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

Submission to the Inquiry into the health impacts of alcohol and other drugs in Australia

Submission: QuIHN Ltd and QuIVAA Inc

To Whom it May Concern,

Thank you for the opportunity to provide this submission to the House Standing Committee on Health, Aged Care and Sport's *Inquiry into the health impacts of alcohol and other drugs in Australia*. This submission has been submitted jointly by QuIHN Ltd and QuIVAA Inc. QuIHN and QuIVAA welcome aperture for discussion and amplification of recommendations from the range of AOD peers and lived and living experience representatives in our network of communities.

QuIHN Ltd is a not-for-profit charity providing a range of specialist social and health services relating to alcohol and other drug use and mental health since 2005. Operating Queensland-wide, QuIHN provides programs across a continuum of care comprising of harm reduction programs, therapeutic programs, and primary medical care. At QuIHN we envision a world where all people who use substances can reach their full potential, and the health and well-being outcomes of our communities are maximised.

QuIVAA has been representing the voices of people who use drugs in Queensland since 1985. QuIVAA Inc is a charitable organisation with a mission to advocate, educate, and raise awareness about the issues facing people who use drugs to enable them to live healthy lives, free from stigma and discrimination. QuIVAA also aims to develop, support, and promote policies, training, and programs that support and advocate for equal health and human rights for people who use drugs in Queensland.

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Terms of Reference

a) Assess whether current services across the alcohol and other drugs sector is delivering equity for all Australians, value for money, and the best outcomes for individuals, their families, and society.

b) Examine the effectiveness of current programs and initiatives across all jurisdictions to improve prevention and reduction of alcohol and other drug-related health, social and economic harms, including in relation to identified priority populations and ensuring equity of access for all Australians to relevant treatment and prevention services.

c) Examine how sectors beyond health, including for example education, employment, justice, social services and housing can contribute to prevention, early intervention, recovery and reduction of alcohol and other drug-related harms in Australia.

d) Draw on domestic and international policy experiences and best practice, where appropriate.

Response to Terms of Reference

Most people who use alcohol and other drugs (AODs) do not experience problematic use; however, there is a shortage of specialist AOD treatment and harm reduction services to meet demand for those who do. Funding for Australia's AOD sector remains insecure, insufficient to match need for specialist services, and overly complex. The lack of adequate funding results in inequitable access to care for marginalised populations, including individuals with problematic substance use, Aboriginal and Torres Strait Islander peoples, people from culturally and linguistically diverse background (including migrants and refugees), young people, and LGBTQIA+ communities. The AOD funding system needs better integration and coordination across multiple bodies. A national governance structure is essential to align priorities and funding across Australia's AOD service sector, ensuring integrated planning, performance management, and alignment at all levels, including State and Territory sources.

Address complexity and chronic shortages in funding for the AOD service system

AOD treatment and harm reduction services depend on a complex mix of Commonwealth, State, and Territory funding. Commonwealth-level funding comes through PHN commissioning, the Department of Health and Aged Care, and the National Indigenous Australians Agency (NIAA). Most services require multiple funding streams to operate fully, with individual services often funded by several sources, including multiple State/Territory government agencies. (1–4) For example, in the last financial year, QuIHN managed 18 contracts across federal agencies and state government departments, along with additional support from Medicare and private social impact investments.

Many AOD treatment and harm reduction services rely on a patchwork of funding to deliver a complete program designed to function 'as a whole'. This creates a 'house of cards' effect: if one funding stream faces administrative issues, it can disrupt staff retention and client service. Services also face multiple reporting and

compliance requirements, navigating numerous funding applications and extensions with contracts on varying timelines.

> ***Key Message 1: National stewardship and leadership of AoD funding is urgently required to*** better integrate and coordinate services that address inequity across multiple bodies.
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> ***Key Recommendation 1: A national governance structure is essential to align priorities and funding*** across Australia's AOD service sector, ensuring integrated planning, performance management, and alignment at all levels, including State and Territory sources.

Ensure long-term (5 year) contracting for core services

Contracts for services under the National Ice Action Strategy (NIAS) and commissioned through PHNs have typically been short-term (1–2 years since 2016). These short-term contracts pose administrative and financial risks for Commonwealth-funded AOD treatment and harm reduction services. Limited funding cycles hinder longer-term planning, forcing services into frequent contingency planning in case funding is not renewed. Although most staff are permanently employed, short funding cycles create uncertainty, leading to turnover as contracts near expiration. This impacts an organisations' capacity, and at a systems level it affects the stability and effectiveness of the entire AOD sector.

