38 pharmacies -One prison Also, alcohol and NRT prescribing in specialist and primary care	ACT Government Commonwealth Government

*38 of the 48 residential beds in use at Canberra Recovery Services as of 16 Aug 2021 were funded by the Salvation Army from philanthropic funds.

Appendix 9 – Type of ATOD treatment delivered, ACT 2019-20

Treatment episodes can be closed, that is finished for the purposes of the data set, for several reasons including successful completion, discharge against advice, a person could not be contacted, or a person changed treatment type.

Table A9.1 below shows the percentage of total closed episodes (for own drug use) by treatment type (first column). The rows show the percentage of people who used each treatment type, broken down by the primary drug for which they sought treatment. Overall, about 85% of services were community-based and about 15% were for residential rehabilitation or withdrawal.

Table A9.1: Type of AOD treatment delivered, ACT 2019-20, showing percentages for the main drugs addressed by treatment (for own drug use) [9]

Treatment type and (percentage of total closed episodes)	**Substance as percentage of closed episodes of each treatment type**			
	1st	**2nd**	**3rd**	**4th**
Information and education (28%)	Alcohol (36%)	Other opioids (18%)	Heroin (11%)	Amphetamines (11%)
Counselling (26%)	Alcohol (43%)	Amphetamines (28%)	Cannabis (18%)	Heroin (7%)
Assessment only (16%)	Alcohol (55%)	Amphetamines (22%)	Cannabis (9%)	Heroin (7%)
Support and case management (15%)	Amphetamines (36%)	Alcohol (33%)	Heroin (15%)	Cannabis (11%)
Withdrawal management (8%)	Alcohol (68%)	Amphetamines (18%)	Cannabis (7%)	Heroin (5%)
Rehabilitation (7%)	Amphetamines (42%)	Alcohol (32%)	Cannabis (13%)	Heroin (6%)

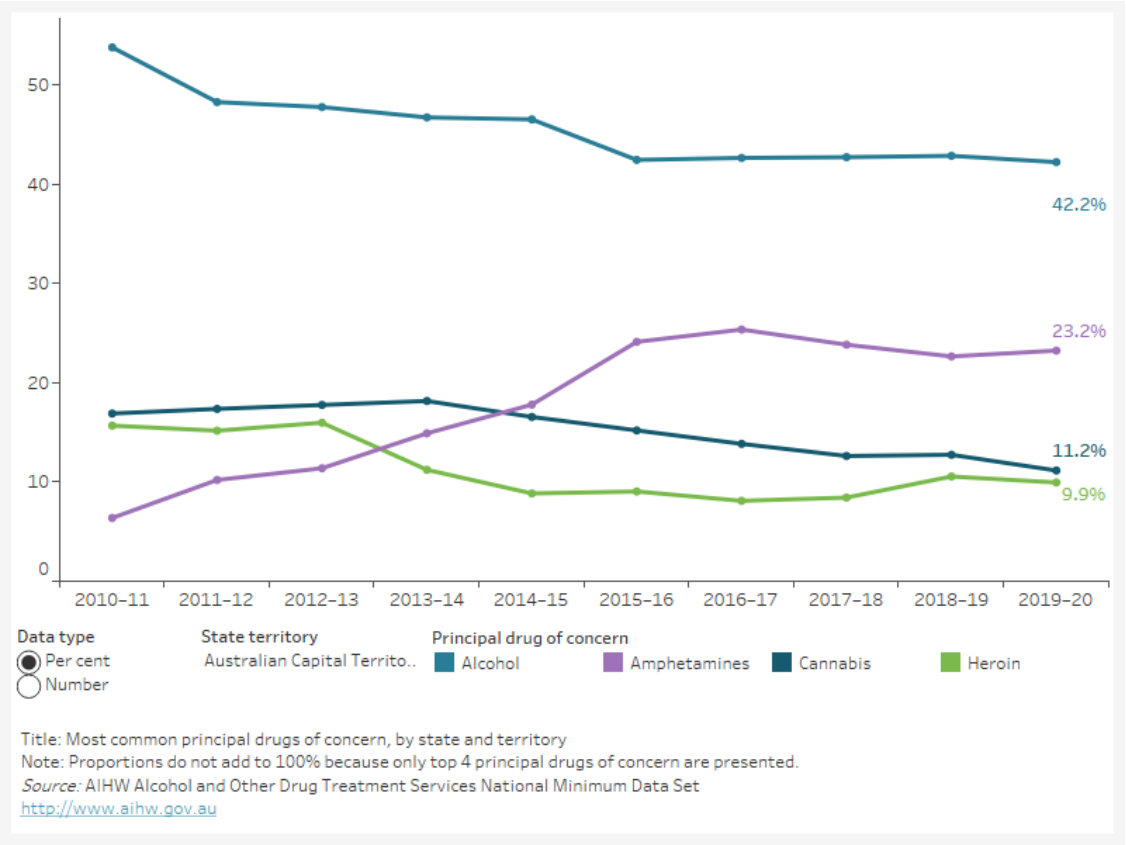
Source:

Australian Institute of Health and Welfare 2021. Alcohol and other drug treatment services in Australia annual report, Table SE ACT. 25 Cat. no. HSE 250. Canberra: AIHW. Viewed 14 September 2021, https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/alcohol-other-drug-treatment-services-australia.

