

RACGP supplementary submission

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

October 2025



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Introduction

The Royal Australian College of General Practitioners (RACGP) welcomes the opportunity to provide this supplementary submission to the inquiry into the health impacts of alcohol and other drugs (AOD) in Australia. In October 2024, the RACGP submitted its original contribution Submission 84 and provided evidence during the public hearing held in the previous Parliament. The RACGP welcomes the decision by the House Standing Committee on Health, Aged Care and Disability to reconsider this information as part of the re-referred inquiry. This supplementary submission builds on our previous input, identifying opportunities to strengthen Australia's response to AOD-related harms within general practice and across the broader health system.

The RACGP is the voice of general practitioners (GPs) across our nation, representing more than 50,000 members in our growing cities and throughout rural and remote Australia. For more than 60 years, the RACGP has supported the backbone of Australia's health system by setting the standards for general practice education, practice and continuous professional development.

GPs provide care across all stages of life, considering patients within their social, cultural, and environmental contexts. Every year, more than 22 million Australians choose to visit a specialist GP for their healthcare needs, making GPs the most accessed health professional in the country.¹ GPs play a central role in the continuum of AOD care, from prevention and early detection to treatment, recovery and long-term support. As the first point of contact for most Australians, GPs are often best placed to identify risky substance use, initiate sensitive and non-judgemental conversations and deliver evidence-based interventions. The ongoing, trusted relationship between a GP and their patients supports continuity of care, coordination with specialist and community services and effective management of complex conditions.

Summary of recommendations

We make several recommendations and opportunities throughout this submission which are summarised here:

Funding and system reform for AOD care in general practice

- Support longer consultations focused on managing complex and chronic health conditions by increasing Medicare rebates by 40% for all standard general practice consultations longer than 20 minutes (level C and D).
- Diversifying funding mechanisms to enable GP-led health services for disadvantaged communities, ensuring the delivery of person-centred, multidisciplinary care.
- Develop a federal dashboard of AOD services with access and coverage targets to improve transparency and equity.
- Support Healthdirect and state-based directories to comprehensively list all private, public, and federally funded AOD options, improving navigation for health professionals and the public.
- Support GPs to access AOD counsellors in-house, either through Primary Health Network (PHN) commissioning or Workforce Incentive Program (WIP) funding, ensuring these services are integrated within general practice and, where possible, delivered in partnership with the person's trusted GP.
- Establish clinical care standards and accreditation for AOD services to encourage close integration with mental health and physical health care and support general practices to provide comprehensive care.
- Institute specific Medicare item numbers or incentive payments for the assessment and management of substance dependence/use disorder, reflecting the complexity, duration of care required, to acknowledge GPs working in this area and encourage more GPs to take up this work.

Clinical guidelines and education

- Update and disseminate primary care clinical practice guidelines for AOD management, ensuring access to current, evidence-based resources and best-practice.
- Invest in RACGP-led guidelines and initiatives that strengthen prevention, early intervention and treatment within general practice.
- Provide ongoing education and skills development for primary care health professionals managing AOD-related issues and ensure that micro-credentialling does not create a barrier to providing services.
- Support the introduction of specific AOD education across all health professional training pathways to decrease stigma and improve expertise in the management of substance use issues.

Alcohol-related care and prevention

- Improve access to specialist liver clinic support for GPs and their patients to improve care for alcohol-related liver disease.
- Consider diverse models of care, including virtual care, and additional funding to support easy access to alcohol withdrawal for people with mild to moderate alcohol dependence.
- Increase funding for specialist AOD to increase access to specialist care for people with severe alcohol dependence and to support collaboration with GP services.
- Support GP education on alcohol dependence management, including prescriptions for relapse prevention and controlled alcohol use.
- Transfer naltrexone oral tablets 50 mg from streamlined authority to restricted access.
- Include disulfiram oral tablets and thiamine oral tablets on the PBS to improve affordability and access.
- Provide funding, education and support for GPs to undertake ongoing conversations with women of childbearing age about the risks of alcohol use during pregnancy and breastfeeding, helping to prevent Foetal Alcohol Spectrum Disorder (FASD).

