PARLIAMENT OF AUSTRALIA

Issues paper relating to the health impacts of alcohol and other drugs in Australia

House of Representatives

Standing Committee on Health, Aged Care and Sport

March 2025

CANBERRA

ISBN 978-1-76092-770-7 (Printed version)

ISBN 978-1-76092-771-4 (HTML version)

Chair's foreword

Inquiry into the health impacts of alcohol and other drugs in Australia

The use and abuse of alcohol and other drugs has long been a concern to communities around the world.

Alcohol overwhelmingly is the most damaging in terms of cost and social impact, but patterns of use are changing, other drugs are increasingly being used recreationally, and new drugs are entering our market.

Governmental responses have varied from punitive and restrictive, to public health-based responses and to disinterest and acceptance.

The costs of substance abuse, including alcohol, are not just financial but also social and include associations with family violence, child abuse and neglect, gambling addiction, family breakdown and huge pressures on police, community service workers and the criminal justice system.

The Health Committee was tasked by the Health Minister with conducting a wide-ranging Inquiry into the health impacts of alcohol and other drugs in Australia.

Several public and private meetings were held, but there was not sufficient time to complete the Inquiry and several key stakeholders, whilst they provided submissions to the Inquiry, were keen to appear before the Committee in person.

My view and the view of the Committee is that further meetings are required before a final report with formal recommendations is provided.

The issues paper lists the significant issues heard to date.

It is our hope that, provided the next government agrees, the Inquiry is continued to its conclusion in the next Parliament.

I wish to thank the Secretariat, the Committee Members (especially Deputy Chair Julian Leeser MP), and all who have provided submissions and appeared before the Committee for their hard work and diligence, and I look forward to completing the Inquiry.

Dr Mike Freelander MP
Federal Member for Macarthur
Chair – Standing Committee on Health, Aged Care & Sport

Terms of reference

The House of Representatives Standing Committee on Health, Aged Care and Sport will inquire into and report on the health impacts of alcohol and other drug use in Australia, with the aim to:

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;

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;

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; and

d) Draw on domestic and international policy experiences and best practice, where appropriate.

Members

Chair

Dr Mike Freelander MP	Macarthur, NSW

Deputy Chair

Mr Julian Leeser MP	Berowra, NSW

Members

Dr Michelle Ananda-Rajah MP	Higgins, VIC
Ms Jodie Belyea MP	Dunkley, VIC
Hon Mark Coulton MP	Parkes, NSW
Dr Gordon Reid MP	Robertson, NSW
Dr Monique Ryan MP	Kooyong, VIC
Ms Anne Stanley MP	Werriwa, NSW
Ms Jenny Ware MP	Hughes, NSW

This Committee is supported by staff of the Department of the House of Representatives.

Abbreviations

AADC	Australian Alcohol and Other Drugs Council
AANA	Australian Association of National Advertisers
ABAC	Alcoholic Beverages Advertising Code
ACCO	Aboriginal Community Controlled Organisations
ACEM	Australasian College for Emergency Medicine
ACIC	Australian Criminal Intelligence Commission
ACMA	Australian Communications and Media Authority
ADF	Alcohol and Drug Foundation
AFP	Australian Federal Police
AIHW	Australian Institute of Health and Welfare
AMA	Australian Medical Association
AOD	Alcohol and Other Drugs
ARBI	alcohol-related brain injury
BSA	*Broadcasting Services Act 1992*
CALD	culturally and linguistically diverse populations
CEDAAR	Centre for Drug Use, Alcohol and Addictive Behaviour Research
COAG	Council of Australian Governments
DACRIN	Drug and Alcohol Clinical Research and Improvement Network
DITRDCA	Department of Infrastructure, Transport, Regional Development, Communication and the Arts
ED	emergency department
EDNA	Emerging Drugs Network of Australia
EDRS	Ecstasy and Related Drugs Reporting System

FARE	Foundation for Alcohol Research and Education
FASD	Fetal Alcohol Spectrum Disorder
FDSV	family, domestic and sexual violence
FSANZ	Food Standards Australia New Zealand
GHB	gamma-hydroxybutyrate
IDRS	Illicit Drug Reporting System
IUIH	Institute for Urban Indigenous Health
LGBTIQ+	lesbian, gay, bisexual, transgender, intersex and queer
LSD	lysergic acid diethylamide
MARC	Monash Addiction Research Centre
MBS	Medicare Benefits Scheme
MDAF	Ministerial Drug and Alcohol Forum
MDMA	methylenedioxymethamphetamine
MERIT	Magistrates Early Referral Into Treatment
MRFF	Medical Research Future Fund
NACCHO	National Aboriginal Community Controlled Health Organisation
NCCRED	National Centre for Clinical Research on Emerging Drugs
NCETA	National Centre for Education and Training on Addiction
NCYSUR	National Centre for Youth Substance Use Research
NDARC	National Drug and Alcohol Research Centre
NDRI	National Drug Research Institute
NIAA	National Indigenous Australians Agency
NMHRC	National Medical and Health Research Council
NOFASD	National Organisation for Fetal Alcohol Spectrum Disorders
NQF	National Quality Framework for Drug and Alcohol Treatment Service
NSMHWB	National Study of Mental Health and Wellbeing

NSP	Needle and Syringe Program
OTP	Opioid Treatment Program
PBS	Pharmaceutical Benefits Scheme
PHN	Primary Health Networks
PROM	person reported outcome measure
QNADA	Queensland Network of Alcohol and Other Drug Agencies
QNMU	Queensland Nurses and Midwives' Union
RANZCP	Royal Australian and New Zealand College of Psychiatrists
UNSW	University of New South Wales
WDO	Work and Development Order
WET	wine equalisation tax

List of recommendations

Recommendation 1

6.11 The Committee suggests that the successive Standing Committee on Health, Aged Care and Sport (or equivalent) in the 48th Parliament consider completing a full inquiry report into the health impacts of alcohol and other drugs in Australia.

Recommendation 2

6.12 The Committee recommends that the Department of Health and Aged Care consider public submissions and evidence received by this inquiry as it prepares advice to Government on revisions to the National Drug Strategy.

Contents

Chair's foreword iii

Terms of reference v

Members vii

Abbreviations ix

List of recommendations xiii

Report

1. Introduction 1

2. Health impacts of alcohol and other drugs: an overview 7

3. Australia's alcohol and other drugs policy and research 15

4. Alcohol and other drugs services in Australia 37

5. Preventing and reducing harm caused by alcohol and other drugs 63

6. Areas for further investigation 95

Appendixes

Appendix A. Submissions 97

Appendix B. Additional documents 107

Appendix C. Hearings and witnesses 109

Additional Comments by Coalition Members 113

1. Introduction

1.1 Harm related to the use of alcohol and other drugs is a major cause of preventable disease, illness and death, and imposes a considerable socio-economic burden on the Australian community. The term 'alcohol and other drugs (AOD)' encompasses 'psychoactive substances which when consumed or administered can alter consciousness, mood or cognitive processes'.[1] Drugs in this context is a term used in reference to prescribed medications, medications used for non-prescribed purposes, and illegal substances.

1.2 The House of Representatives Standing Committee on Health, Aged Care and Sport (the Committee) commenced an inquiry into the health impacts of AOD in Australia in August 2024—a moment in which the National Drug Strategy 2017-2026 was entering the final stage of its term, and with the National Alcohol Strategy 2019-2028 also in its final operational years. As such, the inquiry represented an opportunity to reflect on these strategies, with a view to ensuring that the subsequent iteration of each document is informed by a comprehensive understanding of the AOD sector and its short and long-term needs.

1.3 While the current National Drug Strategy has generally been viewed in positive terms, it is clear from the evidence presented during the inquiry that there are opportunities to revise and enhance Australia's response to AOD. Multiple AOD sector bodies expressed the view that the re-establishment of a national governing body—to oversee the implementation of the National Drug Strategy, to coordinate federal and state and territory-level AOD strategies, and to facilitate cross-sector collaboration—must be central to these efforts.[2]

1.4 Equally, it is clear that the present funding allocation across the three pillars of the National Drug Strategy—demand reduction, supply reduction and harm reduction—has been strongly weighted towards law enforcement efforts aimed at reducing supply. AOD sector representatives repeatedly raised concerns relating to the present funding imbalance, insisting that more needs to be done to refocus Australia's policy toward a health-led response to AOD harm.[3]

1.5 These issues have also been flagged as part of the recent inquiry into challenges and opportunities for law enforcement in addressing Australia's illicit drug problem, undertaken by the Parliamentary Joint Committee on Law Enforcement.[4] Tabled in May 2024, the inquiry report included recommendations for the establishment of a

1 The Royal Australian and New Zealand College of Psychiatrists, *Submission 19*, p. 3.
2 See Chapter 3.
3 See Chapter 3.
4 Parliamentary Joint Committee on Law Enforcement (May 2024), *Australia's illicit drug problem: Challenges and opportunities for law enforcement*.

national governing body, and an evaluation of the National Drug Strategy, including in respect to the resourcing of the three pillars.

1.6 The Committee was grateful to receive written evidence and hear from witnesses about a range of issues pertaining to current AOD service delivery, the need for developing AOD responses tailored to different communities, and the urgent challenge of raising the capacity of the AOD workforce. The Committee was also encouraged to learn about the research undertaken in the field of AOD, the value of AOD-related data, and opportunities for developing better data collections and using new technologies to create more effective health messaging.

1.7 There are multiple elements of the inquiry terms of reference that the Committee was unable to fully explore. The impact of the COVID-19 pandemic on AOD-related conditions, or the implications that zero-alcohol beverages may have for consumption, are just some of the emerging topics in this domain that would merit close analysis in future.

1.8 Equally, it was not possible to convene hearings with all sectors that provided written submissions in support of the inquiry, such as those representing the alcoholic beverage industry or medical cannabis producers. The Committee deemed it appropriate to prioritise wherever possible hearings with individuals with living and lived experience of AOD-related harm.

About the inquiry

1.9 On 22 August 2024, the Committee adopted an inquiry into the health impacts of AOD in Australia, which had been referred by the Minister for Health and Aged Care, the Hon Mark Butler MP.

1.10 The inquiry undertook a health-focused review of alcohol and other drugs policy, treatment services, community programs, and workforce to determine whether current settings support the prevention, reduction and recovery of AOD-related harms on individuals, families and communities.

1.11 In recognising that substance use is a complex problem that cuts across health, social and economic areas, the Committee also sought to examine opportunities for closer collaboration between sectors in tackling AOD use, as well as international responses in this domain that can provide valuable lessons.

Conduct of the inquiry

1.12 On 26 August 2024, the Committee formally announced the inquiry and issued a call for submissions. The Committee also wrote to and invited submissions from a range of individuals and organisations with an interest in AOD issues, including federal and state government departments and agencies, not-for-profit and charity organisations working in the AOD sector, industry groups and peak bodies, think tanks, academics, health practitioners, medical research organisations, and pharmaceutical companies.

1.13 The Committee received 204 submissions in support of this inquiry. The full list of submissions is at Appendix A.

1.14 The inquiry received 9 additional documents, including answers to questions taken on notice at public hearings. The full list of additional documents presented to the inquiry is in Appendix B.

1.15 The Committee held seven days of public hearings:

- 28 October 2024—Melbourne, VIC
- 29 October 2024—Melbourne, VIC
- 30 October 2024—Brisbane, QLD
- 7 November 2024—Canberra, ACT
- 21 November 2024—Canberra, ACT
- 28 November 2024—Canberra, ACT
- 7 February 2025—Canberra, ACT

1.16 The list of witnesses who attended these public hearings is available at Appendix C. Transcripts of all public hearings are available on the Committee website.

1.17 The Committee was keen to hear from witnesses and communities impacted by AOD-related harms across the nation. In the initial phase of the inquiry, the Committee travelled to Melbourne and Brisbane where it had the opportunity to hear from a series of witnesses and undertake site visits.

1.18 On 28 October 2024, the Committee undertook a site visit to two locations in St Kilda, Victoria: The Salvation Army's Access Health, a specialised Comprehensive Primary Health Care Service that supports the health and other needs of people who use drugs; and Windana's residential detox program for people aged 18 and over.

1.19 On 30 October 2024, the Committee visited the Alcohol and Drug Assessment Unit at Princess Alexandra Hospital and heard from its Director, Dr Paul Clark, its staff, and unit patients about some of the unique challenges associated with addressing AOD harm in a hospital setting.

Timeframe

1.20 The Committee appreciates the time taken by the witnesses in providing information in these submissions, hearings, and site visits, which constitute a wealth of high-quality evidence addressing the terms of reference.

1.21 Noting the breadth of the terms of reference, it was not possible to produce a final report addressing all the aspects of the inquiry prior to the expected dissolution of the House of Representatives for the 2025 Federal Election. In acknowledgment of the significance of this issue for the Australian community, the Committee has produced

the issues paper to provide an overview of the evidence and to inform work underway by the Government to update the National Drugs Strategy.

1.22 The Committee urges its successor in the 48th Parliament to re-adopt the terms of reference for this inquiry, and to give this important topic the consideration it deserves, including gathering further evidence if required to produce the final report.

Acknowledgements

1.23 The Committee would like to thank individuals and organisations who provided written submissions and gave evidence at public hearings. The fact the Committee received over 200 submissions from a wide range of stakeholders, including government agencies, peak bodies, researchers and clinicians, and harm reduction services among others, speaks to the level of interest in, and urgency of, addressing AOD-related harms.

1.24 Over the course of the inquiry, multiple witnesses shared their experience of AOD use or supporting someone with substance use problems. The Committee was impressed by the courage and strength these witnesses demonstrated, and their commitment to use personal experience to help others in tackling the impact of AOD-related harm. Individuals with living and lived experience, along with their families and friends, present an invaluable source of knowledge, and the Committee was grateful to draw on their insight in preparing this paper.

Issues paper structure

1.25 This paper comprises six chapters. Chapter 2 provides an overview of the health impacts of alcohol and other drugs in Australia, drawing on data from the Department of Health and Aged Care, the Australian Institute of Health and Welfare, and the work of Australia's leading research centres. It outlines the levels of AOD use in Australia and examines some emerging trends.

1.26 Chapter 3 focuses on Australia's AOD policy and the sector's funding landscape. The National Drug Strategy and the suite of sub-strategies and frameworks that sit under it are examined, along with state and territory policies. The chapter further discusses Australia's shift towards a health-led AOD policy response, as well as AOD research and data collections that inform the evidence base.

1.27 Chapter 4 examines current AOD service provision and the level of demand for services. It focuses on AOD priority populations, as they are identified under the National Drug Strategy, and the type of services that are required to address some of the unique needs of these populations.[5] The chapter also examines challenges in building the capacity of the AOD workforce.

[5] The National Drug Strategy 2017-2026 identifies the following cohorts as priority populations: Aboriginal and Torres Strait Islander people; people with mental health conditions; young people; older people; people in

1.28 Chapter 5 outlines the role of AOD prevention and harm reduction services. The issue of stigma, which presents a major barrier in accessing AOD support, is examined, along with the debates surrounding the question of decriminalisation of personal drug use. In addition to discussion of current harm reduction programs and their effectiveness, the chapter also focuses on the levels of current alcohol use in Australia and strategies to mitigate the effects of alcohol-related harm.

1.29 Chapter 6 identifies a range of topics that were not able to be covered in this paper, but that the Committee believes are nonetheless deserving of attention. In addition to examining international experience in the field of AOD, the question of risky AOD use within certain professions, AOD impact on priority populations, the relationship between AOD and domestic and family violence, and the relationship between our physical environment and substance use are some of the areas that merit further examination. These are matters which could form the basis for a renewed inquiry in the next Parliament.

contact with the criminal justice system; culturally and linguistically diverse populations; people identifying as lesbian, gay, bisexual, transgender, and intersex.

2. Health impacts of alcohol and other drugs: an overview

2.1 Drawing on data published by research institutions around Australia, this chapter explores both the established and emerging health impacts of alcohol and other drugs (AOD). While alcohol remains a major source of substance-related harm in the community, new psychoactive substances present increasingly complex challenges. In considering the impact of AOD, this chapter also places focus on populations who face heightened risks of experiencing AOD-related harm.

Health impacts of alcohol and other drugs

2.2 AOD use is associated with a range of adverse health outcomes, including substance use disorder and heightened rates of mental illness, suicide, infectious diseases, injuries, overdoses, and cardiovascular and liver disease.[1] Harmful use of alcohol and other drugs encompasses the consumption of alcohol outside the National Medical and Health Research Council (NMHRC) alcohol guidelines, the non-prescribed use of prescription drugs, and the use of illicit substances.

2.3 Substance use disorder—a condition defined by uncontrolled use of a substance despite harmful consequences—is a primary health impact of AOD consumption. In its submission to the inquiry, the Matilda Centre for Research in Mental Health and Substance Use (the Matilda Centre) highlighted that AOD use disorders are common health conditions in Australia and have remained so for over a decade.[2] Drawing on the 2020-21 Australian National Study of Mental Health and Wellbeing (NSMHWB), the Matilda Centre submitted that 19.6 per cent of Australians had experienced an AOD disorder in their lifetime, and 3.3 per cent in the past 12 months. This represents a minimal decrease in AOD disorder prevalence from the previous iteration of the NSMHWB conducted in 2007.[3]

2.4 Drug Policy Modelling Program at the University of New South Wales submitted that approximately 10 per cent of alcohol users, 23 per cent for heroin users, and 17 per cent of cocaine users develop a substance use disorder. The use of AOD, however, can develop a broad spectrum of other health harms, which vary by type of

1 Suicide Prevention Australia, *Submission 12*; Alcohol, Tobacco and other Drugs Council Tasmania, *Submission 22*, p. 3; Alcohol and Drug Foundation (ADF), *Submission 77*, p. 8; Foundation for Alcohol Research and Education (FARE), *Submission 87*, pp. 8-9.

2 The Matilda Centre for Research in Mental Health and Substance Use, The University of Sydney (The Matilda Centre), *Submission 24*, p. 5.

3 The Matilda Centre, *Submission 24*, p. 5.

substance.[4] This was emphasised by Dr Elizabeth Moore, President of the Royal Australian and New Zealand College of Psychiatrists, who said:

> The health impacts of alcohol, nicotine and other drugs in Australia are profound. We recognise their impact not only on the individual but on families, carers and communities.[5]

2.5 Throughout the inquiry, alcohol was identified as the main driver of AOD-related health harm. The World Health Organization's International Agency for Research on Cancer classifies alcohol as a Group 1 carcinogen (in the same category, for example, as tobacco and asbestos), which means that, as the George Institute for Global Health noted, its use is not safe in any quantity.[6] In January 2025, the Office of the U.S. Surgeon General published a report that identified alcohol as a risk factor for several types of cancer, including breast (in women), colorectum, oesophagus, voice box, liver, mouth and throat.[7]

2.6 AOD use is also associated with pregnancy complications, including a risk of the development of Fetal Alcohol Spectrum Disorder (FASD) in infants. FASD is a term that describes a range of neuro-developmental impairments. It is a lifelong disability, which impacts the brain and body of individuals who were prenatally exposed to alcohol. People living with FASD experience 'challenges in their daily living and need support with motor skills, physical health, learning, memory, attention, communication, emotional regulation, and social skills to reach their full potential'.[8]

2.7 Evidence to the inquiry reveals a broad spectrum of AOD health impacts. Dementia Australia, for example, submitted that alcohol and tobacco use is a modifiable risk factor for dementia. Excessive alcohol use is associated with reduced brain volume; furthermore, alcohol use can result in alcohol-related brain injury (ARBI). Both conditions present significant health impairments.[9]

2.8 Multiple witnesses also drew attention to the link between AOD and oral health, noting that people with substance use disorders have higher risk of tooth decay, periodontal disease, and oral cancer than the general population. This cohort is less likely to receive dental care. As witnesses noted, poor oral health further adds to the stigma associated with AOD use and contributes to poor general health.[10]

2.9 Beyond the immediate health impacts, AOD use is a factor associated with a range of other risks to health and wellbeing, including increased family, domestic and

---

4 Drug Policy Modelling Program, UNSW Sydney, *Submission 17*, n.p.

5 Dr Elizabeth Moore, President, Royal Australian and New Zealand College of Psychiatrists (RANZCP), *Committee Hansard*, Melbourne, 28 October 2024, p. 1.

6 World Health Organization, International Agency for Research on Cancer (IARC), IARC Monographs on the Identification of Carcinogenic Hazards to Humans, 'Alcohol Drinking', Volume 44, 1988, p. 259; The George Institute for Global Health, *Submission 169*, p. 1.

7 The U.S. Surgeon General's Advisor (January 2025), *Alcohol and Cancer Risk*.

8 FARE, *Submission 87*, p. 23.

9 Dementia Australia, *Submission 16*.

10 Australian Dental and Oral Health Therapists' Association (ADOHTA), *Submission 63*, n.p.; Oral Health Care Training and Education, *Submission 20*, p. 2; Healthy Cities Illawarra, *Submission 133*, p. 4.

sexual violence, and engagement in risky behaviour that can cause traffic collisions, swimming accidents, workplace harms and broader community safety issues.[11]

2.10 The Foundation for Alcohol Research and Education (FARE) noted that alcohol is a significant contributor to gendered violence in Australia, with alcohol present in 34 per cent of intimate partner violence incidents and over 29 per cent of family violence incidents. Harms to children, FARE further explained, are significantly greater in households where a person drinks alcohol at higher risk levels.[12]

The level of AOD use in Australia

2.11 In its submission to the inquiry, the Department of Health and Aged Care noted that 'alcohol and illicit drug use remain public health challenges in Australia'.[13] In 2022-2023, more than 30 per cent of people in Australia consumed levels of alcohol that put their health at risk. At the same time, almost 18 per cent had acknowledged using an illegal drug in the past 12 months, with cannabis being the most common. Australia also has a higher rate of opioid and cocaine use compared to other countries within the Organisation for Economic Co-operation and Development (OECD).[14]

Alcohol consumption in Australia

2.12 According to data from the Australian Institute of Health and Welfare (AIHW), the use of alcohol is more common than the use of tobacco, e-cigarettes, illicit drugs and non-medical use of pharmaceuticals. Alcohol presents one of the leading contributors to the overall burden of disease and it also accounts for a larger number of ambulance attendances, hospitalisation and deaths than illicit drugs.[15]

2.13 The National Drug Research Institute (NDRI) at Curtin University provided further details on the impact of alcohol use, noting that in 2017-2018, nearly half a million Australians were dependent on alcohol, with alcohol accounting for more than 5,200 deaths over that 12-month period. NDRI further calculated that the tangible cost of alcohol use (to health care, workplace, and areas such as family violence) amounted to $18.2 billion, and the intangible cost (including, for example, premature death and lost quality of life) to $48.6 billion.[16]

2.14 The Department of Health and Aged Care noted some positive trends in alcohol consumption, highlighting that in the last 15 years there has been a steady (although modest) decline in the proportion of the population that drinks alcohol. Australia has also seen a reduction in high-risk drinking behaviours across all age cohorts. At the same time, the percentage of people who abstained from alcohol increased from

---

11 Alcohol, Tobacco and other Drugs Council Tasmania, *Submission 22*, p. 3; ADF, *Submission 77*, p. 8.
12 FARE, *Submission 87*, p. 10.
13 Department of Health and Aged Care, *Submission 157*, p. 7.
14 Department of Health and Aged Care, *Submission 157*, p. 10.
15 Australian Institute of Health and Welfare (AIHW), *Submission 142*, p. 2.
16 National Drug Research Institute (NDRI), *Submission 141*, n.p.

19.9 to 23.5 per cent.[17] Risky consumption of alcohol for males between 2010 and 2023 has decreased across all aged groups, with 14-19 years and 60-69 years age groups exhibiting the most significant reductions. While the consumption of alcohol by males aged 20-29 years is trending downwards, this age cohort was most likely to engage in risky consumption.[18]

2.15 Alcohol consumption by women in the same period reveals a different trajectory. Risky consumption of alcohol trended downward from 2010 until 2019 but subsequently increased between 2019 and 2023 for females aged 20-29, 40-49, 60-69 and those above the age of 70.[19] The Department of Health and Aged Care noted that females are more likely than males to consume alcohol at risky levels.[20]

2.16 This trend was also highlighted by Dr Paul Clark, Professor of Medicine at the University of Queensland and Director of the Alcohol and Drug Assessment Unit at Princess Alexandra Hospital, who told the Committee:

> In terms of the changes in the distribution, I do think there's an increase in younger women presenting with advanced liver disease early and also alcohol related hepatitis … That's something that's definitely been observed in the last five years, particularly post-COVID. Alcohol related hepatitis is a very morbid presentation too, so it's important. We have increased representation of women in alcoholic hepatitis, and alcoholic hepatitis in that subgroup is a very morbid presentation.[21]

2.17 While Australian data points to the fact that attitudes towards alcohol are shifting as the population is becoming more aware of the health harms associated with alcohol abuse, alcohol consumption remains deeply embedded in Australian culture. Alcohol is often seen as an integral element of social gatherings and celebrations, and this normalisation of alcohol consumption, according to the Department of Health and Aged Care, inhibits efforts to reduce its harmful effects.[22]

2.18 In Australia, the NHMRC provides guidelines on the health effects of drinking alcohol. According to the NHMRC guidelines, a healthy adult should consume no more than 10 standard drinks each week, and no more than four standard drinks in any one day. A standard drink contains 10 grams of pure alcohol; in most contexts, a serving of beer or wine contains more than one standard drink.[23]

2.19 Guidelines for alcohol consumption in other countries differ from Australia. In 2023, the Canadian Centre on Substance Use and Addiction recommended limiting alcohol consumption to two drinks per week and warned that seemingly even moderate

---

17 Department of Health and Aged Care, *Submission 157*, p. 7.
18 Department of Health and Aged Care, *Submission 157*, p. 8.
19 Department of Health and Aged Care, *Submission 157*, p. 8.
20 Department of Health and Aged Care, *Submission 157*, p. 9.
21 Dr Paul Clark, Director, Alcohol and Drug Assessment Unit, Princess Alexandra Hospital, Brisbane, *Proof Committee Hansard*, Canberra, 7 February 2025, p. 26.
22 Department of Health and Aged Care, *Submission 157*, p. 6.
23 National Health and Medical Research Council (2020), *Australian guidelines to reduce health risks from drinking alcohol*.

drinking poses a serious health risk, including cancer, heart disease and stroke.[24] In the United States, official guidelines recommend no more than two drinks per day for men, and one drink per day for women.[25]

2.20 Multiple submissions insisted that the level of understanding of the impact of alcohol consumption remains low in Australia. A significant portion of the population is not familiar with the NHMRC guidelines, and while recognition of the link between, for example, alcohol and liver damage is high, Australians are not fully aware of the spectrum of health conditions triggered by alcohol use.[26]

2.21 In her submission, Ms Narella Coleman-Flood shared her experience with alcohol consumption and observed that current health messaging on alcohol use had limited reach, highlighting that:

> We need more targeted messaging around the link between alcohol and breast cancer, which remains largely under-communicated. Public health campaigns and interventions should focus on educating women and targeting young women about these risks and address drinking behaviours before they escalate into "alcohol use disorder".[27]

2.22 The National Organisation for Fetal Alcohol Spectrum Disorders (NOFASD) similarly noted that, despite ongoing efforts to raise awareness about the risks of alcohol consumption during pregnancy, there are still significant gaps in public knowledge:

> The Australian Institute of Health and Welfare (AIHW) reported that 77% of Australians aged 14 and over consumed alcohol in 2022-23, and approximately 25% of women continued drinking after learning they were pregnant. A 2021 poll by the Foundation for Alcohol Research and Education (FARE) found 30% of Australians are unaware that alcohol use during pregnancy can cause FASD. Awareness is particularly low amongst men (63%) compared to women (77%), and nearly 23% of Australians mistakenly believe that some alcohol consumption during pregnancy is safe.[28]

2.23 NOFASD also advocated for more public education about the impact of drinking before a pregnancy is confirmed. As Interim Chief Operating Officer Mrs Sophie Harrington explained:

> It's important to consider, when we talk about prenatal alcohol exposure, that the onset of pregnancy symptoms is commonly experienced at around five to six weeks and that at least 40 per cent of pregnancies in Australia are unplanned or unintended. With this in mind, and when we take into consideration Australia's

---

24 Canadian Centre on Substance Use and Addiction (2023), *Canda's Guidance on Alcohol and Health: Final Report*.

25 The U.S. Surgeon General's Advisory (January 2025), *Alcohol and Cancer Risk*.

26 ADF, *Submission 77*, p. 25. See also National Heart Foundation of Australia, *Submission 164*; Alcohol Change Vic, *Submission 166*; FASD Hub Australia, *Submission 184*.

27 Ms Narella Coleman-Flood, *Submission 40*.

28 National Organisation for Fetal Alcohol Spectrum Disorders (NOFASD), *Submission 129*, p. 6; See also Australian College of Midwives, *Submission 101*.

