NSW Alcohol and Other Drugs Strategy 2026 – 2036

Consultation Submission

Mental Health Coordinating Council

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mental health coordinating council

Mental Health Coordinating Council

Ground Floor, Building 125
Corner of Church and Glover Street
Lilyfield NSW 2040

PO Box 668 Rozelle NSW 2039

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FOREWORD

Mental Health Coordinating Council (MHCC) is the peak body principally for community-managed mental health organisations (CMOs) in New South Wales (NSW). It is also a Registered Training Organisation (RTO) delivering accredited and non-accredited programs. We mostly represent community-based, non-government organisations that support people living with mental health challenges. MHCC's 160+ members assist people to live well in the community by delivering mental health and psychosocial supports including social inclusion, rehabilitation, and clinical services. Our purpose is to promote a strong and sustainable community-managed mental health sector with the investment, resources, and workforce it needs to provide effective psychosocial, health and wellbeing programs and services to the people of NSW.

MHCC provides policy leadership, promotes legislative reform and systemic change, and develops resources to assist community-based organisations to build their capacity to deliver quality services, informed by a human rights-based, trauma-informed, recovery-oriented practice approach.

MHCC welcomes the opportunity to contribute to the NSW Alcohol and Other Drugs Strategy 2026–2036 Draft Consultation. We emphasise the value of its recognition that alcohol and other drug (AOD) use is a health and social issue requiring coordinated action across government and community services. Our feedback to discussions focuses on the interface between the AOD and mental health service systems, particularly for people with co-occurring mental health and AOD needs as well as for people living with psychosocial disability.

While the Strategy includes positive commitments to integrated, person-centred care, stronger implementation measures are needed to ensure that people are not excluded, redirected between services or required to navigate fragmented systems. MHCC recommends that the Strategy establish a clear "no wrong door" approach, shared accountability across the mental health and AOD systems, and funded mechanisms for integrated service delivery, workforce development, sustainability and evaluation processes that support quality improvement.

For further information about this submission, please contact Corinne Henderson, Director Policy & Systems Reform, at corinne@mhcc.org.au or Michelle Hoomans, Director, Workforce Development at michelle.h@mhcc.org.au

Dr Evelyne Tadros
Chief Executive Officer
Mental Health Coordinating Council
Adjunct Associate Professor,
School of Clinical Medicine Psychiatry & Mental Health, UNSW

INTRODUCTION

This submission focuses on the interface between the mental health and alcohol and other drug (AOD) systems, particularly for people with co-occurring mental health and AOD needs and people living with psychosocial challenges. While the Strategy contains positive commitments to integrated care, stronger implementation measures are required to prevent people from being excluded from services, redirected between systems or left to navigate fragmented pathways without support. MHCC recommends that the Strategy establish a clear statewide "no wrong door" approach, shared responsibility across mental health and AOD services, and funded mechanisms for integrated service delivery, workforce capacity building and sustainability and accountability.

Our submission responds to the draft Strategy through a mental health and psychosocial lens, focusing across both mental health and alcohol and other drug systems and the experiences of people with co-occurring needs. It considers each of the Strategy's three pillars - before identifying cross-cutting priorities for integrated service delivery, workforce capability, lived experience involvement, implementation and accountability.

The submission also makes practical recommendations under each pillar, together with cross-cutting recommendations, to strengthen integrated care, clarify responsibilities and support measurable implementation of the Strategy.

Overarching recommendations are that Strategy establish:

- a clear statewide "no wrong door" approach
- shared responsibility across mental health and AOD service systems
- integrated referral and transition pathways
- funded mechanisms for integrated service delivery
- reciprocal workforce development
- meaningful lived and living experience involvement
- measurable implementation and accountability arrangements

Pillar 1 — Reduce demand: prevention, early intervention and integrated treatment

Key issues

Mental health and AOD services remain fragmented, and people with co-occurring needs may be excluded from one system because they require support from the other. Referral and transition arrangements are inconsistent, while AOD services are not always adequately resourced to respond to mental health and psychosocial needs. Effective prevention and early intervention must also address lived experience of trauma, mental distress, housing instability and other drivers of escalating need.

