Dalgarno INSTITUTE

RECOMMENDATIONS FOR NATIONAL DRUG STRATEGY 2027–2036

A Prevention & Recovery Framework

Building Safe, Healthy and Resilient Communities

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INTRODUCTION FROM DALGARNO INSTITUTE

Australia stands at a crossroads. The United Nations Office on Drugs and Crime's World Drug Report 2025 confirms what families and communities already know: our current approach to the substances and drugs issue is failing those global demographics. Australia now leads the world in cocaine consumption (per capita) and has 'by far the highest' global prevalence of ecstasy use. Our cannabis use is three times the global average among school students. Over 40% of Australians in drug treatment are there for methamphetamine, the highest proportion globally. Most concerning, 55% of those in treatment are under 35 years of age.

These statistics represent real people: sons and daughters, brothers and sisters, mothers and fathers, community members with unfulfilled potential. Behind each number is a family in crisis, a childhood disrupted, a future compromised.

Yet we know what works. Between 1998 and 2007, Australia's 'Tough on Drugs' policy achieved a 39% reduction in illicit drug use and a 67% reduction in opiate deaths. Sweden reduced student drug use by 80%. Iceland achieved 60–90% reductions. Prevention policies actually implemented and followed up on produce a $12.88 saving in future damage management costs for every dollar invested.

The evidence is clear: prevention works, recovery is possible and productive, children can be protected, and families must be educated and equipped to that end.

This policy brief is a priority option for the National Drug Strategy 2027–2036, which returns to evidence-based prevention as the foundation of drug policy. It prioritises protecting children, supporting comprehensive recovery, and building drug-use-declining communities. It honours Australia's international obligations under Article 33 of the Convention on the Rights of the Child, the most ratified UN treaty in history.

We can no longer afford policies that normalise drug use while claiming to reduce its harms. The time for a seriously resourced and thoroughly implemented prevention and recovery framework has come.

EXECUTIVE SUMMARY

The Crisis

The UN World Drug Report 2025 documents Australia's unprecedented drug crisis:

- Highest global cocaine use in the Australia-New Zealand subregion
- By far the highest' global ecstasy prevalence worldwide
- Cannabis use exceeding 12% (vs 4.4% global average; school students 13% vs 4.4%)
- 40% in treatment for methamphetamine, highest proportion globally
- 55% under age 35 in drug treatment (vs 25% global average)
- 73% of police contact for possession/use offences (vs 32–33% in Africa/Asia)

Only 8.1% of people with drug use disorders globally receive treatment. Regardless of what has been put on paper, Australia's response has been reactive crisis management rather than proactive prevention.

Why Current Approaches Fail

Australia adopted Harm Minimisation as policy in 1985. By 1998, Australia led the OECD in drug consumption, effectively double any other developed nation. Drug use increased: Amphetamine +500%, Cannabis +300%, Cocaine +400%, Ecstasy +750%, Heroin +300%.

When 'Tough on Drugs' prioritised prevention (1998–2007), illicit drug use decreased 39% and opiate deaths fell 67%. When this approach ended in 2007, drug use increased 34% by 2022, and deaths climbed back toward crisis levels.

What Works: The Evidence

Prevention Approaches with Documented Success

- Australia's Tough on Drugs (1998–2007): 39% reduction in illicit drug use; 67% reduction in opiate deaths; from 7.0 to 2.2 deaths per 100,000
- Sweden: 80% reduction in student drug use (restrictive-compassionate approach)
- Iceland: 60–90% reduction (community resilience approach over 20 years)
- USA (1980s): 50–70% reduction (comprehensive prevention)
- Communities That Care: $12.88 return per dollar; 10% reduction in adolescent alcohol use; 8% reduction in youth hospitalisations; 5% reduction in youth crime
- AA/TSF (12-Step): Superior to alternative interventions for long-term abstinence (Cochrane 2020)
- Peer Recovery Coaching: 73% engage in volunteering, 39% secure employment

The Alternative Framework

Pillar One: Primary Prevention & Demand Reduction

- Evidence-based prevention school education (15–50 hours minimum)
- Community-wide denormalisation campaigns
- Protective factor development
- Values education integration
- Parent and family engagement
- Early childhood interventions

Pillar Two: Supply Reduction & Law Enforcement

- Intelligence-led policing (not mass incarceration)
- Diversion programmes (Kenton County model: 60% reduction in reoffending)
- Secure welfare facilities to enable recovery, not prison
- Border protection enhancement
- Organised crime disruption

Pillar Three: Recovery & Abstinence-Goaled Treatment

- AA/TSF expansion (Cochrane gold standard for long-term abstinence)
- Therapeutic communities investment
- Peer recovery coaching (lived experience integration)
- Community-based recovery advocacy
- Residential treatment capacity
- Recovery alumni pathways

Priority Substances

This strategy addresses Cannabis, Methamphetamine, Opioids, Cocaine, MDMA/Ecstasy, Alcohol, and Other Substances including GHB and Novel Psychoactive Substances, with specific prevention, treatment and enforcement measures for each.

Performance Framework

The current system measures activity, not outcomes. Only 7.6% of 537 performance measures used in funding agreements were outcome measures. This strategy replaces throughput metrics with verified recovery outcomes: sobriety at 6 and 12 months, housing stability, employment, and reduced recidivism.

Implementation Priorities

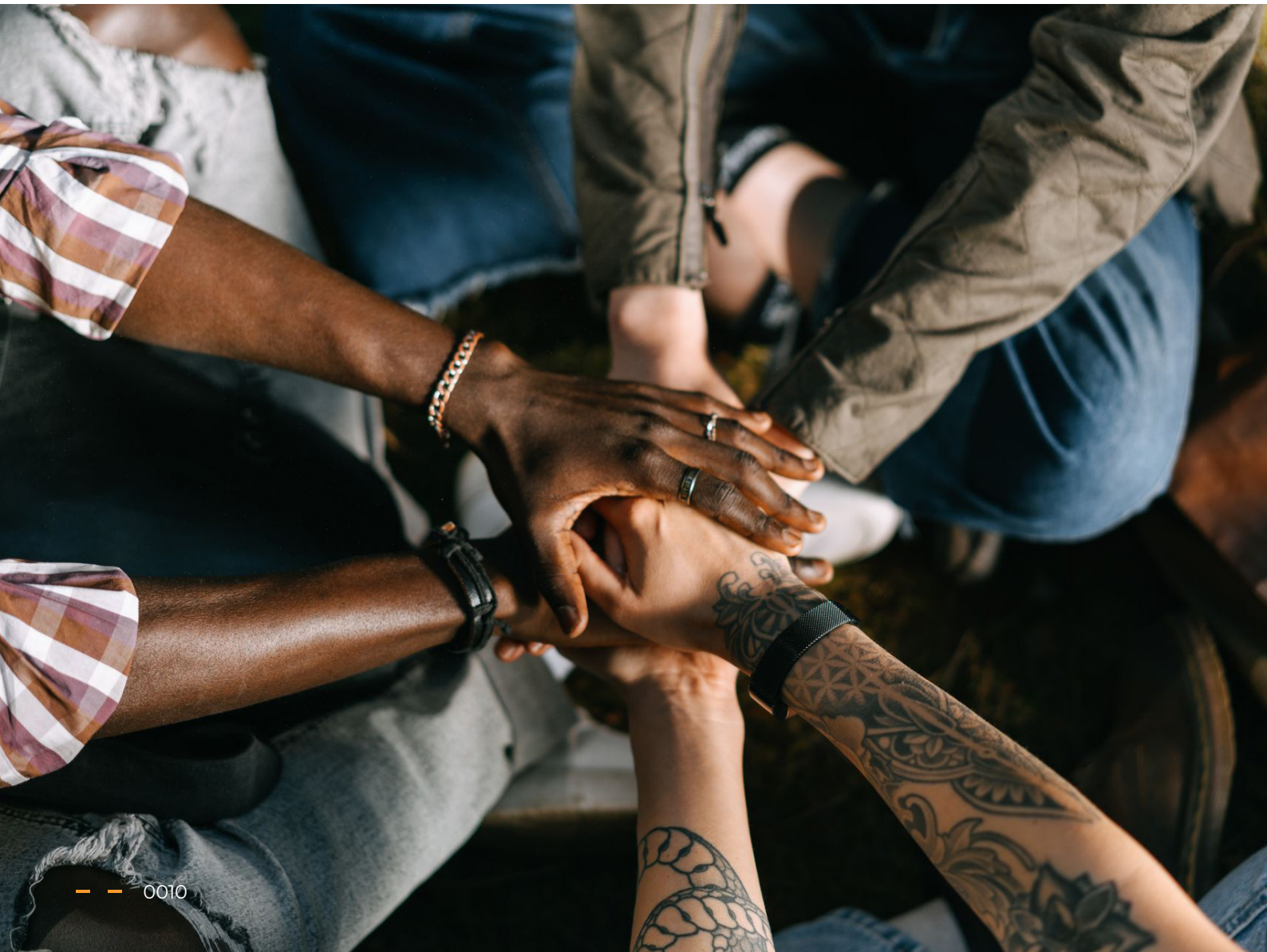
- Years 1–2: Foundation building, education system integration, community mobilisation pilots

  Years 3–5: Scaling up, national Community-based recovery advocacy, recovery alumni pathway
- Years 6–10: Consolidation, sustained prevention culture, comprehensive recovery networks

The Choice

> *Across much of Europe, and Australia, addiction policy has drifted into moral autopilot. Harm reduction, born from genuine humanitarian necessity, gradually expanded from a clinical response into a governing philosophy. The state's task became preventing death while asking very little about life afterwards. Abstinence came to sound punitive, stigmatising even. Managed dependency was reframed as progress.*
>
> *This is the deeper failure. Not that Australia embraced compassion, but that it narrowed compassion's horizon. Survival became the goal rather than the beginning.*
>
> *Annemarie Ward, CEO, FAVOR, UK*

Australia can continue policies that have made us a world leader in drug consumption, or we can return to evidence-based prevention that protects children and families, supports recovery, and builds drug-free communities. The evidence is clear. Both the health and moral imperatives are compelling. The time to act is now.



SECTION 1: INTRODUCTION & CONTEXT

1.1 Why This Alternative is Needed

The National Drug Strategy 2017–2026 expires in 2026, creating a critical opportunity to reset Australia's approach to drugs based on evidence, outcomes, and international obligations.

Four decades of harm minimisation have produced catastrophic results. Australia adopted this framework in 1985 as a world-leading 'novel approach.' By 1998, we led the OECD in drug consumption. When prevention was prioritised through Tough on Drugs (1998–2007), use dropped 39% and opiate deaths fell 67%. When we returned to harm reduction dominance post-2007, use climbed 34% and deaths multiplied.

The UN World Drug Report 2025 confirms Australia's crisis:

- Highest cocaine use globally (Australia-New Zealand subregion) By far the highest' ecstasy use worldwide
- Cannabis use three times the global average among school students (13% vs 4.4%)
- 40% in treatment for methamphetamine (highest globally)
- 55% under 35 in treatment (vs 25% global average)

This is not a marginal problem affecting a fringe population. This is a mainstream crisis affecting the emerging generation.

1.2 Australia's Drug Crisis: The Evidence

The Harm Minimisation Era (1985–1998)

Australia introduced harm minimisation in 1985, explicitly stating drug use was 'part of our society' and prohibition should be abandoned in favour of management. Drug use increases from 1988–1998:

- Amphetamine: +500%
- Cannabis: +300%
- Cocaine: +400%
- Ecstasy: +750%
- Heroin: +300%

By 1998, Australia's aggregated drug use rate was approximately double any OECD nation. Opiate deaths peaked at 1,116 in 1999 (7.0 per 100,000).

The Prevention Era (1998–2007)

The Howard Government implemented Tough on Drugs in 1998, maintaining harm reduction programmes while prioritising prevention and enforcement. Results:

·39% reduction in overall illicit drug use
·67% reduction in opiate deaths (7.0 to 2.2 per 100,000)
·14 tonnes of heroin seized
·Heroin drought from December 2000 lasting approximately 10 years
·Sustained reductions across all major drug categories

Return to Harm Reduction Dominance (2007–Present)

The Rudd Labor Government scrapped Tough on Drugs in 2007–2008. Results by 2022:

- 34% increase in illicit drug use
- Opiate deaths increased 2.5x (2.2 to 5.75 per 100,000)
- Accelerating trajectory matching pre-1998 patterns

1.3 International Obligations

Article 33: Convention on the Rights of the Child

The Convention on the Rights of the Child (CRC) is the most ratified UN treaty in history, with 196 countries committed to its provisions. Article 33 states:

> *'States Parties shall take all appropriate measures, including legislative, administrative, social and educational measures, to protect children from the illicit use of narcotic drugs and psychotropic substances as defined in the relevant international treaties, and to prevent the use of children in the illicit production and trafficking of such substances.'*

Australia's obligation is not to manage drug use among children or to teach 'safer use.' It is to protect children from all aspects of illicit drug use. With 13% of Australian 15–16 year olds using cannabis (vs 4.4% globally), 55% of treatment recipients under 35, and 39% of out-of-home care due to parental drug issues, Australia is failing its Article 33 obligations.

The Eindhoven Declaration (March 2025)

International experts, impacted families, grassroots organisations, and youth movements gathered in Eindhoven, Netherlands (20–21 March 2025) to reaffirm Article 33 commitments, with seven recommendations including: securing drug-free society protecting children's rights; prioritising prevention of drug use initiation; mobilising communities to lead prevention efforts; and resisting normalisation of drug use.

1.4 Scope and Purpose

This Alternative National Drug Strategy 2027–2036 provides a Prevention-First Framework, a Recovery-Oriented Approach, a Child Protection Mandate grounded in Article 33 CRC obligations, and a 10-Year Implementation Plan with clear governance, performance indicators, phased rollout, and funding reallocation from failed interventions to proven approaches.

This strategy does not eliminate all harm reduction measures (e.g. roadside drug testing, diversion projects, needle and syringe exchange as an exit strategy remain appropriate). It repositions them as tertiary responses within a prevention-first framework.

The goal is unambiguous: build safe, healthy, drug-free communities where children are protected, prevention is prioritised, and recovery is comprehensive.

SECTION 2: VISION & PRINCIPLES

2.1 Our Vision

A drug-free society where:

- Children are protected from all aspects of drug use and grow up in environments that promote health, dignity, and full human potential
- Prevention is prioritised through evidence-based education, community engagement, and protective factor development
- Recovery is comprehensive through abstinence-based treatment, peer support, and pathways to productive contribution
- Communities are empowered to build resilience, reject normalisation, and support drug-free lifestyles
- Policy is evidence-driven based on documented outcomes, not ideology or commercial interests

2.2 Guiding Principles

1. Child Protection First

Children have a right under Article 33 CRC to protection from all aspects of illicit drug use. Every policy, programme, and practice must be evaluated against this standard: does it protect children or expose them to greater risk?

2. Prevention Over Intervention

Upstream prevention is more effective, more humane, and more cost-efficient than downstream crisis management. $1 in prevention equals $18 in savings. Communities That Care returns $12.88 per dollar. Delaying uptake by 2 years through education has lifelong benefits. 44% of students receiving only 1 lesson annually is preventable failure.

3. Recovery is Possible

Abstinence is the gold standard of prevention and a comprehensive key to recovery. Cochrane reviews demonstrate AA/TSF superior to alternative interventions for long-term abstinence. Therapeutic communities, peer recovery coaching, and residential treatment work. Recovery alumni achieve employment, contribute to communities, and serve as living proof that change is not merely possible, but readily achievable with the correct supports in place.

