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RACP Submission in response to the NSW Alcohol and Other Drugs Strategy 2026- 2036

October 2026

About The Royal Australasian College of Physicians (RACP)

The RACP trains, educates and advocates on behalf of over 24,400 physicians and 9,800 trainee physicians, across Australia and Aotearoa New Zealand. The RACP represents a broad range of medical specialties including addiction medicine, general medicine, paediatrics and child health, public health medicine, infectious diseases medicine, sexual health medicine, occupational and environmental medicine, geriatric medicine and rehabilitation medicine. Beyond the drive for medical excellence, the RACP is committed to developing health and social policies which bring vital improvements to the wellbeing of patients, the medical profession and the community.

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We acknowledge and pay respect to the Traditional Custodians and Elders – past, present and emerging – of the lands and waters on which RACP members and staff live, learn and work. The RACP acknowledges Māori as tangata whenua and Te Tiriti o Waitangi partners in Aotearoa New Zealand.

Executive Summary

The Royal Australasian College of Physicians (RACP) welcomes the opportunity to comment on the draft New South Wales (NSW) Alcohol and Other Drugs Strategy 2026–2036. This submission draws on the expertise of our members, including addiction medicine specialists in the RACP's Australasian Chapter of Addiction Medicine (AChAM), and on the RACP's published positions on alcohol and drug policy.

The RACP supports the draft Strategy's foundation in harm minimisation, its framing of alcohol and other drug (AOD) use as a health and social issue, and its ten-year, whole-of-government commitment.¹ However, much of the draft Strategy describes existing programs rather than new commitments, sets no measurable goals and makes no choices about what to de-emphasise. It does not commit to funding services to the level of need; it is silent on the addiction medicine workforce, and it adds no new measures on alcohol, which causes the most harm.

Our key recommendations are set out below, followed by comments that follow the draft Strategy's structure.

Recommendations

The RACP recommends that the final Strategy and its workplans:

- 1) **Commit to a significant increase in AOD treatment funding**, with services planned using an updated population-based model, such as the Drug and Alcohol Services Planning Model (DASPM), weighted for rural delivery costs.
- 2) **Commit to investing in and prioritising the addiction medicine workforce** to meet community need.
- 3) **Add the addiction medicine specialist and training workforce**, including funded advanced training positions, as a priority under 'Strengthening the workforce' in the first workplan.
- 4) **Introduce Drug and Alcohol Brief Intervention Teams (DABIT) in hospitals, especially where there is no AOD consultation service**, to make screening, brief intervention and referral routine in hospitals and mental health services.
- 5) **Expand opioid agonist treatment (OAT)**, with a coverage target set in the first workplan, including in custody, and **improve access to medicines for alcohol use disorder**.
- 6) **Turn the principles of Aboriginal self-determination, community control and cultural safety into measurable commitments**, with sustainable funding for Aboriginal Community Controlled Health Organisations (ACCHOs) and Aboriginal-specific outcomes.
- 7) **Add stepped and integrated care as core concepts, add older people as a priority population**, and **strengthen care in pregnancy and early childhood**, including Fetal Alcohol Spectrum Disorder (FASD) assessment.
- 8) **Introduce an indexed minimum floor price for alcohol**, statutory controls on alcohol promotion, limits on trading hours and outlet density and council's powers to set licence conditions and cap licensed premises
- 9) **Strengthen court diversion strategies**, including:

¹ Royal Australasian College of Physicians. Achieving a health-focused approach to drug policy in Australia and Aotearoa New Zealand: RACP position statement [Internet]. Sydney: RACP; 2024 Nov [cited 2026 Oct 2]. Available from: <https://www.racp.edu.au/docs/default-source/advocacy-library/racp-position-statement-achieving-a-health-focused-approach-to-drug-policy-in-australia-and-aotearoa-new-zealand.pdf>

- a) reforming the Early Drug Diversion Initiative (EDDI) to increase uptake and reduce disparities from police discretion, with diversion rates reported publicly by Aboriginality and region.
 - b) expanding the Magistrates Early Referral into Treatment (MERIT) program, and extending the Drug Court to regional areas, with the treatment places they need.
- 10) **Extend harm reduction beyond festivals**, including fixed-site and mobile drug checking, extending naloxone access to anyone at risk, including carriage by NSW Police, providing free sterile injecting equipment, prioritising regional and rural areas, and trialling needle and syringe programs in custody.

