

2024

New South Wales

Drug Summit

Companion

Document

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BACKGROUND PAPERS

Prior to the Sydney drug summit forum, a suite of background papers was made available to assist delegates to understand the context of drug policy in NSW and support discussions at the Summit. These were published in mid-November 2024 on the [NSW Health website](#), covering the following topics:

- Key themes for summit discussions
- Current landscape of substance use and associated impacts
- Service delivery and funding structures in NSW
- Approaches to prevention and early intervention
- Current legislative framework around drug use and possession in NSW
- Monitoring and reporting on drug trends in NSW
- Medicinal cannabis use and public safety considerations
- Treatment approaches and integrated care for alcohol and drug use
- Fact sheet: drug data trends and the criminal justice system.

2024 NSW DRUG SUMMIT PRIORITIES FOR ACTION

To guide prioritisation of attendees' solutions, a list of recommendations was generated from a rapid review of the scribed notes from the Griffith, Lismore and day 1 of the Sydney forums, and review of the submissions and 'Have your say' responses. These recommendations were presented, according to the 5 summit themes, to each large breakout group on day 2 of the Sydney forum, and open for discussion and voting. Each themed breakout group was supported by expert panellists in a town hall style format. Panellist biographies are available at Appendix B.

Following this session, the chair of each panel was asked to bring the generated polling results and additional issues to the plenary session. These priorities were then included in guiding the relative importance of issues in the main report.

Below are presented the top 20 (or in the case of theme 1: health promotion and wellbeing, 24) priorities for action, as presented to each themed breakout group:

THEME 1: HEALTH PROMOTION AND WELLBEING

1. Enhance professional education to address stigma and discrimination in various settings
2. Integrate and co-locate alcohol and other drugs (AOD) with other health services (e.g. mental health, dental and primary care)
3. Enhance navigation support, streamlined wraparound care (no-wrong door)
4. Introduce drug checking services
5. Enable more supervised injecting facilities (SIFs) by removing the legislative restriction to one facility in NSW
6. Introduce safe consumption rooms
7. Expand and enhance drug-specific responses (e.g. opioid substitution treatment; naloxone initiatives)
8. Increase funding for AOD treatment services including detox and post-treatment support services
9. Increase and strengthen enforcement of illicit drug supply responses
10. Deliver a whole-of-government strategy focusing on AOD as a health issue
11. Legislate to reform use and possession of drugs for personal use
12. Embed research, evaluation and monitoring into service delivery models and program implementation
13. Increase availability of regional AOD services via mobile and/or telehealth
14. Mandate the use of Safe Script in NSW
15. Establish an AOD care charter applicable across all health services including trauma informed care and minimum standards

16. Increase funding for workforce development, including nurse practitioners, Aboriginal health workers and lived and living experience
17. Expanding age appropriate AOD education in schools and other educational settings
18. Expand peer workforce across the spectrum of AOD services, including Aboriginal peer workforce
19. Tailor and co-design harm reduction messaging including for hard-to-reach communities
20. Enhance funding for prevention and early intervention programs
21. Improve access to pain management services for people with current or prior AOD use
22. Increase place based local services that build community capacity and connection
23. Develop and set targets for access to treatment
24. Improve access to information regarding the effects of image/performance enhancement drugs.

THEME 2: EQUITY, RESPECT AND INCLUSION

1. Address systemic stigma by integrating people with lived and living experience into policies and training
2. Develop a whole-of-government AOD Strategy for specific communities (i.e. culturally and linguistically diverse and Aboriginal communities)
3. Expand access to culturally safe services for diverse communities, with community leadership and family engagement
4. Align cannabis-related driving laws with prescription medications (i.e., impairment model)
5. Legislate to reform use and possession of drugs for personal use
6. Ensure that all programs meet standards for community consultation, information sharing and equity
7. Develop a media code of conduct for reporting on AOD issues and provide practical tools on how to reduce stigma
8. Implement a lived experience ambassador program
9. Expand on-Country detox services for Aboriginal communities
10. Prioritise access to treatment and support for Aboriginal people
11. Support GPs to be trained and provide: opioid dependence treatment, cannabis prescribing and broader AOD treatment
12. Improve access to involuntary drug and alcohol treatment programs for individuals with complex needs
13. Increase ability of aged care services addressing AOD issues
14. Invest in AOD workforce sustainability (including wellbeing)
15. Support frontline services and first responders' capability and wellbeing
16. Equitably expand access to treatment and support
17. Remove barriers to employment for people with lived and living experience
18. Provide ongoing care and support for people receiving long-term treatment
19. Improve AOD service access for people living with disability
20. Improve access to AOD services for gender diverse populations.

THEME 3: SAFETY AND JUSTICE

1. Promote naloxone access in pharmacies and across a range of settings (including emergency departments and carrying by first responders)
2. Review of the Early Drug Diversion Initiative (EDDI) including enhanced eligibility, removing police discretion, consistency between EDDI and the Cannabis Cautioning Scheme and a clear evaluation framework
3. Stop the use of drug detection dogs at music festivals and in public spaces
4. Introduce drug checking services
5. Increase remand, custodial and post-custodial AOD treatment and supports
6. Trial a needle and syringe exchange program in custodial settings
7. Expand alternative sentencing methods (e.g. Circle Sentencing, Youth Koori Court, and Drug Courts)
8. Enhanced access to diversion programs (e.g. Magistrates Early Referral into Treatment (MERIT))
9. Decriminalise drug use and possession
10. Legalise drug use and possession
11. Focusing policing on the supply of drugs
12. Legalise and regulate the supply of all drugs
13. Improve early intervention and family support in collaboration with child protection agencies
14. Undertake legislative reform specific to cannabis (including driving, possession and use)
15. Enhance cultural capability and AOD stigma training for police and health professionals
16. Strengthen police referral systems and partnerships with health providers
17. Stop strip searches for suspected drug possession
18. Remove the requirement to admit guilt to access diversionary services (e.g. through reform to the *Young Offenders Act*)
19. Review the threshold quantities for drugs in the *Drug Misuse and Trafficking Act*
20. Increase use of youth justice conferencing.

THEME 4: KEEPING YOUNG PEOPLE SAFE AND SUPPORTING FAMILIES

1. Improve alcohol and other drug education in schools and the community
2. Address stigma and improve families and young people's access to services and support
3. Expand specialised AOD support for pregnant women and children in the first 2000 days
4. Implement school-based harm reduction education & resilience building programs including out-of-hours school programs and community events
5. Establish youth-specific drug courts
6. Introduce drug checking services
7. Improve cross-agency partnerships, including wraparound services and coordination between health, mental health, education and Justice supports
8. Support families of people who use drugs through dedicated services and resources
9. Establish youth worker programs in high-need areas

10. Create multidisciplinary team hub models
11. Raise the age of criminal responsibility and explore non-custodial responses
12. Improve navigation tools and access points for families seeking support
13. Increase co-design of services with young people and peer workforce
14. Strengthen our harm reduction response at music festivals
15. Enhance access to digital AOD programs, especially for peer support
16. Enhance access to treatment and support for children and young people
17. Enhance access to services for women and children (incl. detox, rehabilitation, and related supports)
18. Improve support for children whose parents are incarcerated
19. Improved support for children of parents/carers with AOD use
20. Allow access for young people under 18 to the medically supervised injecting centre.

THEME 5: INTEGRATED SUPPORT AND SOCIAL SERVICES

1. Deliver a whole-of-government strategy focusing on AOD as a health issue
2. Improve system navigation and intake, including directories and digital apps, to simplify access
3. Ensure increased access to and continuity of care between detox, rehabilitation, and ongoing support
4. Address barriers to service access through increased investment in housing, prioritising a Housing-First model and transport
5. Increase provision of transitional housing post treatment
6. Increase post-custodial support services including transfer of care
7. Develop and implement equitable, sustainable funding models across regions
8. Better integrate mental health and AOD services through improved funding models
9. Fund long-term, outcome-focused models to improve workforce retention and service stability
10. Review threshold for involuntary drug treatment (IDAT) entry
11. Strengthen collaboration across sectors, including GPs, NGOs, and community services
12. Enhance information sharing across agencies while maintaining privacy protections
13. Support pharmacies to improve access to opioid substitution treatment and naloxone
14. Promote integration of domestic violence services, such as hub and co-location models
15. Increase availability of regional AOD services via mobile and/or telehealth
16. Integration and co-location of AOD services with other health services (e.g., mental health, dental and primary care)
17. Improve the regulation of medicinal cannabis to ensure responsible prescribing
18. Adequately fund existing AOD services to meet demand
19. Ensure support for people on treatment waitlists (i.e., via web-based apps, SMS etc.)
20. Ensure all health professionals receive AOD education and training.

ANALYSIS OF CONSULTATIONS

There were three major inputs into the process of consultation for the 2024 NSW Drug Summit. The next sections set out how all the material generated through the forums, 'Have your say', and submissions were analysed following the completion of the Drug Summit.

1. DRUG SUMMIT BREAKOUT SESSIONS

During each small group session at each drug summit forum, notes were taken of the discussion that occurred. These notes have been used to conduct a thematic analysis to understand the detail and breadth of ideas expressed and which ideas and views were most frequently expressed. Each group had an individual facilitator to ensure that all voices had an opportunity to contribute, and to clarify and refine suggestions and solutions.

Method of analysis

Each breakout session had at least one note taker present.

Following the Drug Summit all notes were grouped by their drug summit theme and Copilot¹ was used to create an initial thematic framework of the main topics raised. This framework consisted of headings and subheadings with short descriptions. Using this initial thematic framework, notes were grouped manually and the framework adapted as needed as more information was added from across the three different forums. From these refined notes an analysis was conducted, summarising the breadth of ideas within the notes and expressing which ideas or points were most frequently raised.

The co-chairs then reviewed this analysis and selected major priorities areas and further grouping of ideas was completed according to these 12 priority topics. A revised thematic analysis was conducted within the topic framework on the complete notes to add specific concepts, details and source supportive quotations. This compiled all three strands of consultation: the summit forums, the 'Have your say' portal results and the submissions.

Excerpts of this revised thematic analysis organised around the 12 priority topics were then used to form the basis of the main report and shape the priorities for action. A complete version is presented here in the companion document. Removal of duplication has occurred where possible, so that the priority topics in the main report and the corresponding companion document could be read in tandem for a complete overview of the ideas expressed at the Drug Summit.

The notes are summaries of the discussion as recorded by attending scribes, rather than direct quotations or transcription, therefore attribution to individuals were removed.

2. 'HAVE YOUR SAY'

To allow people from NSW the ability to contribute their perspectives, ideas, concerns and suggested solutions to the 2024 NSW Drug Summit, an online 'Have your say' portal was made available.

1 Microsoft Corporation. Microsoft Copilot [Internet]. Available from: <https://www.microsoft.com/copilot>.

The online survey was open from 11 October to 17 November 2024 and had 3,669 responses. A range of promotion activities were undertaken to raise awareness of the survey including social media, inclusion in NSW Government and other organisation newsletters.

The survey included questions on respondent demographics and several questions with free-text responses (up to 1500 words each) based on the five summit themes.

The survey page received a total of 21,311 visits during the time the survey was open, with most visitors coming to the page from the Service NSW newsletter, the direct survey link, Facebook, the NSW Health Drug Summit website, Google search, Instagram or reddit, in order of most visits.

Method of analysis

Demographic data

Respondent demographics were descriptively analysed using R statistical analysis software². The proportions endorsing each option are presented. All questions were optional, and there are varying amounts of missing data across questions. Some items also allowed multiple answers, and these are noted in the results.

Open ended responses – thematic coding and analysis

NSW Ministry of Health staff read all open-ended responses and undertook thematic coding to identify key topics raised in the responses. The following steps were involved in this process:

- A preliminary review of data received in the first week of the survey was undertaken. Themes were identified deductively, and a list of themes developed to be used as the basis for analysis of the complete dataset.
- Once data collection was completed, staff read each response and applied thematic coding, identifying and tagging each topic raised in a response, using the list of themes previously developed. New themes identified were discussed and added to the list as they emerged. These were retrospectively applied to data where relevant. Where themes were not clear, staff discussed until consensus was reached.
- Once thematic coding of all responses was complete, the applied codes were reviewed to ensure consistency across all responses.

The most frequently raised topics were then identified for each of the five drug summit themes. Example quotes were extracted from responses.

Qualitative analysis of responses for priority areas identified in the report

Responses were further analysed to provide insight into the ideas and discussion from 'Have your say' respondents around the priority areas identified for the main report. Relevant responses were identified using the thematic codes and through key word searches. These were reviewed and a narrative description was produced for each of the priority areas and relevant quotes extracted.

2 R Core Team. R: A language and environment for statistical computing. Vienna, Austria: R Foundation for Statistical Computing; 2023. Available from: <https://www.R-project.org/>.

3. SUBMISSIONS

Over 80 submissions were received from organisations, institutions and individuals through the drug summit email address. This section provides a summary of these submissions, and is divided into:

- **Submissions from organisations and groups** – This includes submissions from peak bodies, research organisations and other groups.
- **Submissions from individuals** – This includes personal statements, positions and stories from individuals, families and community members.
- **Position papers** – These are position papers that were published on organisations' websites prior to the summit with key recommendations or views.

The submissions capture a variety of views including people with lived and living experience, family of those with lived and living experience, students, researchers, academics, healthcare workers, alcohol and other drugs (AOD) organisations and services, justice and legal representatives.

Method of analysis

Submissions were either emailed to the drug summit inbox or sourced through organisational websites. Each submission was read by NSW Ministry of Health staff. Microsoft Copilot³ was used to generate initial summaries and extract recommendations. Summaries and recommendations were reviewed and cross-checked for accuracy and fidelity.

The NSW Ministry of Health contacted authors for consent to reference or quote their submissions in the report. The summaries provided herein were prepared by NSW Ministry of Health staff, with all efforts made to ensure accuracy. If you are interested in a submission or position paper however, we suggest contacting the organisation directly to seek the submission or clarification.

3 Microsoft Corporation. Microsoft Copilot [Internet]. Available from: <https://www.microsoft.com/copilot>

2024 NSW DRUG SUMMIT BREAKOUT SESSIONS BY TOPIC

The following priority topics are discussed in the 2024 NSW Drug Summit Report. In this section an expanded overview of the views of participants is included.

THE SERVICE SYSTEM: ACCESS, INTEGRATION AND DESIGN

A. ACCESS TO TREATMENT AND SUPPORT

Access to services was discussed in relation to both service availability, and specific limitations or barriers to access for certain populations. Participants noted that access barriers need to be addressed, particularly in regional and rural areas.

Increased funding for alcohol and other drug (AOD) treatment services was a key priority for many participants, with the need for adequate funding to meet demand. This includes the need for increased funding for a range of treatment services, including detox and post-treatment support services. Participants also called for sustainable, long-term funding models that would allow services to maintain consistent staffing levels, reduce waiting times, and develop appropriate services for diverse populations.

Regional and rural challenges

The specific challenges of access to services in regional and rural areas came up often in discussions with a range of issues identified including limited availability of services, infrastructure, distance to services, demand outweighing supply, challenges attracting and retaining workforce, and experience of stigma and discrimination.

Discussion highlighted the strain on services in regional areas, where limited options often force people to travel long distances for treatment. Issues raised included long waiting lists, limited transport options, and a lack of sufficient after-hours services. Telehealth was seen as part of the solution but not the complete answer. Participants emphasised the need for outreach services and mobile treatment options to reach isolated communities.

Treatment approaches

The importance of flexible treatment options, to 'meet people where they are at' was raised, with participants noting that not everyone will want or need to go to residential rehabilitation or be seeking an abstinence approach.

Opioid treatment was a frequent point of discussion with participants noting that the Opioid Treatment Program (OTP) needs expansion and better integration with primary care. Issues included limited access in regional areas, pharmacy participation barriers, and the experience of stigma. Recent changes to the Pharmaceutical Benefits Scheme (PBS) were noted as creating additional challenges to program delivery. Suggestions included better support for prescribers, expanded pharmacy participation, and addressing stigma in healthcare settings.

Cultural safety was highlighted as crucial for Aboriginal people and communities, and culturally and linguistically diverse (CALD) communities in ensuring accessibility. This was identified as particularly important when designing and delivering effective services.

B. PRIORITY POPULATIONS

Inclusivity

Participants discussed the need for service design to be more inclusive and accessible for priority populations including women with children, families, young people, lesbian, gay, bisexual, trans, queer and intersex (LGBTQI+) communities, people with disabilities, people in and exiting custody, and people from culturally and linguistically diverse backgrounds. The needs of Aboriginal people were frequently discussed. There is more detailed discussion of Aboriginal social and emotional wellbeing including service inclusivity in other sections of this document and the main report. Specific solutions included providing childcare at all treatment services, ensuring physical accessibility of facilities including residential rehabilitation, offering more gender-specific services using trauma-informed care principles, and developing culturally appropriate programs with bilingual workers.

The importance of co-design with affected communities was consistently emphasised, with calls for dedicated funding streams to support this work. Services need to move beyond simple language translation services to meaningful cultural safety.

People in custody and post-release

People in custody, and post-release were identified as priority population groups, with significant unmet need. Treatment access in custody (including remand) and post-release support were identified as critical gaps. Participants highlighted lost opportunities during remand periods and poor continuity of care upon release. A large proportion of the prison population are on remand, and there is very little AOD treatment for this group.

Discussion noted barriers to AOD treatment in custodial settings including being unable to access Medicare or the PBS, delays in discharge planning, and poor coordination between corrections and community services. Participants advocated for expanding the Compulsory Drug Treatment Correctional Centre program and implementing needle and syringe programs in prisons.

Post-custody and transitional support were identified as systemic gaps that require particular attention and dedicated resources. Data was cited that the highest risk of recidivism and risk of harm occurs in the first six weeks post-release. Lack of coordinated transitional support was identified as a key factor, with current support described as inadequate, with people often released without preparation or connections to housing and health services.

Participants emphasised the need for pre-release planning, throughcare and supported transition programs including specific consideration of medication continuity (especially for opioid substitution treatment) and immediate access to housing. The importance of maintaining connection with support services during custody was highlighted, along with the need for better coordination between justice health and community services.

Women with children, and families

Providing better support, and a safe, non-stigmatising space for women with children, and families, including pregnant women was raised many times. This related to several factors, including the experience of domestic and family violence, fear of child removal and stigma, and lack of access to programs where children can accompany their parents.

There was a lot of discussion about the impact of the current child protection system particularly on Aboriginal families. Participants expressed the view that the current system often removes children without adequate support for parents to address substance use issues.

Some solutions which were suggested including designated midwives for pregnant women with substance use concerns, more detox services for women as well as for women with children, more residential services that accept parents with their children, better coordination between AOD and child protection services, more flexible child protection policies, and more integration between AOD and violence, abuse and neglect (VAN) services.

Culturally and linguistically diverse communities

Services for culturally and linguistically diverse communities require specific focus and development. There is diversity within culturally and linguistically diverse communities, with many different perspectives to acknowledge in the design and delivery of programs. Participants noted that current approaches often fail to recognise different cultural understandings of dependence and recovery, as well as the unique experiences of shame, stigma and discrimination.

Participants highlighted that current funding application processes are often complex and resource intensive, excluding smaller organisations including culturally and linguistically diverse organisations.

Culturally and linguistically diverse communities discussed the need for dedicated funding and support to develop their own solutions. Place-based, community-led local services that build community capacity and connection were identified as crucial for effective health promotion and treatment. This approach requires flexible funding models that allow services to adapt to local needs and circumstances.

Solutions proposed included targeted funding streams for CALD community-controlled organisations, increased funding for multicultural services, better use of interpreters, and specific engagement strategies for different cultural communities. The importance of working with religious and community leaders and building trust was emphasised, along with the need for services to employ workers from diverse cultural backgrounds.

LGBTQI+ communities

The need to increase access to services and tailored support for LGBTQI+ communities was raised by participants. Strategies to improve support for gender diverse communities included upskilling the workforce, improved data collection and outcomes measurement, the need for more integrated support and a reduction in stigma and discrimination while acknowledging the impact this can have on engagement with services. Inclusion of LGBTQI+ communities within the lived and living experience (or peer) workforce was noted as important to increase accessibility of services.

People with disabilities

There is a need for more targeted services, improved accessibility and increased awareness for people with disability, including brain injuries and cognitive impairment. Some participants noted the gaps in suitable programs and support for people with neurodiversity.

C. SYSTEM INTEGRATION AND SERVICE CO-ORDINATION

System integration and service coordination was discussed often and from a variety of perspectives, though particularly in addressing the multiple, co-occurring health and social needs of people who use AOD. The importance of understanding and addressing the social determinants of health was raised many times, particularly in terms of focusing on the circumstances that lead to AOD use, or that can support improved longer-term health and social outcomes. Participants noted many services exclude people with complex presentations, creating a gap for those most in need.

It was mentioned by many participants that system navigation and integration between services, and across the service system requires significant improvement to ensure equitable access. Highlighted consistently was that many people face multiple barriers including homelessness, mental health issues, violence abuse and neglect, social inequity, intergenerational cycles of vulnerability, and complex trauma, yet services remain siloed.

Challenges in current system

Participants reflected that coordination between services needs significant improvement to provide “no wrong door” access.

Integration between mental health and AOD was an example highlighted many times. Many participants noting the artificial separation of these services despite high rates of co-occurrence. The current systems often require people to address either mental health or AOD issues separately rather than concurrently, creating significant barriers to effective treatment. While some advocated for complete integration of these services, others warned that mental health services tend to dominate when combined, potentially reducing AOD-specific focus. There were multiple suggestions for specialised ‘dual diagnosis’ services and a dedicated workforce, but also acknowledgement of the need to retain dedicated program funding streams.

Other examples raised were the need for improved access to pain management and dental care, both of which can be better integrated with AOD care. Services reported that competitive funding models can discourage collaboration, with organisations sometimes “fighting for clients” rather than working together.

A particular point of discussion was the need to improve cross-agency partnerships, including wraparound services and coordination between health, mental health, justice, education, child protection (child wellbeing) and vocational supports. Current siloed approaches mean people often tell their story multiple times and may receive conflicting advice or support from different services. Regional summits particularly emphasised the need to break down silos between government agencies and improve transparency and accountability, with examples shared of successful cross-agency meetings to address complex cases.

Proposed models

Suggestions for improvement included shared care protocols and case management systems, co-location of services, wraparound services, formal partnerships between services, multidisciplinary teams, better co-ordination of care, and removal of restrictive eligibility criteria that prevent holistic care.

Solutions included establishing dedicated system navigator positions, creating “no wrong door” policies across all services, more emphasis on ‘warm referrals’, developing integrated care hubs that provide multiple services in one location, and review of strategies across all relevant government portfolios (AOD, housing, child protection, domestic and family violence, mental health, policing etc.) to ensure complementary planning.

The role of vocational support was noted as an important enabler for supporting recovery, and meaningful participation in the community. Creating opportunities for training and education, and work readiness or pathways to employment were raised in the context of social determinants of health. Some participants acknowledged the value of establishing cross agency partnerships that supported life skills development, such as with Centrelink, TAFE, or companies that facilitate work placement opportunities.

Specific approaches were discussed, such as the Housing First model, designed in a way that removes some of the exclusion criteria for accessing various models of drug treatment. There was also a lot of discussion of the intersection between child protection and AOD use, and the importance of taking more of a strengths based/family preservation approach and better supporting parents and families who may be involved with child protection services. It was noted that the child protection system is often overwhelmed, which can create challenges for services working in partnership.

Effective models

Several examples of successful practice were named including hub models that offer multiple services in one location, headspace’s integrated youth model, Aboriginal community-controlled health organisation’s holistic model of care and the Royal Prince Alfred’s ‘virtual hospital’.

Hub models were seen as particularly effective at reducing barriers to access and enabling and facilitating ‘warm referrals’ between services, though some participants noted some constraints with family and domestic violence services and their co-location (although coordinated care was mentioned many times). The effectiveness of hubs

was attributed to their ability to provide multiple entry points while maintaining coordination of care and reducing the burden on clients to navigate complex systems. Participants emphasised the need for hubs to be designed with significant input from people with lived and living experience and to include peer workers in key roles.

Participants discussed interagency examples of models that work, and which could be further adapted for the AOD sector. These included:

- PACER (police, ambulance, clinical, early response) enables liaison between health and police
- Housing first models: Housing and Supported Accommodation Initiative (HASI)
- NSW Council of Social Services funded roles that bring health, education and social services together
- Intensive family support models such as the Family Preservation Program
- The Adult Survivors Program: integrated services for adult survivors of child sexual abuse with complex needs. These programs address the intersection and complexity for clients who have cooccurring needs.

FUNDING MODELS

Participants identified that current funding models require significant reform to support better integration and an adequate volume of service delivery. It was widely reported that short-term, siloed funding arrangements create competition between services, with services feeling burdened with spending excessive time on grant applications. Discussions noted that existing funding can be impacted by the type of funding model (e.g. activity-based funding), purchasing arrangements (e.g. by program area, duration, funding body, ad-hoc tender processes) and reporting structures.

Specific impacts of funding arrangements were mentioned in relation to mental health and AOD services, with suggestions that it reinforces siloed approaches. Similarly, concerns were raised in relation to integration with other parts of health such as VAN services as well as maternity, and child and family health.

The challenges associated with short term funding cycles and lack of coordinated funding approaches for non-government organisations (NGOs) and Aboriginal community-controlled organisations were acknowledged. Many attendees pointed to the number of sources NGOs receive funding from, including from different levels of government. In addition to the contract duration challenges created from different funding cycles, participants noted the burden of the different reporting expectations.

Stakeholders expressed strong support for sustainable funding models focused on outcomes and impacts rather than outputs, with flexibility to adapt to local needs.

The suggestion of longer funding cycles (minimum 5 years) for NGOs and Aboriginal community-controlled organisations was consistently raised by multiple participants, along with calls for pooled funding approaches that could support more integrated service delivery.

It was emphasised that funding reform should support relationship building and integration between services, allow for proper evaluation of programs, and provide certainty for workforce retention and service planning. Many participants noted that current funding models actively discourage collaboration through competitive tendering and incompatible reporting requirements.

Several attendees suggested that more collaboration between Commonwealth and state governments would ensure better planning of services, alignment of funding and reporting arrangements, and may enable more treatment to be delivered in primary care via the Medicare Benefits Scheme (MBS).

PREVENTION AND EARLY INTERVENTION

Funding and sustainability

Participants identified a need for enhanced, sustainable and long-term funding for prevention and early intervention programs. They suggested short-term pilot programs are insufficient, and expressed the view that longer-term funding would provide the opportunity to demonstrate impact. Participants noted that with limited program availability, there is a critical need for programs at primary, secondary and tertiary levels of prevention.

Participants observed that prevention does not receive sufficient funding, with treatment programs being favoured. Some noted that other states have dedicated prevention agencies.

Community-based programs

According to participants, community-based prevention programs need greater support and resources, including targeted approaches for specific population needs such as culturally and linguistically diverse communities, Aboriginal people, and young people. The community drug action teams (CDATs) were often cited by participants as effective but under-resourced.

Participants emphasised the importance of locally led, grass roots, and community co-designed initiatives that can respond to specific community needs and circumstances. Success stories shared by participants included creative and sports-based programs, cultural connection activities for young people, including Aboriginal youth, and community events that build protective factors. Participants highlighted the need for better evaluation and sharing of successful approaches.

Regional forums emphasised community-led solutions and prevention activities that engage whole communities. Participants from regional areas noted the limited availability of such programs in their regions. They emphasised the importance of building on existing community strengths and relationships and expressed a need for sustainable funding to maintain programs.

Aboriginal young people

Participants suggested early intervention and prevention programs needed greater focus on Aboriginal young people. They emphasised the importance of preventing initial contact with the justice system through culturally appropriate early intervention. Discussion highlighted the need for programs that strengthen cultural identity and connection, while addressing underlying factors that may lead to substance use. Many participants called for expansion of the Youth Koori Court model and development of further Aboriginal-specific diversion options for young people.

Youth transition points

According to participants, prevention programs should target key transition points in young people's lives, with particular focus on the move from primary to high school, and school to work/further education. Solutions proposed by participants focused on building resilience, coping skills and positive social connections during these vulnerable periods, with strong emphasis on providing meaningful activities and engagement opportunities.

Participants viewed after-hours activities as crucial for achieving prevention aims, but noted many community-based programs like PCYCs are declining due to lack of funding and volunteer support, while available programs are often too expensive for many to access. Services such as Ted Noffs Street University were cited as innovative programs that provide activities for young people, a community for engagement, and opportunistic engagement with health and other supports. Some religious leaders echoed calls for more prevention activity such as after-school care and youth programs, which they suggested could help prevent young people's initiation of AOD use.

Early intervention services

Participants indicated early intervention services need major expansion and reform to be more holistic and trauma-informed, with particular focus on children under 12 who they described as currently underserved. They suggested universal screening and assessment programs need to be affordable and accessible, noting that current costs for assessments required to access the National Disability Insurance Scheme (NDIS) assessments are prohibitive and create barriers for families.

Service providers emphasised the need to work with whole families rather than just individuals, noting that trauma-informed, culturally appropriate early intervention before crisis is particularly lacking in regional areas. There was strong support among participants for expanding the wellbeing health in-reach nurse (WHIN) program to all schools.

Alcohol-specific prevention

Some participants noted that greater preventative efforts are required for alcohol, including banning advertising, restricting trading hours and reducing access to alcohol for young people, as they suggested this can lead to other drug use. Senior clinicians called for a greater focus on the prevention of foetal alcohol spectrum disorder (FASD).

Funding allocation

Participants observed that funding for prevention generally flows to larger services rather than evidence-based services. Participants identified general practitioners (GPs) as a critical workforce for assessment and intervention and suggested they should be an initial contact when parents recognise their children might have an issue. However, participants expressed a view that GPs need further education on how to talk about drug use.

Prevention approaches

A prevention advocacy organisation noted demand reduction should be the first principle, with a focus on primary prevention over treatment. One participant noted “you can’t drug-proof a person,” while another observed some people develop dependence through legally prescribed medications.

INFORMATION AND EDUCATION

School-based education reform

Many attendees provided support for improving AOD information and education, noting it needed to be credible, pragmatic, and consistent with the experiences of young people. Current school-based education initiatives were criticised by many, with messaging being oriented towards abstinence-based messaging. Attendees noted that such campaigns do not resonate with young people and are seen as unrelatable or counterproductive.

Reform options were discussed, including greater inclusion of harm reduction messages, ensuring that it does not stigmatise people who use drugs, and prioritising education providers who are health professionals and peer educators. Participants emphasised that school-based education should start earlier, at primary school, with a focus on resilience and strengths, and continue to young adulthood, with tailored messaging for different age groups.

Attendees noted schools required better resourcing, including AOD counsellor specific positions, utilising evidence-based programs (such as resilience building), and out of hours programs and community education. An education provider representative called for greater workforce investments for teachers and leaders in schools on drug education, noting there is insufficient knowledge on where to go for referrals.

Consistency and evidence-based approaches

Participants discussed how current education approaches vary significantly between schools, with content often heavily influenced by individual school leadership and parental attitudes, leading to inconsistent messaging and gaps in crucial harm reduction information. There was strong support for programs like “Got It” (Getting on Track in Time) that provide whole-of-school screening and early intervention.

An education provider noted the importance of recognising the multiple settings for education, and the importance of community and workplace education. Participants discussed the need for evidence-based approaches, with some mentioning initiatives like the Matilda Centre's ‘OurFutures’ program, which has shown positive evaluation results.

Community and digital education

Community education approaches were cited as a useful way to increase awareness of AOD related harm and reduce stigma. Initiatives such as the ‘Are You OK?’ campaign were recognised as impactful in normalising conversations about mental health.

Digital platforms and social media could be better utilised for health promotion and education. Young people particularly noted that current information channels are outdated and don’t reach their demographic effectively. Suggestions included developing evidence-based apps for early intervention, using social media platforms for drug alerts and harm reduction messaging, and creating online communities for peer support. Concerns were raised about misinformation on social media, with calls for authoritative but youth-friendly content.

Co-design and engagement

Many attendees noted the importance of co-design for educational content for young people, both for community education campaigns and school-based initiatives.

A common theme throughout the consultation was that education initiatives should focus on providing factual, balanced information rather than fear-based messaging, with many noting that young people respond better to honest conversations about risks and harm reduction strategies than to abstinence focused approaches.

FAMILY AND COMMUNITY SUPPORT

Throughout the summit forums, attendees emphasised the impact of an individual's drug use on whole families, and the importance of supporting family members as well as the person using drugs. Participants noted that ‘family’ is a broad concept, and reference to families throughout discussions captured a complex range of relationship dynamics, perspectives and needs.

The fundamental importance of family was reflected in the breadth of references to it, and in the widespread endorsement among attendees of the critical need to empower and support families to support their family members experiencing drug-related harm. A carer advocacy organisation drew attention to the lack of recognition for carers (who are often family members), and the need for families and carers to be given appropriate recognition, inclusion and support to provide effective care to their family member.

Parents with lived and living experience of a child's drug use spoke of the impact of their responsibility over the long-term, while an advocacy organisation drew particular attention to the burden on grandparents of raising their grandchildren when child protection concerns arise.

Elected officials described the desperation of constituents who approach them seeking support for their family member with drug dependence, noting the critical need to support families and carers to ensure that the person using drugs is not isolated or rejected, and that families are sufficiently equipped to care for them.

The role of family in primary prevention was highlighted. Education and capacity building among families to prevent drug-related harm was described within a broader need to equip all community members with better knowledge and understanding about drugs to enable family and community members to care for one another.

A social services organisation attendee cited research on the economic costs of child poverty, and the importance of addressing social determinants of health by implementing systems that connect and support children, young people and families through early intervention. There is limited data about how different services connect. Participants described an example of a useful position that is philanthropically funded to bring health, education and social services together to help families navigate the system and build connection.

The need for integration across health, education and social services to support families in a holistic way to address the social determinants of health and reduce drug-related harm was widely recognised across the summit forums. This was noted as particularly true where there are co-occurring experiences of AOD use, family violence and other health and social risk factors.

There was wide recognition among attendees that any program which educates and upskills young people around drug use should also educate their parents. Attendees discussed the importance of schools and families working together. Education sector representatives pointed to the need for workforce development to equip teachers and schools to deliver prevention, education and early intervention to both students and parents, including appropriate referral pathways for individuals and families requiring support.

Other locations were flagged as important settings to identify at-risk families and young people. Some attendees, including from the education sector, spoke of the need to intervene with at-risk families and children before they attend school (e.g., to screen for FASD), and to include the entire family. Service providers discussed missed opportunities to identify and support families in complex circumstances before crisis occurs, for example, in juvenile justice health settings, or where there may be a history of family violence.

Attendees noted that much more work is required to reach disengaged families across settings where they present. Innovative engagement strategies will require partnerships between health and other services, such as faith/prayer rooms located inside service hubs. The importance of access for families and young people to sporting and other meaningful activities and events that allow families to participate in their wider communities was also noted.

Discussion of prevention and early intervention within families included the specific need to better support children exposed to harmful AOD within their family. Many participants noted that children and young people at risk of harmful drug use due to intergenerational disadvantage are often in out-of-home care, and early intervention programs must be able to reach children who do not live with their families.

Special reference was made to the lack of support for children whose parents are incarcerated, as well as to the need for more impartial support for young people in detention. A provider of a faith-based youth service described concerning conditions in detention centres as posing a risk to incarcerated young people, particularly those who do not have families able to support them. The establishment of an impartial advocate position within the justice system was suggested to enhance the safety of young people in custody.

Supporting family engagement

The role of families in preventing escalation of drug use to harmful or dependent use, and the need for education and capacity building to support this role, were widely discussed. Lack of knowledge and understanding may lead families to inadvertently stigmatise or discriminate a family member experiencing drug-related harm.

Multiple attendees reported that families would benefit from education and support around how to have conversations about drug use and seeking care. Some attendees suggested that families be upskilled around stages of change and motivational interviewing, supported by written material and conversation guides.

The experience of stigmatisation of drug use and people who use drugs can also extend to their family members. Families may experience shame that makes them reluctant to disclose drug use and related harms and potentially limits their willingness to consider early intervention to reduce the risk of escalation.

Participants noted that families willing and able to support and advocate for a family member may experience challenges in navigating the complexities of the service system and accessing care. Examples of the challenges navigating health services for family members experiencing drug related conditions, such as psychosis, was discussed.

Many providers from sectors other than AOD (e.g., mental health) spoke to the important opportunities for intervention during any crisis encounter, and the need for formal agreements between AOD and other services to enable provision of appropriate education and referrals at any point of entry to the service system. Attendees described the critical role of service navigation positions to link families to services and increase their capacity to support their family members. A family support care coordination program currently being trialled for people impacted by domestic and family violence was considered effective, but attendees stated that it is currently too small in scale to have significant impact.

Family inclusive approaches

Involving family in AOD treatment was considered fundamental to enhancing treatment outcomes, but it was widely agreed that more family inclusive services are required to achieve this goal. Participants described a spectrum of family involvement, with many providers, particularly those in specialist youth services, speaking to the value of family therapy—providing treatment to a whole family unit—in producing good outcomes.

The accessibility of family therapy in NSW is low, with the majority of AOD treatment tailored to individuals. Where resource limitations preclude provision of treatment to a family, attendees advocated for the engagement of family members in an individual's treatment program through other means, including the provision of education, regular communication, support and welcoming family to attend treatment sessions as appropriate.

A residential rehabilitation provider stated that engaging with young people and their families while they await treatment can provide important opportunities for education and connection, while for people too young to consent to treatment, engaging with families to obtain consent is a key part of the service's role. Provisions for family members to attend sessions where interventions are being negotiated or navigated by people undertaking treatment were also considered important.

It was recognised that workforce development is required to equip AOD clinicians with the skills and the capacity to engage effectively with the families of people in treatment. A professional association drew attention to the lack of options for tertiary studies in family therapy.

Family services

There was repeated discussion of the critical lack of residential rehabilitation services that can accommodate parents with children, especially mothers. The need for services that can accommodate whole families, including fathers and partners, was noted, particularly in regional areas. A family recovery centre was cited as a positive model, but many more services are needed.

Family-centred, strengths-based approaches need greater emphasis, according to participants, particularly supporting parents with AOD issues to maintain care of their children. Lack of residential services might increase the risk of child removal rather than supporting families to stay together safely.

One service provider shared an example where a mother was told she would need to go to rehabilitation in a major city while her children were taken into care, leading the family to disengage from treatment entirely. Regional consultations suggested that services place support workers within families and communities, rather than removing children from their homes.

Participants mentioned several organisations providing wraparound services for families that prioritise keeping children with their parents. These included a community services organisation that focuses on supporting families to thrive and keeping children with their families, and a youth legal service that provides support for families with parental problematic drug use, including housing for parents exiting treatment to facilitate restoring families. Attendees noted that if parents fear losing their children if they seek help, they will not access services.

There were calls for greater funding investment in support services for families and carers, across the state and particularly in regional and rural areas. Attendees called for face-to-face support and anonymous family support groups to be made more widely available. To help families manage stress, and maintain boundaries while supporting recovery, families would benefit from respite care options as well as counselling services.

Many families reported feeling isolated and unsupported, particularly in regional areas where services are limited. Support programs provided by peers—people with lived and living experience of their own family member's drug use—are of great importance in reducing stigma experienced by these families, according to several participants.

