



PARLIAMENT OF AUSTRALIA

Report on the health impacts of alcohol and other drugs in Australia

House of Representatives

Standing Committee on Health, Aged Care and Disability

September 2026

CANBERRA

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Chair's foreword

The true cost of addiction to alcohol and other drugs in Australia is almost impossible to calculate but is measured in the tens of billions of dollars.

For example, the cost of alcohol misuse and addiction is estimated at over seventy billion dollars per year with deaths, severe illness, workforce losses, injuries, crime and family violence being contributing causes, but there are many other costs such as policing that are hard to quantify.

Alcohol is by far the most significant cause of societal costs and damage but other drugs, both illicit and prescription, have significant financial and societal costs, with overdose deaths now exceeding the national road toll for the last ten years.

Estimates of the financial impact of drugs, other than alcohol, suggest overall costs of over fifteen billion dollars, not to mention the social costs of family breakdown, loss of workforce participation and family violence.

Whilst various studies have noted some variations in overall costs, the estimates all show that the huge financial, social and structural costs associated with alcohol addiction and of the damage caused by other drugs are increasing every year.

Tobacco use and its costs were not within the remit of this inquiry but in spite of reduced smoking rates over the past ten years, the continued costs of tobacco use are enormous and should not be forgotten.

Opioids are the most common drug type associated with overdose deaths but more recently, stimulants have replaced benzodiazepines as the second most common drug type associated with fatal overdose. Other drugs associated with fatal overdose include alcohol, antidepressants and other prescription drugs, cannabis and cocaine. It is important to note that other synthetic narcotics and other synthetic drugs such as fentanyl are increasingly involved in overdose deaths in other jurisdictions and their use should be monitored in Australia.

Overdose deaths occur in all areas of Australia but deaths are disproportionately higher in rural and regional areas. Most of these deaths are preventable.

This inquiry seeks to bolster policy understanding and awareness, improve data collection, reduce harms and look at innovative solutions to these intractable issues that are affecting Australians daily, in all walks of life and in all areas.

Trends in alcohol and other drug use

Alcohol and drug usage patterns have changed and this is reflected in unintentional drug overdose deaths, changes in alcohol consumption and significant increases in drug use as reflected in wastewater testing around the country.

Alcohol

Australians have had a problematic relationship with alcohol since the days of the Rum Rebellion. Whilst, over the last twenty years overall alcohol consumption has been trending down, and younger generations in particular are drinking less, there is huge pressure on our health systems, particularly our hospitals, to deal with alcohol harms.

Alcohol use is a major cause of poor health and premature death for a large number of people and a very significant factor in social harms such as violence against women and children, gambling addiction, emergency department presentations and antisocial behaviours. Alcohol abuse is a major factor in health costs and one only has to visit an emergency department of virtually any hospital in Australia to see the results of alcohol abuse and the problems it causes.

Alcohol abuse increases the workload of virtually every medical specialty from fetal alcohol syndrome in paediatrics to dementia in geriatrics. High risk alcohol consumption increases cancer risks, increases the risk of chronic neurological and cardiovascular disease and significantly increases the risk of mental health disorders. The fact that fetal alcohol syndrome causes long term harm in some of the most disadvantaged communities in high numbers is a national shame.

Some groups are at higher risk of alcohol related problems, such as older Australians, Indigenous Australians and people born in Australia who are at a higher risk than those born overseas, with males more at risk than females.

Approximately one in three people drink more than recommended in the adult risk guidelines. Many of the risks related to alcohol have lifelong social consequences such as fetal alcohol spectrum disorder, suicide, road traffic accidents, family violence, violence against others and family breakdown. There are also significant workforce effects including reduced productivity, absenteeism and workplace injuries.

Around 30% of the adult population drink at levels that exceed AIHW risk guidelines, but more older people exceed guidelines than younger people.

Alcohol accounts for three in five drug related presentations, with 60% of these being males, of which, 60% are aged over 45.

Alcohol intake in high-risk groups is an ongoing problem and increasingly identified as a factor in family violence, family breakdown and violence against women and children.

Other drugs

Other drugs include cannabis, cocaine, methamphetamine (ice/speed), heroin, prescription drugs, ketamine, fentanyl, other opioids and MDMA/ecstasy.

There have been significant changes in patterns of illicit drug use in Australia over the last twenty years.

Cannabis remains the most commonly used illicit drug followed by cocaine, stimulants and then narcotics.

There have been gradual increases in the use of methamphetamine and other stimulants. The use of cocaine also has increased significantly over the last 20 years.

Deaths due to illicit drugs have consistently been twice the road toll at over 2,300 per year. Most are accidental and most are preventable.

There are several high-risk groups including Indigenous Australians, those with mental health conditions and those with a family history of drug use or alcohol abuse. There is evidence based on wastewater screening that overall illicit drug use is increasing over 2024 and 2025, particularly ice, cocaine, ecstasy and MDMA.

Drug usage patterns have changed and this is reflected in changes in unintentional overdose deaths with significant increases in stimulant overdose deaths between 2001 and 2023.

How do we manage the harm that alcohol and other drugs cause to Australian society? How do we manage the ongoing risks and changing environment and how do we protect future generations?

Firstly, it is important to note that Australia does have a National Drug Strategy. This is a well thought out program based on a balanced approach based across the three pillars of harm minimization: demand reduction, supply reduction and harm reduction.

The National Drug Strategy is due for review, and it has never been more important for harm minimization to be strengthened and supported given the number of deaths and societal damage and costs to a broad range of portfolios, from health to the criminal justice system, social security, business and education amongst many.

A completely punitive approach and one that is based entirely on supply reduction has not and will not change outcomes.

It is important that all three pillars are supported, and we should note the success of safe injecting rooms, pill testing and medical support are some of Australia's strengths in this area and we should continue to encourage and support these measures.

Education to reduce demand, whilst important, will not remove the problem. Supply reduction is also important, clearly, however better funding to support supply reduction for our law enforcement agencies to look at business models of those who promote illicit drug use should be a priority. These approaches, I hope, will reduce the scale of the problem.

Managing alcohol and other drug use

Alcohol

Alcohol consumption has been falling but some groups are at high risk of harm, including older Australians, those with a family history of alcohol abuse, Indigenous groups and those who also abuse other drugs.

As mentioned, harm minimization remains the cornerstone of management, including:

- 1 Education about alcohol harm across the community.
- 2 Research into the key data about at-risk populations.
- 3 Reducing access to alcohol by restricting the number of outlets, time of availability and restricting financial access to alcohol in certain populations should be considered. The availability of alcohol on-demand services at any time of day or night is contributing to harm and consideration should be given to restricting that access.
- 4 Management also needs to recognize the nexus between alcohol and family violence, abuse of other drugs, family breakdown, economic loss and the gambling industry. These should be examined in detail and data be more freely available regarding these issues.

Treatment of alcohol abuse and addiction has traditionally been via an inpatient and residential model, but this is expensive, removes sufferers from society and has high relapse rates. Innovative non-residential models are available, including out-patient models, and the use of digital and telehealth services should be supported.

This also includes supporting GPs and other healthcare workers involved in the alcohol and drug addiction space, with better funding for longer consultations and support for nurse practitioners and drug and alcohol nurses to work with the patients in the community.

Other drugs

A harm minimization model by general consensus is the most effective way of managing the harms of drug addiction and abuse. This also includes policies to reduce supply and accidental overdose, which now causes significant morbidity and mortality across Australia.

There are good models of care such as safe injecting rooms, pill testing and supply of narcotic overdose treatments such as naloxone that are available and these should be fostered and expanded in the community across the country.

It is important to evaluate how effective these measures are and the outcomes they achieve. This should be supported by wastewater testing, along with support for law enforcement to track drug importations. Together, these measures can provide a strong system for identifying and monitoring trends in drug use, particularly the emergence of new drugs.

Further, funding law enforcement to look at business models of individuals and organizations suspected of involvement in drug importation and/or sales should be a priority in management.

The rise of telehealth has seen an increased uptake in medicinal cannabis and ADHD prescriptions. This unfortunately has also seen a rise in overuse and possible abuse of medicinal cannabis and ADHD and their role in overdose and presentations to hospital needs to be also monitored and explored.

Prescriptions for medicinal cannabis, after increasing over the last ten years, have reduced recently.

The number of prescriptions for medications for adults diagnosed with ADHD has dramatically increased. There is little research available as to why this has occurred and the geographic data is also very different from state to state, this needs to be explored and examined carefully.

Summary

In summary, drug and alcohol abuse is changing in Australia and as it changes, we need to consider the importance of having policies that can adapt to these changes. We need to use new technologies; we need to collect better data so we are aware of the trends and we need also to make sure that our management policies are as efficient at getting support to those in need as quickly as possible.

There is no doubt that drug and alcohol abuse causes significant harm at all levels across the country. With appropriate management, not only can we reduce the cost, but we can also reduce significant societal harm, reduce pressure on our health systems and have a system that can work well for years to come.

I would like to thank the Secretariat for all their hard work in what has been a long and fascinating inquiry. They have supported the Committee in the most professional, caring and intelligent manner and I look forward to continuing to work with them.

I would like to thank all our Committee Members who have worked together in the most collegiate, supportive and decent manner across two Parliaments. I have enjoyed working with them.

I would like to thank in particular my friend and colleague, Dr Monique Ryan MP, the Member for Kooyong, for her ongoing support, intelligent contributions and cooperative manner with which she has supported myself and the inquiry.

As with any inquiry, two paediatricians are better than one.

Dr Mike Freeland MP
Federal Member for Macarthur
Chair – Standing Committee on Health, Aged Care and Disability

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consumption, as total weight consumed nationally, Year 1 to Year 9 of the Program



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



Terms of reference

The House of Representatives Standing Committee on Health, Aged Care and Disability 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.

List of recommendations

Recommendation 1

- 7.8** The Committee recommends that the Australian Government establishes a new mandatory alcohol advertising and marketing regulatory framework, which should ensure:
- That decisions are made to reduce exposure to children and those at greatest risk.
 - That the collection and use of personal information for marketing is prohibited unless a person has opted in.
 - That there is harmonisation with other relevant frameworks (e.g. Broadcasting Services Standards) and across platforms (e.g. television, online).
 - That there are appropriate monitoring and punishments for non-compliance.

Recommendation 2

- 7.9** The Committee recommends that the Australian Government remove its representative from the Alcohol Beverages Advertising Code Scheme Management Committee to safeguard independence while consideration of a new framework is undertaken.

Recommendation 3

- 7.14** The Committee recommends the Department of the Treasury undertakes modelling of alcohol taxation and then advises the Australian Government on whether reforms are needed to ensure that it remains fit for purpose from both an economic and public health standpoint.

Recommendation 4

- 7.19** The Committee recommends that the Australian Government commissions research on the alcohol point of sale and retail data that it should collect into the future. This information will be vital to better informing alcohol harm-reduction policies through a fuller understanding of alcohol pricing, the types and volume of alcohol sold, and the timing of these sales.

Recommendation 5

- 7.23** The Committee recommends the Australian Government work with the States and Territory governments to develop and implement national standards for the online sale and delivery of alcohol. These standards should consider restrictions on online alcohol purchasing hours and the merits of a safety pause between purchase and delivery.

Recommendation 6

- 7.41** The Committee recommends the Australian Government continues to prioritise support for Fetal Alcohol Spectrum Disorder, facilitated through implementation of the National Fetal Alcohol Spectrum Disorder Strategic Action Plan 2018 – 2028. This should include the following key elements:
- Continued investment in national Fetal Alcohol Spectrum Disorder surveillance frameworks to improve the collection and accuracy of prevalence data that can support policy development and the proper allocation of services and resources.
 - Working with Primary Health Networks to enhance awareness of Fetal Alcohol Spectrum Disorder by targeting areas with an identified increase in alcohol consumption and also at-risk groups. This should be designed to complement existing awareness activities including the Every Moment Matters and Strong Born campaigns and ensure that the messaging is inclusive, non-stigmatising, and culturally safe.
 - Conducting a pilot study in out of home care (OOHC) settings to improve Fetal Alcohol Spectrum Disorder screening practices and the provision of wraparound support. Consideration must be given to the integration with diagnostic support services and of culturally appropriate supports for families and the OOHC workforce.
 - Working with State and Territory governments to improve access to Fetal Alcohol Spectrum Disorder diagnostic services. This should include a focus on increasing hub-and-spoke and culturally appropriate models of care, as well as recognition of the lifelong consequences of Fetal Alcohol Spectrum Disorder and long term supports.

Recommendation 7

- 7.48** The Committee recommends that the Australian Government works with State and Territory governments to develop a nationally coordinated early warning system for illicit drugs, to include a focus on:
- Roles and responsibilities between Commonwealth, State and Territory jurisdictions and non-government organisations;
 - Monitoring and surveillance (utilising health and law enforcement data);

- Preparedness plans;
- Communication of alerts; and
- Early detection of new trends, geographic distribution of new drug trends and early access to harm reduction measures.

Recommendation 8

- 7.52** The Committee recommends that the Australian Government continues to implement the Take Home Naloxone Program, with a focus on increasing awareness, reducing stigma and increasing access to first responders and those at greatest risk from an overdose.

Recommendation 9

- 7.66** The Committee recommends that the Australian Government works to implement mandatory evidence-based alcohol and other drug education programs for secondary school students. These programs must include a strengthening of protective factors, consideration of the National Principles for school drug education, a focus on Fetal Alcohol Spectrum Disorder and the risks of prenatal alcohol exposure. These programs must also be tailored to different population groups including Aboriginal and Torres Strait Islander students and those from culturally and linguistically diverse backgrounds.

Recommendation 10

- 7.67** The Committee recommends that the Australian Government provides supporting guidance for schools on the implementation of alcohol and other drug education to ensure that teachers and other educators have the capability and confidence to have conversations with students around alcohol and other drugs.

Recommendation 11

- 7.70** The Committee recommends the Australian Government provides resources and guidance for parents to support them to have informed discussions around alcohol and other drugs. This guidance should include detailed information on Fetal Alcohol Spectrum Disorder and the risks of prenatal alcohol exposure.

Recommendation 12

- 7.78** The Committee recommends that the Australian Government funds cross-sectoral alcohol and other drug training to include the mental health, family, domestic and sexual violence, employment, housing and justice sectors, to

build their capacity, capability, and shared expertise, and thereby improve support for people with intersecting needs.

Recommendation 13

- 7.79** The Committee recommends that the Australian Government work with the States and Territory governments to increase investment in integrated models of care with the aim of reducing fragmentation between services, improving referral pathways, and responding to co-occurring needs. The implementation of this should be conducted concurrently with that of recommendation 15.

Recommendation 14

- 7.83** The Committee recommends that the Australian Government implements routine alcohol screening and brief intervention in primary and antenatal care services.

Recommendation 15

- 7.84** The Committee recommends that the Australian Government builds the capability of the primary and antenatal care workforce to undertake screening and brief intervention through provision of training and professional development. This should incorporate the Australian Guidelines for Assessment and Diagnosis of Fetal Alcohol Spectrum Disorder.

Recommendation 16

- 7.90** The Committee recommends that the Australian Government invest in the scaling of digital models-of-care that can provide evidence-based prevention and early intervention services for alcohol and other drugs. The aim is to expand the reach, accessibility and effectiveness of these tools, improve the integration between different tools, and develop more effective connections between digital and face-to-face services.

Recommendation 17

- 7.96** The Committee recommends that the Australian Government look at improving access to general and other health practitioners by funding prolonged consultations through the Medicare system, as well as funding an increase in the employment of drug and alcohol nurses.

Recommendation 18

- 7.97** The Committee recommends that the Australian Government work with the State and Territory governments to improve the recruitment and retention of

the alcohol and other drugs workforce. This strategy must address workforce shortages in regional, rural and remote Australia, and build alcohol and other drug capabilities among medical, nursing, allied health and Aboriginal health workers.

Recommendation 19

- 7.98** The Committee recommends that the Australian Government work with medical colleges to mandate alcohol and other drug training in their learning curricula.

Recommendation 20

- 7.100** The Committee recommends that the Australian Government work with the States and Territory governments to develop a nationally consistent framework for recognising and employing peer workers in the alcohol and other drug service sector. This framework should include:

- The development of national guidelines.
- The development and delivery of training and education through targeted training programs, recognised qualifications, and career development opportunities.
- The development of proper position descriptions and the integration of peer workers into care models.
- The development of resources to support the employment of peer workers.
- The development of guidance to ensure that lived experience is embedded into alcohol and other drug service design, governance, delivery and evaluation.

Recommendation 21

- 7.109** The Committee recommends that the Australian Government embed equity for priority populations as a central objective of the next version of the National Drug Strategy, including measurable equity targets, public reporting on access and outcomes, and assessment of unmet demand for alcohol and other drug services.

Recommendation 22

- 7.112** The Committee recommends that the Australian Government promotes the improvement of national alcohol and other drug datasets to better identify the access, needs and outcomes of priority populations. This must involve the consistent and appropriate collection of cultural, language, migration-related, sex, gender, variations of sex characteristics and sexual orientation indicators, where safe and appropriate.

Recommendation 23

- 7.116 The Committee recommends that the Australian Government develop, fund and implement a new National Aboriginal and Torres Strait Islander Peoples' Drug Strategy, in partnership with Aboriginal and Torres Strait Islander peoples, Aboriginal Community Controlled Organisations and relevant peak bodies.**

Recommendation 24

- 7.120 The Committee recommends that the Australian Government increase funding to Aboriginal Community Controlled Organisations and Aboriginal Community Controlled Health Organisations to deliver culturally safe, trauma-informed and community-led alcohol and other drug treatment, prevention and harm reduction services.**

Recommendation 25

- 7.124 The Committee recommends that the Australian Government in cooperation with the State and Territory governments reviews existing alcohol and other drug funding models to ensure they adequately reflect the higher costs of service delivery in regional, rural and remote areas.**

Recommendation 26

- 7.128 The Committee recommends that the Australian Government work with the State and Territory governments to improve access to harm reduction services in regional, rural and remote communities, including needle and syringe programs, opioid dependence therapy, take-home naloxone and culturally safe harm reduction education.**

Recommendation 27

- 7.132 The Committee recommends that the Australian Government dedicate funding for interpreter services, translated resources and multilingual alcohol and other drug supports.**

Recommendation 28

- 7.136 The Committee recommends the Australian Government work with State and Territory governments to increase access to alcohol and other drug treatment services that are exclusively for women, including residential rehabilitation services that allow children to remain with their mothers where safe and appropriate, and improve integration between alcohol and other drug services and domestic, family and sexual violence services.**

Recommendation 29

- 7.138** The Committee recommends funding contracts should be of a sustainable length of at least five years. Longer term contracts allow for planning and support the recruitment and retention of the workforce supporting those seeking help with alcohol and other drug addiction or concerns.

Recommendation 30

- 7.139** The Committee recommends that drug checking and testing be used to support harm minimisation in all jurisdictions. Drug testing allows opportunities for support and strategies to cease the use of harmful drugs, education opportunities and provide surveillance strategies for rapid changes in the illicit supply chains.



Abbreviations

AADANT	Association of Alcohol and other Drug Agencies NT
AADC	Australian Alcohol and other Drugs Council
AAPI	Australian Association of Psychologists incorporated
ABA	Alcohol Beverages Australia
ABAC	Alcohol Beverages Advertising Code Scheme
ACA	Alcohol Change Australia
ACCHOs	Aboriginal Community Controlled Health Organisations
ACCOs	Aboriginal Community Controlled Organisations
ACEM	Australasian College for Emergency Medicine
ACIC	Australian Criminal Intelligence Commission
ACL	Australian Christian Lobby
ACM	Australian College of Midwives
ACMA	Australian Communications and Media Authority
ACRRM	Australian College of Rural and Remote Medicine
ACV	Alcohol Change Vic
ADD	attention deficit disorder
ADF	Alcohol and Drug Foundation
AFP	Australian Federal Police
AHMRC	Aboriginal Health and Medical Research Council
AIFS	Australian Institute of Family Studies
AIHW	Australian Institute of Health and Welfare
AIVL	Australian Injecting & Illicit Drug Users League

AMA	Australian Medical Association
ANMF	Australian Nursing and Midwifery Federation
AOD	Alcohol and other drugs
AODCCC	Alcohol and Other Drug Consumer and Community Coalition
APA	Advanced Pharmacy Australia
APY	Anangu Pitjantjatjara Yankunytjatjara
APS	Australian Psychological Society
ARACY	Australian Research Alliance for Children and Youth
ARTG	Australian Register of Therapeutic Goods
ASSIST	Alcohol, Smoking and Substance Involvement Screening Test
ATCA	Australasian Therapeutic Communities Association
ATDC	Alcohol, Tobacco and other Drugs Council Tasmania
ATODA	Alcohol Tobacco and Other Drug Association ACT
AUDIT	Alcohol Use Disorders Identification Test
CALD	culturally and linguistically diverse
CAPR	Centre for Alcohol Policy Research
CICADA	Care and Intervention for Children and Adolescents affected by Drugs and Alcohol
CIG	Community Industry Group
CPI	consumer price index
CRC	Community Restorative Centre
DAAE	Drug and Alcohol Addiction Education
DASSA	Drug and Alcohol Services South Australia
DFA	Drug Free Australia
DIB	Drug Info Bot
DITRDCA	Department of Infrastructure, Transport, Regional Development, Communications and the Arts

EDNA	Emerging Drug Network of Australia
EWS	early warning system
FARE	Foundation for Alcohol Research and Education
FASD	Fetal Alcohol Spectrum Disorder
FDSV	family, domestic and sexual violence
HSM	Hello Sunday Morning
LGBTIQA+	lesbian, gay, bisexual, transgender, intersex, queer, asexual and other sexually or gender diverse
LSAC	Longitudinal Study of Australian Children
LSD	lysergic acid diethylamide
MBS	Medicare Benefits Scheme
MDMA	methylenedioxymethamphetamine
MHFFTas	Mental Health Families and Friends Tasmania
NACCHO	National Aboriginal Community Controlled Health Organisation
NADA	Network of Alcohol and other Drug Agencies
NAS	National Alcohol Strategy
NCCRED	National Centre for Clinical Research on Emerging Drugs
NCETA	National Centre for Training and Education on Addiction
NCYSUR	National Centre for Youth Substance Use Research
NDARC	National Drug and Alcohol Research Centre
NDRI	National Drug Research Institute
NDS	National Drug Strategy
NDSHS	National Drug Strategy Household Survey
NHMRC	National Health and Medical Research Council
NIAA	National Indigenous Australians Agency
NIDAC	National Indigenous Drug and Alcohol Committee

NOFASD	National Organisation for Fetal Alcohol Spectrum Disorders
NPS	novel psychoactive substances
NQF	National Quality Framework for Drug and Alcohol Treatment Services
NRHA	National Rural Health Alliance
NSPs	Needle and Syringe Programs
NSWCCL	New South Wales Council for Civil Liberties
NT	Northern Territory
PAE	prenatal alcohol exposure
PBS	Pharmaceutical Benefits Scheme
PHAA	Public Health Association of Australia
PHN	Primary Health Network
PSA	Pharmaceutical Society of Australia
QANDA	Queensland Network of Alcohol and other Drug Agencies
QMHC	Queensland Mental Health Commission
QPAODN	The Queensland PHN Alcohol and Other Drugs Network
QulHN	Queensland Injectors Health Network
RACGP	Royal Australian College of General Practitioners
RANZCP	Royal Australian and New Zealand College of Psychiatrists
RDA	Retail Drinks Australia
SACOSS	South Australian Council of Social Service
SHAHRP	School Health and Alcohol Harm Reduction Project
SHARC	Self Help Addiction Resource Centre
SHS	Specialist Homelessness Services
SMART	Self Management and Recovery Training
SSDP	Students for Sensible Drug Policy

TGA	Therapeutic Goods Administration
THC	tetrahydrocannabinol
THN	take home naloxone
TSOC	Transnational, Serious and Organised Crime
UK	United Kingdom
UNSW	University of New South Wales
VADA	Victorian Alcohol and Drug Association
VLA	Victorian Legal Aid
WAMHC	Western Australian Mental Health Commission
WANADA	Western Australian Network of Alcohol and other Drug Agencies
WET	wine equalisation tax
WHO	World Health Organisation
YETI	Youth Empowered Towards Independence



1. Introduction

About the inquiry

- 1.1 On 22 August 2024, the Committee adopted an inquiry into the health impacts of alcohol and other drugs in Australia, which had been referred by the Minister for Health and Aged Care, the Hon Mark Butler MP.
- 1.2 The inquiry was to involve a health-focused review of alcohol and other drugs (AOD) policy, treatment services, community programs, and workforce to determine whether current settings support the prevention, reduction and recovery of AOD-related harms on Australian individuals, families and communities.
- 1.3 The *Terms of Reference* for the inquiry were as follows:

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.*
- 1.4 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 could potentially provide valuable lessons.
 - 1.5 Given the wide scope of the terms of reference, it was not possible to produce a final report addressing all aspects of the inquiry prior to the dissolution of the House of Representatives on 28 March 2025 due to the Federal Election in May of that year.

The Committee therefore presented an issues paper to the Parliament on 27 March 2025 (summarised below) to provide an overview of the evidence it had received at that stage, and to inform work that the Government had commenced to update the National Drug Strategy.

- 1.6 The Committee at that time urged its successor in the 48th Parliament to seek a rereferral of this important inquiry, with the same terms of reference, and gather further evidence as required to produce a final report.
- 1.7 On 28 August 2025 the Minister for Health and Ageing, the Hon Mark Butler MP, re-referred the inquiry into the health impacts of alcohol and other drugs in Australia to the House Standing Committee on Health, Aged Care and Disability (the Committee) which was subsequently adopted by the Committee with identical terms of reference.

Conduct of the inquiry in the 47th Parliament (August 2024–March 2025)

- 1.8 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.
- 1.9 The Committee received 204 submissions to the inquiry and 9 additional documents (that included answers to questions taken on notice at public hearings). The full list of submissions and documents received in the 47th Parliament is at Appendix A.
- 1.10 The Committee also held seven public hearings, which are detailed at Appendix B:
 - 28 October 2024—Melbourne
 - 29 October 2024—Melbourne
 - 30 October 2024—Brisbane
 - 7 November 2024—Canberra
 - 21 November 2024—Canberra
 - 28 November 2024—Canberra
 - 7 February 2025—Canberra
- 1.11 A list of witnesses who provided evidence during these public hearings is available at Appendix B. Transcripts of all public hearings are available on the Committee's website.
- 1.12 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.

- 1.13 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.

Conduct of the inquiry in the 48th Parliament (August 2025–September 2026)

- 1.14 On 29 August 2025, the Committee issued a media release announcing the recommencement of the inquiry and calling for submissions.
- 1.15 The Committee again invited submissions from a range of individuals and organisations with an interest in the health impacts of alcohol and other drugs as well as those who had made a submission to the inquiry in the previous Parliament. This included federal and state government departments and agencies, industry groups and peak bodies, academics, health practitioners, and the general public.
- 1.16 The inquiry received a further 98 submissions and 11 supplementary submissions, both of which included responses to questions taken on notice and which are also listed at Appendix A. The Committee fully considered the 204 submissions and 9 additional documents received in the 47th Parliament in its preparation of this final report.
- 1.17 The Committee held eight public hearings for the inquiry following its re-referral as follows:
- 12 March 2026 – Canberra
 - 26 March 2026 – Canberra
 - 27 March 2026 – Canberra
 - 14 April 2026 – Perth
 - 15 April 2026 – Perth
 - 14 May 2026 – Canberra
 - 28 May 2026 – Canberra
 - 29 May 2026 – Canberra
- 1.18 A list of witnesses who provided evidence during these public hearings is also available at Appendix B and transcripts of all public hearings are available on the Committee's website.

Background

- 1.19 AOD, including the harms related to their use, are a major cause of preventable disease, illness and death in Australia. Additionally, AOD misuse imposes a considerable socio-economic burden on the Australian community. AOD also encompasses a range of psychoactive substances that when consumed or

administered can alter consciousness, mood or cognitive processes.¹ These substances can include prescribed medications, medications used for non-prescribed purposes, and illegal substances.

- 1.20 It is important to recognise also that AOD harms are shaped by a complex range of factors. These include the social determinants of health and the social and economic conditions in an individual's life that can influence their health and wellbeing. In the context of AOD harms these can include socioeconomic status, education, access to healthcare, housing and employment, as well as trauma and discrimination.
- 1.21 These social determinants are not experienced equally. Aboriginal and Torres Strait Islander peoples, the LGBTIQ+ community, people of a lower socioeconomic status, or those living in regional and remote areas are often more likely to experience poorer health outcomes.
- 1.22 Another important consideration is the role that stigma contributes to AOD harms. AOD-related stigma can manifest itself in a variety of ways, including through negative attitudes and beliefs, social exclusion, unequal treatment and discrimination, and feelings of shame and low self-esteem. These can create barriers to seeking help and accessing specialist treatment supports. Stigma can also limit employment opportunities, access to other services such as housing, and can extend to the families and friends of the affected person.
- 1.23 Although alcohol is associated with many social and cultural activities within Australia, it is also the leading risk factor for the burden of disease nationally. Further to this, it is associated with a range of health and social harms including hospitalisation and death. The Australian Institute of Health and Welfare (AIHW), Australia's national agency for information and statistics on health and welfare, estimated the social cost of alcohol use in Australia was set to reach \$75 billion in 2022–23, with projected costs relating to premature mortality and morbidity; and workplace-related costs.²
- 1.24 The AIHW conducts the National Drug Strategy Household Survey every two to three years (summarised below). This is the leading survey of alcohol, tobacco and licit and illicit drug use in Australia and the data it collects are used to inform the development of policies relating to drug-related issues and Australia's response.³

National Drug Strategy

- 1.25 The National Drug Strategy is designed to provide a framework for identifying national priorities relating to tobacco, alcohol and other drugs, and guide the associated actions by Federal and State/Territory governments in partnership with

¹ The Royal Australian and New Zealand College of Psychiatrists, *Submission 19 (47th Parliament)*, p. 3.

² Australian Institute of Health and Welfare (AIHW), *Alcohol, tobacco & other drugs in Australia report*, last updated 26 April 2026, <https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia/contents/drug-types/alcohol> (accessed 3 June 2026).

³ AIHW, *Alcohol, tobacco & other drugs in Australia report* (accessed 3 June 2026).

the community and service providers. It also outlines a national commitment to harm minimisation through effective demand, supply and harm reduction strategies.

- 1.26 The National Drug Strategy was established in 1985 and has had seven iterations to date. The latest of these, for the period from 2017–2026, aims to:

... build safe, healthy and resilient Australian communities through preventing and minimising alcohol, tobacco and other drug -related health, social, cultural and economic harms among individuals, families and communities.⁴

- 1.27 There are three pillars that make up the National Drug Strategy: demand reduction, supply reduction and harm reduction. These pillars seek to reduce risky behaviours and encourage safer settings, prevent uptake and delay first use, reduce harmful use and support people to recover. They also aim to reduce illicit drug availability and accessibility and control licit drug and precursor availability.⁵

National Drug Strategy Household Survey

- 1.28 The National Drug Strategy Household Survey (NDSHS) is operated by the AIHW on behalf of the Department of Health, Disability and Ageing (hereafter Department of Health) and is part of the National Drug Strategy. The NDSHS operates every two to three years and collects information on alcohol and tobacco consumption, and illicit drug use among the general population. It also surveys people's attitudes and perceptions relating to alcohol, tobacco and illicit drug use.⁶

- 1.29 The results from the 2025 survey had not been released at the time of writing. The results from the previous survey in 2022–23 indicated the following key trends:

- 1 Risky alcohol consumption remained stable from previous iterations of the survey with one in three people drinking alcohol in ways that put their health at risk.
- 2 Alcohol consumption whilst pregnant continued to decline. One in four women consumed alcohol while pregnant, which is a decrease from 42 per cent of women consuming alcohol whilst pregnant in 2013.
- 3 One in five people had used illicit drugs in the previous 12 months. This equated to approximately 3.9 million people, which was an increase from 3.4 million people in 2019.⁷

⁴ Department of Health, Disability and Ageing (hereafter Department of Health), *National Drug Strategy 2017–2026*, 18 September 2017, <https://www.health.gov.au/resources/publications/national-drug-strategy-2017-2026?language=en> (accessed 26 May 2026).

⁵ Department of Health, *National Drug Strategy 2017–2026*, 18 September 2017 (accessed 26 May 2026).

⁶ AIHW, *National Drug Strategy Household Survey*, 8 April 2024, <https://www.aihw.gov.au/about-our-data/our-data-collections/national-drug-strategy-household-survey> (accessed 31 July 2026).

⁷ AIHW, *National Drug Strategy Household Survey 2022–23*, 27 May 2025, <https://www.aihw.gov.au/reports/illicit-use-of-drugs/national-drug-strategy-household-survey-2022-2023/contents/summary> (accessed 3 August 2026).

Issues paper (released in the 47th Parliament)

1.30 On 6 March 2025, prior to the prorogation of the 47th Parliament, the Committee tabled an issues paper which summarised the key issues raised during the inquiry to that point and made two recommendations, including that the inquiry be re-referred in the 48th Parliament.⁸ The issues paper contained six chapters, summarised below.

- Chapter 1 – introduced the issue of harms associated with AOD use; presented the National Drug Strategy and the need to enhance Australia’s response to AOD use; and the referral of the inquiry including the steps taken by the committee during the inquiry.
- Chapter 2 – provided an overview of the health impacts of AOD in Australia by drawing on data from the Department of Health, the AIHW and Australia’s leading research centres. It also outlined the levels of AOD use in Australia and highlighted emerging trends.
- Chapter 3 – focused on Australia’s AOD policy and the funding landscape. This chapter discussed the National Drug Strategy including sub-strategies and frameworks that it incorporates in addition to state and territory policies. Also discussed was Australia’s shift to a health-led AOD policy response including AOD research and data collections that inform the evidence base.
- Chapter 4 – examined the provision and demand for AOD services focusing on priority populations which were identified in the National Drug Strategy. Also identified and examined were the types of services needed to address the unique needs of these populations and the challenges in building the capacity of the AOD workforce.
- Chapter 5 – discussed the role of AOD prevention and harm reduction services. This chapter highlighted the issue of stigma and the barrier it creates in accessing AOD support, and the debates surrounding the question of decriminalisation for personal use. This chapter also discussed the effectiveness of harm reduction services, focused on the current levels of alcohol use in Australia, and examined strategies to mitigate the effects of alcohol-related harm.
- Chapter 6 – identified topics that had not been canvassed in the issues paper to that point, including examining international experience in the field of AOD; risky AOD use associated with some professions; AOD impacts on priority populations; the relationship between AOD and domestic and family violence; and the interaction between physical environment and substance use.

1.31 The issues paper contained two recommendations as follows:

- Recommendation 1: 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.

⁸ House of Representatives Standing Committee on Health, Aged Care and Sport, *Issues paper relating to the health impacts of alcohol and other drugs in Australia*, March 2025.

- Recommendation 2: 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.⁹

Final report structure

- 1.32 This is the final report for the inquiry, structured into seven chapters including this introduction.
- 1.33 Chapter 2 focuses on alcohol policy in Australia and explores the current trends in alcohol consumption and associated harms, and the influence and impact of existing policies aimed at reducing these harms through channels of availability and promotion of alcohol. This chapter also examines localised policies that have been tailored to support the needs of communities in relation to treatments and services for harmful alcohol consumption, and reviews the impacts of current alcohol accessibility, with a particular focus on online sales and home delivery.
- 1.34 Chapter 3 examines other drug use in Australia, including the surveillance of new and emerging trends, and early warning systems for new drugs. The chapter further discusses current drug harm reduction strategies, including an examination of the role law enforcement has in disrupting the supply of drugs. This chapter also discusses how law enforcement interacts with other drug use.
- 1.35 Chapter 4 explores the factors that shape AOD use, including education and early life experiences, economic security and housing, and mental health and family, domestic and sexual violence. It also reviews the strategies, programs and services available to prevent or reduce harmful AOD use as well as other related risk factors. Finally, it explores barriers and enablers to AOD care, including the current treatment workforce, funding, and the commissioning of new and emerging models of care.
- 1.36 Chapter 5 focuses on Fetal Alcohol Spectrum Disorder (FASD), including its prevalence, and the associated harms and current awareness of both FASD and prenatal alcohol consumption, in Australia. The chapter also reviews the effectiveness of current FASD awareness campaigns, and the importance of screening and access to diagnostic and other support services. Additionally, it explores intersections of FASD with other sectors, including education, justice and child protection.
- 1.37 Chapter 6 examines some of the priority populations identified by the National Drug Strategy that experience disproportionate AOD-related harms. These populations include Aboriginal and Torres Strait Islander people, rural and remote communities, culturally and linguistically diverse communities, young people and old people, women and LGBTIQ+ cohorts. The chapter looks at the barriers faced by these

⁹ House of Representatives Standing Committee on Health, Aged Care and Sport, *Issues paper relating to the health impacts of alcohol and other drugs in Australia*, March 2025.

populations to accessing AOD services, how these barriers can compound harmful AOD use and whether AOD services are currently being delivered equitably for all Australians. The chapter also looks at whether current prevention, treatment and harm reduction initiatives are effective for these priority populations.

- 1.38 Chapter 7, entitled 'A way forward', contains the Committee's in-depth comments on the inquiry evidence and the conclusions it has drawn. It also contains the Committee's recommendations for the Australian Government for policy changes that the Committee believes will better address, and consequently reduce, AOD harms for all Australians into the future, regardless of who they are, where they live, or their particular personal circumstances.

Acknowledgements

- 1.39 The Committee thanks the many contributors to the inquiry over both the 47th and 48th Parliaments who provided vital evidence and expertise without which this report would not have been possible.
- 1.40 The Committee also appreciated the willingness of many submitters and witnesses to provide robust, informative, and considered input on their lived experience of the health impacts of alcohol and other drugs on themselves, and their families and communities. The committee recognises these vital contributions and acknowledges the value and courage of those who shared their unique perspective for the purpose of achieving better outcomes for all. The Committee greatly benefited from the knowledge and experience of these individuals, many of whom had not previously contributed to a parliamentary inquiry.



2. The alcohol landscape in Australia

- 2.1 The inquiry evidence indicated that alcohol remains the leading contributor to substance-related harm in Australia. The Australian Institute of Health and Welfare (AIHW) stated in its submission that alcohol is the most common drug for which people receive alcohol and other drug (AOD) treatment, and that it accounts for a larger number of ambulance attendances, hospitalisations and deaths than illicit drugs.¹
- 2.2 This chapter provides an overview of the current landscape of alcohol consumption in Australia, for which the regulatory and policy responsibility lies between Commonwealth and State and Territory governments and the alcohol industry. A range of policy approaches aimed at reducing harms is explored.

Alcohol consumption and related harms

- 2.3 As reported by the AIHW, alcohol contributed to 4.1 per cent of the total burden of disease in Australia in 2024 (the sixth highest). AIHW indicated that this burden of disease for alcohol included alcohol dependence, cancers, cardiovascular diseases, chronic liver disease, and injuries.²
- 2.4 The link between alcohol consumption and cancer was emphasised by Cancer Council Australia (Cancer Council), which stated in its submission that ‘alcohol is an established class 1 carcinogen and is causally linked to an increased risk of cancer of the bowel, breast, liver, mouth, throat (pharynx and larynx), oesophagus and stomach’.³
- 2.5 There were 1,667 alcohol-induced deaths recorded in Australia in 2023, which the National Heart Foundation of Australia (Heart Foundation) submitted was an increase of nearly 29 per cent over the last 10 years.⁴
- 2.6 The Heart Foundation also commented in its evidence to the inquiry that drinking alcohol during pregnancy can lead to birth defects and behavioural or

¹ Australian Institute of Health and Welfare (AIHW), *Submission 142 (47th Parliament)*, p. 2.

² AIHW, *Alcohol, tobacco & other drugs in Australia web report*, last updated 26 April 2026, <https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia/contents/drug-types/alcohol> (accessed 8 July 2026).

³ Cancer Council Australia, *Submission 110 (47th Parliament)*, p. 3.

⁴ National Heart Foundation of Australia (Heart Foundation), *Submission 164 (47th Parliament)*, p. 6.

neurodevelopmental issues, known as Fetal Alcohol Spectrum Disorder (FASD)⁵ (see Chapter 5).

- 2.7 Alcohol Change Victoria informed the inquiry that alcohol harms are also associated with suicide and mental illness, and that alcohol use disorder is responsible for 1 per cent of the global suicide burden and was associated with a 223 per cent increase in suicide risk.⁶
- 2.8 Expanding on this link, the National Indigenous Australians Agency (NIAA) stated that suicide is the most common cause of alcohol-related deaths among Aboriginal and Torres Strait Islander men and the fourth most common cause among Aboriginal and Torres Strait Islander women.⁷
- 2.9 As highlighted by the Committee in its scoping report for the inquiry at the end of the 47th Parliament entitled '*Issues paper relating to the health impacts of alcohol and other drugs in Australia*', the consumption of alcohol is widespread within Australia and associated with many social and cultural activities. The Committee noted from the evidence that embedded cultural norms can often negatively impact efforts to reduce harmful alcohol use.⁸
- 2.10 The Public Health Association of Australia (PHAA) suggested in its submission that alcohol harm is preventable, and that reducing alcohol consumption will reduce health and social harms in the Australian community.⁹
- 2.11 Whilst the Department of Health, Disability and Ageing (Formerly Health and Aged Care, hereafter Department of Health), stated in its submission that there were positive downward trends in alcohol consumption in Australia¹⁰, the George Institute for Global Health stated that it is still consumed at high rates in this country, with over 9.5 litres of pure alcohol consumed per capita per year compared to a global average of 5.5 litres per capita.¹¹
- 2.12 AIHW found, using the National Health and Medical Research Council (NHMRC) risk guidelines to reduce the risk of alcohol-related harm, that around 1 in 3 people in Australia (31 per cent or 6.6 million people) aged 14 and over consumed alcohol at risky levels in 2022–2023.¹² Risky alcohol consumption is defined by the NHMRC as

⁵ Heart Foundation, *Submission 164 (47th Parliament)*, p. 6.

⁶ Alcohol Change Victoria, *Submission 166 (47th Parliament)*, p. 5.

⁷ National Indigenous Australians Agency (NIAA), *Submission 140 (47th Parliament)*, p. 12.

⁸ House of Representatives Standing Committee on Health, Aged Care and Sport, *Issues paper relating to the health impacts of alcohol and other drugs in Australia*, March 2025, p. 10.

⁹ Public Health Association of Australia (PHAA), *Submission 106 (47th Parliament)*, p. 4.

¹⁰ Department of Health, Disability and Ageing (Department of Health), *Submission 157 (47th Parliament)*, p. 17.

¹¹ The George Institute for Global Health, *Submission 169 (47th Parliament)*, p. 1.

¹² AIHW, *Alcohol, tobacco & other drugs in Australia web report*, last updated 26 April 2026 (accessed 8 July 2026).

having more than 10 standard drinks per week, and/or more than 4 standard drinks in a single day.¹³

- 2.13 The evidence to the inquiry further indicated that harms from alcohol are not equally distributed amongst Australians, and that some groups experience higher levels of this harm.
- 2.14 Alcohol Change Australia stated in its submission that Australians living in regional and remote areas are 1.4 times as likely as those in major cities to use alcohol at high-risk levels.¹⁴
- 2.15 The National Aboriginal Community Controlled Health Organisation (NACCHO) submitted that while Aboriginal and Torres Strait Islander people generally consume alcohol at lower rates, they experience higher levels of lifetime risk, single occasion risk, and risky drinking behaviours.¹⁵
- 2.16 Harm is also not equally distributed among different age groups or genders. The National Health Survey conducted by the Australian Bureau of Statistics indicates that risky alcohol consumption was more prevalent in older adults, with one in four (24.6 per cent) people aged 55–64 years and one in five (21.6 per cent) people aged 65–74 years consuming more than 10 standard drinks in the last week.¹⁶
- 2.17 Evidence to the inquiry also indicated an unequal distribution of alcohol harms. The Alcohol and Drug Foundation (ADF) submitted that, based on findings from the *National Drug Strategy Household Survey*, recent alcohol consumption among high school aged females (14 to 17 years old) increased from 28 per cent in 2019 to 35 per cent in 2022-23.¹⁷ The Matilda Centre stated in its submission that alcohol is the number one contributor to the burden of disease among young Aboriginal and Torres Strait Islander people aged 15-24.¹⁸

Alcohol policy

- 2.18 The inquiry was informed that policy and legislative responsibility for alcohol is complex and is jointly shared by all Australian governments. The Department of Health stated in its submission:

The Australian Government has responsibility for alcohol labelling standards, and some marketing and advertising. State and territory governments are responsible for enforcing labelling standards and the specific laws and regulations regarding

¹³ National Health and Medical Research Council, *Australian guidelines to reduce health risks from drinking alcohol*, 2020, <https://www.nhmrc.gov.au/about-us/publications/australian-guidelines-reduce-health-risks-drinking-alcohol> (accessed 8 July 2026).

¹⁴ Alcohol Change Australia, *Submission 76 (47th Parliament)*, p. 1.

¹⁵ National Aboriginal Community Controlled Health Organisation (NACCHO), *Submission 145 (47th Parliament)*, p. 6.

¹⁶ Australian Bureau of Statistics, (15 December 2023), <https://www.abs.gov.au/statistics/health/health-conditions-and-risks/alcohol-consumption/latest-release> (accessed 8 July 2026).

¹⁷ Alcohol and Drug Foundation (ADF), *Submission 77 (47th Parliament)*, p. 12.

¹⁸ The Matilda Centre, *Submission 24 (47th Parliament)*, p. 11.

the sale, supply and consumption of alcohol within their jurisdictions. This includes licensing requirements for venues and restrictions on where alcohol can be consumed.¹⁹

- 2.19 It was noted also during the inquiry that the alcohol industry itself also has a role to play in reducing alcohol-related harms. The *National Alcohol Strategy 2019-2028* (NAS) provides that industries which benefit from revenue through alcohol sales have a responsibility to provide support and take appropriate action that will assist in the prevention and minimisation of alcohol-related harms.²⁰
- 2.20 The Centre for Alcohol Policy Research at La Trobe University commented in its submission that the level of alcohol consumption in a population is affected by legislative and regulatory controls on the availability of alcoholic beverages, and their enforcement.²¹
- 2.21 There was support from multiple submissions to the inquiry for the World Health Organization's (WHO) 'best buys for alcohol' as a guide to reduce the level of alcohol consumption.²² It was noted that this 'best buys' guide contains a list of the most cost-effective and feasible measures to reduce alcohol-related harm.²³ The Issues Paper referenced some of these measures, including:
- restricting exposure to alcohol advertising
 - increasing excise taxes on alcohol beverages, and
 - restricting the physical availability of retailed alcohol.²⁴
- 2.22 The NAS acknowledges the importance of effective health promotion and prevention policies in reducing alcohol-related harm and that messages need to be informed by the evidence, and communications must be targeted to at-risk populations and populations experiencing disproportionate harm.²⁵ The NAS further recognises that alcohol-related harms are not experienced uniformly across the population and that disproportionate levels of harm are experienced within some contexts and communities.²⁶

¹⁹ Department of Health, Disability and Ageing, *Submission 157 (47th Parliament)*, p. 13.

²⁰ Department of Health, *National Alcohol Strategy 2019–2028*, December 2019, <https://www.health.gov.au/sites/default/files/documents/2020/11/national-alcohol-strategy-2019-2028.pdf> (accessed 25 June 2026).

²¹ Centre for Alcohol Policy Research, La Trobe University, *Submission 7 (47th Parliament)*, p. 1.

²² See for example: Centre for Alcohol Policy Research, *Submission 21 (47th Parliament)*, p. 1; The National Centre for Education and Training on Addiction (NCETA), *Submission 43 (47th Parliament)*, p. 5; Alcohol Change Australia (ACA), *Submission 76 (47th Parliament)*, p. 2; ADF, *Submission 77 (47th Parliament)*, p. 5; Stroke Foundation, *Submission 143 (47th Parliament)*, p. 2; The George Institute, *Submission 169 (47th Parliament)*, p. 1; Cancer Council Australia, *Submission 22*, p. 4.

²³ World Health Organization (2024), *Tackling NCDs: best buys and other recommended interventions for the prevention and control of noncommunicable diseases* (accessed 25 June 2026), p. 9.

²⁴ House of Representatives Standing Committee on Health, Aged Care and Sport, *Issues paper relating to the health impacts of alcohol and other drugs in Australia*, March 2025, p. 84.

²⁵ Department of Health, *National Alcohol Strategy 2019–2028*, December 2019 (accessed 25 June 2026), p. 27.

²⁶ Department of Health, *National Alcohol Strategy 2019–2028*, December 2019 (accessed 25 June 2026), p. 8.

- 2.23 This chapter also explores several examples of alcohol policy responses that are tailored to local contexts.

Alcohol advertising and marketing

- 2.24 In its submission, the Department of Infrastructure, Transport, Regional Development, Communications and the Arts (DITRDCA) commented that there are several regulatory frameworks that guide alcohol advertising:

Generally, the regulatory and co-regulatory frameworks relate to the scheduling and placement of advertisements, whereas the self-regulatory framework regulates the content of advertisements. Responsibility for these frameworks is shared between the Commonwealth, state and territory governments, and independent third parties.²⁷

- 2.25 DITRDCA stated in this regard that the intention of alcohol regulation is to strike a balance between legitimate commercial interests and appropriate community safeguards.²⁸
- 2.26 Evidence received throughout the inquiry from multiple contributors advocated for a strengthening of alcohol advertising regulation, with a focus on the self-regulatory framework, specifically the Responsible Alcohol Marketing Code (the Code) administered through the Alcohol Beverages Advertising Code Scheme (ABAC).²⁹
- 2.27 Alcohol Beverages Australia (ABA) explained in its submission that the self-regulatory Code, established by industry and operating in conjunction with state and territory alcohol advertising legislation, applies to both traditional advertising mediums (television, radio, print and outdoor), and digital advertising.³⁰
- 2.28 DITRDCA outlined that under this Code, advertisements must not depict excessive or rapid alcohol consumption, market the strength of alcohol, or portray abstinence in a negative light. DITRDCA further stated in its submission that the Code also sets rules around not targeting minors or using imagery or language that is likely to appeal to minors, and strict rules against using minors in alcohol advertising.³¹
- 2.29 ABAC discussed in its submission impacts of the Scheme since it commenced operating in 1998, notably:
- 100 per cent compliance with panel determinations by signatories.

²⁷ Department of Infrastructure, Transport, Regional Development, Communications and the Arts (DITRDCA), *Submission 197 (47th Parliament)*, p. 3.

²⁸ DITRDCA, *Submission 197 (47th Parliament)*, p. 3.

²⁹ See for example, ADF, *Submission 24*, p. 11; Deakin, *Submission 19*, p. 6; OurWatch, *Submission 27*, p. 2; Alcohol Change Australia, *Submission 50*, p. 5; Self Help Addiction Resource Centre (SHARC), *Submission 79*, p. 40; Foundation for Alcohol Research and Education (FARE), *Submission 80*, pp. 15-16; University of New South Wales (UNSW), *Submission 82*, p. 1.

³⁰ Alcohol Beverages Australia (ABA), *Submission 61 (47th Parliament)*, p. 11.

³¹ DITRDCA, *Submission 197 (47th Parliament)*, p. 7.

- Very high voluntary compliance by the overall alcohol industry (the lowest compliance was 97 per cent, with 100 per cent compliance for most years of the Scheme).
 - Non-compliance referred to State/Territory liquor authorities that have enforcement powers in relation to their alcohol promotion guidelines.³²
- 2.30 ABAC also cited its ability to move swiftly to regulate new marketing technologies as they emerge, giving as an example the regular review and updating of its *Digital Alcohol Marketing Best Practice Guide*, which includes directions on the protection of minors through a broad array of digital platforms.³³
- 2.31 Alcohol Change Australia expressed concerns, however, with the operations of the ABAC Code, stating in its submission that:
- The Code is too narrow in scope and complaints are frequently dismissed even where children are clearly exposed to alcohol marketing, because the placement of the ad does not breach the Code.
 - It is voluntary and does not cover the entire alcohol industry.
 - There is no active monitoring of alcohol marketing, with the system instead relying on community complaints.
 - There are no penalties for companies found in breach of the Code and compliance is dependent on advertiser goodwill rather than enforceable sanctions.³⁴
- 2.32 The Department of Health is a member of the ABAC Management Committee that oversees the operations of the ABAC Scheme.³⁵ In its submission, the Department of Health stated that the ABAC Code is non-enforceable and both international and domestic evidence has shown that industry self-regulation of alcohol marketing is ineffective at reducing the negative health impacts of advertising or protecting vulnerable populations, including underage youth.³⁶
- 2.33 There were particular concerns raised by multiple submitters around the exposure to alcohol marketing of children and young people, as well as those at higher risk of harm.³⁷

³² Alcohol Beverages Advertising Code Scheme (ABAC), *Submission 51*, pp. 6-7.

³³ ABAC, *Submission 51*, p. 7.

³⁴ Alcohol Change Australia, *Submission 50.1*, p. 1.

³⁵ Prof the Hon Michael Lavarch, Chief Adjudicator, Alcohol Beverages Advertising Code Scheme, *Committee Hansard*, 27 March 2026, p. 52.

³⁶ Department of Health, *Submission 157 (47th Parliament)*, p. 17.

³⁷ See for example, Cancer Council Australia, *Submission 110 (47th Parliament)*, Public Health Association of Australia *Submission 106 (47th Parliament)*, ADF, *Submission 77 (47th Parliament)*, Injury Matters, *Submission 29 (47th Parliament)*, National Heart Foundation, *Submission 164 (47th Parliament)*, The George Institute, *Submission 169 (47th Parliament)*, Alcohol Change Australia, *Submission 76 (47th Parliament)*.

- 2.34 The Foundation for Alcohol Research and Education (FARE) noted, in expressing these concerns, that it has been linked to earlier initiation of drinking and increased likelihood of high-risk alcohol use later in life.³⁸
- 2.35 This was supported by the Cancer Council which submitted that exposure to alcohol marketing influences children and young people's beliefs and attitudes about drinking, and increases the likelihood that adolescents will start to use alcohol and will drink more if they are already using alcohol.³⁹
- 2.36 Since 2012, the Australian Institute of Family Studies (AIFS) has administered Ten to Men, an Australian longitudinal study of the health and wellbeing of Australian boys and men. AIFS states in its submission to the inquiry that this study has found that male drinking before the age of 18 was strongly predictive of moderate-to-high-risk alcohol use in their adulthood (47 per cent of underage drinkers compared to 20 per cent of underage non-drinkers).⁴⁰
- 2.37 In relation to individuals at higher risk of harm, the Drug Awareness and Relief Foundation also emphasised in its evidence to the inquiry that marketing can amplify positive perceptions of alcohol, trigger cravings in at-risk individuals or those with alcohol use disorders, and evoke a desire to drink among those in recovery.⁴¹
- 2.38 The Heart Foundation submitted that the expansion of digital technologies has given alcohol manufacturers and distributors the opportunity to advertise and promote their products through highly targeted and interactive ways (for example through sponsored advertisements, brand engagement, social media influencers and user-generated content).⁴²
- 2.39 This was supported by the Cancer Council, which commented that alcohol companies use algorithms to explicitly target people who drink at high-risk levels, who are then regularly exposed to alcohol marketing. The Cancer Council also stated in its submission that people in recovery have raised concerns about alcohol marketing acting as a trigger and posing a risk to their recovery.⁴³
- 2.40 FARE submitted advertising policies need a broader scope, given children and young people are often exposed to advertising in a range of environments alongside adults. FARE stated that advertising policies focusing on reducing exposure and content that primarily appeals to children and young people will be largely ineffective in protecting this group.⁴⁴
- 2.41 FARE further provided an account of how the exposure of minors to the digital advertising of alcohol can occur:

³⁸ FARE, *Submission 87 (47th Parliament)*, p. 8.

³⁹ Cancer Council Australia, *Submission 110 (47th Parliament)*, p. 5.

⁴⁰ Australian Institute of Family Studies (AIFS), *Submission 67*, p. 6.

⁴¹ Drug ARM, *Submission 44 (47th Parliament)*, p. 11; see also ADF, *Submission 77 (47th Parliament)*, pp. 34-35; Alcohol Change Australia, *Submission 76*, p. 6; FARE, *Submission 87*, p. 18.

⁴² Heart Foundation, *Submission 164 (47th Parliament)*, pp. 10-11.

⁴³ Cancer Council Australia, *Submission 110 (47th Parliament)*, p. 5.

⁴⁴ FARE, *Submission 87 (47th Parliament)*, p. 18.

Alcohol advertising is now pervasive in digital environments. Tens of thousands of ads are pushed through platforms like Facebook and Instagram each year with no meaningful way for people to opt out. This is not passive exposure; it is targeted, data driven marketing designed to reach people at the moments they are most at risk, including children, young people and people experiencing or recovering from dependence.⁴⁵

- 2.42 This was further emphasised by the National Drug and Alcohol Research Centre, which cited findings at the public hearing on 27 March 2026 from research undertaken by Deakin University on the exposure levels of young people to alcohol marketing online:
- People aged eight to 13 years old see approximately four alcohol ads a day.
 - Six alcohol ads a day for those aged 14 to 17 years.
 - Approximately seven alcohol ads a day among those aged 18 to 25.⁴⁶
- 2.43 Consistent with this, the submission from the University of New South Wales (UNSW) cited the findings of several Australian studies that children and young people are routinely exposed to alcohol marketing on digital platforms, often in subtle, normalised ways that are difficult to identify as advertising. UNSW additionally noted that self-declared age restrictions are easily bypassed, and that there are no comprehensive statutory regulations specifically targeting alcohol advertising on digital platforms.⁴⁷
- 2.44 Acknowledging the growing change in how people view media content, FARE submitted also that over 91 per cent of Australians now watch on demand services, and more people watch streaming than free-to-air TV.⁴⁸ FARE further stated:
- Yet existing codes apply only to live TV and radio, not to online catch-up or global streaming platforms. In practice, this means Australians face intensive alcohol, gambling and unhealthy food advertising online with no effective oversight.⁴⁹
- 2.45 The Committee's Issues Paper referenced various loopholes that allowed children to be exposed to alcohol advertising in avoidable ways, such as the exception to the banning of alcohol advertising from live TV during children's viewing hours for televised sport.⁵⁰
- 2.46 Deakin University cited peer-reviewed research on this issue, commenting that:

⁴⁵ Ms Ayla Chorley, CEO, FARE, *Committee Hansard*, 27 March 2026, p. 2.

⁴⁶ Dr Amy Peacock, Deputy Director, National Drug and Alcohol Research Centre, University of New South Wales (UNSW), *Committee Hansard*, 27 March 2026, p. 40.

⁴⁷ UNSW, *Submission 82*, pp. 1-2.

⁴⁸ FARE, *Submission 80*, p. 17.

⁴⁹ FARE, *Submission 80*, p. 17.

⁵⁰ House of Representatives Standing Committee on Health, Aged Care and Sport, *Issues paper relating to the health impacts of alcohol and other drugs in Australia*, March 2025, p. 88.

Alcohol advertising during sports broadcasts contributes a relatively small proportion of revenue to Australian television networks, less than 1% in most cases. Importantly, 45% of these ads were shown during children's viewing times. The study concludes that banning alcohol advertising during sports broadcasts would likely result in minimal financial impact for broadcasters, while offering substantial public health benefits.⁵¹

- 2.47 Echoing this contention, the Centre for Alcohol Policy Research at La Trobe University stated:

On advertising and other marketing, the TV, radio and web advertising and promotion should be federally prohibited. Alcohol beverage promotion should not be allowed in sports events and during daytime—that's 6 am to 9 pm—and alcohol advertising should be prohibited on public property, including public transport vehicles, stops and other installations.⁵²

- 2.48 Deakin University also cited its own recent research in its submission involving modelling the financial impact of removing both alcohol advertising and sponsorship from elite sport. Deakin stated that it found from this analysis that while alcohol sponsorship is widespread, it contributes a small proportion of revenue for most sporting codes and is likely to be readily replaced.⁵³
- 2.49 FARE noted in its submission that recently, in June 2025, the Australian Communications and Media Authority (ACMA) refused to endorse a revised Commercial TV Code that had proposed extending "M" program slots (allowing alcohol ads) into daytime and school-holiday hours. FARE commented that ACMA had stated it was 'not satisfied that the revised code would provide appropriate community safeguards'.⁵⁴

Taxation and pricing

Taxation

- 2.50 The regulation of alcohol pricing through taxation was highlighted in the inquiry evidence as a lever that could further reduce alcohol related harm. ADF submitted that reducing the availability of the cheapest alcohol products can in turn influence a reduction in alcohol consumption.⁵⁵
- 2.51 It was noted by various contributors that alcohol is currently not taxed uniformly in Australia. The Heart Foundation stated in its submission that the current system consists of two main alcohol taxes:

⁵¹ Deakin University, *Submission 19*, p. 5.

⁵² Professor Robin Room, Centre for Alcohol Policy Research, La Trobe University, *Committee Hansard*, 29 October 2024, p. 2.

⁵³ Deakin University, *Submission 19*, p. 5.

⁵⁴ FARE, *Submission 80*, p. 17.

⁵⁵ ADF, *Submission 77 (47th Parliament)*, p. 35.

- The alcohol excise, which is a volumetric tax applied to producers of beer, spirits, and certain other alcohol products, with rates varying based on alcohol volume and other product characteristics (such as packaging).
 - The wine equalisation tax (WET), which is a 29 per cent tax applied to wine and certain other alcohol products made from fruits and vegetables (e.g. traditional ciders), based on the product's monetary value.⁵⁶
- 2.52 ADF also noted that whilst the alcohol excise is adjusted for inflation every 6 months, in line with the consumer price index (CPI), the WET is set at a consistent rate.⁵⁷
- 2.53 The differences between these taxes were argued by the Cancer Council to cause inconsistencies that do not encourage reduced alcohol use.⁵⁸
- 2.54 The impacts of the tax arrangements for alcohol in Australia were explored further by ADF, which stated that, under the current regime, the availability of cheaper alcohol products under the WET can be seen to enable product substitution for individuals sensitive to the price of alcohol products. ADF commented that the data suggests that people who drink at the riskiest levels, and who are most likely to experience harm, are those most likely to purchase cheap alcohol products.⁵⁹
- 2.55 PHAA echoed similar views, commenting in its submission that as the WET is a percentage of the wholesale price, it incentivises the production of lower value products, thereby ensuring producers pay less tax. PHAA submitted that, as a result of this tax arrangement, an increased supply of inexpensive wines and ciders is currently being sold in Australia, and such products (for example cask wine) provide the cheapest alcohol per standard drink on the market.⁶⁰
- 2.56 The Cancer Council expressed comparable concerns around the increasing availability of cheaper products under the WET, submitting:
- As the WET is based on the wholesale price of wine, not its alcohol content, it incentivises the production of lower cost wine products, which has contributed to an oversupply of cheap wine products in Australia.⁶¹
- 2.57 This was also argued by Alcohol Change Australia which expressed the view that low-cost wine products, such as cask wine, are contributing to significant harm as they are most often consumed by people who drink most heavily.⁶² Alcohol Change Australia stated, as an example of this, that wine is often available at bottle shops for as little as 30 cents per standard drink and it is currently possible to purchase 8 litres of wine, or 64 standard drinks, for \$20 from a leading liquor retailer.⁶³

⁵⁶ National Heart Foundation, *Submission 164 (47th Parliament)*, pp. 8-9.