> ***Key Message 2: Short-Term Contracts for specialist AOD services hinders service planning and sustainability*** therefore impacting capacity and effectiveness.
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> ***Key Recommendation 2: 5-year block funding for Commonwealth funded contracts are necessary*** *for stability and to ensure comprehensive care for clients.*

Address scarcity and uncertainty in service by reducing delays in commissioning and contracting

For instance, in 2022, processing delays in budget allocations—such as for the Drug and Alcohol Treatment Services Maintenance (DATSM) measure and core contract extensions — caused setbacks. Despite May 2022 assurances that funding would be forthcoming, providers received neither updated contracts nor payments until October 2022, even though extensions were announced in the March Federal Budget of that year. This left programs unfunded for 3 – 4 months, forcing organisations to either enact contingency plans, risking staff and service cuts, or fund operations from their own reserves. For smaller organisations with limited resources, this isn't feasible. For the service providers and the communities they serve, this leads to increased stressors because of uncertainty.

> ***Key Message 3: Administrative delays exasperate system insecurity and service providers*** and risks loss of service capacity and therefore effectiveness.
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> ***Key Recommendation 3: Longer multi-year contracting should occur*** with contract lengths extended from the typical 1 to 2 years to 4 to 5 years. Longer-term funding commitments would allow better financial planning, reduce the need for frequent reapplications, and provide stability for service delivery and staffing.

Match appropriate indexation to make service capable and effective

The AOD service system has experienced the ongoing absence or lack of adequate indexation on Commonwealth service contracts, which has been a persistent issue for the better part of a decade. This has slowly but surely resulted in significant erosion of service capacity. The lack of a clear methodology for indexation leads to insufficient adjustments to meet rising operational costs, further diminishing service effectiveness. There is an urgent need for review of how indexation is applied to better reflect inflation, ensuring that AOD services can sustain operations, meet community needs, and ultimately ensuring capacity and effectiveness of the 'whole of system'.

Key Message 4: Lack of appropriate indexation is slowly eroding the service system, its capacity, and effectiveness.

Key Recommendation 4: Ensure fair indexation by establishing a robust Indexation Framework for federal AOD funding. This requires the appropriate application of a clear methodology for adequate indexation on Commonwealth AOD funding.

Increase access and equity in primary care

Many people who use AODs, despite their level of use, feel unsafe to talk about their substance use in primary care settings. (5) Primary care practitioners also have limited knowledge and/or confidence in delivering basic AOD assessments and brief interventions. (5) The limited availability of and support at a local level from specialist AOD services can also compound the reluctance of primary care practitioners to explore AOD issues due to long wait times to access more intensive treatment if required and limited referral pathways.

Service provision example: equity and access for people who use drugs (PWUD)

QuIHN is a unique model that provides comprehensive services across harm reduction, psychosocial therapy, and clinical care, meeting the diverse needs and preferences of our clients. In 2014 QuIHN established its own General Practice (GP) clinic, the Better Access Medical Clinic (BAMC), to address the complex healthcare needs of our communities and inequity in their access to primary care. The practice has always been a fully bulk-billing practice as it was established to service a highly socio-economically disadvantaged population. The clinic focuses on providing medical services to disadvantaged populations, including people who use drugs, those with mental health illnesses, sex workers, individuals living with HIV, and patients requiring care for blood-borne viruses and sexually transmitted infections. The clinic experiences a set of unique issues that are common across clinics that serve disadvantaged populations, including:

- Longer consultations compared to mainstream practices, reflecting the complexity of clinical presentations managed in a single consult. GPs often need to prioritise urgent care requirements due to patients presenting with multiple issues. Current Medicare billing models disincentivise longer appointment times over throughput and shorter appointments.
- The demand for services has seen a steady increase due to the shortage of bulk billing options, low-cost care, and the complexity of patient cases. This increased demand simply cannot be met.
- Non-attendance (DNAs) by patients has a significant impact on capacity and revenue due to the loss of GP time. Managing patient appointments and providing nursing support is more complex as a result.
- Although there are many longer consultations and eligible patients, there are relatively few patients with care plans in place. The lack of adequate nursing support for care plans, like chronic disease management plans (CDMPs), has been identified as a significant barrier.
- Even if provided a Care Plan, there are significant down-stream factors that create barriers for clients in accessing allied health. Patients face barriers to accessing private ancillary services due to high costs and long wait times.
- The use of EPC billing for internal ancillary services, such as psychology and social work, is limited due to issues with meeting MBS (Medicare Benefits Schedule) requirements and accessing both block funding and MBS payments.