Cultural considerations

Attendees emphasised that support services must cater for extended family networks and whole-of-community approaches, particularly in Aboriginal communities. Community-led solutions, and the role of community in supporting Aboriginal families, were emphasised in regional consultations.

Many rehabilitation services were described as culturally inappropriate for Aboriginal people and their families. For example, not being able to have contact with family while in treatment was identified as a major barrier to residential rehabilitation and treatment. Aboriginal-led and culturally appropriate services require significant expansion and dedicated funding streams.

The experiences of Aboriginal people and communities with the child protection system was noted as a particular barrier to seeking help. It was noted by Aboriginal participants that this system contributes to continuing trauma, intergenerational trauma, and re-traumatisation and as such requires significant reform.

An elected representative noted that the COVID-19 lockdowns in a culturally diverse area of Sydney provided clear illustrations of the challenges in attempting to separate the concepts of 'family' and 'community' in culturally and linguistically diverse communities; the message to 'stay with your family' was understood to be their whole community network. Partnering with religious and community leaders to communicate key messages around COVID-19 was positively received and effective for these communities.

A representative from a faith-based organisation suggested that migrant families may benefit from a religious community approach, suggesting that spiritual/religious leaders are an underutilised workforce that can be leveraged for support to provide referrals for culturally and linguistically diverse populations. They argued that youth programs that do not involve the family may not be appropriate for culturally and linguistically diverse communities.

Some participants pointed out that there can be complexity with new migrant families' perspectives on drug use which create increased barriers to help seeking. Some cultures take a zero-tolerance approach to drug use, and in such situations, young people may not seek help due to fear of repercussions within the family. Education to address more rigid forms of stigma may help to increase the capacity of culturally and linguistically diverse families to support and care for a young person using drugs.

Other recommendations made by attendees included support groups specific to culturally and linguistically diverse families, education for children, young people and families tailored to the communities they aim to reach and careful consideration of service costs, especially where people may be Medicare ineligible.

YOUTH SPECIFIC SERVICES

Young people were consistently identified as a priority population during consultations. Participants across multiple sessions discussed the experiences, risk factors, protective factors, unique needs and service outcomes for young people. Many issues affecting young people are covered in other sections of this report and companion document. This section focused on summit attendees' comments on youth specific services and on the youth-specific consultation held in Sydney.

System wide challenges

Several system-wide challenges affecting young people's access to AOD services were highlighted.

Participants reported significant difficulties for young people and families in navigating complex service systems, particularly when multiple systems (health, community, justice) are involved. Service providers acknowledged that even experienced sector professionals struggle to navigate changing program landscapes. Current siloed approaches were reported to result in young people repeating their stories multiple times, receiving conflicting advice, experiencing disconnected support, and being referred between services without resolution.

Consultation feedback identified numerous barriers to service access. Physical environments that appear formal, clinical or intimidating were noted as deterrents. Inflexible opening hours, cost barriers, lack of independent Medicare cards and parental consent requirements were also mentioned as obstacles. Many services were described as lacking developmentally appropriate approaches for young people.

Participants consistently identified critical service gaps including insufficient early intervention options and limited treatment services, particularly for ages 10 to 16. Inadequate transition support between youth and adult services was frequently mentioned. Few options exist for young people with complex needs including mental health conditions and neurodiversity. Consultation participants noted minimal youth-specific residential rehabilitation and detox services across NSW.

Regional consultation participants emphasised additional challenges including young people being forced to leave communities for treatment and transport limitations. Workforce recruitment difficulties, particularly for youth workers, were highlighted as ongoing issues. The need for culturally safe and community-controlled services was strongly emphasised in regional discussions.

Service approaches

Consultation feedback strongly supported several approaches to improve youth services. Strong endorsement was expressed for "one-stop shop" approaches providing wraparound support for young people. Integration of health and wellbeing services to address multiple concurrent needs was seen as essential. Participants favoured models that build trust by embedding services in youth-friendly, non-traditional spaces. Examples cited included the Ted Noffs Street University and Youthblock models.

Participants indicated that young people want after-hours access and less formal approaches including outreach and mobile service delivery. Greater involvement of young people in service design and policy development was recommended to ensure responsiveness. Family-inclusive approaches were highlighted as an important component of effective youth services.

Expanded transitional housing with longer support timeframes was identified as a critical need alongside integrated case management for young people exiting custody. Programs maintaining connection to Country and community were emphasised as important, particularly Aboriginal community-controlled transition support programs.

Exploration of cultural Elder involvement models similar to approaches taken in New Zealand Aotearoa was proposed for Aboriginal and Torres Strait Islander young people.

Youth consultation

A dedicated youth consultation session was held during the lunchtime period of day one of the Sydney Drug Summit forum on 4 December 2024 and consultation notes were taken by a scribe.

The discussion focused on two key areas: drug checking services, and treatment and support options for young people. Participants prioritised fixed site over mobile testing facilities, as fixed sites offer greater accessibility and more comprehensive and representative data about the drug market. Mobile drug checking at music festivals was highlighted as important to test substances acquired on-site, and presents valuable opportunities for brief interventions and education.

Participants advocated for youth-specific alcohol and other drug (AOD) services. Several approaches received substantial support, including peer-led initiatives, culturally conscious support programs, lower thresholds for treatment access (pre-crisis), more integrated mental health and AOD support, diversifying educational approaches in school settings, and improved promotion of available services. Many participants reported difficulties in identifying appropriate support services.

Several powerful personal testimonies were shared during the consultation, including issues related to access to residential rehabilitation for young people, with very few youth-specific AOD rehabilitation facilities available.

Following the session, participating youth provided feedback that additional time and discussion would be required to appropriately explore the issues raised. In response to this feedback another youth session was facilitated as a follow up to the consultation after the following the summit. A statement was prepared by a working group, and is available at Appendix E.

ABORIGINAL SOCIAL AND EMOTIONAL WELLBEING AND CULTURAL SAFETY

Aboriginal people at the Summit expressed concern about Aboriginal representation at the summit and in its processes. A follow up meeting and yarning circle was held between Aboriginal representatives and the Minister for Health. The full report of this yarning circle is available at Appendix D, and includes details of the discussions, including key topics. The Yarning Circle Report should be read alongside this section, which is focussed primarily on the consultations at the drug summit forums, as a key input into the final report.

The importance of cultural safety for Aboriginal people and communities was raised across most topics. Culture is essential to healing, helping people feel connected and empowered. AOD services can be improved by being flexible—for instance allowing for meeting of clients outside and connecting on Country. A strengths-based approach to healing was emphasised.

Aboriginal self-determination and community control requires genuine commitment and resources. Aboriginal participants emphasised the need for separate Aboriginal-specific AOD strategies developed by and for Aboriginal people, sustained funding for Aboriginal community-controlled organisations, and recognition of cultural healing approaches.

Proposed solutions

Proposed solutions included quarantining of specific funding for Aboriginal-led AOD programs and services delivered by community-controlled organisations, with a focus on funding to achieve equitable health outcomes. Development of the Aboriginal workforce was discussed across multiple topics, with additional resourcing, opportunities and supports identified as essential components. This is discussed in further detail in the section: *Workforce*.

Discussion focussed on the importance of ensuring Aboriginal people are in decision-making positions at all levels, including both the service level, as well as in funding and policy decision roles. Additionally, the importance of supporting alternatives to mainstream treatment approaches for Aboriginal people that acknowledges cultural importance and the builds on strengths of community was broadly discussed.

Some of the specific considerations included drawing on the strengths of Aboriginal people and communities, to build meaningful supports and services. The importance of increasing access to services on Country as well as more emphasis on cultural connection in all services. Building the Aboriginal community-controlled sector, including growing and building opportunities for the Aboriginal workforce.

Early intervention and prevention programs for Aboriginal young people that were designed by Aboriginal people, including young Aboriginal people, were considered an important area for further development. The importance of better integration between community-controlled and mainstream services, for seamless and supported care was another key area for opportunity. It was emphasised that ongoing work is needed to improve cultural safety in mainstream services across all sectors.

WORKFORCE

Participants described the AOD workforce as consisting of highly dedicated, committed and compassionate professionals. They emphasised what they saw as critical workforce challenges in attracting, recruiting and retaining qualified staff, and the impacts this has on service continuity and ability to meet increasing demand for AOD services. Some participants noted that workforce supply challenges resulted in under-utilised beds within services.

Attendees identified existing challenges for the current workforce, which they indicated are exacerbated by insufficient funding, short-term funding and contracts and recruitment difficulties. Noted challenges that were discussed included burnout, high caseloads, vicarious trauma, insufficient support and supervision, job insecurity, reduced workforce stability, and pay disparity compared to other jurisdictions and areas of the health system.

Participants noted that supervision is often inadequate, particularly in NGO settings. They suggested such issues impact overall service quality and ability to provide whole-of-person care. Participants emphasised the importance of retaining highly qualified and experienced staff, noting that effective service integration relied on maintaining staff who can build and retain relationships across sectors.

All participants observed that these challenges were more pronounced in regional areas, which face additional barriers in attracting qualified workforce. Participants also noted that the AOD sector has an ageing workforce, and suggested more efforts need to be directed towards building a workforce pipeline.

Attendees discussed potential solutions to workforce challenges. They suggested a greater focus on wellbeing and support was required, including professional development, additional qualifications and training, improved access to supervision (including expanding the pool and skillset of supervisors) enhanced specialisation pathways, and better career progression opportunities. Participants indicated this would assist in allowing AOD expertise to be better recognised across the health sector and reduce the stigma AOD workers experience from other health professionals.

Participants also noted pay disparities with other jurisdictions and between the NGO and government sector as contributing to staffing attrition and loss of skilled workers. For regional areas, additional solutions suggested by participants included “grow your own” workforce approaches, incentivising locals to receive qualifications and work within the sector, regional training hubs, and improving telehealth solutions to leverage metropolitan specialists. Participants emphasised the importance of peer workers in regional settings where there is less access to specialist staff.

Summit attendees observed that recruitment challenges existed across most roles. However, specific roles were identified as requiring urgent attention, including medical and specialist workforces and Aboriginal workers. Participants noted the importance of the workforce reflecting the diversity of the community it serves, with more efforts required to ensure workforce diversity. Options discussed were to establish more identified roles for Aboriginal, culturally and linguistically diverse and LGBTQI+ workforces.

Aboriginal workforce

Development of the Aboriginal AOD workforce was identified by participants as particularly crucial to achieve health outcomes. They identified specific additional challenges for the Aboriginal workforce, who carry additional community responsibilities and cultural load. Suggestions from participants included improved access to adequate supports, including cultural supervision, adequate remuneration, a focused effort on growing the workforce, and establishing meaningful career pathways, including leadership roles.

Participants emphasised that cultural competency and diversity within the broader workforce needs substantial improvement across all service types. They highlighted the need for cultural safety training for all staff, which moves beyond basic knowledge to genuine understanding and practice change. Participants noted rural and regional areas faced challenges in recruiting and retaining culturally diverse staff, requiring specific strategies and additional resourcing.

Broader health and social services workforce

Many participants noted the importance of working with and better upskilling the mainstream health and other social service workforces. They observed that current tertiary and vocational training has limited AOD content, which they suggest contributes to ongoing stigma and a lack of confidence in working with people who use drugs.

Participants indicated that AOD content should be mandatory across diverse training areas, assisting in cultural change and addressing discriminatory attitudes. Many participants noted the importance of including people with lived and living experience in professional education. Key workforces identified by participants included police, education providers, pharmacists, medical, nursing, allied health, domestic and family violence, and child protection workers. Key health areas that were identified included emergency departments, maternity services and general practice.

Participants noted that cross-sector training and shared learning opportunities were important enablers of service integration. Successful examples shared by participants included joint training sessions between agencies, cross-sector placements, and regular opportunities for staff from different services to work together. This was seen as particularly valuable for building understanding between AOD, mental health, and other health and social services. Participants highlighted the importance of creating ongoing opportunities for workers from different sectors to build relationships and understanding of each other's roles.

Participants observed that some programs providing training to mainstream health services had been successful and should be scaled up, and suggested all training should include content on trauma-informed care and cultural safety.

Role of general practitioners

Participants noted that GPs have a critical role to play as they are often the first point of entry with the health system. Participants expressed concern that GPs do not receive sufficient AOD education but are ideally placed to provide early intervention and referral. Additionally, participants indicated insufficient numbers of GPs currently prescribe opioid substitution treatment. Participants noted the importance of nurse practitioners in providing these functions, with suggestions to build and scale this workforce.

Harm reduction workforce

Other suggestions from participants included increasing the AOD workforce focussed on prevention and early intervention along with better integration of harm reduction workers with other health services. Participants noted harm reduction workers often operate separate to mainstream health services, often missing opportunities for coordinated care. Suggestions to resolve this siloed care provision included embedding harm reduction workers in emergency departments and primary care settings. The important role of other workforces in providing linkages and supports, such as religious and community leaders, was acknowledged by participants. They suggested more education is needed to upskill religious organisations and communities around how to respond to AOD and domestic and family violence, indicating such approaches could empower communities to upskill, and provide opportunities for community-based support.

Lived and living experience workforce

Participants indicated the lived and living experience (peer) workforce requires specific focus and development, with strong support for expanding peer worker roles throughout the system. They noted that peer workers are often employed casually or on short-term contracts with limited career progression.

Participants emphasised the need for a dedicated peer workforce framework for AOD, noting that existing mental health frameworks are not always appropriate for the AOD context. Particular attention was paid by participants to the need for appropriate remuneration that recognises the value of lived and living experience, along with proper supervision, training and support, career pathways, organisational readiness and support structures.

Participants noted there are many parts of the lived and living experience workforce that are working well, including distribution of take-home naloxone, harm reduction workers at festivals, and community education and

would benefit from expansion and additional resourcing. Many noted the recent expansion of the peer workforce through districts and NGOs is a welcome change that has been working well and represents an important shift for inclusion.

Expansion of the peer workforce across the spectrum of AOD services was consistently emphasised by participants, with particular focus on Aboriginal peer workers and regional settings. Participants noted peer workers' unique ability to build trust and engage people who might otherwise avoid services. Discussion included the need for better career pathways and removal of barriers such as criminal record checks that can exclude people with relevant lived and living experience.

Participants identified the peer workforce as having an important role within multidisciplinary teams, for building trust, and for reaching people who may not otherwise engage with treatment. They suggested there isn't enough funding for this workforce, not enough training, insufficient role descriptions, and that supervision is required. Participants expressed the view that we need to elevate the knowledge and support of the peer workforce and ensure they are well supported.

Solutions proposed by participants included establishing pay scales and career progression for peer workers, providing comprehensive training including a certificate IV in AOD peer work, ensuring supervision and support structures, and creating identified peer positions at all levels of organisations including senior management, with clearly defined roles. Participants suggested peer workers need to be properly resourced and supported rather than being expected to share their experiences without appropriate support.

Participants noted the mental health space as a good example of where a lived and living experience workforce is working well, with national guidelines in place and peer workers being embedded across the system, including leadership roles.

STIGMA AND DISCRIMINATION

Participants identified significant stigma and discrimination experienced by people who use drugs across various contexts and settings. This issue was raised across all consultation themes, with participants widely recognising the need to address stigma and discrimination to improve treatment access, enhance quality of care and reduce drug-related harm.

While participants' perspectives on implementation differed, many supported decriminalisation as a crucial step toward reducing stigma and discrimination. Numerous participants expressed the view that community sentiment regarding drug use, is driven by its illegal status, and that while criminalisation remains the dominant legislative approach, stigma and discrimination will be sustained.

An NGO representative expressed the view that laws perpetuate stigma, which in turn perpetuates the laws. The lead of a large national information and education organisation suggested that only changes to legislation will effectively address stigma, as education campaigns cannot address root causes including unconscious bias.

Participants observed that police interactions and criminal justice responses perpetuate discrimination and create significant barriers to equitable treatment access. Some providers perceived that certain programs are less likely to be funded due to stigma associated with different behaviours, noting that alcohol harm reduction messaging is more common and credible than harm reduction information about illicit drugs. Other participants highlighted significant stigma attached to problem alcohol use despite its legal status.

Service access and delivery

Discussions emphasised what participants saw as the importance of non-judgmental services to encourage engagement by building trust and rapport. Participants recognised the value of peer workers for creating welcoming and inclusive environments, with these roles being even more critical in small communities where anonymity is difficult to maintain.

According to participants, implementation of true “no wrong door” approaches requires both system reform and cultural change within services. Many noted that while this principle is often endorsed, services continue to exclude people based on AOD use or refer them elsewhere without proper support. Participants identified this as particularly problematic in hospital settings and mainstream health services.

Participants provided examples where improvement is needed, including access to pain management and dental care for people who use drugs. Better integration of these services with AOD care was suggested. Participants shared success stories of services effectively implementing inclusive approaches, along with specific suggestions for policy and practice changes. A government agency shared their experience providing multidisciplinary services that effectively minimise stigma and reduce barriers to care.

Structural stigma

Participants described the structural stigma within health and social service systems, arguing that drug use and people who use drugs are treated differently from other health conditions, and other health consumers. Participants suggested structural stigma requires systematic addressing through policy change and accountability measures, such as embedding anti-stigma requirements in service accreditation, developing organisational policies that explicitly address discrimination, and creating accountability mechanisms.

Participants particularly emphasised the need to address systemic barriers faced by pregnant women and parents seeking treatment, including fear of child removal. Housing discrimination against people who use drugs was highlighted by participants as requiring specific policy responses. Many emphasised that stable housing is crucial for recovery and harm reduction, yet many organisations exclude people currently using drugs. Discussion included participants' views on the need for housing first approaches and removal of zero-tolerance drug use policies.

Education and training

Participants considered education for healthcare workers, social services workforce, police and the general population key for reducing stigma and discrimination. They repeatedly pointed to the mental health sector, and to a lesser extent, the domestic and family violence sector, as providing models for positive outcomes achievable when significant effort and resources are devoted to stigma reduction.

Culturally and linguistically diverse community stakeholders reported a need to work with religious and community leaders to reduce stigma so young community members feel more comfortable seeking support.

Regarding healthcare settings specifically, participants noted that AOD content in professional training is often minimal, which they suggested perpetuates negative stereotypes and contributes to reluctance to work with people who use drugs. Participants indicated that lack of confidence and skills among health professionals can be perceived as stigma and discrimination by people who use drugs.

Some participants reported that certain interventions are stigmatised among health professionals. Multiple participants raised concerns about the small numbers of pharmacies where naloxone is immediately available and limited opioid treatment program prescribers.

Participants proposed solutions including mandatory AOD education in health profession training programs, ongoing professional development requirements, expansion of successful programs providing trauma-informed AOD training to mainstream services, better incentivisation for opioid treatment program prescribers, and education delivered by people with lived and living experience.

Some participants emphasised the need for cultural safety training, highlighting that a person may hold multiple stigmatised identities and experience concurrent forms of discrimination.

Stigma by association and media representation

A smaller number of participants drew attention to what they described as 'stigma by association' experienced by people who work with people who use drugs, which they suggested can lead to lowered productivity and wellbeing. Representatives from the NGO sector described feeling stigmatised within their professional sphere due to perceptions of lower clinical expertise compared with government services.

Youth representatives suggested that fear-focused education campaigns can create stigma by emphasising harms without providing harm reduction information. Participants proposed solutions included developing media guidelines, mandatory training for media organisations, supporting people with lived and living experience to share stories safely, and creating campaigns challenging stereotypes.

The need to address discriminatory language and portrayal of drug use in mainstream media was emphasised, along with better representation of diverse experiences of drug use and recovery. Participants noted the Mindframe guidelines aim to influence media reporting on mental health and AOD-related issues, improve community attitudes and increase help-seeking behaviour. Some argued these guidelines are limited by lack of capacity to monitor compliance.

Employment and community participation

Participants identified employment support and meaningful activity as crucial elements of recovery and reintegration. They suggested employment discrimination and criminal record impacts create ongoing barriers to recovery and community participation.

Participants proposed solutions including reforms to spent convictions schemes, employment opportunity programs, and addressing workplace discrimination. They emphasised the need for stepped approaches to employment recognising people may initially engage only in limited hours. Participants shared examples of successful programs including employer incentive programs and ongoing support to maintain employment.

Participants highlighted the importance of addressing discrimination against people with AOD use histories in employment, along with the need for better integration between AOD services and employment support programs. They noted impacts for Aboriginal people and young people as requiring specific attention.

CANNABIS AND DRIVING

Participants expressed that drug driving laws need reform to focus on impairment rather than presence, particularly for prescribed cannabis patients. It was noted by some participants that current laws can deter people from accessing prescribed medications and don't accurately reflect road safety risk. Some attendees called for better community education around medicinal cannabis and current drug driving tests.

Attendees across forums noted the impact the current system has for people in regional areas, where there are limited public transport options, and the consequences are broader. Regional attendees noted that there have been people in the community who have lost their license, and the impact this has in country towns where everything is geographically dispersed.

Alternative approaches

Evidence was discussed showing different approaches in other jurisdictions that participants argued perform better at balancing road safety with medical needs. These included Victoria and Tasmania, where medical exemptions and impairment considerations apply. Stakeholders advocated for considerations of medical exemptions for prescribed cannabis, for both driving, and testing in the workplace.

Calls were made for utilising similar methodology for testing impairment, as used for alcohol. It was felt that there is a robust and well-established system to test for alcohol impairment and acknowledged that testing for

THC and its associated impairments requires further research.

Some groups noted priorities in this area, including better regulation of prescribed cannabis to reduce drug-induced psychosis, with active monitoring from the prescribing GP, and reforming driving laws to test for impairment over presence, and investing in research to establish threshold recommendations for cannabis and driving.

The current system

A government representative noted that the regulatory framework around drug driving offences, and the emergence of medicinal cannabis is a significant issue for transport and road safety agencies and law enforcement. To enable consideration of whether this can be changed there needs to be research into the effect on driving from the range of prescription cannabis options available.

The variation in what is being prescribed was explained by attendees as being an issue. The oral fluid test was described as attempting to detect recent use – within 24 hours, however the variation in cannabis products and routes of administration has produced challenges in validating this timeframe.

Law enforcement participants spoke of the disproportionate impacts experienced by young people who are experimenting with drugs, are no longer impaired, but continue to have presence of THC in their system, and the consequences of interactions with the criminal justice system and loss of licence.

Reform options

Calls were made for equitable access to medicinal cannabis, noting a low percentage of GPs currently prescribe.

Calls were also made for an urgent review and revision of the *Roads and Transport Act 2013* (NSW) to expand to include an exemption for medical cannabis.

Attendees queried whether there was any evidence to show that increased availability through prescribed cannabis had led to a change in roadside testing statistics, crashes, or death and harm indicators. Improved data availability in this regard was mentioned.

HARM REDUCTION

A. DRUG CHECKING

Participants across all forums with few exceptions, strongly supported the introduction of drug checking services as a harm reduction strategy.

Participants cited various evidence of the effectiveness of drug checking services from other jurisdictions such as the Australian Capital Territory, including disposal rates of substances after testing, when the expected substance was not detected, an additional substance was found, or the results were inconclusive.

The consultations noted a strong sense of urgency about the introduction of drug checking, due to fear surrounding increasing contamination of substances and emerging synthetic substances.

Stakeholders highlighted the dual benefits of direct harm reduction and enhanced early warning system capabilities about dangerous substances in circulation. Drug checking may impact on the drug market and supply by improving quality and removing adulterated substances from the market. Some noted that a forensic lab is required for confirmatory testing and that funding for this also needs to be assured. Such an increased capability is important given increasing amounts of synthetic substances, not all of which can be identified through drug checking.

Service models

Discussion emphasised the need for both fixed and mobile services, to address varied use contexts, with suggestions for establishing at least one permanent site which could develop expertise in detecting new substances. It was noted that services should be available in the community for people who don't attend festivals. Co-location of other services would allow for and promote opportunistic interventions, including provision of naloxone.

The importance of including peer workers within models was noted. Support was expressed for expanding peer-based harm reduction services that provide non-judgmental support and education. Services like DanceWize were frequently cited as effective models, providing trusted sources of harm reduction information at music festivals and other youth events. Young people emphasised that they often have their first conversations about drugs with peer workers rather than in school or healthcare settings. Regional perspectives emphasised the importance of these services being culturally appropriate and available after hours, with strong support for training local community members as peer workers rather than relying on fly-in fly-out services.

Other aspects of drug checking recommended by participants included integration with broader health services (the example of the Netherlands was mentioned), access to peer workers and health professionals who can provide accurate, non-judgmental harm reduction advice, coordination with police and forensic lab capability for confirmatory testing.

Participants called for simpler, plain-language health warnings and faster dissemination through peer networks. Integration of drug checking data with early warning systems was seen as crucial. There were suggestions to further increase engagement through social media and peer networks for alert distribution, while ensuring messaging doesn't inadvertently promote use.

Other participant perspectives

Service providers noted that current testing technology has limitations but supported a comprehensive approach including mobile and postal testing services to ensure access in regional areas. There was strong emphasis on ensuring drug checking services include access to peer workers and health professionals who can provide accurate, non-judgmental harm reduction advice.

While some expressed concerns about liability, a more commonly expressed concern was that drug checking can potentially encourage drug use. Others argued that there is no evidence to support this concern. Attendees noted that drug checking needs to be considered alongside the police response with specific reference to the use of sniffer dogs. An arrangement with police is required to allow drug checking to work in practice.

Representations were noted from parents who called for drug checking services and a community organisation representative who suggested that drug use will continue, and there was an imperative to make it safer. A sentiment expressed throughout was that drug checking at music festivals should be seen as a commonsense approach to reducing harms and is no longer something that is politically controversial.

B. NEEDLE AND SYRINGE PROGRAMS (NSP)

The Needle and Syringe Program (NSP) received strong support, but it was expressed that they require expanded hours, coverage, and services. Feedback confirmed that NSPs provide critical opportunities to engage people with health services and can serve as an entry point into many services, including treatment. Participants noted people who inject drugs are often not connected with mainstream health services.

Service enhancement proposals included 24-hour access through vending machines, co-location of MSICs with NSPs and better integration with other health services. Participants mentioned data which showed significant gaps in regional and rural coverage, with calls for mobile services to reach underserved areas. Discussion included the cost-effectiveness of NSPs in preventing blood-borne virus transmission.

Many attendees noted the positive impacts of NSPs, including the opportunity to be an entry point to being connected to other health services. They called for expanded access, particularly in rural and regional areas, and noted the positive impacts of co-locating health services, and opportunities for existing services to include alternative models of supervised consumption rooms.

Service providers noted that current NSP guidelines effectively outline service delivery to under 18s while managing mandatory reporting requirements, but similar guidance is needed for other harm reduction services.

NSPs and custodial settings

There were calls to increase access to harm reduction programs in custodial settings, specifically the introduction of the NSP. Attendees noted the rates of hepatitis C reinfection and need for retreatment in people in custody was substantially higher than in the general community. This was presented in the context of the potential cost savings. Many participants made calls for people in custody to receive the same access to the range of harm reduction healthcare that is available to the community.

C. TAKE HOME NALOXONE

Take-home naloxone programs were identified as highly effective but requiring significant expansion and destigmatisation. Stakeholders emphasised the need for broader community education about naloxone use, particularly given the increasing risk of synthetic opioid contamination.

Implementation recommendations from participants included incorporating naloxone into standard first aid kits, ensuring availability in emergency departments, expanding pharmacy access, and having police carry it, as happens in Western Australia and Queensland (though training requirements and liability were noted by some as barriers). There were calls to examine successful models from other jurisdictions, particularly programs in the US where naloxone is widely available. The need for better coordination between ambulance services and police at overdose scenes was highlighted, with concerns that police presence can deter people from calling for medical help. Attendees raised in addition that naloxone use should be included as part of first aid training and be made available wherever community automated external defibrillators are located.

More health promotion around naloxone was called for including re-education and revisiting the take home naloxone program with pharmacists, and having it included as part of first aid kits. There were calls for increased awareness of naloxone through education, and incentivising all pharmacies to stock it, with a no questions asked policy.

Access to naloxone for young people was specifically highlighted as a concern, with multiple participants emphasising the importance of making naloxone widely available, including in schools and youth services, with suggestions that it should be included in every first aid kit. It was noted that better access is required in regional areas, with participants of regional forums identifying challenges in accessing harm reduction services outside metropolitan areas, with some communities relying on inadequately funded NGOs to deliver essential harm reduction programs.

D. MEDICALLY SUPERVISED INJECTING CENTRES (MSIC)

The Kings Cross MSIC was frequently cited as a successful model, with participants noting zero deaths and thousands of people connected to treatment and support services over its operation. Stakeholders emphasised that local health districts should be empowered to assess need and establish facilities based on local drug use patterns and community desire.

Calls for more MSICs, in more diverse areas in response to community needs, including in regional areas were strong. Only having one MSIC creates an equity and access issue. It can be the only point of contact with the health system for very marginalised people. There was also discussion of the need to consider access to 'safe consumption rooms' (i.e. for other modes of administration aside from injecting).

Implementation considerations

Participants suggested using NSP data and ambulance callout patterns to identify areas of need. Integration with other health services was seen as critical, with suggestions to co-locate facilities with existing healthcare services. Attendees noted that alternatives to the Kings Cross model could be utilised, such as co-locating services with existing NSPs, community drug health centres (that already have AOD nurses), or NGOs and could be run at a community level.

The consultation highlighted options to utilise alternative less-costly models for MSICs, such as integration into existing NSP services. The perversity of handing people injecting equipment, knowing they will use it for the purpose of injecting drugs, for them to leave and use in unsafe areas, with no access to overdose support was raised by a medical practitioner and advocate as a significant challenge.

Opposition centred mainly around concerns about public amenity, though evidence was presented showing improved community safety around existing facilities. Participants discussed research that demonstrates that MSICs improve public amenity rather than harming it.

Client perspectives

A testimony came from an MSIC service user who said they wouldn't be alive without the care they received from the centre. They described how the centre provided a community of people who treated them normally, made them feel normal and good about themselves. The user was connected to services, including housing, and other social and health supports (dental and food). Other users of MSICs highlighted how they had received education and health promotion through the service.

THE CRIMINAL JUSTICE SYSTEM AND POLICING

Diversion programs: Status and reform opportunities

Participants expressed the view that better integration between health and justice systems would prevent criminalisation of what they feel to be health issues. Attendees described diversion programs as representing a successful application of responding to drug use as a health issue, with several programs demonstrating positive health and criminogenic outcomes.

Attendees supported expansion of pre-court diversion programs. Reform of the Early Drug Diversion Initiative (EDDI) received strong support, including extending eligibility criteria to remove restrictions on access related to polydrug use and/or criminal history, threshold quantities, and creating standardised implementation protocols. Attendees from a wide range of backgrounds including the judicial and coronial systems called for a review of quantities deemed for personal use under the *Drug Misuse and Trafficking Act 1985* (NSW), arguing that deem supply provisions should be repealed because the onus on the offender to prove their innocence, opposing the key legal tenant of 'innocent until proven guilty'. Making quantities more realistic and reflective of people's patterns of drug use would expand the number of people eligible for diversion.

Removal of police discretion for diversion programs, enforcement of consistent diversion practices and presumption of diversion as a clear first preference, regardless of criminal history, were considered imperative to address the current low rates for EDDI (around 8% of legal actions for drug possession and/or use), particularly in regional areas. The NSW Bar Association suggested that the *Crimes (Sentencing Procedures) Act* could be amended to incorporate an assumption of diversion for personal use quantity offences.

Law enforcement representatives felt that provision of immediate health interventions at the time of referral would increase program uptake and impact for eligible people through the EDDI. Attendees described significant disparities in implementation of EDDI across different population groups and regions, with particular concern expressed about disparity in access for Aboriginal people. A service provider drew attention to the chronic relapsing nature of drug dependence, arguing that we must be realistic about what an individual's outcomes

might be after a single instance of diversion, and that people should be offered diversion programs as many times as they encounter police for drug use/possession offences.

There were mixed views about whether EDDI and the Cannabis Cautioning Scheme (CCS) should be merged. Discussions around the CCS related to eligibility and access, including extending it to young people, and increasing the number of cautions a person can receive. There were concerns that combining the schemes could create a more restrictive environment for cannabis.

Alternatives to incarceration

Attendees also supported expansion of alternatives to incarceration. Drug Court expansion received strong support. Discussion highlighted implementation challenges in regional areas, including lack of treatment and other support services to which attendees could be referred, and significant transport barriers. Attendees called for allowing transfers between drug courts, expanding eligibility criteria, and increasing funding for support services.

Attendees including those from the judicial system praised the Magistrates Early Referral into Treatment (MERIT) program, pointing to its demonstrated effectiveness. Strong support was expressed for MERIT's expansion to a wider range of courts, particularly in regional areas, along with an extension to its scope to include alcohol. Barriers to access to MERIT were identified, including eligibility restrictions tied to bail status and limited treatment availability. The need to support people with complex needs including histories of violence, who are often excluded from diversion programs, was recognised.

Youth-specific diversion

Youth-specific diversion programs were identified as requiring significant enhancement, with strong support expressed for exploring non-custodial responses and increasing diversionary options for young people who use drugs to prevent young people entering the criminal justice system. Compounding the issue is the absence of suitable services to support a young person on a diversion program including limited support to find pathways into treatment.

It was noted that there are currently very few diversion options for young people, with the main avenue being through the *Young Offenders Act* (NSW), such as cautioning or youth conferencing. Participants from a legal organisation suggested that reforms to the *Act* in 2019 which extended opportunities for diversion of young people are not being implemented to full effect. Other participants noted that there is still more opportunity to reform the *Act* further to remove the obligation for a young person to admit guilt before receiving a caution. This was seen to be a deterrent for both the young person and police, and potentially a missed opportunity for early intervention, and breaking the cycle of criminalisation.

A magistrate explained that the *Young Offenders Act* (NSW) and its provisions for cautioning and/or youth conferencing has a greater range of eligible offences than the CCS. This is an existing model that works and some aspects of it could be scaled up to adults.

Many attendees called for reinstatement of the Youth Drug Court with proper legislative backing and enhanced service integration. There was emphasis on the importance of family involvement and support in youth programs.

Aboriginal-specific considerations

The over-representation of young Aboriginal people in the criminal justice system is a significant issue, with considerable data to demonstrate the need for reform. Practices such as Elder cautioning, or cultural healing where police and the courts hand over responsibility for young offenders to cultural Elders, similar to what takes place in New Zealand Aotearoa were suggested as a potential way forward. The Youth Koori Court was cited as an effective model, with data showing those that attend were less likely to receive a control order, but it is currently only available in limited locations. Regional summits emphasised the need to expand the Youth Koori Court beyond metropolitan areas and increase funding for diversionary programs that keep young people connected to culture and community.

While expressing support for general expansion of diversion programs, attendees also noted the importance of access to targeted diversion programs for specific populations. Aboriginal stakeholders highlighted the importance of culturally safe diversion, calling for culturally appropriate versions of court programs with greater community control and consideration of cultural obligations.

Attendees noted that appropriately resourced Aboriginal-led programs and community control are essential for effective service delivery. Discussion emphasised the importance of cultural connection in healing, including access to Country and engagement with Elders. They highlighted that diversion models must be appropriate for Aboriginal people for participation to be meaningful and achieve positive outcomes. Participants felt that alternative sentencing models such as Circle Sentencing and the Walama List work well, but they are not widely available, and there may be differential outcomes and experiences for Aboriginal men and women. There were also calls to expand justice reinvestment initiatives such as the Just Reinvest program to more locations.

Regional considerations

Geographic inequities in service access identified throughout the regional forums included limited treatment options, poor public transport and workforce shortages. It was recognised, including by government agencies that transportation issues in the regions constitute barriers to both court attendance and diversion program participation.

The limited treatment and support to which diversion programs can refer their participants was perceived as particularly pressing in the regions, with attendees pointing out that diversion programs can only work if there is enough capacity in the services to meet demand. The expansion of the Drug Court to Dubbo highlighted the challenges of implementation in the absence of supporting infrastructure. Regional consultations also drew attention to the fact that, with respect to diversion, the impact of individual police officer discretion is more significant in small communities, and that there are different policing dynamics in these communities. Unique challenges can be experienced in regional areas close to state borders such as inconsistent approaches to diversion and difficulties coordinating court programs across jurisdictions, emphasising the need for better interstate cooperation and information sharing.

Policing

Participants noted that discussions around policing practices featured across numerous themes throughout the consultation.

Many expressed the view that current practices lead to undue impact of criminalisation and long-term issues of distrust, particularly for young people and Aboriginal people.

Participants suggested that policing practices can be a barrier for people seeking help. The underlying principle of treating drug use as a health issue, rather than a criminal one was at the core of many of these discussions.

Police culture and training emerged as key areas participants identified as benefiting from reform. Participants noted the need for a fundamental shift from enforcement to health and wellbeing approaches, with suggestions for mandatory AOD and mental health training for all officers, and for police to carry naloxone.

There were calls from participants for more guidance for police on the range of harm reduction and diversion schemes available, particularly for junior officers, and shifting response to health-based approaches to improve outcomes. Participants suggested this would also assist with reducing stigma.

Police participants noted the impacts of workforce challenges including high turnover and the inexperience of many officers, particularly in regional areas.

Discussions highlighted what participants described as successful examples of police working collaboratively with health services, such as at the Medically Supervised Injecting Centre in Kings Cross. Some noted that partnerships in the festival space were working well, with police representatives citing the example of the 'low contact' approach taken by police when working with DanceWize and medical teams.

Inequities in policing practices

Geographic and demographic inequities in policing practices were widely discussed. It was noted that data indicates significant disparities in how discretion is applied across different socioeconomic areas and between Aboriginal and non-Aboriginal people.

Some participants felt that profiling of certain demographics occurs, creating disproportionate impact of current policing practices particularly for Aboriginal people, young people, and culturally and linguistically diverse communities.

Discussions highlighted the experience of discrimination and inequity for vulnerable populations. There were calls for standardised protocols, such as around application of discretion, to ensure equitable treatment.

Resource allocation

Police resource allocation and priorities were examined, with many participants suggesting that drug enforcement diverts resources from more serious crimes. Law enforcement representatives expressed support for reforms that focussed on supply and serious drug trafficking rather than personal use.

The concept of 'public health policing' was raised as an approach that could better enable responses to drug use as a public health issue, with an emphasis on early intervention and prevention of harm.

Specific practices

Participants identified specific police practices needing significant reform, including strip searching, drug detection dogs at festivals, and police attendance at overdose events.

Strip searching

Strip searching for suspected drug possession was strongly opposed by many participants, with evidence presented about its harmful impacts.

Participants cited psychological trauma, particularly for young people and vulnerable populations, and questioned the practice's legality and effectiveness. Festival organisers and health professionals emphasised how strip searching causes harm and damages trust between young people and law enforcement, creating barriers to help-seeking behaviour.

Discussions highlighted particular concerns about impacts on minors. For under-18s festivals, participants noted there is a requirement to provide a witness for strip searching, placing them in an uncomfortable position and impacting levels of trust between young people and police.

Law enforcement participants noted that strip searching has a role to play in maintaining public safety, stating that many illegal weapons are seized as a result of these processes.