Appendix 10 – Most common principal drugs of concern in the ACT, 2010-2020

Figure A10.1 reproduces an AIHW figure on principal drugs of concern. It shows the proportion of closed treatment episodes for client's own drug use only.

Figure A10.1: Most common principal drugs of concern in the ACT, 2010-2020[25]



Source:

Australian Institute of Health and Welfare 2021. Alcohol and other drug treatment services in Australia: early insights, Figure 2. Cat. no. HSE 242. Canberra: AIHW. Viewed 14 September 2021, https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/alcohol-other-drug-treatment-services-aus

Appendix 11 – ATOD treatment provided in the ACT in 2019-20 compared to 2018-19

Table A11.1 compares ATOD treatment provided in the ACT in 2018-19 with that provided in 2019-20.

Table A11.1: AOD treatment provided in the ACT in 2019-20 compared to 2018-19

Program/service type	**Closed episodes of care 2019-20 (own or other's drug use)**	**Closed episodes of care 2018-19 (own or other's drug use)**
Counselling	1,736	1,877
Withdrawal management	491	521
Support and Case Management only	927	920
Rehabilitation	412	428
Information and Education only	1,803	1,912
Assessment Only	987	917
Other	82	41
Total	**6,438[27]**	**6,700[27]**
Opioid Pharmacotherapy	1,120 clients on snapshot day[22]	1,121 clients on snapshot day[22]
Needle and Syringe Programs	949,864 sterile needle and syringes distributed[31]	885,996 sterile needles/syringes distributed[55]

Sources:

- AODTS-NMDS data on closed episodes of care (for own or other's drug use) from Australian Institute of Health and Welfare's Alcohol and other drug treatment services in Australia: early insights[25]
- National opioid pharmacotherapy statistics (NOSPAD) 2020[22]
- Needle Syringe Program National Minimum Data Collection: national data reports, 2019 & 2020[31, 55]

Appendix 12 – Funding sources for AOD services in the ACT

In the ACT, the funding of services between the Commonwealth sources and ACT Health is critical to ensure programs are available to the community. For many treatment types only one funder exists. In the case where there are multiple funders for a single intervention type (e.g., counselling) this typically exists because demand is such that it outstrips the capacity of a single provider, or the intervention is delivered in a different setting (e.g., outreach) or to a specific target group (e.g., women only, people in prison etc).[48]

Table A12.1: Funding sources for AOD services in the ACT

Funding	Funder	Commissioner
Specialist Alcohol and Other Drug Treatment and Support Services	ACT Health	ACT Health
Drug and Alcohol Treatment Services - Flexible Funding	Australian Government Department of Health	CHN
Drug and Alcohol Treatment Services for Aboriginal and Torres Strait Islander people – Flexible Funding	Australian Government Department of Health	CHN
Drug and Alcohol Treatment Services – Transition Funding	Australian Government Department of Health	CHN
Drug and Alcohol Treatment Services	Australian Government Department of Health	Australian Government Department of Health
Aboriginal and Torres Strait Islander-specific alcohol and other drug treatment services	Department of the Prime Minister and Cabinet	Department of the Prime Minister and Cabinet
Community Health and Hospitals Program	Federal Government	Australian Government Department of Health
Fee-for-service (service user contributions)	Service user	N/A
Philanthropy, church funds etc	Various	Various
Other Territory Government sources	Various ACT Government departments	Various ACT Government departments
Other Commonwealth Government sources	Various Commonwealth Government departments	Various Commonwealth Government departments
Medicare Benefits Scheme	MBS	Department of Health
Pharmaceutical Benefits Scheme	PBS	Department of Health

Appendix 13 – Specialist AOD activities currently purchased by the CHN

Table A13.1 gives an overview of the types of specialist AOD activities currently purchased by the CHN against its main funding streams.

Table A13.1: Specialist AOD activities currently purchased by the Capital Health Network by funding stream

Funding stream	Source/context	Contracted activity	Number of organisations funded
Drug and Alcohol Treatment Services - Flexible Funding	National Ice Action Strategy (NIAS)	Counselling	2
		Case management	1
Drug and Alcohol Treatment Services - Transition Funding	Core AOD and Operational funding *This was previously referred to as NGOTGP and SMSDGF funding (excluding residential rehabilitation and peaks). Note: SMSDGF was re-profiled from capacity building to front-line service delivery.*	Case management	1
		Day program	1
		Specialist AOD primary and secondary health care services	1
		Peer support	1
		Screening, day program and counselling	1
Drug and Alcohol Treatment Services for Aboriginal and Torres Strait Islander people – Flexible Funding	National Ice Action Strategy (NIAS)	Case management	1
Community Health and Hospitals Program (CHHP)	ACT PHN	Withdrawal Support service	1
ACT Health	Early Morning Centre and Needle and Syringe Program	Needle and Syringe Program	1
PHN Core Flexible funding	PHN – Innovation funding	Primary Health, AOD treatment and outreach services	1

The total value of funds provided to CHN-commissioned AOD services (inclusive of carry-forwards from prior years) for 2021-2022 is $3,091,863.20.

