



Response to: National Safety and Quality Health Service (NSQHS) Standards (third edition)

Australian Commission on Safety and Quality in Health Care

www.safetyandquality.gov.au

GPO Box 5480 Sydney NSW 2001

Level 5, 255 Elizabeth Street, Sydney NSW 200

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Acknowledgement of Country

The Alcohol and other Drug Consumer & Community Coalition acknowledges Aboriginal and Torres Strait Islander peoples as the traditional custodians of this country and its waters. We pay our respect to elders past and present and extend this to all Aboriginal and Torres Strait Islander peoples.

Recognition of Lived and Living Experience

We recognise the individual and collective expertise of those with a lived or living experience of alcohol and other drugs. We appreciate and respect the emotional labour and vulnerability that is present in this space. We recognise the work of those who came before us to build the foundations to enable this work to take place.

About AODCCC

The Alcohol and Other Drug Consumer & Community Coalition (AODCCC) is the peak body for alcohol and other drug consumer and community informed systemic advocacy in Western Australia. With over a thousand members onboard, the AODCCC is a conduit for individuals and families with living & lived experience of alcohol and other drugs to have their voice heard. Our aim is to empower the voices of consumers, their families and supports, ensuring the health and wellbeing of our community. The knowledge, insights and expertise of lived & living experience is integral not only to the work of the AODCCC but also plays a vital role for communities all over WA.

Executive Summary

The Alcohol and Other Drug Consumer & Community Coalition (AODCCC) welcomes the opportunity to contribute to the Australian Commission on Safety and Quality in Health Care (the Commission) consultation, National Safety and Quality in Health Service (NSQHS) Standards 3rd edition.

AODCCC supports the proposed direction outlined in the [Rational for Change](#) and welcomes the Commission's commitment to strengthening the NSQHS Standards [1]. We support the proposed consolidation of the existing eight standards into three integrated standards; Clinical Governance, Person-Centred Practice, and Safe Clinical Systems as an approach which holds potential to help create safer, less stigmatising, higher-quality care within our health services. The Commission's commitment to stronger governance presents a timely opportunity to strengthen consumer and carer partnerships, enhance workforce capability, and elevate Lived and Living Experience (LLE) leadership to improve Australia's health systems. These represent priorities which also align with aspirations of people with lived and living experience of alcohol and other drug (AOD) use, including families, carers, kin, and significant others.

AODCCC's work on AOD-related stigma in Western Australian health settings shows that stigma is not merely an individual attitude or behaviour, but a systemic issue embedded in healthcare structures and practices. It takes the form of self-stigma, public stigma, stigma by association and structural stigma. Structural stigma arises when policies, procedures and health service systems create barriers to care or exclude people, families and carers because of actual or perceived AOD use [2]. As the primary framework guiding safety, quality, governance, and workforce expectation in Australian healthcare, the NSQHS Standards present a significant opportunity, and responsibility, to explicitly address such stigmas and drive system wide change.

Australian jurisdictions are increasingly recognising AOD related stigma as a systemic barrier to health access, safety, and equity, therefore are beginning to embed stigma reduction within policy and reform agendas. For example, [The Queensland Alcohol and Other Drugs Plan 2022-2027](#) explicitly identifies reducing stigma as a core priority within health system reform [3]. Within this context, the absence of stigma as a priority area within the proposed NSQHS Standards is a significant omission. Today jurisdictions both locally and globally are increasingly embedding AOD related stigma awareness and reduction into policy and systems reform, hence the NSQHS Standards risk lagging behind contemporary best practice. As Australia's leading safety and quality framework, they should demonstrate national leadership by explicitly recognising, measuring, and addressing stigma across the broader health system.

Community Voices

This submission draws on feedback gathered through AODCCC's reference groups and broader systemic advocacy activities. During August and September 2026, AODCCC members with lived and living experience of AOD use, inclusive of families, carers, kin, and significant others reviewed the draft NSQHS Standards (3rd Edition) whilst participating through AODCCC-led consultation activities. In doing so, they gave effect to the Commission's vision of “*empowered patients, families, carers, and communities*”, where healthcare is designed and delivered in partnership with the people it impacts [4]. This vision recognises that safe, high-quality healthcare is strengthened when patients, families, carers and communities are actively involved in decision-making, service design and quality improvement processes. For people with AOD lived and living experience, inclusive practice is similarly grounded in relational and systems-based approaches, recognising that AOD use, harm, treatment and recovery occur within interconnected family, kinship and social networks. Accordingly, the extent to which health services engage with and support these broader systems can significantly influence safety, health outcomes and experiences of care for all individuals, families and communities alike [5].