Drug detection dogs

Many participants called for the cessation of using drug detection dogs, noting the threat of arrest and detection leads to panic consumption and increased harm. Use of detection dogs at festival entrances were noted as problematic, resulting in altered behaviour from patrons, increasing the likelihood of an adverse outcome. There was a strong sense among participants that the presence of police in riot uniform with dogs does not establish trust with the community.

It was noted that the percentage of supply offences being detected is low, which they suggested shows that the use of drug detection dogs is not achieving this outcome. Opinion was shared by young people that ceasing use of drug detection dogs would lead to improved relationships between the community and police.

Legal reform advocates called for the immediate cessation of drug detection dogs, noting that a lot of drug use is non-problematic, and resources would be better directed into treatment rather than catching people for personal use.

Law enforcement participants noted the role that detection dogs serve a purpose and have a role in maintaining public safety. They described them as a critical resource that are well trained, effective for large crowds, and maintaining peace. There was a sense held by some police representatives that withdrawing dogs may increase organised crime at events. Others did not agree that they were effective in controlling large crowds, and suggested they conversely lead to more harm due to panic ingestion.

Participants noted that introduction of drug checking services needs to be considered alongside reforming the use of drug detection dogs and strip-searching practices, otherwise it may have a counter-intuitive or contradictory effect.

Police attendance at overdose events

Participants emphasised that fear of police contact, including at overdose events, prevents many people from accessing harm reduction services or seeking medical help. According to participants, young people fear the implications of detection, such as family members knowing and fear of arrest. Participants noted police often attend overdose scenes before ambulances, which can act as a deterrent to calling emergency services. There were calls to better equip police so that they can deliver a harm reduction response, such as naloxone.

Discretion in policing

Participants called for the removal or adjustment of police discretion in the context of strip searching, use of dogs, and for diversion schemes. Some participants noted that discretion is important for different areas of policing; however, more education and greater feedback to police could be helpful which may impact how discretion is applied.

Multiple participants across regional and Sydney forums identified issues with the way police discretion is applied for diversion schemes, noting the schemes are particularly important for diverting people into treatment and health system responses. Participants called for greater guidance being provided to police, and less 'discretionary' applications for diversion, particularly the EDDI.

Some participants noted challenges for police who witness crime noting they are trying to enforce law and do their jobs, whereas discretion may ask them to do something different. There were calls to remove the discretionary component and allow for a standardised process to be applied to everyone, where diversion is presumed as the first step, regardless of history.

Focus on supply reduction

Participants discussed the balance of police responses in street level policing versus illicit drug supply responses. Some participants noted the importance of a continued focus on supply and trafficable offences.

There were mixed responses about the effectiveness of current supply reduction measures, with some participants noting readily available access to drugs, without evidence of price changes. It was acknowledged that Australia's large coastline would create significant challenges for border enforcement.

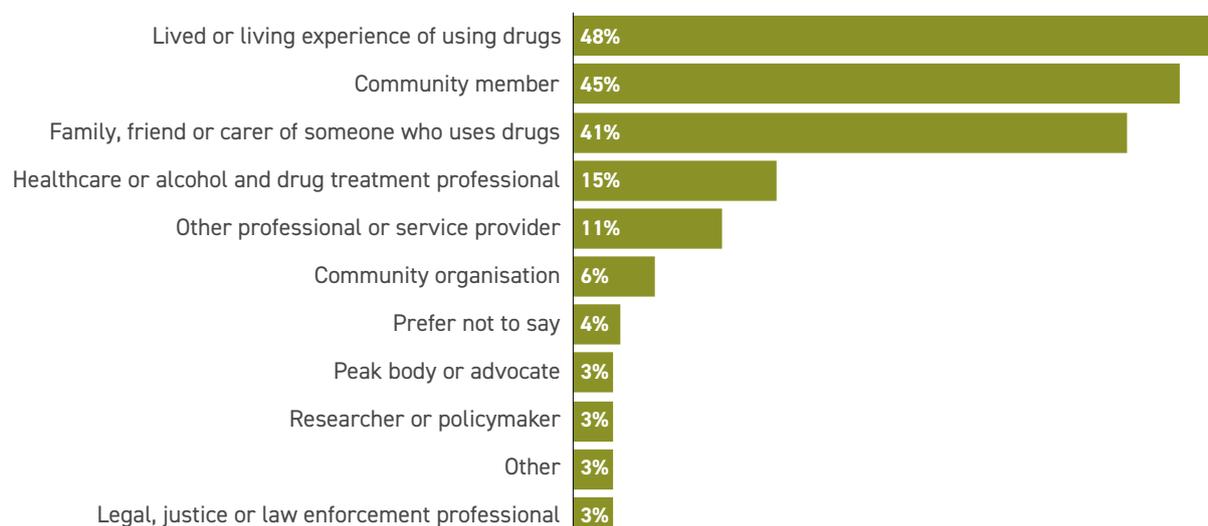
HAVE YOUR SAY

1. DEMOGRAPHICS

The demographic data show that responses were received from a broad cross section of the NSW population. However, it should be noted that this is a self-selected sample and is not representative of the NSW population.

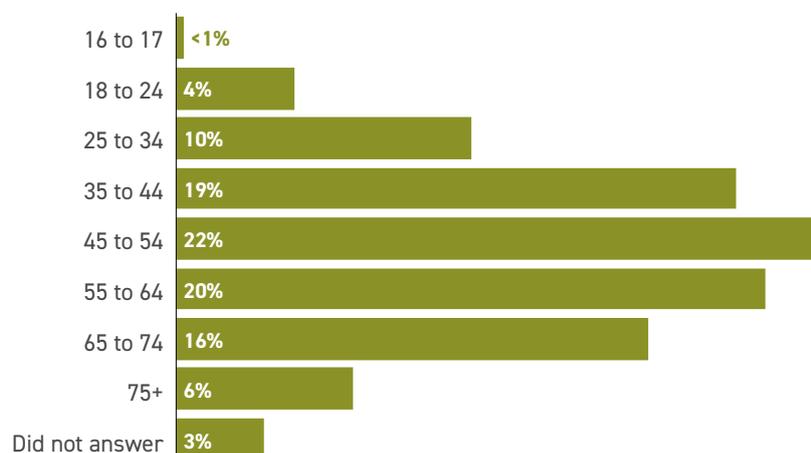
Of the 3,669 responses received, 31% reported being from regional or rural NSW and 49% from metropolitan areas (Sydney, Newcastle or Wollongong areas), 2% reported being from outside NSW and 18% preferred not to say or did not respond to the question. When asked about the perspective respondents represented, 48% reported having lived or living experience of drug use, 45% as being community members and 41% as being a family member, friend or carer of someone who uses drugs (Figure 1). Respondents could select multiple answers for this question.

Figure 1: Respondent perspective



Respondents reported ages from 16 to 75 years or older, with most respondents being aged between 35 to 64 years (Figure 2).

Figure 2: Respondent age range



When asked which applied to respondents in terms of their demographics, experiences and background:

- 47% identified as female, 46% as male, 1% as non-binary, 2% preferred another term and 5% did not answer
- 14% identified as LGBTQI+
- 5% identified as Aboriginal or Torres Strait Islander people
- 13% were from a culturally or linguistically diverse (CALD) background
- 25% reported a lived experience of disability
- 13% reported having experienced homelessness.

2. THEMATIC ANALYSIS OF THE OPEN-ENDED RESPONSES

The responses were often passionate and expressed a wide variety of views, ranging from requests for legalisation, to decriminalisation, to wanting a stronger police response to drug supply offences, to improving alcohol and other drug (AOD) education, to increasing access to AOD services in regional and rural areas. Respondents raised big picture ideas such as reducing stigma and discrimination, and more specific practical or solution-based ideas such as running social media campaigns to educate the community as a way of reducing stigma and discrimination.

Two topics that were raised by many respondents across the multiple questions were improving access to AOD and mental health services across the state and improving school and community AOD education.

A common thread across responses was the hope for positive outcomes in NSW and a desire for cultural change around how we respond to drug and alcohol issues - from the community through to treatment services, law enforcement, education and government.

People described their own experiences, some making the point that their drug use was recreational and others describing their struggles with drug dependence. Family members told us about experiences with needing support for their loved ones and themselves.

- Topics raised consistently across multiple of the Drug Summit themes included:
- Reducing stigma and discrimination
- Treating drug use as a health issue
- Decriminalisation of personal use and possession of drugs
- Increase access to AOD services
- Improving AOD education in a range of settings
- Enabling drug checking services
- Increasing access to mental health treatment
- Stronger policing of drug supply offences
- Legalising cannabis or legalising all drugs.

TOP THREE ISSUES FOR RESPONDENTS

Question:

Thinking about what we could do better to keep people safe and well, what are the top 3 issues that need to be addressed?

The most frequently raised issue in response to this question was to the need to improve AOD education, in both schools and in broader community settings. This was also the top issue identified by respondents from both regional/rural and metropolitan locations (Table 1).

Table 1: Comparison of most frequently raised topics between metropolitan and rural/regional respondents

Metropolitan	Rural and regional
Improve AOD education in schools and community	Improve AOD education in schools and community
Allow drug checking services (festivals and/or community)	Increased access to AOD services
Decriminalise drug possession for personal use	Decriminalise drug possession for personal use
Increased access to AOD services	Legalise cannabis
Reduce stigma and discrimination	Stronger policing of drug supply
Treat drug use as a health issue	Allow drug checking services (festivals and/or community)
Legalise drugs	Increased access to mental health services
Increased access to mental health services	Treat drug use as a health issue
Stronger policing of drug supply	Housing support
Legalise cannabis	Increase services in regional and rural areas

Note: Those highlighted in grey are uniquely in the top ten topics for metropolitan or regional/rural respondents

THEME 1: HEALTH PROMOTION AND WELLBEING

The most frequently raised topic for health promotion and wellbeing was the need to improve AOD education in schools and for the community. Many expressed the need for education to be evidence based, to include harm reduction information or to include voices of people with lived and living experience. Improving education was identified as an important way to prevent drug related harm and reduce stigma and discrimination. While there were some who wanted to see an education approach that emphasised the harms of drugs, many respondents mentioned that health promotion messages should not demonise people who use drugs, as it prevents people from engaging with the information. Instead, respondents frequently suggested that drug use and dependence should be treated as a health issue. Similar topics were raised by regional/rural and metropolitan respondents, with some small differences (Table 2).

Many other topics were also raised, including increasing awareness about available services; more alcohol regulation; ending the drug detection dog program; stronger police response to drug supply offences; increasing peer support services and peer workers; responding to social determinants of health; more community engagement; improved regulation of medicinal cannabis; more services for young people; improving AOD education for professionals; addressing barriers to service access including cost, transport and accessibility; and increasing community events and activities.

Table 2: Health promotion and wellbeing: Comparison of most frequently raised topics between metropolitan and rural/regional respondents

Metropolitan	Rural and regional
Improve AOD education in schools and community	Improve AOD education in schools and community
Allow drug checking services (festivals and/or community)	Harm reduction education and activities
Harm reduction education and activities	Allow drug checking services (festivals and/or community)
Reduce stigma and discrimination	Reduce stigma and discrimination
Decriminalise drug possession for personal use	Treat drug use as a health issue
Treat drug use as a health issue	Decriminalise drug possession for personal use
Legalise drugs	Public awareness campaigns
Regulated drug supply	Legalise drugs
Public awareness campaigns	Promote healthy lifestyles
More safe consumption centres	Legalise cannabis

Quotes

“Many drug-related harms stem from a lack of accurate information about drug content, potency, and safe usage. Implementing harm reduction practices, such as pill testing at events and safe consumption spaces, along with a nationwide campaign on the risks and safe use of legal substances, would empower individuals to make informed choices.”

Male, 25-34, lived experience of drug use, metropolitan.

“We need more information getting to young people there needs to be investment in social Media platforms where young people get their information. It is also vital that we get information out quickly a friend of mines Son died 2 weeks ago after using cocaine that was laced with Fentanyl. We need Naloxone flooding the community if we are to prevent more deaths”

Female, 55-64, metropolitan.

“Provide better education about drugs and drug related harms. Also better harm reduction information - if people are going to use drugs, then they should do its safely and reduce the impact to communities.”

Female, 35-44, metropolitan.

“Open discussion about drugs in schools from an early age. Resources for parents and young people that are accessible. Targeted advertising and advertising campaigns for younger people as well as adults.”

Female, 25-34, region not provided.

“Give realistic information about potential harms without sensational nonsense. When I was in school in NSW several real consequences of drug use were not mentioned, but they said you could easily get psychosis from occasional cannabis use”

Non-binary, 25-34 years, LGBTQI+, metropolitan

“We need to decrease stigma around illicit drug use first - otherwise health promotion messages don’t get to the people who are most in need.”

Female, 45-54, LGBTQI+, lived experience of drug use, metropolitan.

“Education provision to young people is fear driven, and lacks practical advice for that large proportion that will inevitably indulge in drug use at some point. A more honest, balanced approach would provide these young people with knowledge from which to make better decisions.”

Male, 45-54, regional/rural.

“If the government adopted a harm minimisation approach and provided testing services at these events, studies have shown that drug consumers make informed choices and even discard their drugs in some instances.”

Gender not disclosed, 35-44, lived experience of drug use, metropolitan.

“Don’t frame messaging as a war on drugs so as not to marginalise users who may be self medicating a mental illness. Families of users need to feel supported not judged.”

Female, 45-54 years, lived experience of drug use, region not disclosed.

THEME 2: EQUITY, RESPECT AND INCLUSION

The most frequently raised issue under the equity, respect and inclusion theme was the need to increase access to AOD services, as well as mental health services. Suggestions included tailored support for specific populations, culturally appropriate care, and addressing barriers to treatment such as transport, affordability and childcare. A small number of respondents expressed the desire for equality of treatment access for all and were not in favour of demographic-specific services.

Additionally, there were specific calls for more AOD services in rural and regional areas, where access is currently limited. Respondents emphasised the need for local access to services to prevent the need for travel to larger towns or cities, which is a significant barrier to seeking support. The cost of primary care, specialist services and private care were also raised.

Stigma and discrimination were identified as key barriers to seeking help and achieving better outcomes. Many respondents highlighted stigma in healthcare and other services, calling for further education on alcohol and other drug issues among professionals working across healthcare, law enforcement, criminal justice and social services sectors. Decriminalising drugs and treating drug use as a health issue were seen as ways of reducing stigma and discrimination.

A diverse range of other topics were also raised, including calls to increase staff in AOD services, expand Aboriginal-specific services and growing the peer workforce. Suggestions also included legalising cannabis, better integration of AOD and mental health services, providing housing and financial assistance, enhancing online and digital care, and ensuring access to services for people in custody. Regional/rural and metropolitan respondents again raised similar topics (Table 3).

Table 3: Equity, respect and inclusion: Comparison of most frequently raised topics between metropolitan and rural/regional respondents

Metropolitan	Rural and regional
Increased access to AOD services	Increased access to AOD services
Reduce stigma and discrimination	Increase services in regional and rural areas
Affordable AOD and health services	Reduce stigma and discrimination
Increase services in regional and rural areas	Affordable AOD and health services
Decriminalise drug possession for personal use	Address barriers to service access
Need for culturally appropriate services	Increased funding for AOD services
Treat drug use as a health issue	Increased access to mental health services
Services tailored to specific populations	Treat drug use as a health issue
Address barriers to service access	Decriminalise drug possession for personal use
Increased funding for AOD services	Services tailored to specific populations

Quotes

“Many people facing substance use issues lack the financial means to access private treatment or counselling. Expanding funding for free or low-cost services, including rehabilitation, mental health support, and harm reduction programs, can make help more accessible to everyone in need.”

Male, 45-54, CALD, lived experience of homelessness and drug use, metropolitan.

“Decriminalising and regulating cannabis, reducing stigma, and expanding harm reduction services can improve equitable access and inclusion for people seeking support for drug use.”

Gender not disclosed, 45-54, lived experience of drug use, from outside of NSW.

“Integrating social services like housing, mental health care, and job assistance within drug support frameworks can make care holistic and more impactful.”

Male, 35-44, CALD, lived experience of drug use, metropolitan.

“Many people face barriers to mental health and substance abuse support, especially in rural and lower-income areas. Expanding affordable, timely access to integrated mental health and addiction services is critical. This includes increasing funding for community clinics, tele-health options, and mobile outreach, ensuring everyone can receive help when they need it.”

Female, 45-54, metropolitan.

“Local access to services in regional rural and remote areas. Having to travel to larger towns or cities prevents people from being able to access those supports.”

Female, 35-44, LGBTQIA+, regional/rural.

“Partnering with local community organisations and leaders can enhance outreach and trust-building, particularly in marginalised communities. This fosters a supportive environment where people feel safe and respected when accessing help.”

Male, 45-54, CALD, lived experience of drug use, metropolitan.

“The stigma surrounding drug use can prevent people from seeking support. Public campaigns and education that destigmatise drug-related issues encourage individuals to pursue help without fear of judgment, promoting fairness and respect within healthcare settings.”

Male, 45-54, CALD, lived experience of homelessness and drug use, metropolitan.

“More availability of free drug and alcohol health services (detox beds, counselling, follow up, mental health treatment). More investment into digital health solutions that focus on harm-reduction and comorbid mental health.”

Female, 55-64, regional/rural.

“Different cultural backgrounds have unique experiences with substance use, which affects how they approach treatment. Training staff on cultural awareness and providing materials in multiple languages ensures services are inclusive and respectful, meeting people where they are rather than expecting one-size-fits-all solutions.”

Male, 45-54, CALD, lived experience of drug use, metropolitan.

THEME 3: SAFETY AND JUSTICE

Decriminalisation of drugs for personal use was raised by many respondents who wanted to see less punitive responses to drug use. Legalisation and implementing a regulated and taxed drug market were frequently suggested together. Decriminalisation was often suggested in the context of reducing policing burden, thereby allowing a focus on more serious crime.

Stronger law enforcement response to drug supply, including harsher penalties and more policing was frequently raised to protect the community and act as a deterrent. Some respondents wanted to see a stronger response to all drug use or related offences, while others wanted the focus to be shifted to supply reduction, particularly for organised crime. However, many respondents suggested police cease both the drug detection dog program and strip searches in public spaces and at events.

Treating drug use as a health issue and reducing police involvement and law enforcement response to drug use was also frequently suggested, often paired with suggestions to increase diversion into AOD treatment programs as an alternative to incarceration. There were some differences in the topics most frequently raised by metropolitan and regional/rural respondents, including drug driving law reform being raised more often by regional and rural respondents (Table 4).

Other topics raised by respondents included diverting funds from law enforcement to health; harm reduction; community engagement; the disproportionate policing/harassment of certain groups; trauma informed care; stopping use of strip searches; sanctions for police non-compliance; drug checking; police carrying naloxone; and drug driving reform including testing for impairment rather than presence of substances.

Table 4: Safety and justice: Comparison of most frequently raised topics between metropolitan and rural/regional respondents

Metropolitan	Rural and regional
Decriminalise drug possession for personal use	Decriminalise drug possession for personal use
Treat drug use as a health issue	Stronger policing of drug supply
Stronger policing of drug supply	Stronger police response to drug offences
Diversion to AOD treatment	Treat drug use as a health issue
End drug detection dog program	Diversion to AOD treatment
Legalise drugs	Legalise cannabis
Improved police AOD education and skills	Drug driving law reform for cannabis
Regulated drug supply	Regulated drug supply
Less policing around drug use	Improved police AOD education and skills
Stronger focus on supply reduction	Legalise drugs

Quotes

“Decriminalisation of personal drug use - once someone is criminalised it can be hard to rehabilitate because the criminal record acts a barrier to a wide range of opportunities...”

Female, 55-64, lived experiences of homelessness, regional/rural.

“Addiction is an illness not a crime. Crime that is addiction related should always have penalties that include mandatory rehab.”

Female, 18-24, lived experience of disability and drug use, region not specified.

“Help those recover from drug addiction rather than fining them and putting them in prison.”

Female, 45-54, CALD, lived experience of drug use, metropolitan.

“End Police sniffer dog program - evidence shows that Aboriginal people are over-represented in the number of people searched. This program harms police relationships with the broader community and means that drug users are less likely to request help from police.”

Male, 25-34, LGBTQIA+, metropolitan.

“This is challenging and police need to keep community safe. This doesn’t mean drug users shouldn’t be treated with dignity and respect when they are the victims.”

Female, 55-64, lived experience of disability and homelessness, regional/rural

“Prisons must adopt needle-exchange services. This will reduce the prevalence of violence for the purpose of obtaining needles and syringes, as well as the significantly higher rates of blood borne viruses in the incarcerated population.”

Male, 18-24, LGBTQIA+, lived experience of drug use, regional/rural.

“Pill testing at festivals, concerts etc should be in place to ensure those younger adults are safe from possible poisonous chemicals. We are not going to stop them from taking so why not provide real time information on what is in the ‘pill’.”

Male, 65-74, lived experience of disability and drug use, regional/rural.

“Legalise marijuana, decriminalise pills, allow a small amount of possession of heroin, but come down hard on Ice usage. There should be extreme jail sentences for peddlers of Ice.”

Male, 65-74, lived experience of drug use, metropolitan.

“Anyone who works in law enforcement (including myself) will tell you that the ‘war on drugs’ is an abject failure and only marginalises people.”

Male, 45-54, CALD, region not disclosed.

“Drug use should be treated as a health issue not a criminal one.”

Female, 65-74, metropolitan.

“Better training of law enforcement officers to recognise & deal with compromised individuals to try to ensure everyone’s safety.”

Female, 65-74, lived experience of homelessness and drug use, region not disclosed.

“Overhaul current drug driving laws to focus on impairment rather than mere presence of drugs, aligning them more closely with alcohol-related driving laws.”

Male, 25-34, LGBTQIA+, lived experience of drug use, metropolitan.

“The revolving door in the court system needs to be shut. The community needs better protection from reoffenders. The police needs greater powers.”

Female, 55-64, region not disclosed.

THEME 4: KEEPING YOUNG PEOPLE SAFE AND SUPPORTING FAMILIES

The need to improve AOD education in schools and the community was the most frequent topic raised. Many responses highlighted the importance of education being evidence based, taking a harm reduction approach and including lived experience stories. A smaller group of respondents suggested a stronger focus on abstinence or were opposed to providing harm reduction information.

Respondents expressed the need for more parent and family support services including prevention and early intervention services, and holistic services that address the social determinants of health (including housing, mental health and financial stress). The need for a range of services was highlighted, including rehabilitation services for those with dependent children, support services for family and carers, whole of family interventions, and parenting support.

Implementing drug checking services at festivals and in the community was a common topic, with respondents seeing this a way to reduce harms and increase young people's access to health information. There was also a small group opposed to these services as they felt these services normalise drug use.

Many other topics were also raised, including increasing opportunities for young people; more community engagement; building community connection; financial assistance; reforming child support services; banning or reducing alcohol advertising; ending the drug detection dog program; upskilling AOD workforce; increased prevention activities; access to mental health services; de-normalising drug use; promoting healthy lifestyles; people taking responsibility for their behaviour; decriminalisation of drugs; and stronger policing and penalties.

There were several differences in the top ten topics for regional/rural and metropolitan respondents (Table 5).

Table 5: Keeping young people safe and supporting families: Comparison of most frequently raised topics between metropolitan and rural/regional respondents

Metropolitan	Rural and regional
Improve AOD education in schools and community	Improve AOD education in schools and community
More family and parent support services	More family and parent support services
Allow drug checking services (festivals and/or community)	Stronger policing of drug supply
Reduce stigma and discrimination	Early intervention services
Early intervention services	Increased access to mental health services
Increased access to mental health services	Community events or activities to build connection
Harm reduction education and activities	Reduce stigma and discrimination
Opportunities for young people	Better support for children or parents using AOD
Decriminalise drug possession for personal use	Opportunities for young people
Stronger policing of drug supply	Expand AOD and health workforce

Quotes

“Drug use at young ages is often associated with other social issues in children’s lives including domestic violence, neglect and mental health issues. The more we do to support young people facing these issues, the more we can do to ensure their safety and reduce risk of drug use in youth.”

“Creating safe spaces and youth engagement programs that offer positive cultural activities and mentorship, providing alternatives to risky behaviours and fostering a sense of belonging.”

Female, 25-34, metropolitan.

“Education is the best key for prevention. Lived experience mentors are great for talking with young people.”
Female, 45-54, metropolitan.

“More community activities that are free and accessible so children can build healthy support networks even if disadvantaged.”
Female, 25-34, lived experience of drug use, metropolitan.

“Instead of telling everyone not to do drugs, we should be teaching them how to be safe around drugs. It doesn’t mean we condone it, but it does mean we are protecting everyone and making sure everyone knows when to call emergency services and that they are safe to do so even if they broke a law by doing the drugs.”
Gender not disclosed, 25-34, LGBTQIA+, lived experience of drug use, metropolitan.

“More rehab facilities that are able to facilitate families into care including parenting classes as well as addressing their substance use. Improved family support services such as Centrecare. More services that will engage parents into care and treatment that can be done during school hours to allow for better access (e.g. - day programs)”
Female, 45-54, regional/rural.

“Actually educate all people about drug use- include the idea of set and setting in this education so that young people are not afraid to talk to their parents about these inevitable issues so that parents are able to have more cohesive relationships with their children and assist them in making better and safer choices for themselves.”
Female, 25-34, CALD, lived experience of drug use, regional/rural.

“More wraparound support for at-risk families and better early intervention (as early as possible).”
Female, 55-64, CALD, metropolitan.

“Music festivals and large clubs must be allowed to have pill-testing facilities, and police presence at these locations must be drastically reduced, to prevent risky behaviours (such as someone consuming all of their pills at once to avoid being caught), and to reduce the prevalence of illegal strip searches.”
Male, 18-24, LGBTQIA+, lived experience of drug use, metropolitan.

THEME 5: INTEGRATED SUPPORT AND SOCIAL SERVICES

Increased and ongoing funding for AOD and social services to meet the need for high-quality services across the state was the most frequently raised topic under this theme. Improved collaboration between AOD and mental health, but also health, social and other services and sectors was frequently mentioned. Co-location of services was regularly suggested, as was the idea of sharing client data between services.

Respondents wanted to see services provide holistic and multidisciplinary care that treats clients with respect and considers the whole person and not just their AOD use, including addressing barriers to engagement with care and social determinants such as stable housing and employment. Increasing services in regional and rural areas was more often raised by regional and rural respondents (Table 6).

A wide variety of other topics were also raised, including providing bulk-billed or free services; trauma informed care; employing more peer workers; culturally appropriate services; support for system navigation; increasing pay rates to retain AOD staff; revising funding models; more family support services; and early intervention.

Table 6: Integrated support and social services: Comparison of most frequently raised topics between metropolitan and rural/regional respondents

Metropolitan	Rural and regional
Increased funding for AOD services	Improved collaboration between services and sectors
Improved collaboration between services and sectors	Increased funding for AOD services
Increased access to AOD services	Increased funding for other health and social services
Increased funding for other health and social services	Increase services in regional and rural areas
Provide holistic and multidisciplinary care	Expand AOD and health workforce
Housing support	Increased access to AOD services
Expand AOD and health workforce	Revise service funding models
Address social determinants	Upskill the AOD and health workforce
Conduct service evaluations	Housing support
Upskill the AOD and health workforce	Provide holistic and multidisciplinary care

Quotes

“Increase access to, and range of, treatment options including residential programs.”

Male, 55-64, metropolitan.

“Ensure that people impacted by AOD are treated holistically and not just for their AOD use in isolation. As a service provider the areas of greatest need we see in our clients are housing, justice system support, and mental health. A desirable outcome of the Drug Summit would be support to create partnerships with service providers that specialise in these areas.”

Gender and age not disclosed, service provider representative, metropolitan.

“Employing individuals who understand complexities of substance use alongside other crisis events or other issues occurring (mental health, housing, reintegration into society, leaving out of home care).”

Gender not disclosed, 18-24, LGBTQIA+, lived experience of drug use, regional/rural.

“Have people support navigating these systems or simplify them.”

Female, 45-54, lived experience of drug use, metropolitan.

“Centres must be well staffed and resourced, [and] run proven, measurable programs.”

Non-binary, 55-64, CALD, metropolitan.

“There needs to be a greater focus on coordinated care rather than silo’d services or ‘mental health isn’t my problem or AOD isn’t my problem from health and social care staff. Focus on brokerage models that bring services together, replicate successful models of integrated care.”

Female, 35-44, metropolitan.

“Stop funding what doesn’t work and increase funding to what does. Measure the outcomes, there are programs that work, and they should be accessible. People need housing, counselling, work opportunities.”

Female, 45-54, CALD, lived experience of homelessness, regional/rural.

“Adequate staffing and positions. This requires funding from the government. There is no secret to keeping employees - better pay and conditions.”

Female, 45-54, CALD, metropolitan.

“Housing first models of care. Recognises that often mental health, AOD and other issues overlap and this could mean they need several support services to help someone.”

Female, 35-44, lived experiences of disability, homelessness and drug use, metropolitan.

“Increase the funding of integrated support and social services so they are available across the state, particularly in areas of increased drug use or where critical support services is needed. Develop more infrastructure to house these integrate support and social services”

Male, 25-34, lived experience of drug use, metropolitan.

3. QUALITATIVE ANALYSIS OF RESPONSES RELEVANT TO THE IDENTIFIED PRIORITY TOPICS

PRIORITY AREA 1: THE SERVICE SYSTEM - ACCESS, INTEGRATION AND DESIGN

Access to treatment and support

Increasing access to AOD services was a common point of discussion. Respondents wrote about difficulty accessing AOD services due to a variety of factors such as lack of services in their local area, long waiting lists, costs, ability to travel to services, lack of services that accept people with dependent children, restrictive entry criteria for some services. Many respondents raised the need for services that are tailored to different populations, such as Aboriginal services, services for young people, parents, culturally and linguistically diverse people, and LGBTQIA+ populations. Respondents also highlighted that people should have flexibility and choice in which service they use. There was also a small minority of respondents who preferred equality of access to services and were not in favour of services tailored to specific populations.

Respondents expressed the need for improved access to the entire spectrum of treatment services, including community based, inpatient services, detoxification services, residential rehabilitation, Aboriginal specific services, cultural programs, mobile and outreach services for at risk populations, home based services, and online services. There was a desire for a greater choice of services and options of varying intensity.

Improving the capacity of primary health care services to respond to AOD issues was raised. There was a strong theme of wanting services that could address comorbid mental health and other issues, through integration of AOD with other health and social services, multidisciplinary teams, holistic care models and longer-term treatment or follow up options. Specifically, access to mental health, family/parenting, and housing services alongside AOD treatment were frequently raised. Increased access and affordability of services for the diagnosis and management of cognitive disability and neurodiversity was also raised by a small number of respondents.

There was strong desire to see waiting time to access all types of services reduced, as well as greater geographic distribution – the need for more services in regional and rural NSW was clearly described. Respondents also suggested that more services provided in varying modalities may help to address needs in regional and rural areas, including telehealth, online, home-based and outreach.

Increasing access to AOD (and other) services for people in the criminal justice system was also frequently raised. Responses discussed the cycle of drug dependence, drug-related offending and prison time that some people experience and how the lack of treatment and support services both within prison and post-release impacts this.

Affordability of AOD and other health care was commonly raised. People reported experiencing financial barriers to accessing primary health care, specialist treatment services (including psychiatry and psychology care) and AOD services. Respondents raised concerns about the lack of publicly funded AOD services and places and the high expense of accessing private AOD services. People who were able to access public services also described issues such as having no income whilst in residential treatment, as well as related costs for travel and accommodation.

Respondents wrote about the need for services and safe spaces that cater specifically for LGBTQI+ populations and understand the unique issues that this population face. Suggestions included services run by peers or staff from the LGBTQI+ community, allowing people to self-describe gender and specify pronouns, services that are trauma-informed and improving understanding and sensitivity around LGBTQI+ culture and needs in mainstream services. Some respondents suggested that AOD services work with already trusted organisations such as ACON, to encourage help seeking.

Quotes

"I think we could improve equitable access and inclusion for people requiring drug and alcohol support by having clearer promotion for alcohol & drug support and working towards the normalisation of accessing these support services. Connection is of utmost importance when it comes to drug use and addiction, so finding ways to strengthen support networks and creating new pathways to make new connections would be beneficial for people who use drugs - nobody likes feeling alone and misunderstood. 24 hour hotlines or service centres could be helpful especially for rural communities."

18-24 years, Aboriginal, LGBTQIA+, lived experience of disability, homelessness, drug use, regional/rural.

"More home visit based services and assistance for people struggling to get help. For example, when my partner and I decided to get on the Opioid Antagonist Treatment program we were lucky enough to have a worker from brighter futures pay for a taxi \$90 to the hospital for our first dosing visit. My partner would not have come. We would have had to get a 7am bus for 2hrs and wait a couple more for our appt. We also did not have the 8\$ for the bus fare.

We then had to get the 7am bus everyday for 2hrs each way for our daily dosing. The weekends we had to hitchhike as there was no bus service. I had 2 broken bones and a small fracture in my foot. Wearing a moon boot and crutches. Everyday for 3 months I had to walk for KMs restricting the ability for my foot to heal. Sometimes stealing food to save money for the bus trips. I felt like giving up so many times as it was that hard just to attend the dosing centre it wasn't funny. I was in so much pain by the time I would get home it took all day getting home by 4 or 5pm. My partner found it difficult being in public and trapped on busses for hrs at a time while he adjusted to his dose and the side affects. If there was a home visit nurse that could have brought us out daily dose at least for the first part until we were settled and until we went to the chemist for dosing. Or maybe a community bus just for patients."

Female, 35-44, Aboriginal, lived experience of homelessness and drug use, regional/rural.

"Impossible to get quality rehab without private health insurance, especially when people are coming out of episodes of drug use and need intense level of support. Need more services both specialist services and multidisciplinary for people with special needs eg mental illness. My daughter was not able to access majority of drug rehabs as she has a schizophrenia diagnosis, despite the fact that she is medicated and not symptomatic."

Female, 55-64 years, CALD, metropolitan

"Ensuring people in NSW have equity of access to quality alcohol and other drug (AOD) care and support is hindered by insufficient funding, resources, and a lack of nationally consistent standards of quality care."

Gender and age not disclosed, metropolitan.

“Easy access from all community centres provision for transport to and from centres and offer to visit online for free treatment advice and in person at homes, schools community centres hospitals or anywhere people may meet. Take treatment to the people. Confidentiality is of course essential and trauma informed care to be included in all training and administration of help and assistance.”

Female, 65-74 years, metropolitan.

“Place-based, peer-run services are more effective and cheaper than mainstream services. Where I live, there is a NFP called Queer Family, which is Queer/Trans-led and focused just on the local towns. They do far more for our community than any other organisation, but they do this very cheaply. You need to fund the small, localised groups and orgs like Queer Family to do the work for their own communities. They then provide cultural safety and they have cultural knowledge and local knowledge which makes the work far more effective. Plus they care more, because they are local and part of the minority community.”

Non binary, 45-54, LGBTQI+, lived experience of disability, homelessness and drug use, regional/rural

“I think our current approach in Metropolitan NSW is absolutely amazing. This is from lived experience where I was struggling with complex mental health challenges while struggling to come to terms with my sexuality. My usage increased rapidly fearing my family would find out and while I was getting the support I needed through various programs via NSW Health, they referred me to the cannabis clinic which helped greatly in learning to control my use. The problem is in regional communities like where I've grown up before moving to Sydney by myself at a young age, LBGT people are extremely fearful of reaching out for support in case people find out. In addition the programs like safe haven and clinics should be more widely available in regional settings.”

Male, 18-24, LGBTQIA+, lived experiences of disability and drug use, metropolitan

“As a bisexual woman my experience of community-led harm reduction in party spaces has been best in queer spaces and I think there's a lot to learn and support there. It's also important to understand the history and present of the role of drug use in connection and community for many LGBTQI+ people”.

Female, 25-34 years, LGBTQIA+, lived experience of drug use, metropolitan

“I think that there is room for increasing the networking available for people working in the different sectors—including community sector, religious groups, CALD groups etc. It is not easy to try and work out who I need to contact to get help for someone. If I can get someone connected into one place there is no guarantee they will be connected with their other needs. There is not always a case manager so I often see people come back with different needs e.g. housing, not enough money for food etc. How to look at a person holistically is really important and that is not easy but I think is the focus of integrated service.”

“Work directly with affected populations to design and implement services that meet their unique needs. Collaboration with community leaders, organisations, and people with lived experience fosters trust and ensures programs are relevant and effective.”

Female, 35-44, CALD, lived experience of drug use, metropolitan

“Community-Based Programs: Bringing services closer to people—through local centres, mobile units, or online access—ensures that even those in remote or underserved areas can receive help when they need it.”

Male, 45-54, CALD, lived experience of homelessness and drug use, metropolitan.

Priority populations

Respondents often raised the need to improve the cultural safety of mainstream AOD services for different populations. Cultural responsiveness or competence training for all staff, employing numerous staff in varying levels from those communities, expanding the peer workforce were suggested as ways to support this. Many responses also discussed the need for services tailored to suit the needs of different priority populations, either through person centred approaches in mainstream services, or specialist services targeting different groups. The demands and expectations placed on Aboriginal workers was discussed and the tendency to assign all things related to 'Aboriginal' to the Aboriginal staff member. Some respondents raised that services need to consider intersectionality as people may be part of several different populations/groups.

The importance of community engagement and involvement in service design was raised multiple times along with genuine relationships with funding bodies with the Aboriginal community-controlled sector. Co-designing services with people who are from the communities being served and who have lived or living experience of treatment will make the services more relevant and appropriate.

Some respondents wanted to see improved collaboration between different services, which would enable better referrals and management of the range of needs people may have, including cultural, language and religious. Several respondents advocated for local, community-led and peer run services. Responses also advocated for the availability of various treatment modalities including telehealth, outreach services, mobile clinics, online services, hub like models etc to improve access for different groups.

Increasing awareness of how to access services and having clear pathways into culturally safe care was also mentioned. Some respondents noted that it can be difficult to know who to contact to get help for themselves or others. People often rely on their personal networks. This feeds into the need for integrated and holistic services, where there is 'no wrong door' and clients can be linked in with appropriate services via a range of different options.

Quotes

“Socio-economically disadvantaged communities, First Nations, LGBTQIA+ community, CALD communities, people with mental health issues, are disproportionately impacted by our drug laws. Without changing our harmful laws that funnel disadvantaged communities through the criminal justice system we cannot fundamentally improve equity and inclusion for people seeking support. Stigma perpetuates our drug laws - and our drug laws perpetuate stigma.”

Male, 35-44 years, LGBTQI+, lived experience of disability, metropolitan.

“Culturally Competent Services: Different cultural backgrounds have unique experiences with substance use, which affects how they approach treatment. Training staff on cultural awareness and providing materials in multiple languages ensures services are inclusive and respectful, meeting people where they are rather than expecting one-size-fits-all solutions”

Male, 45-54, CALD, lived experience of homelessness and drug use, metropolitan

“The people that answer the phones and greet at the door need to be more understanding, have specific training around AOD. When a person reaches out for help and the person that greets them is short in the way they speak, seem disinterested or judgemental you will lose them for life. they are already struggling and ashamed of their own behaviours and looking for change”

Female, 35-44, Aboriginal, lived experience of disability and drug use, regional/rural

“Having people from those specific communities help those communities.”

