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Drug Strategy
Policy Division, ACT Health
GPO Box 825
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Submission on the proposed *ACT Alcohol, Tobacco and Other Drug Strategy 2010-2014* from the Public Health Association of Australia, ACT Branch

Thank you for the opportunity to contribute to the consultation phase regarding the proposed *ACT ATOD Strategy 2010-2014*.

The Public Health Association of Australia Inc (PHAA) is a national organization comprising individual members and representing over 40 professional groups concerned to promote health at a population level. This includes, but goes beyond the treatment of individuals to encompass health promotion, prevention of disease and disability, recovery and rehabilitation, and disability support. This framework, together with attention to the social, economic and environmental determinants of health, provides particular relevance to, and expertly informs the ACT Branch's submission on the *ACT Alcohol, Tobacco and Other Drug Strategy 2010-2014*.

We have noted with interest the media release by Minister Gallagher dated 2 December 2009 in which she listed some of the achievements of the previous ACT ATOD Strategy and invited comments on the consultation draft of the next Strategy. The reduction in the use of both legal and illegal drugs, mentioned in the media release, is welcomed and closely accords with the public health goals of PHAA.

This submission deals briefly with the following issues: vision, aims and guiding principles; priority setting; best practice approaches and their implementation; the recommendations of the National Preventative Health Taskforce in relation to alcohol and tobacco; monitoring, evaluation and reporting; alcohol and tobacco information systems; the establishment of an ACT alcohol and other drug sector peak body; peer administered naloxone; traffic safety initiatives; and expanding the range of prescribed opioids as treatment interventions.

Vision, aims and principles

The Branch notes the stated vision, aims and guiding principles underlying the Strategy and is pleased to see that it is continuing the successful approach adopted previously both nationally and in the ACT. We encourage the Government to maintain its harm minimisation approach covering implementation across the health, criminal justice system, education, business regulation, and community support sectors, and addressing both legal and illegal drugs in a single strategy. We also strongly support the Strategy's emphasis on an evidenced-informed approach, dealing with the antecedents of harmful drug use and applying a partnership approach. We also support the undertaking that the Strategy's Action Plan will be implemented 'in a manner that respects, protects and promotes human rights' as a commitment to ensuring that human rights are not eroded in the name of 'getting tough on drugs'.

Priority setting

The Branch is also pleased to note that setting priorities for action has been undertaken systematically. Combining the use of the Basic Priority Rating Model and a reasonably comprehensive set of indicators of drug-related harm and interventions addressing them means that the priority setting process has been both systematic and transparent, providing a model for other

jurisdictions. The conclusion that tobacco and alcohol use create a far greater burden of disease and injury, and social disruption, within the ACT community than do the illicit drugs, should guide resource allocation and priority setting within the Action Plan.

Best practice approaches and their implementation

We note that one of the aims of the Strategy is to 'develop evidence-based policies and initiatives to ensure that issues associated with harmful alcohol, tobacco and other drug use are addressed in an effective way'. Although we have some concern about the use of the term 'evidence-based policies', believing that 'evidence-informed policies' is a term that better reflects the realities of making policy in a pluralistic society, we strongly support this orientation of the Strategy.

Differing levels of evidence in different sectors

An ongoing issue in developing evidenced-informed drug policies is that, while the evidence base for drug treatment is reasonably sound and clear guidelines exist for implementing it, the same cannot be said with regard to the prevention and law enforcement components of the Strategy. Nonetheless, a significant body of evidence exists about what works in school-based drug education and we urge that this be taken into account in further developing this important area. We also have a strong body of evidence about the effectiveness of taxation and supply control in reducing the harms caused by the licit drugs alcohol and tobacco.

Similarly, some research-based information is available about what works in drug law enforcement concerned with the currently illicit drugs, including the use of intelligence led enforcement, hotspot policing and diverting people from the criminal justice system into drug education and treatment.

Law enforcement interventions

Cannabis law enforcement

The Branch continues to be concerned about the large numbers of people apprehended by ACT Policing for minor cannabis offences, and the very small numbers apprehended for serious drug offences.¹ This appears to be contrary to the stated policy of Australian Governments that they primarily address drug-trafficking rather than ordinary drug users and low-level user/dealers whose needs are far better met through the health system than the criminal justice system. The Branch urges the ACT Government, in implementing its Strategy, to guide ACT Policing (who after all are contractors to the ACT Government) to operate more consistently within a harm minimisation framework rather than arresting large numbers of people for minor cannabis offences. That said, we support the diversion provisions of the Strategy, including the continuation of the current diversion programs and expanding them to also cover alcohol-related offences as per Action #13.

