Report on the

2024 New South Wales Drug Summit

Co-chairs Carmel Tebbutt and John Brogden

ACKNOWLEDGEMENT OF COUNTRY

We acknowledge the Aboriginal and Torres Strait Islander peoples as the First Peoples and Traditional Custodians of Australia, and the oldest continuing culture in human history.

We pay respect to Elders past and present and commit to respecting the lands we walk on and the communities we walk with.

We celebrate the deep and enduring connection of Aboriginal and Torres Strait Islander peoples to Country and acknowledge their continuing custodianship of the land, seas and sky.

We reflect on the enduring impact of government policies and practices and recognise our responsibility to work with and for Aboriginal and Torres Strait Islander peoples, families and communities to improve health, economic, social and cultural outcomes.

RECOGNITION OF LIVED AND LIVING EXPERIENCE OF DRUG USE

We recognise the lived and living experience of people who use alcohol and other drugs, and those who have been impacted by use and harm. We recognise their contributions to this process, often at personal cost. We also acknowledge those who love, have loved or care for them.

CONTENTS

CO-CHAIRS

THE HON CARMEL TEBBUTT

A former NSW Deputy Premier and Minister, Carmel Tebbutt has made a significant contribution to public policy during her parliamentary career and, more recently, in CEO roles in the non-government sector.

Carmel was a member of the NSW Parliament for 17 years, including 11 years holding key ministerial portfolios in health, education and community services. She has deep knowledge of the mental health and alcohol and other drugs sectors, serving as the former CEO of the Mental Health Coordinating Council and the current CEO of Odyssey House NSW, one of the state's leading drug and alcohol rehabilitation services.

Carmel understands the impact harmful drug use can have on individuals, families and communities and the need for intervening early, integrating services and reducing stigma. Her extensive experience continues to drive impactful advancements in public health and drug policy.

Carmel has served on numerous boards and committees and is currently a director of the Australian Museum Trust and the Sydney Local Health District.

JOHN BROGDEN AM

John Brogden is a chairman, non-executive director and former member of the NSW Parliament. He has more than 30 years' experience in business, the public sector, and professional and not for profit organisations.

From 1996 to 2005, John was the Member for Pittwater. He was leader of the opposition for more than 3 years. After parliament, his executive roles included CEO of Manchester Unity, the Financial Services Council, the Australian Institute of Company Directors and Landcom.

John is a leading Australian and international suicide prevention advocate and campaigner for suicide decriminalisation. He is Honorary President of LifeLine International and was the Chair of Lifeline Australia for 10 years.

He is currently Chair of Australian Payments Network and the Advisory Board of Urban Property Group.

He holds a Master of Public Affairs from the University of Sydney, is a Fellow of the Australian Institute of Company Directors and is a Member of the Order of Australia.

FOREWORD

Drug policy reform is a difficult yet critical area of public policy. Developing a shared understanding of effective solutions is essential if we are going to reduce the harm caused by drugs to individuals and our community.

Whilst alcohol remains by far the most used drug in Australia, the use of illegal substances continues to adversely affect individuals, families, communities and the health and justice systems.

Far too many people do not get the help they need, when they need it, in the places and manner in which they need it. Lives and livelihoods are lost when more can and must be done.

In 2024 the NSW Government held the state's second drug summit, 25 years after the historic 1999 Drug Summit, to seek ideas, policies and strategies to reduce these harms.

Over 550 individuals and 250 organisations engaged in the process of meetings held over four days in regional NSW and Sydney. These views were augmented with thousands of online contributions. As co-chairs, we feel an enormous sense of responsibility to do justice in our report to the breadth of discussions that occurred.

These are the basis of the 56 priority actions that we recommend to the government in this report. They cover:

- The service system: Access, integration and design
- Funding models
- Prevention and early intervention
- Information and education
- Family and community support
- Youth-specific services
- Aboriginal social and emotional wellbeing and cultural safety
- Workforce
- Stigma and discrimination
- Cannabis and driving
- Harm reduction
- The criminal justice system and policing.

Some of these priorities are longstanding. Others are new, reflecting changes in the health and social environment over the last 25 years and with an eye to the future. None were possible without the discussions and deliberations at the summit, particularly the contributions of people with a lived and living experience who shared their stories.

We are grateful to all participants for every recommendation, and we particularly acknowledge those providing services on a daily basis.

The sheer breadth and number of recommendations requires us to identify priorities. In doing so we have chosen actions that we ask the government act on swiftly. We consider the priorities selected – and where needed the funding, policy and legislation required – can be commenced or fully actioned over the next 1 to 2 years.

Lastly, we believe that these priorities will change and improve the lives of many citizens of NSW. The government's response and implementation will be measurable across many areas. To this end we ask the government to report progress against our priorities transparently.

It is our privilege to present this important report to the NSW Government.

THE HON CARMEL TEBBUTT

JOHN BROGDEN AM

EXECUTIVE SUMMARY

The NSW Government announced in July 2024 that it would hold a drug summit to bring people together to find 'new ways forward' to improve outcomes for people impacted by drugs in NSW.

The summit announcement was in line with the government's commitment to improving drug-related outcomes in NSW. The National Drug Strategy 2017–2026 clearly outlines the well-recognised and evidence-based harm minimisation approach that acknowledges drug use is primarily a health issue. However, growing evidence links social disadvantage and co-occurring mental and physical health concerns with drug use and harms. It is important that this understanding informs new policies and services, taking into account opportunities and challenges seen internationally in recent years.

The 2024 NSW Drug Summit included a range of activities held in the final months of 2024. These included 4 days of forums, targeted discussions with experts, submissions by organisations and individuals, and a 5-week online consultation process open to the public.

Consultations were designed to gather a variety of perspectives from people working in the sector, experts, families and members of the community. They also involved listening to those with lived and living experience of drug use and harms to gather vitally important guidance and ensure services and programs are informed by the experiences and voices of the people they serve. The goal was to identify and understand challenges and opportunities, to generate achievable actions for better health outcomes for people in NSW impacted by drugs.

The drug summit forums were held in 3 locations: Griffith on 1 November, Lismore on 4 November and Sydney on 4–5 December. They included families, Aboriginal community leaders, justice representatives and frontline service providers. Attendees had expertise in areas ranging from lived and living experience to health and policing. Members of parliament from across the political spectrum also attended. In addition, we received more than 3,600 submissions through the 'Have your say' portal, and over 80 submissions and position statements from organisations and individuals. Multiple additional consultations were also held.

We examined all aspects of the vast and richly detailed consultations and submissions. This report summarises the key discussions and deliberations, and considers the resulting major themes. The companion document and appendices contain detailed discussions that might not be captured in this report and provide an in-depth analysis of submissions and the responses received through the 'Have your say' portal. We encourage readers to consider them together.

PRIORITIES FOR ACTION

Based on our broad-ranging consultations, we recommend that the NSW Government consider the following 56 priority actions, grouped into 12 overarching topics.

1 The service system: Access, integration and design

1.1 Within 12 months, release a 10-year whole-of-government alcohol and other drugs strategy that:

- **i.** is underpinned by a harm-minimisation approach
- **ii.** is developed and implemented by a steering committee comprising members from relevant government and non-government agencies
- **iii.** appropriately addresses the disproportionate harms experienced by Aboriginal communities
- **iv.** includes a whole-of-government monitoring and evaluation framework.

1.2 Ensure new or redesigned programs and services are co-designed with the communities they serve.

1.3 Engage with culturally diverse communities and their leaders to better understand how to use evidence-based treatments to reduce drug-related harms in their communities and enhance community awareness and acceptability of drug use as a health issue.

1.4 Ensure specific and inclusive program delivery and service access to meet the unique needs of diverse communities, including lesbian, gay, bisexual, transgender, queer and intersex (LGBTQI+), culturally and linguistically diverse and Aboriginal communities.

1.5 Appropriately fund the integration of health and social services through innovative models that respond to the holistic needs of clients, including availability of mobile and/or telehealth services, and digital programs and navigation support.

1.6 Ensure access to specialist mental health services is available in all residential rehabilitation services that receive public funding, in order to increase the number of residential rehabilitation facilities that cater to individuals with co-occurring conditions.

1.7 Improve alcohol and drug treatment services (including detox) in custodial settings (including remand) and post release.

1.8 Support research and development in new and existing pharmacotherapies for methamphetamine use disorder and other emerging drugs of concern.

2 Funding models

2.1 Significantly increase funding for alcohol and other drugs services to address unmet need and client complexity. Funding increases should commence within six months and distribution should be informed by:

- **i.** a population-based service planning model
- **ii.** a focus on equitable access across rural and remote NSW
- **iii.** weighting to reflect the higher cost of service provision in rural and remote areas
- **iv.** a demonstration of outcomes.

2.2 Provide 5-year funding contracts for non-government service providers that include cost escalation and support for service evaluation and aligned contract conditions, where possible, to improve service stability and workforce retention.

3 Prevention and early intervention

3.1 Enhance funding for prevention and early intervention programs, prioritising the first 2,000 days of a child's life.

3.2 Provide safer and more affordable housing through increased investment in public and social housing, including support for transitional housing, and prioritising Housing First models.

3.3 Increase place-based local programs that build community capacity and connection, including out-of-school-hours activities and community events.

3.4 Ensure greater access to learning and development opportunities across the alcohol and other drugs, 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 use.

4 Information and education

4.1 Ensure all health professionals receive alcohol and other drugs education and training that includes trauma-informed care and addresses stigma and discrimination.

4.2 Expand evidence-based age-appropriate alcohol and other drugs education in schools and other community settings.

4.3 Co-create social media content with young people to provide credible information about drugs and treatment.

4.4 Where required, support provision of community-led and targeted information and community development activities to meet the specific needs of priority population groups.

4.5 Improve alcohol and other drugs education and health promotion with a high-profile awareness campaign for the community.

5 Family and community support

5.1 Enhance family-inclusive practices and expand support services for families and carers impacted by alcohol or other drugs use to fully meet need.

5.2 Improve navigation tools and access points for families seeking support, including implementing a lived and living experience ambassador program.

5.3 Expand specialised alcohol and other drugs support and treatment for pregnant women, parents and the first 2,000 days of their child's life, particularly where there is a risk of child removal.

5.4 Strengthen education and capacity-building initiatives with community and faith-based leaders to address stigma and cultural barriers to seeking support.

6 Youth specific services

6.1 Increase co-design of services and navigation tools with young people and the peer workforce.

6.2 Enhance access to treatment and support for children and young people, particularly those with complex needs, using flexible approaches and access points (e.g. 'no wrong door' approach and co-located services).

6.3 Implement harm-reduction education, community engagement and resilience-building programs.

6.4 Increase the availability of supported accommodation and transitional housing for young people.

7 Aboriginal social and emotional wellbeing and cultural safety

7.1 Elevate the role of, and enhance supports for, the Aboriginal community-controlled sector to deliver holistic supports for people impacted by alcohol and other drugs.

7.2 Expand access to culturally safe services for Aboriginal communities by supporting holistic and culturally grounded Aboriginal led approaches, particularly in mainstream services.

7.3 Improve trauma-informed care and support for Aboriginal children and parents impacted by drugs, with a focus on family rebuilding, particularly for Stolen Generations survivors.

7.4 Prioritise appropriately funded and Aboriginal-led prevention, early intervention and family support, to meaningfully address high rates of child removal and redress the disproportionate harms experienced by Aboriginal people and communities through system improvements that reduce involvement in the criminal justice and out of home care systems.

8 Workforce

8.1 Fully implement the *NSW Alcohol and Other Drugs Workforce Strategy 2024–2032*.

8.2 Increase funding for workforce development and sustainability across the government and non-government sectors and disciplines.

8.3 Expand the peer workforce across the spectrum of alcohol and other drugs services, including the Aboriginal peer workforce.

8.4 Optimise care and outcomes for clients of alcohol and other drugs services by ensuring vocational and professional training that addresses stigma and discrimination.

8.5 Provide appropriate supervision and supports to strengthen frontline alcohol and other drugs staff capability and wellbeing.

8.6 Expand access to opioid substitution treatment and improve integration with primary care, including increasing the number of general practitioners and nurse practitioners who prescribe opioid substitution treatment.

9 Stigma and discrimination

9.1 Ensure that the NSW Government collaborates with relevant stakeholders to strengthen the implementation of the Mindframe guidelines for the media.

9.2 Establish a taskforce to report in 12 months on how the NSW Public Service will take a leadership role in reducing stigma and discrimination by:

- **i.** removing barriers to employment for people with lived and living experience
- **ii.** integrating the perspectives of people with lived and living experience into policies, programs and training.

9.3 Develop, using co-design processes, community education campaigns to address stigma and discrimination.

9.4 For the purposes of the *Criminal Records Act 1991*[1], reduce the period for a conviction for use or possession of a prohibited drug to be considered spent from 10 years to 5 years for adults, and 3 years to 1 year for juveniles, for minor drug offences.

1 *Criminal Records Act 1991* (NSW). Available at https://legislation.nsw.gov.au/view/whole/html/inforce/current/act-1991-008.

10 Cannabis and driving

10.1 Legislate for a medical defence for people using medically prescribed cannabis who are driving and include:

- **i.** an option for police at the roadside or a court to assess the defence
- **ii.** guidelines that are developed by relevant government agencies (such as Transport, Health, Police and Justice) to support implementation
- **iii.** a review after 12 months.

11 Harm reduction

11.1 Immediately implement a pilot of drug-checking services at music festivals, which includes:

- **i.** a health and peer workforce
- **ii.** provision of harm-reduction advice
- **iii.** an exclusion zone
- **iv.** integration with the current drug surveillance and early warning system
- **v.** an evaluation that can inform additional models such as a fixed-site drug checking service/s.

11.2 Enhance current drug monitoring systems to prepare for the emergence of new drugs of concern in Australia.

11.3 Amend section 36A of the *Drug Misuse and Trafficking Act 1985* (NSW) to remove the legislative restriction that currently limits medically supervised injecting centres to one premises in Kings Cross, noting substantial community consultation would be required to accompany any decisions about establishing additional medically supervised injecting centres.