Legislative changes to drug laws are out of scope for this consultation. However, the draft Strategy itself foreshadows drug-driving legislation (Strategy 3.5.3). We therefore include the following recommendations that reflect the RACP's published positions:

- 11) **Introduce a legislated presumption of diversion** for personal possession of all drug types, limiting police discretion.
- 12) **Strengthen supervised consumption services** by increasing the number of services, including in regional centres, and trial new, less resource-intensive models, such as services within needle and syringe programs.
- 13) **Review the drug-driving framework for medicinal cannabis** to optimise public safety, focusing on deterring and detecting impairment as a consequence of drug use, rather than the presence of tetrahydrocannabinol (THC); any THC threshold should be set on independent expert advice.

In addition:

- 14) **Include addiction medicine specialist representation on the NSW AOD Strategy Committee** and any clinical or expert advisory groups; exclude the alcohol industry, and set workplan indicators and headline ten-year outcomes, with a mid-point review, independent evaluation and public reporting.

Overall approach and harm minimisation

The Strategy should state plainly that moderate to severe substance use disorder is a chronic, relapsing health condition that often needs long-term treatment,¹ and that AOD treatments are as effective as treatments for other chronic conditions.^{1, 2}

Alcohol. The draft Strategy data shows alcohol causes the most harm in NSW, with 534 deaths in 2023 and more than 54,000 hospitalisations in 2023/24.³ Alcohol was also the principal drug of concern in 42% of NSW publicly funded AOD treatment episodes for clients' own drug use in 2024-25.⁴ Yet most new commitments target illicit drugs. Actions on alcohol treatment, price and promotion should match its share of the harm.

Funding. The draft Strategy makes no funding commitment (p.14). NSW has the lowest rate of specialist AOD treatment of any jurisdiction (369 per 100,000, against 1,381 in the Northern

² Royal Australasian College of Physicians. RACP submission: Australian Parliamentary inquiry into the health impacts of alcohol and other drugs in Australia [Internet]. Sydney: RACP; 2024 Oct [cited 2026 Oct 2]. Available from: <https://www.racp.edu.au/docs/default-source/advocacy-library/racp-submission-to-the-parliamentary-inquiry-into-the-health-impacts-of-alcohol-and-other-drugs-in-australia.pdf>

³ NSW Government. NSW Alcohol and Other Drugs Strategy 2026-2036: consultation draft. Sydney: NSW Government; 2026

⁴ Australian Institute of Health and Welfare. Alcohol and other drug treatment services in Australia annual report 2024–25: New South Wales [Internet]. Canberra: AIHW; 2026 [updated 2026 Sep 15; cited 2026 Oct 2]. Available from: <https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/alcohol-other-drug-treatment-services-australia/contents/state-and-territory-summaries/new-south-wales>

Territory),⁵ and an estimated 101,773 people in NSW want treatment but cannot get it.⁶ Unmet demand for treatment is significant, and the Strategy should rebalance spending towards treatment and harm reduction and away from a criminal justice response.² As the NSW Drug Summit recommended, treatment funding should increase significantly, with the level and location of services set by a population-based planning model.⁶

Whole of government action. Housing, employment, education and socio-economic inequalities shape AOD use, and criminalisation causes further harm, disproportionately for Aboriginal and Torres Strait Islander peoples.¹ The Strategy should adopt an intersectoral, whole of government approach to these social determinants.²

Core concepts

The RACP supports trauma-informed practice as a core concept and recommends that all healthcare professionals and essential-service staff be trained in trauma-informed care and evidence-informed AOD treatment,¹ to complement key non-judgmental interactional skills.