> drinking culture, we can start to create a picture of what the actual prevalence of FASD in Australia could look like … Mainstream education is needed. We must have courageous conversations and address the elephant in the room, which is alcohol.[29]

Drug use in Australia

2.24 With respect to illicit drug use, the Department of Health and Aged Care noted that there had been an increase in the prevalence of all illicit drug use since 2010, with the rise of hallucinogens and ketamine use particularly notable.[30] The use of marijuana, heroin, methamphetamine and amphetamine, and cocaine have remained unchanged in this period, while the use of ecstasy, non-medical pain killers and opioids has declined.[31]

2.25 According to NDRI data, more than two million Australians use cannabis, with 152,000 individuals dependent on the drug. The use of cannabis is also attributable to over 3,400 adult prison sentences. The tangible cost of cannabis use amounts to $4.4 billion, while intangible costs are estimated at $106 million.[32]

2.26 NDRI further revealed that over 645,000 Australians use extra-medical opioids, which include the illegal use of heroin and the misuse of pharmaceutical opioids. Approximately 104,000 Australians are dependent on extra-medical opioids, and 2,203 Australian deaths are attributable to this use. The tangible costs of extra medical opioid use amount to $5.63 billion, while intangible costs are estimated at $10.13 billion.[33]

2.27 In analysing illicit drug use by age and gender, the Department of Health and Aged Care highlighted that aside from males aged 14-19, for which the use of illicit drugs decreased, all other age groups experienced a small increase between 2010 and 2023.[34] The use of illicit drugs has significantly increased for females aged 14-19, 20-29 and 30-39. For both males and females, recent illicit drug use was highest among those aged 20-29, which echoes the findings for alcohol use.[35]

2.28 Use of both alcohol and other drugs among women of all ages continues to rise, and this fact was raised by multiple witnesses as matter of emerging concern.[36] The Alcohol and Drug Foundation (ADF), for example, noted in its submission the rise of

---

29 Mrs Sophie Harrington, Interim Chief Operating Officer, National Organisation for Fetal Alcohol Spectrum Disorders Australia (NOFASD), *Proof Committee Hansard*, Canberra, 7 February 2025, p. 14.
30 Department of Health and Aged Care, *Submission 157*, p. 7.
31 Department of Health and Aged Care, *Submission 157*, p. 8.
32 NDRI, *Submission 141*, n.p.
33 NDRI, *Submission 141*, n.p.
34 Department of Health and Aged Care, *Submission 157*, p. 9.
35 Department of Health and Aged Care, *Submission 157*, p. 9.
36 Department of Health and Aged Care, *Submission 157*, p. 11; ADF, *Submission 77*, p. 12; Uniting Communities, *Submission 142*, p. 4.

illicit drug use among women and that the gap between young men and women drinking at risky levels was narrowing.[37]

2.29 The Committee was deeply concerned not only by the evidence pertaining to the increase of illicit drug use, but also by the expanding range of available drugs. Yarra Drug and Health Forum noted, for example, that many drugs have become cheaper to produce and easier to transport, lowering consumer prices and making them accessible to more people than ever before. Its submission further emphasised that:

> New drug types, including synthetic opioids, New Psychoactive Substances (NPS) and amphetamine-type stimulants present greater dangers compared to those from 10 or 20 years ago. Not only do these drugs pose significantly higher risks, but they are also often consumed in riskier ways, exacerbating both the acute and chronic risks associated with drug use.[38]

2.30 Multiple submissions raised concerns regarding the use of adulterants in the drug supply, particularly potent synthetic opioids like fentanyl and nitazenes.[39] ADF reported that, over the past three years, nitazenes have been detected across Australia and have been linked to several overdose deaths in Victoria, New South Wales and South Australia.[40]

2.31 Throughout the course of the inquiry, various witnesses informed the Committee that most people using AOD will experience minimal or even no harm. According to AIHW, an estimated 18 per cent of the population use an illicit substance each year, while 77 per cent of people consume alcohol each year in Australia. It is estimated that 3.3 to 5 per cent of people experience an AOD use problem.[41] These findings are largely in line with international evidence, with the Global Commission on Drug Policy noting that the use of drugs encompasses a wide spectrum of behaviours, ranging from non-problematic to profoundly harmful, with 10 per cent of people who use drugs globally considered 'problem users'.[42] Those who are affected by their AOD use will, however, face serious health challenges, and will likely encounter a range of difficulties in accessing the right type of services in a timely manner.

2.32 Moreover, the Committee acknowledges that AOD-related harm disproportionally affects Australia's most vulnerable populations. As Mr Joseph Coyte, Executive Director of Ngaimpe Aboriginal Corporation (The Glen Group) emphasised:

> … humans have consumed drugs, including alcohol, for thousands of years, perhaps more, and this is not likely to change any time soon. Some drug consumers, probably most, don't suffer significant, immediate adverse

---

37 ADF, *Submission 77*, p. 12.

38 Yarra Drug and Health Forum, *Submission 135*, p. 4.

39 Queensland Network of Alcohol and Other Drug Agencies (QNADA), *Submission 75*, p. 5; Australian Federal Police, *Submission 87*; cohealth, *Submission 186*, p. 4. Penington Institute, *Submission 188*, p. 12.

40 ADF, *Submission 77*, p. 12.

41 Australian Institute of Health and Welfare (2023), *National Study of Mental Health and Wellbeing*, cited in Australian Alcohol and Other Drugs Council (AADC), *Submission 45*, p. 3.

42 The Global Commission on Drug Policy (2014), *Taking Control: Pathways to Drug Policies that Work*, p. 11.

> consequences or create significant societal problems from their usage, although all drug use does cause some longer-term harm. In regard to problematic drug use, the use itself is often only a symptom of the real problem. The people who are more likely to be involved in problematic drug use are the people who don't score well on the basic social determinants of health. Sadly, the most vulnerable people in our community are over-represented in all problematic drug related statistics.[43]

Committee comments

2.33 The Committee acknowledges that the health impacts of AOD use are extensive, and that they present a major burden to individuals, their families, and communities. While recognising some positive trends in alcohol consumption across Australia, the Committee notes with concern that alcohol remains a significant contributor to AOD-related harm, with particularly troubling trajectories of increased consumption among certain population cohorts. The emergence of new and potent illegal substances presents additional challenges that warrant careful attention. The Committee emphasises that detailed monitoring of changes in AOD patterns and types of use is essential for shaping effective responses in this domain and informing the direction of any future policy in this domain.

[43] Mr Joseph Coyte, Executive Director, Ngaimpe Aboriginal Corporation (The Glen Group), *Committee Hansard*, Canberra, 7 November 2024, p. 1.

3. Australia's alcohol and other drugs policy and research

3.1 This chapter analyses the policy framework that shapes Australia's response to alcohol and other drugs (AOD). Central to this discussion is the widespread call to establish a national governing body for the AOD sector, along with debate pertaining to the current funding landscape. The chapter also examines Australia's AOD-related data collections and explores strategies to enhance the nation's capacity to gather and utilise this critical information.

3.2 While the evidence outlined in this chapter focuses on health-based approaches to AOD use, input from the criminal justice system and law enforcement agencies is vital in forming a comprehensive understanding of the key issues. Further evidence from these areas will be required to develop an effective policy response.

Alcohol and other drugs policy landscape

3.3 In Australia, responsibility for AOD is shared by all levels of government, and across both health and law enforcement agencies. In its submission, the Department of Health and Aged Care stated that over time AOD policies have tended to emphasise health more than law enforcement response. According to the Department, the fact that a health-led policy approach has gained dominance across the world represents a recognition that substance dependence is primarily a health and social issue, rather than a criminal justice or moral issue.[1]

3.4 The Australian Government uses a range of instruments to guide the national AOD response, including:

- The National Drug Strategy 2017-2026
- Statutory and delegated regulation covering the labelling standards, importation, exportation, manufacture, production and cultivation of controlled substances
- Restrictions on alcohol advertising
- Guidelines covering alcohol consumption
- Funding for prevention and treatment services
- Funding for relevant research and evaluation.[2]

1 Department of Health and Aged Care, *Submission 157*, p. 13.
2 Department of Health and Aged Care, *Submission 157*, p. 13.

3.5 The National Drug Strategy is Australia's framework for addressing the adverse impacts of AOD use. Set around a 10-year framework covering the period from 2017 to 2026, the Strategy aims to reduce the harmful effects of alcohol, tobacco and other drugs. There are several sub-strategies and national frameworks under this document, which focus on specific issues and cover different time periods:

- National Aboriginal and Torres Strait Islander People Drug Strategy 2014-2019
- National Alcohol and Other Drug Workforce Development Strategy 2015-2018
- National Alcohol Strategy 2019-2028
- National Fetal Alcohol Spectrum Disorder (FASD) Strategic Action Plan 2018-2028
- National Ice Action Strategy 2015
- National Tobacco Strategy 2023-2030
- National Framework for Alcohol, Tobacco and Other Drug Treatment 2019-2029
- National Quality Framework.[3]

3.6 The shift towards a harm minimisation approach in drug policy occurred in Australia in response to the HIV/AIDS epidemic in the 1980s. The current National Drug Strategy reflects the health-led approach; it acknowledges a wide range of health, social, and economic harms resulting from AOD use, and emphasises the need for a coordinated response to reduce these harms.[4]

3.7 The approach to harm minimisation within the Strategy is structured around three pillars: demand reduction (preventing the uptake or delaying the onset of use of alcohol, tobacco and other drugs), supply reduction (preventing or reducing the supply of illegal drugs, and controlling the availability of legal drugs), and harm reduction (reducing the adverse health, social and economic consequences of AOD use). The Strategy further identifies three priority areas for implementation:

- priority actions (such as, for example, enhanced access to treatment and development of AOD research and data)
- priority populations (with 7 at-risk population cohorts identified)
- priority substances (methamphetamine, alcohol, tobacco, cannabis, non-medical use of pharmaceutical, opioids, and new psychoactive substances).[5]

3.8 The Strategy exists in parallel with other policy instruments. In particular, it aligns with the National Preventative Health Strategy 2021-2030, which includes four targets for reducing AOD related harm:

- at least a 10 per cent reduction in harmful alcohol consumption by Australians (≥14 years) by 2025, and at least a 15 per cent reduction by 2030

---

3 Department of Health and Aged Care (2017), *National Drug Strategy 2017-2026*, p. 38; Department of Health and Aged Care, *Submission 157*, pp. 27-30.

4 Youth Support and Advocacy Service (YSAS), *Submission 32*, n.p.

5 Department of Health and Aged Care (2017), *National Drug Strategy 2017-2026*, pp. 1-2.

- less than 10 per cent of young people (14–17-year-olds) are consuming alcohol by 2030
- less than 10 per cent of pregnant women aged 14-49 are consuming alcohol whilst pregnant by 2030
- at least a 15 per cent decrease in the prevalence of recent illicit drug use (≥14 years) by 2030.[6]

3.9 Some states and territories also have their own AOD strategies. These documents broadly align with the Natural Drug Strategy, seeking to achieve harm minimisation through demand, supply and harm reduction:

- ACT Drug Strategy Action Plan 2022-2026
- The Queensland Alcohol and Other Drugs Plan 2022-2027
- South Australian Alcohol and Other Drug Strategy 2024-2030
- Reform Agenda for the AOD Sector in Tasmania and the Tasmanian Drug Strategy 2024-2029.[7]

3.10 In the Northern Territory, the response to reducing AOD harms is guided by several national strategies, including the National Drug Strategy 2017-2026, its sub-strategies, and the National Pharmaceutical Drug Misuse Framework 2012-2015. The Northern Territory also has a strategy focused specifically on fetal alcohol spectrum disorder, entitled Addressing Fetal Alcohol Spectrum Disorder (FASD) in the Northern Territory 2018-2024.

3.11 The Western Australian government is currently developing a new Mental Health and Alcohol and Other Drug Strategy 2025-2030 and Outcomes Measurement Framework, which will replace the Western Australian Alcohol and Drug Interagency Strategy 2018-2022. In July 2024, the Western Australian Government also established a new Office of Alcohol and Other Drugs.[8]

3.12 While New South Wales does not currently have a state-level strategy (the most recent one expired in 2010), during the NSW Drug Summit held in late 2024, the AOD sector called for the development of a state-level AOD instrument.[9] Meanwhile, in Victoria, the Victoria Police Drug Strategy 2020-2025 and a Statewide Action Plan aimed at reducing drug related harms both frame the AOD response.

3.13 Multiple witnesses drew the Committee's attention to the complexity of the AOD policy landscape (which includes a multiplicity of strategies with varied timeframes)

---

6 Department of Health and Aged Care, *Submission 157*, p. 13.

7 For the Tasmanian context, see The Department of Health, Tasmanian Government, *Submission 200*, n.p.

8 Government of Western Australia, Mental Health Commission, *Mental Health and Alcohol and Other Drugs Strategy 2025-2030 and Outcome Measurement Framework*; Government of Western Australia, Mental Health Commission (12 March 2024), "Office of Alcohol and Other Drugs to be established".

9 Sam Nichols and Joseph Hathaway-Wilson (4 December 2024), 'NSW drug summit an opportunity for new government strategy to address risks of drug harm, experts say', ABC News.

and argued that the absence of national coordination presents a major impediment to the sector's effective functioning.[10]

3.14 A national level governing body for the AOD sector was originally established as part of the National Ice Action Strategy in 2015. Indeed, the Council of Australian Governments (COAG) established the Ministerial Drug and Alcohol Forum (MDAF) at the time, which was responsible for the oversight, development, implementation and monitoring of Australia's national drug policy frameworks and reported directly to COAG. MDAF was removed in 2020, when COAG was replaced by National Cabinet. Since then, there has been no formal oversight over the implementation or coordination of AOD strategies across jurisdictions.[11]

3.15 There are at present certain mechanisms that allow AOD-related matters to be addressed at a ministerial level, although these tend to be ad hoc in nature, and are not focused on AOD use alone. Mr Ben Mudaliar, Assistant Secretary, Alcohol and Other Drugs Branch at the Department of Health and Aged Care, explained:

> The Health Ministers Meeting and the Health Chief Executives Forum, which sits underneath it, do provide a mechanism for ministers and for jurisdictions to come together. And there are opportunities, through things like the Health Ministers Meeting, for them to invite ministerial colleagues from other sectors. I suppose the issue is that they have a broad spectrum of issues that they need to attend to. We have seen health ministers deal with things like opioid dependence issues and the kinds of policy reforms we need in that space.[12]

3.16 In its submission, Alcohol, Tobacco and other Drugs Council Tasmania identified the lack of coordination and communication between and from the Commonwealth and state governments as a major challenge for the AOD sector.[13] The Australian Alcohol and Other Drugs Council (AADC), the Alcohol and Drug Foundation (ADF) and the National Centre for Education and Training on Addiction (NCETA) each highlighted that this situation inhibited a dialogue between the AOD sector, different tiers of government, funding and commissioning bodies, and other relevant stakeholders. Furthermore, the abolition of the MDAF deprived the sector of the ability to act proactively in response to new issues such as, for example, vaping, the online sale and delivery of alcohol, emerging contaminants in the drug supply, or responses to opioid dependence treatment.[14]

---

10 See, for example, Alcohol, Tobacco and other Drugs Council Tasmania, *Submission 22*; The Matilda Centre for Research in Mental Health and Substance Use, The University of Sydney (the Matilda Centre), *Submission 24*; Australian Alcohol and other Drugs Council (AADC), *Submission 45*; The Salvation Army, *Submission 68*; Alcohol and Drug Foundation (ADF), *Submission 77*.

11 Department of Health and Aged Care (2017), *National Drug Strategy 2017-2026*, pp. 35-37; ADF, *Submission 77*, pp. 14-15.

12 Mr Ben Mudaliar, Assistant Secretary, Alcohol and Other Drugs Branch, Department of Health and Aged Care, *Proof Committee Hansard*, Canberra, 7 February 2025, pp. 29-30.

13 Alcohol, Tobacco and other Drugs Council Tasmania, *Submission 22*, p. 7.

14 AADC, *Submission 45*, p. 11; ADF, *Submission 77*, p.16; National Centre for Education and Training on Addiction (NCETA), *Submission 43*, p. 2.

3.17 AADC added that, in the absence of a national governance structure, there is a lack of monitoring of current strategies, sub-strategies and frameworks that guide AOD work.[15] As a result, there had been no mid-point review of either the National Drug Strategy 2017-2026 or the National Alcohol Strategy 2019-2028, while the National Aboriginal and Torres Strait Islander People's Drug Strategy and National Alcohol and Other Drug Workforce Development Strategies both lapsed without a review of outcomes.[16]

3.18 The Matilda Centre for Research in Mental Health and Substance Use at the University of Sydney (the Matilda Centre) drew attention to the fact that the lack of national oversight had a direct impact on the implementation of standards for AOD services. In 2018, the Australian Government introduced the National Quality Framework for Drug and Alcohol Treatment Service (NQF), which was intended to have an implementation period from 2019 to 2022 under MDAF guidance. Since the disbandment of MDAF, however, ownership of the NQF has not been transferred to any other national body.[17]

3.19 In its submission, the Queensland Network of Alcohol and Other Drug Agencies (QNADA) expressed concern about the lack of NQF monitoring and implementation, noting that:

> While the majority of the funded AOD service sector provides evidence-based, safe, high-quality care, stigma around substance use and the root causes of substance use problems means anyone can establish a residential service and make untested claims about their approach.[18]

3.20 While there are high levels of compliance among funded providers in the public and non-government sector, QNADA submitted that 'the status of providers not receiving government funding is more difficult to establish, as there is no mechanism requiring them to be licenced to provide treatment'.[19] The Matilda Centre highlighted that findings from two recent inquiries into Victorian and Western Australian private AOD sectors 'both advocated for consistent, nation-wide regulation to protect clients from poor treatment outcomes and abuse'.[20]

3.21 The Committee also heard evidence that the complexity of AOD cases necessitated cross-sector collaboration. Such collaboration would see closer engagement between mental health, disability, housing, employment and education sector in AOD service provision. A national governance body has been recommended as an optimal forum for coordinating these different areas.[21]

3.22 A national governing structure was also identified as a channel through which individuals with living or lived experience of AOD use could be better heard.

---

15 AADC, *Submission 45*, pp. 11-13.
16 AADC, *Submission 45*, p. 11.
17 The Matilda Centre, *Submission 24*, p. 6.
18 Queensland Network of Alcohol and Other Drug Agencies (QNADA), *Submission 75*, p. 10.
19 QNADA, *Submission 75*, p. 10.
20 The Matilda Centre, *Submission 24*, p. 6.
21 AADC, *Submission 45*, p. 18; Foundation for Alcohol Research and Education (FARE), *Submission 87*, p. 16.

Throughout the inquiry, witnesses repeatedly drew attention to the importance of this cohort in the design of policies and the delivery of services. In its submission, the Foundation for Alcohol Research and Education (FARE), stated that there is a need for a national network of AOD lived experience advisory groups, to ensure that policy and programs reflected people's experiences, and that these should comprise diverse communities with lived experience of harm, such as domestic and family violence, mental health disorders, FASD and chronic disease. As FARE explained:

> A focus on data alone can sometimes obscure the real-life pain, suffering and trauma experienced by people harmed by alcohol, as well as the far-reaching ripple effects on the health and wellbeing of their families and loved ones. Engaging people with lived and living experience as active partners in co-design and co-production ensures policies are informed by people who are most affected by them.[22]

A health-led policy response

3.23 Evidence gathered during this inquiry points to a growing recognition that social, economic and environmental conditions are key contributors to AOD use. The Committee also heard that legal and criminal sanctions are ineffective and costly responses.[23] According to the Youth Support and Advocacy Service (YSAS) and the AADC, government policy approaches that reduce criminal sanctions for some drug offences (personal drug possession and use), and strengthen AOD prevention, treatment and rehabilitation measures have been demonstrated as most effective.[24]

3.24 Throughout the inquiry, witnesses highlighted the fact that a shift in response to the possession and use of illegal drugs from the justice to health sector is taking place across the world. The Global Commission on Drug Policy, for example, has advocated for the decriminalisation of drugs for individual use for more than a decade.[25] In addition, several United Nations agencies, such as the Joint United Nations Programme on HIV/AIDS, the World Health Organization, the United Nations Development Programme, and the Office of the United Nations High Commissioner for Human Rights have all expressed the view that the possession of drugs for personal use should be decriminalised.[26]

3.25 Notably, several countries have already undertaken drug policy reform of this nature, redeploying resources previously dedicated to policing and criminal justice into drug treatment. Portugal and Canada were most frequently cited as exemplars of this approach during the inquiry.[27] Dr Jeremy Hayllar, Clinical Director at Metro North

---

22 FARE, *Submission 87*, p. 11.
23 AADC, *Submission 45*, pp. 8-9.
24 YSAS, Submission 32, n.p.; AADC, *Submission 45*, p. 9; see also Drug Free Australia, *Submission 176*, pp. 5-6.
25 The Global Commission on Drug Policy (2014), *Taking Control: Pathways to Drug Policies that Work*.
26 YSAS, *Submission 32*, n.p.
27 YSAS, *Submission 32*; Youth Empowered Towards Independence, *Submission 51*; ADF, *Submission 77*; LGBTIQ+ Health, *Submission 189*.

Mental Health Alcohol and Drug Service, Queensland Health, for example, shared his view of the Portuguese model:

> I went to Portugal in 2018 with the mental health commissioner, and it was really interesting. They took a very bold step in 2001 to change the whole approach. They weren't trying to avoid the big criminals at the top, who were doing all the dealing and supplying. It was mainly the street dealers that were no longer going to be taken into custody, locked up and tried, et cetera. They had dissuasion commissions around the country where people would attend for a session, and that was it. They might have a small fine. The worry was that this might encourage people to use more substances. It has not done so at all. Compared with countries nearby—Spain and other European countries—there has really been no significant increase in substances. Whereas, the rate of overdoses, which was the chief driver for this change, has dropped precipitously. I think by most standards it has been very, very effective.[28]

3.26 The Department of Health and Aged Care noted that Australia's approach to drug policy can be considered progressive in the international context.[29] Professor Kate Seear and her colleagues from the Australian Research Centre in Sex, Health and Society at La Trobe University further explained that in 2021, Australia ranked fifth out of 30 countries in the Global Drug Policy Index, behind Norway, New Zealand, Portugal and the United Kingdom.[30]

3.27 The Australian Research Centre in Sex, Health and Society noted that the Global Drug Policy Index, a project of the Harm Reduction Consortium that gathers a range of civil society and community organisations, scored each country out of 100 on a range of different measures, and also provided an overall score out of 100. Australia's overall score was 65/100, and although Australia did well on some measures, it scored poorly on others, including equity of impact of criminal justice responses (25/100), imprisonment for non-violent drug offences (25/100), decriminalisation (33/100), equity of access to harm reduction (33/100).[31]

3.28 This result echoes evidence from several witnesses who, while viewing Australia's drug policy positively, argued that there was a need for a more decisive shift away from the law enforcement and toward a health-led response to AOD harm.[32] In its submission, QNADA called for a reframing of Australia's current drug policies to a narrative that emphasised drug use harm as health issues and acknowledged that dependent, problematic illicit drug use is a minority experience.[33]

---

28 Dr Jeremy Hayllar, Clinical Director, Metro North Mental Health Alcohol and Drug Service, Queensland Health, *Committee Hansard*, Brisbane, 30 October 2024, p. 35.

29 Department of Health and Aged Care, *Submission 157*, p. 13.

30 Professor Kate Seear, *Submission 33*, p. 14; The Global Drug Policy Index, *Ranking*.

31 Professor Seear, *Submission 33*, p. 14.

32 ADF, *Submission 77*.

33 QNADA, *Submission 75*, p. 15; Australian Institute of Health and Welfare (2023), *National Study of Mental Health and Wellbeing*, cited in AADC, *Submission 45*, p. 3.

3.29 Echoing the findings of the Global Drug Policy Index, QNADA submitted that drug legislation and policy tend to have disproportionate and compounding impacts for lower socio-economic and marginalised populations. In a 2020 survey that QNADA undertook together with the Queensland Injectors Voice for Advocacy and Action (QuIVAA) and the Queensland Aboriginal and Islander Health Council's Substance Misuse Council (QAIHC/QISMC), many participants cited police harassment and other legal consequences associated with AOD use (court, probation, parole, child safety and imprisonment) as the primary areas of concern.[34]

3.30 The Committee acknowledges the important role of law enforcement in drug related harm reduction. In its submission, Australian Federal Police (AFP) noted that the agency prioritised offshore detections, disruption and deterrence to stop illicit drugs at their source of origin or transit points. In 2023-24, the AFP seized 34 tonnes of illicit drugs and precursors, resulting in an estimated $12.5 billion in harm avoidance. The agency also assistant in the seizure of 36.5 tonnes of illicit drugs by overseas police.[35]

3.31 The AFP also focuses on disrupting transnational, serious and organised crime figures, who are responsible for importing high volumes of illicit drugs. The AFP submitted that, in 2019-20 Australia's cocaine consumption increased by 38 per cent. Between July 2020 and December 2022, however, AFP seized approximately 12.5 tonnes of cocaine (more than double the annualised average consumption of approximately 5 tonnes). These actions may have contributed to Australia's cocaine consumption decreasing 40 per cent (2.29 tonnes) from 2019-20 to 2021-22 and falling to historic lows in 2022.[36]

3.32 While the supply reduction is undoubtedly an important aspect of the national AOD response, multiple witnesses expressed concern that Australia's response to illicit drugs is disproportionately weighted toward law enforcement. Entities such as QNADA, YSAS, and AADC claimed there was an imbalance in Australia's response reflected in funding across the three pillars of harm minimisation within the National Drug Strategy, being the demand reduction (prevention and treatment), supply reduction (law enforcement), and harm reduction (initiatives such as, for example, needle and syringe programs).[37]

3.33 In 2024, the Drug Policy Modelling Program within the UNSW Social Policy Research Centre published its analysis of Australian 'drug budget' for the financial year 2021/22 across four policy domains: prevention, treatment, harm reduction, and law enforcement. Of the total $5.45 billion (0.63 per cent of government expenditure), law enforcement received 64.3 per cent, treatment 27.4 per cent, prevention 6.7 per cent, with harm reduction allocated 1.6 per cent.[38]

---

34 QNADA, *Submission 75*, pp. 16-17.
35 Australian Federal Police (AFP), *Submission 89*, n.p.
36 AFP, *Submission 89*, n.p.
37 Alcohol, Tobacco and Other Drug Council Tasmania, *Submission 22*; YSAS, *Submission 32*; QNADA, *Submission 75*.
38 Drug Policy Modelling Program (DPMP), Social Policy Research Centre, UNSW, *Submission 17*, p. 2.

3.34 AADC expressed concern that while multiple AOD related inquiries since 2018 have identified a need for more balance across the three pillars of the National Drug Strategy, 'law enforcement, criminalisation and supply reduction actions lead Australia's response to AOD use and harms'.[39] Funding for law enforcement interventions, AADC reiterated, outweighed health responses by a factor of almost 2:1.[40]

3.35 AADC further submitted that 'despite the emphasis on law enforcement and supply reduction as the primary means to respond to illicit drug use in Australia, these efforts do relatively little to reduce the availability and use of illicit substances in the absence of a corresponding investment in demand reduction measures'.[41] According to a study undertaken by the UNSW National Drug and Alcohol Research Centre, 18 per cent of Australians aged 14 and over have used an illicit substance in the past 12 months, and 43 per cent have used an illicit substance at some point in their lives, with the majority of illicit drug types being rated as 'easy' or 'very easy' to obtain.[42]

3.36 For AADC, an over-emphasis on law enforcement and supply reduction under a framework of drug criminalisation comes at significant cost to community health and wellbeing. Drug criminalisation tends to incentivise the supply of more potent substances of unknown quality, increasing the risk of fatal and non-fatal overdoes, driving an increase in the transmission of blood borne viruses, encouraging risky consumption practices through fear of police and other means of detection, and creating barriers to AOD treatment, employment, and social inclusion.[43]

3.37 Meanwhile, multiple witnesses emphasised the value of investing in a health-led response. Drawing on Australian Institute of Criminology data, the Australian Alcohol and Drugs Council claimed that for every $1 invested in AOD treatment, $5.40 is returned in benefit to the community—but for every $1 invested in harm reduction programs, $27 is returned in community benefit.[44]

Service delivery and funding

3.38 At the Commonwealth level, AOD treatment programs are funded primarily through

- direct funding from the Department of Health and Aged Care
- direct funding from the National Indigenous Australians Agency under strategies such as the Indigenous Advancement Strategy
- commissioning via the 31 Primary Health Networks across the country

39 AADC, *Submission 45*, p. 3.
40 AADC, *Submission 45*, p. 3.
41 AADC, *Submission 45*, p. 8.
42 AADC, *Submission 45*, pp. 8-9.
43 AADC, *Submission 45*, p. 9.
44 AADC, *Submission 45*, p. 3.

- other time-limited supplementary budget measures, such as the Drug and Alcohol Treatment Services Maintenance (DATSM) program, Wage Cost Indices (WCI) and Community Sector Organisation (CSO) payments.[45]

3.39 Most AOD treatment in Australia is provided through the specialist AOD system and the generalist health service system. The specialist AOD system provides withdrawal, psycho-social therapies, residential rehabilitation, and pharmacotherapy maintenance, among other treatment types. The generalist service system provides a similar set of treatments, with GPs providing pharmacotherapy maintenance and brief interventions; clinical psychologist providing psycho-social therapy (counselling); general hospitals provide withdrawal services; and welfare services that can also provide psycho-social therapy.[46]

3.40 Since 2015, the Australian Government has commissioned Primary Health Networks (PHNs) to provide funding for locally based AOD treatment services in line with community need. PHNs are independent organisations that are funded to coordinate primary health care in their designated region.[47] PHNs are allocated operational and flexible general grant funding (which could be used for AOD treatment services); they also receive additional flexible funding for AOD services through the Australian Government's Drug and Alcohol Program.[48]

3.41 As such, PHNs are responsible for most specialist AOD treatment planning and commissioning. They work in consultation with state and territory government regional health services, jurisdictional and national drug and alcohol peak bodies and relevant stakeholders, including Local Hospital Networks (LHNs), Aboriginal Community Controlled Health Organisations (ACCHOs) and other service providers.[49] More than $400 million in funding for the AOD sector has been commissioned through PHNs since their establishment, making them a major funder of AOD services.[50]

3.42 In its submission, the Victorian-Tasmanian Primary Health Networks Alliance explained that PHN commissioned services focus on community codesign, equity, and cost-effective care models that align with the needs of specific populations. In metro Victoria, for example, PHN commissioned programs include initiatives such as Rainbow Recovery that are designed for LGBTIQA+ communities by offering peer-led, culturally appropriate AOD services for this population; Bendigo District Aboriginal Cooperative was commissioned to pilot Therapeutic Day Rehabilitation

45 AADC, *Submission 45*, p. 13.

46 Alison Ritter, Lynda Berends, Jenny Chalmers, Phil Hull, Kari Lancaster and Maria Gomez, Drug Policy Modelling Program, National Drug and Alcohol Research Centre, University of New South Wales, Sydney (2014), *New Horizons: the review of alcohol and other drug treatment services in Australia final report*, p. 24

47 Victorian and Tasmanian Primary Health Networks Alliance, *Submission 41*, p. 3.

48 Department of Health (2014), *Primary Health Networks, Grant Programme Guidelines*; Australian Institute of Health and Welfare (AIHW) (2014), *Alcohol and other drug treatment service in Australia annual report*.

49 Department of Health (2014), *Primary Health Networks, Grant Programme Guidelines*; AIHW (2014), *Alcohol and other drug treatment service in Australia annual report*.