Tobacco and nicotine dependence

- Support GPs with funding, training and referral options to address nicotine dependence in pregnancy and post-partum for pregnant people, parents and all householders.

- Subsidise short-acting nicotine replacement therapy (NRT) through the PBS to enable ease of access to combined therapy.
- Investigate the utility of cytisine for smoking cessation and support TGA and PBS approval as an additional smoking cessation medicine.
- Support from research into the efficacy and effectiveness of treatments for vaporised nicotine cessation.

Cannabis access

- The current quasi-medicinal model for cannabis is not working. Consider changing the approach to cannabis access with more regulated supply to adults that ensures separation of dispensing from the prescribing, prescribing limited to evidence-based clinical indications, and requirements for face to face prescribing .

Opioid dependence treatment and access

- Review how Medicare can better support the long-term management of opioid dependence treatment in the general practice setting
- Allow opioid dependence treatment to be exempt from the 12 month telehealth rule, similar to how hepatitis C and sexual health are exempt.
- Fund the administration of long-acting injectable Buprenorphine within general practice for GPs who choose to provide this treatment in their setting.
- Ensure vulnerable people experiencing opioid dependence can continue to access long-acting injectable buprenorphine in supportive settings by allowing access to funded medications outside the current PBS model
- Learn from international experience to develop models of care and access to opioid dependence treatment that minimise harm from high-risk medicines, including potent opioids.
- Include intranasal naloxone in the PBS prescribers bag list.

Additional comment

The RACGP acknowledges and supports the submission from the National Aboriginal Community Controlled Health Organisation (NACCHO) to this inquiry and echoes its recommendations, in particular 1,2,3 and 11.² The RACGP and NACCHO have a strong history of working in partnership and advocating for increased awareness of barriers to quality healthcare faced by Aboriginal and Torres Strait Islander people.³

Funding and system reform for AOD care in general practice

As the most accessed health professionals in the primary care health system, GPs are uniquely placed to provide comprehensive and coordinated preventive care. This helps keep patients out of hospitals and reduces pressure on other parts of the health system. Most practising GPs provide a wide range of preventive health services for their patients including AOD prevention and smoking and vaping cessation.¹ More than one-third (36%) of Australia's burden of disease last year could have been prevented by reducing exposure to modifiable risk factors, such as smoking or alcohol use. Many of these factors can be addressed in general practice, including through opportunistic care when people see a GP for a routine or unrelated matter.¹

Structural and funding barriers continue to limit effective AOD care in general practice. The current Medicare Benefits Schedule (MBS) privileges short consultations, despite strong evidence that longer appointments are essential for managing complex and chronic health conditions. Recent data shows the average length of a GP consultation has increased to 19.7 minutes, reflecting a long-term trend of increasing complexity in consultations.¹ Yet rebates decrease on a per-minute basis for longer consultations, financially disadvantaging GPs and patients who require time-intensive care. GPs routinely forgo the financial benefits associated with shorter consultation because high-quality care, particularly for patients with complex needs, requires time and continuity. (The [RACGP Pre-budget Submission 2025-2026](#) outlines the investment required to support longer consultation consultations)

Beyond financial disincentives, working with people with complex needs can be isolating, emotionally and cognitively demanding due to the limited access to specialist support and challenges navigating social services and allied health care. GPs cannot deliver this care in isolation. Complex conditions require coordinated, multidisciplinary responses that address the full spectrum of a person's health needs. GPs are well-positioned to serve as the central point of care coordination within such teams. However, current funding arrangements restrict the ability of Medicare-funded services to access complementary funding sources, thereby limiting capacity to deliver integrated, multidisciplinary care. Aboriginal Community Controlled Health Organisations (ACCHOs) provide a strong example of how diversified funding models can enable flexible team-based and culturally responsive care. GPs working in these settings report high levels of professional satisfaction. Extending similar flexibility to general practice through diversified funding streams, while maintaining access to Medicare, would improve continuity and equity of AOD care, particularly for people in disadvantaged communities and with complex conditions.