Involuntary treatment should be used only as a last resort for a very small number of severely unwell, high-risk people, and always led by specialist clinicians.¹ Stepped care and integrated care should be added as core concepts, with mental health care and housing provided alongside AOD treatment rather than deferred until abstinence. Cultural safety should be supported by Aboriginal and Torres Strait Islander trauma-informed frameworks¹ that recognise colonial and intergenerational trauma.

Enablers for success

Workforce

Neither the draft Strategy nor the NSW AOD Workforce Strategy 2024-2032 mentions addiction medicine specialists or trainees, nor the medical specialist workforce as a distinct group,⁷ yet access to specialists is a key barrier to treatment, particularly in regional NSW.⁶

The Strategy should commit to investing in and prioritising the addiction medicine workforce.¹ Addiction medicine specialists are leaders, educators and clinicians across the AOD sector. The Strategy should commit to growing the specialist pathway through funded advanced training positions across local health districts, including regional and rural services, so trainees train and stay in NSW. Where possible, NSW Health services should offer addiction medicine rotations in Basic Physician Training and supervised addiction medicine terms for interns and residents.¹ NSW Drug Summit submissions also called for general practice trainees to be exposed to hospital AOD clinics.⁶

Rural participants in the NSW Drug Summit consultation highlighted poor access to specialists, with one calling for resident addiction specialists and psychiatrists rather than reliance on fly-in-fly-out (FIFO) services, with more junior doctors rotated through the sector.⁶ Given the workforce shortages the draft Strategy identifies in rural and regional areas,³ access

⁵ Australian Institute of Health and Welfare. Alcohol and other drug treatment services in Australia annual report 2024–25: trends in clients in states and territories [Internet]. Canberra: AIHW; 2026 [cited 2026 Oct 13]. Available from: <https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/alcohol-other-drug-treatment-services-australia/contents/state-and-territory-summaries/insights>

⁶ Tebbutt C, Brogden J. Report on the 2024 NSW Drug Summit [Internet]. Sydney: NSW Government; 2025 [cited 2026 Oct 2]. Available from: <https://www.health.nsw.gov.au/aod/summit/Documents/2024-nsw-drug-summit-report.pdf>

⁷ NSW Ministry of Health. NSW Alcohol and Other Drugs Workforce Strategy 2024–2032 [Internet]. St Leonards (NSW): NSW Ministry of Health; 2024 Jul [cited 2026 Oct 2]. Available from: <https://www.health.nsw.gov.au/aod/resources/Publications/aod-workforce-strategy.pdf>

for rural and remote populations should be prioritised, including through telehealth and mobile services.¹

The RACP supports building AOD capability across general practice/primary care, emergency, pain, obstetrics, paediatrics and mental health, backed by the Drug and Alcohol Specialist Advisory Service and consultation liaison, and funded Aboriginal and Torres Strait Islander and peer workforce positions.^{1, 7} As the Australian government holds funding and policy responsibility for general practice and primary health care,³ NSW should also advocate to the Australian government for adequate reimbursement of AOD treatment by addiction medicine specialists and other medical, nursing and allied health professionals, and for addiction medicine specialists to be able to refer directly to key disciplines, such as psychologists.¹

Strategic commissioning, technology and data

The RACP supports five-year non-government organisation (NGO) funding agreements,⁸ which should include cost escalation and funding for evaluation.⁶ The Special Commission of Inquiry into the Drug 'Ice' recommended that the Drug and Alcohol Service Planning Model (DASPM) be updated and made available to all local health districts, primary health networks and NGOs;⁶ the Strategy should commit to this, with funding for capital works.⁹

All AOD services, including NGO lead services should report against quality and outcome frameworks that measure outcomes that matter to patients.¹ Telehealth and mobile services should be expanded for rural and remote communities, including to supplement specialist assessment,^{1, 6, 9} and a national AOD clinical research network supported.¹

Priority populations

Aboriginal and Torres Strait Islander peoples

The RACP supports the dedicated Aboriginal Implementation Plan and the central role of ACCHOs. The Strategy's principles should become measurable commitments: self-determination and shared decision-making in governance, implementation and evaluation; sustainable funding for ACCHOs and Aboriginal-led commissioning;⁶ accountability for cultural safety; and inclusion of social and emotional wellbeing. Workforce and access to addiction medicine in rural and regional NSW should be built through partnerships with ACCHOs.

