ATODA
Alcohol Tobacco & Other Drug Association ACT

The Hon Dr Mike Freelander MP
Chair
House Standing Committee on Health, Aged Care and Sport
PO Box 6021
Parliament House
Canberra ACT 2600
By email only: Health.Reps@aph.gov.au

Submitted by:
Anita Mills
Chief Executive Officer
Alcohol Tobacco and Other Drug Association ACT (ATODA)
info@atoda.org.au/ (02) 6249 6358/ PO Box 7009 Kaleen, ACT 2617

4 October 2024

Dear Dr Freelander,

**Re. Submission to the Inquiry into the health impacts of alcohol and other drugs in Australia**

The Alcohol, Tobacco and Other Drug Association ACT (ATODA) represents the alcohol, tobacco and other drug (ATOD) sector in the ACT. Members include specialist alcohol and other drug treatment and harm reduction organisations, including the peer-based organisation for people with lived experience of drug use in the ACT; distinguished drug experts with knowledge of the criminal justice system and population health; and allied sectors.

Underpinning ATODA's work is a commitment to health equity, the social and cultural determinants of health, and the values of collaboration, participation, diversity, human rights, social justice and reconciliation between Aboriginal and Torres Strait Islander people and other Australians. ATODA's purpose is to lead and influence positive outcomes in policy, practice and research, as the peak body for the alcohol, tobacco and other drug sector in the ACT. These outcomes flow from initiatives in prevention, early intervention, harm reduction, treatment, peer services, and continuing care.

The *Inquiry into the health impacts of alcohol and other drugs in Australia* (the Inquiry) presents a welcome opportunity for ATODA to engage with the Commonwealth on key issues impacting the alcohol, tobacco and other drugs (ATOD) sector. Our submission articulates the need for resourcing that adequately matches the demand for treatment and the complexity of concerns of people using alcohol, tobacco and other drug treatment services. Further, we highlight the need for a national governance structure to better support integrated planning, strategic coordination, cohesive funding approaches, and responses to emerging challenges. Our submission has also taken the opportunity to illustrate the effectiveness of ATOD services at providing high-quality treatment and harm reduction programs to the ACT community, despite limited and insufficient funding.

It is important to note at the outset that Australian Government expenditure on ATOD allocates only 1.6 percent of the available budget to harm reduction, despite there being substantial evidence that these measures reduce the rate of health harms and death from ATOD use.[1] Despite this funding shortfall, current services across the ATOD sector are delivering best-practice evidence-based treatment to Australians. There are various current challenges facing ATOD treatment services in Australia, including population growth, burgeoning demand for services, and increasing complexity in service user profiles. To continue to work at full capacity in delivering the best outcomes for individuals, families and society, the ATOD sector needs to be bolstered by resourcing that matches demand and by the establishment of a national governance structure.

The ATOD sector is deeply interconnected with various allied sectors, including criminal justice, housing and homelessness, family and domestic violence, and mental health. Despite the critical nature of these interactions, community health and allied sectors often receive inadequate funding for effective cross-sector collaboration at a policy or practice level. Our submission provides some examples of how ATODA is working across the community to support people with complex needs, and we invite the committee to consider ways in which governments can also support cross-sectoral collaboration and innovation.

ATODA appreciates the opportunity to provide a submission into this Inquiry and we welcome the opportunity to provide any additional information that may be required. Please reach out on the details provided above in the first instance.

Yours sincerely,

Anita Mills
Chief Executive Officer
Alcohol Tobacco and Other Drug Association ACT (ATODA)

Sharon Tuffin
Chair
Alcohol Tobacco and Other Drug Association ACT (ATODA)

ATODA
Alcohol Tobacco & Other Drug Association ACT

## Table of Contents

**A) Assess whether current services across the alcohol and other drugs sector is delivering equity for all Australians, value for money, and the best outcomes for individuals, their families, and society**

### Current status of the ATOD sector in Australia

The ATOD sector in Australia delivers high quality evidence-informed treatment services to ensure that, even in the context of resourcing constraints and high service demand, health harms from ATOD are reduced across the population. This work includes withdrawal and rehabilitation programs, AOD assessments and brief interventions, and harm reduction measures. As the AOD sector implements population health measures to reduce harms from tobacco, ATODA acknowledges these services as forming the alcohol, *tobacco* and other drug (ATOD) sector. The ATOD sector across the country works cohesively across government and non-government services. In the ACT alone, the ATOD treatment sector delivers more than thirty programs across the main treatment types. A description of programs in the ACT can be found in the ACT Alcohol, Tobacco and Other Drug Services Online Directory at www.directory.atoda.org.au.