Male, 25-34, LGBTQI+, metropolitan

“Implementing services specifically tailored for underserved groups is also essential. Mobile health units or telehealth options can improve accessibility for people in rural and remote areas, reducing geographic barriers and providing critical support where permanent facilities may not be feasible. Additionally, outreach programs designed for young people, culturally and linguistically diverse (CALD) communities, and Indigenous populations can deliver culturally respectful and language-appropriate care. Programs like Australia’s “The Glen,” which provides culturally safe treatment for Aboriginal communities, demonstrate that culturally tailored services can enhance engagement and outcomes.”

Male, 45-54 years, LGBTQI+, CALD, lived experience of disability and drug use, metropolitan

“Facilities that cater for ALL people regardless of genders, cultures, sexual preferences, People need to be able to go to a facility locally and not have to find one that is suitable to their culture. It should be available to everyone equally without bias of gender etc.”

Female, 45-54, lived experience of drug use, metropolitan

“Community Partnerships: Partnering with local community organizations and leaders can enhance outreach and trust-building, particularly in marginalized communities. This fosters a supportive environment where people feel safe and respected when accessing help.”

Male 45-54, CALD, lived experience of homelessness and drug use, metropolitan

“Multiple options for accessing support and finding information, including in person, telephone, online. Support workers who have inclusive practices for people with diverse abilities (such as providing diverse communication needs), support in many languages, culturally competent support workers who understand different people’s needs and communication preferences, etc. also support for people with mental illnesses and neurodivergence such as AAC, social stories, etc so they understand and feel confident when accessing services - they will know what to expect. Working with people and truly understanding their needs, values and experiences to get them more personal support.”

Female, 22-34, metropolitan

Cultural safety for people from culturally and linguistically diverse (CALD) backgrounds

Respondents raised the need for services that suit the needs of CALD communities, noting that the CALD community is diverse and has many different perspectives and unique needs. There was acknowledgement that some CALD communities are particularly impacted by stigma and shame, and that many will be hesitant to seek help due to this. Some respondents advocated for greater engagement with communities and community leaders to raise awareness of services and reduce stigma and shame around AOD use, as well as engaging community members in the co-design and delivery of services. Suggestions to improve services included employing varied staff that are reflective of the communities they are working in, translators and multilingual resources, staff cultural sensitivity and an understanding of the specific cultural, social and historical factors that may be important for people from different CALD backgrounds. Having a choice of services and service modality types (e.g., telehealth and online) was seen as important to improve access and the ability to anonymously attend services.

Quotes

“There is still not enough done in CALD communities to decrease STIGMA and increase access that is culturally safe. QR codes that allows different languages to convey the messages around support regarding AOD is a valuable source of communication that allows CALD communities to access AOD services and information without feeling judged by their community if they were seen to enter the office of a AOD service, it allows anonymity and a safe way to access information. There needs to be better ways of providing AOD information to CALD communities.”

Female, 35-44 years, CALD, metropolitan

“Ensure services are informed and led by individuals and organisations representative of priority populations eg: CALD communities. Important to have translators, translations for cultural groups which are meaningful and accurate. Community needs to be consulted and provide translation.”

Female, 45-54, metropolitan

“Travelling programs, outreach support, cultural “champions” and culturally sensitive communications.”

Female, 35-44, CALD, metropolitan

“Culturally and Linguistically Diverse Communities: Stigma directed towards AOD use is a major barrier for individuals from CALD backgrounds. To support CALD communities, services need to create culturally appropriate pathways, educate to reduce stigma, and train specialist CALD AOD workers.”

Health service response, metropolitan

Integration

Integration of health and social services to address the needs of individual clients was frequently raised. Respondents described challenges with identifying and accessing appropriate services to address their multiple and co-occurring needs, and instances of falling through the gaps between services due to the siloed nature of the health and social services systems. There were many responses discussing how services need to acknowledge and address the impacts of social determinants of health on AOD use and harms, with respondents describing the need for treatment to be holistic. These needs may have to be addressed before they can realistically address harmful AOD use, for example stabilising mental health conditions, accessing stable housing, addressing physical health issues, help leaving a domestic violence situation, service access on leaving custody, or support accessing education, or seeking vocational or work opportunities.

There was strong support for hub type models where multiple services are co-located or integrated into multidisciplinary teams. The types of services that were frequently raised as being important in addition to AOD services included housing, mental health, DCJ and Centrelink. More funding for varied positions within services was raised, including allied health, social workers, and case coordinators. Hub and spoke models were also mentioned, with discussion around outreach or mobile services providing the 'spokes' and delivering the services identified as needed by the community e.g. dental care, legal advice, youth services, ADHD diagnosis and support, and chronic disease care.

Better integration with mental health was particularly raised as an issue by respondents, with discussion around the high rate of co-occurrence, the need for dual diagnosis and treatment services, and for mental health and AOD services to work together to support clients. Support for people in the criminal justice system was also raised as a key issue to be addressed, with respondents reporting limited access to services upon exiting custody including difficulty with finding housing and accessing AOD treatment. Criminal records were identified as a barrier for accessing some services and supports. Housing first models of care were recommended, with discussion around the need for transitional housing when exiting custody or residential rehab, support accessing affordable housing more broadly and addressing the risk of losing public housing when in rehab services.

Improving collaboration and communication between service and sectors to support enabling a 'no wrong door' approach to provision and continuity of care, information sharing and referral pathways was raised many times. Some suggestions included putting systems in place to support integration, for example formal agreements and MOUs between services, shared KPIs that encourage teamwork, agreed referral pathways, cross agency staff, centralised data collection systems or central case management roles. Having a stable funding model for services was seen to support effective integration as well as long term care for clients. Digital technologies were identified as a tool for improving system navigation and access, with several respondents suggesting centralised access.

Many wrote about the need for consistent case management, support with service navigation in a complex system and improved continuity of care across various domains. A solution suggested by several respondents was a centralised primary case worker model, who oversees a client on their journey through various services and provides long term support. This cross-sector role would not only support system navigation and ensure access to a range of services, but may assist with breaking down silos, improving relationships and pathways between services and sectors. Responses wrote about the need for a centralised data collection accessible to various services to support continuity of care (while respecting client privacy) and so that client's do not have to retell their stories multiple times.

A whole of government AOD strategy was suggested by multiple respondents as an initial action needed to drive system level integration. This should provide clear guidance on the need for, and methods of, integration across the system. Defined cross sector partnerships, responsibilities and communication pathways should be outlined. Respondents advocated for the strategy to take a health in all policies approach.

The need for significant reform of DCJ family and child services was raised, with respondents wanting much closer collaboration and coordination of Health and DCJ services to support families and children impacted by AOD use and harms. Additionally, the need for more access to AOD treatment services where parents can attend with their children was discussed. Not being able to take children with you to treatment was identified as barrier

for treatment access. Some responses also discussed the need for support for women or parents who have had their children removed and want to work on restoration, with respondents emphasising the value of reunification of the family unit.

Quotes

"I think we could improve equitable access and inclusion for people requiring drug and alcohol support by having clearer promotion for alcohol & drug support and working towards the normalisation of accessing these support services. Connection is of utmost importance when it comes to drug use and addiction, so finding ways to strengthen support networks and creating new pathways to make new connections would be beneficial for people who use drugs - nobody likes feeling alone and misunderstood. 24 hour hotlines or service centres could be helpful especially for rural communities."

18-24 years, Aboriginal, LGBTQIA+, lived experience of disability, homelessness, drug use, regional/rural.

"I believe that we urgently require more residential rehabilitation facilities in NSW in general, however even more urgently I think we need residential rehabilitation facilities that can cater for women who have had their children removed from their care and would like to work on having them returned to their care (with supervision at a facility) for a longer period until they are able to them be discharged with their children back in their care. The system is overflowing with children in care in NSW and not enough is being done to work with these mothers who are extremely vulnerable members of our community and who do not have the resources they need to help them or access to services that can work with them towards this important goal. The statistics tell us that children do so much better with their birth parents so why aren't we throwing everything that we have on reunification of the family unit."

Female, 35-44, lived experience of homelessness and drug use, regional/rural

"Developing and fostering partnerships with local communities to co-design services will ensure they are culturally responsive. Expanding program scope to include offering transport assistance, increasing funding for more immediate access to care, and integrating mental health, social, and emotional wellbeing support alongside drug and alcohol treatment can make services more effective. Involving Elders and community organisations and leaders can foster a sense of cultural connection and helping to break down barriers and improve overall access to care for Aboriginal people seeking support for drug use."

Female, 45-54, Aboriginal, regional/rural.

"Drug use is not isolated from other social factors -- poverty, homelessness, relationship breakdown, domestic violence etc Provide a holistic approach and coordinate the work of state and federal agencies"

Female, 65-74, CALD, lived experience of disability, metropolitan

"Also, housing is a priority. From my own experience of being a poly drug user and on methadone for over ten years - having an affordable home was the basis of what allowed the change which has been 19 years of being drug and alcohol free."

Female, 45-54, lived experience of disability, homelessness and drug use, metropolitan.

"From my viewpoint, NSW services tend not to be well integrated and lack accountability for outcomes. For example, DCJ child services aren't clearly accountable to anyone regarding the validity of their interventions and outcomes. Workers lack both training and resources to properly assist those who need their help. If the harmful drug use epidemic currently gripping our society is to be solved, all relevant services need to be connected with pathways to desired outcomes developed, and there needs to be an overseeing body to handle complaints, assess actual outcomes, and tweak those pathways or services where desired outcomes are not being delivered."

Female, 55-64 years, lived experience of drug use, regional/rural.

"Support should never just be cut off when leaving prison or rehab. These people need continuing help and support. It all comes down to available workers and housing."

Female, 65-74, regional/rural.

"Make sure people are aware of what services are available. As a 16 year old I went into drug and alcohol service and told them I was homeless and living on the streets. It's like they ignored that entire part of my story because it was too hard for them, and so they basically wished me well. I didn't know where else to turn. I understand now as an adult drug and alcohol services don't help with homelessness, but it would've been gold for them to refer me on to service that could assist me and help find me somewhere safe to live!"

Female, 25-34, Aboriginal, lived experience of disability, homelessness and drug use.

"This needs to be a nationwide/federal issue every state needs to get back to basics to fix the broken health, justice, education and housing systems and give everyone living in Australia that need to access any of these services what they need my son has now been in adult jail for 6 months and I was told on Friday that because they have 900 inmates and only 1 psychiatrist they will get around to him when they can.

"This 6 months should of been the start of focusing on rehabilitation education and skills not waiting for the system to get around to him , he still hasn't even been sentenced he still has access to substances in jail because at least twice he has been under the influence when he has called us although calls are few and far between because it cost \$1 a min to phone us."

Female, 35-44, lived experience of disability and homelessness, regional/rural.

"Form partnerships between healthcare, housing, employment, education, mental health, and AOD services to ensure continuity of care. Develop shared service agreements and frameworks to clarify roles and responsibilities. Appoint managers responsible for coordinating efforts across sectors, especially for complex cases. Implement a centralised system (e.g., call centres or digital platforms) that provides access to multiple services from one contact point. Train staff to refer clients to appropriate services, even if it falls outside their immediate scope. Assign case managers to support individuals, ensuring their needs are met holistically and services are well-coordinated. Develop personalised care plans that reflect each person's goals and unique circumstances, with input from both service providers and clients."

Female, 35-44, LGBTQIA+, lived experience of drug use, metropolitan.

"This is critical!! Agencies need to talk to each other and have a client/patient centred approach supported by consistent and empowered case management. My daughter has complex needs mental illness, drug use, self harming activity and it seems agencies - police, health, community and rehab were racing to drop her and pass the buck. The cost to her was enormous and it almost tore our family apart. She needed care from us, which she got, but she needed a whole lot more from agencies that didn't come. Families and carers need to be part of an integrated care system"

Female, 55-64, CALD, metropolitan

"As a mental health social worker- I am often frustrated when seeking to refer someone for dual diagnosis treatment within the AOD sector. I am often told- 'no that's mental health- we can't see them until they see a psychiatrist'. Then you refer them to community mental health- who say they first need to detox before they can have a 'proper mental health assessment and treatment'. Maybe it's worse in the regions - but government services both in AOD and mental health need to be educated in providing dual diagnosis- this should not just be a specialist service - which does not exist in the regions/rurally."

Male, 35-44, LGBTQIA+, lived experience of disability, homelessness and drug use, regional/rural.

"There is significant opportunity to link together social services in order to create efficiencies and ensure that people impacted by AOD are treated holistically and not just for their AOD use in isolation. As a service provider the areas of greatest need we see in our clients are housing, justice system support, and mental health. A desirable outcome of the Drug Summit would be support to create partnerships with service providers that specialise in these areas. Another action to advance this domain is increased support for service navigation for people accessing, or wanting to access, social services. This could come in the form of peer navigators who provide guidance, service hubs, service mapping, or government resources which guide individuals."

Healthcare / AOD worker or service provider, metropolitan

“There is far too much bureaucracy and red tape that prohibits services from actually working together to develop integrated and intersectional responses that provide holistic support and care. There is a profound lack of continuity across departments as well - while the language and discourse appears very socially informed and committed to addressing the underlying causes of drug use, this is of little impact when police and those in charge are still pushing a war on drugs and tough on crime agenda which completely negates any of the work being done at the community and sector level.”

Female, 25-34 years, LGBTQIA+, lived experiences of disability and drug use, metropolitan.

“That is why a primary case worker who has the time and resources to oversee each of their client’s service needs and liaise continuously with each service to ensure that their clients are receiving what they need, from housing through to employment and education, medications, etc. This sort of long-term support enables clients to form healthy habits which start to include paying their bills on time, getting their medications filled on time, turning up to appointments. Forming healthy habits is very difficult after years of drug and alcohol abuse, where clients are escaping the pressures of normal life for whatever reason, trauma, illness, low self-worth and it takes time for them to develop these basic skills and coping with normal life.”

Female, 55-64, lived experience of disability, homelessness and drug use, regional/rural.

“We need holistic and multi-disciplinary responses from services. People affected by drug use often need multiple services involved and there needs to be more wrap around services for that - e.g. DCJ child services, housing, justice agencies, GP’s, MH and AOD clinicians - all working together for one client/ family unit.”

Female, 25-34, regional/rural

“Every time someone interacts with a social service there is an opportunity to offer wrap around care - people may not initially identify an AOD issue but this can emerge later once immediate needs are addressed. Often people can’t start addressing their AOD use until they have somewhere safe to live and feel supported and have built trust with someone in order to start delving into deeper issues. All social services should be asking if there are any other issues they can assist with - linking people into other services.”

Female, 45-54 years, metropolitan

“I like the idea of hubs and one-stop shops, where individuals can access multiple services to meet their needs. Peers and people with lived experience should be embedded in any such model. We would also need to make sure that services outside any hub locations are included and collaborated with, rather than hubs becoming isolated and insular silos. However, co-location can be challenging, as clients usually assume you’re all one organisation. Consumers need and deserve choice and diversity. We need flexible, outreach-based services, in addition to any centralised office locations for services.”

Male 35-44 years, metropolitan

“Y’all need to hear me right now - primary care services are wildly inaccessible. Read that 3 times please. I previously worked as a Centrelink psychologist and would be trying to get clients (no job, in housing) into primary care because again, no job no money. They would need to go through their GP, which I need to remind you is hardly bulk billed recently, to get a referral, to then ensue a massive wait and this is the important bit - I cannot help them as a case worker because I cannot be involved in primary care referrals.

You have created a massive barrier on the system meant to be most accessible for those in the most need, it has been horrifying to interact with. And as a psych what it reads to me is: in order to get this primary care you really need to end up in the hospital for the referral to go through in a timely and organised manner. There is such an easy way around this - primary care providers need to have a GP who is free within the service, who can unlock their services. They can also conduct their own triage and reach out to doctors themselves for the OK. At the moment you’re asking homeless people to chase a treatment plan, it’s actually insane, that’s my job. And you can tell how unfair this is when you look at referral into paid healthcare services - I can refer my clients with a letter from me, their psychologist, into a detox service - only if they have money for it. Are you with me?”

Female, 25-34 years, CALD, lived experience of drug use, metropolitan

“Prevention is the best way but once someone has an active addiction I think perhaps medical services that are not judgemental in their approach to promoting health, obviously the best thing would be they stop but it doesn’t happen easily for some and is a journey of years, I’ve seen a doctor that did not pursue medical issues because my son had not done a urine drug test for him, he was also told he’s taking up appointments that other people could be taking! I wonder if there could even be a holistic service where drug users could access physical, mental and drug information and recovery referrals all in one place”

Female, 55-64 years, region not specified.

“as a drug user for the past 20 years, who has been on the housing waiting list for at least the last 6 years, who has experienced homelessness, and has had significant mental health issues - their is no integration, even where there is supposed to be. Significant resources need to be spent on increasing these services.”

Male, 35-44 years, LGBTQIA+, lived experience of homelessness and drug use, metropolitan.

“Obviously more and better targeted funding. Currently, drug and alcohol care is differentiated from mental health care and they are both cause and effect for each other. This results in being shoved from system to system without continuity of care.

My son has cost the health care system a fortune as he continually enters hospital for over-doses, psychosis and resultant physical health problems. Counselling is the answer to try to get him off drugs not patching up the problems. He is not in any of the ‘inclusion’ categories in the explanation because I continually support him and he too needs help. There should be funding for whoever needs it without anyone missing out.”

Female, 65-74 years, metropolitan

Service design

There were few responses addressing this issue. A small number of responses discussed the need for service management to be improved and for improving and modernising service facilities, e.g. disabled access, comfortable and welcoming spaces. There were a number of responses around how services should identify and address barriers to access e.g. transport, services that can accommodate dependent children, accessibility, restrictive intake procedures and opening hours. Having services in areas of need was raised, with many comments on the current geographic distribution of services with regional and rural areas underserved. Suggestions to respond to this included more services, mobile services, home visits or outreach services. There were also a few responses discussing how current eligibility and exclusion criteria make service access difficult e.g. criminal records, pharmacotherapy use, mental health issues, pregnancy.

There was strong support for more integrated models of service delivery, with a range of services easily accessible in a single location. This is discussed in depth in the integration section above. There were a small number of responses discussing how services should take a more strengths-based approach to care. Some respondents wanted to see services offering a wider range of supports, including positive cultural activities, vocational and training opportunities, community engagement and family involvement.

Quotes

“Despite improvement in the transport infrastructure across Greater Metropolitan Sydney, most people cannot rely on public transport to access services. More outreach/mobile services are required, particularly for Aboriginal clients, carers of young children and people with a disability. For people who are ‘institutionalised’, travelling to unknown places and visiting offices is extremely daunting and often impractical. In addition, people exiting prison will often need to attend multiple appointments in one day at different locations. Having someone to transport them, whilst also providing therapeutic support can make a huge difference in reducing risk of harm to themselves and others. Relational and non-judgemental support from a professional who is able to walk alongside them during these difficult times is essential.”

Male, 35-44, metropolitan

“A well-designed treatment pathway would need to incorporate all the above-mentioned considerations. Importantly, critical factors have not been identified above. These include Skills-Building to provide a sense of achievement & purpose, Educational Opportunities for Self-Improvement, Return-to Work-Mentorship & Graduated-Return to family & community. We must always be aware that much AOD consumption has resulted from pain & trauma. People learn unhealthy coping strategies to shield them from this pain, which become habitualised (instinctive). Therefore, when an individual has a set-back or finds themselves in a similar environment to where they felt they had to use unhealthy coping strategies in the past, they may well unthinkingly utilise their previous coping strategy. Therefore, Strength-Based Practices must be utilised to aid in the recovery journey.”

Female, 55-64, lived experience of homelessness, regional/rural.

“Increased mobile services- take the information and support to the people and the places they attend.”

Female, 55-64, metropolitan

“There are way too many little services around spending a fortune on administrative tasks so only half the funding is spent on workers. Larger centres like Hunter primary care would work more effectively.”

Female, 55-64, metropolitan

“MoH should provision an audit of local services available from each LHD as there is significant variation in services vs local population. Likely that over years some LHD services have been poorly managed and not had appropriate level of advocacy to procure extra resources to address population growth and underlying demographic change and patterns of drug use.”

Male, 25-34, regional/rural

“make them accessible to attend and encourage people to reach out, even if they are not ready to fully quit. provide step by step goals and plans and link people in with services in their community, or a number to call if they need immediate help. provide programs e.g. work programs to give people a sense of purpose, or other programs e.g. animal/garden therapies, to provide a broad reaching strategy that will hopefully be long lasting.”

Gender not disclosed, LGBTQIA+, lived experience of drug use, metropolitan.

Co-design of services

Co-design of services with people with lived and living experience of AOD use, harms and/or treatment and people from the communities that the services are serving was raised many times. Giving clients meaningful input into their treatment and the ability to provide feedback on their care was also important to respondents, with numerous suggesting increased use of patient reported measures to guide care and quality improvement. Feedback from clients and staff on what is working and what is not was seen as an important component of service evaluation.

Increasing peer led services, and peer worker roles in mainstream services was raised, with many respondents indicating that peers provide a trusted and safe point of engagement for care.

Quotes

“Ask the people involved and don't only be guided by policymakers. Community based feedback needs to be actioned and funded. Wholistic long term community solutions need priority over political quick fixes.”

Female, 55-64, lived experience of drug use, metropolitan

“More lived and living experience collaboration and inclusion in DECISION MAKING rather than a second hand involvement and tokenistic collaboration.”

Healthcare/AOD worker, lived experience of drug use, metropolitan

“Co-design services with users. Keep evaluating them, ensuring that lived experience is central to the evaluation methodology.”

Female, 55-64 years, CALD, metropolitan.

“Design the support to be client-driven rather than health service-driven. What do the clients need / want / require?”

Gender not disclosed, 35-44, lived experience of drug use, metropolitan.

“Streamlined Access to Services: Make it easier for individuals to access various services in one location or platform. Creating “one-stop” service centers where people can access health, financial, and social support reduces barriers and ensures a smoother experience, and the ability to choose private drug rehabs or other non profit options and have it funded.”

Male, 45-54, CALD, lived experience of homelessness and drug use, metropolitan.

“Consulting with people with lived experience to ensure that services are adequately addressing the problems being faced. Co-designing services improves patient outcomes and also helps increase service engagement because people are more likely to attend if they know it has been co-designed by people with similar experiences. Better feedback systems to ensure that services are working well and meeting the needs of those engaging with services. Be willing to receive constructive criticism and feedback - making sure service users feel safe to provide honest feedback to accurately assess the service’s effectiveness. Engaging service users in ongoing evaluation whilst receiving care to make sure the client’s goals are clear, there is a plan in place to work towards them, and to check that the client feels like they are supported to reach these goals.”

Female, 18-24 years, LGBTQIA+, lived experience of disability, metropolitan

Monitoring and evaluation

There was strong support for continuous monitoring and evaluation of services, with respondents wanting to know that the care being delivered was evidence-based and continually improved. Involvement of peer workers in service evaluation was identified as important. Respondents wanted service evaluation to explore multiple aspects of service delivery, not just AOD related outcomes. Barriers and facilitators to access and engagement, client experiences, staff experiences, value for money, reach, capacity, service gaps, unintended consequences and client outcomes were identified as important measure. Funding based on outcome measures was mentioned many times.

Quotes

“Regular Program Evaluation and Feedback Loops: Conduct routine evaluations to assess service effectiveness and gather feedback from those using the services. Community advisory boards, surveys, and direct feedback sessions can provide insights into areas needing improvement.”

Male, 35-44, LGBTQIA+, metropolitan.

“Feedback Mechanisms: Regularly gather input from service users to assess service effectiveness and adapt programs accordingly, ensuring services meet real community needs.”

Female, 45-54, metropolitan

“Regular feedback from service users, coupled with data-driven evaluations, ensures services remain responsive, user-centered, and continuously evolving to meet changing needs.”

Male, 35-44, CALD, lived experience of drug use, metropolitan

“Better feedback systems to ensure that services are working well and meeting the needs of those engaging with services. Be willing to receive constructive criticism and feedback - making sure service users feel safe to provide honest feedback to accurately assess the service’s effectiveness.”

Female, 18-24 years, LGBTQIA+, metropolitan

“Measure the actual results and outcomes. Make organisation accountable based on real results and only support those actually making a difference to reduce the problem”

Male, 55-64, CALD, metropolitan

“Utilise evidence-based programs and embedded peer supports.”

Male, 25-34, regional/rural.

PRIORITY AREA 2: FUNDING MODELS

The need for increased funding for services across health was raised by a large number of respondents. Many described the lack of availability of current services and argued for greater investment in existing and new services to address this. Many also described financial barriers to accessing services including the costs of accessing various services. There was strong support for increasing the number of bulk billing services and government services to address the financial burden of seeking appropriate healthcare and reduce the need to seek costly private service options. Increasing access to Medicare schemes such as general practice mental health care plans was raised, with a desire for an increased number of sessions to be covered by the scheme, to address the chronic nature of mental health issues. Enhancing Medicare generally was frequently mentioned by respondents. A number of people also raised the prohibitive cost of accessing medicinal cannabis, with requests for this to be included on the PBS.

Respondents also raised the need to revise funding models for services. Some suggestions included increasing contracts lengths to reduce uncertainty about funding and support long term service delivery, continuity of care, longer contracts for staff, improved staff retention and development. Responses discussed how longer term, or continuous funding would also reduce the administrative burden of grant applications and could help with streamlining reporting and compliance processes to free up service time. Flexible funding models were also suggested, including dynamic models where funding could be scaled up or down to respond to demand. There were several responses that suggested that funding enhancements to increase capacity for those services that are shown to be effective should be explored, rather than aiming to fund new services. Funding services for client outcomes and improved client experiences, rather than block or activity-based funding was suggested. A small number of responses suggested benchmarking of services, or working towards achieving this.

Other notable topics raised included working towards better integration of services, including funding of hub type models where people can access multiple services in one place. Successfully integrated services may need to use different funding models. Models that encourage collaboration between services rather than competition were suggested. A small number of responses argued for not all funding being directed to large providers, but that there is a need for community led and smaller services, as one size does not fit all. Providing more funding to Aboriginal community controlled services was raised.

Increasing rates of pay for AOD and other health workers was also raised frequently, acknowledging that staff retention is a challenge in the sector. Continuity of staff not only supports the building of trust with clients but provides security for staff and more opportunity to develop skills and expertise. This needs to come with increased opportunities for career progression and pay.

Quotes

“By funding services appropriately over longer periods to ensure continuity of service and staff retention. Reduce and simplify contracts to allow services to not work in silos and focus on outcomes. Integration requires investment in streamlining referral pathways, information sharing and agreed outcome measures.”

Female, 45-54 years, regional/rural

“Support the full time staff members more in those programs and look at maybe not having an endless cycle of new staff rotating through. Being in a treatment program myself there are a core few staff who work full time but the doctors and councillors are just rotating every 3 months and as soon as you start to gain trust and confidence in one of them they move onto the next place. Instead of viewing the substance abuse clinics as a tick off for new and in training health specialist maybe you need to employ more full time doctors all year round in those places. It not only helps the patients a lot but the other staff members there too.”

Female, 35-44 years, LGBTQIA+, lived experience of drug use, metropolitan

“Be serious about funding services properly and ensuring streamlining of those services. The double up and waste I have seen in services is appalling. Have integrated wellness centres staffed with experts in their fields (Counselling, DV, Drugs/ Alcohol, Disability, young people etc etc etc). Centres must be well staffed and resourced, run proven measurable programs, run by the government and not farmed out to a lowest not for profit bidder and regularly audited for proven outcomes benchmarked to specific standards by a statutory body who can penalise any disregard of the “rules”.”

Non-binary, 55-64 years, CALD, metropolitan

“There are way too many little services around spending a fortune on administrative tasks so only half the funding is spent on workers. Larger centres like Hunter primary care would work more effectively”

Female, 55-64 years, CALD, metropolitan

“By funding them on a permanent basis so that there isn’t constant closures of services and anxiety around if the service will continue. This creates great distress to all involved and causes lack of trust and faith of the services by the community and people in need.”

Female, 55-64 years, lived experience of disability, homelessness and drug use, regional/rural.

“Stop pushing more and more ridiculous compliance requirements on services. This would free up at least 20% of a services admin and management costs which could be directed to front line service provision. Why not actually use the myriad data NSW Gov collects via the AOD minimum data set to plan and prioritise services?”

Male, 55-64 years, lived experience of drug use, regional/rural

“FUND APPROPRIATELY - Benchmark eventually. These services are fundamental in their role in the communities. Fund for the long term, not per year or every 4 years. They NEED to know they can train up these workers to be skilled professionals and retain them year after year. You have to pay properly. You don’t get good workers or services when you don’t remunerate properly.”

Female, 35-44 years, Aboriginal, LGBTQIA+, Lived experience of disability, homelessness and drug use.

“Ensure that services are funded for outcomes, improved client experiences and integration with other services, instead of block funding or activity funding.”

Male, 45-54 years, LGBTQIA+

“The lack of proper funding and support is appalling. The only way my family member made it was through pooling our resources and paying tens of thousands of dollars for treatment and long term recovery. More needs to be done to make this affordable.”

Female, 45-54 years, LGBTQIA+, Lived experience of disability, homelessness and drug use, metropolitan

“Reduce admin and bureaucracy, empower and support your frontline better and reduce your spend on consultants, reports and other management activities.”

Female, 35-44 years, lived experience of drug use, metropolitan

“Fund agencies for long periods, ensure that there are a range of agencies who can specialise in targeting different groups. Ensure wrap around services. Ensure that clients aren’t precluded from assistance because of their drug issues.”

Female, 65-74 years, metropolitan

“Reduce competition for funding, funding to include collaboration, write up and promote successful models.”

Female, 65-74 years, lived experience of disability, metropolitan

“Obtaining access to health services of any type in NSW is expensive with long waiting lists. Medicare needs to be revitalised.”

Male, 55-64 years, lived experience of drug use, regional/rural

“You need more outpatient clinics like the one at RNSH in Herbet street for Opioid Treatment Programs where people can get free access to not only medically assisted sobriety medications but staff and resources all in one central place. There needs to be more of these clinics in more suburbs and areas. Just having more of these services offered will mean more people will hear about the program, want to try the program and get the support and resources they need without the added costs that may be preventing them from stating sobriety in the first place. This clinic saved my life and its such a shame that more don't exist. The fact that people may have to travel 2+ hours in just Sydney to attend daily let alone rural areas means less people stay with the program.”

Female, 35-44 years, LGBTQIA+, lived experience of drug use, metropolitan

“Make access to counselling realistic- an offender with a drug problem on Centrelink cannot wait 3-6months for an appointment nor can they afford \$460 for an appointment with a psychiatrist/psychologist. All consultations should be via medicare and for free. The cycle continues if they are unable to access the services.”

Female, 55-64 years, lived experience of disability, metropolitan

PRIORITY AREA 3: PREVENTION AND EARLY INTERVENTION

Many respondents commented that prevention would be a cost-effective strategy, calling for investments in evidence-based programs and early interventions for children, young people, families and priority populations including Aboriginal people, those from a CALD background and those who have had contact with the criminal justice system.

Many respondents expressed the need for prevention-focused strategies like community and peer led programs that use co-design principles which identified local AOD issues to be addressed, identified at risk populations, supports families, promote healthy lifestyles, resilience and equity. There was also support for increasing funding for regional/rural areas for community programs. Greater community engagement and activities that promote community connection, as well as more healthy activities and opportunities (including training and employment opportunities) for young people to engage with were identified as important for delaying initiation and prevention of problematic drug use.

Education was mentioned many times as a key tool, with schools playing a central role in integrating early intervention programs, raising awareness about the risks of AOD use, and supporting young people. Some respondents wanted programs exposing children and young people to the dangers and harms of drug use.

Prevention of harms related to alcohol in Australia was raised numerous times, with respondents identifying a need to include education around alcohol, reducing or completely banning alcohol advertising and strengthening alcohol regulation. Better early intervention and support for children with FASD or parents with problematic alcohol or other drug use was also raised, with discussion around breaking familial cycles of substance issues.

Some would like to see better collaboration across agencies - particularly health, police, and education which could help reduce the stigma and discrimination against those people who use AOD and ensuring integrated support for families and individuals. Respondents discussed that this would make it easier for people to seek help earlier.

Additionally, some suggested stricter policies to deter AOD use, including zero-tolerance approaches in sports and to stop the glamourisation of drug taking in the media and celebrity culture. Health promotion strategies, like fostering healthy lifestyles and using real-world consequences to educate young people, were also mentioned on a couple of occasions.

Overall, respondents felt that prevention and proactive intervention could be improved to be more effective and sustainable.

Quotes

“Invest in place based community led AOD prevention programs. Support communities through partnerships, funding, resources to identify their AOD issues and run activities to reduce and prevent AOD harms. Online resources, access to information, support services, and support culturally sensitive community run programs which focus on building strong protective factors such as social connection, sense of belonging.”

Female, 45 -54 years, metropolitan.

“Greater investment in evidence-based prevention initiatives in NSW. This could include: 1. Community-led, place-based prevention programs which modify risk and protective factors for AOD related harm based on identified needs. The existing CDAT program can be significantly improved and extended. 2. AOD prevention programs that aim to strengthen protective factors in young people, including peer support, mentoring and parenting programs. 3. Targeted, tailored prevention programs for specific cohorts of the population that are at risk of AOD harm, such as alcohol behaviour change programs for young men (i.e. programs that address alcohol expectancies, increase awareness of alcohol-related harms and how to respond).”

Female, 45 – 54 years, metropolitan

“Many current interventions and programs focus on addressing drug issues among existing users, rather than preventing them in the first place. However, prevention and early intervention programs are crucial to effectively prevent and reduce drug use. By prioritising these proactive approaches, we can address the root causes and reduce the incidence of drug-related problems before they escalate.”

Male, 35 – 44 years, regional/rural.

“Communities need support to develop their ideas on prevention and turn them into community programs with real scope for impact. More funding and resources need to be pushed into this area to protect young people and families from AOD harms.”

Male 25 – 34 years, lived experience of drug use.

“Education should be provided to young people by people with lived experience. Education should be balanced and age-appropriate. Parents should be encouraged to seek support for their own drug experiences, and must not be worried about the threat of losing their children if they seek this support.”

Male, 18-24 years, LGBTQIA+, lived experience of disability and drug use, regional/rural.

“We also need to stop waiting until somebody is a “problem” to respond.”

Male, 45-55 years, LGBTQIA+, Aboriginal, regional/rural.

“To keep young people safe and support families, a proactive, community-driven approach focused on prevention, education, and family support is essential. Early, honest education in schools and community programs can equip young people with the knowledge to understand the risks of drug use, especially regarding the effects on brain development and long-term health. Education should be age-appropriate, culturally sensitive, and emphasize decision-making, resilience, and coping skills to handle peer pressure and stress.”

Male, 45-54 years, CALD, lived experience of disability.

“My lived experience of a loved one drug use started around the age of 14 and has been an ongoing issue ever since. Harms of drugs needs to be addressed early on”

Female, 45 – 54 years, metropolitan.

“More accessible (affordable) alternate activities for young people to engage in. These activities need YP involvement and development assisting in growing and/or establishing alternate activities. Breaking of cycles - previously mentioned rehabilitations that provided an opportunity for families and YP [young people] to be able to engage in work, education, sport and community while the offender is in a holistic rehabilitation. More funding and resources to educational facilities to have key staff and workers on site to provide holistic health and wellness activities and supports.”

Female, 45-54 years, CALD, Lived experience of disability and homelessness, regional/rural.

“A holistic approach is essential for supporting our young people and their families, particularly through early intervention, community engagement, and access to culturally responsive mental health services. Creating support services for Aboriginal and Torres Strait Islander families that respect cultural traditions and values. Creating Safe spaces and youth engagement programs that offer positive cultural activities and mentorship, providing alternatives to risky behaviours and fostering a sense of belonging. Access to trauma-informed care, counselling, and mental health services that are culturally responsive, and provide holistic support.”

Female, 45-54 years, Aboriginal, regional/rural.

PRIORITY AREA 4: INFORMATION AND EDUCATION

Many respondents expressed a desire for more comprehensive AOD education in schools and in the community. There were diverse opinions on the approach that education programs should take, ranging from providing evidence-based information in a non-stigmatising way through to using more fear-based messaging. On one side of the spectrum, respondents called for strong messaging around the harms that drugs cause to individuals, families and communities, with stories from people with lived and living experience of drug harms. These responses frequently suggested that messaging needed to be tougher and attempt to shock people out of considering the use of drugs. On the other side, there was a desire to empower people through knowledge. These responses suggested pragmatic messaging that provides information on the positive and negative aspects of drug use, contextual factors and reasons why people may use drugs, harm reduction information for people who use drugs and more information about signs of dependent drug use and pathways to accessing help. Non-stigmatising and accessible language were seen to better engage with people who use drugs, particularly young people.

There was a consistent theme throughout the responses that AOD education should begin in primary school and continue throughout high school, with age-appropriate messaging. There was support for normalising conversations and education about AOD from early ages. Many responses suggested that diverse stakeholders should be involved in the development and delivery of education programs. Similarly, there were suggestions that education should be delivered via a diverse range of means and media types to maximise its reach. Providing education to parents as well as young people was also seen as important for preventing harmful use.

Suggestions for the type of information that could be included in AOD education included legal rights and laws, drug driving information, harm reduction, promotion of healthy lifestyle choices, information on the harms related to alcohol, increased information on use of and access to naloxone, mental health and self-care, dealing with peer pressure, identifying triggers and potential causes of disordered substance use, safer ways to use and harm reduction information, quality of drug market and potential for adulterants, when, how and where to seek help. A focus on delaying initiation of drugs or alcohol rather than complete abstinence was suggested by some respondents, including discussions around how to support healthy brain development. Multiple responses emphasised the need for more opportunities for young people and drug free activities alongside improved AOD education.

Involvement of peers/people with lived or living experience in harm reduction education and activities was seen as important. Peers were seen as trusted supports for people who use drugs, and the inclusion of lived and living experience stories in education was seen as valuable.

Examples of harm reduction information respondents wanted to see included:

- Information about drug driving – relationship between time of use, detection time frames, impairment and recommended time periods to wait before driving.
- Event based safety behaviours – drug dosing and mixing, water consumption, ambient temperature.
- Injecting drug use safety behaviours – new injecting equipment, wound care.
- Naloxone access and use.
- Drug specific information including key interactions, dosing, quality.

Respondents wanted to see, and access, balanced evidence-based information provided through various communication channels that avoids stigmatising, politicising, sensationalising or downplaying potential harms, to support people to make informed choices about the use of drugs. Festivals, events and community and school settings were seen as important arenas for harm reduction, with messages and activities needing to be targeted to specific populations e.g. the needs of festival goers are likely to be different to those of people who inject drugs. The need for broader community education on harm reduction was also raised. It was advanced as a way to reducing stigma and enable a broader range of people to understand and apply harm reduction and overdose prevention strategies.

There were also responses that discussed the need for easier to access AOD information and support to navigate AOD and other health treatment pathways. Increased awareness of the types of support available and how to access these was discussed.

Quotes

“Make publicly funded resources and services more widely known about- I did not know about the drug and alcohol counselling service before an organisation made a referral for me, and I found it very useful in my recovery.”

Male, 18-24 years, LGBTQIA+, lived experience of disability and drug use, metropolitan.

“Making sure that treatment and support services are set out in a single portal to improve accessibility. Education campaigns to ensure that people understand both legal and prohibited drugs can be harmful with pathways to get support to manage.”