Appendix 14 – Services currently funded by the CHN

Table A14.1: Services currently funded by the CHN

Program Name	Provider	Brief description
Provision of Assertive Outreach AOD Counselling (Reaching Out Program)	CatholicCare	Assertive outreach community-based specialist Alcohol and Other Drug (AOD) counselling through the Reaching Out program to meet the needs of individuals over 13 years of age with severe alcohol and/or other drug problems.
Community Based AOD Counselling for those linked with the Criminal Justice System	Karralika	Specialist Alcohol and Other Drug (AOD) counselling for people with severe alcohol and/or other drug use who are involved with the ACT Justice system.
Provision of AOD Counselling for the Connection Outreach Service	CAHMA	Enhance CAHMA's The Connection Outreach Service through the employment of 1.0FTE Aboriginal and/or Torres Strait Islander Alcohol and Other Drug (AOD) worker.
Specialist AOD Case Management Services via Assertive Outreach 2019-2021 (former NGOTGP)	CatholicCare	Evidence-based specialist Alcohol and Other Drug (AOD) case management services via assertive outreach.
Arcadia House 2019-2021 (former NGOTGP)	Directions	Day Program.
CAHMA Peer Treatment Support Service 2019-2021 (former NGOTGP)	CAHMA	Evidence-based specialist Alcohol and Other Drug (AOD) peer treatment services.
Althea Wellness Centre 2019-2021 (former NGOTGP)	Directions	Primary and Secondary health care for individuals with Alcohol and Other Drug (AOD use and their families at Althea Wellness Centre.
Toora AOD Service 2019-2021 (former NGOTGP)	Toora Women	Evidence-based gender-specialist Alcohol and Other Drug (AOD) services including the provision of AOD Screening, day program and counselling services.
Nurse Led Outreach Primary Health Care Clinic at Civic Needle Syringe Program (NSP) and Ainslie Village	Directions Health Services Limited	Nurse Led Outreach Primary Health Care Clinic at Civic Needle Syringe Program (NSP) and Ainslie Village to improve access to primary health care services to vulnerable and/or hard-to-reach people.
Innovative Primary Health, Alcohol and Other Drugs (AOD) Treatment and Support Outreach Services	Directions Health Services Limited	Integrated AOD and primary care outreach services to vulnerable populations that experience significant barriers to accessing services.
Innovative Models of Service delivery in Specialist AOD Treatment Services	Karralika	Non-residential drug withdrawal service to support ACT residents with low to moderate withdrawal needs living, or accessing services, in the ACT. Builds on the existing AOD Innovation Grant pilot program funded by CHN.
Indigenous Specific AOD services	CAHMA	Indigenous specific drug and alcohol case management for Aboriginal and Torres Strait Islander people in ACT.

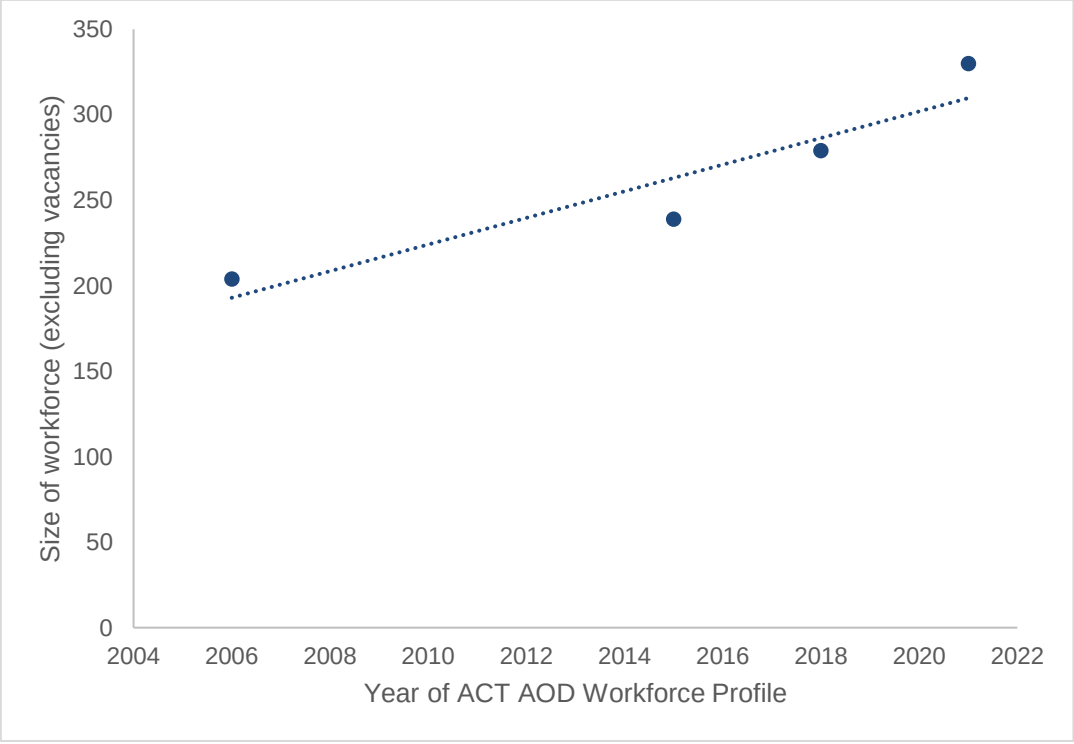
Appendix 15 – Preliminary results of 2021 Workforce Profile