Australia's ATOD sector maintains an excellent international reputation, leading in harm reduction measures such as needle-and-syringe programs, peer education and support services, opioid overdose education, and sobering up shelters.[2] It is also a particularly innovative sector and a global leader in evidence-based ATOD policy perspectives with a harm reduction focus, where examples include drug checking services and the provision of take-home naloxone. The ATOD workforce is well-qualified for delivering alcohol and other drug interventions and provides person-centred and trauma-informed care that reduces ATOD harms in line with best practice. In the ACT, approximately 87 percent of workers have, or are working towards, the minimum formal qualification requirements under the ACT ATOD Qualifications Strategy, indicating a highly qualified and professional workforce.[3]

A majority of intensive treatment types for moderate to severe ATOD-related problems are delivered through specialist ATOD treatment services. In Australia, 69 percent of treatment is delivered by non-government organisations (NGOs), which provide 73 percent of all treatment episodes. In the ACT, 88 percent of treatment services are delivered by NGOs.[4] NGOs provide the majority of treatment and harm reduction interventions that require long-term and often intensive engagement and case management with highly complex service users.[5] Intensive interventions such as residential rehabilitation and day rehabilitation programs, and harm reduction interventions such as needle and syringe programs, drop-in services, peer support, and family support, are exclusively offered by NGO services. There are also 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, limiting the availability of these treatments.

### Complex and co-occurring needs

Demand for specialist ATOD treatment services is increasing and the sector is currently working at full capacity to meet the increasingly complex and co-occurring needs of people using their services. This includes working with service users experiencing co-occurring mental health conditions, dental health concerns, physical health morbidities, and disability. Where people using ATOD have dual diagnosis of co-morbid conditions, the severity is exacerbated for each co-occurring condition. People who use ATOD can frequently have co-occurring experiences of insecure housing and

homelessness, domestic and family violence, unemployment, interactions with the justice system, and gambling harm.[6, 7]

Current treatment services are managing each person as appropriate, but their workforces are limited by factors such as insufficient and siloed funding, referral pathways being reliant on informal connections between allied services, and already over-stretched personnel with barriers to accessing professional development.[5] Workforce development is therefore limited in meeting complex needs, as it requires funding for training, clinical supervision, attractive salaries, and education opportunities. For example, ATODA has released a series of recommendations to improve pathways of care between ATOD services and housing and homelessness services. However, the recommendations made, such as developing population-specific interventions and improving coordination of care between ATOD and housing sectors, are not enabled through resourcing to the ATOD sector.[8] ATOD treatment services are prepared to address the specific considerations required for priority populations and people with complex and co-occurring needs in ATOD treatment services, so that equity of health outcomes will improve. To do so, however, the ATOD sector must be adequately resourced to address these well-known priorities.

### Current resourcing of the Australian ATOD sector

Current resourcing does not adequately enable services to provide best-practice treatment generally or to the specific cohort of people with complex and co-occurring needs, let alone expand their services to meet growing demand. Services continue to take on increased responsibility in the absence of funding growth in real terms.

Findings from the recent Drug and Alcohol Service Planning Model (DASPM) indicate the number of people nationally who require and seek alcohol and other drug (AOD) treatment in any one year is over double the number of people who currently receive treatment in a year.[9, 10] DASPM reporting of the ACT's ATOD service system, indicates that, annually, up to 4,750 more people require treatment than are currently being treated in a year through existing services. Furthermore, there is an investment gap of approximately $24 million per annum.[11] Given some of the limitations of the DASPM data, this is almost certainly an underestimate of current need.[12] Research undertaken at UNSW on the latest iteration of the Australian 'drug budget', finds that total government expenditure on health-based approaches to illicit drug use amounts to 35.7 percent of the total budget, where 6.7 percent is spent on prevention, 27.4 percent on drug treatment, and 1.6 on harm reduction measures. Health responses, such as those provided by ATOD treatment services, cannot be expected to improve where 64.3 percent of expenditure on drug responses is directed to law enforcement.[1]

Years of resourcing below demonstrated community demand without any cost benchmarking, has inevitably impacted ATOD treatment capacity. While organisations are delivering more treatment episodes, they are doing so on relatively less funding, with the consequences of this imbalance experienced in, for example, longer wait times for and between treatment episodes and an aging workforce against the backdrop of low recruitment to the sector. While the *ACT Drug Strategy Action Plan 2022-26* (the Action Plan) notes the met demand of individuals requiring intensive treatment for ATOD as between 48-58 percent, this highlights that up to 52 percent of demand for treatment goes unmet.[7, 11] These standards for unmet demand would not be acceptable for other health conditions, such as cardiovascular conditions.