Analysis and commentary

The Strategy should establish shared responsibility for people with co-occurring mental health and AOD needs and develop integrated care pathways supported by formal referral and transition protocols. This should include expanded co-commissioning of mental health and AOD services and sustainable funding for multidisciplinary mental health capability within AOD services, including mental health nursing, peer support, psychology, social work and access to psychiatry.

The NSW Government should also expand peer navigation, community outreach and community-based residential services including step-up-step-down programs, alongside youth-specific, family-inclusive and culturally safe services capable of responding to mental health, AOD and psychosocial challenges collectively.

Pillar 2 — Reduce supply: proportionate, health-led and rights-based responses

Key issues

Supply-reduction and law-enforcement measures must not undermine the Strategy's recognition of AOD use as a health and social issue. Criminalisation and police contact may disproportionately affect people experiencing mental health and/or psychosocial challenges, when justice-system involvement can disrupt treatment, housing, family connections and psychosocial supports. Police and other first responders may also lack the skills and local service knowledge required to respond safely to people with co-occurring needs.

Analysis and commentary

The Strategy should prioritise diversion and therapeutic pathways for personal use and possession, minimise unnecessary police discretion, and avoid responses that increase criminalisation or service disengagement. Police and other first responders should receive mandatory training in mental health, trauma-informed practice, de-escalation, harm reduction, stigma and discrimination, and local referral options.

The NSW Government should monitor the effects of supply-reduction measures on people experiencing mental health and psychosocial challenges and other experiences of disadvantage, including unintended impacts on access to services, housing stability and continuity of care.

Pillar 3 — Reduce harm: psychosocial support, continuity of care and safe engagement

Key issues

Harm reduction must extend beyond immediate clinical treatment and overdose prevention. People can experience gaps in medication, treatment and psychosocial support when moving between services.

Abstinence requirements may prevent access to housing, mental health care and other essential supports. Psychosocial disability is not sufficiently visible in descriptions of complex need and priority populations, and people are too often redirected rather than supported to enter appropriate services.

Analysis and commentary

The Strategy should explicitly recognise people with psychosocial challenges and co-occurring mental health and AOD needs. Harm-reduction responses should include psychosocial support, continuity of care and medication, safe service transitions, stable housing, peer support and access to services without abstinence as a precondition.

A statewide "no wrong door" approach should apply across mental health, AOD, primary care, psychosocial, housing, disability and justice services. Services should provide supported or warm referrals rather than simply redirecting people, and peer workers and peer navigators should be funded to operate across service boundaries.

Cross-cutting implementation priorities

The Strategy's commitments will depend on specific, funded and measurable actions in the first implementation plan. MHCC recommends that the first implementation plan:

- establish a statewide "no wrong door" framework with shared responsibility across mental health, AOD, psychosocial, housing, disability, primary care and justice services;
- fund co-commissioned mental health and AOD programs, including residential, step-up-step-down-down and community-based and outreach programs;
- require integrated care pathways and supported transitions between mental health and AOD services;
- build specialist mental health capability within AOD services and AOD capability within mental health services;
- mandate and fund joint workforce development on co-occurring needs, trauma-informed practice, de-escalation, stigma and discrimination;
- include people with lived and living experience of co-occurring mental health and AOD needs—including people with psychosocial disability—in governance, co-design, co-production and evaluation;
- include mental health and psychosocial expertise on the NSW AOD Strategy Implementation Committee and in the development of implementation work plans; and
- publish outcome measures covering service access and exclusion, supported referrals, continuity of care, housing stability, consumer experience and outcomes for people with co-occurring needs.