11.4 Expand the delivery and accessibility of evidence-based harm reduction strategies including needle and syringe programs, particularly in regional, rural and remote areas.

12 The criminal justice system and policing

12.1 Reform the Early Drug Diversion Initiative to extend eligibility criteria to address restrictions relating to possession of multiple drugs, criminal history and threshold drug quantities; limiting police discretion with an assumption of diversion for personal use quantities; and ensuring a clear monitoring and evaluation framework.

12.2 Ask the Attorney-General to review opportunities for consistency in the Cannabis Cautioning Scheme and the Early Drug Diversion Initiative.

12.3 Expand the Magistrates Early Referral into Treatment program to fully meet demand.

12.4 Expand the Drug Court to regional areas, prioritising the Far North Coast, the Central Coast and Wollongong, ensuring accompanying service infrastructure.

12.5 Strengthen diversion programs for young people, including by better utilising and reforming the *Young Offenders Act 1997* (NSW) and consider reinstating the Youth Drug and Alcohol Court of NSW.

12.6 Expand access to alternative sentencing models for Aboriginal people, including the Walama List, Youth Koori Court, Circle Sentencing and Justice Reinvestment.

12.7 Increase police understanding of available local health and social services to support referrals.

12.8 Provide comprehensive harm-reduction training for NSW Police officers and other relevant first responders and equip them with naloxone to respond to opioid overdoses.

12.9 Strengthen enforcement of illicit drug supply, targeting suppliers.

12.10 Cease the use of drug detection dogs and strip searching for suspected drug possession during the current trial of drug-checking services at music festivals, with consideration to extending this to all music festivals.

INTRODUCTION

The 2024 NSW Drug Summit occurred 25 years after the historic 1999 NSW Drug Summit, recognising the evolving nature of drug-related challenges and the need for evidence-based policy reform. The 2024 Drug Summit built on the report and recommendations of the Special Commission of Inquiry into the Drug 'Ice'.

It brought together people with diverse voices and views – including those with lived and living experience, health experts, police officers, families, Aboriginal community leaders and frontline service providers – to gather a range of perspectives. This enabled an understanding of what was working well and where improvement was needed, building on the government's commitment to better outcomes for people impacted by drugs.

The 1999 NSW Drug Summit marked a significant and enduring shift in Australian drug policy by championing harm-reduction approaches and leading to initiatives like the Uniting Medically Supervised Injecting Centre in Kings Cross, Sydney. The Drug Summit's recommendations helped transform drug use from being seen as a criminal justice issue to being recognised as a public health challenge, influencing policy reforms across Australia. Its lasting impact can be seen in Australia's adoption of a harm minimisation approach, expanded treatment options, and more nuanced public discourse around drug policy that continues to shape approaches to substance use today.

By contrast, the 2024 NSW Drug Summit occurred at a time of increased public support for harm- reduction approaches and recognition of drug use as primarily a health issue. A quarter-century of research, data and practical experience implementing harm-reduction programs provided policymakers with evidence of what works. At the same time, successful reforms, ranging from cannabis policy changes internationally to initiatives in other Australian states and territories, such as drug-checking services at festivals, expanded options for discussion and consideration.

Increasingly, links between substance use, mental health and social disadvantage, and rising concerns about youth mental health and wellbeing as well as family and domestic violence in NSW, are being recognised. Concerns are also growing about challenges experienced in other countries, such as people overdosing on fentanyl and other novel synthetic substances. At the same time, social media and other forms of digital communication have increased public discourse about evidence-based approaches to drug use and related issues in NSW.

The Drug Summit process included forums that enabled participants to speak and to listen, increasing their understanding of the issues and how they impact a range of people and communities in NSW. It also included discussions with experts, submissions from organisations and responses received via the 'Have your say' portal.

From this broad-ranging consultation process, we developed priorities for action for the NSW Government to consider. These are in line with the National Drug Strategy's focus on harm minimisation through reducing harm, supply and demand and seeks to extend this to all people in NSW, regardless of location, background or socio-economic circumstances.

The priorities focus on addressing the impact of drug use on individuals, families and communities, and the underlying causes that contribute to harmful drug use. Fundamental to improving responses to drugs in NSW is the ongoing work of reducing stigma, which enables more effective community responses by encouraging open dialogue, earlier help seeking, and broader participation in developing and implementing solutions.

DRUG SUMMIT THEMES

HEALTH PROMOTION AND WELLBEING

Health and wellbeing describe quality of life and the ability to contribute to the world with a sense of meaning and purpose. The conditions in which people are born, grow, work, live and age – known as the 'social determinants of health' – significantly influence health outcomes. Health promotion activities support the social, environmental and economic conditions that promote health through education, campaigns, legislation and regulation. Such initiatives focus on building social and physical environments that support healthy behaviours and reduce harms. Key health promotion and wellbeing responses relevant to drug use include drug harm prevention programs, harm-reduction services, drug treatment services, and programs to address prescription drug misuse.

EQUITY, RESPECT AND INCLUSION

Outcomes are improved when services are inclusive and accessible, and people are treated with fairness and respect. Health is a fundamental human right, and supporting equitable service access and health outcomes has far-reaching social benefits. Achieving equitable access and inclusion relies on addressing avoidable social, economic, demographic and geographic barriers. Services must be oriented to those who need them most, including young people, Aboriginal people and communities, people in regional areas, and members of culturally diverse populations. Special attention is needed for populations that may experience more drug-related harms or require greater access to services, including LGBTQI+ communities and people experiencing family and domestic violence.

SAFETY AND JUSTICE

Australia's national approach to addressing drug use is known as 'harm minimisation', which relies on a coordinated health and justice response. This comprehensive approach works to reduce demand, regulate and disrupt supply, and reduce harm when use occurs. Key areas encompass law enforcement responses to drug use, use of penalties, and programs that focus on diverting people away from the justice system. This approach also addresses responses that enable safe and liveable communities, while recognising the role of alcohol and other drugs in exacerbating domestic and family violence.

KEEPING YOUNG PEOPLE SAFE AND SUPPORTING FAMILIES

Early drug use is associated with immediate and lifetime health risks, increased harm to the developing brain and increased likelihood of substance dependence. Supporting young people and families can have lifelong health, social and financial benefits, starting with ensuring babies and children have the best start in the first 2,000 days of life. Key approaches include providing age-appropriate and evidence-based education, ensuring the availability of early intervention services, and supporting families caring for someone struggling with substance use. Setting-specific responses, including at music festivals, and drug-checking services are critical components.

INTEGRATED SUPPORT AND SOCIAL SERVICES

Specialist treatment and support services help people dealing with a drug issue and their families while addressing the underlying social determinants of health. These critical services include mental health support, housing and support transitioning out of custody. The integration and connection of support and social services shape their effectiveness, requiring service coordination and continuity across the continuum of care. Key responses include treatment and rehabilitation services, housing and employment support, integrated linked data, and services addressing domestic and family violence with co-occurring alcohol and other drugs (AOD) use.

DRUG SUMMIT PROCEEDINGS

The Drug Summit was held over 4 days, with single-day forums in Griffith and Lismore, and a 2-day forum in Sydney. Both regional forums included a panel discussion followed by 2 facilitated theme based discussion groups.

The Sydney event included keynote presentations and small and large facilitated discussion groups. (Recordings of the Sydney forum plenary sessions are available at Watch the NSW Drug Summit 2024 on the NSW Health website.)

GRIFFITH

The Griffith Leagues Club hosted the forum on 1 November 2024. (The organisations represented are available at Appendix A.)

First, there was a visit by Minister Park and the co-chairs to Pathways NSW, a service delivered by Directions Health Services. Pathways NSW runs programs in regional areas (Moruya, Cooma, Goulburn, Wagga Wagga and Griffith) that offer a range of community-based services, as well as treatment and support services, to individuals, families and friends impacted by alcohol, tobacco and other drugs.

Then the forum opened with a Welcome to the Wiradjuri Nation by Ms Desma Newman. Multiple members of parliament attended, including the local member, Mrs Helen Dalton MP, Member for Murray.

A panel of 5 speakers provided local perspectives and priorities relating to AOD services. The panel included Ms Anna McKenry, Clinical Advisor (Executive) of Karralika Programs; Ms Vickie Louise Simpson, Chair of the Aboriginal Corporation Drug and Alcohol Network (ACDAN) and Regional Alcohol and Other Drugs and Social and Emotional Wellbeing Coordinator at the Griffith Aboriginal Medical Service; Dr Hester Wilson, Clinical Director of Alcohol and Other Drugs Services at Murrumbidgee Local Health District (LHD) and the Chief Addiction Medicine Specialist for the NSW Ministry of Health; Assistant Commissioner Joe Cassar APM, NSW Police Southern Region; and Mr Spencer Barberis, Peer Worker at Murrumbidgee LHD. (Speaker biographies are available at Appendix B.)

The panel discussion brought together people with a range of perspectives – from healthcare providers, community service representatives, including peer workers and law enforcement – to explore challenges and opportunities in addressing drug use across the community.

Rural and regional areas were described as facing substantial challenges with limited resources, geographical barriers and insufficient access to care, particularly for Aboriginal communities. The experience of stigma and its amplification in rural and remote areas was highlighted. Different perspectives were heard, with some panellists identifying issues including the impact of drug-related offences, increasing incidents of violence, behavioural disturbance and mental health concerns. The culture of acceptability of drug use among young people, particularly around cocaine use, was highlighted as a significant concern.

Service providers reported that many individuals only seek help when there is a crisis rather than accessing early intervention services. They said there was an observable increase in trauma and the complexity of the presentations of those affected by drug use.

Several initiatives were endorsed as working well, including diversion programs such as the Magistrates Early Referral into Treatment (MERIT) program, the Cannabis Cautioning Scheme (CCS) and the Early Drug Diversion Initiative (EDDI). However, it was noted that low numbers of people were accessing EDDI and there are issues with its implementation in rural and regional areas. Some panellists praised the Australian Capital Territory's fixed-site drug testing service, though it was noted that it faces ongoing challenges with uptake.

Panellists acknowledged workforce challenges, particularly retention and burnout, and specific challenges in recruiting for Aboriginal communities. Interactions between drug use and out-of-home care and child protection were mentioned as concerning. There was an emphasis on finding culturally appropriate solutions for Aboriginal people, including staying on Country.

Reducing stigma around substance use and improving service accessibility and wraparound models were seen as important for improving outcomes. Discussion highlighted the importance of moving beyond approaches that focus on individuals to addressing broader systemic issues, while also ensuring services are culturally appropriate and maintain privacy, particularly in smaller communities where lack of anonymity is a concern. Strong inter-agency collaboration was noted as a key factor in successful interventions, though resource constraints continue to limit the scope and reach of many programs.

Following the panel discussion, 2 breakout sessions were held with participants allocated to key focus areas, based on preference, for facilitated and small-group discussions. Plenary sessions discussed outcomes from breakout sessions, and we gave closing addresses. (The program is available at Appendix C.)

LISMORE

The Lismore Workers Club hosted the forum on 4 November 2024 (the organisations represented are available at Appendix A). First, there was a visit by the Minister for Health and co-chairs to The Buttery, a not-for-profit charity working with people who have addiction and mental health conditions. It delivers evidence-based short- and long-term residential rehabilitation and outreach programs to support people to recover and rebuild their lives.

Then the forum opened with a welcome to Bundjalung Country provided by Uncle Gilbert Laurie and Aunty Thelma James. Multiple members of parliament attended including Ms Janelle Saffin MP, the Member for Lismore.

A panel of 5 speakers provided local perspectives and priorities relating to AOD services. The panel included Dr Patricia Collie, Clinical Director, Alcohol and Other Drugs, Northern NSW LHD; Ms Leone Crayden, CEO of The Buttery and Chair of the Network of Alcohol and other Drugs Agencies; Assistant Commissioner David Waddell, NSW Police Northern Region; Ms Di Edwards, CEO Namatjira Haven; and Mx Mel Sass, People and Pathways Coordinator at the Beacon Laundry.

The panel brought together diverse stakeholders to examine challenges and potential solutions in the Northern Rivers region. They included law enforcement leadership, healthcare professionals, community service organisation executives, and representatives with lived and living experience of AOD use. From a policing perspective, it was identified that drug supply and related crime are a major police focus, alongside responding to violence and critical incidents. Motor vehicle accidents were also highlighted as a significant area requiring police response.

From both AOD service delivery and lived and living experience perspectives, several problems were identified including insufficient access to care and appropriate social services, under resourced services that are struggling to manage highly complex cases, and workforce shortages that are creating long waiting lists.

Panellists noted that barriers to accessing support included stigma and discrimination – this includes community perceptions and fear of potential loss of employment. The panel acknowledged the increase in the number of people in the workforce with lived and living experience was a positive step toward challenging negative attitudes and beliefs.

The discussion emphasised the need for health promotion and education targeted at younger ages, particularly using a whole-of-community approach including schools, to change the trajectories of young peoples' lives. Complexity in navigating the health system was raised as a contributing issue, with prospective clients applying for residential rehabilitation facing onerous paperwork, and clients being bounced between services when seeking help. Hub models and compassionate workforce practices were cited as an important part of the solution.

Regarding aspects of the system that are working well, Lismore's culture of collaboration and partnership in care delivery was highlighted as a strength. Service integration between the AOD sector and mental health services was occurring. However, consistent funding was identified as needed for stable service delivery. Law

enforcement, court diversion programs, the CCS, the MERIT program, multi-agency programs and partnerships delivering wraparound programs – including youth support, vocational education and counselling – were praised as effective.

Panellists' hopes for the Drug Summit outcomes included the actualisation of accessible and wide-ranging treatment along the continuum of care, regardless of setting, person-centred approaches to care, and expanded access to diversion programs.