The ATOD sector across Australia has been repeatedly raising these concerns and research has long identified the mismatch of funding and demand for ATOD services. For instance, in the ACT, increased ATOD sector funding to meet the treatment needs of service users has been requested multiple times. In addition, previous ACT Budget consultation summaries and the ACT Action Plan acknowledge the need for increasing funding to meet demand and acknowledge the significant role of NGO's to deliver treatment.[7, 13] However, the ACT Government budgets and current policy settings do not align with these acknowledgements of need for the ATOD sector. This example illustrates a recurring pattern in ATOD resourcing and policy, where the need to appropriately meet demand and client complexity is noted by governments, but not addressed. To reduce the health harms of alcohol and other drugs for all Australians, the level of unmet demand and shortfall of resourcing for the ATOD sector must be addressed properly.

### National governance framework

To address the shortfall of national ATOD funding and lack of coordination in priorities, the Australian ATOD sector requires a national governance framework. As noted by the Australian Alcohol and Other Drugs Council submission to this Inquiry, the previous governance framework for the ATOD sector was disbanded. Reinstating a governance structure is pivotal to enhance capacity of the sector to coordinate priorities, including approaches to address demand and complexity of treatment services. An ATOD governance framework would also ensure effective monitoring and evaluation against the *National Drug Strategy 2017-2026*, *National Alcohol Strategy 2019-2028*, and *National Quality Framework for AOD treatment services*. The structure would enable oversight and coordinated responses to national ATOD issues, including the development, implementation, and monitoring of key strategies, sub-strategies and frameworks; the allocation of Commonwealth funding to ATOD organisations and primary health networks; national responses to emerging drugs of concern, and to increasing rates of overdose; and the coordination of approaches to building capacity across treatment and harm reduction services.

**B) Examine the effectiveness of current programs and initiatives across all jurisdictions to improve prevention and reduction of alcohol and other drug-related health, social and economic harms, including in relation to identified priority populations and ensuring equity of access for all Australians to relevant treatment and prevention services**

The ATOD sector in the ACT is a specialist health sector that works collaboratively to deliver the full range of evidence-informed ATOD treatment types. This minimises duplication, maximises efficiency, and provides program options that can be matched to need and adjusted to maximise outcomes. The ACT ATOD sector operates as an integrated, collaborative sector, with strong partnerships between government and non-government organisations that enable flexibility, agility and specialisation in service delivery.

ATOD organisations in the ACT are required to meet a series of quality activities that constitute a quality framework, including meeting national accreditation standards as required; reporting to ACT and national data sets, such as the National Minimum Data Set for AOD Treatment Services; participating in sector-wide networking and evaluation activities; developing and documenting detailed program-level models of care; and ensuring their workforce meets the minimum standards set in the ACT Alcohol and Other Drug Qualifications Strategy.[14]

### Quality service delivery by ATOD programs

The 2023 ACT ATOD Service Users Survey of Outcomes, Satisfaction and Experience (SUSOSE) surveyed 302 individual service users across the entire ACT ATOD sector—including all treatment and harm reduction intervention types. The survey found that people using ATOD services in the ACT reported high satisfaction with programs and positive self-reported outcomes across a range of ATOD-specific and associated health and wellbeing outcomes. Among other findings, self-reported changes since using ATOD programs included:

- 74 percent reporting that both the quantity and frequency of their alcohol and other drug (AOD) use had decreased ('a lot' or 'a bit') or they had stopped altogether;
- 69 percent reporting that their risk of involvement with police and the justice system had decreased 'a lot' or 'a bit'; and
- 74 percent reporting that their overall quality of life was 'a bit', or 'a lot' better.

People accessing ACT ATOD programs also reported high mean scores across several items measuring experiences of service-use. For example:

- 95 percent agreed or strongly agreed with the statement: "At this service, I'm treated like a person, not like 'a problem'" (person-centred);
- Only 10 percent agreed with the statement: "At this service, I feel judged for being someone who uses alcohol and other drugs" (Non-judgmental, non-stigmatising and non-discriminatory).

### Responding to co-occurring issues and complex needs in the ACT

People who use ATOD services frequently have co-occurring and complex issues in their lives, as well as possible health co-morbidities. Data from the ACT SUSOSE, outlines some of these co-occurring issues and gives the ACT ATOD sector a clear idea of how to improve outcomes for service users. The profile of service users accessing ACT ATOD programs, points to the need for close cross-sectoral collaboration to address a range of co-occurring issues and complex needs. For example:

- 39.3 percent of service users surveyed as part of the SUSOSE were homeless or at risk of homelessness;
- 68.4 percent were unemployed or not working;
- 37.1 percent identified as a person with a disability; and
- 44.6 percent of female service users had experienced domestic and family violence in the past 12 months.