Aboriginal and Torres Strait Islander people are imprisoned at 13.3 times the rate of non-Indigenous Australians and have largely not benefited from discretionary diversion,¹ so the RACP supports more health-based responses. Alcohol measures that apply only to Aboriginal communities should be used only where communities request, develop and lead them.¹⁰ Aboriginal people made up 22% of clients of NSW publicly funded AOD treatment in 2024-25 (19% nationally),⁴ and the Strategy should include Aboriginal and Torres Strait Islander-specific outcomes and monitoring.

⁸ Park R, Catley Y. NSW Government delivers response to the 2024 Drug Summit Report [media release]. Sydney: NSW Government; 2025 Oct 28 [cited 2026 Oct 16]. Available from: <https://www.nsw.gov.au/ministerial-releases/nsw-government-delivers-response-to-2024-drug-summit-report>

⁹ Royal Australasian College of Physicians. RACP submission to the Australian Senate's inquiry into effective approaches to prevention, diagnosis and support for fetal alcohol spectrum disorder [Internet]. Sydney: Royal Australasian College of Physicians; 2019 Dec [cited 2026 Oct 16]. Available from: https://www.racp.edu.au/docs/default-source/advocacy-library/c-racp_fasd-submission_gm-approved.pdf

¹⁰ Royal Australasian College of Physicians; Royal Australian and New Zealand College of Psychiatrists. Alcohol policy [Internet]. Sydney: RACP; 2016 [cited 2026 Oct 2]. Available from: <https://www.racp.edu.au/docs/default-source/advocacy-library/pa-racp-ranzcp-alcohol-policy.pdf>

Regional, rural and remote communities

The draft Strategy acknowledges higher harms in regional areas.³ The Strategy should commit to specialist treatment, withdrawal and residential capacity outside metropolitan areas, and address transport, cost and confidentiality barriers.^{1, 2}

Children, young people and pregnancy

Preventing adverse childhood experiences should be an explicit, funded priority, through home visiting, parenting programs, family violence programs and social-emotional learning.¹

Pregnant women should be routinely and non-judgementally screened for alcohol use, with accessible treatment available, as fear of losing custody of their child/children and/or stigma often keep women from care.^{8, 9} Funded prevention, early intervention and family support should address high rates of child removal, with Aboriginal-led approaches for Aboriginal and Torres Strait Islander families.⁶ Pregnancy messaging should include partners.⁸

Every child should have access to multidisciplinary developmental assessment, with FASD screening in youth justice and out-of-home care, where FASD is heavily over-represented.^{2, 8} Youth services are scarce and need an alcohol focus, with the peak age of onset for alcohol use disorder at 18 years of age.^{2, 9}

Older people

Older people should be added as a priority population. The draft identifies “ageing cohorts with long-term dependence” as an emerging challenge,³ and later-life alcohol problems are increasing.⁹

Pillar 1: Reduce demand

Awareness and education (1.1). *Poorly designed campaigns can be counterproductive*, so campaigns must be monitored and evaluated.¹ The RACP supports evidence-informed school drug education.⁶ Education works when it reinforces measures on price, availability and marketing, not as a substitute for them.⁹

Prevention and early intervention (1.2). Fewer than 30% of hospital patients with a substance use disorder are identified through routine care.¹ Screening, brief intervention, and referral should be routine in hospitals, emergency departments, and mental health services, and every acute hospital, including regional and rural hospitals, should have an AOD consultation liaison available.^{1, 7} The RACP **strongly supports wider use of screening and brief intervention in health, justice and community settings, and recommends establishing Drug and Alcohol Brief Intervention Teams (DABITs) in hospitals**, prioritising those without an AOD consultation service. DABITs are specialist AOD clinicians, based mainly in emergency departments, who screen, assess and deliver brief interventions and link patients to treatment. They operate successfully across Queensland Health.¹¹ The RACP also supports general practitioner (GP) screening and brief intervention,⁹ which complements, but does not replace, specialist treatment.