⁵⁷ ADF, *Submission 77 (47th Parliament)*, p. 36.

⁵⁸ Cancer Council Australia, *Submission 22*, p. 6.

⁵⁹ ADF, *Submission 77 (47th Parliament)*, p. 36.

⁶⁰ Public Health Association of Australia, *Submission 106 (47th Parliament)*, p. 4.

⁶¹ Cancer Council Australia, *Submission 110 (47th Parliament)*, p. 10.

⁶² Alcohol Change Australia, *Submission 76 (47th Parliament)*, p. 7.

⁶³ Alcohol Change Australia, *Submission 50 (Attachment 1)*, p. 1.

- 2.58 The George Institute recommended a uniform volumetric tax across all alcohol products in its submission, suggesting this would increase the effectiveness of, and align, the taxation system for alcoholic beverages. The Institute advocated that this uniform volumetric tax be based on the alcohol content per volume of the product and applied across all categories (including wine and cider).⁶⁴
- 2.59 FARE, as well as other contributors to the inquiry, noted that a volumetric tax on alcohol has also been recommended across several previous government reviews, including the Henry Tax Review in 2010.⁶⁵
- 2.60 ADF also cited references to such volumetric tax in several Government Strategies including the *National Alcohol Strategy 2019-2028* and the *National Drug Strategy 2017-2026*.⁶⁶
- 2.61 ADF further referenced the United Kingdom (UK) as an international example of a standardised volumetric taxation system, which it introduced in 2023 having previously had a similar system to Australia. The ADF noted that this new system in the UK aimed to reduce harmful consumption while improving fairness and coherence in the alcohol taxation laws.⁶⁷
- 2.62 ADF also highlighted in its submission a number of measures that were introduced by the UK to ease the transition for industry and support smaller producers, in relation to these new standardised alcohol taxes:
- Measures included temporary “easements” to allow businesses time to adapt, duty reliefs for small producers, and a “draught relief” scheme providing reduced tax rates for drinks below 8.5 per cent ABV sold from kegs and pumps. These adjustments helped balance public health goals with economic and administrative considerations, creating a more sustainable and transparent system.⁶⁸
- 2.63 Submissions to the inquiry from Australian alcohol industry representatives expressed concerns around the use of broad population focussed instruments to address harms and argued that population-wide approaches are ineffective and penalise the vast majority of people who drink responsibly whilst simultaneously failing to address harmful alcohol consumption amongst problem drinkers.⁶⁹
- 2.64 Concerns were also raised throughout the inquiry around the production and sale of illicit alcohol, both from the perspective of potential harms to people’s health if consumed, and also in terms of the potential loss of revenue for the government.
- 2.65 As cited by Retail Drinks Australia (RDA) in its submission, the Australian Taxation Office estimated in 2019-20, that around 91 per cent (\$6 billion) of alcohol duty was

⁶⁴ The George Institute for Global Health, *Submission 169 (47th Parliament)*, p. 3.

⁶⁵ FARE, *Submission 87 (47th Parliament)*, pp. 16-17.

⁶⁶ ADF, *Submission 77 (47th Parliament)*, p. 36.

⁶⁷ ADF, *Submission 24*, p. 12.

⁶⁸ ADF, *Submission 24*, p. 12.

⁶⁹ Retail Drinks Australia (RDA), *Submission 105 (47th Parliament)*, p. 13; ABA, *Submission 61 (47th Parliament)*, p. 11.

reported, as expected, but that a gap of 9.4 per cent (\$629 million) was identified, with around \$577 million or 92 per cent of this unreported alcohol duty due to illicit activity. RDA stated that this level of unreported duty had increased to \$745 million in 2021-22.⁷⁰

- 2.66 ABA explained at the public hearing on 28 May 2026 that illicit alcohol comes from a variety of sources:

It could be the under-reporting of alcohol that is otherwise produced legally. It could be illegally imported. In that, it could be an under-reporting of the amount that's been imported or it could be through more nefarious means—in addition to counterfeit alcohol, where one brand could be substituted for another brand and therefore try to get the financial uplift that would come from a more premium product.⁷¹

- 2.67 The inquiry also received evidence on the extent to which the illicit alcohol market has been present in Australia and suggestions for appropriate responses. The Australian Criminal Intelligence Commission (ACIC) stated at the hearing on 29 May 2026:

The market has existed for some time, albeit a lot lower than what we would see with illicit tobacco.... The volume for alcohol is not at that level across the market, but it is still a part of the market and, again, an area where we're particularly focused in understanding to what degree would serious and organised crime be looking to scale activity, or not, in that space as part of that broader business model.⁷²

- 2.68 The ACIC further commented at the hearing that there does not appear to be a significant involvement of organised crime in the broader illicit alcohol market in Australia. ACIC additionally remarked that a focus area will be to think about the lessons learnt from illicit tobacco, develop an understanding of what some of the early warning signs look like, and then be able to monitor for those in the illicit alcohol market.⁷³

- 2.69 Whether or not the current taxation system is a contributing factor to the illicit alcohol market was also explored by the Committee. As noted by ABA in this regard at the hearing on 28 May 2026:

The tax system is obviously unique for beer, wine and spirits, so there are going to be different issues that affect the different categories. It is obvious that there are some creeping unintended consequences as a result of the high tax system

⁷⁰ RDA, *Submission 105 (47th Parliament)*, p. 7.

⁷¹ Mr Alistair Coe, Executive Director, ABA, *Proof Committee Hansard*, 28 May 2026, p. 4.

⁷² Mr Adam Meyer, Acting Deputy Chief Executive Officer, Intelligence Group, Australian Criminal Intelligence Commission (ACIC), *Proof Committee Hansard*, 29 May 2026, p. 34.

⁷³ Mr Meyer, ACIC, *Proof Committee Hansard*, 29 May 2026, p. 36.

by way of illicit alcohol. But there's no doubt that, across the board, the tax settings need to be considered.⁷⁴

Pricing

- 2.70 Evidence to the inquiry argued for a minimum unit price for alcohol to be introduced to reduce harm, that is, a price per standard drink below which alcohol could not be sold. It was emphasised to the Committee also that responsibility for any such changes to minimum unit prices would lie with the State and Territory governments through their respective liquor laws.
- 2.71 PHAA stated in its submission that the primary objective of a minimum unit price is to increase the cost of stronger alcoholic beverages, particularly those sold at disproportionately low prices such as cask wine.⁷⁵
- 2.72 This contention was supported by Alcohol Change Victoria which submitted that the consumption of low-cost cask wine by the top 40 per cent of people in Victoria who drank the most alcohol accounts for 83 per cent of all cask wine purchased by Victorian households.⁷⁶
- 2.73 There were opposing views expressed in the evidence however around the benefits of implementing a minimum unit price.
- 2.74 RDA commented that one of the major reasons why minimum unit price is an ineffective policy measure is that it does not target those who misuse and abuse alcohol. RDA stated that heavy drinkers are the least responsive to price change, and that their alcohol consumption shifts to other categories or other potentially more harmful substances in the presence of a floor price change in alcohol.⁷⁷
- 2.75 PHAA stated in their submission that a minimum unit price does not financially impact people who consume alcohol in low to moderate amounts.⁷⁸ This was supported by the National Drug Research Institute (NDRI) which argued that a minimum unit price raises the price of the cheapest alcohol, which is disproportionately consumed by the heaviest drinkers, while moderate consumers remain largely unaffected.⁷⁹
- 2.76 The Northern Territory (NT) introduced a minimum unit price (\$1.30 per standard drink) in 2018 and has been the only jurisdiction in Australia to do so. Whilst this legislation was repealed in March 2025, a number of submissions to the inquiry expressed the view that it had been a valuable measure.⁸⁰

⁷⁴ Mr Coe, ABA, *Proof Committee Hansard*, 28 May 2026, p. 2.

⁷⁵ PHAA, *Submission 106 (47th Parliament)*, p. 7.

⁷⁶ Alcohol Change Victoria, *Submission 166 (47th Parliament)*, pp. 8-9.

⁷⁷ RDA, *Submission 105 (47th Parliament)*, p. 14.

⁷⁸ PHAA, *Submission 106 (47th Parliament)*, p. 7.

⁷⁹ National Drug Research Institute (NDRI), *Submission 141 (47th Parliament)*, p. 9.

⁸⁰ See for example, Central Australian Aboriginal Congress (Congress), *Submission 158 (47th Parliament)*, p. 17; NDRI, *Submission 141 (47th Parliament)*, p. 9; Cancer Council Australia, *Submission 110 (47th Parliament)*, p. 10; FARE, *Submission 87 (47th Parliament)*, p. 19.

- 2.77 In its submission, Turning Point, an Australian addiction research and education centre, stated that this minimum unit price in the NT resulted in a 50 per cent reduction in per capita consumption of cask wine in the year after its introduction, while having no negative impact on the NT alcohol industry or economy.⁸¹
- 2.78 The ADF further described positive outcomes of the minimum unit price in the NT as part of a package of responses to reduce alcohol harms there including:
- Large declines in alcohol consumption.
 - Declines in the rate of deaths attributable to alcohol and alcohol-related emergency department presentations.
 - An 11 per cent reduction in all domestic family violence assaults.
 - A 21 per cent reduction in alcohol-related domestic violence assaults.⁸²
- 2.79 Central Australian Aboriginal Congress (Congress), a large Aboriginal Community Controlled Health Service established more than 50 years ago and based in Mparntwe (Alice Springs), cited the LEARNT study at Deakin University at the public hearing on 15 April 2026 as the strongest evidence on the effectiveness of the NT minimum unit price:
- Look at what happened to alcohol induced deaths across the Northern Territory and how they're trending down, towards the national average...that is the best evidence that I think we had of the effectiveness of the floor price. It's no panacea. It doesn't get rid of all alcohol related problems, but it absolutely contributes at the heaviest end of drinking.⁸³
- 2.80 In relation to the removal of the NT minimum unit price legislation in 2025, Congress further commented at the public hearing that there had been a voluntary continuation of a minimum price in Alice Springs through the Alice Springs Liquor Accord, where all the retailers have decided to keep the price at \$1.30 a standard drink.⁸⁴
- 2.81 The NDRI pointed in its submission to the absence of indexation as being a flaw to the implementation of the NT's minimum unit price, noting that the initial positive impacts of the policy have likely diminished over time.⁸⁵
- 2.82 This view was supported by Congress which stated:
- ...it started at \$1.30. It was meant to be indexed for CPI, and it became less effective because it was never indexed. Even though it was legislated that it should be indexed, it never happened. By the time it was removed last year, it

⁸¹ Turning Point, *Submission 91 (47th Parliament)*, p. 14.

⁸² Alcohol and Drug Foundation, *Submission 77 (47th Parliament)*, p. 42.

⁸³ Dr John Boffa, CEO and Chief Medical Officer, Congress, *Committee Hansard*, 15 April 2026, p. 21.

⁸⁴ Dr Boffa, Congress, *Committee Hansard*, 15 April 2026, p. 22.

⁸⁵ NDRI, *Submission 141 (47th Parliament)*, p. 10.

should have been up towards \$1.70, based on CPI, and it wasn't, so it was becoming less effective.⁸⁶

- 2.83 ADF highlighted Scotland as an example internationally where a minimum unit price has been implemented since 2018. ADF submitted recent findings from Scotland that this policy was not associated with an increased expenditure on alcohol by households that generally bought it in small amounts and, in particular, those with low incomes.⁸⁷
- 2.84 Similarly, the Cancer Council cited findings from a five-year review of Scotland's minimum unit pricing in its submission that this measure had reduced deaths due to alcohol by 13 per cent, hospitalisations by 4 per cent, and population-wide alcohol use by 3 per cent.⁸⁸
- 2.85 NDRI stated that indexation was again a potential flaw to this model, noting in its submission that the latest modelling from Scotland demonstrated a lower effectiveness of minimum unit pricing over time if it was not adjusted for inflation.⁸⁹
- 2.86 Both the Burnet Institute and NDRI submitted that any pricing policy aimed at reducing alcohol-related harms needed to be supported with data that informs as well as evaluates those policies. Both organisations highlighted point of sales data as of particular importance, stating that Australia could consider such an approach to monitoring alcohol-related harm, wherein retail sales data are collected by government that provide information on the price alcohol is being sold for, the time-of-day sales are made, and the quantity of alcohol purchased at any one time.⁹⁰

Online sales and delivery

- 2.87 Considerable evidence to the inquiry expressed concerns on the currency of laws and regulations currently in place in Australia due to the rapidly evolving nature of the sale and delivery of alcohol. It was noted in multiple submissions that responsibility for the online sale and delivery of alcohol lies predominantly with state and territory laws and regulations.
- 2.88 The George Institute emphasised that the sale of alcohol online had nearly quadrupled from 2012 (\$539 million) to 2022 (\$2.0 billion). The Institute further stated that in 2020, 10 per cent of people in Australia purchased takeaway alcohol online, and that it is currently estimated that one in six Australians who drink alcohol purchased it via delivery.⁹¹
- 2.89 The Drug and Awareness Relief Foundation submitted on this issue that significant shifts have occurred in how alcohol is marketed, sold, and consumed, but that the

⁸⁶ Dr Boffa, Congress, *Committee Hansard*, 15 April 2026, p. 22.

⁸⁷ ADF, *Submission 77 (47th Parliament)*, p. 42.

⁸⁸ Cancer Council Australia, *Submission 110 (47th Parliament)*, p. 10.

⁸⁹ NDRI, *Submission 141 (47th Parliament)*, p. 10.

⁹⁰ Burnet Institute, *Submission 178 (47th Parliament)*, pp. 13-14; NDRI, *Submission 141 (47th Parliament)*, p. 12.

⁹¹ The George Institute, *Submission 169 (47th Parliament)*, p. 5.

laws have not evolved accordingly. The Foundation argued that existing restrictions on alcohol availability, originally designed with traditional brick-and-mortar stores in mind, no longer align with the digital age.⁹²

2.90 This position was also taken by RDA, which stated in its submission:

The online alcohol sale and delivery sector is a relevant example of the disparate policy approaches undertaken by different Australian state and territory governments. Whilst certain jurisdictions already have comprehensive legislative and regulatory frameworks in place, there are others where these frameworks have yet to be developed.⁹³

2.91 ADF stated at the public hearing on 28 October 2024 regarding online alcohol sales:

We have a licensing system for alcohol which has been developed over the last 50 or 60 years and it has been structured around bricks-and-mortar premises, on- and off-premise licences. We now have a method of access and availability that undermines all of that. You can get something delivered in 30 minutes. It's really complicated as to who is liable. Often there is a bottle shop whose licence is being used by DoorDash, Uber Eats and so on. It's not actually their own licence.⁹⁴

2.92 Deakin University also cited a series of findings by Dr Kerri Coomber from studies of alcohol sales online that people can get alcohol delivered to their home within approximately 30 minutes and that ID checks are not always undertaken as per regulations. Deakin University commented in its submission from this research that people who use alcohol home delivery are also more likely to drink at high-risk levels, and that high-risk drinkers are also more likely to use alcohol home delivery to extend their drinking sessions.⁹⁵

2.93 In the context of family, domestic and sexual violence (FDSV), several submissions highlighted that online sale and delivery facilitate easy access to alcohol late at night, at which time evidence shows that assaults in the home are more likely to occur. This was a point of particular concern to the Heart Foundation of Australia and ADF, who both cited evidence that domestic violence rates increase substantially between 6pm and 3am, with 37 per cent of alcohol-fuelled assaults occurring in the home and more than half (57 per cent) of those being family violence.⁹⁶

2.94 The ADF also highlighted in its submission that considerations around alcohol availability and access, including online sale and delivery, had been raised in several other recent inquiries. ADF cited as examples the 2016 Victorian and 2025 South Australian Royal Commissions into Family and Domestic Violence, and the 2024

⁹² Drug and Awareness Relief Foundation, *Submission 44 (47th Parliament)*, p. 10.

⁹³ RDA, *Submission 105 (47th Parliament)*, p. 12.

⁹⁴ Mr Robert Taylor, Manager, Policy and Engagement, ADF, *Committee Hansard*, 28 October 2024, p. 11.

⁹⁵ Deakin University, *Submission 19*, p. 6.

⁹⁶ Heart Foundation of Australia, *Submission 164 (47th Parliament)*, p.11; ADF, *Submission 77 (47th Parliament)*, p. 37.

National Cabinet meeting where First Ministers reaffirmed their commitment to the National Plan to End Violence Against Women and Children 2022–2032.⁹⁷

2.95 In response to concerns around the online sale of alcohol, attention was drawn in the inquiry evidence to the industry-developed Retail Drinks Online Alcohol Sale and Delivery Code of Conduct, which was designed to enhance compliance in the responsible online sale of alcohol. ABA submitted that this includes self-exclusion requests, mandatory training for delivery drivers, a blanket ban on same day, unattended, alcohol deliveries and preventing alcohol deliveries to designated dry zones. ABA further commented however that whilst voluntary, non-compliance with this code is subject to a formal disciplinary process which can result in loss of code signatory status and RDA membership.⁹⁸

2.96 FARE also highlighted, at the public hearing on 27 March 2026, various harms caused by rapid delivery and sale of alcohol:

There was a survey that was done recently about those who are using these online platforms and rapid delivery, and it showed that of the people who were surveyed—and this was representative—38 per cent of people were drinking in excess of 11 standard drinks on the day of that rapid delivery. That's significant. A Victorian study of people having alcohol delivered weekly found that 70 per cent drink in excess of 11 standard drinks in a sitting a week, 57 per cent experienced memory loss from alcohol delivered rapidly and 48 per cent were involved in an alcohol related injury after having alcohol delivered rapidly.⁹⁹

2.97 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.¹⁰⁰

2.98 Several submissions to the inquiry outlined the regulatory focus areas that need to be considered to ensure adequate community protections are in place. This included: improving age verification, delaying delivery times, prohibiting late-night deliveries, restricting targeted marketing, and improving reporting on monitoring and enforcement activities.¹⁰¹

2.99 FARE noted at the 27 March 2026 hearing that the two most impactful regulatory focus points are a two-hour safety pause on delivery times, and restrictions to delivery hours.

At the moment, depending on the state and territory, they vary greatly. We would like to see delivery hours contained between 10 am and 10 pm. This is what's

⁹⁷ ADF, *Submission 24*, p. 8.

⁹⁸ ABA, *Submission 61 (47th Parliament)*, p. 10.

⁹⁹ Ms Ayla Chorley, CEO, FARE, *Committee Hansard*, 27 March 2026, pp. 2-3.

¹⁰⁰ ADF, *Submission 77 (47th Parliament)*, p. 37.

¹⁰¹ Burnet Institute, *Submission 61 (47th Parliament)*, p.13; National Heart Foundation, *Submission 164 (47th Parliament)*, p. 11.

been found within the evidence. It was included within the federally commissioned rapid review into family, domestic and sexual violence, and it was also found and reported on in the recent South Australian Royal Commission into Domestic, Family and Sexual Violence as a key safeguard that is needed to reduce the level of harm we're seeing.¹⁰²

- 2.100 ADF had expressed the same views previously at the 28 October 2024 public hearing, where it stated:

We advocate quite strongly across the different jurisdictions for things like introducing a two-hour safety pause, so that alcohol is not delivered within 30 minutes, where the risk of extending a drinking session and heightening risks of intoxication, heightening risks of incidents in the home like domestic and family violence, are increased. There should be cut-off times of 10 am and 10 pm for deliveries...¹⁰³

Alcohol policy in local contexts

- 2.101 The Committee was interested in ensuring any consideration of effective regulation of alcohol supply and cost looked at localised policies as well as policies aimed at high levels of alcohol-related harm. The inquiry received evidence on such possible measures.
- 2.102 The Western Australian Network of Alcohol and other Drug Agencies (WANADA) submitted that policy considerations needed to include community as an essential stakeholder, arguing that this was especially the case for priority populations and in regional and remote communities. WANADA further suggested that community-led approaches are grounded in the principle that local communities are best placed to identify emerging issues, build trust, reduce barriers and mobilise strengths, and implement culturally safe, holistic, and integrated responses to reduce harm.¹⁰⁴
- 2.103 A number of submissions highlighted public health policies implemented in the NT as examples of more localised policies that have demonstrated positive effects on alcohol-related harms. The examples given included the Stronger Futures policy, interim Alcohol Protected Areas, and other community-based restrictions on alcohol availability.¹⁰⁵
- 2.104 The Association of Alcohol and other Drug Agencies NT (AADANT) stated in its submission that communities should be supported and empowered to make

¹⁰² Ms Ayla Chorley, CEO, FARE, *Committee Hansard*, 27 March 2026, pp. 2-3.

¹⁰³ Mr Robert Taylor, Manager, Policy and Engagement, ADF, *Committee Hansard*, 28 October 2024, p. 12.

¹⁰⁴ Western Australian Network of Alcohol and other Drug Agencies, *Submission 43*, p. 5.

¹⁰⁵ Association of Alcohol and other Drug Agencies NT (AADANT), *Submission 26 (47th Parliament)*, p. 9; Congress, *Submission 158 (47th Parliament)*, p. 13; The Northern Territory Department of Health, *Submission 64 (47th Parliament)*, p. 4.

decisions about alcohol availability, based on evidence and adequate support to implement measures that minimise alcohol-related harms.¹⁰⁶

Alcohol policy in the NT

2.105 The Northern Territory Department of Health commented in its submission that the harms from alcohol are disproportionately higher in some areas of Australia, including in the NT, and stated that:

- The NT has the highest per capita alcohol consumption in Australia.
- Alcohol-attributable deaths for Aboriginal people in the NT are up to 10 times higher compared to non-Indigenous people.
- 69 per cent of treatment episodes are for alcohol; in remote / very remote areas of the NT, the figure is even higher at 76 per cent.¹⁰⁷
- Two in five people in the NT used alcohol at levels putting their health at risk (40 per cent).¹⁰⁸

Stronger Futures / Alcohol Protected Areas

2.106 In its submission, Congress explained that in 2012 as part of the *Stronger Futures in the Northern Territory Act 2012 (Alcohol Protected Areas)*, alcohol was restricted in 34 town camps, six Aboriginal Land Rights Act communities and 74 Community Living Areas declaring them 'dry'.¹⁰⁹ As outlined by the NT Department of Health on this legislation, this meant people could not bring in, possess, consume, sell or supply alcohol in these areas unless authorised to do so.¹¹⁰

2.107 Congress stated in its submission that when these provisions expired in mid-July 2022, the NT Government established an 'opt-in' model where the previous alcohol protected areas had all lapsed, communities could apply to opt back in to alcohol restrictions.¹¹¹

2.108 AADANT emphasised that multiple non-government organisations criticised the lack of consultation about the removal of restrictions that suddenly made alcohol available in nearly 400 dry communities.¹¹²

2.109 The inquiry learned that in February 2023 the opt-in model was replaced by an 'opt out' model to apply to all communities previously subject to alcohol restrictions. The NT Department of Health explained in its submission that this meant all communities

¹⁰⁶ AADANT, *Submission 26 (47th Parliament)*, p. 9.

¹⁰⁷ Congress, *Submission 158 (47th Parliament)*, p. 6.

¹⁰⁸ The Northern Territory Department of Health, *Submission 64 (47th Parliament)*, p. 2.

¹⁰⁹ Congress, *Submission 158 (47th Parliament)*, p. 13.

¹¹⁰ NT Department of Health, *Submission 64 (47th Parliament)*, p. 4.

¹¹¹ Congress, *Submission 158 (47th Parliament)*, p. 13.

¹¹² AADANT, *Submission 26 (47th Parliament)*, p. 9.

previously under the Stronger Futures provisions were subject to interim Alcohol Protection Area provisions, making them once again 'dry' areas.¹¹³

- 2.110 The NT Department of Health further reported to the inquiry that communities could then decide whether alcohol will be available in community, and/or how much alcohol is available, by developing a Community Alcohol Plan and either becoming a general restricted area or potentially opting out of formal alcohol controls.¹¹⁴

Other community-based restrictions on availability

- 2.111 As noted by the submission from Congress, in January 2023 the NT Government implemented other restrictions on take away alcohol availability, specifically in Alice Springs, including:

- One sale per day per person, following industry guidance.
- Alcohol-free days on Monday and Tuesday for takeaway alcohol purchases.
- Limiting hours of alcohol being sold between 3pm-7pm, except for on Saturdays.¹¹⁵

Evidence of effectiveness

- 2.112 In its submission, Congress also provided detailed information to the inquiry regarding the effects of implementation, removal, and subsequent re-establishment of Alcohol Protection Areas in the NT, and stated that:

- The expiry of Stronger Futures in July 2022 led to a 15 per cent increase in consumption.
- From January 2023, following the new regulations including 'dry areas' and the two takeaway alcohol-free days a week, there was a 26 per cent fall in consumption.
- The expiry of Stronger Futures in July 2022 led to a 93 per cent increase in alcohol-related domestic violence.
- In 2023 there was a considerable reduction in domestic and family violence (alcohol-related domestic violence assaults fell by 41 per cent in the months after the regulations were introduced, and a further 4 per cent since then).¹¹⁶

- 2.113 As highlighted further by Congress at the public hearing on 15 April 2026:

When the Stronger Futures provisions did expire, we saw an exponential increase in alcohol related harm, much of it suffered by Aboriginal women and children... Following the January 2023 regulations, alcohol consumption, as measured by wholesale sales, fell by a quarter—26 per cent, to be precise. Official police crime statistics show that alcohol related domestic violence fell by

¹¹³ NT Department of Health, *Submission 64 (47th Parliament)*, p. 4.

¹¹⁴ NT Department of Health, *Submission 64 (47th Parliament)*, p. 4.

¹¹⁵ Congress, *Submission 158 (47th Parliament)*, p. 13.

¹¹⁶ Congress, *Submission 158 (47th Parliament)*, p. 14.

43 per cent. Alcohol related presentations at the Alice Springs Hospital emergency department fell by a quarter, or 25 per cent.¹¹⁷

2.114 The two takeaway alcohol-free days in Alice Springs were cited by Congress in its submission as being very effective in reducing harm. Congress argued, however, that their effectiveness could have been improved by regulating the payment of all Centrelink entitlements on days when takeaway alcohol sales are prohibited in the region (e.g. Mondays under the current arrangements).¹¹⁸

2.115 This point was further explored by Congress at the public hearing:

In spite of those two takeaway-free days being really effective, there's still the option for people to move their Centrelink payments to later in the week, and I understand that's happened to a large extent. If the Centrelink payments all occurred on the Monday, you would have almost 48 hours where there would be no takeaway alcohol accessible...

We've got two completely takeaway-free days a week, and if Centrelink payments were linked to one of those days, it would add further to the reduction in harm, based on previous evidence.¹¹⁹

Other restrictions

2.116 Commenting on other possible relevant legislative reforms, Congress also brought the Committee's attention at the hearing to liquor licensing and what responsibility licensees have to reduce alcohol-related harm:

A condition of licensing should be that licensees are held responsible for alcohol related crimes that are committed immediately upon people leaving their venues. This has happened in South Australia; the liquor act has been amended like that. This makes an enormous difference to the responsible service of alcohol if you have that provision, and it could be in the Liquor Act. It says to licensees that, if you serve people to the point of significant intoxication and then they leave your premises and stab or assault someone or hang themselves, you'll be held partly accountable for that. You're not taking away individual responsibility, but, in addition to individual responsibility, you're saying to licensees, 'You've got a responsibility'.¹²⁰

Awareness and understanding of harms

2.117 Multiple submissions to the inquiry expressed concerns around Australians' limited awareness of the risks and harms associated with alcohol consumption.

¹¹⁷ Dr Boffa, Congress, *Committee Hansard*, 15 April 2026, p. 19.

¹¹⁸ Congress, *Submission 158 (47th Parliament)*, p. 18.

¹¹⁹ Dr Boffa, Congress, *Committee Hansard*, 15 April 2026, p. 20.

¹²⁰ Dr Boffa, Congress, *Committee Hansard*, 15 April 2026, p. 24.

2.118 Focussing on NHMRC's risk guidelines to reduce the risk of alcohol-related harm, FARE cited a National Poll that found only 26 per cent of Australians are familiar with the current NHMRC guidelines.¹²¹

2.119 This concern was echoed by Alcohol Change Australia, which noted that recent polling showed:

- Less than half of Australians (46 per cent) know that alcohol can cause cancer.
- One-third of Australians are unaware that drinking alcohol during pregnancy is associated with FASD.
- Over a quarter do not associate alcohol with accidents and injuries (27 per cent) or poor mental health (28 per cent).¹²²

2.120 The Australasian College for Emergency Medicine (ACEM) pointed to the benefits of public health messaging in its submission, stating that this plays a vital role in shaping community attitudes toward how alcohol is consumed. ACEM also stated that Australia has demonstrated that evidence-based public education campaigns, when delivered consistently alongside regulatory action, can influence societal attitudes and contribute to measurable reductions in alcohol-related harm.¹²³

2.121 This view on messaging and education about alcohol was echoed by Alcohol Change Australia, which submitted that empowering Australians with the knowledge that alcohol causes harm is an important part of any comprehensive approach to reducing this harm. Alcohol Change Australia stated:

Campaigns that highlight the harms caused by alcohol have been effective in changing knowledge, attitudes, and beliefs about alcohol. For example, the 'Alcohol. Think Again' public education program in Western Australia includes campaigns informing the public of alcohol harms and promoting the NHMRC alcohol guidelines; these campaigns have increased understanding of the link between alcohol products and cancer and have ranked among the most effective advertisements in the world for motivating people to reduce their alcohol use.¹²⁴

2.122 The Matilda Centre at the University of Sydney highlighted the Strong and Deadly Futures Program in its submission, stating that this is the first AOD prevention program designed for Aboriginal and Torres Strait Islander youth that delivers preventative and health promotion messages at school. The Matilda Centre reported:

A pilot trial of the program found that this culturally-inclusive approach to AOD prevention was well received by both Aboriginal and/or Torres Strait Islander and non-Aboriginal youth, and school staff appreciated the engaging and inclusive

¹²¹ FARE, *Submission 87 (47th Parliament)*, p. 20.

¹²² Alcohol Change Australia, *Submission 76 (47th Parliament)*, p. 7.

¹²³ Australasian College for Emergency Medicine, *Submission 10*, p. 4.

¹²⁴ Alcohol Change Australia, *Submission 76 (47th Parliament)*, pp. 7-8.

format of the program and were able to implement the program with high fidelity (accuracy).¹²⁵

- 2.123 Hello Sunday Morning referred in its submission to the possible cost benefit of investing in prevention initiatives, such as education programs, and stated:

Preventive alcohol interventions are even more cost-effective than treatment when focusing on harms related to alcohol. Every dollar spent on alcohol and other drug prevention results in savings ranging from \$2.40 to \$19.64.¹²⁶

Committee comment

- 2.124 The Committee acknowledges the significant impacts and burden that alcohol contributes to individuals, families, communities and the broader health system. Whilst evidence received has shown some positive declines in consumption, the Committee remains concerned around the continued high levels of harm being experienced, noting that these harms are not equally distributed across population groups, genders or parts of Australia. This was particularly concerning given other evidence received highlighted the current lack of awareness Australians have around alcohol-related harms, and how this affects prevention, early intervention and harm minimisation efforts.
- 2.125 Reducing the harms caused by alcohol cannot be left to the individual. Broader regulatory and policy approaches need to be enacted that prevent earlier uptake of alcohol, ensure those at greater risk as well as vulnerable populations have the appropriate level of supports in place, and that greater awareness is provided to enable informed and evidence-based decisions.
- 2.126 The policy and regulatory landscape that exists in Australia with regard to the advertising and marketing, pricing and taxation of alcohol is complex. The role that advertising and marketing plays in influencing behaviours and attitudes towards alcohol is also concerning, in particular on young people and those at-risk of alcohol dependence. There are key challenges for policymakers in developing and supporting a more effective regulatory framework for alcohol. These include the multitude of different bodies responsible for legislating aspects of advertising and marketing, the reliance on industry-driven voluntary frameworks, and the rapidly changing digital landscape.
- 2.127 It was pleasing to note that there are examples of effective federal, state and territory and international policies that have shown positive impacts on reducing alcohol-related harms. Any consideration regarding the wide implementation of any alcohol policy must also ensure it does not marginalise certain communities, particularly Aboriginal and Torres Strait Islander communities.

¹²⁵ The Matilda Centre, *Submission 24 (47th Parliament)*, p. 11-12.

¹²⁶ Hello Sunday Morning, *Submission 38 (47th Parliament)*, p. 2.

2.128 There is a clear need to prioritise the monitoring of alcohol consumption patterns and trends, as well as utilise key data in the implementation and evaluation of policies. This will support evidence-based approaches that effectively meet the needs of the Australian population as well as the long-term monitoring of policy outcomes.



3. Other drugs in Australia

- 3.1 The drug use landscape in Australia is complex, with some drugs legal in certain circumstances and not in others. Some drugs are legal until they are used inappropriately, and decriminalisation creates a situation where certain drugs are legal in some jurisdictions but illegal in others. This, coupled with a rapidly changing environment where new and emerging drugs are entering the market, including in place of more traditional medications, further complicates the drug landscape in Australia.
- 3.2 This chapter explores Australia's drug landscape including themes and issues brought to the committee's attention during the inquiry. Some of these themes include the difference between legal and illegal drugs, and trends in drug use and how Australia monitors these trends. This also includes an examination of new and emerging drugs due to the changing environment of both drug supply and usage.
- 3.3 Harm reduction is a key pillar of the *National Drug Strategy 2017–26*, and harm reduction strategies featured heavily in the inquiry evidence. This chapter examines some harm reduction strategies to provide an overview of what is working and what can be improved as well as exploring the role of law enforcement in reducing harms.

Drug landscape in Australia (including surveillance of emerging trends)

- 3.4 The Department of Health, Disability and Ageing (Department of Health) provided information to the inquiry regarding the prevalence of illicit drug use by people aged 14 years and older in Australia between 2010 and 2023. This information highlighted that overall, the trend for the use of all illicit drugs was up between 2010 and 2023, although there was a significant decline in the use of ecstasy and non-medical pain killers, relievers and opioids between 2019 and 2023. Conversely, there has been a statistically significant increase in the use of ketamine and hallucinogens within the same time period. The Department of Health reported no statistically significant changes in the use of marijuana, heroin, methamphetamine and amphetamine, and cocaine during 2019–2023.¹

¹ Department of Health, Disability and Ageing (Department of Health) *Submission 157 (47th Parliament)*, pp. 7–8.

Illicit vs licit drugs

- 3.5 According to the Addiction Centre, the term illicit drugs refers to substances that are illegal at the state and federal levels because they are deemed to be dangerous to the person using them and may pose a threat to the community. The Addiction Centre further highlights that Illicit drugs are not only dangerous but can also be naturally occurring, made from naturally occurring substances (semi-synthetic), or completely synthetic.²
- 3.6 The Alcohol and Drug Foundation (ADF) notes in its public advice that illicit drugs are not regulated or controlled in terms of drug strength and may contain additives the user is unaware of.³
- 3.7 Illicit drugs extend further than illegal drugs or those that are prohibited from manufacture, sale and possession. They may include pharmaceuticals that are misused or subject to non-medical use such as prescription pain medications, anti-anxiety medications and sleeping pills. The Addiction Centre advises on its website that illicit use can include taking prescribed medications at higher doses, more frequently than prescribed, taking someone else's medication, or purchasing these types of drugs illicitly.⁴
- 3.8 Although licit drugs are substances which are legal to use, possess and sell, such as prescription medicines, they are deemed illicit when used for the wrong purposes. Licit drugs can include alcohol, caffeine, nicotine and antihistamines. Cannabis has also been legalised in certain situations and will be discussed in the next section.

Impacts of illicit drug use

- 3.9 The misuse of drugs in Australia, both licit and illicit, has direct health impacts on individuals and the broader community. In 2018, the total disease burden from the misuse of drugs was three per cent. It was submitted to the inquiry by the Pharmacy Guild of Australia that in 2022–23, 1.1 million people aged 14 and over in Australia used pharmaceutical drugs for non-medicinal purposes.⁵
- 3.10 As stated by the National Aboriginal Community Controlled Health Organisation (NACCHO) in its submission to the inquiry, alcohol and other drug (AOD) use is complex, influenced by a variety of environmental, social, and economic factors, as well as by aspects of social and emotional wellbeing.⁶

² Addiction Centre, *Illicit Drug Addiction and Abuse*, <https://www.addictioncenter.com/drugs/illicit-drugs/> (accessed 7 July 2026).

³ Alcohol and Drug Foundation (ADF), *The Law*, <https://adf.org.au/talking-about-drugs/law/> (accessed 13 July 2026).

⁴ Addiction Centre, *Illicit Drug Addiction and Abuse* (accessed 7 July 2026).

⁵ Pharmacy Guild of Australia, *Submission 52 (47th Parliament)*, p. 3.

⁶ National Aboriginal Community Controlled Health Organisation (NACCHO), *Submission 145 (47th Parliament)*, p. 6.

- 3.11 The motivations that drive illicit drug use are multifaceted, and include enjoyment, relaxation, social bonding, and curiosity. Other drivers could include as a coping mechanism to alleviate stress or other forms of trauma.
- 3.12 The Queensland Network of Alcohol and Other Drug Agencies (QNADA) submitted that while most people who use drugs do so without problems, issues that arise from AOD use is often predicated by experiences of trauma and influenced by social, cultural, historical, and structural determinants of health.⁷
- 3.13 In its submission to the inquiry, the Burnet Institute commented that while there is a risk of harm associated with drug use, few people who use drugs will become dependent on or experience significant harms from using these substances. The Burnet Institute further stated:

The harms associated with substance use are inequitably distributed; people who inject drugs, people with substance dependence, people from lower socio-economic backgrounds, Aboriginal and Torres Strait Islander people, lesbian, gay, bisexual and queer people, and people in contact with the criminal justice system experience elevated rates of drug-related harms.⁸

Medicinal cannabis

- 3.14 The Australian Government amended the *Narcotic Drugs Act 1967* in 2016 to allow the supply of medicinal cannabis products to treat patients with certain health conditions. The Therapeutic Goods Administration (TGA) sits within the Department of Health and manages the regulation of medicinal cannabis as a prescription medicine in Australia. The Department of Health submitted to the inquiry that there are only two medicinal cannabis products which have been evaluated and approved by the TGA for inclusion on the Australian Register of Therapeutic Goods (ARTG). One of these is used to treat certain patients with multiple sclerosis, and the other is for patients with certain epileptic conditions.⁹
- 3.15 As noted also by the Department of Health in its submission, other avenues for a person to be prescribed medicinal cannabis, that have not been approved by the TGA, are the *Special Access Category B Scheme* and *Authorised Prescriber Scheme*. These schemes enable medical practitioners to apply to the TGA for permission to prescribe an unapproved (non-ARTG listed) medicinal cannabis product to a patient under their care, where clinically appropriate. The Department of Health emphasises that the applying medical practitioner must provide suitable clinical justification for the use of any unapproved goods, including why approved products are not suitable for treatment of the patient.¹⁰

⁷ The Queensland Network of Alcohol and Other Drug Agencies (QNADA), *Submission 75 (47th Parliament)*, p. 5.

⁸ Burnet Institute, *Submission 178 (47th Parliament)*, p. 3.

⁹ Department of Health, *Submission 157 (47th Parliament)*, p. 16.

¹⁰ Department of Health, *Submission 157 (47th Parliament)*, p. 16.

- 3.16 The inquiry received a range of opinions on the use of medicinal cannabis in Australia. Some organisations, such as ADF, indicated support for its use in their inquiry submission but called for tighter regulatory oversight. ADF further acknowledged in its submission that the cannabis market in Australia has shifted, stating:

Australia's cannabis market has rapidly changed with the emergence of medicinal cannabis. While the Therapeutic Goods Administration has taken steps to regulate access, ongoing challenges remain around product quality, prescribing practices, and advertising controls. The ADF supports greater regulatory oversight of medicinal cannabis products to ensure consistency, safety and evidence-based use... Australia must remain proactive and adaptive in this space to prevent the rapid expansion of a profit-driven cannabis industry, and to ensure that regulation promotes public health and community wellbeing.¹¹

- 3.17 At the 12 March 2026 public hearing, the TGA acknowledged that there had been an increase in prescriptions being supplied through both the *Special Access Category B Scheme* and *Authorised Prescriber Scheme*, stating:

...we have some data that reflects the number of prescriptions supplied for a single person by a single prescriber. We are seeing a dramatic increase over the last couple of years, particularly in the category of products that have very high levels of THC [tetrahydrocannabinol, the main psychoactive compound in cannabis].¹²

- 3.18 The TGA further noted that a recent consultation process had been undertaken to explore concerns raised around increases in prescriptions, especially products with high levels of THC:

We are now seeing category 5 products, in a single-year period, outnumber all the other categories being prescribed in the Special Access Scheme. We're also seeing these being prescribed to a younger population...this is 18- to 30-year-olds—and we're also seeing it being prescribed largely for chronic pain or anxiety. It's this sort of pattern which we think is quite concerning, and it's against that landscape that we have recently run our consultation on medicinal cannabis in the community, looking at a number of areas including safety, approvals, regulatory pathways and other safety issues around labelling.¹³

- 3.19 Professor Kate Seear also observed in her submission that the lack of legal protections for people who use medicinal cannabis means they can run afoul of roadside drug testing and workplace drug testing regimes.¹⁴ This view was echoed by the Students for Sensible Drug Policy (SSDP) which submitted that drivers with a prescription for medicinal cannabis should be afforded the same rights as with any

¹¹ ADF, *Submission 77 (47th Parliament)*, p. 10.

¹² Professor Robyn Langham, Chief Medical Adviser, Therapeutic Goods Administration, Department of Health, *Committee Hansard*, 12 March 2026, p. 7.

¹³ Professor Langham, Therapeutic Goods Administration, *Committee Hansard*, 12 March 2026, pp. 7-8.

¹⁴ Professor Kate Seear, *Submission 33 (47th Parliament)*, p. 13.

other prescription medication. The SSDP further argued that current drug driving laws ‘unjustly impact people with chronic health conditions, as well as older people and those who consume cannabis medicinally for pain management’.¹⁵

- 3.20 The Australian Christian Lobby (ACL) offered an opposing view on this in its submission to the inquiry. ACL commented that there is no such thing as a safe consumption of cannabis, including medicinal cannabis, and stated that there is scientific evidence linking cannabis use to psychiatric disorders, cognitive impairment and physical harm.¹⁶ Additionally, ACL argued against allowing people with a prescription for medicinal cannabis to drive with it in their system, expressing the view that it impairs drivers and causes accidents and road deaths. ACL further cited studies that have reported that cannabis impairs cognitive and motor skills and increases the risk of hitting an obstacle while driving by 16 times.¹⁷
- 3.21 ACL argued in addition that a rise in prescriptions under the TGA’s Special Access Scheme has allowed the proliferation of unregulated cannabis products, particularly those marketed under the guise of medicinal use. ACL expressed the view that this presents a growing health concern that ‘demands urgent regulatory and clinical attention’.¹⁸

Surveillance

- 3.22 Drug surveillance involves the utilisation of different sources of data that enable the monitoring of consumption trends and drug supply markets, and support the dissemination of information around new and emerging types of drugs.
- 3.23 Australia’s drug surveillance framework includes wastewater monitoring conducted by the Australian Criminal Intelligence Commission (ACIC), and this is discussed in this section, as is the operation of the Emerging Drug Network of Australia (EDNA).

Australian Criminal Intelligence Commission – Wastewater analysis

- 3.24 The ACIC states on its website that it provides unique, actionable and insightful intelligence to fight threats to Australia from serious and organised crime.¹⁹ Notably, ACIC has since 2016 undertaken assessments of wastewater in key cities and regions in Australia to monitor and provide coordinated research and intelligence on illicit (and licit) drugs that can be abused. ACIC notes from its reporting on these evaluations that wastewater analysis is a tool applied internationally to measure and interpret drug use within populations.²⁰

¹⁵ Students for Sensible Drug Policy (SSDP), *Submission 59 (47th Parliament)*, p. 13. See also: Harm Reduction Australia, *Submission 85 (47th Parliament)*, p. 4.

¹⁶ Australian Christian Lobby (ACL), *Submission 70*, p. 3.

¹⁷ ACL, *Submission 70*, p. 6.

¹⁸ ACL, *Submission 70*, p. 7.

¹⁹ Australian Criminal Intelligence Commission (ACIC), *About*, <https://www.acic.gov.au/about> (accessed 29 June 2026).

²⁰ ACIC, *National Wastewater Drug Monitoring Program reports*, <https://www.acic.gov.au/publications/national-wastewater-drug-monitoring-program-reports> (accessed 29 June 2026).

- 3.25 ACIC also states in its reports on the analysis of wastewater that these findings are used to guide government law enforcement, health, education and community organisations in their response to drug trends and through informing policy responses. The ACIC website emphasises that ‘wastewater provides an important, timely and consistent tool for developing holistic drug responses’.²¹
- 3.26 *Report 25 of the National Wastewater Drug Monitoring Program*, which was published by ACIC on 30 April 2026, analysed data collected from December 2024 to October 2025. The report indicated that the monitoring activities covered up to 57 per cent of the population (approximately 14.5 million people) and examined the consumption habits of 12 substances. The four major illicit drugs tracked by the program were methylamphetamine (meth), cocaine, MDMA and heroin. Figure 3.1 shows the results for the estimated consumption of each of these drugs for each year the program has operated.

Figure 3.1 Estimated annual methylamphetamine, cocaine, MDMA and heroin consumption, as total weight consumed nationally, Year 1 to Year 9 of the Program

Drug	Estimated consumption (kilograms per annum)									% Change	
	Year 1 2016–17	Year 2 2017–18	Year 3 2018–19	Year 4 2019–20	Year 5 2020–21	Year 6 2021–22	Year 7 2022–23	Year 8 2023–24	Year 9 2024–25	Year 8 to Year 9	
Meth	8,405	9,847	11,516	11,147	8,838	9,018	10,585	12,815	15,791	↑	23
Cocaine	3,057	4,115	4,636	5,675	4,711	3,385	4,037	6,835	7,985	↑	17
MDMA	1,251	1,162	2,226	2,630	1,231	723	962	1,430	1,711	↑	20
Heroin	830 ^a	750	941	1,021	984	1,077	999	1,137	1,397	↑	23
Total	13,543	15,874	19,319	20,473	15,764	14,203	16,583	22,217	26,884	↑	21^b

a. Heroin estimates for Year 1 are based on one collection period.

b. This figure is not a summation of percentage change entries in this column, it represents the percentage difference in total consumption between Years 8 and 9 of the Program.

Source: ACIC, *National Wastewater Drug Monitoring Program Report 25*, 30 April 2026, p. 13

- 3.27 As indicated by the data in Figure 3.1, Australia’s consumption of drugs has changed over time. ACIC stated in *Report 25* that Australia’s major drug markets displayed sustained growth, with the national consumption of meth, cocaine, heroin and methylenedioxymethamphetamine (MDMA) of 26.8 tonnes representing a 21 per cent combined increase on the previous year.²² ACIC further stated in *Report 25*:

Longitudinal data captured by the Program increase[s] our understanding of drug use nationally, in specific locations and over time. They provide valuable insight

²¹ ACIC, *National Wastewater Drug Monitoring Program reports* (accessed 29 June 2026).

²² ACIC, *National Wastewater Drug Monitoring Program Report 25*, 30 April 2026 (accessed 6 July 2026), p. 2.

into trends and emerging issues in drug consumption across Australia and can identify new sources of risk.²³

Emerging Drug Network of Australia (EDNA)

- 3.28 The Emerging Drugs Network of Australia (EDNA) is a national monitoring and reporting system comprising a national network of emergency physicians, toxicologists, forensic laboratories and public health authorities. It aims to provide analytical data on patients presenting to emergency departments after using illicit drugs, including novel psychoactive substances (NPSs). The Australasian College for Emergency Medicine (ACEM) submitted to the inquiry that EDNA provides a unique source of information on substances directly causing harm, including how drug intoxications are assessed and managed in emergency departments (based on self-reports and presenting symptoms with no objective data on the causative agent).²⁴
- 3.29 The EDNA program was established in Perth, Western Australia, in 2020, and was subsequently extended nationally with the federal government providing funding until 2025–26 through the National Health and Medical Research Council (NHMRC). The submission from ACEM stated that the key benefit of EDNA was ‘the capacity to provide timely laboratory-confirmed toxicology data on emerging drug-related threats in the community which acts as an early warning system’.²⁵ ACEM further expressed the view this has led to improvements in clinical, forensic laboratory and public health related harm responses and commented that EDNA made Australia’s first contribution of national emergency departments data on NPSs to the United Nations Office on Drugs and Crime Global SMART Forensics program.²⁶

Other surveillance opportunities

- 3.30 Although the aforementioned frameworks have been designed to support drug surveillance in Australia, the inquiry evidence also discussed additional opportunities to strengthen what is currently available in this regard, including through the expansion of surveillance activities into a more comprehensive early warning system (EWS) and better use of other available data sources, such as those held by law enforcement agencies.
- 3.31 SSDP submitted that one benefit of a coordinated EWS is the distribution of information on various drugs (e.g., high potency, risk of overdoses, adulteration). SSDP stated that early warnings can reduce harms by informing people and enabling them to make decisions based on better information on what they might be taking.²⁷
- 3.32 Turning Point Eastern Health and the Monash Addiction Research Centre (Turning Point) emphasised in its submission that an EWS was needed given the continuously evolving illicit drug market. Turning Point stated in this regard that it is critical that

²³ ACIC, *National Wastewater Drug Monitoring Program Report 25*, 30 April 2026 (accessed 6 July 2026), p. 9.

²⁴ Australasian College for Emergency Medicine (ACEM), *Submission 95 (47th Parliament)*, p. 3.

²⁵ ACEM, *Submission 95 (47th Parliament)*, p. 5.

²⁶ ACEM, *Submission 95 (47th Parliament)*, p. 5.

²⁷ SSDP, *Submission 59 (47th Parliament)*, p. 23.

Australia stays at the forefront of identifying and responding to emerging drug-related threats, including timely alerts to government agencies, health services, and consumers, to limit and appropriately respond to AOD harms.²⁸

- 3.33 This was echoed by Cohealth, which recommended in its submission that a national EWS be implemented to detect drugs that are now entering the illicit drug market and pose a significant threat to the community. Cohealth further emphasised that this would complement drug checking and research projects currently undertaken at the state level and build on national initiatives such as the *Prompt Response Network*.²⁹
- 3.34 ADF called on the Australian Government in its submitted evidence to take a leadership role in establishing or coordinating a national EWS to ensure rapid, effective, and evidence-based responses to emerging drug harms.³⁰
- 3.35 The involvement of law enforcement was also argued by SSDP as an opportunity to support a more comprehensive national EWS. SSDP stated in its submission that it believes law enforcement plays a key role in contributing to drug early warning systems, and therefore in reducing drug-related harms experienced by Australians:
- Law enforcement data on drug seizures comprises one of the largest datasets on drugs in circulation in Australia which could be used to meaningfully shift from policing and criminalisation to supporting the wellbeing and safety of communities. Data from a variety of sources is critical for accurate monitoring, and the data from drug seizures, forensic toxicology and border detection collected through the criminal system would greatly assist in identifying drugs in circulation and allow for preparedness to minimise the potential harms.³¹
- 3.36 Harm Reduction Australia agreed in its submission in which it expressed the view that opportunities exist at both the national and state and territory level for law enforcement agencies to share information from customs and seizures with public health-focused systems to provide harm reduction benefits in Australian communities.³²

New and emerging drugs

- 3.37 The inquiry evidence provided insights into the surveillance of drug consumption and supply both in Australia and around the world, and its identification of new and emerging trends in drug use. Combined with data on changes in supply, such information allows policy makers, law enforcement and the broader community to react appropriately to minimise the impact these substances may have on the general population. The emerging drugs of most concern to the contributors to the inquiry were NPSs and novel substances derived from them.

²⁸ Turning Point Eastern Health and the Monash Addiction Research Centre, *Submission 92*, pp. 9–10.

²⁹ Cohealth, *Submission 186 (47th Parliament)*, p. 4.

³⁰ ADF, *Submission 24*, p. 13.

³¹ SSDP, *Submission 59 (47th Parliament)*, pp. 26–27.

³² Harm Reduction Australia, *Submission 85 (47th Parliament)*, p. 18.

Novel psychoactive substances

- 3.38 NPS is a broad term used to describe a range of new and emerging drugs, including novel benzodiazepines and novel opioids, designed to mimic the effects of established drugs such as cannabis, cocaine, MDMA and lysergic acid diethylamide (commonly known as LSD). As noted in a recent publication from ADF, manufacturers of these drugs introduce new chemicals to replace those that are banned, which ultimately changes the chemical structure of these drugs.³³ The current evidence also indicates that NPSs can appear and disappear quickly from drug supplies, and there is often a lack of understanding regarding their composition, strength, effects and risks.
- 3.39 Multiple submitters to the inquiry argued for the need for EWS frameworks to ensure adequate and ongoing funding for monitoring, analysis and early detection of NPSs. These contributors further suggested that drug checking was an innovative tool that could be used to help identify NPSs and contribute to harm reduction.³⁴
- 3.40 Drug and Alcohol Services South Australia highlighted comments from the United Nations Office of Drugs and Crime that NPSs ‘have started to spread globally along with toxic adulterants found in drugs, requiring close monitoring, early detection and timely responses’.³⁵

Novel benzodiazepines

- 3.41 Benzodiazepines are mild tranquilisers typically prescribed for anxiety and insomnia; however, they can also be used to treat alcohol withdrawal and epilepsy. ADF notes in its publications that traditional benzodiazepines are produced, prescribed and regulated under strict guidelines and only available with a prescription in Australia due to the high risk of overdose, dependency and their interaction with other drugs.³⁶
- 3.42 Novel benzodiazepines often have similar chemical structures to prescribed benzodiazepines but can be stronger and more unpredictable. As further outlined by ADF, some novel benzodiazepines sold online have been developed by drug companies overseas but have not been tested or approved for sale in Australia and are often sold online as ‘legal’ replacements for prescription medications.³⁷
- 3.43 QNADA informed the Committee at the public hearing on 28 November 2024 that people over 35 were sourcing novel benzodiazepines due to the cost-of-living crises and being unable to afford medication, with cheaper alternatives sourced over the

³³ ADF, *What are New psychoactive substances?*, 2 June 2026, <https://adf.org.au/drug-facts/new-psychoactive-substances/> (accessed 24 June 2026).

³⁴ See for example: DASSA, *Submission 177 (47th Parliament)*, p. 3; Department of Health, *Submission 157 (47th Parliament)*, pp. 3–4; Cohealth, *Submission 186 (47th Parliament)*, p. 4; Penington Institute, *Submission 188 (47th Parliament)*, p. 13; The National Drug & Alcohol Research Centre, University of New South Wales (UNSW), *Submission 111 (47th Parliament)*, p. 17.

³⁵ Drug and Alcohol Services South Australia (DASSA), *Submission 177 (47th Parliament)*, p. 3.

³⁶ ADF, *The rise of novel benzos in Australia*, 3 October 2022, <https://adf.org.au/insights/novel-benzos/> (accessed 25 June 2026).

³⁷ ADF, *The rise of novel benzos in Australia*, 3 October 2022 (accessed 25 June 2026).

internet.³⁸ The Network further stated at the hearing that this was evidenced by those accessing drug testing facilities:

... one of the unintended benefits of the drug-checking service that has been established here in Brisbane is the identification of a group of people who are not looking to get high as such but are looking to source medications on the internet—things like novel benzodiazepines or the nitazene in an opioid—because they can't afford access to general practice or can't find a mental health professional to service them.³⁹

- 3.44 In relation to people sourcing novel benzodiazepines, the Queensland Network also commented at the hearing:

The other thing we're noticing is the novel benzodiazepines coming through with people who can't access mental health services, who are then trying to self-medicate anxiety, ADHD, maybe even obsessive-compulsive disorders. Whether they're diagnosed or not, access to that system is so problematic that, for some people, self-medication by buying medications off the internet is really the only option that they see.⁴⁰

Novel opioids

- 3.45 Synthetic opioids are emerging in the Australian drug market. These substances include fentanyl, its analogues (compounds that are structurally or functionally similar to another substance), and nitazenes, and are responsible for increasing drug harms both in Australia and internationally. While there were a number of novel opioids noted by inquiry participants as important to be aware of, nitazenes appeared to be causing the most concern in the inquiry evidence.
- 3.46 SSDP outlined in its submission that nitazenes are potent synthetic opioids that can be up to 500 times stronger than heroin. SSDP further noted that several warnings have been issued in Australia relating to nitazene contamination of drugs such as MDMA, ketamine, methamphetamine and cocaine. SSDP also stated that there have also been at least 17 overdose deaths in Victoria and seven in South Australia from nitazenes, partially due to other drugs being unknowingly contaminated with them, as well as due to individuals consuming these opioids without knowing their effects. SSDP further pointed out that, in some instances, people inadvertently consumed the nitazenes as they were contained in drugs sold as something else.⁴¹
- 3.47 Nitazenes were identified in other evidence to the inquiry as the most harmful substances among the known NPSs, including novel benzodiazepines and novel opioids. A number of submitters to the inquiry highlighted the value of naloxone

³⁸ Ms Rebecca Lang, Chief Executive Officer, Queensland Network of Alcohol and other Drug Agencies (QNADA), *Committee Hansard*, 28 November 2024, p. 3.

³⁹ Ms Lang, QNADA, *Committee Hansard*, 28 November 2024, p. 3.

⁴⁰ Ms Lang, QNADA, *Committee Hansard*, 28 November 2024, p. 3.

⁴¹ SSDP, *Submission 59 (47th Parliament)*, p. 24.

access for treating potential overdoses from novel benzodiazepines and nitazenes.⁴² The Department of Health noted in its submission that naloxone is a highly effective opioid reversal medication with few side-effects that can be administered by anyone present when an overdose is occurring.⁴³

- 3.48 In relation to new and emerging drug trends, including NPSs, the Department of Health also submitted:

Research and the translation of findings into clinical practice can support a prompt response to emerging drugs of concern. Additionally, drug checking, supervised consumption and other harm reduction measures such as the use of naloxone, a drug that can temporarily reverse the effects of an opioid overdose or adverse reactions, are measures which are being used nationally (or in some states and territories) to respond to the significant risks associated with emerging drugs of concern.⁴⁴

Harm reduction strategies

- 3.49 Harm reduction is one of the three pillars of the Australian Government's *National Drug Strategy 2017–26*. This pillar aims to incorporate approaches that target specific risks arising from AOD use, noting these risks can affect the individual, family members and the broader community. The harm reduction pillar seeks to reduce these impacts through public policy and by providing education to address risky behaviours associated with AOD use. This section examines some of the harm reduction plans targeting drug use in Australia.

Take Home Naloxone program

- 3.50 Naloxone temporarily reverses the effects of opioid overdose and works by blocking drugs such as heroin and oxycodone from attaching to opioid receptors in the brain. Naloxone can be injected intramuscularly or through a nasal spray. Multiple inquiry submitters agreed that naloxone availability for people who use drugs and members of the community who may be present at an overdose event is an important harm reduction strategy.⁴⁵
- 3.51 From 1 July 2022, the Australian Government commenced the *Take Home Naloxone (THN) program* with \$19.6 million provided in funding over the following four years.⁴⁶

⁴² See: Penington Institute, *Submission 188 (47th Parliament)*, p. 12; Dr Simon Holliday, *Submission 9 (47th Parliament)*, p. 10; Pharmacy Guild of Australia, *Submission 52 (47th Parliament)*, p. 5; SSDP, *Submission 59 (47th Parliament)*, p. 24; Royal Australasian College of Physicians (RACP), *Submission 96 (47th Parliament)*, p. 9; QulHN Ltd & QulVAA Inc, *Submission 109 (47th Parliament)*, pp. 12–13.

⁴³ Department of Health, *Submission 157 (47th Parliament)*, p. 12.

⁴⁴ Department of Health, *Submission 157 (47th Parliament)*, p. 33.

⁴⁵ ADF, *Submission 77 (47th Parliament)*, p. 27. See also: The National Drug & Alcohol Research Centre, UNSW, *Submission 111 (47th Parliament)*, p. 28; Yarra Drug and Health Forum, *Submission 135 (47th Parliament)*, p. 5; National Drug Research Institute, *Submission 141 (47th Parliament)*, p. 16.

⁴⁶ Harm Reduction Australia, *Submission 85 (47th Parliament)*, p. 8.

This program allows anyone who may experience or witness an opioid overdose or reaction to access free naloxone from pharmacies without a prescription. The Department of Health notes in its public information that the THN program is aimed at the following populations:

- people at risk of an opioid overdose or adverse reaction including their families, carers, and friends
- approved providers including community pharmacists, dispensing doctors, and hospital pharmacists
- authorised alternative suppliers, including needle and syringe programs, AOD treatment centres, and outreach services.⁴⁷

3.52 The THN program makes naloxone available at participating pharmacies across Australia, but each state and territory determines where naloxone will be available in non-pharmacy settings. As outlined by the Department of Health, these potential sites include community and hospital-based pharmacies, alcohol and drug treatment centres, needle and syringe programs, and custodial release programs.⁴⁸ ADF submitted to the inquiry in this regard that there is no evidence that use of naloxone can cause harmful physical effects, nor can it be used to get high, and that there is little potential for its non-prescribed use.⁴⁹

Challenges

3.53 While the evidence to the inquiry relating to the THN program was overwhelmingly supportive, some submitters noted that there were challenges associated with the current program design.

3.54 The Pharmaceutical Society of Australia (PSA) expressed the view that gaps remained in identifying and supplying naloxone to people at risk of experiencing or witnessing opioid toxicity. PSA submitted in addition that this issue was compounded by a lack of accurate information for consumers on THN program access. Further to this, PSA commented in its submission that a dedicated website or app which captures up-to-date information could be launched to provide information to people needing to access the THN program.⁵⁰

3.55 The Penington Institute echoed these views in its inquiry evidence, and argued that more can be done at both the federal and state and territory levels to increase awareness of the THN program, stating:

The federal government's investment in broadening the program is a welcome one. Nonetheless, more can be done by governments at both the federal and

⁴⁷ Department of Health, *About the Take Home Naloxone program*, 26 May 2026, <https://www.health.gov.au/our-work/take-home-naloxone-program/about-the-take-home-naloxone-program?language=en> (accessed 11 June 2026).

⁴⁸ Department of Health, *About the Take Home Naloxone program*, 26 May 2026 (accessed 11 June 2026).

⁴⁹ ADF, *Submission 77 (47th Parliament)*, p. 27.