This complexity of need and the additional capacity demands placed on ACT ATOD services is further demonstrated by the SUSOSE data on requests for support being made by service users across all ACT ATOD programs. For instance, 53 percent of respondents requested support for their mental health, and a significant proportion of people using services had complex issues with social housing, needed emergency accommodation, required legal help, or requested support after police diversion, court diversion or release from prison.[15]

While it is the goal of ATOD services to provide targeted and person-centred responses to service users with highly complex needs, the capacity to do so is limited by inadequate resourcing, and in some cases, by a lack of specialised training in the workforce. ACT ATOD services have established

strong referral relationships across allied sectors, but organisations and programs in these sectors are also under financial pressure, and service users consequently risk falling through the cracks in the service system.

### Facilitating access to ATOD services by priority populations

ATOD programs in the ACT have demonstrated engagement with a range of priority populations identified in the *National Drug Strategy 2017-2026* and the *ACT Drug Strategy Action Plan 2022-2026*. For example, the 2023 SUSOSE shows that:

- 19.1 percent of service users identify as Aboriginal and/or Torres Strait Islander;
- 14.0 percent of service users identify as lesbian, gay, bisexual, transgender, and/or intersex (LGBTQI+);
- 36.2 percent of service users identify as female;
- 26.8 percent of service users were aged under 30 years; and
- 25.8 percent were aged over 50 years.

Fewer than 10 percent of service users identified in the SUSOSE as being from a culturally and linguistically diverse (CALD) background—other than Aboriginal and/or Torres Strait Islander backgrounds. There is limited data available on ATOD use in CALD communities. However, anecdotally, services recognise that ACT CALD communities need improved access to ATOD programs. Certainly, the SUSOSE data shows limited engagement by CALD communities in ACT ATOD programs, pointing to an area that should be examined and better resourced.

**C) Examine how sectors beyond health, including for example education, employment, justice, social services and housing can contribute to prevention, early intervention, recovery and reduction of alcohol and other drug-related harms in Australia**

ATODA has sought to establish and maintain cross-sectoral partnerships in the ACT through project-specific collaborations, reciprocal membership arrangements and the establishment of strategic networks. Awareness of intersectional and co-occurring conditions enables more effective ATOD treatment and better treatment outcomes. However, inadequate funding can hamper the establishment of long-lasting and beneficial relationships between sectors.

### Justice

Evidence shows that punishment alone is not an effective tool in reducing recidivism,[16] and that decades of criminal and law enforcement approaches to drug use has not resulted in reduced drug use, or reduced recidivism.[16] The ACT is leading the nation in taking a health-focused approach to drug use, rather than a criminal one through the *Drugs of Dependence (Personal Use) Amendment Act 2022* (more detail provided below). ATODA recommends that efforts to reduce interactions with the justice system, in line with stated government priorities, focus on strengthening health-focused approaches to ATOD use and that investment is made in treatment as a viable alternative to incarceration, where appropriate.

Across Australia, an estimated 65 percent of people entering prison had used illicit drugs in the past year.[17] Effective ATOD treatment and management can make an important contribution to reducing recidivism for people whose ATOD use contributed to their offence. The ATOD sector has provided

many examples of the effectiveness of treatment and its correlations with reductions in recidivism.[18] However, not all ATOD services can be accessed by people in custodial settings, thereby increasing demand on available services, and limiting options for people to utilise a service that best meets their needs. For example – access to needle and syringe programs (NSPs) are an effective harm reduction measure to improve equity of health outcomes for people who use drugs in correctional settings. However, the approach to harm reduction in custodial settings is variable across States and Territories.[19] ATODA recommends a nationally consistent, evidence-based approach to provision of harm reductions services for people who use drugs in prisons, such as NSP's.[20]

### Housing and homelessness

Poor access to stable housing can result in a range of harms and can significantly exacerbate underlying ATOD harms and co-occurring conditions.[21] These include poor physical and mental health; violence and victimisation; long-term unemployment; lack of quality social relationships; and increased interaction with the criminal justice system. Homelessness or insecure housing can also make it prohibitively difficult for people to change their ATOD use, and can increase the likelihood of recurrent ATOD harms.[21] Additionally, barriers such as lack of affordable housing, unemployment, the rising cost of living, increasing co-occurring conditions, such as mental health concerns, and experiences of domestic and family violence can result in increased cases of homelessness. Without providing assistance to priority population groups experiencing homelessness, achieving lasting population-level improvements to health and wellbeing in the context of ATOD use is unlikely.[21]