50 AADC, *Submission 45*, p. 16.

programs that allow individuals to access intensive alcohol and other drug treatment while remaining within their communities.[51]

3.43 Multiple witnesses emphasised that the complexity of funding arrangements hinders the work of the AOD sector. AADC, for example, illustrated some shortcomings of the current funding system by noting that:

> … a single service may be funded for different activities through multiple funding streams at the Commonwealth level – each requiring its own application, management, reporting and reconciliation – as well as potentially a range of different State and Territory funding streams.[52]

3.44 Similarly, Mr Geoffrey Davey, Chief Executive Officer of the Queensland Injectors Health Network (QuIHN) said:

> QuIHN relies on 18 different contracts to run its programs. That creates a patchwork of funds, which actually raises a number of administrative and financial risks; it creates a house of cards. Also, we navigate multiple recording and compliance requirements, with numerous funding applications and extensions of contracts that have varying timelines.[53]

3.45 The absence of national governance adds an additional layer of complexity to the task of achieving integrated planning and prioritisation of funding allocation, with the AADC further noting: 'The result is for example different agencies prioritising funding for the same location, while completely missing or under-funding other locations'.[54]

3.46 The Committee also heard about inconsistencies in the application of indexation on Commonwealth funding contracts. In some instances where indexation has been applied, the rates were significantly below those applied by state and territory governments, which resulted in a significant reduction in funding in real terms.[55] Supplementary budget measures have been introduced to address some of these issues, but as the Committee understands the situation, while these payments were necessary for addressing current funding shortfalls, they have not been rolled into core sector funding.[56] To address this problem, the Glen Group, an Aboriginal Community Controlled Organisation that operates rehabilitation centres in NSW, recommended embedding indexation in funding agreements.[57]

3.47 The short-term nature of many commissioning contracts in the sector has been identified as a major driver of funding instability. AADC noted that the Commonwealth makes use of grant making processes, which are often three years or less in length. As consequence, the sector was hindered by:

---

51 Victorian-Tasmanian Primary Health Network Alliance, *Submission 41*, pp. 5-6.
52 AADC, *Submission 45*, p. 13.
53 Mr Geoffrey Davey, Chief Executive Officer, Queensland Injectors Health Network, *Committee Hansard*, Brisbane, 30 October 2024, p. 9.
54 AADC, *Submission 45*, p. 14.
55 AADC, *Submission 45*, p. 4.
56 AADC, *Submission 45*, p. 16.
57 Ngaimpe Aboriginal Corporation (The Glen Group), *Submission 118*, n.p.

> A commissioning environment that requires frequent recommissioning due to short contract lengths, necessitating services to re-direct their resources, and late contract executions and other delays that often result in services whose main source of funding is through the Australian Government, being required to cover funding gaps. In addition, for regional, rural and remote services, funding and commissioning processes frequently do not account for the higher cost of service provision outside of metropolitan areas. These factors contribute to an overall picture of funding instability and insecurity, leading to challenges in workforce retention, and resulting in services working around – rather than in partnership with – funding bodies to deliver outcomes.[58]

3.48 QNADA reiterate this point, and informed the Committee that:

> … less than one fifth of NGO AOD providers across Australia have some portion of their funding as recurrent. Despite relaying on community-based NGOs to provide 71 percent of all treatment episodes nationwide, the funding and purchasing arrangements for these services serve to increase organisational instability and vulnerability.[59]

3.49 QNADA further noted that the Commonwealth's 'stop-start funding arrangements and last-minute contract renewals impact the ability of services to develop and maintain a skilled and available workforce …'[60]

3.50 AADC insisted that contracting and commissioning issues were 'frequently most acutely felt through PHN commissioning processes', and explained that:

> Delays in the Australian Government confirming ongoing funding for the PHN program create flow-on contract execution delays for commissioned AOD services. In addition, budget measures such as CSO, WCI and DATSM are not automatically applied to PHN funding contracts and where they are, the level of discretion individual PHNs have in applying these budget measures creates additional instability and insecurity within the AOD sector.[61]

3.51 In its submission, the Victorian-Tasmanian Primary Health Networks Alliance suggested that 'the iterative nature of the PHN commissioning cycle provides regular opportunities for planning the delivery of services in line with community needs, in a way that is cognisant of and promotes linkages and integration between providers'.[62]

3.52 In order to address funding instability in the sector, the AADC explained that some state and territory governments have progressively adopted longer contract lengths, which provided a level of security and stability within respective jurisdictions. The South Australian Government, for example, uses 3+3+3 year contract lengths,

---

58 AADC, *Submission 45*, p. 4.
59 QNADA, *Submission 75*, p. 12.
60 QNADA, *Submission 75*, p. 12.
61 AADC, *Submission 45*, p. 16.
62 Victorian-Tasmanian Primary Health Networks Alliance, *Submission 41*, p. 5.

providing up to nine years security where key performance indicators are met. The Australian Capital Territory Government has introduced 7+3 year contract lengths in its latest recommendation process.[63]

AOD research and data

3.53 The study of AOD-related issues in Australia is concentrated around five major research hubs, funded by the Commonwealth Government:

- National Centre for Education and Training on Addiction, Flinders University (NCETA)
- National Drug and Alcohol Research Centre, UNSW Sydney (NDARC)
- National Centre for Youth Substance Use Research, The University of Queensland (NCYSUR)
- National Drug Research Institute, Curtin University (NDRI)
- National Centre for Clinical Research on Emerging Drugs (NCCRED).[64]

3.54 Other notable research hubs include, for example, the Centre for Drug Use, Alcohol and Addictive Behaviour Research (CEDAAR), the Monash Addiction Research Centre (MARC), the Matilda Centre for Research in Mental Health and Substance Use (the Matilda Centre), and the NSW Drug and Alcohol Clinical Research and Improvement Network (DACRIN).

3.55 AOD research sector receives government funding through Medical Research Future Fund (MRFF) and grants awarded by the National Health and Medical Research Council (NHMRC). According to the Department of Health and Aged Care, between 2015 and 2024, the MRFF has invested $48.17 million in 30 grants with a focus on AOD use research. During the same period, NHMRC has expended $229.1 million towards research relevant to AOD addiction. In May 2024, the Government announced up to $20 million in MRFF funding for AOD focused projects, with application outcomes for these grants expected to be announced in July 2025.[65]

3.56 In its submission, the Matilda Centre highlighted the need for the establishment of national research strategies in the field of AOD. The importance of national research strategies has been recognised by the health sector more broadly and the mental health specifically through the National Health and Medical Research Strategy, which is currently under development, and the inaugural National Mental Health Research Strategy (2022). No equivalent strategy, however, has been developed for the AOD field. According to the Centre, a national AOD research strategy has the potential to help identify evidence gaps, reduce the duplication of efforts across NHMRC, MRFF

63 AADC, *Submission 45*, p. 16.
64 Department of Health and Aged Care, *Submission 157*, p. 33.
65 Department of Health and Aged Care, *Submission 157*, p. 33.

and other funded AOD research, build the AOD research workforce, and ultimately strengthen Australia's response to AOD harms.[66]

3.57 The Matilda Centre further emphasised support for collaboration with people who had personal experience with addiction, as well as for Aboriginal and Torres Strait Islander communities, as being vital for addressing AOD harm in Australia.[67] These forms of collaboration and research co-design processes have been raised through the inquiry as important areas of focus and development for the sector.

3.58 The Institute for Urban Indigenous Health submitted that Aboriginal and Torres Strait Islander-led research and evaluation of AOD services must be recognised as a separate, dedicated stream of research and evaluation component of the AOD system.[68] Such an approach would recognise that AOD has a disproportionate effect on Indigenous communities. According to the Institute, more Aboriginal Australians die due to drug and alcohol-related causes than any other disease group, including suicide and cardiovascular illnesses. Among young Aboriginal people aged 15 to 24, alcohol is the number one contributor to the burden of disease.[69]

3.59 In reflecting on the close relationship between trauma and AOD use, the research sector also emphasised the need for the development of culturally specific understanding of trauma for priority groups, and research and evaluation of trauma-informed approaches to AOD treatment. Such an approach would help to better situate AOD related problems and trauma in the context of related social issues of gender and family violence, racism, sexual discrimination, criminalisation, poverty, and homelessness.[70]

3.60 Through the course of the inquiry, the efficacy of new AOD treatments was cited as a priority area for further research.[71] Equally, the study of chronic liver problems was noted as being vital to addressing alcohol-related liver disease. According to Dr Paul Clark, Professor of Medicine at the University of Queensland and Director of the Alcohol and Drug Assessment Unit at Princess Alexandra Hospital, liver disease is 'the most common medical problem and occupies the biggest burden of disease and cost from alcohol in our community'.[72]

3.61 The Committee also heard evidence on how AOD research has been translated into clinical practice. In its submission, the Department of Health and Aged Care underlined the critical role that research and research translation have in informing a quick response to new and emerging issues in the AOD sector. As an example, the Department cited work related to the identification of new psychoactive substances in

66 The Matilda Centre, *Submission 24*, p. 9.
67 The Matilda Centre, *Submission 24*, p. 11.
68 Institute for Urban Indigenous Health, *Submission 155*, p. 20.
69 The Matilda Centre, *Submission 24*, p. 11.
70 Professor Carla Treloar, *Submission 31*, p. 2.
71 National Centre for Clinical Research on Emerging Drugs (NCCRED), *Submission 171*, pp. 13-14.
72 Dr Paul Clark, Director, Alcohol and Drug Assessment Unit, Princess Alexandra Hospital, Brisbane, *Proof Committee Hansard*, Canberra, 7 February 2025, p. 23.

order to inform government responses. These substances are constantly evolving, expanding and diversifying, and their toxicity is often difficult to quantify:

> Also referred to as 'emerging drugs' there are increasing fears about these substances, particularly considering recent overdose deaths where other drugs have been adulterated with nitazenes, a particularly potent category of synthetic opioids.[73]

3.62 Commenting on the capacity to respond to rapidly evolving drug markets, NCCRED drew the Committee's attention to the importance of 'futures focussed foresight' approaches to support preparedness. Research that informs such an approach involves a study of social, economic and ecological shifts that influence drug markets and drug use in several ways such as, for example, how the development of encrypted technologies has impacted drug manufacturing and supply.[74]

3.63 Other entities also emphasised the need for more agile and responsive research and research translation approaches in the AOD domain. NCYSUR noted that more investment focus needed to be placed on hybrid implementation trials:

> Even when an intervention is found to be effective, it can take up to 17 years for evidence to change practice. Hybrid effectiveness implementation trials, which blend the design components of clinical effectiveness and implementation research and are conducted in real-world settings, increase the speed of knowledge creation and its translation into clinical practice and policy.[75]

3.64 In raising the issue of research translation, the Committee also heard from witnesses about the need for stronger support for health service research.[76] Reconnexion, a support service for benzodiazepine withdrawal, noted that at the beginning of 2024, the United Kingdom's Maudsley Hospital, well known for its psychiatric prescribing guidelines, released de-prescribing guidelines for antidepressants and benzodiazepines. According to Reconnexion, these are the most comprehensive guidelines to date; while previous guidelines were general, this was the first time a medical authority has laid out the clear guidelines for how to de-prescribe.[77] This document, however, is complex and requires translation for general use by medical professionals.[78]

3.65 Reconnexion subsequently launched a research project involving a cohort of general practitioners around Australia, along with the author of the Maudsley guidelines, working on translating the de-prescribing guidelines into practice. Developing this type of AOD translational research, Reconnexion noted, was vital for ensuring that most up-to-date strategies are implemented across the sector. As Dr Erin Oldenhof,

---

73 Department of Health and Aged Care, *Submission 157*, p. 33; See also Odyssey Victoria, *Submission 136*.
74 NCCRED, *Submission 171*, p. 11.
75 The Australian National Centre for Youth Substance Use Research (NCYSUR), *Submission 120*, pp. 7-8.
76 Reconnexion, *Committee Hansard*, Melbourne, 28 October 2024, pages 26-34; Odyssey Victoria, *Submission 136*, p. 3.
77 Dr Erin Oldenhof, Benzodiazepine Withdrawal Counsellor and Research and Innovation Lead, Reconnexion, *Committee Hansard*, Melbourne, 28 October 2024, pp. 28-30.
78 Dr Oldenhof, Reconnexion, *Committee Hansard*, Melbourne, 28 October 2024, pp. 28-30.

Reconnexion Benzodiazepine Withdrawal Counsellor and Research and Innovation Lead, told the Committee:

> You've got academics and researchers with great ideas and doing wonderful research, but it stays there and it doesn't move into the world. And it doesn't often work with the services to inform the design and development. So they have the evidence but then they realise, 'Oh, that doesn't work for the service trying to provide it.' This is that missing piece.[79]

3.66 Throughout the inquiry, the importance of using high-quality data collections to inform AOD research and policy response was repeatedly impressed upon the Committee. The Australian Government funds the collection of national data on AOD, with many of these collections administered by the Australian Institute of Health and Welfare (AIHW).[80]

3.67 The AIHW manages two main AOD data collections on behalf of all state and territory governments: the Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS NMDS) and the National Opioid Pharmacotherapy Statistics Annual Data collection. The first captures information about publicly funded AOD treatment services—including agencies, clients, and treatment received—and covers the period from 2000. The second collection gathers information on clients who access opioid pharmacotherapy, prescribers of opioid pharmacotherapy, and dosing point sites where clients receive pharmacotherapy since 2004.[81]

3.68 The AIHW also manages the National Drug Strategy Household Survey on behalf of the Commonwealth government. This survey captures information on alcohol, tobacco and illicit drug use among the general population in Australia, including people's attitudes and perceptions relating to AOD use.[82] Conducted every two to three years since 1985, the collection includes information on AOD related impacts, such as:

- treatment seeking
- high risk drug use
- risky alcohol consumption
- experiences of overdose
- drink spiking
- risky activities undertaken while under the influence of alcohol and other drugs
- injuries sustained while under the influence of alcohol or other drugs
- harms experienced from someone under the influence of alcohol or other drugs.[83]

---

79 Dr Oldenhof, Reconnexion, *Committee Hansard*, Melbourne, 28 October 2024, p. 30.
80 Department of Health and Aged Care, *Submission 157*, p. 33.
81 Australian Institute of Health and Welfare (AIHW), *Submission 142*, Attachment 1, p. 1.
82 AIHW, *Submission 142*, Attachment 1, p. 1.
83 AIHW, *Submission 142*, Attachment 1, p. 3.

3.69 Numerous other data collections assist in analysing the AOD impacts and harms. These include, for example, the Department of Health and Aged Care Pharmaceutical Benefits Scheme and Medicare Benefits Scheme data collections, as well as data from the Australian Secondary Students Alcohol and Drug survey. The Australian Criminal Intelligence Commission's National Wastewater Drug Monitoring Program also provides an important source of data in this context.[84]

3.70 In its submission, AIHW noted that data pertaining to such things as ambulance services, patients admitted across public and private hospitals, the health status of people in Australia's prisons, pregnancy and childbirth, access to homelessness services, and burden of disease database all provide different information points that help to build the picture of the use and impact of AOD.[85]

3.71 Up-to-date data is critical for monitoring new and emerging issues. The National Drug and Alcohol Research Centre (NDRAC) coordinates the Drug Trends Program, which serves to inform policy response through the early identification of emerging problems in substance use in the country. The program uses a range of data sources, including the Illicit Drug Reporting System (IDRS) and the Ecstasy and Related Drugs Reporting System (EDRS) drug monitoring projects, which collect data among people from metropolitan regions who regularly use stimulant drugs and who regularly inject drugs.[86]

3.72 In its submission, the Department of Health and Aged Care underscored the critical value of these monitoring systems:

> These projects aim to identify emerging trends of local and national concern in illicit drugs and related drug markets. Both projects seek to monitor the price, purity, availability, and patterns of use of specific illicit drugs including heroin, cocaine, ecstasy, cannabis, methamphetamine, ketamine, GHB (gamma hydroxybutyrate), MDMA (Methylenedioxyamphetamine) and LSD (lysergic acid diethylamide).[87]

3.73 The Emerging Drugs Network of Australia (EDNA), a national toxico-surveillance system, has also been identified as an invaluable data source. EDNA draws its data from patients presenting to the emergency departments (EDs) after using illicit drugs. It is a collaborative national network of emergency physicians, toxicologists, forensic laboratories and public health authorities. The key benefit of EDNA is the capacity to provide timely laboratory-confirmed toxicology data on emerging drug-related threats in the community, which acts as an early warning system. EDNA has made Australia's first contribution of national ED data on novel psychoactive substances to the United Nations Office on Drugs and Crime Global SMART Forensics program. It has strengthened Australia's contribution to global surveillance networks. Concerns

84 Department of Health and Aged Care, *Submission 157*, p. 34.
85 AIHW, *Submission 142*, Attachment 1, p. 1.
86 Department of Health and Aged Care, *Submission 157*, p. 32.
87 Department of Health and Aged Care, *Submission 157*, p. 32.

have been raised, however, that funding for EDNA, which comes from the NHMRC, may cease in 2025-26.[88]

3.74 NCCRED submitted that Australia had a strong history of monitoring illicit drug trends over time, and since 2020 also a better capacity to detect concerns relating to novel psychoactive substances and drug potency in real time. NCCRED emphasised, however, that there is presently no national system to collate and analyse events-based data in real time:

> There is a range of data sources that if analysed and triangulated in a timely fashion could facilitate real time access to data points such as substance related harms and treatment episodes. The establishment of such a data source may support improved public health decision making.[89]

3.75 The AIHW similarly noted a number of AOD data gaps, highlighting that 'the available data on harms are more limited than data on consumptions, particularly at the national level'.[90] This includes information on:

- targeted treatment programs for groups with specific needs
- treatment outcomes (to understand the most effective treatments)
- AOD workforce data (similar to the AIHW's existing National Mental Health Service Planning Framework)
- AOD expenditure data
- data on demand for AOD services (such as, for example, wait times)
- data from the broader AOD service sector (such as the private treatment services).[91]

3.76 There is currently no coherent, national evidence base containing data on AOD use and harms in the context of inter-related psychosocial factors that may increase the risk of harm. AIHW noted that it was well established that drug use often co-occurred with psychosocial factors including mental health conditions, family, domestic and sexual violence (FDSV), socioeconomic disadvantage, chronic health conditions, experiences of homelessness, and self-harm. While AIHW data holdings provide coverage of many of these topics, there is limited data available at the national level that allow for the examination of these factors in combination.[92]

3.77 The AIHW is currently undertaking several linkage programs to address these gaps, such as National Health Data Hub, Child Wellbeing Data Asset, and NACS linked dataset, a bespoke data linkage project including data on all-cause mortality among

88 Australasian College of Emergency Medicine (ACEM), *Submission 95*, pp. 3-4.
89 NCCRED, *Submission 171*, p. 10-11.
90 AIHW, *Submission 142*, p. 2.
91 AIHW, *Submission 142*, pp. 3-4.
92 AIHW, *Submission 142*, p. 4.

people who have accessed specialised AOD treatment and or specialist homelessness services.[93]

3.78 Witnesses made several recommendations for the strengthening of current data collections, in particular the AODTS NMDS. NCYSUR noted, for example, that the set lacks information on the safety, quality, and more specific details of the treatment delivered:

> … only information on the main physical setting (e.g., residential treatment facility, outreach setting) and broad type of treatment delivered (e.g., withdrawal management, counselling, rehabilitation, pharmacotherapy), is collected.
>
> We recommend the development of NMDS items to collect information on the specific subtype/s of treatments being delivered during withdrawal management, counselling, rehabilitation and pharmacotherapy treatment in AOD services to ensure they are safe and evidence based.[94]

3.79 The NCYSUR submission further highlighted that there had been no measures for the quality outcomes or effectiveness of treatment:

> Despite nearly two decades of calls to collect person reported outcome measures (PROMs) in Australia, there has been limited success to date, as AOD service providers lack the time, infrastructure and staffing to collect and utilise this valuable data.[95]

3.80 In response, NCYSUR developed QuikFix, an evidence-based PROM system designed specifically for AOD treatment services which focuses on outcomes that matter to clients. The routine collection of PROM is seen as vital for approving AOD treatment service in Australia.[96]

3.81 Multiple witnesses emphasised the need for better data to help measure the effectiveness of different programs. Mr Adam Miller, Chief Communications Officer at Windana, told the Committee that a significant shift is needed to support the implementation of effective and equitable policy responses:

> … and part of this shift can be driven by the data the federal government mandates service providers like us to collect and a shift from outputs to outcomes—for example, from capturing whether someone was referred to a housing agency to capturing whether their housing security has improved.
>
> To do this, data collection at all levels needs to include a meaningful focus on the social determinants of health. It's often said that, if it's not written down, it didn't happen. Take a quick look at the data that service providers are mandated to collect in the alcohol, tobacco and other drug services database and you'll see that what we're being asked to capture primarily relates to demographic data and

93 AIHW, *Submission 142*, p. 5.
94 NCYSUR, *Submission 120*, p. 8.
95 NCYSUR, *Submission 120*, p. 8.
96 NCYSUR, *Submission 120*, p. 9.

> outputs—how many sessions, who ran the sessions and so forth. There is little if anything about outcomes—about what a person needs to be able to meet their recovery goals. This is what matters, yet it's not captured in federal government mandated data fields.[97]

3.82 Mr Joseph Coyte, Executive Director at Ngaimpe Aboriginal Corporation (The Glen Group) similarly emphasised the importance of collecting data that would enable the objective measurement of achieved outcomes:

> I'd love to really understand who's funding what and what outcomes on the ground we are achieving as a society. That's what we're trying to do. For instance, in New South Wales recently, there was a half-billion-dollar investment after the ice inquiry. Now, we've got to make sure we monitor that to actually see what outcomes were achieved on the ground. It's not about who you funded so you can tick your box and say, 'We gave that person that money and this person this money.' I don't think anyone cares, as long as the outcome on the ground is worth a half-a-billion-dollar improvement to the state of New South Wales.[98]

3.83 In other to enhance current AOD data collections, the Australasian College for Emergency Medicine (ACEM) urged Australian governments to require reporting on alcohol and drug related presentations to ED and use this to inform prevalence. ACEM noted that current coding systems has not sufficiently evolved to capture the complex nature of AOD presentations. The organisation noted that, for example, the New South Wales Special Commission of Inquiry into the Drug 'Ice' found that systematic data collection under-reports methamphetamine ED presentations by 40 per cent.[99]

3.84 The Australian Medical Association (AMA) added that: 'Accurate, timely and comprehensive indicators and monitoring of alcohol and other use, and substance-related harms, must be uniformly collected across the states and territories as a matter of urgency'.[100] In acknowledging the vital work conducted by AIHW, AMA also recommended additional measures that should be taken to strengthen Australia's AOD data:

> Alcohol sales data should be collected so the sales volumes of each beverage and outlet type can be determined at a local level to facilitate evaluation of community initiatives to reduce alcohol-related harms. Data should be collected on foetal alcohol spectrum disorder, both in the general population and in high-risk groups.[101]

---

97 Mr Adam Miller, Chief Communications Officer, Windana, *Committee Hansard*, Melbourne, 29 October 2024, p. 29.

98 Mr Joseph Coyte, Executive Director, Ngaimpe Aboriginal Corporation (The Glen Group), *Committee Hansard*, Canberra, 7 Novembre 2024, p. 5.

99 ACEM, *Submission 95*, p. 7.

100 Australian Medical Association (AMA), *Submission 80*, p. 13

101 AMA, *Submission 80*, p. 13.

3.85 NDRI reiterated that accurate measures of alcohol consumption are lacking within Australia. Only five states and territories currently collect some level of data from alcohol wholesalers, and of these only the Northern Territory has made this data publicly available since 2018.[102]

3.86 NDRI recommended that Australia should consider moving to a Point-of-Sale approach to monitoring alcohol-related harm, which would see retail sales data be collected by government. Such data would inform government of the price alcohol is being sold for, the time of day these sales are made, and the quantity of alcohol that is purchased at any one time. The NDRI submitted: 'This information can be used to inform effective and targeted alcohol prevention programs in areas with elevated levels of alcohol-related harm'.[103]

3.87 In reflecting on current data collections, the National Indigenous Australians Agency (NIAA) emphasised that improving the AOD evidence base was essential to achieving better outcomes for First Nations People. Furthermore, the NIAA highlighted the importance of data for self-determination, and noted that data practitioners should have greater awareness and acceptant of the principles of Indigenous Data Sovereignty. This involves First Nations people leading discussion on matters that affect them, including the 'conceptualisation, prioritisation, design, collection, management, and use of data and research to inform policy and programs'.[104]

Committee comments

3.88 The Committee recognises that the AOD governance framework has grown increasingly complex, underscoring the critical need for renewed national leadership to strengthen coordination and oversight in this area. In developing the next National Drug Strategy, robust research and data collection remain fundamental for properly understanding sector needs and crafting effective policies. Our research institutions continue to make vital contributions, and their capacity to translate new knowledge into clinical practice is an essential part of Australia's ability to provide a meaningful response to AOD harms.

102 National Drug Research Institute (NDRI), *Submission 141*, n.p.
103 NDRI, *Submission 141*, n.p.
104 National Indigenous Australians Agency, *Submission 140*, p. 15.

4. Alcohol and other drugs services in Australia

4.1 The National Drug Strategy 2017-2026 recognises seven 'priority populations' who are particularly vulnerable to alcohol and other drug (AOD)-related harm. This chapter evaluates Australia's AOD service provision, with particular focus on the unique health challenges these priority populations face and the systemic barriers that impede their access to treatment. The discussion extends to critical workforce challenges within the AOD sector, and includes consideration of potential strengthening strategies, while also highlighting the essential contribution of family support and peer workers—individuals with living or lived experience of AOD harm—in delivering effective care.

Demand for services

4.2 Most AOD treatment services are provided through the Australian Government's Drug and Alcohol Program. Demand for such services is significant: according to the Australian Alcohol and Other Drugs Council (AADC), 'Australia's AOD sector provides 235,000 episodes of care to at least 131,000 Australians each year'.[1]

4.3 There are also a number of other harm reduction services that support people with AOD-related problems, such as, for example, Needle and Syringe Programs (NSPs) which distribute more than 50 million sterile needles, syringes and other injecting equipment annually. These programs also offer an estimated 1,800 occasions of care in the form of health education and referrals daily across the country.[2]

4.4 In its analysis of AOD treatment services in 2022-23, the Australian Institute of Health and Welfare (AIHW) found that more than 46 per cent of clients are new to treatment. Most clients lived in major cities and inner regional areas, although the rate of clients was highest in remote and very remote areas—1,133 and 1,412 per 100,000 people respectively, compared to 487 per 100,000 people in major cities.[3]

4.5 In its submission, the Alcohol and Drug Foundation (ADF) explained that individuals are generally required to contact the service personally, and they are able to access help and support via a range of access points or 'front doors':

> Some access points refer through to other access points so people seeking help are connected to different providers as they seek to understand the best option

1 Australian Alcohol and Other Drugs Council (AADC), *Submission 45*, p. 3.
2 AADC, *Submission 45*, p. 3.
3 Australian Institute of Health and Welfare (AIHW), *Submission 142*, Attachment A, p. 2.

> for their needs … Many referrals come through other sectors: Emergency Departments, housing services, mental health providers, community health services, AOD treatment services directly, pharmacy, and the justice system.[4]

4.6 ADF further noted that many individuals simply use search engines, with the organisation's website receiving 85 percent of its 10 million annual visits through Google.[5]

4.7 AOD telephone services often represent the first option for people experiencing substance use harm. Adis, which provides information, brief counselling and referral services for individuals with AOD concerns and their loved ones (as well as health professionals), currently operates in Queensland, South Australia, New South Wales, and Western Australia. Other states have similar AOD telephone support services. Mrs Kiara Palmer, Acting Director of Adis 24/7 Alcohol and Drug Support in Queensland, told the Committee that the service receives about 3,000 phone calls a month from different parts of the state, and about 300 contacts via their WebChat function.[6]

4.8 The Matilda Centre for Research in Mental Health and Substance Use (the Matilda Centre) submitted that AOD treatment episodes have increased more than 20 per cent in the last decade. There is, however, still substantial unmet demand for treatment. In 2019, the University of New South Wales Drug Policy Modelling Program estimated annual unmet need for AOD treatment to be between 26.8 and 56.4 per cent. There is also substantial delay in accessing treatment, with estimates indicating that, on average, Australians live with substance use problems for 18 years before making initial contact with treatment services.[7]

4.9 In reflecting on the process for accessing treatment services, the Queensland Nurses and Midwives' Union (QNMU) asserted that long wait times are a significant challenge, and can result in lost opportunities for initial engagement:

> After the initial referral has been made, it can take weeks before a suitable time slot for an intake assessment. It may be a further week for the service to discuss the suitability of the referral and, if accepted, to allocate a case manager, and another week before the first meeting between the case manager and consumer can take place. It is not unheard of for some consumers to wait up to 8 weeks before being able to start treatment.[8]

4.10 This challenge was echoed by Ms Stephanie Taylor, who shared her experience of navigating the health sector to support her brother Richard in his battle with alcohol

---

4 Alcohol and Drug Foundation (ADF), *Submission 77*, p. 18.
5 ADF, *Submission 77*, p. 18.
6 Mrs Kiara Palmer, Acting Director, Adis 24/7 Alcohol and Drug Support, *Committee Hansard*, Brisbane, 30 October 2024, pp. 31; 34.
7 The Matilda Centre for Research in Mental Health and Substance Use (The Matilda Centre), *Submission 24*, p. 5; The Drug Policy Modelling Program, Social Research Centre, UNSW, *Submission 17*, p. 2.
8 Queensland Nurses and Midwives' Union (QNMU), *Submission 34*, p. 8.

use disorder. Ms Taylor's submission outlines the difficulty of first having her brother agree to seek help, and then accessing treatment services:

> This is a soul destroying process as you learn very quickly hospital detox beds and rehab spots are incredible hard to secure. For example, each time our family reached the desperate point of encouraging Richard to go to rehab, it had to be on his terms. He was an adult who had ultimate control of whether he went to hospital detox and rehab. The number of phone calls I made to hospitals and rehabs in sheer desperation, crying and begging for help, only to be met with, 'call back in a month' or 'we do have a detox bed, but I'm sorry you are not in our local area' or 'can you please have Richard call us'.[9]

4.11 Ms Taylor also highlighted the challenge of navigating bureaucratic requirements to access help:

> On some occasions, after days of ringing around, I would secure a rehab place for Richard, get him to a point of calling them to confirm he wanted to go to rehab, only to be told he must complete hospital detox first. We lost so many rehab places as we could not secure a hospital detox. On several occasions I would speak with a wonderful healthcare worker, very kind and compassionate, who had detox beds available but couldn't offer Richard a spot as he was not in the local area.[10]

4.12 An inability to access services when they are needed, as Ms Taylor's account demonstrates, can result in a lost opportunity to engage with health services:

> On more than five occasions, we would secure a hospital detox bed and/ or rehab spot for a few weeks away, but Richard would then decide he did not want to go.[11]

4.13 This point was similarly highlighted by Ms Rachel Allen, who lost her son Dylan to alcohol use disorder:

> We sometimes get a window—I have often talked about this—or a space to make a difference, and if all those resources don't come together and align at the time then that opportunity is gone.[12]

4.14 The Australian National Centre for Youth Substance Use Research (NCYSU) reiterated that long waitlists in public services, high gap fees in private services, and a lack of available services in regional and remote communities made it difficult for many Australians to access treatment. For those who do, the average number of service contacts per year is only 1.8, which is not regarded as effective or consistent with evidence-based clinical guidelines.[13]

---

9 Ms Stephanie Taylor, *Submission 11*, p. 1.
10 Ms Taylor, *Submission 11*, p. 1.
11 Ms Taylor, *Submission 11*, p. 2.
12 Ms Rachel Allen, private capacity, *Proof Committee Hansard*, Canberra, 7 February 2025, p. 10.
13 National Centre for Youth Substance Use Research (NCYSUR), *Submission 120*, p. 7.