Please note that the data presented in this appendix is unpublished preliminary data from the *2021 ACT AOD Workforce Profile* and should not be cited or distributed at this stage.

The 2021 ACT AOD Workforce Profile involved workers from 9 participating ACT specialist alcohol and other drug services. A representative from each organisation completed an Organisation Survey, and a total of 188 workers completed a Worker's Survey. The survey has been conducted three-yearly since 2006, making this the sixth ACT AOD Workforce Profile.

Based on these surveys, the total current AOD workforce in the participating organisations is estimated to be around 330 staff, plus approximately 15 further vacant staff positions. This figure has increased steadily since 2006, with an approximately 18.3% increase since the 2018 survey figure of 279 (Graph A16.1).

***Figure A13.1: Change in the size of the ACT* Alcohol and Other Drug (AOD) workforce, 2006 – 2021** (Sources: ACT AOD Workforce Profile—Organisation Surveys, 2006, 2015, 2018, 2021)



The response rate to the 2021 Workforce Profile Workers Survey was about 55% with 188 workers completing the survey. Table A16.1 includes some basic demographics of the workforce in specialist AOD services as measured in the 2021 Workforce Profile. The table also compares these to the demographic profile of ACT AOD service users, as measured in the 2018 Service Users' Satisfaction and Outcomes Survey (SUSOS) (see Appendix 4).

Table A15.1: Demographics of the AOD workforce compared to service users of specialist AOD services (Sources: 2021 ACT AOD Workforce Profile—Workers' Survey; 2018 ACT AOD Service Users' Satisfaction and Outcomes Survey)

Attribute		AOD Workforce	Service users
Gender	Man	31.9%	58.3%
	Woman	63.3%	39.8%
	Non-binary or self-described	1.1%	1.3%
Mean age		43.7 years	37.5 years
Aboriginal and/or Torres Strait Islander (mainstream services only)	Yes	2.7%	17.9%
	No	96.3%	80.3%
	Prefer not to say	1.1%	1.8%
Culturally and Linguistically Diverse background (other than being of Aboriginal and/or Torres Strait Islander background)*		32.4%	9.5%
Sexual orientation	Heterosexual/straight	80.6%	86.0%
	LGBTIQ	10.9%	9.7%
	Other	0.5%	1.6%
	Prefer not to say	7.0%	2.6%

* Note that being from a CALD background was measured differently in each survey: this table reports 'country of birth' for the Workforce Profile; and the response to the question 'Do you identify as being from a culturally and linguistically diverse background?' for the SUSOS.

The following similarities and differences between the two groups are noted:

- The proportions of people identifying as LGBTIQ are approximately equal for these two groups: 10.9% for workers and 9.7% for service users. This is likely to contribute to responsive and supportive service environments for people who identify as LGBTIQ.
- While the service user group is predominantly male (58.3%), the workforce is predominantly female (63.3%). This may have implications for the delivery of treatment and support within specific contexts; for example, it may impact on disclosures in the therapeutic context, or affect responses to specific issues such as domestic and family violence.
- While people identifying as Aboriginal and/or Torres Strait Islander make up about 18% of the service user group, only 2.7% of workers responding to the survey identified as Aboriginal and/or Torres Strait Islander. This is not sufficient to address the cultural security needs of Aboriginal and Torres Strait Islander people utilizing mainstream specialist AOD services. ACT specialist AOD services have recognized for many years the need to recruit workers to Aboriginal and Torres Strait Islander-specific positions and have put in place formal and strategic mechanisms to attempt to do this. However, they have often faced difficulties in attracting and retaining

people to these positions. As pointed out in successive Workforce Profiles, the ATOD sector would continue to benefit from a strategic plan for improving recruitment, retention and development of a specialist AOD Aboriginal and Torres Strait Islander workforce.

- The ACT AOD workforce is highly culturally diverse with about one-third identifying as being from a culturally and linguistically diverse background (CALD). The workforce is, therefore, well placed to respond to and support cultural diversity among service users. While the proportion of workers identifying as CALD is three-times the proportion of service users, it should be noted that the questions were posed very differently in each survey.