4. Evidence, Not Ideology

Policy must be driven by documented outcomes that do not affirm damage management confirmation bias. This strategy draws on Cochrane systematic reviews, peer-reviewed academic research, longitudinal population studies, international comparative data, and Australian historical evidence.

5. Life-Course Development

Interventions must target appropriate developmental stages. Brain development continues to age 25–28. 'Harm reduction' education for adolescents not only contradicts neuroscience but also violates Article 33 CRC obligations.

6. Community Ownership

Parents, families, schools, faith communities, grassroots organisations, and local government are the primary agents of prevention and recovery. Iceland's success came from whole-of-community mobilisation. The government's role is to resource, coordinate, and support, not dictate.

7. One Focus, One Message, One Voice

Australia's tobacco QUIT campaign succeeded because every government agency, health authority, education institution, and media message aligned: Don't start. If you use, quit. Cannabis, methamphetamine, cocaine, ecstasy, and opioids deserve the same clarity.

8. Lived Experience Integration

Recovery alumni possess unique credibility and insight. Peer recovery coaching achieves 73% volunteering engagement and 39% employment outcomes with highly vulnerable populations. Integrating lived experience and earned resiliency into prevention education, treatment programmes, and policy development strengthens every aspect of this strategy.

9. No Normalisation

Any policy, programme, or practice that normalises drug use violates prevention principles and child protection obligations. This includes 'safer use' education in schools, pill testing, supervised injection facilities, decriminalisation messaging, and cannabis legalisation. Denormalisation is the foundation of effective prevention.

10. Dignity and Hope

Every person has inherent dignity and capacity for change. Policies that write people off as permanently dependent, or that prioritise keeping them alive in misery over supporting recovery, are failures of both compassion and imagination.

11. Enforceable Standards

Effective drug policy requires that prohibited conduct is detectable, measurable, and evidenceable in a consistent and legally defensible manner. The Dalgarno Institute has a 40-year history of supporting evidence-based enforcement standards, including advocacy for BAC breathalyser legislation for alcohol. Australian alcohol enforcement operates through measurable concentration thresholds that function as proxies for impairment, providing a clear and graduated basis for consistent enforcement action. Drug enforcement currently operates primarily on presence-based detection, which does not reliably correspond to functional impairment across all substances and individuals (Quilter and McNamara, 2017). This strategy commits to developing impairment-based standards that align drug enforcement logic with the evidence base and support consistent, legally defensible decision-making across road, workplace, and judicial contexts.

2.3 Strategic Objectives

By 2036, Australia will:

1. Reduce youth drug use to Sweden/Iceland levels (currently 13% cannabis use ages 15–16 vs 4.4% global average)
2. Protect children from parental drug exposure (reduce % exposed, increase % in drug-free homes)
3. Increase prevention education from 44% receiving one lesson to 100% receiving 15–50 hours evidence-based curriculum

4. Scale evidence-based treatment through nationwide Community-based recovery advocacy, AA/TSF expansion, therapeutic communities
5. Achieve Tough on Drugs outcomes (39% reduction in use, 67% reduction in deaths) and sustain them
6. Integrate recovery alumni into prevention, treatment, and policy development (73% volunteering, 39% employment model)
7. Reallocate funding from failed interventions to proven approaches
8. Reduce treatment demand among under-35s (currently 55% vs 25% global average) through upstream prevention
9. Eliminate normalisation through coordinated messaging (One Focus, One Message, One Voice)
10. Fulfil Article 33 obligations demonstrably protecting children from all aspects of drug use

SECTION 3: THE EVIDENCE BASE

3.1 Prevention Works: Documented Success

Australia: Tough on Drugs (1998–2007)

Investment: Anti-narcotics budget increased from 0.1% to 0.41% of GDP. $1.3 billion federal spending (1998–2005). $3.2 billion combined federal/state spending (2002–03).

Outcomes:

- 39% reduction in overall illicit drug use (2001 NDSHS)
- 67% reduction in opiate deaths (7.0 to 2.2 per 100,000)
- Sustained reductions across all major drug categories through 2007
- Heroin drought from December 2000 lasting approximately 10 years

Post-2007: Rudd Government scrapped Tough on Drugs. By 2022, drug use increased 34% and opiate deaths increased 2.5x. This is not historical curiosity. This is evidence that prevention-first policies work in Australia.

Sweden: Zero Tolerance, Zero Harm Reduction

Sweden has maintained zero tolerance to drug use for decades. Outcomes:

- 80% reduction in student illicit drug use (from 1970s baseline)
- Lowest drug use in OECD (1998 UN data)
- 15% youth cannabis use (1971) to 6–7% (2006)

Sweden demonstrates that denormalisation, consistent messaging, and zero tolerance work without harm reduction infrastructure undermining prevention.

Iceland: Community Resilience Approach

Iceland implemented a comprehensive community-based prevention model targeting protective factors. Outcomes:

- 60–90% reduction in student illicit drug use (depending on substance)
- 65% reduction in adolescent cannabis use
- Sustained reductions over 20 years
- Model now replicated internationally

Communities That Care: Evidence-Based Framework

Outcomes (Australia):

- 10% reduction in adolescent alcohol use
- 8% annual reduction in child/youth hospitalisations for injury
- 5% annual reduction in police-reported youth crime
- 2% annual reduction in violent crime
- $12.88 return for every dollar invested

Treatment Evidence: Abstinence-Based Approaches

AA/TSF: Cochrane Review (Kelly et al., 2020) found AA/TSF superior to alternative interventions including Cognitive Behavioural Therapy for long-term abstinence. 21% improvement at 12 months, sustained at 24 and 36 months. Australia under-utilises AA/NA: 0.1% of Australian population attends vs 0.5% in USA.

Peer Recovery Coaching: 73% of retained participants engage in active volunteering, 39% secure stable employment, with success across highly vulnerable populations.

3.2 Current Approaches Fail: Documented Outcomes

Opiate Substitution Therapy (OST)

Cochrane Review (Mattick et al., 2009), gold standard review of 11 RCTs of methadone maintenance, found: ‘Methadone was not statistically different in criminal activity or mortality’ compared to no treatment. 45% of methadone patients still purchasing/using heroin. Many remain on methadone 30–40 years.

Needle & Syringe Programmes (NSP)

US Institute of Medicine Review (2007), 24-member expert panel: Evidence for HIV transmission reduction was ‘limited and inconclusive.’ Evidence for HCV transmission reduction: ‘multiple studies show NSPs do not reduce transmission.’ Despite decades of ‘best practice’ NSPs, 65% prevalence of HCV remains among Australian IDUs.

Injecting Rooms

Melbourne MSIR (2020 evaluation) failed 5 of 6 legislated objectives. Overdoses were 102 times greater than street rates, indicating experimentation with larger doses in a 'safe' environment. The facility cost approximately $6 million to save 1 life while failing its stated community objectives.

Pill Testing

Dr Amanda Roxburgh study found 392 MDMA-related deaths (2000–2018). Pill testing addresses only 3 'bad batch' deaths (0.8% of total) while being unable to address individual vulnerabilities (14%), co-use with other drugs (48%), or intoxication accidents (29%), which account for 95%+ of deaths.

Decriminalisation: Portugal

Official Portuguese data shows: Adult drug use +59% by 2016. High school minors +80% by 2011. Overdose deaths +111% by 2019. Portugal's cities rank amongst the top 3–4 across Europe for cocaine, ecstasy, ketamine, and cannabis use in wastewater analysis.

Cannabis Legalisation: Colorado

Outcomes (2009–2016/2020): Cannabis-related hospitalisations +360%. Cannabis-related traffic deaths +230%. Cannabis-related suicides +410%. 250% increase in child marijuana use over 20 years. $4.50 cost per $1 revenue. Legal cannabis created a black market that expanded despite legalisation.

3.3 Children as Primary Victims

Drug use is not victimless. Children bear the greatest burden:

- 1 in 840 US children lost parent/caregiver to fatal drug overdose (2021)
- 39% of children in out-of-home care: parent has drug issue
- 75% of child sex-trafficking cases involve illicit drug-using caregivers
- 76% of Australian injecting drug users experience food insecurity (hungry children)
- 13% of Australian 15–16 year olds using cannabis (vs 4.4% global average)
- Cannabis use directly increases psychosis risk in ALL young users, not just those with genetic vulnerability

Every policy must be evaluated against child protection. If it increases children's exposure, whether through parental use, youth experimentation, or normalisation, it violates Article 33.

3.4 The Economic Case for Prevention

Prevention ROI:

- Australian Research (Newton, 2021): '$1.00 in prevention gives the community a saving of $18.00'
- Communities That Care (Kuklinski et al., 2021): '$12.88 return for every dollar invested'
- To change behaviour requires 50 hours of education (Carruthers, 1996): 15 hours to change knowledge, 30 hours to change attitudes, 50 hours to change behaviour
- 44% of Australian students aged 12–17 receive only one lesson on illicit drugs per year

Melbourne MSIR cost $6 million to save 1 life while failing 5 of 6 legislated objectives. OST and NSPs have been funded for decades with no demonstrated mortality or criminality benefit. Prevention is not just morally superior, it is economically rational.

SECTION 4: THE THREE PILLARS

4.1 PILLAR ONE: Primary Prevention & Demand Reduction

Objective: Deny and delay drug uptake, particularly among children and adolescents, through evidence-based education, community engagement, and protective factor development.

Evidence Base: University of Illinois study (128,000+ youths): 'Belief that drugs are bad' has twice the magnitude of impact compared to other protective factors. For each unit increase in belief that drug use is wrong: 39% increase in abstinence likelihood (8th graders), 50% increase (10th graders), 53% increase (12th graders).

1. School-Based Prevention Education

Minimum Standards: 15–50 hours evidence-based curriculum per student (Years 7–12). Annual instalment refreshers and knowledge/skills scaling via behavioural health learning modules. Interactive pedagogy, not passive lectures. Integration into Health & PE, PDHPE, Values Education.

Content: Why drugs are harmful (neuroscience, addiction pathways, long-term consequences). Protective factors (family bonds, community engagement, purpose/meaning). Refusal skills (peer pressure resistance, decision-making). Critical thinking (media literacy, recognising manipulation). Debunking myths.

Approach: Abstinence-based (not 'safer use'). Values-aligned. Evidence-driven. Engaging (real stories from recovery alumni, not scare tactics).

2. Community Mobilisation

Model: Communities That Care (demonstrated $12.88 ROI). Local leadership through community coalitions including parents, schools, faith groups, local government, and business. Youth engagement through peer leadership and service learning. Cross-sector collaboration across health, education, justice, and social services.

3. Parent and Family Engagement

Parent education programmes (Iceland model). School-home partnerships. Family activities (bonding time, shared values). Monitoring and supervision. Evidence shows school trials with parent education discouraging adult supply reduced adolescent heavy alcohol use by 25%. Iceland's parent education on emotional support, monitoring, and time with children drove 60–90% reductions.

4. Values Education Integration

The National Framework for Values Education in Australian Schools (2005) identified nine core values for Australian schooling: Care and compassion; Doing your best; Fair go; Freedom; Honesty and trustworthiness; Integrity; Respect; Responsibility; Understanding, tolerance and inclusion. Drug prevention naturally integrates these values through responsibility, ethics, judgment, and accountability.

5. Media Literacy and Counter-Marketing

Objective: Inoculate youth against pro-drug messaging through recognising manipulation (edibles designed like candy, influencer marketing); deconstructing myths ('natural = safe,' 'medical = harmless'); critical analysis of cannabis industry tactics; and understanding addiction science.

6. Early Childhood Interventions

Target: Protecting children 0–10 from parental substance use exposure. Strategies include parenting support for substance-using parents, home visiting programmes (nurse-family partnerships), early childhood education (protective environments), and developmental screening. Prevention at this stage breaks intergenerational transmission.

7. Denormalisation Campaigns

Model: Tobacco QUIT campaign. One Focus: Don't use drugs. One Message: Drugs harm you, your family, your future. One Voice: Government, health, education, media aligned. Application to illicit drugs includes zero tolerance messaging, consequences made clear, recovery stories highlighted, and community standards reinforced.

Performance Targets by 2037

- 100% of students receive 15–50 hours evidence-based prevention education
- Adolescent cannabis use reduced from 13% to 6% (Sweden baseline) among 15–16 year olds
- Communities That Care implemented nationally (all LGAs)
- Parent engagement: 80% of parents complete prevention education modules
- Media campaigns reach 95% of population annually

4.2 PILLAR TWO: Supply Reduction & Law Enforcement

Objective: Reduce drug availability through intelligence-led enforcement, border protection, diversion programmes, and organised crime disruption, without mass incarceration.

1. Intelligence-Led Policing

Target organised crime groups, not low-level users. Disrupt supply chains. Asset seizure and money laundering prosecution. International cooperation. Resource allocation prioritises major importation and trafficking (high priority), street-level dealing (moderate priority), and personal possession (lowest priority, diversion, not incarceration).

2. Diversion Programmes

Model: Kenton County Strong Start (60% reduction in reoffending). First-time, non-violent drug offenders diverted from prosecution. Intensive supervision and treatment with employment pathways and housing stability. Phases: Assessment and case planning; Intensive services and supervision; Step-down to community support; Long-term follow-up.

3. Border Protection and Trafficking Interdiction

Enhanced screening at airports, seaports, and mail. Regional cooperation (Pacific partnerships, intelligence sharing). Technology investment (scanners, detection equipment). Priorities: Large-scale importation, precursor chemicals, dark web shipments, airfreight and parcel post.

4. Organised Crime Disruption

Follow the money (asset seizure, financial crime prosecution). Target leadership, not just street-level operatives. Dismantle networks. International cooperation. Unexplained wealth laws, proceeds of crime confiscation, serious crime penalties.

5. Community Safety

Visible policing (community reassurance, deterrence). Drug-free zones (schools, parks, public transport). Thoughtful, caring policing (Sweden model). Balance enforcement with compassion. Support diversion where appropriate. Firm consequences for serious offences.

Performance Targets by 2037

- Reduce Australia's global ranking in cocaine and ecstasy use (from #1 to outside top 10)
- Diversion programme access: 80% of eligible first-time offenders
- Recidivism reduction: 50% among diverted offenders
- Organised crime disruptions: 50% increase in operations dismantled
- Border seizures: 30% increase
- Police contact for possession/use: 73% to 50% (increased diversion)

6. Impairment Detection & Evidentiary Standards

Effective supply reduction and enforcement depend not only on detecting substance presence, but on accurately identifying functional impairment. Current Australian drug enforcement operates primarily on presence-based detection: a person is liable if a substance is detected, regardless of whether impairment is demonstrated. This diverges from the alcohol enforcement model, which uses measurable concentration thresholds as proxies for impairment, providing a clear, graduated, and legally defensible basis for enforcement action.

This divergence creates three identifiable problems. First, inconsistent enforcement: presence testing does not reliably map to functional impairment, meaning impaired individuals may not be identified while unimpaired individuals may be penalised. Second, reduced public confidence: enforcement perceived as disconnected from demonstrated risk undermines community trust in the legal framework. Third, operational exposure: workplaces, transport operators, and courts are left without objective and defensible standards for fit-for-duty and liability decisions.