4.15 Multiple witnesses highlighted that the lack of services was particularly grave in rural and remote areas.[14] Drug ARM submitted that these areas are underserviced and explained that its Clean Needle Program in Adelaide saw clients travelling significant distances from rural areas to access essential harm reduction services.[15]

4.16 In her submission, Ms Taylor stated that '[t]here is, without question, a strong need for more services,' adding that '[l]iving in Sydney, you can't assume that a high population provides greater access to services'.[16] Multiple submissions asserted that an inability to access services in a timely manner would ultimately result in increased presentations to emergency departments.[17]

Priority populations

4.17 Evidence presented in the course of this inquiry repeatedly highlighted that whole-of-population strategies play an important role in reducing total harm and social impact of alcohol and drug use.[18] There are, however, populations that are known to have a 'higher risk of experiencing disproportionate harm (direct and indirect) associated with alcohol, tobacco and other drugs'.[19] The Committee accepts that, for these populations, it is appropriate that a more tailored approach is taken to tackle the impact of AOD. The National Drug Strategy 2017-2026 identifies the following priority populations:

- Aboriginal and Torres Strait Islander people
- people with mental health conditions
- young people (between ages 10 and 24)
- older people (aged 60 or over)
- people in contact with the criminal justice system
- culturally and linguistically diverse (CALD) populations
- people identifying as lesbian, gay, bisexual, transgender, and intersex.[20]

4.18 Some state and territories identify additional priority groups in their AOD strategies. The Tasmanian Drug Strategy 2024-2029, for example, includes people living in rural or remote areas, pregnant women and their partners, people experiencing sexual abuse and violence, families, friends and carers of people with AOD use problems,

---

14 Australian College of Rural and Remote Medicine, *Submission 93*; Royal Australian and New Zealand College of Psychiatrists (RANZCP), *Submission 19*; The Matilda Centre, *Submission 24*; New South Wales Council for Civil Liberties, *Submission 28*.

15 Drug ARM, *Submission 44*, p. 1.

16 Ms Taylor, *Submission 11*, p. 2.

17 QNMU, *Submission 34*, p. 8; Australasian College for Emergency Medicine (ACEM), *Submission 95*.

18 The Salvation Army Australia, *Submission 68*; The National Drug and Alcohol Research Centre, UNSW, *Submission 111*; Western Australian Mental Health Commission, *Submission 159*.

19 Department of Health and Aged Care (2017), *National Drug Strategy 2017-2026*, p. 26.

20 Department of Health and Aged Care (2017), *National Drug Strategy 2017-2026*, p. 2.

as well as people who use performance and image enhancing drugs as at-risk populations.[21]

Aboriginal and Torres Strait Islander people

4.19 The impact of AOD harms on Aboriginal and Torres Strait Islander peoples is recognised in the National Agreement on Closing the Gap (the Agreement), and efforts to address harmful substance use cut across most targets and outcomes set out in the Agreement. The following suite of documents further frames the national approach to addressing AOD harm among the Indigenous population:

- The National Drug Strategy 2017-2026, along with its sub-strategy National Aboriginal and Torres Strait Islander Peoples Drug Strategy 2014-2019,
- The National Aboriginal and Torres Strait Islander Health Plan (2021-2031), and
- The National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing (2017-2023).[22]

4.20 In its submission, the Institute for Urban Indigenous Health (IUIH) stated that Aboriginal and Torres Strait Islander people are less likely to drink alcohol and use illicit drugs than non-Indigenous Australians. Those who do, however, are more likely to do so at problematic levels. The significant adverse health impacts of alcohol and other drugs on Aboriginal and Torres Strait Islander people in Australia continues to present a major source of concern.[23]

4.21 The Committee received substantial evidence demonstrating that Aboriginal and Torres Strait Islander people experience greater AOD harm than non-Indigenous Australians. Data from the AIHW and the National Indigenous Australians Agency (NIAA) reveals that mental health and substance use disorders continue to be the largest disease groups contributing to the health gap between First Nations people and non-Indigenous Australians. First Nations people (who comprised 3.3 per cent of Australia's population in 2021) are overrepresented in the AOD treatment data, constituting 18 per cent of the AOD client cohort in 2022-23 and 12 per cent of opioid pharmacotherapy clients in 2023.[24]

4.22 The IUIH submitted that the rate at which Aboriginal and Torres Strait Islander people are hospitalised with alcohol related and substance use related diagnosis reflects the inadequacy of culturally responsive prevention and early intervention strategies. In the decade leading up to 2018-2019, hospitalisation for someone with a drug related diagnosis increase by 144 per cent for Aboriginal and Torres Strait Islander people, compared to 29 per cent for non-Indigenous Australians.[25]

---

21 Alcohol, Tobacco and other Drugs Council Tasmania, *Submission 22*, pp. 5-6.
22 National Indigenous Australians Agency (NIAA), *Submission 140*, p. 4.
23 Institute for Urban Indigenous Health (IUIH), *Submission 155*, p. 4
24 AIHW, *Submission 142*, p. 3; NIAA, *Submission 140*, p. 4.
25 IUIH, *Submission 155*, p. 7.

4.23 The National Aboriginal Community Controlled Health Organisation (NACCHO) submitted that AOD use within Aboriginal and Torres Strait Islander communities must be viewed through the lens of trauma, and informed 'by an understanding of the unique history of colonisation of Aboriginal and Torres Strait Islander peoples, their ongoing experiences of dispossession and marginalisation, of systemic and interpersonal racism, and intergenerational trauma'.[26]

4.24 Evidence presented to this inquiry identified the experience of trauma and the associated distrust of official institutions (including the health system) as a major barrier for accessing AOD treatment. Negative experience, magnified by the AOD-related stigma, presents a major challenge in providing timely AOD interventions. Uncertainty about where to access help, misunderstanding of treatment and diagnosis, and logistical challenges (such as the lack of transportation) all present additional barriers to care.[27]

4.25 A healthcare approach that is exclusively grounded in Western medical tradition can also adversely impact Aboriginal and Torres Strait Islander peoples. The submission provided by La Trobe University Centre for Alcohol Policy Research offers an example of the use of screening tools that were designed for Australians of western background, and which may not be effective for Aboriginal and Torres Strait Islander people. These tools rely on western frames of reference and assume western drinking patterns, which are relatively stable over time. National surveys tend to ask about overall frequency of drinking and the usual quantity consumed on each occasion. Such methods tend to be inadequate for the screening of Aboriginal and Torres Strait Islander peoples, whose drinking patterns may be more episodic and irregular.[28]

4.26 Multiple witnesses further highlighted that while Aboriginal and Torres Strait Islander people represent a significant percentage of the demographic receiving AOD treatment, the AOD service system is dominated by mainstream providers who may lack cultural competence.[29] The Royal Australian and New Zealand College of Psychiatrists (RANZCP) noted that the AOD service delivery is often hindered by difficulties in adapting mainstream work practices to meet the specific needs of Aboriginal or Torres Strait Islander clients, and called for system-wide recognition of the significance of culture and community in the healing process.[30]

4.27 Multiple witnesses emphasised the value of applying a 'bicultural model of care', which recognises Aboriginal and Torres Strait Islander ways of knowing, being and

---

26 National Aboriginal Community Controlled Health Organisation (NACCHO), *Submission 145*, p. 7. See also Southern Aboriginal Corporation*, Submission 3*, p. 3 and Foundation for Alcohol Research and Education (FARE), *Submission 87*, pp. 14-15.

27 NIAA, *Submission 140*, p. 6; NACCHO, *Submission 145*, p. 6; Centre for Alcohol Policy Research (Priority Populations), La Trobe University, *Submission 21*, p. 1.

28 Centre for Alcohol Policy Research (Priority Populations), La Trobe University, *Submission 21*, p. 2.

29 IUIH, *Submission 155*, p. 4; NACCHO, *Submission 145*, pp. 5-6; NIAA, *Submission 140*, p. 6.

30 RANZCP, *Submission 19*, p. 5.

doing in the delivery of AOD services.[31] The Aboriginal Health and Medical Research Council of NSW further endorsed community-based treatment, which predominantly occurs in an individual's home or local community, and where the community becomes the 'treatment facility'.[32]

4.28 The role of the Aboriginal Community Controlled Organisations (ACCO) in the delivery of AOD treatment services, and the emphasis on service designed in line with the Aboriginal Drug and Alcohol Residential Rehabilitation Network model of care, which prioritises life skills in addition to withdrawal management, are recognised as being central for AOD care in Indigenous communities. This is illustrated in the work of the Glen Group, an AOD rehabilitation service located on the Central Cost of New South Wales operated by Ngaimpe Aboriginal Corporation. According to research conducted by the Glen Group, its participants have higher treatment completion rates than counterparts at non-ACCO services.[33]

4.29 Evidence gathered in the course of this inquiry emphasised a strong preference for these services among Aboriginal and Torres Strait Islander peoples, whether in rural and remote communities, or in a metropolitan context.[34] As IUIH noted, nearly 66 per cent of Aboriginal and Torres Strait Islander people live in urban areas in major cities and inner-regional centres, and it is expected that this population will continue to grow. There is an expectation that Aboriginal and Torres Strait Islander people will access mainstream services in urban areas, but the proximity to these services does not mean that Aboriginal and Torres Strait Islander people will access them. The IUIN stated that more community-controlled services in urban areas are needed, along with better referral pathways between ACCO and mainstream services.[35]

4.30 A significant portion of AOD services in Australia are funded by the Australian Government through the Primary Health Networks (PHNs), and many PHNs provide and support programs that focus on Aboriginal and Torres Strait Islander people. NACCHO submitted, however, that 'PHNs often do not have the skills to engage with, commission or deliver services for Aboriginal and Torres Strait Islander communities'.[36] NACCHO further explained that while there is a Guiding Principles document for PHN engagement with ACCHOs, this document:

> … has not been updated in over a decade, does not reflect the Priority Reforms of the National Agreement and does not include accountability for engagement or any requirement for PHNs to demonstrate their performance against the Guiding Principles.[37]

---

31 Centre for Alcohol Policy Research (Priority Populations), La Trobe University, *Submission 21*, p. 3. See also QNMU, *Submission 34*; Yarra Drug and Health Forum, *Submission 135*; NIAA, *Submission 140*; Queensland Mental Health Commission, *Submission 167*.

32 The Aboriginal Health and Medical Research Council of NSW, *Submission 69*, n.p.

33 NACCHO, *Submission 145*, p. 9; Ngaimpe Aboriginal Corporation (The Glen Group), *Submission 118*, n.p.

34 The Aboriginal Health and Medical Research Council of NSW, *Submission 69*, n.p.; NACCHO, *Submission 145*, p. 9.

35 IUIH, *Submission 155*, p. 11.

36 NACCHO, *Submission 145*, p. 15.

37 NACCHO, *Submission 145*, p. 15.

4.31 NACCHO further expressed its disappointment that the National Aboriginal and Torres Strait Islander Peoples Drug Strategy 2014-2019 has not been updated in over a decade, and there were currently no mechanisms to support the inclusion of Aboriginal and Torres Strait Islander voices in the development of policies and programs for AOD use:

> Aboriginal and Torres Strait Islander people have no direct voice to government in relation to AOD issues, since defunding of the National Indigenous Drug and Alcohol Committee (NIDAC). Furthermore, there is no Aboriginal and Torres Strait Islander representation on the Australian National Advisory Committee on Alcohol and Drugs (ANACAD), which is the principal advisory body to the government on AOD matters.[38]

4.32 Reflecting upon this situation, NACCHO stated that '[i]t is clear that the policy foundations for guiding government responses to AOD are woefully out of date and that urgent systemic reform is required'.[39]

4.33 The intersection between AOD abuse and family and domestic violence in Aboriginal and Torres Strait Islander communities has also been a feature of evidence presented to this inquiry. The Southern Aboriginal Corporation—an Aboriginal Community Controlled Organisation operating across the Great Southern, Southwest and Wheatbelt regions of Western Australia—noted, for example, that rates of reported drug offences, family assaults and breaches of violence restraining orders combined have almost doubled in the port city of Albany since 2016. In the same period, rates of Aboriginal children in the out-of-home care system in the Great Southern region have continued to grow. In 2023, more than 57 per cent of children in care in the region were Aboriginal.[40]

4.34 Adverse health and social outcomes related to parental AOD exposure continues to be a major concern within Australia's Indigenous population. In its submission, NIAA highlighted the need for increased support for pregnant and parenting First Nations women and their children. Pregnant women frequently face the stigma associated with AOD use and difficulties in accessing AOD treatment (such as services that can accommodate parenting responsibilities) and support if they are experiencing family and domestic violence. These difficulties are further compounded for First Nations women.[41]

4.35 The impact and prevalence of Fetal Alcohol Spectrum Disorders (FASD) in Australia among priority populations, such as First Nations communities, is substantial. Multiple witnesses drew the Committee's attention to the case of the Banksia Hill Detention Centre in Western Australia, where one third of 10 to 17 years olds were diagnosed with FASD in 2015–16, with 74 per cent of the detention population being First Nations children.[42] These witnesses highlighted both the need for further

---

38 NACCHO, *Submission 145*, p. 6.
39 NACCHO, *Submission 145*, p. 7.
40 Southern Aboriginal Corporation, *Submission 3*, p. 5.
41 NIAA, *Submission 140*, p. 7.
42 NIAA, *Submission 140*, p. 7; AADC, *Submission 45*, pp. 18-19; FARE, *Submission 87*, p. 24.

research into FASD, and the need for campaigns such as *Strong Born*, designed to raise awareness of FASD and the harms of drinking alcohol while pregnant and breastfeeding among Aboriginal and Torres Strait Islander peoples.[43]

4.36 Petrol sniffing is also identified as a significant issue for Indigenous communities, causing serious health impact, including brain damage and death. NIAA expressed support for arrangements that facilitate the supply of low aromatic fuel to replace regular unleaded petrol. Low aromatic fuel is an unleaded petrol that has been designed to discourage people from sniffing by lowering the amount of the toxic aromatic components, which can cause intoxication. Drawing on longitudinal studies, the University of Queensland have indicated that introduction of low aromatic fuel has been highly effective, with a 95 per cent reduction in petrol sniffing from 2006 to 2018 in communities surveyed that stock low aromatic fuel.[44]

People with mental health conditions

4.37 AOD use disorders are often accompanied by co-occurring mental health disorders.[45] In its submission, RANZCP noted that one third of individuals with an AOD use disorder also experience at least one co-existing mental health disorder.[46] Some research indicates that only seven per cent of people with co-existing mental illness and substance use disorders will receive treatment for both conditions.[47]

4.38 Some witnesses noted that AOD use is to be expected in people accessing mental health services, and that the sector needs to adopt a collaborative approach to services. For example, RANZCP highlighted that for AOD services to be truly effective, AOD-related harm needed to be recognised as a mental health condition.[48]

4.39 Mind Australia Limited, a community-managed mental health provider, noted however, that entry criteria often restrict those who are experiencing mental health complexities from accessing AOD services, and vice versa. In some cases, this was a decision made by organisations delivering services, but as Mind Australia Limited submitted 'in many cases this is a problem created by restrictive commissioning by government departments and other funding bodies, that excludes mental health or AOD considerations'.[49]

4.40 Ms Caroline Radowski, Executive Manager, Mental Health and Wellbeing at Brisbane North Primary Health Network further explained:

> If you enter a mental health service and you come with a substance use disorder as well, what often happens is that you will be segregated back to the AOD sector. You will be asked to work on your substance problem and then come

43 NACCHO, *Submission 145*, p. 10; See also National Organisation for Fetal Alcohol Spectrum Disorders (NOFASD), *Submission 129*.
44 NIAA, *Submission 140*, p. 11.
45 The Matilda Centre, *Submission 24*, p. 7.
46 RANZCP, *Submission 19*, p. 3.
47 Mind Australia Limited, *Submission 138*, p. 6.
48 Mind Australia Limited, *Submission 138*, p. 6; RANZCP, *Submission 19*, p. 3.
49 Mind Australia Limited, *Submission 138*, p. 5.

> back to the mental health service. Straight away, you are fragmented in that way. What often then happens is that the practitioners on the AOD side don't have the mental health practitioners. It's very difficult to treat somebody separately for those two areas. You need to treat them holistically as a person.[50]

4.41 Describing the difficulties she experienced in accessing adequate support for her son, Ms Allen told the Committee:

> In terms of community mental health and mental health facilities, he was overlooked due to his problems being considered purely alcohol related and not mental health related, although it was profoundly evident that his alcohol misuse was associated with his mental health. It couldn't be separated.[51]

4.42 Dr Elizabeth Moore, RANZCP President, acknowledged these difficulties, which can result in poor, and even tragic, outcomes:

> The college notes that the current AOD services do not adequately address substance use disorders as a mental health condition. This leads to fragmented care, particularly in rural areas and among Aboriginal and Torres Strait Islander communities. For individuals experiencing substance use disorders alongside a comorbid mental health condition, they are likely to receive less effective management and treatment, as services are often ill-equipped to support individuals with complex presentations.[52]

4.43 While mental health issues and substance use are a common comorbidity, multiple witnesses asserted that neither mental health services nor AOD services are positioned to care for individuals experiencing both conditions.[53] The Matilda Centre explained that 'AOD workers feel overwhelmed when treating clients with co-occurring mental disorders, as they don't have access to adequate knowledge and resources'.[54] The latest national AOD workforce survey underscores this point, finding that more than 60 per cent of AOD workers want additional training to manage clients with co-occurring mental health issues.[55]

Young people

4.44 It is common to first commence AOD use during adolescence. The Matilda Centre noted that this is 'the peak time for the onset of AOD use, with the initiation of alcohol use typically occurring during middle to late adolescence, and the onset of drug use during late adolescence'.[56] This is a particularly vulnerable age, as the transition to

---

50 Ms Caroline Radowski, Executive Manager, Mental Health and Wellbeing, Brisbane North Primary Health Network, *Committee Hansard*, Brisbane, 30 October 2024, p. 25.

51 Ms Allen, private capacity, *Proof Committee Hansard*, Canberra, 7 February 2025, p. 1.

52 Dr Elizabeth Moore, President, Royal Australian and New Zealand College of Psychiatrists (RANZCP), *Committee Hansard*, Melbourne, 28 October 2024, p. 1.

53 Dr Moore, RANZCP, *Committee Hansard*, Melbourne, 28 October 2024, p. 2; IUIH, *Submission 155*, p. 12.

54 The Matilda Centre, *Submission 24*, p. 7.

55 The Matilda Centre, *Submission 24*, p. 7.

56 The Matilda Centre, *Submission 24*, p. 9.

adulthood is often associated with significant personal and social changes, such as the commencement of new employment or study, new living arrangements, and increased autonomy and responsibility.[57]

4.45 In recent years, Australia has seen some positive developments regarding AOD use among young people, with data showing a reduction in tobacco smoking and alcohol consumption among those aged between 18 and 24 years old. There has also been an increase in the average age of the initiation of tobacco smoking, drinking alcohol, and using illicit drugs.[58]

4.46 Unfortunately, however, young people remain the most vulnerable age group for risky drinking behaviours and illicit drug use. AOD use remains the top preventable cause of death among young people.[59] In 2022-23, 42 per cent of individuals aged between 18 and 24 years old were at risk of alcohol related disease or injury. The Australian Research Alliance for Children and Youth also expressed concern that the average age of initiation of alcohol consumption, tobacco smoking and illicit substance use continues to be below 20 years old.[60] The age of initiation is critical, as the Matilda Centre noted, because:

> … early initiation of alcohol and other drugs increases the risk of negative outcomes, many of which can have long-term impact, including poor school performance, school dropout, juvenile offending, increased risk of drug dependence and mental illness during adulthood.[61]

4.47 The South Australian Commissioner for Children and Young People, Ms Helen Connolly, informed the Committee that 'as young people navigate adolescence, it is normal for some to be curious, experiment and take risks, while others may never try drugs or alcohol'.[62] Within the cohort of young people that does use AOD, only a small portion will develop substance use problems.[63] Young people who do develop serious AOD issues often have a range of other vulnerabilities, such as experience with the justice system, exposure to family violence or a mental health diagnosis, which requires a multipronged AOD response.[64]

4.48 Ms Allen's experience with her son Dylan echoes this evidence:

> When he was 18 he started to drink along with many of his friends, however little did we know at that time that for him this was a decision that would destroy his life. Initially it was the need to fit it that drove him to drink however [over time] he became fully dependent on it, to the point where he was completely preoccupied with needing to drink on a daily basis. Because this coincided with him getting

57 The Matilda, Sub 24, *Submission 24*, p. 13
58 Australian Research Alliance for Children and Youth, *Submission 23*, n.p.
59 NCYSUR, *Submission 120*, p. 9.
60 Australian Research Alliance for Children and Youth, *Submission 23*, n.p.
61 The Matilda Centre, *Submission 24*, p. 9.
62 SA Commissioner for Children and Young People, *Submission 10*, p. 1.
63 The Young Support and Advocacy Services, *Submission 32*, n.p.
64 Professor Carla Treloar, *Submission 31*, p. 3.

> depression I felt it was a means for him to numb out his low opinion of himself while also drawing out his negative thoughts.[65]

4.49 Young people face numerous barriers in accessing services. According to the National Centre for Youth Substance Use Research (NCYSUR), only 11 per cent of male and 18 per cent of female young Australians with AOD disorders seek treatment.[66] The Australian Association of Psychologists Incorporated (AAPI) suggested that young people are often reluctant to engage in health and treatment services. At times they may also have limited health literacy and difficulties navigating the health system. Other challenges may include geographic isolation, poverty, social exclusion, language barriers, and concerns about confidentiality.[67]

4.50 To enhance access to support, NCYSUR submitted that AOD treatment services and early intervention programs for young people need to be accessible in the environments in which they interact, including social media and messaging applications, as well as settings where they are at higher risk of AOD-related harm, such as universities, colleges and nighttime economies.[68] Integration of AOD services with other youth specific service systems, such as primary and mental health services, homelessness services and services that address violence, is also acknowledged as being vital for tackling substance use problems in young people.[69]

4.51 Mr Andrew Bruun, Chief Executive Officer of Youth Support and Advocacy Services, further emphasised that effective engagement with young people requires a proactive approach:

> … take the services to the young people, and make the right door for them to get through. Don't sit back and wait with no wrong door; go out there, engage, and create the right door. That now goes for South Sudanese young people, young people from Aboriginal and Torres Strait Islander backgrounds, and young people who are LGBTIQA+. Often, they all have their own requirements for how to make a service accessible and useful, and work on their terms.[70]

Older people

4.52 The National Drug Strategy notes that harmful use of prescription medication, and the effects of illicit drugs and alcohol is on the increase among older people (aged 60 years and over) in Australia. Older people can be more susceptible to alcohol, tobacco and other drug problems as a result of difficulties with pain and medication management, isolation, poor health, significant life events and loss of independent living.[71]

---

65 Ms Rachel Allen, *Submission 81*, p. 1.
66 NCYSUR, *Submission 120*, p. 9.
67 Australian Association of Psychologists Incorporated (AAPI), *Submission 6*, p. 3.
68 NCYSUR, *Submission 120*, p. 10.
69 SA Commissioner for Children and Young People, *Submission 10*, p. 4.
70 Mr Andrew Bruun, Chief Executive Officer, Youth Support and Advocacy Service, *Committee Hansard*, Melbourne, 28 October 2024, p. 18.
71 Department of Health and Aged Care (2017), *National Drug Strategy 2017-2026*, p. 28.

4.53 In the course of this inquiry, dependency on benzodiazepines emerged as a particularly concerning issue among this population. Benzodiazepines, such as Valium, Xanax and Temazepam, are central nervous system depressants typically prescribed for anxiety and insomnia. Reconnexion, a service that provides treatment, education, and support for benzodiazepine dependency and withdrawal, noted in its submission that this class of medication is also commonly misused in illicit drug use for the same effects. Benzodiazepines are the leading pharmaceutical and single-drug contributor in polysubstance overdose deaths in Australia (65 per cent) and are the most common substance involved in drug-induced suicides (44 per cent).[72]

4.54 When benzodiazepines are indicated, Reconnexion explained, their use should be limited to short term dosages because of their high risk of dependency. About 80 per cent of people taking benzodiazepines as prescribed for longer than six months will experience withdrawal if they stop. For some people, Reconnexion highlighted, withdrawal will be a protracted and debilitating experience, which can also cause seizures.[73]

4.55 These medications are prescribed disproportionately to older adults. Reconnexion submitted that this cohort is up to 56 per cent more likely to suffer hip fracture if prescribed a benzodiazepine. In older adults, benzodiazepines have also been linked to an increased risk of pneumonia, dementia and mortality. Reconnexion emphasised that, 'with an ageing population, and high rates of older adult hospitalisations and emergency department presentations than ever before, Australia should be leading international efforts to curb inappropriate benzodiazepine prescription'.[74]

4.56 Reflecting on AOD use among older Australians, Emeritus Professor Jake Najman, Chair of the National Policy Council, Drug ARM, told the Committee:

> We're starting to see a quite unexpected ageing of the illicit drug use pattern in the community. It's coming in a number of ways. One is that we're starting to see more middle-aged and older people affected by illicit drugs—or licit but overprescribed. At one stage, I looked at the number of people aged 65 and over, I think, who were being prescribed opioids. The percentage was extraordinary. Between 15 and 20 per cent of older women were receiving opioid treatment. I looked at that and thought it was extraordinary. We're finding that middle-aged men are now being diagnosed with attention deficit disorder and being prescribed amphetamines. We're also seeing a spike in alcohol use into older age. We're looking at this and thinking that the pattern of illicit drug use, which used to be tightly concentrated in young people, is now starting to reoccur in a different way in older age groups.[75]

---

72 Reconnexion, *Submission 97*, p. 4.
73 Reconnexion, *Submission 97*, p. 4.
74 Reconnexion, *Submission 97*, p. 4.
75 Emeritus Professor Jake Najman, Chair, National Policy Council, Drug ARM, *Committee Hansard*, Brisbane, 30 October 2024, p. 4.

4.57 The Committee was particularly concerned to hear about an increase in the use of counterfeit drugs. Mr Cameron Francis, Chief Executive Officer of the Loop Australia, which provides drug checking services, explained:

> An example of what we are seeing at the moment … are significant numbers of people using counterfeit benzodiazepines. A lot of that is in response to untreated or undiagnosed mental health conditions. People are self-medicating using counterfeit benzodiazepines that they are purchasing on the internet. In that context they are developing dependence and, in some cases, worsening their mental health symptoms.[76]

4.58 Reflecting on Committee questions about the use of drug checking services among elderly people, Mr Francis drew the Committee's attention to the use of counterfeit weight loss medications:

> Their GP has prescribed them a weight loss medication, they've gone to fill the prescription and they can't afford it. They've gone online and searched for 'weight loss medication' on the internet and imported something from overseas then brought that down to us to have it tested because they're aware that there can be counterfeit substances.[77]

Prison population

4.59 People entering adult prison are more than four times as likely to report recent illicit drug use than people in the general community, and seven times more likely to drink to excess, according to the Legal Aid Commission of New South Wales (Legal Aid NSW). Mental health conditions also tend to be over-represented in the prison population.[78]

4.60 The Committee received evidence that there is at present an inequitable gap in the provision of harm reduction and prevention services in prisons. UNSW Drug Policy Modelling Program submitted that while people in prisons have high levels of drug and alcohol use compared to the general Australian population:

> … a number of key harm reduction interventions are not available to people in prison. As a result, people in prisons experience much higher rates of blood borne viruses than the general public, including hepatitis C and HIV, and are at risk of overdose and highly-complex injecting-related injuries and disease such as septicaemia.[79]

4.61 This situation appears common, despite the fact that, as foregrounded in the submissions made by Drug Policy Modelling Program and the Australian Research Centre in Sex, Health and Society, Australia is a signatory to the *United Nations*

---

76 Mr Cameron Francis, Chief Executive Officer, The Loop Australia, *Committee Hansard*, Brisbane, 30 October 2024, p. 15.

77 Mr Francis, The Loop Australia, *Committee Hansard*, Brisbane, 30 October 2024, p. 21.

78 The Legal Aid Commission of New South Wales, *Submission 18*, p. 9.

79 Drug Policy Modelling Program, UNSW, *Submission 17*, p. 4.

Standard Minimum Rules for the Treatment of Prisoners. Often referred to as 'the Mandela Rules', these principles require healthcare in prisons to be equivalent to that in the community.[80]

4.62 In discussing health care provision in prison settings, Dr Simon Holliday highlighted that:

> There is a natural tension between the prison authorities and those delivering healthcare to prisoners. Prison authorities need to ensure control of the environment ensuring the avoidance of any risks. Those delivering healthcare are trying to reduce symptoms and prevent or treat disease. My impression is that this is not a meeting of equals but one where the former dominates the latter. Given that incarceration is not an infrequent transit point in the lifecycle of a AOD consumer, prison policy may drive AOD outcomes.[81]

4.63 Multiple submissions criticised the lack of provision of clean injecting equipment in prisons (with the exception of the ACT), or NSPs, which are known to reduce the transmission of blood borne viruses. As such, people who inject drugs often use makeshift injecting equipment or share syringes, which increases the likelihood of spreading blood borne viruses like hepatitis C and HIV. The lack of NSP, it is suggested, runs counter to the Australian Government target to end HIV transmission and hepatitis C by 2030.[82] The lack of access to ongoing AOD counselling as well as Opioid Treatment Programs (OTP) in the prison setting presents additional barriers to the equitable treatment for people in the prison system.[83]

Culturally and linguistically diverse populations

4.64 In Australia, the term CALD refers to 'culturally and linguistically diverse' individuals who were born, or have parents who were born in countries where English is not the predominant language, or whose culture may not align closely with Anglo-European norms. In 2021, nearly half of Australians were either born overseas or had at least one parent born overseas, and one in five spoke a language other than English at home.[84]

4.65 According to NCYSUR, CALD individuals remain substantially underrepresented in AOD research. Targeted programs for this cohort remain underfunded, NCYSUR further noted, and stated that 'AOD services in Australia are failing to deliver equitable outcomes for individuals from Culturally and Linguistically Diverse backgrounds'.[85]

---

80 Drug Policy Modelling Program, UNSW, *Submission 17*; Professor Kate Seear, *Submission 33*, p. 18.
81 Dr Simon Holliday, *Submission 9*, p. 2.
82 Department of Health and Aged Care (2023), *The Sixth National Hepatitis C Strategy 2023–2030*; Department of Health and Aged Care (2023), *The Ninth National HIV Strategy 2023–2030*; NSW Council for Civil Liberties, *Submission 28*; Professor Seear, *Submission 33*; Hepatitis Australia, *Submission 36*.
83 NSW Council for Civil Liberties, *Submission 28*, pp. 7-8; Indivior, *Submission 25*, p. 6; Hepatitis Australia, *Submission 36*; NACCHO, *Submission 145*, pp. 12-13.
84 NCYSUR, *Submission 120*, p. 10.
85 NCYSUR, *Submission 120,* p. 10.