Bulk billing models are becoming less common, and most practices now charge out-of-pocket expenses ranging from $20 to $30 for low-cost care and up to $90 to $120 at the higher end for a standard consultation. There are concerns that socio-economically disadvantaged patients may struggle to afford these out-of-pocket expenses, so there is a limited ceiling for price increases to ensure continued access to care. Indeed, Medicare rebates set a price ceiling for our clinic due to its fully bulk-billed model, while they represent a price floor for the market more generally.

The clinic has experienced growth, stabilisation, and periods of destabilisation due to reduced GP capacity, loss of nursing staff, and challenges in recruiting and retaining reception staff. Staff recruitment and retention contribute to the strategic issue at hand. Given the significance of these issues, the ongoing strategic decision for the clinic is whether to continue providing GP services or shut down operations.

If the BAMC did not exist, many patients would not have access to health care at all. Without the BAMC, there is also a high risk of delayed diagnosis and treatment, leading to preventable complications and the need for emergency presentations and other tertiary care services. **By offering primary care in appropriate settings that meet the needs of our populations, this plays an important role in addressing the inequity of access to health care for our populations, save lives and reduces healthcare costs by minimising the use of emergency and tertiary care and therefore avoiding the high costs of hospital treatments.**

There are several priority populations who experience similar equity issues in accessing primary care and there are several niche primary care providers who grapple with similar challenges. QuIHN is part of a collective called the *Health Equity Coalition*, which consists of health, social, and community service organisations operating primary care services in the Greater Brisbane region. The issues of equity that unite us are universal across Australia for similar contexts, regions and populations served. We believe in collective advocacy to bring evidence to highlight the growing issues that are faced by our communities, organisations and people, highlighting the growing disaster that awaits us as a society if we do nothing.

Our patients/participants are some of the most socially disadvantaged and marginalised in the community. They include people experiencing homelessness, disenfranchised youth and culturally diverse people from asylum seekers to

migrants and first Australians alongside people with substance dependence, mental health, and diverse sexual orientations to name a few. They experience stigma and discrimination in the health system which contributes to a further erosion of their social determinants and hinders access to mainstream services. The primary care system is not designed with them in mind.

> ***Key Message 5: The current system is not designed with our populations in mind*** and is not able to effectively support individuals with complex AOD needs. Many individuals struggle to access necessary primary care, exacerbated by stigma and discrimination within the healthcare system, and the absence of specific funding or Medicare items for AOD treatment discourages General Practitioners (GPs) from engaging with complex cases.
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> ***Key Recommendation 5: New and innovative funding models for primary care services*** that improve equity and access for underserved and socially disadvantaged populations.

Ensure equity through rebalancing across the three pillars of Australian AOD policy spending

The current national policy does not equitably support the pillars of the National Drug Strategy (2017–2026). Recent findings from the Drug Policy Modelling Program (DPMP) at UNSW indicate that 65% ($3.5 billion) of state and federal spending on illicit drug efforts is directed toward law enforcement, including $1.8 billion on routine policing. (1) This is in stark contrast to spending on drug treatment services and prevention activities, with 27% and 7% of the total spend respectively. (1) Even more concerningly, less than 2% of the federal spend on illicit drug response budget are spent on harm reduction measures. (1)

The over emphasis on policing and supply reduction responses and under resourcing of harm and demand reduction responses has been highlighted by at least two national Government inquiries led by the Australian Parliamentary Joint Committee on Law Enforcement. (6,7) Both inquiries recommended reviewing and reallocating resources to better balance funding across harm, demand, and supply

reduction measures. (6,7) Public priorities also show a disconnect; according to the National Drug Strategy Household Survey (NDSHS), taxpayers consistently prioritise spending on education and treatment over law enforcement.(8)

The inequitable allocation of resources for drug treatment services results in an inability to meet demand. In 2022–2023, 125,948 Australians accessed AOD treatment services, yet estimates indicate an unmet demand of around 593,951 people per year — more than four times the current capacity. (8, 2–4,9) This gap is evident in extensive waitlists and long wait times, which act as a significant disincentive for people seeking treatment. Access is even more limited for those in rural and remote areas, who may often have some of the highest levels of need, where AOD services are often unavailable. This forces individuals to travel to regional or urban centers for treatment.