Workforce capability

The Strategy should build reciprocal capability across the mental health and AOD workforces. This should involve:

- mental health and psychosocial training for AOD workers
- AOD training for mental health and psychosocial support and peer workers
- joint learning opportunities and practice supervision
- human rights, trauma-informed and culturally safe practice
- supported decision-making to be embedded in the practice approach
- de-escalation skills

- stigma and discrimination across mental health and AOD
- access to external practice supervision and continuing professional development
- development and support of the peer workforce including in leadership roles

Data, evaluation and accountability

Implementation measures should assess whether people with co-occurring needs experience improved access, continuity and long-term outcomes.

Measures should not be limited to service activity or numbers of referrals. They should examine whether people successfully receive support and whether fragmentation and exclusion are being reduced.

Proposed actions

MHCC recommends that the NSW Government:

1. Include mental health, psychosocial disability and community-managed sector expertise on the NSW AOD Strategy Implementation Committee and in the development of implementation work plans.
2. Ensure that people with lived and living experience of co-occurring mental health and AOD needs are meaningfully involved in governance, co-design, co-production, implementation and evaluation.
3. Fund reciprocal workforce capability, including mental health training for AOD workers and AOD training for mental health and psychosocial support workers.
4. Mandate joint workforce development covering co-occurring needs, human rights and trauma-informed practice, supported decision-making, , cultural safety and capability, stigma and discrimination awareness.
5. Support the development and sustainability of the lived and living experience workforce, including peer navigation roles that operate across service settings and boundaries.
6. Assign clear responsibilities, funding commitments, timeframes and performance measures to actions concerning the mental health–AOD interface.
7. Publish outcome measures relating to:
    - access to appropriate services
    - service exclusion including digital exclusion
    - supported referrals
    - continuity of care, safe transitions
    - housing stability
    - consumer experience feedback
    - sustained engagement
    - outcomes for people with co-occurring needs
8. Require regular public reporting on implementation, including progress in reducing fragmentation and improving equitable access to integrated mental health, AOD and psychosocial supports.

CONCLUSION

MHCC supports the development of a lived experience informed, health-led, person-centred NSW Alcohol and Other Drugs Strategy 2026-2036.

The Strategy provides an important opportunity to address the longstanding disjunction between the mental health and AOD systems. However, integration must be translated from a broad principle into funded service models, increasing workforce capability, clear responsibilities, supported pathways and measurable outcomes.

People with co-occurring mental health and AOD needs should receive coordinated support regardless of where they first seek assistance. Embedding a statewide “no wrong door” approach, strengthening psychosocial support and establishing shared accountability and collaboration across service systems will be essential to achieving the Strategy’s objectives.

Appendix 1: Suggested clarifications in the Draft Strategy

- Pillar 1 (page 3) – Include interface with mental health and psychosocial needs at the early stage to reduce remand
- Pillar 2 (page 3) – include mental health in capability development
- Pillar 3 (page 4) - Include interface with mental health and psychosocial support services as clear additional enablers
- Pillar 3 (page 4) – Re Enablers for Success, reducing stigma and discrimination – recognise the difference in stigma and discrimination in the mental health and AOD sectors and how working across both areas that would be acknowledged
- Impact of AOD and other use (page 9) – recognise the interface between DV, trauma and mental distress frequently leading to AOD use
- Alcohol and other drug use affects the whole community (page 11 and 13) – sustained action to include early intervention to prevent, delay or reduce harms
- A unified strategy for a complex issue (page 12) – mental health to be explicitly included in range of initiatives for alignment and integration
- From priorities to action (page 14) - emphasise the multiplicity of skills that the peer workforce will need to have to work across co-existing conditions and an integrated system
- Also, page 14 – Improve access to mental health and psychosocial services informed by best practice
- Reducing Stigma and Discrimination (page 14) – review structural barriers to employment – stigma and discrimination are often long term and structural in nature
- Reduce harm (page 15) – inclusion of support alongside treatment
- Core concepts (page 16) – re social determinants, include a clearer focus on the relationship between AOD, mental health and disadvantage leading to psychosocial challenges
- Trauma-informed practice (page 17) - include that trauma-informed best practice is human rights focused
- Priority populations (pages 19/20) - include people with lived and living experience of trauma, and childhood trauma survivors
- People with complex needs (page 20) – mental health to be explicitly included as an intersecting challenge
- Multicultural communities (page 21) – include the need for non-clinical approaches and healing-informed, culturally responsive and place based strategies led and informed by CALD communities
- Point 1.3.1 (page 25) – include peak bodies as a support
- Point 1.3.2 (page 25) - integrated service models must include both public and community-based service contexts
- Point 1.6.2 (page 29) - leaving custody should also clearly include mental health and psychosocial supports for these people who often fall between service gaps.
- Point 3.7.1 (page 39) – inclusion of a taskforce that extends across Government and community contexts to address common barriers to employment and a collaborative effort to reduce stigma and discrimination
- Point 3.7.2 (page 39) – ensure ambassador program allows for genuine expression and authentic lived and living experience storytelling rather than predetermined key messages
- Point 3.7.2 (page 39) – highlight organisational readiness and workplace responsibility in reducing structural stigma and improving work cultures, practices and environments to reduce colonial load, burn out and turnover of lived and living experience workers