4.66 In its submission, NCYSUR explained that while people who are born overseas generally report lower rates of AOD use compared to people born in Australia who only speak English at home, those who are at risk of experiencing AOD related harms face significantly greater challenges and barriers to accessing treatment and support services. The scale of the problem is likely underestimated due to language and cultural barriers, and reluctance in some communities to speak about the AOD use due to stigma and cultural taboos.[86]

4.67 In instances where CALD individuals do seek help, current AOD services are said to lack culturally appropriate interventions and support systems. In its submission, Drug ARM, which provides mental health, AOD awareness, rehabilitation and management programs, reported 'having to turn away non-English speaking clients due to lack of funding for interpreter services'.[87]

4.68 NCYSUR further highlighted similar barriers for the CALD population:

> Research demonstrates that this lack of cultural tailoring results in distrust towards health services, decreased engagement, reduced self-efficacy in managing health, and poorer health outcomes. Limited availability of interpreter services, particularly in regional areas, combined with insufficient multilingual resources can lead to delayed or inadequate treatment for non-English speaking individuals seeking help.[88]

Gay, lesbian, bisexual, transgender or intersex people

4.69 Sexuality and gender diverse people continue to be a priority population in many state and federal alcohol and other drug strategies. According to ACON, an HIV and LGBTQ+ health organisation, there is a higher prevalence of AOD use, riskier use, and higher proportion of people accessing treatment within the lesbian, gay, bisexual, transgender, intersex and queer (LGBTIQ+) community compared to the general population.[89]

4.70 LGBTIQ+ people typically underutilise health services and delay seeking treatment. ACON explained:

> The challenges that arise for LGBTQ people access health services, including AOD support, encompass a lack of cultural safety and inclusivity, fear of stigma relating to their gender and/or sexuality, compounded by multiple minority status such as Aboriginality, HIV status, disability or cultural background, the stigma associated with AOD use, and, in addition, the belief that AOD services lack appropriate expertise to treat LGBTQ people.[90]

86 NCYSUR, *Submission 120*, p. 11.
87 Drug ARM, *Submission 44*, p. 1.
88 NCYSUR, *Submission 120*, p. 11
89 ACON, *Submission 30*, p. 3.
90 ACON, *Submission 30*, pp. 3-4.

4.71 In their submissions, researchers from the Australian Research Centre in Sex, Health and Society at La Trobe University noted that AOD services do not adequately meet the demand for specialist LGBTIQ+ service provision.[91] ACON further explained that many services in the community are run by faith-based organisations, and 'while the work of these organisations is admirable, accessing such services can be challenging for members of the LGBTIQ+ community for fear of discrimination'.[92]

4.72 The Committee also heard evidence that mainstream services are generally not set up for the LGBTIQ+ population, which was reflected, for example, in residential rehabilitation programs often being segregated by gender. This approach is said to make these programs unsafe for some trans and gender diverse people.[93]

4.73 Similar to other population cohorts, there is a strong preference among LGBTIQ+ people for tailored support and tailored services, which produce better outcomes than mainstream AOD services. According to ACON, '[p]art of this is due to an inherent recognition of the unique profile and patterns of use within sexually and gender diverse communities, which may lead to different treatment needs and responses'.[94]

Pregnant women and their partners

4.74 FASD describes a range of neuro-developmental impairments. It is recognised as a lifelong disability, which impacts the brain and body of individuals who were prenatally exposed to alcohol.

4.75 In recognition of the harm caused by alcohol use during pregnancy, the National Drug Strategy contains a specific sub-strategy that focuses on FASD as a major alcohol-related form of harm for pregnant women and their children. Some state and territory AOD strategies also identify pregnant women and their partners as a priority population within the context of AOD harm reduction efforts.[95]

4.76 Multiple submissions noted that, while there is a level of awareness of the health risks associated with drinking during pregnancy, and before confirmation of pregnancy, public education in this area needs to be further enhanced. Mrs Sophie Harrington, Interim Chief Operating Officer of the National Organisation for Fetal Alcohol Spectrum Disorders stated:

> The Australian Department of Health and Aged Care should be applauded for their commitment to the implementation of the National FASD Strategic Action Plan. However, FASD prevention and training must be embedded into the national AOD framework. Universal screening for alcohol use in pregnancy, sustained public awareness campaigns and culturally safe education programs tailored to at-risk communities are essential. FASD informed care must be implemented across AOD services … with treatment models adapted to

91 Professor Seear, *Submission 33*, page 10.
92 ACON, *Submission 30*, p. 4; Alcohol, Tobacco and Other Drugs Council Tasmania, *Submission 22*, p. 6.
93 ACON, *Submission 30*, p. 4.
94 ACON, *Submission 30*, p. 4.
95 Alcohol, Tobacco and other Drugs Council Tasmania, *Submission 22*, p. 5.

> recognise the approaches required to support individuals with a brain based disability rather than continuing cycles of ineffective rehabilitation.[96]

4.77 Although the focus tends to be placed on mothers in the context of FASD, the National Drug Research Institute (NDRI) highlighted that father's alcohol consumption has a direct impact on pregnancy and child outcomes through sperm development and biological changes to the foetus. These impacts include increases in spontaneous abortion, stillbirth, low gestational birth age, congenial heart disease, lymphoblastic leukaemia, and intellectual developmental disorders.

4.78 NDRI further drew the Committee's attention to a male partner's role in social facilitation of maternal drinking, noting that women were more likely to drink alcohol during pregnancy if their male partners consumed alcohol. According to NDRI research, Australian pregnant women tend to drink in their own home, with over 75 per cent of pregnant women drinking with their partner, and male partners initiating 40 per cent of drinking occasions. In reflecting on the evidence, NDRI suggested that:

> Decisions about alcohol use during pregnancy are not solely made by women but also involve their male partner. Therefore, social facilitation of maternal drinking leading to alcohol exposed pregnancies is an important prevention strategy.[97]

4.79 The Committee heard that there are presently significant challenges associated with obtaining correct diagnoses for FASD, as well as supporting individuals living with FASD in an optimal manner. In sharing her experience of living with FASD, Ms Jessica Birch told the Committee:

> Time today doesn't actually allow me to fully communicate the difficulty, confusion, humiliation and profound emotional pain of living with undiagnosed FASD or the many, many years of physical and mental illness during my journey to diagnosis, throughout which I was often blamed for my functioning, denied referral, gaslit, scoffed at and regularly dismissed and belittled by the medical professionals from whom I was seeking help, nor can I fully detail the ongoing challenges I face today in accessing informed health care and informed NDIS support. Suffice to say, had my mother not intervened in my health care or had I not received the family support that I did, it is arguable that I would be a living, breathing person in front of you today, such was the deterioration of my physical health and the severity of my despair.[98]

4.80 Ms Angelene Bruce, whose son is diagnosed with FASD, outlined similar challenges in obtaining correct diagnosis:

> My son's first misdiagnosis was also moderate autism, even with his high risk exposure having been disclosed—they were told. I challenged that with a second

---

96 Mrs Sophie Harrington, Interim Chief Operating Officer, National Organisation for Fetal Alcohol Spectrum Disorders (NOFASD), *Proof Committee Hansard*, Canberra, 7 February 2025, p. 15.

97 National Drug Research Institute, *Submission 141*, n.p.

98 Ms Jessica Birch, private capacity, *Proof Committee Hansard*, Canberra, 7 February 2025, p. 15.

> opinion, and he was formally diagnosed with FASD at four, so he was really young. He also lives with extremely high anxiety and low confidence. I thought the correct diagnosis would open many doors to appropriate FASD-informed allied health services and I wouldn't have to disclose again. Sadly, this was not the case as, whilst ASD is broadly known by the public and extensively studied by allied health and medical students across Australia, FASD is not, even though it is the largest spectrum of non-genetic disability in this country.[99]

4.81 QNMU drew the Committee's attention to the challenge that women with children face in accessing AOD support. The lack of women-only rehabilitation facilities that allow children to accompany their mothers can deter women from seeking treatment due to concerns about childcare and the fear of intervention from child protection services.[100] QNMU submitted that there was a value in exploring alternative models of care for public detox and rehabilitation services. This could include home detox programs with appropriate staffing by nurses and other healthcare professionals to provide daily support and monitoring as an option for low-risk individuals.[101]

Workforce

4.82 Australia's AOD workforce comprises specialist and generalist staff. Specialist AOD workers, whose core role involves preventing and responding to AOD harm, include nurses, social workers, doctors, peer workers, NSP workers, prevention workers, addiction medicine specialists and specialist psychologists and psychiatrists. More generally, many non-AOD-related roles can prevent and minimise AOD harm, such as, for example, emergency medicine staff, general practitioners, or pharmacists.[102]

4.83 Throughout the inquiry, witnesses repeatedly highlighted the nation-wide shortage of specialists working in the AOD field. This is the case, for example, in the field of addiction medicine, which involves the provision of medical care to people with substance use and addiction disorders, including drug and alcohol addiction and pharmaceutical dependency.[103] According to a 2021 audit of the Australian Fellows in the Chapter of Addiction Medicine, this area faced a significant challenge as the majority of addiction specialists were close to retirement age.[104]

4.84 Within the AOD workforce, psychiatrists serve as both generalists and addiction subspecialists, as RANZCP explained in its submission. RANZCP drew the Committee's attention to a 'chronic and severe psychiatry workforce shortage in Australia' that also accounted for the undersupply of addiction psychiatrists within the AOD sector.[105]

---

99 Ms Angelene Bruce, private capacity, *Proof Committee Hansard*, Canberra, 7 February 2025, p. 17.
100 QNMU, *Submission 34*, p. 9.
101 QNMU, *Submission 34*, p. 9.
102 Department of Health and Aged Care (2014), *National Alcohol and other Drug Workforce Development Strategy 2015-2018*, p. 6.
103 Australian Medical Association, *Submission 80*, p. 3.
104 Dr Simon Holliday, *Submission 9*, p. 5.
105 RANZCP, *Submission 19*, p. 4.

4.85 Multiple submissions asserted that the specialist AOD workforce is in short supply throughout the nation, and especially in rural and remote Australia. As a result, AOD care is often transferred to general practitioners or emergency departments, which do not always have the capacity or expertise to manage AOD patients.[106]

4.86 The Australasian College for Emergency Medicine (ACEM) noted that identifying and responding to AOD related harm accounts for a significant proportion of the emergency department (ED) workload, as EDs often serve as default entry points into the healthcare system. Emergency physicians are responsible for providing the initial response during the acute intoxication phase and have a significant role minimising harm from AOD through identification, assessment and referral of patients with AOD problems.[107]

4.87 ACEM highlighted, however, that the lack of capacity within the AOD workforce generates a rise of AOD crisis presentations in EDs, and creates substantial strain on the emergency medicine workforce:

> EDs experience a surge in patient presentations and alcohol and drug-related incidents, overdoses, injuries and mental health crisis during peak times, typically on weekend nights and public holidays. These higher presentation numbers add strain to ED capacity, resourcing and staff stress. Treating these patients is resource and time intensive.[108]

4.88 There may also be some reluctance among the generalist workforce to take on AOD patients due to the complexity of their presentations.[109] This reluctance is, in part, related to a lack of knowledge about AOD among medical and nursing staff. As Australian College of Nurse Practitioners explained in its submission, generalist staff:

> receive a limited amount of drug and alcohol education as part of their preparation for practice and as a result, they can have negative attitudes and stereotyped perceptions of persons experiencing drug and alcohol problems … The integration of a substance misuse component in the undergraduate and postgraduate curriculum is essential. Interdisciplinary and multidisciplinary education programs and mentorship are also key to developing a health workforce ready to provide contemporary best practice.[110]

4.89 The National Centre for Education and Training on Addiction (NCETA) echoed this point, noting that there is limited exposure to AOD content in tertiary-level qualifications 'for workers seeking AOD-related career pathways, let alone for all the workers who are highly likely to engage with clients impacted by AOD use, such as psychology, nursing, and social work'.[111] This lack of AOD related content made it

---

106 QNMU, *Submission 34*, p. 8; Health and Community Services Union, *Submission 46*, p. 11; QNADA, *Submission 75*, p. 12.

107 Australasian College for Emergency Medicine (ACEM), *Submission 95*, p. 1.

108 ACEM, *Submission 95*, p. 2.

109 Australian College of Nurse Practitioners, *Submission 4*, n.p.

110 Australian College of Nurse Practitioners, *Submission 4*, n.p.

111 National Centre for Education and Training on Addiction (NCETA), *Submission 43*, p. 3.

challenging, NCETA argued, 'to attract new entrants to the sector and to counter stigmatised attitudes toward AOD in the broader health workforce'.[112]

4.90 The Salvation Army similarly recommended embedding AOD treatment and support education within undergraduate programs for nursing, medicine and social work. The organisation emphasised that early exposure to AOD training 'may also go some way to establishing clear succession plans for specialists in AOD treatment by exposing junior staff early enough to this specialist area'.[113]

4.91 The Matilda Centre further explained that there is no national accreditation body for AOD workers. Minimal qualification standards for AOD workers have been implemented in select jurisdictions only. While some specialist AOD workers are registered under the Australian Health Practitioner Regulation Agency, the most recent national AOD workforce survey indicates that less than half of workers have AOD related qualifications at a vocational or tertiary level.[114]

4.92 An aging specialist workforce, combined with insufficient exposure to AOD training that would attract younger cohorts to specialise in the field has hindered efforts to develop a sustainable AOD workforce in Australia. The capacity of this workforce has also been undermined by the current funding model for the sector, which perpetuates employment uncertainty and precarity.[115]

4.93 In reflecting on AOD workforce challenges, ADF noted that the 'AOD sector is staffed by a dedicated workforce, but jurisdictional workforce surveys show that many AOD workers are experiencing job insecurity and low remuneration'. According to these findings:

> Up to 25% of workers across Australia feel that there is at least a medium chance that they could lose their job within the next 12 months. Up to 75% of AOD workers are earning less than jurisdictional average salaries. Job insecurity and low remuneration are often cited by both AOD workers and employers as reasons for leaving the AOD sector as well as challenges for recruiting and retaining staff.[116]

4.94 To address the current situation, multiple organisations have called for an urgent renewal of the National Alcohol and Other Drug Workforce Development Strategy 2015-2018, which was one of the sub-strategies under the National Drug Strategy 2017-2026, but which has not been renewed since it lapsed in 2018.[117]

4.95 In addition to renewing the AOD workforce strategy, it was impressed upon the Committee that there are many current opportunities for addressing shortages in the AOD workforce by mobilising, enabling, and upskill staff from other areas. The

---

112 NCETA, *Submission 43*, p. 3.
113 The Salvation Army, *Supplementary submission 61.1*, p. 4.
114 The Matilda Centre, *Submission 24*, pp. 6-7.
115 The Matilda Centre, *Submission 24*, pp. 5-6; NCETA, *Submission 43*, p. 2.
116 ADF, *Submission 77*, pp. 17-18.
117 Department of Health and Aged Care (2014), *National Alcohol and Other Drug Workforce Development Strategy 2015–2018*; NCETA, *Submission 43*, p. 3; ADF, *Submission 77*, p. 18.

Australian College of Nurse Practitioners noted, for example, that nurse practitioners who work with patients experiencing AOD problems can support them through withdrawal, prescribe pharmacotherapy and facilitate access to counselling services. Patients of nurse practitioners, however, have restricted access to the national Medicare Benefits Schedule (MBS) and the Pharmaceutical Benefits Scheme (PBS), which means that some medications and services requested by nurse practitioners may require patients to pay full costs. This model, consequently, hinders nurse practitioners to support AOD clients.[118]

4.96 QNMU acknowledged that recent addition of an MBS item for nurse practitioners conducting long assessment—which are necessary in the AOD context—is a positive step in recognising the role of nurses in this area. QNMU insisted, however, that MBS system overall failed 'to adequately recognise and remunerate the valuable work of nurses and midwives in the field of AOD'. QNMU added that there is a need within MSB 'for more targeted items that incentivise primary health clinicians to engage in AOD screening, assessment, and prevention activities'.[119]

4.97 The Salvation Army echoed some of these concerns and emphasised that general practitioners and nurse practitioners should be better incentivised to work in the AOD service. This should be the case in particular in the context of service models that work with community members 'who are harder to reach or experiencing greater disadvantage'.[120]

4.98 Reflecting on the shortage of psychologists working in the AOD field, the AAPI suggested an expansion of MBS eligibility to provisional psychologists as a measure that could meet some of the demand for psychology services. As APPI explained, provisional psychologists are at a minimum, four or five-year educated psychologists embarking on a final period of supervised practice, overseen and mentored by a qualified psychologist. They have studied each of the competencies required for registration and are gaining relevant experience and supervision to meet full registration requirements. An expansion of Medicare rebate to provisional psychologist would see an 8,000 additional staff enter the system.[121]

4.99 According to the Pharmacy Guild of Australia (the Guild), pharmacists too can play a role in improving the capacity of the AOD sector. Community pharmacies are, the Guild submitted, no longer 'just a place to go to get a prescription dispensed or to get a non-prescription medicine or free advice to manage common ailment', but rather a space that can offer multiple services.[122] As such, the Guild advocated for an enhanced capability of pharmacists to manage alcohol, nicotine and other drug use where appropriate.[123]

---

118 Australian College of Nurse Practitioners, *Submission 4*, n.p.
119 QNMU, *Submission 34*, pp. 11-12.
120 The Salvation Army, *Supplementary submission 61.1*, p. 3.
121 AAPI, *Submission 4*, pp. 3-4.
122 The Pharmacy Guild of Australia, *Submission 52*, p. 8.
123 The Pharmacy Guild of Australia, *Submission 52*, p. 8.

4.100 Throughout the inquiry, the relationship between AOD and mental health disorders emerged as a common theme and was frequently raised in relation to the sustainability of the AOD workforce. In its submission, Mind Australia Limited supported greater integration between mental health and AOD service provision in recognition of the fact that there is a 'bi-directional relationship between mental health and AOD use', adding that:

> Best practice AOD treatment, prevention and workforce training should similarly acknowledge the frequent co-occurrence of these challenges. Regardless of whether an individual's use meets the criteria for an AOD use disorder, people with mental health challenges and their families are vulnerable to the effects of AOD use and the subsequent impact this can have on their health and lives.[124]

4.101 Reflecting on the need for a multidisciplinary approach to AOD, ACEM submitted that some hospitals have begun to invest in reorienting EDs to include models of care that integrate specialist expertise in mental health, emergency medicine, and drugs and alcohol. Some examples include:

- the Psychiatric and Non-prescription Drug Assessment (PANDA) Unit at St Vincent's Hospital Sydney in New South Wales
- the Mental Health Observation and Assessment (MHOA) Units and Urgent Care Centres (Toxicology) in Western Australia
- the Alfred Mental Health Service at the Alfred Hospital in Victoria.

These models are multidisciplinary in their staffing mix, targeted to manage the health effects of drug and alcohol use while also reducing the risks related to aggression and violence in the ED.[125]

4.102 In recognising the need to increase mental health capability in the AOD sector, the Commonwealth Department of Health and Aged Care invested in the development and dissemination of *Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment setting* (the Guidelines). The Guidelines are accompanied by resources to facilitate their update intro practice, including a website, an online self-paced and skill-based training program, an online community of practice, an organisational implementation toolkit and the first National Practice Standards for co-occurring conditions, which will be available in 2025.[126]

4.103 While many of those who contributed to the inquiry emphasised the need for better coordination between the areas of mental health and AOD care, some witnesses called for a cautious approach to service integration, highlighting that AOD's unique characteristics and complexities necessitated its establishment as a distinct speciality area. QNMU noted that there has been a trend to view AOD as a subspeciality within the broader field of mental health, even though the AOD sector has developed its

---

124 Mind Australia Limited, *Submission 138*, p. 4.
125 ACEM, *Submission 95*, p. 3.
126 The Matilda Centre, *Submission 24*, p. 7.

own expertise and workforce separate from mental health. QNMU warned, '[m]erging AOD into mental health risks overlooking or "diluting" this distinct body of knowledge and expertise'.[127]

4.104 Evidence presented in the course of this inquiry indicates that an integrated model of care is essential for effectively servicing AOD clients, whose needs are often complex and interconnected. While coordination between AOD and mental health service providers is important, witnesses suggest that integration should extend further to include, for example, domestic violence services, employment support, Centrelink assistance, and community engagement programs.[128] As highlighted in the Salvation Army's submission, such a comprehensive approach would likely best be achieved through 'cross-sector partnerships, co-location of services and specialists and the development of cross-sector training loops'.[129]

Peer workforce

4.105 Much of the evidence presented in support of this inquiry foregrounded the importance of attracting people with lived or living experience of AOD use into the sector workforce. The Australian Research Centre in Sex, Health and Society submitted that 'employing people with lived and living experience in the AOD sector contributes to more effective services and better outcomes for people accessing services, their families, supporters and communities'.[130]

4.106 Multiple witnesses discussed in particular the vital role peer workers have in supporting priority populations. The IUIH explained, for example, that peer workforce referred to an Aboriginal and Torres Strait Islander health or support worker, a health support worker with lived or living experience of substance use, or a health or support worker who both identifies as Aboriginal and Torres Strait Islander and has experience of substance use. This workforce is seen as being central in shaping a culturally safe AOD service provision for Aboriginal and Torres Strait Islander communities, across both Indigenous-led and within mainstream services.[131]

4.107 In highlighting the importance of First Nations AOD peer workforce, NACCHO advocated for a systemic workforce development and support for this staff, including through establishment of a national professional body for Aboriginal and Torres Strait Islander AOD workers; peak body for Aboriginal and Torres Strait Islander controlled AOD services; and Aboriginal Identified AOD Worker positions. NACCHO submitted

---

127 QNMU, *Submission 34*, p. 5.

128 Network of Alcohol and Other Drugs Agencies, *Submission 46*; National Women's Safety Alliance, *Submission 47*; Professor Seear, *Submission 33*; The Salvation Army, *Submission 68*; Dr Paul Clark, Director, Alcohol and Drug Assessment Unit, Princess Alexandra Hospital, Brisbane, *Proof Committee Hansard*, Canberra, 7 February 2025.

129 The Salvation Army, *Submission 68*, p. viii.

130 Professor Seear, *Submission 33*, p.10.

131 IUIH, *Submission 155*, p. 6; NIAA, *Submission 140*, p. 8; Australian Medical Association, *Submission 80*, p. 4.

training should be strengthened in this area, along with promotion of AOD work as a career of choice for Aboriginal and Torres Strait Islander people.[132]

4.108 Students for Sensible Drug Policy similarly asserted that peer-led harm reduction services are highly effective among young people, as peer workers are perceived to be 'credible, legitimate, approachable, and trustworthy by the communities the services are designed to support'.[133] Peer workers are said to present a vital point of contact for people who require support but feel uncomfortable approaching medical staff, police, security or other services.[134] ACON similarly suggested that in the context of LGBTIQ+ AOD services, 'peer-led interventions typically allow for an earlier entry point into interventions and services via brief, peer-led, non-judgemental intersections that encourage people to consider reducing their use'.[135]

4.109 While employing people with lived experience in the AOD sector is thought to promote better health outcomes, according to the Australian Research Centre in Sex, Health and Society, efforts to resource and support the needs of this unique workforce remained underexplored. Existing research suggests that a high prevalence of lived and living experience workers in the AOD sector in Australia face stigma and discrimination. There are also a series of inherent legal and other risks associated with this employment.[136]

4.110 With a view to better supporting the AOD peer workforce, NCETA is currently developing a National Harm Reduction Peer Workforce Framework in collaboration with the Australian Injecting and Illicit Drug Users League (AIVL). This initiative aims to provide information and guidance for people working in peer positions and organisations considering or already employing peer workers.[137]

Family support

4.111 Engaging family, friends, carers and the wider community is vital in supporting the recovery and ongoing wellbeing of individuals experiencing AOD related harm.[138] Achieving such support, however, can be very challenging.

4.112 While being a major source of support, as ADF noted, family and friends are themselves impacted by their loved one's AOD use.[139] Family Drug Support submitted that families and friends actively conceal their AOD issues, in fear both for the person they care about, and for being judged by the broader community. AOD-related shame and stigma is ultimately not specific to the people who use AOD, but extends its negative effects toward their immediate circle and networks.[140]

---

132 NACCHO, *Submission 145*, p. 14.
133 Students for Sensible Drug Policy Australia, *Submission 59*, p. 18.
134 Students for Sensible Drug Policy Australia, *Submission 59*, p. 18.
135 ACON, *Submission 30*, p. 5.
136 Professor Seear, *Submission 33*, pp. 10-11.
137 NCETA, *Submission 43*, p. 3.
138 RANZCP, *Submission 19*, p. 5; Family Drug Support, *Submission 5*, p. 4.
139 ADF, *Submission 77*, p. 11.
140 Family Drug Support, *Submission 5*, p. 2.

4.113 Mental Health Families and Friends Tasmania highlighted the fact that carers of those suffering AOD harm often experience social exclusion, as they do not, for example, go on holidays, participate in social activities, or cultivate other relationships as a result of 'the hypervigilance they experience to be ready for crisis and the unpredictability of their loved one's addition'.[141] Many families of AOD users experience significant financial hardship, often associated with legal or drug debts, rehabilitation costs, and reduced hours of work.

4.114 In discussing the impact of her brother's alcohol use disorder, Ms Taylor submitted:

> I feel that Richard's alcoholism put my life on hold. He went to rehab nine (9) times before he died, some stints were 4 weeks long, his longest was 8 months long. It was ALL consuming. It was very hard to live a full life when you are on the rollercoaster.[142]

4.115 In seeking to recognise the work undertaken by friends and families of those who suffer from AOD harm, and the unique impact that AOD use has on this cohort, the Royal Commission into Victoria's Mental Health System recommended creating a number of dedicated family and friends hubs to address the needs of this vital, but often invisible, cohort.[143] In Tasmania, carers of people who have an AOD dependence are formally recognised in the *Carer Recognition Act 2023* (Tas), the only Australian jurisdiction which does this.[144]

Committee comments

4.116 The Committee acknowledges the substantial unmet demand for AOD services across Australia and emphasises that no single approach can adequately address the diverse needs of those seeking support. A flexible and responsive model of care is essential for ensuring that meaningful and effective assistance is received by individuals experiencing AOD-related issues. The sustainability of the AOD workforce—encompassing generalists, specialists and those with lived and living experience—presents significant challenges that require careful attention. The Committee also recognises that AOD-related harm extends far beyond the individual, profoundly affecting families and support networks in enduring ways. Supporting these often-overlooked caregivers and family members must be an integral part of any comprehensive response to the AOD challenge.

141 Mental Health Families and Friends Tasmania, *Submission 27*, p. 3.
142 Ms Taylor, *Submission 11*, p. 1.
143 Family Drug Support, *Submission 5*, pp. 2-3.
144 Carers Tasmania, *Submission 39*, p. 5.

5. Preventing and reducing harm caused by alcohol and other drugs

5.1 In examining the submissions received by this Committee, there are a range of issues relating to alcohol and other drug (AOD) that a future Committee might consider. The issues include:

- The regulation, marketing, access to alcohol
- Education about AOD for families and schools
- Public health campaigns
- The stigma associated with accessing AOD services
- The utility of drug checking services
- Supervised injecting centres and needle and exchange programs
- Take home naloxone programs
- Opioid dependence treatment programs
- Diversion initiatives
- AOD screening
- Decriminalisation initiatives, such as those in the ACT

These issues are often highly contested, and it will be important that the Committee receives submissions from a wide range of stakeholders to test evidence on these issues before coming to conclusions, if any.

Addressing the stigma

5.2 According to the World Health Organization, alcohol and illicit drug use are among the most stigmatised health conditions globally.[1] Throughout the inquiry, witnesses stressed that stigma is a major barrier to the access of both general health care and AOD services. For individuals experiencing AOD-related harms, stigma associated

[1] Windana, *Submission 50*, p. 5.

with substance use impacts not only their health, but extends to all aspects of their lives, such as employment prospects and social connectivity.[2]

5.3 Professor Dan Lubman AM, Executive Clinical Director at Turning Point and Director of the Monash Addiction Research Centre emphasised the negative impact of AOD-related stigma:

> Everyone knows someone who is struggling with alcohol or drug use, because one in four Australians will. They are our friends, family and colleagues. But roughly half a million people aren't accessing the treatment, care and support they need, with individuals not knowing where to go for help and families not knowing how to support their loved ones. That's largely because addiction is one of the most stigmatised health conditions in the world. People internalise stigma and shame, which causes them to hide their use and delay help seeking.[3]

5.4 The Queensland Network of Alcohol and other Drug Agencies (QNADA) further asserted that AOD-related stigma is not exclusive to people who use AOD, but that it also impacts their family members, friends and communities. This situation has a detrimental impact on people directly experiencing AOD-related harm, QNADA explained, as it 'commonly results in a weakened support network, which further impedes their ability to initiate better health outcomes'.[4]

5.5 The origin of the stigma associated with the use of illicit drug and alcohol dependence remains a matter of debate. The Alcohol and Drug Foundation (ADF) submitted that this attitude is 'wrapped up in a complex history that incorporates religious influences, racism, marginalisation, criminalisation, economic pressures, fear, politics and the influence of powerful individual actors in critical times and places'.[5]

5.6 ACON further suggested that there is 'a direct relationship between policy and stigma, with more punitive policy associated with higher level of stigma'.[6] Citing research conducted for the Queensland Mental Health Commission, QNADA said that AOD-related stigma and discrimination often stems from the fact that personal illicit drug use remains a criminal offence.[7]

5.7 Witnesses expressed particular concern regarding the stigma that exists in the healthcare system towards people who use drugs. ACON informed the Committee that people who inject drugs report high levels of stigma, particularly in healthcare settings, with two thirds delaying or not attended health appointments to avoid being treated negatively by health workers.[8] According to one survey, 86 per cent of the

---

2 Windana, *Submission 50*, p. 5; Queensland Network of Alcohol and Other Drugs (QNADA), *Submission 75*, p. 19.

3 Professor Dan Lubman AM, Executive Clinical Director, Turning Point, Eastern Health; Director, Monash Addiction Research Centre, *Committee Hansard*, Melbourne, 29 October 2024, p. 9.