This strategy commits to the following actions to close this gap:

- **National impairment definition:** Develop a nationally consistent, safety-focused definition of impairment that is operationally distinct from substance presence or historical use, applicable across road, workplace, and judicial contexts.
- **Enforcement model clarification:** Specify when presence-based offences apply and when impairment-based offences apply, with clear evidentiary pathways for each.
- **Substance-specific impairment proxies:** Where supported by evidence, develop proxies for drug impairment analogous to the blood alcohol concentration thresholds used in alcohol enforcement, reducing reliance on detectability as a universal standard.
- **Deployable screening standards:** Establish national evaluation pathways for impairment screening tools capable of producing reproducible, objective, and legally defensible assessments under field conditions.
- **Workplace and medicinal use frameworks:** Explicitly address the practical challenges of presence-based testing in workplace and transport contexts, particularly where medicinal substance use may not correspond to functional impairment.

Performance Targets by 2037

- National impairment definition developed and adopted across jurisdictions (by Year 2)
- Substance-specific impairment proxy standards established for priority substances (by Year 4)
- Accreditation pathway for deployable impairment screening tools operational (by Year 3)
- Workplace fit-for-duty guidelines updated to reflect impairment-based standards (by Year 3)

4.3 PILLAR THREE: Recovery & Abstinence-Based Treatment

Objective: Provide comprehensive, evidence-based treatment focused on abstinence and long-term recovery, integrating lived experience and peer support. The use of harm reduction practices are harnessed in concert with the continuum of care that starts with denying/delaying uptake through to exiting substance use.

The interrogation of all drug policies, policy interpretation and practice is vital to ensure best health care and safety are optimised. The following questions must be asked of all policy offerings: Does this policy and/or practice reduce, remediate or facilitate recovery from substance use? Or does it enable, equip, empower or otherwise endorse ongoing drug use?

1. AA/TSF Expansion

Current gap: 0.1% of Australians attend AA/NA vs 0.5% in USA despite gold standard evidence. Strategies: Public education (AA/NA as evidence-based), referral pathways from treatment services, GPs, and courts, increased meeting availability, culturally appropriate meetings, and online/hybrid options.

2. Therapeutic Communities

Model: Residential treatment environment (6–24 months). Components include structured daily routine, peer support, work therapy, education and training, family involvement, and aftercare planning. Target populations: severe dependence, co-occurring disorders, criminal justice involvement, repeat treatment failures.

3. Peer Recovery Coaching

Model: Well Communities approach (73% volunteering, 39% employment). Recovery alumni employed as coaches providing one-on-one support, group facilitation, community reintegration, and crisis intervention. Lived experience creates authentic relationships, reduces stigma, extends professional workforce, and provides employment pathways for alumni.

4. Residential Treatment Capacity

Current gap: Inadequate bed availability creates waitlists, delayed access, treatment drop-out. Expansion priorities: Geographic coverage (metropolitan, regional, remote); population-specific (youth, women, Indigenous, CALD); intensity levels (medical detox, intensive, supportive); length of stay.

5. Recovery Alumni Pathways

Employment: Peer recovery coaching, treatment facility staff, prevention educators, policy advisors. Volunteering: Community service, mentoring, advocacy, governance. Pathways: Education and training, employment support, financial assistance, recognition and credentialing. Example: Wandoo Rehabilitation Prison (sub-1% recidivism) demonstrates recovery-focused approaches work.

6. Treatment Alternatives to OST

Abstinence-based alternatives: Naltrexone (opioid antagonist with implant or monthly injection); Residential detox + long-term treatment; 12-step integration; Peer recovery coaching. Transition strategy: New entrants to treatment offered abstinence-based pathways first. Existing OST patients supported to transition where willing. No coercion, but clear messaging: recovery is the goal, maintenance is not.

Performance Targets by 2037

- Reduce % under 35 in treatment: 55% to 35% (through upstream prevention)
- Increase AA/TSF access: 0.1% to 0.5% of population (USA baseline)
- Therapeutic community capacity: triple bed availability
- Peer recovery coaches: 1,000+ employed nationally
- Recovery alumni pathways: 5,000+ in employment/ education/volunteering
- Comprehensive recovery: 50% of treatment completers abstinent at 12 months

SECTION 5: PRIORITY POPULATIONS

5.1 Children (0–12 years)

Objective: Protect from all aspects of drug use, particularly parental exposure, ensuring drug-free environments for development.

Key evidence: 39% of out-of-home care due to parental drug issues. 76% of Australian IDUs experience food insecurity. 75% of child sex-trafficking cases involve drug-using caregivers.

Strategies include parental support (pregnant and parenting treatment programmes, home visiting, parenting skills), early intervention (developmental screening, early childhood education, family support services), and age-appropriate education (primary school programmes, building resilience, positive activities).

Performance Targets

- Reduce % children in out-of-home care due to parental drugs: 39% to 25%
- Increase access to parenting support programmes:
- 50% of substance-using parents
- Early childhood education participation: 95% of at-risk children

5.2 Adolescents (13–17 years)

Objective: Deny and delay uptake through evidence-based education, protective factor development, and clear messaging.

Key evidence: 13% of Australian 15–16 year olds use cannabis (vs 4.4% global average). Brain development continues to age 25–28. ‘Belief that drugs are bad’ has twice the impact of other protective factors. 50 hours education needed to change behaviour (currently 44% receive 1 lesson).

Strategies: School-based education (15–50 hours), protective factors (family bonding, community connection, purpose and meaning), media literacy, alternatives to use (healthy activities, youth centres, mentoring), and early intervention.

Performance Targets

- Reduce cannabis use (15–16 year olds): 13% to 6% (Sweden baseline)
- 100% receive 15–50 hours evidence-based prevention education
- 80% participate in organised activities (sport, arts, community)
- Early intervention: 90% of identified users receive brief intervention with in 2 weeks

5.3 Young Adults (18–29 years)

Objective: Support abstinence, provide early intervention, prevent generational transmission to children.

Key evidence: 55% of treatment recipients under 35 (vs 25% global average). This cohort is in prime childbearing years (generational transmission risk).

Strategies: Prevention continuation (university/TAFE programmes, workplace education, social marketing), abstinence support (peer-led recovery groups, alcohol-free/drug-free events), early intervention (GP screening, mental health integration), and recovery pathways.

Performance Targets

- Reduce % under 35 in treatment: 55% to 35% (through prevention)
- Early intervention reach: 70% of young adults with problematic use
- Education/employment: 80% of young adults in recovery engaged in productive activity

5.4 Parents and Caregivers

Objective: Reduce parental substance use to protect children, prevent generational transmission, support family stability.

Key evidence: 39% of out-of-home care due to parental drug issues. Parental supervision reduces adolescent use. Parent education reduces adolescent heavy drinking by 25%.

Strategies: Parent education (prevention information, monitoring and supervision, family activities, identifying warning signs), family-centred treatment, child protection collaboration, and prevention of parental initiation.

Performance Targets

- Reduce children in out-of-home care (parental drugs): 39% to 25%
- Parent education reach: 80% of parents complete prevention modules
- Treatment for parents: 70% of substance-using parents access family-centred services
- Successful reunification: 60% of children returned home (with ongoing monitoring)

5.5 People in Recovery

Objective: Support long-term recovery, integrate into community, employ as prevention/treatment workforce, eliminate stigma.

Key evidence: 73% of peer recovery coaching participants engage in volunteering. 39% secure stable employment. AA/TSF superior to alternatives for long-term abstinence. Wandoo Rehabilitation: sub-1% recidivism.

Strategies: Recovery support (AA/NA access, peer recovery coaching, recovery housing, community integration), employment pathways (peer recovery coach certification, treatment facility employment, prevention education), education and training, volunteering, and stigma reduction.

Performance Targets

- Recovery alumni employment: 5,000+ in AOD workforce nationally
- Volunteering: 80% of recovery alumni engaged in community service
- Peer recovery coaches: 1,000+ certified and employed
- Stigma reduction: 50% increase in positive media coverage of recovery

5.6 Indigenous Communities

Objective: Culturally appropriate prevention, treatment, and recovery that respects self-determination and builds on community strengths.

Key evidence: Higher rates of substance-related harm in some Indigenous communities. Historical trauma and dispossession drive risk. Community-led solutions most effective. Cultural connection is a protective factor.

Strategies: Community governance (Indigenous-led design and delivery, local decision-making, cultural adaptation, elder involvement), culturally grounded prevention (connection to country, culture, community), culturally safe treatment services, and economic participation in recovery.

Performance Targets

- Indigenous community governance: 100% of Indigenous-specific programmes community-designed
- Workforce: 50% of staff in Indigenous services are Indigenous
- Cultural safety: 90% of Indigenous clients report culturally safe experiences
- Outcomes: Close the gap in substance-related harms (measured locally, not imposed)

5.7 Regional and Remote Areas

Objective: Ensure equitable access to prevention, treatment, and recovery services regardless of geography.

Key evidence: Regional/remote Australians face service access barriers. Higher rates of some substance use (e.g. methamphetamine). Treatment gaps of 52–70%. Rural Australians must travel 100–500 kilometres for services.

Strategies: Telehealth (video counselling, phone support, online groups), regional hubs, outreach services, local capacity building, online AA/NA meetings, and rural generalist training with financial incentives.

Performance Targets

- Service access: 100% of regional/remote residents within 2 hours of treatment (physical or telehealth)
- Prevention reach: 100% of schools deliver evidence-based programmes
- Workforce: 30% increase in AOD workers in regional/remote areas

SECTION 6: PRIORITY SUBSTANCES

6.1 Cannabis

Current Crisis: 12% prevalence in Australia/NZ (vs 4.4% global average). 15–16 year olds: 13% (vs 4.4% globally). Legalisation push despite catastrophic Colorado outcomes (360% hospitalisation increase, 230% traffic deaths, 410% suicides).

Evidence: Causes 33 cancers (vs 16 for tobacco). 89 of 95 birth defects. Psychosis risk in ALL young users. Memory impairment and anxiety. Epigenetic transmission 3–4 generations.

Strategies

Prevention: Evidence-based education (neuroscience, cancer, mental health). Denormalisation campaigns. Debunking myths ('natural = safe', 'medical = harmless').

Treatment: Abstinence-based. Dual diagnosis (mental health co-occurring). Cognitive remediation. Family therapy.

Policy: Reject legalisation. Resist medical cannabis expansion beyond tight legitimate indications. Enforcement to prevent diversion.

Performance Targets

- Reduce use (15–16 year olds): 13% to 6%
- Prevent legalisation (evidence-based rejection)
- Increase treatment access for cannabis use disorder

6.2 Methamphetamine

Current Crisis: 40% of Australians in treatment (highest globally). 'Ice epidemic' recognised but inadequately addressed. High community harm (violence, crime, psychosis).

Evidence: Highly addictive. Severe mental health impacts (psychosis, paranoia, aggression). Long-term cognitive damage. High treatment dropout rates. Social harms (family violence, child neglect).

Strategies

Prevention: Education (neurotoxicity, addiction pathways, psychosis risk). Community awareness. Alternatives (healthy stimulation: exercise, achievement, connection).

Treatment: Residential (intensive, long-term for severe dependence). Therapeutic communities (6–24 months). Mental health integration. Family support.

Enforcement: Precursor controls. Clandestine lab detection. Organised crime disruption.

Performance Targets

- Reduce treatment demand: 40% to 25% (through prevention)
- Increase residential treatment capacity (double beds)
- Reduce methamphetamine-related crime (20% reduction)

6.3 Opioids

Current Crisis: Deaths increased 2.5x since 2007 (returning toward 1999 peak). OST ineffective (no mortality/criminality benefit vs no treatment). Prescription opioid diversion persistent.

Evidence: Cochrane confirms OST no better than no treatment for mortality/criminality. Abstinence-based treatment (AA/TSF, naltrexone, residential) effective.

Strategies

Prevention: Prescription monitoring (real-time tracking). Prescriber education. Public education. Youth prevention.

Treatment: Abstinence-based priority (naltrexone, residential, 12-step). Medical detox. Therapeutic communities. Peer recovery coaching. OST transition.

Enforcement: Prescription fraud detection. Illicit heroin interdiction. Fentanyl targeting.

Performance Targets

- Reduce opioid deaths to Tough on Drugs levels (5.75 to 2.2 per 100,000)
- Transition OST patients: 30% to abstinence-based treatment (voluntary)
- Reduce prescription diversion (50% reduction)
- Increase naltrexone access (implant/injection availability)

6.4 Cocaine

Current Crisis: Highest global use in Australia/NZ subregion. Driven by affluent users ('occasional use' masking harm). Cardiovascular risks, mental health impacts.

Evidence: Highly addictive (rapid progression from casual to dependent). Cardiovascular harm (heart attack, stroke risk). Mental health (paranoia, aggression, depression).

Strategies

Prevention: Target demographics (young professionals, party scene). Workplace education. Denormalisation.

Treatment: Cognitive behavioural therapy. Contingency management. Residential. 12-step.

Enforcement: Importation interdiction (Pacific gateway focus). High-profile prosecutions.

Performance Targets

- Reduce use from #1 globally to outside top 10
- Increase treatment access (currently under-resourced)

6.5 MDMA/Ecstasy

Current Crisis: 'By far the highest' global prevalence. Pill testing push despite addressing <1% of deaths. Youth normalisation (festivals, party culture).

Evidence: MDMA responsible for 95% of ecstasy deaths, not adulterants. Individual vulnerabilities account for 14%, co-use with other drugs 48%, intoxication accidents 29%. Only 3 'bad batch' deaths from 2000–2018.

Strategies

Prevention: Youth education (MDMA dangers, not 'adulterant' focus). Festival/event messaging. Peer education. Debunking pill testing myths.

Treatment: Cognitive remediation. Mental health (depression, anxiety following use). Brief intervention.

Policy: Reject pill testing. Festival safety measures should not include pill testing.

Performance Targets

- Reduce prevalence from 'by far highest' globally to outside top 10
- Prevent pill testing implementation (evidence-based rejection)

6.6 Alcohol

Current Context: Legal substance with enormous harms. Integration needed with drug strategy (not separate silos). No safe level (WHO: abstinence minimises cancer risk).

Evidence: Leading preventable cause of death and disease. Foetal alcohol spectrum disorders. Family violence link. Youth binge drinking.

Strategies

Prevention: Adolescent abstinence (brain development to age 25–28). Parent education (secondary supply, supervision). School programmes. Community standards.

Treatment: AA/TSF (gold standard evidence). Brief intervention. Residential. Family therapy.
Regulation: Age restrictions (18+ rigorously enforced). Trading hours. Secondary supply laws. Pricing. Marketing restrictions.

Performance Targets

- Reduce youth alcohol use (continuing current declining trend)
- Increase abstinence among under-18s (to 90%+)
- Align alcohol and drug policies (integrated framework)

6.7 Other Substances (GHB, Novel Psychoactive Substances)

Current Crisis

GHB (gamma-hydroxybutyrate) is increasingly present in Australian nightlife and party culture, posing a severe and underacknowledged risk. Novel Psychoactive Substances (NPS), including synthetic cannabinoids, synthetic cathinones ('bath salts'), and designer benzodiazepines, represent a rapidly evolving threat that deliberately exploits legislative gaps. New substances appear faster than regulation can respond. Both GHB and NPS are disproportionately present in contexts involving sexual assault, hospitalisation, and youth experimentation.