Non-binary, LGBTQIA+, lived experiences of disability and drug use, metropolitan.

“Introducing accessible ‘theory of mind’ classes in high-school to teach stress/anxiety/trauma self care in these years of change where new ideas remain acceptable and brains are still sponges. With a goal of preventing future disordered substance use”

301094 Male, 35-44 years, metropolitan, lived experience of drug use.

“Target specific age groups and demographics with tailored messaging around danger of drugs specific to the group. Social media metrics can assist with identifying and targeting. In order to show integrity, Rely on actual medical data and demonstrate the evidence, people have so much access to information, unless any message can be verified, it may be viewed as false or misleading advice. Ignore lobby group interference or industry influence when educating about dangers of legally available products.”

305630 Male, 45-54 years, region not disclosed, lived experience of drug use

“Give realistic information about potential harms without sensational nonsense. When I was in school in NSW several real consequences of drug use were not mentioned, but they said you could easily get psychosis from occasional cannabis use.”

306411 Non-binary, 25-34 years, LGBTQIA+. regional/rural

“I think we can improve health promotion & reduce drug harms by having a total rehaul of the education system around drug use to lessen the fear mongering, stigmatisation and the preaching of the negative downsides to drug use and to work towards an honest and transparent education system for young people to make their own informed decisions without feeling pressure from either “side”. This improved education system would hopefully allow young people to feel safe enough to step forward if they are having any problems in regards to alcohol & other drugs and feel confident enough to support their friends who may be struggling with addiction or drug use.”

304807 Gender not disclosed, 18-24 years, Aboriginal, LGBTQIA+, lived experience of drug use, disability and homelessness, regional/rural.

“Develop comprehensive education programs that inform individuals, especially youth, about the risks associated with drug use. These campaigns should focus on evidence-based information, covering topics like addiction, mental health, and the effects of various substances.”

305873 Female, age not disclosed, CALD, lived experience of drug use, metropolitan

“Tell kids the truth about drugs - what they actually do - the real affects they will have on their body & mind. Show & represent this honestly, as drugs are currently glamorised & normalised to the point where people start believing they are not really that harmful.”

304823 Female, 45-54 years, CALD, lived experience of drug use, disability and homelessness, metropolitan

PRIORITY AREA 5: FAMILY AND COMMUNITY SUPPORT

The need for greater support for families was a commonly raised topic in HYS. This ranged from the need for general or practical support for all families related to cost of living, service access, schooling, parenting etc through to needing family centred AOD treatment services or services that can accept and treat whole families for AOD and mental health concerns.

Prevention and early intervention were identified as important. Respondents discussed the need to address social determinants of health, support children to engage with schooling, support parents with education and work opportunities, financial assistance, housing, and keeping families out of poverty. Respondents wanted comprehensive and evidence-based education for children and parents and primary prevention programs to build protective factors for young people and families and prevent harmful drug use. A desire for more community activities, spaces and events to build connection, encourage healthy choices, provide positive activities, foster resilience and connection, develop networks, strengthen family dynamics and support healthy development was raised. Specific targeted prevention and early intervention for families at risk of drug related harm was also considered important. Greater access to and support with diagnostic and early intervention services for autism, ADHD or other neurodiversity was raised.

There was a strong desire for more integrated family support services to help with a wide range of issues from AOD, to child custody, to domestic and family violence, financial and social assistance, mental health, family dynamics, service navigation. Several responses discussed the need for improved DCJ and child wellbeing services, with respondents wanting better capacity for case managers to provide hands on support to families to prevent the need for children being removed, as well as greater support for families who have had children removed and seek to have them returned into their care. This was particularly important for Aboriginal families.

Respondents who had family members in AOD treatment wrote about struggles with managing their treatment and a limited ability to make decisions for their loved ones, even when this was clearly needed. Respondents wrote about the need for more family inclusive practice in AOD treatment. Families want to be involved in assessment and intervention for AOD issues and want greater support for and acknowledgement of their role in managing the logistics of attending appointments, navigating the system, providing support and making decisions for family members in AOD treatment. Many respondents felt that there was little or no support for families and carers, nor acknowledgement of the burden they carry including isolation, stress and mental health issues, financial issues, family breakdown etc. There were some respondents who wrote about needing financial assistance to

help with lost income and opportunities, costly counselling or other services, and costs of looking after children. They also wrote about the need to reduce barriers to accessing services, with suggestions including increased services in more locations, specific services for young people, parents or families, and pregnant women. Access to affordable childcare and early childhood education was raised, with benefits for both the children and their parents or carers cited.

Quotes

“Address the crisis in the child protection system that is removing children from their homes only to be placed in equally (if not more) unsafe places like group homes and for-profit OOHC services. Significant investment needs to be made into keeping children with family and redirecting the millions of dollars spent on OOHC into the families struggling with poverty (not neglect).”

Female, 25-34, LGBTQIA+, lived experience of drug use, metropolitan.

“I don't believe enough attention is given to families and supporting them to help a person with addiction in their family. My son is 32 and considered an adult but his brain, when drug-affected, does not function and so I have to be involved in decisions with him. There must be a system for sharing care with the family. My son loses his phone, does not confirm appointments or even get to them without my help. When I stood next to him at the local drug unit and sought permission for appointments to be sent to me (my son gave his permission) I was told that it could only happen that time not continually, even though he was standing there to give permission. Families are part of the care and should not be excluded.”

Female, 65-74, metropolitan

“Early intervention, wrap around support for struggling families. making preschool and day care centres available to parents who need to work to survive, way more centres and workers needed, reducing stress on families. We need more services to support families who are struggling to deal with addicted family members but also to assist those family members to stay safe.”

Female, 45-54, Aboriginal, regional/rural.

“This is an area of specialisation for Odyssey as we run one of the few residential rehabilitation services in the country that enables parents (including single mothers and fathers, as well as couples) to undertake treatment whilst their children (0-12 years) live with them. Since opening the Family Recovery Centre at Odyssey House NSW, demand for its services has increased, especially from single parents. The upfront cost of caring for families with inherent complexity is significant, yet the outcomes are intergenerational and lifechanging. Odysseys House's programs can result in family restoration which improves quality of life, can prevent intergenerational trauma and saves significant costs to government in avoided use of justice system, health, hospital and welfare services over an individual's lifetime.”

Healthcare/AOD provider, metropolitan.

“More direct finding so no child lives in poverty. More support for families with mental health issues including special teams that are there for each family to help with all aspects of lives without the fear of children being taken away. Better supervision of foster parents & support for children in care on turning 18”

Female, 65-74, metropolitan

“Increase capacity of DCJ workers to support young ones whose families are at risk of drug harm: providing support to the whole family so children do not have to be removed, with more resources made available to the parents to keep children safely within their family of origin”

Female, 75+ years, metropolitan

“Primary prevention programs focused on building protective factors for youth and their families need to be in all community. Gov orgs/non-gov community orgs and groups need to be given agency to create place-based evidence informed programs that support protective factors and reduce risk factors.”

Male, 25-34, lived experience of drug use

"Much greater early intervention services designed to support the whole family unit. Families need to be supported in ensuring safe, secure housing, stable income, education opportunities, and access to healthy food to ensure all over healthy family homes. Parents should be supported with culturally appropriate education in caring for children as needed to prevent generational trauma from resulting in further drug harm. Children themselves should have access to care and education outside the home for as few or as many hours as needed to ensure they have the best start to life, and a good foundation for further education. Appropriate in home or residential rehabilitation should be available for all affected by drug use at all ages. Counselling should also be provided by family members around those using drugs to ensure that they do not suffer mental health issues which can result in them going down the same path"

Female, 25-34, LGBTQIA+, lived experience of disability, regional/rural

"Integration means communication between all support services including family. I am a mother of someone with mental health and drug and alcohol addiction issues and have been blocked trying to support and help my son access support. Services appear to not acknowledge me as his advocate even when he has given permission and I am asked to provide housing etc. I have never in 15 years been invited to a case meeting with his mental health or D and A services."

Female, 65-74, regional/rural.

*"**Family Support Services:** Providing accessible counselling, parenting programs, and family therapy can strengthen family bonds and help address challenges together. Programs like these can offer parents skills to support their children effectively and create a supportive family environment."*

Female, 35-44, LGBTQIA+, lived experience of homelessness and drug use, regional/rural

"Give families at risk with young children more hands on support with parenting rather than just another course they are expected to attend. Give them actual support --workers who can offer both mentoring and hands on support in the home. Give families with children actual wrap around services that encompasses mental health, addiction, physical health, case management, transport, support work etc all in one program. Stop fragmenting care and having numerous services involved, this causes confusion and puts to much strain on families at risk going to so many different providers. Create holistic services that have a team of professionals, including First Nations workers that can cater to one person on all levels."

Female, 25-34, lived experience of drug use, regional/rural

"Keep families together where possible. Involve the whole immediate family in care discussions and planning. Have emergency accommodation for young parents at risk, so they can access their children. Their children are a major reason for them to get clean."

Female, 55-64, lived experience of drug use, regional/rural

"This requires looking after whole families so that both children and parents / carers have sufficient health knowledge, finances, safe housing, access to healthy food and good education, and also that their intergenerational trauma is managed. This requires multi-sector collaboration - an example of this occurs in Western Sydney KEYS Network"

Female, 45-54, regional/rural

"I live in the inner west of Sydney near a major public hospital. When I enquired at their drug unit for referral for family counselling, I was referred to private counselling, which is costly and not necessarily drug specific. Drug use in our family has affected my elder son, who now has private counselling, and my ability to sometimes do my job. This is in Sydney, I can only wonder what happens in the regions. I sometimes feel I am seen as being an enabler whereas I am just struggling to keep my son alive."

Female, 65-74, metropolitan

"Tailored support for the families, carers and friends of people who use drugs in harmful ways. Family inclusive practice in AOD services is important but this group needs tailored support for them/their caring burden, which was highlighted in the Special Commission of Inquiry into the Drug Ice, i.e. financial hardship, additional caring responsibilities, compromised mental health, etc."

Female, 25-34, metropolitan

“The stigma of using drugs and the stigma of mental illness needs to be addressed. Why do parents not access help for drug use or mental illness? FEAR. They fear you will take their children and so they fear being honest. Parents DO want help with their drug use and/or their mental illness but coming forward to ask for help = removing children. We need support services that don’t only just cater to single men. We need services that incorporate the entire family and for couples also. Support the entire family without putting the fear of god into them for being honest about the help they need. If parents knew that they would not be judged and stigmatised for their drug use or having mental illness then more people would seek assistance.”

Female, 55-64, CALD, lived experience of disability and drug use, metropolitan.

“Thinking about substance use of young people without considering the whole family unit is futile. Early onset, problematic drug use needs to be identified via education or services involved with young people and their needs to be more youth specific AOD supports, that are inclusive of working with the families. Refer to the work of the Bouverie Centre in Victoria on family centred practice.”

Female, 45-54 years, regional/rural.

Families for LGBTQA+ people may be family of choice or logical family rather than family of origin. We need to be broad in our understanding of family across the NSW population, with many different types of family structures outside of nuclear family. Young people can be supported though evidence based age appropriate information so they can make informed choices about their bodily autonomy. Scare and stigma based campaigns need to be avoided as young people who are from key populations with increased experiences of stigma and discrimination will be amplified and likely to be unsuccessful.”

Non-binary, 35-44, LGBTQIA+, lived experience of homelessness, disability, drug use, metropolitan.

PRIORITY AREA 6: YOUTH SPECIFIC SERVICES

Considerable frustration and concern was expressed about the lack of services for young people, particularly in rural and regional areas. Many indicated that there is a critical need for withdrawal and residential rehabilitation services specifically for young people under 18 years of age. Respondents described unacceptable wait times and distances involved to the age-appropriate services that do exist. Many suggested that delaying treatment due to a lack of services was placing the lives of young people at risk. Some recommended that there should be a specialised youth health service in every district.

Given the known association between drug use and mental health problems, many respondents also highlighted the need for increased access to youth mental health services, with some describing the difficulties they have experienced in seeking treatment for their child. The need for integrated care was also mentioned. Parents of adult children also expressed frustration about the lack of support services for families affected by drug use.

There was strong support for funding youth community services capable of building greater youth engagement and providing opportunities for young people (e.g. training, work experience, job opportunities, recreational/social activities). Drop-in centres that operate 24/7 and provide a safe space for young people to talk about drug use issues and other concerns and receive harm reduction education and referral to other services if needed were also suggested.

Quotes

“We live in regional nsw. There are no drugs support groups or services in our town for teenagers. To able to access these services one needs to travel to the next major town or city depending on the required service. The local hospital is overwhelmed and has little facilities as it is to treat sick people let alone provide services to teens with drug issues. We have been waiting 10 months to get a referral for my son to see a psychologist (through telehealth) as there is no availability locally... in 10 months his situation has significantly worsened.”

Female, 35-44, regional/rural.

“Removing any hurdles that stand between a young person and the help they need. These could be financial, cultural (Indigenous people) geographical and physical (young people living with a disability). Young people need youth specific services, such as detox and rehab. Adult services are not safe or appropriate for young people. Waiting lists and red tape are the enemy of young people seeking help.”

Female, 65-74, rural/regional.

“There needs to be free provision of programs and services to support young people who are struggling with trauma, mental health problems and associated drug use. Especially early on. Eg rehabilitation programs, sport and rec camps and school based programs to support wellbeing.”

Female, 45-54, N/A.

“Integration of Mental health and drug health programs with youth justice.”

Female, 45-54, metropolitan.

“Provide substantially increased mental health support for children and young people with trauma history, including those in touch with the child protection and out of home care systems. They have much higher rates of mental health, drug and alcohol issues. The lack of support in outer regional, rural and remote areas is atrocious.”

Female, 45-54, disability.

“Include a youth health service in every health district. Fund specialist youth drug and alcohol services.”

Female, 35-44.

“More public funded youth specific drug and alcohol services - not co-located with adult services, hospitals or community health centres.”

Female, 55-64, LGBTQIA+, metropolitan.

“I found that there was no help or support related to my son’s addiction, apparently he has rights once he reaches the age of 18. I personally feel that a parent or guardian should be able to request that the person gets rehabilitation. I had no support from any organisation regarding this. The drug user is really not in the right frame of mind to be making their own decisions. There literally was no support or help for my son to overcome his addiction, until it is all too late. Either they start offending and go to jail, or they overdose unfortunately.”

Female, 45-54, homelessness, metropolitan.

“More support for youth-focused community spaces, so that young people have places they can use to stay connected. These spaces could be a stepping stone for young people to find support if they need it.”

Male, 35-44, metropolitan.

“Increase Police, DCJ and Youth Services AOD Community Engagement programs.”

Male, 65-74

“NSW Government needs to invest substantially more funds into culturally safe and appropriate drug and alcohol related support services for young people. As noted earlier, there are very few addiction and support services in regional, rural and remote NSW - and none that specialise in youth drug use/addiction.”

Female, unknown age, metropolitan.

“Simply put, the services that are there, need a greater ability to support families. Services are being squeezed, and only a limited number of people are being seen. The services need to cover a wider range of supports. The services that supply the initial supports e.g. HeadSpace, school counsellors, are struggling to see the young people quickly. If the child, young person and family need more support, there is then difficulties in getting them into services Mental Health and Drug and Alcohol services for young people are also struggling to see people quickly and to support them adequately. We also need to see what other services are needed. Do we need more youth refuges, and safe spaces for children and young people? Do we need to

have Mentors for young people and their families, as they go through hard times? We need to look broadly at the situations that are there. We also need to look at ways of helping young people and their families engage in the services.”

Female, 55-64 years, regional/rural

PRIORITY AREA 7: ABORIGINAL SOCIAL AND EMOTIONAL WELLBEING AND CULTURAL SAFETY

There were several responses discussing cultural safety and community led responses specifically for Aboriginal people. There was broad agreement that cultural safety is important in achieving outcomes and needs to be improved across AOD and other health and social services. Suggestions to achieve this included stronger community engagement and collaboration with Elders or community leaders to codesign and implement services, cultural safety training for all staff in health and social services, expanding the Aboriginal health workforce, and funding more Aboriginal specific services including community-controlled services. There were calls for more cultural models for rehabilitation services, and more services available in regional and rural areas so that Aboriginal people have more opportunities for on-Country treatment and support. Respondents suggested expanding early intervention and prevention services, including positive cultural activities. Provision of holistic care was seen as important.

Quotes

“Culturally Safe Support for First Nations Populations: First Nations communities face unique and compounded challenges related to drug use, stemming from intergenerational trauma, systemic racism, and socioeconomic inequities. Incorporating culturally safe practices and First Nations leadership into both the peer workforce and policy development is critical to ensuring equitable support.”

Female, 35-44 years, CALD, lived experience of drug use, metropolitan

“Ensure services are appropriate for Aboriginal and Torres Strait Islander people including young people and women by working in partnership with Aboriginal Community-Controlled Services including Aboriginal health services and legal services to refer and provide wraparound support.”

Female, 55-64, metropolitan.

“Effective health promotion involves working with communities to create culturally appropriate and relatable programs. For diverse populations, including Aboriginal and Torres Strait Islander communities, this means collaborating with local leaders and organisations to ensure that messages and interventions resonate and respect cultural values. It means that the standard white centric approach should not be used on every population, and that more co-designed programs need to be designed and implemented. If it has been designed in SLHD, SESLHD, or NSLHD, then the program CAN NOT BE APPLIED TO OTHER LHDs.”

Female, 35-44, CALD, metropolitan

“First Nations communities face unique and compounded challenges related to drug use, stemming from intergenerational trauma, systemic racism, and socioeconomic inequities. Incorporating culturally safe practices and First Nations leadership into both the peer workforce and policy development is critical to ensuring equitable support.”

Female, 35-44, CALD, lived experience of drug use, metropolitan

PRIORITY AREA 8: WORKFORCE

Health, social and education workforce

Improved AOD education and training for the general health, education and social services workforce was identified by respondents as a way to reduce stigma and discrimination, improve the timeliness of AOD referrals and the quality of care provided. There was acknowledgement that primary health practitioners and in particular GPs are already stretched and the workforce struggling to keep up with demand. Solutions to this issue would also have an impact on AOD care.

Respondents suggested that AOD education should be included in all tertiary health and social degrees, and that develop more AOD professional development courses, supervision or mentoring programs. Stigma and discrimination training was also identified as an important to ensure that people who use drugs are treated with compassion, respect and understanding when they present to health or social services. A need for training on how to identify AOD issues and refer appropriately was also noted. Some respondents highlighted the need for teachers to have at least some training in AOD to better support young people who may be struggling.

Quotes

“Mandatory training for GPs on the way drug use can impact mental health and ways to effectively support that isn’t just a blanket “don’t use drugs”. That has never and will never work. It needs to be a holistic approach that takes away judgement and focuses on support and treatment. With the aid of government funded healthcare, would make it really accessible for anyone to seek care and easily through their local GP.”

Female, 25-34 years, lived experience of drug use, metropolitan.

“Educate primary health care workers, ED staff that just because the person presents as “drug affected” or has a history of “substance misuse” that they should be dismissed as a D&A issue and not treat/investigate underlying causes or conditions.”

Female, 45-54 years, metro

“While I am tempted to expound on the types of training and programs that can assist GPs and other primary health practitioners in providing greater access to health and treatment services for people who use drugs, it means nothing while GPs remain chronically underfunded (acknowledging that this is the domain of C/W funding but also that NSW and the C/W government are of the same Labor party).”

Female, 35-44 years, lived experience of homelessness and drug use, LGBTQIA+, metropolitan.

“Health professionals & our legal blue collar workers have to show more compassion instead of stereotyping all drug dependant people. My daughter passed away earlier this year due to her drug dependency and was given zero help and support especially from the people that ripped out her heart and removed her children.”

Female, 55-64 years, lived experience of drug use, metropolitan.

“Shift the focus from punitive approaches to harm reduction in truth. Healthcare workers should have education and training around AOD emphasised, and destigmatisation is an ongoing process that needs to be committed to be anyone who provides care to people, and particularly for healthcare providers. The amount of archaic perspectives on AOD use that are still held by people is embarrassing, and is dangerous if those people are healthcare workers. If people don’t feel safe accessing services because of the people providing that service, then how can we even begin to address the reduction of AOD related harm.”

Male, 25-34 years, Lived experience of disability, homelessness and drug use, regional.

“Hospitals and general emergency departments do not seem well equipped with dealing with drug users in a positive and supportive way often. Sometimes you get staff who understand addiction but often staff are uninformed and not helpful in linking people presenting to emergency with problems of addiction. Especially we found in rural and regional areas. The family member we were supporting with amphetamine addiction eventually moved to the city to get better hospital/ED support. People with addictions often don't have good organisational skills so establishing and maintaining a GP isn't very practical. They end up in ED a lot and it would be helpful if staff could be trained to be more supportive and to link in with community services more.”

Female, 55-64 years,

AOD workforce

Upskilling the AOD workforce was a commonly raised topic. Respondents identified a need for ongoing opportunities for the AOD workforce to engage in education and training, including specialist training in areas such as addiction medicine, cultural responsiveness, addressing social determinants, trauma informed care, mental health, dual diagnosis, and providing tailored care for priority populations (young people, CALD, Aboriginal, LGBTQIA+, older people etc). Continuing education was seen as having benefits for clients but also supporting the workforce in career progression and growth. AOD nurse practitioners, psychologists, psychiatrists, community support workers, case workers, school counsellors, Aboriginal health workers and lived and living experience workers were identified as important groups to expand.

There were responses highlighting the importance of retaining experienced staff in the AOD sector. Overwork, vicarious trauma, low rates of pay, not being valued and understaffing were among the reasons identified for difficulties with retaining staff. Suggestions to improve retention included increasing pay rates, improving career development and progression opportunities, providing better support and supervision to staff to avoid burn out, addressing overworking/overtime, incentives, and improving work stability and contract lengths.

Respondents also emphasised that the AOD sector is understaffed and that services often have difficulty filling positions – there is an urgent need to expand the workforce through attracting (and then retaining) new staff. Respondents noted that this requires additional funding to be directed to workforce. Some respondents emphasised the need to listen to front line services and communities about the kind of staff and services that are needed.

Quotes

“These roles are difficult working on the frontline with people and children suffering serious problems. Burnout is high, morale is often low so strong leadership is required, and higher benefits are needed such as more pay and holidays, and there should be more options for part time work which suits women and men with children. There has to be a strong desire to help people coupled with compassion for the battler. Like teachers, these jobs are not for everyone.”

Female, 65-74 years, lived experience of drug use, regional/rural

“Improved funding for more NSW health clinicians -including improved pay conditions for workers to sustain people in the workforce. As clinicians are not adequately paid and there are limited clinicians available, many people cannot access services as they are understaffed.”

Female, 25-34 years, regional/rural.

“Make sure you hire enough people to provide those services. If the workload gets too high, people will quit, and it becomes a vicious cycle. Invest substantially in both an up front, and ongoing manner.”

Non-binary, 25-34 years, LGBTQIA+, lived experience of drug use, metropolitan.

“Increased Investment in Alcohol and Other Drugs (AOD) Nurse Practitioners: With rising demand, there is an urgent need for more AOD Nurse Practitioners. However, achieving this also requires funding to support existing nurses in advancing to a nurse practitioner level, ensuring they can meet specialized care needs effectively.”

Male, 55-64 years, LGBTQIA+, lived experience of drug use, regional

“Subsidise the training of those in these fields, increase their wages and incentivise new students to follow this career path. If the job is thankless and holds a low social standing, there is no way to attract new or even retain existing staff.”

Female, 35-44 years, CALD, lived experience of homelessness and drug use, metropolitan.

“Training and support for front line workers and employing sufficient numbers of workers to prevent overwork and burn out. Appropriate placement of services so those rural regions also benefit. Employing multicultural workers and providing services in a culturally sensitive manner.”

Female, 65-74 years, metropolitan

“Continuous Staff Training and Development: Invest in ongoing training for staff across agencies in areas like trauma-informed care, cultural competence, and interagency collaboration. Well-trained staff are better equipped to offer comprehensive support and make referrals effectively.”

Male, 35-44 years, LGBTQIA+, metropolitan

Lived and living experience workforce

While not a frequent topic of responses, there were a number of respondents who raised the importance of the peer workforce to the AOD sector and advocated for its expansion and strengthening. Responses discussed the value that peer workers bring to services and clients, in understanding client’s experiences, approaching support with a non-judgemental attitude, encouraging vulnerability and breaking down barriers, and helping to reduce stigma and discrimination within services and the broader community. There were a small number of responses that addressed the need to support people with lived and living experience to enter the workforce, such as through supported training and education, mentoring and hiring targets. Several respondents also called for more peer led services and gave examples of successful services such as NUAA and AIVL.

Quotes

“We need to demonstrate that the feelings of “I can’t do this”; “No one understands or cares”; “I’m worthless,” can be moved beyond & options of empathy and guidance are within reach. Lived Experience Support Workers can be placed before an individual ready to choose the Rocky AOD Road. LESWs provide an approachable, non-judgemental, stable influence who can demonstrate that “Life can get better after the darkness.” And most importantly, they are great motivators. LESWs should be placed in medical centres, mental health services, and first Responders would benefit from their assistance in de-escalations. However, LESWs must have local, accessible treatment pathways to refer the individual for detox, rehab & reintegration into community.”

Female 55-64, lived experience of homelessness, regional/rural.

“... tailoring services to reflect and respect cultural differences, including language needs, traditions, and varying perspectives on drug use and recovery. Involving community leaders and people with lived experience in the design and delivery of programs can help shape services that resonate with different groups. Additionally, having staff who reflect the diversity of the community can enhance trust and improve engagement, making it more likely for individuals to seek and receive the support they need.”

Male, 35-44, lived experience of drug use, metropolitan.

“Again, take away the stigma, shame. Stop treating users as criminals. Employ people with experience. Noone wants to take advice from a 25 year old with a degree. Addicts are people, not all commit crimes, some of us hold down jobs and raise families in addiction too scared it will be taken away if anyone finds out.”

Female, 45-54 years, Lived experience of disability and drug use.

“Strengthen/Expand the Peer Workforce: Peer workers—individuals with lived experience of drug use—offer unique insights and relatability, breaking down stigma and fostering trust among service users. Expanding the peer workforce across harm reduction services, treatment facilities, and outreach programs ensures services are informed by lived experience and meet the diverse needs of clients.”

Female, 35-44 years, CALD, lived experience of drug use, metropolitan

“20% FTE hiring targets for Peer Workers in Drug Health services - hiring workers with a lived experience of being shamed by health workers due to their drug use can help health services transform any inadvertently shaming practices. Peer workers are also well placed to offer support directly to service users as they can lead with vulnerability which health reduce barriers of self shaming/internalised stigma and they are often very good at working in trauma responsive ways.”

Non-binary, 35-44 years, LGBTQIA+, lived experience of disability and drug use, metropolitan.

“Incentivise more people to train as mental health practitioners (free study-as people with lived experience and knowledge may not be able to afford to study but could be the best people for the job) Also incentivise experienced mental health practitioners for mentoring, follow ups and checking handling of unwell clients etc.”

Female, 65-74 years, lived experience of disability and homelessness, regional/rural

“Social services will only work when people who have been there are part of the support programme if you haven’t been there how do you know what people are going through and give ideas on what might work not someone who has just come out of uni”

Male, 55-64 years, metropolitan

“Provide adequate funding over the long term to services with a proven track record of continued engagement with the community. Allow People with lived and living experience to be a part of every aspect of designing, creating and maintaining support services. Allow consumer review of support services so that we are consistently improving the quality of the service. create dynamic models of funding that can increase if a service is popular, successful or oversubscribed. Allow for Lived experience Peer roles to be imbedded within all AOD services”

Female, 35-44 years, lived experience of homelessness and drug use, regional/rural

“Allow the voice of people with lived and living experience to be centred and fronted at everything we do.”

Male, 35-44, CALD, LGBTQI, lived experience of homelessness and drug use, metropolitan

“...Fund Lived experience Peer Worker roles in all AOD services statewide. Fund Lived experience Peer Worker roles in all public hospitals to allow patients direct access to support from someone who they feel comfortable with and can act as a bridge between the clinical side and the patient themselves. As a person with lived/living experience I have been treated poorly and stigmatized and discriminated against repeatedly within NSW Health’s care. If you treat a person that way they will not take on any kind of harm reduction advice that is given. However if you support the person, allow them access to a Peer worker who can advocate for them, the path becomes improved outcomes for everyone. the Patient feels supported and listened to, is less likely to leave or become non-compliant, the overall experience is easier for everyone involved.”

Female, 35-44 years, lived experience of homelessness and drug use, regional/rural.

“Culturally competent and inclusive services are vital in ensuring people from diverse backgrounds feel welcomed and understood when seeking help. This requires tailoring services to reflect and respect cultural differences, including language needs, traditions, and varying perspectives on drug use and recovery. Involving community leaders and people with lived experience in the design and delivery of programs can help shape services that resonate with different groups. Additionally, having staff who reflect the diversity of the community can enhance trust and improve engagement, making it more likely for individuals to seek and receive the support they need.”

Male, 35-44 years, lived experience of drug use, metropolitan

PRIORITY AREA 9: STIGMA AND DISCRIMINATION

Reducing stigma and discrimination was one of the most frequently raised topics in Have Your Say. People described their experiences of stigma and discrimination around AOD use in the community, in health and social services, by the police force and in the criminal justice system. Stigma and discrimination were identified as key barriers to seeking help and achieving better outcomes. Responses described not seeking help, or waiting until issues had gotten much worse before seeking help due to experiences of discrimination or stigma, or fear of people's reactions. Some respondents raised specific issues in regional and rural or other close communities where there may be limited appropriate services; people may avoid attending services for fear of being recognised. A small number of respondents also noted the additional barriers and experiences of discrimination faced by certain groups including Aboriginal people, those with a history of criminal justice system interactions and people with children in out of home care.

Many respondents highlighted stigma in healthcare and other services, calling for further training and education on alcohol and other drug issues among professionals working across healthcare, law enforcement, criminal justice and social services sectors, not just among AOD service staff. Emergency departments and general practices were often mentioned as places where stigma and discrimination were experienced by people who use drugs. Respondents emphasised the importance of non-judgemental care and being treated with respect, compassion and empathy no matter what your circumstances. Suggestions included broader education and training for anyone working in AOD services (including administration or other non-clinical roles), other health and social services and police; expanding and strengthening the peer workforce; having dedicated AOD workers in all EDs to support staff with AOD clients; co-designing services with people with lived and living experience of treatment and involving them in decision making; implementing complaints processes in services where complaints about discrimination or poor treatment are taken seriously.

Decriminalising drugs and treating drug use as a health issue were seen as ways of reducing stigma and discrimination, with responses arguing that criminalising drug use drives it underground and means that the community views drug use through a moral lens rather than a health lens. There were discussions around the need for greater understanding of the impact of social determinants of health, trauma and intergenerational trauma on drug use and dependence and that this would be more possible if drug use was treated as a health issue rather than a criminal issue.

There were discussions about how language is used in the media, by politicians and leaders, and in the broader community, that exacerbates stigma and discrimination. Many respondents supported the use of appropriate and non-stigmatising language across the community. Some respondents suggested public awareness campaigns around language and respectful behaviours.

Several responses argued that better cross system collaboration and integration would also work to reduce stigma and discrimination, through broader understanding of the range of issues that people may be experiencing.

Quotes

"...reduce the stigma and encourage people to seek help (particularly pregnant women). I am a child of two heroin addicts, I was removed from their care because I experienced abuse and neglect due to their drug use. I have come to learn that my father had schizophrenia and likely used heroin to self medicate. If he had been treated earlier he may not have turned to drugs."

Female, 25-34 years, LGBTQIA+, lived experience of disability and drug use, metropolitan

"If young people are inclined to hard drug use, then I, as a former child of kings cross urge you to ask why. I was very young when I started using drugs and nobody ever asked me why. I started using to make myself feel better. I was not a drug addict. I was just another young person trying to find a way to live and survive neglect and abuse. Nobody ever spoke to me about those things, only ever drugs. I think that when a society looks at young people living with damage and overlook that damage and pain, instead focusing on drug use stigma, then we have a social problem that affects us all."

Male, 55-64 years, LGBTQIA+, lived experience of disability, homelessness and drug use, metropolitan.

"I feel like the stigma and discrimination towards people who use drugs will be persistent until such time as criminalisation is no longer the policy approach. In my every day work I have seen people who use drugs in dependent patterns of use, use a service where they're treated with respect and they're allowed to have a bad day. I see that same person in a different service where they're treated less respectfully, more punitive or take away the autonomy of the person and that person behaves differently. Clearly it's not the person who is responsible for their behaviour, rather it is the worker and setting that provokes the behaviour, resulting in exclusion from a service. Imagine going to a service that is supposed to help you with housing food shower and you get treated like shit and you get excluded because you were treated like shit but then you're held personally responsible I think that's pretty unfair."

Non-binary, 35-44 years, lived experience of homelessness, disability and drug use, metropolitan

"Non judgmental attitudes. No stigma. Leave your moral judgements at home. Treat EVERYONE with respect. If people are treated with respect and not judged the first time they come in to access health services, they will come back again. If they are treated with judgement and attitude they won't come back, the issue will fester, until it costs the health service way more money than if they just treated the person with dignity and respect the first time."

Female, 55-64 years, lived experience of homelessness and drug use, regional/rural

"Better training for healthcare staff around discrimination, stigma; especially with regards to injecting drug users. Centring the experiences community members lives experience in decision making, policy design, and initiatives moving forward. Ensuring those accessing the healthcare system know their rights, and that the complaint process is easy and taken seriously."

Male, 25-34 years, LGBTQIA+, lived experience of drug use, metropolitan.

"Stop doctors from discriminating against drug users. Provide education to doctors to ensure that drug users actually receive medical care, and that their conditions are properly investigated and not dismissed as being due to their drug use. This is an issue I don't think has much visibility. They cannot be identified here for obvious reasons but there are doctors out there who provide inadequate care if they know somebody uses drugs. It is known in the community. Because of this, there is reluctance to admit to using drugs."

Female, 25-34 years, LGBTQIA+, Aboriginal & CALD, lived experience of disability, homelessness and drug use, regional.

"Reducing stigma and increasing awareness are critical for improving equitable access and inclusion for people seeking support for drug use. Community education campaigns that challenge harmful stereotypes and highlight addiction as a health issue, rather than a moral failing, can significantly reduce stigma. Such campaigns should emphasize the importance of compassion and support, fostering a climate where individuals feel safe reaching out for help. Equally, training service providers in trauma-informed care and cultural competence is essential. When healthcare and social services staff understand the complexities of addiction and approach clients without judgment, it creates a more inclusive and supportive environment for all."

Male, 35-44 years, lived experience of drug use, metropolitan

"The bidirectional nature of mental health and substance use cannot be further reemphasised. Substance use and mental illness must be comanaged and not siloed. Less pathologisation of substance use and mental health could be considered, looking at the social practices to support change in individual behaviour. Health workers deserve to be treated with respect and as are consumers irrespective their substance use history or status. People can be allowed to have a bad day in a health service, should be allowed to make mistakes."

Non binary, 35-44, disability, homeless, LGBTQI

"Stop doctors from discriminating against drug users. Provide education to doctors to ensure that drug users actually receive medical care, and that their conditions are properly investigated and not dismissed as being due to their drug use. This is an issue I don't think has much visibility. They cannot be identified here for obvious reasons but there are doctors out there who provide inadequate care if they know somebody uses drugs. It is known in the community. Because of this, there is reluctance to admit to using drugs."

Female, 25-34 years, LGBTQIA+, Aboriginal & CALD, lived experience of disability, homelessness and drug use, regional.

PRIORITY AREA 10: CANNABIS AND DRIVING

There was support for revision of the current drug driving laws around medicinal cannabis.

Quotes

“Not fair at all. I have lost my drivers license due to having been detected with cannabis by the police, this has greatly impacted on both my family and work life. I use medical Marijuana and had used 48 hours prior to driving, i was not impaired.”

Male, 35-44 years, CALD, Metropolitan, lived experience of drug use.

“This is my main issue. Stop testing NSW drivers for minute amounts of THC they only measures past use not current impairment. A roadside positive drug test for a Dr prescribed cannabis medication results in responsible people getting their license suspended and having a conviction recorded. This is so unfair and doesn't make roads safer. I am too scared to take my cannabis medication as I need my license for my job and my daughter lives in USA and I would like to be able to visit her so I take heavy and addictive pharmaceutical painkillers instead. The THC threshold is set super low in the road side drug tests as it is for integrity testing in the armed forces. Road side testing should be for impairment only. Stop prosecuting responsible people for taking their prescribed medication.”

Male, 55-64 years, metropolitan

“Modernisation of road user regulations/legislation and industry drug and alcohol policy guidelines to have greater understanding of prescription cannabis use. The existing legislation and policies are contradictory and discriminatory, don't effectively manage testing for intoxication/impairment, and rely on presence of THC in body (with can be detectable for weeks after last consumption) as the determination of impairment.”

Male, 35-44 years, lived experience of disability and drug use.

“1. A shift toward impairment-based testing, as seen in other jurisdictions, would better balance public safety with patient rights. Reforming NSW's laws to recognise the distinction between impairment and non-impairing THC presence would protect the rights of medicinal cannabis users and set a compassionate example. This change would alleviate socio-economic stress on rural patients, allowing them to use prescribed treatment without undue fear of criminalisation and to maintain essential driving privileges. Regional and rural NSW is further disadvantaged by their lack of public transport leaving no other option when a license is suspended for 3-months.”

Gender not disclosed, 25-34 years, Lived experience of disability and homelessness, LGBTQIA+, Regional/Rural

“The current cannabis driving laws are discriminatory and not based on evidence. How can someone who is prescribed benzodiazepines and opiates be free from judicial repercussions for driving, but people who are prescribed cannabis to treat their medical conditions are treated with the same prejudice as drink drivers? It is outrageously discriminatory and forces people to switch to addictive drugs to treat their conditions. It's time we grew up as a nation and started moving forward. This puritanical approach is destroying any progress we should be making as a world leader in many domains.”

Male, 35-44 years, Lived experience of disability and homelessness, Regional/Rural

“Allow cannabis users to take their medicine and drive the next day while not intoxicated so they can live their lives without fear”

Female, 25-34 years, CALD, Lived experience of drug use, Metropolitan

“Currently the regulatory frameworks in New South Wales act as a distinctive for patients prescribed medicinal cannabis to take their medication as prescribed by their Doctor. Roadside drug testing only tests for the presence of medicinal cannabis containing THC and not whether the driver is impaired.

There is no delineation between recreational and medicinal cannabis and no legal defence for a patient correctly taking their prescribed medication if they are caught with THC present in their system but not impaired.

This forces patients to not take their medication as prescribed, or at all, if they need to drive to work, take their kids to school, attend a medical appointment, disproportionately impacting regional and rural patients.”

Male, 25-34 years, Metropolitan

PRIORITY AREA 11: HARM REDUCTION

Drug checking

There was strong support for drug checking services being made available at festivals/events and at fixed sites in the community. There were also a small number of responses opposing the implementation of drug checking services.