A significant proportion of people who use ATOD in ways that are harmful also access homelessness services.[22, 23, 24] Evidence demonstrates that people who receive support from both a specialist homelessness service and a publicly-funded ATOD treatment service were more likely to be returning service users, present with complex service needs, and received longer periods of support and treatment.[25] In Australia, for people who use ATOD, long-term housing was the least provided service, where of the 59 percent requiring this service, only 6.7 percent receive access to it.[25] Additionally, evidence shows that people without a permanent place to live at some point in their life are more likely to have had a 12-month substance use disorder than people who had not (8.2 percent compared with 2.9 percent).[26] While there is evidence to suggest that ATOD dependence can lead to homelessness, there is also evidence suggesting that the longer a person is homeless the more likely they are to engage in risky ATOD use.[24] Given the rates of homelessness among people who use ATOD, a significant reduction in ATOD harms could be facilitated by improving access to long-term housing options and through the resourcing of ATOD services to screen, manage, refer and support people to achieve safe and secure housing.

### Mental health

People who use alcohol and other drugs are at increased risk of experiencing ill health, including co-occurring mental health conditions that can perpetuate the risk of experiencing harms.[27, 28] Co-occurring mental health conditions in those who access ATOD services increases complexity of care and requires specialist expertise to manage. A high number of specialist ATOD workers indicate that they manage co-occurring ATOD and mental health on a regular basis, with available research suggesting that somewhere in the region of 50 percent of people attending alcohol and drug agencies have a co-occurring mental health disorder.[29] People presenting with complex co-occurring needs are also at increased risk of falling through the gaps in service delivery. This highlights the

need for increased supports and funding to provide education and training, for streamlined processes for people with co-occurring conditions, and to foster improved collaboration across sectors.

The ACT Alcohol, Tobacco and Other Drug (ATOD) and Mental Health Alliance (the Alliance) was funded by the ACT Government in 2023-25 to explore and recommend ways to achieve better outcomes for people experiencing co-occurring ATOD and mental health issues in the ACT region, and to build on existing relationships, initiatives, and programs. ATODA recommends that similar models are employed with appropriate support and resourcing to continue to improve cross-sectoral collaborations and improve treatment outcomes for people with complex and co-occurring needs.

### Domestic and family violence

The ATOD sector can be a key partner in reducing the harms of domestic and family violence (DFV). ATOD use and DFV frequently co-occur and people accessing ATOD treatment services are proportionally more likely than the general population to have used and/or to have experienced DFV.[30] Workers in the ATOD sector have an important role in detecting for DFV and are ideally placed to identify and screen for DFV and to provide appropriate interventions and referrals. Legislative efforts to address Australia's DFV crisis can be supported by addressing policy and resourcing shortfalls to the ATOD sector.

ATODA has previously collaborated with DFV services to develop an ACT Alcohol and Other Drug *Safer Families Program*, to address the significant role that the ACT ATOD sector can play in addressing DFV. If resourced adequately, this program would allow for the establishment of coordinated AOD and DFV interventions within specialist ACT ATOD services, while enhancing the capacity of the service system.[31]

**D) Draw on domestic and international policy experiences and best practice, where appropriate**

### Harm reduction measures in the ACT

The ACT has led efforts to embed harm reduction in drug policy, and we have set several key benchmarks for other jurisdictions to learn from.

#### *Decriminalisation*

There is a significant body of evidence to suggest that taking person-centred and health-based approaches to drug use results in better health outcomes and reduces harms across a range of measures.[32] Personal possession of small quantities of illicit drugs are decriminalised in the ACT – under the *Drugs of Dependence (Personal Use) Amendment Act 2022*. Under this legislative reform, personal possession of illicit drugs attracts the option of attending a counselling session in a therapeutic health setting, or pay a $100 fine.[32, 33, 34] Although this reform has not yet been fully evaluated, the decriminalisation of illicit drugs for personal use will, over time, reduce population-level interactions with the criminal justice system and is predicted to reduce recidivism over time. Long-term trends show that there is decreasing support amongst the Australian public for a response to illicit drug use that involves prison sentences and law enforcement and increasing support for education and harm reduction approaches.[35] The ACT model of drug decriminalisation increases interactions of people who use drugs with the health system.[36]

Quantified outcomes of decriminalisation in the ACT are not publicly available, however ATOD services in the ACT have anecdotally recognised that decriminalisation has not presented additional burdens on the sector, despite concern that this policy might result in an overwhelmed ATOD system. ACT ATOD services have not reported additional perceived drug use or drug harms due to decriminalisation. The Alcohol and Drug Services department of Canberra Health Services have reported success in reaching a greater number of people who use ATOD for information and assessment of drug-related harms and ATOD treatment service provision in the ACT.