4 QNADA, *Submission 75*, p. 19.

5 Alcohol and Drug Foundation (ADF), *Submission 77*, p. 11.

6 ACON, *Submission 30*, p. 7.

7 QNADA, *Submission 75*, p. 19.

8 Professor Carla Treloar, *Submission 31*, p. 1.

general public and 56 per cent of healthcare workers self-report their own negative attitudes towards people who inject drugs.[9]

5.8 ACON highlighted that AOD-related stigma is further amplified for cohorts that are experiencing additional social pressures or forms of exclusion, 'such as people with HIV, Aboriginal and Torres Strait Islander People, LGBTQ+ people, sex workers, people who have been incarcerated, people experiencing mental distress, people living with disabilities and people who experience homelessness'.[10] Professor Lubman similarly foregrounded the need to consider the intersectional impact of stigma in efforts to address barriers that might prevent people from seeking help.[11]

5.9 Much of the evidence submitted to this inquiry suggests that a lack of knowledge about AOD often drives stigmatised attitudes, and presents a major impediment to cross-sector collaboration in tackling AOD harm. To raise knowledge levels about AOD and create a stronger basis for the integration of services, the National Centre for Education and Training on Addiction (NCETA) has developed resources to enhance the capacity of other sectors to identify and respond to AOD-related harms, such has the Screening and Withdrawal Tools Collection, and the National Alcohol and Drug Knowledgebase.[12]

5.10 Throughout the inquiry, the Committee was urged to conder the use of language and its potential to perpetuate stigma and cause harm. The Australian Research Centre in Sex, Health and Society highlighted the need to move away from language that is thought to be stigmatising, such as 'substance abuse', 'substance misuse', 'recovery', 'addiction', 'addict', and 'substance use disorder'.[13] Language that was inaccurate or dehumanising, the ADF further argued, is a major contributor to stigmatisation.[14]

5.11 The UNSW Drug Policy Modelling Program further explained that the use of the term 'recovery' was not consistent with the evidence demonstrating 'the journey in and out of substance use over a lifetime'.[15] Similarly to chronic medical conditions, AOD treatment is a lifelong commitment to behavioural change, and in many cases also the use of medications, with a majority of people requiring multiple treatment episodes before changing their relationship with substances.[16]

5.12 In its submission, the Foundation for Alcohol Research and Education (FARE) recommended the development of government communication guidelines aimed at avoiding the use of stigmatising and blame-apportioning language. Such guidelines, FARE suggested, should build on examples such as *Guidelines for communicating*

---

9 ACON, *Submission 30*, p. 7.

10 ACON, *Submission 30*, p. 7; See also Mind Australia, *Submission 138*, pp.4-5; Windana, *Submission 50*, p. 5.

11 Professor Lubman AM, Turning Point, Eastern Health; Monash Addiction Research Centre, *Committee Hansard*, Melbourne, 29 October 2024, p. 17.

12 National Centre for Education and Training on Addiction (NCETA), *Submission 43*, p. 4.

13 Professor Kate Seear, *Submission 33*, p. 2.

14 ADF, *Submission 77*, p. 11.

15 Drug Policy Modelling Program, UNSW, *Submission 17*, p. 2.

16 Drug Policy Modelling Program, UNSW, *Submission 17*, p. 2.

about alcohol and other drugs, developed by Mindframe (a national program for safe media reporting about suicide, mental health and AOD) and *Language matters*, published by the Network of Alcohol and Other Drugs Agencies (NADA).[17]

5.13 The Australian Research Centre in Sex, Health and Society pointed out that drugs are routinely depicted as 'self-evident problems', 'generating a range of problems including criminal behaviour, illness, injury and death. The notion that drugs are inherently harmful is both commonplace and taken-for-granted in much policy'.[18] These entrenched views about AOD, the Centre argued, stigmatise people who consume AOD and also obscure the fact that in many cases AOD use does not produce harm.[19]

5.14 Law enforcement entities, according to QNADA, can perpetuate stigma and discrimination towards people who use drugs, especially through their engagement with media around illicit drug seizures. An examination of how Australian news media depicted illicit drug stories between 2003 and 2008 revealed that reporting on these matters was heavily biased towards a 'crime and deviance' narrative.[20] Reframing of this narrative, witnesses suggested, had a major role to play in reducing the AOD-related stigma, and by extension, increasing readiness of individuals to seek support.

5.15 In reflecting on ways to address AOD-related stigma, Windana—which supports people experiencing AOD harms—called for a public health campaign aimed at destigmatising drug consumption. Any such campaign would draw upon experience from previous successful health campaigns, including those designed to destigmatise mental health issues. The organisation further recommended the development of a comprehensive Australian Stigma Reduction Strategy.[21]

Decriminalisation of personal drug use

5.16 Responsibility for the oversight, development, implementation and monitoring of Australia's national illicit drugs policy framework is shared between the Department of Health and Aged Care, Australian Border Force, and the Attorney-General's Department (AGD). The AGD is responsible for the administration of criminal justice and law enforcement policy, including administering Commonwealth illicit drug use offences under the *Commonwealth Criminal Code Act 1995* and *Criminal Code Regulation 2019*, as well as administering Commonwealth courts and tribunals. States and territories have primary responsibility for laws governing the possession and use of illicit drugs within their jurisdictions. This includes laws relating to decriminalisation or legalisation, and supply, demand and harm reduction.[22]

---

17 Foundation for Alcohol Research and Education (FARE), *Submission 87*, p. 13.
18 Professor Seear, *Submission 33*, pp. 5-6.
19 Professor Seear, *Submission 33*, p. 7.
20 QNADA, *Submission 75*, p. 16.
21 Windana, *Submission 50*, pp. 2; 5-6.
22 Department of Health and Aged Care, *Submission 157*, p. 14.

5.17 Throughout the inquiry, the Committee heard substantial evidence pertaining to the extent to which the current legal framework impacts Australia's ability to effectively address the harmful consequences of AOD use. Multiple witnesses submitted that drug criminalisation had little effect on the availability of illicit substances, and that it could, in fact, elevate the risk of harm related to drug use.[23] According to the Australian Research Centre in Sex, Health and Society:

> the law plays a central role in generating, magnifying, exacerbating (and thus ameliorating) AOD-related harms. It does so in several ways, including through laws that criminalise drug use, possession and supply, thus exposing people to criminalisation and stigma, incarceration and social exclusion. In this sense, criminal laws exacerbate social disadvantage and generate other social problems, such has the persistent effects of criminal records on employment, housing, welfare and so on.[24]

5.18 ACON submitted that there is growing evidence to support a shifting of focus away from the law enforcement response, 'especially with regard to communities disproportionately impacted by policing, including LGBTQ+ people, but also First Nations communities and people experiencing complex mental distress'.[25] In its submission, Healthy Cities Illawarra drew attention to the findings of the Johns Hopkins-Lancet Commission on Drug Policy and Health, which concluded that there was no evidence that the threat of imprisonment was an effective deterrent against drug use.[26]

5.19 Concerns were expressed in multiple submissions regarding the use of drug detection dogs as part of the law enforcement response. Police dog deployment can be particularly traumatising to certain populations. Students for Sensible Drug Policy further noted that their presence can also trigger 'panic consumption'—use of greater amount of substance than the person intended in order to avoid detection—which further increases the risk of harm.[27]

5.20 According to data from the Australian Criminal Intelligence Commission (ACIC), drug markets are continuing to expand, with law enforcement seizures increasing by 39 per cent over the past 10 years. ADF submitted that relatively few arrests for drug-related offences relate to supply, with ACIC data revealing that of the 140,624 national drug arrests in 2020-21, 87 per cent were for personal use.[28]

5.21 Many witnesses expressed strong support for the decriminalisation of personal drug use. ADF explained that:

> Decriminalisation of personal drug use refers to the removal of criminal sanctions for individuals in possession or using illicit substances, or in possession of

---

23 QNADA, *Submission 75*, p. 19; ACON, *Submission 30*, p. 8.
24 Professor Seear, *Submission 33*, p. 12.
25 ACON, *Submission 30*, p. 8.
26 Healthy Cities Illawarra, *Submission 133*, p. 2.
27 Students for Sensible Drug Policy, *Submission 59*, p. 7; See also ACON, *Submission 30*, p. 8.
28 ADF, *Submission 77*, p. 7.

> paraphernalia to use illicit substances. Decriminalisation differs from the regulation or legalisation of illicit drugs, as the supply, trafficking, and production of illicit drugs remains criminalised. This provides the person using illicit substances better access to health services, while law enforcement continues to disrupt the supply and production of illicit drugs.[29]

The decriminalisation approach, as ADF further noted, is based upon a recognition that personal drug use inevitably takes place, and that, as such, a health rather than justice response is a more effective and appropriate way to reduce associated harms.[30]

5.22 QNADA echoed this point, explaining that:

> Across the world, countries which have embarked on reform decriminalising illicit drug use and emphasising health-based responses have witnesses decreased drug-related harms and deaths and declines in costs to law enforcement and criminal justice system, all without a comparable increase in illicit drug use. These benefits are particularly realised where illicit drug decriminalisation occurs with concurrent investment in the health system.[31]

5.23 Some states and territories have moved towards the decriminalisation of drugs for personal use. In 2020, the Australian Capital Territory (ACT) introduced legislation to remove criminal penalties for the possession and cultivation of small amounts of cannabis for personal use. A recent review found that in the time that has since elapsed, there has been no significant change in cannabis use prevalence, ambulance or hospital admissions related to cannabis, or in the price and availability of cannabis.[32] In October 2023, the ACT Government decriminalised the personal possession of small amounts of the most commonly used illicit drugs, including amphetamines, cocaine, heroin and some hallucinogens. The reforms did not change laws regarding supply and manufacture of drugs, nor did they alter drug driving laws.[33]

5.24 In May 2024, the Police Drug Diversion Program in Queensland, which originally only applied to minor drug offences including cannabis, was expanded to include a wider range of personal use drug possession offences. While the manufacture and supply of drugs remains a criminal offence, people in Queensland found with small amounts of drugs for personal use are given up to three diversion opportunities, including a warning only (for first offences) or referral to a health intervention. The fourth interaction with police would result in a court notice.[34]

5.25 Although the decriminalisation of personal drug use is largely the legal responsibility of the states and territories, ADF submitted that leadership from the federal

---

29 ADF, *Submission 77*, p. 29.
30 ADF, *Submission 77*, p. 29.
31 QNADA, *Submission 75*, p. 19.
32 ADF, *Submission 77*, p. 48.
33 ADF, *Submission 77*, p. 49.
34 ADF, *Submission 77*, p. 49.

government could aid jurisdictions in designing and implementing evidence-based drug policies. ADF also recommended that the federal government examine and address any conflict between its laws and those of the states and territories, including a current case in which ACT laws clash with the *Commonwealth Criminal Code Act 1995,* which makes the possession of controlled substances an offence. Equally, a review of the threshold set out in the *Commonwealth Criminal Code Act 1995* that delineates personal possession and trafficking was suggested as an initiative that could provide more consistent guidance for states and territories.[35]

5.26 In its report *Australia's illicit drug problem: Challenges and opportunities for law enforcement* (May 2024), the Parliamentary Joint Committee on Law Enforcement recommended that the Australian Government commission research to better understand the impact of decriminalisation in Australian and international jurisdictions where reforms have been implemented, with an evaluation of the longitudinal impacts on individuals, communities and law enforcement.[36] The Committee recognises that an in-depth investigation of decriminalisation initiatives is a critical step in informing future policy in this area.

Prevention and harm reduction strategies

5.27 The goal of prevention and early intervention is to slow and ideally stop progress along a continuum that begins with first or experimental AOD use, and moves to occasional or regular use, before escalating to risky use or dependency.[37] According the Drug Policy Modelling Program at UNSW, responses at both population level and individual level are required along the full continuum; these range from strategies to prevent or delay the commencement of AOD use, preventing the transition to more harmful consumption, and reducing the harms associated with consumption, to the provision of treatment.[38]

5.28 The Committee received substantial evidence pertaining to programs and strategies used to prevent or reduce harm associated with AOD use. Focus was placed in particular on:

- Family-focused initiatives
- School-based programs
- Drug checking services
- Supervised injecting centres
- Needle and Syringe Programs
- Take Home Naloxone Program
- Diversion initiatives

35 ADF, *Submission 77*, p. 30.
36 Parliamentary Joint Committee on Law Enforcement (May 2024), *Australia's illicit drug problem: Challenges and opportunities for law enforcement*, p. xiii.
37 ADF, *Submission 77*, p. 20.
38 Drug Policy Modelling Program UNSW, *Submission 17*, p. 2.

- AOD screening.

Family-focused initiatives

5.29 In its submission, ADF emphasised that the relationship between young people and their parents plays a critical role in preventing AOD-related harm among young people. Parental monitoring, high quality parent-child relationships, parental support, and parental involvement all act as vital protective factors against harmful substance use.[39]

5.30 Beyond positive engagement between parents and children, the South Australian Commissioner for Children and Young People also emphasised the importance of fostering strong relationships between families and their communities as a protective factor.[40] The Commonwealth Department of Education reiterated this point, noting:

> Productive partnerships between schools, family, and the community […] provide a strong network of connections that can help protect young people against a range of harms including those associated with drug use, emotional distress and problem behaviours.[41]

5.31 In highlighting the role that parental factors in particular play in alcohol use among adolescents, ADF submitted that family-focused initiatives should provide opportunities for parents to enhance their knowledge about alcohol consumption and reduce risky behaviours such as the parental provision of alcohol, favourable parenting attitudes towards alcohol, and parental drinking:

> Research shows that when parents give young people alcohol, or let them drink at home, that young person is more likely to start drinking earlier, drink more often, and drink higher quantities of alcohol. That young person will also be at a higher risk for experiencing problems with alcohol both in adolescence, and later in life.[42]

ADF further noted that underage drinking is likely to rise when a parent treats drinking as humorous, or discloses their own negative experiences with alcohol.[43]

5.32 DrinkWise—a not-for-profit organisation established in 2005 with funding from alcohol industry producers and the Federal Government—also submitted that parents are critical to encouraging underage abstinence. Throughout its history, the organisation has run a series of campaigns aimed at promoting the importance of parental oversight in this context:

> From the first DrinkWise campaign in 2008, Kids Absorb Your Drinking, which saw a dad ask his son to get him a beer from the fridge and the generational

39 ADF, *Submission 77*, p. 22.
40 SA Commissioner for Children and Young People, *Submission 10*, p. 6.
41 Department of Education, *Submission 126*, p. 4.
42 ADF, *Submission 77*, p. 22.
43 ADF, *Submission 77*, pp. 22-23. See also DrinkWise, *Submission 194*, n.p.

> cycle repeating – causing many Australian parents to reflect on their own drinking behaviours and role modelling within the home – to the latest It's okay to say nay campaign [launched in 2022], the success of DrinkWise campaigns has in the ability to resonate with parents.[44]

School-based programs

5.33 In its submission, the Department of Education observed that as nearly all children and young people attend school, the school environment makes for 'an ideal setting for delivering drug and alcohol education, as well as identifying at risk children and young people'.[45] As such, state and territory governments and non-governmental education authorities have adopted a broad range of policies and programs to address the impact of AOD on schools.[46]

5.34 The Department of Education emphasised the importance of AOD use prevention messaging for children and young people, noting the significant impact that substance use has on this cohort: 'In addition to the short-term impacts which can include impaired judgement, memory difficulties and impulsive behaviour, there are significant long-term impacts of ongoing use, which are particularly acute for children and young people'.[47]

5.35 Exposure to drugs or alcohol at a young age, which is a crucial phase of brain development, can lead to a lasting impairment in functions such as physical coordination, planning, judgement, decision making, impulse control, learning and memory. Regular drinking, according to Department of Education data, is also linked to an increased risk of developing mental health problems, including anxiety and depression.[48]

5.36 The relationship between AOD use among young people and their engagement with the digital environment was raised as a major source of concern within several inquiry submissions.[49] The Department of Education drew attention to research on the link between online advertising and substance use:

> As children and young people continue to spend more time online, including to access social media, there are concerns that exposure [to] content positively portraying alcohol and drug use may influence their consumption. Social media consistently exposes teenagers to alcohol and substance-related content including through posts from peers and curated advertising content. Research has suggested that viewing advertising for alcohol can increase intention to drink, likelihood of underage drinking, and levels of alcohol consumed. It has also been

---

44 DrinkWise, *Submission 192*, n.p.
45 Department of Education, *Submission 126*, p. 2.
46 Department of Education, *Submission 126*, p. 2.
47 Department of Education, *Submission 126*, p. 2.
48 Department of Education, *Submission 126*, pp. 2-3.
49 Alcohol and Drug Foundation, *Submission 77*; Department of Education, *Submission 126*; Australasian Injury Prevention Network, *Submission 151*; Heart Foundation, *Submission 164*; The George Institute, *Submission 169*.

> shown that adolescents who are exposed to high levels of substance use, including through social media, are more likely to use and develop issues with alcohol, tobacco and cannabis.[50]

5.37 As previously noted, recent data on the rates of alcohol use in young people aged 14-24 shows that the consumption has decreased over the past 20 years. At the same time, however, there has been an increase in the use of illicit drugs, including pharmaceutical products. While the use of vapes or e-cigarettes is not the focus of this inquiry, the Committee acknowledges the concern that has been raised by witnesses regarding the use of these products, as younger people are at greater risk of developing nicotine dependence than adults.[51]

5.38 In discussing the impact of current school-based education programs on AOD use, the Department of Education explained that the Australian Curriculum (Version 9.0) addresses the health impacts of AOD as part of health and physical education learning. This content is delivered in an age-appropriate way across the years of schooling from Foundation to Year 10, with students progressively learning about safe practice in relation to a range of drugs, from prescription drugs, household poisons, energy drinks, caffeine, to tobacco, alcohol, and other drugs.[52]

5.39 The Australian Government also funds a range of other programs that focus on AOD education. The Student Wellbeing Hub, for example, provides information and resources for educators, students, and parents to support students from Foundation to Year 12. The Life Education Australia (Life Ed) is another well-established preventative health and safety education program. Colloquially known as 'Healthy Harold' after the giraffe character that features in the program, this initiative supports children aged between three and 13 to make safer and healthier choices throughout their education years, and their lives.[53]

5.40 While school-based programs provide a useful avenue for prevention messaging, the National Centre for Youth Substance Use Research (NCYSUR) emphasised that these are 'often outdated and not informed by current international best practices'.[54] Multiple witnesses asserted that health promotion and education campaigns for young people must be informative, evidence-based, and tailored to reflect the experiences of young people, and avoid being fear-driven.[55] As Dr Adrian Farrugia from La Trobe University explained:

> When drug education initiatives do not sufficiently address and value lived experience and local knowledge of consumption, they can contribute to

---

50 Department of Education, *Submission 126*, p. 3.
51 Department of Education, *Submission 126*, p. 3; National Centre for Youth Substance Use Research (NCYSUR), *Submission 120*, pp. 13-14.
52 Department of Education, *Submission 126*, p. 5.
53 Department of Education, *Submission 126*, pp. 5-6.
54 NCYSUR, *Submission 120*, p. 13.
55 SA Commissioner for Children and Young People, Submission 10, p. 4; Students for Sensible Drug Policy, *Submission 59*, p. 21.

> scepticism, including a broader cynicism about all 'official' sources of information such as those perceived to be produced by governments.[56]

5.41 Dr Farrugia further noted that AOD education must be designed with ethical issues in mind, and in manner than does not perpetuate stigma or negative stereotypes. He recommended a review of drug education programs to ensure that content is free from gender-based stereotypes, and does not place disproportionate focus on consumption by young women, or position young people who consume drugs as morally compromised and shameful.[57]

5.42 Students for Sensible Drug Policy Australia similarly recommended that current drug education and harm reduction programs should be reviewed and updated to include culturally relevant and reliable health material, tailored towards multiple platforms, and co-designed with the population they aimed to reach.[58] ADF also called for a review of school-based programs to ensure they reflect the International Standards of Drug Prevention, published by the United Nations Office of Drug and Crime, which provides a guide to best practice for prevention in schools.[59]

5.43 NCYSUR further recommended investment in emerging technologies to strengthen the existing health messaging programs. The Centre explains its current work in this field:

> … researchers at NCYSUR have begun utilising artificial intelligence (AI) and youth input to cost-effectively and rapidly generate vaping prevention messages which are designed with social media as the focus. Preliminary data from over 600 young people showed that these rapidly generated AI messages are as effective as existing media campaigns which are more costly and time-consuming to create.[60]

Drug checking services

5.44 Drug checking (which is also sometimes referred to as pill testing) is a process of examining the chemical content of drugs before their consumption. This service aims to reduce the risk of harm of illegal drugs, which can be highly unpredictable in terms of the substances they contain and their purity.[61]

5.45 According to NCYSUR, drug checking services play an important part in reducing the harms associated with drug use. Its submission draws attention to evidence from the European drug checking services, which demonstrated the public health benefits of

---

56 Dr Adrian Farrugia, *Submission 14*, p. 5.
57 Dr Farrugia, *Submission 14*, p. 2.
58 Students for Sensible Drug Policy Australia, *Submission 59*, p. 21.
59 ADF, *Submission 77*, pp. 31-32.
60 NCYSUR, *Submission 120*, p. 14.
61 ACT Government, 'Drug checking.'

drug checking, and the additional role these services provide as an early warning system by detecting harmful substances circulating in drug markets.[62]

5.46 In Australia, drug checking services have been piloted in Queensland (CheQpoint), and the ACT (CanTEST), with a further service to be established in Victoria 2025. Since its launch in July 2022, CanTEST has analysed more than 2,900 samples, detected 252 novel psychoactive substance and released 20 community notices of dangerous substance detection.[63] Evaluation of the CanTEST pilot, conducted by the Australian National University, revelated that 70 per cent of people who used the service had never previously spoken to a healthcare worker about AOD, and two thirds accepted an AOD or general health intervention after using the service.[64]

5.47 Numerous witnesses, including the Alcohol, Tobacco and other Drugs Council (Tasmania), NCYSUR, ACON, ADF, New South Wales Council for Civil Liberties, Healthy Cities Illawarra, and Students for Sensible Drug Policy Australia recommended investment in fixed-site drug checking services as well as mobile drug checking services at events such as music festivals.[65] The Australian Medical Association (AMA) similarly expressed its support for 'sanctioned, appropriately supervised, and monitored high-quality pill testing trials to minimise the risk to young people and build an evidence base to determine the effectiveness of pill testing in Australia'.[66]

5.48 Mr Cameron Francis, Chief Executive Officer of the Loop Australia—a not-for-profit organisation delivering drug checking services in Queensland, New South Wales and Victoria—emphasised that these services also play a critical role by providing an entry point into the healthcare system for at-risk clients:

> Harm reduction approaches like drug-checking are able to reach new and different populations that are not currently accessing treatment or engaged in the service system. The majority of clients we see in our drug-checking services are not currently engaged in the system at all. The majority have never spoken to a health professional about alcohol and drug concerns. We are the first people they have ever spoken to about their substance use. From that, we are able to identify a range of hidden populations that are genuinely not connected or not otherwise represented.[67]

5.49 Mr Francis also provided an example of how this service functions:

> We are also seeing significant numbers of people using drugs like methamphetamine who are not interested in treatment. They are presenting to

---

62 NCYSUR, *Submission 120*, pp. 11-12.

63 ADF, *Submission 77*, p. 26.

64 New South Wales Council for Civil Liberties, *Submission 28*, pp.4-5.

65 Alcohol, Tobacco and other Drugs Council (Tasmania), *Submission 22*; NCYSUR, *Submission 120*; ACON, *Submission 80*; ADF, *Submission 77*; New South Wales Council for Civil Liberties, *Submission 28*; Healthy Cities Illawarra, *Submission 133*; Students for Sensible Drug Policy Australia, *Submission 59*.

66 Australian Medical Association (AMA), *Submission 80*, p. 6.

67 Mr Cameron Francis, Chief Executive Officer, The Loop Australia, *Committee Hansard*, 30 October 2024, p. 15.

> get their drugs tested because they think the drugs are not working anymore and are saying, 'It must be cut with something.' We are able to show them that is not the case; it is their tolerance that is causing those changes. That opens the door to a discussion regarding treatment. Each week, when we open the service, clients in that category come through who are not seeking treatment. We are able to point out the impacts of their regular methamphetamine use and engage them in treatment conversations.[68]

5.50 In addressing a Committee query as to whether drug checking services might have adverse impacts, such as by creating an impression that illegal substances are condoned, Mr Francis said:

> We don't give anyone an 'okay'. The common misconception of drug-checking services is that they somehow pass or fail the test. We actually explain to the person what we believe the compound to be in their sample, and we explain the risks of that drug to the person. There is no green light—passing or failing—to the test […]
>
> We don't confiscate drugs from people. We test drugs with people's consent. They provide us those drugs voluntarily. If we encounter a highly-dangerous sample we have a conversation with someone about that. We are very successful at getting people to hand those over for disposal. One of our reports from last month indicated that we got a 100 per cent discard rate in an unexpected result in our client group. That is down to the skill and experience of our staff who are able to have those respectful conversations with people.[69]

Supervised injecting centres

5.51 Supervised injecting facilities (also referred to as overdose prevention services) are spaces where people who use drugs can be safely monitored, treated in the event of overdose, and referred to medical and healthcare services. There are presently two medically supervised injecting centres in Australia: Uniting's Medically Supervised Injecting Centre (MSIC) in Kings Cross, New South Wales, and a centre in North Richmond, Victoria.[70]

5.52 International evidence, NCYSUR submitted, revealed that overdose prevention sites tend to be used by middle to older-aged clients. NCYSUR noted that the service needs of young people in this context remain a point of concern, and recommended investment in research and evaluation of youth-focused models of care within overdose prevention sites.[71]

---

68 Mr Francis, The Loop Australia, *Committee Hansard*, 30 October 2024, p. 15.
69 Mr Francis, The Loop Australia, *Committee Hansard*, 30 October 2024, pp. 18-19.
70 New South Wales Council for Civil Liberties, *Submission 28*, p. 4.
71 NCYSUR, *Submission 120*, p. 12.

Needle and Syringe Programs

5.53 Needle and Syringe Programs (NSPs) are public health programs that provide sterile injecting equipment, both at fixed or mobile sites, with the aim of reducing the transmission of bloodborne viruses.[72] These programs also provide peer support and healthcare information to people who inject drugs. As the Pharmacy Guild of Australia further explained, NSPs:

> … may also involve the safe collection and disposal of used syringes via a community pharmacy depot. The use of clean injecting equipment as well as safe disposal of used syringes significantly reduces the health risks to an individual and the burden to a community of blood-borne diseases such as HIV, hepatitis B or C.[73]

5.54 Australia has historically been an early adopter of harm reduction measures, including needle and syringe programs.[74] In recent times, multiple countries have extended NSPs to prisons, but Australia is currently behind in the expansion of NSPs. The Australian Research Centre in Sex, Health and Society explained that prison NSPs were an extremely valuable harm reduction service with many potential benefits, including the prevention of AOD-related harms such as hepatitis C transmission. Based on 2020 research data, 37 per cent of all hepatitis C treatments were delivered to people in prison. The reinfection rate within prisons is often high.[75]

5.55 As noted in Chapter 4, multiple submissions to this inquiry highlighted the fact that Australia is a signatory of the *United Nations Standard Minimum Rules for the Treatment of Prisoners* (the Mandela Rules), which state that prisoners ought to have access to the health services available in the country without discrimination on the grounds of their legal situation.[76] Access to NSPs in programs, witnesses highlighted, was a matter of basic human right to healthcare access.

5.56 In expressing its support for the program, the Pharmacy Guild of Australia recommended an establishment of a national NSP

> to allow for the supply of clean injectable equipment and the safe collection and disposal of needles and syringes through community pharmacies. Any national program should be supported by the State and Territory governments, as people should not be disadvantaged in how they access a NSP based on where they choose to live.[77]

---

72 Professor Seear, *Submission 33*, p. 18.
73 The Pharmacy Guild of Australia, *Submission 52*, p. 6.
74 Professor Seear, *Submission 33*, p. 18.
75 Professor Seear, *Submission 33*, p. 18.
76 Professor Seear, *Submission 33*, p. 18.
77 The Pharmacy Guild of Australia, *Submission 52*, p. 7.

Opioid Dependence Treatment Program

5.57 Opioid treatment programs provide treatment to people experiencing opioid dependence. This may include illicit drugs, such as heroin, as well as non-prescribed or prescribed opioids (most commonly opioids prescribed for pain relief). The treatment framework is broad and can include the provision of medication that helps to reduce opioid withdrawal symptoms and control the cravings associated with opioid dependence.

5.58 In July 2023, the Pharmaceutical Benefits Scheme (PBS) introduced the National Opioid Dependence Treatment Program (ODT program). The PBS ODT program ensures that patients using the service can access their medicines as a pharmaceutical benefit.[78]

5.59 The Pharmacy Guild of Australia noted that ODT treatment has long relied on a small number of high-caseload general practitioners, who are subject 'to increasing attrition by age and regulatory scrutiny'.[79] In order to address the current shortage, the Guild recommended enhancing access to the PBS ODT program by allowing appropriately trained pharmacists to become ODT prescribes and fully remunerating community pharmacy for these services.[80]

5.60 In his submission, Dr Simon Holliday expressed his support for the use of opioids for palliative care as well as active cancer treatment and end-of-life care. He also argued that the PBS should review support for opioid analgesics for chronic noncancer pain, highlighting that in the period between 2013 and 2017, just 16 per cent of Australians were dispensed opioids, almost all for chronic noncancer pain.[81]

5.61 Dr Holliday further explained that opioid use over longer periods may lead to addiction and overdose. While they relieve suffering, opioids create 'psychosocial changes' and thus their use overlaps between pain management and addiction. The PBS indications, Dr Holliday submitted, require review as they do not presently reflect this complexity. In addition, he recommended that PBS should require the return of unused opioids to avoid their accumulation and potential misuse.[82]

5.62 Evidence presented to the inquiry indicated that it is often difficult for clinicians to refuse a request for the initiation of strong pain killers. Dr Holliday explained, however:

> Doctors can prevent patients from initiating or maintaining opioids for chronic pain by initiating active self-management strategies. In parallel with this, chronic opioid analgesic patients may require the introduction of therapeutic boundaries as seen in methadone-programmes.[83]

---

78 The Pharmacy Guild of Australia, *Submission 52*, p. 4.
79 The Pharmacy Guild of Australia, *Submission 52*, p. 4.
80 The Pharmacy Guild of Australia, *Submission 52*, p. 4.
81 Dr Simon Holliday, *Submission 9*, p. 10.
82 Dr Holliday, *Submission 9*, pp. 9-12.
83 Dr Holliday, *Submission 9*, p. 11.