⁵⁰ Pharmaceutical Society of Australia (PSA), *Submission 170 (47th Parliament)*, p. 5.

state and territory levels to increase awareness about naloxone and make it available in as many environments as possible.⁵¹

- 3.56 Advanced Pharmacy Australia also indicated its support for the THN program but highlighted in its submission areas for further improvement, including increased access across jurisdictions, and giving first responders, counsellors, and social workers the authority to carry naloxone without requiring a permit. Advanced Pharmacy Australia additionally stated:

The Take Home Naloxone program is a great public health initiative that can prevent opioid related overdose deaths and needs, however, needs to be better utilised across all health settings and not confined to community pharmacies. Additionally, increasing access to take home naloxone in jurisdictions must be considered, where first responders, police, counsellors and social workers should be given access to carry these medicines without requiring a licence.⁵²

- 3.57 The Committee noted that the Government had contracted an evaluation of the THN program pilot in 2021 by the University of Queensland, and that this review estimated that 1,649 overdose reversals had been enabled by this initiative, equating to three lives saved per day.⁵³ As noted by the Department of Health's report on this assessment, the evaluation also found that THN availability at services outside of the AOD sector provided additional opportunities to raise awareness of overdose risks among people who did not use illicit opioids but were either themselves at risk, or likely to witness an overdose by another person.⁵⁴

- 3.58 This commissioned evaluation of the THN further reported that this pilot scheme addressed (or partially addressed) several barriers to access and/or uptake of THN including:

- cost;
- availability in a range of settings;
- access to naloxone through a range of sites;
- consumer knowledge of how to use naloxone; and
- staff knowledge of THN.⁵⁵

- 3.59 The Committee noted that the THN evaluation also identified barriers to naloxone access that needed to be addressed, which included stigma around the use of opioids, consumer and community awareness, awareness of the risk of overdose,

⁵¹ Penington Institute, *Submission 188 (47th Parliament)*, p. 12.

⁵² Advanced Pharmacy Australia, *Submission 2*, p. 20.

⁵³ Department of Health, *Evaluation of the Pharmaceutical Benefits Scheme Subsidised Take Home Naloxone Pilot*, 3 February 2022, <https://www.health.gov.au/resources/publications/evaluation-of-the-pharmaceutical-benefits-scheme-subsidised-take-home-naloxone-pilot?language=en> (accessed 26 June 2026).

⁵⁴ Department of Health, *Evaluation of the Pharmaceutical Benefits Scheme Subsidised Take Home Naloxone Pilot*, 3 February 2022 (accessed 26 June 2026).

⁵⁵ Department of Health, *Evaluation of the Pharmaceutical Benefits Scheme Subsidised Take Home Naloxone Pilot*, 3 February 2022 (accessed 26 June 2026).

wider availability of the THN program at different locations, and other barriers such as law enforcement responses to naloxone and negative perceptions of naloxone.⁵⁶

Drug checking and pill testing

- 3.60 Drug checking was regarded in much of the evidence to the inquiry as an effective harm reduction strategy, although it is currently not available in most states and territories in Australia. The Committee noted during the inquiry that AOD service providers in jurisdictions where drug checking is available are using it as an opportunity to provide people with accurate harm reduction information, as well as other support services they may need. Additionally, as submitted by LGBTIQ+ Health Australia, public support for drug checking in Australia has grown with 64 per cent of respondents to the *2022–23 National Drug Strategy Household Survey* endorsing the practice.⁵⁷
- 3.61 Drug checking was first introduced in Europe in the 1990s and has since expanded to at least 28 countries across Europe, the Americas, New Zealand and Australia. ADF notes in its publicly available information that this harm reduction strategy can have either ‘mobile’ or fixed site’ services. ADF states also in its website information that the Australian Capital Territory, Victoria, and New South Wales have drug checking services available, but that the remaining states and territories either do not have any services or have taken steps to prohibit drug checking.⁵⁸
- 3.62 The Loop Australia informed the Committee at the public hearing on 30 October 2024 that the drug checking process involves checking and analysing substances, contents and concentration (strength), further stating that whilst this process is commonly referred to as pill checking, this implies that drug checking services only analyse pills when in reality these services test various types of drugs.⁵⁹
- 3.63 A number of other submissions to the inquiry emphasised that, aside from supporting harm reduction through informing an individual on the contents of their substance, drug and pill testing also doubles as a surveillance strategy that can provide timely and accurate data which can then be used to identify and respond to rapid changes in illicit drug markets.⁶⁰
- 3.64 Various submissions noted the operation of the CanTEST service in the ACT and that it has been operational since July 2022 and has analysed over 2,900 samples, of which 252 showed detectable levels of NPSs, and released over 20 notices advising the Canberra community of dangerous substances. As indicated also by ADF, the

⁵⁶ Department of Health, *Evaluation of the Pharmaceutical Benefits Scheme Subsidised Take Home Naloxone Pilot*, 3 February 2022 (accessed 26 June 2026).

⁵⁷ LGBTIQ+ Health Australia, *Submission 189 (47th Parliament)*, p. 9.

⁵⁸ ADF, *Pill testing in Australia*, 29 May 2026, <https://adf.org.au/insights/pill-testing-australia> (accessed 13 July 2026). See also: LGBTIQ+ Health Australia, *Submission 189 (47th Parliament)*, p. 8.

⁵⁹ Mr Cameron Francis, Chief Executive Officer, The Loop Australia, *Committee Hansard*, 30 October 2024, p. 21.

⁶⁰ ADF, *Submission 77 (47th Parliament)*, p. 26; LGBTIQ+ Health Australia, *Submission 189 (47th Parliament)*, p. 9; Alcohol, Tobacco and Other Drug Association ACT (ATODA), *Submission 13*, pp. 1–2.

Australian Medical Association (AMA) and other inquiry contributors, CanTEST has provided more than 4,000 health and AOD brief interventions in its first two years of operation, regarded by these stakeholders as a demonstration of its ability to support harm reduction across multiple fronts.⁶¹

- 3.65 CanTEST received praise also from the Department of Health, which acknowledged at the public hearing on 12 March 2026 that an increasing number of people were bringing drugs to be checked by this service:

When you look at the results that are coming out of CanTEST, they show there is a significant increase in numbers of people who are getting their drugs tested prior to using them, and then, amongst those people, there are increasing numbers of people who are then disposing of their drugs after they get the results of that test. In terms of being effective in reducing potential harms, I think we have enough evidence to suggest that it's something that could be pursued by states if it's consistent with their policy objectives.⁶²

- 3.66 The New South Wales Council for Civil Liberties (NSWCCL) commented in its submission that drug checking services provide another avenue for information to be provided to people using drugs. NSWCCL further stated that 70 per cent of people who used the CanTEST service in the ACT had never spoken to a healthcare worker for AOD advice, and that two thirds accepted an AOD or general intervention after using the service.⁶³

- 3.67 Conversely, Drug Free Australia (DFA) expressed the view in its submission on drug testing that it fails to prevent deaths linked to allergic reactions, polysubstance use or drug-related accidents. DFA further commented in this regard that of the 392 documented MDMA-related deaths occurring in Australia between 2000 and 2018, only three were due to “bad batches”. DFA argued in this regard ‘that the broader issue lies in MDMA itself rather than contaminants, which pill testing alone cannot address’.⁶⁴

- 3.68 The ACL also submitted in this same vein that while it advocates for comprehensive prevention, education and treatment programs, it believes pill testing or drug checking to be ineffective for the following reasons:

- There is no such thing as a safe illegal drug. Even if drugs are tested there is no guarantee of safety.
- Pill testing provides a false sense of security that dangerous drugs are safe. This increases the risk of harm to festival goers, and may increase drug taking.

⁶¹ ADF, *Submission 77 (47th Parliament)*, p. 26; Australian Medical Association (AMA), *Submission 80*, p. 6; 360Edge, *Submission 54 (47th Parliament)*, p. 7, Penington Institute, *Submission 188 (47th Parliament)*, p. 13.

⁶² Mr Ben Mudaliar, Assistant Secretary, Alcohol, Other Drugs and Food Branch, Department of Health, *Committee Hansard*, 12 March 2026, p. 2.

⁶³ New South Wales Council for Civil Liberties (NSWCCL), *Submission 28 (47th Parliament)*, p. 5.

⁶⁴ Drug Free Australia (DFA), *Submission 176 (47th Parliament)*, p. 5.

- On-site tests have a limited capacity to accurately detect harmful substances. They may not detect contaminants or other toxic compounds in pills effectively.
- Many illegal drugs are laced with other harmful substances and their purity and potency can vary widely.
- Openly testing drugs that are illegal gives contradictory messaging about the risks and makes enforcement for possession harder.⁶⁵

Lack of access to drug checking

- 3.69 QNADA submitted to the inquiry that in April 2024, CheQpoint was launched in Queensland as a permanent drug checking service with both fixed locations and mobile units for deployment at festivals. QNADA stated that in its first four months of operation, CheQpoint tested 392 samples from 219 people and that, following their interaction with the drug checking service, 23 per cent of people indicated an intention to reduce their dose and 16 per cent chose to dispose of the substance.⁶⁶
- 3.70 The Committee noted during the inquiry that despite the evidence for harm reduction provided by CheQpoint, the service encountered opposition from the Queensland state government which in September 2025 passed legislation which effectively outlawed drug checking. In media statements at that time, the Queensland government cited a ‘zero-tolerance-policy towards drug use when passing the legislation’.⁶⁷
- 3.71 QUIVAA and QUIHN, not-for-profit charities in Queensland that provide AOD and mental health services, provided a joint submission to the inquiry which stated in relation to this decision:
- The recent closure of Queensland’s fixed site drug checking service, CheQpoint, and the Queensland Government decision to completely outlaw drug checking runs counter to the evidence base and scientific empirical evidence in support of drug checking.⁶⁸
- 3.72 Other evidence received by the inquiry from both ATODA and the National Centre for Clinical Research on Emerging Drugs (NCCRED) argued for increased accessibility to drug testing services and that limited drug checking services inhibit the capacity of people who consume drugs to make safer and more informed decisions.⁶⁹

⁶⁵ ACL, *Submission 70*, p. 13.

⁶⁶ QNADA, *Submission 75 (47th Parliament)*, p. 4.

⁶⁷ Australian Broadcasting Corporation, *Queensland outlaws pill testing*, 19 September 2025, <https://www.abc.net.au/listen/programs/radionational-breakfast/queensland-bans-pill-testing-/105790118> (accessed 15 June 2026).

⁶⁸ QuIVAA and QuIHN, *Submission 38*, p. 6.

⁶⁹ ATODA, *Submission 13*, pp. 1–2; Queensland Mental Health Commission, *Submission 167 (47th Parliament)*, p. 10; National Centre for Clinical Research on Emerging Drugs (NCCRED), *Submission 171 (47th Parliament)*, p. 10.

- 3.73 The Loop Australia noted at the public hearing on 30 October 2024 that people using drug checking services now aged from 17 to 80 years, due to an increase in the sourcing of cheaper medications through unregulated means.⁷⁰

Supervised injecting services

- 3.74 As noted by ADF in its submission to the inquiry, supervised injecting services (SISs) are dedicated spaces where people can use illicit drugs whilst under the care of health professionals, typically nurses, social workers or other trained workers and volunteers. ADF further submitted that these facilities provide users with clean injecting equipment, emergency care (including overdose and wound care), education, access to rehabilitation, treatment and health care, and disease transmission prevention.⁷¹
- 3.75 Further evidence to the inquiry highlighted that SISs are typically located in areas experiencing high levels of drug-related issues, such as injecting in public, and were established as a harm reduction response. The Committee learned from various submissions that there are currently two SISs in Australia, one in Kings Cross, Sydney and one in North Richmond, Melbourne. The Committee was further informed that since opening in 2001, the SIS in Kings Cross has recorded zero fatalities and has provided over 22,000 accepted referrals for ongoing care and support services.⁷²
- 3.76 ADF stated in its submission that these SISs have been effective in reducing drug-related harm and that ambulance callouts to Kings Cross dropped by approximately 80 per cent following its opening. ADF further submitted that ambulance attendances involving the opioid overdose reversal medication naloxone fell by half in the area surrounding North Richmond in the three years since that SIS was opened.⁷³
- 3.77 The Committee was also informed during the inquiry that evaluations of SISs have shown that these services provide a critical role in preventing and managing overdose events, thereby saving lives, and in supporting often marginalised people to access evidence-based treatment and other support services.
- 3.78 In discussing the impact of the SISs, the AMA stated at the public hearing on 27 March 2026:

Medically supervised injecting centres, while they're few and far between, have been really valued by communities along with needle syringe exchange programs, including in prisons and other environments. These programs need to be supported. We would appreciate both Commonwealth and state based leadership on this. I think advocacy groups and medical groups, including the AMA, have been talking about this for decades. It still seems to be a fight, and it

⁷⁰ Mr Francis, The Loop Australia, *Committee Hansard*, 30 October 2024, pp. 17–18.

⁷¹ ADF, *Submission 77 (47th Parliament)*, p. 27.

⁷² NSWCCCL, *Submission 28 (47th Parliament)*, p. 4; 360Edge, *Submission 54 (47th Parliament)*, p. 7; Miss Georgia-Maree Softa, *Submission 35 (47th Parliament)*, p. 5.

⁷³ ADF, *Submission 77 (47th Parliament)*, p. 27.

shouldn't have to be. These are medical services that support the health of our citizens. Yet continuing things like pill testing or existing medically supervised injecting centres—let alone expanding them—seems to be a really difficult fight when it shouldn't have to be. There's good evidence for these programs, and they need to be supported.⁷⁴

3.79 NSWCCCL also recommended in its submission that there be increased access to SISs, citing the benefits of these facilities in providing harm minimisation through focused AOD support. NSWCCCL further recommended government funding and resources to further support these services.⁷⁵

3.80 The 360Edge consultancy on alcohol and other drugs raised concerns in its evidence regarding the lack of SISs, and that this limits accessibility for people outside of the two current locations:

With 1,878 unintentional drug induced deaths occurring across Australia in 2022, the expansion of medically supervised injecting facilities is an important step to reducing rates of overdose and other harms.⁷⁶

3.81 Harm Reduction Australia agreed with this sentiment, stating in its submission:

There is strong support in wider community for these facilities with 87.7% of respondents to our latest national drug policy survey supporting the establishment of new drug consumption/safe injecting facilities in locations with demonstrated community need.⁷⁷

3.82 The Social Policy Research Centre at the University of New South Wales stated in agreement at the public hearing on 27 March 2026:

I think what's important about the locations of supervised consumption sites is that they're located in areas where there is an existing cluster of people who are injecting in risky and harmful ways to their health. That's an important consideration. They are very site specific.⁷⁸

3.83 Conversely, contributors such as ACL and DFA argued that SISs are not effective, that they proliferate and encourage risky drug use, and that they increase drug transactions in the surrounding area and waste funding that could be used for rehabilitation programs.⁷⁹

3.84 The ACL further referenced *The Ryan Review of the Melbourne SIS* (completed in February 2023) in its submission and stated that this review acknowledged a growing

⁷⁴ Dr Danielle McMullen, President, AMA, *Committee Hansard*, 27 March 2026, p. 32.

⁷⁵ NSWCCCL, *Submission 28 (47th Parliament)*, p. 11.

⁷⁶ 360Edge, *Submission 54 (47th Parliament)*, p. 7.

⁷⁷ Harm Reduction Australia, *Submission 85 (47th Parliament)*, p. 8.

⁷⁸ Professor Alison Ritter, Director, Drug Policy Modelling Program, Social Policy Research Centre, UNSW, *Committee Hansard*, 27 March 2026, p. 41.

⁷⁹ See: ACL, *Submission 70*, p. 11; DFA, *Submission 176 (47th Parliament)*, p. 5.

drug trade around this site.⁸⁰ ACL cited additional findings from the review that 49 per cent of the SIS clients came to the area to buy drugs while only six per cent came for the sole purpose of visiting the facility.⁸¹

- 3.85 It was further argued by DFA that the SISs lead to riskier drug taking as people will be more likely to experiment in a 'safe' environment. DFA submitted that the Melbourne SIS recorded overdose rates that were 102 times greater than those occurring on the street, arguing from this that users are willing to experiment with riskier drug doses under supervision and that this complicated harm reduction goals.⁸²

Needle and syringe programs

- 3.86 As described by the Pharmacy Guild of Australia in its submission, needle and syringe programs (NSPs) represent another harm reduction strategy in which the transmission of bloodborne viruses among drug users is reduced by providing clean injecting equipment. The Guild further outlined that NSPs can be delivered via both fixed and mobile sites at which sterile injecting equipment is freely distributed, and that NSPs are recognised as essential to reducing the spread of viruses such as hepatitis C and HIV.⁸³ Evidence from ASHM Health indicated that NSPs are a key harm reduction measure under the *National Hepatitis C Strategy 2018–22*.⁸⁴
- 3.87 Evidence to the inquiry also discussed how NSPs can be additionally used to provide education on safer practices to people injecting drugs. Drug and Alcohol Services South Australia stated at the public hearing on 15 April 2026 that 'for any individuals who are seeking syringes from our needle and syringe program, we'll have a conversation with them about what it is they're using, how to dispose of the syringes safely, do they need any other support'.⁸⁵
- 3.88 Uniting NSW.ACT, which runs the SIS in Kings Cross in Sydney, remarked at the public hearing on 29 May 2026 that it is using NSPs to build relationships with people injecting drugs, and that this can lead to opportunities to provide better healthcare in the long run:

Rather than giving the syringe and then saying, 'Go away,' we give the syringe and say: 'You're important. Stay. You're safe here. You're welcome. Over time, if I actually treat you with dignity and respect, I can then, as you say, start making referrals into treatment, care and support. It doesn't happen on the first visit.'⁸⁶

⁸⁰ See: Victorian Department of Health, *Review of the Medically Supervised Injecting Room - Final Report: Key findings and recommendations*, February 2023.

⁸¹ ACL, *Submission 70*, p. 11.

⁸² DFA, *Submission 16 (47th Parliament)*, p. 5.

⁸³ The Pharmacy Guild of Australia, *Submission 52 (47th Parliament)*, p. 6.

⁸⁴ ASHM Health, *Submission 57 (47th Parliament)*, p. 3.

⁸⁵ Mr Mark Thompson, Director, Aboriginal Clinical Services and Strategy, Drug and Alcohol Services South Australia, *Committee Hansard*, 15 April 2026, p. 32.

⁸⁶ Dr Marienne Jauncey, Medical Director, Medically Supervised Injecting Centre, Uniting NSW.ACT, *Proof Committee Hansard*, 29 May 2026, p. 10.

- 3.89 The Social Policy Research Centre at the University of New South Wales also argued for combining NSP strategies with other types of support to achieve the best health outcomes for people using injecting equipment, stating at the public hearing on 27 March 2026:

I think we're at a point with the international literature where we shouldn't be thinking about brick-and-mortar services. We should be thinking more about mobile services, which are available overseas—a van that drives around and assists people, for example.

In addition, I think there is opportunity to think about needle syringe programs as offering a place for someone to also safely consume. There's an enormous paradox, in our extensive distribution of clean needles and syringes and injecting equipment, in that we provide this but we don't provide the support. We know that someone's going to inject, but we don't then provide the support for a safer, more healthy opportunity for injecting. I think there are some innovations there around needle syringe programs being able to, potentially, also offer support in relation to safer consumption.⁸⁷

- 3.90 Advanced Pharmacy Australia commented in its submission on the positive outcomes NSPs achieved and argued that these programs need to be expanded across all jurisdictions, including to prisons where they are not available (as discussed in the next section). Advanced Pharmacy Australia further submitted that expanding these programs could contribute to lowering the overall healthcare costs associated with drug use, particularly in relation to bloodborne diseases.⁸⁸

Needle and syringe programs in prisons

- 3.91 Evidence to the inquiry raised issues regarding the lack of NSPs in prisons and other custodial settings. Professor Kate Seear submitted that prisons can become hotbeds for shared syringe and needle products which, in turn, contributes to the transmission of bloodborne diseases and increases the disease burden.⁸⁹
- 3.92 Professor Seear further commented in her submission that more than 60 countries around the world operate NSPs in prisons and that they represent an extremely valuable harm reduction service in these settings as well as in the general population.⁹⁰
- 3.93 Hepatitis Australia drew the Committee's attention in its first submission to the inquiry to Principle 9 of the *United Nations Basic Principles for the Treatment of Prisoners* which states 'Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation'. Hepatitis Australia submitted additionally that people held in detention and in correctional

⁸⁷ Professor Alison Ritter, Director, Drug Policy Modelling Program, Social Policy Research Centre, University of New South Wales, *Committee Hansard*, 27 March 2026, p. 41.

⁸⁸ Advanced Pharmacy Australia, *Submission 2*, p. 21.

⁸⁹ Professor Kate Seear, *Submission 33 (47th Parliament)*, p. 18.

⁹⁰ Professor Kate Seear, *Submission 33 (47th Parliament)*, p. 18.

facilities are entitled to NSPs as they are available in all Australian states and territories for people who are not detained. Hepatitis Australia further commented in this context that prisons help sustain the hepatitis C epidemic in Australia and are the primary site of transmission nationally.⁹¹

- 3.94 Hepatitis Australia underlined in its additional submission to the inquiry that the latest data suggests that more than half of all prison detainees nationally have injected drugs. Hepatitis Australia further cited evidence that seven per cent of these prisoners will inject drugs while incarcerated but not when living in the community; that a third report injecting drugs within the previous month while in prison; and that 93 per cent report using shared injecting equipment.⁹²

Harm minimisation and interactions with law enforcement

- 3.95 As noted by the Department of Health in its submission to the inquiry, the current policy and legislative responsibilities for AOD use is shared by all levels of government in Australia, and also across health and law enforcement agencies. The Department of Health submitted also that, at an individual level, drug use and dependence is regarded as a health and social issue rather than a criminal justice or moral issue and that health agencies usually take the lead on tackling AOD policy.⁹³
- 3.96 The Committee is aware also from the inquiry evidence and other sources that the control of illicit drugs and associated precursor chemicals is a shared responsibility between law enforcement, justice and health portfolios across Australia's different jurisdictions. States and territories primarily govern the possession and use of illicit drugs within their respective jurisdictions. This includes existing laws relating to demand, supply and harm reduction initiatives including those pertaining to decriminalisation.

Decriminalisation

- 3.97 ADF explained in its submission that the decriminalisation of drugs for personal use refers to the removal of criminal sanctions for individuals in possession of, or using, small quantities of illicit substances. ADF further noted that this approach is based on the assumption that personal drug use is likely to occur regardless of its legality and that a health response, rather than a judicial response, is a more effective and appropriate way to reduce the harms associated with this. ADF argues that this in turn reduces the burden on police and the courts, reduces unnecessary incarceration, improves access to healthcare, and reduces the stigma associated with illicit drug use.⁹⁴

⁹¹ Hepatitis Australia, *Submission 36 (47th Parliament)*, pp. 3–4.

⁹² Hepatitis Australia, *Submission 23*, p. 2.

⁹³ Department of Health, *Submission 157 (47th Parliament)*, p. 13.

⁹⁴ ADF, *Submission 77 (47th Parliament)*, p. 29.

- 3.98 ADF further comments in its submission to the inquiry that decriminalisation differs from the regulation or legislation of illicit drugs as the supply, trafficking and production of illicit drugs remains a criminal activity. ADF submits that this facilitates better access to health services while allowing law enforcement to continue disrupting the supply and production of illicit drugs.⁹⁵
- 3.99 A number of submitters argued for the decriminalisation of drugs for personal use, stating that this has many societal benefits in addition to reducing the burden on the judicial system.⁹⁶ Listed among these benefits in the inquiry evidence are a reduction in costs to the health system of acute care due to the potential to improve health outcomes and the quality of life for people who use drugs. Further to this, it was argued by ADF in its submission that decriminalisation also improves pathways to treatment by ensuring individuals have access to support services and there was little evidence to suggest decriminalisation led to increased illicit drug use. ADF stated:
- Through decriminalisation, additional resources are made available to be invested into prevention, education, and treatment. Together this investment results in fewer health related harms, which in turn lowers the overall impact of personal drug use on the health system, as well as law enforcement.⁹⁷
- 3.100 NSWCCCL also argued in its evidence that decriminalisation does not increase drug use but in fact has the opposite effect and makes additional tools available to access advice, support and treatment:
- There is consistent evidence that decriminalisation doesn't encourage drug use or increase drug taking in the community. In fact, decriminalisation may have the opposite effect, as more people are able to access advice, support and treatment for any problematic health issue resulting from drug use.⁹⁸
- 3.101 It was recognised in other evidence to the inquiry that whilst decriminalisation remains a state and territory responsibility, there is still work that can be undertaken at the federal level to support this. ADF submitted that leadership and coordination at the federal level would better support jurisdictions in designing and implementing evidence-based drug policy.⁹⁹ Victoria Legal Aid commented also on this issue at the hearing on 27 March 2026:
- Obviously the decriminalisation point and the establishment of diversionary and therapeutic models are largely the responsibility of the states and territories, but we feel that there is a real role for the federal government to aid jurisdictions in essentially designing and implementing evidence based drug policies.¹⁰⁰

⁹⁵ ADF, *Submission 77 (47th Parliament)*, p. 29.

⁹⁶ See: ADF, *Submission 77 (47th Parliament)*, p. 30; NCCRED, *Submission 171 (47th Parliament)*, p. 1; Miss Tayla Payne, *Submission 182 (47th Parliament)*, p. 9; The Construction Industry Drug and Alcohol Foundation, *Submission 185 (47th Parliament)*, p. 5.

⁹⁷ ADF, *Submission 77 (47th Parliament)*, p. 30.

⁹⁸ NSWCCCL, *Submission 28 (47th Parliament)*, p. 5.

⁹⁹ ADF, *Submission 77 (47th Parliament)*, p. 30.

¹⁰⁰ Ms Jen Black, Co-Director, Summary Crime and Therapeutic Justice, Victoria Legal Aid, *Committee Hansard*, 27 March 2026, p. 50.

3.102 ADF remarked in its submission that if decriminalisation were to be pursued at a state and territory level, it would be greatly assisted by the federal government revising threshold quantities set out in the *Criminal Code Act 1995* that delineate between personal possession and trafficking.¹⁰¹ ADF submitted also that

Australian research in the last decade has clearly demonstrated that the amounts set in both federal and state and territory legislation for trafficking will likely capture individuals who are in possession of personal use amounts.¹⁰²

3.103 ADF further commented that this provides the opportunity for the federal government to develop evidence-based legislated threshold quantities using existing research. ADF submitted in addition that both Australian and international evidence supports the effectiveness of decriminalisation in reducing stigma, freeing up criminal justice resources and improving access to treatment and support.¹⁰³

3.104 Turning Point emphasised in its submission that a reduction in incarceration has the potential to improve employment opportunities and other socioeconomic factors:

In the criminal justice sector, decisions regarding sentencing can have a profound impact on AOD service engagement and recovery trajectories. Criminal sanctions, particularly custodial sentences, can exacerbate harm, disrupting housing, employment, and social supports, while also contributing to stigma and long-term disadvantage. A criminal record can limit future opportunities, rendering individuals ineligible for certain forms of employment, education, housing, or community participation, thereby compounding the very risk factors associated with ongoing substance use.¹⁰⁴

3.105 The Legal Aid Commission of New South Wales (Legal Aid NSW) discussed flow on benefits of decriminalisation, including reduced interactions with law enforcement, submitting that:

There is also evidence that decriminalisation results in measurable savings in health costs, social costs and costs to the justice system. Savings for the justice system can include freeing up police time, allowing them to focus on more serious crimes, savings on court and legal resources, and reductions in prison overcrowding.¹⁰⁵

Jurisdictions moving towards decriminalisation

3.106 Edge360 observed in its submission that the ACT had decriminalised small quantities of illicit drugs while other states and territories had police diversion schemes in place (which are either mandatory or discretionary). As noted further by Edge360, people found by police in the ACT, Queensland and South Australia to possess a small

¹⁰¹ ADF, *Submission 77 (47th Parliament)*, p. 6 and 30.

¹⁰² ADF, *Submission 77 (47th Parliament)*, p. 30.

¹⁰³ ADF, *Submission 77 (47th Parliament)*, p. 30.

¹⁰⁴ Turning Point Eastern Health and the Monash Addiction Research Centre, *Submission 92*, p. 27.

¹⁰⁵ The Legal Aid Commission of New South Wales (Legal Aid NSW), *Submission 18 (47th Parliament)*, p. 15.

quantity of drugs for personal use are directed to a health education session or given a health assessment. Edge360 further noted that the ACT offers the option of paying a \$100 fine instead of attending the health session assessment, while in Queensland, persons are issued a warning in the first instance and a health referral on the second and third instances.¹⁰⁶

- 3.107 An evaluation by the University of New South Wales on the first two years of decriminalisation in the ACT noted a decline in the number of consumer offences, an increase in the proportion of those being diverted, police exercising discretion to take no action, and reduction in court matters.¹⁰⁷
- 3.108 Edge360 further stated in its submission that all other states and territories have some form of police diversion in place, but that these usually only relate to cannabis and are discretionary. Edge360 further commented in this regard that as the police in these jurisdictions can choose when to exercise these powers, this could lead to certain populations being unfairly marginalised or targeted.¹⁰⁸

Portugal

- 3.109 Edge360 outlined Portugal's decriminalisation in 2001 of the use and possession of all drugs while simultaneously increasing funding to harm reduction, prevention, social reintegration and treatment programs. Edge360 further explained in its submission that people in possession of drugs in Portugal are referred to 'dissuasion commissions' — small multidisciplinary teams of psychology, social and legal professionals who determine whether further support is warranted and make referrals as necessary. Edge360 states that Portugal's model is considered to be one of the strongest globally and that its benefits include:
- social, health and justice related savings;
 - reduced incarceration;
 - increased access to treatment services and higher engagement with treatment services;
 - reduced unsafe injecting and HIV transmission;
 - increased access to health and social support services;
 - reduced harms related to drug use;
 - reduced rates of drug related deaths; and
 - no change to rates of drug use.¹⁰⁹
- 3.110 The effectiveness of the Portuguese decriminalisation model was also commented on by Queensland Health at the public hearing on 30 October 2024:

¹⁰⁶ 360Edge, *Submission 54 (47th Parliament)*, p. 10.

¹⁰⁷ University of New South Wales, *Final report on the Evaluation of the Operation of the ACT Drugs of Dependence (Personal Use) Amendment Act 2022*, 31 March 2026 (accessed 8 July 2026), p. 10.

¹⁰⁸ 360Edge, *Submission 54 (47th Parliament)*, p. 10.

¹⁰⁹ 360Edge, *Submission 54 (47th Parliament)*, p. 11.

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...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.¹¹⁰

- 3.111 The Alcohol and Other Drug Consumer and Community Coalition also commented on the Portuguese approach at the hearing on 14 April 2026 and the role support services have played in addition to the decriminalisation of drugs in that country:

...decriminalisation is one of the significant approaches in Portugal. They've found that what's important in regard to that is that it's not just decriminalising drugs and letting people just get on with their lives; it's actually having health services backing that up, supporting people to enter into health services and support, in addition to the decriminalisation.¹¹¹

Engagement with the legal system

- 3.112 The inquiry evidence pointed to a significant overlap in drug landscapes and the legal system around the world with many contributors noting that while the legal system still has a key role to play, some jurisdictions have shifted their focus to the principal suppliers of illicit substances rather than targeting minor offences such as personal possession, as discussed in the previous section on decriminalisation.
- 3.113 This section examines law enforcement's role in disrupting the supply of drugs to Australia and discusses the higher proportion of funding given to law enforcement agencies through the *National Drug Strategy 2017–26* (National Drug Strategy).
- 3.114 The supply reduction pillar of the National Drug Strategy targets availability and access to alcohol, tobacco and other drugs with an aim to reduce the associated problems. The strategy characterises illicit drugs as 'drugs that are prohibited, such as cannabis, heroin, cocaine and methamphetamine, and those diverted from legitimate use, such as pharmaceuticals'.¹¹²
- 3.115 This pillar of the Strategy also encompasses the illicit supply of substances that are legitimately available, including alcohol, tobacco, solvents and precursors used in

¹¹⁰ Dr Jeremy Hayllar, Clinical Director, Metro North Mental Health Alcohol and Drug Service, Queensland Health, *Committee Hansard*, 30 October 2024, p. 35.

¹¹¹ Mr Alex Arpino, Executive Manager, Alcohol and Other Drug Consumer and Community Coalition, *Committee Hansard*, 14 April 2026, p. 3.

¹¹² Department of Health, *National Drug Strategy 2017–2026*, 18 September 2017, <https://www.health.gov.au/resources/publications/national-drug-strategy-2017-2026> (accessed 6 July 2026), p. 11.

illicit drug manufacture. By preventing or disrupting the supply of illicit drugs, the strategy seeks to reduce their availability which leads to a reduction of use and consequential harms. The Australian Federal Police (AFP) notes in its submission to the inquiry that it is one of the main agencies charged with combatting the supply of illicit drugs.¹¹³

Law enforcement and supply reduction

3.116 In its submission to the inquiry, the AFP states that it prioritises offshore detection, disruption and deterrence in its approaches to stopping illicit drugs at their sources and transition points, before they can cause harm to the Australian public. The AFP submitted to the inquiry also that in 2023–24, it seized 34 tonnes of illicit drugs and precursors which ‘resulted in an estimated \$12.5 billion in harm avoided’.¹¹⁴ The AFP further commented in its evidence that, in addition to stopping illicit drugs at their source, it also focusses on disrupting Transnational, Serious and Organised Crime (TSOC) figures who are responsible for importing large amounts of illicit drugs to Australia.¹¹⁵

3.117 At the 29 May 2026 public hearing, the AFP stated that another of its strategies to disrupt the supply of drugs is dismantling the overarching criminal business models:

We feel that taking that profit away from those organised crime groups so that they're not living that lavish lifestyle but also not investing in their reoffending is important. That's where we can really make impact. That's where we're focused.¹¹⁶

3.118 The AFP noted also in its submission that supply reduction affects market dynamics and results in wholesale prices of drugs increasing relevant to persistent demand. The AFP asserted in this context that parallel efforts in supply reduction and demand reduction are required from both governments and the community to reduce the harms of illicit drugs.¹¹⁷

3.119 Flinders University submitted to the inquiry that law enforcement subsumes the majority of drug policy expenditure globally and that Australia was no exception. Flinders University further commented in its submission that research has shown much of the investment in drug law enforcement does not achieve the intended goals of reducing the demand for and supply of illicit drugs, stating ‘drug markets have proven highly resilient to drug enforcement efforts, with markets continuing to expand and diversify year on year’.¹¹⁸

¹¹³ Australian Federal Police (AFP), *Submission 89 (47th Parliament)*, p. 1.

¹¹⁴ AFP, *Submission 89 (47th Parliament)*, p. 1.

¹¹⁵ AFP, *Submission 89 (47th Parliament)*, p. 1.

¹¹⁶ Ms Raegan Stewart, Acting Assistant Commissioner, Crime, AFP, *Committee Hansard Proof*, 29 May 2026, p. 30.

¹¹⁷ AFP, *Submission 89 (47th Parliament)*, p. 1.

¹¹⁸ Flinders University, *Submission 73*, p. 2.

Inequity of funding for drug law enforcement

- 3.120 Much of the evidence to the inquiry questioned the proportions of government funding allocated across the three pillars of the National Drug Strategy, specifically the much higher amount allocated to law enforcement for supply reduction, compared with health-focussed demand and other harm reduction responses.
- 3.121 The Australasian Therapeutic Communities Association (ATCA) estimated in its submission that \$3.5 billion was spent annually in Australia on drug law enforcement, compared with \$2 billion allocated to AOD prevention, harm reduction and treatment. ATCA argued that this drove higher rates of incarceration stating that 'over 60 per cent of people are in prison as a consequence of their AOD use and a high majority have a history of mental health issues (63 per cent)'.¹¹⁹
- 3.122 ATCA further stated that a shift in funding priorities towards AOD treatment services was needed and noted there is substantial evidence indicating incarceration is ineffective in rehabilitating individuals or reducing recidivism rates.¹²⁰
- 3.123 The Drug Policy Modelling Program, at the University of New South Wales, commented in its submission that prisoners in Australia have higher levels of AOD use compared to the general population and that a number of key harm reduction interventions are not available to people in prison.¹²¹
- 3.124 St Vincent de Paul Society (Society) NSW & QLD highlighted a large proportion of people entering correctional facilities in Australia have a history of risky AOD use and dependence. The Society further submitted that people leaving correctional facilities tend to have a higher rate of AOD dependence and mental illness and that this results in healthcare costs that are two times greater than in the general population.¹²²
- 3.125 The Society additionally submitted that corrective and justice health services have a duty to improve the health and wellbeing outcomes for people with AOD dependence, especially those voluntarily seeking support. The Society further suggested that connecting people with appropriate and available treatment services, both during their incarceration and as part of their release planning, would be appropriate courses to take.¹²³

Committee comment

- 3.126 Australia's relationship with drugs is complex and multifaceted as they are often used for enjoyment, social bonding or to alleviate stress or trauma. Whether licit or illicit, drug use patterns continue to increase in Australia and whilst often not leading to

¹¹⁹ Australasian Therapeutic Communities Association (ATCA), *Submission 56*, p. 5.

¹²⁰ ATCA, *Submission 56*, p. 5.

¹²¹ Drug Policy Modelling Program, UNSW, *Submission 17 (47th Parliament)*, p. 4.

¹²² The Society NSW & QLD, *Submission 52*, p. 7.

¹²³ The Society NSW & QLD, *Submission 52*, p. 7. See also Drug Policy Modelling Program, UNSW, *Submission 17 (47th Parliament)*, p. 6.

ongoing concerns or dependence, the harms exist and must be recognised. These harms can place a significant burden on the individual and their families, the healthcare system and the broader community.

- 3.127 Whilst trends in drug use are continuously evolving, in part due to supply and demand, the emergence of new drugs such as novel benzodiazepines and novel opioids is deeply concerning. The highly unpredictable nature of these substances in terms of composition and strength, coupled with being found adulterated in other more commonly consumed drugs, poses a real threat to people's lives.
- 3.128 The surveillance of drugs is an important tool for health, law enforcement and community services to identify and respond to these emerging trends and threats and equip the public with accurate up-to-date information. A number of surveillance system types were presented throughout the inquiry. The Committee is of the view that there is value in optimising these systems to support a more collaborative and consistent approach to data collection and data sharing on drug use and misuse, as well as to the communication of alerts as part of an early warning system.
- 3.129 Harm reduction strategies are another key element to reducing the impacts of drug use. It is critical that the public understands the risks, has access to information and services, and can access medicine such as naloxone should an adverse event occur. As highlighted above, this is increasingly important with the increased access to new drugs such as novel psychoactive substances. Greater awareness and understanding also plays a role in reducing the stigma associated with people who use drugs. Expanding harm reduction strategies including increasing access to the Take Home Naloxone program, supervised injecting sites, needle and syringe programs and making drug checking more accessible would offer valuable opportunities to reduce drug-related harms.
- 3.130 In considering supply, demand and the increasingly volatile nature of the substances now available in the illicit drug market, it is clear that there needs to be greater collaboration between the health and law enforcement sectors. This includes a more equal distribution of efforts across all pillars of the *National Drug Strategy*.
- 3.131 A key role for law enforcement continues to be focussing efforts to disrupt and deter criminal networks importing and supplying large quantities of drugs. The Committee's view however is that this should also be coupled with other strategies to reduce demand and harms. This includes working with health services to increase pathways to treatment and better support for those either incarcerated or leaving correctional facilities. Decriminalisation has also been shown to reduce interactions with law enforcement on smaller possession charges while supply reduction can still target the 'big' criminals responsible for importation, as has been seen in Portugal.
- 3.132 Overall, it must be recognised that more can be done to reduce the health impacts of drugs in Australia. Further comments and recommendations for Government on enhancing and improving Australia's drug policies are discussed in greater depth in chapter 7.



4. Managing the health impacts of alcohol and other drugs

- 4.1 The evidence to the inquiry has indicated that the impacts of alcohol and other drug (AOD)-related harms cut across health, social, and economic domains, and are shaped by social determinants of health. This chapter explores the intersection of AOD use and these social determinants, with a focus on education and early life experiences, economic security and housing as well as mental health and family, domestic and sexual violence.
- 4.2 Uniting NSW.ACT noted for example at the public hearing for the inquiry on 29 May 2026 that:
- The social determinants of health are the conditions into which we are born and then we emerge, live, grow, learn and work and are fundamentally what shape your long-term trajectory.¹
- 4.3 This chapter also considers the support services that are currently available, including workforces, and examines the new and emerging models of care that could address unmet need and complement existing prevention, early intervention and treatment programs.
- 4.4 LGBTIQ+ Health Australia submitted that addressing the social determinants of health requires a coordinated, systemic response that prioritises equity, and further stated in its evidence that by investing in education, housing, community infrastructure, and accessible healthcare, policymakers could create environments that reduce AOD-related harms, supporting healthier, safer communities for all.²
- 4.5 The Self Help Addiction Resource Centre (SHARC) argued in its submission that stigma and discrimination function as both obstacles to care and root contributors to substance use challenges. SHARC further commented in its evidence that stigma undermines dignity, social inclusion, housing, employment, and family and community engagement, while increasing isolation, shame, and substance use.³
- 4.6 Given the evidence for the significant role that stigma and discrimination play in a person's interaction with AOD, this is addressed throughout the chapter.

¹ Dr Marianne Jauncey, Medical Director, Medically Supervised Injecting Centre, Uniting NSW.ACT, *Proof Committee Hansard*, 29 May 2026, p. 13.

² LGBTIQ+ Health Australia, *Submission 189 (47th Parliament)*, p. 5.

³ Self Help Addiction Resource Centre (SHARC), *Submission 79*, pp. 34-35.

Education and early life experiences

- 4.7 Findings from the National Drug Strategy indicated that young people (between the ages of 10 and 24) face specific risks in relation to alcohol and other drug problems, that the rates of risky behaviours are generally higher in this demographic, and that associated harm can be reduced by delaying initiation.⁴
- 4.8 The inquiry received considerable evidence regarding the importance of supporting young people as a priority in relation to reducing risky AOD behaviour. In relation to this, this section of the chapter focuses on early life experiences, the role of prevention and early intervention, as well as the role of schools, parents and peers, and the integration of digital supports and examples of best practice.
- 4.9 In its submission to the inquiry, headspace National Youth Mental Health Foundation (headspace) highlighted what it believed were the key reasons for regarding young people as a priority focus for harmful AOD use:
- It is a peak time for beginning to use AOD, although only a subset of young people will develop a problem with AOD use.
 - Those who do need help with their AOD use can experience barriers accessing support, including limited health literacy, geographic isolation, stigma, social exclusion or concerns about confidentiality.
 - Early intervention and proactive approaches are essential.⁵
- 4.10 headspace further stated in its submission that behaviour established during adolescence and early adulthood is a factor that can impact life-long trajectories, with earlier use of AOD leading to increased risk of harm, and that most AOD use peaks in young adulthood between the ages of 18 and 25.⁶
- 4.11 Griffith University supported this view in its submission, commenting that adolescence is a critical window where substance use tends to be experimental and socially influenced, shaped by perceptions of risk and peer norms.⁷
- 4.12 headspace further acknowledged the complexities of the years between adolescence and young adulthood in relation to AOD use, suggesting this as a period of emerging risk for young people—of risk taking, of identity formation and also of an increased risk of getting into distress around mental health or AOD needs. headspace additionally stated in this regard that many young people use AOD to cope with anxiety, trauma, social pressures, and other issues.⁸

⁴ Department of Health, *National Drug Strategy 2017–2026*, 18 September 2017, <https://www.health.gov.au/resources/publications/national-drug-strategy-2017-2026?language=en> (accessed 6 July 2026), p. 27.

⁵ headspace National Youth Mental Health Foundation (headspace), *Submission 25*, p. 2.

⁶ headspace, *Submission 67 (47th Parliament)*, pp. 5-6.

⁷ Griffith University, *Submission 29*, p. 1.

⁸ Ms Nicola Palfrey, Head of Clinical Practice, headspace, *Proof Committee Hansard*, 14 May 2026, p. 1.

- 4.13 Whilst evidence to the inquiry indicated that the current cohorts of young people are delaying the initiation of substance use to a greater extent than previously, the Matilda Centre noted that the rate of escalation of use from late adolescence to young adulthood remained high. The Matilda Centre further affirmed in its submission that this post-school period is an important opportunity to reinforce and strengthen the skills learnt at school, or to assist those young people who require additional support to acquire these skills or to navigate the challenges of emerging adulthood.⁹
- 4.14 The Australian Research Alliance for Children and Youth (ARACY) submission drew from information gathered from its Young and Wise Alcohol and Other Drugs roundtable, a forum designed to bring together young people to share their lived experiences, insights and ideas. As noted by ARACY from these discussions, substance abuse in young people was linked to housing stress, academic issues, family and/or peer pressures, in addition to the cost and availability of mental health care.¹⁰
- 4.15 An approach to addressing the interplay between AOD use and different aspects of a young person's life was suggested by headspace at the public hearing on 14 May 2026:
- We know that young people tend not to present first with an issue to do with alcohol or other drugs. They often turn to us for help with anxiety, relationship distress or situational distress, and then, over the course of time with engagement and trust, they may open up a bit more about the alcohol and other drug use. It's really important that we have it on our radar and that our workforce feel confident to bring it up and ask questions directly, because young people don't often offer it up in their first interactions with us.¹¹

Intersections with trauma

- 4.16 Various contributors to the inquiry stated that trauma is one of the most significant and consistent determinants of AOD use in Australia. Ms Donna Bennett pointed to national and international research showing that experiences of childhood adversity, family violence, institutional harm, homelessness, racism, and intergenerational trauma significantly increase the likelihood of substance use as a coping strategy.¹²
- 4.17 Odyssey House supported this evidence in its submission, stating that a child's family circumstances can significantly impact on their social, emotional and physical development.¹³

⁹ Matilda Centre, *Submission 24 (47th Parliament)*, p. 13.

¹⁰ Australian Research Alliance for Children and Youth (ARACY), *Submission 32*, pp. 5-6.

¹¹ Ms Palfrey, headspace, *Proof Committee Hansard*, 14 May 2026, p. 1.

¹² Ms Donna Bennett, *Submission 59*, p. 2.

¹³ Odyssey House, *Submission 179 (47th Parliament)*, p. 6.

- 4.18 The National Centre for Clinical Research on Emerging Drugs (NCCRED) also agreed, submitting that adverse childhood experiences are a known risk factor for problematic substance use.¹⁴
- 4.19 Edon Place, a provider of services and programs to support families impacted by family and domestic violence in the Bundaberg and Wide Bay region of Queensland, also stated in its submission that developmental trauma is a key underlying factor that connects AOD use, family and domestic violence, and intergenerational harm. Edon Place further commented that exposure in childhood to violence, neglect or instability increases the vulnerability of these individuals to harmful substance use and relationship violence later in life.¹⁵
- 4.20 Factors such as certain childhood experiences and intersections with the criminal justice system or mental ill health were also highlighted by the inquiry evidence in relation to an increased risk of harmful AOD use.
- 4.21 In her submission to the inquiry, Professor Carla Treloar, from the Centre for Social Research in Health at the University of New South Wales, cited findings in this regard from a prior review undertaken on survivor narratives from the publicly available material published by the *Royal Commission into Institutional Responses to Child Sexual Abuse*:

There are well-established links between adverse childhood experiences and later contact with criminal justice and mental health systems. However, the narratives in this sample show that we continue to fail children and young people by providing systems of care that exacerbate rather than reduce trauma. This is because of the failure of services to recognise that a young person's behaviours may be related to trauma, and the failure in responding only with criminal justice intervention.¹⁶

- 4.22 In its submission, Youth Empowered Towards Independence (YETI), a support agency for young people aged 12 to 25 years located in Far North Queensland, discussed links between childhood experiences with trauma, AOD use and mental health, stating:

Some young people use substances like alcohol or drugs to self-medicate for underlying trauma, or emotional or mental health issues. Without early intervention it can worsen feelings of hopelessness, depression, and isolation. Poor emotional regulation through substance use, diminishes a young person's capacity and coping skills, leading to increased impulsivity, risk-taking behaviours, and difficulty managing stress.¹⁷

¹⁴ National Centre for Clinical Research on Emerging Drugs (NCCRED), *Submission 171 (47th Parliament)*, pp. 20–21.

¹⁵ Edon Place, *Submission 33*, p. 3.

¹⁶ Professor Carla Treloar, *Submission 31 (47th Parliament)*, p. 3.

¹⁷ Youth Empowered Towards Independence (YETI), *Submission 51 (47th Parliament)*, p. 3.

- 4.23 NCCRED suggested in its submission that optimising maternal and family care from the antenatal period (before birth) through to preschool will facilitate environments with a lower risk of adverse childhood experiences. NCCRED further recommended that policies should also promote stable housing, employment, and education for families, stating that these factors significantly impact perinatal health and child development.¹⁸
- 4.24 Early intervention services, including early childhood education and specialised services were highlighted by Odyssey House as an effective way to break the cycle of intergenerational substance use and address some of the social determinants of health.¹⁹
- 4.25 NCCRED also called in its submission for a holistic, trauma-informed response to a child that has experienced harm through the integration of family support services with broader public health strategies, such as mental health support and substance use prevention.²⁰

Prevention and early intervention

- 4.26 headspace indicated in its submission that prevention and early intervention approaches for young people can take many forms, including screening, brief interventions, mentoring, and school-based education programs. headspace stated in this regard that such interventions can also be designed universally (focused on the whole population), selective (focused on an at-risk group), or targeted (focused on those already engaged in risky AOD use).²¹
- 4.27 The Alcohol and Drug Foundation (ADF) commented in its initial submission to the inquiry that the goal of prevention and early intervention is to stop or slow progression along the continuum (scale) of AOD use.²² ADF stated in its most recent submission in this context that:
- Prevention strengthens protective factors such as connection to family, school, and community as well as factors such as housing, employment and supportive environments. Because many factors contribute to AOD harm, prevention requires a systemic approach – ensuring policies, services and initiatives target the multiple drivers of harm and build resilience across the whole community.²³
- 4.28 headspace indicated that a member of its Youth National Reference Group had emphasised the importance of strengthening protective factors, given the complexities of young people's relationship with AOD:

¹⁸ NCCRED, *Submission 171 (47th Parliament)*, pp. 20-21.

¹⁹ Odyssey House, *Submission 179 (47th Parliament)*, p. 6.

²⁰ NCCRED, *Submission 171 (47th Parliament)*, pp. 20-21.

²¹ headspace, *Submission 67 (47th Parliament)*, pp. 5-6.

²² Alcohol and Drug Foundation (ADF), *Submission 77 (47th Parliament)*, p. 20.

²³ ADF, *Submission 24*, p. 9.

Young people's relationship with alcohol and other drugs is complex and shaped by many factors (such as social, emotional, and environmental etc). Substance use is often less about recklessness and more about coping with what's happening beneath the surface. I think many young people turn to alcohol or drugs as a way to manage anxiety, social pressure, or trauma, especially when other coping supports are unavailable or stigmatised.²⁴

- 4.29 Mission Australia also acknowledged the importance of having strategies that build and maintain strong family, education, and community connections for young people, including the development of resilience and protective factors to reduce the likelihood that they will become involved in harmful alcohol consumption and illicit drug use.²⁵
- 4.30 In its submission, Mental Health Families and Friends Tasmania (MHFFTas) remarked that the basic skills that will be beneficial to build for young people throughout their schooling years include self-esteem, confidence, problem resolution, conflict resolution, coping skills, health literacy, social skills, and emotional regulation. MHFFTas additionally pointed to evidence-based programs and initiatives targeted at different periods of young people's development as being effective, such as before experimentation, first exposure, and first experiences.²⁶
- 4.31 Whilst a large number of submissions to the inquiry focused on school-based programs, it was acknowledged by different contributors that a focus on other settings was also required, especially for those not attending school, transitioning to workplaces, or undertaking other studies.
- 4.32 Mission Australia emphasised the importance of broader youth programs, stating that they provide a safe, supportive environment where young people can engage in constructive activities that foster personal and emotional growth, social connections, and resilience. Mission Australia further commented that by diverting focus away from harmful behaviours and toward constructive pursuits, these programs can prevent problematic use, support recovery, and promote long-term well-being.²⁷

School-based programs

- 4.33 The inquiry received evidence on the role the education system plays in preventing and delaying AOD use in young people. The ADF pointed to school-based education as a means to build knowledge, strengthen protective factors such as social connection and resilience, and help establish lifelong healthy behaviours.²⁸
- 4.34 The Matilda Centre also viewed schools and the online environment as opportune settings in which to implement AOD prevention activities, stating that schools provide

²⁴ headspace, *Submission 25*, p. 2.

²⁵ Mission Australia, *Submission 115 (47th Parliament)*, p. 9.

²⁶ Mental Health Families and Friends Tasmania, *Submission 27 (47th Parliament)*, p. 9.

²⁷ Mission Australia, *Submission 115 (47th Parliament)*, p. 9.

²⁸ ADF, *Submission 24*, p. 9.

both the infrastructure to deliver education and the appropriate social and learning environment to attenuate risks.²⁹

4.35 360Edge, a national specialist AOD consultancy, argued in its submission that approaches aimed at preventing or delaying the initiation of harmful alcohol and other drug use generally take place in the classroom as most people begin experimenting with alcohol and other drug use during adolescence, a period when risks of harm are elevated.³⁰

4.36 This was contended also by headspace, which discussed in its submission how the education sector interacts in several ways to reduce AOD harm in young people:

Engagement with school is a protective factor, with more young people who are more engaged with school, less likely to experience harm from AOD. Engaging students in AOD education can also help shape their attitudes and behaviours toward AOD, now and in the future. It can help them develop strategies for risky situations, and empower them to make safer and healthier choices.³¹

4.37 Turning Point, a national addiction treatment centre, commented also on this issue that, outside of supporting students to understand AOD harms and complexities, education also assists with the influence of societal attitudes, social media, and peers, and with the importance of assertive communication, help-seeking, and values that promote health and safety.³²

4.38 It was acknowledged also in the inquiry evidence, however, that whilst schools and educational settings are important for providing young people with the information and support to help prevent risky AOD use, there were notable barriers to this being done successfully in these situations.

4.39 One such potential drawback brought to the attention of the inquiry was the equality of these support systems across jurisdictions. 360Edge emphasised in its evidence that there is a need to ensure that every student has equal access to evidence-based AOD education at school and cited research from 2022-23 showing:

- 26.7 per cent of secondary school students reported not receiving any level of alcohol education at school
- 35.9 per cent did not receive any level of illicit drug education at school.³³

4.40 There were several reasons suggested by inquiry contributors as to why these shortfalls exist. Turning Point stated in its submission that many educators report a lack of confidence, resources, time, and the professional development opportunities that are required to effectively deliver AOD education. Turning Point contended that

²⁹ Matilda Centre, *Submission 24 (47th Parliament)*, p. 13.

³⁰ 360Edge, *Submission 54 (47th Parliament)*, p. 8.

³¹ headspace, *Submission 67 (47th Parliament)*, p. 31.

³² Turning Point, *Submission 91 (47th Parliament)*, pp. 14-15.

³³ 360Edge, *Submission 54 (47th Parliament)*, p. 8.

better access to up-to-date information, evidence-based teaching practices, ongoing professional training, and clearer guidance would mitigate these limitations.³⁴

- 4.41 Griffith University echoed these same concerns, noting that schools are among the few settings that can systematically reach young people before risky behaviours emerge, but commenting that they are often expected to lead prevention without adequate training, resources or evidence-based programs.³⁵
- 4.42 Another concern in this regard was raised by ARACY which noted that young people participating in its Young and Wise program described most school programs as repetitive, patronising, and fear based.³⁶
- 4.43 Consistent with this, the National Drug and Alcohol Research Centre (NDARC) suggested that school-based prevention activities need to take care to not alienate students that are already engaging in substance use and instead work to increase students' access to education and support services as needed.³⁷
- 4.44 The National Indigenous Australians Agency (NIAA) highlighted the need to embed social and emotional wellbeing supports into any program, in particular for Aboriginal and Torres Strait Islander students, submitting that:
- Students who feel connected at school and have positive role models may be less likely to experience AOD related harm. For First Nations students, this means ensuring cultural safety, a diverse workforce and engagement from Elders, parents and community in schools. It is also essential that school based AOD policies avoid perpetuating racism and stereotypes.³⁸
- 4.45 ARACY cited findings from its Alcohol and Other Drugs Roundtable Report that participants wanted honest, non-judgmental education that starts earlier, focuses on coping and participation, and recognises the social context in which choices are made. ARACY further suggested in its submission that this includes integrating AOD education within school wellbeing frameworks that focus on coping, participation, and belonging; with content co-designed with young people.³⁹
- 4.46 The National Drug Research Institute (NDRI) remarked in relation to tackling alcohol misuse that programs placed at developmentally appropriate periods are the most successful in impacting alcohol-related behaviours. NDRI stated in its submission that alcohol programs that commence in the year just prior to when the majority of children start to experiment (school years 8-10), with booster interventions occurring in the year when the majority start to consume alcohol regularly, are the most behaviourally successful.⁴⁰

³⁴ Turning Point, *Submission 92*, p. 7.

³⁵ Griffith University, *Submission 29*, p. 1.

³⁶ ARACY, *Submission 32*, p. 4.

³⁷ The National Drug and Alcohol Research Centre (NDARC), *Submission 111 (47th Parliament)*, p. 30.

³⁸ National Indigenous Australians Agency (NIAA), *Submission 140 (47th Parliament)*, p. 12.

³⁹ ARACY, *Submission 32*, p. 5.

⁴⁰ National Drug Research Institute (NDRI), *Submission 141 (47th Parliament)*, p. 43.

- 4.47 ADF suggested that digital innovation also offers significant opportunities to strengthen early intervention and self-management of AOD risk. ADF argued in its most recent submission to the inquiry that accessible digital tools can provide a crucial first point of engagement for young people who are often reluctant to access traditional AOD services due to stigma, privacy concerns or mistrust of institutions.⁴¹
- 4.48 The Matilda Centre echoed the potential role of digital supports in this context, citing research in its submission indicating that digital prevention and early intervention programs can reduce AOD use among young people. The Centre further stated that digital AOD interventions also offer several potential advantages over other methods, including increased student engagement, higher accuracy of implementation, and ready scalability to meet the needs of young people.⁴²
- 4.49 Another consideration that was raised in the inquiry evidence was the role of peer friendship groups. ADF stated in its submission:
- Peer influences are an important factor in reducing AOD related harm. Peer support relationships are based in the equality of the participants. They centre around support and connection being provided by someone who is relatable and potentially more credible to the young person as a member of their peer group. Peer programs comprise activities led by peers of the same age or older age in formal and informal settings such as schools, community centres, and youth clubs. In education settings they are usually one component of a larger program, rather than a sole intervention.⁴³

Parents and young people's AOD use

- 4.50 The important role of parents in preventing risky AOD use by their children was highlighted by the ADF, which submitted that parenting behaviours and attitudes are key influencers of AOD consumption by adolescents.⁴⁴
- 4.51 ARACY submitted that its Alcohol and Other Drugs Roundtable Report had found that alcohol use is often normalised in families and communities. ARACY stated, as an example of this, that participants in the roundtable had said that parents who drink may allow their children to drink with them and justify it as part of Australian culture.⁴⁵
- 4.52 Several submissions to the inquiry cited research on the relationship between parental supply of alcohol and associated harms:
- NDARC's longitudinal study of parental and peer supply of alcohol to young Australians, aged 13 to 19, found that earlier initiation of parental supply increased the risk of heavy episodic drinking and alcohol-related harm.⁴⁶

⁴¹ ADF, *Submission 24*, p. 14.

⁴² Matilda Centre, *Submission 24 (47th Parliament)*, p. 20.

⁴³ ADF, *Submission 77 (47th Parliament)*, p. 22.

⁴⁴ ADF, *Submission 77 (47th Parliament)*, p. 22; Matilda Centre, *Submission 24 (47th Parliament)*, p. 12.

⁴⁵ ARACY, *Submission 32*, p. 6.

⁴⁶ NDARC, *Submission 111 (47th Parliament)*, p. 30.

- Deakin University noted research findings from a randomised school trial that discouraging parental supply of alcohol reduced adolescent binge drinking by 25 per cent.⁴⁷
- 4.53 The Australian Institute of Family Studies (AIFS) discussed in its submission its ongoing study since 2004 *Growing Up in Australia: The Longitudinal Study of Australian Children* (LSAC), noting that it followed the lives of children and their families from all over Australia. AIFS stated that, from LSAC findings, teens permitted to drink at home were more likely to consume alcohol regularly (77 per cent vs 63 per cent) and experience alcohol-related harm (23 per cent vs 17 per cent) compared to those who did not have this permission.⁴⁸
- 4.54 Mental Health Families and Friends Tasmania commented that parents can have positive effects, through parenting programs and other family therapies, in preventing and treating AOD use in young people.⁴⁹ The Matilda Centre submitted also in this regard that:
- It is critical that parents are equipped with evidence-based prevention information and resources. Young people with concerns related to drug and alcohol turn to parents as a primary source of support, and parenting practices are consistently associated with delayed initiation and use of AOD among teenagers.⁵⁰
- 4.55 A lack of clear guidance was highlighted as being a barrier for parents in this respect. The Matilda Centre further commented in its submission that parents will actively seek information about illicit drugs and parenting practices to prevent drug use, primarily from friends or the internet, but that they report low to modest confidence in communicating and influencing their children's choices around AOD use.⁵¹
- 4.56 ADF suggested in this regard that skills training programs for parents can be effective at preventing AOD harm among young people:
- Parenting programs aim to provide parents with opportunities to enhance their knowledge, skills and understanding to improve both child and parent behavioural and psychological outcomes. Parent programs typically focus on social competence skills including communication, promoting parent-child connection, problem solving and conflict resolution on the grounds that a mutually close and trusting relationship will bond the child to the parents' values and help the child to reject substance use.⁵²
- 4.57 The Matilda Centre additionally outlined research identifying a number of parenting strategies that it stated were consistently associated with delayed initiation of alcohol use among teenagers. These included parental monitoring, limiting access to alcohol,

⁴⁷ Deakin University, *Submission 19*, p. 2.

⁴⁸ Australian Institute of Family Studies (AIFS), *Submission 67*, p. 5.

⁴⁹ Mental Health Families and Friends Tasmania, *Submission 27 (47th Parliament)*, p. 6.

⁵⁰ Matilda Centre, *Submission 24 (47th Parliament)*, p. 12.

⁵¹ Matilda Centre, *Submission 24 (47th Parliament)*, p. 13.

⁵² ADF, *Submission 77 (47th Parliament)*, p. 23.

parent-child relationship quality, parental involvement and communication. The Centre also stated that parental discipline and disapproval of adolescent alcohol use was shown to reduce alcohol consumption.⁵³

Examples of programs for young people

- 4.58 Examples of successful programs and frameworks to support young people and reduce risky AOD use were provided in submissions to the inquiry.

Principles of Drug Education for Schools

- 4.59 Various submissions referenced the *Principles of Drug Education for Schools* (*Principles*) framework. Turning Point stated that the *Principles* program was first established in 1994 as an evidence-informed framework designed to support consistent, high-quality AOD education across Australia.⁵⁴
- 4.60 ADF stated that *Principles* is intended to guide school executives, teachers and staff, as well as families, community agencies and other stakeholders, in making decisions related to drug education practice within school communities.⁵⁵
- 4.61 Turning Point further outlined recent developments in relation to *Principles* in its submission, stating that the New South Wales government had commissioned both Turning Point and Monash University to review this framework to ensure it continued to reflect contemporary evidence, respond to emerging challenges, and remain grounded in the realities of Australian schools.⁵⁶
- 4.62 Alcohol Change Victoria noted that whilst they are being updated, investment is needed to scale *Principles* so it has national reach and includes resources to support schools to deliver effective AOD education across the country.⁵⁷
- 4.63 Turning Point also echoed the importance of national reach, commenting that as part of the review process, a comprehensive 'Implementation Guide' was being developed to support a revised *Principles* tool that outlines clear and practical actions for governments, school leaders, teachers, wellbeing teams, families, communities, and students.⁵⁸

OurFutures

- 4.64 As explained by the Matilda Centre in its submission, *OurFutures* is a suite of digital interventions delivered in schools that is designed to prevent the uptake of, and to reduce, harmful AOD use:

⁵³ Matilda Centre, *Submission 24 (47th Parliament)*, p. 13.