Internationally, the published and widely observed positive outcomes and impacts of drug decriminalisation are numerous. An uncoupling of individual-level drug policy from criminal justice is found to increase access to ATOD treatment services and increase help-seeking behaviours, as individuals have less fear of being penalised for drug-related health concerns. Removing stigma and discrimination and increasing help-seeking behaviour is potentially life-saving, reduces a wide range of harms experienced by the individual, their family, social networks, and the broader community, while also reducing the long-term burden on the public healthcare system.[34] Where a jurisdiction implements decriminalisation alongside an increase in treatment and harm reduction services, engagement in treatment services increases, drug-induced deaths are lowered, drug use-related infections such as HIV and Hepatitis C decrease, and drug use can, in some cases, decrease as well.[32, 33]

### *Drug checking*

CanTEST, established in 2022, is Australia's first fixed site drug checking and health service. It is a free and confidential health and harm reduction service funded by the ACT Government. CanTEST provides chemical analysis of drugs, and people attending the service can access a registered nurse or qualified harm reduction worker to receive interventions and information about drug harms.[37] The service reported that 70 percent of people accessing CanTEST had never accessed a health care worker for information about drug use before, and 10 percent of people utilising the service discarded their drugs following testing.[38] ATODA acknowledges the establishment of fixed-site drug checking services in Queensland to expand their harm reduction services.[39] ATODA recommends that drug checking facilities are established across states and territories to reduce harms and increase access to drug-related information, education and support for people who use drugs.

### *Supervised consumption rooms*

Supervised consumption rooms play an important role in a comprehensive harm reduction framework, reducing drug-related harms to the individual and the broader community. ATODA recommends that the Government commits to resourcing this harm reduction service for the ACT in the next term of government. This should be designed to be responsive to the specific context of the jurisdiction, meet consumer needs, and be informed by best practice models.

## Best practice international policy

An international policy setting that establishes best practice is the World Health Organisation (WHO) *Framework Convention on Tobacco Control* (FCTC). Australia has met many of the obligations under the convention, such as plain packaging and advertising bans on tobacco, and abiding by the measure to ensure health policies are not influenced by the tobacco industry.[40] The tobacco industry is not accepted as a contributor to tobacco health policies, as their vested commercial interest in the

sale of tobacco contradicts their involvement in health policy boards and committees regarding tobacco. This model of best practice should be followed in relation to alcohol industry involvement in alcohol health policy, particularly as alcohol is recognised as a cause of significant social harm—outranking any other drug in terms of harm caused to others and being a leading cause of death in Australia.[41] Alcohol should be of higher concern to policy-makers, as it is the fifth highest risk factor contributing to the national burden of disease and is the primary drug of concern in ATOD treatment services across Australia (43 percent of service users).[4, 42] The involvement of the alcohol industry in alcohol-related policies and regulation has become a commercial determinant of health for Australians.

An Australian framework on the involvement of the alcohol industry in alcohol-related health policy, modelled on the FCTC, would be a significant step in curtailing the activities of the alcohol industry and reducing harms to the Australian public. Notably, alcohol industry actors continue to deny or downplay the harms of alcohol through policy submissions and contributions to policy discussions that are clearly in contradiction to the scientific literature and the evidence base.[43, 44] They have utilised tactics that place the burden of harm reduction onto individual consumers, without adequately acknowledging the role the industry itself plays in perpetuating harms. Policy settings can actively reduce harms, including via the regulation of the supply of alcohol. For example, where alcohol outlets are clustered, the rates of assault increase,[45] yet appropriate supply reduction policy measures can prevent this. Moreover, when health issues are raised, industry will focus on social and cultural norms around drinking, instead of the role that their advertising and targeted marketing plays in the strong acceptability of alcohol consumption.[46, 47] Federal, State and Territory governments can address this with stronger regulation.

ATODA supports stronger action on alcohol industry marketing and the licensing of online sale and delivery of alcohol. Alcohol marketing is predatory and targets those most at risk of experiencing harms from their own alcohol use,[46] particularly because people who have or have had a dependence on alcohol report a stronger urge to drink when viewing alcohol advertisements.[48] The online sale and delivery of alcohol can increase the risk of a range of harmful outcomes including increased risk of violence, including domestic and family violence (DFV), gendered violence and sexual violence.[49, 50] ATODA recommends that population-level alcohol harms should be reduced through the establishment of a national framework that addresses the role that the alcohol industry plays as a commercial determinant of Australian health.