Among workers responding to the Workforce Profile, the majority (45.3%) were Alcohol and Other Drug Workers—for example, Case Workers, Case Managers, AOD practitioners, Intake and/or Assessment Workers, Support Workers, Youth AOD Workers, and Harm Reduction Workers. Workers (across all roles) reported having been in the sector for, on average, 7.9 years, in their current organisation for an average of 4.9 years, and in their current position for an average of 3.1 years. This has increased slightly from year to year since 2006 and shows a reasonable rate of retention in the workforce. Further, when asked 'what are your career plans over the next 12 months?', 64.9% responded that they plan to remain in their current role.

One of the factors likely to impact on attracting and retaining workers in the sector is the lower remuneration when compared to perceived high stress and responsibility of the roles. When asked why workers leave the sector, 63.3% responded 'high stress/burnout', followed by 'low salary/poor benefits' (38.8%), 'workload' (34.0%), and 'experience of difficult clients' (32.4%). For workers in the ATOD sector of all employment types (including full-time, part-time and casual), 58.4% earn below the ACT average weekly total earnings (May 2021) of $1,500.30.[56]

The ACT AOD workforce is highly qualified with 59.2% having attained a bachelor or above qualification. Among the workers who have direct client contact, 58.2% meet all of the requirements of the ACT AOD Qualification Strategy (QS)—that is, they hold AOD qualifications at, or above, the equivalent of an AOD Certificate IV, and a current first aid certificate. A further 14.8% meet the qualification component, but do not have a current first aid certificate. A further 14.9% (21 workers) are either currently undertaking, or plan to undertake the study to meet the QS requirements.

Appendix 16 – Analysis of available information on demand for AOD services

The increasing demand overall for ACT specialist AOD services over time is illustrated through an analysis of the annually reported data to the AODTS-NMDS.[9] The data for 2019-20 is available but has been excluded as it is heavily skewed by the impact of the COVID-19 pandemic.

Residential treatment beds have not meaningfully increased in number over the past decade, and consequently data on 'withdrawal' and 'rehabilitation' offered in residential settings has remained stable—as shown by the flat trend (solid blue line) in Figure A16.1. The statistics from the latest Service User Satisfaction and Outcomes Survey summarised in section 2ii indicate that service users often experience significant wait times to access residential services.[15]

The dotted line in Figure A16.1 clearly illustrates the upward trend in non-residential services provided. At least some of the increasing demand has been met with additional investment (for example for counselling through the CHN from mid-2017).

Based on available information at this stage, we hypothesise that the waiting times for residential services reported by services relate to the careful matching of clients to residential settings based on their individual profile (male, female, accompanied by children etc.). The undersupply of non-residential services and increasing demand for these consistently reported by service providers is clearly underscored by the data. The most concerning issue is that service providers report they regularly have to provide a lower intensity of care for many clients than assessed as appropriate due to insufficient funding.

Application of the Drug & Alcohol Service Planning model to ACT data sets in consultation with the ATOD sector will provide an opportunity to interrogate existing and future demand more thoroughly.

Appendix 17 – Categories of importance and urgency used for scoring priorities

The following categories were developed by ATODA and used for scoring the priorities for investment outlined in Table 3.1. Categories for importance were based on their projected contribution to improving health outcomes, with those assessed as extremely important providing both a significant improvement in health outcomes and a 'best buy' in terms of return on investment. Assessments on the quality of the investment was undertaken by ATODA, with the requirement that any extremely important investments need to be well-supported in the literature. Urgency was assessed based on the extent to which the investment priority can be delayed without significant health or financial impacts.

Importance categories

Extremely important (4) – Will significantly improve health outcomes at a population level AND represents a 'best buy' in terms of Burden of Disease (BOD) reduction per dollar invested

Important (3) – Will significantly improve health outcomes at a population level and/or represents a good investment in terms of BOD reduction per dollar invested

Somewhat important (2) – Will moderately improve health outcomes as a population level, due to a low number of people affected or a relatively small effect per person

Not important (1) – Will not significantly improve health outcomes at a population level

Urgency categories

Extremely urgent (4) – Is required as a precursor to a new program or represents an urgent need for an existing initiative

Urgent (3) – Each year of delay would result in significant health impairment or financial waste.

Moderately urgent (2) – Each year of delay would result in moderate health impairment or financial waste

Not urgent (1) – Can be delayed several years without any major health or financial impacts

* *Urgency categories which have an asterisk* – Require a new program, process, legislation or policy before it can be implemented

Appendix 18 – Classification of priorities by code & outcomes

The priorities have been classified against the proscribed sub-categories for AOD services listed in the Primary Health Network needs assessment completion guide, 2021 (Table A16.1).[49]