Appendix 2: Recommendations in Brief

Pillar 1 — Reduce demand

1. Establish shared responsibility and collaboration across the mental health and AOD systems for people with co-occurring needs, so that no person is excluded from one service because they require support from the other.
2. Implement a statewide "no wrong door" approach, under which any mental health, AOD, psychosocial, primary care, housing, disability or justice service that a person approaches is responsible for facilitating timely access to appropriate support.
3. Develop integrated care pathways and formal referral and transition protocols between mental health and AOD services, including requirements for supported or warm referrals rather than redirection to another service.
4. Expand co-commissioning of mental health and AOD programs, including community-based residential, outreach and step-up/step-down models for people with co-occurring mental health, AOD and psychosocial support needs.
5. Provide sustainable funding for specialist mental health capability within AOD services, including mental health nursing, psychology, social work and access to psychiatry.
6. Invest in the AOD and mental health lived and living experience workforce to identify drivers of demand, increase prevention and early intervention and support sector capability.
7. Strengthen prevention and early intervention responses by addressing mental distress, trauma, housing instability and other social factors that may contribute to escalating mental health and AOD needs.
8. Invest in youth-specific, family-inclusive and culturally safe services that can respond to young people's mental health, AOD and psychosocial needs in an integrated way.

Pillar 2 — Reduce supply

1. Ensure that supply-reduction measures are consistent with a health-led, trauma-informed and human rights-based approach to alcohol and other drug use, prioritising the reduction of unnecessary mandatory treatment.
2. Prioritise diversion and therapeutic pathways for personal use and possession, particularly where a person is experiencing mental ill-health, psychosocial disability or other forms of social disadvantage.
3. Minimise unnecessary police discretion and avoid enforcement responses that increase criminalisation, service disengagement or disruption to treatment, housing and psychosocial supports.
4. Mandate and fund training for police and other first responders in mental health, trauma-informed practice, de-escalation, harm reduction, stigma and discrimination, and local health and social service referral options.
5. Monitor the impact of supply-reduction and enforcement measures on people with mental ill-health, psychosocial disability and co-occurring AOD needs, including any unintended effects on access to services, housing stability and continuity of care.

Pillar 3 — Reduce harm

1. Explicitly recognise people with psychosocial disability and people with co-occurring mental health and AOD needs within the Strategy's discussion of priority populations and complex needs.
2. Adopt a broad understanding of harm reduction that includes psychosocial support, continuity of treatment and medication, stable housing, safe service transitions, peer support and sustained engagement with community-based services.
3. Ensure that people are not denied mental health, housing, psychosocial or other essential supports solely because they are using alcohol or other drugs or have not achieved abstinence. Ensure consumer choice through a range of services that support the spectrum of harm reduction to abstinence.
4. Fund lived and living experience workers and peer navigators, and community health navigators to operate across mental health and AOD service boundaries, supporting people to navigate service complexity, understand their options, remain engaged with services and exercise choice and control over their care.
5. Require continuity-of-care arrangements for people moving between hospital, residential rehabilitation, community services, custody and other service settings, including the continuation of medication, psychosocial support and follow-up care.