## References:


1. Ritter A, Grealy, M, Kelaita, P, Kowalski, M. *The Australian 'drug budget': Government drug policy expenditure 2021/22*. Sydney: Social Policy Research Centre, UNSW, 2024.
2. 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*. Canberra: ATODA, 2017/.
3. Alcohol Tobacco and Other Drug Association ACT (ATODA). *ACT Alcohol and Other Drug Workforce Profile 2021: Qualifications, Remuneration and Wellbeing*. Canberra: ATODA, 2022.
4. Australian Institute of Health & Welfare (AIHW). Alcohol and other drug treatment services in Australia: early insights. 16 April 2024 ed. Online: Australian Institute of Health & Welfare (AIHW), 2024.
5. Alcohol Tobacco and Other Drugs Association ACT (ATODA). *Submission to the Select Committee Inquiry, Drugs of Dependence (Personal Use) Amendment Bill*. Canberra: ATODA, 2021.
6. Alcohol Tobacco & Other Drug Association of ACT (ATODA). *Response to the Review and Revision of the National Alcohol and Other Drug (AOD) Workforce Development Strategy Discussion Paper*. 2022. Online.
7. ACT Health Directorate. *ACT Drug Strategy Action Plan 2022-2026*. Canberra: ACT Government, 2022.
8. Alcohol Tobacco & Other Drug Association of ACT (ATODA). *Better Health through Housing*. Canberra: ATODA, 2024.
9. 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 2015).
10. Ritter A, Chalmers, J & Gomez, M. Measuring Unmet Demand for Alcohol and Other Drug Treatment: The Application of an Australian Population-Based Planning Model. *Journal of Studies on Alcohol and Drugs* 2019: 42-50. DOI: https://doi.org/10.15288/jsads.2019.s18.42.
11. Mellor R. Ritter A. *Demand and Service Modelling Project ACT Final Report*. 2021. Social Policy Research Centre UNSW.
12. Cockburn G. Jervis-Bardy D. Census 2021: ACT population undercount could cost territory 'hundreds of millions of dollars'. *The Canberra Times*, 28 June 2022.
13. ACT Government. *2024-25 Budget Consultation: Report on What We Heard*. ACT Government, 2024.
14. Alcohol Tobacco & Other Drug Association of ACT (ATODA). *ACT Alcohol and Other Drug Qualifications Strategy*. Canberra: ATODA, 2017.
15. Alcohol Tobacco and Other Drug Association ACT (ATODA). *Service Users' Satisfaction and Outcomes Satisfaction and Experience (SUSOSE) 2023: a survey of people accessing alcohol, tobacco and other drug services in the ACT*. ATODA, In Publication.
16. Payne J. *Recidivism in Australia: findings and future research*. 2020.
17. Australian Institute of Health and Welfare (AIHW). *The Health of Australia's Prisoners 2018*. Canberra: AIHW, 2019.
18. Bartle J, Bothwell S, Lee N, et al. *What works. Alcohol and other drug treatment in prisons*. 2nd ed. Melbourne: 360Edge, 2021.
19. O'Keefe F. Towards the finish line? Trial of needle and syringe program announced for ACT prison. 10. Epub ahead of print October 2012.
20. Jürgens R, Lines, R., Cook, C. *Out of Sight, Out of Mind: Harm reduction in prisons and other places of detention.* London: International Harm Reduction Association, 2010.
21. Center on Budget and Policy Priorities. Meeting the housing needs of people with substance use disorders.
22. 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*. Canberra: ATODA, 2020.
23. Australian Institute of Health & Welfare (AIHW). Specialist Homelessness Services Annual Report 2021-22: Clients with Problematic Drug and/or Alcohol Use. AIHW, 2023.
24. Alcohol and Drug Foundation. Alcohol and other drug use, and homelessness. 2018; https://adf.org.au/insights/alcohol-and-other-drug-use-and-homelessness/.
25. Australian Institute of Health & Welfare (AIHW). *Specialist homelessness services annual report 2022–23*. 2024.
26. Australian Bureau of Statistics. National Study of Mental Health and Wellbeing. 2022; https://www.abs.gov.au/statistics/health/mental-health/national-study-mental-health-and-wellbeing/latest-release.
27. Australian Bureau of Statistics (ABS). *Snapshot of Australian Capital Territory* 2022. ABS, 2023.