Fragmentation between primary care and AOD services remains a major barrier to coordinated, continuous and effective care. GPs frequently support patients whose needs span multiple systems, including AOD treatment, mental health, housing, and social services, but communication pathways, referral processes and funding streams are often misaligned. This lack of integration leads to duplication, delays, and service gaps, particularly for people with co-occurring health conditions or complex needs, those living in rural and remote areas and priority populations who already face barriers to accessing care. Effective integrated and shared care models reduce fragmentation and improve health system efficiencies.⁴ When transfers of care are handled well, patients feel informed and in control of their care. GPs have identified health system fragmentation and communication issues as the leading concern for the future.¹

There are GPs who have a specific interest in addiction medicine and who manage high caseloads of people with AOD issues. These GPs work across a range of settings, including general practice clinics, AOD withdrawal units, AOD residential rehabilitation services, and community health organisations. This expertise remains under-recognised and unrewarded within Medicare. Similar to the Medicare items that support GP engagement in mental health, recognising and supporting these practitioners, through specific item numbers or incentive payments, would acknowledge their contribution and encourage more GPs to take up this work.

Recommendations and opportunities

- Support longer consultations focused on managing complex and chronic health conditions by increasing Medicare rebates by 40% for all standard general practice consultations longer than 20 minutes (level C and D).
- Diversifying funding mechanisms to enable GP-led health services for disadvantaged communities, ensuring the delivery of person-centred, multidisciplinary care.
- Develop a federal dashboard of AOD services with access and coverage targets to improve transparency and equity.
- Support Healthdirect and state-based directories to comprehensively list all private, public, and federally funded AOD options, improving navigation for health professionals and the public.
- Support GPs to access AOD counsellors in-house, either through Primary Health Network (PHN) commissioning or Workforce Incentive Program (WIP) funding, ensuring these services are integrated within general practice and, where possible, delivered in partnership with the person's trusted GP.
- Establish clinical care standards and accreditation for AOD services to encourage close integration with mental health and physical health care and support general practices to provide comprehensive care.
- Institute specific Medicare item numbers or incentive payments for the assessment and management of substance dependence/use disorder, reflecting the complexity, duration of care required, to acknowledge GPs working in this area and encourage more GPs to take up this work.

Clinical guidelines and education

Guidelines are critical pieces of health infrastructure needed to support the delivery of evidence-based care. The RACGP takes an active role in the development and provision of evidence-based guidelines such as:

- [Smoking, Nutrition, Alcohol and Physical Activity \(SNAP\)](#) designed to assist GPs and practice staff (the GP practice team) to work with patients on the lifestyle risk factors of SNAP.

- [Prescribing drugs of dependence in general practice](#) a series of guidelines to help reduce risky, hazardous, harmful and dependent use of pharmaceutical drugs and associated harms.
- [Supporting smoking cessation guide](#) helps professional support patients to quit smoking through behavioural advice, pharmacotherapy and tailored interventions for diverse populations.
- [Guidelines for preventive activities in general practice \(Red Book\)](#) remain Australia's primary evidence source for preventive care. The Red Book includes chapters on alcohol, smoking, and nicotine vaping. Complementary guidance in the [NACCHO–RACGP National Guide](#) supports culturally safe and appropriate care for Aboriginal and Torres Strait Islander peoples.

Regular review and updating of these guidelines are critical to ensure they reflect new evidence and evolving patterns of AOD use. As evidence evolves rapidly, maintaining current guidelines has become increasingly challenging. Ongoing government support is essential to sustain the development, dissemination, and implementation of RACGP clinical guidelines. Investment must extend beyond publication to include education, quality improvement initiatives, and digital integration within clinical information systems.

Delivering high-quality, equitable AOD care depends on a confident, skilled, and well-supported primary care workforce. The RACGP curriculum includes a unit on [addiction medicine](#), providing registrars with the knowledge and skills to identify, assess and manage substance use disorders within a holistic, evidence-based framework. In 2019, the RACGP was funded by the Commonwealth to deliver a skills-based [Alcohol and Other Drugs GP Education Program](#) for GPs. This program successfully trained 3,042 GPs, illustrating the interest GPs have in investing in their AOD skills. Further investment in general practice education and continuing professional development (CPD) will strengthen the capacity to address AOD use across Australia.