Respondents identified multiple potential benefits of drug checking services. Information about the contents, strength and dose of drugs could be provided to individuals, as well as other festival attendees and the broader community. This information was seen as being able to support safer consumption, reducing potential harms and overdose, and potentially having a broader influence on the quality of the drug market. Understanding the contents of drugs was seen as providing people with the information and opportunity to make informed decisions about their drug use and related behaviours.

Respondents also highlighted that drug checking services would facilitate engagement with people who use drugs who otherwise might not access a health service. Multiple methods of engagement along the spectrum of use and harm are needed. Services users could access accurate health advice and increase their knowledge of harm reduction behaviours. Respondents identified that most people who use drugs do not do so problematically, but that these people can also benefit from harm reduction interventions provided with drug checking. Those people who do want or need help can be linked with appropriate services or made aware of pathways to help for the future.

The increasing complexity of the drug market was also highlighted as a reason to implement drug checking. Adulteration with fentanyl, other synthetic opioids or other new psychoactive substances was seen as making drug use higher risk than in the past. Dissemination of the results of drug checking to the public was seen as an important way to communicate about these harmful substances.

Several responses also raised how police presence at festivals and events might impact engagement with drug checking services. Respondents discussed how service users would need to be confident that they would not be targeted by police if using the service.

There was support for both community based and festival-based services. Several responses suggested that drug checking services could be made available at existing local health services or community pharmacies. There was a desire for services be accessible to everyone, confidential, free of charge, linked with other health services and available in regional and rural locations as well as cities.

Quotes

“People aren’t going to stop doing drugs. People who wants drugs will always find drugs. But let’s offer them a way that is safer and also safer for the community at large. Thinks like injection centres or and no risk pill testing could help.”

302623 Female, Aboriginal, 35-44 years, regional/rural

“Definitely offer pill testing at festivals and events especially now that Fentanyl and other dangerous drugs are in Australia”

Female, Metropolitan NSW, 55-64 years, lived experience of drug use.

“Peer support, drug education, pill and substance testing and counselling + social support services at music festivals and other areas where increased levels of drug use are likely. People at these events often find themselves vulnerable, open to help, or actively searching for support. Services like Dancewize (or the addition of public service personnel) could serve as a trusted node of peers to connect people in need to the services that could make a difference in their lives. Types of services could include counselling, DV support, housing support, DOA [Drug or Alcohol] treatment/support...”

302535 Male, 35-44 years, CALD, lived experience of drug use and homelessness.

“There need to be more ways in engaging with people who use drugs at various points of their trajectories. Drug checking or drug consumption sites have been proven as effective programs to engage with people who use drugs, to provide health information, and to link to support services when needed.”

301001 Female, 35-44 years, CALD, Metropolitan NSW.

“Education is key - people need to know what they’re taking, how it will affect them and the associated risks. This includes having things like pill-testing at major festivals and concerts, so that people are able to avoid consuming dangerous substances, and putting a strain on our essential services. It really is a no-brainer.”

304084 Male, Metropolitan NSW, 25-34 years, lived experience of drug use.

“Please bring in pill testing. I have no reason to ever need the service but I can see the positive benefits of it. People will take what they want to. We might as well let them know what is in it. At least then they can make a more balanced decision. Education is key.”

304043 Male, 35-44 years.

Needle and syringe programs (NSPs)

While not a frequently raised topic, there was support for expanding NSP services from some respondents. Respondents noted that many people do not have easy access to these services, particularly in regional and rural areas. Expanding the hours these services are open, locations, mobile services, the types of equipment provided and links with other health and social services were raised. Several people also mentioned provision of NSPs in prison and custodial settings.

Quotes

“1. Reinststitute providing sterile waters and butterfly syringes in the Needle Exchange programs. These were removed years ago for various reasons. It is well known that for dollars spent in Needle Exchange programs saves many dollars down the track in health care. 2. Improve access to Needle Exchange programs out of hours. In Newcastle the main 2 programs are only open 9-5, Mon. - Fri. Once upon a time in Newcastle the Needle Exchange program opened in the afternoon until about 10pm at night, and was open on weekends and public holidays. Regular users have equipment. Irregular users out on weekends generally don’t and are more at risk of using used equipment during these times. This previous Newcastle Needle Exchange (circa 1991) was also set up as a place where you could make a coffee and sit down and talk to staff in a relaxed environment.”

Female 55-64 years, lived experience of drug use, metropolitan

“Injecting rooms in regional and rural areas, increased number of needle and syringe exchanges and disposal places and accessibility to free Naloxone.”

Female, 45-54 years, regional/rural

Take home naloxone

Take home naloxone was raised by a small number of respondents who wanted to see the program expanded to more pharmacies and awareness of the program promoted across the community. Points raised by respondents included the need for wider availability, that it should be provided free at events, the need for more varied methods of information dissemination to reach a wider group of people, increased awareness of the potential for contaminated drugs and the value of naloxone e.g. cocaine laced with fentanyl, teaching people how to identify

a potential opioid overdose and include naloxone in harm reduction education programs. Respondents wanted increased funding to make it more available and easier to access. A few respondents also mentioned wanting police to carry naloxone.

Quotes

“Promotion of the Naloxone program. I am a registered nurse and most of work colleagues in hospitals, community and pharmacy didn’t know this program existed until I made them aware. Promoting that people will not get into trouble for calling an Ambulance for an overdose, or either will the person who has overdosed. Promoting the signs of overdose, actions to take. This needs to start in high schools. Promoting the dangers of mixing drugs including prescription drugs.”

Female, 35-44 years, regional/rural

“We need more information getting to young people there needs to be investment in social Media platforms where young people get their information. It is also vital that we get information out quickly a friend of mines Son died 2 weeks ago after using cocaine that was laced with Fentanyl. We need Naloxone flooding the community if we are to prevent more deaths.”

Female, 55-64 years, metropolitan

“Have Naloxone easily available where people feel they can access without judgement. Especially in small towns.”

Female, 35-44 years, regional/rural

“Just Say No” & Scare Campaigns don’t work, use age-appropriate truthful resources. Along with an increase in pill testing also make fentanyl and nitazene test kits available, ensure that people using stimulants drugs such as cocaine are aware that these can also be adulterated with fentanyl and nitazenes for which they may have no tolerance severely increasing the risk overdose. Ensure Police and other first responders carry nasally administered naloxone such as nyxoid.”

Male, 55-64 years, Lived experience of disability, metropolitan

“Naloxone in pubs, clubs, security, police and every first aid kit.”

Female, 55-64 years, metropolitan

Medically supervised injecting services

There was support for the introduction of additional safe consumption services from respondents. Comments regarding this included a desire for amendment of Section 36A of the *Drug Misuse and Trafficking Act 1985* (NSW) to allow more than one license to be issued for more than one premise. Respondents also raised that there is evidence showing that these services work to prevent overdose and link clients with health services if wanted. The need for these services in a range of locations was mentioned, with Western Sydney and regional and rural areas specifically mentioned. The need for these services to be integrated with other health and social services and for collaboration with police to ensure exclusion zones around services was discussed. Some respondents mentioned expanding these services to allow other forms of drug consumption such as smoking. Mobile services or alternative models were suggested.

Quotes

“We need more supervised injecting facilities -but currently, the law in NSW is that there can only be one. We can make this happen by:

Amending section 36A of the Drug Misuse and Trafficking Act 1985 to allow more than one license to be issued for more than one premises.”

Female, 55-64 years, Regional/Rural

“The focus must be on harm reduction for the community, this means providing more Safe Injecting Centres in NSW where those that are using can use safely, and then have access to social support that can assist them to find stable housing, access to health care and mental health support. Injecting centres can be the portal that starts this process to assist the most marginalised and vulnerable people in our communities. The flow on effect is that Injecting centres help to reduce drug use in hidden parts of communities, preventing deaths and being the starting point for a person to change their course of drug use.”

Male, 25-34 years, Metropolitan

“The best health promotion I have witnessed is that inside the Kings Cross Medically Supervised Injecting Centre. As such we need more SIFs (safer injecting facilities) and the establishment of Drug Consumption Rooms (because not all drug users inject). Within these centres/rooms effective health promotion can take place. When these facilities have been established then there needs to be public campaigns to inform those who needs these facilities to know where they are located and encouragement to use them.”

Female, 55-64 years, Lived experience of disability and drug use, CALD, metropolitan

“More injecting centres in areas with known high levels of drug use, this should be combined with healthcare facilities that can provide basic healthcare to those that are vulnerable. There needs to be access to GP like services that are bulk billed and available as a drop in centre, as many of the vulnerable drug using community do not have access to basic primary healthcare, and so use Emergency departments as their health service, or do not seek healthcare at all.”

Male 25-34 years, metropolitan

“Keep the funding available for these services even by increasing the number of them as someone who has in the past used the supervised injecting place in kings cross that place is amazing there should be more places like it”

Male, 35-44 years, LGBTQIA+, lived experience of disability and drug use, regional/rural.

PRIORITY AREA 12: THE CRIMINAL JUSTICE SYSTEM AND POLICE

While there was substantial support for decriminalisation, many acknowledged that full decriminalisation was unlikely to happen and recommended that diversion to treatment schemes be significantly expanded as a next best option. Many respondents discussed examples of the effectiveness of existing diversion programs such as MERIT and Drug Court and strongly advocated for expansion and additional funding to enable greater participation. The need for having enough treatment places to meet the demand from expanded diversion programs was identified. Offering a range of treatment options of different intensities to suit the varied needs of clients was also seen as important, ranging from simple brief interventions for those without problematic drug use, through to residential rehabilitation for those seeking greater levels of support for their drug use and related harms. A number of responses highlighted a particular need for expanding the availability of diversion programs in regional and rural areas.

Allowing young people to access diversion programs was also noted by a small number of respondents. The Youth Drug Court program was seen as an effective program that could be reinstated. There was a small group of respondents who felt that compulsory diversion to treatment was an appropriate response. Others discussed the importance of choice and engagement in treatment as predicting positive treatment outcomes. Improving awareness of diversion programs across the community was also recommended to improve referral and uptake. Regular monitoring and evaluation to identify whether programs are working effectively was also suggested.

Ensuring the consistent application of diversion programs in different regions and populations was also raised as an important issue. Improving police knowledge of and referral to these programs, training to prevent discriminatory practices and unconscious bias and the removal of police discretionary powers for diversion were key issues raised. Respondents wanted to see clear guidance for police on the use of discretion and consistent responses to minor drug offences, with a large group suggesting that police should instead focus on drug supply

offences. Removing limits on the number of times someone can be referred to a diversion program was also suggested, with discussion around the chronic and relapsing nature of drug dependence and that some people need several opportunities to achieve their desired treatment outcomes.

Improving the EDDI program was raised numerous times, with suggestions including expanding the eligibility criteria to allow people with previous drug charges, multiple offences, multiple drug types or greater quantities of drugs to be eligible. Removing police discretion for diversion to EDDI was also raised, with a number of responses describing the need for equitable responses for all population groups. Some respondents noted that particular suburbs, drug types, demographic groups, Aboriginal people and other groups were currently less likely to be offered the EDDI program.

Respondents suggested changes to the *Drug Misuse and Trafficking Act 1985* (NSW) (DMTA) thresholds for personal use to reflect drug use patterns in the community, specifically, that the allowable amounts considered personal use amounts should be increased. The current thresholds are seen to be too low, particularly for those using drugs regularly. Other changes to the DMTA were suggested, including removing the deemed supply provisions which assume that someone with a quantity of drugs considered a supply amount are assumed to be a supplier. Respondents argued that the onus of proof should be reversed, that the courts/police should have to prove a supply intent or offence. These changes would enable greater numbers to be eligible for diversion programs.

Quotes

“NSW can also enhance community safety by implementing diversion programs, which redirect individuals caught with small amounts of drugs into health services rather than the legal system. These programs have been effective in reducing recidivism and supporting recovery by addressing underlying issues related to substance use. In the ACT, the “Simple Cannabis Offence Notice” scheme exemplifies a balanced approach, where fines and educational interventions replace criminal charges for minor cannabis-related offences. Expanding similar initiatives across NSW could improve public safety while supporting rehabilitation over punishment.”

Male, 45-54 years, CALD, lived experience of disability, homelessness and drug use, metropolitan.

“I’ll use my own experiences on this one I’ve been charged with deem supply of drugs three times since 2006 & the amount of drugs involved in the three times adds up to 31.5 grams which is valued at less than ten thousand dollars & for that I’ve done six & a half years jail which has cost the NSW government \$910,000 so the NSW tax payer is really getting value for their money. The government spent nearly a million dollars to keep me in jail & as soon as I’m locked up there will be at least six people to take my place in the drug world I’ll be the first person to put my hand up saying that I’ve a drug problem not a crime problem I’ve been using drugs for nearly fifty years now and the only way I’ll stop is to die & because I’m not stupid & buy large amounts of drugs at the same time the law works against me because the law is if I’ve got three or more grams it’s an automatic deem supply charge but that doesn’t mean that I was supplying the drugs to anyone it just means that the police deem the amount to be supplyable & about the only way to beat the charge is to say that it was just for personal use which is basically impossible to prove in court. Locking me up for so long doesn’t make the community any safer as the only person who is in danger from my actions is me plus jail isn’t the answer as most jails are flooded with drugs and it’s easier to get drugs in jail than outside of jail.”

Male, 65-74 years, Lived experience of disability, homelessness and drug use, metropolitan.

“We all know the response is different depending on who is involved. A white person with some cannabis is more likely to be ignored, than a person of colour. The law isn’t fair when the police can look the other way, whenever they chose.”

Male, 35-44 years, Lived experience of disability and drug use

“We know that people use illicit substances and we know that it is very prevalent across all demographics. I think further decriminalisation of small quantities for personal use but mandatory drug counselling sessions would assist in decreasing the stigma around accessed drug and alcohol services and would open more people up to accepting help without legal restrictions.”

Male, 25-34 years,

“What we need is more options for our courts to be able to sentence these people in a way that is not going to give them the opportunity to grow themselves as a criminal, but to sentence them in circumstances that are the complete opposite of that. Rehabilitation is one option. Either full time residential or full time day programs, as just two examples. Give the department of justice more resources to be able to supervise offenders in the community with intensive programs as an alternative to prison. From someone that has completed a community corrections order where I was supervised by NSW corrections for a period of 12 months and then another 12 months for a similar crime, I actually derived so much support from that supervision that I credit the officer who supervised me to saving my life in terms of providing the support I needed to cease using heroin.”

Female, 35-44 years, Lived experience of homelessness and drug use, regional.

“Appropriate use of diversionary sentencing is key. Also, the process of being charged criminally, then moved to mental health/medical based sentencing is extremely slow. As such, if mental health support and requirements can be implemented earlier in the process (before final sentencing), offenders can productively work towards sentence reduction and improve problematic behaviours at a time when they often feel the most unmoored and are at a heightened risk of further backsliding.”

Male, 35-44 years, CALD, lived experience of homelessness and drug use.

“People with early stage drug issues that end up in trouble with the law, should first and foremost be given the option of a rehab centre, the drug court, the CDTCC or other form of drug support. Early intervention to drug use is key rather than the courts/cops jumping on locking people up for drug possession, theft to pay for drugs etc. if the justice system actually helped people get to and stay on the path of health, work, education etc them and the community have a better chance.”

Female, 25-34 years, Metropolitan, lived experience of drug use.

“EDDI, MERIT and Drug Court programs are helpful, however they are ad hoc and the pervading stigma associated with illicit drug use will always ensure that people take ever greater risks to their health. AOD use issues require a health response and police officers are points of contact to refer people into services. Punitive responses will always engender mistrust and lessen the likelihood that people will voluntarily address their AOD use through treatment.”

Female, 25-34 years, region not disclosed.

“Other diversionary programs such as the Early Drug Diversion Initiative provide important opportunities to divert people from the justice system and connect them with appropriate health support. Further reforms should be made to the scheme to ensure the criteria for participation are not unnecessarily restrictive. Any reforms should ensure diversionary efforts do not lead to individuals being moved into treatment settings which are more intensive than appropriate for their circumstances, as this risks diverting resources from those who may need treatment.”

AOD Service representative

“Current drug laws are not fair, not proportionate and not effective. There is discretion available to police but it is not being used fairly and is too restrictive and punitive. Let’s remove the discretion and make the law easy and transparent. Decrim personal amounts. Confiscate them. No fine. Offer treatment if required. Most people who use drugs don’t need treatment but some people will. Fund it from the law enforcement budget.”

Justice reform

Decriminalisation of drugs for personal use and possession was one of the most raised topics, with many people supporting decriminalisation of all drugs or at least some specific drugs (commonly cannabis, psychedelics and MDMA). Many of those who supported decriminalisation also mentioned implementing health interventions for people who are caught with substances. Several models were provided as examples including the approach in Portugal and in the ACT. Some respondents argued for no policing response to drug use and possession, while others argued for diversion models, where people caught with drugs are diverted into appropriate health

treatment. There were many responses that discussed the impact that the criminal justice system has on people's lives and how contact with it could be reduced with decriminalisation. Some responses also discussed how decriminalisation would benefit marginalised groups of people who are disproportionately impacted by drug laws and law enforcement.

There was discussion around how decriminalisation may also save money from the law enforcement budget and free up police to address other more serious crimes. Some respondents also noted that police could spend more time going after drug suppliers and criminal groups if personal use was decriminalised. Responses also discussed how decriminalisation would help to reduce stigma and discrimination and may help people to seek help earlier, as fear of law enforcement and punishment is a common barrier to help seeking. Decriminalisation was seen as a key step in treating drug use and dependence as a health issues. There was a small number of respondents who argued specifically against decriminalisation based on the harms drugs can cause, some mentioning mental health problems and experiences of open public use in parts of the United States.

There were also numerous responses supporting a legalisation model, where some or all drugs were made legal and could be sold through legal and regulated avenues. Responses discussed how this would reduce harm through the improvement in quality and consistency of substances and through getting rid of the black market and associated criminal activities. Suggestions included medical models where people are provided with scripts for substances, free market models for certain drugs (for e.g. cannabis in the USA). Some respondents drew attention to the fact that alcohol is legal and causes more harms to society than illegal drugs. Many of these responses talked about other potential benefits including tax income, reducing the burden on police and the criminal justice system. There were also a small number of calls for home cultivation of cannabis plants to be allowed, with responses discussing the high costs associated with medicinal cannabis and home cultivation seen as a way to reduce these costs. There were a small number of responses arguing against any legalisation of drugs.

Reforming the justice system was raised by several respondents, with many responses arguing for a stronger focus on rehabilitation and diversion, rather than criminalising people. Consistency of policing and sentencing was raised, with discussion around disproportionate policing of some groups and different sentencing depending on the judge or the person being sentenced.

Quotes

“Furthermore, as many drug-related issues are brought before Magistrates who tend to make decisions that another Magistrate may not make based on their discretionary powers, there is an arbitrariness about the implementation of the law.”

Male, 55-64 years, LGBTQIA+, lived experience of drug use, regional/rural.

“Locking up drug users is contrary to the evidence of what is going to solve problems and keep people safe. It just creates more drug users. The response should be evidence based, and I understand that it is currently at the mercy of law and order politicians that are pandering to populism and not following the evidence about what works and what does not. There should be properly funded drug programs in jail and support for people when they come out of jail. It costs money, but in the long term it will save money. There should be diversionary programs. Addressing inequality is also a critical measure.”

Female, 65-74 years, metropolitan

“Place more focus on restorative and transformative justice approaches, and less focus on punitive justice.”

Female, 25-34 years, LGBTQIA+, CALD, metropolitan.

“Most of the harms of drugs are because of the failed war on drugs, which allows unregulated substances of unknown composition, with no supplied list of ingredients and no dosage advice, to be marketed by criminals. There would be far less danger to health if the supply of drugs was legal and regulated. Legalising cannabis, the safest drug of all, would be an easy way to start this process.”

Male, 65-74 years, lived experience of drug use

“Children should not be criminalised. Children should be educated or hospitalised if using drugs excessively. There are children using drugs and it’s because they live in poverty. Yes children live in poverty in Sydney and get involved in drugs. Raise the incomes of children who work at places like McDonald’s to adult rates for same work. A better quality life means children can afford to do fun things. Fun things cost money. Doing drugs is cheaper.”

Female, 18-24 years, lived experience of drug use, metropolitan

“The decriminalisation of drugs would benefit all marginalised peoples. We see that indigenous (and certain minority communities) are disproportionately indicted and punished for all offences due in part to over-policing, in particular with drug related charges. There is nothing inherently immoral about struggling with substance abuse, and thusly it is immoral to confiscate peoples’ freedom on account of substance abuse. The legal status of marijuana is particularly egregious, given that far fewer people die from its use compared to other legal drugs, namely alcohol and tobacco. It is not by any means without its harm risks, but criminalising its recreational use only serves to disadvantage disproportionately policed communities.”

Female, 18-24 years, LGBTQIA+, CALD, lived experience of disability and drug use, metropolitan

“Putting people in prison for using drugs doesn’t help anyone. Having a criminal record for something like personal drug use can ruin someone’s life, as having a criminal charge is a barrier to accessing housing and employment. If you have limited opportunities, what reason would you have to stop using drugs? Personal drug use should not be a crime, if NSW is serious about harm reduction, the personal use of drugs must be decriminalised and the money spent on keeping people with minor drug offences in prison should be reinvested into rehabilitation programs and counselling services.”

Female, 25-34 years, LGBTQIA+, CALD, lived experiences of disability and drug use, Metropolitan.

“Decriminalise everything and adopt a harm reduction methodology. Treat it like alcohol, if you can behave while intoxicated then you are not a target for prosecution. Many narcotics are far less prone to triggering antisocial behaviours than alcohol, and I would expect to see a reduction in domestic violence as people switch to alternatives.”

Male, 35-44 years, lived experience of drug use, metropolitan

“Decriminalise personal drug use. Law enforcement resources are wasted policing personal drug use, and it often escalates a problem by having casual drug users exposed to the criminal justice system.”

Non-binary, 25-34 years, LGBTQIA+, lived experience of disability, metropolitan.

Drug detection dogs

There was considerable support for ceasing the use of drug detection dogs (“sniffer dogs”) at music festivals, on trains and in public spaces. Very few suggested increasing the use of sniffer dogs. Some suggested that the only acceptable place for the use of dogs was in airports for border patrol purposes. Many respondents indicated that the use of sniffer dogs created fear in the community and encouraged unsafe drug use practices among young people. Several raised concerns about the increased risk of drug overdose due to music festival attendees taking all their drugs at once prior to the festival or on seeing the police and detection dogs. Increased overdose risk was also mentioned in relation to the practice of storing drugs in body cavities to avoid detection. Some suggested that the use of sniffer dogs was the opposite of harm reduction, with many indicating it increases harms.

Several respondents indicated that the use of sniffer dogs is detrimental to the relationship police have with the public. It was emphasised that if young people are fearful and suspicious of the police, they will be unlikely to seek help from them when they need it.

Many respondents cited the low accuracy of sniffer dog drug detection and questioned the evidence on which their use is based. Several suggested police resources could be used more effectively in targeting distributors rather than substance users.

Quotes

"The draconian and outdated campaign by the NSW Police in their use of Sniffer Dogs and Strip Searches at Festivals and Concerts needs to be reformed. How is it that they continue to operate against the advice of the Coroner's report where they are proven to successfully detect illicit substances only 25% of the time. It is punishing recreational use as opposed to targeting supply, and it is having a disproportionate effect on youth demographics. Additionally, as per the Coroner's report, it actually promotes high-risk consumption of substances as our youth aim to avoid these sniffer dogs."

Male, 18-24 yrs, metropolitan.

"A big one - stop having half the police force and sniffer dogs swarming every music festival. It's dangerous and I personally ingested 0.7g of MDMA years back to avoid being detected when entering the event at Moore Park. I was vet close to collapse from overheating and the intensity of it caused me to sweat profusely for hours, I felt like I was boiling from the inside and about to combust."

Male 35-44, metropolitan.

"Stop using sniffer dogs and strip searches at festivals, train stations, etc. The harm caused by these invasive methods is much greater than the harm caused by drug use at these places. You are making vulnerable people more distrustful of the police and less likely to seek help."

Female 35-44, metropolitan.

"Stop public use of police sniffer dogs to detect personal use of drugs: it is demeaning, inefficient, inaccurate and net harmful. It is also discriminatory in practice."

Male 55-64, metropolitan, disability.

"The enforcement of drug laws, particularly the use of sniffer dogs, has been shown by a number of reviews to be expensive and ineffective."

Male 65-74, metropolitan.

"Drug checking at festivals without a drug-sniffing dog presence is important. People see police and police dogs, down their drugs all at once to avoid getting caught, and then they overdose. Implement a drug diversion program. Be helpful not intimidating and scary."

Female, 35-45.

"Availability of drug testing facilities on-site at music festivals, avoiding the use of drug detection dogs, and abolishing unwarranted police searches. These are proven life-saving measures backed up by scientific evidence. Instating such measures saves lives. Refusing to do so costs lives."

Male 35-44, LGBTQIA+, regional.

Strip searching

There was strong support for the cessation of strip searches by police. Respondents indicated that the fear of being searched encourages young people to engage in greater risk-taking behaviour (e.g. ingesting substances to avoid detection) and increases the risk of harm such as overdose. Many respondents considered public strip searches to be a violation of human rights and were particularly concerned that minors were being subjected to these searches.

Several respondents expressed concern that police strip searches were not equitable, unfairly targeted vulnerable members of society (e.g. young people, Aboriginal people, those on public rather than private transport) and caused harm rather than preventing it. Some respondents described police strip searches as unlawful, and cited evidence in an Inquiry into NSW Police Force strip search practices by the Law Enforcement Conduct Commission. The use of drug detection dogs, strip searches were considered by many to damage the relationship police have with the community.

Quotes

"You can't forcibly remove our clothes in public and then claim to encourage healthy behaviours. For example, just last week I spoke to someone who was concerned because they had just taken 4 MDMA capsules in one go in order to avoid being strip searched, and they immediately sought medical attention."

Male, 25-34, LGBTQIA+, metropolitan

"crack down on police strip searching adults and children, leading to intense psychological harm."

Female 35-44, Disability, LGBTQIA+, LLE. metropolitan.

"Stop strip searching minors and provide more drug testing and support not policing."

Male 55-64, Disability, LLE, metropolitan

"ban strip searching which is a violation of human rights."

Female, 55-64, CALD, metropolitan.

"There is PLENTY of evidence in Inquiry into NSW Police Force strip search practices by the Law Enforcement Conduct Commission that outlines that police officers consistently abuse their powers. The follow-up report in 2023 reported that they did not follow their own policies, with many officers not completing the festival modules before being on duty at a festival. In this space, police need to be held accountable in order to have a fair, proportionate and effective response to drug users. Youth should not have to undergo traumatic searches. Additionally, there should be stricter regulations on who should and when can someone be searched as minorities have a higher rate of being searched."

Female, age unknown, CALD, metropolitan.

"Get rid of strip searches! These are disproportionately used on young people and negatively impacts how they engage with authorities now and in the future."

Female 35-44, homelessness, metropolitan.

"Avoid strip searches at events, which can lead to risky behaviours like consuming all substances at once".

Male, 25-34, metropolitan.

"Sniffer dogs and strip searching, a practice that goes hand-in-hand and abuses the most vulnerable in society (children - over 1,000 have been strip searched & as young as 10). It's an unconscionable act and it NEEDS to go."

Male, 25-34, metropolitan

Education

There was strong support for increased education and training for professionals including police. Suggested topics for police education and training included harm reduction, trauma informed care, cultural sensitivity, the social determinants of drug use, treatment referral options and pathways, self-awareness of biases and the impact and prevention of stigma and discrimination.

Quotes

"Equip police officers with training on trauma-informed care, de-escalation techniques, and cultural sensitivity. This helps ensure people seeking help feel safe, understood, and respected rather than criminalised."

Female, 25-34, Disability, homelessness, LGBTQIA+, IND, metro

"Increase training amongst law enforcement in social determinants of health including trauma, working with people with a disability and working with First Nations people."

Female, 25-34, Disability, metro

"Mental health and substance use trainings to be mandatory for law enforcement workers."

Male, 35-44, CALD, metropolitan

"Train law enforcement on drug use as an illness and a disease. Being arrested or treated as less than for having an addiction is disgraceful."

Female, 45-54.

"I think law enforcement being adequately trained and appropriately responsive to drug affected people could go a long way to how a person responds to the offer of treatment. When someone feels marginalised or criminalised by their drug use they will shy away from treatment."

Female, 55-64.

"education for all law enforcement regarding trauma, substance use, known factors and influences into use - destigmatisation of drug use; - education around drug use, how to work with those affected by substances during crisis etc."

Male, 18-24, disability, LGBTQI+, regional.

"Opportunities for education to be provided to Law Enforcement by Service providers so they have a better understanding of what Services offer as well as the limitations."

Drug supply response

Many respondents were supportive of a stronger response to drug supply, with a greater focus on organised crime and stronger penalties for drug dealers. Some raised concerns that the sentences for drug supply were not harsh enough, and that known drug dealers in the community did not appear to get arrested. Comments in support of a stronger response to drug supply ranged from harsher penalties for 'top end dealers' to zero tolerance for any use or supply.

Many respondents requested less focus on supply reduction and more on harm reduction. They questioned the evidence base for measures seeking to disrupt and reduce the drug supply, while highlighting the evidence for harm reduction measures. As outlined previously, there was also a strong call for the legalisation of some, if not all drugs, with many suggesting that government regulation would effectively remove the drug supply from the hands of organised criminals and enable drug use to be treated as a health issue rather than a legal one.

Quotes

"Focus on the organised crime aspects of drug supply. Drug use is a health issue and should be addressed as such."

Male, 65-74, LGBTQIA+, rural/regional.

"Going after manufacturers of drugs and not users. Stop punishing the lowest rung."

Female, 25-34, metropolitan.

"Eradicate the source of supply, better border controls, harsher penalties for suppliers."

Sex (prefer not to say), 55-64, metropolitan.

"Stop allowing drug dealers to make plea deals to get out of convictions."

Female, 35-44, homelessness, rural/regional.

"Going after manufacturers of drugs and not users. Stop punishing the lowest rung."

Female, 25-34, metropolitan.

"Focus on combatting the top end dealers who are preying on the users."

Male, 55-64.

“My concern is that Policing in NSW is under resourced and this is demonstrated in my Community where only a few Police Officers are on Duty at any time. We have drug distributors who are known to many but it appears none of the drug distributors have been arrested and juvenile crimes are on the upward trend.”

Male, 65-74, rural/regional.

“Enforce death penalty for drug dealers which cuts off drug supply and subsequently, drug related harms.”

Female, 25-34, disability, homelessness, CALD, metropolitan.

“The only way to control an illegal problem is to make legal and accessible in a controlled manner.”

Female, 45-54, disability, LLE.

“Regulate, disrupt supply, heavy penalties for drug traffickers.”

Female, 65-74, metropolitan.

“focus law enforcement on drug dealing and allow drug users to benefit from a health response.”

Sex: other or no response, age unknown, CALD, rural/regional.

“I am a former NSW Police Officer. I don't believe the strict enforcement that is in place now reduces harm. In fact, the aggressive proactive policing strategies targeting users puts community members at greater risk, by cornering them into a position that encourages overdose when faced with the possibility of arrest.”

Male, 35-44, CALD, metropolitan.

“In Australia, about 2/3 of government expenditure in response to illicit drugs is allocated to measures to disrupt & reduce drug supply. Evidence for the effectiveness of these measures is poor while evidence of their serious adverse consequences is abundant. Substantial health, social & economic gains are available from reducing the emphasis on supply reduction & increasing the emphasis on harm reduction & demand reduction”.

Male, 75+, metropolitan.

Police discretion

Several respondents raised concerns about current police discretionary powers being applied inconsistently, particularly in relation to diversion to treatment, court appearance notices versus on-the-spot fines, and the use of drug detection dogs and strip searches.

Quotes

“I have worked with Aboriginal Communities for 20 years and I have witnessed that Aboriginal people are disproportionately affected by drug law enforcement. Individuals from Aboriginal Communities are much more likely to interact with law enforcement and receive criminal convictions, even for small drug possession charges and this is largely a result of “discretionary” policing.”

Male, 45-54, rural/regional.

“Decrease discretionary policing, remove deemed supply provisions, adjust threshold quantities to reflect drug use patterns, reserve drug detection dogs for major supply, and cease their use around festivals, train stations and other public places where young people congregate (because they increase perceptions of fear/lack of safety, & bring police into disrepute).”

Female, 55-64, metropolitan.

“Decriminalisation of small amounts of drugs for personal use - the application of these laws should not be at the discretion of the police, it should be driven purely by the quantity of the substance, not who the person is or the drug type they have.”

Male, 45-54, metropolitan.

“The NSW government should also genuinely consider the disproportionate harms that First Nations experience. The EDDI police power is not an effective measure in this regard, given the history between the police and First Nations. According to parliamentary evidence, (Questions and Answers No. 273), this power is not being utilised by police over their arrest powers. Drug consumption is a health issue and should be treated as such. Not left in the hands of police discretion.”

Sex: Other/No response, Age unknown, metropolitan.

“It’s also apparent that police apply discretion unfairly, based on statistics released to the media that identify low level drug possession charges by postcode. A white collar professional in a metro area is more likely to receive an on the spot fine, or diversionary opportunity which affords them the luxury of avoiding a court appearance. This is not enforced by police uniformly, as people in regional/rural/Aboriginal communities are much more likely to receive a court notice or be charged with an offence for a similar “crime”.

Sex: Other/No response, 35-44, metropolitan.

“NSW has expanded the cannabis caution scheme to other substances under a three strike police diversion scheme. Focus on further amendments to NSW’s diversion scheme, including the removal of police discretion in applying the policy.”

Female, 45-54, metropolitan.

“Decrim (full, no penalties, no fines), + consideration of reg’d supply. In absence, removal of police discretion - evidence shows discretion is applied unevenly to First Nations, CALD and people living in low SES suburban and regional areas. Diversion or any non-criminal policy setting based on discretion is inequitable.”

Male, 35-44, LGBTQIA+, CALD, metropolitan.

“There should be no discretion for police to apply a non-criminal response if there is any capacity for them to do so.”

Male, 35-44, metropolitan.

“Rescind or clarify discretionary police powers.”

Female, 45-54, rural/regional.ve Your Say

SUBMISSIONS

Over 80 submissions and position papers were received. Most were from organisations and groups, followed by several individual submissions.

These contained a wide variety of information, opinions, evidence and recommendations that are summarised in the following section. The recommendations from all submissions were collated and reviewed by NSW Ministry of Health staff. The top five most raised topics were:

1. Decriminalisation of the personal use and possession of drugs
2. Implementation of fixed and mobile drug checking services
3. Increased funding for alcohol and other drug treatment
4. Establishment of new supervised consumption facilities
5. Delivery of evidence-based education and awareness campaigns.

SUBMISSIONS

1. 360 Edge

The 360 Edge submission emphasises the need for drug policies driven by human rights, health outcomes, and evidence-based approaches. The submission references peer-reviewed research to support advocacy for expanding harm reduction initiatives such as drug checking services, supervised injecting facilities and needle and syringe programs. The submission highlights the importance of significant funding increases for AOD services to address current resourcing constraints, improve equitable access, and support early intervention. It also calls for the decriminalisation of all drugs for personal use to reduce the harms associated with criminal justice involvement and promote a public health approach. Additionally, the submission recommends better integration of AOD services with other social and health services through a whole-of-government strategy.

Recommendations

- Drive all drug-related initiatives by human rights principles, a health outcomes focus, and evidence-based approaches.
- Expand harm reduction initiatives, including drug checking services, supervised injecting facilities and needle and syringe programs.
- Significantly increase funding for alcohol and other drug (AOD) services to address resourcing constraints and improve equitable access.
- Implement investment mapping, demand analysis, and evaluation to guide funding and ensure effective use of resources.
- Make police diversion schemes mandatory to eliminate police discretion and ensure fair application.
- Decriminalise all drugs for personal use to reduce harms associated with criminal justice involvement and promote a public health approach.
- Implement fixed site and mobile drug education and checking services to keep young people safe.
- Expand early intervention and treatment services, particularly for women with children and those with a history of trauma.

2. Australian Health Promotion Association (NSW/ACT Branch)

The Australian Health Promotion Association, led by Vice President Gabi Martinez, has submitted a proposal emphasising the importance of health promotion in New South Wales. They advocate for banning alcohol advertising, increasing funding for Community Drug Action Teams and implementing the PreVenture program in public high schools. They also recommend decriminalising drugs for personal use, establishing drug checking services, expanding supervised injecting facilities, and adopting a Health in All Policies approach to address the broader determinants of health. These measures aim to create a healthier, more resilient society through prevention, early intervention, and harm reduction.

Recommendations

- Ban alcohol advertising, including on government property and at sporting events.
- Increase funding for Community Drug Action Teams (CDATs) from \$7,000 to \$70,000 per team.
- Implement the PreVenture program consistently in NSW public high schools with adequate funding.
- Decriminalise drugs for personal use and shift focus to treatment and prevention.
- Establish fixed-site and mobile drug checking services to prevent overdoses.
- Expand the number of supervised injecting facilities across NSW.
- Adopt a health in all policies (HiAP) approach to address broader health determinants.

3. Australian Natural Therapeutics Group

The Australian Natural Therapeutics Group (ANTG) submission emphasised their commitment to producing high-quality medicinal cannabis. They highlighted their state-of-the-art facilities in Armidale, NSW, certified under industry standards, and their focus on research and development, including clinical trials. ANTG advocates for policy reforms to improve access to medicinal cannabis, reduce stigma, and promote social equity, particularly for marginalised communities. They stress the importance of evidence-based medicine, regulatory compliance, and public education to enhance patient outcomes and support a healthier, more equitable society.

Recommendations

- Health promotion:
 - Promote evidence-based medicine and clinical research for medicinal cannabis.
 - Educate the public and healthcare providers on the therapeutic potential of medicinal cannabis.
 - Reduce stigma associated with medicinal cannabis use.
- Policy reform:
 - Simplify the regulatory framework for medicinal cannabis to reduce high costs and complex licensing procedures.
 - Prioritise harm reduction and social equity in cannabis policies.
 - Ensure marginalised groups have access to the benefits of medicinal cannabis.
- Support for young people:
 - Provide accurate information and education about the effects and risks of cannabis use.
 - Ensure availability of integrated support, social services, and treatment for individuals experiencing cannabis-related health issues.

- Support data collection and research to inform evidence-based policy adjustments.
- Track long-term outcomes of medicinal cannabis regulation.
- Continue ongoing research, public education, and stakeholder engagement to support regulatory changes.
- Collaborate with the government, industry stakeholders, and the community to remove barriers to access and reduce stigma.
- Ensure medicinal cannabis is an integral part of the health and wellbeing landscape in Australia.

4. Association of Children's Welfare Agencies

The submission by the Association of Children's Welfare Agencies (ACWA) emphasises the need for an integrated, family-focused approach to address parental drug misuse and its impact on children. ACWA highlights the significant challenges faced by children and families due to parental drug misuse, advocating for coordinated support services that include prenatal care, mental health, and domestic violence services. The submission calls for non-stigmatising, non-punitive support for parents, tailored responses for methamphetamine use, and increased collaboration between services to improve outcomes for families.