28. Marel C, Siedlecka E, Fisher A, et al. Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings. 2022; https://comorbidityguidelines.org.au/pdf/comorbidity-guideline.pdf.
29. Saunders B and Robinson, S. Co-occurring mental health and drug dependency disorders: work-force development challenges for the AOD field. *Drug and Alcohol Review* 2009; 21: 231-237. DOI: https://doi.org/10.1080/0959523021000002688.
30. Miller P, Cox, E., Costa, B., et al. *Alcohol/Drug-Involved Family Violence in Australia (ADIVA)*. Canberra: National Drug Law Enforcement Research Fund (NDLERF), 2016.
31. Alcohol Tobacco & Other Drug Association of ACT (ATODA). *ACT Alcohol and Other Drug Safer Families Program 2017-2021: Design, Model, Implementation Plan and Evaluation Framework.* Canberra: ATODA, 2016.
32. Unlu A, Tammi, T., Hakkarainen, P. *Drug Decriminalisation Policy: Literature Review: Models, Implementation and Outcomes*. Finnish institute for health and welfare, 2020.
33. Ashton H. Drug Decriminalisation in Portugal: A Public Health Response, a Humanistic Approach. *Health for the Millions* 2019; 45: 41-43.
34. Benfer I, Zahnow R, Barratt MJ, Maier L, Winstock A, Ferris J. The impact of drug policy liberalisation on willingness to seek help for problem drug use: A comparison of 20 countries. *The International journal on drug policy* 2018; 56: 162-175. DOI: 10.1016/j.drugpo.2018.03.032.
35. Australian Institute of Health & Welfare (AIHW). National Drug Strategy Household Survey 2022-23. 29 February 2024 ed. Online: Australian Institute of Health & Welfare, 2024.
36. ACT Government. Drug law reform, https://www.act.gov.au/health/topics/drugs-alcohol-smoking-and-vaping/drug-law-reform (2024, accessed September 2024).
37. CanTEST Health and Drug Checking Service (CanTEST). CanTEST Health and Drug Checking Service: About, https://cantest.com.au/about/ (2024, accessed September 2024).
38. Stephen-Smith R. CanTEST final report finds strong community support. Rachel Stephen-Smith, MLA, 2023.
39. Queensland Government. Drug checking services, https://www.health.qld.gov.au/public-health/topics/mhaod/for-healthcare-providers/programs-and-services/drug-checking-services (2024, accessed September 2024).
40. Department of Health and Aged Care. WHO Framework Convention on Tobacco Control, https://www.health.gov.au/topics/smoking-vaping-and-tobacco/tobacco-control/who-framework (2023, accessed September 2024).
41. Bonomo Y, et al. The Australian drug harms ranking study. *Journal of Psychopharmacology* 2019; 33: 759-768. DOI: 10.1177/0269881119841569.
42. Australian Institute of Health & Welfare (AIHW). Australian Burden of Disease Study 2018: Interactive data on risk factor burden. 2021 ed. Online: Australian Institute of Health and Welfare, 2021.
43. Miller PG, de Groot, F., McKenzie, P., Droste, N. Alcohol indsutry use of social aspect public relations organisations against preventative health measures. *Addiction* 2011; 106: 1560-1567. DOI: https://doi.org/10.1111/j.1360-0443.2011.03499.x.
44. Martino FP, Miller, P.G., Coomber, K., Hancock, L., Kypri, K. Analysis of Alcohol Industry Submission against Marketing Regulation. *PLOS ONE* 2017; 12. DOI: https://doi.org/10.1371/journal.pone.0175661.
45. Livingston M. Alcohol outlet density and harm: comparing the impacts on violence and chronic harms. *Drug and Alcohol Review* 2011; 30: 515-523. DOI: 10.1111/j.1465-3362.2010.00251.x.
46. Foundation for Alcohol Research and Education (FARE). *Alcohol advertising on social media platforms - A 1-year snapshot*. March 2023 2023. fare.org.au: FARE.
47. World Health Organization (WHO). *Gender-responsive approaches to the acceptability, availability and affordability of alcohol*. WHO, 2024.
48. Cook M, Mojica-Perz Y, Callinan S. *Distribution of alcohol use in Australia*. Centre for Alcohol Policy Research, La Trobe University & Foudnation for Alcohol Research and Education, 2022.
49. Alcohol Change Victoria. Dangerous practices of on-demand alcohol delivery companies place Victorian children and vulnerable people at risk of harm, https://www.alcoholchangevic.org.au/our-work/research (2021, accessed April 2024).
50. Noonan P, Taylor A, and Burke J. *Links between alcohol consumption and domestic and sexual violence against women: Key findings and future directions*. 2017.