⁵⁴ Turning Point, *Submission 92*, p. 7.

⁵⁵ ADF, *Submission 77 (47th Parliament)*, p. 23.

⁵⁶ Turning Point, *Submission 92*, p. 7.

⁵⁷ Alcohol Change Victoria, *Submission 166 (47th Parliament)*, p. 13.

⁵⁸ Turning Point, *Submission 92*, p. 7.

The OurFutures programs were co-designed with >210 students & >390 teachers and include a range of curriculum aligned, interactive online program for students in years 8-10 to prevent the use of alcohol, cannabis, ecstasy, and psychostimulants, and to improve mental health and lifestyle risk behaviours.⁵⁹

- 4.65 The Cancer Council Australia stated that *OurFutures* has demonstrated proven effectiveness in increasing knowledge about alcohol, and that this program had contributed to reduced use of alcohol and binge drinking.⁶⁰
- 4.66 ADF reported in its submission that this program had been developed over two decades and had demonstrated its impact through many evaluations of randomised controlled studies. An example of this provided by ADF was that a study looking at alcohol use seven years after commencement of the *OurFutures* program provided evidence of its effects in reducing risky drinking that lasted into early adulthood.⁶¹
- 4.67 This impact was supported by ARACY which submitted that *OurFutures* had achieved a 25 per cent reduction in alcohol and cannabis use 12 months after delivery, demonstrating that programs combining digital delivery with practical coping strategies can significantly reduce harmful use among adolescents.⁶²

SHAHRP: School Health and Alcohol Harm Reduction Project

- 4.68 ADF discussed the *School Health and Alcohol Harm Reduction Project* (SHAHRP) in its submission, noting that it is a school-based curriculum program targeting alcohol use in young people. ADF further commented that SHAHRP was developed by the NDRI and that evidence had shown its positive effects in reducing risky alcohol use among participants.⁶³
- 4.69 NDRI stated also regarding this program:

SHAHRP was particularly successful with early unsupervised drinkers who experienced 18.4% less alcohol related harm after participating in SHAHRP, and this difference was maintained (19.4%) 17 months after participation in SHAHRP.⁶⁴
- 4.70 NDRI in its submission further remarked that SHAHRP had a well-established proof-of-impact confirmed through independent randomised controlled trials, which consistently reported positive behavioural outcomes. NDRI stated that SHAHRP has had global impact and been adopted into practice by over 2,500 organisations, across 30 sectors in 54 countries.⁶⁵

⁵⁹ The Matilda Centre, *Submission 24 (47th Parliament)*, p. 16.

⁶⁰ Cancer Council Australia, *Submission 22*, p. 5.

⁶¹ ADF, *Submission 77 (47th Parliament)*, p. 24.

⁶² ARACY, *Submission 32*, p. 5.

⁶³ ADF, *Submission 77 (47th Parliament)*, p. 24.

⁶⁴ NDRI, *Submission 141 (47th Parliament)*, p. 42.

⁶⁵ NDRI, *Submission 85*, pp. 1-2.

Blurred Minds

4.71 In its submission, Griffith University explained that *Blurred Minds* is a national youth substance education tool developed at the university that includes in-person workshops; an online learning academy for students; professional development for teachers; and free community and parent resources.⁶⁶

4.72 Blurred Minds noted in its evidence at the public hearing on 29 May 2026 that it has operated for more than 16 years in the school sector and engaged thousands of students, teachers and multidisciplinary researchers on this initiative (600 schools have used its resources and programs). Blurred Minds further indicated to the Committee that through in-person and online workshops, digital learning tools, teacher training and community partnerships, it has reached young people and educators across metropolitan, regional and remote communities.⁶⁷

4.73 Blurred Minds further stated at this hearing:

We have 35-plus peer-reviewed publications on our programs and evaluations. From our programs we have evaluated behavioural determinants. That means that we have improved inaccurate social norms of substance use. We have improved refusal skills. We have improved positive attitudes towards substance use and turned them into negative attitudes towards substance use. We've also improved knowledge and behavioural intentions. Those are our main drivers of behaviour that we work within our prevention.⁶⁸

Positive Choices

4.74 As the Australian Medical Association (AMA) explained in its submission, *Positive Choices* is an online portal designed to help Australian schools and communities access accurate, up-to-date evidence-based alcohol and other drug education resources.⁶⁹

4.75 The AMA outlined the collaboration involved in creating the *Positive Choices* portal, stating that its development involved researchers, teachers, parents and students across Australia, and the federal government, in collaboration with the Matilda Centre.⁷⁰

4.76 The Matilda Centre itself submitted that *Positive Choices* reduces barriers to the effective implementation of school-based AOD programs, such as low confidence, lack of support, lack of knowledge and awareness about the strategies and programs that are evidence based, and time constraints. Speaking to the success of this tool,

⁶⁶ Griffith University, *Submission 29*, p. 2.

⁶⁷ Dr Pamela Saleme, Research Lead, Blurred Minds, Griffith University, *Proof Committee Hansard*, 29 May 2026, p. 37.

⁶⁸ Dr Saleme, Blurred Minds, Griffith University, *Proof Committee Hansard*, 29 May 2026, p. 37.

⁶⁹ Australian Medical Association (AMA), *Submission 80 (47th Parliament)*, p. 11.

⁷⁰ AMA, *Submission 80 (47th Parliament)*, p. 11.

the Matilda Centre further stated that 'Positive Choices has disseminated evidence-based AOD prevention resources to over 4 million school staff, parents and youth'.⁷¹

- 4.77 As further outlined by the Matilda Centre in its submission, particular consideration was also given when implementing this service to marginalised and harder-to-reach populations, including Aboriginal and Torres Strait Islander young people and Australians living in regional and rural areas:

In 2017 the Positive Choices Aboriginal and Torres Strait Islander Peoples portal was launched, providing access to drug prevention resources specifically developed for, and in consultation with, Aboriginal and Torres Strait Islander youth and their teachers and parents.⁷²

Addressing other risk factors

- 4.78 As highlighted in the submission from the Country South Australia PHN, individuals struggling with AOD misuse have complex and often overlapping needs, requiring a holistic and integrated approach.⁷³
- 4.79 In its submission, the Foundation for Alcohol Research and Education (FARE) stated that reducing AOD harms requires coordinated action across multiple sectors beyond health and noted that a coordinated and integrated service system would include AOD, family, domestic and sexual violence, child protection, justice, and mental health sectors collaborating seamlessly to provide holistic support for people with complex needs.⁷⁴
- 4.80 This was supported by the evidence from ADF, which suggested that each of these sectors plays a critical role in prevention, early intervention, recovery and harm reduction – whether through shaping environments that influence health behaviours, providing opportunities for social connection and stability, or supporting pathways to treatment and recovery.⁷⁵
- 4.81 FARE further explained in its submission that, in such a coordinated system, people would encounter a 'no wrong door' approach, where no matter which service they access, they receive appropriate care, early identification of issues, and timely referrals.⁷⁶

Mental health co-morbidity

- 4.82 St Vincent de Paul Society (Society) NSW and QLD submitted that the comorbidity of AOD use and dependence, and mental health concerns, is high. Between 50-76 per

⁷¹ The Matilda Centre, *Submission 24 (47th Parliament)*, p. 14.

⁷² The Matilda Centre, *Submission 24 (47th Parliament)*, p. 14.

⁷³ Country SA PHN, *Submission 14*, p. 5.

⁷⁴ Foundation for Alcohol Research and Education (FARE), *Submission 80*, p. 14.

⁷⁵ ADF, *Submission 24*, p. 8.

⁷⁶ FARE, *Submission 80*, p. 14.

cent of people entering AOD treatment programs in Australia are eligible for a diagnosis for at least one other mental illness.⁷⁷

- 4.83 This was supported by Gayaa Dhuwi (Proud Spirit) Australia, which noted in its submission in relation to First Nations communities:

Collectively, mental health and substance use disorders are the leading cause of disease burden for Aboriginal and Torres Strait Islander people. Due to the co-morbidity of mental health disorders and substance use, AOD services require a multi-systemic, integrated approach with improved linkages across services, models of shared care for a holistic approach and workforce development strategies and partnerships.⁷⁸

- 4.84 The Network of Alcohol and other Drugs Agencies (NADA) referenced the Matilda Centre's '*Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings*' as a valuable resource.⁷⁹

- 4.85 Drug and Alcohol Services South Australia also submitted that it is important for services to continue to have a strong focus on co-morbidity and referred to this management framework, stating:

The Guidelines build the capacity of AOD workers to be 'comorbidity informed', providing evidence-based information on the management of co-occurring mental health conditions when providing AOD treatment.⁸⁰

- 4.86 NADA also highlighted several areas in its submission where actions would lead to better outcomes, including:

- Stronger partnerships between AOD and mental health services, other community services such as housing, domestic and family violence, and family support services.
- Effective and efficient referral pathways and relationships between services across sectors.
- A greater integration and a multidisciplinary approach to practice.⁸¹

- 4.87 Ms Donna Bennett highlighted the need for better integration and pathways between services in her submission, citing research from the National Mental Health Commission and the Productivity Commission's *Inquiry into Mental Health* that identified wide service gaps, long wait times, inconsistent eligibility criteria, and a mismatch between service models and the lived realities of people with co-occurring AOD and mental health needs.⁸²

⁷⁷ St Vincent de Paul Society (Society) NSW and QLD, *Submission 52*, p. 6.

⁷⁸ Gayaa Dhuwi (Proud Spirit) Australia, *Submission 78*, pp. 4-5.

⁷⁹ Network of Alcohol and other Drugs Agencies (NADA), *Submission 66*, p. 15.

⁸⁰ Drug and Alcohol Services South Australia, *Submission 177 (47th Parliament)*, p. 2.

⁸¹ NADA, *Submission 66*, p. 15.

⁸² Ms Donna Bennett, *Submission 59*, p. 3.

- 4.88 This was argued also by SHARC, which advocated for better collaboration between sectors:

People describe having both a mental health challenge and an AOD challenge as a barrier to support, with individuals frequently passed between services due to being viewed as “too complex.” A more appropriate response is for services to meet with the person and work collaboratively to identify what is required to support their wellbeing.⁸³

Family, domestic and sexual violence

- 4.89 The links between AOD use and family, domestic and sexual violence were discussed in a number of submissions to the inquiry, and the evidence indicated that the intersections between AOD use and family, domestic and sexual violence (FDSV) are complex.
- 4.90 The Salvation Army submitted that AOD use intersects with family and domestic violence in a variety of ways, such as:
- While alcohol and other drug use does not cause family and domestic violence, we know that it can increase the frequency and severity.
 - Victim-survivors may use alcohol and other drugs as a way to cope with ongoing violence and abuse, mental health symptoms, trauma and other stressors.⁸⁴
- 4.91 Other submissions highlighted the gendered nature of FDSV. As outlined by the Australian Injecting & Illicit Drug Users League (AIVL) in its submission:
- Sexual, domestic and family violence (including coercive control) is a gendered phenomenon that is overwhelmingly perpetrated by men against women in heterosexual relationships. Evidence shows that SDFV can and does occur in relationships among LGBTQA+ people at similar rates to non-LGBTQA+ people, however, gender remains a critical explanatory factor.⁸⁵
- 4.92 This was explored in further detail in the submission from the AMA, which provided evidence that, in 2021-22, almost half (47 per cent) of the women who had experienced male-perpetrated sexual assault in the prior 10 years believed alcohol or another substance contributed to the most recent incident.⁸⁶
- 4.93 The Salvation Army submitted in this regard that research estimates had indicated that anywhere from 40 to 80 per cent of women in alcohol and other drug treatment services have experienced violence.⁸⁷

⁸³ SHARC, *Submission 79*, p. 32.

⁸⁴ The Salvation Army, *Submission 68 (47th Parliament)*, p. 37.

⁸⁵ Australian Injecting & Illicit Drug Users League (AIVL), *Submission 57*, p. 8.

⁸⁶ AMA, *Submission 80 (47th Parliament)*, p. 10.

⁸⁷ The Salvation Army, *Submission 68 (47th Parliament)*, p. 37.

4.94 FARE also highlighted the effects on children, stating in its submission that harms to children are significantly greater in households where a person drinks alcohol at higher risk levels. FARE emphasised that one in six children (17.1 per cent) have experienced harm from the alcohol use of adults around them, with two-thirds of harm being attributed to an adult in their home.⁸⁸

4.95 YETI also commented in its submission on the effects of AOD use on young people:

Alcohol and drug use can strain family dynamics, leading to relationship breakdowns, homelessness, and estrangement. This is especially true for young people experiencing trauma, neglect, or domestic violence, who may turn to substances to cope with their circumstances.⁸⁹

4.96 The role of both AOD and FDSV services was also raised in the inquiry evidence. In its submission, the Association of Alcohol and other Drug Agencies NT (AADANT) stated that AOD is a significant contributor to gendered violence, and that domestic and family violence services play an important role in identifying and responding to AOD harms, for both perpetrators and victim/survivors.⁹⁰

4.97 The Society NSW & QLD provided further details on this intersection, referencing its own data in NSW which shows that referrals for AOD services regularly come from family and domestic violence support services. Society NSW & QLD argued strongly in its submission that whether AOD use or dependence are causal factors in domestic violence perpetration, or in reinforcing risk factors, it is vital that both the AOD and FDSV sectors collaborate.⁹¹

4.98 Different submissions to the inquiry raised concerns around AOD services not being equitably accessible, including for individuals experiencing FDSV.

4.99 As stated in the submission from the Clean Slate Clinic, providers of virtual and digital AOD care:

We know that survivors of domestic violence have a higher prevalence of substance use disorder, but accessing treatment is extremely challenging. If the person experiencing domestic violence wishes to leave their situation, there are very few shelter providers nationally that are able to accommodate individuals with substance use disorder.⁹²

4.100 This was discussed also in the submission from Uniting Victoria and Tasmania:

A range of barriers reduce women's access to AOD treatment, including stigma and bias, lack of visibility of women's AOD use, past and ongoing experiences of trauma and violence, childcare responsibilities, fear of child protection

⁸⁸ FARE, *Submission 87 (47th Parliament)*, p. 10.

⁸⁹ Youth Empowered Towards Independence, *Submission 51 (47th Parliament)*, p. 3.

⁹⁰ Association of Alcohol and other Drug Agencies NT (AADANT), *Submission 26 (47th Parliament)*, p. 11.

⁹¹ Society NSW & QLD, *Submission 52*, p. 9.

⁹² Clean Slate Clinic, *Submission 122 (47th Parliament)*, p. 4.

involvement and lack of treatment options providing specialist treatment that responds to the specific challenges for women who use drugs.⁹³

- 4.101 This view was also expressed by the Monash Addiction Research Centre, which informed the Committee at the public hearing on 29 October 2024 in relation to treatment access:

Ideally, in other parts of health, we've seen that split into gender-specific units. We also know that many of the women that present to us often are victims of violence and trauma, and putting them in situations where they may feel at risk, obviously, might in some ways delay the decision to seek treatment.⁹⁴

- 4.102 Whilst the evidence to the inquiry is that AOD treatment and service barriers exist, AIVL did note that women were more likely to achieve their AOD-related goals to a greater extent when services explicitly recognised and accommodated their distinct socioeconomic, substance use, and gendered challenges.⁹⁵

- 4.103 The National Women's Safety Alliance suggested that current AOD services often focus primarily on addiction without addressing underlying issues and further stated in its submission that a more integrated model that combines AOD treatment with DFSV services can lead to improved mental health, safety, and stability for individuals and families.⁹⁶

- 4.104 The idea of improving accessibility through better integration between sectors and services was highlighted in a number of submissions.

- 4.105 AADANT submitted that accessibility is also impacted by how well different service sectors are integrated. AADANT suggested that establishing shared models of care between the AOD sector and other services such as domestic violence, health, housing and community services, can improve early identification, referral pathways, and create a 'no wrong door' service system.⁹⁷

- 4.106 In its submission, SMART Recovery noted these partnerships are crucial for addressing the broader challenges faced by individuals in recovery and for ensuring that recovery support is integrated into all aspects of their lives.⁹⁸ SMART Recovery further stated:

This approach helps to ensure that people in recovery do not fall through the cracks, but instead, receive the wraparound support they need to overcome the compounded challenges they face.⁹⁹

⁹³ Uniting Victoria and Tasmania, *Submission 165 (47th Parliament)*, p. 16.

⁹⁴ Professor Dan Lubman AM, Executive Clinical Director, Turning Point, Eastern Health; Director, Monash Addiction Research Centre, *Committee Hansard*, 29 October 2024, p. 17.

⁹⁵ AIVL, *Submission 57*, p. 11.

⁹⁶ National Women's Safety Alliance, *Submission 47 (47th Parliament)*, p. 6.

⁹⁷ AADANT, *Submission 26 (47th Parliament)*, p. 8.

⁹⁸ SMART Recovery Australia, *Submission 168 (47th Parliament)*, p. 21.

⁹⁹ SMART Recovery Australia, *Submission 168 (47th Parliament)*, p. 19.

- 4.107 The Society NSW and QLD expressed the view that improving education and training programs for AOD and FDSV workers is necessary to upskill workers and develop best practice responses to support both victim-survivors and respond to perpetrators who use or are dependent on AOD.¹⁰⁰
- 4.108 The Salvation Army supported this view in its submission, remarking that developing cross-sector training is important to increase the capacity of the wider service sector to prevent, minimise and respond to alcohol and other drug-related harms. The Salvation Army also expressed the view that training should be delivered across sectors such as alcohol and other drug treatment providers and family and domestic violence workers.¹⁰¹
- 4.109 Emphasising this argument further, the Salvation Army stated:
- Due to the intersectional needs of those impacted, and the often hidden nature of family and domestic violence, it is critical that all frontline staff, including alcohol and other drug services, have access to specialised training on family and domestic violence to ensure they are able to identify and respond with meaningful support options.¹⁰²

Economic security and housing

- 4.110 There was notable evidence to the inquiry that the social determinants of health, such as socioeconomic status, and access to employment and housing, all have impacts on the prevention, early intervention, recovery and reduction of AOD-related harms.
- 4.111 This section of the chapter focuses on the role of economic security and housing on AOD outcomes. Multiple contributors to the inquiry commented that employment and socioeconomic status, as well as access to housing, are intersecting issues and can both be drivers as well as risk factors related to AOD-related harms.
- 4.112 Dr Pushkar Cordoba submitted that the harms from AOD misuse are deeply connected to the social determinants of health, stating that the systems of housing, employment, education, and justice all profoundly influence both substance use and recovery trajectories.¹⁰³
- 4.113 The Salvation Army also highlighted in its submission how the drivers and risk factors for AOD-related harms can unfold, stating that:

For some people, experiencing financial strain or poverty will lead to them cutting back on their alcohol and other drug use. For others, the stress can lead to an increase in alcohol and other drug use and leave individuals without adequate

¹⁰⁰ St Vincent de Paul Society NSW & QLD, *Submission 52*, p. 9.

¹⁰¹ The Salvation Army, *Submission 68 (47th Parliament)*, p. 34.

¹⁰² The Salvation Army, *Submission 68 (47th Parliament)*, p. 37.

¹⁰³ Dr Pushkar Cordoba, *Submission 37*, p. 4.

finances and resources to access treatment, support or strategies which would otherwise help manage their concerns.¹⁰⁴

- 4.114 Echoing this view, Tayla Payne discussed research that showed that the relationship between AOD use and homelessness is multifaceted, with many experiencing homelessness turning to AOD as a coping mechanism for the ongoing stress, trauma, and mental health challenges that emerge from living on the street.¹⁰⁵
- 4.115 Contrastingly, Ms Payne also reported that AOD use can also be a causative factor for homelessness, as problematic AOD behaviours can impact personal relationships, employment, and finances, ultimately contributing to housing instability.¹⁰⁶
- 4.116 Exploring the complex and often overlapping issues that are connected to AOD-harms, LGBTIQ+ Health Australia noted in its submission that a person's socioeconomic status is a major determinant of this, stating that poverty, unemployment, and housing insecurity increase vulnerability to substance use. LGBTIQ+ Health Australia further commented that financial stress and limited healthcare access in disadvantaged communities can drive higher rates of dependency, harm, and barriers to treatment.¹⁰⁷
- 4.117 The Salvation Army emphasised that the current cost of living pressures disproportionately impact people on low incomes, stating that this may increase some people's AOD use to cope with associated stress. The Salvation Army expressed the view that this may contribute to cycles of unmanageable debt, homelessness, and entrenched disadvantage.¹⁰⁸
- 4.118 Cost of living considerations were also highlighted by the submission from ARACY, with a focus on young people. ARACY cited evidence that one in five young Australians delays or avoids healthcare because of cost, and that AOD-related ambulance attendances are concentrated in postcodes with high youth unemployment and rental stress.¹⁰⁹
- 4.119 Stable and appropriate housing was also highlighted by the inquiry evidence as a key factor in reducing AOD related harms. The NSW Council for Civil Liberties described a strong correlation between homelessness and unstable housing, and problematic AOD use, commenting that people experiencing homelessness or housing instability are more likely to engage in problematic drug use.¹¹⁰

¹⁰⁴ The Salvation Army, *Submission 68 (47th Parliament)*, p. 44.

¹⁰⁵ Tayla Payne, *Submission 182 (47th Parliament)*, p. 3.

¹⁰⁶ Tayla Payne, *Submission 182 (47th Parliament)*, p. 3.

¹⁰⁷ LGBTIQ+ Health Australia, *Submission 189 (47th Parliament)*, p. 5.

¹⁰⁸ The Salvation Army, *Submission 68 (47th Parliament)*, p. 13.

¹⁰⁹ ARACY, *Submission 32*, p. 6.

¹¹⁰ NSW Council for Civil Liberties, *Submission 28 (47th Parliament)*, p. 8.

4.120 This contention was supported by the Western Australian Network of Alcohol and other Drug Agencies (WANADA), which stated in this regard at the public hearing on 14 April 2026:

Some of the trends I've seen most prominently in my work in the last decade are increasing housing insecurity and increasing cost-of-living pressures, and we tend to see more problematic patterns of substance use in response to those pressures...If I meet someone who's homeless and they're drinking alcohol heavily, I don't expect them to stop drinking alcohol while they're homeless. I'm going to try and focus on getting them into stable and suitable accommodation, and then their alcohol use is going to be easier to deal with.¹¹¹

4.121 Uniting Victoria and Tasmania emphasised in its submission on this issue that:

Not every person who uses alcohol and other drugs has experiences of homelessness and conversely, not all people experiencing homelessness will be using substances. However, research has identified that experiencing these issues concurrently creates significant barriers in accessing treatment and health services, and that there is a need to explore innovative and collaborative solutions to support the multiple needs of this population.¹¹²

4.122 In its submission, the Australian Institute of Health and Welfare (AIHW) referred to its Specialist Homelessness Services Collection and provided data showing that clients with problematic AOD use in 2022–23 accounted for 8.6 per cent of all specialist homelessness services (SHS) clients (23,507 clients in total), and that 3 in 5 of these clients (13,467) were homeless.¹¹³

4.123 NIAA highlighted evidence for the disproportionate harms between Aboriginal and Torres Strait Islander people and the non-Indigenous population by also referring to AIHW data that First Nations SHS clients in 2022-23 had a higher rate of reported harmful AOD use than the total population of SHS clients (12 per cent and 10 per cent, respectively).¹¹⁴

4.124 The Alcohol Tobacco and Other Drug Association ACT (ATODA) further emphasised the need for close cross-sectoral collaboration to address co-occurring issues and needs. Citing the findings from its *2023 ACT ATOD Service Users Survey of Outcomes, Satisfaction and Experience*, ATODA noted that:

- 39.3 per cent of service users surveyed were homeless or at risk of homelessness.
- 68.4 per cent were unemployed or not working.¹¹⁵

¹¹¹ Mr Paul Dessauer, Chief Executive Officer, Peer Based Harm Reduction WA; and Board Director, Western Australian Network of Alcohol and other Drug Agencies (WANADA), *Committee Hansard*, 14 April 2026, p. 38 and p. 43.

¹¹² Uniting Victoria and Tasmania, *Submission 165 (47th Parliament)*, p. 18.

¹¹³ Australian Institute of Health and Welfare, *Submission 142 (47th Parliament)*, Attachment A, p. 7.

¹¹⁴ NIAA, *Submission 140 (47th Parliament)*, p. 12.

¹¹⁵ The Alcohol Tobacco and Other Drug Association ACT (ATODA), *Submission 72 (47th Parliament)*, p. 7.

- 4.125 Further to this evidence, the South Australian Council of Social Service (SACOSS) cited research findings from homelessness services in Melbourne that 43 per cent of the homeless population reported AOD use issues. SACOSS noted in this regard that, of these 43 per cent, one-third reported AOD issues prior to becoming homeless, with the remaining two-thirds reporting they developed AOD issues following homelessness.¹¹⁶

Barriers and enablers

- 4.126 Many inquiry submissions highlighted the importance of access to housing as both a protective factor to reduce risk of AOD-related harms and as an enabler to engage in treatment and support.

- 4.127 The Salvation Army submitted in this context:

Having access to affordable, safe and sustainable housing provides a vital foundation for a person to obtain and maintain employment, education, training, family and social networks, health and wellbeing. These essential foundations are protective factors that reduce the risk of alcohol and other drug-related harms and enable people to engage in support and treatment.¹¹⁷

- 4.128 In its submission, the National Rural Health Alliance (NRHA) echoed the importance of housing and employment opportunities as foundational needs. NRHA stated that once these foundational needs are met, people are able to engage in opportunities for social diversion and community inclusion to foster relationships and strengthen long-term recovery outcomes.¹¹⁸

- 4.129 The importance of connection, especially post-treatment was also emphasised by SHARC who, on reflecting voices of its members and staff, stated in its submission:

We're often abandoned after treatment to navigate complex recovery journeys alone, without sustained support for housing, employment, learning, and social engagement ... this isolation directly impacts our health, increasing risks of overdose, relapse, chronic disease, mental health issues, suicide and subsequent service contact.¹¹⁹

- 4.130 Housing insecurity was also referenced as a barrier to entering and exiting treatment. The Salvation Army noted that inpatient and residential treatment services will require a person to have a safe discharge destination prior to being accepted into treatment. The Salvation Army emphasised that it is difficult therefore to provide appropriate treatment and support for people in the community if they do not have access to safe and stable accommodation.¹²⁰

¹¹⁶ South Australian Council of Social Service, *Submission 58 (47th Parliament)*, p. 16.

¹¹⁷ The Salvation Army, *Submission 68 (47th Parliament)*, p. 43.

¹¹⁸ National Rural Health Alliance (NRHA), *Submission 62*, p. 16.

¹¹⁹ SHARC, *Submission 79*, p. 22.

¹²⁰ The Salvation Army, *Submission 68 (47th Parliament)*, p. 41.

- 4.131 The Alcohol and Other Drug Consumer & Community Coalition (AODCCC) posited similar views, commenting also at the public hearing on 14 April 2026 on the challenges of accessing treatment whilst being able to maintain housing:

Our members have shared with us is the challenge of maintaining a rental property or housing when there is a requirement for people to step out of that for a period of time and put their income into the residential rehabilitation phase. There can be some difficult decisions that have to be made as to whether to give up housing to access these types of services.¹²¹

- 4.132 Utilising findings from a dedicated consumer focus group as well as its members, the AODCCC noted in its submission that another barrier is the lack of follow-up care once individuals leave a service, which can lead to negative outcomes such as homelessness, lack of job opportunities, and other social issues.¹²²

- 4.133 The Australian Alcohol and other Drugs Council (AADC), a national peak body representing the AOD sector, acknowledged the need for cross-sector collaboration noting an increase in clients experiencing personal and environmental complexity. AADC further submitted that this can be exacerbated by a lack of capacity in other intersecting sectors, resulting in those with AOD use being referred into the AOD system as a means to alleviate capacity issues within other support sectors.¹²³

- 4.134 Further submissions to the inquiry stated the importance of co-ordinated, cross-sectoral responses that include focuses on community and other wraparound supports.

- 4.135 Alcohol Change Victoria emphasised that the importance of wraparound support, including after exiting rehabilitation, is underscored by the fact people experiencing addiction are more likely to experience insecure housing and homelessness, social isolation, and other forms of disadvantage, further stating:

Greater investment in programs that are codesigned with people with lived and living experience, address social determinants of health, and provide peer and wraparound support is needed to improve treatment engagement and system navigation, which ultimately improves health outcomes and reduces costs.¹²⁴

- 4.136 ATODA drew attention in its submission to the success of collaboration between services, referencing evidence demonstrating that people who receive support from both a specialist homelessness service and a publicly funded AOD treatment service were more likely to be returning service users, present with complex service needs, and receive longer periods of support and treatment.¹²⁵

¹²¹ Mr Alex Arpino, Executive Manager, Alcohol and Other Drug Consumer and Community Coalition, *Committee Hansard*, 14 April 2026, p. 3.

¹²² Alcohol and Other Drug Consumer & Community Coalition, *Submission 148 (47th Parliament)*, p. 7.

¹²³ Australian Alcohol and other Drugs Council (AADC), *Submission 45 (47th Parliament)*, p. 18.

¹²⁴ Alcohol Change Victoria, *Submission 166 (47th Parliament)*, p. 18.

¹²⁵ ATODA, *Submission 72 (47th Parliament)*, p. 9.

- 4.137 This was supported also by the Financial Counsellors' Association of WA, which stated at the public hearing on 14 April 2026:

Financial stress is both a driver and a consequence of alcohol and other drug harm... evidence to this committee has highlighted that people experiencing alcohol and other drug harm do not follow through on external referrals due to shame, chaos in their lives, limited transport or limited capacity to navigate fragmented systems. Co-located onsite financial counselling within alcohol and other drug services removes these barriers. Wraparound service models allow financial and clinical issues to be addressed concurrently, strengthening engagement and reducing drop-off from care.¹²⁶

- 4.138 First Step emphasised the importance of continuity of support and collaboration across sectors, particularly during key life transitions such as hospital discharge, release from custody, or entry into treatment. First Step submitted that without coordinated responses, individuals risk moving through services without achieving long-term stability.¹²⁷
- 4.139 SACOSS recommended establishing community-based peer support groups and harm-reduction networks, suggesting they can make a significant contribution to prevention and to supporting substance users and other affected groups of people, particularly in terms of connecting people with outreach health and support services.¹²⁸

Intersections with criminal justice system

- 4.140 In its submission, the Community Restorative Centre (CRC), an organisation in NSW providing specialist support to people affected by the criminal justice system, stated that people in prison experience higher rates of homelessness and housing instability which heightens the risk of AOD dependence. CRC emphasised that better access to secure and appropriate housing for criminalised communities is a crucial component of addressing AOD related harms in Australia.¹²⁹
- 4.141 This view was echoed by the Community Industry Group (CIG), a peak body for community services and organisations in southern NSW, which noted that 48 per cent of prison discharges are expected to be homeless once released. CIG suggested establishing a post-release plan that focuses on housing stability and coordinating a holistic healthcare response is paramount to reducing this.¹³⁰
- 4.142 Flinders University noted in this context that implementing transitional accommodation outside the prison gate provides a safe and secure set of housing options for those exiting prison, particularly for those needing temporary or short to

¹²⁶ Ms Melanie Hopkinson, Chief Executive Officer, Financial Counsellors' Association of WA, *Committee Hansard*, 14 April 2026, p. 66.

¹²⁷ First Step, *Submission 65*, p. 16.

¹²⁸ South Australian Council of Social Service, *Submission 58 (47th Parliament)*, p. 17.

¹²⁹ Community Restorative Centre (CRC), *Submission 56 (47th Parliament)*, p. 10.

¹³⁰ Community Industry Group, *Submission 152 (47th Parliament)*, p. 6.

mid-term housing supports which aims to address underlying issues including reducing AOD-related harms.¹³¹

- 4.143 CRC discussed the *Reintegration Housing Support Program* in relation to this issue, which aims to connect people leaving custody and at risk of homelessness with specialist support workers who will assist with securing access to suitable accommodation, as well as provide wrap-around psychosocial support. CRC stated that support workers work alongside NSW Department of Communities and Justice Housing staff to assist program participants to secure and sustain long-term housing once they leave custody.¹³²

Housing first approach

- 4.144 A number of submissions made reference to a housing first approach, a model for providing sustainable housing for people experiencing long term or recurring homelessness that includes significant support for people where needed.
- 4.145 The Consumers Health Forum of Australia emphasised that this approach prioritises finding a person housing before focussing on providing support for AOD rehabilitation.¹³³
- 4.146 Uniting NSW/ACT expressed the view that the housing first approach is founded on several principles:
- stable housing as a human right and the base upon which employment, community connections and better health can be built;
 - stable housing and flexible support are functionally separate;
 - the people seeking housing exercise choice and self-determination;
 - support uses a harm reduction approach.¹³⁴
- 4.147 The Burnet Institute also highlighted housing first models as a means to improve housing stability and reduce emergency department and hospital admissions.¹³⁵
- 4.148 Tayla Payne explained that housing stability provides individuals engaging in AOD use with a restored sense of security and stability, improving their overall health and well-being as well as assisting individuals in reducing AOD use overall.¹³⁶
- 4.149 NADA outlined other recent AOD-related inquiries in its submission where this approach was recommended, namely the 2020 *NSW Special Commission of Inquiry into the Drug 'Ice'*. NADA noted that that inquiry recommended that the NSW

¹³¹ Flinders University, *Submission 73*, p. 8.

¹³² CRC, *Submission 56 (47th Parliament)*, p. 3.

¹³³ Consumers Health Forum of Australia, *Submission 128 (47th Parliament)*, p. 8.

¹³⁴ Uniting NSW/ACT, *Submission 79 (47th Parliament)*, p. 5.

¹³⁵ Burnet Institute, *Submission 178 (47th Parliament)*, p. 20.

¹³⁶ Tayla Payne, *Submission 182 (47th Parliament)*, pp. 8-9.

Government pilot a housing first approach to supporting people who use drugs and are experiencing housing instability.¹³⁷

- 4.150 Whilst there was strong support for this model in the inquiry evidence, it was noted by several submitters that a current barrier to implementation is the availability of housing options. Tayla Payne commented that increasing these options was crucial for supporting and implementing a housing first model and ensuring that individuals with AOD issues have access to the housing needed for the safety and stability required to improve their overall wellbeing and recovery.¹³⁸

Overview of support services for alcohol and other drugs

- 4.151 As noted in the *National Drug Strategy 2017-2026* (Strategy), a wide spectrum of AOD services and support is available in Australia, ranging from peer-based community support through to more intensive specialist treatment services with the aim of reducing risky AOD use.¹³⁹
- 4.152 Evidence submitted throughout the inquiry provided detailed information to the Committee on these different types of support services with various areas of focus, examples of which are provided throughout this report. This section assesses the evidence received on the importance of rehabilitation services, as well as on new and emerging models of care.

Rehabilitation

Residential rehabilitation

- 4.153 The Committee was informed by the inquiry evidence that residential rehabilitation for people experiencing AOD dependence involves a highly structured live-in program to enable support and treatment. The duration of a residential rehabilitation program is typically three months but is case by case dependent and can last up to 18 months. Treatments include cognitive behaviour therapy, motivational interviewing, relapse prevention and individual and group counselling.¹⁴⁰
- 4.154 As noted by ADF in its submission, AOD treatment in Australia is voluntary and a person in residential rehabilitation cannot be forced to remain in the program. ADF further highlighted however that both Victoria and New South Wales have legislation in place which allows for compulsory treatment to be imposed in very limited circumstances. Although comparable legislation is not in place in other states and territories, ADF emphasised that a person may be required to attend compulsory treatment anywhere in Australia if they are the subject of a court order as it is a

¹³⁷ NADA, *Submission 66*, p. 16.

¹³⁸ Tayla Payne, *Submission 182 (47th Parliament)*, pp. 8-9.

¹³⁹ Department of Health, *National Drug Strategy 2017–2026*, 18 September 2017 (accessed 6 July 2026), p. 9.

¹⁴⁰ Health Complaints Commissioner, *Submission 199 (47th Parliament)*, p. 28.

reserved sentencing option for people with AOD dependency who have committed a serious criminal offence.¹⁴¹

- 4.155 The inquiry received evidence that residential rehabilitation is often viewed as a front-line treatment option for people with complex and severe substance use issues. The National Centre for Youth Substance Use Research at the University of Queensland discussed this at the public hearing on 21 November 2024:

Residential treatment is often seen as first-line treatment, but it really shouldn't be. The public seems to think that that is what drug and alcohol treatment is. We could probably educate the public that you do have other options. You could look at online resources. You could do a brief intervention with the drug and alcohol service. You could do a day program where people go in and receive the equivalent of residential treatment programs but stay in the community and are not cut off from their social supports et cetera. Every one of those has pros and cons.

Residential treatment tends to be required when someone's got quite severe and complex substance use issues and are troubled with mental health, physical health and pain issues. They often receive it when they've run out of other options—they're homeless or about to be homeless; they don't have an income. It's seen as that last resort and it really shouldn't be. It's a valid treatment option. It's got an important role, but there are a lot of other options that people could try first.¹⁴²

- 4.156 One of the issues raised in the inquiry evidence regarding residential rehabilitation services was the long wait times to access treatment. Victoria Legal Aid (VLA) submitted that the numbers of publicly funded detox and rehabilitation beds for AOD treatment, addiction specialists and counselling services are currently insufficient stating:

In VLA's practice experience, due to the shortage of AOD services, people who use alcohol and other drugs have often ended up in the criminal justice system rather than getting the early health interventions they needed... When there are long wait times to access AOD services, a person often loses motivation to engage in treatment. AOD issues can escalate when people do not get the help they need, which can in turn cause or contribute to offending behaviour.¹⁴³

Mobile rehabilitation services

- 4.157 The inquiry received contributions from some rehabilitation services with expanded programs that include a mobile outreach component. Goldfields Rehabilitation Services was one example of this. This organisation states that it provides a holistic

¹⁴¹ ADF, *What is residential rehabilitation?*, 13 December 2022, <https://adf.org.au/insights/residential-rehabilitation/> (accessed 15 July 2026).

¹⁴² Professor Leanne Hides, Deputy Director, National Centre for Youth Substance Use Research, University of Queensland, *Committee Hansard*, 21 November 2024, p. 5.

¹⁴³ Victoria Legal Aid, *Submission 47*, pp. 1–2.

and supervised residential rehabilitation service for people aged 18 years and over who have been affected by drug and/or other drug dependency. This service also covers a wide area from Esperance to Kalgoorlie in Western Australia and its mobile outreach recovery component is indicated as a key feature, indicated as a measure to ensure all clients who have been referred to the rehabilitation service are assisted.¹⁴⁴

4.158 As part of its mobile outreach activities, Goldfields Rehabilitation Services informed the Committee at the public hearing on 15 April 2026 that it sends staff, including medical staff, to communities to meet with clients and their families to ensure they have whatever support is needed to assist with rehabilitation. It further stated to the Committee at the hearing that it provides transport for clients to the rehabilitation centre and other kinds of assistance as needed.¹⁴⁵

4.159 The Committee was interested to hear of any challenges with this mobile outreach initiative, particularly if it was difficult to get clients to follow-up on treatment. Goldfields Rehabilitation Services further stated at the hearing in this regard:

It is very challenging, especially with the locations, but we find the existence of the outreach is really good. The detox facility is also a significant program. That is where the clients are assessed thoroughly. It is important to have the outreach because sometimes we need to pick them up, transport them and help their families as well. It has its challenges, but I think the mobile outreach and strengthening that day after day are very essential. We're getting some successes as well.¹⁴⁶

4.160 Evidence was received by the inquiry indicating how mobile rehabilitation services are used for alcohol rehabilitation as well as other drugs in rural and regional communities, and the benefits being achieved. This was also of interest to the Committee. Drug and Alcohol Services South Australia detailed at the public hearing on 15 April 2026 how funding had been secured to acquire a mobile alcohol and other drugs van, noting that it is driven to rural and remote regions with an addiction specialist on board who can have conversations with people regarding their alcohol and other drug use:

For any individuals who are seeking syringes from our needle and syringe program, we'll have a conversation with them about what it is they're using, how to dispose of the syringes safely, do they need any other support. And because we have the addiction medicines specialist on-site with us, we're able to fast-track referrals into our withdrawal services unit at the Glenside campus.¹⁴⁷

¹⁴⁴ Mrs Jane Fajardo, Chief Executive Officer, Goldfields Rehabilitation Service Inc., *Committee Hansard*, 15 April 2026, p. 1.

¹⁴⁵ Mrs Fajardo, Goldfields Rehabilitation Service Inc., *Committee Hansard*, 15 April 2026, p. 1.

¹⁴⁶ Mrs Fajardo, Goldfields Rehabilitation Service Inc., *Committee Hansard*, 15 April 2026, p. 2.

¹⁴⁷ Mr Mark Thompson, Director, Aboriginal Clinical Services and Strategy, Drug and Alcohol Services, South Australia, *Committee Hansard*, 15 April 2026, p. 32.

- 4.161 In addition to this mobile van, Drug and Alcohol Services South Australia also noted at the hearing that it facilitates a fly-in-fly-out service in the Anangu Pitjantjatjara Yankunytjatjara Lands (APY Lands) in South Australia:

We have a fly-in fly-out service. We currently spend two weeks every month in the APY Lands. We do a hub-and-spoke model. We're based in Amata, that's where our houses are, and from there we will outreach to the other major communities within the APY Lands.¹⁴⁸

New and emerging models of care

- 4.162 This section of the chapter considers new and emerging models of care to complement existing service offerings, including a focus on assessment and screening, service integration and prevention, and early intervention. The Committee was interested to learn how equity of access and coverage of these emerging services could be ensured, including in rural and remote areas and among diverse population groups.
- 4.163 ADF stated in its most recent submission to the inquiry that Australia's AOD services deliver high-quality, evidence-based and life-saving interventions across diverse models of care, including counselling, pharmacotherapies, residential rehabilitation and brief interventions.¹⁴⁹
- 4.164 AADC submitted however that whilst Australia's AOD services are providing high-quality care, the evidence indicates that there are not enough services available or that are sustainably funded to meet increasing community demand.¹⁵⁰
- 4.165 Alcohol Change Victoria argued for the importance of ensuring that programs are codesigned with people with lived and living experience, that they addressed social determinants of health, and provided wraparound support to improve treatment engagement and system navigation.¹⁵¹
- 4.166 The NIAA emphasised that a focus on the Aboriginal and Torres Strait Islander community-controlled sector to enable the provision of culturally appropriate care was vital, in line with Closing the Gap, Priority Reform Two.¹⁵²

Digital interventions and support

- 4.167 Given the barriers to treatment and other support services that emerged in the inquiry evidence, the Committee was interested in the potential to use and integrate digital technologies to improve the access to the different types of AOD support.

¹⁴⁸ Mr Thompson, Drug and Alcohol Services South Australia, *Committee Hansard*, 15 April 2026, p. 32.

¹⁴⁹ ADF, *Submission 24*, p. 6.

¹⁵⁰ AADC, *Submission 11*, p. 3.

¹⁵¹ Alcohol Change Victoria, *Submission 166 (47th Parliament)*, p. 18.

¹⁵² NIAA, *Submission 140 (47th Parliament)*, p. 14.

- 4.168 In its submission, Turning Point highlighted evidence that only about one in five (22.4 per cent) Australians with an AOD use disorder actually sought help. Turning Point mentioned in this regard that barriers to accessing these treatments include service availability (e.g., hours of operation), geography (e.g., restricted transport options and scarcity of services in regional/rural areas), stigma, and concerns about anonymity.¹⁵³
- 4.169 Turning Point submitted also that many people experiencing emerging AOD harms do not initially require intensive specialist treatment but would benefit from brief interventions, motivational support, harm prevention strategies, psychoeducation, or regular follow-up.¹⁵⁴
- 4.170 The Queensland Nurses and Midwives' Union stated in its submission that investing in the development and funding of alternative models of care, and boosting existing public services, would create a more accessible and affordable system for individuals seeking help for AOD issues and reduce the associated harm.¹⁵⁵
- 4.171 The Queensland Nurses and Midwives' Union also outlined some of the barriers to accessing AOD care, including concerns around privacy, stigma, and discrimination. It noted in its submission that addiction treatment systems are also complex and difficult to navigate, so people seeking help often do not know who to contact first or how to find the right support that meets their needs and expectations.¹⁵⁶
- 4.172 Turning Point further cited supporting evidence on this issue showing that the complexity and fragmentation of services make it difficult for individuals to know where or how to seek help, often resulting in delayed treatment-seeking, disengagement from care, or escalation of harms before support is finally accessed.¹⁵⁷
- 4.173 Turning Point submitted that expanding Australia's digital addiction infrastructure would support a more efficient and sustainable AOD system by allowing specialist services to be reserved for people with more severe or complex needs, with others being able to access earlier and more proportionate interventions.¹⁵⁸
- 4.174 ADF contended that digital technologies can be used to bring together various AOD services and programs. ADF stated that digital systems can facilitate a single "front door" through which appropriate interventions can be accessed, provide options for people requiring AOD treatment, and provide better connectivity so the experience is less fragmented for the person requiring help and support.¹⁵⁹
- 4.175 ADF further stated in this context:

¹⁵³ Turning Point, *Submission 91 (47th Parliament)*, pp. 33-34.

¹⁵⁴ Turning Point, *Submission 92*, p. 5.

¹⁵⁵ Queensland Nurses and Midwives' Union, *Submission 34 (47th Parliament)*, p. 9.

¹⁵⁶ Alcohol Change Victoria, *Submission 166 (47th Parliament)*, p. 18.

¹⁵⁷ Turning Point, *Submission 92*, p. 4.

¹⁵⁸ Turning Point, *Submission 92*, p. 6.

¹⁵⁹ ADF, *Submission 77 (47th Parliament)*, pp. 19-20.

Digital innovation offers significant opportunities to strengthen early intervention and self management of AOD risk. Approaches such as online screening and brief interventions, mobile apps, chatbots, and interactive education tools can help users identify risk, receive tailored feedback, and connect to supports anonymously and on their own terms.¹⁶⁰

- 4.176 The Department of Health, Disability and Ageing (Department of Health) submitted that providing access to online/virtual early intervention activities allows Australians experiencing harmful AOD use to better access support services. The Department of Health additionally stated that digital tools increase accessibility for those experiencing issues associated with stigma, financial constraints, rurality, as well as those experiencing FDSV or other forms of isolation that may make access to or attendance at face-to-face services difficult.¹⁶¹
- 4.177 This was echoed by Hello Sunday Morning (HSM) which cited evidence in its submission that delivering support and treatment services online can help to reduce barriers by overcoming problems related to cost, accessibility, lengthy waitlists and stigma for people not seeking, or not able, to receive in-person support and treatment.¹⁶²
- 4.178 Turning Point also referenced in its submission, as a possible guide for enhancing AOD digital support, recent Australian Government investment in mental health digital services to facilitate access to free, low-intensity online appointments.¹⁶³

Screening and assessment tools

- 4.179 Several submissions to the inquiry cited both the Alcohol Use Disorders Identification Test (AUDIT) and Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) as two currently available effective and validated digital screening and assessment tools for risky AOD use.¹⁶⁴
- 4.180 The Australasian College of Emergency Medicine (ACEM) explained in its submission that the routine use of validated, standardised screening tools offers an important mechanism for identifying, reducing and preventing problematic AOD use and dependence.¹⁶⁵
- 4.181 This position was supported by FARE, which noted in its additional submission to the inquiry that:

Routine alcohol screening and brief intervention should be standard medical practice, enabling early identification of Alcohol Use Disorder and timely support for those at risk... these interactions can serve as pivotal moments for

¹⁶⁰ ADF, *Submission 24*, p. 14.

¹⁶¹ Department of Health, *Submission 157 (47th Parliament)*, p. 20.

¹⁶² Hello Sunday Morning (HSM), *Submission 38 (47th Parliament)*, p. 3.

¹⁶³ Turning Point, *Submission 91 (47th Parliament)*, pp. 32-34.

¹⁶⁴ Rodney Holmes Policy Submissions, *Submission 174 (47th Parliament)*, pp. 16-17; PHN NSW/ACT AOD Network, *Submission 55 (47th Parliament)*, p. 10; FARE, *Submission 87 (47th Parliament)*, pp. 20-21.

¹⁶⁵ Australasian College of Emergency Medicine, *Submission 95 (47th Parliament)*, p. 4.

prevention, early intervention, or referral to treatment, reducing long-term harm and improving patient outcomes.¹⁶⁶

4.182 Further to this, the Burnet Institute also highlighted the importance of upskilling health professionals to deliver routine, non-stigmatising health assessments and harm reduction education.¹⁶⁷

4.183 AOD screening and brief interventions, delivered in primary healthcare settings, was acknowledged by AADANT as also being effective in helping to prevent alcohol-related harms. AADANT also noted in its submission however that several barriers existed in this regard, including competing demands on health practitioners' time, reluctance by health providers to question people about AOD use, and a lack of referral options for follow-up support or treatment. AADANT suggested that these can be addressed with improved training and support for staff and adequately resourced and coordinated referral pathways.¹⁶⁸

4.184 PHN NSW/ACT AOD Network explained the operation of the AUDIT digital tool, developed by the World Health Organization (WHO):

The AUDIT has ten questions on consumption and its consequences, simple and effective method of screening for unhealthy alcohol use, defined as risky or hazardous consumption or any alcohol use disorder. Changes in AUDIT scores ranged from 24.63 at baseline (high-risk, dependence likely) to 1.72 (low risk).¹⁶⁹

4.185 The Committee noted that, in relation to broader substance abuse, ASSIST was also developed by the WHO as a technical tool for the early identification of substance use-related health risks and disorders in primary health care, general medical care and other settings.¹⁷⁰

4.186 The Centre for Alcohol Policy Research (CAPR) made reference in its submission to another digital validated tool 'Grog App' which is focused on Aboriginal and Torres Strait Islander people. CAPR stated that this is the first digital health tool, worldwide, that enables accurate, acceptable, flexible and culturally tailored drinking assessments:

Each person who completes the Grog App also receives a digital brief intervention tailored to their survey responses. We have found that the using a digital screening tool was an effective way to let people report on their drinking in culturally appropriate ways.¹⁷¹

¹⁶⁶ FARE, *Submission 80*, p. 9.

¹⁶⁷ Burnet Institute, *Submission 178 (47th Parliament)*, p. 15.

¹⁶⁸ AADANT, *Submission 26 (47th Parliament)*, p. 11.

¹⁶⁹ PHN NSW/ACT AOD Network, *Submission 55 (47th Parliament)*, p. 10.

¹⁷⁰ World Health Organization, The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST), 2010, <https://www.who.int/publications/i/item/978924159938-2> (accessed 2 July 2026).

¹⁷¹ Centre for Alcohol Policy Research, *Submission 21 (47th Parliament)*, pp. 2-3.

Path2Help

- 4.187 Path2Help, as noted by the ADF, is a national information and support service that links users to relevant information to help prevent and reduce alcohol and other drug harms.¹⁷²
- 4.188 As explained by the ADF, the Path2Help platform also includes an online directory housing detailed information about more than 12,000 locally available support and information services. ADF stated that Path2Help is searchable by location, need (i.e. counselling, rehabilitation, etc), specific drug and type of service (online, face-to-face) as well as utilising a screening process (the ASSISTLite) to tailor search results ensuring that people receive information about services that most meet their needs.¹⁷³
- 4.189 ADF further submitted that between 100,000 and 120,000 people access the Path2Help service annually, and over 30,000 complete the self-assessment.¹⁷⁴

Daybreak

- 4.190 The Daybreak smartphone app was launched by HSM in 2016. HSM explained in its submission that this tool provides support in the form of a peer-led community of individuals seeking to change their relationship with alcohol, and that the app is accessible worldwide and offered free of charge to Australian residents.¹⁷⁵
- 4.191 HSM further noted that an independent evaluation of Daybreak found that in the first three months of participation:
- Reduces alcohol consumption by 50 per cent
 - Reduces psychological distress by 80 per cent
 - Significantly improves quality of life.¹⁷⁶
- 4.192 Speaking to the effectiveness of the Daybreak app, HSM further reported that:
- 65 per cent of individuals accessing their service are women
 - 30 per cent of members are based in rural locations.¹⁷⁷
- 4.193 HSM submitted also that Daybreak is highly cost effective, and that the economic benefit from health and social savings and productivity gains is \$2.49 for every dollar provided by the Australian Government.¹⁷⁸

¹⁷² ADF, *Submission 77 (47th Parliament)*, p. 19.

¹⁷³ ADF, *Submission 77 (47th Parliament)*, pp. 19-20.

¹⁷⁴ ADF, *Submission 77 (47th Parliament)*, p. 20.

¹⁷⁵ HSM, *Submission 38 (47th Parliament)*, p. 1.

¹⁷⁶ HSM, *Submission 38 (47th Parliament)*, p. 4.

¹⁷⁷ HSM, *Submission 38 (47th Parliament)*, p. 5.

¹⁷⁸ HSM, *Submission 38 (47th Parliament)*, p. 1.

4.194 Drink Tracker and My Drink Check were further highlighted by HSM as part of the Daybreak program. HSM stated that:

- Drink Tracker is an easy-to-use self-monitoring feature which allows members to set goals and track their alcohol use over time.
- My Drink Check is a free self-screening tool that increases awareness of potentially risky alcohol use and points individuals in the direction of appropriate resources and services for alcohol use and related issues.
- Evaluation of the Drink Tracker and My Drink Check showed similar reductions in alcohol consumption and improvements in psychological wellbeing.¹⁷⁹

drug info bot

4.195 ADF described in its submission its AI-powered chatbot and screening tool, drug info bot (dib), stating that it designed this tool, with clinical input, to connect users with reliable, nonjudgemental AOD information.¹⁸⁰

4.196 ADF explained that dib was launched in January 2025 and integrates the clinically validated ASSIST tool, thereby enabling users to assess their own AOD use and risk, and providing brief interventions and referrals to appropriate support.¹⁸¹

4.197 The ADF further submitted in relation to dib that:

Early results demonstrate dib's reach and potential: since January 2025, it facilitated over 21,000 conversations, with nearly half (47 per cent) of users aged 18–25 and 62 per cent aged 18–34. Users engage for an average of 4.5 minutes, most seeking trustworthy information about AOD (53 per cent of queries) or treatment and support (15 per cent).¹⁸²

4.198 The ADF additionally commented in its submission that expanding the reach of safe, evidence-based digital tools would be a valuable national intervention – helping counter misinformation and improve public understanding of AOD.¹⁸³ ADF stated also that 'unlike commercial AI models, dib operates on a closed-loop system, drawing only from the ADF's expert-curated, evidence-based content'.¹⁸⁴

Other screening and assessment programs

Smart Recovery Australia (SMART)

4.199 SMART Recovery Australia (SMART) submitted to the inquiry that it provides accessible, high-quality primary prevention and relapse prevention interventions.¹⁸⁵

¹⁷⁹ HSM, *Submission 38 (47th Parliament)*, p. 4

¹⁸⁰ ADF, *Submission 24*, p. 14.

¹⁸¹ ADF, *Submission 24*, p. 14.

¹⁸² ADF, *Submission 24*, p. 14.

¹⁸³ ADF, *Submission 24*, p. 13.

¹⁸⁴ ADF, *Submission 24*, p. 14.

¹⁸⁵ SMART Recovery Australia, *Submission 168 (47th Parliament)*, p. 1.

As further indicated by SMART, this includes resources to help people reflect on their alcohol consumption and change unhelpful behaviours without being prescriptive, judgemental or shame-based.¹⁸⁶

- 4.200 SMART stated that it trains over 500 professionals annually—spanning government and non-government organisations (NGOs)—to deliver more than 400 recovery meetings across Australia. SMART commented that these meetings, available both face-to-face and online, provide accessible and inclusive support for individuals seeking recovery.¹⁸⁷
- 4.201 SMART also indicated in its submission that it has tailored programs to address the needs of young Australians and Aboriginal and Torres Strait Islander communities known as Youth SMART and Yarn SMART, respectively.¹⁸⁸
- 4.202 SMART also cited the following findings from its program:
- 81 per cent, or 146,998 Australians, left their SMART meeting with a 7-day plan to reduce the harm caused by alcohol and other drugs in their life
 - 77 per cent of attendees stated the plan was extremely helpful or very helpful in managing their behaviour so they can live a balanced and healthy life.¹⁸⁹
- 4.203 SMART additionally reported in its evidence that the integration of its program into three public AOD treatment programs in Victoria highlighted its effectiveness as a peer-led recovery initiative, with strong demand and positive outcomes, notably:
- 94 per cent of participants either reducing their use or maintaining abstinence
 - participants reported improvements in physical and mental health, with 71 per cent and 74 per cent noting better health outcomes, respectively.¹⁹⁰

Clean Slate

- 4.204 Clean Slate explained in its submission to the inquiry that it is a virtual multidisciplinary care program based on Australian national treatment guidelines and best evidence, and that it incorporates SMART recovery groups as part of its aftercare.¹⁹¹
- 4.205 As further highlighted by Clean Slate, its program supports patients for a full 12-month period and offers services from assessment to withdrawal through to aftercare and relapse prevention, with 40 to 50 new clients taken on every single week.¹⁹²
- 4.206 Clean Slate further submitted that the demographic of its patient cohorts demonstrates that many of its clients face barriers in accessing residential or

¹⁸⁶ Mr Simon Hirtzel, *Submission 131 (47th Parliament)*, p. 2.

¹⁸⁷ SMART, *Submission 168 (47th Parliament)*, p. 3.

¹⁸⁸ SMART, *Submission 168 (47th Parliament)*, p. 3.

¹⁸⁹ SMART, *Submission 168 (47th Parliament)*, p. 6.

¹⁹⁰ SMART, *Submission 168 (47th Parliament)*, p. 11.

¹⁹¹ Clean Slate, *Submission 122 (47th Parliament)*, p. 7.

¹⁹² Clean Slate, *Submission 122 (47th Parliament)*, p. 1.

outpatient services, making its service their only choice for drug or alcohol treatment.¹⁹³

- 4.207 Clean Slate further stated that its program enables the delivery of high quality, affordable and accessible care, and that this is available irrespective of geography, with 33 per cent of clients coming from regional or remote communities. Clean Slate commented also that its program also creates the opportunity for its clients to maintain other responsibilities they may have, such as caregiving.¹⁹⁴
- 4.208 Clean Slate referenced in its submission a 2023 evaluation of its program by Sydney University and the findings from this review that:
- The model is “highly adoptable” with an 82 per cent completion rate.
 - It offers a “feasible model for enabling participants to achieve their goals (84 per cent), substantially reducing alcohol intake and reducing psychological distress”.
 - Patients saw a shift in their AUDIT (Alcohol Use Disorders Identification Test) score from high risk to low risk within the first month.
 - After one month, patients experienced a reduction in their K10 (Kessler Psychological Distress Scale) rating from high to low psychological distress.¹⁹⁵

Community-led approaches

- 4.209 WANADA emphasised in its submission that community-led approaches are grounded in the principle that local communities are best placed to identify emerging issues, build trust, reduce barriers and mobilise strengths, and implement culturally safe, holistic, and integrated responses to reduce harm.¹⁹⁶
- 4.210 Uniting Care Australia (Uniting) submitted in this regard that community-based and non-residential rehabilitation allows people to address substance use in flexible and locally accessible ways. Uniting further stated that these programs play a vital role in supporting people to change their substance use, while enabling them to stay at home and remain connected to family and community.¹⁹⁷
- 4.211 The NRHA contended that community-led strategies are essential to ensure that individuals in rural areas can receive effective, compassionate care that acknowledges their unique circumstances and promotes recovery within their communities.¹⁹⁸

¹⁹³ Clean Slate, *Submission 122 (47th Parliament)*, p. 1.

¹⁹⁴ Clean Slate, *Submission 122 (47th Parliament)*, pp. 1-2.

¹⁹⁵ Clean Slate, *Submission 122 (47th Parliament)*, p. 7.

¹⁹⁶ WANADA, *Submission 43*, p. 5.

¹⁹⁷ Uniting Care Australia, *Submission 45*, p. 4.

¹⁹⁸ NRHA, *Submission 62*, p. 11.

Day based rehabilitation

- 4.212 The NSW Health webpage indicates that day rehabilitation programs provide structured non-residential education, support and counselling services where people attend for set times during the day and/or evening but remain living at their usual place of residence.¹⁹⁹
- 4.213 NIAA submitted in relation to these types of services that they may be suitable for people who have a level of stability in their lives or for people in rural areas who are accessing shared-care arrangements.²⁰⁰

Catalyst

- 4.214 Uniting Vic.Tas described its Catalyst program in its submission, stating that it has delivered this service in Victoria since 2010 and that it is a non-residential rehabilitation program, otherwise known as a 'dayhab'. Uniting Vic.Tas further stated that Catalyst has been delivered in three locations in Melbourne to just over 3,000 people and has piloted it in Hobart for the last three years to around 100 participants.²⁰¹
- 4.215 Uniting stated in its submission that this program involves five to six weeks of structured, intensive post-withdrawal support, designed to equip participants with coping skills and reinforce their motivation to sustain change. Uniting further submitted that Catalyst involves a holistic approach intended to address the mental, emotional and physical dimensions of substance use in rehabilitation.²⁰²
- 4.216 In discussing the outcomes of Catalyst, Uniting Vic.Tas commented:
- We find that 73 per cent of people—this is data across 3,000 people over the last 16 years—report reduced psychological distress, reduced severity of dependence and increased global overall health through a range of measures.²⁰³
- 4.217 A key part of the success of the Catalyst model that was emphasised by Uniting was peer workers. Uniting submitted that peer workers provide support before and after the program participation, draw on their own recovery journeys, inspire and guide participants, and offer insights that build trust and connection within the group.²⁰⁴
- 4.218 In further outlining the operation of its Catalyst model, Uniting Vic.Tas explained:
- With Catalyst, people come in every day and they go home every night to their normal environment, which we often know is very challenging. They come back

¹⁹⁹ NSW Health, *About alcohol and other drug treatment*, <https://www.health.nsw.gov.au/aod/Pages/about-treatment.aspx> (accessed 7 July 2026).

²⁰⁰ NIAA, *Submission 140 (47th Parliament)*, p. 10.

²⁰¹ Mr Adrian Webber, Executive Director, Alcohol and Other Drugs and Wellbeing Services, Uniting Vic.Tas, *Proof Committee Hansard*, 29 May 2026, p. 14.

²⁰² Uniting Care Australia, *Submission 45*, p. 4.

²⁰³ Mr Webber, Uniting Vic.Tas, *Proof Committee Hansard*, 29 May 2026, p. 14.