Participants emphasised the Commission's vision cannot be fully realised while AOD related stigma remains embedded within healthcare systems, continuing to undermine safe, equitable, and person-centred care.

This submission reflects the collective expertise of AODCCC's diverse membership. Many contributors drew on both personal and professional experience within health systems, offering a uniquely comprehensive perspective on how the proposed Standards may operate in practice and shape the safety, equity and effectiveness of care.

Our members voices are included throughout this submission as direct feedback and are further thematically summarised in the Community Consultations section.

“The standards need to specifically state that AOD use does not reduce a person's right to safe and respectful healthcare, and that stigma around AOD use is a risk to patient safety. Tell patients they have the right to be believed when they describe pain or symptoms, and to have their health conditions assessed properly even if they use alcohol or other drugs.”

“From my own lived experience, I have felt reluctant to share what was really going on for me because of the obvious lack of compassion shown by staff in some of the healthcare facilities I attended. It was often admin staff and sometimes the doctor. Their eyerolling and sighing made me feel burdensome and made me want to flee rather than open up.”

AODCCC 5 Key Recommendations are that NSQHS Standards

1. Recognise stigma as a patient safety and quality issue

Explicitly name and recognise AOD related stigma within *safe clinical systems standard* as a preventable source of harm, a barrier to safe, equitable, accessible, and person-centred care.

Must identify, monitor, and address the impacts of perpetuating stigma as part of a continuous quality and safety improvements.

“This shouldn't just be a gesture of paying lip service by sticking a policy on the wall. Every staff member should be trained in how to relate to clients, their carers and families in need. It's very often about body language, not words.”

2. Strengthen Family and Carer Inclusion

Strengthening practice guidance by explicitly recognising that confidentiality and consent are not barriers to acknowledging and supporting families, carers, kin and significant others.

Health services should be encouraged to engage with families respectfully, receive information from them, provide general information and support, and recognise their caring role, even where consent to disclose personal health information has not been provided.

“You have to know what to say to get the treatment your loved one needs and deserves (if you are lucky!)”

3. Embed Lived and Living Experience (LLE) leadership in governance and service design and improvement

Require health service organisations to include AOD lived and living experience expertise in the design delivery and evaluation of *person-centred practice standards*, within consumer, carer, family and employee feedback mechanisms.

To increase AOD LLE leadership within *clinical governance standard* requires health service organisations to adapt, and to evolve within governance, leadership, planning, and service improvement structures.

“Lived experience is only now starting to receive the merits that it deserves... this has not yet included appropriately the voices of families and carers.”

4. Align health system with harm reduction

To ensure healthcare pathways, policies and clinical responses actively uphold the dignity, human rights and inclusion of people who use drugs by eliminating stigma and punitive practices as barriers to care. *Safe clinical standards systems* must be designed to foster trust, engagement and equitable access, by embedding harm reduction as an evidence-based standard of care and ensuring that no person is excluded, criminalised or denied care because of their substance use.

“Recognise and encourage every step towards harm reduction. Peer support workers with lived experience should be embedded in healthcare settings, especially emergency departments. With appropriate training, they could support people through a crisis while they wait for medical care, helping them feel less judged and encouraging them to remain and receive treatment.”

5. Build workforce capability to reduce stigma and improve care

Require health services to actively build workforce capability in stigma awareness and reduction *within person centred practice standard*. This is achieved through training that has been co-designed and informed by people with LLE of AOD.

Stigma reduction to be recognised as a core safety and quality competency, with health services required to demonstrate its application through measurable improvements in clinical practice and the experiences of consumers, families, carers and employees.

“Educating staff about the importance of meeting people and families where they're at is critical. Stigma exists because of stories, some of which are hard-hitting and are usually showing how people with addictions have wreaked havoc on the lives of their loved ones. This feeds the narrative that 'addicts' choose to be 'addicts' and because of this, they deserve to be treated with less respect.”

“I believe we need a diverse range (including family) peer workers in the healthcare system as a must. Someone who understands, has lived experience and can help support rather than judge.”