The persistently high rates of overdose deaths in Australia are partly a symptom of chronic underfunding of AOD harm reduction services. A comprehensive response to overdose and the growing threat of novel psychoactive substances (NPS), including synthetic opioids like nitazenes, is urgently needed. This coordinated response should include:

- **Rebalancing drug policy investment** to prioritise essential harm reduction measures, creating a responsive system to address high overdose rates and the increasing threat of potent synthetic opioids.
- **Enhancing access to Opioid Dependence Treatment (ODT)** requires addressing significant bottlenecks in the community and reducing the reliance on high patient-to-prescriber ratios. This can be achieved by diversifying entry points for ODT and developing new service models. While the federal government deserves praise for normalising ODT medications on the Pharmaceutical Benefits Schedule (PBS), further efforts are necessary to improve access to prescribing and dispensing by both state and federal governments.
- **Expanding access to drug checking services** across jurisdictions is essential for public health safety, as it helps keep the community informed about and monitors the potential circulation of harmful adulterants and

emerging classes of NPS. Approximately 64% of Australians surveyed in the National Drug Strategy Household Survey (NDSHS) support the expansion of these services. (11)

- **Expanding the establishment of overdose prevention centers** (supervised drug consumption facilities) is vital for providing lifesaving services and connecting individuals to healthcare, support, and AOD treatment services they might not otherwise access. Approximately 58% of Australians surveyed in the NDSHS support the expansion of medically supervised injecting facilities as a crucial service for reducing overdose rates and other associated harms in the community. (11)
- **Increasing the availability of naloxone and ensuring widespread training** in overdose response and management throughout the community is essential. The federal government deserves praise for implementing the national take-home naloxone program, but further efforts are needed to ensure that naloxone is accessible to all Australians at risk of experiencing or witnessing an overdose.
- **A nationally coordinated approach to Drug Early Warning Systems (EWS)** is necessary, co-led by health agencies, customs, police, and community organisations (including those with Lived and Living Experience (LLE)), with an emphasis on public health and harm reduction benefits for the Australian community rather than policing or research objectives. This national EWS should build upon the work of and collaborate with state and territory governments.
- **A nationally coordinated approach to enhancing overdose monitoring programs** in Australia is essential. This is crucial for addressing the growing complexity of the drug landscape, facilitating timely and accurate data collection on community overdoses, and informing effective policy and resource allocation to shape targeted public health responses.

Key Message 6: Chronic under funding of AOD demand and harm reduction services result in significant equity issues thereby reducing capacity to respond to the complexity of AOD public health issues and effectiveness of the national response.

Key Recommendation 6: Address the urgent need for rebalancing of the three pillars of the National Drug Strategy in terms of their resourcing and investment.

Key Message 7: Enhancing access to ODT requires diversifying entry points and new service models.

Key Recommendation 7: The Australian Government should lead a nationally coordinated approach to increasing access to ODT*.*

Key Message 8: Increasing the availability of naloxone and ensuring widespread training in overdose response and management is essential.

Key Recommendation 8: The Australian Government should significantly increase current investment in the Take Home Naloxone Program to ensure wider spread adoption.

Key Message 9: Harm reduction initiatives, like drug checking, should be acknowledged, particularly given the current challenges in drug supply.

Key Recommendation 9: All state and territory governments should urgently implement drug checking services (where such services do not exist) and in jurisdictions where drug checking exists continue to provide such services while expanding and securing recurrent funding.

Key Message 10: There is an immediate need for better coordination and resourcing of drug checking and Early Warning Systems in Australia.

Key Recommendation 10: The Australian Government should lead a nationally coordinated approach to Drug Early Warning Systems (EWS), co-led by health agencies, customs, police, and community organisations

(including those with Lived and Living Experience (LLE)), with an emphasis on public health and harm reduction benefits.

Increase funding for co-designed peer led harm reduction approaches

A notable example of a co-designed peer approach in Queensland is the introduction of CheQpoint drug checking services, developed through a partnership led by QuIHN with QuIVAA and The Loop Australia. These services are available at two fixed locations — Brisbane, which opened in April 2024, and Gold Coast, which opened in July 2024 — and were also provided at a multi-day festival earlier this year in May. Peer support workers are a key component of the service model. However, funding and therefore reach for this service remains limited. CheQpoint delivers specific, timely, and targeted data and information about psychoactive drugs and performance image enhancing drugs (PIEDs) that informs diverse communities about decision-making regarding various substances, playing a crucial role in reducing and preventing drug-related harms. Since launching the fixed sites, the service has provided harm reduction access to 219 individuals and tested nearly 400 samples. Notably, half of the users had never consulted a healthcare worker about their alcohol or drug use before; a third identified as LGBTIQASB+; 23% expressed a desire to reduce their dosage, and 16% indicated they would dispose of their substances. The CheQpoint service has also identified a range of unexpected adulterants in samples, such as dimethyl pentylone in what was believed to be cocaine and 2-FNENDCK in samples thought to be ketamine. This data foreshadows a broader and more menacing harm.