Two breakout sessions were held before and after lunch, with participants allocated to key focus areas, based on preference, for facilitated and small group discussions. Plenary sessions covered outcomes from breakout sessions and we gave closing addresses. (The program is available at Appendix C.)

SYDNEY

The forums were held on 4–5 December at the International Convention Centre in Darling Harbour. (The organisations represented are available at Appendix A.)

Day 1

Arrernte and Barkindji Elder Uncle Brendan Kerin from the Metropolitan Local Aboriginal Land Council gave a welcome to Country. The Hon Chris Minns MP, Premier of NSW, then delivered opening remarks. Invited speakers were asked to provide key updates and their perspective, based on their experience.

Dr Annie Madden AO, Executive Director of Harm Reduction Australia, was one of 2 speakers who had addressed parliamentarians at the 1999 Drug Summit. Dr Madden encouraged delegates at the 2024 Drug Summit to use evidence and experience when advising the NSW Government on behalf of affected individuals and families. She urged the government to implement the recommendations it receives. On behalf of Harm Reduction Australia, she outlined 6 key proposals for NSW drug policy reform, including expanding harm-reduction funding, implementing pill testing, increasing AOD treatment resources, improving opioid overdose prevention measures, reforming drug driving laws, and taking a staged approach to drug decriminalisation, with potential future regulation.

Associate Professor Amy Peacock, Deputy Director of the National Drug and Alcohol Research Centre (NDARC) and a National Health and Medical Research Council (NHMRC) Emerging Leadership Fellow presented data on the use of substances in NSW. Alcohol is the most used drug (excluding tobacco). Of the illicit substances, cannabis continues to be the most used, followed by cocaine, opioids, MDMA and methamphetamines. Rates of harms associated with these drugs have changed over time yet the burden of these harms is still substantial and experienced disproportionately by marginalised populations. Associate Professor Peacock explored opioids, methamphetamines and cannabis-related harms in detail. She noted the complex and dynamic nature of modern drug markets and discussed key emerging trends, such as the increased purity and availability of some drugs and increased harm from novel synthetic drugs and drug adulteration.

Professor Maree Teesson AC, Director of the Matilda Centre for Research in Mental Health and Substance Use and a NHMRC Leadership Fellow at the University of Sydney, emphasised the critical role of prevention and early intervention in drug policy. Noting that substance use typically begins during adolescence, she presented evidence of effective programs such as OurFutures. The results from the Australian Treatment Outcome Study, which tracked 600 individuals with heroin dependence over 20 years, was presented. This study showed that heroin dependence is associated with high mortality, but treatment is highly effective.

Mr Ted Wheeler, Mayor of Portland, Oregon from 2017 to January 2025, was a key figure in the city's decision in 2020 to decriminalise possession of small amounts of illicit drugs, downgrading it to a civil citation, with a focus on treatment services. While the state Senate repealed the decriminalisation in 2024, Mr Wheeler emphasised the lessons learnt. These included the need to prepare carefully before such a move – including having comprehensive infrastructure, transportation, treatment facilities, outpatient services and housing. He reflected on the inadequate treatment capacity and lack of a staged approach to drug decriminalisation in Portland that contributed to a range of adverse outcomes.

NDARC's Professor Don Weatherburn PSM, a former Executive Director of the NSW Bureau of Crime Statistics and Research, presented key questions that should be considered when making decisions about drug policy. He described the potential effects of decriminalisation, including benefits for specific groups such as Aboriginal people who experience disproportionate harm from prosecution, a lower likelihood of being offered diversion and an increased likelihood of arrest. He also discussed harms from decriminalisation and presented mixed evidence of its effect, including likely differences that depend on the drug in question.

Professor Alison Ritter AO, Director of the Drug Policy Modelling Program at the University of New South Wales, described the complexity of drug policy and the obligation for all government portfolios to be concerned with its development and outcomes. She described 4 key goals of drug policy – reducing the supply of drugs, reducing the demand for drugs, minimising harms from drug use and supply, and preventing or delaying drug use initiation.

She outlined opportunities for big picture reforms as well as small and no-cost reforms. Understanding the context of drug use and harms in NSW is vital for successful policy, as well as using existing evidence of effective policy levers. Professor Ritter described using the uniting principles and shared values of inclusivity, justice and compassion to guide the outcomes of drug policy.

Dr Madden, Associate Professor Peacock, Professor Teesson, Professor Weatherburn and Professor Ritter participated in a panel discussion. Concerns were raised about examining issues affecting Aboriginal people without Aboriginal representation. Associate Professor Michael Doyle, a Bardi man and head of the Aboriginal and Priority Populations team at the Edith Collins Centre, University of Sydney, was invited to join the panel. We thank Associate Professor Doyle for providing his perspectives and recognise that Aboriginal representation was required for this discussion.

Panel members noted the concerning over-representation of Aboriginal people in the criminal justice system, prisons, and AOD treatment programs, citing evidence that one in 4 people entering treatment are an Aboriginal person. They emphasised that responses to these issues must be governed, led and driven by Aboriginal people. Associate Professor Doyle highlighted the uneven application of 'well-intentioned diversion'. Both Associate Professor Doyle and Professor Weatherburn suggested that removing police discretion in the application of diversion and caution schemes would help reduce Aboriginal peoples' contact and pursual through the justice system.

On the topic of stigma, Dr Madden provided powerful insights, indicating that "criminalisation, that is what drives people's attitudes towards people that use drugs". She said people equate illegal with immoral and as a result feel they have a right to treat people who use drugs as inferior. She called for personal action, urging everyone to challenge stigmatising language whenever or wherever it was encountered. Regarding future directions, Dr Madden advocated for increased funding for existing initiatives, noting that many "very effective programs are doing half the job they could really do". She also supported the introduction of drug-checking services, stating "the evidence is well and truly in".

Associate Professor Peacock highlighted several effective harm-reduction initiatives, noting that compared to the United States, NSW and Australia have effective treatment options for opioid dependence that have prevented loss of life. She specifically mentioned the success of needle and syringe programs, take-home naloxone, and medically supervised injecting centres in preventing overdoses. Associate Professor Peacock also discussed the evaluation of drug checking in the Australian Capital Territory, emphasising benefits beyond substance disposal, including connecting people to services and providing information on high-risk substances.

Professor Ritter called for legislative amendments to facilitate additional medically supervised injecting centres, citing research that 62% of Australians support these changes. She emphasised place-based initiatives in which communities develop their own solutions, stating, "It's not about the government deciding, but about the government removing barriers for communities to then decide what they want".

In the afternoon, 2 breakout sessions were held, with facilitated small-group discussions. The sessions focused on the 5 Drug Summit themes. Delegates had the opportunity to attend 2 separate breakout sessions, allowing them to contribute to 2 different themes.

To complete day one, delegates heard from Mr Kurt Simpson, a Gamilaraay man from Walgett who is the Aboriginal Program Coordinator at South West Sydney LHD and a Board member of ACDAN. Mr Simpson spoke about his passion for his work in AOD services and shared his personal story of addiction and its effect on his life and the lives of his family members. In speaking about his journey, Mr Simpson described the importance of culture in healing. In the tradition of his people, he considers himself a knowledge holder, someone who can share his experience with addiction and help other people find pathways out of drug use.

Day 2

The Minister for Health, Minister for Regional Health and Minister for the Illawarra and the South Coast the Hon Ryan Park MP, gave the opening address on day 2. Invited speakers were asked to provide key updates and their perspectives, based on their experience.

Professor Dan Howard SC, who led the Special Commission of Inquiry into the Drug 'Ice', spoke about the inquiry's recommendations, their ongoing relevance and the need for continued legislative reform. The results of the inquiry were delivered in an extensive and independent report, with 109 recommendations to the NSW Government in January 2020. The report has been widely acknowledged in the AOD sector as providing a blueprint for contemporary drug policy and law reform in NSW.

Professor Howard highlighted initiatives that could be achieved as a result of the Drug Summit, including decriminalisation of simple use and possession. He called for the redesign of the Early Drug Diversion Initiative to remove police discretion, and for a realistic approach to quantities permitted for personal use. He also highlighted the need to expand medically supervised injecting centres, to introduce drug checking services, improve school and community drug education, and further expand and properly resource treatment services. Professor Howard also stated that much more needs to be done to ensure that prisoners have proper access to treatment and rehabilitation programs, harm-reduction programs and effective supports on returning to the community.

Ms Megan Moses, a drug reform advocate, detailed the harmful effects of stigma on her life and on the lives of people who use substances, sharing personal reflections of pivotal moments in her life. Ms Moses said stigmatising views of substance use are entrenched in community thinking, describing it as the 'cement' that prevents change. She said she extrapolated the message she received from a young age – that 'drugs are bad' – to 'drug users are bad'. Ms Moses began advocating to end stigma after speaking at an event hosted by the Medically Supervised Injecting Centre 4 years ago. She encouraged Drug Summit attendees to look inward for willingness to view this issue with compassion instead of judgement.

Dr Mary Ellen Harrod, CEO of the NSW Users and AIDS Association (NUAA), said she understands that pregnant women seeking drug treatment faced an unfair choice. By seeking health care, pregnant women face their baby being removed at birth, effectively preventing them from accessing health care during pregnancy. Dr Harrod, whose non-government organisation (NGO) works to improve the health and human rights of people with lived or living experience of illicit drug use, also spoke about the effect of stigma on individuals, including herself. She called on members of parliament to take on the once-in-a-generation chance the Drug Summit provided to bring about much-needed change, noting the frustration and anger of many as opportunities slip by. Dr Harrod called on the government to commit to a drug strategy and to enhance the lived and living experience workforce, including by removing structural barriers such as criminal record checks that prevent those with a history of substance use from gaining employment.

In addition to speakers, panellists were available to participate in 5 breakout sessions (these are listed in Appendix B). The panellists discussed the solutions the regional forums and the breakout sessions on the first day of the Sydney forum offered for each theme. Polling was conducted to determine which were most supported by participants. The chair of each breakout panel presented these solutions and other relevant issues for further discussion in the plenary session. Feedback from the breakout sessions conveyed disappointment with some of the solutions offered for polling, with some groups choosing not to poll final priorities. We reassured attendees that the scribed notes for each breakout session would be fully examined and aspects would be included in the final report. (The program is available at Appendix C.)

ABORIGINAL YARNING CIRCLE

Following the Sydney forum, and the concerns raised by some attendees that Aboriginal perspectives were not fully heard during the Drug Summit, a yarning circle was arranged for Minister Park and Aboriginal representatives. A yarning circle aims to have those present share ideas and knowledge and build relationships without a formal hierarchy. The yarning circle was held at the National Centre for Indigenous Excellence on 6 February 2025. It was guided by a working group chaired by Ms Tina Taylor, a Ngiyammpaa Weilwan woman and Senior Aboriginal Engagement Officer with the NSW Ministry of Health, and Associate Professor Michael Doyle. (The working group's report on the yarning circle is available at Appendix D.)

Members of the working group put considerable personal time into preparing for and reporting on the findings of the yarning circle. We thank the working group for their dedication and productive information sharing. The report is a critical review of Aboriginal affairs and was instructive to this process.

YOUTH SESSION

More than 35 attendees participated in a dedicated youth session held over lunch on the first day of the Sydney forum. Young people were invited to speak with the co-chairs about their priorities for action. Contributions from this session were scribed and have been incorporated into this report.

Youth delegates raised concerns that insufficient time was allocated to exploring their priorities and solutions in detail. A follow-up consultation was held, with facilitation and secretariat support from the NSW Ministry of Health, on 19 December 2024 (the outcomes have been incorporated into this report). A later submission, 'Youth Statement on the NSW (Sydney/Gadigal) Drug Summit', was shared with Minister Park and the Minister for Water, Minister for Housing, Minister for Homelessness, Minister for Mental Health and Minister for Youth, the Hon Rose Jackson MLC (the submission is available at Appendix E).

We also thank the many youth representatives who put their time and effort into delivering this statement.

OTHER PRIORITY GROUPS

It is also noted that other priority groups – particularly culturally and linguistically diverse communities, and lesbian, gay, bisexual, transgender, queer and intersex (LGBTQI+) communities – echoed the sentiments raised by Aboriginal people and youth regarding representation of voice and the importance of ongoing discussions and priority setting to meet community needs. Culturally and linguistically diverse community leaders have requested to meet, and Minister Park has agreed, and further targeted consultation with the LGBTQI+ community are underway.

CONSULTATIONS

The public also had an opportunity to provide input to the Drug Summit through a public consultation process.

'HAVE YOUR SAY'

The NSW Government invited public consultation via the 'Have your say' portal for 5 weeks from October to November 2024. The survey was shared with more than 5 million people and received 3,669 responses. Survey responses came from people with a wide variety of perspectives: 48% had lived or living experience of drug use, 31% were from rural or regional NSW, 14% identified as LGBTQI+, 5% were Aboriginal and/or Torres Strait Islander people, 13% were from a culturally or linguistically diverse background, 25% reported a lived experience of disability and 13% reported having experienced homelessness. (A full summary of the 'Have your say' responses can be found in the companion document.)

WRITTEN SUBMISSIONS

In addition to the public submissions received through the 'Have your say' portal, NSW Health received more than 80 submissions and position statements from organisations and individuals through the NSW Drug Summit email address. The submissions captured a variety of views, including from people with lived and living experience of drug use, families, young people, researchers and academics, healthcare workers, AOD organisations and services, justice and legal representatives, and people working in law enforcement. (A full summary of the submissions and public position statements is available in the companion document.)

TOPICS AND PRIORITIES FOR ACTION

1. THE SERVICE SYSTEM: ACCESS, INTEGRATION AND DESIGN

A. Access to treatment and support

Effective, available and affordable treatment for people with substance use or dependence is crucial for improving their physical and mental health, reducing their substance use and its complications, and enhancing their quality of life. Access to treatment and support relies on increasing the availability of services – including the number, geographical spread and sufficiency of funding to operate at full capacity – and reducing barriers in existing services to enable certain population groups to access safe and effective care. There was a shared concern about unmet demand for treatment and support.