“More education to front liners and having inclusive lived experience people in governance and on boards so that lived and living experience people are involved in decision-making.”

“Every person, irrelevant of background, deserves to be met where they're at in any given moment when they are looking for support. Specifically, the Standards around ‘care environment’ currently focuses on providing training for staff in managing behaviours of concern in relation to clients. I would like to see there be training for health staff in how to leave their biases behind when they come to work.”

Written survey overview feedback:

Why stigma awareness and reduction belong within the NSQHS standards

AODCCC’s central concern is that the NSQHS Standards (3rd edition) do not explicitly recognise alcohol and other drug-related stigma as a safety and quality priority. Whilst the Standards acknowledge bias, discrimination, cultural safety and equity, they stop short of recognising stigma as a distinct and measurable barrier to healthcare access, experience and better health outcomes. This is a significant gap in Australia’s primary healthcare safety and quality framework. [AODCCC](#) and other leading Australian organisations, including the [Alcohol and Drug Foundation](#) and [Cancer Council WA](#), have repeatedly shown that the harms of AOD stigma arise across society, ranging from being found within systemic patterns and individual attitudes. These impacts are most effectively addressed through governance, workforce development, and by systems design working together.

For our members AOD related stigma continues to manifest through judgement, differential treatment, and exclusion in health service [2]. These experiences influence whether a person, their family, and their carers seek health support, disclose important health information, engage in health treatment, or even return for ongoing healthcare.

Despite policy directions such as [National Preventive Health Strategy NPHS \(2021-2030\)](#), which commits to valuing health before illness, and supporting longer, healthier lives through prevention and early intervention [6], AODCCC consultations evidenced that AOD related stigma continues to undermine the objectives of the NPHS.

Anticipated and experiencing AOD related stigma will deter people from accessing healthcare early, contributing to poorer health outcomes and increasing the risk of preventable harm. Structural and policy settings are creating barriers to care even within low-threshold services, particularly where treatment approaches prioritise abstinence and detoxification over harm reduction resulting in the exclusion of people whose goals do not align with these models of care [7]. As such AOD-related stigma extends beyond individual attitudes and behaviours; it is embedded in healthcare systems, organisational cultures, policies and practices [8]. Consequently, it can compromise accurate clinical assessment, informed decision-making, continuity of care, and the trust that consumers, families and carers place in health services.

Australians use AOD in varied ways and with differing frequency, and most AOD use does not result in dependence [9]. However, attitudes are often shaped by stereotypes that fail to reflect this diversity. People who use AOD, including those experiencing substance dependence, come from all walks of life and are not defined by income, occupation, age, cultural background or

geographic location [10]. Misconceptions about AOD use reinforce stigma, contribute to discriminatory treatment and create barriers to healthcare. AOD-related stigma therefore reflects entrenched social assumptions rather than the diverse realities of people affected by substance use and dependence.

Explicitly recognising AOD-related stigma alongside bias, discrimination, cultural safety and equity would help the NSQHS Standards address a persistent and preventable barrier to healthcare access and better outcomes. As Australia's leading safety and quality framework, the Standards can drive system-wide change by requiring health services to identify, measure and reduce stigma. AODCCC therefore calls on the Commission to embed stigma reduction throughout the Standards. This would strengthen the commitment to safe, equitable and person-centred care and help ensure that everyone seeking healthcare is treated with dignity, respect and compassion.

AODCCC members respond to both Consumer and Health Sector Surveys

“People need to be able to read or be told that the Standards recognise AOD stigma as a safety and quality issue and that services are expected to prevent the harms it causes”

“References to bias, equity or person-centred care are not enough on their own, they leave too much room for interpretation and too little accountability, I think”

“Healthcare workers and service providers need better support and education so they can be open-minded in order to ensure people who require (AOD) support get the best chance of recovery.”

“Non-judgement, compassion, empathy and a can-do attitude will help a client to feel safe, respected and willing to return for care.”

“The standards should involve authentic family voice, families are still not included”

“Without knowledge we are flying blind”

“Services can meet the letter of the Standards while people continue to be dismissed blamed avoided, undertreated or treated differently because of their substance use.”