Repealing the offence of self-administration of an illicit drug

In drawing attention to the importance of evidence-informed drug policy, we note that the provision of the previous Strategy that the offence of self-administration of an illicit drug be repealed was not implemented during the life of that Strategy and does not appear in the proposed 2010-2014 Strategy. We urge the ACT Government to place this provision into the new Strategy and to implement it during the 2010-2014 period. This is an initiative which has been recommended by many high-level expert public health committees as an important intervention to help reduce the spread of communicable diseases including hepatitis C and HIV/AIDS. It is also relevant to the principle of focusing law enforcement efforts on high-level drug offences rather than on drug users. The State of Queensland does not have an offence of self-administration of drugs and has not found

¹ In 2007-08, people classified as cannabis consumers (rather than producers) made up 58% of *all drug arrests* in the ACT. More worrying, however, is that 94% of all cannabis arrests were consumers. This proportion is higher than all the States and the NT. Source: Australian Crime Commission 2009, *Illicit drug data report 2007-08*, Australian Crime Commission, Canberra, and author's calculations.

any consequent difficulties with regard to policing drugs. We urge the ACT Government to follow Queensland's lead in this regard, in the interests of population health.

Implementing the recommendations of the National Preventative Health Taskforce in relation to alcohol and tobacco

The Branch notes that while the draft Strategy refers to the report of the National Preventative Health Taskforce, it does not seem that the recommendations have been systematically analysed and incorporated, insofar as they apply to the ACT. This may reflect the timetable of the draft Strategy's preparation. Although the Strategy does address many of the areas in which the Task Force issued recommendations, we suggest that the next draft of the Strategy reflect more systematic consideration of the Taskforce's recommendations.

Priority populations for tobacco interventions

We note the prominence given to tobacco, with the first set of actions addressing this drug. The target populations listed in Action #1 are all important, but we are surprised to see no mention of the inmates and staff of the Alexander Maconochie Centre as priority populations for smoking interventions. No consensus exists in Australia about banning smoking in prisons though, as the National Preventative Health Taskforce points out, bans are in place in the USA in all Federal penitentiaries and in 10 states. This has largely been a consequence of litigation in that nation, and we could see the same thing happening in the ACT if the government continues to deny prisoners and prison staff the right to live and work in a smoke-free environment. At the very least, prison inmates should be identified as a priority population group for intensive smoking cessation programs.

Furthermore, the Branch is concerned to see that a number of drug treatment agencies in the ACT, including some funded by ACT Health, continue to allow staff and clients to smoke on their premises. We note that the Government, through the ACT AOD Sector Project, is addressing this anomaly.

Other priority population groups for smoking interventions are pregnant women and their partners, parents of young children, men in blue-collar occupations, students in ACT secondary colleges and tertiary institutions and people who smoke at licensed premises.

Monitoring, evaluation and reporting

The Branch has been favourably impressed by the systematic approach taken to monitoring and evaluation in the previous phase of the Strategy. We have perused the regular monitoring and evaluation reports on the ACT Health website and commend those responsible for both their thoroughness and comprehensiveness, as well as for this high level of transparency. In this regard, the ACT provides a model to other jurisdictions that do not have such systematic and transparent monitoring, evaluation and reporting processes.

Information systems: alcohol and tobacco availability and consumption

The Branch supports the proposed Action #51 regarding the development of tactical and strategic early warning systems about drug availability and drug-related harm.

The monitoring and evaluation systems referred to in the previous section seem satisfactory with regard to alcohol, and other drug interventions, but appear to have some serious deficiencies with regard to information on the availability and levels of consumption of some other drugs. The Branch is pleased to see the commitment in the Strategy (Action #56) to reinstating the collection of wholesale alcohol sales data and urges the Government to implement this quickly and to make the resulting data publicly available. This should include the development and publication of an ongoing time series of alcohol consumption data for the ACT.

The Branch continues to be disappointed that the ACT (along with other jurisdictions) is not taking a corresponding approach to monitoring the availability and consumption of tobacco. We find this an

anomalous situation, particularly considering that cigarette smoking accounts for some 65% of Australia's burden of disease and injury resulting from drug use. Accordingly, we urge that the new Strategy include a commitment to collect, analyse and report upon data on tobacco availability and consumption within the Territory. An ongoing time series in this area should be available in parallel with the dataset covering alcohol consumption.

Establishing an ACT alcohol and other drug sector peak body

The Branch strongly supports the ACT Government's initiative to develop an alcohol and other drug sector peak body for the ACT. We work closely with ADCA, the national NGO peak body in the substance-abuse field, and have long been concerned that the ACT (unlike all the Australian States) has not had a Territory peak body to work locally and to be represented at that national forum. We are aware that the current ACT ATOD Sector Project is operating effectively and producing sound outcomes.