A Drug Policy Modelling Program analysis has estimated *"there are 101,773 people in NSW who do not receive treatment despite being suitable for and wanting treatment"*.[2]

Additionally, Drug Summit participants broadly agreed that the growing complexity of people's needs means multidisciplinary teams are required to provide AOD treatment and post-treatment support (also known as 'continuing care'), and to address the underlying issues contributing to drug use.

The Drug Summit heard that the government has made a significant investment in services as part of its response to the Special Commission of Inquiry into the Drug 'Ice', but more is required to meet need. This investment has largely been used to establish new services, but funding for existing services has not kept pace with need and the complexity of presentations. Adequate funding for AOD services across the spectrum of prevention, detoxification (withdrawal management), treatment and post treatment was a key priority for many participants. In particular, participants called out the need to increase funding to improve access to detox specific services, particularly for women with children. They highlighted specific challenges relating to services in regional areas, including limited availability of services, infrastructure, distance to services, and challenges with workforce recruitment. It was suggested that a population-based service planning model, such as the Drug and Alcohol Service Planning Model, be used to inform need and the allocation of new funding.[3]

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

Female, 55–64 years, culturally and linguistically diverse community member, living in a metropolitan area

When planning improved access, consideration should be given to innovative models and structural supports, including telehealth, mobile services, after-hours services, transport supports and flexible treatment options. Opioid treatment was frequently raised during consultations, with a recommendation to expand the NSW Opioid Treatment Program (OTP) and better integrate it with primary care. Issues with the current delivery of the OTP included limited access in regional areas, pharmacy participation barriers, and stigma limiting engagement.

2 A Ritter (2024). *Evidence brief: The NSW non-government alcohol and other drug sector*. Drug Policy Modelling Program, UNSW Sydney.

3 Social Policy Research Centre (2024). Drug and Alcohol Services Planning Model (DASPM), UNSW Sydney. Available at https://www.unsw.edu.au/research/sprc/our-projects/drug-and-alcohol-services-planning-model-daspm.

B. Priority populations

To ensure equitable access, it is essential that services are inclusive and accessible for priority populations, including people from culturally and linguistically diverse backgrounds, women with children, families, young people, LGBTQI+ community members, people living with disability, people in and exiting custody, and neurodiverse people. The importance of services that provide culturally safe care for Aboriginal people was raised consistently across all consultations (discussed in more detail in the section 'Aboriginal social and emotional wellbeing and cultural safety'). The importance of co-design with affected communities was consistently emphasised, with calls for dedicated funding streams to support this work.

"These priority populations are very important to engage with, and services should be available to meet their needs. Saying that, sometimes people might not fully identify with their priority population and so services do also need to be flexible in their approach."

Male, 25–34 years, member of the LGBTQI+ community, lived experience of drug use, living in a metropolitan area

Services for culturally and linguistically diverse communities require specific focus and development. Members of these communities bring many different perspectives that need to be acknowledged in the design and delivery of programs. Participants noted that current approaches often fail to recognise different cultural understandings of drug dependence and recovery, as well as the unique experiences of shame, stigma and discrimination.

Solutions proposed included place-based, community-led services that build capacity and connection, and work with community strengths and protective factors. The role of religious and faith-based leaders in certain cultures was considered essential to set the tone, promote trust and encourage help seeking in the community. Additional discussion focused on increasing funding for multicultural services, making better use of interpreters, and introducing specific engagement strategies for different cultures. Lastly, having a culturally diverse workforce was seen as strengthening ties between the community and services.

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 lack of access to parenting programs that allow children. There was a lot of discussion about the impact of the current child protection system, particularly on Aboriginal families. Participants noted that under the current system, children are often removed without adequate support being provided for parents to address substance use issues or to actively work towards restoration of their children, sometimes perpetuating substance use.

Suggested solutions included designated midwife positions for pregnant women with substance use, more withdrawal management services for women, and 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.

Participants raised the need to increase access to services, safe spaces and tailored support for LGBTQI+ communities. Suggestions included introducing services run by peers or staff from the LGBTQI+ community, allowing people to self-describe gender and pronouns, establishing services that are trauma-informed, and improving understanding and sensitivity around LGBTQI+ needs in mainstream services. Some respondents suggested that AOD services already work with trusted organisations, such as ACON, to build trust with the community and encourage help seeking. Strategies to improve support for gender-diverse communities included upskilling the workforce, improving data collection (such as gender and sexual identity data) and outcomes measurement, and providing more integrated support.

"As a queer person, drug use is a major issue in the community. One way that could possibly help lower drug usage is to provide more safe, inclusive spaces for queer people, especially minors and young adults who may have an unsafe home or work environment. For all other groups (including queer people), better access to safe, inclusive and free health care is a major step in the right direction, as well as safe accommodation."

Male, 18–24 years, member of the LGBTQI+ community, living in a metropolitan area

There is a need for more targeted services, improved accessibility and increased awareness for people with disability, including those with brain injuries and cognitive impairment. Navigating the National Disability Insurance Scheme (NDIS) and pathways to supports can be challenging. Additionally, NDIS clients fear that disclosing drug use may affect their support package. Some noted the gaps in suitable programs and supports for neurodiverse people, in particular young people with attention deficit hyperactivity disorder (ADHD) and autism spectrum disorder. The lack of medical treatment options for people who predominantly use methamphetamine was also discussed.

"I just got diagnosed with ADHD at 38 years old. People who have undiagnosed conditions like ADHD are much more likely to be pulled into addiction. Making diagnosis and medication much less expensive and more accessible would drastically help."

Female, 35–44 years, lived experience of disability and drug use

Treatment access in custody 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 is in remand, and there are limited services for this group. Barriers to health care include ineligibility for Medicare in custody, delays in discharge planning and fractured coordination between corrections and community services, as well as lack of access to the suite of harm-reduction approaches such as needle and syringe programs.

Post-custody and transitional support were identified as systemic gaps that require particular attention and dedicated resources. Data was cited that showed that the highest risk of poor health and justice outcomes is in the first 6 weeks post release, with lack of coordinated support identified as a key factor. Current transition support was described as inadequate, with people often released without connections to housing and health services. Participants emphasised the need for pre-release planning, supported transition programs, including specific consideration of medication continuity and immediate access to housing. The importance of maintaining connections between community-based support services for people in custody was highlighted, to allow better coordination following release.

C. System integration and service coordination

The importance of system integration and service coordination was a cross-cutting theme throughout all consultations. The impact of social determinants on health outcomes – both influencing the circumstances that lead people to take drugs and the broader significant health impacts – is well established. This is compounded by difficulty accessing appropriate care and highlights the importance of addressing the multiple, co-occurring health and social needs simultaneously for any health interventions to achieve sustained and effective outcomes.

Siloed service delivery causes a lack of integration between AOD services, mental health services and primary care services, as well as social services such as justice, housing, child protection, and VAN services. Participants considered that this lack of integration, or artificial separation, created significant barriers to effective treatment, given high rates of co-occurring needs. Participants reflected that many existing services exclude people with complex presentations, or needs that spanned multiple social services, and that coordination between services needed significant improvement to achieve 'no wrong door' access. The 'no wrong' door approach aims to reduce barriers to service access by connecting people with the right services regardless of their entry point.

The lack of integration between mental health and AOD services was highlighted as a significant barrier to effective treatment. Participants suggested improvements such as dual diagnosis services with dedicated workforces, shared care protocols and case management systems, co-location of services (or 'hub' models), wraparound services and formal partnerships between services. Better support to navigate the system was also flagged as key to ensuring coordination across agencies, such as health, justice, education, homeless services and child protection, and VAN services.

There was strong support for having a comprehensive, whole of government NSW AOD strategy to underpin a unified approach and complementary planning. An overarching monitoring and evaluation framework to direct and evaluate the activity and planning is needed to support this strategy, with a range of indicators to understand progress.

"Provide better guidance, infrastructure and architecture to enable better collaboration and connect care between alcohol and other drug services and a range of other clinical and social services, including mental health, homelessness, education and the justice system, by introducing a whole-of-government strategy."

360 Edge submission

PRIORITY ACTIONS

1 The service system: Access, integration and design

1.1 Within 12 months, release a 10-year whole-of-government alcohol and other drugs strategy that:

- **i.** is underpinned by a harm-minimisation approach
- **ii.** is developed and implemented by a steering committee comprising members from relevant government and non-government agencies
- **iii.** appropriately addresses the disproportionate harms experienced by Aboriginal communities
- **iv.** includes a whole-of-government monitoring and evaluation framework.

1.2 Ensure new or redesigned programs and services are co-designed with the communities they serve.

1.3 Engage with culturally diverse communities and their leaders to better understand how to use evidence-based treatments to reduce drug-related harms in their communities and enhance community awareness and acceptability of drug use as a health issue.

1.4 Ensure specific and inclusive program delivery and services access to meet the unique needs of diverse communities, including lesbian, gay, bisexual, transgender, queer and intersex (LGBTQI+), culturally and linguistically diverse and Aboriginal communities.

1.5 Appropriately fund the integration of health and social services through innovative models that respond to the holistic needs of clients, including availability of mobile and/or telehealth services, and digital programs and navigation support.

1.6 Ensure access to specialist mental health services is available in all residential rehabilitation services that receive public funding, in order to increase the number of residential rehabilitation facilities that cater to individuals with co-occurring conditions.

1.7 Improve alcohol and drug treatment services (including detox) in custodial settings (including remand) and post release.

1.8 Support research and development in new and existing pharmacotherapies for methamphetamine use disorder and other emerging drugs of concern.

2. FUNDING MODELS

There were strong calls to significantly increase overall funding to address need.

Funding models and contracts for services that respond to the spectrum of substance use vary and are delivered by public sector services, NGOs and Aboriginal Community Controlled Health Services. These include services for prevention, information and community education, harm reduction, treatment and continuing care programs. Public health services are delivered by LHDs and specialty health networks.

Regarding NGOs, attendees across the forums and in consultations broadly agreed that current funding models require reform to better support system integration, sustainability and delivery. Identified issues include the short-term and siloed nature of available funding. Participants discussed the split sources of funding – the Australian and state governments – observing that varied and misaligned contract lengths and arrangements affect service planning and sustainability. The requirement to complete multiple grant applications was seen as a barrier to service delivery that also created a competitive culture in the sector. There was strong support for longer-term (minimum 5 years) funding cycles for Aboriginal Community-Controlled Health Organisations and NGOs. This funding stability would have benefits in terms of workforce development and retention.

"Government funding of NGO services is short term, limited and has not kept up with the cost to deliver services. A lack of clear policy direction has had negative flow-on effects for innovation, service planning and delivery, workforce and organisation sustainability – making it impossible for the NGO sector to meet the growing demand for services."

Network of Alcohol and Other Drugs Agencies submission

Integration and collaboration across the range of agencies or organisations responsible for health and wellbeing was discussed in detail. Many attendees and contributors to the consultations noted that the funding arrangements, such as competitive tendering, actively discouraged collaboration. Incompatible reporting requirements and compliance burdens that required organisations to report the same data to multiple funders were also raised. More collaboration between the Australian and state governments would ensure better planning of services and alignment of funding and reporting arrangements. It may also enable more treatment to be delivered through primary care via the Medicare Benefits Scheme.

"The ATOD sector is deeply interconnected with various allied sectors, including criminal justice, housing and homelessness, family and domestic violence, and mental health. Despite the critical nature of these interactions, community health and allied sectors often receive inadequate funding for effective cross-sector collaboration at a policy or practice level."

Alcohol Tobacco and Other Drug Association submission

Broader funding model issues that were raised included performance monitoring frameworks that are currently seen to favour outputs, rather than outcome measures (for both individuals and their families). There was also discussion of how current funding arrangements are not reflective of the complexity of issues that AOD services respond to, particularly the need for mental health support and post-treatment support. Clients of services also require support with a range of social issues such as housing, food security and family support, so they can address and manage their AOD concerns.

Participants supported increasing the share of funding directed toward harm-reduction activities. Some participants suggested that funding should be more needs-based and informed by data, such as census data, community needs analysis and cost-benefit analysis. The Drug and Alcohol Service Planning Model was put forward as a tool for informing planning and funding. The Special Commission of Inquiry into the Drug 'Ice' included a recommendation that the model be periodically updated and made available to all LHDs, primary health networks and NGOs.

The compounding effect of insufficient funding was discussed in relation to its impact on vulnerable children and families, as well as rural and remote communities where the cost of ancillary services, such as transport, may be drawn from available funding.

"Despite national strategies across these intersecting systems emphasising the importance of cross-sector collaborations and partnerships to address the complexity experienced by overlapping priority populations, funding structures and grant opportunities often do not incentivise, enable or resource this work. The absence of funding to support cross-sector collaboration and coordination was noted in a recent rapid review of approaches to prevent domestic and family violence."

Australian Alcohol and Other Drugs Council submission

PRIORITY ACTIONS

2 Funding models

2.1 Significantly increase funding for alcohol and other drugs services to address unmet need and client complexity. Funding increases should commence within six months and distribution should be informed by:

i. a population-based service planning model

ii. a focus on equitable access across rural and remote NSW

iii. weighting to reflect the higher cost of service provision in rural and remote areas

iv. a demonstration of outcomes.

2.2 Provide 5-year funding contracts for non-government service providers that include cost escalation and support for service evaluation and aligned contract conditions, where possible, to improve service stability and workforce retention.

3. PREVENTION AND EARLY INTERVENTION

Prevention takes place at multiple levels. Primary prevention attempts to avoid or delay drug uptake before use starts. It includes education, health promotion and regulation. It also includes initiatives targeting the underlying social determinants of health and wellbeing by addressing risk and protective factors. The goal is to improve overall wellbeing, build resilience and create environments that support healthy behaviours. Drug harm prevention aims to avoid or delay uptake, reduce use and harms, and intervene early.