²⁰⁴ Uniting Care Australia, *Submission 45*, p. 5.

in each day, they work through with our clinicians who are generally social workers or psychologists, and they work also with our peer worker and with the peer group.²⁰⁵

- 4.219 Uniting Vic.Tas further remarked in its submission that this program supports cohorts that otherwise cannot access residential services, including a parent with child-caring responsibilities; somebody with broader family and social responsibilities and people in full-time roles.²⁰⁶

BreakThrough

- 4.220 *BreakThrough*, as Turning Point explained in its submission, is a digitally delivered peer-led education and support for families, friends, and partners of people experiencing addictive behaviours. Turning Point co-developed this service and submitted to the inquiry that it provides participants with evidence-based information relating to substance use, communication, coping strategies, family violence, safety, and self-care, alongside pathways into additional support services.²⁰⁷
- 4.221 Turning Point also noted in its submission that more than 15,000 family members have participated in the program, with participants consistently reporting it provides a stigma-free environment where they feel validated, supported, and better equipped to understand and respond to their experiences.²⁰⁸

Workforce

- 4.222 The evidence to the inquiry consistently indicated that Australia's AOD sector is staffed by a dedicated and highly skilled workforce and that this is reflective of how complex, challenging and demanding AOD work is. The inquiry evidence also stressed the importance of an appropriately skilled workforce and the crucial role these workers play in preventing, as well as responding to, AOD use and harms.
- 4.223 The focus of this part of the chapter is on the challenges currently present in the AOD workforce including stigma, the need for better integration of training and support across sectors, and opportunities for more equitable access and provision of care. This includes harnessing the broad range of workforce types available including peer workers, Aboriginal Health Workers and other primary and allied health care professionals.
- 4.224 Details on both Aboriginal workers and the rural and remote workforce that provide AOD services are also provided in chapter 6 on priority populations (paragraphs 6.49–6.55 and 6.60–6.71, respectively).

²⁰⁵ Mr Webber, Uniting Vic.Tas, *Proof Committee Hansard*, 29 May 2026, p. 14.

²⁰⁶ Mr Webber, Uniting Vic.Tas, *Proof Committee Hansard*, 29 May 2026, p. 15.

²⁰⁷ Turning Point, *Submission 92*, p. 6.

²⁰⁸ Turning Point, *Submission 92*, p. 6.

- 4.225 The Committee was cognisant throughout the inquiry that this evidence needed to be considered in the context of the broader issues also discussed in this chapter, such as funding and commissioning challenges, which also have a significant impact on Australia's current AOD workforce.

AOD workforce landscape

- 4.226 The Western Australian Mental Health Commission (WAMHC) submitted that AOD services are delivered by a diverse specialist and generalist workforce committed to improving individual and community outcomes.²⁰⁹
- 4.227 Odyssey House concurred in its submission, stating that the AOD workforce comprises a broad range of disciplines that is reflective of demand, complexity and the need for a collaborative and diverse approach from multiple sectors, and from a multidisciplinary workforce.²¹⁰
- 4.228 AADC submitted in this regard:
- Each year 235,000 episodes of care are provided to over 131,000 Australians. This is in addition to the work of the array of harm reduction workers and services, such as Needle and Syringe Programs, which distribute more than 50 million sterile needles, syringes and other injecting equipment annually and offer an estimated 1,800 occasions of care in the form of health education and referrals daily.²¹¹
- 4.229 Multiple submissions to the inquiry highlighted a current shortage in Australia of specialist AOD treatment and harm reduction services to meet demand. WAMHC cited evidence, as one example of an estimated 200,000 to 500,000 people each year in Australia that need and seek AOD treatment but do not receive it.²¹²
- 4.230 Aside from AOD service availability, other factors affecting the AOD workforce were also raised in the inquiry evidence. ADF submitted that job insecurity and low remuneration are often cited, by both AOD workers and their employers, as significant challenges in terms of recruiting and retaining staff.²¹³
- 4.231 Concerns around job security were further highlighted by ADF who cited research from jurisdictional workforce surveys in its submission indicating that up to 25 per cent of AOD workers across Australia felt that there is at least a medium chance that they could lose their job within the next 12 months. ADF stated that these surveys also showed that up to 75 per cent of AOD workers are earning less than the jurisdictional average salary.²¹⁴

²⁰⁹ Western Australian Mental Health Commission (WAMHC), *Submission 159 (47th Parliament)*, p. 7.

²¹⁰ Odyssey House, *Submission 179 (47th Parliament)*, p. 5.

²¹¹ AADC, *Submission 45 (47th Parliament)*, p. 10.

²¹² WAMHC, *Submission 159 (47th Parliament)*, p. 7.

²¹³ ADF, *Submission 77 (47th Parliament)*, p. 18.

²¹⁴ ADF, *Submission 77 (47th Parliament)*, p. 17.

- 4.232 AADC echoed these concerns in its submission, in addition to highlighting other issues such as funding not being commensurate with need or demand, inconsistent contract indexation, funding insecurity and delays in contract execution, which impacted the ability of AOD services to recruit, retain and grow their workforce.²¹⁵
- 4.233 The NRHA also raised concerns around the composition of an ageing workforce citing a 2020 study where workers 50 years and over made up approximately 39 per cent of the workforce, with 41 per cent having been in the sector for more than 10 years. NRHA suggested that attrition due to retirement may significantly affect the future of this important workforce, leading to a loss in expertise.²¹⁶
- 4.234 As echoed in the Committee's Issues paper for the inquiry, published in March 2025, this is further exacerbated in specialist areas of the AOD workforce. The Committee noted that addiction medicine specialists are an example of an ageing workforce and that the inquiry evidence has flagged this expertise as facing a critical shortage into the future.²¹⁷ As explained by the AMA, addiction medicine involves the provision of medical care to people with substance use and addiction disorders, including drug and alcohol addiction and pharmaceutical dependency.²¹⁸
- 4.235 AADC submitted that the sustainability of the AOD workforce is also challenged by a declining presence of AOD-related units within tertiary level degrees, such as psychology and social work where there is frequently little to no AOD-related content.²¹⁹
- 4.236 This was also highlighted by the National Centre for Training and Education on Addiction (NCETA) in its submission:
- 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. This lack of AOD-related content can make it challenging to attract new entrants to the sector, and to counter stigmatising attitudes towards AOD in the broader health workforce.²²⁰
- 4.237 NCETA further highlighted that, given the broad range of disciplines engaged in AOD work, improving the AOD knowledge and skills of generalist workers outside of the health sector is needed so that they are equipped to contribute to reducing AOD-related harms.²²¹

²¹⁵ AADC, *Submission 45 (47th Parliament)*, p. 17.

²¹⁶ NRHA, *Submission 62*, p. 7.

²¹⁷ House of Representatives Standing Committee on Health, Aged Care and Sport, *Issues paper relating to the health impacts of alcohol and other drugs in Australia*, March 2025, p. 55; WAMHC, *Submission 159 (47th Parliament)*, p. 7.

²¹⁸ AMA, *Submission 80 (47th Parliament)*, p. 3.

²¹⁹ AADC, *Submission 45 (47th Parliament)*, p. 17.

²²⁰ National Centre for Training and Education on Addiction (NCETA), *Submission 43 (47th Parliament)*, p. 3.

²²¹ NCETA, *Submission 43 (47th Parliament)*, p. 4.

- 4.238 The Australasian Injury Prevention Network submitted in this context that opportunities are available to provide focused training programs to increase the confidence, knowledge and skills of the health workforce to identify and address harmful AOD use. The Network added in its evidence that this education would help minimise the risk of adverse AOD interactions and enhance the effectiveness of treatment approaches by giving healthcare workers the skills to confidently discuss AOD use with their patients.²²²

Stigma

- 4.239 The inquiry evidence consistently indicated that stigma directed towards people who use alcohol and other drugs, as well as to the AOD workforce, is another barrier to both individuals accessing such services and to people either joining or remaining in the AOD workforce.
- 4.240 NCETA stated in its submission that a lack of knowledge, and stigmatising attitudes, from other sectors with regard to AOD misuse is a barrier to collaboration and holistic client care.²²³
- 4.241 This was echoed by the Australian Psychological Society, which commented in its submission that the level of stigma regarding AOD misuse and abuse remains high among many health care workers, and that staff who do not specifically work in this area often lack the expertise on how to provide appropriate treatment and support.²²⁴
- 4.242 Uniting Victoria and Tasmania further highlighted how this can affect the AOD workforce, submitting that the AOD workforce itself experiences stigma and is often viewed as lacking a specialist skill set. Uniting further cited research in its submission where a study of AOD nurses across Australia and New Zealand found that many participants spoke of the stigma attached to the specialty, making attracting new entrants and graduates difficult.²²⁵
- 4.243 As highlighted also by the Australian College of Nursing in this context:
- Stigma is a significant issue for both AOD clients and the nurses supporting them. Studies report that as AOD nurses, other nursing community view them as less than other nurses, questioning their ability to get a respectable job. Nurses report that the stigma they experience is similar to that of clients with AOD issues. In turn, the stigma levelled at AOD nurses contributes to the reluctance nurses have for joining the AOD workforce.²²⁶

²²² Australasian Injury Prevention Network, *Submission 151 (47th Parliament)*, p. 7.

²²³ NCETA, *Submission 43 (47th Parliament)*, p. 4.

²²⁴ Australian Psychological Society, *Submission 150 (47th Parliament)*, p. 4.

²²⁵ Uniting Victoria and Tasmania, *Submission 165 (47th Parliament)*, p. 23.

²²⁶ Australian College of Nursing, *Submission 146 (47th Parliament)*, p. 7.

- 4.244 A possible solution to combatting the effects of these types of stigma, and that could lead to 'normalising AOD-related work within the health field', was suggested by the Penington Institute:

One tool routinely cited by clinical and allied health practitioners in the sector is requiring exposure to AOD-related issues... at the undergraduate and post-graduate levels, inclusion of specific AOD units using materials directly informed by the perspectives of people subjected to stigma is a key element. The combination of improved training and better material conditions is foundational in normalising AOD work as a core element of mainstream, effective care.²²⁷

Lived and living experience workforce

- 4.245 The inquiry received evidence on the importance of developing, supporting and empowering the AOD lived/living experience (peer) workforce as a key focus point in strengthening the AOD workforce. Various submissions commented that peer workers are able to draw on their current or previous experiences of AOD use, recovery, or supporting someone close to them as a family member, carer or supporter.

- 4.246 The value of the peer workforce was emphasised by Alcohol Change Victoria, which stated in its submission:

The peer workforce is an essential component of addiction treatment, care, and support. Through their shared lived experience, peer workers build a strong sense of trust, belonging and community through their knowledge, skills, and ability to authentically connect with clients. Peer workers are also ideally placed to help clients navigate the health system given their experience doing so.²²⁸

- 4.247 This was echoed by SHARC, which submitted that peer workers can often be the difference between an individual continuing to seek support or not:

Our community say access to workers who will not judge them—such as peer workers—and who can help navigate the system, can be the difference between giving up when services are unavailable, and staying connected when they feel isolated, unsupported, or at risk of relapse.²²⁹

- 4.248 Uniting Victoria and Tasmania noted in its submission that peer workers may be employed in a variety of roles within AOD services, bringing with them their expertise as a person with real-life experience, coupled with skills acquired from specialist AOD training, to support people impacted by AOD use.²³⁰

- 4.249 The Burnet Institute acknowledged that each Australian State or Territory has shown a commitment to developing a AOD peer workforce. The Institute listed, as an

²²⁷ Penington Institute, *Submission 188 (47th Parliament)*, p. 14.

²²⁸ Alcohol Change Victoria, *Submission 166 (47th Parliament)*, p. 18.

²²⁹ SHARC, *Submission 79*, p. 19.

²³⁰ Uniting Victoria and Tasmania, *Submission 165 (47th Parliament)*, p. 23.

example, the utilisation of peers in the AOD workforce in Victoria, submitting that this is now recognised as an integral part of AOD service delivery, leading to the integration of AOD peer workers across many organisations.²³¹

4.250 Despite the understanding of the value peer workers play across the AOD support sector, SHARC referenced a consultation undertaken with Victorian peer workers that highlighted several ongoing challenges that they are facing, including:

- Roles often being poorly understood, reduced to storytelling, affected by role creep, and undermined by stigma related to AOD use and professional legitimacy.
- Roles often being short-term, underpaid and treated as entry-level, with limited career pathways and no pay parity with other sectors e.g. mental health peers.
- A lack of peer-led supervision, funded training pathways and lived and living experience leadership, with peer workers frequently excluded from governance and decision-making.
- Organisations unprepared to embed peer roles, with clinical dominance limiting autonomy, impact and genuine power-sharing.
- Organisations not being flexible in terms of imposing standard business hours on employment which can restrict effective engagement when someone might need support the most.
- A lack of community diversity in the workforce and funded family and supporter lived-experience roles.²³²

4.251 LGBTIQ+ Health Australia supported this in its submission, stating:

Peer workers face challenges that limit their impact, including lack of autonomy in generalist AOD services, a lack of formal recognition, funding, and career pathways. Stigma within the sector can undermine their contributions, while the emotional demands of the role place workers at risk of burnout without adequate supervision or mental health support.²³³

4.252 ADF called in this regard for increased support and resourcing to create a thriving, sustainable peer workforce:

Investment in AOD peer workforce development is needed to create pathways for career development of peer workers, in [addition] to supporting organisations to prepare for the introduction and sustainability of peer workforces.²³⁴

4.253 Other submissions to the inquiry suggested that a clearer understanding of peer workers roles and pathways to formal employment and career progression was needed. AADANT submitted in this regard that as peer worker roles in AOD services

²³¹ Burnet Institute, *Submission 178 (47th Parliament)*, p. 14.

²³² SHARC, *Submission 79*, pp. 36-37.

²³³ LGBTIQ+ Health Australia, *Submission 189 (47th Parliament)*, p. 7.

²³⁴ ADF, *Submission 77 (47th Parliament)*, p. 17.

are often voluntary, consideration should be given to professionally recruiting, training and adequately remunerating peer workers.²³⁵

- 4.254 This was echoed by the Queensland Mental Health Commission (QMHC) which commented:

Fostering growth of the peer workforce requires formalised pathways into employment and career progression, appropriate levels of supervision and support, and integration of roles [at] all levels of an organisation to achieve positive impact and sustainability.²³⁶

- 4.255 ADF remarked in its submission that family and friends are a major source of support for people experiencing AOD harms. ADF further submitted however that families and friends can themselves receive health impacts from AOD use by others and that their rates of access to support are low, contributing to poorer outcomes.²³⁷

- 4.256 Alcohol Change Victoria suggested that utilisation of the peer workforce is an essential component of addiction treatment, care, and support including to families and friends. Alcohol Change Victoria further noted that, through their shared lived experience, peer workers build a strong sense of trust, belonging and community through their knowledge, skills, and ability to authentically connect with clients.²³⁸

- 4.257 SHARC highlighted the National Peer Workforce Framework as a positive step towards better supporting peer workers. SHARC noted in its submission that this Framework is supported by the Commonwealth government, led by the AIVL in partnership with NCETA, and is an important opportunity to strengthen recognition, consistency and sustainability of peer worker roles nationally.²³⁹

- 4.258 It was also suggested from the inquiry evidence that the AOD sector could look at utilising progress made by the mental health sector in harnessing its peer workforce. The Burnet Institute submitted in this regard:

In Australia, the peer workforce development initiatives within the mental health sector are entirely transferrable to the AOD sector peer workforce, including progressing the formalisation, professionalisation and integration of peer workers into the broader AOD workforce, and their importance is increasingly recognised in the delivery of effective treatment services.²⁴⁰

- 4.259 The submission from the PHN Cooperative further noted that the mental health sector has a recognised qualification (Certificate IV in Mental Health Peer Work) and the AOD sector would benefit from an equivalent qualification to encourage and formalise the AOD peer workforce.²⁴¹

²³⁵ AADANT, *Submission 26 (47th Parliament)*, p. 8.

²³⁶ Queensland Mental Health Commission (QMHC), *Submission 167 (47th Parliament)*, p. 3.

²³⁷ ADF, *Submission 77 (47th Parliament)*, p. 11.

²³⁸ Alcohol Change Victoria, *Submission 166 (47th Parliament)*, p. 18.

²³⁹ SHARC, *Submission 79*, p. 36.

²⁴⁰ Burnet Institute, *Submission 178 (47th Parliament)*, p. 14.

²⁴¹ PHN Cooperative, *Submission 26*, p.7.

- 4.260 The NSW Users and AIDS Association was also supportive of leveraging similar frameworks from the mental health sector and argued in its submission that this work should be undertaken at the Commonwealth level to reduce duplication of effort and support consistency and quality across jurisdictions.²⁴²

Aboriginal and Torres Strait Islander workforce

- 4.261 As the NIAA explained, the Aboriginal and Torres Strait Islander AOD workforce is diverse, with workers frequently holding multiple roles, particularly in regional and remote areas, often supporting clients with co-morbidities and multi-faceted needs.²⁴³
- 4.262 Gayaa Dhuwi (Proud Spirit) Australia, a national leadership body for Aboriginal and Torres Strait Islander social and emotional wellbeing, mental health, and suicide prevention, submitted that harms relating to AOD use among Aboriginal and Torres Strait Islander people often do not exist in isolation and can be shaped by intersecting factors including intergenerational trauma, systemic racism, mental health issues and social disadvantage.²⁴⁴
- 4.263 The National Aboriginal Community Controlled Health Organisation (NACCHO) stated in its evidence that the shared cultural background of Aboriginal and Torres Strait Islander AOD workers can often help build trust and rapport with clients, and that this is crucial for effective treatment and support. NACCHO further commented that this can also help improve the quality and accessibility of AOD services, ensuring they are more responsive to the needs of community.²⁴⁵
- 4.264 The Royal Australian College of Psychiatrists argued for the importance of Aboriginal Community Controlled Organisations (ACCHOs) in supporting the health system. The College further submitted that ACCHOs play a vital role in integrating culturally safe services within communities, thereby supporting continuous quality improvement in an integrated health system that is Aboriginal and Torres Strait Islander-led.²⁴⁶
- 4.265 The role of ACCHOs was further highlighted by Congress who acknowledged their ability to attract, train and retain Aboriginal staff leading to greater cultural appropriateness of services as well as benefits through providing employment and capacity building in the Aboriginal community, especially for Aboriginal women.²⁴⁷
- 4.266 NACCHO cited data in its submission showing that the Aboriginal and Torres Strait Islander AOD workforce across the ACCHOs is significantly underdeveloped:

Workforce data reported to the AIHW shows a decrease of FTE clinical staff per 1,000 population of around 20-30 per cent in ACCHOs and a 50 per cent

²⁴² NSW Users and AIDS Association, *Submission 198 (47th Parliament)*, p. 2.

²⁴³ NIAA, *Submission 140 (47th Parliament)*, p. 8.

²⁴⁴ Gayaa Dhuwi (Proud Spirit) Australia, *Submission 78*, p. 2.

²⁴⁵ National Aboriginal Community Controlled Health Organisation (NACCHO), *Submission 145 (47th Parliament)*, p. 13.

²⁴⁶ The Royal Australian College of Psychiatrists, *Submission 19 (47th Parliament)*, p. 5.

²⁴⁷ Central Aboriginal Congress, *Submission 158 (47th Parliament)*, p. 11.

increase in the number of unfilled positions since the start of the COVID-19 pandemic in 2020.²⁴⁸

4.267 The inquiry evidence was consistent in arguing that building and supporting the Aboriginal and Torres Strait Islander workforce is critical to ensuring cultural safety across the health system.

4.268 A number of areas of focus were presented to the inquiry as needing attention to improve the recruitment and retention of Aboriginal and Torres Strait Islander workers. Drug and Alcohol Services South Australia (DASSA), a statewide AOD health service, referenced the following as important components of this:

- Establishing strong partnerships with Aboriginal educational institutions that creates tailored pathways into the AOD workforce. This includes offering targeted scholarships, traineeships, and cadetships.
- Developing culturally safe job advertisements that communicate the organisation's commitment to respecting and valuing a person's cultural identity.
- Offering mentorship programs that provide guidance, support, and career development opportunities.
- Offering leadership development initiatives that focus on enhancing technical skills and leadership capabilities that enables opportunities to advance to higher roles.
- Creating and maintaining a culturally supportive work environment, including providing comprehensive cultural competency training for all employees, fostering a workplace culture that values diversity, and promptly and effectively addressing any instances of racism or discrimination.²⁴⁹

4.269 NACCHO provided supporting statements for this approach, noting that whilst Aboriginal and Torres Strait Islander people have a clear preference for using Aboriginal and Torres Strait Islander services, the currently limited availability and access to ACCHO AOD treatment support means that many will need to use a mainstream service. NACCHO further submitted in this regard that mainstream workforces must therefore be appropriately culturally competent.²⁵⁰

4.270 This was echoed by the Aboriginal Health & Medical Research Council of NSW which stated:

Previous reports on the delivery of AOD supports found that Aboriginal and Torres Strait Islander clients receive less tailored care compared to non-Indigenous clients, often due to a lack of culturally competent services and insufficient resources in the ACCHO sector, resulting in relapse.²⁵¹

²⁴⁸ NACCHO, *Submission 145 (47th Parliament)*, p. 13.

²⁴⁹ Drug and Alcohol Services South Australia (DASSA), *Submission 177 (47th Parliament)*, pp. 5-6.

²⁵⁰ NACCHO, *Submission 145 (47th Parliament)*, p. 9.

²⁵¹ Aboriginal Health & Medical Research Council of NSW, *Submission 69 (47th Parliament)*, p. 3.

- 4.271 The Royal Australian College of Psychiatrists also suggested that further consideration be given to providing culturally informed care to the AOD workforce, alongside culturally relevant tertiary and vocational qualifications, placements, traineeships and scholarships for Aboriginal and Torres Strait Islander students. The College emphasised that this is vital to developing a workforce adept in delivering culturally appropriate AOD services that respect Indigenous methodologies.²⁵²

Supporting the rural and regional workforce

- 4.272 NRHA emphasised the fundamental importance of engaging with the broad factors influencing substance use, and barriers to seeking help, in order to effectively tackle the drivers of AOD use in rural Australia. NRHA stated in its submission that this includes addressing the healthcare workforce shortage in rural Australia, and the limited services and infrastructure that impact this demographic.²⁵³
- 4.273 Recruiting and retaining staff in regional, rural and remote areas was described as a challenge by QMHC, which also noted that meeting demand for services in rural and regional Australia must be supported by a workforce to deliver them.²⁵⁴
- 4.274 The NRHA agreed, outlining educational opportunities as another area for consideration:
- Offering rural-specific educational opportunities in AOD use can enhance the clinical skills of rural health professionals and promote a broader utilisation of the healthcare workforce in addition to bolstering recruitment and retention of the AOD workforce.²⁵⁵
- 4.275 The Australian College of Rural and Remote Medicine similarly commented on the shortfalls in the current rural and regional AOD workforce:
- Address the specific challenges of working in rural and remote communities by expanding training programs such as the ACRRM Drug and Alcohol Addiction Education (DAAE) Program, and increase funding pathways for health professionals to strengthen their capacity to deliver effective care in rural and remote environments.²⁵⁶
- 4.276 The AMA also stated that specialised addiction services are in short supply in rural and remote Australia, commenting that a lack of resources was leading to extensive wait times for treatment induction as well as inadequate follow up for patients who frequently have a range of health-related issues.²⁵⁷

²⁵² The Royal Australian College of Psychiatrists, *Submission 19 (47th Parliament)*, p. 5.

²⁵³ NRHA, *Submission 90 (47th Parliament)*, p. 4.

²⁵⁴ QMHC, *Submission 167 (47th Parliament)*, p. 3; AADC, *Submission 45 (47th Parliament)*, p.15; NRHA, *Submission 90 (47th Parliament)*, p. 6.

²⁵⁵ NRHA, *Submission 90 (47th Parliament)*, p. 7.

²⁵⁶ Australian College of Rural and Remote Medicine, *Submission 93 (47th Parliament)*, p. 5.

²⁵⁷ AMA, *Submission 80 (47th Parliament)*, p. 4.

4.277 NRHA also addressed this issue in its submission, stating:

A significant challenge in recruiting a specialised workforce is the accreditation process, which is inherently metrocentric and is a largely one-size-fits-all mechanism. This model fails to recognise the inherent differences in rural healthcare provision in smaller rural hospitals and health services, limiting opportunities for trainees and supervisors to engage in high-quality rurally-focused training pathways. It is imperative that rurally-responsive training and accreditation pathways to increase the attraction and retention of the specialist workforce in rural Australia.²⁵⁸

Addressing workforce shortages

4.278 A number of submissions to the inquiry referred to the *National Alcohol and Other Drug Workforce Development Strategy 2015-2018*. ADF commented that with this lapsing in 2018, there was currently no guidance on AOD workforce development.²⁵⁹

4.279 The WAMHC called for a new workforce framework with appropriate cross-sector governance mechanisms, remarking that this would provide a strategic and coordinated approach to focus and guide workforce development planning and investment at the jurisdictional level.²⁶⁰

4.280 WAMHC further emphasised the importance of developing a new AOD workforce plan given that responsibility for supporting these workers is shared between the Commonwealth and State and Territory Governments, and the value and support that a new strategy would bring.²⁶¹

4.281 Odyssey House noted that a new national AOD workforce strategy is needed to effectively address workforce challenges by bringing diverse, skilled, stable, resilient and caring people into these roles. Odyssey House stated in addition that this framework should include consideration of a broad range of disciplines, including counsellors, nurses, psychologists, doctors, social workers, psychiatrists, and also lived and living experience roles.²⁶²

4.282 The PHN Cooperative, an alliance of Primary Health Network (PHN) Chief Executive Officers, advocated for the role PHNs play at the regional level to support AOD workforce planning, recruitment, retention and capacity building. The Cooperative noted in its submission that this includes gathering local intelligence on the current and anticipated supply of an AOD workforce, including in regions that have thin or failing markets.²⁶³

²⁵⁸ NRHA, *Submission 90 (47th Parliament)*, pp. 9-10.

²⁵⁹ ADF, *Submission 77 (47th Parliament)*, p.17.

²⁶⁰ WAMHC, *Submission 159 (47th Parliament)*, p. 7.

²⁶¹ WAMHC, *Submission 159 (47th Parliament)*, p. 7.

²⁶² Odyssey House, *Submission 179 (47th Parliament)*, p. 5.

²⁶³ PHN Cooperative, *Submission 26*, p. 7.

Role of primary care

- 4.283 A significant body of the evidence to the inquiry discussed the greater role health professionals in the primary care system can play in reducing AOD-related harms, including GPs, pharmacists, psychologists, nurses and nurse practitioners.
- 4.284 ADF noted that the primary care system is often the first point of contact, or opportunity to identify at risk alcohol and other drug use.²⁶⁴ The AMA submitted also that GPs play a crucial role in the prevention, detection and management of harmful substance use, dependence and behavioural addictions.²⁶⁵
- 4.285 This was further highlighted by the Royal Australian College of General Practitioners, which stated at the public hearing on 14 May 2026:
- We as GPs are the most accessed health professionals in Australia and play a central role in alcohol and other drug care, from prevention and early intervention to treatment, recovery and long-term support... GPs can provide both short- and long-term evidence based treatments, refer to specialist services when required, facilitate collaborative care across multidisciplinary teams and provide ongoing aftercare and support for individuals, families and carers.²⁶⁶
- 4.286 The Australian Psychological Society (APS) commented in its submission that psychologists are also a significant part of the workforce providing AOD treatment services. APS further stated in this regard that psychologists can work across the full spectrum of prevention, early identification, treatment, and recovery in diverse organisations and settings.²⁶⁷
- 4.287 Another consideration raised in the inquiry evidence was the role that pharmacists play in the AOD workforce. The Pharmaceutical Society of Australia (PSA) emphasised that pharmacists are medicine and medication management experts, and also custodians of the safe, effective and quality use of medicines by all Australians. PSA stated:
- The roles Australian pharmacists provide in harm minimisation include the provision of opioid dependence treatment, needle and syringe programs, provision of naloxone and screening services. However, compared with other countries, Australian pharmacists are still considered underutilised, and could potentially have a more prominent role in harm minimisation and AOD services.²⁶⁸
- 4.288 NRHA also made reference to the role of pharmacists in providing health services in rural Australia, including for families living with, or seeking support for, AOD issues.

²⁶⁴ ADF, *Submission 77 (47th Parliament)*, p. 17.

²⁶⁵ AMA, *Submission 80 (47th Parliament)*, p. 2.

²⁶⁶ Dr Hestor Wilson, Chair, Addiction Medicine Specific Interest Group, Royal Australian College of General Practitioners, *Proof Committee Hansard*, 14 May 2026, p. 6.

²⁶⁷ Australian Psychological Society (APS), *Submission 150 (47th Parliament)*, p. 5.

²⁶⁸ Pharmaceutical Society of Australia, *Submission 170 (47th Parliament)*, pp. 2-3.

NRHA submitted in this regard that rural pharmacists often serve as the sole health professional in some rural and remote locations.²⁶⁹

- 4.289 The Australian College of Nurse Practitioners also discussed how its members working with patients experiencing AOD problems can support and enhance existing care models for these individuals in various settings, including through withdrawals, and can prescribe pharmacotherapeutics and facilitate access to counselling services.²⁷⁰
- 4.290 NRHA cited findings from the *Australian Primary Health Care Nurses Association's 2024 Workforce Survey* in its submission that 33 per cent of nurses working in general practice wanted to be more involved in AOD training, emphasising the desire for primary health care nurses to be more proactive and responsive to AOD patient health needs. NRHA commented that nurses can also deliver basic AOD interventions and conduct opportunistic and targeted screening, while referring complex cases to their colleagues with specialist drug and alcohol intervention skills.²⁷¹
- 4.291 The Committee reflected these discussions in its Issues paper for the inquiry, including the proposals that increasing AOD treatment via nurse practitioners, psychologists, as well as through nurses and midwives could be enhanced via an increased access to Medicare Benefits Schedule (MBS) and the Pharmaceutical Benefits Scheme (PBS).²⁷²

Funding and commissioning challenges

- 4.292 This section considers possible short-term funding models, the current lack of consistency across jurisdictions, the stated need in the inquiry evidence for improved contracting and performance management, and for a unified national approach, with consideration of state versus federal limitations in tackling AOD issues.
- 4.293 The evidence to the inquiry indicated consistently that the AOD sector is facing significant and immediate challenges to its ability to deliver services to the Australians who need them. Injury Matters submitted that an estimated 180,000 and 553,000 people need yet cannot currently access AOD services.²⁷³ The AADC also cited funding shortfalls as a longstanding problem for those providing services in the AOD sector and for people trying to access them.²⁷⁴
- 4.294 Inquiry contributors noted the need for more sustainable, long-term funding structures and models to develop a more integrated and coordinated treatment

²⁶⁹ NRHA, *Submission 90 (47th Parliament)*, p. 7.

²⁷⁰ Australian College of Nurse Practitioners, *Submission 4 (47th Parliament)*, p. 2.

²⁷¹ NRHA, *Submission 62*, p. 8.

²⁷² House of Representatives Standing Committee on Health, Aged Care and Sport, *Issues paper relating to the health impacts of alcohol and other drugs in Australia*, March 2025, p. 58.

²⁷³ Injury Matters, *Submission 29 (47th Parliament)*, p. 2.

²⁷⁴ AADC, *Submission 45 (47th Parliament)*, p. 14.

system.²⁷⁵ Professor Kate Seear further submitted that most states and territories were unable to meet the community's current need for AOD service and that this was mainly attributed to underfunding.²⁷⁶

- 4.295 The Committee was informed during the inquiry that funding for Australia's AOD sector is complex, is provided through a mix of Commonwealth and State and Territory sources and is unable to meet current needs.²⁷⁷ The inquiry evidence indicates that, at the federal level and in addition to primary health network commissioning, funding is also provided directly through the Department of Health and the NIAA.²⁷⁸

Short-term funding models

- 4.296 It was brought to the attention of the inquiry that organisations typically receive funding from the Commonwealth in two- or three-year cycles with funding typically only being renewed within six months of the funding ending.²⁷⁹ The evidence further indicated that short-term funding has flow on impacts which affect workforce recruitment and retention, disrupts AOD service continuity and reduces the overall provision of services.²⁸⁰ When this is coupled with current workforce shortages, short-term funding is compounding the problems related to service delivery.²⁸¹
- 4.297 One suggestion in the submission from the Primary Health Network NSW ACT Alcohol and Other Drugs Network was to shift the funding for PHNs to a five-year cycle to provide greater security for AOD services and workforces. The Network argued that this would lead to increased capacity and improve continuity of care for consumers. The Network further submitted that funding models should take into account the increased costs of delivering services to regional and remote areas.²⁸²
- 4.298 The call to switch to five-year funding models was echoed by the Salvation Army in its submission to the inquiry, which called on the federal government to fully-fund vital aspects of AOD treatment services. The Salvation Army stressed the need for AOD services to meet the diverse needs of people accessing them and that current system planning and funding models are falling short and need to support innovative, tailored interventions that address diverse needs effectively. The Salvation Army stated that there were a range of approaches to achieve this including 'community-designed and led programs, co-designed programs and partnerships'.²⁸³

²⁷⁵ Professor Kate Seear, *Submission 33 (47th Parliament)*, p. 8.

²⁷⁶ Professor Kate Seear, *Submission 33 (47th Parliament)*, p. 8.

²⁷⁷ AADC, *Submission 45 (47th Parliament)*, p. 13.

²⁷⁸ AADC, *Submission 45 (47th Parliament)*, p. 13; NADA, *Submission 46 (47th Parliament)*, p. 3; Department of Health, *Submission 157 (47th Parliament)*, p. 19.

²⁷⁹ Primary Health Network NSW ACT Alcohol and Other Drugs Network, *Submission 55 (47th Parliament)*, p. 5.

²⁸⁰ Primary Health Network NSW ACT Alcohol and Other Drugs Network, *Submission 55 (47th Parliament)*, p. 5.

²⁸¹ Primary Health Network NSW ACT Alcohol and Other Drugs Network, *Submission 55 (47th Parliament)*, p. 5.

²⁸² Primary Health Network NSW ACT Alcohol and Other Drugs Network, *Submission 55 (47th Parliament)*, pp. 5–6; The Queensland PHN Alcohol and Other Drugs Network, *Submission 104 (47th Parliament)*, p.3.

²⁸³ The Salvation Army, *Submission 68 (47th Parliament)*, p. 23.

- 4.299 The Queensland PHN Alcohol and Other Drugs Network also supported five-year funding cycles, stating:

Extending contract funding timeframes to five years would significantly enhance planning efforts and effectively address the diverse challenges faced by regions and population groups. Additionally, it would offer job security and longevity, retaining skilled staff within services with the potential to progress career wise in the organisation and sector more broadly.²⁸⁴

- 4.300 Additional evidence to the inquiry argued that short-term funding models are acting as barriers to providing accessible treatment. In support of the position taken by The Salvation Army in this regard, Uniting Victoria and Tasmania also commented that it is treating people with multiple health and social disadvantages and stated that its ability to do so effectively 'is impeded by funding models that prioritise shorter-term intervention and practice guidelines that promote a fixed length of intervention (e.g. 4 or 6 weeks)'.²⁸⁵

- 4.301 Queensland Injectors Health Network discussed the benefits of block funding at the public hearing on 30 October 2024:

We need a system that gives sustainability to those services, whether it be block funding or another mechanism. I think services like ours would certainly have more stability and ability to attract, recruit and retain general practice workforces and nurse practitioner workforces et cetera if block funding models were available for them.²⁸⁶

Consistency across jurisdictions

- 4.302 The inquiry evidence informed the Committee that funding for AOD treatment stems from a range of different bodies, primarily the Commonwealth and state and territory governments, but that this has complicated the landscape due to the differences in reporting requirements and key performance indicators that it causes. Different contributors to the inquiry stated that this lack of coordination is burdening organisations and their workforces, creating inefficiencies, and ultimately reducing accessibility to AOD services.

- 4.303 The Mental Health Lived Experience Peak Queensland drew the Committee's attention to a Productivity Commission report in 2020, which recommended improvements to funding and commissioning, noting this report's findings around the lack of consistency, coordination and cooperation between federal and state and territory governments:

Cooperation and coordination between the Australian Government's Primary Health Networks and State and Territory Governments' Local Hospital Networks

²⁸⁴ The Queensland PHN Alcohol and Other Drugs Network, *Submission 104 (47th Parliament)*, p.3.

²⁸⁵ Uniting Victoria and Tasmania, *Submission 165 (47th Parliament)*, p. 14.

²⁸⁶ Mr Geoffrey Davey, Chief Executive Officer, Queensland Injectors Health Network, *Committee Hansard*, 30 October 2024, p. 11.

is very patchy, which undermines accountability for delivering improved consumer outcomes.²⁸⁷

4.304 QMHC stated in its submission that AOD treatment and harm reduction services traditionally have a strong return on investment including significant social and fiscal benefits to the community. QMHC asserted in this context that addressing issues with planning, system design, workforce capacity and gaps in care will likely enhance equity and contribute to reducing long-term social and economic impacts of AOD use, and further suggested the following strategies to improve system coordination, collaboration and communication:

- Harmonised performance monitoring
- Joint planning and co-commissioning initiatives
- Improving transparency and information sharing
- Coordinating governance mechanisms at the intra-jurisdictional and inter-jurisdictional level.
- Stabilising funding arrangements (e.g. longer contracting), proportionate to consumer price index, to enhance consistency of available services.²⁸⁸

4.305 Evidence submitted throughout the inquiry also focused on consistency in the monitoring and implementation of the *National Quality Framework for Drug and Alcohol Treatment Services* (NQF).

4.306 Australia has both public and privately funded AOD treatment services. As noted on ADF's website, publicly funded programs must follow relevant state and territory accredited standards, policies or guidelines, which involves maintaining certain levels of health and quality standards, and are assessed on whether they are meeting those standards. ADF indicates that this includes meeting the requirements of the NQF.²⁸⁹

4.307 As indicated by DASSA in its submission, the NQF was developed in 2018 and was designed to provide a nationally consistent quality benchmark for the broad range of AOD treatment service providers in Australia, including clinical governance requirements and required accreditation standards that could ensure that AOD treatment services are effective, evidence-based and consumer-focused.²⁹⁰

4.308 The Matilda Centre commented that the NQF only had an implementation period of three years (2019-2022) due to the disbanding of a national governance mechanism. The Centre stated that with no new national committee taking ownership for implementing the NQF, this has resulted in low levels of uptake across services as of 2023.²⁹¹

²⁸⁷ Productivity Commission 2020, *Mental Health, Report no. 95*, Ch 23 Funding and Commissioning, p. 1133, <https://www.pc.gov.au/inquiries-and-research/mental-health/report/> quoted in Mental Health Lived Experience Peak Queensland, *Submission 191 (47th Parliament)*, pp. 11–12.

²⁸⁸ Queensland Mental Health Commission, *Submission 167 (47th Parliament)*, p. 3.

²⁸⁹ ADF, *What is residential rehabilitation?*, 13 December 2022 (accessed 15 July 2026).

²⁹⁰ DASSA, *Submission 177 (47th Parliament)*, p. 2.

²⁹¹ Matilda Centre, *Submission 24 (47th Parliament)*, p. 6.

- 4.309 AADC also referenced national governance as a barrier to implementation and monitoring of the NQF, submitting that the previous mechanism had provided a vehicle for policy, program and funding coordination between Commonwealth and State and Territory governments. AADC further commented that whilst the majority of AOD treatment services provide evidence-based, safe, high-quality treatment, the lack of NQF implementation leaves the community at risk of accessing unfunded (not funded by Government) and/or fee-for-service treatments which use treatment models that lack a rigorous base of evidence and efficacy.²⁹²
- 4.310 The Queensland Network of Alcohol and other Drug Agencies (QNADA) expressed similar views on monitoring NQF compliance. QNADA submitted that while compliance with the NQF is high among funded providers in the public and non-government sectors, the status of providers not receiving government funding is more difficult to establish, as there is no mechanism requiring them to be licensed to provide treatment, outside of requirements by other professional bodies such as the Australian Health Practitioner Regulation Agency.²⁹³
- 4.311 The AADC also submitted in this regard that:
- The Commonwealth should work with State and Territory Governments to fund and monitor the implementation of the NQF to drive a nationally coordinated approach to AOD service regulation, and reduce the risk of people in need of AOD treatment accessing unsafe services which operate without an evidence-based treatment model.²⁹⁴

Contracting and performance management

- 4.312 The inquiry evidence pointed to funding issues for AOD services and indicated that they have been further exacerbated by the lack of indexation on Commonwealth contracts. It was also suggested by this evidence that this has contributed to the reduction in service capacity and to workforce shortages as service providers are unable to sustain existing staff levels while meeting minimum wage requirements.
- 4.313 The inquiry also received evidence that the AOD sector faces mounting financial pressure from inflation, wage increases and the need to invest in service infrastructure. It was stated by a number of contributors that current arrangements are failing to keep pace with rising costs and services are forced to do more with less, and that providers are often forced to patch together funding from multiple resources just to deliver services without any guarantee of future funding arrangements.
- 4.314 The Queensland PHN Alcohol and Other Drugs Network stated in its submission on these resourcing issues:

²⁹² AADC, *Submission 11*, p. 2.

²⁹³ QNADA, *Submission 75 (47th Parliament)*, p. 10.

²⁹⁴ AADC, *Submission 45 (47th Parliament)*, pp. 5-6.

Without adequate indexation, AoD services are unable to scale up in line with demand, leading to staff shortages, service reductions, and compromised client care. Additionally, limited resources for professional development reduce the ability of AoD services to provide contemporary accessible culturally safe care, which is essential for our First Nations populations.

- 4.315 QNADA submitted that less than one fifth of NGO AOD service providers have some portion of funding that is recurrent and that this makes these services extremely vulnerable. QNADA commented that is the case even though community-based NGOs provide up to 71 per cent of all treatment episodes nationwide which serves to increase organisational instability and vulnerability.²⁹⁵ QNADA further stated in its submission:

In an already stretched and under-resourced system, with known workforce pressures, we should be looking to increase stability and predictability in order to facilitate access to treatment for those who need it, through the continuation of block-funding as the preferred model of funding for the alcohol and other drugs system.²⁹⁶

International approaches

- 4.316 There was interest from the Committee throughout the inquiry in some of the overseas approaches to addressing AOD risk and service provision that might help to inform future developments in Australia to reduce AOD harms.

New Zealand

- 4.317 New Zealand operates an early warning system for dangerous drugs called *High Alert*. This initiative is operated by Drug Information and Alerts Aotearoa New Zealand and is supported by a network of health professionals and social services both government and non-government. High Alert states that it gathers and analyses data to determine if a high-risk situation exists and then publishes the alert on its website.²⁹⁷
- 4.318 Harm Reduction Australia stated in its submission to the inquiry that the development of any early warning system in Australia should be modelled on *High Alert*. Harm Reduction Australia commented also that such an early warning system should be primarily focussed on public health and harm reduction rather than on research or law enforcement.²⁹⁸

²⁹⁵ QNADA, *Submission 75 (47th Parliament)*, p. 12.

²⁹⁶ QNADA, *Submission 75 (47th Parliament)*, p. 13.

²⁹⁷ High Alert Drug Information and Alerts Aotearoa New Zealand, *About Us*, <https://www.highalert.org.nz/about-us/> (accessed 13 July 2026).

²⁹⁸ Harm Reduction Australia, *Submission 85*, p. 3.

Switzerland's four pillar approach

- 4.319 Switzerland's stated drug policy aims are to reduce drug use and its negative consequences for users and society. The published information on this framework is that it is based on four pillars: prevention, therapy, harm reduction and repression. The first pillar is health promotion, prevention and early detection and includes measures for general health promotion intended to strengthen individual health resources and prevent addiction. The first pillar also subsumes measures for behavioural and situational prevention concerning a person's health behaviour with an aim to prevent the emergence of risk behaviour.²⁹⁹
- 4.320 The second pillar is focused on therapy and counselling. Measures in this pillar are aimed at people with addiction and who are seeking to reduce their consumption (including measures to assist a person's relatives). Counselling, treatment and therapy is intended to support a person to regain control over their addiction and assist them to in beating their addiction. Additionally, this pillar aims to improve quality of life and the physical and psychological condition of those affected as well as their social and professional reintegration.³⁰⁰
- 4.321 Switzerland's third pillar is targeted at harm reduction and risk minimisation with the goals of stabilising the health of those affected, maintaining their social integration (or facilitate reintegration) and providing survival assistance by encouraging less risky and harmful behaviours. This pillar also seeks to preserve the quality of life of those affected by addiction and later encourage them to seek help with withdrawal and therapy.³⁰¹
- 4.322 The final pillar targets regulation and enforcement and seeks to regulate alcohol, drugs, tobacco, medicines and gambling to protect a person's health. In relation to legal substances, this pillar includes government interventions aiming to limit accessibility and availability of psychoactive substances or behaviours (such as gambling). The enforcement arm seeks to implement the existing legal framework surrounding these substances or behaviours.³⁰²
- 4.323 YETI stated in its submission to the inquiry that the Swiss four-pillar approach also emphasised youth engagement and commented that the harm reduction services from this strategy, such as supervised drug consumption rooms and heroin-assisted treatment, were part of a broader approach to maintaining youth well-being by connecting young people through education and employment. YETI remarked that these programs in Switzerland helped to reduce stigma and offered social reintegration. Additionally, YETI emphasised that studies had shown reductions in

²⁹⁹ Switzerland Federal Office of Public Health, *The Swiss four-pillar policy on Addiction*, <https://www.bag.admin.ch/en/the-four-pillar-policy> (accessed 29 June 2026).

³⁰⁰ Switzerland Federal Office of Public Health, *The Swiss four-pillar policy on Addiction* (accessed 29 June 2026).

³⁰¹ Switzerland Federal Office of Public Health, *The Swiss four-pillar policy on Addiction* (accessed 29 June 2026).

³⁰² Switzerland Federal Office of Public Health, *The Swiss four-pillar policy on Addiction* (accessed 29 June 2026).

overdose deaths and improvements in public health indicators among young people in Switzerland as a result of this policy.³⁰³

Committee comment

- 4.324 The health, social and economic harms from risky AOD use, and the profound impact they can have on individuals, their families and communities, are clearly evident and well understood. It is also not in question that prevention, early intervention, harm reduction, and treatment and support services are all essential components of any approach to improving the health and wellbeing of people affected by AOD misuse.
- 4.325 Prevention, early intervention and harm reduction are especially important in supporting children, adolescents and young people. The Committee supports a focus on preventing the earlier uptake of AOD, whilst also equipping this group with the skills and resources that helps them navigate adolescence and builds protective factors that supports wellbeing and reduces risk of harms later in life.
- 4.326 There must be equitable access for children, families and the community to evidence-based AOD education, resources and support. The Committee acknowledges the inquiry evidence that this can have a positive effect on reducing harms whilst also providing opportunities to make informed choices.
- 4.327 Sectors outside of the AOD sector are clearly also integral to supporting any journey across the continuum from prevention to recovery. Greater integration and partnerships across sectors are necessary to deliver care, support earlier identification of issues and streamline referrals between services. AOD use rarely presents as the affected individual's only concern, and these partnerships should enable a capability uplift across sectors to address these complexities.
- 4.328 The Committee is of a firm view that the employment and housing, mental health, family, domestic and sexual violence, education, and justice sectors also have a critical role to play in addressing AOD harm. A focus on cross-sector training and education, partnerships between services, as well as enabling better access to basic housing and employment needs will undoubtedly improve the long-term wellbeing of people suffering from AOD issues and do so significantly. A focus on the mental health, and on the family, domestic and sexual violence sectors must be an immediate policy priority in this regard.
- 4.329 AOD services play a hugely important role in providing quality care and support to communities, whilst at the same time navigating challenges from restricted funding and commissioning of services, as well as the increasing complexity of client needs. AOD services are delivered by a dedicated and experienced workforce, committed to improving outcomes for people, and this must be continually acknowledged across all levels of government in all jurisdictions. The ongoing problem is that the AOD

³⁰³ YETI, *Submission 51 (47th Parliament)*, p. 14.

workforce is just not sufficient to meet the current levels of demand for services and the pressures on existing workers are stark.

- 4.330 The mental health sector has made welcome improvements in both its digital service offering as well as in terms of the recognition and support for their peer workforce. The Committee's view is that the Commonwealth government should build upon the great work that has been undertaken in that sector and apply it to the AOD sector.
- 4.331 Leadership is required across Government to support the scaling of existing digital tools in the AOD space that would provide greater coverage and access, as well as an enhanced integration between digital tools and existing services. Leadership is also required to ensure there is consistency in the recognition of the peer workforce, both through training and development opportunities, qualifications, as well as resources for organisations that support employment opportunities for this workforce.
- 4.332 There must also be a focus on attracting, training and retaining the Aboriginal and Torres Strait Islander AOD workforce and also the AOD workforce in rural, regional and remote Australia. The Committee is aware that this responsibility is jointly shared between Commonwealth and state and territory governments, but a more consistent approach and strategy to addressing these issues is needed. Whether this is achieved through the development of the next *National Drug Strategy*, or through a national governance mechanism, supporting the AOD workforce must be a policy priority.
- 4.333 The Committee's views on these issues are further outlined in chapter 7, along with its considered recommendations to the Australian Government that are proposed as a way forward to reducing AOD harms in Australia.



5. Fetal Alcohol Spectrum Disorder

The prevalence and the harm of FASD

- 5.1 Fetal Alcohol Spectrum Disorder (FASD) is defined by the National Health and Medical Research Council (NHMRC) as ‘a lifelong condition characterised by severe neurodevelopmental impairments (with/without physical impairments) that results from prenatal alcohol exposure’.¹
- 5.2 Current NHMRC guidelines for alcohol consumption state that ‘to prevent harm from alcohol to their unborn child, women who are pregnant or planning a pregnancy should not drink alcohol’.²
- 5.3 FASD was emphasised by multiple stakeholders throughout the inquiry as a significant negative outcome of risky alcohol use in Australia. The Australian College of Midwives (ACM) submitted that alcohol consumption during pregnancy was far higher here than has been reported globally, stating in its submission:
- Twenty-eight percent of Australian women report consuming alcohol while pregnant. This is considerably higher than the global average of 9.8%. While many women do stop or reduce their alcohol consumption once they are aware of the pregnancy, the percentage of women continuing to drink is concerning given the risks of Fetal Alcohol Syndrome Disorder (FASD) and other negative effects on mothers and babies.³
- 5.4 ACM further stated that ‘approximately one in every 13 women who consume alcohol during pregnancy will give birth to a child with FASD’.⁴
- 5.5 The University of Sydney and the Care and Intervention for Children and Adolescents affected by Drugs and Alcohol (CICADA) Service cited data in its submission that approximately 60 per cent of Australian women consume alcohol during pregnancy.⁵ This figure was also cited by FASD Hub Australia.⁶

¹ National Health and Medical Research Council (NHMRC), *Fetal Alcohol Spectrum Disorder: Public health case study*, <https://www.nhmrc.gov.au/about-us/resources/impact-case-studies/fetal-alcohol-spectrum-disorder-public-health-case-study>, (accessed 15 June 2026).

² NHMRC, *Australian guidelines to reduce health risks from drinking alcohol*, <https://www.nhmrc.gov.au/health-advice/alcohol>, (accessed 1 July 2026).

³ Australian College of Midwives (ACM), *Submission 15*, p. 3.

⁴ ACM, *Submission 15*, p. 3.

⁵ University of Sydney and the Care and Intervention for Children and Adolescents affected by Drugs and Alcohol (CICADA) Service, *Submission 134 (47th Parliament)*, p. 3.

⁶ FASD Hub Australia, *Submission 184 (47th Parliament)*, p. 3.

- 5.6 The Public Health Association of Australia (PHAA) commented in its submission that alcohol exposure at any stage of pregnancy can cause FASD and that one in four Australians were unaware of the dangers of alcohol consumption during pregnancy. PHAA further indicated different aspects of the damage that could result from prenatal alcohol consumption:

Alcohol can damage a developing baby's brain, body, and organs, resulting in challenges throughout child- and adulthood such as physical and emotional development delay, impaired speech and language development, difficulty controlling behaviour, and learning difficulties such as issues with memory and attention.⁷

- 5.7 The specific damage that can be caused by alcohol consumption during pregnancy was outlined also by FASD Hub Australia in its submission:

Alcohol is a teratogen (toxic to the developing embryo and fetus). When alcohol is consumed during pregnancy it readily crosses the placenta and may disrupt the normal growth and development of the baby's brain and other organs. Prenatal alcohol exposure (PAE) can cause miscarriage, stillbirth, premature birth, low birth weight, birth defects and Fetal Alcohol Spectrum Disorder.⁸

- 5.8 FASD Hub Australia further emphasised that FASD occurs in all parts of Australian society, ie, wherever alcohol is consumed, but that despite the gains made to reduce its prevalence through awareness campaigns and public health initiatives, it is unlikely to ever be eliminated.⁹

- 5.9 The Salvation Army noted that the 'effects of FASD vary considerably across a spectrum but many people who live with FASD experience significant cognitive, behavioural, health and learning difficulties'.¹⁰

- 5.10 Dr Kelly McNamara and Ms Ebony Quintrell cited evidence that the global incidence of FASD was 7.7 per 1,000 and noted that this prevalence was higher than known congenital abnormalities such as Down Syndrome or neural tube defects.¹¹

- 5.11 Alcohol Change Australia (ACA) highlighted in its submission recently published Australian research that provides an estimated prevalence of FASD in Australia. Published in June 2025, ACA reported that the study estimated a national FASD prevalence of 3.64 per cent, or up to one in 28 Australians.¹²

- 5.12 The National Organisation for Fetal Alcohol Spectrum Disorders (NOFASD) also cited this same research, acknowledging it as the first robust national estimate of FASD prevalence in Australia, and that it used pooled Australian data on prenatal

⁷ Public Health Association of Australia (PHAA), *Submission 106 (47th Parliament)*, p. 9.

⁸ FASD Hub Australia, *Submission 184 (47th Parliament)*, p. 2.

⁹ FASD Hub Australia, *Submission 184 (47th Parliament)*, p. 2.

¹⁰ The Salvation Army, *Submission 68 (47th Parliament)*, p. 11.

¹¹ Dr Kelly McNamara and Ms Ebony Quintrell, *Submission 183 (47th Parliament)*, p. 5.

¹² Alcohol Change Australia, *Submission 50*, p. 6.

alcohol exposure, combined with internationally validated risk estimates, to calculate the likely population prevalence.¹³

- 5.13 NOFASD further reported that the modelling from the relevant research suggests that prevalence is likely to be significantly higher in vulnerable or over-represented groups, including children in out-of-home care, youth justice cohorts, and communities experiencing structural disadvantage.¹⁴
- 5.14 The Royal Australian College of General Practitioners (RACGP) submitted that, in Australia, 'FASD is the most common preventable non-genetic cause of developmental disability' and cites estimates that at least one child in every classroom has FASD.¹⁵
- 5.15 The Parents Under Pressure Program at Griffith University also noted in its submission that FASD was significantly more prevalent in priority populations, including 16-21 per cent of children in out-of-home care and up to 36 per cent in detention centres.¹⁶
- 5.16 Alcohol Beverages Australia commented on the current lack of data on the incidence of FASD, citing research findings from the Australian Institute of Family Studies that an accurate understanding of the extent of FASD in Australia is needed to help with prevention efforts.¹⁷
- 5.17 The National Indigenous Australians Agency (NIAA) commented on the impacts of FASD on individuals, families and communities, including as a driver of youth crime and incarceration rates, noting in particular that FASD has likely been 'severely underdiagnosed within the child protection system and may be 10-15 times more prevalent among these children compared to the general population'.¹⁸
- 5.18 The University of Sydney and the CICADA Service also noted the negative impacts of FASD on health and mental health, education, justice, and the disability and community sectors, further suggesting in its submission that three per cent of the general population in Australia has FASD.¹⁹
- 5.19 FASD Hub Australia cited World Health Organization (WHO) data indicating a global FASD rate of 1 per cent but commented that this incidence was highly variable across different countries and that a prevalence of between 2 to 5 per cent was estimated for Australia, the United States, and Canada. It was also noted that this higher rate equated to about one child in every classroom.²⁰

¹³ National Organisation for Fetal Alcohol Spectrum Disorders (NOFASD), *Submission 44*, p. 5.

¹⁴ NOFASD, *Submission 44*, p. 5.

¹⁵ Royal Australian College of General Practitioners (RACGP), *Submission 84 (47th Parliament)*, p. 2.

¹⁶ Griffith University: Parents Under Pressure, *Submission 195 (47th Parliament)*, pp. 8–9.

¹⁷ Alcohol Beverages Australia, *Submission 61 (47th Parliament)*, p. 15.

¹⁸ National Indigenous Australians Agency (NIAA), *Submission 140 (47th Parliament)*, p. 7.

¹⁹ University of Sydney and the CICADA Service, *Submission 134 (47th Parliament)*, p. 3.

²⁰ FASD Hub Australia, *Submission 184 (47th Parliament)*, p. 4.

- 5.20 FASD Hub Australia cited additional statistics in its submission indicating that an Australian child with this condition will commonly have the following characteristics:
- High level prenatal alcohol exposure
 - Diagnosed at 8.8 years of age
 - Male (66 per cent)
 - Indigenous (55 per cent of FASD sufferers from only 3 per cent of the general population)
 - One of several affected siblings (19 per cent)
 - In contact with child protection services (75 per cent)
 - Not living with a biological parent (78 per cent).²¹
- 5.21 FASD Hub Australia further noted in its submission that children with FASD in Australia were over-represented in Western Australia and in remote or very remote regions.²²
- 5.22 In a private anonymised submission to the inquiry, a FASD sufferer stated in relation to the lived experience with this condition:
- Many of us face challenges with executive functioning—such as planning, time management, and decision-making—and adaptive functioning like social skills and managing daily life. These struggles can ripple through our lives affecting learning opportunities, employment prospects, relationships, and our interactions with systems like healthcare, education, and justice.²³
- 5.23 This submitter emphasised also that FASD is incurable but preventable and that prevention strategies must exist alongside robust diagnostic frameworks, for which adequately trained healthcare professionals are needed.²⁴
- 5.24 The University of Sydney held similar views, stating at the public hearing on 14 April 2026 that ‘although potentially preventable, FASD remains underrecognised and underdiagnosed’. The University of Sydney further commented at this hearing that services are inadequately resourced and access to services is inequitable; thus, waitlists are long and many children do not receive the early intervention they need to thrive’.²⁵
- 5.25 Another private contributor to the inquiry, Ms Angelene Bruce, whose submission described both her lived experience with a child with FASD, and as a peer worker for people dealing with the misuse of alcohol and other drugs, stated:

²¹ FASD Hub Australia, *Submission 184 (47th Parliament)*, p. 4.

²² FASD Hub Australia, *Submission 184 (47th Parliament)*, p. 4.

²³ Name withheld, *Submission 187 (47th Parliament)*, p. 1.

²⁴ Name withheld, *Submission 187 (47th Parliament)*, p. 2.

²⁵ Distinguished Professor Elizabeth Elliot, Speciality of Child and Adolescent Health, Faculty of Medicine and Health, University of Sydney, *Committee Hansard*, 14 April 2026, p. 45.

So many individuals living with undiagnosed and unaccommodated FASD will fall into substance misuse disorders. I cannot understate how common that is, nor how common FASD is. It's the largest spectrum of disability in Australia, by a long way, probably more than we know due to misdiagnosis of autism also being common.

These individuals also lack the executive functioning to navigate how to get help. Remembering to make a phone call or even trying to think where to begin is a challenge and a barrier. The missing of appointments will happen without support due to memory deficits. It is not laziness, nor apathy, nor deliberate. It is FASD.²⁶

5.26 Another FASD sufferer, Ms Jessica Birch, appearing in a private capacity at the public hearing for the inquiry on 7 February 2025, informed the Committee of 'the difficulty, confusion, humiliation and profound emotional pain of living with undiagnosed FASD'.²⁷

5.27 Ms Birch indicated that she had only recently been diagnosed with FASD at the age of 33 and emphasised that she was continuing to face challenges in accessing health care and NDIS support that was informed. Ms Birch stated also:

Please understand that FASD is a blanket term for a range of complex disorders presenting in myriad combinations due to the individual variations in timing and amount of exposure. This is a full-body physical injury associated with over 400 comorbid conditions and high rates of secondary disability due to stigma, misdiagnosis and lack of support.²⁸

Previous parliamentary committee inquiries

5.28 The House of Representatives Standing Committee on Social Policy and Legal Affairs conducted an *'Inquiry into the prevention, diagnosis and management of Fetal Alcohol Spectrum Disorders'* in 2012. That committee made 19 recommendations to the Australian Government in its final report, including that it should:

- implement a general public awareness campaign which promotes not drinking alcohol when pregnant and develop specific awareness campaigns to target youth and Indigenous communities
- work with State and Territory governments to identify and implement effective strategies for pregnant women with alcohol dependence or misuse
- seek to include health warning labels for alcoholic beverages, including a warning label that advises women not to drink when pregnant or when planning a pregnancy
- raise with the States and Territories the critical importance of strategies to assist Indigenous communities in managing issues of alcohol consumption and to assist

²⁶ Ms Angelene Bruce, *Submission 201 (47th Parliament)*, pp. 16-17.

²⁷ Ms Jessica Birch, *Committee Hansard*, 7 February 2025, p. 15.

²⁸ Ms Birch, *Committee Hansard*, 7 February 2025, p. 15.

community led initiatives to reduce high-risk consumption patterns and the impact of alcohol

- develop educational material to raise awareness about FASD.²⁹

5.29 More recently, the 2020 report of the Senate Community Affairs References Committee arising from its '*Inquiry into effective approaches to prevention and diagnosis of Fetal Alcohol Spectrum Disorder*' made 32 recommendations, which included that the Australian Government should:

- develop a broader strategy and budget for a national public education campaign over the life of the *National Fetal Alcohol Spectrum Disorder (FASD) strategic action plan 2018–2028*
- develop FASD education resources to be used in secondary school curriculums
- run a specific public education campaign with respect to the roll-out of mandatory pregnancy warning labels
- work with State and Territory Governments to provide all educators with professional development training in the awareness, understanding and management of FASD
- work with State and Territory Governments to ensure all schools can deploy and resource FASD-specific strategies and assistance to support educators and to support students with FASD and suspected FASD, irrespective of IQ level
- allocate specific funding aimed at supporting First Nations community-led projects to prevent and manage FASD.³⁰

Awareness of FASD and its associated harms

5.30 The evidence to the inquiry consistently indicated that public awareness of the risks of prenatal alcohol consumption and FASD in Australia remained low.

5.31 NOFASD remarked in its submission that awareness of FASD is low both domestically and internationally, and that 'there is a need to learn from best practices and adapt them to the Australian context'.³¹ NOFASD further commented that:

Despite ongoing efforts, significant gaps in public knowledge about the risks of alcohol consumption during pregnancy persist. 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.³²

²⁹ House of Representatives Standing Committee on Social Policy and Legal Affairs, *The Hidden Harm: Inquiry into the prevention, diagnosis and management of Fetal Alcohol Spectrum Disorders*, November 2012, Canberra.

³⁰ Senate Community Affairs References Committee, *Effective approaches to prevention, diagnosis and support for Fetal Alcohol Spectrum Disorder*, March 2021, Canberra.

³¹ NOFASD, *Submission 129 (47th Parliament)*, p. 10.

³² NOFASD, *Submission 129 (47th Parliament)*, p. 6.