Table A18.1: Classification of priorities by code & outcomes

Project	Priority sub-category	Expected outcome	Collaboration & partnership opportunities
Treatment			
Community-based outreach models	Access	Improved health outcomes for targeted populations	Various AOD service providers/CAHMA
Intensive community-based care models for people with complex needs	Vulnerable population	Improved health outcomes for hard-to-reach group	AOD & Mental Health providers
Early intervention support to families and children	Early intervention and prevention	Improve MH & reduce risk of developing substance dependence	Various AOD service providers, Mental Health providers
More community-based withdrawal options	Access	Increased reach for programs	Various AOD service providers, including Karralika
More residential rehabilitation service places	Access	Reduce waiting times and increase treatment seeking	Leverage capacity in service providers with unfunded capacity
Infrastructure audit and fund facility upgrades	Access	Improved facilities	Labor commitment
New Aboriginal Community Controlled residential rehabilitation facility	Aboriginal and Torres Strait Islander Health	Culturally secure access for Indigenous people	Joint Labor/Green commitment
More AOD specialist capacity to respond to ancillary needs	Safety and quality of care	Enhanced quality of care	Specialised training providers
Improving cultural security including funding Aboriginal AOD workers	Appropriate care (including cultural safety)	Improve access to culturally secure care for Indigenous people	Aboriginal Controlled Health Services, all AOD providers
Specialised support/ treatment for families at risk of interaction with	Vulnerable population	Enhance ability of AOD treatment	CAHMA, Youth Protection Services

Project	Priority sub-category	Expected outcome	Collaboration & partnership opportunities
child protection system due to AOD issues		users to maintain their family units	
More robust pre- and post-program supports, including flexible options	Continuity of care	Reduce waiting lists and relapse rates	All AOD service providers
Increased diversion for low-level offending associated with AOD use	Vulnerable population	Reduce harm from interaction with criminal justice system	ACT Gov't issue (JACS)
Further opportunities to provide in-reach across specialist AOD services	Safety and quality of care	Enhance quality of care	
Increase capability of AOD service users to provide treatment that integrates dependent children	Vulnerable population	Enhance mental health outcomes for dependent children	Karralika, Toora
Improve AOD & MH sector collaboration, and develop an integrated treatment framework	Multi-disciplinary care	Improve health outcomes for comorbid MH/AOD	ATODA, MHCC, AOD service providers
Develop an integrated model of care across services & with allied sectors	Care coordination	Improve health and other social determinants for AOD users	ATODA, AOD service providers
Harm reduction			
Crisis supports/accommodation, including for intoxicated clients and those with an AOD history	Early intervention and prevention	Reduce ED presentations & improve long-health outcomes	Partner with residential rehabilitation providers
Treatment with Injectable Opioids as a prescription option	Vulnerable population	Improve health outcomes for long-term heroin users	GP networks
Trialling stimulant treatment pharmacotherapy	Vulnerable population	Improve health-outcomes for stimulant users	Organisation in another jurisdiction (TBC)
Expanding access to a Needle and Syringe Program	Vulnerable population	Prevent blood-borne diseases in people who inject drugs	Directions, CAHMA, ADS

Project	Priority sub-category	Expected outcome	Collaboration & partnership opportunities
NSP in the AMC	Vulnerable population	Reduce infection from dirty needles	Directions, Corrective Services Union
Supervised injecting facility	Early intervention and prevention	Reduce overdose and bloodborne disease risk	Existing medical facility, CAHMA for peer support
Boost medical practitioners routinely prescribing naloxone	Access	Reduce overdose risk	Directions, CAHMA, GP networks
Boost medical practitioners registered as OST prescribers	Access	Improve health outcomes for opioid users	Directions, CAHMA, GP networks
Providing access to a choice of pharmacotherapies to people in custody	Access	Improve health outcomes for people who use opioids in custody	Correct Services Union, CAHMA, Directions
Other			
Develop a resource for consumers to understand services available, based on Directory	Care coordination	Improve awareness of services for consumers	ATODA, ADS, CAHMA
Increase services to support family members of people who use drugs, including improved online & phone advice, support groups	System integration/ vulnerable population	Improve mental health of families	Family Drug Support, FFDLR, CAHMA, Directions