Secondary prevention aims to prevent or interrupt harmful patterns early in drug use. This includes health promotion programs, routine screening and brief intervention by health professionals and other support services. Early intervention can prevent, reduce or delay harms.

Tertiary prevention focuses on reducing impact after harmful use is established. Tertiary prevention includes treatment and harm reduction to support the person, their family and the community.

Because harmful drug use is usually the result of the interplay between individual, social and environmental factors, successful programs target a range of factors – for example, early life experiences of family and domestic violence increase the risk of harmful AOD use later in life. So, a drug prevention program may incorporate family support as a component of its delivery. Under a Housing First model, providing stable and affordable housing is a priority for people experiencing or at risk of homelessness. This is accompanied by wraparound supports such as AOD counselling and mental health care and other social services.

Many attendees identified a need for enhanced, sustainable and long-term funding for prevention and early intervention programs. Attendees discussed funding shortfalls in prevention and early intervention, and the need for greater investment in earlier prevention activity to avoid more expensive treatment later. The cycles of shorter-term funding impacting service stability and continuity were discussed. Service organisers described the challenges this created for data collection and reporting to demonstrate impact. Service organisers also said the requirement to report similar information to multiple funders was unnecessarily burdensome.

In relation to practices that support families, some discussion focused on screening, early intervention and care prior to crisis. Settings such as early education (daycare and preschool), school and extra-curricular activities were identified as places where screening should occur for all families, focusing on at-risk families. Participants from the education sector suggested that screening and intervention should ideally occur before children start school. Calls for direct resourcing to upskill staff in a range of sectors was heard. This would provide an opportunity for screening and referral in any service setting the child and/or parent might present (the 'no wrong door' approach). Examples of successful programs included NSW Health's Wellbeing and Health In-reach Nurse (WHIN) Coordinator Program, with calls to ensure this is delivered across public schools in NSW.

"More support for families with family violence, mental health, disability or neurodivergence, especially free early intervention. If kids get a good start and are able to deal with challenges facing them, they are at less risk to take up drug use or become addicted. Reducing and lessening the impact of trauma in childhood will support families. Take away the stigma associated with parent drug users — get them support, don't just take their kids away and expect everyone to be better. Removal creates new trauma and new addiction risks. Getting parents support early, especially those at risk (young, poor, Aboriginal, culturally and linguistically diverse, low education, their own trauma) so they seek help rather than punitive interventions."

Female, 45–54 years, lived experience of drug use, living in a metropolitan area

The regional forums emphasised the need for community-led solutions that engage the whole community and build on existing strengths and relationships. The Community Drug Action Teams were cited as effective but under-resourced, with calls to expand this successful grassroots approach. Funding sustainability was also mentioned as a barrier in regional settings.

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

Female, 45–54 years, living in metropolitan area

Equitable access to prevention and early intervention was discussed in relation to increasing the focus on Aboriginal young people. Discussion highlighted the need for programs that strengthen and support cultural identity and community connection, as well as the drivers of substance use. Initial contact with the justice system, and its consequences, was seen as an area that should be targeted, with calls to expand successful Aboriginal-specific court models such as Koori Court.

The cross-sectoral nature of early intervention services was raised, receiving strong support for expanding and reforming this area. Participants supported using a holistic and trauma-informed model that prioritises children in their first 2,000 days and their families. The need for coordinated action across government and non-government human services agencies, more community-based services supporting children and families, along with access to affordable early learning programs and intensive family support were highlighted.

The link with universal screening programs for children was discussed; however, barriers to the accessibility and affordability of follow-up assessments and NDIS entry requirements were described as prohibitive. Regional Drug Summit attendees expressed concerns about the lack of culturally safe and trauma-informed early intervention services – especially prior to crisis. The WHIN Coordinator Program in schools was seen as a successful model for screening and early intervention, and there was strong support to expand this program to all schools.

Attendees discussed the workforce disciplines and settings required for prevention and early intervention, with some wanting to see improved drug and alcohol education in the general practitioner workforce. Others called for a focus on maternity settings, such as preconception, antenatal and post-natal care.

PRIORITY ACTIONS

3 Prevention and early intervention

3.1 Enhance funding for prevention and early intervention programs, prioritising the first 2,000 days of a child's life.

3.2 Provide safer and more affordable housing through increased investment in public and social housing, including support for transitional housing, and prioritising Housing First models.

3.3 Increase place-based local programs that build community capacity and connection, including out-of-school-hours activities and community events.

3.4 Ensure greater access to learning and development opportunities across the alcohol and other drugs, 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 use.

4. INFORMATION AND EDUCATION

AOD education encompasses information and engagement about substance use, treatment and the service system across the lifespan, in different settings (such as schools) and tailored to priority populations. These include LGBTQI+ communities, Aboriginal and Torres Strait Islander people and culturally and linguistically diverse communities. Education should focus on a balanced description of risks and benefits, address the social determinants of health, treatment access and system navigation.

Young people felt that drug education initiatives in schools poorly resonated with their experience and were unrelatable. They said education programs needed to be grounded in a narrative centred around drug use as a health issue, with appropriate personnel to deliver this. Inconsistencies in the delivery of curricula, which is heavily influenced by individual school leadership and parental attitudes, was also discussed. There was strong support for programs like Getting on Track In Time – *Got It!* that provide whole-of-school screening and early intervention, and broader community education with initiatives such as R U OK? were recognised as impactful.

Creating and co-creating digital platforms and social media campaigns with young people was called for. Young people felt that current information channels were outdated and therefore ineffective at reaching target demographics. They suggested approaches that included youth-friendly content that comes from authoritative sources but is agnostic on the decision about whether to use drugs.

The 'Have your say' portal heard from people with lived and living experience of drug use and their involvement in harm-reduction education across the spectrum of information gathering, event-based safety behaviour, safe injecting behaviour and naloxone access.

> ***"Plenty of age-appropriate, evidence-based education about all drugs (including alcohol, nicotine, caffeine) from an early age. Plenty of education for parents on best ways to stay engaged with their kids and have useful conversations well before high school. Emphasis on addiction and drug harms as being a health and social issue (not a moral failing or wilfully criminal)."***
>
> Aboriginal female, 55–64 years, member of the LGBTQI+ community, lived experience of drug use, living in a metropolitan area

Submissions from academic and peak drug and alcohol organisations supported wide delivery of public drug and alcohol education campaigns. The design of programs should be sensitive and address stigma and discrimination, and avoid using fear or scare campaigns. They said information and education should be provided at multiple levels, including at workplaces.

"Evidence-informed and targeted information provision using all forms of media, but especially social media. No 'scare campaigns'. Engagement with people from abstinence to consumer groups, religious, ethnic and sexual diverse groups. Recognise that age grouping matter – e.g. prevention of older adults experiencing health issues and loneliness to young experimenters."

Male, 75+ years, member of the LGBTQI+ community, living in a metropolitan area

There were also calls to tailor education to priority populations, such as Aboriginal people, LGBTQI+ communities and members of culturally and linguistically diverse communities, ensuring material and campaigns represent diverse voices. This would improve the accessibility of services to people who may face additional barriers.

PRIORITY ACTIONS

4 Information and education

4.1 Ensure all health professionals receive alcohol and other drugs education and training that includes trauma-informed care and addresses stigma and discrimination.

4.2 Expand evidence-based age-appropriate alcohol and other drugs education in schools and other community settings.

4.3 Co-create social media content with young people to provide credible information about drugs and treatment.

4.4 Where required, support provision of community-led and targeted information and community development activities to meet the specific needs of priority population groups.

4.5 Improve alcohol and other drugs education and health promotion with a high-profile awareness campaign for the community.

5. FAMILY AND COMMUNITY SUPPORT

The impact of drug use on families was broadly acknowledged across the forums and through online consultations. 'Family' is a broad term and might include a person who cares for someone who uses drugs or is cared for by a person who uses drugs (e.g. children of a parent who uses drugs). Across many discussions, attendees from a range of backgrounds emphasised the importance of services across the spectrum of AOD interventions having the flexibility to recognise broad definitions of 'family'. They emphasised the need to move beyond traditional nuclear family models to support chosen families, extended family networks, and whole-of-community approaches, particularly in Aboriginal, multicultural and LGBTQI+ communities.

A. Family-inclusive practices and support for families

The importance of family was reflected in the extensive references and endorsement across consultations regarding the need to empower and support families during a person's recovery. Family inclusive practices at service and program levels were seen as critical to achieving better outcomes.

"Love, family, and connection are essential elements in supporting healing and fostering change for those experiencing alcohol and other drug issues... Early, proactive, family-inclusive support presents a powerful opportunity to mobilise resources and prevent escalation into crisis."

fams submission

Respondents to the 'Have your say' portal wrote about the difficulties of managing and supporting the treatment of their loved one if family-inclusive practices were not embedded in AOD treatment. There was agreement that services were lacking to support families when a person's drug use might be causing significant impacts on mental health, financial issues and family breakdown, including the removal of children. There were calls for greater involvement of families in the assessment and management of AOD use, and for greater accessibility of family therapy.

There was a strong desire to make family support services more holistic given the challenges experienced in complex families, especially when child protective services were involved. This was identified as particularly important for Aboriginal parents who experience higher rates of child removal. There was wide recognition 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.

The lack of residential rehabilitation services that accommodate parents with children – which is more severe in regional NSW – was raised repeatedly. Participants said greater emphasis should be placed on a family-centred and strengths-based approach. This included supporting parents with AOD issues to maintain care of their children while undergoing treatment. The current models of rehabilitation mean parents are often forced to choose between treatment and child custody.

Solutions to reduce barriers to access support included increasing the number and geographical spread of services. Some participants called for specific services for young people (especially those who might have a parent with drug use issues), parents, family members, and pregnant women or those supporting pregnant women. Access to affordable child care was seen as critical for child and parent wellbeing. Lastly, special reference was made to young, incarcerated people – especially those who may not have family to support them – who would benefit from impartial advocacy that was external to the Justice system.

B. Culturally and linguistically diverse families and communities

Attendees described the close connections between families from culturally and linguistically diverse backgrounds and their broader communities. They noted the need for culturally sensitive services that reflect the cultural and spiritual/religious values of migrant families. Education and capacity building among religious leaders was seen as a useful approach, given the trust instilled in leaders in some communities. There was discussion about the appropriateness of delivering youth programs independently of family and how this impacts their accessibility and effectiveness.

People with lived experience of drug use pointed out that new migrant families can have complex perspectives on drug use, which can increase barriers to help seeking. Some cultures take a zero-tolerance approach to drug use. In such situations, young people may not seek help due to fear of repercussions within the family, which can be extremely serious.

Attendees saw value in wraparound, place-based support services that specifically target multicultural families, ideally when newly arrived. They noted that the provision, delivery and communications in relation to those services are all important factors to consider. Education and support could address a lack of knowledge regarding cultural norms in Australia, and what services are available for health concerns.

> ***"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, living in a metropolitan area

Specific considerations regarding Aboriginal people and family connection, as well as regional perspectives, are explored in detail in the companion document.

PRIORITY ACTIONS

5 Family and community support

5.1 Enhance family-inclusive practices and expand support services for families and carers impacted by alcohol or other drugs use to fully meet need.

5.2 Improve navigation tools and access points for families seeking support, including implementing a lived and living experience ambassador program.

5.3 Expand specialised alcohol and other drugs support and treatment for pregnant women, parents and the first 2,000 days of their child's life, particularly where there is a risk of child removal.

5.4 Strengthen education and capacity-building initiatives with community and faith-based leaders to address stigma and cultural barriers to seeking support.

6. YOUTH-SPECIFIC SERVICES

Young people were identified as a priority population throughout the Drug Summit. Their perspectives, experiences, unique needs and outcomes were discussed across many sessions. Much information relevant to young people is presented in other sections of this report. This section draws together Drug Summit attendees' comments on youth-specific services.

Many attendees commented on the gaps in services for young people, with a focus on ensuring touchpoints along the spectrum of drug use (from experimentation and recreational use to dependent use). Integrating the contribution of education providers, family, Elders, peers, child wellbeing services and justice agencies was considered critical for interrupting the trajectory of AOD-related harms for young people.

Young people and families identified navigating the system – knowing about services and how to access them – as an issue. This factor is amplified for young people required to navigate the justice and health systems. Strengthening cross-agency partnerships, especially coordination across and within health (e.g. alcohol and other drugs and mental health), education and justice services, would help to avoid silos, disconnected support from multiple services, and the requirement to tell one's story repeatedly. There was strong support for peer navigator roles and 'warm' referrals between services to ensure that young people who don't fit a particular service due to eligibility criteria do not fall through the gaps. A warm referral ensures support to connect with a service.

"In my role working with young people, I would say working with community groups/youth hubs where their foundation is set as a soft entry point as a way to encourage young people to access such supports. This helps with that first step of them being able to approach those services."

Female, 25–34 years, living in a metropolitan area

Deterrents to accessing youth services were explored, with location, formality of physical spaces and inflexible opening hours seen as reinforcing stigma and contributing to intimidation. Service approaches that silo care for young people (e.g. neurodiverse young people, those with a mental illness or who use alcohol and other drugs) were seen as contributing to their ineffectiveness. Integration across services was raised as a core component of ensuring care is appropriate for young people, and co-located as much as possible.

"Make sure people are aware of what services are available. As a 16-year-old I went into [a] 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 to [a] service that could assist me and help find me somewhere safe to live!"

Aboriginal female, 25–34 years, lived experience of disability, homelessness and drug use

"Drugs and mental health are closely interconnected, and we cannot address one without considering the other. Even if there is a waiting list and a lack of resources for one, the other will still persist. Therefore, resources and programs need to focus on addressing both issues simultaneously and developing integrated programs to tackle them together."

Male, 35–44 years, living in a rural/regional area

Attendees said there was a strong need for expanded youth-specific AOD treatment options, including residential rehabilitation, detox services and developmentally appropriate day programs that are separate from adult services. Attendees reported that there were only a small number of youth detox beds across NSW. They said many young people were being inappropriately placed in adult services or having to travel long distances from their support networks to access care. Regional perspectives reinforced these views, and emphasised the importance of keeping young people connected to Country and community.