Cross-cutting implementation and accountability

1. Include mental health and psychosocial disability expertise on the NSW AOD Strategy Implementation Committee and in the development, implementation and evaluation of work plans under the Strategy.
2. Ensure that people with lived and living experience of co-occurring mental health and AOD needs — including people living with psychosocial disability — are meaningfully involved in governance, co-design and evaluation.
3. Build reciprocal workforce capability by funding mental health training for AOD workers and AOD training for mental health and psychosocial support workers, including cross sector training opportunities.
4. Mandate joint workforce development covering co-occurring needs, trauma-informed practice, supported decision-making, cultural safety, stigma and discrimination.
5. Assign clear responsibilities, funding commitments, timeframes and performance measures to each action concerning the mental health–AOD interface.
6. Publish outcome measures relating to service access, exclusion, supported referrals, continuity of care, housing stability, consumer experience and outcomes for people with co-occurring needs.
7. Require regular public reporting on implementation, including progress in reducing service fragmentation and improving equitable access to integrated mental health, AOD and psychosocial supports.

Workforce capability

- Build reciprocal capability across the mental health and AOD workforces by funding mental health and psychosocial training for AOD workers and AOD training for mental health, psychosocial support and peer workers, including cross sector training opportunities.

- Provide joint learning and practice-development opportunities for mental health and AOD workers, including access to external practice supervision, networking and collaboration opportunities, mentoring, communities of practice, and continuing professional development.
- Embed human rights-based, trauma-informed and culturally safe practice across workforce development initiatives.
- Where required, embed supported decision-making within workforce education and practice, enabling workers to uphold people's rights, autonomy, choice and control.
- Strengthen workforce capability in identifying and responding to stigma and discrimination across the mental health and AOD service systems.
- Develop and sustain the lived and living experience workforce, including peer navigation, specialist practice and leadership roles that operate across service boundaries.
- Invest in tailored accredited training for the AOD lived and living experience workforce to address internalised stigma, support workforce capability and sector development.
- Identify and map emerging skills the existing and future workforce will need across the ten year strategy to future proof workers, promote retention and sustainability, and remain responsive and adaptive to ever-changing and increasingly complex social, political and economic landscapes.
- Ensure workforce development responds to co-occurring and intersecting needs, including mental health, psychosocial disability, maternal health, trauma, violence, abuse and neglect, housing instability and other experiences of disadvantage.

Data, evaluation and accountability

- Establish outcome measures that assess whether people with co-occurring needs experience improved access, continuity of care and longer-term outcomes.
- Measure whether referrals result in people successfully receiving appropriate support, rather than reporting only the number of referrals made, centring the consumer experience.
- Collect and report data on service exclusion, including exclusion associated with co-occurring mental health and AOD needs, psychosocial disability, abstinence requirements and digital barriers.
- Evaluate whether implementation is reducing fragmentation between mental health, AOD and psychosocial support services.
- Monitor continuity of care and safe transitions between hospitals, residential rehabilitation, community services, housing and homelessness services, custody and other service settings.
- Include measures relating to housing stability, sustained engagement, consumer experience and access to psychosocial support for people with co-occurring needs.
- Include qualitative evidence and lived and living experience feedback alongside quantitative service and outcome data.
- Disaggregate relevant data to identify inequities in access and outcomes, including for Aboriginal and Torres Strait Islander communities, culturally and linguistically diverse communities, young people and people living in regional, rural and remote areas.
- Use data to inform changing priorities and adjust rolling workplans to remain responsive to identified needs.

- Assign clear responsibilities, funding commitments, timeframes and performance measures to actions concerning the mental health–AOD interface.
- Require regular public reporting on implementation, including progress in reducing service fragmentation, exclusion and inequitable access to integrated mental health, AOD and psychosocial supports.

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Lilyfield NSW 2040

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T. 02 9060 9627
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W. mhcc.org.au