Although Australia has experienced the current global synthetic opioid crisis differently than countries like the United States, synthetic opioids such as nitazenes now pose a recognised threat to the Australian community. Health departments in several states have issued public alerts regarding the harms associated with nitazenes, including fatalities. (12) These substances have been detected in drugs marketed as cocaine, MDMA, ketamine, benzodiazepines, and heroin, increasing risks for all drug users. The importance of harm reduction initiatives like drug checking is increasingly acknowledged, particularly given the

current challenges in drug supply, to ensure that marginalised communities do not bear the burden of costs, stigma, discrimination, and the ongoing loss of life.

There is an immediate need for better coordination and resourcing of drug checking and prompt response networks in Australia that can facilitate awareness of emerging substances and effectively disseminate timely alerts, advisories, notifications, and health promotion messaging based on local, national, and international data sources. Messaging for such must be designed, developed, and distributed with input from people who use drugs and key stakeholders to ensure relevance, utility, and reach.

Without appropriate resourcing of such responses there is no way to adequately respond to and reduce harms, ultimately mortality, associated with overdose in Australia. Overdose is a critical public health, social, and economic issue and it is deserving of a national focus through the development of a National Overdose Prevention Sub-Strategy as a matter of urgency.

Key Message 11: Expanding the establishment of overdose prevention centers (supervised drug consumption facilities) is vital.

Key Recommendation 11: National leadership on the importance of overdose prevention centres is required, with support to state/territory governments to fund and establish/implement, including new models of delivery.

Key Message 12: There is an urgent need for a national action on overdose through the development of a National Overdose Prevention Sub-Strategy, with attention to the response preparedness for emerging drug threats such as nitazenes.

Key Recommendation 12: Develop a National Overdose Prevention Sub-Strategy that includes response preparedness for emerging drug threats associated with potent synthetic opioids.

Target equity for priority populations

The experience of AOD related harms is influenced by a complex and dynamic relationship with the social determinants of health. (13) The priority populations of peoples identified in the current National Drug Strategy are more likely to experience problematic AOD use, as well as peoples experiencing other significant social stressors, such as homelessness, impacts of family and domestic violence, and social isolation. Many people who experience problematic AOD concerns may also experience high psychosocial complexity, such as housing issues, cooccurring mental health concerns, involvement with criminal justice and/or child protection systems and other physical health conditions (such as sexual health and blood borne viruses). (14) Such issues may take precedence for people over their AOD use.

Equity is often given less importance than efficiency in current health care service design, development, and delivery and particular groups therefore continue to be maligned in terms of access to existing services. QuIHN work with a range of groups who are marginalised from mainstream services, including Aboriginal and Torres Strait Islander peoples, people from culturally and linguistically diverse communities, individuals experiencing vulnerable housing and homelessness, and people involved in the criminal justice system. All face significant challenges in accessing appropriate services. This is further compounded in more rural and remote locations that are under resourced and lack a sufficient service infrastructure. The role of Aboriginal and Torres Strait Islander community-controlled services in the Australian AOD sector needs greater recognition in both the commissioning and funding processes. There also exists an ongoing need to resource and build the capacity of other service sectors, such as those that work with culturally and linguistically diverse communities and housing and homelessness services to integrate with existing AOD service systems. QuIHN has partnered with a large residential social service housing provider based in Brisbane, this partnership provides an example of a proactive response to AOD

issues through embedding a AOD harm reduction worker with an Integrated Health team to provide harm reduction, brief intervention, and referral services to better respond to AOD issues within a social housing resident community. However, this program is self-funded by housing provider itself and does not receive funding from external sources.

In addressing inequity for priority populations and to meet the needs of community, harm reduction approaches led by people with Lived and Living Experience (LLE) of substance use, whom the community acknowledge as peers and representatives, are proven measures. The insights of People Who Use Drugs (PWUDs) must be harnessed to improve the relevance and acceptance of various programs, advocacy initiatives, policymaking efforts, and research across diverse fields.

Key Message 13: The community-controlled health services in the Australian AOD sector needs greater recognition in both the AOD commissioning and funding processes.