"Access for children under 16 years old to rehabilitation & detox centres."

Female, 18–24 years, member of the LGBTQI+ community, living in a metropolitan area

Attendees identified a critical need for supported accommodation places for young people. Current short-term accommodation options (often just 2–3 days) were seen as inadequate, particularly for people leaving custody or treatment, which is considered a 'high-risk' period. Service providers noted that many young people exit custody into homelessness or unsafe living situations, leading to cycles of disadvantage or reoffending. Attendees called for expanded transitional housing programs, with integrated case management, complemented by Aboriginal community-controlled transition programs tailored to Aboriginal young people.

PRIORITY ACTIONS

6 Youth specific services

6.1 Increase co-design of services and navigation tools with young people and the peer workforce.

6.2 Enhance access to treatment and support for children and young people, particularly those with complex needs, using flexible approaches and access points (e.g. 'no wrong door' approach and co-located services).

6.3 Implement harm-reduction education, community engagement and resilience-building programs.

6.4 Increase the availability of supported accommodation and transitional housing for young people.

7. ABORIGINAL SOCIAL AND EMOTIONAL WELLBEING AND CULTURAL SAFETY

The Drug Summit heard a range of Aboriginal perspectives on key issues. Concern was raised early in the Sydney forum that Aboriginal perspectives were not adequately represented or structured into the program in a way that recognised the primacy of Aboriginal affairs in the AOD space. This led to a meeting being arranged between Minister Park and Aboriginal people, academics and organisations following the Drug Summit to discuss issues they had generated through an independent working group.

A yarning circle was held at the National Centre for Indigenous Excellence on 6 February 2025 guided by a working group co-chaired by Ms Taylor and Associate Professor Doyle.

The report has been considered by the co-chairs and has separately been provided to government. This section aims to summarise the pertinent issues of Aboriginal cultural safety, and health and wellbeing, as raised during the forums and through the 'Have your say' portal and submissions. But it should be read and considered alongside the Yarning Circle Report and other sections of this report.

Almost 25% of people accessing AOD services are Aboriginal people, highlighting the need to transform mainstream and Aboriginal-led services. The strength and resilience of the Aboriginal AOD workforce, and successful examples of reorienting services to meet the needs of Aboriginal people, were discussed across the consultations. Cultural concepts of healing and connection were highlighted, as was the importance of on-Country service delivery along the spectrum, from early prevention to treatment. Areas of focus included ensuring cultural safety in mainstream services and providing and prioritising the resources needed for Aboriginal-determined approaches.

Cultural safety in mainstream services needs to be significantly improved according to participants. Discussion highlighted how current service models often fail to meet Aboriginal community needs or understand cultural obligations. Participants called for enhanced accountability measures for cultural safety, suggesting Aboriginal people could assess and accredit services' cultural competency. Recommendations included mandatory employment of Aboriginal staff across all services, development of culturally appropriate clinical care standards, and ensuring all programs address the social determinants of health, emphasising cultural understandings of health and healing. The role of social and emotional wellbeing and the centrality of trauma-informed approaches that recognise the enduring impacts of colonisation and dispossession were repeatedly discussed.

"To improve equitable access and inclusion, services must be culturally safe and trauma-informed. Establishing more Aboriginal-led programs, employing Aboriginal health workers, and offering culturally responsive care will ensure that services are better aligned with the needs of Aboriginal communities. 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 help to break down barriers and improve overall access to care for Aboriginal people seeking support for drug use."

Aboriginal female, 45–54 years, living in a rural/regional area

Data sovereignty and evaluation frameworks were raised in relation to how these serve, or disadvantage, Aboriginal communities. Participants emphasised the importance of data being owned and controlled by Aboriginal people. They also noted that Aboriginal people experience over-surveillance. Discussion highlighted the need for more nuanced data collection to understand underlying trends and social determinants. Suggestions included implementing Aboriginal-led evaluation frameworks, ensuring Aboriginal interpretation of data, and developing specific indicators for measuring cultural safety and appropriateness of services.

Participants' discussions centred on Aboriginal self-determination and community control across the range of required service improvements. They said commitment and resources were needed to realise their aims, with solutions including sustained and quarantined funding for Aboriginal-led and community-controlled programs and the backing of an Aboriginal-specific AOD strategy.

The issue of disproportionate child removal in Aboriginal communities was raised in relation to the enduring impacts of the Stolen Generations and intergenerational trauma on service access. Family-inclusive care was cited as a solution, alongside ensuring community control in the design and delivery of such services. A consistent theme raised across Aboriginal cultural safety and other topics was the need for services that allow infants and children to stay with their parents while they are having treatment and recognising help seeking as protective factors in the care of children, rather than a cause for further child protection involvement.

"Parents obviously worry that they won't get their kids back, especially if they've had previous child protection intervention. It doesn't matter what you say."

Anonymous, quoted in fams submission

PRIORITY ACTIONS

7 Aboriginal social and emotional wellbeing and cultural safety

7.1 Elevate the role of, and enhance supports for, the Aboriginal community-controlled sector to deliver holistic supports for people impacted by alcohol and other drugs.

7.2 Expand access to culturally safe services for Aboriginal communities by supporting holistic and culturally grounded Aboriginal led approaches, particularly in mainstream services.

7.3 Improve trauma-informed care and support for Aboriginal children and parents impacted by drugs, with a focus on family rebuilding, particularly for Stolen Generations survivors.

7.4 Prioritise appropriately funded and Aboriginal-led prevention, early intervention and family support, to meaningfully address high rates of child removal and redress the disproportionate harms experienced by Aboriginal people and communities through system improvements that reduce involvement in the criminal justice and out of home care systems.

8. WORKFORCE

Workforce considerations were a recurring topic linked to improvements in the quality and accessibility of services. Workforce matters discussed included attraction, recruitment and retention, the peer workforce (the lived and living experience workforce) and workforce diversity, focusing on Aboriginal, culturally and linguistically diverse and LGBTQI+ people in the AOD sector. Various contributions were also received on related workforces, such as the police and the education sector.

Current workforce challenges identified were burnout, vicarious trauma, lack of senior support and supervision, job insecurity and instability, attrition and pay disparity. Factors cited contributing to these challenges were differences in the award for employees in public organisations and NGOs, and insufficient and often short-term funding arrangements. These issues were exacerbated in regional and rural areas, especially in relation to workforce supply and retention.

The needs of the NGO sector were raised in submissions to the 'Have your say' portal and by Drug Summit attendees. A sustainable NGO workforce is critical to an effective service system, given that the NGO sector provides a significant proportion of AOD treatment in NSW. Issues include the duration of funding contracts, workforce sustainability, professional development opportunities, including the ability to move between the NGO and public sectors, clinical and cultural supervision, and the wellbeing of staff.

Participants highlighted that attraction to and recruitment for the NGO workforce were key to the sustainability of the overall AOD sector. They emphasised that strategies to improve the health and wellbeing of staff were a priority. Solutions included increased funding specific for the NGO AOD workforce and adequate resourcing to implement the *NSW Alcohol and Other Drugs Workforce Strategy*.[4]

Participants' perspectives again highlighted that these issues are exacerbated in rural and regional areas, impacting equitable access to a specialist workforce.

"Equitable access would include being able to see addiction specialists and psychiatrists in the rural setting. Not relying on FIFO services. More effort put into attracting clinicians to the bigger rural areas. This requires more junior doctors being rotated through this sector."

Person living in a rural/regional area

4 NSW Health (2024). *NSW Alcohol and Other Drugs Workforce Strategy 2024–2032*. Available at https://www.health.nsw.gov.au/aod/resources/Pages/aod-workforce-strategy.aspx.

The Aboriginal workforce and leadership, and its importance in the delivery of holistic and culturally safe care for Aboriginal people, was discussed. Additional community responsibilities, cultural 'load', inadequate remuneration and limited meaningful career pathways were cited as additional barriers. Cultural load refers to the knowing or unknowing pressure applied to Aboriginal employees to provide Indigenous knowledge, education and support. Participants said solutions require a focused effort on recruitment and cultural supervision, and support to ensure retention.

"Involving grassroots communities and individuals with lived experience is crucial for creating programs that truly resonate with Aboriginal communities, offering invaluable insights into the real challenges our communities face and ensuring that health initiatives are culturally relevant and accessible. Working collaboratively enhances the effectiveness of health-promotion efforts, leading to long-term behaviour change and stronger, healthier communities."

Aboriginal person, 45–54 years, living in a rural/regional area

In relation to the peer workforce, participants consistently emphasised expansion across the spectrum of AOD services. Discussion recognised the need for funding to support development and integration in the workforce, and to move away from 'tokenistic' roles to establish meaningful career pathways and pay scales that recognise progress and encourage leadership. Participants said that, in particular, the peer workforce requires psychological support and supervision, given the personal and potentially re-traumatising nature of the work. There was discussion about how organisations can ensure readiness to support peer workers. Despite the challenges, participants saw proper resourcing of this workforce, to build trust and engagement with marginalised people and communities, as a valuable investment.

Participants cited examples of client engagement service models where the peer workforce contributed to destigmatisation. These included the mental health peer workforce and mobilising organisations with people with lived and living experience of drug use to distribute naloxone.

The requirement for a criminal record check for AOD workers was presented as a particular barrier for people with lived and living experience of drug use who have criminal convictions for possession or use of drugs. The cost of these checks was also borne by individual workers and was seen as a barrier for some.

Attendees noted that cross-sector training and shared learning opportunities were important enablers of service integration. Successful examples 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. A specific suggestion was made to reintroduce an education and training in drugs and alcohol program that focuses on generalist and specialist workforces.

"It is critical that the NSW Drug Summit accounts for the current barriers to AOD LLE [lived and living experience] Workforce development and continues to invest in reforming recruitment, onboarding and retention strategies to better ensure appropriate use of employment background checks, appropriate supervision mechanisms, more opportunities for professional development and improved career opportunities."

NUAA submission

Many attendees noted the importance of working with and better upskilling the mainstream health and other social services workforces. They noted that current undergraduate, tertiary and vocational training has limited AOD content. This contributes to stigma and a reluctance to work with people who use drugs. Many attendees noted the importance of employing people with lived experience to deliver professional education. Key workforces included police officers, education providers, health workers, domestic and family violence workers, and child protection workers. Key health areas included emergency department staff, maternity staff and general practitioners (GPs).

Attendees felt that GPs have a critical role, as they are often the first point of entry to the health system. GPs were seen as ideally placed to provide early intervention and referral. Some participants called for better training in providing these services; however, the availability of GP prescribers was noted as a significant issue. The importance of using nurse practitioners to fill these gaps was noted, with suggestions to build and scale this workforce. Medical practitioners, including GPs, made submissions calling for the inclusion of prevention and treatment for addictive disorders in the curriculum and assessable content, and for general practice trainees to be exposed to hospital AOD clinics.

PRIORITY ACTIONS

8 Workforce

8.1 Fully implement the *NSW Alcohol and Other Drugs Workforce Strategy 2024–2032*.

8.2 Increase funding for workforce development and sustainability across the government and non-government sectors and disciplines.

8.3 Expand the peer workforce across the spectrum of alcohol and other drugs services, including the Aboriginal peer workforce.

8.4 Optimise care and outcomes for clients of alcohol and other drugs services by ensuring vocational and professional training that addresses stigma and discrimination.

8.5 Provide appropriate supervision and supports to strengthen frontline alcohol and other drugs staff capability and wellbeing.

8.6 Expand access to opioid substitution treatment and improve integration with primary care, including increasing the number of general practitioners and nurse practitioners who prescribe opioid substitution treatment.

9. STIGMA AND DISCRIMINATION

Stigmatisation and discrimination are distressing for people who experience them, and they act as a barrier to accessing services. They make people less likely to seek services, or to wait until concerns are acute, more difficult to manage before they access services and which can lead to potentially poorer health outcomes. The impacts of stigma and discrimination arose across all Drug Summit themes, forums and consultations. There was a clear imperative to address stigma and discrimination to improve access to treatment, improve quality of care and reduce drug-related harms.

The legislative drivers of stigma and discrimination were the subject of extensive discussion. Many attendees argued that the community equates illegal activity with immoral activity. They said that as long as our legal system regards drug use and possession as a crime, stigma will be perpetuated. Many attendees, and submissions by professional and peer-based groups, and through the 'Have your say' portal called for decriminalisation of drug possession and use.

> ***"Stigma is a social construct, often fuelled by misinformation, stereotypes and fear. The criminalisation of drug use exacerbates the stigma faced by people who use drugs. It can manifest in various ways, from discrimination, internalisation and social exclusion that actively reduce access to healthcare services and employment opportunities. It can worsen the challenges faced by people who use drugs, making it harder for them to seek help and support and to receive appropriate care."***
>
> Royal Australasian College of Physicians

The disparities people with higher levels of social disadvantage faced was seen as a compounding reason for greater discrimination, highlighting the need for multi-agency coordination to address the social determinants of health.

Many flagged the importance of non-judgemental services (both treatment and harm reduction) to build trust and rapport, encouraging engagement. Participants recognised the importance of peer workers who break down stigma by providing a welcoming and inclusive environment. They raised the lack of anonymity in regional and rural settings, saying it makes peer worker roles even more critical in small communities.

Participants said the 'no wrong door' approach should be strengthened across the health and social care sector – through systemic and cultural reforms. They felt that while many organisations endorsed the approach in principle, the experience of clients, especially in a hospital setting and mainstream health services, was of exclusion and lack of support. Examples used to illustrate this issue included clients with a history of AOD use being given inadequate pain relief and the discrimination faced by people accessing dental care who have a history of drug use or are current users.

"My son never tells his doctor the whole truth because he fears losing treatment. For example, when on suboxone, he may use some drug as well. It has caused severe mental health issues. He can't get help because he fears losing his suboxone or worse."