“Staff need to engage with every client with respect. What does this look like? Listening. Not rolling eyes. Not sighing. Speaking calmly and with a genuine desire to help the person get the support they need. Speaking quietly and discreetly is also important. Very often a client will feel shame. They need to be protected”
“Stop allowing the use of stigmatising language”

Disability awareness; involving families and carers where appropriate, with continuity of care”

“Connect the supports”

“A good manager of first impressions counts this may be the receptionist”

We speak openly and honestly within our health services

AODCCC recommends that the *Clinical Governance Standard* requires health service organisations to identify, collect, monitor, and respond to data relating to AOD related stigma as a clinical safety and quality indicator. This would include the collection and analysis of incident reports, consumer, family and carer feedback, and complaints data analysed and disaggregated by AOD use status where possible. Governance and quality improvement processes should also examine whether organisational policies, triage practices, service entry pathways, and escalation procedures inadvertently reinforce stigma or create barriers to equitable care. Embedding these measures within clinical governance would strengthen accountability and enable health services to identify, measure, and reduce the impacts of stigma for consumers, families and carers experiences.

AODCCC considers governance to be the most effective mechanism for addressing structural stigma within healthcare settings. This includes reviewing policies and practices through a stigma and equity lens, strengthening cross-sector collaboration, and establishing transparent accountability mechanisms. AOD-related stigma can be particularly harmful when health, justice, education, housing, and social support systems operate in silos, resulting in fragmented care and poorer outcomes for consumers and their families and carers. Yet stigma reduction can be embedded within governance systems as a measurable and reportable quality improvement priority, rather than treated as an aspirational objective. AODCCC recommends that the Clinical Governance Standard explicitly establish the following foundations for transformative, continuous learning in future health service implementation, for instance:

- Receive regular board and executive-level reporting on AOD related stigma and discrimination complaints, incidents, and feedback as part of standard clinical governance and quality reporting.
- Review policies, procedures, models of care, and patient record systems for language, assumptions, and practices that may stigmatise people who use alcohol and other drugs, as well as their families, carers, kin, and communities.
- Establish AOD related stigma as a distinct, named, and monitored clinical risk and complaints category, rather than subsuming it within broader discrimination or consumer experience categories. Issues that are not explicitly identified are less likely to be measured, monitored, or acted upon.
- Improve health literacy, champion sector-wide language reform by advocating for organisational, clinical and policy standards that promote person-first care and address stigmatising terminology. Language is a driver of transformative service design and decision-making. A substantial body of evidence demonstrates the influence of stigmatising language in shaping perception and attitudes within our health services [8].
- Report publicly on stigma reduction initiatives, quality improvement activities, and measurable outcomes to ensure accountability, transparency, and continuous improvement across health services.

Lived and Living Experience Inclusion

AODCCC calls for the increased inclusion of LLE Leadership within the NSQHS Standards as a distinct, recognised, and valued form of expertise. This expertise when embedded across governance, service design, quality improvement, and system transformation processes, ensures that people with lived and living experience of AOD use can contribute equally, meaningfully, and safely at all levels of the health system. Workforce development initiatives are required to address AOD-related stigma, particularly training that is co-designed and co-delivered with people who have lived and living experience, such as [Substance Use Stigma: Awareness & Action Training](#) where outcomes can be evaluated through measurable change rather than assumed benefit. Consistent with these approaches, workforce development best operates through systemic, organisational, and individual levels, rather than focusing solely on practitioner knowledge and skills [11]. For instance:

- Ensure LLE inclusion provisions apply equally to individual consumers who use AOD, and families, carers, kin and significant others of people who use AOD, all of whom reported being excluded from service communication, including care conversations because of stigma.
- Require health services to proactively invite families, carers, kin, and significant others input on a regular basis, rather than leaving inclusion to individual service planning and staff discretion.

- Further embed diverse AOD peer workers, people with AOD LLE, and family/ carers/ kin/ significant others with AOD LLE directly into health services, health consultancy, clinical settings, board rooms, and training settings, as advocates, educators, and innovators.