Recommendations

- Coordinated support options for pregnant women and mothers experiencing drug misuse, including access to prenatal care, childcare, domestic and family violence and mental health services.
- Increased recognition at the policy level of the needs of children and other family members in relation to drug misuse, including appropriate funding models and expanded minimum data sets.
- Early access to non-stigmatising, non-punitive supports for parents, to keep families together and reduce negative impacts on children.
- Strengthened child and family sensitive practice across all services supporting parents who experience problematic drug use.
- Tailored, non-judgemental responses to parents using methamphetamines, from screening and assessment through to harm reduction and treatment interventions.
- Adapting the service system to better enable practitioners to provide individualised support that recognises the central importance of family and community relationships.
- Tailored support for relative and kinship carers who are raising children due to parental drug misuse.
- Increased service collaboration and integration to ensure that parents receive support to address the multiple challenges that frequently occur alongside drug misuse.
- Greater access to learning and development opportunities across the AOD, child protection, mental health and domestic and family violence sectors, to increase understanding and awareness of child and family needs in the context of parental drug misuse.

5. Alcohol, Tobacco and Other Drug Association

The Alcohol, Tobacco and Other Drug Association (ATODA) highlights the need for increased funding and resources to meet the growing demand and complexity of alcohol, tobacco, and other drug (ATOD) treatment services. They emphasise the effectiveness of harm reduction measures, such as drug checking and supervised consumption rooms, and advocate for decriminalisation and evidence-based policy reforms. ATODA also underscores the importance of cross-sector collaboration, particularly with mental health, housing, and the criminal justice sectors, to address the co-occurring needs of service users. The submission calls for a national governance structure and better resourcing to ensure high-quality, person-centred care and improved health outcomes. The submission includes recommendations for the ACT Government.

Recommendations

- Increase funding and resources to match the growing demand and complexity of ATOD treatment services.
- Establish a national governance structure for the ATOD sector.
- Support cross-sector collaboration, particularly with mental health, housing, and criminal justice sectors.
- Implement decriminalisation of personal possession of small quantities of illicit drugs.
- Expand drug checking services across states and territories.
- Develop a national framework to address the role of the alcohol industry in health policy, like the World Health Organization Framework Convention on Tobacco Control.
- Strengthen regulation of alcohol marketing and the online sale and delivery of alcohol.
- Improve access to ATOD programs for culturally and linguistically diverse (CALD) communities.
- Enhance workforce development through funding for training, clinical supervision, and education opportunities.
- Support ongoing research, public education, and stakeholder engagement to inform evidence-based policy adjustments.

6. Australian Alcohol and Other Drugs Council

The Australian Alcohol and other Drugs Council (AADC) submission emphasises the need for a national, coordinated approach to address alcohol and other drug (AOD) issues. Key recommendations include enhancing prevention and early intervention efforts, addressing AOD-related stigma, reforming the legal framework to prioritise health outcomes over criminalisation, and establishing a national governance structure to support cross-sector collaboration. The AADC also highlights the importance of adequate funding for AOD services, and calls for the implementation of evidence-based, high-quality treatment standards to ensure better health and social outcomes for individuals and communities.

Recommendations

- Prevention and early intervention actions be strengthened through prioritisation of support in the early stages of life and provision of enhanced family support to avoid engagement in child protection systems. This should include community-led prevention and early intervention programs that utilise community development with a particular focus on First Nations peoples and communities.
- AOD and intersecting sectors should be resourced to build cross-sector capabilities and local partnerships to enhance support for people with multiple needs.
- The NSW Government develop a plan for reducing AOD-related stigma and discrimination.
- Undertake reform to the legal environment which prioritises health and wellbeing outcomes, including the exploration of models for the decriminalisation of illicit drug possession for personal use.
- The NSW Government review its funding response to AOD with the aim of creating more balance across the pillars of demand, harm and supply reduction, and fund the AOD treatment and harm reduction sectors at a level commensurate with need.
- The NSW Government support and advocate to the Australian Government for the establishment of a sector-inclusive national governance structure for the AOD sector.
- The national governance framework should be designed to have the capacity to engage with and address social determinants of health that drive AOD-related harms by facilitating engagement and coordination with related sectors such as mental health, disability and the NDIS, First Nations health and wellbeing, housing and criminal justice.

- Through the creation of a national governance framework, the NSW Government contribute to an increase in the quantum of core funding to the AOD sector to deliver enhanced capacity to meet current demand/ need for specialist, quality services. This should include sensitivity to the costs of service delivery in regional, rural and remote areas.
- Acknowledging the complexity of intersecting issues faced by people presenting to AOD treatment services, particular consideration be given to how services are funded to meet the needs of priority populations.
- The NSW Government also note the recommendations in relation to increasing access to specialist AOD services in NADA's briefing paper to the NSW Drug Summit.

7. Australian Multicultural Action Network

The Australian Multicultural Action Network (AMAN) supports the NSW Drug Summit and emphasises the need for culturally responsive drug support services tailored to culturally and linguistically diverse (CALD) communities. Key recommendations include developing culturally tailored services with bilingual staff, engaging community leaders, implementing multilingual education campaigns, focusing on youth initiatives, integrating support services, collecting data on drug use in CALD communities, and advocating for policy changes to promote equity in access to drug treatment and recovery services. AMAN stresses the importance of including CALD voices in drug policy discussions to create effective and inclusive strategies.

Recommendations

- Develop culturally responsive services: Fund drug support services tailored to CALD (culturally and linguistically diverse) communities. Employ bilingual staff and provide translation services.
- Engage community leaders and grassroots organizations: Include individuals with lived and living experiences from CALD backgrounds.
- Implement education and awareness campaigns: Conduct health promotion campaigns in multiple languages and address stigma associated with drug use within CALD communities.
- Focus on youth initiatives: Empower youth in CALD communities. Promote resilience, offer safe spaces for discussion, and provide education about drugs and their effects.
- Establish integrated support services: Connect health, social services, and community support to provide comprehensive care.
- Invest in data collection and research: Examine the impact of drug use within CALD communities to tailor interventions and inform future strategies.
- Advocate for policy change: Address systemic barriers affecting CALD communities. Promote equity in access to drug treatment and recovery services.

8. Australian Psychedelic Society

The Australian Psychedelic Society's submission advocates for the decriminalisation of psychoactive substances, arguing that criminal penalties hinder health promotion and harm reduction efforts. The submission highlights the success of decriminalisation in Portugal and the ACT and calls for a comprehensive approach to drug law reform that includes legalisation and safe supply. The Society outlines specific recommendations to optimise the benefits of decriminalisation and reduce harm, emphasising the need for evidence-based harm reduction education, drug-checking services, and safe consumption locations.

Recommendations

- Decriminalise possession or cultivation of any psychoactive substances for personal use.
- Decriminalise the use of illicit substances.
- Avoid using threshold weight limits to determine personal use; require evidence of supply or trafficking for criminal charges.
- If threshold quantities are used, set them high enough to allow reasonable personal use and consult with people familiar with each substance.
- Prevent police from charging individuals within threshold limits to reduce discrimination.
- Avoid using fines for personal possession, use, or cultivation.
- Do not consider suspicion of possession or use as grounds for police questioning or searches.
- Do not confiscate substances deemed for personal use.
- Make referrals to education or treatment programs voluntary.
- Ensure easy and affordable access to assistance for substance use management.
- Allow non-commercial sharing or trading of substances within personal possession limits.
- Expunge past convictions for possession under personal possession thresholds.
- Do not exclude individuals with criminal histories or those on bail from decriminalisation benefits.
- Weigh each substance separately and avoid multiple penalties for possession of different substances within limits.
- Avoid “three strikes” systems for possession offences.
- Fund and distribute evidence-based harm reduction education.
- Provide publicly funded drug-checking services at fixed and mobile sites.
- Expand publicly funded safe consumption locations with medical oversight.
- Decriminalise the supply and possession of drug administration implements.
- Allow the use of premises for substance consumption without profit.

9. Cancer Council NSW

The Cancer Council NSW’s submission emphasises the significant cancer risks associated with alcohol consumption and calls for its inclusion in the summit’s discussions. The submission highlights the lack of awareness about the link between alcohol and cancer among the NSW population and advocates for a comprehensive, statewide drug and alcohol strategy. It recommends public education campaigns, policy interventions to reduce alcohol availability and accessibility, and support for national policies to prevent alcohol harms. The submission stresses the importance of creating environments that support reduced alcohol consumption to improve community health and safety.

Recommendations

- Develop and release a comprehensive NSW-wide drug and alcohol strategy with clear, measurable aims and targets.
- Fund and launch a public education campaign to increase awareness of the Australian alcohol guidelines.
- Implement the World Health Organization’s ‘best buys’ policy interventions, specifically:
 - Introduce restrictions on alcohol marketing and advertising on state government-controlled assets.
 - Regulate the availability and accessibility of alcohol, including reduced hours of sale and outlet densities.
 - Investigate minimum unit pricing for alcohol.
 - Increase transparency by regularly publishing alcohol sales data for NSW.

10. City of Sydney

The City of Sydney's submission advocates for a harm reduction approach to drug use, focusing on health promotion, equity, and safety. The submission highlights the need for public health campaigns, drug checking services, and continued support for the Medically Supervised Injecting Centre. It also calls for comprehensive harm reduction training for NSW Police and the discontinuation of drug detection dogs at events. The City of Sydney emphasises the importance of integrated support services and collaboration with local health districts to ensure safe disposal of sharps and reduce public health risks.

Recommendations

- Develop public health and educational campaigns promoting harm reduction over abstinence.
- Establish a permanent fixed-site, community-based drug checking service in the City of Sydney and publish annual reports.
- Establish drug checking services at major festivals and events in NSW and publish annual reports.
- Continue NSW Government support for the Medically Supervised Injecting Centre and expand this service to other areas impacted by injecting drug use.
- Collaborate with NSW Councils and local health districts on community sharps programs to ensure safe disposal and reduce public health risks.
- Provide comprehensive harm reduction training for NSW Police officers and consider equipping them with naloxone to respond to opioid overdoses.
- Discontinue the use of drug detection dogs by NSW Police at venues and festivals.
- Implement non-discretionary health diversions for possession of small quantities of illicit drugs, while intensifying efforts against organised drug dealing and public social disorder.

11. Drug and Alcohol Clinical Research and Improvement Network

The Drug and Alcohol Clinical Research and Improvement Network (DACRIN) submission emphasises the need for evidence-based policy and practice to reduce drug harms. DACRIN advocates for targeted educational campaigns, sustainable funding for prevention research, and culturally sensitive treatment programs. The submission highlights the importance of continuous research and evaluation to improve treatment effectiveness and equitable access. DACRIN also calls for drug law reform to prioritise health over punishment and the development of integrated care models to address the complex needs of people with substance use disorders.

Recommendations

- Launch targeted educational campaigns on substance use risks and harm reduction.
- Prioritise research on effective health prevention strategies with continuous evaluation.
- Secure sustainable funding for prevention research and harm-reduction programs.
- Develop and evaluate culturally sensitive treatment programs for underserved communities.
- Identify barriers to treatment for marginalised groups and evaluate inclusiveness and impact.
- Invest in research to identify effective treatments for methamphetamine, cannabis, and cocaine use disorders.
- Secure funding for continuous research and evaluation of treatment programs.
- Use evidence to guide evaluations of drug law reform policies.
- Inform fair policing practices that prioritise health over punishment.
- Advocate for sustained research funding to assess and refine drug policies.
- Implement family-centred interventions to support young people and families.
- Assess the availability and effectiveness of services for individuals with co-occurring mental health and

substance use disorders.

- Promote collaboration among health, social, and community services for integrated care models.
- Advocate for NSW Health to lead in AOD treatment delivery with outcome evaluation.
- Allocate funding to develop and test new integrated care models.

12. Directions Health Services

Directions Health Services' submission advocates for a health-first approach to drug policy, emphasising the need for decriminalisation of drug use and possession for personal use. The submission highlights the limitations of current diversionary initiatives and calls for comprehensive legislative reform, increased funding for community-based treatment and harm reduction programs, and the implementation of pill testing services. Directions Health Services also stresses the importance of integrated and coordinated healthcare responses, particularly in regional areas, to address the complex needs of individuals with co-occurring substance use and mental health issues.

Recommendations

- Decriminalise drug use and possession for personal use.
- Implement pill testing services in NSW.
- Revise drug driving laws to focus on impairment rather than the mere presence of drugs.
- Expand funding for specialist AOD treatment, support, and harm reduction services.
- Invest in integrated primary health, mental health, AOD, and harm reduction services, with additional investment in regional social services.
- Increase access to naloxone and other harm reduction strategies to reduce overdose deaths.
- Implement community education programs to reduce stigma and discrimination against people who use substances.
- Expand Needle and Syringe Programs (NSPs) in regional NSW and streamline approvals.
- Increase the number of general practitioners prescribing opioid replacement therapy.
- Establish more detox and rehabilitation facilities throughout regional NSW.

13. Drug Free Australia

The Drug Free Australia (DFA) submission advocates for a shift from harm reduction policies to a focus on drug prevention and rehabilitation. DFA argues that harm reduction strategies, such as needle and syringe programs, injecting rooms, and drug decriminalisation, have led to increased drug use and related deaths. They highlight the success of drug prevention approaches in Sweden, Iceland, and Australia's "Tough on Drugs" era, which reduced drug use and mortality. DFA recommends prioritising drug prevention messaging, increasing rehabilitation services, and deprioritise harm reduction measures.

Recommendations

- Prioritise drug prevention and rehabilitation:
 - Focus on drug prevention messaging and programming.
 - Vastly increase rehabilitation places.
 - Shift from harm reduction to prevention/rehabilitation:
 - Move from harm reduction policies to a drug prevention/rehab model.
 - Address the increase in drug-related deaths linked to harm reduction policies.

- Analyse successful drug prevention models:
 - Study drug prevention successes in Sweden, Iceland, Australia's Tough on Drugs era, and the US Just Say No approach.
 - Identify elements that can reduce drug use and drug-related deaths in NSW.
 - Avoid implementing interventions that increase drug-related harm and mortality.

14. Fair Treatment Reference Group

The Fair Treatment Reference Group, comprising individuals with lived and living experience of drug use and their families, highlight the negative impacts of criminalisation and stigma on health and wellbeing, the lack of supervised consumption sites, and insufficient harm reduction initiatives. The group calls for decriminalisation of drug possession and use, more youth and homelessness services, better education, and increased funding for treatment services. They also stress the need for trauma-informed care, equity in service provision, and improved support for marginalised groups. Their submission underscores the importance of a coordinated, respectful, and equitable approach to drug policy.

Recommendations

- Decriminalise personal possession and use of drugs.
- Establish needle syringe programs (NSPs) with supervised consumption rooms.
- Implement drug checking services.
- Increase youth and homelessness services.
- Expand harm reduction education in high schools.
- Shift language to reduce stigma against people who use drugs.
- Provide more holistic support for individuals and families.
- Increase funding for treatment services, including medicines and day programs.
- Enhance outreach and clinical services in regional areas.
- Provide first aid training for overdose response, including naloxone use.
- Allow more supervised injecting sites by changing current legislation.
- Ensure trauma-informed services and training.
- Improve equity in service provision, especially for First Nations communities.
- Increase aftercare and support for individuals released from prison.
- Embed lived and living experience workforce in services with formal training opportunities.
- Enhance collaboration between police and the AOD sector.
- Make pharmacotherapy more accessible.
- Abolish the use of drug detection dogs and strip searches.
- Raise the age of criminal responsibility.
- Improve mental health and anti-stigma training for police.
- Develop child-friendly detox and rehabilitation services.
- Establish a whole-of-government AOD strategy with well-allocated funding.

15. Fairfield City Council

Fairfield City Council's submission outlines the outcomes of a series of consultations facilitated by the Fairfield Local Drug Action Team (LDAT). These sessions engaged local community workers, multicultural community leaders, faith leaders, and resident groups to address AOD issues. The consultations highlighted the need for culturally appropriate education, resources, and support for multicultural communities. The submission emphasises the importance of increasing multilingual materials, bilingual support workers, and creating comfortable spaces for AOD discussions. It also calls for more awareness of the risks associated with shisha and vaping, promoting healthy lifestyle choices, and holding AOD information sessions in places of worship or other places of gathering.

Recommendations

- Increase the number of multilingual materials and bilingual support workers.
- Create comfortable spaces for communities to find information and discuss AOD issues.
- Raise awareness of the risks associated with shisha and vaping.
- Promote healthy lifestyle choices within culturally and linguistically diverse (CALD) groups.
- Hold AOD information sessions in places of worship or other community gathering places.
- Improve the cultural relevance of materials to ensure they resonate with individual communities.

16. FAMS

The submission from FAMS to the NSW Drug Summit emphasises the importance of family-centred approaches in addressing AOD issues. It highlights the interconnectedness of child protection, domestic and family violence (DFV), and AOD sectors, and the need for early intervention and comprehensive support for families. The submission calls for culturally safe and inclusive services, particularly for First Nations and culturally and linguistically diverse (CALD) communities. It stresses the need for trauma-informed care, integrated support services, and addressing systemic barriers such as housing insecurity and poverty. FAMS advocates for policies that prioritise family connections and support parents in making positive changes.

Recommendations

- Recognise the early intervention child protection NGO sector as crucial in mitigating AOD impacts.
 - Provide resources for training in health promotion, harm reduction, relapse prevention, and family support strategies.
 - Fund social supports, including peer networks and community-building opportunities.
 - Develop policies and funding streams that prioritise the parent-child relationship in treatment success.
 - Invest in ACCOs to deliver culturally safe and supportive options for First Nations families.
 - Encourage creative and flexible treatment models that accommodate family life.
 - Prioritise investment in culturally responsive supports for CALD families.
 - Address systemic gender and racial biases through comprehensive policy reforms.
 - Develop holistic policies and programs that consider individuals' overall well-being and family connections.
 - Address service access barriers for rural and remote families.
 - Implement trauma-informed, family-centric intervention models.
 - Invest in sector capacity building for DCJ and NGO child protection practitioners.
 - Strengthen assessment skills and capacity in intersecting sectors.
 - Reform the system to tackle social and economic drivers of AOD use.
 - Develop and fund integrated support frameworks, including cross-sector training and case conferencing.
 - Increase coordination and accountability between government and non-government organisations
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17. Hello Sunday Morning

Hello Sunday Morning's submission advocates for a shift towards digital health interventions to address alcohol-related harms. The organisation highlights the effectiveness of their Daybreak app and other digital tools in reducing alcohol consumption and improving mental health. They emphasise the need for preventative measures, such as health promotion campaigns, workplace policies, and expanding alcohol-free social spaces. The submission also calls for integrated support services and equitable access to treatment, particularly for vulnerable populations. Hello Sunday Morning stresses the importance of evidence-based policies and a holistic approach to alcohol-related issues.

Recommendations

- Invest in preventative digital alcohol interventions.
- Develop tailored health promotion campaigns targeting problematic alcohol use.
- Improve awareness of alcohol-related behavioural risks within workplaces.
- Expand alcohol-free social spaces and support sober communities.
- Increase the use of digital health to foster equity and inclusivity.
- Invest in digital technologies to reach priority groups.
- Expand police and drug diversion programs to offer treatment and education.
- Expand community policing with a focus on prevention and harm reduction.
- Ensure consistent application of responsible service of alcohol laws.
- Decriminalise minor alcohol-related offences and replace with health-focused responses.
- Implement alcohol taxes and other price controls.
- Restrict alcohol advertising and marketing, especially to young people.
- Regulate the physical availability of alcohol through restrictions on sales and outlet density.
- Leverage digital technologies to reach young people with alcohol support services.
- Expand evidence-based school education programs on alcohol use.
- Involve family in alcohol and other drug support and treatment.
- Ensure a system-wide approach to reduce alcohol-related harms through integrated support and social services.

18. Illawarra Shoalhaven Community Drug Action Team

Summary

The Wollongong Community Drug Action Team (CDAT) submission advocates for a comprehensive, health-focused approach to drug policy. The submission highlights the need for increased investment in health promotion, community drug action teams, and supervised injecting facilities. It calls for the decriminalisation of drugs for personal use and the implementation of drug checking services. The submission also emphasises the importance of integrating arts and exercise-based therapies in AOD services and adopting a health in all policies (HiAP) approach to address the social determinants of health.

Recommendations

- Invest in health promotion, including implementing the PreVenture program⁴ in all NSW public high schools.
- Increase funding for Community Drug Action Teams to at least \$70,000 per year.
- Ban alcohol advertising, including at sporting events and on NSW government property.

4 Smith J. Guide to fair play. Sydney: Fair Play Australia; 2025. Available from: <https://www.fair-play.org.au/guide>.

- Increase the number of supervised injecting facilities with consideration of Wollongong and Nowra.
- Implement fixed site and mobile drug education and checking services.
- Integrate arts and exercise-based therapies across all NSW Local Health District AOD services.
- Decriminalise drugs for personal use.
- Adopt a HiAP approach to address the social determinants of health.
- Significantly increase AOD funding across the spectrum from health promotion to treatment.

19. Inner City Legal Centre

The Inner City Legal Centre (ICLC) submission to the 2024 NSW Drug Summit highlights the negative impact of drug policing on the LGBTQI+ community, particularly during events like the Sydney Gay and Lesbian Mardi Gras. The submission describes misuse of drug detection dogs, coercive questioning, and unlawful searches, and their impacts, including emotional harm and social exclusion. The ICLC calls for an end to strip searches and police drug operations at LGBTQI+ community events, emphasising the need for a more respectful and inclusive approach to policing and improved training on working with gender diverse people. The submission describes the Fair Play initiative, a partnership project by the ICLC, Mardi Gras and ACON, which aims to share legal and safety information, monitor police operations and provide support to those who are strip searched, charged or arrested at LGBTQI+ community events. The volunteers in this initiative report experiencing hostility and aggression from police. The initiative was ceased due to the level of hostility from police and risk for volunteers.

Recommendations

- Stop strip searches for minor drug possession.
- Training for police on working with gender diverse people
- Significantly scale back or stop drug policing operations at music festivals and other events.
- Withdraw the NSW Police drug operation from the 2025 Mardi Gras After Party and all other LGBTQI+ community events in NSW.

20. The Jumbunna Institute, University of Technology Sydney

The Jumbunna Institute for Indigenous Education and Research at the University of Technology Sydney (UTS) highlights the disproportionate impact of drug criminalisation on Aboriginal communities in their submission to the NSW Drug Summit. They discuss the over policing of Aboriginal people, including stops, searches, arrests, pursuit of legal action, charges and imprisonment, as well as unequal police discretion. The submission emphasises the need to shift from a criminal justice approach to a health and social response, addressing racism and over-policing. They discuss barriers to accessing diversionary schemes for Aboriginal people including a lack of culturally appropriate design and implementation. The submission calls for decriminalisation of drug possession for personal use, harm minimisation strategies, and the inclusion of Aboriginal voices in drug policy reform. The submission also notes the intersection of drug use with child protection systems and the broader social determinants of health.

Recommendations

- Decriminalise drug possession for personal use.
- Increase access to and design of culturally appropriate diversionary schemes.
- Implement changes to police practices to reduce over-policing of Aboriginal people who use drugs.
- Approach drug use as a health and social issue, not a criminal justice problem.
- Focus on harm minimisation and non-coercive measures that do not require cessation of drug use for support.

- Address racism in existing harm reduction approaches and increase access to Aboriginal-designed, led, and delivered harm reduction services.
- Ensure the elevation of Aboriginal community voices in all drug policy reform discussions including the NSW Drug Summit.

21. Justice Reform Initiative

The Justice Reform Initiative's discussion paper, "Drug Use and the Criminal Justice System – Taking Steps Towards a Health-Focused Response," argues that Australia's reliance on criminal law to address drug use is ineffective and costly and exacerbates disadvantage. The paper advocates for a shift to a health-focused approach, highlighting the failure of criminalisation to reduce drug use or address its associated health and social harms and the expense of law enforcement measures. It calls for the removal of criminal penalties for personal drug use and increased investment in health and social services to support those affected by drug dependency. The paper emphasises the need for a comprehensive harm minimisation strategy that addresses the underlying social determinants of drug use.

Recommendations

- Remove criminal penalties and sanctions for the personal use and possession of prohibited drugs. This means amending legislation to remove simple possession and use offences from the criminal law.
- Significantly increase resourcing for a diverse range of effective alcohol and other drug support services, with a focus on the specific support needs of populations who are over-represented in the justice system.
- Ensure culturally appropriate services for First Nations people, including in regional and remote areas.
- Abolish deemed supply provisions and require evidence of actual trafficking for supply charges.
- Redirect resources from the criminal justice system to health and harm reduction programs, and programs that address the social determinants of drug use.
- Implement a comprehensive, integrated, and holistic harm minimisation approach to drug use across all government and community sectors.

22. Legal Aid NSW

The Legal Aid NSW submission advocates for the decriminalisation of drug possession for personal use and emphasises treating drug use as a health issue rather than a criminal one. The note that if the NSW Government continue to rule out decriminalisation, that they recommend Diversion into treatment as a preferred alternative to prosecution. They also recommend expanding harm reduction strategies, such as supervised drug consumption services and substance testing, and increasing access to treatment and residential rehabilitation facilities. The submission also calls for reforms to law enforcement practices, including limiting the use of strip searches and drug detection dogs, and improving support for people exiting custody. Additionally, it highlights the need for culturally appropriate services for Aboriginal people, better mental health support in AOD services, and specific reforms for youth and prisoners to address their unique needs.

Recommendations

- Decriminalise the possession of drugs for personal use.
- Adopt a justice reinvestment approach to support local, community-driven initiatives.
- Expand harm reduction strategies such as substance testing and medically supervised drug consumption facilities.
- Increase access to treatment by investing in specialist alcohol and drug health services.
- Increase the capacity of residential rehabilitation facilities.

- Limit the circumstances in which people are excluded from accessing residential rehabilitation by conducting comprehensive risk assessments.
- Increase the mental health support available at AOD rehabilitation services.
- Recognise and address the broader social needs of people with problematic drug use through a Housing First approach.
- Ensure people retain their social housing while in residential rehabilitation.
- Limit the use of strip searches and drug detection dogs.
- Decriminalise the possession and cultivation of cannabis for personal use.
- Make medicinal cannabis more accessible
- Increase the quantity amounts for psilocin/psilocybin in Schedule 1 of the DMTA.
- Increase the quantity amounts for lysergic acid in Schedule 1 of the DMTA.
- Expand the Drug Court to additional regional locations.
- Expand the Drug Court eligibility criteria and improve the oversight of its decisions.
- Allow NSW Drug Court participants to complete mandatory withdrawal management in the community.
- Repeal or amend section 111 of the *Road Transport Act 2013* (NSW) to create a defence to an offence of driving with illicit drug present if the only drug detected is cannabis and the cannabis is medically prescribed.
- Reform criminal records regarding prohibited drug use/possession by reducing the period before a conviction may be spent from 10 years to two years and in the case of a child or young person, from three years to one year.
- Ensure rehabilitation facilities are culturally appropriate for Aboriginal people including services provided on Country.
- Improve withdrawal support and mental health support for people entering custody.
- Increase and improve AOD services, health care, and supports available for people in and exiting prison.
- Implement a prison-based needle exchange program.
- Increase the number of youth-specific residential rehabilitation and community-based AOD support services.
- Reinstate the NSW Youth Drug and Alcohol Court.
- Create a MERIT style program for young people involved in the criminal justice system.
- Reform the *Young Offenders Act* to allow diversion of all possess prohibited drug offences and certain indictable offences.

23. Multiple organisations - open letter about Police strip searches

The open letter to Premier Minns calls for an end to the strip searching of children and young people under 18 by NSW Police. The letter highlights the traumatic and harmful effects of strip searches, particularly on First Nations people, and argues that drug use should be treated as a health issue rather than a criminal justice issue. It references the 2019 Coronial Inquest into the Death of Six Patrons of NSW Music Festivals, which found that strip searches lead to more dangerous drug use practices.

Recommendations

- Ban the strip searching of children and young people under 18.
- Ensure policing practices comply with child protection principles.
- Treat drug use as a health issue rather than a criminal justice issue.
- Address the disproportionate targeting of First Nations people by police for strip searches.

24. National Centre for Clinical Research on Emerging Drugs

The National Centre for Clinical Research on Emerging Drugs (NCCRED) submission highlights the urgent need for effective treatments for methamphetamine use disorder and emerging substance use disorders, such as those related to GHB. The submission emphasises the importance of prompt detection and response to emerging drugs of concern, including novel opioids (such as nitazenes) and novel benzodiazepines (such as bromazolam). NCCRED advocates for drug law reform to remove criminal penalties for personal use and expand health-first policies like drug courts and diversion programs. The submission also calls for integrated support and social services to address the complex needs of people who use drugs.

Recommendations

- Conduct clinical research into the treatment of methamphetamine use disorder and emerging drugs.
- Develop and translate effective treatments for methamphetamine and GHB use disorders.
- Implement fixed site drug checking linked to laboratory capacity and mobile outreach to festival settings.
- Engage NSW in national information sharing including through the Prompt Response Network.
- Launch evidence-based education campaigns for overdose awareness, particularly related to synthetic opioids.
- Widely distribute naloxone.
- Clinical research needs to be conducted within a health equity framework, including adequate representation and co-design with people with lived or living experience from a range of communities and minority populations
- Reform drug laws to remove criminal penalties for personal use and adopt health-first policies.
- Measure the impacts of drug law reform and health-first policies like drug courts and diversion programs.
- Fund and support family-based interventions for methamphetamine use in pregnancy and young people.
- Develop integrated models of care within the health sector and between health, social, and community services.
- Conduct health systems research to develop and evaluate new integrated models of care and assess gaps for minority and rural populations.
- Workforce development including the development of specialist family worker positions.
- Community based support for families and friends of people affected by drug use
- Peer delivered interventions for young people, including event-based harm reduction services

25. National Drug and Alcohol Research Centre

The National Drug and Alcohol Research Centre (NDARC) at UNSW Sydney's submission to the NSW Drug Summit 2024 highlights the need for investment in developing pharmacotherapies for methamphetamine use disorder, preparing for emerging drugs of concern, and improving opioid agonist treatment services. The submission emphasises expanding harm reduction strategies, such as needle and syringe programs in prisons and take-home naloxone distribution and implementing point-of-care drug checking. It also calls for addressing systemic barriers to equitable access to AOD services, particularly for Aboriginal and Torres Strait Islander people and those in rural areas. NDARC advocates for diversion from the criminal justice system to health responses and enhancing support for people post-prison release.

Recommendations

- Expand needle and syringe exchange programs into prisons.
 - Improve naloxone carriage through targeted education campaigns.
 - Increase access to Medically Supervised Injecting Centres.
 - Implement on-site drug analysis with off-site confirmatory testing.
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- Establish a third pillar of drug monitoring systems (Horizons Scanning).
- Evaluate and upscale opioid agonist treatment medicines.
- Increase the opioid agonist treatment prescriber workforce.
- Promote research on pharmacotherapies for methamphetamine and cannabis use disorders.
- Implement prevention and response training programs for people who use GHB.
- Implement focused initiatives to mitigate harm among specific populations disproportionately affected by AOD use.
- Provide individualised and culturally appropriate care for Aboriginal and Torres Strait Islander people.
- Support sustained access and delivery of AOD treatments in rural and regional areas.
- Implement customised programs for people with complex support needs.
- Adopt a universal precautions approach to stigma in healthcare.
- Diversify diversion programs to reduce inequities and over-representation of Aboriginal people in the criminal justice system.
- Address harms encountered by incarcerated people who use drugs.
- Reconsider the deployment of drug detection dogs.
- Implement evidence-based prevention programs for young people.
- Provide evidence-based treatments for substance use disorders during pregnancy.
- Support family-based therapy programs to reduce child maltreatment.
- Improve engagement and support for people post-prison release.

26. Newtown State Electorate Council

The submission of the Newtown State Electorate Council summarises findings from their distribution of the NSW Drug Summit survey in their local community. The survey, which was distributed at local train stations, over email and through social media for which they received 112 responses (some of which were from across the state).

Recommendations

- Decriminalise drug use and treat personal possession as a health issue.
- Implement pill testing at festivals.
- Establish more safe injecting rooms and needle exchange programs.
- Create clear laws around impairment thresholds for driving.
- Invest in primary prevention programs, particularly mental health support.
- Improve coordination and resourcing of support services, including rehabilitation beds and reducing wait times.
- Enhance public communication and education about available support services.
- Remove stigma around drug use and adopt a harm reduction approach.
- Improve access to, and ensure affordability of addiction services, counselling, and rehabilitation programs.

27. National Roads and Motorists' Association (NRMA)

The NRMA's submission highlights the organisation's concern about the high level of drug-related trauma on NSW roads, noting that drug driving is now the second leading cause of fatalities, surpassing drink driving, fatigue and non-seatbelt use. The NRMA supports the current drug driving laws, including mobile drug testing (MDT) for cannabis, methylamphetamine, MDMA, and cocaine. The submission emphasises the importance of

high visibility policing and education to deter and detect drug drivers. The NRMA advocates for increased police presence on roads, citing a survey where 65% of members believed visible marked police cars were the most effective way to tackle bad driver behaviour.

Recommendations

- Support the current drug driving laws, including Mobile Drug Testing (MDT).
- Increase high visibility policing on roads.
- Pair driver education with enforcement and penalties to deter and detect.

28. NSW Council for Civil Liberties

The NSW Council for Civil Liberties (NSWCCL) submission advocates for the decriminalisation of drug use, emphasizing that criminal penalties for drug possession and use are ineffective, disproportionately harm vulnerable groups, including First Nations people and the LGBTQIA+ community and waste law enforcement time and money. The submission supports the implementation of harm reduction strategies such as pill testing, expanded drug injection facilities, and the removal of punitive measures like drug detection dogs and strip searches. It also calls for the expansion of diversion programs like the Magistrates Early Referral into Treatment (MERIT) and revision of the EDDI eligibility criteria and police discretion. They recommend the adoption of recommendations from the Special Commission of Inquiry into the drug ice. The NSWCCL argues for a shift from a punitive approach to a public health-focused strategy to address drug use and its associated harms. They raise the negative implications that criminalisation has for people who use drugs and have not committed crimes posing harm to society.

Recommendations

- Decriminalise drug use and possession in quantities consistent with personal use.
- Remove prison and large fines as sentencing options for drug use or possession.
- Implement pill and drug testing services.
- Expand drug injection facilities.
- Expand the Magistrates Early Referral into Treatment (MERIT) program.
- Support programs for Indigenous people, such as Circle Sentencing and the Youth Koori Court.
- End the use of drug detection dogs and strip searches at music festivals and other venues.
- End discriminatory and outdated drug driving practices targeting medical cannabis patients.
- Exempt legally prescribed medicinal cannabis patients from prosecution for driving with THC in their system unless there is clear evidence of impairment.
- Redirect resources from policing to rehabilitation and treatment programs.
- Fully implement the recommendations of the Ice Inquiry.
- Focus on priority populations, including Aboriginal people, rural and regional communities, and people in contact with the criminal justice system.
- Address the structural reasons driving drug misuse and dependency, such as social, economic, housing, and education policies.
- Change the way drugs and drug users are discussed to reduce stigma and promote a public health approach.
- Implement a staged approach to reforming cannabis laws, including increasing possession limits, reducing penalties for personal use, and reclassifying non-commercial cannabis sharing as possession rather than supply.
- Limit police search powers and favour the use of cautions over arrests for drug possession.

29. NSW Young Lawyers Law Sub Committee

The NSW Young Lawyers Criminal Law Sub-Committee's submission advocates for a public health approach to drug use, emphasising the limitations of prohibition. They urge consideration of staged decriminalisation or legalisation of certain drugs. They recommend immediate reforms including extending driving exemptions for medicinal cannabis users, reviewing drug quantity thresholds under the *Drug Misuse and Trafficking Act* (DMTA) (including for psilocybin mushrooms, which frequently weigh more than the trafficable quantity and a review of quantities for other drugs), and expanding diversionary options and scope of offences eligible for diversion, for young offenders. Diversions are currently only available for drug weights not exceeding the small quantity proscribed by the DMTA - recommend that this be reviewed. The submission highlights the need for significant investment in addiction treatment, mental health services and rehabilitation facilities.

Recommendations

- Extend driving exemptions for medicinal cannabis users, similar to those for morphine prescription holders.
- Review drug quantity thresholds in Schedule 1 of the *Drug Misuse and Trafficking Act 1985* (NSW), particularly in light of recent case law.
- Expand the scope of drug-related offences eligible for diversion under the *Young Offenders Act 1997* (NSW).

30. Penington Institute

The Penington Institute's submission advocates for a compassionate, evidence-based approach to drug policy, focusing on reducing harm and improving community health and safety. The submission highlights the issue of drug overdoses, particularly in regional and rural areas, and the rise of new psychoactive substances. It calls for a comprehensive overdose prevention and response strategy, including education, naloxone availability, medication-assisted treatment, drug checking services, and supervised consumption sites. Additionally, the submission recommends a regulated adult-use cannabis market to reduce health harms and criminal activity.

Recommendations

- Commit to statewide education efforts on overdose risks and responses.
- Ensure naloxone is readily available in various settings, including libraries, social services, hospitals, police first aid kits, and homes.
- Provide accessible opioid pharmacotherapy and holistic care for patients.
- Introduce drug checking services in the community and at events like festivals.
- Establish mini-overdose prevention sites at needle and syringe programs.
- Create a dedicated Harm Reduction Unit within the Ministry of Health to coordinate harm reduction programs.
- Implement a balanced model of cannabis regulation to facilitate access to regulated adult-use markets and reduce the criminal cannabis market.

31. Police Association of NSW

The Police Association of NSW (PANSW) emphasises the need for careful consideration before making any legislative changes regarding illicit drug use. The PANSW opposes the decriminalisation or legalisation of "hard" drugs, citing the significant harm they cause to individuals and communities. The submission suggests two alternatives for cannabis reform: either legalise and regulate cannabis or continue to manage it as a criminal offence. It also highlights the need for adequate legislative, procedural, and resourcing implementation before any cannabis reform. The PANSW supports maintaining current 'doli incapax' and strip search legislation, arguing that these laws are essential for community safety and effective policing.

Recommendations

- Do not decriminalise or legalise “hard” drugs such as amphetamines, heroin, cocaine, and MDMA.
- Consider either legalising and regulating cannabis or continuing to manage it as a criminal offence.
- Ensure the following preconditions before implementing cannabis reform:
 - Legislate an accurate method to test for drug affectation in road users and provide necessary technology to police.
 - Establish appropriate infrastructure, including a regulating body, health service provisions, training for workers, and a community safety campaign.
- In addition, maintain the current *doli incapax* legislation to balance protection for young people and deterrence of youth crime.
- Maintain the current strip search legislation to reduce drugs and weapons in the community.

32. Public Health Association of Australia

The Public Health Association has emphasised the need for a focus on prevention and early intervention in addressing drug-related issues. They highlight the impact of drug harm on users, families, communities, and the healthcare system, and advocate for community-led prevention efforts and early intervention support. They recommend a robust framework prioritising resource for prevention, behaviour change programs, and early intervention to create a healthier, more resilient society.

Recommendations

- Prioritise prevention and early intervention in addressing drug-related issues.
- Implement community-led prevention efforts to build resilience and reduce harm.
- Provide early intervention support for families to prevent drug-related harm.
- Invest in programs targeting at-risk populations, such as disadvantaged youth and individuals with mental health issues.
- Develop effective alcohol and drug use prevention and harm policies and programs.
- Create impactful behaviour change programs for current and potential drug users.
- Establish early intervention support for individuals experiencing drug use and harm.
- Focus on long-term benefits to reduce crisis-driven responses and create a healthier society.