Evidence

- GHB: Extremely narrow therapeutic window. The difference between a recreational dose and a fatal one is small. Severe dependence develops rapidly. Withdrawal can be fatal without medical supervision. Frequently implicated in drug-facilitated sexual assault.
- NPS: Designed specifically to mimic controlled substances while evading legal classification. Synthetic cannabinoids can be up to 100 times more potent than natural cannabis. Unpredictable composition makes harm prediction impossible. Every batch is potentially different. Limited evidence base due to rapid product evolution.
- Synthetic cathinones linked to severe psychiatric episodes, extreme agitation, cardiovascular collapse, and death.
- Designer benzodiazepines increasingly found in the illicit drug supply, often mislabelled or combined with opioids, significantly increasing overdose risk.
- NPS predominantly distributed online, creating enforcement challenges and enabling rapid market adaptation.

Strategies

Prevention

- Education targeting nightlife, festival, and online communities, with clear messaging that GHB has no safe recreational dose
- NPS awareness campaigns targeting young adults, stressing that 'legal means safe' is false and that designer substances carry unknown risks
- Social media counter-messaging to disrupt NPS normalisation in online communities
- Recovery alumni engagement in prevention education (peer credibility with youth audiences)

Treatment

- GHB withdrawal requires inpatient medical supervision. Community-based withdrawal is clinically dangerous and must not be attempted without medical support.
- Dual diagnosis treatment as a priority, given the high rates of psychiatric comorbidity associated with NPS use
- Residential treatment for GHB dependence, given the severity and duration of withdrawal
- Abstinence-focused treatment model throughout, with no partial substitution strategies appropriate for GHB or NPS

Policy

- Analogue legislation to capture NPS as they emerge, rather than reactive substance-by-substance scheduling that cannot keep pace with market evolution
- Online supply disruption through intelligence-led targeting of domestic and international NPS marketplaces
- Intelligence sharing with international partners on emerging substances through Interpol and regional networks
- Reject any pill testing or drug checking services that would implicitly legitimise or provide quality assurance for NPS or GHB
- Fast-track scheduling processes for newly identified NPS to close legislative gaps within weeks rather than months

Performance Targets

- Reduce GHB-related emergency department presentations (reduce from baseline)
- Establish a national NPS surveillance system with real-time monitoring capability by Year 2
- Implement analogue legislation in all states and territories by Year 3
- Prevent legalisation or normalisation of any NPS category
- 100% of schools and universities include GHB and NPS in evidence-based prevention curricula

SECTION 7: GOVERNANCE & IMPLEMENTATION

7.1 Governance Framework

Ministerial Oversight

- National Cabinet: Strategic direction, funding allocation
- Ministerial Drug and Alcohol Forum: Policy coordination across portfolios (Health, Education, Justice, Social Services)

Operational Coordination

- National Drug Strategy Committee: Implementation oversight, performance monitoring
- Membership: Federal/State/Territory health departments,
- law enforcement, education, community representatives, recovery alumni

Expert Advisory

- Evidence Advisory Panel: Review research, guide evidence-based practice
- Community Advisory Council: Parent, family, grassroots, faith, Indigenous representation
- Recovery Alumni Advisory: Lived experience input into policy and programmes

Reporting

- Annual performance reports (public transparency)
- Independent evaluation (mid-term and end-term)
- Community consultation (ongoing feedback loops)

7.2 Roles and Responsibilities

Federal Government

- National policy framework and coordination
- Funding allocation (grants, programmes)
- International obligations (Article 33 CRC, UN conventions)
- Research and evaluation
- National campaigns (prevention, denormalisation)
- Border protection and importation interdiction
- Regulation (pharmaceutical monitoring, therapeutic goods)

State/Territory Governments

- Policy implementation within jurisdictions
- Treatment service delivery (public and community sectors)
- Law enforcement (police, courts, corrections)
- Education (school-based prevention, teacher training)
- Diversion programmes (court-based, community-based)
- Data collection and reporting

Local Government

- Community mobilisation (Communities That Care, local coalitions)
- Venue provision (AA/NA meetings, recovery groups)
- Alcohol licensing (responsible service, trading hours)
- Public amenity (drug-free spaces, community safety)

Schools

- Prevention education delivery (15–50 hours evidence-based curriculum)
- Teacher training and support
- Parent engagement
- Early intervention (screening, referral)
- Whole-school approach (policy, culture, messaging)

NGOs and Community Organisations

- Treatment delivery (residential, outpatient, peer support)
- Prevention programmes (community-based, faith-based)
- Recovery support (AA/NA, peer coaching, recovery housing)
- Advocacy and awareness

Recovery Alumni

- Peer recovery coaching
- Prevention education (school talks, community workshops)
- Treatment workforce (counsellors, coordinators)
- Policy advisory (lived experience input)
- Community leadership (boards, governance)

7.3 Funding Principles

- Reallocation from failed interventions: Reduce funding for OST, NSPs, injecting rooms (no demonstrated benefit for mortality/criminality). Redirect to prevention, evidence-based treatment, recovery support.
- Evidence-based investment: Fund programmes with demonstrated outcomes. Prioritise Cochrane-reviewed interventions, Communities That Care ($12.88 ROI), and prevention education ($1 = $18 savings).
- Equity: Per capita funding. Loading for disadvantage (Indigenous, regional/remote, CALD). Service access standards.
- Sustainability: Long-term commitments, not short-term pilots. Workforce development. Infrastructure investment.
- Accountability: Outcomes-based contracts. Public reporting. Independent evaluation.

7.4 Coordination Mechanisms

- Data Sharing: National data repository. Real-time prescription monitoring. School drug use surveys. Coordinated research agenda.
- Workforce Development: National qualifications framework. Professional development. Peer worker certification. Supervision and support.
- Quality Standards: Treatment accreditation. Prevention programme certification. Evaluation frameworks.
- Communication: One Focus, One Message, One Voice (coordinated campaigns). Shared messaging. Media guidelines.
- International Engagement: UN conventions compliance. Regional cooperation. Evidence exchange (learning from Sweden, Iceland).

SECTION 8: PERFORMANCE FRAMEWORK

The following performance framework is informed by the current government AOD system data, which reveals a system that measures activity rather than outcomes. Understanding these structural failures is essential context for designing a performance framework that actually tracks recovery.

8.1 Current System Measurement: What Is Counted

Treatment activity is funded and measured by episode volume, bed nights, contact hours, and referrals, not by recovery outcomes. In 2023–24, 241,000 treatment episodes were recorded involving 131,900 clients, 56% of whom were returning clients who had previously been through the system.

A treatment episode is recorded as ‘completed’ if the person finished the programme as planned, was transferred to another service, or was referred elsewhere. Completion does not mean the person is sober, housed, employed, or alive.

Only 7.6% of 537 performance measures used in funding agreements were classified as outcome measures. The remaining 92% measured outputs, processes, and compliance. None of the 537 measures fully met best-practice criteria for performance measurement. Accreditation, the primary gateway to public funding, measures policies, documentation, clinical governance, and staff qualifications. It does not measure whether people achieve sobriety, avoid prison, or survive.

8.2 What the System Does Not Measure

- The current system fails to track:
- Sobriety status at 6 or 12 months post-discharge
- Employment or housing stability after treatment
- Family reunification outcomes
- Recidivism rates of treatment completers
- Deaths in the period following discharge
- Cost per successful outcome
- Readiness at intake, with no classification of client capacity occurring at any point of contact
- Who dies on a waitlist, or how many people relapse, overdose, or are imprisoned before a bed becomes available

8.3 Treatment Outcomes: Current Baseline

The scale of current system failure is documented in its own data:

- Residential rehabilitation completion rate: 32–34%. Self-discharge accounts for 47% of all exits.
- Relapse rate following treatment: 40–60%. Post-discharge AOD events within two years: 57%.
- The critical period for relapse is the first 30 days after discharge. 75% of overdose deaths occur at home, not in clinical settings.
- The treatment rate per 100,000 population has remained essentially unchanged over a decade (564 to 553), despite growing investment.
- Criminal justice diversion into treatment has halved in ten years. More people are going to prison instead of being diverted to treatment.

Scale of Unmet Need

- 4,615 Victorians were waiting for AOD treatment on any given day in 2024, a 93% increase since September 2020
- Typical residential rehabilitation wait time: 12 or more months
- Estimated unmet demand in NSW alone: 100,000 people
- Only 30–48% of people who would benefit from treatment are able to access it
- Rural and remote Australians face treatment gaps of 52–70% and must travel 100–500 kilometres for services

8.4 Proposed Performance Standards

This strategy replaces throughput metrics with verified outcome standards:

- Sobriety status reported at 6 and 12 months post-discharge, as a core funded deliverable
- Housing stability at discharge and at 6 months post-discharge, tracked and reported
- Employment or structured activity status at 6 months post-discharge
- Recidivism data linked between AOD services and corrective services for all residential programme completers
- Death notification linked to treatment history. No person who has received funded treatment should die without that death being recorded against the treatment record.
- Cost per successful outcome calculated for each funded service and published annually
- Funding adjusted in response to outcome performance. Services with sustained poor outcomes must be reviewed and redirected.
- Intake classification documented for every residential treatment admission as a prerequisite for funding claims

8.5 Structural Measurement Failures to Be Addressed

Activity-based funding rewards throughput over results. A 28-day programme turning beds over 13 times per year generates 13 funded episodes. A 12-month programme generates one. Under current settings, the fast-turnover service appears more productive regardless of outcome.

Block grants and episode-of-care models provide no mechanism for outcome accountability. A service with a 90% dropout rate receives equivalent funding to one with a 30% dropout rate.

Data is not linked across systems. The same person appears in health, corrective services, mental health, housing, and child protection records, and no agency connects the picture.

The episodic treatment model treats each admission independently. 56% of clients in 2023–24 had previously been through the system. For heroin, 81% of episodes involved returning clients. The system keeps starting over without asking why people keep returning.

8.6 Population-Level Indicators

Primary Outcomes

- Drug Use Prevalence: Target 39% reduction from 2026 baseline (Tough on Drugs outcome). Measure: NDSHS biennial surveys.
- Youth Drug Use: Target 13% to 6% cannabis (15–16 year olds; Sweden baseline). Measure: School surveys (annual).
- Drug-Related Deaths: Target return to Tough on Drugs levels (2.2 per 100,000 opioids). Measure: NDARC drug-related deaths database.
- Children Protected: Target reduce % in out-of-home care (parental drugs): 39% to 25%. Measure: Child protection data, AIHW.
- Treatment Demand: Target reduce % under 35: 55% to 35% (through prevention). Target reduce methamphetamine treatment: 40% to 25%. Measure: Treatment episode data (AODTS).

8.7 Service and Economic Indicators

Prevention

- Education Reach: Target 100% of students receive 15–50 hours evidence-based prevention. Baseline: 44% receive only 1 lesson annually.
- Communities That Care: Target implemented in all Local Government Areas. Outcome: 10% reduction in youth alcohol use.
- Parent Engagement: Target 80% of parents complete prevention education modules.

Treatment

- AA/TSF Access: Target 0.1% to 0.5% of population attending (USA baseline).
- Residential Treatment: Target triple bed capacity. Outcome: Reduced wait times to <14 days.
- Peer Recovery Coaching: Target 1,000+ certified coaches employed nationally.

Economic Indicators

- Prevention Investment: Increase prevention as % of total AOD budget from baseline.
- Prevention Savings: Maintain $12–18 return per dollar (evidence baseline).
- Avoided healthcare, justice, and productivity costs tracked annually.

8.8 Enforcement and Impairment Measurement

The performance framework applied to treatment and prevention must extend equally to the enforcement layer. Current drug driving and workplace enforcement relies primarily on presence-based detection. Research has identified that presence is not a consistent proxy for functional impairment across substances or individuals, and this limits the accuracy and defensibility of enforcement decisions in road, workplace, and judicial contexts (Quilter and McNamara, 2017; Alcohol and Drug Foundation, 2026).

This strategy adopts the following as measurable indicators for enforcement quality:

- Proportion of drug-related enforcement actions supported by impairment-based evidence (baseline to be established in Year 1)
- Jurisdictional adoption of nationally consistent impairment definitions and standards (target: all jurisdictions by Year 3)
- Number of accredited impairment screening tools available for roadside and workplace use (target: minimum three accredited tools by Year 4)
- Proportion of workplace drug and alcohol policies updated to reflect impairment-based standards (target: 80% of safety-critical industries by Year 5)

SECTION 9: IMPLEMENTATION ROADMAP

The implementation roadmap translates the strategy's three pillars into structured phases of reform. Each phase is built on the premise that the current system's core failure is classifying clients by availability rather than capacity, and funding activity rather than outcomes

9.1 Phase One: Classification and Intake Reform (Years 1–2, 2027–2028)

Foundation building is the priority of Years 1 and 2. The most urgent reform is establishing a classification system that ensures the right people receive the right response at the right moment.

- Mandate intake classification at every point of contact: court, prison admission, hospital, mental health, and residential rehabilitation. Classification must precede any placement decision.
- Develop and issue national classification guidance, with training delivered across all publicly funded AOD contact points.
- Require that classification and the behavioural evidence on which it is based be documented as a condition of funding claims for residential treatment.
- Establish separate programme streams for clients at different stages of readiness. Clients with genuine readiness for change must not be placed in the same therapeutic environment as those who are not. Population separation is a clinical requirement, not an administrative preference.
- Remove waiting list processes for identified clients with genuine and immediate readiness for change. Immediate placement is a clinical requirement. Every day on a waitlist is a day the window is closing.

Parallel actions in Phase One:

- Convene National Drug Strategy Committee (Q1 2027). Establish Expert Advisory Panel and Community Advisory Council (Q2 2027). Recovery Alumni Advisory appointments (Q2 2027).
- Develop national prevention curriculum (15–50 hours) (2027). Teacher training programme launch (Q3 2027). School rollout begins (2028): 20% of schools.

- Pilot Communities That Care in 10 LGAs (diverse: metro, regional, Indigenous) (2027–2028). Evaluate outcomes.
- AA/TSF expansion: 50% increase in meetings (2027–2028). Residential treatment: 20% capacity increase. Peer recovery coaching: develop certification, train 200 coaches.
- Pilot diversion model in 5 jurisdictions (2027–2028). Evaluate outcomes. Develop national standards (2028).
- Baseline NDSHS (2027). School survey baseline (2027). Treatment episode system enhancement (2027–2028).
- Budget reallocations begin (reduce OST/NSP funding; increase prevention/recovery). Federal/state negotiations.

9.2 Phase Two: Funding Model Reform (Years 3–5, 2029–2031)

Scaling up is the priority of Years 3 to 5. Phase Two reforms the funding architecture to reward outcomes rather than activity.

- Shift the primary funding metric from episodes and bed nights to verified outcomes: sobriety at 6 and 12 months, housing stability, employment, and reduced recidivism.
- Replace the 28-day programme as the default funded model. Minimum funded residential duration should be 12 months for clients with genuine readiness. Duration is not a preference. It is the biological minimum required for meaningful neural change.
- Introduce differential funding rates that reflect programme duration and measured outcome quality. Services with sustained poor outcomes are reviewed and funding redirected.
- Cease funding residential programmes that place clients without genuine readiness into therapeutic environments designed for those who are ready. Containment placements must be separately funded, honestly described, and regularly reassessed.
- Restore a national body for AOD workforce planning. The disbanding of Health Workforce Australia in 2014 left no national mechanism for addressing workforce shortages that now affect 90% of psychiatrists.