Treatment, care and support (1.3). The RACP supports the “no wrong door” approach and specialist mental health care in residential rehabilitation.⁶ Opioid agonist treatment (OAT) is at a crossroads, with an ageing prescriber workforce and poor uptake in primary care, hospitals and pain services.^{1, 2} The Strategy should engage private and community addiction

¹¹ Queensland Health. Drug and Alcohol Brief Intervention Team (DABIT): model of service [Internet]. Brisbane: Queensland Health; 2016 Aug [cited 2026 Oct 13]. Available from: https://adis.health.qld.gov.au/sites/default/files/resource/file/1511825874_DABIT-MOS_A3-June2017.pdf

specialists,¹ increase GP and nurse practitioner prescribers,⁶ and expand access to long-acting injectable buprenorphine.⁷

Access to methadone and buprenorphine in custody should be enhanced, with support to stay in treatment after release and take home naloxone on release.^{2, 6} Medicines for alcohol use disorder remain underused, and withdrawal management alone is largely ineffective;⁹ joint NSW and Commonwealth investment in alcohol treatment is needed.²

Diversion (1.4). The RACP supports the draft Strategy's commitment to reform the Early Drug Diversion Initiative (EDDI). Rather than going to court, eligible people found in possession of small amounts of drugs, other than cannabis, can receive up to two fines, at police discretion. Fines are waived if they complete a free phone health intervention with a drug and alcohol clinician. The RACP supports reform that would maximise EDDI uptake across all drug classes and reduce disparities arising from police discretion, which disadvantage Aboriginal and Torres Strait Islander people, culturally diverse communities and young people.^{1, 6} The Magistrates Early Referral into Treatment (MERIT) program should be expanded, and the Drug Court extended to regional areas,⁶ with investment in treatment places that make diversion work.

Price, promotion and labelling (1.5). This section describes existing regulation only, although the draft Strategy calls price and promotion "the most significant drivers of demand for alcohol".³

The RACP recommends:

- A minimum indexed floor price per standard drink.⁹ The Northern Territory's \$1.30 minimum unit price, introduced in 2018, was associated with reduced alcohol-related harms without negative effects on moderate drinkers, retailers or tourism. Following its repeal in March 2025, prices of cheap wine, cider, beer and spirits fell rapidly.¹²
- Statutory controls on advertising and promotion within NSW's powers, rather than reliance on industry self-regulation⁹
- Advocacy to the Australian government, which is responsible for excise taxes,³ for volumetric taxation of all alcohol products, with revenue directed to preventive health^{2, 8}
- Amendment of the Liquor Act to require public reporting of alcohol sales data
- The alcohol industry should have no role in health policy.⁹

Housing, purpose and connection (1.6). Housing should be offered without requiring abstinence, with wraparound support to sustain tenancies.¹

Pillar 2: Reduce supply

The draft Strategy commits to "maintain a strong law enforcement focus on drug misuse" (Executive Summary, Pillar 2: Reduce supply, p. 3). This should read "a strong law enforcement focus on *drug manufacture and supply*". Policing should target the supply chain rather than people who use drugs, in line with the Strategy's health-focused approach.

The RACP supports clinical guidance on prescribing and de-prescribing (Strategy 2.1.2), and a "universal precautions" approach to psychoactive medicines with addictive potential, with addiction medicine specialists in multidisciplinary teams.¹

¹² National Drug and Alcohol Research Centre, UNSW. Repeal of the NT's minimum unit price and the impact on alcohol pricing [Internet]. Sydney: UNSW; 2026 Aug 28 [cited 2026 Oct 13]. Available from: <https://www.unsw.edu.au/research/ndarc/resources/repeal-of-nt-minimum-unit-price-and-impact-on-alcohol-pricing>

On liquor licensing (Strategy 2.1.3), strengthen limits on trading hours and availability, and provide greater local councils control over licensing.^{1, 9}

Pillar 3: Reduce harm

Drug checking (3.1). The RACP supports ongoing festival drug checking,⁶ however, it is already in place, so it should not be an end goal of a ten-year Strategy. It should be the first step towards drug checking for people at greater risk in the community, who are often not reached at festivals. The strategy should commit to trials of fixed-site and mobile community drug checking,^{1, 6} with monitoring for nitazenes and other emerging novel psychoactive substances.⁶ Drug checking also provides an opportunity for early intervention, education and brief intervention, and for linking people to treatment, in line with the Strategy's goals.