Safer Clinical Systems

AODCCC understands that safer clinical systems for people who use AOD, their families and carers are dependent on health care pathways which are harm reduction informed, rather than punitive. Increasingly digitalised health record information systems should protect the privacy of AOD related health information given the heightened risk of stigma and discrimination associated with its disclosure by:

- Explicitly guard against premature or punitive decisions based on a person's current, previous, historic or perceived AOD status.
- Require continuity of care where AOD use intersects with mental health, physical health, justice and disability services and systems.
- Where health services implement digitally enabled care and integrated digital health records to improve continuity of care, care coordination, and service integration. This should be supported by robust privacy protections, informed consent processes, and clear governance arrangements to ensure the appropriate collection, access, sharing, and recording of AOD-related health information.

Community Consultations

During August and September 2026, AODCCC consulted with people with lived and living experience of AOD use, including individuals, family members, carers, kin, significant others, supporters, and allies. Participants brought a diverse range of perspectives and experiences, including those of former and current health professionals, public servants, and community advocates.

Feedback is categorised and summarised into **8 themes**. Which have directly informed **AODCCC's 5 Key Recommendations** on pages 5 and 6, and **written survey overview feedback** on pages 7-10.

Theme 1 - Being Heard, Respected and Understood

- Participants consistently raise the importance of being listened to treated with dignity and respect and having their concerns taken seriously.
- Noted that the Standards can read as aspirational rather than achievable, and questioned whether services have sufficient staff and workable feedback systems to deliver on them in practise.

- Emphasise the first impressions matter; the attitude of reception, triage, and frontline staff often determines whether a person feels safe enough to try to be heard.

“To a professional, it may be a job. To the individual or family seeking health support, it is the most important thing in their life. What may be a routine matter for a health service may be the most urgent and significant experience the individual has ever faced.”

Theme 2 - Family, Carer, Kin, Significant Other Inclusion

- Participants strongly and consistently called for family carers and significant others to be formally included in care, wherever appropriate and with the person's consent.
- Participants reported that, in current practice, family members and significant others often do not feel recognised as important partners in care by health system staff. They noted that families are not proactively engaged, even when their knowledge of the person's condition is essential for ensuring safe and effective healthcare.
- Proposed a standard requiring health services to formalise family carer and significant other systemic advocacy and advisory input.
- Spoke of heightened tension between protecting patient privacy and the risk of family exclusion, which can be navigated rather than defaulted towards exclusion.
- Strengthen recognition of the distinct roles and rights of Next of Kin, family members, carers, kin and significant others, acknowledging that these roles may overlap but are not synonymous.

“Because it affects my whole family. The stress and anxiety...are massive”

“We hold critical, daily tested, knowledge and provide ongoing, unpaid expertise”

“FCSO voices are sometimes included, but often not meaningfully... mainly involved during crises rather than shared planning.”

“No one listens when your child is an adult.”

“You are viewed as an enabler... cannot be trusted.”

Theme 3 - Practise Compassion, Collaboration, Connection and Creativity

- Participants raised the ongoing separation of mental health and AOD care as a significant problem.
- Specifically identified that mental health and AOD care is stopped when a person enters the custody or the justice system.
- Described difficulty with treatment transitions between services and a lack of communication and information sharing between health services resulting in families falling through the gaps.
- Asked for practical follow up after referrals, including confirmation that recommended support services were available and accessed.

“Inclusion is episodic rather than ongoing, consultative rather than determinative.”

Theme 4 - Accountability and Transparency

- Participants wanted health services to regularly seek feedback from individual patients, from families and carers and to demonstrate how and if that feedback has been used.
- Requested improved health service requires improved patient charter of rights that include not being stigmatised, and a parallel charter of rights for family, carers, kin and significant others.
- Requested clearer pathways for raising concerns, comments, and complaints.

“My husband and I’ve been through hell and back... and never been once have we been approached by the service.”

Theme 5 - Making the Standards Accessible

- Participants said that previous NSQHS standards are not accessible to the people they are meant to protect. They asked for a short, plain language summaries documents setting out what consumers, families, carers and providers together should each expect.
- Participants asked for this information to be available in different languages and accessible formats, and to be physically available in hospitals, primary healthcare settings, allied health settings, GP clinics, emergency departments, mental health, drug and alcohol services and all community health services.