Scaling actions in Phase Two:

- 100% of schools implementing 15–50 hour curriculum (by 2031). Teacher training: all Health/PE teachers certified.
- Communities That Care rollout to 50% of LGAs (2029–2030). 100% coverage (2031).
- AA/TSF: 0.5% population attendance (USA baseline achieved). Residential treatment: triple baseline capacity (2031). Peer recovery coaching: 1,000 coaches employed (2031).
- National diversion rollout: 80% eligible offenders diverted (2031). Kenton County outcomes achieved.
- AOD workforce: 50% increase. Regional/remote workers: 30% increase.
- Recovery alumni: 5,000+ in employment/education/volunteering (2031). 80% engaged in community service.

9.3 Phase Three: System Integration and Data Linkage (Years 3–5, 2029–2031)

System-wide data integration must occur in parallel with Phase Two programme scaling.

- Establish linked data infrastructure across health, corrective services, mental health, housing, and child protection that tracks individuals across contact points, not episodes in isolation.
- Require that court sentencing reports include the client's assessed stage of readiness and explain what it means for what the sentence should achieve. Build sentencing options that match each stage: immediate programme access for those ready, maintained legal pressure for those seeking relief only, honest containment for those with no current capacity.
- Prison intake must include mandatory classification assessment. Clients identified as genuinely ready must be separated from the general population and placed in a programme environment within days of admission, not weeks. The window exists at admission and closes as the person adjusts to the institutional environment.
- Hospital discharge protocols must include classification assessment in the hours following stabilisation. A same-day pathway to appropriate placement must be available at every hospital receiving AOD presentations.
- Build data linkage between AOD treatment records and the National Death Index. Deaths following discharge must be recorded, reported, and accounted for in service performance assessment.

9.4 Phase Four: Post-Discharge Continuity (Years 3–10, 2029–2037)

Recovery is not achieved at the gate of a rehabilitation programme. Post-discharge conditions require the same intentional design as the programme itself.

- Fund post-discharge housing as a condition of residential programme completion. Housing must not be in the same area where the addiction was sustained.
- Establish employment and structured activity pathways as a funded component of rehabilitation programmes. The experience of competence, responsibility, and contribution is rehabilitative, not an optional supplement.
- Extend accountability structures beyond programme discharge. A person or structure that remains present in the six months after discharge, notices early difficulty, and can respond before crisis is part of the programme.
- Require programmes to arrange after-discharge conditions before discharge occurs. A discharge plan handed over at the gate is not transition planning.

9.5 Accountability and Review Mechanisms

- Publish annual outcome data for all publicly funded AOD services, disaggregated by programme type, duration, and client classification.
- Establish an independent review body with authority to assess service performance, redirect funding, and close programmes that fail to meet minimum thresholds.
- Require all residential programmes to reassess client classification at regular intervals and whenever there is a significant change in the client's situation.
- Commission a longitudinal study tracking cohorts through the full pathway from first contact to 5-year outcomes.
- Mid-term review (2032): Major evaluation, course correction if needed. End-term review (2037): Comprehensive assessment, next strategy development.

9.6 Years 6–10: Consolidation (2032–2037)

Consolidation priorities: sustain gains, continuous improvement, innovation and adaptation, outcomes achievement.

Outcomes Achievement by 2037

- Drug use: 39% reduction from 2026 baseline
- Youth cannabis use: 6% among 15–16 year olds (Sweden baseline)
- Deaths: 2.2 per 100,000 opioids (Tough on Drugs level)
- Children protected: 25% in out-of-home care (parental drugs; from 39%)
- Treatment demand: 35% under 35 (from 55%)
- Methamphetamine treatment: 25% (from 40%)

9.7 Legislative Requirements

Federal

- National Drug Strategy 2027–2037 enabling legislation (2027)
- Funding appropriations (annual budgets)
- Prescription monitoring enhancements (real-time systems)
- Analogue legislation for Novel Psychoactive Substances
- Therapeutic goods regulations (preventing cannabis medicine circumvention)
- Impairment standards legislation: national framework defining impairment thresholds and evidentiary standards for drug-related enforcement, consistent across road, workplace, and judicial contexts

State/Territory

- Diversion programme legislation
- Education mandates (15–50 hour minimum curriculum)
- Alcohol licensing reforms (secondary supply, trading hours)
- Treatment standards (accreditation requirements)
- Coordination
- Intergovernmental agreements (Federal-State funding, service delivery)
- Data sharing protocols (privacy-protected, research-enabled)
- Workforce standards (national qualifications framework)

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APPENDIX ONE: GOVERNMENT AOD SYSTEM ANALYSIS

Peter Lyndon-James | April 2026

Part 1: System Overview

What the System Is

Australia's alcohol and other drug (AOD) treatment system is a mix of Commonwealth-funded, state-funded, and privately operated services. It includes residential rehabilitation, withdrawal management (detox), counselling, pharmacotherapy (methadone/buprenorphine), outreach, and harm reduction services. The system is fragmented. Each state and territory operates its own service model. There is no unified national approach to purchasing, placement, or outcome measurement.

Who Funds It

State and territory governments fund the majority of specialist AOD treatment. The Commonwealth contributes through Primary Health Networks (PHNs), the Drug and Alcohol Program, and Medicare Benefits Schedule items for addiction medicine specialists.

- Commonwealth investment (2016–2020): $561 million over four years
- Victorian Government AOD budget 2024–25: $376.3 million
- First Nations AOD services boost (2024–25): Up to $66 million

How Funding Works

Activity-Based Funding (ABF): Services are paid per unit of activity. In Victoria, this is measured in Drug Treatment Activity Units (DTAUs). Non-residential services have operated under DTAU since 2014; residential services transitioned in 2019.

The activity-based model pays for bed nights, treatment episodes, contact hours, assessments, and referrals. It does not pay for recovery outcomes, sustained sobriety, employment, housing stability, or reduced recidivism.

Part 2: Treatment System Data (2023–24)

Scale of the System

- Treatment agencies: 1,304 (AIHW)
- Treatment episodes: 241,000 (AIHW)
- Clients treated: 131,900 (AIHW)
- Episodes for own drug use: 219,277 (91%)
- AOD hospitalisations: 146,000 (AIHW)
- Aboriginal/TSI clients: 18% of all clients (AIHW)

Principal Drugs of Concern

- Alcohol: 42% of episodes (91,361 episodes; most common drug of concern)
- Amphetamines: 26% of episodes (58,000 episodes; doubled 2014–2020)
- Cannabis: 16% of episodes (34,248 episodes; declining from peak)
- Heroin: 4.3% of episodes (9,400 episodes; 81% are returning clients)

New vs Returning Clients

- New clients (first treatment since 2013–14): 44% (58,165 clients)
- Returning clients (previously treated): 56% (73,727 clients)
- Heroin clients who are returning: 81%
- Amphetamine clients who are returning: 74%

The treatment rate per 100,000 population has remained essentially unchanged over the past decade (564 to 553), despite growing investment. Criminal justice diversion into treatment has halved in a decade. More people are going to prison instead of being diverted to treatment.

Part 3: Treatment Outcomes

Completion Rates

- Completion rate: 32–34%
- Self-discharge rate: 47%
- House-discharged (rule violations): 20%

Leaving treatment prior to completion is a robust predictor of relapse and leads to poorer substance use outcomes. A 32% completion rate would close any other business. In AOD, it is described as ‘consistent with international literature.’

Relapse Rates

- Relapse rate (research consensus): 40–60%
- Post-discharge AOD events within 2 years: 57%
- Critical period for relapse: first 30 days after discharge
- Deaths at home (overdose): 75%

Most overdose deaths occur at home, not in clinical settings. The first month after discharge represents the highest-risk period for relapse and death.

What the System Measures and Does Not Measure

Measured: number of treatment episodes, number of clients, principal drug of concern, treatment type provided, episode completion status, referral source, agencies providing service.

Not measured: sobriety at 6 or 12 months, employment status post-discharge, housing status post-discharge, family reunification, recidivism rates of completers, deaths post-discharge, readiness at intake, cost per successful outcome.

Performance Measurement Failures

Research examining 537 unique performance measures used in funding agreements found: Measures classified as outcome measures: only 7.6%. Measures classified as output measures: 41.3%. Measures classified as process measures: 23.6%. None of the 537 measures fully met the criteria for best practice in performance measurement.

Part 4: The Cost of Alcohol and Drugs

Social and Economic Costs (2022–23)

- Tobacco: $160 billion total ($19.2 billion tangible, $141 billion intangible)
- Alcohol: $75 billion total ($18.2 billion tangible, $57 billion intangible)
- All illicit drugs: approximately $30 billion total
- Total: approximately $265 billion

Tangible costs include healthcare, workplace absenteeism, crime, road crashes, and premature death. Intangible costs include lost quality of life, suffering, and lost years of life.

Alcohol-Specific Costs

- Deaths caused by alcohol (2017–18): 5,219
- Healthcare costs: $2.8 billion
- Workplace costs (absenteeism, injury): $4.0 billion
- Crime costs: $3.1 billion
- Road traffic crashes: $2.4 billion
- Cost of harm to others from drinking: $19.8 billion

Nobody tracks the cost of a failed treatment episode. Nobody calculates the cost of a person who completes treatment versus one who self-discharges in week three. A service with a 90% dropout rate receives the same funding as a service with a 30% dropout rate. Because nobody measures outcomes, nobody adjusts funding based on results.

Part 5: Deaths

Drug-Induced Deaths (2024)

- Drug-induced deaths: 1,947 (ABS preliminary)
- Accidental drug deaths: 71% (1,377)
- Intentional drug deaths: 21% (402)
- Deaths occurring at home: 75% (NDARC)
- Total overdose deaths since 2002: 42,000+ (Penington Institute)
- Drug deaths exceed road toll: since 2015 (Penington Institute)

Alcohol-Induced Deaths

- Alcohol-induced deaths (2024): 1,765 (predominantly chronic: liver cirrhosis)

Unintentional Deaths Over Time

- Increase in unintentional drug deaths (2002–2022): +108%
- Population increase over same period: +20.4%

Unintentional drug deaths have increased five times faster than population growth.

Indigenous Australians

- Indigenous overdose death rate: 3x non-Indigenous rate
- Indigenous rate (2023): 21.3 per 100,000
- Non-Indigenous rate (2023): 5.7 per 100,000
- Potential years of life lost to drug overdose (2023): 66,636 years (average 31 years lost per death)

Part 6: The Prison System

Prison Population (June 2025)

- Total adult prisoners: 46,998 (+6% from 2024)
- On remand (unsentenced): 42% (up from 31% in 2016)
- With prior adult imprisonment: 60%
- Indigenous prisoners: 17,432 (37%) (+10% from 2024)
- Prison growth over 10 years: +28% (Dec 2015 to Dec 2025)

Drug Use Among Prison Entrants (2022)

- Used illicit drugs in prior 12 months: 73% (general population: 17%)
- Used cannabis: 53% (general population: 12%)
- Used methamphetamine: 46% (general population: 1.3%)
- Ever injected drugs: 29% (general population: approximately 1%)
- High-risk alcohol consumption: 44% (general population: approximately 16%)
- Daily tobacco smoking: 64% (general population: 11%)

Treatment in Prison

- Prison entrants who accessed AOD treatment in custody: only 13%
- Despite 73% of prison entrants having used illicit drugs in the prior year, only 13% accessed treatment while in custody
- Dischargees who used drugs in prison: 37%. Dischargees who injected drugs in prison: 14%

Part 7: Recidivism

- Australia: 60% of prisoners have prior imprisonment
- Australia: 42% return to prison within 2 years
- NSW: 49.3% of adults reoffend within 12 months after custody
- Comparable countries: recidivism rate approximately 20%
- Prison entrants in prison within prior 12 months: 41%
- Prison entrants with 5 or more prior imprisonments: 33% of males

Injecting drug use is an independent risk factor for reincarceration after release from prison. Despite this evidence, only 13% of people leaving prison have accessed AOD treatment in custody. The vast majority are released with untreated addictions into communities where they face housing instability, unemployment, and limited support.

Part 8: Access and Waitlists

- Victoria daily AOD waitlist (2024): 4,615 people
- Victoria increase since September 2020: +93% (from 2,385)
- National residential rehabilitation wait time: 12 or more months (typical)
- NSW unmet demand estimate: 100,000 people
- Only 30–48% of the people who would benefit from AOD treatment are able to access it
- Rural Australians must travel 100–500 km for treatment. Treatment gap: 52–70%.

Nobody tracks who dies waiting. Nobody tracks how many people on waitlists relapse, overdose, go to prison, or die before a bed becomes available.

Part 9: Workforce

- Psychiatrists reporting workforce shortages impact patient care: 90%
- Psychiatrists reporting burnout symptoms: 70%
- Of those burned out, attributed to workforce shortages: 82%

Australia once had a national body to guide health workforce planning: Health Workforce Australia. It was established in 2009 but disbanded in 2014. There is currently no national AOD-specific workforce plan. The workforce is stretched, underpaid, and experiencing high turnover. Rural and remote areas face the most severe shortages.

Part 10: Structural Problems

Fragmentation

The system is fragmented across multiple agencies: Mental Health Commission, Corrective Services, Department of Health, Child Protection, Housing, Police, and Domestic Violence services all operate independently. There is no shared classification framework, no shared data, and no connected records. The same person appears in multiple systems and nobody connects the dots.

Activity-Based Funding Incentives

A 28-day programme turns beds over 13 times per year, generating 13 'episodes' per bed. A 12-month programme turns beds over once per year, generating 1 'episode' per bed. Under activity-based funding, the fast-turnover service looks more 'productive' on paper, even if it has a 70% dropout rate and produces no lasting recovery.

Accreditation vs Outcomes

Accreditation measures policies and procedures, documentation, clinical governance, and staff qualifications. Accreditation does NOT measure whether people get sober, stay sober, avoid prison, or survive. A service can be perfectly accredited with a 70% dropout rate.