- 5.32 NOFASD stated additionally in its submission that ‘awareness is particularly low amongst men (63 per cent) compared to women (77 per cent), and nearly 23 per cent of Australians mistakenly believe that some alcohol consumption during pregnancy is safe’.³³
- 5.33 ACM submitted that there is ‘a lack of awareness or clear guidance about the effects of alcohol consumption in pregnancy, and confusion over whether there is a safe threshold for drinking during pregnancy, with some women receiving conflicting advice from healthcare providers, books and guidelines’.³⁴ ACM further suggested that:
- Some healthcare professionals endorse or even advocate for moderate alcohol consumption during pregnancy, and alongside a lack of high-quality evidence about the effects of low levels of consumption, many women are confused about the accuracy of abstinence messaging.³⁵
- 5.34 Alcohol Change Australia provided comparable statistics, also submitting that one in four Australians remain unaware that alcohol consumption during pregnancy is harmful and that one in three do not know that it can cause FASD.³⁶ Alcohol Change Australia further stated that ‘Australia has one of the highest rates of alcohol use during pregnancy in the world. In 2022-23, around 1 in 4 (28 per cent) Australian women consumed alcohol while pregnant’.³⁷
- 5.35 ACM noted in its initial submission to the inquiry that although many Australian women cease drinking upon learning that they are pregnant, the percentage who do not is concerning given that about 1 in 13 of these women will give birth to a child with FASD. ACM commented also that ‘other outcomes associated with drinking during periconception, and pregnancy include increased risk of miscarriage, small for gestational age baby, and preterm birth’.³⁸
- 5.36 ACM also submitted that there were social and other contributing factors to the consumption of alcohol while pregnant:
- There are many reasons why women continue to drink while pregnant. Social pressure and acceptance of drinking while pregnant are important factors driving the rates of alcohol consumption during pregnancy. Misunderstanding of the risk is also an important contributor. Many women believe that only large amounts or particular types of alcohol are harmful to the developing fetus, with some women even believing that certain amounts and/or types of alcohol are beneficial to maternal or fetal health and development.³⁹

³³ NOFASD, *Submission 129 (47th Parliament)*, p. 6.

³⁴ ACM, *Submission 15*, p. 3.

³⁵ ACM, *Submission 15*, p. 3.

³⁶ Alcohol Change Australia, *Submission 76 (47th Parliament)*, p. 4.

³⁷ Alcohol Change Australia, *Submission 76 (47th Parliament)*, p. 4.

³⁸ ACM, *Submission 101 (47th Parliament)*, p. 3.

³⁹ ACM, *Submission 101 (47th Parliament)*, pp. 3–4.

- 5.37 At the public hearing in Canberra on 7 February 2025, NOFASD stated that there needs to be frank conversations and mainstream education regarding alcohol use during pregnancy as a causal factor for many current societal issues such as mental ill health, substance misuse disorders, disengagement from school and involvement with the justice system.⁴⁰ NOFASD further commented in this regard that FASD was not just a health issue but a social matter that urgently required ‘cross-sector collaboration, recognition and support’.⁴¹
- 5.38 In its follow-up submission to the inquiry, ACM noted there are often inconsistencies in public messaging about alcohol in pregnancy. ACM stated as an example of this that alcohol industry-funded organisations inaccurately represent the risks of consumption of alcohol during pregnancy.⁴²
- 5.39 Ms Birch emphasised the impacts associated with the misunderstanding and misdiagnosis of FASD at the public hearing on 7 February 2025:
- FASD doesn't just appear; it gets missed, often hidden behind bright, engaged children whose many strengths belie their struggles. Time and time again, these challenges go unrecognised until the consequences are irreversible, and this can no longer stand. Today FASD is the leading cause of non-genetic disability in Australia, yet it remains the most underdiagnosed and misunderstood. Too often, it is mistaken, or purposefully misdiagnosed, as autism and ADHD, leading to incorrect treatments, inadequate support and poor outcomes.⁴³

Public awareness campaigns

- 5.40 It was acknowledged that one of the most powerful tools in preventing FASD is education and awareness, particularly in the form of campaigns. As one submitter stated, ‘these campaigns need to be ongoing and more needs to be funded to ensure that this message reaches young people early, before they plan to become parents themselves’.⁴⁴
- 5.41 NOFASD also suggested that expanding collaborations with healthcare providers, regular clinician training on discussing alcohol use during pregnancy, and maintaining culturally appropriate messaging will amplify the impact of campaigns.⁴⁵
- 5.42 The National FASD Campaign, often referred to as “Every Moment Matters” was heavily referenced as an example of a successful awareness program (further details below).

⁴⁰ Mrs Sophie Harrington, Interim Chief Operating Officer, NOFASD, *Committee Hansard*, 7 February 2025, p. 14.

⁴¹ Mrs Harrington, NOFASD, *Committee Hansard*, 7 February 2025, p. 15.

⁴² ACM, *Submission 15*, p. 4.

⁴³ Ms Birch, *Committee Hansard*, 7 February 2025, pp. 15–16.

⁴⁴ Name withheld, *Submission 187 (47th Parliament)*, p. 9.

⁴⁵ NOFASD, *Submission 129 (47th Parliament)*, p. 12.

- 5.43 DrinkWise commented in its submission that its own campaign to increase the public's knowledge of FASD—the DrinkWise FASD Awareness Program—had produced results, and that data from its own tracking research indicated an increase in awareness of FASD from 49 to 61 per cent between 2018 and 2024. DrinkWise stated in this regard that 'DrinkWise FASD messaging includes a consortium of health experts and mums-to-be to ensure a consistent message is delivered by many voices'.⁴⁶
- 5.44 The Brewers Association of Australia noted this DrinkWise program and that FASD is fully preventable and indicated its support for pregnancy warning labels and current NHMRC drinking guidelines.⁴⁷

The National FASD Campaign

- 5.45 The Foundation for Alcohol Research and Education (FARE) stated in its submission that the National FASD Campaign (2020-2024) is the first comprehensive national health promotion campaign on alcohol and pregnancy globally designed to raise awareness of alcohol related harm during pregnancy and breastfeeding.⁴⁸
- 5.46 FARE submitted that this campaign aims to reach four key populations; women who are at an increased risk of alcohol use during pregnancy, health professionals, Aboriginal and Torres Strait Islander people and the general Australian population.⁴⁹
- 5.47 FARE further commented that this campaign is delivered through several different mechanisms and organisations:
- the 'Every Moment Matters' public awareness campaign and dedicated health professional eLearning modules led by FARE.
 - development of dedicated resources for priority groups led by NOFASD.
 - the comprehensive 'Strong Born' campaign, led by the National Aboriginal Community Controlled Health Organisation (NACCHO), empowering Aboriginal and Torres Strait Islander communities.⁵⁰

Every Moment Matters

- 5.48 The Every Moment Matters campaign is described as a domestic best practice initiative aimed at raising awareness about the harms of prenatal alcohol exposure and FASD, providing educational materials, videos, and public health messaging to communicate these risks.⁵¹
- 5.49 NOFASD reported in relation to this initiative that:

⁴⁶ DrinkWise, *Submission 192 (47th Parliament)*, pp. 10-11.

⁴⁷ Brewers Association of Australia, *Submission 83 (47th Parliament)*, p. 5.

⁴⁸ Foundation for Alcohol Research and Education (FARE), *Submission 87 (47th Parliament)*, p. 20.

⁴⁹ FARE, *Submission 87 (47th Parliament)*, p. 20.

⁵⁰ FARE, *Submission 87 (47th Parliament)*, p. 20.

⁵¹ NOFASD, *Submission 129 (47th Parliament)*, p. 10.

The campaign encourages healthcare professionals to engage in non-judgmental, supportive discussions about alcohol use with their patients, reinforcing the message that "every moment matters" for the health of both mother and baby. By fostering stigma-free conversations and providing clear, evidence-based information, the campaign seeks to reduce alcohol exposed pregnancies and improve long-term health outcomes.⁵²

5.50 FARE stated in its submission that an independent evaluation of this campaign found that it had successfully raised Australians' awareness about the risks associated with alcohol consumption during pregnancy, awareness of the NHMRC guidelines, and increased intention to avoid alcohol during conception.⁵³

5.51 The evaluation report highlighted the following positive outcomes:

- There was a significant increase in intention to abstain from alcohol when trying to conceive from 34.2 per cent pre-campaign to 54.0 per cent post-campaign, among women who were planning a pregnancy in the next two years (who were not actively trying to conceive).
- The proportion of Australians who correctly identified the alcohol guidelines for women who are pregnant or planning pregnancy increased significantly from 32.7 per cent pre-campaign to 44.6 per cent post-campaign.
- The proportion of women with planned pregnancies who reported abstaining from alcohol while trying to conceive increased from 30.7 per cent to 58.3 per cent.
- Awareness of the guidelines for breastfeeding women also increased significantly from 64.7 per cent pre-campaign to 74.0 per cent post-campaign.⁵⁴

Strong Born

5.52 The 'Strong Born' campaign was established to increase the understanding of FASD among Aboriginal and Torres Strait Islander communities in order to promote alcohol-free pregnancies and safe breastfeeding practices. The program is led by NACCHO, with support from FARE and the Australian Government.⁵⁵

5.53 Strong Born provides a variety of resources and grant funding to help lower the incidence of FASD among First Nations people, including:

- Community education booklets, posters, and videos
- Resources and funding grants for families, carers, and health workers
- Local awareness activities and community discussions ("yarning") about FASD

⁵² NOFASD, *Submission 129 (47th Parliament)*, p. 10.

⁵³ FARE, *Submission 87 (47th Parliament)*, p. 21.

⁵⁴ Name withheld, *Submission 187 (47th Parliament)*, p. 9.

⁵⁵ National Aboriginal Community Controlled Health Organisation (NACCHO), *Strong Born campaign*, <https://www.naccho.org.au/strong-born-a-new-campaign-supporting-aboriginal-and-torres-strait-islander-communities-to-yarn-about-fasd> (accessed 6 July 2026).

- Customisable materials that communities can adapt to local needs.⁵⁶
- 5.54 NOFASD stated in relation to Strong Born that ‘by fostering open conversations, reducing stigma, and integrating cultural values, the campaign seeks to reduce FASD and improve the health and well-being of Indigenous children’.⁵⁷
- 5.55 In its submission to the inquiry, NACCHO commented that the ‘Strong Born Campaign has increased awareness and prevention of FASD, leading to better health outcomes for mothers and children’.⁵⁸
- 5.56 The Australian College of Midwives cited reports of the Strong Born campaign being well received, stating in its submission that the campaign materials had been translated into eight local languages, and increased staff and community awareness.⁵⁹

National FASD Strategic Action Plan 2018–2028

- 5.57 The National FASD Strategic Action Plan 2018-2028 (the Plan) is a policy framework that commenced in November 2018 at what is now the Department of Health, Disability and Ageing (Department of Health) with the aim of reducing the prevalence of FASD and its impact. The Department of Health stated in its submission regarding this framework:
- The Plan provides a pathway of priorities and opportunities to improve the prevention, diagnosis, support and management of FASD in Australia. National priority areas for action identified in the Plan include prevention, screening and diagnosis, support and management and priority groups.⁶⁰
- 5.58 A number of both government and non-government entities referred to the Plan in their submissions to the inquiry.
- 5.59 Alcohol Change Vic (ACV) commented that this framework ‘shows how dedicated action/implementation plans can result in positive outcomes highlighting, as an example of this, the introduction of pregnancy warning labels on alcohol products and the national FASD awareness campaign’.⁶¹
- 5.60 Other submissions, whilst supportive of the Plan, pointed to priorities that require continued focus.
- 5.61 Deakin University referenced an evaluation of the Plan, reporting it found implementation gaps including inconsistent screening practices, limited training for frontline workers, and lack of integration with justice and education systems.⁶²

⁵⁶ NACCHO, *Strong Born campaign* (accessed 6 July 2026).

⁵⁷ NOFASD, *Submission 129 (47th Parliament)*, p. 10.

⁵⁸ NACCHO, *Submission 145 (47th Parliament)*, p. 10.

⁵⁹ Australian College of Midwives, *Submission 15*, p. 5.

⁶⁰ Department of Health and Aged Care (Department of Health), *Submission 157 (47th Parliament)*, p. 27.

⁶¹ Alcohol Change Vic (ACV), *Submission 166 (47th Parliament)*, p. 6.

⁶² Deakin University, *Submission 19*, p. 3.

- 5.62 FARE listed similar areas of the Plan that it believed required focus, and commented that:

... elements yet to be fully implemented include achieving consistent screening and diagnosis, particularly in the criminal justice and education sectors, establishing comprehensive cross sector support and management for people with FASD, and ensuring sufficient resourcing for the plan's initiatives.⁶³

Tailored and non-stigmatising information

- 5.63 Evidence to the inquiry stressed the need to properly train and equip medical and educational professionals to support children with FASD and their families. It was emphasised however by some of the inquiry contributors with lived experience of FASD that such support must be done in a manner that destigmatises this condition and reduces misinformation.

- 5.64 Ms Birch stated at the public hearing on 7 February 2025 that an earlier recognition and diagnosis was required, along with other key approaches, to preventing further harm from this disorder:

National public health campaigns must be expanded and ongoing, to correct the widespread misinformation about alcohol use in pregnancy. Healthcare professionals must be trained and equipped to recognise and diagnose FASD early, without the bias and the blame, with routine screenings for prenatal exposure embedded in maternal care. States and territories must apply brain-based approaches and FASD-informed care into education, social service and justice, to prevent further harm, to minimise punitive responses and unnecessary criminalisation and to provide pathways for individual success.⁶⁴

- 5.65 Ms Birch also emphasised that reducing the stigma around FASD required certain common misconceptions to be addressed by any awareness and education campaigns, including the mistaken belief that it is a rare disorder or that it can only be caused by large levels of alcohol consumption during pregnancy.⁶⁵

- 5.66 Ms Angelene Bruce, another contributor to the inquiry with lived experience of FASD, noted at this same hearing that her son had been misdiagnosed initially with moderate autism and that although he was eventually correctly diagnosed with FASD at the age of four, the speech and occupational therapy clinics he then attended, and subsequent educational professionals he interacted with, had no real idea of what FASD is.⁶⁶

⁶³ FARE, *Submission 80*, p. 11.

⁶⁴ Ms Birch, *Committee Hansard*, 7 February 2025, p. 16.

⁶⁵ Ms Birch, *Committee Hansard*, 7 February 2025, p. 18.

⁶⁶ Ms Angelene Bruce, *Committee Hansard*, 7 February 2025, p. 17.

- 5.67 Ms Bruce additionally commented, upon questioning from the Committee about how things could have been better at that time, that the education system was a key area of deficiency for supporting children with FASD. She stated:

We need more education about FASD and, while not less education about autism, we need to let teachers know that FASD is not autism... Give education that is around FASD and is FASD specific so that, if a child with a FASD diagnosis comes in, they are appropriately accommodated. Also, teachers will be able to pick out the missed FASD kids in their classroom, because it's really quite obvious, when you know what you're looking at, that you have a FASD child in front of you... Educate the education department on what FASD is, what it looks like and what it isn't...⁶⁷

- 5.68 The Committee heard also from NOFASD at the 7 February 2025 hearing that frank and non-judgemental conversations about alcohol consumption were needed when doctors were treating pregnant women. NOFASD commented that, as alcohol use was a part of everyday normal society, this was about 'normalising those questions to become part of that gathering of medical history'.⁶⁸

- 5.69 Ms Birch remarked however that these were challenging conversations for both the expectant mother and their doctors:

I think it's so important not to underestimate the personal bias or stigmatising thoughts from the treating professionals themselves. That happens quite a lot. Even if you have a tool so women don't have to sit face to face and disclose to their doctors about potential prenatal alcohol exposure, should they tick yes, a further discussion needs to happen. That is very uncomfortable for a lot of people, but it's also very uncomfortable for a lot of health professionals.⁶⁹

- 5.70 NOFASD argued also that every pregnancy should be screened as there was stigma attached to more commonly asking these types of questions in marginalised populations and in people at risk. NOFASD further commented that there needs to be more understanding and that it was 'unbelievable that we're actually having a conversation now in an inquiry where that education is not there and not embedded'.⁷⁰

- 5.71 In its further submission to the inquiry, NOFASD drew on evidence it had collected through its 2025 national survey of parents, carers, adults with FASD, and professionals. As part of this survey, NOFASD highlighted stigma as 'a major barrier to help-seeking, with many families reporting experiences of judgement, shame, or dismissal from services and community'.⁷¹

⁶⁷ Ms Bruce, *Committee Hansard*, 7 February 2025, pp. 17–18.

⁶⁸ Mrs Harrington, NOFASD, *Committee Hansard*, 7 February 2025, p. 19.

⁶⁹ Ms Birch, *Committee Hansard*, 7 February 2025, pp. 19–20.

⁷⁰ Mrs Harrington, NOFASD, *Committee Hansard*, 7 February 2025, p. 20.

⁷¹ NOFASD, *Submission 44*, p. 4.

- 5.72 NOFASD further referenced a particular survey respondent who stated, ‘there is little knowledge in the community that this is not just an issue for children born to alcoholic mothers... FASD occurs in all socio-economic levels of society and can occur before the mum knows she is pregnant’ and emphasised in its submission that such misconceptions continue to prevent early confirmation of alcohol exposure and contribute to delayed diagnosis.⁷²

Management of FASD

- 5.73 As highlighted earlier in this chapter, the inquiry evidence indicated consistently that the intersections between alcohol consumption and pregnancy are complex and multilayered. Whilst this evidence stressed the need for greater awareness of the risks of prenatal alcohol consumption it also argued for better management and support for individuals with FASD, and their families and carers.
- 5.74 The Plan provides for access to screening and diagnostic services that enables earlier identification of a child at risk of FASD, earlier diagnosis of FASD as well as appropriate management and support for individuals with FASD.⁷³
- 5.75 Various submissions to the inquiry also referenced the need to also improve supports for sectors outside of health, including youth justice and child protection and for priority population groups including Aboriginal and Torres Strait Islander people.
- 5.76 The NIAA provided relevant statistics on this in its submission:

A study in Western Australia’s Banksia Hill Detention Centre in 2015-16 (n=99) found the highest prevalence of FASD in a justice setting worldwide. Over a third (36 per cent) of 10- to 17-year-olds were diagnosed with FASD, with 74 per cent of participants being First Nations children.⁷⁴
- 5.77 The Parents Under Pressure Program also reported high rates of FASD in Australian youth justice populations, including 36 per cent of young people in one particular detention centre.⁷⁵
- 5.78 The University of Sydney and the CICADA service stated in its submission that navigating health and social service systems is complex and challenging for young people and advocated for increased investment to address stigma. The University of Sydney and the CICADA service argued that this would improve access to services and support that enable early diagnosis and treatment of FASD and prevent adverse adult outcomes, including contact with the justice system and educational failure.⁷⁶
- 5.79 A number of submitters to the inquiry commented on the impacts of FASD on the young people affected by this condition and stated that they can lead to very serious

⁷² NOFASD, *Submission 44*, p. 4.

⁷³ National FASD Strategic Action Plan 2018 – 2028, p. 21.

⁷⁴ National Indigenous Australians Agency (NIAA), *Submission 140 (47th Parliament)*, p. 7.

⁷⁵ Griffith University: Parents Under Pressure, *Submission 195 (47th Parliament)*, pp. 8–9.

⁷⁶ University of Sydney and the CICADA Service, *Submission 134 (47th Parliament)*, p. 4.

consequences if support and treatment are lacking. Youth Empowered Towards Independence (YETI) made a specific reference to these impacts in its submission:

Young people with Foetal Alcohol Spectrum Disorder (FASD) are particularly vulnerable due to the cognitive, behavioural, and social impairments associated with this condition. Without access to specialised support services, young people often struggle with impulse control, understanding consequences, and emotional regulation, which can lead to increased involvement in risky behaviours.⁷⁷

- 5.80 In a private anonymised submission to the inquiry, a FASD sufferer also discussed the complexities of this condition, including its misdiagnosis:

The complexity of FASD means its effects are felt across all sectors of society—from health to education to employment—and yet it remains largely misunderstood, and more importantly, misdiagnosed. Too often individuals with FASD receive incorrect diagnoses such as autism or Attention Deficit Disorder (ADD), without any discussion about the possibility of prenatal alcohol exposure. This lack of accurate diagnosis denies us the specific support we need to navigate our challenges effectively.⁷⁸

Embedding of alcohol screening in routine care

- 5.81 Dr McNamara and Ms Quintrell submitted that identifying harmful alcohol use in pregnancy provides an opportunity for women and pregnancy care providers to discuss treatment options, pregnancy care pathways and follow up for exposed infants.⁷⁹
- 5.82 The NIAA suggested that engaging women and their partners during the prenatal, inter-conception and postnatal periods can provide opportunities to address harmful AOD use, educate about the potential effects of AOD use during pregnancy and reduce the associated prevalence of neurodevelopmental disorders like FASD.⁸⁰
- 5.83 ACM stated in its submission that although the Plan advocates for universal screening of pregnant women for alcohol consumption, 50 per cent of pregnant women report receiving no advice in relation to drinking alcohol.⁸¹
- 5.84 The need to embed screening and intervention practices was supported by NOFASD which argued that a number of gaps currently exist:
- Only 46 per cent of health professionals routinely ask about alcohol use during pregnancy, and just 32 per cent discuss the risks.
 - 70 per cent of mothers with children diagnosed with FASD do not have alcohol use recorded during pregnancy.

⁷⁷ Youth Empowered Towards Independence (YETI), *Submission 51 (47th Parliament)*, p. 4.

⁷⁸ Name withheld, *Submission 187 (47th Parliament)*, p. 1.

⁷⁹ Dr McNamara and Ms Quintrell, *Submission 183 (47th Parliament)*, p. 4.

⁸⁰ NIAA, *Submission 140 (47th Parliament)*, p. 7.

⁸¹ ACM, *Submission 15*, p. 5.

- Screening gaps also remain, with only 64 per cent of midwives and 22 per cent of paediatricians addressing PAE risks.⁸²

5.85 In their submission Dr McNamara and Ms Quintrell stated in this regard that:

... following recognition of pregnancy, research shows that around 1 in 10 women who were not identified as having a substance use disorder continue to drink alcohol at harmful levels... clinician collected maternity datasets underreport alcohol use disorder, raising concern that alcohol use disorders are not well recognised by maternity providers and that current screening processes are insufficient.⁸³

5.86 The University of Sydney and the CICADA service pointed to evidence on the role of primary healthcare clinicians (e.g. GPs) in caring for women during the preconception, antenatal and postnatal periods in Australia. They advocated for more opportunities for primary healthcare clinicians to screen and refer for assessment of FASD, stating that 'clinicians should assess alcohol use in all women of childbearing age and all pregnant women using a validated tool, discuss the risks, provide advice to abstain during pregnancy, and refer for support'.⁸⁴

5.87 The Australian Medical Association (AMA) echoed these views on support for primary healthcare in relation to preventing FASD:

GPs and other primary healthcare workers, including midwives and child and family health service nurses, must also be supported in discussing alcohol consumption with people of childbearing age, to combat FASD incidence rates.⁸⁵

5.88 FARE advocated for the availability and use of validated screening tools by relevant health professionals, citing the AUDIT tool (discussed in Chapter 4) as an example of this. FARE further stated that 'when PAE is disclosed and recorded during pregnancy, it can serve as an early marker that enables timely and accurate FASD diagnosis later in a child's life'. FARE commented also that 'without early and accurate PAE data, diagnoses of FASD are frequently delayed until at least age three and often misdirected or missed entirely'.⁸⁶

5.89 ACM remarked on the importance of timing when providing information about the risks of drinking during pregnancy, stating that more information is needed during the preconception period as 'very few women abstain from alcohol while trying to conceive, in one study 85.3 per cent of women who were actively trying to conceive reported consumption of alcohol, and 56.3 per cent reported excessive consumption'.⁸⁷

⁸² NOFASD, *Submission 129 (47th Parliament)*, p. 6.

⁸³ Dr McNamara and Ms Quintrell, *Submission 183 (47th Parliament)*, p. 4.

⁸⁴ University of Sydney and the CICADA Service, *Submission 134 (47th Parliament)*, p. 5.

⁸⁵ Australian Medical Association (AMA), *Submission 80 (47th Parliament)*, p. 3.

⁸⁶ FARE, *Submission 80*, p. 12.

⁸⁷ ACM, *Submission 15*, p. 5.

5.90 At the 14 April 2026 hearing, the University of Sydney advocated for earlier support and awareness of FASD before a person becomes pregnant, and described the need for awareness campaigns in schools, and for GPs, primary health professionals and others, to identify women who have a problem with alcohol before they become pregnant.⁸⁸

5.91 The University of Sydney argued also at that hearing, referencing a trial in NSW that screened people as early as possible in their pregnancy, that questions about alcohol should be embedded into the electronic medical records:

When doctors or nurses asked the question, they were then prompted with advice as to what they should do. They should reassure the woman but tell them about the harms or they should provide a brief intervention, which has proven to be effective in helping women to stop drinking, or, if they were alcohol dependent, they should refer them to the appropriate service, which would come up on their screens.⁸⁹

5.92 A number of submissions to the inquiry discussed the role that stigma can play in the accurate disclosure of alcohol consumption, including:

- FARE cited evidence that many women are hesitant to disclose alcohol use during pregnancy to health professionals due to fear of judgment or potential involvement of child protection services.⁹⁰
- NIAA stated that deficit narratives, and experiences of stigma and shame, can deter women from disclosing AOD use during pregnancy and create barriers to accessing supports.⁹¹
- ACM commented that women often underreport current and past substance use with barriers to disclosure include fear of losing child custody, shame and stigma, and a perception of limited treatment options.⁹²

Diagnostic and support services (including out of home care)

5.93 The University of Sydney stated at the 14 April 2026 hearing for the inquiry that whilst screening for FASD in the general population was not viable, there would be value in screening at-risk populations including children going into foster or adoptive care, children in contact with the justice system, as well as any child who is identified as having neurodevelopmental problems at school.⁹³

5.94 The University of Sydney informed the Committee also at the hearing, in referencing its programs of work including supporting the NSW FASD assessment clinic and FASD centre for research excellence, that the majority of children in Australia with

⁸⁸ Distinguished Professor Elliot, University of Sydney, *Committee Hansard*, 14 April 2026, p. 47.

⁸⁹ Distinguished Professor Elliot, University of Sydney, *Committee Hansard*, 14 April 2026, p. 48.

⁹⁰ FARE, *Submission 80*, p. 12.

⁹¹ NIAA, *Submission 140 (47th Parliament)*, p. 7.

⁹² ACM, *Submission 15*, p. 4.

⁹³ Distinguished Professor Elliot, University of Sydney, *Committee Hansard*, 14 April 2026, p. 49.

FASD live in out-of-home care (about 80 per cent), and stressed the importance of screening and supports for the family in these situations:

When any child goes into care, child protection should be asking about prenatal alcohol and other drug exposures, should be looking at the maternity records and, really, should be providing the foster parents with as much support from early on as they can possibly give them. We know that children with good support will do better. We know that the brain is very malleable in early infancy and early childhood and that early interventions have much better effectiveness than interventions provided later.⁹⁴

- 5.95 FARE commented that specific resourcing was needed to properly assess and diagnose FASD and stated that this is challenging to do as it is 'complex, time-consuming and expensive'. FARE further remarked in its submission that this complexity results in many children with this disorder missing out on treatments and as a result being unable to reach their full potential. FARE argued that this will not change if there continues to be insufficient numbers of health professionals with the expertise to make a FASD diagnosis.⁹⁵

- 5.96 FASD Hub Australia also commented that a FASD diagnosis 'is a complex and time-consuming process, and a limited number of Australian health professionals feel competent or confident to complete an assessment'.⁹⁶ FASD Hub Australia further submitted in this regard:

Some people question why a diagnosis for FASD is important when there is a potential for stigma for the mother and child; there are too few services and supports for people with FASD; and children may already have alternative diagnoses such as ADHD or ASD.⁹⁷

- 5.97 FASD Hub Australia stated in its submission however that FASD sufferers and their families understood the importance of receiving an accurate diagnosis to help them understand their unique challenges and access the appropriate supports. FASD Hub Australia further noted in this context that there were high risks of poor outcomes such as school disengagement, mental ill-health and interactions with the justice system in the absence of this diagnosis at an early stage.⁹⁸

- 5.98 NOFASD highlighted the release of the *Australian Guide to the Diagnosis of FASD: 2025* as a 'major advancement in national diagnostic practice'. NOFASD submitted that these updated guidelines strengthen the evidence base for diagnosis, including clearer criteria, expanded guidance for assessment across the lifespan, and explicit expectations for multidisciplinary teams.⁹⁹ NOFASD further commented that the new guidelines also place renewed emphasis on culturally safe and trauma-informed

⁹⁴ Distinguished Professor Elliot, University of Sydney, *Committee Hansard*, 14 April 2026, p. 48.

⁹⁵ FARE, *Submission 87 (47th Parliament)*, p. 24.

⁹⁶ FASD Hub Australia, *Submission 184 (47th Parliament)*, p. 5.

⁹⁷ FASD Hub Australia, *Submission 184 (47th Parliament)*, p. 5.

⁹⁸ FASD Hub Australia, *Submission 184 (47th Parliament)*, p. 5.

⁹⁹ NOFASD, *Submission 44*, p. 3.

practice, reflecting contemporary understandings of the diverse contexts in which prenatal alcohol exposure occurs.¹⁰⁰

- 5.99 Whilst supporting this new diagnostic guide as a positive step in the right direction, NOFASD also commented that key challenges in accessing diagnostic and support services remained, stating:

Many families are still describing multi-year waitlists, regional inequities, and difficulties finding clinicians who are trained or confident in conducting FASD assessments. Access to diagnostic services remains uneven, and many individuals continue to experience delays or incomplete assessments.¹⁰¹

- 5.100 FARE also submitted on this issue:

There are insufficient diagnostic services available, and some jurisdictions, like the ACT, do not have diagnostic clinics. This means that families seeking a diagnosis, which involves months of appointments, often need to travel outside their area to access the services. Current waitlists for Australian children suspected of FASD are up to 3 years at some health services.¹⁰²

- 5.101 This was also the view expressed by the University of Sydney and the CICADA service, who stated that clinic capacity is limited nationally, with a 24 month wait list in NSW for the multi-disciplinary assessment required for a FASD diagnosis and submitted that 'diagnosis and treatment are delayed, inequitable and prevent optimal outcomes'.¹⁰³

- 5.102 The Parents Under Pressure program suggested, whilst supportive of continued specialist diagnostic and support clinics, that more bespoke models were also needed, including:

- Hub and spoke models supporting the extension of more efficient and less resource intensive diagnostic and assessment services is needed to service priority populations across regional and remote settings.
- Culturally appropriate screening and diagnostic support for special populations that include Aboriginal and Torres Strait Islander young people engaged in youth justice and child protection.¹⁰⁴

- 5.103 Workforce capability was also referenced by FARE as a barrier to engaging with services as well as leading to failed treatment attempts.¹⁰⁵

- 5.104 NOFASD noted in its submission that AOD services require training and tools that reflect contemporary neurodevelopmental knowledge and equip practitioners to work effectively with clients whose cognitive and communication profiles differ from typical

¹⁰⁰ NOFASD, *Submission 44*, p. 3.

¹⁰¹ NOFASD, *Submission 44*, p. 4.

¹⁰² FARE, *Submission 87 (47th Parliament)*, p. 24.

¹⁰³ University of Sydney and the CICADA Service, *Submission 134 (47th Parliament)*, p. 3.

¹⁰⁴ Griffith University: Parents Under Pressure, *Submission 195 (47th Parliament)*, p. 4.

¹⁰⁵ FARE, *Submission 80*, p. 8.

treatment assumptions. NOFASD further stated that ‘without systemic support for capacity-building, the AOD workforce will continue to encounter challenges in engagement, retention, and treatment outcomes for individuals with FASD’.¹⁰⁶

- 5.105 AADC informed the inquiry in its submission that one recent development to begin to address some of these issues was the launch in 2025 of the *FASD Informed Practice for the Australian Alcohol and Other Drug Workforce* course. AADC commented that it had codeveloped this course with NOFASD and the Canada FASD Research Network to support AOD professionals to better understand and respond to individuals diagnosed with, or possibly living with undiagnosed, FASD.¹⁰⁷
- 5.106 NOFASD reported in its submission that early engagement with this course indicated a strong demand from AOD practitioners seeking to build capability in recognising and responding to FASD within treatment settings.¹⁰⁸
- 5.107 FARE emphasised in its submission that people with FASD often face a wide range of associated health issues that require multidisciplinary care, yet many existing services are not equipped to provide the depth or breadth of support required. FARE stated that this results in fragmented care, delayed interventions, and significant unmet health and social needs.¹⁰⁹
- 5.108 NOFASD expressed similar views, reporting that structural gaps between the AOD, health, disability, education, child protection, and justice systems continue to undermine early intervention, resulting in missed opportunities for shared assessment pathways, joint planning, or coordinated support.¹¹⁰
- 5.109 FARE commented that services should be readily available, widely disseminated, and designed to respond to the complex and lifelong needs of people with FASD, including cognitive, physical, behavioural, sensory and mental health impacts.¹¹¹
- 5.110 FARE further stated that specialised support services remain limited, inconsistent, and unevenly distributed across regions. Acknowledging that people with FASD often face a wide range of associated health issues that require multidisciplinary care, FARE further noted many existing services are not equipped to provide the depth or breadth of support required, resulting in fragmented care, delayed interventions, and significant unmet health and social needs.¹¹²
- 5.111 Strengthening linkages between sectors was cited by NOFASD as essential to reduce repeated crisis responses, to limit service fragmentation, and to ensure that individuals with FASD receive consistent and disability-informed care across the lifespan.¹¹³

¹⁰⁶ NOFASD, *Submission 44*, p. 7.

¹⁰⁷ AADC, *Submission 11*, p. 1.

¹⁰⁸ NOFASD, *Submission 44*, p. 7.

¹⁰⁹ FARE, *Submission 80*, p. 8.

¹¹⁰ NOFASD, *Submission 44*, p. 7.

¹¹¹ FARE, *Submission 80*, p. 8.

¹¹² FARE, *Submission 80*, p. 8.

¹¹³ NOFASD, *Submission 44*, p. 7.

- 5.112 The FASD Hub was cited by the University of Sydney and the CICADA Service as an essential component of providing resources on alcohol use in pregnancy for professionals (AOD, education, justice), families and teachers respectively.¹¹⁴
- 5.113 In its submission to the inquiry, the FASD Hub reported that among the core content that it hosts is *The Australian Guide to the Diagnosis of FASD* and its associated eLearning course, over 150 other resources, over 400 Australian research papers and reports, and the FASD Hub Service Directory that is designed to link families and FASD-informed clinicians across Australia.¹¹⁵
- 5.114 The FASD Hub also indicated in its submission that its service is relied upon by health professionals, researchers, policymakers, educators, people living with FASD and their families, Aboriginal and Torres Strait Islander Communities, and women who are pregnant, planning pregnancy or breastfeeding.¹¹⁶

Interactions with the justice system

- 5.115 The increased risk of interactions with the justice system for people suffering from FASD was noted by multiple contributors to the inquiry.
- 5.116 FARE cited evidence that contact with the criminal justice system is more likely to occur for people who have experienced mental ill health and problematic AOD use. FARE further stated that equitable justice is not experienced by people with FASD, and that they are over-represented in the criminal justice system.¹¹⁷
- 5.117 NOFASD also cited evidence for sufferers of FASD being overrepresented in the criminal justice system and commented that cognitive and behavioural challenges associated with prenatal alcohol exposure, such as impulse control issues and difficulty understanding consequences, contribute to higher offending rates.¹¹⁸
- 5.118 The South Australian Council of Social Service (SACOSS) submitted that the negative outcomes associated with FASD in young people, such as placement in out-of-home care, negative peer association and early onset of substance use, caused earlier contact with the justice system in this population.¹¹⁹
- 5.119 FARE emphasised in this context that:

The complexity and clustering of risks and unmet needs of children with FASD increase the likelihood of future problems, including ongoing contact with criminal justice. This highlights the importance of early, coordinated and sustained help

¹¹⁴ University of Sydney and the CICADA Service, *Submission 134 (47th Parliament)*, pp. 3-4.

¹¹⁵ FASD Hub, *Submission 184 (47th Parliament)*, p. 1.

¹¹⁶ FASD Hub, *Submission 184 (47th Parliament)*, p. 1.

¹¹⁷ FARE, *Submission 87 (47th Parliament)*, p. 10.

¹¹⁸ NOFASD, *Submission 129 (47th Parliament)*, p. 8.

¹¹⁹ South Australian Council of Social Service (SACOSS), *Submission 58 (47th Parliament)*, p. 12.

for children with FASD and their families. There are no specific FASD screening tools that are recommended for use in Australia.¹²⁰

5.120 YETI submitted that preventing the incarceration of young people with complex health needs requires a multi-layered approach focused on early intervention, provision of comprehensive support services, and systemic reforms in health, education, and justice systems. YETI further suggested that combining early diagnosis, specialised interventions, justice reforms, and interagency collaboration can reduce the number of young people with FASD being incarcerated and better support their long-term health and social well-being.¹²¹

5.121 YETI further emphasised in its submission that justice system reforms are urgently needed due to the disproportionate criminalisation of young people affected by conditions such as FASD and that the federal government should be a lead advocate of these changes. YETI stated:

Implementing trauma or FASD-informed justice practices is crucial, including training for police, legal professionals, and judges to recognise the signs of trauma, drug and alcohol dependence, or FASD, and ensure non-punitive responses. Addressing human rights violations and overpolicing is essential for this approach to succeed.¹²²

5.122 The Parents Under Pressure Program commented in its submission that practice standards and guidelines should be developed across all jurisdictions to ensure 'equitable and appropriate incorporation of neurodevelopmental disabilities including FASD across youth justice and child protection'.¹²³ Parents Under Pressure noted also that 'FASD not only influences the likelihood of engagement in criminal activity, but also impairs the capacity of young people to understand how and why the justice system reacts as it does'.¹²⁴

5.123 FARE submitted that appropriate assessment and diagnostic pathways need to be available when concerns are identified for people involved with criminal justice systems. FARE highlighted that, currently, to access government support for people with disability in the criminal justice system, a person needs to have a type of disability that falls within the relevant definition, and to have certain impairments as a result of that disability.¹²⁵

5.124 FARE further stated on this issue that for people with FASD coming into contact with the criminal justice system, this can mean having to meet some criteria for cognitive impairment that do not match FASD characteristics:

There have been some notable efforts to establish FASD screening methods for people in justice settings. These include training correctional officials to identify

¹²⁰ FARE, *Submission 87 (47th Parliament)*, p. 24.

¹²¹ YETI, *Submission 51 (47th Parliament)*, p. 13.

¹²² YETI, *Submission 51 (47th Parliament)*, p. 6.

¹²³ Griffith University: Parents Under Pressure, *Submission 195 (47th Parliament)*, p. 4.

¹²⁴ Griffith University: Parents Under Pressure, *Submission 195 (47th Parliament)*, p. 10.

¹²⁵ FARE, *Submission 87 (47th Parliament)*, pp. 24-25.

FASD, and intensively screening all inmates via medical evaluation. However, there is only one early study where researchers empirically evaluated a screening tool in a correctional environment. There are no validated, standardised methods for screening offenders for FASD in Australia.¹²⁶

- 5.125 NOFASD submitted that a lack of understanding and specialised training within the justice system can lead to individuals with FASD not receiving appropriate assessments or accommodations during legal proceedings, leading to unjust outcomes.¹²⁷ NOFASD stated:

The justice system must implement training to recognize FASD, integrate FASD-specific assessments, and provide appropriate support, leading to fairer outcomes and improved rehabilitation.¹²⁸

- 5.126 The Parents Under Pressure Program highlighted work they had undertaken for the Queensland Department of Youth Justice in developing a 'Neurodevelopmental Framework and Practice Standards' for the Youth Justice System:

The Framework and Practice standards provides explicit instruction on the identification and management of young people with a range of neurodevelopmental disabilities involved in Youth Justice in recognition that FASD not only influences the likelihood of engagement in criminal activity but also impairs the capacity of young people to understand how and why the justice system reacts as it does (court processes, court orders, incarceration, therapeutic programs).¹²⁹

NDIS and school learning and development

- 5.127 The inquiry received evidence regarding the role of the education sector in addressing FASD through prevention, early intervention, and providing lifelong support. An anonymous submitter who has FASD commented that 'without appropriate recognition and accommodations, students with FASD are often misunderstood, mislabelled, and left to struggle in an education system not designed to understand or meet their needs'.¹³⁰
- 5.128 The Department of Education stated in its submission that FASD sufferers can experience acute challenges in school, and that this condition can cause issues with memory and attention, thereby lowering academic performance, in addition to difficulties with impulsivity that lead to problematic classroom behaviours.¹³¹
- 5.129 Evidence also received by the inquiry made reference to FASD often going undiagnosed leading to misunderstood behaviours, especially in a classroom setting,

¹²⁶ FARE, *Submission 87 (47th Parliament)*, pp. 24-25.

¹²⁷ NOFASD, *Submission 129 (47th Parliament)*, p. 8.

¹²⁸ NOFASD, *Submission 129 (47th Parliament)*, p. 8.

¹²⁹ Griffith University: Parents Under Pressure, *Submission 195 (47th Parliament)*, p. 10.

¹³⁰ Name withheld, *Submission 187 (47th Parliament)*, p. 9.

¹³¹ Department of Education, *Submission 126 (47th Parliament)*, p. 3.

and thus poor educational experiences.¹³² It was highlighted by the anonymous submitter with FASD in relation to schoolchildren with this condition that:

A classroom experience that could have been supportive and empowering often becomes a place of frustration and failure. As a result, they disengage from learning and often a bright child may ultimately drop out of school because the system becomes too hard to navigate without guidance. The lived experience of many individuals with FASD shows that early identification and the right supports—such as teacher aides, individualised learning plans, or accommodations for neurodiverse behaviours—can lead to completely different, positive outcomes.¹³³

5.130 The University of Sydney and the CICADA Service submitted that *Learning with FASD* was a program that provided resources to assist educators to understand and support children with FASD in both primary and secondary schools, and this was highlighted by several other submissions as being an effective evidence-based resource.¹³⁴

5.131 It was emphasised by the aforementioned anonymous submitter with FASD that:

Programs like *Learning with FASD* provide essential resources for teachers to understand the condition and implement strategies in the classroom. Teachers should be mandated to use these resources to ensure students with FASD are seen and supported, rather than punished for behaviours they cannot control.¹³⁵

FASD data collection

5.132 Earlier in the chapter it was noted that recent research had provided Australia with an estimated prevalence of FASD. Notwithstanding this recent development in terms of measured statistics on this condition, the inquiry received other evidence to suggest that ongoing work is required to improve current data collection capabilities with regard to FASD.

5.133 NOFASD argued strongly that a national prevalence study and improved surveillance remain critical to informing AOD policy, prevention efforts, and disability service planning. NOFASD additionally commented in this regard that without comprehensive population data, it remains difficult for governments to plan diagnostic services, allocate funding, build an appropriate workforce, or design targeted prevention strategies.¹³⁶

5.134 The FASD Australian Registry was highlighted by several submissions, including by Advanced Pharmacy Australia (APA), as an important component of FASD data

¹³² Name withheld, *Submission 187 (47th Parliament)*, p. 9.

¹³³ Name withheld, *Submission 187 (47th Parliament)*, pp. 9-10.

¹³⁴ University of Sydney and the CICADA Service, *Submission 134 (47th Parliament)*, p. 4.

¹³⁵ Name withheld, *Submission 187 (47th Parliament)*, p. 10.

¹³⁶ NOFASD, *Submission 44*, p. 5.

collection. APA submitted that the Registry monitors and records cases of FASD across Australia and has been effective in identifying at-risk populations and improving health outcomes for children exposed to alcohol in-utero. APA further advocated for an expansion of this Registry to 'provide a clearer picture of the national burden of FASD and support more uniform intervention strategies'.¹³⁷

Committee comment

- 5.135 The Committee acknowledges that there are many factors that lead to drinking alcohol whilst pregnant. A major driver of this problem in Australia however is a lack of awareness of the risks of this, not only by women who are pregnant or are seeking to become pregnant, their partners and families, but also among health professionals and the broader community. This is hugely concerning given the attitudes and behaviours around drinking and the high estimated prevalence of FASD in this country.
- 5.136 The multitude of challenges that fall upon people with FASD, parents, carers, partners and other family and support are very confronting. The impact of stigma on this is also significant due to its on-going effects on the life journey of an affected individual.
- 5.137 It was pleasing during the inquiry to see positive results from current FASD awareness campaigns, such as those targeting Aboriginal and Torres Strait Islander and other at-risk populations. The outcomes from these campaigns highlight their effectiveness, but continued implementation is required and gaps remain.
- 5.138 The evidence that some in the health profession were providing either no or conflicting advice on safe thresholds for drinking whilst pregnant was astounding. The Committee believes that healthcare providers need to have evidence-based non-judgmental conversations that can reduce the prevalence and support earlier assessment and diagnosis of FASD.
- 5.139 Consistent with this view, sectors that will necessarily have higher interactions with people with FASD must be upskilled, as an urgent priority, to improve their ability to understand this condition. This includes the health, disability, education, child protection, and justice systems. Only then can they provide the required level of care and support with the aim of reducing fragmentation, improving outcomes and strengthening linkages.
- 5.140 The importance of receiving a diagnosis of FASD as early as possible in an affected child is clear, but the issues that lead to FASD diagnostic delays are very troubling, including poor access to services, a low capability among health professionals, and extended wait times to receive professional help. There needs to be equitable access to diagnostic services, and adequate training and resources for health care providers.

¹³⁷ Advanced Pharmacy Australia, *Submission 2*, p. 10.

- 5.141 The Committee understands that universal screening of children for FASD is not required, or feasible, but targeted screening among at-risk populations including youth justice and out of home care populations must now become a core part of Australia's health policy. FASD must also be approached from a strengths-based approach and a key aspect of this will be the implementation of FASD-informed practices.
- 5.142 The Committee's considered views and recommendations for reducing the incidence of FASD, and responding more effectively to those that are affected, are outlined in more depth in chapter 7. The prevalence in Australia of this entirely preventable condition is simply unacceptable.



6. Priority populations

- 6.1 The *National Drug Strategy 2017-2026 (National Drug Strategy)* identifies a number of priority populations that experience, or are at increased risk of experiencing, disproportionate alcohol and other drug (AOD) related harms. These include Aboriginal and Torres Strait Islander people, rural and regional populations, culturally and linguistically diverse (CALD) populations, younger and older people, women, and lesbian, gay, bisexual, transgender, intersex, queer, asexual and other sexually or gender diverse (LGBTIQA+) people.¹ While the National Drug Strategy refers to LGBTI as a priority population, this report considers the broader LGBTIQA+ cohort.
- 6.2 This chapter examines the barriers faced by these populations that can compound harmful AOD use, and prevent equitable AOD service delivery to all Australians, and whether prevention, treatment and harm reduction initiatives are effective for these priority populations.

Equity and effectiveness of services

- 6.3 Evidence to the inquiry suggested that there is not currently sufficient or equitable access to AOD services in Australia, including for priority populations. Various submitters indicated that only 56 per cent of the demand for AOD treatment was being met and that half a million Australians were not accessing AOD treatment despite being in need.² Research cited by the Network of Alcohol and other Drug Agencies (NADA) in its submission indicated that in NSW alone, there were 101 773 people who did not receive AOD treatment despite being suitable for and wanting treatment.³
- 6.4 The Committee heard from multiple witnesses at public hearings that an overrepresented portion of the people not receiving access to AOD services are those in priority populations, i.e., Australians who often experience intersecting issues such as mental health, housing insecurity, family violence, disability and justice system contact.⁴ Odyssey Victoria submitted that these inequities are shaped

¹ Department of Health, Disability and Ageing, *National Drug Strategy 2017–2026*, pp. 26-29.

² National Centre for Youth Substance Use Research (NCYSUR), *Submission 120 (47th Parliament)*, p. 7, Professor Dan Lubman AM, Executive Clinical Director, Turning Point, Eastern Health; and Director, Monash Addiction Research Centre, *Committee Hansard*, 29 October 2024, p. 9.

³ Network of Alcohol and other Drug Agencies (NADA), *Submission 66*, p. 4.

⁴ Mr Dominic Ennis, General Manager, Quality and Service Development, Youth Support and Advocacy Service, *Committee Hansard*, 28 October 2024, p. 19; Mr David Kelly, Executive Director, Programs, Odyssey House NSW, *Committee Hansard*, 27 March 2026, p. 9.

by factors such as geography, stigma, a lack of cultural safety, workforce shortages and the limited availability of tailored models of care.⁵

- 6.5 At the public hearing on 27 March 2026, Odyssey Victoria detailed these factors and the impact they have on health outcomes:

...equity of access remains a critical failure point across Australia. We know that Aboriginal and Torres Strait Islander people, families with children, culturally and linguistically diverse communities, regional people and those identifying as LGBTQIA continue to face barriers to care. We know that stigma, discrimination, the exclusionary practices of other systems, such as even mental health, family violence services, hospital and health, and a lack of culturally safe specialist programs all undermine people's experiences of feeling safe and therefore having the relevant health outcomes.⁶

- 6.6 The Salvation Army said of the importance of equity of local community access in its submission:

Our services see that when people have access to appropriate and flexible community treatment and supports, they seek treatment earlier and can remain connected to their community and supports during treatment.⁷

- 6.7 The Australian Alcohol and other Drugs Council (AADC) submitted that while existing services provide good support, there 'aren't enough of them and they are not adequately and sustainably funded to meet increasing community demand'.⁸

- 6.8 The Queensland Injectors Health Network (QulHN) shared concerns at the 30 October 2024 public hearing around the lack of services and funding, stating that a lack of resources resulted in an inability for AOD services to meet demand. QulHN stated in this regard that this inability then results in extensive wait lists which themselves become a disincentive for people to seek AOD treatment.⁹

- 6.9 NADA stated in its submission that priority populations can have difficulty accessing mainstream health services and that increased funding should be directed to initiatives for these populations to enable services that are delivered by a workforce comprised of those with living and lived experience and from priority populations.¹⁰

- 6.10 Legal Aid NSW shared this view in its submission by stating its support for initiatives that assist services to address the needs of priority populations and commenting that 'health, treatment and rehabilitation facilities must be culturally appropriate, respectful

⁵ Dr Stefan Gruenert, Chief Executive Officer, Odyssey Victoria, *Committee Hansard*, 27 March 2026, p. 8.

⁶ Dr Gruenert, Odyssey Victoria, *Committee Hansard*, 27 March 2026, p. 8.

⁷ The Salvation Army, *Submission 68 (47th Parliament)*, p. 22.

⁸ Australian Alcohol and other Drugs Council (AADC), *Submission 11*, p. 3.

⁹ Mr Geoffrey Davey, Chief Executive Officer, Queensland Injectors Health Network, *Committee Hansard*, 30 October 2024, p. 9.

¹⁰ NADA, *Submission 66*, p. 12.

and safe for individuals with additional vulnerabilities seeking access to these services'.¹¹

- 6.11 Evidence to the inquiry further indicated how culturally safe care and community support can address the inequity of access to AOD services, particularly in relation to Aboriginal and Torres Strait Islander people. Association of Alcohol and other Drug Agencies NT (AADANT) commented at the public hearing on 15 April 2026 that the simple existence of services did not guarantee care, and further stated that:

Equity of access is not just about whether a service exists on paper; it's also about whether a person can access an option that is psychologically safe, gender safe, culturally safe and therapeutically appropriate.¹²

- 6.12 The inquiry received substantial evidence also regarding equity issues for rural and remote communities. The National Rural Health Alliance (NRHA) submitted that small rural towns have 55 per cent fewer healthcare professionals than major cities and that the prevalence of allied health professionals declines with increasing remoteness.¹³
- 6.13 The NRHA further submitted that in 2022-23, just 5 per cent of AOD treatment services were in rural and remote Australia and delivered only 2.3 per cent of all treatment episodes.¹⁴ NRHA additionally commented that this is despite the rate of clients accessing services being the highest in remote and very remote areas.¹⁵
- 6.14 The Alcohol and Drug Foundation (ADF) stated in its submission that the variability in access to AOD treatment and harm reduction services was a contributing factor in the significant disparities in health outcomes between major cities and regional and remote areas (discussed further later in this chapter).¹⁶ The Australian Nursing and Midwifery Federation (ANMF) submitted in this regard that this limited number of specialists and treatment options in more remote regions results in existing services not meeting demand and people seeking treatment traveling large distances to metropolitan centres (increasing demand on them) or not receiving treatment at all.¹⁷
- 6.15 The Matilda Centre for Research in Mental Health and Substance Use (The Matilda Centre) provided evidence to the inquiry that the geographical distances between clients and AOD services, and the time taken to travel to them, is a unique challenge faced by rural and remote communities.¹⁸ The Queensland PHN Alcohol and Other Drugs Network (QPAODN) stated in its submission on this issue that this is in

¹¹ Legal Aid NSW, *Submission 18 (47th Parliament)*, p. 12.

¹² Mrs Stephanie Holmes, Executive Officer, Association of Alcohol and Other Drug Agencies NT (AADANT), *Committee Hansard*, 15 April 2026, p. 27.

¹³ National Rural Health Alliance (NRHA), *Submission 62*, pp. 6-7.

¹⁴ NRHA, *Submission 62*, pp. 6-7.

¹⁵ Australian Institute of Health and Welfare (AIHW), *Submission 142 (47th Parliament)*, p. 9.

¹⁶ Alcohol and Drug Foundation (ADF), *Submission 77 (47th Parliament)*, p. 10.

¹⁷ Australian Nursing and Midwifery Federation (ANMF), *Submission 53*, p. 4.

¹⁸ The Matilda Centre for Research in Mental Health and Substance Use, University of Sydney (The Matilda Centre), *Submission 24 (47th Parliament)*, p. 12.

addition to higher operational costs resulting from transportation, infrastructure maintenance and staffing.¹⁹

- 6.16 While evidence to the inquiry emphasised that telehealth was not a substitute for face-to-face practice, NRHA recognised it as a supporting option that could improve efficiency and accessibility for remote clients.²⁰ Different witnesses at various public hearings for the inquiry cited telehealth use cases for rural and remote clients, such as nurse practitioners providing prescriptions for clients with opioid dependence, alcohol withdrawal services and psychiatric appointments.²¹
- 6.17 Advanced Pharmacy Australia said of the benefits telehealth would provide to rural clients:
- Expanding telehealth services can significantly improve access to AOD care in rural, remote and regional areas, allowing patients to receive counselling, treatment, and harm reduction services without the need for extensive travel. Telehealth can also facilitate consultations with specialists and provide a bridge to vital services like obtaining prescriptions and medication advice.²²
- 6.18 As highlighted also in Chapter 4, Hello Sunday Morning indicated its support for the role digital health services such as apps and online interventions can play in addressing AOD use. Hello Sunday Morning commented that, in addition to helping reducing barriers such as cost, waitlists and stigma, these services can assist those within rural communities overcome the need to travel significant distances to access in-person care.²³
- 6.19 While evidence to the inquiry suggested that telehealth may have a role to play in improving rural and regional equity, it also suggested that the lack of suitable staff was a large factor in rural services not meeting demand. Drug ARM described recruitment for regional and rural as an ‘ongoing challenge’ and said that ‘ineffective service agreement indexing has left not-for-profit service providers unable to attract suitably qualified staff’ which results in long wait lists and gaps in service.²⁴ The causes for these shortages are further explored later in this chapter.
- 6.20 At the 14 April 2026 public hearing, the Alcohol and Other Drug Consumer and Community Coalition (AODCCC) stated that these equity issues for rural and remote communities accessing AOD services have a compounding effect on Aboriginal and Torres Strait Islander people. AODCCC further commented at this hearing that, in addition to geographical and service availability, Aboriginal and Torres Strait Islander

¹⁹ Queensland PHN Alcohol and Other Drugs Network (QPAODN), *Submission 104 (47th Parliament)*, p. 3.

²⁰ Ms Susanne Tegen, Chief Executive, NRHA, *Committee Hansard*, 27 March 2026, p. 23.

²¹ Professor Suzanne Nielsen, Victorian Branch Committee Member, Advanced Pharmacy Australia, *Committee Hansard*, 27 March 2026, p. 23; Dr Elizabeth Moore, President, Royal Australian and New Zealand College of Psychiatrists (RANZCP), *Committee Hansard*, 28 October 2024, p. 4; Dr Paul Grinzi, Member, RACGP Specific Interest Group—Addiction Medicine, Royal Australian College of General Practitioners (RACGP), *Committee Hansard*, 29 October 2024, p. 25.

²² Advanced Pharmacy Australia, *Submission 82 (47th Parliament)*, p. 14.

²³ Hello Sunday Morning, *Submission 38 (47th Parliament)*, pp. 3-4.

²⁴ Drug ARM, *Submission 44 (47th Parliament)*, pp. 1-2.

people have poorer equity to services resulting from a lack of culturally safe care and stigma.²⁵

- 6.21 The Aboriginal Health and Medical Research Council (AHMRC) of NSW also commented on increased AOD service inequities faced by Aboriginal and Torres Strait Islander people:

Geographic isolation and a lack of transportation available to rehabilitation hubs further compounds the disadvantage experienced by Aboriginal communities. Every effort should be made to provide equitable access to AOD services, ensuring that culturally appropriate and safe transport options are available. By prioritising culturally safe practices and addressing logistical barriers like transportation, service providers can make meaningful strides toward closing the gap in health outcomes for Aboriginal communities.²⁶

- 6.22 While not discrediting the need to address regional inequity, the Institute for Urban Indigenous Health stated that AOD service inequities exist also for Aboriginal and Torres Strait Islander people in major cities and inner-regional centres. The Institute submitted to the inquiry that ‘these areas are where the majority of Aboriginal and Torres Strait Islander people live and where, despite proximity to mainstream services, the significant disparities in AOD service access and outcomes persists’.²⁷

- 6.23 The Salvation Army also argued for the importance of tailored community treatment:

Without access to the most appropriate type of treatment, people are less likely to engage in treatment early or at all, or they may receive treatment that does not meet their needs. Our services see that when people have access to appropriate and flexible community treatment and supports, they seek treatment earlier and can remain connected to their community and supports during treatment.²⁸

- 6.24 The New South Wales Council for Civil Liberties commented that ensuring harm reduction services such as needle exchange programs and opioid substitution therapy are culturally safe and accessible in all regions is vital to reducing drug-related harm in Australia.²⁹

- 6.25 Not-for-profit service providers such as Drug ARM informed the inquiry that equity issues experienced by CALD communities were caused by non-English speaking clients being turned away due to a lack of funding for interpreter services.³⁰

²⁵ Mr Ben Kane, Lived Experience Representative and Member, Alcohol and Other Drug Consumer and Community Coalition (AODCCC), *Committee Hansard*, 14 April 2026, pp. 4-5.

²⁶ Aboriginal Health and Medical Research Council of NSW (AHMRC), *Submission 69 (47th Parliament)*, p. 3.

²⁷ Institute for Urban Indigenous Health, *Submission 155 (47th Parliament)*, p. 4.

²⁸ The Salvation Army, *Submission 68 (47th Parliament)*, p. 22.

²⁹ New South Wales Council for Civil Liberties, *Submission 28 (47th Parliament)*, p. 6.

³⁰ Drug ARM, *Submission 44 (47th Parliament)*, p. 1.

Impacts on Aboriginal and Torres Strait Islander communities

AOD impact and trends

- 6.26 The evidence to the inquiry consistently stated that Aboriginal and Torres Strait Islander people experience a disproportionately high burden of AOD harm. This evidence from multiple contributors further argued that the uneven distribution of AOD-related harms is a result of intersecting social and economic inequalities, including poverty, systemic racism, the enduring effects of colonisation, dispossession and intergenerational trauma.³¹
- 6.27 The submission from the National Aboriginal Community Controlled Health Organisation (NACCHO) detailed some of the risks of harmful AOD use:
- Medical conditions linked to AOD include heart disease, stroke, lung cancer, liver disease, diabetes, obesity, oral disease and blood-borne viruses. AOD use has been identified as a significant risk factor for suicide, particularly in Aboriginal and Torres Strait Islander communities.³²
- 6.28 ADF submitted that Aboriginal and Torres Strait Islander people experience this disproportionate AOD burden despite a greater proportion being more likely to abstain from alcohol and stopping using illicit drugs than the rest of the Australian population.³³
- 6.29 NACCHO further stated in its submission that in 2018, alcohol-use disorders accounted for 4.4 per cent of the total disease burden among Aboriginal and Torres Strait Islander people, and alcohol use had contributed to an estimated 10.5 per cent of their total disease burden.³⁴
- 6.30 Uniting NSW.ACT commented on this issue that the age-adjusted burden attributable to illicit drug use was 3.7 times higher for Aboriginal and Torres Strait Islander people than for the rest of the population, and that Aboriginal and Torres Strait Islander people were six times more likely to receive treatment for AOD use.³⁵
- 6.31 The inquiry evidence from various submissions also indicated that illicit drug use was the second greatest contributor to the total disease burden for Aboriginal and Torres Strait Islander people aged between 15 and 44 years and that, in 2022, the rate of unintentional drug-related deaths was more than three and half times higher than non-Aboriginal and Torres Strait Islander people.³⁶

³¹ Australian Association of Psychologists incorporated (AAPi), *Submission 6 (47th Parliament)*, p. 2; ADF, *Submission 77 (47th Parliament)*, p. 9; Uniting Vic.Tas, *Submission 165 (47th Parliament)*, p. 16.

³² National Aboriginal Community Controlled Health Organisation (NACCHO), *Submission 145 (47th Parliament)*, p. 8.

³³ ADF, *Submission 77 (47th Parliament)*, p. 9.

³⁴ NACCHO, *Submission 145 (47th Parliament)*, p. 8.

³⁵ Uniting NSW.ACT, *Submission 79 (47th Parliament)*, p. 10.

³⁶ Uniting NSW.ACT, *Submission 79 (47th Parliament)*, p. 10; Australian College of Rural and Remote Medicine (ACRRM), *Submission 93 (47th Parliament)*, p. 3.

- 6.32 In its submission to the inquiry, Gayaa Dhuwi stated that in 2023-24, Aboriginal and Torres Strait Islander people accounted for 18 per cent of those receiving treatment or support for their own or someone else's AOD use, despite accounting for 3.2 per cent of the Australian population in 2021.³⁷ In collecting data on those who accessed AOD treatment services, NADA stated that 25 per cent of reported episodes were for Aboriginal and Torres Strait Islander people.³⁸

Governance

- 6.33 The inquiry received indications from a number of stakeholders that there are concerns with the lack of a drug strategy tailored for Aboriginal and Torres Strait Islander people. ADF noted in its submission that the *National Aboriginal and Torres Strait Islander Peoples' Drug Strategy 2014-2019*, a sub-strategy of the National Drug Strategy, had lapsed in 2019 and a new plan has not since been established.³⁹
- 6.34 ADF also submitted that the National Drug Strategy recognises the greater impact of AOD use on priority populations and the importance of meaningful partnership with them, but that there was not a targeted strategy for any of these cohorts.⁴⁰ ADF recommended that the future National Drug Strategy has appropriately resourced sub-strategies similar to the expired National Aboriginal and Torres Strait Islander Peoples' Drug Strategy that addresses AOD harm among First Nations people.⁴¹
- 6.35 In addition to the lapsed strategy, the inquiry received evidence of missed opportunities associated with no longer having Aboriginal and Torres Strait Islander involvement in the development of national policies and programs relating to AOD use. Various submissions pointed also to the defunding of the National Indigenous Drug and Alcohol Committee (NIDAC), a body comprised of Indigenous experts and health professionals that had been formed to provide advice to the Commonwealth Government on how to address AOD issues in Aboriginal and Torres Strait Islander communities.⁴²
- 6.36 NACCHO submitted that since the defunding of NIDAC, Aboriginal and Torres Strait Islander people 'have no direct voice to government in relation to AOD issues', while the Victorian Alcohol and Drug Association (VADA) referred to its defunding as 'a lost opportunity to improve cultural safety in health services to address the impacts of AOD for Aboriginal and Torres Strait Islander communities'.⁴³
- 6.37 Submitters stated in this regard that governance structures such as NIDAC were integral to the development and implementation of national drug strategies and 'ensured a better coordinated approach to system development and funding for the

³⁷ Gayaa Dhuwi, *Submission 78 (47th Parliament)*, p. 3.