We consider it important that, in implementing the commitment in the Strategy to developing the new ACT peak body, the Sector Project's activities and achievements are not diminished and that all areas of the ACT ATOD sector are represented. This means that the new sector peak body will need to be funded by the ACT Government for the activities that it will undertake over and above the ongoing Sector Project activities. We urge the Government, in implementing this component of the Strategy, to give high priority to funding the proposed ACT drug sector peak body.

Peer administered naloxone

A commendable feature of the draft Strategy is its commitment to partnership with affected communities, including with people who use drugs. It acknowledges the importance of drug user organisations and to peer support and education activities. In this context, the Association draws attention to the recent publication in the *Medical Journal of Australia* and in *Drug and Alcohol Review* of commentaries by prominent Australian drug researchers about the value of peer administration of naloxone.² It is not necessary to repeat here the arguments set out in those articles but urge the ACT Government to undertake a policy review in this area with a goal of establishing, during the life of the next ACT ATOD Strategy, a program of peer administration of naloxone as a core component of the Strategy's harm reduction actions.

Traffic safety initiatives

It is commendable that the draft Strategy deals with relevant aspects of traffic safety. We note that the term 'random breath testing' is used and question whether the appropriate term is 'roadside breath testing', given that much of the testing is targeted, not random. On the other hand, were random breath testing to occur on an ongoing basis, the resulting data would be a valuable tool for monitoring the success of drink drive interventions. The current policy of targeted roadside drug testing means that the resulting data are not useful for this purpose.

We draw attention to Action #8 which has as its indicator for evaluation 'Reduction in the proportion of persons who self-report to driving while suspecting they are over the prescribed alcohol limit'. While this indicator may have some utility for monitoring the outcomes of the initiative listed, a better one would be a measurement of policing activity and results, such as the number of breath tests administered and the proportion in which the drivers exceeded the prescribed concentration of alcohol. Furthermore, the survey data upon which ACT Policing would need to rely to produce the

² Lenton, SR, Dietze, PM, Degenhardt, L, Darke, S & Butler, TG 2009, 'Naloxone for administration by peers in cases of heroin overdose', *Medical Journal of Australia*, vol. 191, no. 8, p. 469 and Lenton, SR, Dietze, PM, Degenhardt, L, Darke, S & Butler, TG 2009, 'Now is the time to take steps to allow peer access to naloxone for heroin overdose in Australia', *Drug and Alcohol Review*, vol. 28, no. 6, pp. 583–85.

evaluation indicator listed is not sensitive enough (because of the small sample size and the resulting wide confidence interval) to detect any change in the proportion of self-reported drink driving.

Hospital Emergency Department initiatives

The Branch is aware of both challenges and opportunities relating to the impact of alcohol and other drugs in hospital Emergency Departments. These include the need to prevent and manage risks to patients and staff from violent behaviour perpetrated by drug-affected patients. On the other hand, we are aware of the opportunities for early and brief interventions to be provided in these settings, and suggest that the usefulness of these be considered in any revised list of priority actions.

Expanding the range of prescribed opioids for the treatment of opioid dependence

We note the proposed Action #52 which is 'To advocate nationally for clinical trials of hydromorphone and heroin'. The Branch supports further research into the use of hydromorphone in treating opioid dependence owing to the promising reports about hydromorphone from the NAOMI trial.³

With regard to using diamorphine for the treatment of opioid dependence, the Branch's position is that further clinical trials are unnecessary. Sufficient high-quality trials have been conducted overseas, with the results published in leading medical journals, demonstrating the effectiveness, in a wide range of settings with diverse population groups of opioid users, of this form of medical treatment. What is required in Australia is not further research but rather adding diamorphine to the other opioid agonist drugs available for treatment. Accordingly, we urge the ACT Government to advocate nationally for this to occur. If the ready availability of prescribed diamorphine is not possible in the short term, and a fallback position is further research in Australia to replicate the overseas studies, the Branch and the Association would support this as an interim measure.

Conclusion

The ACT Branch of the Public Health Association of Australia supports both the underlying philosophy and most of the proposed actions set out in the draft ACT ATOD Strategy 2010-2014. We commend those responsible for drafting the Strategy and the ACT Government for releasing it for public and professional comment. The Association requests that the additional points set out above be taken into account in preparing the final version of the Strategy.

Yours sincerely

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³ Oviedo-Joekes, E, Brissette, S, Marsh, DC, Lauzon, P, Guh, D, Anis, A & Schechter, MT 2009, 'Diacetylmorphine versus methadone for the treatment of opioid addiction', *New England Journal of Medicine*, vol. 361, no. 8, pp. 777-86.