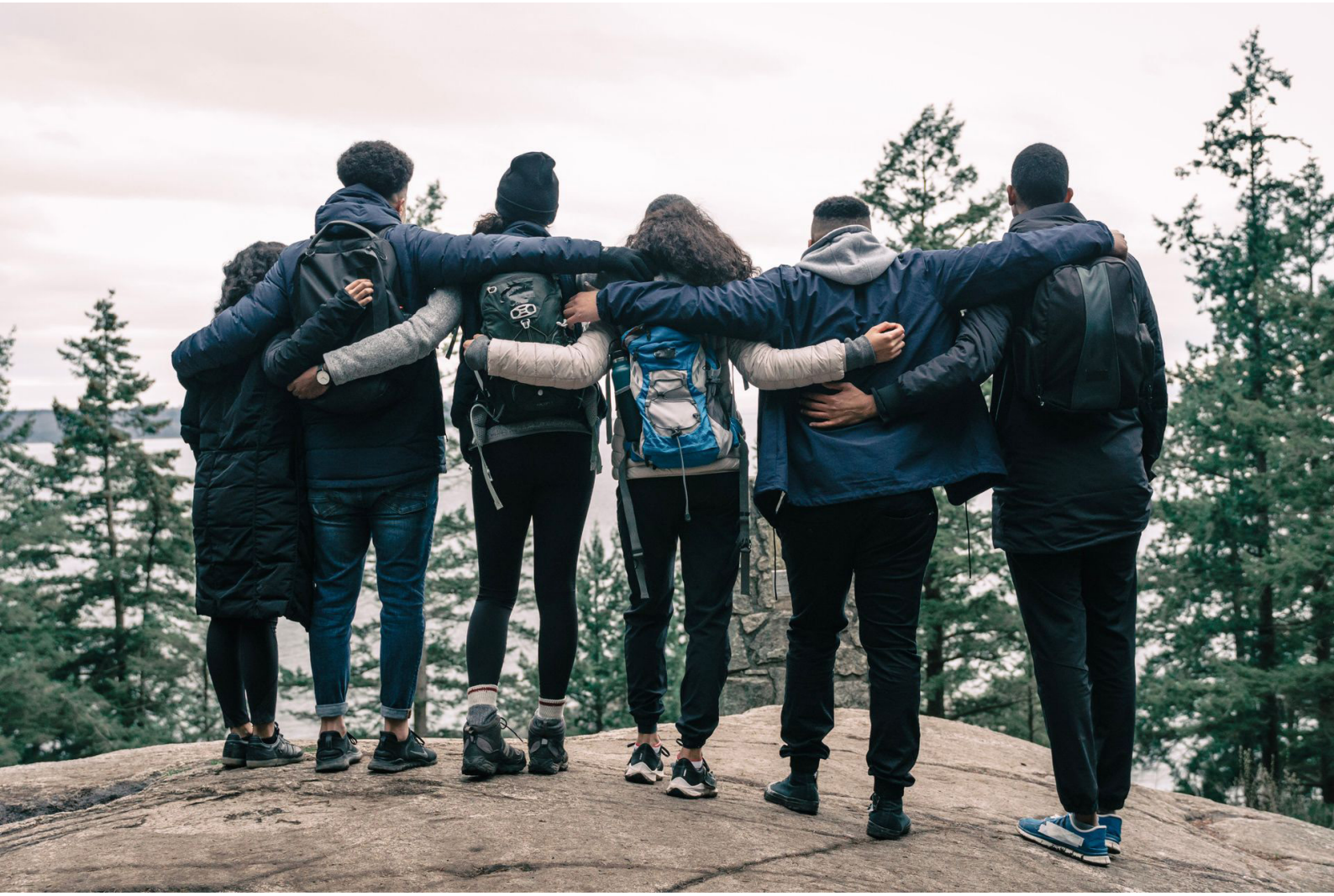
No Feedback Loop

A programme with a 90% dropout rate, 50% relapse among completers, and 40% recidivism receives the same funding as a programme with 30% dropout, 20% relapse, and 10% recidivism. Because nobody measures outcomes, nobody adjusts funding based on results. There is no reward for success and no penalty for failure.

Part 11: Summary

46,998 prisoners. 17,432 Indigenous prisoners. 60% with prior imprisonment. 73% used drugs before entering prison. 37% used drugs in prison. Only 13% accessed treatment in custody. 241,000 treatment episodes. 131,900 clients. 56% are returning clients. 32% completion rate in residential programmes. 47% self-discharge. 40–60% relapse. 57% present for AOD events within 2 years of discharge.

$75 billion social cost of alcohol. $265 billion total cost of tobacco, alcohol, and illicit drugs. 1,947 drug-induced deaths. 1,765 alcohol-induced deaths. 42,000+ overdose deaths since 2002. 4,615 Victorians waiting for treatment on any given



day. 93% increase in waitlists since 2020.
The government funds activity, not outcomes. It counts episodes, not recovery. It measures compliance, not results. A person can cycle through 10 treatment episodes, relapse every time, go to prison, and overdose. The system calls that 10 ‘episodes of care.’

Every statistic in this document comes from government sources (ABS, AIHW), peer-reviewed research (NDARC, Penington Institute, university studies), or state government reports. This is not an outside critique. This is what the system’s own data reveals about itself.

Compiled April 2026. Sources: ABS, AIHW, NDARC, Penington Institute, George Institute, VAADA, BOCSAR

APPENDIX TWO: E, E1, E2 AND E3 — A PRACTICAL GUIDE

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Introduction

This booklet is for anyone who encounters a person at Stage E, regardless of where they sit in the system or whether they are a professional or a family member. It is for the hospital nurse who sees the same person for the third time this year. The court officer who has watched every sentencing produce the same result. The prison programmes coordinator who knows the window exists and watches it close. The rehabilitation worker who does everything right and still cannot understand why the placement failed. The parent who has tried everything and cannot tell anymore whether they are helping or making it worse.

It is also for the policymaker who is responsible for a system that is spending enormous resources producing outcomes that are measurably worse than they should be, and who has the authority to change that if they can be shown what needs to change and why.

The framework in this booklet is built on one question. It is the question that changes every decision that follows it. It is the question that the system does not currently ask: not at hospital intake, not at court, not at prison admission, not at rehabilitation programme entry.

Which E is this person?

E1: genuinely ready for change. E2: wanting relief, not change. E3: no current capacity for genuine engagement with change. Three completely different people. Presenting identically at Stage E. Requiring responses that are not just different but in some cases directly opposite to each other.

> *Words mean nothing. Behaviour means everything. Classify before you decide. Build everything that follows on that classification.*

Chapter 1: Stage E — The Moment of Contact

Most people who end up at Stage E did not arrive there overnight. They arrived after years of a progression that nobody around them fully understood, moving through identifiable stages, each one a little further from the person they started as, each one a little harder to reach.

By the time Stage E arrives, most of those responses have already been tried and failed. The conversations have been had. The ultimatums have been issued and walked back. The money has been paid. The beds have been found and vacated. The promises have been made and broken so many times that the family has stopped counting them.

Stage E is not the end. It is a moment. And what happens in that moment, the decisions made in the hours and days immediately following, determines everything that follows. Get it right and the trajectory changes. Get it wrong and the cycle continues.

What Stage E Looks Like

There is a quality to Stage E that experienced workers recognise before a word has been spoken. It is a particular kind of depletion: not just physical, but something deeper. A person who has been in the progression long enough to arrive at Stage E has spent years managing. Managing the family. Managing the system. Managing the narrative. At Stage E that energy is running out.

Consequences no longer function as deterrents at Stage E. Prison is not a threat to a person who has already been to prison. Hospital is not a wake-up call to a person who has already been hospitalised multiple times. The system keeps reaching for consequences that stopped working at earlier stages, and it keeps being surprised when they produce no change at Stage E.

Promises made at Stage E mean nothing, and this is critical for everyone around the person to understand. Not because the person is a liar in the conventional sense, but because the sincerity of the moment cannot survive the demands of the addiction. When a Stage E person says they are done, they mean it in the moment they say it. But the addiction is more powerful than the feeling, and within days, sometimes hours, the feeling has passed.

The Silence Question

If a person has gone completely silent, not returning calls, cutting off contact with family, disappearing from all the usual points of contact, they have not reached Stage E. They are still at Stage D. Stage E is characterised by contact. The person makes contact. They ring. They show up. They arrive. Chasing a Stage D person does not produce Stage E. It delays it. Hold firm. Wait.

The First Question

Before a placement is discussed. Before a referral is made. Before an assessment form is produced or a bed is sought: one question. Did they ring themselves, or did someone ring on their behalf? This is not a minor administrative detail. It is the first data point in the classification process.

The Most Common Mistakes

- Treating the presentation at face value. Desperation is not readiness. Pain is not capacity.
- Moving to placement before classification. The bed is available. The family is desperate. The placement fails because it was built on presentation rather than reality.
- Allowing the window mythology to override the classification. Act fast, yes, but only for an E1.
- Letting the family's desperation drive the decision. The family is the worst-positioned person to make an accurate classification call.
- Assuming that 'this time is different' without any behavioural evidence that it is.

Chapter 2: The Classification — E1, E2 and E3

The most dangerous moment in the entire process is not when a person is at their worst. It is when they are in front of someone who wants to help them and that person makes the wrong call about who they are actually looking at.

The classification exists to make the decision correctly. That question is this: what is this person genuinely capable of engaging with right now? Not what do they say they want. Not what does the family hope for. Not what does the system have available. What can this person actually engage with, honestly, at this moment?

Why Three Classifications and Not One

- The E1 needs to be moved immediately into a genuine therapeutic environment. Speed matters. The window is open and it will not stay open. Delay is the enemy.
- The E2 needs to be placed in a high accountability environment with consequences that hold and a legal structure that maintains pressure.
- The E3 needs containment. Not rehabilitation. Not a programme. Containment, safety, and honesty about where they are.

These three responses are not variations on a theme. They are fundamentally different. The presenting behaviour that precedes them, the tears, the words, the apparent desperation, the statements about being ready and wanting to change, is not a reliable guide to which response is correct.

The Assessment: What You Are Looking For

- First data point: Did the person initiate contact themselves or were they brought in by someone else?
- The history: How many treatment episodes? What happened at the end of each one? How long after discharge before relapse each time?
- The substance picture: What are they using, how much, and for how long?
- The relationship landscape: Who is in this person's life right now? Is the family aligned or fragmented?
- Motivation: What do their actions say they want, not their stated intentions?
- The negotiation: The E1 does not negotiate. They are past the point of protecting anything. The E2 negotiates from the first conversation.
- Capacity: Can this person follow a simple instruction right now without modifying it?

What the Classification Is Not

The classification is not a judgement about the person's worth or potential. An E3 classification does not mean the person is beyond help or will never change. It means that right now, at this moment, the capacity for genuine engagement with change is not present. The classification is a current capacity assessment, not a life sentence.

The classification is not permanent. A person who is E3 today may be E2 in three months and E1 in six. The classification has to be reassessed every time there is a significant change in the person's situation.

Chapter 3: E1 — The Open Window

The E1 is a person at Stage E who has arrived at a place of genuine readiness for change. Something has happened, a crisis, a loss, a cumulative weight of consequence, a moment of clarity, and for the first time the defences are down. Not lowered. Down. The person is not managing the conversation. They are not performing readiness. They are not negotiating the terms of engagement.

What Genuine Readiness Looks Like

- The E1 places no conditions on the conversation. They are not negotiating where they go, how long they stay, whether their partner can visit.
- The E1's account of their situation is consistent across different people and different contexts. They are not constructing a narrative.
- The E1 does not need to be convinced that change is necessary.
- The E1 is often quieter than expected. What they have is a quality of stillness, of having arrived somewhere.

The Window

The window is real. It is not a metaphor or a motivational construct. It is a neurological, psychological, and relational reality that exists for a finite period following the crisis or accumulation of experiences that produced the E1 state. The window does not stay open indefinitely. The crisis passes. The body stabilises. The family adjusts. The legal pressure becomes familiar.

An E1 who is not placed in the right environment within the window does not simply remain E1 waiting for the next available space. They move. The defences that were down begin to come back up. This is why a waitlist is not a neutral administrative inconvenience for an E1. It is a clinical catastrophe.

What the E1 Needs

- The E1 needs to be moved immediately into the right environment. Not the available environment. The right one.
- Twelve months is the minimum. Not twelve months of sitting in groups and doing worksheets, but twelve months of living differently: structured days, real work, real responsibility, real accountability, real relationships.
- Do not put them on a waitlist.
- Do not place them with E2s and E3s.
- Do not let the family open the doors the programme has closed. Every rescue is a message to the E1 that the environment can be escaped.

> *The goal is not sobriety. The goal is freedom: a life that is genuinely and completely free from all drugs and all substances, in which the person is actually living. Working. Contributing. Connected to people who are real to them. It is not a success until the person is free.*

Chapter 4: E2 — Relief Without Change

The E2 is the classification that breaks the most workers, exhausts the most families, and wastes the most resources in the system. Not because the E2 is the most damaged person in the room. Because the E2 is the most convincing. They arrive with the right words, the right presentation, the right level of apparent distress, and the right degree of cooperation.

Who the E2 Is

The E2 is a person at Stage E who wants relief, not change. The crisis that brought them in is real. The distress is real. The discomfort is genuine. But what they want is for the discomfort to stop, not for the life that produced the discomfort to change. The moment that external pressure is reduced or removed, the motivation for engagement goes with it. This is not a moral failing. It is a clinical reality.

What the E2 Looks Like

- The E2 negotiates. Not always openly, often subtly, dressed up as reasonable requests. Every negotiation is a cost-benefit calculation.
- The E2 is cooperative in a way that is too smooth. Genuine engagement includes friction. The E2's cooperation is smooth because it is management, not engagement.
- The E2's account of their situation changes depending on the audience. Find the gap between what they tell the worker and what the family reports. It will be there.
- The E2 responds to reduced pressure by reducing engagement.

What the E2 Actually Needs

- An environment that holds regardless of how they perform. Consequences have to be applied, not threatened.
- Legal pressure must be maintained. A court order with real consequences for non-compliance is one of the most effective structures for keeping an E2 in an environment long enough for something to shift.
- The exit has to be harder than the engagement. If leaving is easier than staying, the E2 will leave.

Can the E2 shift? Yes. What produces the shift from E2 to E1 is the accumulation of sustained exposure to a consistent environment combined with experiences that land differently. When the shift happens, it is behavioural before it is verbal. The negotiation stops. The performance loses its smoothness. Move them into the right environment. Quickly.

Chapter 5: E3 — No Current Capacity

The E3 is the person the system most consistently mishandles, not because they are ignored, but because they are placed. They are placed in rehabilitation programmes that cannot reach them. They are given beds that should have gone to E1s. They are surrounded by workers who invest genuine effort into engagement that cannot happen yet.

Who the E3 Is

The E3 is a person at Stage E who has no current capacity for genuine engagement with change. The key word is current. The E3 classification is not a verdict on the person's future. It is an accurate description of their present. The crisis that brings an E3 into contact with the system has not produced an opening.

What the E3 Looks Like

- The history is the most reliable indicator. The E3 has an extensive history of system contact across which no sustained change has been produced.
- The E3 navigates institutions with a fluency that comes from long exposure.
- There is often a quality of disconnection in the E3's presentation that is distinct from the E2's management. The E2 is performing. The E3 is enduring.

Why Rehabilitation Is the Wrong Response

Placing an E3 in a rehabilitation programme is one of the most consequential errors the system makes, and it makes it routinely. The E3 cannot engage with the therapeutic work not because they are refusing but because the capacity for that engagement is not present. The E3 does not contribute to the rehabilitation community. They disrupt it, through a persistent quality of non-engagement that communicates to everyone around them that genuine participation is optional.

What the E3 Needs

The E3 needs containment. This word is sometimes heard as abandonment or punishment, and it is neither. Containment is the appropriate clinical response to a person whose current state makes genuine rehabilitation impossible and whose presence in the community carries risk. Containment means a structured environment that keeps the person safe, keeps others safe, and does not make demands of genuine therapeutic engagement that the person cannot currently meet.

The E3 is not permanently E3. A system that classified someone as E3 two years ago and has not reassessed since is not using the framework. It is using a label.

Chapter 6: Where They Show Up

Court

The court is one of the most powerful leverage points in the entire system and one of the most consistently misused. The E2 at court is the most common presentation. The court has real leverage over the E2: legal pressure is one of the most effective tools available. What does the court do with this leverage? In most cases, it removes it. A suspended sentence, a diversion programme with no real consequences for non-completion: these reward the presentation of cooperation without maintaining the pressure that might eventually produce something real.

What courts need to do differently: require reports at sentencing that include the client's assessed stage of readiness. Build sentencing options that match each stage: immediate programme access for E1, maintained legal pressure for E2, honest containment for E3.