References

1. Australian Government Department of Health. Needs Assessment Toolkit. Supporting Primary Health Networks in conducting regional drug and alcohol treatment needs assessments. Department of Health, 2016.
2. ACT Health Directorate. *ACT Drug Strategy Action Plan 2018-2021*. Canberra, https://www.health.act.gov.au/about-our-health-system/population-health/act-drug-strategy-action-plan: ACT Health, 2018.
3. Australian Institute of Health and Welfare. *Australian Burden of Disease Study 2018: key findings*. 2021. Canberra: Australian Institute of Health & Welfare.
4. Australian Institute of Health and Welfare. *Australian Burden of Disease Study: impact and causes of illness and death in Australia 2015*. 2019. Canberra: AIHW.
5. ATODA. *Submission to the Select Committee Inquiry, Drugs of Dependence (Personal Use) Amendment Bill*. 2021.
6. Australian Institute of Health and Welfare. *Impact of alcohol and illicit drug use on the burden of disease and injury in Australia: Australian Burden of Disease Study 2011*. 2018. Canberra: AIHW.
7. Australian Bureau of Statistics. *National Health survey, first results, 2017–18*. Report no. ABS cat. no. 4364.0.55.001, Dec 21, 2018. Canberra: ABS.
8. ACT Health Directorate. Statistics and Indicators: Alcohol use- drinking status, https://www.health.act.gov.au/about-our-health-system/data-and-publications/healthstats/statistics-and-indicators/alcohol-use-0 (accessed 16/09/21).
9. Australian Institute of Health and Welfare. *Alcohol and other drug treatment services in Australia annual report*. 2021. Canberra: AIHW.
10. Australian Institute of Health & Welfare. Illicit drug use: snapshot, https://www.aihw.gov.au/reports/australias-health/illicit-drug-use (2021).
11. Department of Health. *National Drug Strategy 2017-2026 2018 Annual Report*. 2020. Canberra: Department of Health, Commonwealth of Australia.
12. ACT Health Directorate. Statistics and Indicators: Recent illicit use of any drug by year, https://www.health.act.gov.au/about-our-health-system/data-and-publications/healthstats/statistics-and-indicators/recent-2 (accessed 16/09/21).
13. Australian Bureau of Statistics. *National, state and territory population statistics about the population and components of change (births, deaths, migration) for Australia and its states and territories*. 2020. Canberra: ABS.
14. ACT Council of Social Service (ACTCOSS). Factsheet: Poverty and inequality in the ACT. 2020.
15. Alcohol Tobacco and Other Drug Association ACT (ATODA). *Service Users' Satisfaction and Outcomes Survey 2018: a census of people accessing specialist alcohol and other drug services in the ACT*. 2020. Canberra: ATODA.
16. Australian Institute of Health and Welfare. *People with disability in Australia*. 2020. Canberra: AIHW.
17. National Health and Medical Research Council. *Australian guidelines to reduce health risks from drinking alcohol*. 2020. Canberra: NHMRC.
18. Ritter A, King, T, Hamilton, M. *Drug use in Australian society*. South Melbourne: Oxford University Press, 2013.
19. Vuong T, Ritter A, Hughes C, et al. *Mandatory alcohol and drug treatment: What is it and does it work?* 2019. Sydney: Drug Policy Modelling Program, Social Policy Research Centre, UNSW Sydney.
20. Australian National Council on Drugs. *ANCD Position Statement: mandatory treatment*. Canberra: ANCD, 2014.
21. 360Edge and Alcohol Tobacco and Other Drug Association ACT (ATODA). *The specialist alcohol, tobacco and other drug sector: a description and examination of treatment*

and support approaches. 2017. Canberra: Alcohol Tobacco and Other Drug Association (ATODA).
22. Australian Institute of Health & Welfare. *National opioid pharmacotherapy statistics (NOPSAD) 2020*. Canberra 2021.
23. Ministerial Drug and Alcohol Forum. *National Quality Framework for Drug and Alcohol Treatment Services*. 2019. Canberra: Commonwealth Department of Health.
24. ACT Health Directorate. *Government Submission to the Select Committee Inquiry, Drugs of Dependence (Personal Use) Amendment Bill* 2021. Canberra: ACT Government.
25. Australian Institute of Health & Welfare. Alcohol and other drug treatment services in Australia: early insights. Canberra: AIHW, 2021.
26. Preventive and Population Health Branch Health Improvement Projects Unit. Data collection guidelines: ACT Data collection for alcohol and other drug treatment services, Version 1 July 2019. ACT Health Directorate, Canberra, 2019.
27. Australian Institute of Health and Welfare (AIHW). *Alcohol and other drug treatment services in Australia 2019-20: key findings*. 2021. Canberra: AIHW.
28. Australian Institute of Health and Welfare. *National Drug Strategy Household Survey 2019*. 2020. Canberra: AIHW.
29. Chan GCK and Hall W. Estimation of the proportion of population cannabis consumption in Australia that is accounted for by daily users using Monte Carlo Simulation. *Addiction* 2020; online ahead of print 15 January 2020. DOI: 10.1111/add.14909.
30. AshaRani P, Hombali A, Seow E, Ong WJ, Tan JH, Subramaniam M,. Non-pharmacological interventions for methamphetamine use disorder: a systematic review. *Drug & Alcohol Dependence* 2020; 212.
31. Heard S IJ, Geddes L, Kwon JA and Maher L, . *Needle Syringe Program National Minimum Data Collection: National Data Report 2020*. 2020. Sydney Kirby Institute, UNSW
32. Alcohol Tobacco and Other Drug Association ACT (ATODA). ACT Alcohol and Other Drug Workforce Profile 2021: Qualifications, Remuneration and Well-being.
33. Alcohol Tobacco and Other Drug Association ACT (ATODA). *ACT Alcohol and Other Drug Workforce Profile 2017: Qualifications, Remuneration and Well-being*. 2019. Canberra.
34. Alcohol Tobacco & Other Drug Association of ACT (ATODA). *ACT Alcohol and Other Drug Qualifications Strategy*. 2017. Canberra: ATODA.
35. Skinner N, McEntee, A. & Roche, A, . *Australia's Alcohol and Other Drug Workforce: National Survey Results 2019-2020*. 2020. Adelaide, South Australia.
36. The National Health Information and Performance Principal Committee. The Australian Health Performance Framework. In: AIHW, (ed.). 2017.
37. Ettner SL, Huang D, Evans E, et al. Benefit–Cost in the California Treatment Outcome Project: Does Substance Abuse Treatment "Pay for Itself"? *Health Services Research* 2006; 41: 192-213. DOI: https://doi.org/10.1111/j.1475-6773.2005.00466.x.
38. Frontier Economics. *Specialist drug and alcohol services for young people–a cost benefit analysis*. 2011. London: Department for Education.
39. Wilson DP, Donald B, Shattock AJ, et al. The cost-effectiveness of harm reduction. *International Journal of Drug Policy* 2015; 26: S5-S11. DOI: https://doi.org/10.1016/j.drugpo.2014.11.007.
40. Hood JE, Behrends CN, Irwin A, et al. The projected costs and benefits of a supervised injection facility in Seattle, WA, USA. *International Journal of Drug Policy* 2019; 67: 9-18. DOI: https://doi.org/10.1016/j.drugpo.2018.12.015.
41. Fairley M, K H, VR J, et al. Cost-effectiveness of treatments for opioid use disorder. *JAMA Psychiatry, vol 78, no 7* 2021; 78, no. 7: 767-777.
42. Onuoha E, Leff, JA, Schackman, BR, McCollister, KE, Polsky, D & Murphy, SM,. Economic evaluations of pharmacologic treatment for opioid use disorder: a systematic literature review. *Value in Health, vol 24, no 7* 2021; 24, no. 7: 1068-1083.