5.63 These processes demand substantial amounts of time and emotional energy from the clinician and therefore, it was argued, they need to be supported by the MBS. In addition, Dr Holliday suggested that a brief training should be mandated before doctors could prescribe opioid analgesics, similar to the practice that has been introduced in the United States in response to the opioid epidemic.[84]

5.64 The Pharmacy Guild of Australia also expressed its support for a staged supply approach as a valuable strategy in this context:

> Staged supply is a clinically indicated, structured pharmacist service where the patient is given the doses of their medicine in periodic instalments that are less than the originally prescribed quantity. It is used for people who may be at risk of self-harm, abuse, or misuse of a particular medicine if they were to be supplied a full or substantial quantity at any one time. This typically means the patient picks up their dose on a daily to weekly basis and allows the pharmacist to monitor and check with the patient to ensure that they are taking their medicine appropriately.[85]

5.65 The Guild noted, however, that the Commonwealth program was presently restricted to prescriber initiation, and had a patient cap which meant that each pharmacy was funded to make the program available to a certain number of patients (currently 15 per month). Further expansion of this program, according to the Guild, would significantly contribute to substance use management.[86]

Take Home Naloxone Program

5.66 The Take Home Naloxone Program is an initiative that makes naloxone available for free and without a prescription through community and hospital pharmacies, as well as alcohol and drug treatment centres.[87] ADF explained that naloxone is a valuable harm reduction tool that worked by:

> blocking opioid drugs, such as heroin and oxycodone, from attaching to opioid receptors in the brain. In can be injected intramuscularly or delivered by intranasal spray. It may be administered by medical professionals, as well as family, friends or bystanders in an emergency where someone is experiencing an overdose. Importantly, there is no evidence that extended use of naloxone can cause harmful physical effects or dependence.[88]

5.67 The Pharmacy Guild of Australia emphasised that naloxone is 'not only suitable for people that use illicit opioids but can also be a life-saver for people using prescription opioids to manage their pain or as part of the ODT program'.[89]

---

84 Dr Holliday, *Submission 9*, p. 11.
85 The Pharmacy Guild of Australia, *Submission 52*, p. 5.
86 The Pharmacy Guild of Australia, *Submission 52*, pp. 5-6.
87 The Pharmacy Guild of Australia, *Submission 52*, p. 5.
88 ADF, *Submission 77*, p. 27.
89 The Pharmacy Guild of Australia, *Submission 52,* p. 5.

5.68 Multiple witnesses explained that the naloxone program has been critical in efforts to prevent fatal overdoses. Students for Sensible Drug Policy warned that in Australia there had been increasing detections of synthetic opioids, particularly nitazenes—a synthetic opioid up to 500 times stronger than heroin. There have been growing reports of harms from the use of these synthetic opioids, including hospitalisation, and at least 17 overdose deaths in Victoria and seven in South Australia. 'In some cases', the organisation suggested, 'people have inadvertently consumed nitazenes contained in drugs sold as something else, such as cocaine or MDMA'.[90] Naloxone can effectively and temporarily reverse nitazene toxicity during overdoses.

5.69 In addition to expressing strong support for the Take Home Naloxone Program, witnesses suggested that it might be usefully expanded to further assist efforts to counteract opioid toxicity. Students for Sensible Drug Policy suggested that all first responders, including 'peer led harm reduction services, and medical services should be appropriately funded to carry naloxone and should undergo nationally recognised training in administering naloxone to respond to an opioid overdose'.[91]

5.70 The Pharmacy Guild of Australia reiterated this point, noting:

> the Commonwealth must work with the pharmacy and patient sector to promote availability, uptake and access to the take home naloxone program. More must be done at national level to increase uptake of the program by community pharmacies and access to products by people at risk of opioid overdose.[92]

Diversion initiatives

5.71 Drug diversion programs provide people who are caught in possession of drugs with an alternative to criminal prosecution. Instead of facing arrest and criminal charges, participants can enter treatment, counselling, or support services to address their drug use. According to NCYSUR:

> … police drug diversion programs have been found to be effective in preventing criminal offending and show promising results for improving health outcomes and diminishing social cost as well as costs associated with processing drug-related offences.[93]

5.72 In its submission, the Legal Aid Commission of New South Wales (Legal Aid NSW) noted that while it perceived decriminalisation of the possession of prohibited drugs for personal use as preferable, where this is not an option, diversion from the criminal justice system represents a preferred alternative to criminal prosecution.[94] The organisation submitted that in NSW there is currently a number of diversion schemes in place, including the Cannabis Cautioning Scheme and the Early Drug Diversion

90 Students for Sensible Drug Policy Australia, *Submission 59*, p. 24.
91 Students for Sensible Drug Policy Australia, *Submission 59*, p. 24.
92 The Pharmacy Guild of Australia, *Submission 52*, p. 5.
93 NCYSUR, *Submission 120*, p. 13.
94 Legal Aid Commission of New South Wales (Legal Aid NSW), *Submission 18*, p. 6.

Initiative. These schemes allow the police to use formal cautions or fines for initial offences, combined with the provision of support services.[95]

5.73 Drug courts, which offer offenders the chance to participate in the drug court program, have also been proven effective in reducing reoffending in both the Australian and international contexts.[96] In discussing drug courts, AMA highlighted that it saw:

> … a real value in drug courts, which accept referrals from local courts for those who will be charged and imprisoned, who are dependent on prohibited drugs. If a person is accepted into one of the drug court programs, specialised addiction support is given, helping to reduce recidivism in the future.[97]

5.74 Legal Aid NSW also commended the use of Work and Development Orders (WDO), which allow people experiencing disadvantage to clear fines through unpaid work, courses or treatment. These orders are available to people who are experiencing harm from drugs, alcohol or volatile substances, and they can engage in treatment as part of a WDO.[98]

5.75 Multiple submissions articulated support for the establishment of the Magistrates Early Referral Into Treatment (MERIT) Program.[99] This is a multiagency initiative of the NSW Department of Communities and Justice, the Chief Magistrate's Office, NSW Health and NSW Police, with support from Legal Aid NSW and Aboriginal Legal Service (NSW/ACT). The program, which commenced in 2000 as a trial at Lismore Local Court, enables eligible defendants to have their matter adjourned to allow them to focus on treating their drug or alcohol problem. Successful engagement with the program (which usually takes 12 weeks) is taken into account in sentence proceedings.[100]

AOD screening

5.76 Screening for alcohol and drug use is essential for linking people with treatment.[101] Dr Holliday noted, however, that alcohol use disorders, for example, are often not identified by clinicians until at extreme levels, and that as such there is an urgent need for improved screening mechanisms.[102]

5.77 AOD screening and brief interventions delivered in primary healthcare can be, according to FARE, effective in AOD harm prevention. In addition, social services can also be effective settings for early identification and referral for people

---

95 Legal Aid Commission of New South Wales (Legal Aid NSW), *Submission 18*, pp. 18-20.
96 Legal Aid Commission of New South Wales (Legal Aid NSW), *Submission 18*, pp. 19-20.
97 AMA, *Submission 80*, p. 8.
98 Legal Aid Commission of New South Wales (Legal Aid NSW), *Submission 18*, p. 22.
99 Community Restorative Centre, *Submission 56*; Australian Dental and Oral Health Therapists' Association, *Submission 63*; NSW Users and AIDS Association (NUAA), *Submission 198*.
100 Legal Aid Commission of New South Wales (Legal Aid NSW), *Submission 18*, pp. 20-21.
101 Centre for Alcohol Policy Research, La Trobe University, *Submission 21*, p. 2.
102 Dr Holliday, *Submission 9*, p. 9.

experiencing AOD harm. Efforts to increase the capacity for cross-sector screening for AOD, FARE submitted, is vital step in countering AOD related harm.[103]

5.78 The Australian College for Emergency Medicine (ACEM) expressed its support for the recommendation by the World Health Organization that emergency departments be resourced to conduct screening and other brief interventions, as well as referral for treatment programs. As ACEM noted, 'the routine use of validated, standardised screening tools offers an important mechanism for identifying, reducing and preventing problematic use, abuse, and dependence on alcohol and other drugs'.[104]

5.79 Mrs Sophie Harrington, Interim Chief Operating Officer of the National Organisation for Fetal Alcohol Spectrum Disorders, also highlighted that every pregnancy should be screened for prenatal exposure to alcohol. Furthermore, in noting the general increase in alcohol consumption among women of childbearing age combined with the level of unplanned pregnancies, a general screening for FASD in children was recommended. Witnesses also raised the issue of increased alcohol consumption during the COVID pandemic, and emphasised the need for screening children who were born during or after the pandemic.[105]

Alcohol harm reduction

5.80 Over the course of the inquiry, the widespread cultural acceptance and normalisation of alcohol use in Australia has been repeatedly raised as a major cause for concern. AMA noted:

> Alcohol is viewed as a fabric of Australian culture and not as a drug that has serious health and social implications. Alcohol is a psychotropic drug, and just like cannabis, cocaine and LSD, has an impact on cognition, emotions, and perception.[106]

5.81 The Queensland Nurses and Midwives' Union (QNMU) similarly highlighted that alcohol has become ubiquitous in everyday social interactions across Australia, and present at all major events, including family gatherings, celebrations, sporting events, work parties, and entertainment venues.[107]

5.82 In Australia, the National Health and Medical Research Council (NHMRC) is charged with publishing national alcohol guidelines. The NHMRC guidelines suggest that healthy individuals should drink no more than 10 standard drinks in a week, and no

---

103 FARE, *Submission 87*, p. 22.

104 Australian College for Emergency Medicine (ACEM), *Submission 95*, p. 4.

105 Mrs Sophie Harrington, Interim Chief Operating Officer, National Organisation for Fetal Alcohol Spectrum Disorders (NOFASD), *Proof Committee Hansard*, Canberra, 7 February 2025, p. 20. See also Ms Jessica Birch, private capacity, *Proof Committee Hansard*, Canberra, 7 February 2025, p. 16; Ms Angelene Bruce, private capacity, *Proof Committee Hansard*, Canberra, 7 February 2025, p. 21.

106 AMA, *Submission 8*0, p. 2.

107 Queensland Nurses and Midwives' Union (QNMU), *Submission 34*, p. 3; see also FARE, *Submission 87*, p. 10.

more than four standard drinks on any one day.[108] A standard drink contains 10 grams of pure alcohol, which is, on average, the amount of alcohol the human body can process in one hour.[109] In most situations, a standard serving of alcohol is larger than one standard drink: for example, a 375mL can of full-strength beer equates to 1.4 standard drinks, and a 150mL glass of red wine (a typical restaurant serving) equates to 1.6 standard drinks.[110]

5.83 Multiple witnesses expressed concern that Australians do not have an adequate understanding of what constitutes low risk alcohol use.[111] Furthermore, NHMRC guidelines mainly apply to healthy Australians. AMA suggested that the NHMRC should develop guidelines that specify what level of consumption presents risk in different contexts: 'For example, people can have health conditions where any consumption of alcohol can exacerbate symptoms'.[112]

5.84 In reflecting on the overall low level of understanding of health risks related to alcohol, ADF noted:

> A recent poll conducted by Alcohol Change Australia (ACA) found that knowledge of Australian alcohol guidelines is low; over half of participants are either unsure of lifetime risk guidelines, or overestimate the number of standard drinks to remain at low risk of harm. While knowledge of the relationship between alcohol and liver disease was high (87%), less than half of respondents were aware that alcohol can cause cancer. Only 14% were aware that alcohol can cause breast cancer.[113]

Alcohol regulation

5.85 The Australian Government has responsibility for national alcohol labelling standards, and some marketing and advertising, while state and territory governments are responsible for enforcing labelling standards and the specific laws and regulations regarding the sale, supply and consumption of alcohol within their jurisdictions. State and territory oversight also includes licensing requirements for venues and restrictions on where alcohol can be consumed.[114]

---

108 National Health and Medical Research Council (2020), *Australian guidelines to reduce health risks from drinking alcohol*, p. 2.

109 Spirits and Cocktails Australia, *Submission 113*, p. 24.

110 Spirits and Cocktails Australia, *Submission 113*, p. 24.

111 ADF, *Submission 77*, p. 25; FARE, *Submission 87*, p. 20; Cancer Council Australia, *Submission 110*; National Heart Foundation of Australia, *Submission 164*, p. 7; Alcohol Change Vic., *Submission 166*, p. 11; DrinkWise, *Submission 192*, n.p.

112 AMA, *Submission 80*, p. 10.

113 ADF, *Submission 77*, p. 25.

114 Department of Health and Aged Care, *Submission 157*, p. 13.

Product labelling

5.86 To raise awareness of the harmful health impact of alcohol, multiple witnesses suggested the introduction of more comprehensive labels.[115] In its submission, the Department of Health and Aged Care explained that Food Standards Australia New Zealand (FSANZ) was responsible for developing and maintaining the Australia New Zealand Food Standards Code, which includes specific requirements for the labelling of alcoholic beverages. The Department cited research demonstrating that labelling requirements supported the prevention of alcohol related harms, and as such

> alcoholic beverages sold in Australia are required to include the following information on their label:
>
> • alcohol content (for beverages containing 0.5% or more alcohol by volume (ABV))
>
> • number of standard drinks (for beverages containing more than 0.5% ABV), and
>
> • a pregnancy warning label (for beverages containing more than 1.15% ABV).[116]

5.87 In addition, the Department noted that alcoholic beverages must comply with general food standards within the Australia New Zealand Food Standards Code, such as those relating to approved ingredients and food safety.[117]

5.88 While the Australian and New Zealand Governments already mandate pregnancy health warnings on alcohol products, ADF suggested that further health messages are needed 'to communicate the wide range of other harms caused by alcohol'.[118] In January 2025, the U.S. Surgeon General issued advice on the alcohol and cancer risk, which, among other things, called for clearer health warning labelling on alcoholic beverages.[119]

5.89 ADF submitted that Australia's experience with pregnancy health warnings demonstrated the necessity of mandating labelling requirements, rather than relying on industry-led voluntary schemes:

> [T]he current mandated pregnancy warning label was introduced by Food Standards Australia and New Zealand (FSANZ) in 2020, following the use of voluntary labels developed by the alcohol industry since 2011. This voluntary scheme was ineffective and poorly adhered to, with a review in 2013 finding that there was only 38% uptake.[120]

5.90 ADF also noted that health warning labels on alcohol products have been implemented in some international jurisdictions, and proven effective in increasing

---

115 AMA, *Submission 80*; FARE, *Submission 87*; Royal Australian College of General Practitioners (RACGP), *Submission 84*; ADF, *Submission 77*; Cancer Council Australia, *Submission 110*.

116 Department of Health and Aged Care, *Submission 157*, p. 16.

117 Department of Health and Aged Care, *Submission 157*, p. 16.

118 ADF, *Submission 77*, p. 34.

119 The U.S. Surgeon General's Advisory (January 2025), *Alcohol and Cance Risk*, p. 17.

120 ADF, *Submission 77*, p. 34.

consumer awareness and knowledge of alcohol harm.[121] The organisation thus recommended that the federal government introduce mandatory, standardised health warning labels on alcohol products to help raise awareness of the short- and long-term harms caused by alcohol, explaining that:

> … while this policy is enacted through Food Standards Australia and New Zealand (FSANZ), the federal government must take a leadership role in establishing health warning labels to ensure agreement and cooperation across the jurisdictions.[122]

5.91 AMA submitted that energy labelling standards be introduced for alcohol products as an appropriate energy intake was major contributing factor to maintaining good health and reducing the risk of chronic disease related to unhealthy body weight.[123] FSANZ is currently examining the introduction of such labels.[124]

5.92 Industry entities, however, cautioned against additional labelling. Adding more information, according to Spirits and Cocktails Australia, risked overcrowding, and by extension, reducing the effectiveness of existing regulatory information. Proposals have been made for an introduction of QR codes on alcohol labelling that would complement existing label information as an alternative.[125]

Marketing and advertising

5.93 Multiple submissions, including those from the Centre for Alcohol Policy Research at La Trobe University and NCETA, drew the Committee's attention to the World Health Organization's three key strategies (refer to as 'best buys') in the regulation of alcohol beverages to reduce health harms from drinking:

- restricting exposure to alcohol advertising
- increasing excise taxes on alcohol beverages, and
- restricting the physical availability of retailed alcohol.[126]

5.94 In its submission, the Department of Infrastructure, Transport, Regional Development, Communication and the Arts (DITRDCA) explained that the advertising of alcohol is subject to a range of regulatory, co-regulatory and self-regulatory frameworks. Regulatory and co-regulatory frameworks tend to cover the scheduling and placement of advertisements, while the self-regulatory framework governs the content of advertisements.[127]

---

121 ADF, *Submission 77*, p. 44.
122 ADF, *Submission 77*, p. 34.
123 AMA, *Submission 80*, p. 5.
124 Food Standards Australia and New Zealand, 'Energy labelling of alcoholic beverages'.
125 Spirits and Cocktails Australia, *Submission 113*, pp. 29-30.
126 Centre for Alcohol Policy Research, La Trobe University, *Submission 7*, p. 1; NCETA, *Submission 43*, p. 5.
127 Department of Infrastructure, Transport, Regional Development, Communication and the Arts (DITRDCA), *Submission 197*, p. 3.

5.95 At the federal level, DITRDCA has primary responsibility for media and advertising regulation for broadcasting and online services. Oversight and regulation of the broadcasting and media industry is the responsibility of the Australian Communications and Media Authority (ACMA). Under the *Broadcasting Services Act 1992* (BSA), ACMA is also responsible for the regulatory and co-regulatory advertising frameworks. Advertising in outdoor settings (such as train stations or stadiums) is the responsibility of state and territory governments.[128]

5.96 In addition to Commonwealth and state and territory governments, a set of independent third-party entities regulates the content of advertisements:

- The Australian Association of National Advertisers (AANA) Code of Ethics sets the overall standard for social responsibility that is expected of advertisers and marketers
- The Alcohol Beverages Advertising Code Responsible Alcohol Marketing Code (ABAC Code) sets out specific requirements for advertising alcoholic beverages across all traditional forms of media (television, radio, print and outdoor) as well as digital and social media marketing
- Ad Standards, established by AANA in 1998, is responsible for receiving complaints against these codes.[129]

5.97 DITRDCA submitted that 'most content broadcast on television and radio is regulated by co-regulatory codes of practice under BSA'.[130] Codes of practice are developed by industry in consultation with ACMA. Once ACMA is satisfied with a new or revised code, the code is then registered and becomes enforceable. The codes, as DITRDCA explained, do not currently apply to streaming services, as these are excluded under the BSA:

> Noting the ACMA's powers in relation to advertising are limited to the types of services regulated under the BSA, remedial directions and civil penalties cannot be pursued against online services under the ACCTS [Broadcasting Service (Australian Content and Children's Television) Standards 2020] and industry codes, including subscription video-on-demand services, broadcast video-on-demand services and digital platforms.[131]

5.98 In its submission, DITRDCA drew the Committee's attention to recent proposals for a change in the regulation of free-to-air broadcast networks that could increase the extent to which children are exposed to alcohol advertising. The Commercial Television Industry Code of Practice 2015 (Commercial TV Code) was developed by Free TV Australia—the industry body representing Australia's commercial free-to-air broadcast networks. The Code presently allows for alcohol advertising between 8.30pm and 5.00am, and between 12pm and 3pm on school days—periods when content is less likely to be viewed by children. The proposed changes to the Code

128 DITRDCA, *Submission 197*, p. 3.
129 DITRDCA, *Submission 197*, p. 3.
130 DITRDCA, *Submission 197*, p. 4.
131 DITRDCA, *Submission 197*, pp. 4-5.

would impact the times during which alcohol advertising is permitted, and potentially result in greater exposure of children to alcohol advertisements.[132] The Department of Health and Aged Care, as well as entities such as FARE, submitted that these changes would expose young people alcohol advertising, which could be harmful.[133]

5.99 Multiple witnesses reflected on the link between alcohol consumption and the role of advertising and marketing, with ADF arguing that these practices promote positive attitudes towards alcohol, and are linked to an earlier initiation into and higher levels of drinking.[134]

5.100 Much of the evidence presented during the course of the inquiry sought to highlight the shortcomings of the current regulatory framework. FARE noted in its submission that legislative and regulatory instruments (referred to as Liquor Acts and Regulations) across Australia's states and territories were established decades ago, and expressed the view that many of these instruments are no longer fit for purpose:

> We are also now moving into an environment in which existing controls on alcohol availability, which were designed with brick-and-mortar stores in mind, are no longer suitable in a world where every phone is a bottle shop and a billboard. These digital changes are not addressed in our laws, despite the rapid delivery of alcohol via online order being the fastest growing area for expansion in alcohol retail. This, in combination with digital marketing technologies which facilitate targeted, round-the clock advertising, creates a frictionless environment – where a targeted ad can, with one click, result in the rapid delivery of unlimited quantities of alcohol to an individual's doorstep.[135]

5.101 The Committee was concerned to receive evidence pertaining to the targeted promotion of alcohol on social media platforms, and the influence of online marketing on children and young people in particular.[136] The Committee also heard evidence pertaining to targeted marketing to frequent consumers, with evidence suggesting in Australia, 54 per cent of all alcohol is sold to 10 per cent of people who drink alcohol.[137]

5.102 In its submission, Spirits and Cocktails Australia explained that the Alcohol Beverages Advertising Code (ABAC), was founded in 1998 by the alcoholic beverage industry and is overseen by the ABAC Scheme. The Commonwealth, through the Department of Health and Aged Care, is an observer on the ABAC Scheme.[138] The

---

132 DITRDCA, *Submission 197*, p. 5.

133 Ms Caterina Giorgi, Chief Executive Officer, Foundation for Alcohol Research and Education (FARE), *Proof Committee Hansard*, Canberra, 7 February 2025, p. 6; Mr Ben Mudaliar, Assistant Secretary, Alcohol and Other Drugs Branch, Department of Health and Aged Care, *Proof Committee Hansard*, Canberra, 7 February 2025, p. 31.

134 ADF, *Submission 77*, p. 34.

135 FARE, *Submission 87*, p. 17.

136 ADF, *Submission 77*, pp. 34-35; Department of Education, *Submission 126*.

137 FARE, Submission 87, p. 8; See also Dr Erin Lalor, Chief Executive Officer, Alcohol and Drug Foundation, *Committee Hansard*, Melbourne, 28 October 2024, p. 8.

138 DITRDCA, *Submission 197*, p. 7.

ABAC Scheme applies beyond traditional forms of advertising (television, radio, print and outdoor), encompassing the digital and social media environment.[139]

5.103 DITRDCA further outlined the remit of the ABAC Scheme:

> The ABAC Code applies to both traditional advertising mediums (television, radio, print and outdoor) and digital advertising, including user-generated content on social media, and provides that advertisements must not depict excessive or rapid alcohol consumption, market the strength of alcohol, or portray abstinence in a negative light. The Code also sets rules around not targeting minors, using imagery or language that is likely to appeal to minors, creating confusion with other products such as soft drinks, and strict rules on using minors in advertising.
>
> The ABAC Code does not consider broader community concerns regarding alcohol advertising (for example, broader concerns in relation to health and safety). However, the regulatory-framework addresses these concerns through the AANA Code.
>
> The ABAC Code places the onus on advertisers to comply with requirements around the advertising of alcohol.[140]

5.104 In its submission, the ABAC Scheme explained that the scheme had 100 per cent voluntary compliance by its signatories, which included approximately 562 alcohol producers, distributors and retailers. The ABAC Scheme also drew the Committee's attention to the National Alcohol Strategy, and in particular its objectives of reducing opportunities for the availability, promotion and pricing contributing to risky alcohol consumption, and minimising the promotion of risky drinking behaviours and other inappropriate marketing, noting that the Scheme is aligned with these aims.[141]

5.105 The Department of Health and Aged Care informed the Committee that in July 2002, all Australian governments agreed to an industry and government review of Australia's regulatory system for alcohol advertising and established the Australian Beverages Advertising Code (ABAC) Committee. The ABAC Committee reviews complaints about alcohol advertisements from members of the public, and its determinations are non-enforceable. The Department stated that self-regulation in this domain did not always produce optimal results, noting that:

> … international and domestic evidence demonstrated that industry self-regulation of alcohol marketing is ineffective at reducing the negative impacts of advertising and at protecting vulnerable populations including underage youth.[142]

5.106 AMA expressed particular concern about online alcohol advertising and the 'lack of fit-for-purpose regulation to keep pace with emerging platforms and technologies'.[143] AMA further explained that:

---

139 Spirits and Cocktails Australia, *Submission 113*, p. 15.
140 DITRDCA, *Submission 197*, p. 7.
141 The ABAC Scheme Limited, *Submission 139*, p. 3.
142 Department of Health and Aged Care, *Submission 157*, p. 17.
143 AMA, *Submission 80*, p. 12.

> During the COVID-19 pandemic, the marketing and accessibility of alcohol online boomed. Due to the increased use of digital advertising, children are more likely to see alcohol marketing in their day-to-day live than adults. This is due to digital platform use, with the lack of age-restriction regulation allowing easy access to alcohol companies' social media accounts, websites and points of sale by default. The alcohol industry collects data through loyalty programs, which can be matched with social media data, to generate models that link purchase patterns with time of day, week or month, mood and social events. These algorithms can identify those who consume at a high-volume and disproportionately, because the algorithms work to identify the most susceptible consumers.[144]

5.107 In a submission to the Australian Beverages Advertising Code (ABAC) Scheme Limited Responsible Alcohol Marketing Code Review, AMA called for a prohibition of marketing that targeted or appeals to children and young people. It further recommended a prohibition of alcoholic energy drinks and marketing that promoted the consumption of energy drinks in conjunction with alcohol. As part of its recommendations, AMA also sought a limitation of alcohol advertising and sponsorship at sporting events, a reduction of advertising exposure of young people, and the introduction of advertising that outlines the consumption limits recommended by NHMRC.[145]

5.108 AMA echoed the view that self-regulation and voluntary codes are not effective in stemming inappropriate and irresponsible promotion of alcohol to younger people.[146] ADF submitted evidence to the same effect, and suggested that the current regulatory framework contains loopholes that allowed children to be 'exposed to alcohol advertising in avoidable ways':

> As an example, alcohol advertising is banned from live TV during children's viewing hours with the exception of televised sport. Research has found that in 2012 alone, children and adolescents in Australia received 51 million exposures to alcohol advertising through sport on TV. And whilst alcohol cannot be advertised during children's viewing hours on live TV, this does not apply to broadcast video on demand (BVOD). This means children watching a show streamed at any time of the day, may be exposed to alcohol advertisements.[147]

Taxation regime

5.109 The regulation of alcohol pricing through taxation presents another avenue for reducing alcohol related harm. The current alcohol taxation regime in Australia is composed of two main taxes: the alcohol excise and the wine equalisation tax (WET). The alcohol excise is a volumetric tax levied on producers of beers, spirits, and certain other alcohol products, at different rates, based on their volume of alcohol and other characters. WET is a 29 per cent tax paid by wine and certain other

144 AMA, *Submission 80*, p. 12.
145 AMA, *Submission 80*, p. 5.
146 AMA, *Submission 80*, p. 5.
147 ADF, *Submission 77*, p. 35.

alcohol products made from fruit and vegetables (e.g. traditional ciders) on the value of the product produced.[148]

5.110 In its submission, ADF set out the main differences between the two taxes:

- excise paid is generally based on the amount of alcohol contained within the product, whereas the WET is calculated on the monetary value of the product sold
- excise also differs based on characteristics including the product type, its packaging (e.g. keg or bottled), and whether the alcohol is sold for on or off-premises consumption
- excise is adjusted for inflation every six months in line with the consumer price index (CPI), while the WET is set at a consistent rate
- excise is set based on a certain amount per litre of pure alcohol in the product, rather than the volume of the total product itself.[149]

5.111 ADF noted that when the price of a certain alcoholic beverage increases, those who drink at the riskiest levels tend to substitute for cheaper alcohol products. Under the current tax system, ADF argued that the availability of cheaper alcohol products under the WET can be seen to enable product substitution for individuals who are price sensitive. The organisation thus recommended that the federal government reform the alcohol taxation system in Australia by removing the WET and placing wine on the excise system. This approach would limit the sale of cheap, high alcohol-volume wine products that contribute to alcohol-related harms, such as cask wine.[150]

5.112 Professor Diana Egerton-Warburton from the College for Emergency Medicine similarly stated that 'our taxation system has been described as illogical', noting:

> I'd particularly like to highlight the wine equalisation tax as an issue which results in wine being able to be sold based upon the wholesale price rather than the amount of the volume of alcohol. So 65 per cent of wine sales are less than $8 for a bottle of wine. That equates to around 24 cents a standard drink for wine.[151]

5.113 Professor Egerton-Warburton further highlighted the impact of the current alcohol pricing model:

> Quite often—or almost always—in the emergency department, I ask people about their drinking habit, and it's that group of really problematic drinkers who are most affected by that price point. Sometimes when I ask the problem drinker, 'How much do you drink a day?' I get this response quite commonly: 'As much as I can afford to buy.' It's this group that target the really cheap alcohol and where we see a disproportionate amount of harm.[152]

---

148 ADF, *Submission 77*, p. 36.
149 ADF, *Submission 77*, p. 36.
150 ADF, *Submission 77*, p. 36.
151 Professor Diana Egerton-Warburton, Representative, Public Health and Disaster Committee, Australasian College for Emergency Medicine (ACEM), *Committee Hansard*, Melbourne, 29 October 2024, p. 47.
152 Professor Egerton-Warburton, ACEM, *Committee Hansard*, Melbourne, 29 October 2024, p. 47.