Sterile injecting equipment (3.2). Equipment should be free and widely available¹, with priority for regional and rural areas,^{1, 6} and needle and syringe programs should be trialled in custody, where none currently exist² as a priority, given high rates of hepatitis C transmission in this context.¹³

Overdose prevention (3.4). Take-home naloxone should be available to anyone at risk of experiencing or witnessing an overdose, including people on prescribed opioids, which were involved in 43.6% of unintentional opioid deaths in 2022.² With nitazenes entering the drug supply, broad access is more urgent than ever.¹ The Strategy's commitment to expand naloxone access and harm-reduction training for police and first responders (3.4.4) should extend to NSW Police carrying naloxone.⁶

The draft Strategy describes the Uniting Medically Supervised Injecting Centre (MSIC) in Kings Cross, Sydney as a centre that links people to treatment and support, but does not commit to expand, open new sites or evaluate it. Noting that changes to drug laws are out of scope, the RACP supports more supervised consumption services, including in regional centres, and trials of lower-cost models, such as within needle and syringe programs, centres that allow drug inhalation and reflect local need.^{1, 6}

Road safety (3.5). The drug-driving framework for medicinal cannabis should be reviewed to optimise public safety, focusing on impairment rather than the presence of THC; any THC threshold should be set on independent expert advice¹ Research into how impairment is assessed should continue.⁶

Safe event planning (3.6). Longer trading hours are associated with higher alcohol consumption and harms, including violence and road crashes,¹⁰ so extended trading in Special Entertainment Precincts, designated areas where councils can change trading hours and sound rules to help local hospitality and entertainment operators thrive, should be assessed for health impacts.

Stigma (3.7). The RACP supports the proposed employment barriers taskforce and reform of spent conviction schemes. Both would help reduce the structural stigma and discrimination that people who use alcohol and other drugs face in accessing employment. Stigma within health care, including inadequate pain relief, should also be addressed, as should criminal record checks that prevent the employment of peer workers.⁶

¹³ Hajarizadeh B, Carson JM, Byrne M, Grebely J, Cunningham E, Amin J, et al. Incidence of hepatitis C virus infection in the prison setting: the SToP-C study. *J Viral Hepat* [Internet]. 2024 Jan [cited 2026 Oct 16];31(1):21-34. Available from: <https://doi.org/10.1111/jvh.13895>

Governance, monitoring and evaluation

The NSW AOD Strategy Committee does not name any medical college or addiction medicine body; clinical input is described only as “clinical and academic research institutions”.³ The Committee, and any clinical or expert advisory group that sets workplan priorities, should include addiction medicine specialist representation.

Aboriginal organisations on the Committee should share decision-making, not only advise.

The alcohol industry should have no role in the Strategy or its workplans.⁸

Workplans should include indicators for treatment access and unmet need, specialist workforce and trainee positions by region, Aboriginal-specific outcomes, overdose deaths, blood-borne viruses and patient-reported outcomes.⁶

As targets belong in workplans, the first workplan should set a few measurable ten-year outcomes, such as fewer alcohol-related deaths and higher OAT coverage. New or reformed programs should be independently evaluated and progress reported publicly.^{1, 6}

Closing Comment

We welcome the NSW Government’s consideration of our recommendations and look forward to working together to reduce the harms of AOD for people and communities across NSW.

If you require further information or would like to engage with the RACP, please contact Debra Moss, Policy and Advocacy Officer, via the RACP Policy and Advocacy unit at policy@racp.edu.au.