Key Recommendation 13: Commissioners of services and policy makers should ensure they work with Aboriginal and Torres Strait Islander communities in genuine partnership to support wider adoption of appropriate models of care that encapsulate physical, social, emotional, cultural, and spiritual healing and embed cultural and community governance.

Key Message 14: Enabling and building capacity in adjacent service sectors is needed, such as services working with culturally and linguistically diverse communities, LGBTQIA+, youth, and people experiencing housing and homelessness.

Key Recommendation 14: Resourcing and capacity be targeted to supporting adjacent service sectors to integrate existing AOD systems to better serve priority populations.

Key Message 15: Harm reduction approaches led by people with diverse LLE of substance use are proven measures.

Key Recommendation 15: Insights from diverse groups of People Who Use Drugs (PWUDs) must be harnessed to improve the relevance and acceptance of various programs, advocacy initiatives, policymaking efforts, and research across diverse fields.

Address ineffective responses within statutory service systems perpetuate stigma and discrimination, while contributing to demand in the specialist AOD service system

A recent Queensland Peer Peak Scoping Survey illustrated that most people who use alcohol and other drugs do not experience problematic use or interact with services related to their use. (15) However, those who do come into contact with health services, or agencies such as police, justice (including court, probation and parole, and the prison system), and child safety often have a range of negative experiences including; unfair treatment, increased stress and social isolation, racism and discrimination, family pressures and relationship conflict, and disruptions to treatment (particularly during periods of incarceration). (15) The adverse outcomes for people who do access specialist AOD treatment from contact with agencies like policy, justice, and child safety include:

- Impacts on a person's disclosures with drug treatment services potentially having subsequent impacts for treatment effectiveness.
- Heightened psychological and emotional stress.
- Disruptions to treatment delivery, particularly during periods of incarceration.

Many people often move between statutory systems at various points in their life course, which can often lead to compounding harms and disadvantage over the longer term, this can then lead to further system engagement, restricting access to secure housing, and/or limiting future employment opportunities. There is a requirement to situate AOD systems as part of the broader systems of criminal justice, corrections, and child protection to address the underlying social determinants that inform AOD related harms.

Key Message 16: Many people move between statutory systems at various points in time, this leads to compounding harms and disadvantage over the longer term, driving further system engagement, restricting access to secure housing, and/or limiting future employment opportunities.

Key Recommendation 16: Situate AOD systems as part of the broader systems of criminal justice, corrections, and child protection to address underlying social determinants that inform AOD related harms.

Address drug related stigma and discrimination

Specific to people who use illicit substances, increased equity requires targeted action to address stigma and discrimination using approaches attuned to the needs of the most marginalised in the community. (16) Stigma and discrimination against people who use AODs extend beyond those with dependency issues and problematic use, and it impacts employment opportunities and access to responsive services. (17) The experiences of stigma and discrimination are common among people with a lived and/or living experience of AOD use and this creates barriers to help seeking, compounds social disadvantage, leads to social isolation, and detrimentally impacts a persons' mental and physical health. (18,19) Drug use stigma and discrimination is deeply embedded across society and its institutions, and it can be fatal. The impacts of drug stigma and discrimination was demonstrated recently in the findings of the *Victorian Coronial Inquest* into the death of Veronica Nelson. (23) The report on the Inquest found that drug stigma was so normalised it desensitised the very staff charged with her health and social care, ultimately failing in her care and casually contributing to her death. (23)

Many population groups experience sub-optimal support and care based on stereotypes and stigma. People can often be misunderstood and stigmatised, and this can have impacts on late diagnosis of a life limiting disease. (20) For example, people may often delay and avoid critical healthcare based upon previous experiences. (20) Alienating prior experiences with the health care

system, escalating physical symptoms, limited cognitive capacity, social and self-stigma, as well as assumptions made by health and other professionals can mean people become 'lost in the system', are mismanaged, or support and care is received too late (20) Estimates suggest that only 11% of people who use drugs experience a substance use disorder. (21) However globally, it is estimated that seven out of eight people who suffer from drug use disorders remain without appropriate care. (21)

Stereotypes and stigma have adverse impacts on individuals' feelings of self-worth, mental health, and sense of connection to community. (22) Stereotypes and stigma can leave people feeling worthless and hopeless, which in turn is a trigger for use of AODs and a barrier to seeking health behaviour change in their lives. (22) People who use AODs, whether socially or dependently, may also feel unsafe and unable to talk about their AOD use. Experiences of stereotypes and stigma creates barriers to seeking help or getting treatment, even at times when it is really needed. (22) Delaying and/or avoiding health care contributes to the higher burden of morbidity and mortality for priority population groups who experience such stigma and discrimination.