Prison

Prison is where the E1 window is most consistently missed. The E1 inside prison is one of the most significant and most wasted opportunities in the entire framework. The person has been removed from the substance and from the environment that sustained the addiction. What does the system do with it? It processes the person through standard intake, assigns accommodation, and puts them on a waiting list for programmes. By the time the programmes coordinator gets to them, the window has often closed.

What prisons need to do differently: mandatory classification at intake, separate programme streams, immediate action on E1 identification rather than waitlist processing, regular reassessment, and a direct pathway from prison to appropriate programme for any person whose classification shifts during their sentence.

Hospital

The standard hospital response to an overdose or addiction-related crisis is medical stabilisation followed by discharge with a referral list. The E1 in hospital has a window the hospital is currently walking past. What hospitals need to do differently: train social workers and discharge nurses in the classification framework, build a same-day E1 pathway that can be activated without a waitlist, and treat the hours after stabilisation as the clinical opportunity they are.

Rehabilitation

The intake decision is the classification decision. Every other decision in a rehabilitation programme follows from the classification. A programme that makes the intake decision without the classification is making every subsequent decision on a foundation that may be wrong. Fix the intake. Ask the classification question before admitting anyone. Redirect E3s to appropriate containment. Place E2s in a separate high accountability stream. Give the E1s the environment that was built for them.

Chapter 7: The Pathway to Freedom

> *The goal is not sobriety. The goal is not reduced harm. The goal is not stable enough to manage. The goal is freedom: a life that is genuinely and completely free from all drugs and all substances, not white-knuckled abstinence maintained by willpower and fear, but actual freedom, in which the person is living rather than surviving, working rather than existing, connected rather than isolated.*

The Four Stages

Detox

Detox is where the pathway begins. It is not where the pathway ends, and treating it as if it were is one of the system's most expensive and persistent errors. A person who has completed detox has not recovered. They have reached the starting line. Detox has to be connected to what follows immediately. The gap between detox completion and the next step is one of the most dangerous periods in the entire pathway.

Stabilise

Stabilisation is the period during which the body and the nervous system begin to recover from the sustained assault of long-term addiction. Sleep is disrupted, sometimes severely, for weeks or months. Emotional regulation is profoundly disrupted. Thinking is foggy. What stabilisation requires is an environment that holds, that provides structure, safety, routine, and basic support without demanding therapeutic engagement that the person cannot yet sustain.

Treat the Root Causes

The substance was never the problem. The person became addicted because the substance solved a problem, managed a pain, filled a void, provided a way of being in the world that felt more bearable than being in it without the substance. The substance was the solution. The problem the substance was solving is what has to be addressed here. Trauma, pain from childhood, identity structures built around inadequacy, unresolved grief, unaddressed shame. None of this can be addressed in a session or a week or a month.

This is where the lived experience of staff becomes critical. A worker who has been through this process themselves brings something that no amount of professional training can replicate: the genuine knowledge that the discomfort passes, that what is on the other side is worth the cost, and that the person in front of them is capable of what they are being asked to do.

Rewire the Brain

Addiction produces measurable, observable changes in the brain's structure and function. The reward pathways that normally respond to the full range of human experience have been recalibrated around the substance. None of this is reversed by insight, intention, or therapeutic conversation alone. The brain changes through experience. Specifically, through new experiences practised repeatedly, consistently, over time.

Real work produces the experience of competence. Every day of real work in a real role with real standards produces a small amount of evidence that they can do something, build something, contribute something. The rewiring takes time. The timeline of meaningful neural change is measured in months and years, not weeks. This is the biological reason why duration matters. The twelve-month minimum is not arbitrary.

What Comes After the Programme

The person who walks out of a genuine twelve-month rehabilitation programme and walks into no housing, no employment, no structured support, and a social network composed entirely of people still in addiction will relapse. The period immediately following discharge from residential rehabilitation is the highest-risk period in the entire recovery journey.

The conditions after discharge require the same intentional design as the programme itself. Housing that is not in the same suburb where the addiction was sustained. Employment that is structured, meaningful, and appropriate for someone rebuilding a work identity. Community that continues the connection and accountability of the programme.

The programme that builds this pathway, that arranges the after-discharge environment before the discharge happens, that treats the end of the programme as a transition rather than a conclusion, is a programme that is completing the work it started.

Closing Statement

The system is not failing because the people inside it lack skill or commitment. The workers are skilled. The families are committed. The institutions are funded and staffed and operational. What is missing is the one question that would allow all of those resources to be directed correctly.

Which E is this person?

That question costs nothing. It requires no new institution, no new building, no new funding stream, no new legislation. It requires a decision, made by someone with the authority to make it, that the question will be asked. Every time. At every point of contact. Before any other decision is made.

This is not a prediction. It is a description of what happens when the framework is actually used. Thirteen years of it. Over two thousand people. A return-to-prison rate less than half the state average. No government funding. The results are not theoretical. They are documented.

> Is this person free? That is the question every decision has to be oriented toward. Not is this episode complete. Not is this bed occupied. Not is this programme at capacity. Is this person free. Until the answer is yes, the work is not done.

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APPENDIX THREE: THIRTY YEARS OF WATCHING AND WAITING: HOW AUSTRALIA'S DRUG MONITORING SYSTEM LOST SIGHT OF PREVENTION

WRD News Analysis | June 2026

Introduction

In May 2026, the National Drug and Alcohol Research Centre (NDARC) marked thirty years of its Drug Trends program with a quiet announcement and a new bulletin series. The launch was framed as a milestone: three decades of monitoring Australia's drug markets, a commitment to drawing together multiple data sources, and a new series designed to make that evidence more accessible to policymakers and health services.

It is serious work, and the first bulletin it produced — a detailed snapshot of cocaine in Australia — is among the more damning indictments of Australian drug prevention policy published in recent years. Not because NDARC intended it that way, but because the numbers tell a story the framing does not. Cocaine use among Australians aged 14 and over has grown from 1% in 2004 to 4.5% in 2022–23. Wastewater analysis recorded the highest cocaine consumption in Australian history in 2024–25. Deaths have risen fivefold since 2000. Hospitalisations have tripled since 2011. The cocaine market is, in the bulletin's own words, "growing and more established."

Thirty years of monitoring and every indicator moving in the wrong direction. The question worth asking at this anniversary is not whether Drug Trends has done its job — it has, at its face. The question is what job it was designed to do, and what that design choice has meant for Australian drug prevention policy over three decades.

What Drug Trends Was Built to Measure

The four monitoring systems that make up the Drug Trends program are described in the anniversary announcement in plain terms. The Illicit Drug Reporting System (IDRS) monitors "trends in illicit drug markets" through

annual interviews with people who inject drugs. The Ecstasy and Related Drugs Reporting System (EDRS) tracks "emerging trends" in ecstasy and stimulant markets through interviews with people who regularly use those substances. The National Illicit Drug Indicators Project (NIDIP) was established to disseminate "trends in the epidemiology of drug-related harms." The Drugs and New Technologies project monitors online drug marketplaces and dark web availability.

Every one of these systems is oriented toward people already using drugs, markets already operating, and harms already occurring. Not one was designed to measure whether fewer Australians are choosing to use drugs in the first place. Not one of these reporting mechanisms even acknowledges prevention, let alone tracks the effectiveness of prevention efforts. Not one asks whether the policy environment is discouraging uptake among people who have not yet begun.

This is not a criticism of the researchers who built and operate these systems — monitoring markets and harms is necessary work. However, the architecture of Drug Trends reflects a set of assumptions about what Australian drug prevention policy is fundamentally for, and preventing uptake is not among them. Over thirty years, that architecture has shaped what evidence gets generated, what questions get asked, and what policy responses get recommended.

The Drift Toward Harm Reduction

Australia's shift toward harm reduction as the dominant policy framework did not happen at once, and it did not begin recently. When the Hawke government launched the National Campaign Against Drug Abuse in 1985, harm minimisation was introduced as the organising principle from the start. Every iteration of the National Drug Strategy since then — through 1993, 1998, 2004, 2010, and 2017 — has carried the same overarching commitment to harm minimisation across three pillars: supply reduction, demand reduction, and harm reduction. Prevention of uptake was folded into demand reduction, never given its own pillar, and never given proportionate funding. A 2024 UNSW report found that of the $5.45 billion Australian governments spent on illicit drug countermeasures in 2021–22, just 7% went to prevention. Law enforcement consumed 64%. Treatment took 27%. Prevention — the only pillar directly aimed at stopping people from starting — received $363 million in a $5.45 billion budget.

By the time Drug Trends reached its thirtieth year, harm reduction had become the organising logic of most public health responses to illicit drug use in Australia. Drug checking services now operate in the ACT and Victoria. Needle and syringe programmes proliferate nationally. Supervised consumption facilities have opened in two states. The language shifted, over those decades, from discouraging use to managing damage.

The cocaine bulletin reflects this orientation precisely. Its policy recommendations identify three priorities: continued monitoring of cocaine markets and harms; expansion of drug checking and public risk communication systems; and improved access to treatment and early intervention services. The word "prevention" does not appear in the policy implications section. There is no recommendation directed at reducing the number of Australians who begin using cocaine. There is no target for reducing uptake. There is no acknowledgement that the fourfold increase in cocaine use over two decades represents a failure of Australian drug policy to prevent, one that warrants a different kind of response.

This absence is not accidental — it is the logical endpoint of a monitoring framework that has, over thirty years, progressively redefined success. Success no longer means fewer people using drugs. These are different goals, and pursuing one does not automatically serve the other.

Harm Reduction's Real Limits

The cocaine bulletin documents that drug checking services in the ACT and Victoria found some samples sold as cocaine contained opioids, a contamination risk that kills people. Multiple drug alerts between 2024 and 2026 flagged opioids in cocaine samples across NSW, ACT, and Victoria. In that specific context, drug checking has a clear purpose — but consumption of uncontaminated substances does not slow.

Harm reduction as a primary policy framework, rather than one tool among many, carries consequences the bulletin's own data make visible. Across thirty years of Drug Trends monitoring, cocaine use has grown every decade. The market has become more established, not less. Perceived availability among people who regularly use ecstasy and other stimulants reached over 40% in 2025 reporting cocaine was "very easy to obtain." Harm reduction does not reduce demand. It manages the consequences of demand that already exists, but when demand grows — as it has in Australia across thirty years — the harm reduction burden grows with it. More hospitalisations to manage. More treatment episodes to fund. More ambulance attendances to respond to. Treatment episodes for cocaine quadrupled over the past decade.

That is not a system succeeding. It is a system absorbing the consequences of a problem it was not designed to prevent.

Where Did Prevention Go?

Prevention, in the sense of reducing the number of people who initiate drug use, has all but disappeared from Australian drug demand reduction policy. It has been progressively marginalised, underfunded, and in much public health discourse, treated with scepticism. Some of that scepticism has legitimate roots — school-based drug education programmes of the 1980s and 1990s produced mixed results, mostly because of a lack of volume, consistency, and follow-through. Those experiences generated caution about prevention as a category. However, caution became abandonment, and the monitoring infrastructure Drug Trends built over thirty years reinforced that abandonment, because it generated no evidence about prevention outcomes. You cannot make the case for investment in something you have no data on.

The cocaine bulletin contains a figure that should be at the centre of any serious prevention conversation. Only 3% of people who used cocaine in 2022–23 did so weekly or more frequently. Ninety-seven per cent used occasionally. The shift to more harmful, more entrenched patterns of use is not yet widespread at population level. There is a large cohort of occasional users who have not crossed into frequent use, and a broader population of non-users who have not started at all. The bulletin itself acknowledges that “increased availability and, as a result, potential reductions in price may contribute to broader uptake and more frequent use over time.” It then recommends drug checking and treatment access. It identifies a prevention-relevant window and walks straight past it.

What the Numbers Say About Policy

The cocaine data in this bulletin covers a period during which Australia maintained one of the world’s most sophisticated drug monitoring systems, spent heavily on law enforcement — including record seizures of 5.6 tonnes in 2023–24 and a single operation that netted 2 tonnes in November 2024 — and progressively expanded harm reduction services. Across that same period, cocaine use grew fourfold.

A monitoring system that tracks harms but not prevention outcomes will produce evidence that supports harm reduction responses. That is not a conspiracy — it is how evidence framing works. The questions you ask determine the answers you get, and the answers you get determine the policies you build. For Australian drug prevention policy to change direction, the questions being asked need to change first.

What Needs to Change

A prevention-focused complement to the existing Drug Trends framework would need to do things the current systems do not. It would need to understand the social and cultural factors driving cocaine uptake among the specific populations the bulletin identifies: young, employed, city-dwelling Australians with tertiary education, and gay, lesbian, and bisexual Australians reporting use at 15.1%, more than three times the general population rate. It would develop and evaluate targeted prevention approaches for these groups, rather than treating prevention as a spent category.

It would set explicit targets for reducing uptake, not just for reducing death rates per user, and measure performance against them. It would build prevention outcome data into the monitoring architecture, so that after another thirty years there is actually evidence on which to base prevention investment. None of this requires dismantling what Drug Trends has built, but a framework that measures harms without measuring whether fewer people are choosing to use drugs is incomplete. The cocaine bulletin, read carefully, makes that incompleteness impossible to ignore.

Conclusion

NDARC's thirty-year anniversary marks a real achievement in Australian public health research. The Drug Trends program has built a sustained, rigorous evidence base that the sector depends on. However, the anniversary also marks thirty years in which cocaine use grew from a marginal issue to the second most commonly used illicit drug in Australia. Thirty years in which the monitoring framework watching that growth was not designed to ask whether it could have been prevented. Thirty years in which harm reduction expanded and prevention contracted, without a single explicit decision that this was the right direction for Australian drug prevention policy to travel.

The bulletin series NDARC has launched is titled Trends in Drug Markets, Use and Health Impacts in Australia. It is an accurate title. Markets, use, and health impacts are what Drug Trends measures. After thirty years, it is reasonable to ask whether a system that does not measure prevention can ever produce the evidence needed to achieve it.

> *This article draws on the NDARC announcement 'Marking 30 Years of Drug Trends: Introducing a New Bulletin Series' (28 May 2026) and the associated bulletin 'Trends in Drug Markets, Use and Health Impacts in Australia: Cocaine' (May 2026). WRD News provides prevention-focused analysis of*

APPENDIX FOUR SUMMARY OF REPORT ON INQUIRY INTO THE HEALTH IMPACTS OF ALCOHOL AND OTHER DRUGS IN AUSTRALIA – PARLIAMENT

The inquiry's final report recommends a **health-led, nationally coordinated alcohol and other drugs (AOD) system**: stronger alcohol regulation and prevention, earlier intervention, better access to integrated treatment, workforce and digital-care investment, harm-reduction measures, and targeted action for communities with the greatest unmet need. Prevention and demand reduction are prominent; recovery is embedded mainly through treatment, integration and peer-informed supports; and abstinence is not framed as the sole or universal outcome.