³⁸ NADA, *Submission 66*, p. 12.

³⁹ ADF, *Submission 77 (47th Parliament)*, p. 14.

⁴⁰ ADF, *Submission 77 (47th Parliament)*, p. 14.

⁴¹ ADF, *Submission 77 (47th Parliament)*, p. 6.

⁴² AADC, *Submission 11*, p. 5; Queensland Network of Alcohol and other Drugs Agencies, *Submission 75 (47th Parliament)*, p. 10.

⁴³ Victorian Alcohol and Drug Association (VADA), *Submission 114 (47th Parliament)*, p. 7; NACCHO, *Submission 145 (47th Parliament)*, p. 6.

AOD sector at both Commonwealth and State/Territory levels'.⁴⁴ In discussing its views regarding an overhaul of the national governance framework for the AOD sector, AADC called for the re-establishment of NIDAC.⁴⁵

Culturally safe care

- 6.38 NACCHO submitted to the inquiry that AOD policy for Aboriginal and Torres Strait Islander people must be culturally safe and trauma-informed if it is to be most effective.⁴⁶
- 6.39 The Australian Association of Psychologists incorporated (AAPI) stated in its submission that components of culturally safe care include a focus on Aboriginal and Torres Strait Islander cultural engagement, restoring cultural connections, tailored resources, support delivered on Country and involving the local community. AAPI further submitted that culturally safe care creates a stronger patient-clinician relationship and improves the effectiveness of care.⁴⁷
- 6.40 Evidence to the inquiry from AAPI additionally cited the benefits of culturally safe care being driven by community members, leaders or Elders.⁴⁸ The Southern Aboriginal Corporation also emphasised the importance of this culturally safe care being delivered by Aboriginal community controlled organisations (ACCOs):
- ...the lack of cultural safety inherent in service delivery to Aboriginal people by non-Aboriginal Community Controlled Organisations creates barriers to access for Aboriginal communities across the region. Research into the lived experiences of Aboriginal Australians in AOD treatment services argues that cultural safety is imperative.⁴⁹
- 6.41 The inquiry heard from Uniting NSW.ACT that ACCOs possess local knowledge, expertise and connections with the community, making them an ideal candidate for culturally safe care.⁵⁰ AADANT submitted in this regard that ACCO-delivered, culturally safe service models and their benefits are rooted in Aboriginal and Torres Strait Islander relationships, with health being interpersonal and community-based.⁵¹
- 6.42 AHMRC commented that AOD rehabilitation programs run by the Glen Centre, a NSW-based ACCO, was an example of those 'based in First Nations values' that predominantly support clients in their home or local community, making the community itself the 'treatment facility'.⁵² The Glen Group submitted itself to the inquiry that its programs based on the Aboriginal Drug and Alcohol Residential

⁴⁴ NACCHO, *Submission 145 (47th Parliament)*, p. 6; AADC, *Submission 11*, p. 11; Self Help Addiction Resource Centre (SHARC), *Submission 79*, p. 15.

⁴⁵ AADC, *Submission 11*, p. 26.

⁴⁶ NACCHO, *Submission 145 (47th Parliament)*, p. 7.

⁴⁷ AAPI, *Submission 6 (47th Parliament)*, p. 4.

⁴⁸ AAPI, *Submission 6 (47th Parliament)*, pp. 4-5.

⁴⁹ Southern Aboriginal Corporation, *Submission 3 (47th Parliament)*, p. 4.

⁵⁰ Uniting NSW.ACT, *Submission 79 (47th Parliament)*, pp. 5-6.

⁵¹ AADANT, *Submission 26 (47th Parliament)*, p. 9.

⁵² AHMRC, *Submission 69 (47th Parliament)*, p. 4.

Rehabilitation Network are outcomes-focused, and that this meant they prioritise life skills in addition to withdrawal management, and ensure individuals are equipped for reintegration into society and their community.⁵³

- 6.43 In recognising the benefits of ACCO-delivered care, the National Indigenous Australians Agency (NIAA) stated at the public hearing on 12 March 2026 that the Commonwealth Government's support for a community-controlled sector involved working in partnership in the design and delivery of ACCOs, rather than working separately in isolation.⁵⁴
- 6.44 Uniting NSW.ACT also stated in its submission that culturally safe care does not have to be delivered solely by ACCOs and that larger organisations can improve capacity by providing infrastructure support while ACCOs deliver the service.⁵⁵
- 6.45 NACCHO submitted in this same context that embedding cultural safety in mainstream institutions is a Priority Reform of the National Agreement on Closing the Gap and would in part, help address the structural drivers of AOD misuse.⁵⁶
- 6.46 The inquiry also learned of some of the new and innovative ways of delivering culturally safe care. The Centre for Alcohol Policy Research pointed to their collaboration with the Aboriginal Drug and Alcohol Council (SA) Aboriginal Corporation to develop a digital health tool to help Aboriginal and Torres Strait Islander peoples describe their alcohol consumption. As discussed in Chapter 4, this 'Grog App' tool utilises voiceovers in traditional languages and provides an avenue where people can talk about their drinking habits, reducing stigma or fear around talking about drinking and providing an intervention based off their responses'.⁵⁷
- 6.47 QPAODN cited data in its submission indicating that the non-Indigenous health workforce also had a role to play in delivering culturally safe care:
- Data from Western Queensland PHN's Cultural Competency Framework emphasises the importance of continuous cultural training for all health workers, especially those serving Indigenous populations. However, rural providers often lack the funding required to support this ongoing professional development. This results in lower staff retention and limited capacity to offer culturally responsive care, further contributing to poor health outcomes for Aboriginal and Torres Strait Islander populations.⁵⁸
- 6.48 NADA detailed the results of cultural competence improvement processes it had undertaken and how its AOD service delivery had measurably improved:

⁵³ The Glen Group, *Submission 118 (47th Parliament)*, p. 1.

⁵⁴ Ms Deborah Fulton, Acting Deputy Chief Executive Officer, Policy and Programs, National Indigenous Australians Agency (NIAA), *Committee Hansard*, 12 March 2026, p. 10.

⁵⁵ Uniting NSW.ACT, *Submission 79 (47th Parliament)*, pp. 5-6.

⁵⁶ NACCHO, *Submission 145 (47th Parliament)*, p. 5.

⁵⁷ Centre for Alcohol Policy Research, La Trobe University, *Submission 21 (47th Parliament)*, pp. 2-3.

⁵⁸ QPAODN, *Submission 104 (47th Parliament)*, p. 6.

The evaluation demonstrated that all participating services achieved improved cultural competence, from baseline audits, with improvements maintained at two year follow up audit. Services also showed an increase in the proportion of episodes of care provided to Aboriginal people, with an average increase of 11 per cent and a number showed increase in the number of completed episodes by Aboriginal people. Other outcomes included enhanced relationships with local Aboriginal communities and services and increase in employment of AOD workers identifying as Aboriginal.⁵⁹

Workforce

- 6.49 NIAA stated in its submission that the need to provide culturally safe care is intertwined with the need to grow the Aboriginal and Torres Strait Islander AOD workforce. NIAA further remarked in this regard that if this workforce grows and strengthens, higher quality AOD treatment would be provided to clients and better health outcomes are achieved for Aboriginal and Torres Strait Islander people.⁶⁰
- 6.50 The Australian Medical Association (AMA) described the current Aboriginal and Torres Strait Islander AOD workforce as ‘underdeveloped’ and stated that although 17 per cent of AOD-treatment clients in Australia are Aboriginal and Torres Strait Islander, just 6 per cent of the AOD workforce is.⁶¹
- 6.51 AAPI submitted that Aboriginal and Torres Strait Islander clients prefer to receive care from an AOD worker who is also Aboriginal and Torres Strait Islander, further stating that if a greater focus is placed on growing the Aboriginal and Torres Strait Islander workforce, engagement with AOD services may improve and the reach and access to community-based AOD treatment would increase.⁶²
- 6.52 NACCHO also supported growing the Aboriginal and Torres Strait Islander workforce in its submission, particularly within Aboriginal Community Controlled Health Organisations (ACCHOs):

In our consultations, ACCHOs have overwhelmingly expressed the need for support to grow their workforce to address unmet service needs, and for training to support and sustain that workforce. The current piecemeal funding of programs across the spectrum of health and care makes it difficult for services to attract and retain staff and may impact patient continuity of care. ACCHOs engage local community members as part of their workforce, and therefore are an effective and efficient investment to improve both community health and local employment outcomes.⁶³

⁵⁹ NADA, *Submission 66*, p. 11.

⁶⁰ NIAA, *Submission 140 (47th Parliament)*, p. 8.

⁶¹ Australian Medical Association (AMA), *Submission 80 (47th Parliament)*, p. 4.

⁶² AAPI, *Submission 6 (47th Parliament)*, pp. 4-5.

⁶³ NACCHO, *Submission 145 (47th Parliament)*, p. 13.

- 6.53 NIAA commented at the public hearing on 12 March 2026 that a barrier to creating a sufficient workforce in this respect was the difficulty in attracting, retaining and ensuring sufficient development for staff.⁶⁴ Appearing at the 14 April 2026 hearing, NT Health also recognised this issue and described its efforts to address it:

In the Territory we recognise that we actually have an untapped workforce that exists out there in remote communities. We're taking an approach of looking at how we can better create jobs that are more relevant and more appropriate, recognising the skills of local people, creating better pathways into these jobs and recognising better ways of training people. That's taking into consideration place based training and microcredentialing, where learning is conducted in microsessions.⁶⁵

- 6.54 The importance of stable and coordinated funding towards the Aboriginal and Torres Strait Islander AOD workforce was repeatedly emphasised in submissions to the inquiry.⁶⁶ The Royal Australian and New Zealand College of Psychiatrists (RANZCP) detailed the areas where it believed this funding should be directed to build current and future capability for Aboriginal and Torres Strait Islander AOD services:

To develop and maintain a skilled Aboriginal and Torres Strait Islander AOD workforce, there is a pressing need for secure funding, job security, pay equity and ongoing opportunities for training and support. Providing culturally informed care to the AOD workforce, alongside culturally relevant tertiary and vocational qualifications, placements, traineeships and scholarships for Aboriginal students, is vital to developing a workforce adept in delivering culturally appropriate AOD services that respect Indigenous methodologies.⁶⁷

- 6.55 NIAA commented that Aboriginal and Torres Strait Islander AOD workers were often required to hold multiple roles and support clients with complex needs. NIAA further stated in its submission that in addition to workforce development and better support and remuneration, strategies to avoid burnout amongst the existing workforce were needed.⁶⁸

Rural and remote communities access challenges

Outcomes

- 6.56 Evidence to the inquiry indicated that regional and remote communities experience higher AOD use and AOD-related harms. NRHA stated in its submission that there was:

⁶⁴ Ms Fulton, NIAA, *Committee Hansard*, 12 March 2026, p. 10.

⁶⁵ Ms Ameina Brunker, Director, Community Led Harm Reduction Unit, NT Health, *Committee Hansard*, 14 April 2026, p. 29.

⁶⁶ Drugs and Alcohol Services South Australia, *Submission 177 (47th Parliament)*, p. 5; ANMF, *Submission 53*, p. 7; RACGP, *Submission 75*, p. 5.

⁶⁷ RANZCP, *Submission 19 (47th Parliament)*, p. 5.

⁶⁸ NIAA, *Submission 140 (47th Parliament)*, p. 8.

- higher AOD use among individuals aged 14 and over in remote communities
 - a higher prevalence of alcohol-related harm in rural and remote areas
 - the highest rate of drug-related hospitalisations in remote and very remote areas
 - an overrepresentation in unintentional drug-induced deaths in rural and remote areas.⁶⁹
- 6.57 ADF stated that these higher rates of use and harm occur in a broader context of poorer health outcomes for people living in regional and remote Australia and remarked also that people living in rural and remote regions are more likely to experience negative health outcomes compared to those in major cities.⁷⁰
- 6.58 ADF further submitted that regional and remote communities had higher rates of chronic conditions and burden of disease and that the 'significant disparities in health outcomes between major cities and regional and remote areas can also be attributed to variability in access to treatment and harm reduction services'.⁷¹
- 6.59 The Matilda Centre indicated in its submission that these disparities and poor access to treatment make AOD prevention even more critical for rural and regional Australians, stating that existing prevention and promotion programs are not tailored for the unique experiences of living in regional areas such as longer travel times and higher rates of isolation.⁷²

Workforce

- 6.60 A number of submitters commented that the disparity in health outcomes outside of the major capitals was linked to poor access to services and a lack of rural healthcare workers.⁷³ The Alcohol, Tobacco and other Drugs Council (Tasmania) (ATDC Tasmania) stated that a lack of GPs in rural areas resulted in residents receiving delayed care and subsequently exacerbating health issues.⁷⁴
- 6.61 ATDC Tasmania further submitted that this lack of GPs also contributed to reduced access to bulk billing and said this was particularly prevalent in rural Tasmania, again creating barriers to care. ATDC Tasmania called for 'targeted funding, enhanced workforce support, and comprehensive care models that prioritise accessibility in rural, regional and remote areas' to address these workforce shortages and regional inequity.⁷⁵

⁶⁹ NRHA, *Submission 62*, p. 3.

⁷⁰ ADF, *Submission 77 (47th Parliament)*, p. 10.

⁷¹ ADF, *Submission 77 (47th Parliament)*, p. 10.

⁷² The Matilda Centre, *Submission 24 (47th Parliament)*, p. 12.

⁷³ NRHA, *Submission 90 (47th Parliament)*, p. 6, ACRRM, *Submission 93 (47th Parliament)*, p. 3, Royal Australasian College of Physicians, *Submission 96 (47th Parliament)*, p. 8.

⁷⁴ Alcohol, Tobacco and other Drugs Council (Tasmania) (ATDC Tasmania), *Submission 22 (47th Parliament)*, p. 4.

⁷⁵ ATDC Tasmania, *Submission 22 (47th Parliament)*, p. 5.

- 6.62 Advanced Pharmacy Australia stated in its submission that limited expertise and uneven access to harm reduction compounded AOD workforce issues even when rural clients were able to access these services:

Even when patients can access AOD services, there is a lack of local expertise and limited awareness of available harm reduction initiatives and management programs. These gaps mean that many individuals do not benefit from potentially life-saving interventions such as opioid replacement therapy or needle exchange programs. The lack of awareness about these programs, compounded by a shortage of trained, skilled staff, leads to fragmented care and inconsistent treatment. Over time, this contributes to poorer health outcomes for rural populations and results in higher long-term costs for the healthcare system due to the need for more complex and expensive treatments in the future.⁷⁶

- 6.63 The inquiry evidence further indicated that workforce challenges in regional, rural and remote areas are not only a matter of recruitment but are also affected by housing shortages, insecure funding and higher living costs. AADC submitted that a lack of housing and competitive salaries compared to other industries in rural areas made relocating staff difficult.⁷⁷

- 6.64 AADC also commented in its evidence that higher costs of living in regions meant that even when competitive salaries were offered, the financial benefits were negated by living expenses. AADC argued that funding processes needed to accommodate these factors to ensure a sustainable workforce and equitable care.⁷⁸

- 6.65 QPAODN highlighted the point that the increased distances between rural and regional areas also results in higher operational costs for service providers due to factors such as transportation and infrastructure maintenance and indicated that existing funding arrangements do not account for these increased costs.⁷⁹

- 6.66 NRHA detailed the need for funding arrangements to sustain specialist services in geographically dispersed communities, stating at the public hearing on 27 March 2026:

Some specialist services cannot be sustained on their own, because there isn't enough work for them. So you have to fly-in fly-out or drive-in drive-out.... there needs to be support so they can actually drive or fly. Through the NDIS, the PBS and Medicare, we've actually had a massive reduction of coverage of many of those costs for the clinicians—we've sometimes got the clinicians—to go to another community to service that community. As we know, from our cost-of-living crisis, people are not able to afford to drive to those communities. We can't

⁷⁶ Advanced Pharmacy Australia, *Submission 82 (47th Parliament)*, p. 14.

⁷⁷ AADC, *Submission 45 (47th Parliament)*, p. 15.

⁷⁸ AADC, *Submission 45 (47th Parliament)*, p. 15.

⁷⁹ QPAODN, *Submission 104 (47th Parliament)*, p. 3; AADC, *Submission 45 (47th Parliament)*, p. 15.

even do many medication reviews because there's no coverage for it. There's no cost recovery so that they can make it sustainable.⁸⁰

- 6.67 Evidence to the inquiry advocated, as discussed also in Chapter 4, that workforce issues could be alleviated by making better use of locally available health professionals and expanding their role in AOD care. The Australian College of Nurse Practitioners highlighted findings from Monash University research that nurse practitioners could improve AOD treatment access for regional or remote areas by supporting patients through withdrawal, prescribing pharmacotherapy and facilitating access to counselling services.⁸¹
- 6.68 As also discussed in Chapter 4 relation to broader AOD workforce issues, NRHA also identified pharmacists as an underutilised resource, particularly in communities where they may be the only local health professional available. The Alliance stated in its submission that pharmacists could enable services such as the *Take Home Naloxone program* and assist with injecting drugs in accordance with therapeutic guidelines. NRHA also submitted that approximately 22 per cent of Australia's community pharmacies are located in rural and remote areas and that AOD services and support could improve by utilising the already established workforce.⁸²
- 6.69 AAPI called for incentives such as subsidised education and infrastructure development to support more psychologists in rural and regional areas and stated in its submission that this would provide more holistic care for AOD use and assist with early intervention.⁸³
- 6.70 The National Drug and Alcohol Research Centre commented that treatment models requiring daily attendance can be particularly difficult for people in regional, rural and remote areas. The Centre indicated in its submission that more flexible approaches, such as takeaway doses and long-acting injectable buprenorphine, had been utilised during the COVID-19 pandemic and could be re-deployed to improve AOD support and access.⁸⁴
- 6.71 RANZCP emphasised in its submission to the inquiry that a locally integrated health workforce was 'essential' to improving the AOD workforce in rural areas. RANZCP recommended longer-term workforce development strategies, including rural training pathways, specialist posts, supervision and incentives for psychiatrists and other professionals to work in regional, rural and remote areas.⁸⁵

⁸⁰ Ms Tegen, NRHA, *Committee Hansard*, 27 March 2026, p. 23.

⁸¹ Australian College of Nurse Practitioners, *Submission 4 (47th Parliament)*, p. 3.

⁸² NRHA, *Submission 90 (47th Parliament)*, p. 7.

⁸³ AAPI, *Submission 6 (47th Parliament)*, p. 6.

⁸⁴ National Drug and Alcohol Research Centre, University of NSW, *Submission 111 (47th Parliament)*, p. 12.

⁸⁵ RANZCP, *Submission 19 (47th Parliament)*, p. 4.

Culturally and linguistically diverse communities

Cultural stigma and responsiveness

- 6.72 Evidence to the inquiry suggested that there are unique stressors that expose CALD communities to increased risk of AOD harm and that create barriers to these populations seeking support.
- 6.73 The Queensland Mental Health Commission stated in its submission that these stressors include:
- Stressors inherent to the settlement process
 - Experiences of torture and trauma
 - Financial difficulties
 - Racism
 - Separation from family and friends
 - Employment challenges
 - Intergenerational conflict
 - Language barriers
 - Limited access to culturally appropriate programs and services
 - Lack of awareness of the support available
 - Different cultural and spiritual conceptualisations of alcohol and other drugs use that may impact on help seeking
 - Stigma and shame associated with AOD use.⁸⁶
- 6.74 The inquiry received considerable evidence relating to the stigma specifically faced by CALD communities. The Drug Policy Modelling Program NSW stated that when examining Western Sydney, commenting that this is an area in which over a third of the population was born overseas, both geographical and cultural stigma shaped the effectiveness and reach of AOD harm reduction and support. Its submission called for research to explore 'more tailored interventions for particular areas and communities, with specific focus on areas of intersecting cultural stigma around AOD use'.⁸⁷
- 6.75 The NSW/ACT PHN AOD Network emphasised the importance of culturally responsive care for CALD communities and the role it can play in reducing stigma. Similar to the culturally safe care that is consistently and strongly advocated for Aboriginal and Torres Strait Islander people, the Network remarked that culturally responsive care 'recognises the importance of responding to specific cultural needs to ensure that care is safe, equitable and of high standard'.⁸⁸

⁸⁶ Queensland Mental Health Commission, *Submission 167 (47th Parliament)*, p. 6.

⁸⁷ Drug Policy Modelling Program NSW, *Submission 17 (47th Parliament)*, pp. 4-5.

⁸⁸ PHN NSW ACT AOD Network, *Submission 55 (47th Parliament)*, pp. 7-8.

- 6.76 The NSW/ACT PHN AOD Network also pointed in its submission to a cultural inclusion audit previously conducted by the UNSW Centre for Social Research in Health that highlighted the need for improved cultural inclusion education across AOD services and recommended increased training opportunities for all AOD health workers, including senior staff.⁸⁹
- 6.77 NADA commented on this same audit and accompanying plan to improve cultural inclusiveness that it 'identified service enhancements in policies, intake procedures to better identify multicultural clients, staff training, established client prayer spaces, increased involvement of families, and enhanced relationships with local multicultural communities and services'.⁹⁰
- 6.78 The Yarra Drug and Health Forum stated that improving cultural responsiveness extends beyond professional development for frontline staff and must involve systemic reform to address barriers creating stigma and preventing AOD care. The Forum's submission further argued that increasing accessibility is essential as it is not always culturally appropriate or sensitive to approach some CALD communities regarding AOD use.⁹¹
- 6.79 The Australian National Centre for Youth Substance Use Research (NCYSUR) submitted that a lack of culturally tailored interventions can result in CALD communities having a 'distrust towards health services, decreased engagement, reduced self-efficacy in managing health, and poorer health outcomes'.⁹²
- 6.80 NCYSUR submitted that when individuals from CALD communities do seek treatment, services often lack culturally safe care and support which subsequently affects the quality of care received. Also emphasised by NCYSUR in its evidence was that limited availability of interpreter services and multilingual resources can lead to delayed or inadequate treatment for non-English speakers.⁹³
- 6.81 The Australian Multicultural Action Network also supported this call for multilingual AOD services, stating that stigma and cultural norms often prevent early help-seeking. The Network commented in its submission that services which acknowledge faith, language, and community norms can help enhance trust and participation among CALD communities.⁹⁴
- 6.82 In addition to multilingual services, Odyssey Victoria emphasised the benefits resulting from long-running targeted education campaigns and community engagement at the 27 March 2026 public hearing:

We've had a number of programs that directly target generally newly arrived communities or communities that we know aren't accessing drug and alcohol services. An example from 2000 was, in the Vietnamese community, we did a

⁸⁹ PHN NSW ACT AOD Network, *Submission 55 (47th Parliament)*, pp. 7-8.

⁹⁰ NADA, *Submission 66*, p. 11.

⁹¹ Yarra Drug and Health Forum, *Submission 135 (47th Parliament)*, p. 7.

⁹² NCYSUR, *Submission 120 (47th Parliament)*, p. 11.

⁹³ PHN NSW ACT AOD Network, *Submission 55 (47th Parliament)*, pp. 7-8.

⁹⁴ Australian Multicultural Action Network, *Submission 5*, p. 2.

whole lot of community development work with faith leaders and other community members. We bridged that pathway into services but also helped build the capacity within the services to better respond to, and understand the needs of, that cultural community... We're doing the same with people of Islamic faith. We worked with the council of imams. They all did a sermon together right across their mosques to say: 'Look, we've got an issue in this community. We need to seek help and not just let our young people end up in prison.' Again, we were capacity building both the community and the services.⁹⁵

- 6.83 AODCCC also commented on the effectiveness of direct community engagement at the hearing on 14 April 2026:

We see that, in a diverse community, it's important to actually engage those community members directly and speak, draw out and understand what their specific needs are in terms of access. Again, it comes back to that lived experience informed approach. If we're engaging the community directly and speaking to those individuals and understanding what the barriers are, it's going to be a lot more accessible and fit for purpose. Regardless of the approach that we're taking, if there's lived experience voices around the table, we're going to be far more effective in supporting those communities. So, when we're talking about culturally and linguistically diverse communities, obviously there are language barriers, and there are cultural barriers that we may not understand. It's important to bring those individuals to the table to really understand those concerns⁹⁶

Data gaps

- 6.84 NCYSUR noted in its submission that cultural stigma preventing engagement with AOD services also results in under-recognition within datasets.⁹⁷ The Alcohol Tobacco and Other Drug Association ACT described the currently available data around AOD use by CALD communities as 'limited'.⁹⁸

- 6.85 NCYSUR emphasised in its submission that limited data in this context did not indicate limited AOD-related harm. NCYSUR further stated:

National data indicates that while people who are born overseas generally report lower rates of AOD use compared with people born in Australia who only speak English at home, those who are at risk of experience AOD-related harms face significantly greater challenges and barriers to accessing treatment and support services. Figures from national surveys also likely underestimate true prevalence due to language and cultural barriers in English language surveys and a

⁹⁵ Dr Gruenert, Odyssey Victoria, *Committee Hansard*, 27 March 2026, p. 10.

⁹⁶ Mr Alex Arpino, Executive Manager, AODCCC, *Committee Hansard*, 14 April 2026, pp. 3-4.

⁹⁷ NCYSUR, *Submission 120 (47th Parliament)*, p. 10.

⁹⁸ Alcohol Tobacco and Other Drug Association ACT, *Submission 13*, p. 8.

reluctance within some communities to report use due to stigma and cultural taboos.⁹⁹

6.86 VADA submitted that inconsistent data practices and limited data collection on the health impacts of AOD outside of treatment ‘undermines the needs of cohorts that face barriers to accessing pathways to support, such as refugee and migrant communities’.¹⁰⁰

6.87 At the public hearing on 27 March 2026, Odyssey House NSW commented that existing datasets may not identify those with a CALD background, even when recording related indicators:

...we know that 50 per cent of Australians are of CALD background—that is, the first or second generation were from a non-English-speaking country. We also know that 33 per cent of Australians were born overseas—that is, they are first generation... we definitely know that there's inequity of access for people from CALD communities. I should say 'we think there is', because we don't actually record people from CALD communities accessing treatment and drug and alcohol services. We record what language they speak at home and what country they were born in, but we don't record in the national minimum dataset whether people are from CALD backgrounds.¹⁰¹

6.88 In its submission to the inquiry, the AIHW identified gaps within two of its AOD treatment data sets and that these gaps included CALD communities (and other priority populations) and also related information on availability of targeted treatment programs for these groups with specific treatment needs. AIHW stated additionally that if this data were available, it could help inform access, equity and service planning.¹⁰²

Intersections with age

Young people's AOD usage

6.89 AIHW submitted that young people are a priority population, as a young age is a peak time for beginning AOD use and that those who need help with their use can experience barriers accessing support such as limited health literacy, geographic isolation, stigma, social exclusion and concerns about confidentiality.¹⁰³

6.90 headspace discussed the importance of early interventions for AOD use in young people in its submission:

⁹⁹ NCYSUR, *Submission 120 (47th Parliament)*, p. 11.

¹⁰⁰ VADA, *Submission 114 (47th Parliament)*, p. 9.

¹⁰¹ Mr David Kelly, Executive Director, Programs, Odyssey House NSW, *Committee Hansard*, 27 March 2026, p. 9.

¹⁰² AIHW, *Submission 142 (47th Parliament)*, p. 3.

¹⁰³ headspace, *Submission 25*, p. 2; AAPI, *Submission 6 (47th Parliament)*, p. 2.

Typically, most AOD use starts in adolescence and peaks in young adulthood between the ages of 18 and 25. While there is some evidence AOD use has decreased among young people in recent years, it remains relatively common, and young people are less likely to recognise the risks of AOD use. Behaviour established during adolescence and early adulthood can impact life-long trajectories. Earlier use of AOD can also lead to increased risk of harm. Early intervention before substance use has become deeply ingrained represents a crucial strategy for reducing and preventing both immediate and long-lasting harm.¹⁰⁴

6.91 Evidence to the inquiry from multiple submissions noted that while there was a measurable decline in underage and young people drinking in Australia, young adults were the most likely of all age groups to be at risk of alcohol-related disease or injury in 2022-23, and there had not been a reduction in harms resulting from alcohol.¹⁰⁵

6.92 ADF discussed this concentrated harm at the 28 October 2024 public hearing:

...on the whole we are seeing a decrease in the number of young people who are consuming alcohol, but there continues to be a cohort who are using it in a risky manner and increasing their use. In this age group we see the highest rates of ambulance callouts and alcohol-related hospitalisation. A lot of harm goes on in that group. Substance use in young people is at a relative all-time low. The 20-year graph for illicit substance use by under 18-year-olds shows it has been on a significant downward trajectory for the last 20 years or so. It is not as simple as someone replacing one behaviour with another.¹⁰⁶

Tailored, holistic and preventative care

6.93 NCYSUR submitted that the current health system has failed to engage or adequately treat young people with AOD use problems and that there was an average gap of 18 years between the onset of AOD problems and receiving treatment.¹⁰⁷

6.94 In addition to the barriers previously listed, Mission Australia commented in its submission that many treatment facilities are only available to those over 18 years of age and are not appropriate or successful at treating younger people. Mission Australia further stated that these services don't provide the necessary support for young people, particularly if they're traumatised, and can even expose them to additional trauma:

Often adult detox facilities are not suitable for young people, even young people over 18, and it can be scary to be with much older people in an environment that

¹⁰⁴ headspace, *Submission 67 (47th Parliament)*, p. 5.

¹⁰⁵ Alcohol Beverages Australia, *Submission 61 (47th Parliament)*, p. 3; Department of Health and Aged Care, *Submission 157 (47th Parliament)*, p. 11; Dr Erin Lalor, Chief Executive Officer, ADF, *Committee Hansard*, 28 October 2024, p. 8.

¹⁰⁶ Mr Robert Taylor, Manager, Policy and Engagement, ADF, *Committee Hansard*, 28 October 2024, p. 8.

¹⁰⁷ NCYSUR, *Submission 120 (47th Parliament)*, p. 9.

is not youth friendly. There have been cases of assault and sexual assault reported and young people often don't last in these adult environments. A distinct service approach for young people is required. Youth-specific facilities which deal with young people holistically in a safe, secure and encouraging environment are much more likely to succeed long-term.¹⁰⁸

- 6.95 The SA Commissioner for Children and Young People called in its submission for the development of community infrastructure and separate AOD services tailored for young people. The Commissioner further submitted that services should be 'therapeutic and trauma informed, and promote young people's progress towards developmental tasks, such as exploring their social and vocational identity, developing their skills and learning to make mature judgments'.¹⁰⁹
- 6.96 AAPI stated in its submission that AOD services must engage with the drivers of disadvantage and incorporate holistic wraparound supports.¹¹⁰ headspace stated in this context that despite the strong relationship between AOD use and poor mental health, most AOD and mental health services are separate.¹¹¹
- 6.97 headspace further submitted that this service relationship made holistic care for young people requiring AOD interventions 'essential' and that it 'needs to be developmentally appropriate, consider young people's mental and physical health, and ideally delivered by the same provider, or otherwise under a single treatment plan'.¹¹²
- 6.98 Further evidence to the inquiry strongly supported prevention and early intervention for young people in relation to AOD, particularly through school, family and community settings. The Youth Support Advocacy Service and Blurred Minds at Griffith University stated that beyond the benefits to the health and wellbeing of individuals, families, and communities, preventative care saves downstream health, education and justice costs.¹¹³
- 6.99 The Department of Education also discussed the benefits of school-based AOD education in its submission:

Engaging students in alcohol and other drug education can help shape their attitudes and behaviours toward alcohol and other drugs, now and into the future. It can also help them develop strategies for risky situations and empower them to make safer and healthier choices. Creating an inclusive school culture and positive student experiences, along with having a comprehensive alcohol and other drug policy and educational programs in place, are crucial in promoting healthier behaviours. A whole of school approach recognises that student health

¹⁰⁸ Mission Australia, *Submission 115 (47th Parliament)*, pp. 5-6.

¹⁰⁹ SA Commissioner for Children and Young People, *Submission 10 (47th Parliament)*, p. 3.

¹¹⁰ AAPI, *Submission 6 (47th Parliament)*, p. 5.

¹¹¹ headspace, *Submission 67 (47th Parliament)*, pp. 2-3.

¹¹² headspace, *Submission 67 (47th Parliament)*, pp. 2-3.

¹¹³ Youth Support Advocacy Service, *Submission 32 (47th Parliament)*, p. 18; Blurred Minds, Griffith University, *Submission 29*, p. 1.

and wellbeing can be influenced by many complex and overlapping factors. For example, having good relationships with peers, teachers, school counsellors can impact a young person's development. Students who feel connected at school and have positive role models may also be less likely to experience harms from alcohol and other drugs.¹¹⁴

- 6.100 The Matilda Centre also provided evidence in its submission that school-based programs for AOD prevention were the most effective. The Centre commented that schools provide the infrastructure to deliver AOD preventative education and the appropriate social and learning environment to mitigate risks. The Centre also emphasised the importance of parents in the socialisation of young people, stating that it was 'critical that parents are equipped with evidence-based prevention information and resources'.¹¹⁵
- 6.101 The Matilda Centre further cautioned in its submission that schools face barriers to delivering effective evidence-based programs such as 'low teacher confidence, lack of support, lack of knowledge and awareness about the strategies and programs that are evidence based, and time constraints'.¹¹⁶
- 6.102 ADF identified digital tools as an opportunity for AOD prevention and early intervention in young people, stating that tools such as apps, chatbots and online platforms could provide non-judgemental, evidence-based information to young people who may be reluctant to seek help through traditional pathways.¹¹⁷

Youth justice diversion

- 6.103 The Australian Research Alliance for Children and Youth submitted that despite the downward trend in smoking and alcohol use among general population younger Australians, this did not extend to young people in youth justice. The Alliance commented in its submission that between 2012-16, one in three young people under youth justice supervision had received AOD treatment.¹¹⁸
- 6.104 The UNSW School of Population Health Advocacy Lab called in its submission for a focus on diverting youth from entering the justice system through AOD treatment. The Lab commented in this regard that there was strong evidence that 'diversion to AOD treatment reduces recidivism as well as acute care presentations'.¹¹⁹
- 6.105 The SA Commissioner for Children and Young People stated that holistic care also benefited those in youth justice and recommended a 'no wrong door' approach to young people attached to government services, including child protection, education, primary and mental health and youth justice.¹²⁰

¹¹⁴ Department of Education, *Submission 126 (47th Parliament)*, p. 4.

¹¹⁵ The Matilda Centre, *Submission 24 (47th Parliament)*, pp. 10, 12 and 14.

¹¹⁶ The Matilda Centre, *Submission 24 (47th Parliament)*, p. 10.

¹¹⁷ ADF, *Submission 24*, p. 7.

¹¹⁸ Australian Research Alliance for Children and Youth, *Submission 23 (47th Parliament)*, p. 4.

¹¹⁹ UNSW School of Population Health Advocacy Lab, *Submission 156 (47th Parliament)*, p. 7.

¹²⁰ SA Commissioner for Children and Young People, *Submission 10 (47th Parliament)*, p. 4.

- 6.106 The SA Commissioner's submission further argued that the most effective strategies will integrate AOD services into youth-specific services such as primary and mental health services, homelessness services and services that address violence.¹²¹

Older adults

- 6.107 Evidence to the inquiry identified older adults as an emerging priority cohort experiencing increasing AOD-related harms, with limited targeted services and under-detection of alcohol problems. AIHW commented that older Australians make up a considerable proportion of the population and can be more susceptible to AOD harm. AIHW cited data showing a rise in the median age of opioid pharmacotherapy clients, the proportion of AOD treatment clients aged 50 and over, and the rates of older age group AOD-related hospitalisations and deaths.¹²²
- 6.108 The Australasian Injury Prevention Network submitted that older adults faced an increased risk to harm resulting from AOD use due to their use of multiple medications and existing health conditions which can result in a heightened sensitivity to alcohol, which can lead to injury due to falls. Despite this, the Network commented that older adults are less likely to be screened for alcohol after such an injury and there are limited strategies tailored to their needs.¹²³
- 6.109 Injury Matters stated that there was little investment in targeted programs or services despite Australia's ageing population and that the *National Alcohol Strategy 2019-2028* recognised that older Australians have an increased susceptibility to harmful alcohol use.¹²⁴
- 6.110 The Tasmanian Department of Health also noted in its submission that people between the ages of 60 and 65 with long-term AOD issues were experiencing health issues resulting from their use and because this demographic fell outside of the scope of service providers for older persons as they did not meet the age criteria.¹²⁵

Women and LGBTIQ+ cohorts

AOD impacts and services for women

- 6.111 The inquiry heard that AOD trends and harms differ by gender, and that AOD use and harm had changed among women and girls in Australia, including recent increases in risky alcohol consumption and illicit drug use among younger women. ADF stated in this regard that women were showing increased engagement with higher-risk AOD use, with particular rises among young women and a narrowing gender gap in risky alcohol consumption among younger adults more broadly.¹²⁶

¹²¹ SA Commissioner for Children and Young People, *Submission 10 (47th Parliament)*, p. 4.

¹²² AIHW, *Submission 142 (47th Parliament)*, pp. 2-3.

¹²³ Australasian Injury Prevention Network *Submission 151 (47th Parliament)*, p. 5.

¹²⁴ Injury Matters, *Submission 29 (47th Parliament)*, p. 2.

¹²⁵ Tasmanian Department of Health, *Submission 200 (47th Parliament)*, p. 1.

¹²⁶ ADF, *Submission 77 (47th Parliament)*, p. 12.

Torrens University also submitted that women aged between 45 and 64 were a cohort that has been drinking more alcohol over the past two decades.¹²⁷

6.112 A major theme in the evidence to the inquiry also was the relationship between AOD use and gendered violence. This was also discussed in Chapter 4.

6.113 Various submitters emphasised that while AOD use does not cause violence, it can exacerbate its severity and frequency and can compound patterns of control and abuse.¹²⁸ Edon Place submitted in this regard:

Whilst AOD use does not cause violence, it can compound existing patterns of control and abuse. Substance use can significantly diminish an individual's capacity for emotional regulation, impulse control and sound decision-making, which in turn intensifies volatility, coercion and the frequency and severity of violent incidents. This intersection heightens risk to victim-survivors and children and compounds challenges in safety planning, intervention efforts and accountability pathways. International and Australian evidence reflects that illicit drug involvement in [domestic family violence] contexts correlates with higher severity, frequency and lethality (ANROWS, 2020; AIHW, 2023), reinforcing the need for targeted responses for men using violence with co-existing AOD usage.¹²⁹

6.114 The National Women's Safety Alliance highlighted data showing that of the 240 women in Australia murdered by a current or former male partner between 2010 and 2018, more than 60 per cent of the male perpetrators had been affected by AOD.¹³⁰

6.115 A University of Melbourne research team also provided data to the inquiry indicating that alcohol was involved in 24 to 54 per cent of all domestic and family violence reported to police, and that victim-survivors were two to three times more likely to experience severe harm when alcohol was present.¹³¹

6.116 The Centre for Women's Health Research and the Australian Longitudinal Study on Women's Health presented evidence on AOD use resulting from domestic, family and sexual violence. Its research indicated that across multiple generations of women, those who experienced this violence were more likely to engage in risky behaviours such as smoking, vaping, high-risk alcohol consumption and illicit drug use than women who had not experienced violence.¹³²

¹²⁷ Torrens University Australia, *Submission 61*, p. 4.

¹²⁸ AADANT, *Submission 26 (47th Parliament)*, p. 7; Edon Place, *Submission 33*, p. 2.

¹²⁹ Edon Place, *Submission 33*, p. 2.

¹³⁰ National Women's Safety Alliance, *Submission 47 (47th Parliament)*, p. 3.

¹³¹ Hon. Professor Cathy Humphreys, Dr Margaret Kertesz and Van Callaly, *Submission 20*, p. 1.

¹³² Centre for Women's Health Research and the Australian Longitudinal Study on Women's Health, *Submission 1*, p. 2.

- 6.117 Evidence from AADANT suggested that domestic, family and sexual violence services can help protect against AOD harm and play an important role in identifying and responding to AOD harms for both perpetrators and victim survivors.¹³³
- 6.118 The Queensland Nurses and Midwives' Union also spoke in its submission of the importance of women's-only rehabilitation facilities that allow children to accompany their mothers, stating that the absence of these services can 'deter women from seeking treatment due to concerns about childcare and the fear of intervention from child protection services'.¹³⁴

LGBTIQA+ use and services

- 6.119 Evidence from ACON identified LGBTIQA+ people as another priority population associated with higher and riskier rates of AOD use combined with insufficient tailored support. ACON stated that LGBTIQA+ people had higher rates of use compared to the general population and also faced particular barriers to accessing treatment:
- LGBTQ people typically under-utilise health services and delay seeking treatment. The challenges that arise for LGBTQ people accessing health services, including AOD support, encompass a lack of cultural safety and inclusivity, fears 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.¹³⁵
- 6.120 Professor Kate Seear stated in her submission that the LGBTIQA+ cohort often experience more abuse and trauma which can result in higher rates of AOD use. Professor Seear called for funding and development of culturally safe, targeted gender and sexuality-specific services.¹³⁶
- 6.121 An additional service gap was identified for LGBTIQA+ people in rural and regional areas by ACON, which submitted that in these areas where AOD services are already less available, those that are present are often faith-based and that this can be challenging for LGBTIQA+ people to access due to fear of discrimination.¹³⁷
- 6.122 LGBTIQ+ Health Australia argued in its submission that punitive drug policy settings exacerbate harms by discouraging engagement with what is often culturally unsafe care. LGBTIQ+ Health Australia's submission also stated that inadequate data collection resulted in an incomplete evidence base and it called for the *2020 ABS Standard for Sex, Gender, Variations of Sex Characteristics and Sexual Orientation Variables* to be applied across all AOD datasets to 'provide a clearer understanding

¹³³ AADANT, *Submission 26 (47th Parliament)*, p. 11.

¹³⁴ Queensland Nurses and Midwives' Union, *Submission 34 (47th Parliament)*, p. 9.

¹³⁵ ACON, *Submission 30 (47th Parliament)*, pp. 3-4.

¹³⁶ Professor Kate Seear, *Submission 33 (47th Parliament)*, p. 10.

¹³⁷ ACON, *Submission 30 (47th Parliament)*, p. 4.

of the needs and experiences of LGBTIQ+ people, enabling more effective and equitable resource allocation'.¹³⁸

Committee comment

- 6.123 The Committee recognises that priority populations continue to experience a disproportionate burden of AOD-related harm and that this harm is often driven by a complex interaction of social, economic, geographic and health-related factors. Many people within these cohorts clearly face significant barriers to accessing timely, appropriate and effective treatment and support. These barriers include workforce shortages, limited service availability, stigma, cultural and linguistic barriers, and a lack of culturally safe and tailored models of care. It is of great concern that these inequities persist despite longstanding recognition of priority populations within the National Drug Strategy.
- 6.124 The importance of services that are designed and delivered in partnership with the communities they serve cannot be underestimated. This is particularly evident for Aboriginal and Torres Strait Islander peoples, where culturally safe and community-controlled approaches were repeatedly identified in the inquiry evidence as critical to improving engagement and outcomes in AOD services.
- 6.125 The absence of a current Aboriginal and Torres Strait Islander drug strategy and the limited number of First Nations voices informing AOD policy and program development is very troubling and must be addressed urgently.
- 6.126 While the nature of the challenges faced by priority populations clearly differs across cohorts, and this must be considered in any policy responses, a common theme emerging from the inquiry evidence was the need for flexible and locally responsive services that recognise the unique circumstances of individuals and communities. The Committee was encouraged by the evidence highlighting the positive role of telehealth, digital interventions, community engagement and integrated models of care in improving access and reducing barriers to treatment.
- 6.127 Achieving equity in AOD outcomes requires more than simply increasing service availability. It requires a sustained commitment to culturally safe care, workforce development, improved data collection and the design of services that reflect the lived experience and needs of the particular priority population that requires the treatment and support. The Committee agrees fully with the many contributors to the inquiry that any response to AOD harms must place equity at its centre, ensuring that the populations and communities in Australia most affected by AOD-related harms are able to access appropriate support without restriction, regardless of who they are, where they live, or their personal circumstances.
- 6.128 These issues are discussed further and in more depth in Chapter 7, as are the Committee's recommendations for policy responses from the Australian Government.

¹³⁸ LGBTIQ+ Health Australia, *Submission 189 (47th Parliament)*, pp. 3-4.



7. A way forward

- 7.1 This chapter is a crystallisation of the Committee's comments and conclusions, drawn from its detailed consideration and observations of the evidence received to the inquiry over two successive Parliaments. This chapter also includes the inquiry recommendations to the Australian Government that the Committee believes will chart an effective way forward to better address and significantly reduce the harms that are caused by the misuse and risky consumption of alcohol and other drugs (AOD) in this country.

The case for alcohol and other drug policy reform in Australia—current gaps

Alcohol policy

Alcohol marketing

- 7.2 The strong culture of drinking in Australia is of concern given the current statistics on continued high levels of risky drinking, and a lack of awareness around alcohol-related risks and harms among Australians. The marketing and advertising of alcohol is hugely influential in reinforcing these societal attitudes and behaviours towards alcohol consumption.
- 7.3 The promotion of alcohol needs to be regulated in a way that can more effectively prevent earlier uptake of drinking by children, adolescents and young people, reduce social norms around drinking, as well as reduce risky drinking and the potential cues that may affect those at risk of alcohol dependence.
- 7.4 The extent of the evidence to the inquiry that the regulation of the promotion of alcohol was not meeting its desired aims was also very troubling. This includes the repeated exposure of children and young people, as well as to those at more risk of dependence, to the promotion of alcohol. Especially concerning in this context is the rise of the digital marketing of alcohol, and the use of data to directly target an individual (through emails, text messages, and push notifications), as well as the evolving nature of promotion techniques such as sponsorships and product placement.
- 7.5 This issue of poor regulation of alcohol marketing is due, at least in part, to the complexities of Australia's current regulatory frameworks in relation to this practice. Responsibility for this lies with different Commonwealth agencies, State and Territory governments, as well as self-regulation by the alcohol industry. The lack of a

harmonised approach across these different bodies enables gaps to be exploited, as well as increases the difficulty in ensuring that each responsible area keeps up with the changes in the regulatory environment. The increasing and invasive use of digital marketing tools to sell more alcohol is a prime example of this.

- 7.6 Whilst evidence to the inquiry indicated a willingness of the alcohol industry to ensure marketing does not exacerbate alcohol-related harms, the Committee is of the firm view that self-regulation cannot adequately safeguard children, adolescents or young people, or those at highest risk of alcohol abuse. Even with high compliance from those who have signed on to the self-regulatory 'Responsible Alcohol Marketing Code', its voluntary nature, lack of enforceability, and inability to minimise the amount of content being seen by those at greatest risk, makes it unfit for purpose. In the current operation of this code, a complaint needs to be raised and assessed before the advertisement is potentially removed, during which time it may be seen by a countless number of people, serving its purpose from the producers' viewpoint but potentially also leading to increased harms.
- 7.7 In summary, the Committee considers the current regulatory framework for the promotion of alcohol products in Australia to be insufficient to protect those at risk or to support shifts in societal attitudes and behaviours around alcohol consumption.

Recommendation 1

- 7.8 **The Committee recommends that the Australian Government establishes a new mandatory alcohol advertising and marketing regulatory framework, which should ensure:**
- That decisions are made to reduce exposure to children and those at greatest risk.
 - That the collection and use of personal information for marketing is prohibited unless a person has opted in.
 - That there is harmonisation with other relevant frameworks (e.g. Broadcasting Services Standards) and across platforms (e.g. television, online).
 - That there are appropriate monitoring and punishments for non-compliance.

Recommendation 2

- 7.9 **The Committee recommends that the Australian Government remove its representative from the Alcohol Beverages Advertising Code Scheme Management Committee to safeguard independence while consideration of a new framework is undertaken.**

Awareness of alcohol guidelines

- 7.10 Australians, both men and women, lack awareness of current guidelines to reduce health risks from drinking alcohol. This is true across all age groups and in women

who are pregnant or breastfeeding. This is particularly concerning given the evidence to the inquiry of the estimated prevalence of Fetal Alcohol Spectrum Disorder (FASD) in Australia, as well as continued levels of risky drinking that are evident among certain population groups. In understanding the role that parents play in delaying or reducing children's, adolescent and young people's drinking, it is also important that there be broader awareness of the guidelines to support this understanding and enable informed decision making.

Pricing policies

- 7.11 The implementation of pricing policies and taxation arrangements in the regulation of alcohol is an important mechanism for reducing harms. The Committee noted with interest during the inquiry that there are considerable concerns that the current taxation system does not provide adequate safeguards to those at greatest risk of alcohol harm, due to the continued availability of cheap alcohol products. This is undoubtedly a result of the non-uniform taxation of alcohol in Australia, leading to the production of cheaper products that attract a lesser tax. The predominant example of this is the Wine Equalisation Tax, where products such as cask wine can be produced and sold at lower prices.
- 7.12 The Committee acknowledges that this is not the first time this issue around alcohol taxation has been raised, as evidence advocating for a uniform taxation system has been received by several related parliamentary inquiries since 2010. The Committee agrees that a uniform approach to alcohol taxation based on a volumetric tax would disincentivise the production of the cheaper alcohol products that cause the greatest harms, whilst enabling a more coherent taxation system.
- 7.13 Concerns were also raised in the inquiry that there is a potential emerging threat of illicit alcohol and that this could lead to more illegally produced or counterfeit alcohol that could be adulterated with dangerous chemicals such as methanol. Evidence received by the inquiry was unclear however as to the extent of the current illicit market and what the causative factors were. More up to date taxation data and continued surveillance of the current market are required to provide a more accurate picture and evidence-informed response. Any consideration of changes to the taxation system should take this into account, ensuring public health priorities are met whilst reducing the chances of any unintended consequences.

Recommendation 3

- 7.14 **The Committee recommends the Department of the Treasury undertakes modelling of alcohol taxation and then advises the Australian Government on whether reforms are needed to ensure that it remains fit for purpose from both an economic and public health standpoint.**
- 7.15 The Committee was interested in the inquiry evidence advocating that a minimum unit price be imposed on alcohol sold in Australia. This would effectively set a price below which a unit of alcohol could not be sold as a means to reduce the availability of cheap alcohol such as cask wine. Whilst there was variability in the supporting

evidence in terms of whether this could reduce harms on its own, positive health results were evident from a comparable measure in Scotland, whilst in the Northern Territory positive health results were described as part of other measures. A key takeaway from the inquiry evidence regarding any future implementation of a minimum unit price is ensuring the indexation of this, with evidence both from the Northern Territory and Scotland highlighting that its effectiveness will decrease if there is no account of inflation.

- 7.16 The Committee is aware that a possible minimum unit price is a matter for State and Territory governments and encourages them to give it strong consideration. It could also be used to complement other harm reduction approaches such as imposing alcohol restricted areas and restricting the availability of take away alcohol.
- 7.17 It was encouraging to see the commitment by retailers in Alice Springs to effectively keep a minimum unit price even after their legal obligation to do so was removed. In relation to the implementation of restrictions on takeaway alcohol availability, the Committee encourages the Government to align Centrelink payments with alcohol-free days, as this will further reduce harms.
- 7.18 Any policies aimed at reducing alcohol-related harms need to be supported by evidence, and the collection of meaningful data is key in this respect as it provides an opportunity to monitor progress, evaluate outcomes, and tailor any approaches to meet the needs of the population in question. These policies must also be co-designed with the communities that are affected, ensuring it does not marginalise particular groups, particularly Aboriginal and Torres Strait Islander people.

Recommendation 4

- 7.19 The Committee recommends that the Australian Government commissions research on the alcohol point of sale and retail data that it should collect into the future. This information will be vital to better informing alcohol harm-reduction policies through a fuller understanding of alcohol pricing, the types and volume of alcohol sold, and the timing of these sales.**

Online sales and delivery

- 7.20 There has been an exponential growth of online sales and delivery of alcohol in Australia since the COVID pandemic. It was extremely concerning to hear during the inquiry that the rapid sale and delivery of alcohol in this way has been a contributing factor to the increased prevalence of family, domestic and sexual violence, alcohol-fuelled violence more broadly, as well as enabling greater access to alcohol for those who are alcohol-dependent or at increased risk of harm.
- 7.21 The majority of the State and Territory liquor laws are designed for traditional brick-and-mortar stores and other venues that sell alcohol and the legislation has therefore not kept pace with the huge increase in the online sale and delivery of alcohol. The usual barriers to buying alcohol that involve a person's level of intoxication or welfare are far less likely to be implemented if the purchase is made online. The

responsibility for ensuring the safety of an individual who has made such a purchase cannot be left to a delivery driver and additional safeguards are now needed to address this.

- 7.22 The Australian Government has a leadership role to play to ensure there is a nationally consistent approach to the online sale and delivery of alcohol, particularly given its links to increased levels of family, domestic and sexual violence. The evidence submitted to this inquiry leaves the Committee in no doubt that controls are needed for both the time periods within which alcohol can be delivered, as well as the time from which alcohol purchased online can be received.

Recommendation 5

- 7.23 The Committee recommends the Australian Government work with the States and Territory governments to develop and implement national standards for the online sale and delivery of alcohol. These standards should consider restrictions on online alcohol purchasing hours and the merits of a safety pause between purchase and delivery.**

Fetal Alcohol Spectrum Disorder

- 7.24 The strong culture of drinking in Australia and the associated societal attitudes and behaviours towards drinking, coupled with the complexity of the broader health system in this country, and markedly insufficient awareness of the risks of alcohol exposure, have some very stark consequences. None are more serious than the alarmingly high estimated prevalence of FASD in Australia, particularly among Aboriginal and Torres Strait Islander children as well as in certain sectors such as the youth justice system. This prevalence of FASD needs to also be considered in the broader context of alcohol use, with policies that focus on the promotion, pricing and availability of alcohol all factors that need to be considered.
- 7.25 Fundamentally of course, the continuing lack of understanding among many men and women in Australia of the risks of drinking while pregnant, or while seeking to become pregnant, cannot continue.
- 7.26 The Committee understands the importance of recent research that has been undertaken to provide an accurate estimate of prevalence of FASD in Australia. Continued data collection and surveillance is required to assist with this and better inform policymakers and ensure services, systems and funding can continue to be allocated based on need.
- 7.27 Whilst FASD is a preventable condition, due to the complexities highlighted above, the likelihood of it ever completely being eradicated in Australia is low. A strengths-based approach should be taken in supporting people with FASD as each person is unique and will have strengths and difficulties in different areas. Assisting people with FASD to navigate from childhood to adolescence and into adulthood is a core component of the support that must be provided.

- 7.28 The continued lack of awareness around the dangers of alcohol consumption when planning a pregnancy, during pregnancy as well as when breastfeeding is hugely frustrating given the many previous inquiries that have highlighted this problem. The fact is that the rates of alcohol consumption in Australia during pregnancy are far higher than the global average and this cannot continue to be accepted.
- 7.29 The complexity of the factors associated with prenatal alcohol consumption are understood by the Committee, with a low awareness of the risks of drinking just one factor alongside others such as alcohol dependency, and alcohol use as a coping mechanism for issues such as family, domestic and sexual violence (FDSV), mental health, and social determinants such as financial or economic stress.
- 7.30 The Committee was dismayed by the evidence to the inquiry by individuals with lived experience of FASD, while at the same time appreciative of the courage shown in providing it. The struggles these individuals have endured to just receive a FASD diagnosis, sometimes well into adulthood, and the lack of FASD awareness in the health and other sectors and how this has affected their access to health care and other appropriate supports, were tough to comprehend.
- 7.31 Given that several separate parliamentary inquiries have made recommendations around greater awareness of both FASD and the harms of prenatal alcohol consumption, including as far back as 2010, and notwithstanding the extraordinary work of many individuals and organisations in that time in trying to tackle this affliction, something is just not working. Too many individuals, families and communities, but also professionals in the health, education and other adjoining sectors, are unaware of FASD, even now in 2026.
- 7.32 The Committee notes some improvements in public awareness of FASD and prenatal alcohol consumption through the National FASD Campaign. The Campaign has appropriately targeted several key population groups including women at increased risk, health professionals, Aboriginal and Torres Strait Islander people (through the *Strong Born* campaign) and the general population (through the *Every Moment Matters* campaign). Given awareness does not solely fall on the person who is pregnant, there also needs to be a greater focus on the influencing role that a partner or family can have towards attitudes and behaviours towards drinking.
- 7.33 Proper awareness of FASD is also equally important for reducing the stigma that exists around this condition and providing an environment where parents, carers, families, health professionals and others can have safe conversations around pre-natal drinking and FASD.
- 7.34 The results of the National FASD Campaign highlight the importance of it being continued, with a strong need to focus on the *Strong Born* and *Every Moment Matters* campaign. There must however, and this is a matter of the highest urgency, be amplification of this framework across risk populations including in rural, regional and remote areas and among all health and education professionals.
- 7.35 The evidence to the inquiry that women were either receiving no information at all, or conflicting advice, around whether there is a safe threshold for drinking alcohol

during pregnancy from their health care provider is hugely concerning and must also be addressed urgently. This is a key touch point that provides an opportunity to address harmful AOD use, educate about the potential effects of AOD use during pregnancy, and also enable screenings and referrals for the assessment of FASD as appropriate. The Committee has no doubt that this will increase the awareness of FASD and reduce its prevalence and enable earlier diagnosis and support for those affected with this condition.

- 7.36 Whilst there are barriers associated with the disclosure of drinking during pregnancy, greater awareness and normalisation of these conversations with health professionals is an important step to reducing the stigma associated with this.
- 7.37 Further to this, whilst universal screening of children for FASD is not viable, there would be great value in the targeted screening of at-risk populations. The examples provided to the Committee regarding the numbers of children with FASD in both youth justice settings, as well as in out of home care, indicate that there are key areas of vulnerability to this affliction.
- 7.38 The importance of receiving a FASD diagnosis as early as possible was clear from the inquiry evidence, as were the significant issues that prevent this including wait times, the inequitable distribution of relevant health services across Australia, and also the limited number of appropriately trained health professionals. Given the limited number of services available to a number of communities in relation to FASD, consideration of more innovative models of service and support, including hub-and-spoke and culturally appropriate frameworks, must be developed for rural, regional and remote Australia, and for priority populations. This needs to be coupled with greater resources for the training and support of health professionals to improve the diagnostic capabilities and treatments for FASD.
- 7.39 It is clear to the Committee that sectors that will have higher interactions with people suffering from FASD need improvements in their skills and knowledge levels to fully and adequately support and provide FASD-informed practices and care. This will go a long way to addressing the currently fragmented and inconsistent care that is available for FASD in Australia, help to meet the needs of those suffering from this condition, and strengthen linkages between sectors. The health, disability, education, child protection, and justice systems are not sufficiently equipped at present to respond to and support Australians with FASD.
- 7.40 The Committee was pleased to see examples during the inquiry of the excellent resources and training provided by programs such as *Learning with FASD*, the *FASD Informed Practice for the Australian Alcohol and Other Drug Workforce* course, the *Australian Guide to the Diagnosis of FASD: 2025* and the FASD Hub. These types of evidence-based programs need to be more widely accessed by the sectors listed above.

Recommendation 6

- 7.41** The Committee recommends the Australian Government continues to prioritise support for Fetal Alcohol Spectrum Disorder, facilitated through implementation of the *National Fetal Alcohol Spectrum Disorder Strategic Action Plan 2018 – 2028*. This should include the following key elements:
- Continued investment in national Fetal Alcohol Spectrum Disorder surveillance frameworks to improve the collection and accuracy of prevalence data that can support policy development and the proper allocation of services and resources.
 - Working with Primary Health Networks to enhance awareness of Fetal Alcohol Spectrum Disorder by targeting areas with an identified increase in alcohol consumption and also at-risk groups. This should be designed to complement existing awareness activities including the *Every Moment Matters* and *Strong Born* campaigns and ensure that the messaging is inclusive, non-stigmatising, and culturally safe.
 - Conducting a pilot study in out of home care (OOHC) settings to improve Fetal Alcohol Spectrum Disorder screening practices and the provision of wraparound support. Consideration must be given to the integration with diagnostic support services and of culturally appropriate supports for families and the OOHC workforce.
 - Working with State and Territory governments to improve access to Fetal Alcohol Spectrum Disorder diagnostic services. This should include a focus on increasing hub-and-spoke and culturally appropriate models of care, as well as recognition of the lifelong consequences of Fetal Alcohol Spectrum Disorder and long term supports.

Other drugs in Australia

- 7.42** Evidence to the inquiry highlighted patterns of drug use in Australia, including the current trends by age, sex and type of drug, and provided the Committee with a more detailed understanding of the types and forms of drug-related harm. It is clear that whilst the types of drugs being consumed in Australia will continue to change, influenced in part by national and international policies that affect supply and distribution, there is little doubt that the use of both licit and illicit drugs will continue to remain popular in this country.
- 7.43** Whilst it was put to the Committee during the inquiry that only small numbers of users experience dependence or significant harm from drug use, the rapid and continued emergence of new illicit drugs in Australia clearly has the potential to cause significant harm, especially in populations with low awareness of the presence or effects of these substances, or of harm reduction measures.
- 7.44** The advancement of digital service provision, such as telehealth appointments and online prescriptions, can increase access to treatments and medications, which is an important and positive development, especially for those living in regional, rural and

remote Australia. These advancements need to be met with an appropriate regulatory response to ensure safeguards are in place to reduce potential harms. In the case of medicinal cannabis, the increases in the number of prescriptions of higher strength products needs to be carefully monitored to ensure there are no unintended consequences.

- 7.45 A number of different surveillance systems and programs with a health or law enforcement focus were highlighted during the inquiry. The importance of drug surveillance was clear, as it provides an evidence base to support public health policy and health service planning and enable appropriate responses to emerging drug-related issues.
- 7.46 Whilst the value of Australia's current drug surveillance activities is not in question, there is a need for a more consistent approach between the Commonwealth Government and those of the States and Territories to optimise what is currently available and more robustly safeguard against a potential mass overdose or similar harmful event. A more consistent approach in this regard would enable more timely responses to emerging threats through alerts, the implementation of harm reduction strategies and through the mobilisation of appropriate supports. This would benefit both health and law enforcement agencies, as well as health services and consumers.
- 7.47 A more consistent approach across the jurisdictions in Australia should include strengthening current surveillance activities, the sharing of data between health and law enforcement, agreed upon roles and responsibilities that can be activated as needed, consistent communication of alerts, and consideration of supporting preparedness activities.