5.114 In reflecting on the availability and appeal of low-cost alcohol, Mr Benn Veenker, a lived experience advocate at Turning Point, noted:

> There were numerous times when I would go paycheque to paycheque. I would have maybe $20 left in my wallet, and I would choose buying alcohol over food, but it would be a case of, 'I know I can buy a cask of wine for $4, and that's going to serve.' In those last few years of drinking, it was just cask wine, because it was cheap and available and easy to get.[153]

5.115 Efforts to reduce alcohol consumption through price control can have certain limitations. Dr Paul Clark, Professor of Medicine at the University of Queensland and Director of the Alcohol and Drug Assessment Unit at Princess Alexandra Hospital, told the Committee that demand for alcohol in people with alcohol dependency is 'relatively inelastic':

> You can increase the price of alcohol but you do not necessarily change the demand for alcohol in somebody with alcohol dependence. The impact of changing a price to volumetric pricing does not necessarily have the same effect on the part of the community that is not alcohol dependent. Unit pricing has a lot of benefits in moderating the alcohol intake in people with unformed binge pattern drinking, younger people who have more constraints on their expenditure and people who aren't alcohol dependent. It might use price to moderate consumption in a more interactive way, but it may not have the same effect on people who are severely alcohol dependent.[154]

5.116 Increasing the price of alcohol can have an unintended impact on those who are alcohol dependent. As Dr Clark noted, people with alcohol dependency may spend greater portion of income on alcohol rather than seeing a reduction in their alcohol intake. There is also the potential for a rise in illegal alcohol production.[155]

Trading hours and outlet density

5.117 In addition to pricing, trading hours and outlet density were identified as important factors shaping alcohol availability. While these elements of liquor licencing are controlled by the states and territories, ADF submitted that it was essential for the federal government to show leadership in ensuring a comprehensive, evidence-based approach to regulating alcohol availability.[156]

5.118 Multiple witnesses expressed concern regarding the online sale and delivery of alcohol. ADF stated that:

---

153 Mr Benn Veenker, Manager, Lived Experience, Workforce and Advocacy, Turning Point, Eastern Health, *Committee Hansard*, Melbourne, 29 October 2024, p. 18.

154 Dr Paul Clark, Director, Alcohol and Drug Assessment Unit, Princess Alexandra Hospital, Brisbane, *Proof Committee Hansard*, Canberra, 7 February 2025, p. 22.

155 Dr Clark, Princess Alexandra Hospital, Brisbane, *Proof Committee Hansard*, Canberra, 7 February 2025, pp. 22-23.

156 ADF, *Submission 77*, p. 37.

> Online sale and delivery facilitate easy access to alcohol late at night, when evidence shows assaults in the home are more likely to occur. This is of particular concern, given that alcohol related assaults increase substantially between 6pm and 3am, with 37 per cent of alcohol fuelled assaults occurring in the home and more than half (57%) of those being family violence.[157]

5.119 ADF further drew attention to research indicating that the online sale and delivery of alcohol can increase the risk of harm by bypassing Responsible Service of Alcohol (RSA) processes, age verification, increasing rapid access (as quickly as 30 minutes after ordering), and encouraging extending drinking sessions.[158]

5.120 Submission from Multicultural Women Victoria highlighted the impact of this practice:

> It is horrifying for a family member to see alcohol being delivered to a heavily intoxicated family member […] It is our understanding that there is currently no obligation for online sales to operate under the same rules as pubs, restaurants and events. There are no links back to the point of sale if violence or injury occurs.[159]

5.121 Expressing the view that there is an urgent need to address harms associated with online alcohol delivery, Ms Caterina Giorgi, FARE Chief Executive Officer, reiterated the need for a ban on alcohol delivery between 10pm and 10am, and recommended the introduction of a two-hour safety pause around delivery:

> We should have a two-hour safety pause around deliveries, because we know that when people are delivered alcohol rapidly—so within 30 minutes or two hours—about 40 per cent of them say they drink 11 or more standard drinks […] Having a two-hour safety pause would mean that, if people order alcohol, it can be delivered to them two hours later and not sooner, and we know that that will then give people that friction point which will allow them to pause and reconsider. This is what governments need to do—help give people those friction points.[160]

5.122 Representatives from the alcoholic beverages industry, however, noted that alcohol is a highly regulated industry, with manufacturers required to hold licences issued by the Australian Taxation Office, and state and territory liquor licences to manufacture and sell alcohol.[161] In response to concerns around the online sale of alcohol, industry representatives drew attention to the industry-developed the Retail Drinks Online Alcohol Sale and Delivery Code of Conduct, which is designed to enhance compliance in the responsible online sale of alcohol. These include self-exclusion requests, mandatory training for delivery drivers, a blanket ban on same day, unattended, alcohol deliveries and preventing alcohol deliveries to designated dry

---

157 ADF, *Submission 77*, p. 37.
158 ADF, *Submission 77*, p. 37.
159 Multicultural Women Victoria, *Submission 130*, p. 5.
160 Ms Giorgi, FARE, *Proof Committee Hansard*, Canberra, 7 February 2025, p. 5.
161 Spirits and Cocktails Australia, *Submission 113*, p. 14; Alcohol Beverages Australia, *Submission 61*, p. 4.

zones.[162] Further regulation, including taxation, could have adverse consequences, such as a proliferation of illegal alcohol.[163]

5.123 In their submissions to the inquiry, industry representatives highlighted that the majority of Australians were drinking responsibly and in moderation.[164] Drawing on the AIHW data, Spirits and Cocktails Australia reiterated that alcohol consumption in Australia has declined, and that risky and heavy episodic drinking has reduced, along with overall consumption by young people. The organisation further highlighted that a cultural change was already underway as Australians are choosing to drink less, but higher-quality products.[165]

Public health campaigns

5.124 DrinkWise outlined in its submission the initiatives that it had implemented with the aim of reducing alcohol-related harm. These include campaigns aimed at parents regarding the supply of alcohol to children (*It's okay to say nay*), as well as initiatives pertaining to alcohol consumption during occasions such as school leavers' week (*Schoolie Survival Tips*), or sport and music events. In noting the impact of the COVID-19 pandemic on youth mental health, the organisation highlighted its campaign to encourage young people to avoid relieving stress through alcohol consumption.[166]

5.125 During the inquiry, the Committee heard repeated calls for a comprehensive, sustained and targeted public health campaign dedicated to AOD-related harms and the support that is available for those impacted. Professor Dan Lubman AM, Executive Clinical Director at Turning Point and Director of the Monash Addiction Research Centre, told the Committee:

> We don't have any community public messaging around alcohol. In my time here over the last two decades, I've never seen a government advertising campaign promoting the idea that this is an actual health issue, that treatment is available and this is how you access treatment. We see that very much in the gambling space. I think one of the things we can say that is positive around gambling at the moment is that there is a very clear message around where to get help. There's no message about where to get help for alcohol and drug problems.[167]

5.126 Professor Lubman further emphasised the need to shift the framing of AOD-related issues as a personal responsibility, and articulate AOD use as a health condition:

---

162 Retail Drinks Australia, *Submission 105*, n.p; Spirits and Cocktails Australia, *Submission 113*, p. 16; Alcohol Beverages Australia, *Submission 61*, p. 10.

163 Spirits and Cocktails Australia, *Submission 113*, p. 26; Independent Brewers Association, *Submission 117*, n.p; Alcohol Beverages Australia, *Submission 61*, p. 14.

164 Spirits and Cocktails Australia, *Submission 113*, p. 3; Alcohol Beverages Australia, *Submission 61*, n.p.; Brewers Association of Australia, *Submission 83*, n.p.

165 Spirits and Cocktails Australia, *Submission 113*, p. 3; See also Independent Brewers Association, *Submission 117*, n.p.; Retail Drinks Australia, *Submission 105*, n.p.

166 DrinkWise, *Submission 192*.

167 Professor Lubman AM, Turning Point, Eastern Health; Monash Addiction Research Centre, *Committee Hansard*, Melbourne, 29 October 2024, p. 11.

> [T]here are prevailing community myths that alcohol, actually, is around personal responsibility; it's about bad people making bad choices. It's not about the fact that the drug is harmful, and that it can create health issues, and that there are opportunities to get help. We need to change that community perspective. Most people in the community don't believe that, when you have problems with alcohol and drugs, the treatment works. So people don't put up their hand for help, and they only put their hands up for help when things have got so bad that there's no other choice.[168]

5.127 The need for a public campaign has been described as particularly urgent in the context of the raise in AOD-related problems triggered by the COVID-19 pandemic. As Professor Lubman noted:

> What we saw during COVID was a huge increase in presentations for alcohol intoxications. […] We're inundated at the moment—both our work privately and, obviously, through Turning Point—with referrals for people who are struggling with their alcohol since COVID. And that's largely driven by the fact that it was widely available and actually endorsed as the key coping strategy for COVID. That was something that was commonly talked about, that alcohol is a way that everyone looked forward to knocking off from work at home and drinking. And the industry actually promoted alcohol parties.[169]

5.128 Dr Paul Grinzi from the Royal Australian College of General Practitioners similarly told the Committee that he had seen a significant increase in new patients since COVID-19:

> COVID lockdown flushed out people who had been drinking and now couldn't hide it because the family were around […] Then the prolonged lockdowns also gave people an opportunity to drink and then continue drinking, and they then found they couldn't stop.[170]

5.129 Multiple witnesses pointed to Australia's experience with tobacco control as an example of successful public health policy that can be applied to alcohol.[171] NCETA explained that 'tobacco control policy reforms that have been implemented over the past 40 years in Australia have contributed to a 75 per cent reduction in smoking prevalence and significant reduction in disease burden'. Furthermore, 'Australia has led the world in implementing bold reforms such as plain packaging, accompanied by graphic health warnings, education campaigns, bans on advertising, and increases in

---

168 Professor Lubman AM, Turning Point, Eastern Health; Monash Addiction Research Centre, *Committee Hansard*, Melbourne, 29 October 2024, p. 11.

169 Professor Lubman AM, Turning Point, Eastern Health; Monash Addiction Research Centre, *Committee Hansard*, Melbourne, 29 October 2024, p. 11.

170 Dr Paul Grinzi, Member, RACGP Specific Interest Group, Addiction Medicine, Royal Australian College of General Practitioners, *Committee Hansard*, Melbourne, 29 October 2024, p. 27.

171 NCETA, *Submission 43*; Alcohol Change Australia, *Submission 76*; Public Health Association Australia, *Submission 106*.

tobacco excises'. The lessons learned in this context could be applied to reduce alcohol-related harms.[172]

5.130 Dr Clark argued that there is a need to re-frame public health messaging around alcohol dependence following the model used for the 'stop smoking' campaigns:

> I think the cigarette anti-smoking education has actually moved towards trying to promote not smoking. That's a really important and subtle difference—a move from trying to educate people about the harms of smoking, warning them about what they're doing to their unborn baby and warning them about what they're doing to their lungs, to: 'Hey, this might be you jogging down the street if you don't smoke. You might be able to chase your kids around the park.'
>
> Those sorts of public messages are actually very attractive. They create a positive health image around not drinking, rather than reinforcing a negative health image around drinking. People with alcohol dependency are already quite locked in to negative images about themselves. So those sorts of negative images don't help to break people out of the patterns of behaviour that they're already locked in to. Creating positive health images at a public health level does help people think about what they might like to be, rather than confirming what they're worried about already.[173]

Committee comments

5.131 The Committee acknowledges that stigma associated with AOD use is a significant barrier to care. It is clear that tailored public campaigns and enhanced training in AOD-related issues for medical professionals could go a long way toward changing the perception of these issues, both among the general public and within the healthcare sector. The Committee also acknowledges the important impact that different harm reduction strategies have in preventing and responding to AOD use. Over the course of the inquiry, alcohol availability and the impact of alcohol advertising and marketing emerged as a major area of concern, and there is clearly an opportunity to develop a more up-to-date framework for managing exposure to and accessibility of alcohol in the internet age. Any such initiatives need to be coupled with a comprehensive public campaign about the health risks of alcohol consumption, which should be pursued as a priority.

---

172 NCETA, *Submission 43*, pp. 4-5.

173 Dr Clark, Princess Alexandra Hospital, Brisbane, *Proof Committee Hansard*, Canberra, 7 February 2025, p. 23.

6. Areas for further investigation

6.1 In conducting this inquiry, the Committee encountered several issues that it was unable to explore in depth. The Committee believes that it would be beneficial if these matters were given further attention in a future inquiry.

6.2 The Committee recognises that building a comprehensive understanding of evolving patterns and emerging types of alcohol and other drug (AOD) use in Australia remains critical for developing effective policy responses. This endeavour inherently requires further research into enhanced detection and monitoring methods, particularly for new substances entering the Australian market.

6.3 While providing a comprehensive critique of the current service models in the AOD sector, much of the evidence submitted to the inquiry also points to models of care that have proven to be effective. The Committee strongly believes that these best practice models, which exist both in Australia and overseas, should be further explored. New management practices (such as at home detox), and novel pharmacotherapies should also be canvassed.

6.4 The Committee acknowledges that AOD harm does not impact all corners of the country nor all Australians equally. While priority populations have been examined to some extent in this issues paper, further study of these cohorts and their unique requirements would be worthwhile. Additional evidence should be gathered, for example, on the impact of AOD-related harm in culturally and linguistically diverse communities; we should also know more about how AOD impacts older Australians, and how health impacts of AOD are addressed in remote and regional communities.

6.5 In reflecting on how AOD-related harms impact different population groups, the Committee believes that more focus should be placed on specific industries. Submissions from individuals and advocacy groups indicate that a culture of AOD use is particularly strong in certain workplaces—a point that undoubtedly merits further research.

6.6 In recognising that AOD-related harms are the product of multiple and diverse factors, the Committee was intrigued by evidence on how our physical environment influences our health, including AOD consumption. This issue is inevitably linked to questions of culture, and how and where Australians spend their leisure time, which in most cases tends to involve alcohol consumption. How to reimagine our public spaces and our free time away from alcohol-centric venues and activities is certainly a question that requires further study.

6.7 Questions pertaining to the link between AOD consumption and gender violence were repeatedly raised throughout the inquiry evidence. While this topic is not specifically addressed in this issues paper, it inevitably frames much of the

discussion contained within. The Committee acknowledges that this is both a significant and tremendously complex issue, which would be worthy of focused consideration in a future inquiry.

6.8 Support for the decriminalisation of drug possession for personal use is also a matter that has been strongly expressed throughout the inquiry. This is, of course, an issue that requires a multidisciplinary and multisector approach. The Committee believes that further study of this proposed reform is required, and would welcome evidence that would allow for a comprehensive understanding of this subject. In this regard, the Committee notes the recommendation made by the Joint Committee on Law Enforcement, that the Australian Government commission research to understand the impact of decriminalisation in Australian and international jurisdictions.

6.9 A future inquiry into the health impacts of AOD would greatly benefit from an in-depth consideration of the international experience across all the topics that were raised in response to the inquiry terms of reference. The Committee is grateful for the offer from entities such as the Global Commission on Drug Policy to inform the inquiry, and hopes for a future forum where these insights could be shared.

6.10 Finally, the Committee wishes to acknowledge the importance of the contribution made by people with living and lived experience of AOD-related harm in support of this inquiry. These witnesses provided unique insights into the challenges of navigating substance use problems; equally, they articulated practical and often very innovative suggestions for change, ranging from using fantasy role-playing games as part of AOD recovery framework, to designing an application to integrate different AOD services. The Committee hopes that the voices of those with living and lived experience come across clearly in this issues paper, and encourages their continued strong input in future evidence-gathering efforts.

Recommendation 1

6.11 The Committee suggests that the successive Standing Committee on Health, Aged Care and Sport (or equivalent) in the 48th Parliament consider completing a full inquiry report into the health impacts of alcohol and other drugs in Australia.

Recommendation 2

6.12 The Committee recommends that the Department of Health and Aged Care consider public submissions and evidence received by this inquiry as it prepares advice to Government on revisions to the National Drug Strategy.

Dr Mike Freelander
Chair

A. Submissions

1 Dr Colin Mendelsohn

2 *Name Withheld*

3 Southern Aboriginal Corporation

4 Australian College of Nurse Practitioners

5 Family Drug Support

6 Australian Association of Psychologists Incorporated

7 Centre for Alcohol Policy Research, La Trobe University

8 Mr John Shaw

9 Dr Simon Holliday

10 SA Commissioner for Children and Young People

11 Ms Stephanie Taylor

12 Suicide Prevention Australia

13 *Name Withheld*

14 Dr Adrian Farrugia

15 Mr Matthew Daniel

16 Dementia Australia

17 Drug Policy Modelling Program, UNSW

18 The Legal Aid Commission of New South Wales (Legal Aid NSW)

19 Royal Australian and New Zealand College of Psychiatrists

20 Oral Health Care Training and Education

21 Centre for Alcohol Policy Research, La Trobe University

22 Alcohol, Tobacco and other Drugs Council (Tasmania)

23 Australian Research Alliance for Children and Youth (ARACY)

24 The Matilda Centre for Research in Mental Health and Substance Use, The University of Sydney

25 Indivior

26 Association of Alcohol and other Drug Agencies NT (AADANT)

27 Mental Health Families and Friends Tasmania

28 New South Wales Council for Civil Liberties

29 Injury Matters

30 ACON

31 Professor Carla Treloar

32 The Youth Support and Advocacy Service (YSAS)

33 Professor Kate Seear

34 Queensland Nurses and Midwives' Union

35 Miss Georgia-Maree Softa

36 Hepatitis Australia

37 Mindseye Training And Consulting

38 Hello Sunday Morning

39 Carers Tasmania

40 Ms Narella Coleman-Flood

41 Victorian and Tasmanian Primary Health Network Alliance

42 Clubs Australia

43 National Centre for Education and Training on Addiction (NCETA)

44 Drug ARM

- 44.1 Supplementary to submission 44

45 Australian Alcohol and other Drugs Council

46 Network of Alcohol and other Drugs Agencies (NADA)

47 National Women's Safety Alliance

48 Health and Community Services Union

49 Sana Health Group

50 Windana

51 Youth Empowered Towards Independence

52 Pharmacy Guild of Australia

53 Your Community Health

54 360Edge

55 Primary Health Network NSW ACT Alcohol and Other Drugs Network

56 Community Restorative Centre

57 ASHM Health

58 South Australian Council of Social Service (SACOSS)

59 Students for Sensible Drug Policy Australia

60 Royal Australasian College of Surgeons

61 Alcohol Beverages Australia

62 Palmerston Association

63 Australian Dental and Oral Health Therapists' Association (ADOHTA)

64 NT Health

65 Mr Zac Chu

66 Montu

67 headspace National

68 The Salvation Army

- 68.1 Supplementary to submission 68
- Attachment 1

69 The Aboriginal Health & Medical Research Council of NSW (AH&MRC)

70 Mr James Brett

71 Mr Greg Peak

72 Alcohol Tobacco and Other Drug Association ACT

73 Mr Trevor Royals

74 Western Australian Network for Alcohol and other Drug Agencies (WANADA)

75 The Queensland Network of Alcohol and other Drug Agencies (QNADA)

76 Alcohol Change Australia

77 Alcohol and Drug Foundation

- Attachment 1
- Attachment 2

78 Lives Lived Well

79 Uniting NSW ACT

80 Australian Medical Association

81 Ms Rachel Allen

82 Advanced Pharmacy Australia (AdPha)

83 Brewers Association of Australia

84 Royal Australian College of General Practitioners (RACGP)

85 Harm Reduction Australia

86 Food for Health Alliance

87 Foundation for Alcohol Research and Education

88 Ms Margaret Quon

89 Australian Federal Police

90 National Rural Health Alliance

91 Turning Point, Eastern Health and the Monash Addiction Research Centre

92 Australasian Therapeutic Communities Association (ATCA)

93 Australian College of Rural and Remote Medicine

94 South Australian Network of Drug and Alcohol Services

95 Australasian College For Emergency Medicine

96 The Royal Australasian College of Physicians

97 EACH - Reconnexion

98 Confidential

99 Confidential

100 *Name Withheld*

101 Australian College of Midwives

102 Australian Hotels Association (WA)

103 Cannabis Council Australia

104 Queensland PHN Alcohol and Other Drugs Network

105 Retail Drinks Australia

106 Public Health Association Australia

107 St Vincent De Paul Society NSW

108 Dr Gabriel Caluzzi

109 QuIHN Ltd & QuIVAA Inc

110 Cancer Council Australia

111 The National Drug & Alcohol Research Centre, UNSW

112 Confidential

113 Spirits & Cocktails Australia

114 Victorian Alcohol and Drug Association

115 Mission Australia

116 Dr James Gooden and Dr Georgia Bolt

117 Independent Brewers Association

118 Ngaimpe Aboriginal Corporation (The Glen Group)

119 Aboriginal Drug and Alcohol Residential Rehabilitation Network (ADARRN)

120 National Centre for Youth Substance Use Research (NCYSUR)

121 Mr Benn Veenker

122 Clean Slate Clinic

123 Mr Michael Wills

124 Uniting Communities

125 Ms Kathryn Elliott

126 Department of Education

127 *Name Withheld*

128 Consumers Health Forum of Australia

129 National Organisation for Fetal Alcohol Spectrum Disorders (NOFASD)

130 Multicultural women Victoria

131 Mr Simon Hirtzel

132 Dr Sophie Yates and Professor Lorana Bartels

133 Healthy Cities Illawarra

134 The University of Sydney and the CICADA

135 Yarra Drug and Health Forum

136 Odyssey Victoria

137 South-East Monash Legal Service

138 Mind Australia Limited

139 ABAC Scheme Limited

140 National Indigenous Australians Agency

141 National Drug Research Institute

142 Australian Institute of Health and Welfare

143 Stroke Foundation

144 Australian Injecting and Illicit Drug Users League (AIVL)

145 National Aboriginal Community Controlled Health Organisation

146 Australian College of Nursing

147 Fairfield City Council

- Attachment 1

148 Alcohol and Other Drug Consumer and Community Coalition (AODCCC)

149 Orygen

150 Australian Psychological Society

151 Australasian Injury Prevention Network

152 Community Industry Group

153 Ms Kym Valentine

154 Mr Samuel Martin

155 Institute for Urban Indigenous Health

156 UNSW School of Population Health Advocacy Lab

157 Department of Health and Aged Care

158 Central Australian Aboriginal Congress

159 Western Australian Mental Health Commission

160 Mr William Spaul

161 SureScreen Diagnostics (Australia)

162 Painaustralia

163 Royal Life Saving Society Australia

164 National Heart Foundation of Australia

165 Uniting Victoria and Tasmania

166 Alcohol Change Vic

167 Queensland Mental Health Commission

168 SMART Recovery Australia

169 The George Institute for Global Health

170 Pharmaceutical Society of Australia

171 National Centre for Clinical Research on Emerging Drugs (NCCRED)

172 National Suicide Prevention Office

173 South East Community Links

174 Mr Rodney Holmes

175 Associate Professor Geoffry Spurling, Dr Idin Panahi and Dr Warren Jennings

176 Drug Free Australia

- 176.1 Supplementary to submission 176

177 Drug and Alcohol Services South Australia

178 Burnet Institute

179 Odyssey House NSW

180 Eastern Community Legal Centre

181 WA Primary Health Alliance

182 Miss Tayla Payne

183 Dr Kelly McNamara and Ms Ebony Quintrell

184 FASD Hub Australia

185 The Construction Industry Drug and Alcohol Foundation

186 Cohealth

187 *Name Withheld*

188 Penington Institute

189 LGBTIQ+ Health Australia

190 AOD clinicians within the NSW public sector

191 Mental Health Lived Experience Peak Queensland

192 DrinkWise Australia

193 Social Work Policy and Advocacy Action Group (at RMIT University)

194 Karralika Programs Incorporated

195 Griffith University: Parents under Pressure

196 Mr Chris Gimpel

- Attachment 1

197 Department of Infrastructure, Transport, Regional Development, Communications and the Arts (DITRDCA)

198 NSW Users and AIDS Association (NUAA)

199 Health Complaints Commissioner

- Attachment 1

200 The Department of Health, Tasmanian Government

201 Ms Angelene Bruce

202 Confidential

203 Ms Patricia Koskovic

204 Harvest Advisory and Research

B. Additional documents

1 Royal Australian and New Zealand College of Psychiatrists – answers to questions taken on notice at a public hearing on 28 October 2024

2 Alcohol and Drug Foundation – answers to questions taken on notice at a public hearing on 28 October 2024

3 Turning Point and Monash Addiction Research Centre – answers to questions taken on notice at a public hearing on 29 October 2024

4 Royal Australian College of General Practitioners – answers to questions taken on notice at a public hearing on 29 October 2024

5 Brisbane North PHN – answers to questions taken on notice at a public hearing on 30 October 2024

6 Centre for Alcohol Policy Research, La Trobe University – answers to questions taken on notice at a public hearing on 29 October 2024

7 The Loop Australia – answers to questions taken on notice at a public hearing on 30 October 2024

8 National Organisation for Fetal Alcohol Spectrum Disorder – answers to questions taken on notice at a public hearing on 7 February 2025

9 Australian Federal Police – answers to questions taken on notice at a public hearing on 7 February 2025

C. Hearings and witnesses

Monday 28 October 2024 - Melbourne

Royal Australian and New Zealand College of Psychiatrists

- Dr Elizabeth Moore, President

Alcohol and Drug Foundation

- Dr Erin Lalor, Chief Executive Officer
- Ms Chloe Bernard, Senior Policy Officer
- Mr Robert Taylor, Manager, Policy and Engagement

The Youth Support and Advocacy Service (YSAS)

- Mr Andrew Bruun, Chief Executive Officer
- Mr Dominic (Dom) Ennis, General Manager, Quality and Service Development

EACH - Reconnexion

- Dr Andrew Mau, National Practice Lead General Practice
- Dr Erin Oldenhof, Benzodiazepine Withdrawal Counsellor and Research and Innovation Lead
- Mr James Szeto, Team Leader
- Mr Nicholas Teo, Program Director, Mental Health and Alcohol and Other Drugs

Australian College of Nurse Practitioners

- Adjunct Associate Professor Leanne Boase, Chief Executive Officer

Tuesday 29 October 2024 - Melbourne

Centre for Alcohol Policy Research, La Trobe University

- Professor Emmanuel Kuntsche, Director
- Professor Robin Room

Turning Point, Eastern Health and the Monash Addiction Research Centre

- Professor Dan Lubman AM, Executive Clinical Director
- Mr Benn Veenker, Lived Experience, Workforce and Advocacy

Royal Australian College of General Practitioners (RACGP)

- Dr Paul Grinzi, Member, RACGP Specific Interest Group—Addiction Medicine

Windana

- Mr Adam Miller, Chief Communications Officer
- Mr Mark O'Brien, Chief Operations Officer

Centre for Alcohol Policy Research (Priority Populations), La Trobe University

- Adjunct Professor Scott Wilson, Priority Populations Adjunct Professor; and Chief Executive Officer, Aboriginal Drug and Alcohol Council (SA) Aboriginal Corporation
- Professor Kylie Lee, Professor of Public Health and Priority Populations Research Lead

Australasian College for Emergency Medicine

- Professor Diana Egerton-Warburton, Representative, Public Health and Disaster Committee

Wednesday 30 October 2024 - Brisbane

Drug ARM

- Ms Alex Davis, Senior Manager, Communications
- Dr Joseph Debattista, Vice Chair, National Policy Council
- Emeritus Professor Jake Najman, Chair, National Policy Council
- Dr Dennis Young AM, Chief Policy Advocate

Queensland Injectors Health Network (QuIHN)

- Mr Geoffrey Davey, Chief Executive Officer [by audio link]
- Ms Nicola Hayes, Head of Services [by audio link]

The Loop Australia

- Mr Cameron Francis, Chief Executive Officer

Brisbane North Primary Health Networks

- Ms Libby Dunstan, Chief Executive Officer
- Ms Caroline Radowski, Executive Manager, Mental Health and Wellbeing

Alcohol and Drug Information Service

- Dr Jeremy Hayllar, Clinical Director, Metro North Mental Health Alcohol and Drug Service, Queensland Health
- Mrs Kiara Palmer, Acting Director, Adis 24/7 Alcohol and Drug Support

Thursday 7 November 2024 - Canberra

Ngaimpe Aboriginal Corporation (The Glen Group)

- Mr Alexander Lee, Chief Executive Officer
- Mr Joseph Coyte, Executive Director

Thursday 21 November 2024 - Canberra

National Centre for Youth Substance Use Research, The University of Queensland

- Professor Leanne Hides, Deputy Director [by audio link]
- Dr Daniel Stjepanovic, Research Fellow [by audio link]

Thursday 28 November 2024 - Canberra

The Queensland Network of Alcohol and other Drug Agencies (QNADA)

- Ms Rebecca Lang, Chief Executive Officer [by video link]

Friday 7 February 2025 - Canberra

Foundation for Alcohol Research and Education

- Ms Caterina Giorgi, Chief Executive Officer
- Ms Rachel Allen, Private capacity

National Organisation for Fetal Alcohol Spectrum Disorders

- Mrs Sophie Harrington, Interim Chief Operating Officer
- Ms Jessica Birch, Private capacity
- Ms Angelene Bruce, Private capacity

Princess Alexandra Hospital

- Dr Paul Clark, Director, Alcohol and Drug Assessment Unit [by video link]

Department of Health and Aged Care

- Ms Trish Clancy, First Assistant Secretary, Population Health Division
- Mr Avi Rebera, Assistant Secretary, Office of Drug Control
- Mrs Tracey Lutton, Assistant Secretary, Regulatory Practice and Support Division
- Mr Ben Mudaliar, Assistant Secretary, Alcohol and Other Drugs Branch
- Professor Robyn Langham, Chief Medical Advisor [by video link]

Department of Education

- Ms Pamela Banerjee, Assistant Secretary, Wellbeing and Equity Branch
- Ms Paula Sheehan, Assistant Secretary, Inclusion and Disability Branch

Australian Federal Police

- Mr Adam Rice, Acting Assistant Commissioner, Crime Command
- Ms Paula Hudson, Commander Transnational Operations, Crime Command

Additional Comments by Coalition Members

While not disagreeing with the recommendations of the report, Coalition Members would like to clarify several issues in relation to this issues paper.

It is important to emphasise that this is only an issues paper, there are no substantive recommendations in the report. Nothing in this report should lead any reader to the view that the Committee has concluded views about the issues canvased.

In chapter two, in relation to the regulation and effects of alcohol there is a need to hear from both sides before coming to any concluded views.

In chapter three there are a range of controversial observations that have been made about harm minimisation and the approaches of law enforcement—these need to be tested with evidence from state and territory police.

In chapter five, a range of highly contested policy responses are raised. It will be important that the Committee receives submissions and takes evidence from a much wider range of stakeholders to test the evidence, on all matters contained in that chapter, before reaching any conclusions.

Mr Julian Leeser MP

Mr Mark Coulton MP

Ms Jenny Ware MP