Female, 65–74 years, living in a metropolitan area

Educating a range of audiences (healthcare and social services workers, police officers and the general public) in a range of locations (in school, vocational and tertiary education, community, workplace and healthcare settings) was considered key for reducing stigma and discrimination. Attendees repeatedly pointed to the mental health sector, and to a lesser extent, the domestic and family violence sector, as providing models for the positive outcomes that can be achieved when significant effort and resources are devoted to reducing stigma. Cultural and linguistically diverse community stakeholders encouraged working with religious and community leaders to reduce stigma, so that all community members feel more comfortable seeking support.

"First, addressing stigma is key: reducing societal judgement and reframing drug use as a health issue rather than a moral failing can help make support services more welcoming and accessible. This involves extensive community education and awareness campaigns that promote compassion and understanding."

Male, 35–44 years, culturally and linguistically diverse community member, lived experience of drug use, living in a metropolitan area

Attendees said media reporting of AOD issues remains a concern. They suggested that more work is required to gain the media's commitment and adherence to the Mindframe guidelines.[5] These are designed to encourage the media to report safely and responsibly on AOD-related issues to minimise harm and stigma, and encourage help seeking.

Employment discrimination arising from having a criminal record was also seen as a significant barrier to recovering from AOD use and participating in the community. Participants offered potential solutions that included exploring reforms to spent conviction schemes and introducing AOD programs that support vocational and training activity. These programs could partner with or be better integrated with employers. Impacts for Aboriginal people and young people require specific consideration.

5 Mindframe. Alcohol and other drugs: Communicating about someone who uses AOD. Available at https://mindframe.org.au/alcohol-other-drugs/communicating-about-alcohol-other-drugs/mindframe-guidelines.

PRIORITY ACTIONS

9 Stigma and discrimination

9.1 Ensure that the NSW Government collaborates with relevant stakeholders to strengthen the implementation of the Mindframe guidelines for the media.

9.2 Establish a taskforce to report in 12 months on how the NSW Public Service will take a leadership role in reducing stigma and discrimination by:

- **i.** removing barriers to employment for people with lived and living experience
- **ii.** integrating the perspectives of people with lived and living experience into policies, programs and training.

9.3 Develop, using co-design processes, community education campaigns to address stigma and discrimination.

9.4 For the purposes of the *Criminal Records Act 1991*[6], reduce the period for a conviction for use or possession of a prohibited drug to be considered spent from 10 years to 5 years for adults, and 3 years to 1 year for juveniles, for minor drug offences.

10. CANNABIS AND DRIVING

In NSW, it is unlawful to drive impaired by any medicine or with the intoxicating component of cannabis – tetrahydrocannabinol (THC) – present in the blood or saliva. THC is found in a range of prescribed and unregistered products that can be used for various conditions and reasons. THC can affect sensory, cognitive and motor skills necessary for safe driving, such as attention, judgement, memory, vision and coordination, which can result in a crash causing death or injury. (For more information, see NSW Health's prescribed cannabis medicines and fitness to drive document.)

The Drug Summit consultations and 'Have your say' submissions provided a range of views and concerns relating to current drug driving laws. There was broad support for exploring models that would allow people who are using prescribed cannabis products to drive without fear of penalties, while balancing road safety risk.

"She only wants to be able to act like a human being and drive her children to school and herself to work but she cannot due to the THC component. To help her I have been driving her to and from work and home and ferrying her children for several months ... We are not supporting the recreational use of cannabis with THC but its use for people in severe pain ... to be able to live a fairly pain-free life."

Parents of a woman who uses cannabis medicine, individual submission

Participants discussed the approach to alcohol and other impairing prescription drugs, such as opioids, and driving. There were calls for further research into how impairment and sobriety were assessed, and the role of testing technologies and threshold levels for roadside (or other) testing. The Tasmanian medical defence model dictates that an unimpaired driver who can produce a medical certificate or prescription for their medicinal cannabis, and is taking the medicine as prescribed, can lawfully drive. This is like the Victorian model, which came into effect in March 2025. Attendees queried whether the greater uptake of prescription cannabis has increased road safety risks. They also discussed how related data could be collected and used to inform a future model for driving while using prescription cannabis. People from rural and regional areas, which have limited public transport, highlighted disproportionate burdens.

"This challenge is particularly acute for regional residents, who may experience cascading repercussions – including job loss, financial instability and compromised housing security – due to these rigid policies."

Anonymous 'Have your say'

6 *Criminal Records Act 1991* (NSW). Available at https://legislation.nsw.gov.au/view/whole/html/inforce/current/act-1991-008.

The challenges of defining a model for NSW were discussed, including the large number and variety of unregulated products, and their routes of consumption and differing effects. Participants also recognised the role of THC in road crash fatalities, and that changes to legislation would be required, as well as appropriate equipment and resourcing for police officers.

Participants saw road safety models that focused on impairment, rather than the presence of THC, as a potential solution, citing Australian jurisdictions that balance road safety with medical needs. An impairment model usually involves standardised sobriety testing (roadside or otherwise). For alcohol, impairment is determined by a threshold blood concentration; however, a consistent threshold level has not been established for THC. Several academic, peer network and professional bodies, such as the Royal Australasian College of Physicians and NUAA advocate for an impairment model.

"Review driving regulations to optimise individual and public safety, while minimising unnecessary infringements upon civil liberties and avoiding stigma towards people who use drugs. The focus should be on deterring and detecting impairment as a consequence of drug use."

Royal Australasian College of Physicians, organisational submission, recommendation 15

PRIORITY ACTIONS

10 Cannabis and driving

10.1 Legislate for a medical defence for people using medically prescribed cannabis who are driving and include:

- **i.** an option for police at the roadside or a court to assess the defence
- **ii.** guidelines that are developed by relevant government agencies (such as Transport, Health, Police and Justice) to support implementation
- **iii.** a review after 12 months.

11. HARM REDUCTION

The National Drug Strategy 2017–2026[7] outlines Australia's commitment to a harm-minimisation approach. The 3 pillars of this approach are: (1) reduce demand – by preventing the uptake and/or delaying the onset of drug use; by reducing the harmful use of drugs; and by supporting people's treatment and recovery from drug use; (2) reduce supply – by preventing and disrupting the production of illicit drugs; and by regulating the availability of legal drugs; and (3) reduce harm – by decreasing the negative consequences of the drug use for individuals, families and the community.

The third pillar of the National Drug Strategy seeks to reduce the potential harm of drug use when it occurs. Harms are driven by health, social and behavioural factors and include dose, purity, route of administration, use behaviours (such as repeated or high-frequency use, use of various substances together, use of test doses, and use while alone), and access to sterile equipment and emergency care. Reducing harm to individuals, families and communities can result in significant health, social and economic benefits. Harm-reduction strategies also improve safety and stability while a person prepares for change, such as entering treatment, and provide opportunities for engagement. Several harm-reduction strategies and programs were discussed at the forums and in consultations, and raised in the 'Have your say' portal.

7 Australian Government Department of Health (2017). National Drug Strategy 2017–2026. Available at https://www.health.gov.au/resources/publications/national-drug-strategy-2017-2026?language=en.

A. Drug-checking services

Information sharing and frequent testing of unregulated substances that are circulating are required to scan for potential threats. Around 1,200 new psychoactive substances have been identified in global drug markets over the past decade.[8] North America and Europe are experiencing increasing opioid-related deaths from highly potent opioids (e.g. fentanyl and nitazenes). NSW tests illicit drugs from different sources and has sophisticated infrastructure and response systems for potentially dangerous drugs that are circulating. Music and large festival organisers work with NSW Police, Liquor & Gaming NSW, NSW Health and relevant community or peer organisations to plan for health threats, including drug overdose, and to provide peer support.

The Summit and associated consultations heard consistent calls for a trial of drug checking services to supplement other harm reduction activities at festivals. There was also support for fixed-site services, with suggestions that a permanent site could support expertise in detecting new or novel substances. Young people supported the availability of drug-checking services, with a peer workforce, that provide non-judgemental advice on harms and health. Attendees noted that a heavy police presence, and the use of sniffer dogs, can also have an impact on festival goers' risk-taking behaviours, and any festival-based services should be undertaken in collaboration with the police response.

"Implement pill-testing services at festivals, events [and] maybe even a permanent facility. Strategies like the use of drug-detection dogs, strip searching and diversion programs contribute to a mistrust between young people and the government that can deter them from seeking help when needed ..."

18–24 years, lived experience of drug use

Attendees agreed that drug checking alone would not stop all drug-related harms. Many felt its primary benefit would be people making more informed choices regarding potentially unknown substances and dosages, reducing the number of overdoses. Additionally, drug-checking services provide opportunities for conversations that are evidence based and health focused, and for improving the various inputs for drug alerts.

"I think allowing for widespread pill testing at events would promote health. It starts a conversation between drug users and health practitioners even if momentarily; it would show that authority is not necessarily to be feared or is going to automatically prohibit a person's drug taking so it can be relationship building; it helps people make informed decisions that could save their lives and it accepts the reality that people do and will continue to take drugs."

Male, 55–64 years, member of the LGBTQI+ community, living in a regional area

Participants who provided rural and regional perspectives also supported drug-checking services and suggested that mobile and postal testing could support access outside the city.

The accessibility of drug alerts was raised across the forum days and in 'Have your say' submissions. There were calls to use plainer language for alerts and for them to be more visible, such as posting them on social media platforms and circulating them via peer networks.

B. Needle and syringe programs

The NSW Needle and Syringe Program (NSP) provides sterile injecting equipment, peer support and healthcare navigation and referral. The program aims to reduce needle sharing and the transmission of bloodborne viruses such as hepatitis B and C and HIV. The service model includes fixed locations, pharmacy outlets, dispensing machines, outreach, postal and peer-based distribution.

During the forums and consultations, NSPs received strong support, including to expand the availability and number of outlets for NSP services.

8 United Nations Office on Drugs and Crime (2024). UNODC Early Warning Advisory on New psychoactive Substance. Available at https://www.unodc.org/LSS/Page/NPS.

Regional and rural areas have fewer NSP locations compared to metropolitan settings. Increasing the number of dispensing machines in these areas was considered a way to improve access and provide greater anonymity. Extending operating hours of primary NSP sites and their co-location with other services were also explored.

"Improve access to Needle Exchange programs out of hours. In Newcastle, the main 2 programs are only open 9–5, Mon. to Fri. Once upon a time in Newcastle the Needle Exchange program opened in the afternoon until about 10 pm 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.

Reinstitute providing sterile waters and butterfly syringes in the Needle Exchange programs. These were removed years ago for various reasons. It is well-known that dollars spent in Needle Exchange programs save many dollars down the track in health care."

55–64 years, lived experience of drug use, living in a metropolitan area

The issue of access to sterile injecting equipment in custodial settings was raised across all consultations. Attendees put forward the risk of ongoing high rates of infection and re-infection with hepatitis C, and its subsequent treatment costs, as an argument for providing NSPs in custodial settings. There was also discussion of a human rights approach, including toward NSPs, in healthcare delivery that focused on the rights of an incarcerated person to access all forms of available healthcare, including harm reduction programs.

The issue of safety concerns for prison officers was also discussed, with representation from the Public Services Association calling for other custodial programs to be prioritised and funded appropriately.

C. Take Home Naloxone Program

Naloxone (also called Narcan and Nyxoid) is an opioid reversal drug that can be given after an overdose to temporarily reverse its effects. Naloxone is available through community pharmacies; peer, health and other organisations; and targeted programs, such as post-custody programs.

Attendees at the forums supported the Take Home Naloxone Program, saying it was highly effective. They discussed priorities for expanding the service by providing it to young people (such as through schools and youth services) and in first-aid kits, making correct use part of first aid training and promoting its availability at pharmacies and all other settings where it is available. There was also support in all consultations for ensuring that a range of settings and professionals who may see overdose cases, such as police and corrections officers in custodial settings, have access to naloxone.

"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 mine's 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, living in a metropolitan area

Participants described the ancillary benefits of equipping first responders with naloxone, suggesting that reframing drug use and overdose as a health issue, rather than criminal justice issue, will build trust in the community. Regional and rural participants emphasised the importance of appropriately funding local NGOs that deliver essential harm-reduction services outside metropolitan areas.

NDARC suggested targeting public health interventions that improve awareness of, and access to, naloxone in specific populations, such as people experiencing homelessness.

D. Medically supervised injecting and consumption services

The Medically Supervised Injecting Centre in Kings Cross a place where people who inject drugs can self-administer under the supervision of qualified staff. It also provides nursing and medical services for generalised health care.

There were multiple calls across all consultations to expand the number and location of supervised injecting rooms, and to consider establishing supervised consumption rooms, where drugs are taken in different ways (e.g. smoked). Participants discussed the inequitable access created by having a single location, and highlighted lack of access for diverse communities and regional and rural communities. Many supported removing the legislative barrier in the *Drug Misuse and Trafficking Act 1985* (NSW), which limits the number of facilities to one premises.[9] Alternatives to the current model include allowing LHDs to assess need, establish community support and co-locate services with existing AOD services (e.g. NSPs). Opposition was noted to the expansion of injecting rooms, which centres around the impact on public amenity. However, evidence was also presented to show that the Kings Cross injecting room has improved community safety.

Recommendations were also made to have diverse staff and locations.

"For SIFs/Drug Consumption Rooms to be established widely across the state, and not concentrated only in the City of Sydney region. Such facilities should be staffed by people who identify as Aboriginal and Torres Strait Islander people as well as peers of those who fall into these categories: people experiencing or at risk of homelessness, culturally and linguistically diverse communities, LGBTQI+ people and communities and people with disability."

Female, 55–64 years, culturally and linguistically diverse community member, lived experience of disability and drug use, living in a metropolitan area

PRIORITY ACTIONS

11 Harm reduction

11.1 Immediately implement a pilot of drug-checking services at music festivals, which includes:

- **i.** a health and peer workforce
- **ii.** provision of harm-reduction advice
- **iii.** an exclusion zone
- **iv.** integration with the current drug surveillance and early warning system
- **v.** an evaluation that can inform additional models such as a fixed-site drug checking service/s.