43. Australian Government Department of Health. *National framework for alcohol, tobacco and other drug treatment 2019-2029*. Dec 2019 2019. Canberra Australian Government Department of Health
44. Ritter A, Berends L, Chalmers J, et al. *New Horizons: the review of alcohol and other drug treatment services in Australia. Final Report*. Sydney: Drug Policy Modelling Program, National Drug and Alcohol Research Centre, UNSW, 2014 (released Nov. 2015).
45. Justice Reform Group ACT. *Submission to the Select Committee Inquiry, Drugs of Dependence (Personal Use) Amendment Bill*. 2021.
46. Families and Friends for Drug Law Reform. *Submission of Families and Friends for Drug Law Reform to the Inquiry of the Select Committee on the drugs of dependence (personal use) Amendment Bill 2021*. 16 June 2021 2021.
47. Alcohol Tobacco and Other Drug Association ACT (ATODA). Submission to the ACT Budget 2021-22 Consultation, http://www.atoda.org.au/wp-content/uploads/2021/06/ACT-Budget-Submission-2021-22-3.0-1.pdf (2021, accessed 23/07/21).
48. Alcohol Tobacco and Other Drug Association ACT (ATODA). Alcohol, Tobacco and Other Drug Services Online Directory - ACT, http://directory.atoda.org.au/ (2021).
49. PHN Needs Assessment Completion Guide. 2021.
50. Victorian Health Complaints Commission. *Review of private health service providers offering alcohol and other drug rehabilitation and counselling services in Victoria*. 2021. Melbourne: Victorian Health Complaints Commission.
51. ACT Council of Social Service (ACTCOSS). ACT Budget Bulletin 2021-22
52. CC Attkisson TG. *The UCSF Client Satisfaction Scales: I. Client Satisfaction Questionnaire-8 in ME Maruish (ed.), The use of psychological testing for treatment planning and outcomes assessment*. New Jersey: Lawrence Erlbaum Associates, Mahwah.
53. R McBean LH, D Tatow, J Buckley, K Podevin, E Fewings, . Queensland Alcohol and Other Drug Treatment Service Delivery Framework, 2015., https://qnada.org.au/rch_type/qld-frameworks/ (accessed 21 August, 2021).
54. Oviedo-Joekes E, Guh D, Brissette S, et al. Hydromorphone compared with diacetylmorphine for long-term opioid dependence: a randomized clinical trial. *JAMA psychiatry* 2016; online ahead of print, open access http://archpsyc.jamanetwork.com/article.aspx?articleid=2512237 Published online April 06, 2016. DOI: 10.1001/jamapsychiatry.2016.0109.
55. Heard S, Iversen J, Kwon JA, et al. *Needle Syringe Program National Minimum Data Collection: national data report 2019*. Sydney, https://kirby.unsw.edu.au/report/needle-syringe-program-national-minimum-data-collection-report-2019: Kirby Institute, UNSW Sydney, 2019, p.70.
56. Australian Bureau of Statistics. Average weekly ordinary time earnings, full time adults by state, original, https://www.abs.gov.au/statistics/labour/earnings-and-work-hours/average-weekly-earnings-australia/may-2021 (2021, accessed 14/10/2021).