The Queensland Parliamentary Inquiry into the opportunity to improve mental health outcomes for Queenslanders has recommended a public health campaign to reduce drug related stigma and encourage help-seeking and help-offering behaviours. (24) Strategies must target specific audiences and systems and must support, platform, and elevate the lived and living experience (LLE) voice of people who use drugs, and their families and significant others impacted. Education, anti-stigma, and anti-discrimination campaigns and training are required to be tailored and targeted to specific audience and system segments, including media and journalism, health care, welfare and social services, criminal justice (including courts, corrections, and policing), domestic and family violence services, the child protection system, employment, and the general community more broadly.
Such anti-stigma and anti-discrimination campaigns and training must be LLE-led, including by organisations representing lived / living experience of substance use.

Key Message 17: Nationally led and coordinated action against drug-related stigma and discrimination is required. Such action should be in partnership with state and territory governments and led by relevant community stakeholders to elevate and platform LLE voices and experiences.

Key Recommendation 17: Australian Governments *(including states and territories)* ***should extend discrimination laws*** to specifically protect health status as an attribute with focus on protecting people who use or have used illicit drugs from discrimination across systems (e.g., employment, education, health care, housing, and access to services).

Reframe AOD responses to a health and human rights issue

In our Queensland context, a recent review of various Inquiries and Government reports on AOD emphasised significant variations in how AOD use is framed. (25) Some government reports still use language that reinforces stigma and discrimination. This is crucial because the way an issue is conceptualised in terms of policy then affects how programs and initiatives are designed, developed, and implemented. The policy narrative and general discourse on illicit drugs has been framed in policing and supply reduction responses. A reframing of the AOD policy and discourse is required. This involves:

- Framing AOD that leads to harms as a health issue.
- Viewing drug use as a health and human rights issue rather than a criminal justice issue.
- Acknowledging that most people who use drugs do not experience substance dependence and problematic drug use.
- Situating illicit drug use within a public health framework recognising the policy, social, economic, legal, and physical environments that elevate risks of drug related harms. Thereby prioritising action to address these factors.

From a human rights lens and specific to the justice system, we must recognise that drug policy and legislation tends to have disproportionate and compounding impacts for socio-economically disadvantaged and marginalised populations. The

recent Joint Committee on Law Enforcement's Inquiry into the Australia's illicit drug problem: Challenges and opportunities for law enforcement recommended a review of the National Drug Strategy. (7) The review of the National Drug Strategy should address the lack of human rights principles.

> ***Key Message 18: Drug policy and legislation tends to have disproportionate and compounding impacts*** for socio-economically disadvantaged and marginalised populations.
>
> ***Key Recommendation 18: Review of the National Drug Strategy must address the lack of human rights principles.***

Reorient from criminalisation policy responses to health-based responses

The current approach to policing illicit drugs disproportionately impacts more vulnerable populations, including Aboriginal and Torres Strait Islander peoples, young people, and women experiencing domestic violence. There is no strong evidence that supply reduction has any significant or lasting effect on the availability or purity of illicit drugs, or that it discourages people from using illicit drugs, or that it reduces the incidence or prevalence of drug related harm(s) at a community level. (26) Criminalisation has created significant costs and unintended harms. (26) Evidence on supply reduction strategies shows unclear results and unintended consequences. (27,28) There is no evidence that criminalising drug use and possession deters people from drug use, possession, or minor crimes. (29) Reductions in supply through law enforcement activities tend to be short-lived and may perversely increase the risk of harm by diverting buyers to more potent (i.e., 'riskier') substances, such as fentanyl and nitazenes and their analogues. (30) International research continues to suggest that efforts to increase enforcement may work to encourage the supply of more potent substances by criminal networks (commonly referred to as the Iron law of prohibition), and such factors may work to increase the risks of using drugs, including overdose and death. (26)

Drug offences have contributed notably to the growth in imprisonment in Australian jurisdictions and this disproportionately impacts more vulnerable populations, including Aboriginal and Torress Strait Islander peoples, young people, and women experiencing domestic violence. (35) It is also well established that people entering prisons experience higher rates of AOD use, including risky patterns of use, compared to that of the general population. (36,37) People in prison also experience poorer health outcomes than the general population – including higher rates of mental health conditions, communicable disease, smoking, high-risk alcohol consumption, and chronic physical diseases. (38) Poorer health outcomes among people experiencing incarceration is also often a result of state and territory governments failing to meet their obligations under domestic and international law in relation to ensuring all prisoners have access to an equivalent standard of health as the general community.