11.2 Enhance current drug monitoring systems to prepare for the emergence of new drugs of concern in Australia.

11.3 Amend section 36A of the *Drug Misuse and Trafficking Act 1985* (NSW) to remove the legislative restriction that currently limits medically supervised injecting centres to one premises in Kings Cross, noting substantial community consultation would be required to accompany any decisions about establishing additional medically supervised injecting centres.

11.4 Expand the delivery and accessibility of evidence-based harm reduction strategies including needle and syringe programs, particularly in regional, rural and remote areas.

9 *Drug Misuse and Trafficking Act 1985* (NSW). Available at https://legislation.nsw.gov.au/view/whole/html/inforce/current/act-1985-226#pt.2A-div.2.

12. THE CRIMINAL JUSTICE SYSTEM AND POLICING

Respondents and attendees were strong advocates for treating drug use as a health, rather than a criminal justice, issue. There was substantial support for removing criminal penalties for personal possession and use of drugs, replacing them with an enhanced and effective diversion system. In comments made prior to the Drug Summit, the Premier made it clear he did not believe the government had a mandate for decriminalisation and it was not on the government's agenda. Some attendees expressed disappointment that this appeared to rule out action on any Drug Summit recommendations on decriminalisation.

There was strong support for making improvements to the diversionary programs that are working well but need reform so they are more accessible. Diversion is a response that redirects people away from the criminal justice system into health, education or social service pathways. Diversion is used for a range of issues, including drug use, mental illness and traffic offending. Diversion can occur at different points of engagement with the criminal justice system, including at the point of interaction with police, in court or a specialised drug court setting.

A. Early Drug Diversion Initiative

The EDDI is a pre-court drug diversion initiative that was introduced in February 2024. The EDDI was seen by attendees as a successful application of responding to drug use as a health issue, with examples of positive health and crime outcomes cited in support although concern was expressed that the number of people being diverted through the scheme were very low and there were inconsistencies across regions in the application of the scheme. Attendees strongly supported expanding the EDDI, including by removing restrictions on access relating to the possession of multiple drugs, threshold drug quantities or having a criminal history. Standardised implementation was also considered important for any changes.

Regarding police discretion to offer diversion, enforcement of consistent diversion practices and presumption of diversion was a clear first preference, regardless of criminal history. It was considered vital to address the current low rates (around 8% diverted) for EDDI by removing discretion, and addressing the discrepancies seen in various police area commands. The NSW Bar Association suggested that section 10 of the *Crimes (Sentencing Procedure) Act 1999* (NSW) could be amended to incorporate an assumption of diversion for offences for personal use quantities.

Attendees described significant disparities in the implementation of EDDI across different population groups and regions, with particular concern expressed about disparity in access for Aboriginal people. Regarding the inequitable application of the CCS and issues with police discretion, Justice Reform Initiative noted the following.

> ***"In research exploring diversion under the NSW Cannabis Cautioning Scheme, BOCSAR noted that only 11.7% of First Nations adults were cautioned compared to 43.9% of non-Indigenous adults."*** [10]
>
> Justice Reform Initiative submission

Since the publication of this data, the eligibility criteria for the CCS has changed, which may improve access for Aboriginal people.

Attendees broadly agreed that removing discretion and having an automatic offer of diversion would increase the impact of the EDDI, especially for Aboriginal people. The Shopfront Youth Legal Centre noted there were significant geographical discrepancies with how diversion was applied.

10 A Teperksi and S Rahman (2023). 'Why are Aboriginal people less likely to receive cannabis cautions?', *Crime and Justice Bulletin No. 258*, NSW Bureau of Crime Statistics and Research. Available at https://bocsar.nsw.gov.au/documents/publications/cjb/cjb251-300/cjb258-summary-cannabis-cautioning.pdf.

"However, the effectiveness of these measures [EDDI] depends heavily on police discretion. Recent figures have shown that exercise of discretion to divert low-level drug offenders has been limited and has also been very inconsistent across Police Area Commands (PACs). For example, the rate of diversion in Auburn PAC was said to be 52%, compared with only 1.7% in neighbouring Bankstown."

Max Maddison, 'Postcode lottery: Where police have shunned state's new drug laws', *The Sydney Morning Herald* (online, 15 September 2024), available at https://www.smh.com.au/politics/nsw/postcode-lottery-where-police-have-shunned-state-s-new-drug-laws-20240912-p5k9yr.html

The number of times a person was eligible for EDDI was also discussed as a barrier. Medical experts 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. They said people should be offered diversion programs as many times as they encounter police for drug use and/or possession offences.

B. Magistrates Early Referral into Treatment

Attendees including those from the judicial system praised the MERIT program, pointing to its demonstrated effectiveness. They expressed strong support 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 accessing MERIT were identified, including eligibility restrictions tied to bail status and limited treatment availability. Attendees recognised the need to support and improve accessibility for people with complex needs, including those with a history of violence, who are often excluded from diversion programs.

C. Drug Court

Attendees also strongly supported expanding alternatives to incarceration, such as those provided by the Drug Court program. They presented evidence demonstrating good outcomes for program graduates. Geographical limitations were identified as a major barrier, with the Drug Court only operating in 4 locations (Hunter, Parramatta, Sydney and Dubbo). Attendees described this as creating significant 'postcode justice' issues. Discussion highlighted implementation challenges in regional areas, including lack of treatment and other support services to refer people to, and significant transport barriers. Attendees called for the ability to transfer people between Drug Courts, expanding eligibility criteria and increasing funding for support services.

D. Cannabis Cautioning Scheme

Attendees called for consistency between the EDDI and the CCS, although there were mixed views about whether the EDDI and the 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. It was also noted that the CCS was now a 'legacy' model, and consideration should be given to taking a more contemporary approach.

E. Aboriginal people and diversion

While expressing support for the 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 Aboriginal Community Controlled Health Services could be resourced to deliver programs, particularly in regional areas, and argued that diversion programs should offer a higher level of flexibility for Aboriginal people.

The Jumbunna Institute for Indigenous Education and Research highlighted the importance of Aboriginal ownership and design of programs for Aboriginal people.

"Cautioning and diversionary schemes do not benefit Aboriginal people. They are not designed or implemented in a culturally appropriate way, increasing Aboriginal people's barriers to access and successful completion. Disparities in cautioning rates will likely persist despite changes to eligibility criteria, reduction in scope for police discretion, or policies addressing factors that contribute to over-representation of Aboriginal people in the justice system."

Jumbunna Institute for Indigenous Education and Research, University of Technology Sydney

Attendees noted that appropriately resourced Aboriginal-led programs and community control were essential for effective service delivery. They highlighted that to make participation meaningful and achieve positive outcomes, diversion models must be appropriate for Aboriginal people. Participants felt that alternative sentencing models – such as Circle Sentencing, Youth Koori Court and the Walama List – work well, but were not widely available. They also said there may be differential outcomes and experiences for Aboriginal men and women. There were also calls to expand the justice reinvestment approaches to more locations to reduce the number of interactions between Aboriginal people and the police. Discussion emphasised the importance of cultural connection in healing, including having access to Country and engaging with Elders.

F. Young people and diversion

Very few diversion options are available for young people. The main avenue is through the Young Offenders Act, which provides effective levers such as cautioning or youth conferencing. Legal Aid NSW suggested that reforms to the Young Offenders Act in 2019, which extended opportunities for diversion of young people, were not being implemented to full effect. Other participants noted that there was an opportunity to reform the Young Offenders 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 the police, and potentially a missed opportunity for early intervention and breaking the cycle of criminalisation. A Magistrate from the Children's Court of NSW argued that the Young Offenders Act and its provisions have a far greater range of eligible offences than the CCS.

Many attendees called for reinstatement of the Youth Drug Court, focusing on improving integration with health and social services. They emphasised the importance of family involvement and support in youth programs.

G. Supporting rural and regional treatment infrastructure

The lack of treatment and support agencies to which diversion programs can refer people was seen as a particularly pressing issue in the regions. Attendees pointed out that diversion programs can only work if services have capacity 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. They also noted that there were different policing dynamics in these communities, where anonymity was impossible to achieve. Regional areas close to state borders also present unique challenges due to cross-border policing and justice issues. Examples include inconsistent approaches to diversion and difficulties coordinating court programs across jurisdictions, emphasising the need for better interstate cooperation and information sharing.

One AOD service provider cautioned against over-treatment in relation to diversion.

> ***"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 that are more intensive than appropriate for their circumstances, as this risks diverting resources from those who may need treatment."***
>
> AOD service provider

H. Policing

Discussions around policing practices featured across several themes throughout the Drug Summit. While recognising the importance of reducing the supply of drugs – one of the 3 pillars of harm minimisation – there was a sense that many policing practices were disproportionate to the risks and harms that drugs cause and that they also exceeded community expectation for law enforcement. The impact of these practices on trust in policing, especially for Aboriginal people and young people (groups that are disproportionately burdened by contact with the criminal justice system), was of particular concern. The underlying principle of treating drug use as a health issue, rather than a criminal issue, was at the core of many of these discussions.

Police culture and training relating to drug use emerged as an area of discussion. 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. There were calls for more guidance for police, particularly for junior officers, on the range of harm-reduction and diversion schemes available where discretion may not be as easily applied. This would also assist with reducing stigma. Police participants noted the impacts of workforce challenges, including high turnover and staffing, particularly in regional areas.

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 would allow them to focus on supply, and serious drug trafficking, rather than personal use. Discussion included examining successful models of police–health partnerships and suggestions for expanding these approaches. Participants suggested redirecting police resources from personal use enforcement to serious drug trafficking. Some law enforcement participants felt that despite their willingness to embrace harm-reduction approaches, there were legislative constraints. Consideration was given to how police could better support harm-reduction initiatives while maintaining public safety. The concept of 'public health policing' was raised as an approach that could better enable responses to drug use, emphasising early intervention and harm prevention.

Attendees felt that specific police practices, including strip searching, drug detection dogs at festivals, and police attendance at overdose scenes, needed strong reform.

Strip searching for suspected personal drug possession in all settings was strongly opposed, with attendees citing evidence regarding its harmful impacts. Psychological trauma, particularly for vulnerable populations, was seen as a major harm and attendees questioned the practice's effectiveness. Health professionals emphasised how strip searching causes unnecessary harm, and damages trust between young people and law enforcement. It also creates barriers to help-seeking behaviour.

"Our current laws encourage unhealthy and dangerous behaviours because they introduce a conflict of interest when it comes to fully reaching vulnerable communities. The people who are likely to experience the greatest harms are the people we are strip searching and arresting, because clearly the NSW Government's strategy is to demonise and humiliate drug users. You can't forcibly remove our clothes in public and then claim to encourage healthy behaviours."

Male, 25–34 years, member of the LGBTQI+ community, lived experience of disability and drug use, living in a metropolitan area

Many attendees called for an end to using drug detection dogs, noting that the threat of detection and arrest can lead to panic consumption, potentially increasing harm. They also noted that using detection dogs at festival entrances was problematic. There was a strong sense that the presence of police in riot uniforms with drug detection dogs was not commensurate with possession offenses. The Australian Festival Association noted that the percentage of supply offences (compared with possession offences) being detected was low, arguing that using sniffer dogs was not achieving the outcome of prioritising supply offences.

Participants emphasised that fear of police contact, including at overdose events, prevents people from accessing harm-reduction services and/or seeking medical help. Young people described fearing the implications of detection, such as by family members, and of arrest. Attendees felt that because police may attend overdose scenes before ambulances, equipping them with naloxone could rebuild trust in first responders managing health and wellbeing first and foremost. The theme of naloxone was raised across the spectrum of first responders; however, participants felt that police were in a unique position to intervene if required and therefore build trust in taking a health, rather than a criminal justice, approach.

PRIORITY ACTIONS

12 The criminal justice system and policing

12.1 Reform the Early Drug Diversion Initiative to extend eligibility criteria to address restrictions relating to possession of multiple drugs, criminal history and threshold drug quantities; limiting police discretion with an assumption of diversion for personal use quantities; and ensuring a clear monitoring and evaluation framework.

12.2 Ask the Attorney-General to review opportunities for consistency in the Cannabis Cautioning Scheme and the Early Drug Diversion Initiative.

12.3 Expand the Magistrates Early Referral into Treatment program to fully meet demand.

12.4 Expand the Drug Court to regional areas, prioritising the Far North Coast, the Central Coast and Wollongong, ensuring accompanying service infrastructure.

12.5 Strengthen diversion programs for young people, including by better utilising and reforming the *Young Offenders Act 1997* (NSW) and consider reinstating the Youth Drug and Alcohol Court of NSW.

12.6 Expand access to alternative sentencing models for Aboriginal people, including the Walama List, Youth Koori Court, Circle Sentencing and Justice Reinvestment.

12.7 Increase police understanding of available local health and social services to support referrals.

12.8 Provide comprehensive harm-reduction training for NSW Police officers and other relevant first responders and equip them with naloxone to respond to opioid overdoses.

12.9 Strengthen enforcement of illicit drug supply, targeting suppliers.

12.10 Cease the use of drug detection dogs and strip searching for suspected drug possession during the current trial of drug-checking services at music festivals, with consideration to extending this to all music festivals.

ACKNOWLEDGEMENTS AND NEXT STEPS

The process of the NSW Drug Summit and its associated consultations have been instructive. We would like to thank all participants, particularly those who travelled to attend the regional forums and people with lived and living experience, who gave up their time and shared their powerful stories and insights. Thank you to everyone who contributed their ideas, experience and expertise through the 'Have your say' portal.

Thank you to Premier Minns and Minister Park for providing this opportunity and forum.

We ask that the government provide a response to this report and the priorities for action within 6 months. We look forward to the government's response.