Recommendation 7

- 7.48 **The Committee recommends that the Australian Government works with State and Territory governments to develop a nationally coordinated early warning system for illicit drugs, to include a focus on:**
- **Roles and responsibilities between Commonwealth, State and Territory jurisdictions and non-government organisations;**
 - **Monitoring and surveillance (utilising health and law enforcement data);**
 - **Preparedness plans;**
 - **Communication of alerts; and**
 - **Early detection of new trends, geographic distribution of new drug trends and early access to harm reduction measures.**
- 7.49 Harm reduction strategies are another key element of Australia's AOD policy that the Committee explored with interest during the inquiry. As one of the three pillars of the National Drug Strategy, the Committee was pleased to receive solid evidence on some of the effective harm reduction strategies that are currently being implemented.

These included the Take Home Naloxone Program, supervised injecting sites, needle and syringe programs, and drug checking facilities.

- 7.50 With the increasing infiltration of novel psychoactive substances into Australia, including synthetic opioids, concerns were raised during the inquiry around instances of harms caused where other substances were adulterated with synthetic opioids, or when consumers were not aware of the effects of these types of drugs. With many other examples like this received by the Committee, it is clear that a variety of harm reduction strategies need to be considered to respond to these significant risks and ensure that policymakers, AOD service providers and consumers are informed and can respond accordingly.
- 7.51 The benefits and success of the Take Home Naloxone Program were clear to the Committee, as was the lives saved due to its implementation. The Program could be improved upon however, including through an enhanced awareness of naloxone and its availability, and greatly increased access to it. Stigma also remains a barrier to the use of naloxone given its association with opioids, but with increased instances of other less stigmatised substances being adulterated into illicit opioids, the importance of reducing stigma and increasing awareness and access in relation to naloxone cannot be overstated.

Recommendation 8

- 7.52 The Committee recommends that the Australian Government continues to implement the Take Home Naloxone Program, with a focus on increasing awareness, reducing stigma and increasing access to first responders and those at greatest risk from an overdose.**
- 7.53 The inquiry also received strong evidence for the benefits of drug checking, with the operation of the CanTEST service in the ACT seen as a genuine success story. The value of drug checking is multi-faceted, with checking and analysing substances supported by the provision of harm reduction information and brief interventions. Drug checking can also provide data on drug trends and markets that can feed into surveillance activities. The Committee agrees with the view that an important aspect of harm reduction is ensuring that individuals who use drugs have access to information to make safer and more informed decisions.
- 7.54 Similarly, both the use of supervised injecting centres, and of needle and syringe programs, are other strategies that could be considered where there is a demonstrated community need, and to provide safer equipment which has been shown to reduce the transmission of bloodborne viruses. The Committee believes that there should be equitable access to needle and syringe programs and was concerned to hear that this was not the case for people in prison or in other custodial settings.
- 7.55 Harm reduction strategies also need to be considered in localised contexts, where decisions around community need are a key consideration. The Committee encourages both the Commonwealth and State and Territory governments to

consider expanding access to harm reduction strategies and continue to share evidence-based information on those that are working and could be implemented elsewhere.

- 7.56 Throughout the inquiry, multiple contributors expressed the view that the approach to drug use should primarily adopt a health and social standpoint ahead of criminal or justice system considerations. The Committee is supportive of this but nevertheless acknowledges that the law enforcement and justice sectors clearly have a key role to play in reducing drug-related harms. It should be noted that the commitments made by the health, law enforcement and justice agencies under the National Drug Strategy focus on preventing and minimising harms through the three pillars of demand, supply and harm reduction.
- 7.57 Concerns were raised around an unequal distribution of funding and resources allocated across the three National Drug Strategy pillars, with a greater portion focused on supply reduction compared to demand and harm reduction responses. The Committee is not of the view that law enforcement should have their funding reduced but believes there are opportunities for greater collaboration between the health and law enforcement sectors that could shift some of the focus to demand and harm reduction responses.
- 7.58 The need for law enforcement to prioritise efforts on supply reduction is clear, with some of the inquiry evidence showcasing the seizure of large quantities of drugs and their precursors. It is also clear however that the access to illicit drugs in Australia is not reducing and this reinforces the need to focus efforts on other ways to reduce harm.
- 7.59 Legislative changes to address AOD harm such as the decriminalisation of possessing drugs for personal use are of interest to the Committee. Reducing criminal sanctions can support improvements in drug-related harms through increased access to advice, support and treatment and can reduce barriers to social determinants of health such as housing and employment. The Committee notes that the ACT is a jurisdiction that had successfully implemented decriminalisation with positive findings in its recent evaluation report.
- 7.60 Although decriminalisation and other diversionary tactics are in place in different jurisdictions to reduce punitive measures for drug use, the rates of incarceration for individual substance use remain high in Australia. There would be definite value therefore in improving partnerships between the law enforcement and justice sectors and the various AOD health services to help facilitate pathways to access treatment and harm reduction programs, and give those either incarcerated or leaving correctional facilities the supports needed to improve their health and wellbeing.
- 7.61 The Committee believes firmly that considerations around reducing drug-related harms should not come down to a health vs law enforcement standpoint. Instead, efforts should be made to find ways for health and law enforcement agencies to develop more integrated approaches to reducing harms. This could include data sharing, involvement in prevention programs, partnerships with services that see

people moved towards treatment and support services instead of jail, as well as support for people incarcerated or leaving correctional facilities.

Managing the health impacts of alcohol and other drugs

- 7.62 The importance of the early prevention of AOD uptake in children, adolescents and young people cannot be understated. AOD use can interfere with the developing adolescent brain, and the harms associated with this are therefore often higher for young people. While it was pleasing to note from the inquiry evidence that younger Australians are more frequently delaying and reducing AOD use, risky use still remains high among this group, creating the potential to impact the life-long trajectories of many people.
- 7.63 Factors that influence a young person's interaction with AOD are complex, often overlap and can be increased with the challenges of navigating normal adolescent development. This period can come with social, academic, family and peer pressures and AOD use can often be used as a coping mechanism. As challenges are often broader than just AOD, the Committee agrees that a holistic and non-judgemental approach to programs, services and supports is needed. This means that other sectors outside of just AOD, including education and mental health need to have the capability and capacity to address AOD use as part of their responses.
- 7.64 Protective factors are also important to reduce the risk of AOD-related harms in young people, as well as promoting healthy development, resilience and wellbeing. These can significantly support a young person as they transition into adulthood and beyond with family, school, peer and community support enablers to help build these protective factors.
- 7.65 The Committee was pleased to note the many examples of evidence-based school programs that look to strengthen protective factors, prevent or delay the initiation of harmful AOD use and equip young people with supports to be able to make informed life choices. However, the concerns expressed in the inquiry that AOD education programs are not equally distributed throughout schools in Australia, with a significant proportion of school students not receiving alcohol or drug education at school, are also noted. Whilst teachers are not solely responsible for delivering these programs, it is clear that other barriers to provision of AOD education include up-to-date information and evidence-based teaching practices, training as well as formalised guidance for educators.

Recommendation 9

- 7.66 The Committee recommends that the Australian Government works to implement mandatory evidence-based alcohol and other drug education programs for secondary school students. These programs must include a strengthening of protective factors, consideration of the National Principles for school drug education, a focus on Fetal Alcohol Spectrum Disorder and the risks of prenatal alcohol exposure. These programs must also be tailored to**

different population groups including Aboriginal and Torres Strait Islander students and those from culturally and linguistically diverse backgrounds.

Recommendation 10

- 7.67 The Committee recommends that the Australian Government provides supporting guidance for schools on the implementation of alcohol and other drug education to ensure that teachers and other educators have the capability and confidence to have conversations with students around alcohol and other drugs.**
- 7.68 It was clear from the inquiry evidence that the family environment is also an important factor in potentially risky AOD use and it was concerning to see evidence showing the correlation between family behaviours and attitudes influencing an individual's AOD consumption. This was particularly troubling with regard to the normalising of drinking alcohol in some cases among children.
- 7.69 The Committee believes that greater guidance, evidence-based programs, resources and support need to be provided to families to ensure they are appropriately equipped to communicate, support and positively influence their children's choices around AOD use. The broader policy environment, such as the promotion of alcohol as already discussed in this chapter, also plays a role in normalising drinking in the Australian culture.

Recommendation 11

- 7.70 The Committee recommends the Australian Government provides resources and guidance for parents to support them to have informed discussions around alcohol and other drugs. This guidance should include detailed information on Fetal Alcohol Spectrum Disorder and the risks of prenatal alcohol exposure.**
- 7.71 Evidence received throughout the inquiry consistently highlighted the role that other sectors play in AOD prevention, early intervention, harm reduction, treatment and recovery. AOD use often does not present as the sole reason a person is seeking support, and that there are other factors that also need to be addressed. Services should be equipped therefore to deliver appropriate care, identify issues early and refer on to other services in a timely manner.
- 7.72 It is paramount that there be greater integration and better partnerships across sectors to adequately address these complexities. This includes sectors such as employment and housing, mental health, family, domestic and sexual violence, education and justice. This could include cross-sector training and education, partnerships that improves the provision of integrated care and referral between services, as well as enabling better access to basic needs that will significantly improve how someone participates in their treatment and recovery journey, for example housing and employment.

- 7.73 The inquiry evidence also highlighted that a high number of individuals present with both co-occurring substance use and mental health problems. There have been notable improvements to the integration of mental health and AOD services, but many individuals clearly continue to receive fragmented care that can lead to poorer outcomes. There continues to be a need to improve partnerships between AOD and mental health services, greater integration of support between services, referral pathways, and multidisciplinary care.
- 7.74 It was noted by the Committee that complexities exist between AOD use and FDSV. Regardless of whether AOD use increases the frequency and severity of FDSV, or if using AOD is a coping mechanism due to FDSV, the ongoing harms to the victims, children, families and the community are unacceptable and need greater support. The Committee acknowledges that in most cases, victims of FDSV are predominately women and as such, the focus for supports will be through this gendered lens.
- 7.75 The Committee was concerned to hear evidence that AOD and FDSV services are not equitably accessible to those experiencing FDSV or with a substance use disorder, or that both the AOD and FDSV sectors are not appropriately trained and equipped to support either victim-survivors or those with AOD dependence.
- 7.76 There needs to be greater integration of support between the AOD and FDSV sectors and this is urgent. This must occur through earlier identification and provision of care for FDSV and AOD-related harms, improved referral pathways, and access to training and education. There also needs to be greater availability of AOD services that are gender-specific and/or flexible where childcare responsibilities or fear of child protection involvement are factors in being able to access care.
- 7.77 There are also other significant barriers and enablers that affect a person's ability to interact with their own treatment and recovery journey. Access to employment and housing are probably less well known but significant factors that impact AOD use and the ability to access treatment support. This is especially important given current cost of living pressures, noting that socio-economic disadvantage is increased in already vulnerable populations and those at greatest risk of AOD harm.

Recommendation 12

- 7.78 The Committee recommends that the Australian Government funds cross-sectoral alcohol and other drug training to include the mental health, family, domestic and sexual violence, employment, housing and justice sectors, to build their capacity, capability, and shared expertise, and thereby improve support for people with intersecting needs.**

Recommendation 13

- 7.79 The Committee recommends that the Australian Government work with the States and Territory governments to increase investment in integrated models of care with the aim of reducing fragmentation between services, improving**

referral pathways, and responding to co-occurring needs. The implementation of this should be conducted concurrently with that of recommendation 15.

- 7.80 Greater investment and focus clearly needs to go into housing support, including short to mid-term housing for those trying to access treatment, transitional accommodation for those leaving prison, as well as programs such as the 'Housing first approach'.
- 7.81 The Committee believes that this is especially important for those leaving the criminal justice system, where evidence to the inquiry has indicated that people in prison experience higher rates of homelessness and housing instability, increasing their risk of AOD dependence.
- 7.82 Prevention and early intervention are paramount in supporting the long-term wellbeing and treatment trajectory of a person requiring an AOD intervention. Screening and assessments aim for early identification that can reduce or prevent problematic AOD use and dependence. The Committee was dismayed to see this was not seemingly part of standard practice. The implementation of evidence-based, validated screening tools for use by health professionals must be a priority in this regard, ensuring continuity in approach, with consideration in ensuring conversations are non-stigmatising, and tailored to population groups. This is especially important when considering issues such as the low awareness of alcohol risk guidelines, the prevalence of prenatal alcohol consumption, and the high rate of FASD in Australia.

Recommendation 14

- 7.83 The Committee recommends that the Australian Government implements routine alcohol screening and brief intervention in primary and antenatal care services.**

Recommendation 15

- 7.84 The Committee recommends that the Australian Government builds the capability of the primary and antenatal care workforce to undertake screening and brief intervention through provision of training and professional development. This should incorporate the Australian Guidelines for Assessment and Diagnosis of Fetal Alcohol Spectrum Disorder.**
- 7.85 Addressing AOD-related harms needs consideration of the continuum of care, the mitigation of stigma and discrimination, a specific tailoring to population groups, and consideration of other intersecting factors. The evidence highlighted that a one-size fits-all approach is not appropriate. In addition, whilst there continues to be a need for sustained investment in treatment services, a focus on other models of care that complement existing service offerings is also required.
- 7.86 Digital technologies present the greatest opportunity to complement existing service delivery and represent an area where the Commonwealth Government has a definite leadership role. With current demand for AOD services not able to be met in

Australia, investments in digital technologies that focus on earlier interventions have the potential to reduce AOD harm before more intensive treatment is required. Digital technologies can also help to address accessibility issues due to geographical barriers, stigma or financial constraints.

- 7.87 A number of examples of effective screening, brief interventions, and referrals to treatment digital tools were provided throughout the inquiry. Whilst these examples were encouraging in terms of their uptake and rates of success, the Committee's view is that Australian Government leadership could support an improved integration of pathways between digital service models that would greatly benefit people needing to access more than one model.
- 7.88 With the aim of complementing existing services, national guidance is also needed to improve connections between face-to-face services and digital tools. This has the potential also to improve pathways and access into services, as well as provide a better integration between services, supports and across sectors. Equipping people with more accessible digital tools and referral pathways for the self-management of mild-to-moderate AOD risk should allow other services to focus on more complex cases.
- 7.89 The Committee is cognisant that digital tools may not be appropriate for people with complex requirements or dependence, or for some priority population groups, like Aboriginal and Torres Strait Islander people or those experiencing homelessness.

Recommendation 16

- 7.90 The Committee recommends that the Australian Government invest in the scaling of digital models-of-care that can provide evidence-based prevention and early intervention services for alcohol and other drugs. The aim is to expand the reach, accessibility and effectiveness of these tools, improve the integration between different tools, and develop more effective connections between digital and face-to-face services.**
- 7.91 The Committee regards the Commonwealth Government's recent investment in mental health digital health services as a blueprint for what could be done for AOD-specific digital supports.
- 7.92 The AOD workforce plays a critical role in reducing AOD-related harms, and the Committee acknowledges the dedication and skill of these workers, and the challenges and demands that are placed on them. The issues raised during the inquiry around the barriers to recruitment and retention in the AOD workforce are stark. It is important to acknowledge that these issues are further exacerbated by the stigma associated with AOD harms attached to not just the affected person but also the workforce itself.
- 7.93 Given that workforce shortages are not unique to the AOD sector, consideration needs to be given to innovative solutions that can harness the workforces across sectors, better develop and utilise new workers, including the lived and living

experience workforce (ie, the peer workforce) and the Aboriginal and Torres Strait Islander Workforce. Ensuring the equity of services, particularly in regional, rural and remote Australia, has to be at the forefront of this also.

- 7.94 The Committee agrees fully that there is a need to also better equip the broader health workforce, including Aboriginal Health Workers, medical, nursing and allied health employees, with the capabilities needed to support the early identification of AOD-related harms and the subsequent management of people at risk from them. Such a workforce would be better placed to prevent, detect and manage harm from AOD use, as well as improve the referral system and promote the integration of care across services. This is especially important in rural, regional and remote Australia due to their smaller specialist workforces.
- 7.95 Attracting people to train and then remain in rural, regional and remote Australia is another challenge for the AOD service sector. The inquiry evidence emphasised the need to improve rural-specific AOD educational opportunities to harness the workforce already available, as well as expand training programs and funding pathways for health professionals in these regions to improve their capacity to deliver AOD care.

Recommendation 17

- 7.96 The Committee recommends that the Australian Government look at improving access to general and other health practitioners by funding prolonged consultations through the Medicare system, as well as funding an increase in the employment of drug and alcohol nurses.**

Recommendation 18

- 7.97 The Committee recommends that the Australian Government work with the State and Territory governments to improve the recruitment and retention of the alcohol and other drugs workforce. This strategy must address workforce shortages in regional, rural and remote Australia, and build alcohol and other drug capabilities among medical, nursing, allied health and Aboriginal health workers.**

Recommendation 19

- 7.98 The Committee recommends that the Australian Government work with medical colleges to mandate alcohol and other drug training in their learning curricula.**
- 7.99 The Committee acknowledges that the peer workforce plays a significant role in delivering AOD services across the continuum of care and agrees that, as stated in the evidence from multiple contributors to the inquiry, more needs to be done to strengthen and harness this particular cohort among the AOD workforce. Presently, it appears that there is not a consistent approach to how peer workers are recruited,

trained, recognised or supported in the long-term across Australia. The peer workforce would benefit from a greater commitment nationally to recognise and harness their value in the AOD service sector. This should include formalised career development opportunities, targeted training, leadership pathways, and recognised qualifications. A better understanding and clarity around peer worker roles, through well considered position descriptions and integration of these roles into care models, as well as better resources for organisations to employ them, will be vital.

Recommendation 20

7.100 The Committee recommends that the Australian Government work with the States and Territory governments to develop a nationally consistent framework for recognising and employing peer workers in the alcohol and other drug service sector. This framework should include:

- **The development of national guidelines.**
- **The development and delivery of training and education through targeted training programs, recognised qualifications, and career development opportunities.**
- **The development of proper position descriptions and the integration of peer workers into care models.**
- **The development of resources to support the employment of peer workers.**
- **The development of guidance to ensure that lived experience is embedded into alcohol and other drug service design, governance, delivery and evaluation.**

7.101 The funding and commissioning of AOD measures is a further barrier to both the accessibility of AOD services, and the employment and retention of the workforce needed to deliver them. Substantial evidence was provided to the inquiry around the shortfalls caused by short-term funding and inconsistencies in contracting and performance reporting.

7.102 It was clear to the Committee during the inquiry that there is a link between longer-term funding cycles and better AOD service provision, including through planning and continuity activities and workforce recruitment and retention. Unfortunately, inconsistencies between Commonwealth agencies, and between Commonwealth and State and Territory governments, is actively disrupting the quality of care that can be provided.

7.103 This is exacerbated by inconsistencies in reporting requirements and performance indicators, the application of indexation in contracts, and the application of standards of care such as, for example the *National Quality Framework for Drug and Alcohol Treatment Services*. The result of this can be resource constraints when needing to adhere to different reporting requirements, the inability to attract and retain a workforce due to indexation, and a reduction in monitoring of the standards of care being provided.

- 7.104 The Committee understands that alignment of these issues between Commonwealth and State and Territory governments will be challenging but regards it as imperative that work is conducted to bridge these gaps. Recent changes to the Department of Health's Drug and Alcohol Program are a positive step forward in this respect as they include a commitment to longer-term funding and updates to performance reporting requirements.
- 7.105 The Committee believes the Australian Government should play a more proactive role across relevant agencies and with State and Territory governments to improve the consistency in reporting requirements, standards of care, and indexation of funding offers. This view is in line with recent findings from an evaluation of the Commonwealth's Drug and Alcohol Program.

Priority populations

- 7.106 The inquiry received compelling evidence that many priority populations continue to experience poorer access to AOD services and disproportionately higher levels of AOD-related harm. These populations, including Aboriginal and Torres Strait Islander peoples, people living in rural and remote areas, culturally and linguistically diverse (CALD) communities, young people and LGBTQIA+ Australians, often face additional barriers such as stigma, discrimination, workforce shortages, geographic isolation and a lack of culturally safe or tailored services. Addressing these inequities must be a central objective of the next National Drug Strategy to ensure that communities experiencing the greatest burden of harm can access timely, appropriate and effective care.
- 7.107 Evidence to the inquiry also highlighted significant disparities in both service access and health outcomes across priority populations. Witnesses consistently emphasised that service availability alone does not guarantee equitable access, with culturally safe care, responsive service design and community-led approaches identified as critical to improving engagement and outcomes.
- 7.108 The Committee considers it essential that the next iteration of the National Drug Strategy include measurable equity targets and regular public reporting on access and outcomes, enabling governments and service providers to monitor progress, identify persistent gaps and ensure accountability for improving outcomes among priority populations.

Recommendation 21

- 7.109 The Committee recommends that the Australian Government embed equity for priority populations as a central objective of the next version of the National Drug Strategy, including measurable equity targets, public reporting on access and outcomes, and assessment of unmet demand for alcohol and other drug services.**
- 7.110 The Committee is also concerned by the evidence it received demonstrating substantial gaps in the data available to assess unmet need and service accessibility.

It is clear that existing datasets do not adequately capture the experiences of priority populations, including CALD communities and other cohorts with specific treatment needs. The Committee notes from the inquiry evidence that limitations in data collection can obscure the true extent of unmet demand and hinder effective service planning and resource allocation.

- 7.111 Improved assessment and reporting of unmet demand for AOD services would provide governments across Australia's different jurisdictions with a stronger evidence base to direct investment where it is most needed and again better support the development of services that are accessible, culturally appropriate and responsive to local community needs. Embedding equity objectives alongside improved measurement of demand and outcomes would also help ensure that future policy responses are targeted towards reducing disparities and improving health outcomes for all Australians.

Recommendation 22

- 7.112 The Committee recommends that the Australian Government promotes the improvement of national alcohol and other drug datasets to better identify the access, needs and outcomes of priority populations. This must involve the consistent and appropriate collection of cultural, language, migration-related, sex, gender, variations of sex characteristics and sexual orientation indicators, where safe and appropriate.**

- 7.113 Aboriginal and Torres Strait Islander peoples experience a disproportionate burden of AOD related harm, driven by a complex interplay of social and economic disadvantage, intergenerational trauma and systemic racism. Evidence presented to the inquiry indicated strongly that Aboriginal and Torres Strait Islander peoples experience significantly higher rates of AOD-related disease burden, treatment episodes and drug-related mortality than other Australians. Despite this heightened need to address AOD harms among First Nations communities, the *National Aboriginal and Torres Strait Islander Peoples' Drug Strategy 2014–2019* has lapsed and not been replaced, leaving a significant gap in the national policy framework.

- 7.114 The Committee is concerned that the continued absence of this dedicated strategy has reduced opportunities for Aboriginal and Torres Strait Islander peoples to shape national AOD policy and priorities. The Committee also understands the importance of self-determination and partnership in the design of effective responses. Aboriginal and Torres Strait Islander communities are best placed to identify local needs and develop culturally appropriate solutions. Additionally, governance arrangements which embed Aboriginal and Torres Strait Islander leadership are critical to delivering coordinated, effective and culturally safe policies and programs.

- 7.115 A renewed National Aboriginal and Torres Strait Islander Peoples' Drug Strategy would provide a dedicated framework for addressing the unique challenges faced by Indigenous communities and ensure that policy responses are informed by lived experience, community expertise, and evidence-based culturally appropriate practice. Such a strategy should be developed in genuine partnership with Aboriginal

and Torres Strait Islander peoples, Aboriginal Community Controlled Organisations (ACCOs) and relevant peak bodies, and be supported by appropriate funding and accountability mechanisms.

Recommendation 23

7.116 The Committee recommends that the Australian Government develop, fund and implement a new National Aboriginal and Torres Strait Islander Peoples' Drug Strategy, in partnership with Aboriginal and Torres Strait Islander peoples, Aboriginal Community Controlled Organisations and relevant peak bodies.

7.117 A consistent theme throughout the inquiry was the importance of culturally safe, community-led approaches to addressing AOD harms. This care is particularly impactful upon Aboriginal and Torres Strait Islander peoples for whom equitable access to services is not solely determined by whether a service exists, but by whether it is culturally safe, psychologically safe and responsive to the needs of the communities it serves.

7.118 The Committee understands that ACCOs and Aboriginal Community Controlled Health Organisations (ACCHOs) have an essential role in delivering these services. These organisations possess strong community relationships, cultural authority and local knowledge, enabling them to provide care that reflects the lived experiences and cultural needs of Aboriginal and Torres Strait Islander peoples.

7.119 The Committee notes also that many ACCOs and ACCHOs face workforce and funding challenges that limit their capacity to meet existing demand. Stable and sustained investment is necessary to grow the Aboriginal and Torres Strait Islander AOD workforce, expand service availability and address unmet need within communities.

Recommendation 24

7.120 The Committee recommends that the Australian Government increase funding to Aboriginal Community Controlled Organisations and Aboriginal Community Controlled Health Organisations to deliver culturally safe, trauma-informed and community-led alcohol and other drug treatment, prevention and harm reduction services.

7.121 It is also clear to the Committee that AOD services in regional, rural and remote communities face higher delivery costs and more complex operating environments than those in metropolitan areas. Travel distances, transport availability, infrastructure maintenance, outreach delivery and the need to service geographically dispersed communities are all factors that affect this.

7.122 The Committee is concerned that current funding arrangements may not adequately account for these additional costs, which will result in inequitable access to treatment and support. Funding arrangements also do not seem to account for factors reducing

the capacity of rural, regional and remote services to meet local demand, such as workforce shortages, higher operating costs and housing availability.

- 7.123 The Committee considers that a review of AOD funding models is necessary to ensure equitable access to services regardless of where people live. Such a review should examine whether current funding settings adequately account for the true costs of delivering treatment, prevention and harm reduction services in regional, rural and remote communities.

Recommendation 25

- 7.124 The Committee recommends that the Australian Government in cooperation with the State and Territory governments reviews existing alcohol and other drug funding models to ensure they adequately reflect the higher costs of service delivery in regional, rural and remote areas.**

- 7.125 People living in regional, rural and remote communities experience higher rates of AOD-related harm while also facing poorer access to treatment and harm reduction services. The Committee is concerned that this mismatch between need and access contributes to preventable harms and entrenches poorer health outcomes for people outside major cities.
- 7.126 A clear theme in the inquiry evidence was that harm reduction services are not consistently available or accessible across regional Australia. Limited access to needle and syringe programs, opioid dependence therapy, take-home naloxone and other harm reduction supports can leave people without practical, evidence-based interventions and this will increase their risk of overdose, blood-borne virus transmission and other AOD-related harms.
- 7.127 Increased funding is required to expand access to harm reduction services in regional, rural and remote communities but this should be done in a targeted way, including investment in locally available and culturally safe services and harm reduction education that is responsive to the needs of Aboriginal and Torres Strait Islander peoples and other priority populations. Improving access to harm reduction services would support earlier intervention, reduce preventable harm and help ensure that people in these communities can access effective support close to where they live.

Recommendation 26

- 7.128 The Committee recommends that the Australian Government work with the State and Territory governments to improve access to harm reduction services in regional, rural and remote communities, including needle and syringe programs, opioid dependence therapy, take-home naloxone and culturally safe harm reduction education.**
- 7.129 The Committee is concerned about the distinct barriers that CALD communities face when accessing treatment and support. These barriers are compounded by limited

awareness of AOD support services, differing cultural understandings of AOD use, and stigma that discourages help-seeking.

- 7.130 AOD services do not always have the resources or capacity to respond effectively to linguistic and cultural diversity. Limited access to interpreters, translated information and multilingual workers can delay treatment and even prevent people from receiving support. The Committee is concerned that these gaps are contributing to unmet need among CALD communities and limitations in data collection are making the full extent of this need difficult to assess.
- 7.131 The Committee agrees with evidence suggesting that dedicated funding for interpreter services, translated resources and multilingual AOD supports would improve the accessibility, safety and effectiveness of services. Targeted funding would help services communicate clearly with clients, provide culturally responsive information and build trusted pathways into treatment, prevention and harm reduction programs.

Recommendation 27

7.132 The Committee recommends that the Australian Government dedicate funding for interpreter services, translated resources and multilingual alcohol and other drug supports.

- 7.133 Women face distinct and often intersecting barriers to accessing AOD treatment. Evidence to the inquiry highlighted that AOD use does not cause gender-based violence but may intensify existing patterns of family violence, coercion and abuse. This creates a need for services that are safe, trauma-informed and responsive to the needs of women.
- 7.134 The limited availability of female-only treatment services can deter women from seeking or remaining in treatment. This is particularly the case for mothers who may be unable to enter residential rehabilitation without being separated from their children or who fear that seeking support could result in child protection intervention. Residential services that enable children to remain with their mothers, where safe and appropriate, can reduce these barriers while supporting continuity of care, family connection and longer-term recovery.
- 7.135 To expand access to AOD services that are exclusively for women will require coordination between the Commonwealth, State and Territory governments. Improved integration between AOD and domestic, family and sexual violence services would also better support earlier identification of intersecting needs, safer referrals and more coordinated responses for women and children.

Recommendation 28

7.136 The Committee recommends the Australian Government work with State and Territory governments to increase access to alcohol and other drug treatment services that are exclusively for women, including residential rehabilitation

services that allow children to remain with their mothers where safe and appropriate, and improve integration between alcohol and other drug services and domestic, family and sexual violence services.

- 7.137 The Committee recognises the shared responsibility of AOD interventions and support between the Commonwealth, State and Territory governments. The Committee urges the next National Drug Strategy to fully consider and address the issues raised in this report. At a high level this includes stigma and discrimination, equity and access (particularly in priority populations), AOD funding and commissioning, evidence-based harm minimisation policies, alcohol availability measures, FASD, the AOD workforce, and a framework to support the Strategy's implementation.

Recommendation 29

- 7.138 The Committee recommends funding contracts should be of a sustainable length of at least five years. Longer term contracts allow for planning and support the recruitment and retention of the workforce supporting those seeking help with alcohol and other drug addiction or concerns.

Recommendation 30

- 7.139 The Committee recommends that drug checking and testing be used to support harm minimisation in all jurisdictions. Drug testing allows opportunities for support and strategies to cease the use of harmful drugs, education opportunities and provide surveillance strategies for rapid changes in the illicit supply chains.

Dr Mike Freeland MP
Chair
3 September 2026



A. Submissions

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- 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)
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- 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
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- 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
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- 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
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- 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
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- 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
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- 197** Department of Infrastructure, Transport, Regional Development, Communications and the Arts (DITRDCA)
- 198** NSW Users and AIDS Association (NUAA)
- 199** Health Complaints Commissioner
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- 200** The Department of Health, Tasmanian Government
- 201** Ms Angelene Bruce
- 202** Confidential
- 203** Ms Patricia Koskovic
- 204** Harvest Advisory and Research

47th Parliament – 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
- 10 Alcohol Change Australia – additional information
- 11 Confidential
- 12 Confidential
- 13 Department of Health and Aged Care – answers to question taken on notice at a public hearing on 7 February 2025

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- 1 Centre for Women's Health Research and the Australian Longitudinal Study on Women's Health
- 2 Advanced Pharmacy Australia
2.1 Supplementary to submission 2
- 3 *Name Withheld*
- 4 Mrs Heidi Gray
- 5 Australian Multicultural Action Network
- 6 Next Gen Nurse Practitioners
- 7 Australian Medical Association
- 8 Australian Criminal Intelligence Commission
- 9 Massage & Myotherapy Australia
- 10 Australasian College for Emergency Medicine
- 11 Australian Alcohol and other Drugs Council (AADC)
- 12 WRAD Health
- 13 Alcohol, Tobacco and Other Drug Association ACT (ATODA)
- 14 Country SA PHN
- 15 Australian College of Midwives
- 16 Relationships Australia

- 17** Lung Foundation Australia
- 18** Mr Luke Twyford, Queensland Family and Child Commission
- 19** Deakin University

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- 20** Hon. Professor Cathy Humphreys
- 21** Health Justice Australia
- 22** Cancer Council Australia
- 23** Hepatitis Australia
- 24** Alcohol and Drug Foundation
- 25** headspace National Youth Mental Health Foundation

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- 26** PHN Cooperative
- 27** Our Watch
- 28** RSL NSW
- 29** Blurred Minds - Griffith University
- 30** Confidential
- 31** NSW Users and AIDS Association
- 32** Australian Research Alliance for Children and Youth (ARACY)
- 33** EDON Place
- 34** Confidential
- 35** Ms Amanda Wyer
- 36** Australian Dental Association
- 37** Dr Pushkar Cordoba
- 38** QuIVAA and QuIHN
- 39** Adj. Professor Michael Akindeju
- 40** Confidential

- 41 Qld Network of Alcohol and other Drug Agencies (QNADA)
- 42 Australian National Audit Office
- 43 Western Australian Network of Alcohol and other Drug Agencies (WANADA)
- 44 NOFASD Australia
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- 49 Incolink
- 50 Alcohol Change Australia
 - 50.1 Supplementary to submission 50
- 51 Alcohol Beverages Advertising Code Scheme Ltd (ABAC)
 - 51.1 Supplementary to submission 51
- 52 St Vincent de Paul Society NSW & QLD
- 53 Australian Nursing and Midwifery Federation (ANMF)
- 54 Better Health Network (BHN)
- 55 Public Health Association of Australia
- 56 Australasian Therapeutic Communities Association
- 57 AIVL - Australian Injecting and Illicit Drug Users League
- 58 Mr Jack Davenport
- 59 Ms Donna Bennett
- 60 *Name Withheld*

61 Kristen Foley, Professor Paul Ward and Dr Belinda Lunnay

62 National Rural Health Alliance

63 Ms Corrine Barraclough

64 Carers NSW

65 First Step

66 Network of Alcohol and other Drugs Agencies

66.1 Supplementary to submission 66

67 Australian Institute of Family Studies

68 Australian Grape & Wine

69 Public Health & Economics Modelling Team, School of Medicine and Dentistry,
Griffith University

70 The Australian Christian Lobby

71 Scarlet Alliance, Australian Sex Workers Association

72 Financial Counsellors' Association of Western Australia (FCAWA)

72.1 Supplementary to submission 72

73 Flinders University

74 Juliet Vrakas

75 Royal Australian College of General Practitioners

76 Penington Institute

Attachment 1

77 Private Healthcare Australia (PHA)

78 Gayaa Dhuwi (Proud Spirit) Australia

79 SHARC

80 Foundation for Alcohol Research and Education (FARE)

81 Department of Health, Disability and Ageing

82 UNSW School of population health advocacy lab

- 83** Australian College of Nursing
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- 86** Alcohol and Other Drug Knowledge Centre
- 87** Camurus Pty Ltd
- 88** Department of Social Services
- 89** Cyrenian House
- 90** WA Primary Health Alliance
- 91** Alcohol and other Drugs Services Central Australia
- 92** Turning Point Eastern Health and the Monash Addiction Research Centre
- 93** ACT Government
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- 94** Royal Australasian College of Physicians
- 95** The Treasury
- 96** National Commission for Aboriginal and Torres Strait Islander Children and Young People
- 97** Australian Federal Police
- 98** Australian Institute of Health and Welfare



B. Public Hearings

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 (QulHN)

- 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

Thursday 12 March 2026 – Canberra

Department of Health, Disability and Ageing

- Ms Trish Clancy, First Assistant Secretary, Population Health
- Professor Robyn Langham, Chief Medical Adviser, Therapeutic Goods Administration
- Mr Avi Rebera, Assistant Secretary, Office of Drug Control
- Mr Ben Mudaliar, Assistant Secretary, Alcohol, Other Drugs and Food Branch

National Indigenous Australians Agency

- Ms Deborah Fulton, Acting Deputy CEO, Policy and Programs
- Ms Ali Jenkins, Group Manager, Social Policy [by video link]
- Mrs Catherine Orchard, Branch Manager, Health and Wellbeing Branch

Thursday 26 March 2026

Department of Social Services

- Mr Allan Ball, Director
- Ms Emily Hurley, Branch Manager

Department of Education

- Ms Jessica Bartlett, Director, Inclusive Practice and Autism Support
- Ms Paula Sheehan, Director, Student Mental Health and Wellbeing

Friday 27 March 2026

Foundation for Alcohol Research and Education

- Ms Ayla Chorley, Chief Executive Officer
- Ms Katherine Berney, Director, Prevention of Gendered Violence

Odyssey Victoria

- Dr Stefan Gruenert, Chief Executive Officer [by video link]

Odyssey House NSW

- Mr David Kelly, Executive Director, Programs [by video link]

Australian Multicultural Action Network Incorporated

- Mr Ravi Krishnamurthy, President [by video link]

Next Gen Nurse Practitioners

- Mr Darren Smyth, Director, Next Gen Nurse Practitioners [by video link]

Advanced Pharmacy Australia

- Ms Rhujul Patel, Senior Policy Analyst [by video link]
- Professor Suzanne Nielsen, Victorian Branch Committee Member

WRAD Health

- Mr Mark Powell, Chief Executive Officer [by video link]

National Rural Health Alliance

- Ms Carmen Ellis, Policy and Research Officer [by video link]
- Ms Susanne (Susi) Tegen, Chief Executive

Australian Medical Association

- Dr Danielle McMullen, President [by video link]

Australian College of Nursing

- Ms Frances Rice, Chief Nursing Officer

UNSW School of Population Health Advocacy Lab

- Dr Fiona D'mello, Postgraduate Student [by video link]
- Ms Amy Leahy, Postgraduate Student [by video link]
- Dr Rachel Rowe, Director [by video link]
- Ms Laura Bathie, Postgraduate Student [by video link]

UNSW, National Drug & Alcohol Research Centre

- Professor Michael Farrell, Director
- Dr Amy Peacock, Deputy Director, Associate Professor and Program Lead, Drug Trends
- Dr Michala Kowalski, Postdoctoral Research Fellow

UNSW, Social Policy Research Centre

- Professor Alison Ritter, Director, Drug Policy Modelling Program [by video link]

CanTEST Canberra

- Ms Stephanie Stephens, Chief Operating Officer, Directions Health Services

Victoria Legal Aid

- Ms Jen Black, Co-Director, Summary Crime and Therapeutic Justice [by video link]
- Ms Elanor Peattie, Co-Director, Summary Crime and Therapeutic Justice [by video link]

Alcohol Beverages Advertising Code Scheme Ltd

- Ms Jayne Taylor, Chief Executive Officer
- Professor the Hon. Michael Lavarch, Chief Adjudicator

Tuesday 14 April 2026

Alcohol and Other Drug Consumer and Community Coalition

- Mr Alex Arpino, Executive Manager
- Ms Alice Guest, Lived Experience Representative and Member
- Mr Ben Kane, Lived Experience Representative and Member

Drug and Alcohol Nurses of Australasia

- Dr Brendan Clifford, Vice-President [by audio link]

Palmerston Association

- Mr Andy Niblock, Executive Manager, Business Development
- Mrs Rebecca Stephens, Executive Manager, Strategy, Engagement and Communication
- Mr Michael Winton, General Manager, Operations

Queensland Mental Health Commission

- Mr Sean Popovich, Director, Alcohol and other Drugs Reform [by video link]

NT Health

- Ms Ameina Brunker, Director, Community Led Harm Reduction Unit

WA Primary Health Alliance

- Mr David Wray, Senior Policy Analyst

Alcohol Change Australia

- Dr Erin Lalor, Chair [by video link]
- Ms Hannah Pierce, Executive Officer [by video link]

Western Australian Network of Alcohol and other Drug Agencies

- Mr Paul Dessauer, Chief Executive Officer, Peer Based Harm Reduction WA; and Board Director
- Mrs Rochelle McIntosh, Second in Command and Sector Development Manager
- Ms Jill Rundle, Chief Executive Officer

The University of Sydney and the CICADA Service

- Professor Elizabeth Elliott, Distinguished Professor, Speciality of Child and Adolescent Health [by video link]
- Associate Professor Sharon Medlow, Associate Professor, Speciality of Child and Adolescent Health [by video link]
- Dr Fiona Robards, Senior Research Fellow, Speciality of Child and Adolescent Health, Faculty of Medicine and Health [by video link]

Australian Indigenous HealthInfoNet

- Dr Bep Uink, Director [by video link]

University of Newcastle

- Dr Kelly McNamara, Senior Lecturer, Obstetrics and Gynaecology [by video link]

Private capacity

- Ms Ebony Quintrell

National Drug Research Institute, Curtin University

- Dr Michael Curtis, Research Fellow [by video link]
- Professor Paul Dietze [by video link]
- Professor Paul Griffiths, Director
- Dr Jodie Grigg, Research Fellow
- Professor Simon Lenton
- Professor Nyanda McBride, Prevention and Early Intervention Team [by video link]
- Dr Nicholas Taylor, Research Fellow [by video link]

Injury Matters

- Ms Sandy Lukjanowski, Chief Executive

Financial Counsellors Association of Western Australia

- Ms Sarah Holman, Policy and Advocacy Lead
- Ms Melanie Hopkinson, Chief Executive Officer

Wednesday 15 April 2026

Goldfields Rehabilitation Service Inc.

- Mrs Jane Fajardo, Chief Executive Officer [by video link]

Jacaranda Community Centre Inc.

- Mrs Lyndsey Fitzgerald, Chief Executive Officer

Kathleen York House, Alcohol and Drug Foundation NSW

- Dr Latha Nithyanandam, Chief Executive Officer [by video link]

Drug and Alcohol Services Australia

- Ms Jocelyn Dhu, Deputy Chief Executive Officer [by video link]

Central Australian Aboriginal Congress

- Ms Ebony Abbott-McCormack, Director and Chairperson [by video link]
- Dr John Boffa, Chief Executive Officer and Chief Medical Officer, Public Health [by video link]

Association of Alcohol and Other Drug Agencies Northern Territory

- Mrs Stephanie Holmes, Executive Officer
- Dr Jennifer Summerville, Capacity Building and Engagement Coordinator

Drug and Alcohol Services South Australia

- Mr Mark Thompson, Director, Aboriginal Clinical Services and Strategy [by video link]

Thursday 14 May 2026

headspace National Youth Mental Health Foundation

- Dr Carl Heslop, National Clinical Adviser [by video link]
- Ms Nicola Palfrey, Head of Clinical Practice

The Royal Australasian College of Physicians

- Professor John Saunders, President, Australasian Chapter of Addiction Medicine

The Royal Australian College of General Practitioners

- Dr Hester Wilson, General Practitioner and Addiction Specialist; and Chair, Addiction Medicine Specific Interest Group [by video link]

Thursday 28 May 2026

Alcohol Beverages Australia

- Mr Alistair Coe, Executive Director

DrinkWise

- Mr Simon Strahan, Chief Executive Officer [by video link]

Retail Drinks Australia

- Mr Kary Petersen, General Manager, Policy and Strategy [by video link]
- Mr Michael Waters, Chief Executive Officer [by video link]

Friday 29 May 2026

Australian Injecting and Illicit Drug Users League (AIVL)

- Mx John Gobeil, Chief Executive Officer
- Mx Joël Murray, Policy and Evaluation Specialist

Network of Alcohol and other Drug Agencies

- Dr Robert Stirling, Chief Executive Officer

Australian Alcohol and other Drugs Council

- Ms Melanie Walker, Chief Executive Officer

UnitingCare Australia

- Mrs Fay Mound, Deputy National Director

Uniting NSW.ACT

- Dr Marianne Jauncey, Medical Director, Medically Supervised Injecting Centre

Uniting Vic.Tas

- Mr Adrian Webber, Executive Director, Alcohol and Other Drugs and Wellbeing Services

National Commission for Aboriginal and Torres Strait Islander Children and Young People

- Ms Sue-Anne Hunter, National Commissioner [by video link]

Self Help Addiction Resource Centre

- Ms Clare Davies, Chief Executive Officer
- Ms Emer Diviney, Manager, Association of Participating Service Users

St Vincent de Paul Society NSW

- Ms Elodie Druitt, Quality Officer, Health Services [by audio link]

- Ms Monica Yanni, Director, Health Services [by audio link]

Australian Criminal Intelligence Commission

- Mr Christopher Davey, National Manager, Operational Analysis
- Mr Adam Meyer, Acting Deputy Chief Executive Officer, Intelligence Group

Australian Federal Police (AFP)

- Mr Jim Rowe, Acting Commander, Crime
- Ms Raegan Stewart, Acting Assistant Commissioner, Crime

Institute for Health Transformation, Deakin University

- Professor Matthew Dunn, Associate Professor, Institute for Health Transformation [by video link]

Griffith University, Blurred Minds program

- Dr Pamela Saleme, Research Lead [by video link]

Australian Institute of Health and Welfare

- Mr Alistair Beasley, Executive Director
- Dr Louise Tierney, Head, Tobacco, Alcohol and Other Drugs Unit

Australian Institute of Family Studies

- Ms Agatha Faulkner, Senior Manager [by video link]
- Dr Sean Martin, Acting Group Head, Data and Lifecourse Studies [by video link]
- Dr Kristen Power, Senior Research Officer [by video link]

Australian Research Alliance for Children and Youth (ARACY)

- Mr Christopher Hatano, Young and Wise Representative
- Melodie Potts Rosevear OAM, Chief Executive Officer



Supplementary comments - Dr Monique Ryan MP

I support the Committee's thirty recommendations and thank my colleagues on the Committee, the secretariat, and the many individuals and organisations who contributed evidence to this inquiry.

I particularly thank the Committee's chair, Dr Mike Freeland MP, for his hard work and generous leadership. It's a privilege to serve as Mike's Deputy on a committee dedicated to evidence-based, consultative and collaborative inquiries.

I believe the Committee's report makes a substantial contribution to the evidence base on alcohol and other drug (AOD) harm in Australia. I provide these supplementary comments to draw attention to several matters that, in my view, warrant either a stronger response than the report currently provides, or an examination that the inquiry's findings do not yet extend to. These comments should be read as amplifying, not detracting from, the Committee's work.

1. Treatment capacity and the missing middle: inpatient and high-intensity care

The inquiry heard that between 180,000 and 553,000 Australians a year are unable to access AOD treatment they need, and that specialist addiction services are in short supply in rural and remote Australia, resulting in extensive wait times for treatment. The Committee's response to this largely consists of a workforce response — funding for prolonged Medicare consultations and AOD nurses (Recommendation 17), workforce recruitment and retention (Recommendation 18), and a review of funding models for regional and remote areas (Recommendation 25).

These measures are necessary but insufficient. They can't, on their own, close the gap between demand and the availability of high-intensity treatment options, particularly inpatient detoxification and residential rehabilitation. These beds remain critically undersupplied relative to demand across Australia. The shortfall is most acute outside metropolitan centres, where patients often face the choice of very long waits, travel of hundreds of kilometres away from family and community, or no treatment at all. This issue is particularly relevant for those under 18, for whom the inquiry heard there is a particular shortage of rehabilitation services.

I recommend that the government should commission a national audit of inpatient and residential AOD treatment capacity against modelled demand (including for youth and adolescent services), broken down by region, as a companion to the funding model review

proposed in Recommendation 25, and that it should prioritise funding certainty for these services alongside the workforce measures the Committee has recommended.

2. Harm reduction and the Drug and Alcohol Program

The National Drug Strategy 2017–2026 recognises harm reduction as one of three pillars of Australia's response to alcohol and other drug harm, alongside demand and supply reduction. The Commonwealth's Drug and Alcohol Program (DAP) — its primary investment in AOD health, which delivered over \$800 million across 819 activities between 2021–22 and 2024–25 and is set to receive \$727 million over the following three years and \$244.2 million annually from 2029–30 — is currently being redesigned through a staged consultation process led by the Department of Health, Disability and Ageing. That redesign has not given harm reduction the standing that the National Drug Strategy assigns it.

The independent October 2025 KPMG/University of Queensland evaluation of the DAP found that harm reduction services received just 2 per cent of DAP direct grants, and no PHN-commissioned grants at all, between 2021–22 and 2024–25. It recommended that the program support initiatives addressing emerging needs, including harm reduction strategies. Despite this finding, the Stage 2 and Stage 3 program logic and KPIs released over the course of 2026 did not establish harm reduction as a standalone pillar: in fact, the term appears only once in the outputs and outcomes framework, and in just one of several dozen KPIs.

Needle and syringe programs, pill testing services and supervised injecting rooms have been explicitly excluded from DAP funding, on the basis that harm reduction is a matter for state and territory legislation. This rationale does not withstand scrutiny. Almost all AOD services, including those the DAP already funds, are delivered by states and territories under their own legislative frameworks. Needle and syringe programs operate in every state and territory and provide a critical link to the health system for a highly marginalised population; their exclusion is difficult to justify on public health grounds.

Penington Institute, jointly with the Australian Alcohol and Other Drugs Council and the Australian Injecting and Illicit Drug Users League, wrote to the Minister for Health in May 2026 seeking that harm reduction be more meaningfully embedded in the DAP framework. The Minister's office acknowledged harm reduction as a key cross-cutting approach, but the Stage 3 program logic and KPIs, finalised in July 2026, contained no additional references to harm reduction. 2024 was the worst year on record for fatal drug overdoses in Victoria, and in Australia as a whole.

I recommend that harm reduction be established as a standalone pillar within the DAP's program logic, outcomes framework and KPIs, with a dedicated and adequately resourced funding stream.

I also recommend that needle and syringe programs, pill testing services and supervised injecting rooms be made explicitly eligible for Commonwealth DAP funding, consistent with their status under the National Drug Strategy. A national drug strategy can't be effective while one of its three stated pillars remains effectively absent from the national funding program designed to support it.

3. Aftercare and the revolving door

This report captures examples of good aftercare practice, such as the Clean Slate Clinic's twelve-month model and SMART Recovery's relapse-prevention resources. However, it does not examine aftercare provision as a systemic issue or connect the gaps in continuing care to relapse and to recidivism, despite the Committee's acknowledgment that diversion to AOD treatment reduces recidivism as well as acute care presentations.

Treatment without continuing care too often produces a revolving door: crisis intervention, brief stabilisation and relapse, followed by re-presentation to acute services, the justice system, or both.

I recommend that any future National Drug Strategy, and the funding model reforms the Committee has recommended, should treat continuing care and aftercare as a core component of the treatment pathway, rather than an optional extra contingent on the capacity of individual services.

4. First Nations AOD services and data collection

I support Recommendation 23 (a new National Aboriginal and Torres Strait Islander Peoples' Drug Strategy) and Recommendation 24 (increased ACCHO funding) without reservation. The report highlights NACCHO's evidence of a 20–30 per cent decline in ACCHO clinical FTE per 1,000 population, and a 50 per cent increase in unfilled positions since the COVID19 pandemic.

Inconsistent and discontinuous AOD data collection for Aboriginal and Torres Strait Islander people is both a service-planning problem, as framed by Recommendation 22, and a Closing the Gap accountability problem.

The government's ability to monitor progress against the Closing the Gap health and wellbeing targets is directly compromised by deficits in AOD data collection across jurisdictions.

It's my recommendation that future national AOD datasets should be explicitly and formally linked to Closing the Gap reporting obligations, such that data gaps in this sector don't obscure lack of progress against national commitments to First Nations health equity.

5. Fetal Alcohol Spectrum Disorder

I strongly support Recommendation 6 and the report's overall treatment of FASD. I'm concerned, however, that the report does not assess inadequacies in the government's implementation of the thirty-two recommendations made by the Senate Community Affairs References Committee's 2021 inquiry into FASD.

Australia still lacks consistent screening and diagnostic services, particularly in the criminal justice and education sectors, and adequate resourcing for treatment of FASD — five years after the 2021 Inquiry recommended them as priorities.

Two further gaps deserve attention. First, there is no National Partnership Agreement funding stream dedicated to FASD assessment and diagnosis, despite diagnostic waitlists of up to three years in some services. Secondly, the report establishes — without stating it explicitly — that people with FASD in the criminal justice system are routinely excluded from disability support because FASD-related impairments often do not meet criteria for access to the NDIS, the Disability Support Pension, or relevant Medicare items. Given that as many as 36 per cent of children in some youth justice facilities have been diagnosed with FASD, as many as 74 per cent of these being First Nations, this is a significant equity and justice failure.

I recommend that the government review eligibility settings for the NDIS, DSP, and Medicare, to ensure that a diagnosis of FASD, and the functional impairments that flow from it, are properly recognised for access purposes — including for children and adults in the criminal justice system — and that professional development on FASD be extended across the health, education, child protection, and justice sectors, as a matter of priority.

6. Alcohol industry accountability: the ABAC scheme, political influence and donations

In the absence of federal legislation, the regulation of alcohol marketing is currently left to the industry-developed ABAC (Alcohol Beverages Advertising Code) Scheme. ABAC is funded and governed by the alcohol industry itself (the Brewers Association of Australia, Spirits & Cocktails Australia, Australian Grape & Wine).

The ABAC's scope is too narrow: it mostly regulates content, not quantity or exposure. It includes some rules for TV and licensed premises but fails completely to address online advertising of alcohol. It undertakes no proactive monitoring or enforcement; it's entirely reliant on community complaints, which can take a long time to resolve.

This is not merely a design flaw. ABAC's own 2023 review acknowledged that replacing the scheme with enforceable government standards is a matter for Australian governments and outside the scope of that review, and that even upheld complaints carry no consequences because the scheme remains entirely voluntary. Alcohol kills an Australian every 90 minutes and hospitalises another every three-and-a-half minutes; a self-regulatory scheme with no penalties for non-compliance is not commensurate with harm of this scale.

Industry self-regulation means that vested commercial interests are free to work against effective restriction of alcohol marketing. It's clear that self-regulation does not and cannot adequately safeguard children, adolescents or young people, or those at highest risk of alcohol abuse.

Effectively, the fox has been left in control of the henhouse, and alcohol marketing is largely unregulated in this country.

The committee heard that Australian children aged 8 to 13 see an average of four alcohol advertisements a day, increasing to six for 14 to 17 year-olds and seven for 18 to 25 year-olds. It further heard that Australia has no comprehensive statutory regulations specifically targeting alcohol advertising on digital platforms. Recommendation 1's new mandatory

framework must be implemented as a matter of priority, with digital and social media platforms being a first-order target for this framework.

I support the Committee's recommendation to establish a new mandatory marketing framework for alcohol (Recommendation 1), and to remove the government's representative from the Alcohol Beverages Advertising Code Scheme Management Committee (Recommendation 2). I support the calls from FARE and the ADF for a legislated Harmful Products Marketing Act to regulate alcohol advertising across digital and online platforms. This should prohibit the tracking, profiling, and targeting of children online for commercial purposes, and limit their exposure to alcohol advertising. It must be backed by mandatory compliance and monitoring, independent (non-industry) administration and enforcement, and proactive surveillance measures like those applied to tobacco advertising.

The National Alcohol Strategy treats alcohol harm largely as a matter of individual behaviour and service response, without addressing the industry structures and incentives that help drive that harm. I recommend that future National Alcohol Strategies explicitly address commercial determinants of health.

In 2024-25, an election year, alcohol and gambling companies and their lobby groups donated more than \$5.5 million to Australia's political parties—more than double the previous year—with alcohol-only donors contributing \$1.9 million of that total. The Coalition took over half of these donations, with Labor close behind. The Australian Hotels Association stood out as the single largest donor.

These sums are directed overwhelmingly at the major parties because they currently hold the levers of alcohol policy—taxation, licensing hours, advertising restrictions, labelling and harm-reduction measures. Donations of this scale buy access and goodwill that ordinary citizens and public health advocates can't compete with.

When an industry that profits from harmful consumption is simultaneously funding the parties that regulate it, the public is entitled to ask whether decisions on alcohol reform reflect the national interest or the interests of donors. Even where no explicit quid pro quo can be proven, the perception of undue influence corrodes trust in our democratic institutions.

I therefore recommend that donations from alcohol companies and industry lobby groups to political parties and candidates be prohibited, and that alcohol industry bodies should be excluded from formal alcohol policy development processes — consistent with the model already applied to the tobacco industry under Article 5.3 of the WHO Framework Convention on Tobacco Control. An industry whose products cause the sort of health and social harm documented in this report should not hold a seat at the table when governments decide how that harm is to be regulated.

7. Marketing, pricing and availability: unfinished business

I support Recommendations 1 through 5 in full and raise two further points.

Taxation and pricing. I support Recommendation 3's call for Treasury modelling of alcohol taxation settings and suggest that this should be with a definite aim to reform of those settings. Australia's wine equalisation tax incentivises production of lower cost wine

products. It should be replaced with a uniform volumetric tax, a reform recommended by no fewer than nine previous government inquiries dating back to the 2010 Henry review.

I note claims in submissions from representatives of the alcohol industry – Spirits and Cocktails Australia, Retail Drinks Australia and Alcohol Beverages Australia - that sales of illicit alcohol are increasing in Australia. Comparison has been made in the media with the illicit tobacco trade, with the suggestion being made that illegal alcohol is a growing problem which should be addressed by a reduction in taxes, fees and charges for alcohol retailers. In fact, the alcohol tax gap has been found by the ATO to be essentially stable (about 9-10% per year), and there is no publicly available evidence to suggest that the price of spirits is driving the illicit alcohol trade. The committee did not find evidence to support reduction of the spirits excise system.

I also recommend that the government give serious consideration to a minimum unit price (MUP) for alcohol, informed by the Northern Territory's successful trial of a MUP from 2018-2025. That trial was associated with an 11- 21 per cent reduction in domestic violence assaults and a 50 per cent reduction in cask wine consumption. That retailers in Alice Springs have voluntarily maintained the \$1.30 floor price after its legal repeal speaks to its perceived value where it has been trialled.

Online sales. I support Recommendation 5's proposed national standards, including the 10am–10pm sales window and two-hour delivery pause. Evidence that 38 per cent of rapid-delivery users consumed more than eleven standard drinks on the day of a delivery, and that alcohol-fuelled violence is concentrated between 6pm and 3am, underlines the urgency of updating state and territory liquor laws — most of which were not designed with rapid home delivery in mind — to properly regulate this issue.

8. An emerging risk: telehealth prescribing of unregulated substances

The report notes, in passing, that “the advancement of digital service provision, such as telehealth appointments and online prescriptions, can increase access to treatments and medications... [and] these advancements need to be met with an appropriate regulatory response”, but it confines its concern to the monitoring of high-strength medicinal cannabis prescriptions. The inquiry did not examine, and the report does not address, the growing use of telehealth services to prescribe substances such as peptides and other compounds without an established evidence base or appropriate regulatory oversight.

This is a significant gap in regulation of healthcare in Australia. I recommend that the government commission a dedicated review of telehealth prescribing practices in Australia, with particular attention to the prescription of peptides and other emerging or unapproved substances, the adequacy of current prescriber obligations and oversight, and the health and safety risks these practices pose.

9. Strategic settings: the National Drug Strategy and the AOD workforce

The current National Drug Strategy 2017–2026 expires this year. The report acknowledges the need for the next iteration of the Strategy to embed equity for priority populations as a central objective (Recommendation 21) and to be accompanied by a renewed National

Aboriginal and Torres Strait Islander Peoples' Drug Strategy (Recommendation 23). I support both recommendations.

Given that the current Strategy's expiry falls within months of this report's tabling, I ask the government to provide clarity, as a matter of urgency, on the timeline, funding envelope and consultation process for its successor, so that the sector is not left operating without a national strategic and funding framework at the end of 2026.

That strategy, and the workforce measures in Recommendations 17 to 20, must also address the specific pressures on the AOD workforce identified throughout this inquiry: up to 25 per cent of AOD workers at risk of job loss within twelve months, and up to 75 per cent earning below the jurisdictional average salary; an ageing workforce, with 39 per cent aged 50 or over; and the specific, compounding pressures on GPs, AOD nurses, pharmacists and the Aboriginal and Torres Strait Islander AOD workforce, which remains underdeveloped relative to the proportion of Aboriginal and Torres Strait Islander clients the sector serves. Workforce reform cannot be treated as a second-order issue. Without it, none of the Committee's other recommendations can be delivered.

Conclusion

The Committee's report and its thirty recommendations represent a substantial and, in most respects, sound response to the evidence before this inquiry. The additional matters raised in these supplementary comments — treatment capacity and aftercare, harm reduction and Drug and Alcohol Program funding, First Nations data and accountability, FASD implementation and access to the NDIS, DSP and Medicare, alcohol industry accountability and political influence, protections for children from alcohol marketing and access, telehealth prescribing risks, and the sector's strategic and workforce foundations — are, in my view, necessary complements to the Committee's work.

I commend the report to the House and urge the government to act on its recommendations, together with the matters raised here, without delay.

Dr Monique Ryan MP
Deputy Chair
Member for Kooyong



Additional comments - Coalition Members

Health impacts of alcohol and other drugs in Australia

Coalition members recognise the serious health and social harms associated with harmful alcohol consumption and illicit drug use. However, we consider that the Committee's report does not adequately acknowledge the substantial changes in Australian drinking patterns, nor sufficiently distinguish between responsible alcohol consumption and harmful alcohol use. Alcohol is a legal product in Australia that can be consumed safely and responsibly by adults within established health guidelines.

Australians are drinking considerably less than previous generations. Apparent alcohol consumption per capita has fallen by more than 20 per cent since the mid 1970s and is around levels not seen for approximately six decades. Risky drinking among Australians aged 14 and over has also fallen, from 38.1 per cent in 2001 to 30.7 per cent in 2022.

The change among younger Australians has been particularly significant. Risky drinking among 14 to 17 year olds fell from 30.7 per cent in 2001 to just 5.5 per cent in 2022/23, while the proportion abstaining from alcohol more than doubled from 31.8 per cent to 69.9 per cent.

Alcohol is a legal and highly regulated product in Australia, with recognised low-risk consumption guidelines for adults. Public policy should continue to target harmful consumption.

Coalition members therefore favour targeted, evidence-based interventions, including prevention, treatment and rehabilitation, and measures addressing demonstrated regulatory failures. Additional regulation should be supported by clear evidence that it will materially reduce harm.

Alcohol Beverages Advertising Code Scheme

Coalition members do not support Recommendations 1 and 2 as expressed. The Committee has not established that Australia's existing alcohol advertising framework has failed, or that a new mandatory Commonwealth regime would deliver better outcomes.

The ABAC Scheme applies across traditional and digital advertising, contains specific protections for children, provides pre vetting of advertising and independent adjudication of complaints, and operates without cost to taxpayers. More than 99 per cent of determinations are voluntarily complied with, with state and territory liquor regulators retaining powers to address non-compliance.

Removing the Australian Government representative from the ABAC Management Committee would reduce government involvement, not strengthen it. If the government feels it needs a stronger voice on the Committee it should change the way it engages, not remove itself entirely.

Where deficiencies in the existing framework are demonstrated, they should be addressed directly rather than used to justify additional layers of Commonwealth regulation.

Alcohol taxation and minimum unit pricing

Coalition members support a review of alcohol taxation but do not support higher taxes as a substitute for targeted action against harmful drinking. These are blunt, population wide measures that increase costs for responsible and harmful consumers alike. Australia already imposes substantial taxation on alcohol.

The Coalition recognises there is significant investment in primary production and supporting industries, and employment that underpins the production of alcohol in Australia. Government receipts from the sector do not start or end with direct taxation of alcohol products.

Coalition members favour directing resources towards prevention, counselling, treatment and rehabilitation for Australians experiencing harmful alcohol use rather than increasing costs for the entire population.

Drug Checking

Coalition members do not agree with the Committee's recommendation supporting the expansion of drug checking or pill testing. Australians need to receive a clear message from government that there is no safe level of illicit drug use. Drug checking can identify substances and provide information, but it cannot make an illicit drug safe.

Coalition members support practical measures that save lives and help Australians overcome addiction, including prevention, treatment and rehabilitation. However, these measures must be based on demonstrated outcomes and should not create a false impression that illicit drug use can be made safe.

Mr Sam Birrell MP
Member for Nicholls

Mr Henry Pike MP
Member for Bowman