Having a criminal record can also lead to long-term harms that severely impact a person's future, limiting employment, education, and housing options while increasing social stigma, family distress, and financial strain — especially for those already facing significant socio-economic disadvantage while further perpetuating continued cycles.

Numerous Inquiries have repeatedly questioned the norm of prohibition and supported decriminalising possession, including the Senate Select Committee on Drug Trafficking and Drug Abuse, the Senate Standing Committee on Social Welfare, the New South Wales Joint Parliamentary Committee upon Drugs, and the South Australian Royal Commission into the Non-Medical Use of Drugs. (35)

Conversely, AOD treatment and harm reduction services provide excellent value for money, for every $1.00 invested in AOD treatment, $7.00 in benefit is returned to Australian society. (31) Similarly, drug harm reduction services, such as Needle and Syringe Programs (NSP) have been found to provide value for money, for every $1.00 invested in NSP, up to $5.50 is returned in benefit. (32) AOD treatment and harm reduction services can deliver significantly positive outcomes for clients

and the wider community, but this continues to be hindered by constraints of available funds to invest into the service system.

Effective responses to AOD use involve interventions that are matched to the patients' needs based on the level of harm and should be evidence-based and informed. (33) The ability to access the right treatment, at the right time is paramount, where people would benefit from accessing a treatment intervention. (34) Evidence informed treatment and harm reduction services demonstrably reduce drug harm(s), improve health status, and improve psychological wellbeing and participation in the community. (31) Recalibration of systems towards health-based responses for people who use illicit drugs represents an opportunity to make substantial budget savings while improving the health and wellbeing of Australian communities. (35) Decriminalisation also provides an opportunity to reframe AOD issues in a lens of human rights. The Queensland Productivity Commission made a compelling economic argument for decriminalisation of low harm drugs within their *Inquiry into Imprisonment and Recidivism* (2020) finding that illicit drugs policy has failed to reduce supply or harm.

> ***Key Message 19: AOD treatment and harm reduction services are critical to reducing rates of AOD related harms across Australia***, but this continues to be hindered by constraints of available funds to invest into the service system.
>
> ***Key Recommendation 19: Effective and evidence-based approaches to reducing AOD harms requires a health led response, not justice led***. Scaling up of harm reduction, prevention, and drug treatment programs will see significant social, health, and economic benefits, while reducing drug related harms and increasing equity of access.
>
> ***Key Message 20: Recalibration of systems towards health-based responses is necessary*** and represents an opportunity to both improve population health and wellbeing while returning economic savings.

Key Recommendation 20: The Australian Government should support State and Territory Governments to adopt full decriminalisation models for all illicit drugs.

Key Recommendation 21: The Australian Government should support State and Territory Governments to meet their obligations to ensuring all prisoners have access to an equivalent standard of care as the general community.

Involve People with Lived and Living Experience at all levels, at all stages of design, development, delivery and evaluation

Improvements that contribute to early intervention, recovery and increased harm reduction services across sectors that impact people who use AODs requires embedding processes to authentically and meaningfully reduce stigma and incorporate the diverse voices of individuals and the heterogenous communities they represent. Such communities possess invaluable lived and living experiences and firsthand knowledge of the challenges, stigmas, and systemic barriers people encounter within society and across systems.

Processes and policies that are founded on research and evaluation from lived and living experiences of substance use will help to identify and address the compounding harm, exclusion, and disadvantage that can result, which often leads to increased future system engagement, limited employment opportunities, and restricted access to secure housing.

Incorporating the voices and experiences of individuals with substance use histories is vital for creating effective policy and interventions. This involves addressing the stigma and systemic barriers they encounter. Engaging peers in harm reduction initiatives can improve program relevance and acceptance, though peers often face stigma and marginalisation themselves. To effectively address the stigma surrounding people who use drugs and to enhance the development of inclusive initiatives, programs and policies across various systems (health, justice, community, child safety, welfare, education, and economic sectors), it is crucial to

incorporate representatives with lived and living experience of drug use. Policy and program reforms across government and services sectors must prioritise a health and human rights perspective, aiming to dismantle systemic structures that perpetuate stigma and discrimination and ongoing cycles of perpetuating socio-economic disadvantage.

Key Message 21: Incorporating the voice and lived and living experience is vital for creating effective policy and interventions.

Key Recommendation 21: All policy responses must incorporate the voices and lived and living experiences of the affected communities.

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