“Most of my contact is in emergency departments and there it varies wildly from Dr to Dr, from nurse to nurses So either there's no guidelines, or they're not being followed”

Theme 6 - Safety, Judgement and the Impact on Disclosure and Health care

- Several participants described withholding information around current or past AOD from health professionals because of an immediate, visible shift in a clinician's body language, tone or attitude.
- Participants shared experiences where a tendency for unrelated symptoms were attributed to AOD use rather than properly investigated.
- Described being judged within AOD treatment settings themselves, including by staff.
- Having their distress or a decision to leave a health service assumed to be about seeking substances rather than being asked about reasons directly.
- Fear of not being believed, particularly in relation to pain and psychiatric symptoms, was a recurring theme, including in situations unrelated to current the use.

“I have refrained from mentioning past or present drug use to doctors because of the immediate change in attitude, and reduction in reason for my symptoms, they assume drug use as being the cause. This has been in a GP's office and in emergency. The risk of this, especially in emergency, is the potential impact of hospital administered drugs interacting with whatever has been taken prior to admission. I have been called drug seeking due to my severe period pain. It took years for me to be clinically diagnosed with adenomyosis despite repeatedly attending hospital, questioned as to whether I was seeking opioids for months when in fact my Mirena had punctured my uterus.”

Theme 7 - What does respectful, Person-Centred Care looks like?

- Participants consistently called for a diverse range of peer workers to be integrated directly within all health services, particularly emergency departments, to support people in crisis, help advocate on their behalf, and educate other staff.
- A person's AOD history to inform, but never to be used to judge their current presentation.
- Participants pointed to the public narrative that frames addiction as a choice as a root cause of stigma and called for better health staff education to be focused on open mindedness, compassion and meeting people where they are.
- Established Lived and Lived Experience designated positions within health workforces at all levels of the health service, including governance.

Theme 8 - Specific changes needed in the NSQHS Standard (3rd edition draft)

- Participants were specific and consistent in calling for AOD related stigma to be named.
- That stigma awareness should be a distinct, measured, monitored clinical risk rather than folded into general discrimination categories.
- Participants also wanted existing health service care, giving an example of repeat pain management prescriptions to be protected from cancellation or restriction without notice or genuine consultation and for health staff to be further trained specifically to identify and set aside their own AOD bias.
- Participants wanted the Standards to state explicitly that AOD/substance use does not reduce a person's right to safe, respectful and properly assessed healthcare and that AOD related stigma is itself a patient safety risk.
- Participants said that generic references to bias, equity and person-centred care are not sufficient on their own because they leave too much room for interpretation and too little accountability when stigma occurs.
- Called for further workforce training to identify and reduce AOD stigma. Citing that lived and living experience informed co-designed training, such [Substance Use Stigma: Awareness & Action Training | AODCCC](#) is effective, delivered with people who have lived and living experience, and its impact is measured rather than assumed.

“Let’s hope we can see a change reflected in health service workplace behaviour, particularly around tone and body language, not only just in policy documents.”

“Every person, irrelevant of background, deserves to be met where they're at in any given moment when they are looking for support. Specifically, the Standards around Care Environment currently focuses on providing training for staff in managing behaviours of concern in relation to clients. I would like to see there to training for staff in how leave their biases behind when they come to work.”

“While I understand that it is often frontline staff who can be the targets of unacceptable behaviour from unwell clients, I have witnessed frontline staff being judgemental and rude to clients who are behaving appropriately but are not hiding their condition.”

“I need decisions not to provide pain relief should be clearly justified and based on clinical evidence, not assumptions about my past AOD use.”

“My clinical records to be free from stigmatising language such as “alcoholic!”

Conclusion

AODCCC supports the overall direction of the NSQHS (third edition) and its shift towards outcomes, learning and person centred, culturally safe care. However, stigma experienced by people who use alcohol and other drugs must be made explicit and measurable with the standards, not left implicit within the broader commitment to bias, cultural safety and equity.

The evidence presented in this submission, including findings from the published literature, AODCCC's Stigma Position Paper, the Queensland precedent of recognising stigma as a distinct policy priority, and the voices of family members, carers, and people with lived and living experience who contributed to this consultation, is clear: stigma remains a significant barrier to safe, high-quality healthcare. However, it can be reduced through deliberate, evidence-based, and structural action.

As a community, we expect our health services to lead honest and open conversations about alcohol and other drugs. No one should be made to feel ashamed, judged or excluded from seeking health support because of their AOD use. When health services foster trust, dignity and non-stigmatising care, people are more likely to speak openly about their needs, access support and achieve better health outcomes.

We urge the Commission to act.

References

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