33. Royal Australian and New Zealand College of Psychiatrists

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) submission advocates for a comprehensive approach to drug policy reform, emphasising harm minimisation and the need for increased investment in treatment services. The submission highlights the negative impact of current drug policies on vulnerable populations and calls for the decriminalisation of drug use, regulated cannabis markets, and improved access to longer term, trauma-focused therapies and opioid substitution treatment, particularly in rural and regional areas. The RANZCP also stresses the importance of culturally appropriate harm reduction services for Aboriginal and Torres Strait Islander communities and the need to attract and retain a skilled workforce in drug and alcohol services. Increased funding for public health awareness campaigns and treatment services is recommended.

Recommendations

- Discuss a trial of regulated cannabis markets in NSW.
- Implement a comprehensive decriminalisation model in NSW.
- Initiate a public health campaign to warn people of the potential harm from using cannabis.
- Increase funding for public health awareness campaigns and treatment services.
- Include longer-term trauma-focused therapies in public addiction treatment centres.
- Invest in treatment facilities that provide harm reduction support in rural and regional NSW.
- Fund opioid substitution treatment services in regional and rural NSW.
- Apply the National Mental Health Service Planning Framework (NMHSPF) Model to determine service gaps in drug and alcohol service delivery in NSW.
- Increase funding to address service gaps identified by the NMHSPF.
- Increase incentives and opportunities for people to enter the professional drug and alcohol treatment workforce.
- Provide culturally appropriate harm reduction services for Aboriginal and Torres Strait Islander communities.

34. School of Law, Western Sydney University

The submission from academics at the School of Law, Western Sydney University, critiques the current drug laws in NSW, arguing that they are ineffective, discriminatory, and harmful. The submission calls for a shift from punitive measures to a health-based harm reduction approach, including the decriminalisation of drug possession and use, and the establishment of more medically supervised drug injection centres and drug-checking services. The academics highlight the negative impacts of current drug policies on human rights, the rule of law, and marginalised communities, and advocate for evidence-based reforms to improve public health and social outcomes.

Recommendations

- Shift the focus of drug policy from policing to a health-based harm reduction approach.
- Decriminalise drug possession and use.
- Reform the *Drug Misuse and Trafficking Act 1985* (NSW).
- Establish more medically supervised drug injection centres.
- Establish and license drug-checking services.
- Address the discriminatory impact of current drug laws on marginalised communities.
- Implement evidence-based harm reduction strategies to improve public health and social outcomes.

35. Sydney Local Health District

The submission from the Sydney Local Health District outlines recommendations to improve health promotion, equitable access, and law enforcement responses related to drug use. Key suggestions include expanding harm reduction programs, increasing the availability of needle and syringe dispensing machines, promoting the use of naloxone and nicotine replacement therapy (NRT), and enhancing culturally safe environments. The document also advocates for better coordination between health and social services, and with police and justice sectors, more integrated community engagement, and the decriminalisation of drug use. It emphasises the need for early intervention, education, and support for young people and families. They provide recommendations across the five summit themes. They highlight the need to address stigma and discrimination in healthcare settings, including through better training, reporting pathways and enhancement of the peer workforce.

Recommendations

- Strengthen commitment to district harm reduction programs.
- Expand availability of automatic needle and syringe dispensing machines across NSW.
- Promote and support the use and availability of naloxone and NRT.
- Align approaches to respond to liquor licensing applications.
- Enhance clinical areas to ensure culturally safe and appropriate environments.
- Expand the distribution of YourRoom posters and materials.
- Advocate for online 'one stop shop' referral pathways.
- Tailor education and awareness campaigns, including culturally appropriate materials.
- Expand harm reduction initiatives, including NSPs and medically supervised injection services.
- Encourage integrated community engagement and presence at events.
- Employ more peers in health promotion roles.
- Support expansion of holistic and integrated services.
- Include holistic drug health and health promotion education in clinical university degrees.
- Provide targeted harm reduction education to law enforcement and education sectors.
- Expand Work Development Order programs.
- Address social determinants of health that lead to problematic drug use.
- Incorporate a strength-based approach focusing on harm reduction.
- Increase collaboration with health services and sector partners.
- Bundle harm reduction messaging with other relevant health information.
- Expand the Behavioural Assessment Unit (BAU) model across public hospitals.
- Consider a Short Stay Unit model to reduce the burden on emergency departments.
- Establish ADHD assessment services more widely.
- Optimise coordination of post-withdrawal residential treatment options.
- Support and strengthen collaborative Substance Use in Pregnancy and Parenting Services.
- Improve coordination of education and support for health professionals.
- Address stigma and discrimination in healthcare settings.
- Improve accessibility and reduce stigma regarding accessing support for drug use.
- Support culturally safe and LGBTQIA+ inclusive services.
- Ensure services are accessible and affordable.
- Normalise clinicians discussing drug use and available support in all clinical encounters.
- Evaluate existing harm reduction services for CALD and non-English-speaking populations.
- Develop health promotion and education programs sensitive to faith-inclusive frameworks.
- Support and expand strategic engagement between health, police, and court sectors.
- Support and expand drug diversion programs.
- Strengthen and resource Tobacco Enforcement Units.
- Build community awareness of access to community liaison officers.
- Establish brokerage funds for disadvantaged young people.
- Promote and implement age-appropriate education in schools.
- Implement family support programs offering parent education and family counselling.
- Implement mental health and screening/early intervention programs.
- Empower and fund young people to pursue programs that build their sense of purpose.
- Ensure data programs and platforms are integrated and more accessible.
- Provide targeted flexible funding to support inter-collaborative practice.
- Strengthen legislative, regulatory, and public health measures to limit the use of vapes and illegal tobacco.

36. Students for Sensible Drug Policy Australia

Students for Sensible Drug Policy Australia (SSDP Australia) reflects SSDP Australia's commitment to evidence, compassion, and human rights in drug policy reform, advocating for meaningful youth representation and inclusive health promotion strategies.

Recommendations

- Youth involvement: Emphasise the importance of involving young people in drug policy decision-making, respecting the principle of “nothing about us without us.”
- Health promotion: Advocate for evidence-based, inclusive, and respectful health promotion strategies.
- Involvement of lived experiences: Include people with lived and living experiences of drug use in program design.
- Tailoring to communities: Customise health promotion efforts to different groups, including young people, CALD communities, queer communities, and First Nations Peoples.
- Policy advocacy: SSDP Australia continues its engagement and advocacy efforts in collaboration with allied organisations to influence broader policy conversations.
- Government engagement: Stress the need for meaningful youth representation at the NSW Drug Summit to bring key communities and stakeholders together.
- Addressing stigma: Highlight the challenges young people who use drugs face in overcoming stigma and discrimination in accessing health, education, and advocacy platforms.
- Health promotion strategies: Suggest health promotion efforts become more relevant and impactful by centering the voices of people who use drugs and those from diverse communities.
- Acknowledgement: Acknowledge recent efforts by the NSW Government to improve practice in health and AOD sectors and express hope for continued reform and meaningful involvement of young people.

37. Students for Sensible Drug Policy Club at Western Sydney University

The Students for Sensible Drug Policy (SSDP) at Western Sydney University advocate for a shift from abstinence-focused drug policies to harm reduction strategies. They emphasise the need for safe injecting centres, drug checking services, and evidence-based education campaigns. The submission highlights the importance of peer-led services and equitable access to support, criticises current punitive law enforcement practices, and calls for the decriminalisation of drug use. SSDP argues for integrated support services and a compassionate approach to drug policy that prioritises health and safety over criminalisation.

Recommendations

- Expand safe injecting centres and drug consumption rooms.
- Invest in widespread drug checking services, including at festivals and youth gatherings.
- Develop evidence-based, non-fear-driven education campaigns.
- Involve people with lived and living experience in service design and delivery.
- Reform Section 29 of the *Drug Misuse and Trafficking Act 1985* (NSW) to shift the burden of proof to the state rather than individuals.
- Ban strip searches at festivals and revise probable cause requirements.
- Implement recommendations from the Law Enforcement Commission Report regarding strip searches.
- Decriminalise drug possession and focus on health-based responses.
- Introduce harm reduction-focused education programs in schools.
- Expand mental health support services integrated with drug education.
- Prioritise funding for peer-led services.

- Reform methadone treatment regulations.
- Implement harm reduction strategies, including drug checking and peer-led initiatives.
- Reform policing practices, including banning drug detection dogs and strip searches.
- Decriminalise drug use and possession and consider legalisation and regulation of substances.

38. The Salvation Army

The Salvation Army's submission advocates for a health, wellbeing, and social services approach to address drug-related harms, criticising the current overemphasis on law enforcement. The submission calls for a statewide alcohol and other drug strategy to ensure evidence-based responses, reduce stigma, and improve equitable access to treatment. It highlights the need for tailored, culturally safe programs, particularly for Aboriginal and Torres Strait Islander communities, and recommends reforms to the criminal justice system to prioritise health and social services over punitive measures. The submission also emphasises the importance of integrated support services and increased investment in AOD treatment, especially in rural and remote areas.

Recommendations

- Develop a statewide alcohol and other drug (AOD) strategy for NSW.
- Increase investment in AOD treatment services, particularly in regional and rural areas.
- Reform the criminal justice response to illicit drug use to focus on health and social services.
- Implement a comprehensive education campaign to reduce stigma and promote evidence-based interventions.
- Ensure AOD treatment models are culturally safe and tailored to diverse needs.
- Adopt a stepped care approach to AOD treatment, providing a continuum of affordable options.
- Conduct a statewide scoping review of AOD treatment services and increase investment.
- Develop a statewide workforce strategy to attract, train, and retain qualified AOD staff.
- Increase investment in integrated youth-specific services to address co-occurring issues.
- Raise the age of criminal responsibility to a minimum of 14 years old.
- Enhance integration between services through strong partnerships, co-located services, and cross-sector training.

39. Uniting

The submission by Uniting NSW/ACT and Fair Treatment advocates for a health-focused approach to drug policy, emphasising the need for decriminalisation, harm reduction, and increased support for treatment services. The submission highlights the negative impacts of criminalisation on individuals and communities, particularly among vulnerable populations. It calls for evidence-based reforms to improve health outcomes, reduce stigma, and provide equitable access to support services. The submission also stresses the importance of involving people with lived and living experience in policy development and implementation.

Recommendations

- Delete section 36A of the *Drug Misuse and Trafficking Act 1985* (NSW) to allow for establishment of more supervised injecting spaces.
 - Introduce fixed site and mobile drug education and checking services.
 - Remove criminal penalties for personal possession and use of drugs and replace with an enhanced and effective Early Drug Diversion Initiative (EDDI) scheme.
 - Address known gaps in treatment & practice.
 - Introduce a whole of government alcohol and other drug strategy within six months.
-

40. UNSW Department of Law and Justice, Police Powers Students

The submission by UNSW Police Powers students critiques the Early Drug Diversion Initiative (EDDI) for its inconsistent application and reliance on police discretion, which undermines its effectiveness. The submission highlights the need for full decriminalisation of drug use and possession, arguing that the current system perpetuates criminalisation and fails to provide equitable access to diversionary benefits. The students call for legislative amendments to ensure fair and consistent application of the EDDI law, moving towards a more just and equitable drug policy in NSW.

Recommendations

- Fully decriminalise the use and possession of all drugs.
- Remove police discretion in issuing drug criminal infringement notices (CINs).
- Establish clear, enforceable guidelines for the consistent application of diversionary measures.
- Ensure equal access to diversionary benefits regardless of postcode.
- Address the underrepresentation of Indigenous people in diversion programs.

41. Wayside Chapel

Rev. Jon Owen, Pastor and CEO of Wayside Chapel, submitted a letter emphasising the importance of treating individuals with respect and dignity, especially those struggling with addiction. He advocates for medically supervised safe injecting centres, effective educational programs for young people, and treating personal drug use as a health issue rather than a criminal one. The submission calls for increased investment in treatment and harm reduction services, equitable access to support, and a holistic government strategy for addressing alcohol and other drug issues. Wayside Chapel's approach is rooted in compassion and acceptance, aiming to support individuals on their path to better health.

Recommendations

- Greater investment in treatment and harm reduction services to ensure timely access to support.
- Dignifying, evidence-based, and health-focused responses to substance use and dependency.
- A holistic, whole-of-government AOD strategy integrated with other support services.
- Equitable access to diversion systems and treatment for all individuals, including First Nations people, those without means, younger people, and people with prior convictions.

POSITION PAPERS

1. ACON

ACON's position paper advocates for a public health approach to drug policy in NSW, informed by NSW's successful response to HIV, emphasising harm reduction and the inclusion of LGBTQ+ communities as a priority population.

Recommendations

- Develop a whole-of-government NSW AOD Strategy: Identify priority populations, including sexuality and gender diverse communities.
- Increase funding for drug health services: Focus on early and brief interventions. Expand community-based treatment services.
- Increase harm reduction options: Implement drug checking facilities. Reduce barriers for peer distribution of injecting equipment. Establish NSPs in custodial settings. Create secondary medically safe consumption sites, including injecting centres. Fund harm reduction campaigns, especially for priority populations.
- Reform to reduce unnecessary contact with police: Review law enforcement's role in perpetuating harm for people who use drugs. Reform NSW policing practices to ensure consistent application of police powers and reduce discretionary impacts.

2. Australasian Therapeutic Communities Association

The Australasian Therapeutic Communities Association (ATCA)'s position paper outlines the critical role of therapeutic communities (TCs) in providing holistic alcohol and other drug (AOD) treatment services across Australia and New Zealand. The paper highlights the need for increased and sustained funding to meet the growing demand for AOD services, particularly in regional and remote areas. It advocates for a shift from criminal justice funding to health-focused responses to reduce stigma and improve outcomes for individuals and communities. The ATCA emphasises the importance of including diverse voices and lived and living experiences in the Drug Summit to ensure comprehensive and effective policy development.

Recommendations

- Develop a robust and well-funded AOD sector with long-term, escalated funding.
- Enhance health, treatment, and rehabilitation responses to AOD use, prioritising health-focused funding over criminal justice allocations.
- Embrace a diverse array of voices and experiences, including those from priority populations and frontline workers, in the Drug Summit discussions.

3. Cannabis Council Australia

The Cannabis Council Australia's submission to the NSW Drug Summit highlights the need for policy reforms to improve access and reduce discrimination against medicinal cannabis patients. They advocate for alternative drug testing methods that assess impairment rather than the mere presence of THC, amendments to driving laws to protect patients using legally prescribed cannabis, and a review of workplace drug testing policies. The submission also emphasises the disproportionate impact of current regulations on regional and rural patients, who face greater challenges due to limited public transport and employment opportunities. The Council calls for a focus on these issues to ensure equitable treatment for all medicinal cannabis patients.

Recommendations

- Undertake a review of alternative testing options to allow proper assessment of impairment, rather than testing for the presence of THC in legitimately prescribed patients.
- Amend Section 111 subsections 5 and 6 of the Road Transport Act 2013 to include legal defences for medicinal cannabis, similar to those for morphine.
- Review existing medicinal cannabis driving provisions from other jurisdictions, including Tasmania, and investigate their suitability for adoption in NSW.
- Consider the additional impact of the current regulatory framework for medicinal cannabis on people in regional and rural communities, particularly as it relates to driving regulations.

4. Fairfield City Local Drug Action Team

The Fairfield City Local Drug Action Team (LDAT) conducted the Leading Stronger Communities consultation in September and October 2024 to address community concerns regarding AOD. The consultation engaged local community workers, multicultural community leaders, faith leaders, and resident groups to identify key issues and support needs. Major concerns included vaping, shisha, and other nicotine use, as well as increasing alcohol consumption among young people. Participants highlighted the need for culturally appropriate education, resources, and support for culturally and linguistically diverse communities. The consultation emphasised the importance of engaging CALD communities in developing and implementing AOD initiatives.

Recommendations

The LDAT's priorities are:

- Expansion of the Stronger and Connected Communities AOD Education Toolkit to include shisha, vaping and other nicotine use. Introduce take home cards with translated information in community languages starting with Arabic and Vietnamese
- Build stronger social media presence to educate communities – utilising apps including Tik Tok and Instagram (co-design with young people)
- Identifying AOD resources available, determining best practice in promoting them to the community

5. Network of Alcohol and other Drugs Agencies

The Network of Alcohol and other Drugs Agencies (NADA) submission highlights the need to address stigma and discrimination, improve access to treatment services, especially in regional areas, and ensure sustainable funding for non-government organisations (NGOs). NADA emphasises the importance of a holistic, person-centred, and trauma-informed approach, and advocates for decriminalisation of personal drug use, increased investment in community education and harm reduction, and the development of a comprehensive drug and alcohol strategy. The submission also stresses the need for a central agency to oversee reform implementation and support for the NGO workforce.

Recommendations

- Centre the Summit around the views and experiences of those most impacted.
- Commit to a holistic, person-centred, and trauma-informed approach.
- Support evidence-informed drug policy.
- Build consensus across NSW Parliament and with federal stakeholders.
- Be transparent about the process and timing for reform implementation.
- Develop a plan to reduce stigma and discrimination.

- Decriminalise personal drug use to reduce barriers to care.
- Invest in community education, prevention, and harm reduction.
- Prioritise delivery of a drug and alcohol strategy.
- Deliver drug and alcohol reform via a central agency.
- Ensure NGO funding reflects service demand and supports holistic treatment.
- Address NGO workforce sustainability.

6. Narcotics Anonymous Australia

The submission by Narcotics Anonymous (NA) Australia highlights the significant role NA plays in supporting individuals recovering from addiction. The NA calls for government support to enhance its outreach and effectiveness.

Recommendations

- Increase public awareness and outreach through health campaigns and partnerships with healthcare providers.
- Allocate consistent, accessible public spaces for NA meetings.
- Encourage healthcare providers to refer clients to NA as part of a comprehensive recovery plan.
- Support government-led initiatives to reduce stigma around addiction.

7. The NSW Users and AIDS Association

The NSW Users and AIDS Association (NUAA)'s position paper emphasises the need for a comprehensive, evidence-based approach to drug policy that prioritises harm reduction and the inclusion of people with lived and living experience of drug use. The paper highlights the failures of the "tough-on-drugs" approach and calls for systemic changes to reduce stigma and discrimination. It advocates for the decriminalisation of drug possession and use, improved harm reduction services, and better coordination between government agencies to address the complex needs of people who use drugs. The paper recommends a stronger focus on harm reduction initiatives and reform of police practices.

Recommendations

- Ensure lived and living experience voices are a part of the Summit
- Whole of government AOD strategy.
- Increase focus on harm reduction and establish a dedicated agency for harm reduction services, including NSPs in prisons and more safe injecting centres.
- Implement the Ice Inquiry recommendations, including provision of injecting equipment in correctional settings, drug checking, and expanding access to take-home naloxone.
- Remove discretionary police powers related to individual drug use and cease harmful practices like drug dog operations and strip searches.
- Invest in a community-wide project to reduce stigma and discrimination and expand anti-discrimination protections.
- Make a commitment to reducing stigma in healthcare
- Adequately fund training and development of the lived and living experience workforce and fund NUAA as a peak body representing these workers.
- Decriminalise the possession and personal use of illicit drugs.
- Adequately fund holistic drug treatment services, especially for priority populations.

- Prioritise First Nations-led AOD service delivery and advocacy.
- Legalise and regulate the personal possession and use of cannabis.
- Reform roadside drug testing to test for impairment instead of presence of cannabis.

8. Royal Australasian College of Physicians

The Royal Australasian College of Physicians (RACP) position statement advocates for a health-focused approach to drug policy in Australia and Aotearoa New Zealand. It emphasises the need for evidence-based education, prevention, harm reduction, and treatment strategies to address drug use. The statement highlights the importance of reducing stigma, decriminalising drug use, and ensuring equitable access to culturally appropriate services. It calls for increased funding for harm reduction measures, comprehensive healthcare for people who use drugs, and the development of a sustainable and skilled workforce in addiction medicine.

Recommendations

- Implement evidence-based measures to address and reduce adverse childhood experiences and trauma.
- Support research to evaluate and contribute to the evidence base for interventions.
- Train health professionals in trauma-informed care and evidence-based AOD treatment.
- Review policies to support trauma-informed practices.
- Engage with Aboriginal and Torres Strait Islander and Māori peoples to ensure culturally appropriate care.
- Increase funding for harm reduction measures.
- Ensure needle syringe programs are widely available.
- Establish a national overdose surveillance system
- Increase the number of supervised consumption services.
- Establish trials of regulated cannabis.
- Expand court and police diversion programs for non-violent drug-related crimes.
- Review and potentially reduce the use of drug detection dogs.
- Expand drug checking sites.
- Implement real-time prescription monitoring with robust evaluation.
- Ensure peer programs are well-resourced and accessible.
- Offer non-abstinence-based housing to homeless individuals.
- Support trauma-informed harm reduction responses.
- Review driving regulations to focus on impairment detection.
- Ensure workplace guidelines deter and detect drug use in safety-critical industries.
- Increase resourcing for evidence-based drug and alcohol treatment services.
- Facilitate comprehensive healthcare for people who use drugs.
- Invest in workforce development in addiction medicine and psychiatry.
- Ensure adequate reimbursement for AOD treatment providers.
- Implement quality and outcome frameworks for AOD services.
- Invest in high-quality research and establish a national AOD clinical research network.
- Engage with priority populations to ensure culturally appropriate measures.

9. Shelter NSW

Shelter NSW's submission focuses on the critical need for secure housing and support services for people experiencing drug-related harm and those exiting the criminal justice system. The submission highlights the barriers these individuals face in accessing stable housing and the impact of homelessness on their health and recidivism rates. Shelter NSW advocates for a comprehensive approach that prioritises housing and integrates support services, including harm reduction initiatives, to improve health outcomes and reduce re-incarceration. The submission calls for increased funding, collaboration between housing and support services, and the development of best practice models to address these issues.

Recommendations

- Increase funding for treatment services, including harm reduction initiatives.
- Develop best practice models of accommodation linked with support services for people with drug dependency and those exiting the criminal justice system.
- Monitor the number of people experiencing drug dependency and those exiting the criminal justice system by region.
- Collaborate with local social and community housing providers to develop core and cluster housing and support services models.
- Engage with Aboriginal Community Housing Providers (CHPs) and local Land Councils to support First Nations people exiting the criminal justice system.
- Ensure support services collaborate with organisations that facilitate family reunification.
- Develop protocols with correctional facilities to ensure supportive accommodation options upon release.
- Investigate land options for supported housing models, particularly in regions like Coffs Harbour.
- Address funding gaps in current treatment services.
- Implement a whole-of-government strategy linking mental health, corrections, AOD, and housing services.

10. Suicide Prevention Australia

Suicide Prevention Australia's submission highlights the strong link between drug-related harms and suicide, emphasising the need for integrated approaches to address both issues. The submission calls for the inclusion of people with lived experience of suicide in the Summit, the development of a governance framework prioritising suicide prevention in drug-related policies, and evidence-based recommendations for government action. It also addresses the issue of drug-induced suicides and the need for improved data collection and reporting.

Recommendations

- Ensure a diverse range of people with lived and living experience of suicide are invited to the 2024 NSW Drug Summit.
- Develop a governance structure to prioritise suicide prevention in drug-related policies, strategies, and services.
- Discuss the integration of screening, assessment, and treatment for drug use into existing suicide prevention services.
- Provide suicide prevention education and training for frontline staff in the drug-related sector.
- Offer targeted suicide prevention training for community members who may encounter people with high levels of drug use.
- Ensure drug use interventions and education target young people on the relationship between drug-related harms and suicidality.
- Commission further research on the efficacy of drug-related interventions in preventing suicidal thoughts, attempts, and deaths, focusing on priority populations.

- Address the prevention of drug overdose deaths by suicide among people aged 60 and over.
- Develop a framework and coding system to improve the identification of drug-induced suicides.

11. Sydney Criminal Lawyers

The Sydney Criminal Lawyers' position paper discusses the forum's potential to drive progressive drug law reform in New South Wales. The paper highlights the need to treat drug use as a health issue rather than a criminal one, advocating for the decriminalisation of drug possession and use. It criticises the current discretionary Early Drug Diversion Initiative and calls for the removal of the deemed supply law. They recommend the removal of police discretion for diversion to EDDI. They also describe how the quantities deemed as supply are inappropriate and depending on where the issue is tried, different penalties apply. The paper also supports harm reduction measures such as pill testing, and the elimination of drug detection dogs and strip searches at public events, particularly music festivals, due to their negative health and social impacts.

Recommendations

- Decriminalise drug possession and use, replacing criminal sanctions with civil penalties or counselling.
- Revoke the deemed supply law to prevent individuals with small amounts of drugs for personal use from being charged with supply.
- Implement pill testing to reduce harm and save lives.
- Eliminate the use of drug detection dogs in public settings, especially at music festivals.
- Remove strip searches, particularly for youth.

12. Sydney Drug Education and Counselling Centre

The submission by the Sydney Drug Education and Counselling Centre (SDECC) highlights the need for a shift from a criminal justice approach to a health-focused, evidence-based policy on drug use. It emphasises the importance of family-inclusive practices in supporting young people and their families affected by substance use. The submission criticises the current punitive approach, noting its high costs and ineffectiveness, and calls for comprehensive implementation of recommendations from recent inquiries. SDECC advocates for sustainable funding for drug education, intervention, and support services, and the introduction of a drug-checking regime to mitigate the risks of adulterated substances.

Recommendations

- Adopt an unambiguous commitment to evidence-based policy and harm reduction philosophy.
- Detach drug policy from the criminal justice system and anchor it in the health system.
- Fully implement recommendations from public and parliamentary inquiries into drug issues.
- Commit to sustainable funding for government and NGO-provided drug education, intervention, support, rehabilitation, and research organisations, with a focus on family and systems-based solutions for young people.
- Introduce a readily available drug-checking regime to protect the population from adulterated drugs.

13. The Law Society of NSW

The Law Society's submission emphasises the need to treat drug misuse as a health and social issue rather than a criminal one. The submission highlights the disproportionate impact of current drug laws on Indigenous communities and calls for reforms to the criminal justice system, including decriminalisation of drug possession for personal use, increased investment in health and rehabilitation services, and the reinstatement of the Youth Drug and Alcohol Court. The Law Society also supports the implementation of harm reduction strategies such as substance testing and needle and syringe programs in custodial settings.

Recommendations

- Reconsider the amount classifications in Schedule 1 of the *Drug Misuse and Trafficking Act 1985* (NSW) for cannabis and other prohibited drugs.
- Remove deemed supply measures that reverse the onus of proof.
- Introduce a medicinal use defence for driving offences involving prescribed illicit drugs.
- Reinstatement of the Youth Drug and Alcohol Court or an equivalent.
- Extend the Magistrates Early Referral Into Treatment (MERIT) program to the Children's Court.
- Reform the *Young Offenders Act 1997* (NSW) to improve outcomes for children and young people.
- Increase investment in rehabilitation facilities, particularly in rural and regional areas.
- Implement the recommendations of the Special Commission of Inquiry into the Drug 'Ice', including decriminalisation of drug possession for personal use.
- Establish a state-wide clinically supervised substance testing service.
- Cease the use of drug detection dogs at music festivals.
- Pilot a needle and syringe program in custodial facilities.
- Ensure comprehensive implementation of supported recommendations from the Ice Inquiry, including improved AOD treatment in custody and transitional support services for people leaving custody.

14. The Matilda Centre

The Matilda Centre's position statement advocates for evidence-based policy reforms to address alcohol and other drug (AOD) use. It emphasises the importance of incorporating research evidence, centring the voices of those most impacted by AOD use, addressing stigma, focusing on prevention and early intervention, increasing access to evidence-based resources and treatments, enhancing support for families and friends, and investing in the AOD workforce. The statement highlights the need for a comprehensive, health-focused approach to improve outcomes.

Recommendations

- Incorporate research evidence on changing trends in AOD use.
- Centre the voices of populations most impacted by AOD use.
- Address stigma around AOD use.
- Focus on prevention and early intervention.
- Increase access to evidence-based resources and treatments.
- Enhance support for families and friends affected by a loved one's AOD use.
- Invest in an AOD workforce for the future.

15. The Shopfront Youth Legal Centre

The Shopfront Youth Legal Centre's submission to the NSW Drug Summit highlights the need for a health-based approach to drug policy, focusing on decriminalisation, diversion, and increased support for vulnerable young people. The submission criticises the current reliance on police discretion for diversion and the harmful impact of stop and search practices, including the use of drug detection dogs and strip searches. It calls for legislative reforms to decriminalise drug possession, amend stop and search powers, and improve drug driving laws. The submission also emphasises the need for increased funding for drug treatment services and residential rehabilitation facilities.

Recommendations

- Adopt the recommendations of the Special Commission of Inquiry into the Drug 'Ice'.
- Consider the recommendations of the First Report of the Inquiry into the Impact of the Regulatory Framework for Cannabis in New South Wales.
- Move towards decriminalisation of possession and use of prohibited drugs.
- Make summary offences in the *Drug Misuse and Trafficking Act 1985* (NSW) fine-only offences and create a presumption in favour of diversion for low-level offences.
- Extend penalty notices to cannabis and prescribed restricted substances under the *Poisons and Therapeutic Goods Act*.
- Amend the Young Offenders Act to include non-commercial supply, cultivation, and similar offences.
- Raise the threshold for stop and search under *Law Enforcement (Powers and Responsibilities) Act 2002* (LEPRA) to require suspicion of a trafficable quantity or intent to supply.
- Repeal or significantly amend Part 11, Division 2 of LEPRA to limit the use of drug detection dogs.
- Reform the offence of "drive with illicit drug in blood/oral fluid/etc" to require proof of impairment.
- Create an exemption for users of medicinal cannabis in drug driving laws.
- Reinstate an honest and reasonable mistake of fact defence for drug driving offences.
- Significantly increase funding for drug treatment services, including residential rehabilitation facilities.

16. The TARA Clinic

The TARA Clinic's submission highlights the unique challenges faced by high-functioning professionals struggling with addiction. These individuals often avoid seeking help due to concerns about confidentiality, stigma, and rigid treatment models that do not fit their schedules. The TARA Clinic is an addiction recovery psychologist service and advocates for outpatient and online treatment options that provide early intervention and flexible, confidential support. The submission includes real-life case studies demonstrating the effectiveness of their approach and calls for systemic changes to better support this demographic.

Recommendations

- Support outpatient models in policy and insurance to recognise them as viable, cost-effective treatment options.
- Encourage corporate engagement in well-being initiatives, including mental health and substance use education.
- Launch a practical, empathetic national awareness campaign to reduce stigma and promote understanding of addiction.
- Recognise the economic benefits of outpatient models, which can provide timely, effective support at lower costs compared to inpatient care.

17. Unharm

Unharm's submission to the NSW Drug Summit, based on a survey of over 6,500 supporters, highlights strong support for evidence-based drug policy reform focused on harm reduction and public health. Key priorities include legalising cannabis for personal use, reforming driving laws for medicinal cannabis users, setting up statewide pill testing services, decriminalising drug possession for personal use, and ending police strip searches. The submission features personal stories that underscore the urgent need for these reforms, illustrating the negative impacts of current drug policies on individuals.

Recommendations

- Legalise cannabis for personal use.
- Reform driving laws for medicinal cannabis users.
- Set up statewide pill testing services, including at festivals.
- Decriminalise drug possession for personal use.
- End police strip searches.
- Increase funding for harm reduction services.
- Establish more safe injecting facilities.

18. UNSW Kirby Institute

This submission highlights the unfinished business from the 1999 NSW Parliamentary Drug Summit, specifically the need to decriminalise drug use and the possession of drug paraphernalia. The submission argues that criminalising drug use has little deterrent effect and exacerbates stigma, discrimination, and social disadvantage. It calls for a health and social approach to drug use, consistent with Australia's National Drug Strategy, and suggests that decriminalisation would improve the effectiveness of harm reduction programs and reduce negative social consequences.

Recommendations

- Repeal Section 11 of the *Drug Misuse and Trafficking Act 1985* (NSW), which criminalises the possession of equipment for drug use.
- Repeal Section 12 of the *Drug Misuse and Trafficking Act 1985* (NSW), which criminalises the self-administration of drugs.
- Approach problematic drug use as a health and social issue rather than a criminal one.
- Address the stigma and discrimination associated with illicit drug use.
- Formalise arrangements between health and police to ensure a complementary approach to drug-related matters.
- Enable needle syringe programs (NSPs) to operate more effectively by decriminalising drug use.
- Allow local communities to consider extending NSPs to include supervised injecting facilities.
- Support harm reduction measures such as pill checking at electronic dance music venues.
- Learn from international jurisdictions that have reformed their drug laws to prioritise health and social approaches to drug use.

19. Young Labor Left

The Young Labor Left NSW submission advocates for the decriminalisation of drug use and possession, supported by a comprehensive health-focused policy framework. The submission highlights the ineffectiveness of the current approaches, calling for evidence-based reforms inspired by successful models in Portugal and Sweden. It emphasises the importance of drug testing facilities, education, and treatment support to reduce harm and improve public health outcomes. The submission also notes the broad support for these measures from both the public and medical institutions.

Recommendations

- Decriminalise drug use and possession.
- Implement a comprehensive health-focused policy framework.
- Establish drug testing facilities to ensure the safety of substances and provide education and treatment support.
- Increase investment in treatment resources and education.
- Promote a shift in public attitudes towards a health-based perspective on drug use.
- Support early intervention initiatives like the Early Drug Diversion Initiative (EDDI) with additional resources.

SUMMARY OF INDIVIDUAL SUBMISSIONS

The submissions from individuals reflect a diverse range of perspectives on drug policy and education. Some advocate for greater emphasis on harm minimisation, decriminalisation of illicit drugs, greater investment in treatment, changes to police practice, while others advocate for stricter regulation of drug use, possession and supply. There are calls to implement drug checking, safe drug consumption rooms, reform to drug driving laws for medicinal cannabis and calls to stop the use of drug sniffer dogs and strip searches.

A key theme is the need for balanced, evidence-based policies that consider both public safety and the well-being of individuals who use drugs.

Some of the recommendations raised by individual submissions include:

- **Drug education and prevention:** Prioritise drug education in high school and include education for parents. Involve people with lived and living experience in the design of drug education.
- **Decriminalisation:** Decriminalise the personal use and possession of illicit drugs, following the ACT model.
- **Driving law reform:** Establish an acceptable THC limit for driving, similar to the blood alcohol level, to allow medicinal cannabis patients to drive. Implement necessary driving restrictions to prevent misuse of medical exemptions.
- **Law enforcement and regulation:** Investigate unethical prescribing and over-prescribing of medicinal cannabis and medication for attention deficit hyperactivity disorder (ADHD). Raise the age of criminal responsibility to 16 years.
- **Stigma:** Address stigma associated with drug use to improve access to services.
- **Investment in treatment and harm reduction programs:**
 - Allocate more funding to harm reduction and treatment services compared to law enforcement.
 - Increase funding for drug and alcohol treatment and rehabilitation services, particularly in rural and regional areas.
 - Enhance services for young people (12-25) with integrated mental health and AOD care.
 - Provide culturally appropriate harm reduction services for Aboriginal and Torres Strait Islander communities.
 - Implement harm reduction initiatives such as additional supervised injecting rooms, needle exchange programs, pill testing, and take-home naloxone.
 - Ensure ongoing funding for FASD prevention, diagnosis, management, and support of families in public health services.
- **Research and evidence-based policies:**
 - Treat drug and alcohol issues as health-related rather than criminal.
 - Ensure drug policy design involves people with lived and living experience of drug use.
 - Develop a state-wide, confidential survey to collect data on reasons for substance use.
 - Enhance surveillance and monitoring programs, particularly for new synthetic opioids like fentanyl and nitazenes.
 - Conduct research to better understand the impacts of drug policy enforcement on mental health and minority groups.
 - Establish a Coronial Drug Death Review Team within the NSW Coroner's Court to analyse drug-related deaths, identify trends and systemic issues, and assist in making public health and safety recommendations.
 - Restrict access to alcohol via taxation, pricing, limiting advertising and promotion, and controlling liquor outlets and opening hours.

• **Workforce:**

- Implement mandatory training and education for clinical staff on illicit substance use.
- Train the mental health and AOD workforce to provide integrated care and early intervention.
- Increase incentives and opportunities for professionals to enter the AOD treatment workforce.
- Improve police training on mental health issues and effective communication with individuals experiencing mental illness or trauma.
- Improve communication between general practice, midwifery, community, and paediatric services about women at risk of alcohol use in pregnancy and infants at risk of FASD.

Quotes

“The MSIC at Kings Cross in Sydney has never had a single death on its premises in all its years of operation. Prior to its establishment accidental overdoses deaths had skyrocketed. It is a well proven strategy to reduce drug harms in the community and should be expanded throughout the state, including mobile premises at festivals.”

Individual submission

Take-home naloxone is a life saver and should be mandated to be included in every first aid kit and included in all first aid training.”

Individual submission

“If we educate children at an early age and show them how drugs change the structures of their brains, often irreversibly, they will be able to make better decisions about making that first step. People who have suffered addiction must be included as they have a wealth of knowledge to share.” - Individual submission “I work in Youth Mental Health where drug use (of young people themselves and also other family members) is a very common issue that complicates engagement, assessment and treatment. Mental health services are often not equipped, staffed or trained to manage these comorbidities. There is a need to train MH and AOD workforce with skills to provide more integration and to improve early intervention and prevention of harm.”

Individual submission

“The lack of coordination between State and Commonwealth regulators prevents better health and community outcomes.”

Individual submission

“Professional College accreditation should require examinations include curriculum to do with the prevention or management of illicit, legal or prescribed addictive substances as mainstream care. International Medical Graduates are an increasing proportion of our primary and secondary care workforce. Questions on addictions should be included in their examinations. GPs shun addiction work and the funding for private addiction medicine providers is not commercial at current MBS rates. To develop the future workforce, we need to support GP registrars doing time in public addiction clinics” -

Individual submission

“I am currently a medical cannabis patient managing severe pain. Yet I’m unable to medicate as required as my employer considers cannabis an illegal drug. I understand not being under the influence at work but a urine test can show positive for weeks after medicating, effectively forcing me out of treatment or to gamble with my livelihood.”

Individual submission

“Medical cannabis oil has changed my life. Unfortunately due to driving laws, I had to change career and move from rural NSW to Sydney as I have to rely on public transport. While medically I have progressed leaps and bounds the reality is that I had to give up everything I had worked for.”

Individual submission

“When my mother was prescribed medicinal cannabis to manage her chronic pain, it greatly improved her quality of life. However, the fear of losing her driving privileges became a constant source of anxiety, impacting her independence and limiting her ability to engage in daily activities.”

Individual submission

“Being a PWID for 30+ years, having access to harm reduction information and drug use paraphernalia besides just fits and always accessing peer-based services has saved my life. The information provided by peers is so worthy. I need to see positive change, I am not a bad person, I pay taxes, work full time, and am a homeowner and yet if I got caught with drugs I could lose everything. Harmful police policies are killing us, strip searches on young people are deplorable, they traumatise them, they traumatise adults, and nothing good can come of this. Sniffer dogs put people at risk of overdose.”

Individual submission