Scope and interpretive note

The link supplied is for the House Standing Committee inquiry that was re-referred in August 2025 and whose final report was publicly presented in September 2026. It should be distinguished from the earlier March 2025 **issues paper**, which contained only two recommendations—one proposing a full successor inquiry and one asking the Health Department to consider evidence and submissions when advising on the National Drug Strategy.aph+2

The current final report has **30 recommendations.** Its policy orientation is harm minimisation: balancing supply reduction, demand reduction and harm reduction, rather than treating criminal sanctions or abstinence alone as the central response. This is important because the National Drug Strategy defines demand reduction as preventing or delaying uptake and reducing harmful use—not simply requiring cessation.aph.gov+1

Key recommendations

Policy area	Key recommendations and intended direction	Principal focus
National policy and accountability	Renew and better coordinate AOD policy across governments; use evidence from the inquiry in National Drug Strategy revision; establish clearer implementation, coordination and accountability arrangements.	System enabler; all pillars
Alcohol availability and marketing	Create a mandatory national alcohol advertising and marketing framework; review alcohol taxation; establish national standards for online alcohol sales and delivery.	Prevention / demand reduction
Health-care responses	Build primary and antenatal-care capability for alcohol screening, brief intervention and FASD-related care; strengthen AOD training across medical colleges and other sectors.	Early intervention; treatment; prevention
Illicit-drug safety	Establish a national illicit-drug early-warning system; increase public awareness of and access to Take Home Naloxone.	Harm reduction; overdose prevention
Schools and young people	Introduce mandatory alcohol and drug education in secondary schools.	Primary prevention / demand reduction
Treatment access and care models	Scale digital models of AOD care; fund integrated models that connect AOD, mental health, primary health and social supports.	Treatment, recovery support, early intervention
Workforce	Improve recruitment, retention, training and recognition of the AOD workforce, including peer workers.	Treatment quality; recovery-oriented care
Equity and place-based access	Improve targeted services in regional and remote areas, Aboriginal and Torres Strait Islander communities and other populations experiencing disproportionate harms or service barriers.	Prevention, treatment, recovery and equity

These priorities reflect the committee's stated emphasis on alcohol-related harm, rising and changing illicit-drug risks, service fragmentation, workforce constraints, stigma, and unequal access to care.aph+1

Prevention and demand reduction

Prevention is one of the report's clearest through-lines. It operates both upstream—reducing exposure, availability and normalisation—and through early identification of risky use before dependence or acute harm develops.

Strongest prevention recommendations

- A **mandatory national framework for alcohol advertising and marketing** is intended to reduce harmful promotion and children's and young people's exposure to alcohol marketing.miragenews
- A review of the **alcohol tax system** and nationally consistent rules for **online sales and delivery address** price, affordability, convenience and rapid availability—population-level levers that can influence alcohol consumption and harm.miragenews
- **Compulsory secondary-school alcohol and drug education** seeks to delay or prevent initiation, build knowledge and skills, and support safer decision-making among young people.miragenews
- Expanded **alcohol screening and brief intervention** in primary and antenatal care places prevention within routine health care. This includes identifying risky use earlier and supporting prevention of alcohol-exposed pregnancy and FASD.miragenews
- A stronger, trained health and community-services workforce makes prevention more feasible across settings—not only in specialist AOD services.miragenews

Where "demand reduction" fits

In Australian policy, demand reduction includes preventing uptake or delaying first use, reducing harmful use, and supporting treatment. The inquiry's demand-reduction agenda therefore includes:

1. Alcohol-control measures: marketing, taxation, online sale/delivery standards.
2. Education: particularly school-based programs.
3. Early intervention: screening, brief intervention and antenatal support.
4. Treatment availability: so that people can reduce or cease harmful use when they want or need support.
5. Anti-stigma and service accessibility measures: reducing barriers to help-seeking.

The earlier inquiry material explicitly identifies demand reduction as the pillar concerned with “preventing the uptake or delaying the onset” of alcohol, tobacco and other drug use, while also reducing harmful use.aph.gov+1

Recovery and abstinence

Recovery

Recovery is supported primarily through service design, not as a standalone recommendation category. The report’s recovery-related focus is evident in recommendations to:

- Expand **integrated models of care**, recognising that AOD recovery often depends on coordinated mental health, primary care, housing, family, employment and social support—not detoxification in isolation.aph.gov+1
- Scale **digital models of care**, which can improve continuity, privacy and access for people in rural, remote or underserved locations, and for people deterred by stigma or travel barriers.
- Strengthen and retain the **AOD workforce**, including peer workers. Lived-experience roles can support engagement, hope, navigation and continuity during recovery.
- Improve services for **regional communities, First Nations peoples and other priority populations**, where culturally safe, locally accessible and community-led care is especially relevant to sustained recovery. miragenews
- Build capability across health and related sectors, so recovery is less likely to be interrupted when people move between emergency care, primary care, mental health services, justice settings or social supports.aph.gov+1

The underlying approach is consistent with recovery as an individual, long-term and multidimensional process—improved health, safety, functioning, connection and quality of life—rather than a short episode of clinical treatment.

Abstinence

Abstinence is not the organising principle of the inquiry’s recommendations. The report does not appear to propose abstinence-only education, abstinence as a condition for care, or abstinence as the universal measure of treatment success. Instead, it adopts a health-focused and harm-minimisation framework that combines prevention, treatment and harm reduction.aph.gov+1

That does **not** mean abstinence is excluded:

- Abstinence can be a person's chosen recovery goal and may be an appropriate outcome for many people, particularly where use is causing dependence or serious health, family or safety harms.
- The inquiry's treatment, workforce, integrated-care and service-access recommendations can support people seeking abstinence-based treatment or rehabilitation.
- However, the report also supports interventions that reduce death, injury, overdose and other harms for people who are not ready, able or willing to stop using immediately—most visibly, Take Home Naloxone and an illicit-drug early-warning system.

Prevent earlier; reduce demand through regulation, education and health care; respond to acute risk through harm reduction; and make recovery support accessible, integrated and equitable.

For a policy or briefing document, it would be accurate to say that the inquiry gives its strongest explicit emphasis to **prevention and demand reduction**, while treating **recovery** as dependent on integrated, accessible, culturally appropriate and workforce-supported care. It does not elevate **abstinence** above other health and wellbeing outcomes; instead, it situates abstinence as one possible outcome within a broader harm-minimisation and recovery-oriented system.

The final report contains 30 recommendations, but the publicly accessible committee material currently provides a reliable **topic-level** list rather than the full numbered wording of each recommendation. I can therefore give a detailed, structured breakdown of the recommendation package, identify its policy purpose and whether each stream is principally prevention, demand reduction, harm reduction, treatment/recovery, or a system enabler; I would not label individual topics as Recommendation 1–30 without the report's complete recommendation pages.

What the 30 recommendations do

The inquiry is explicitly a health-focused review of AOD policy, treatment, community programs and workforce, intended to test whether current arrangements support the **prevention, reduction and recovery** of alcohol- and drug-related harms. Its 30 recommendations form a connected package rather than 30 isolated proposals.aph.gov

Recommendation stream	Detailed policy action indicated by the report	Main intended effect	Primary focus
National AOD governance	Strengthen national coordination, implementation and accountability for AOD policy across Commonwealth, state and territory governments, health, social services and justice systems.	Reduce fragmentation and make national strategy commitments operational.	System enabler
Alcohol marketing Regulation	Introduce a **mandatory national alcohol advertising and marketing framework**	Reduce promotional exposure and alcohol normalisation, especially among children and young people.	Prevention; demand reduction
Alcohol taxation review	Model the alcohol-taxation system to determine whether it remains fit for purpose	Assess whether taxation better reflects alcohol-related harms and discourages harmful consumption patterns.	Prevention; demand reduction
Online alcohol sales	Develop national standards for online alcohol sale and delivery.	Address age assurance, responsible supply, rapid delivery and digital-market risks	Prevention; demand reduction
Primary-care alcohol response	Build capability in primary health care to screen for alcohol use and provide interventions.	Detect risky use earlier and offer brief, accessible support before harms escalate.	Prevention; early intervention
Antenatal alcohol response	Build antenatal-service capacity for alcohol screening and intervention, including FASD-related prevention and care.	Prevent alcohol-exposed pregnancies and improve identification and support where FASD is a concern	Prevention; early intervention

FASD capability	Strengthen health-service knowledge and response relating to fetal alcohol spectrum disorder.	Improve prevention, clinical recognition, referral and longer-term family support.	Prevention; treatment/ support
Illicit-drug early warning	Establish a national early-warning system for illicit drugs.	Detect new, contaminated or unusually potent substances and communicate timely risk information.	Harm reduction; overdose prevention
Take Home Naloxone	Increase awareness of and access to the **Take Home Naloxone Program.**	Prevent fatal opioid overdose by ensuring people and communities can respond quickly.	Harm reduction; mortality prevention
Secondary-school education	Make alcohol and drug education programs mandatory in secondary schools.	Delay uptake, improve literacy and reduce risky patterns of use among adolescents.	Primary prevention; demand reduction
Medical-college training	Require alcohol and other drug education and training in medical colleges.	Make AOD assessment, intervention and referral a routine clinical capability.	Prevention; treatment quality
Cross-sector training	Extend AOD training across relevant sectors, not only specialist treatment services.	Improve identification, reduce stigma and enable appropriate referral in health and community settings.	Early intervention; treatment/ recovery

Digital AOD care	Scale digital models of care.	Expand access to counselling, treatment, follow-up and support, especially outside metropolitan centres or where privacy is a barrier	Treatment; recovery support
Integrated care	Increase funding for integrated models of care.	Connect AOD treatment with mental health, primary care, housing, family, legal and social supports.	Treatment; recovery
AOD workforce retention	Improve recruitment and retention of the AOD workforce.	Stabilise service capacity and reduce waiting times, burnout and discontinuity of care.	Treatment; recovery system
Peer workforce	Support and retain peer workers with lived or living experience.	Improve trust, engagement, navigation, advocacy and recovery-oriented practice.	Recovery; treatment quality
Regional service access	Improve and target AOD services in regional and remote communities.	Reduce geographical inequity in prevention, treatment, aftercare and crisis response.	Equity; treatment; recovery
First Nations services	Improve and target services for Aboriginal and Torres Strait Islander communities	Support culturally safe, community-informed and equitable responses to disproportionate harms.	Prevention; treatment; recovery; equity

Priority-population services	Improve targeted supports for other vulnerable Australians	Address barriers arising from poverty, trauma, mental ill-health, homelessness, stigma, violence, disability or service exclusion.	Equity; treatment; recovery
Community programs	Support community-level prevention and response programs as part of a wider AOD system.	Make interventions locally relevant and responsive to families and communities affected by AOD harms.	Prevention; recovery support
Stigma reduction	Address stigma that discourages people from seeking care or disclosing AOD concerns.	Improve earlier help-seeking and respectful, person-centred engagement.	Early intervention; treatment; recovery
Family and community impacts	Recognise that AOD harms affect families and communities, not only people who use substances.	Encourage more inclusive support systems, including care pathways that consider family needs.	Prevention; recovery support
Evidence-informed policy	Use evidence, monitoring and evaluation to guide AOD policy and service design.	Direct funding toward interventions that demonstrably reduce harm and inequity.	System enabler
Equity in access	Identify and address gaps in service access and outcomes across population groups and locations.	Ensure policy benefits people experiencing the greatest burden of harm.	System enabler; equity

Prevention–treatment continuum	Better link prevention, early intervention, specialist treatment and continuing support.	Avoid gaps where people disengage or deteriorate while moving between services.	Prevention; treatment; recovery
Health-led framing	Maintain a health-centred approach to AOD harms rather than relying principally on punitive responses.	Treat substance-related harms as health and social issues requiring care, support and prevention.	All pillars
Workforce capability	Improve the competence of professionals who encounter AOD-related risk in routine practice.	Ensure opportunities for screening, brief intervention and referral are not missed.	Prevention; treatment
Service integration	Reduce siloing between AOD, mental health and other essential services.	Better serve people with co-occurring mental-health, trauma, housing and social needs.	Treatment; recovery
Accessible models of care	Use flexible, locally suitable and digitally enabled services to reach underserved groups.	Make care more timely and practical for people facing distance, cost, transport or stigma barriers.	Treatment; recovery
Implementation focus	Turn recommendations into funded, accountable policy and service changes rather than aspirational strategy alone.	Produce measurable reductions in AOD-related health harms for individuals, families and communities	System enabler

The public release names the mandatory marketing framework, alcohol-tax modelling, online-sales standards, primary and antenatal care capability, FASD-related intervention, an illicit-drug early-warning system, Take Home Naloxone, compulsory secondary-school education, mandated professional training, digital and integrated care, workforce retention and peer workers, and targeted regional, First Nations and vulnerable-population services.

Prevention and demand reduction

The **most explicit prevention and demand-reduction measures** are the alcohol-control and early-intervention recommendations:

1. Mandatory national alcohol advertising and marketing regulation.
2. Review and modelling of alcohol taxation.
3. National standards for online alcohol sale and delivery.
4. Mandatory alcohol and drug education in secondary schools.
5. Primary-care screening and intervention for alcohol use.
6. Antenatal screening and intervention, including FASD prevention.
7. Mandatory AOD education in medical colleges and broader workforce training.
8. Community programs and stigma reduction that support earlier help-seeking.

These measures operate at different levels. Advertising, pricing and online-supply regulation are **population-level demand-reduction tools**; school education and community programs seek to prevent or delay initiation; and screening and brief intervention aim to reduce harmful use before a person develops more severe dependence or health complications.

Harm reduction and acute safety

The inquiry also gives distinct attention to measures that reduce injury and death even when people have not stopped using substances:

- A **national illicit-drug early-warning system** would identify and communicate risks from new psychoactive substances, contamination, unexpected potency and local drug-market changes.
- Greater awareness of and access to **Take Home Naloxone** would equip people who use opioids, their families, peers and community members to reverse an opioid overdose while emergency help is sought.
- Better trained primary, antenatal and other workforces can identify high-risk use and make earlier, safer referrals.
- Integrated and digitally accessible care can reduce gaps in support following crisis presentations, overdose, withdrawal or hospital discharge.

These are harm-reduction measures, not alternatives to prevention or treatment. They are intended to keep people alive and connected to care, which is often a necessary condition for longer-term recovery.

Treatment, recovery and abstinence

The report's recovery focus is strongest in the **integrated-care, workforce, peer-workforce, equity and access** elements of the package:

- Funding integrated models of care recognises that recovery commonly requires coordinated help with mental health, physical health, trauma, housing, family relationships, employment and social connection.
- Digital care can extend treatment and follow-up where local specialist services are limited or privacy concerns deter help-seeking.
- Retaining trained AOD workers and peer workers makes ongoing engagement and aftercare more realistic.
- Targeted services for regional communities, Aboriginal and Torres Strait Islander communities and other vulnerable groups are intended to address unequal access to culturally safe and relevant recovery support.

Abstinence is not presented as the report's universal or sole outcome. The inquiry adopts a health-oriented framework that includes prevention, reduced harmful use, treatment, recovery and immediate harm reduction. Abstinence may be a valued and appropriate personal goal for many people, and the recommendations on treatment access, workforce capability and integrated care can support it. But the report also recognises that people need effective, respectful care and protection from preventable harms whether or not they are ready or able to cease use immediately.aph.gov+1

Important limitation

The committee's announcement confirms the 30-recommendation total and sets out the substantive themes, but it does not publish the **verbatim, numbered text for Recommendations 1–30** in the material available through the inquiry page and public release. The earlier 2025 issues paper is a separate document with only two recommendations: complete a full inquiry in the next Parliament, and use evidence and submissions in advice on the National Drug Strategy. The Australian Government agreed to the second of those earlier recommendations.

If you can upload the final report PDF or provide its direct download link, I can turn this into a precise numbered table with: the official wording, responsible government body, policy pillar, target population, implementation implications, and a concise assessment of whether each recommendation strengthens prevention, demand reduction, harm reduction, recovery, abstinence-oriented treatment, or system capacity

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