Stigma remains one of the most significant barriers to treatment and recovery for people affected by AOD use. Discrimination, whether implicit or overt, can undermine trust, discourage help-seeking and perpetuate health inequities. Embedding trauma-informed, culturally safe, and anti-stigma principles across all health professional training pathways is essential for fostering compassionate, person-centred care. Education must also incorporate lived-experience perspectives to deepen understanding and empathy. Achieving this will require long-term change that includes modules of education through all phases of healthcare training from undergraduate through to postgraduate education.

Recommendations and opportunities

- Update and disseminate primary care clinical practice guidelines for AOD management, ensuring access to current, evidence-based resources and best-practice.
- Invest in RACGP-led guidelines and initiatives that strengthen prevention, early intervention and treatment within general practice.
- Provide ongoing education and skills development for primary care health professionals managing AOD-related issues and ensure that micro-credentialling does not create a barrier to providing services.
- Support the introduction of specific AOD education across all health professional training pathways to decrease stigma and improve expertise in the management of substance use issues.

Direct responses for alcohol, tobacco, cannabis and opioid

Alcohol-related care and prevention

Alcohol use is common and causes significant harm. GPs have the skills to provide prevention, early intervention, and ongoing management, as well as coordinate multidisciplinary care when needed for most Australians. Access to alcohol treatment is limited, with a wide range of presentations and needs across the population.

Access to care for people with liver dysfunction can be difficult, particularly in regional and rural areas where there is limited specialist liver support for GPs and their patients. Innovative options using telehealth support are occurring but require further expansion and investment.

For people who have developed alcohol dependence, easy access to safe and effective alcohol withdrawal care is essential for improving health outcomes. Withdrawal can be a high-risk time for medical harm if not appropriately assessed and managed in an environment suited to each person's needs. Mild to moderate withdrawal can be successfully managed for most people in the outpatient setting. GPs can deliver this care within general practice, supported by collaboration between the GP, practice nurse, and pharmacist. This usually involves daily review and medication management over a five-to-seven-day period. Virtual options can be appropriate for this group, and there are excellent examples of GPs and nurses successfully delivering this care across Australia with excellent outcomes (eg [Clean State Clinic](#)). People with severe alcohol dependence, however, are at risk of significant medical risks during withdrawal, including seizures, delirium, and death. This requires support from specialist AOD teams and inpatient admission to hospital.

Relapse prevention medications for people with alcohol dependence are underutilised in Australia. As a result, many GPs have limited experience prescribing these medicines. The recent Pharmaceutical Benefits Scheme (PBS) expansion of indications to include both abstinence and controlled use is an important addition. Naltrexone has few side effects and can be a highly successful adjunct to assist people in maintaining changes in alcohol use. It remains a streamlined authority script. Some GPs associate the authority process with riskier medications. It also puts additional administrative hurdles in the way of accessing this medication. Removing the authority process for naltrexone would make it more easily available.

Disulfiram, available on private script, has long been used in alcohol relapse prevention. While it is not a first-line treatment, it is a highly effective treatment for a selected group of patients, but its current cost limits accessibility. Including disulfiram on the PBS would remove cost barriers.

For heavy and dependent drinkers, Thiamine (Vitamin B1) oral tablets are a low cost and effective treatment for thiamine deficiency. While inexpensive, including thiamine on the PBS would remove cost barriers, particularly under Close the Gap, and flag this vitamin's status as an important medication.

Prevention of foetal alcohol spectrum disorder (FASD) is another key opportunity to reduce long-term harm. FASD is a preventable condition that causes lifelong disability and has significant impacts on individuals, families, and communities. GPs and primary care providers can initiate sensitive, non-judgemental conversations about alcohol use with women of childbearing age, including during pregnancy and breastfeeding. Providing funding, education, and clinical support for these preventive consultations would enable consistent, stigma-free care and help reduce the prevalence of FASD.

Recommendations and opportunities

- Improve access to specialist liver clinic support for GPs and their patients to improve care for alcohol-related liver disease.
- Consider diverse models of care, including virtual care, and additional funding to support easy access to alcohol withdrawal for people with mild to moderate alcohol dependence.
- Increase funding for specialist AOD to increase access to specialist care for people with severe alcohol dependence and to support collaboration with GP services.

- Support GP education on alcohol dependence management, including prescriptions for relapse prevention and controlled alcohol use.
- Transfer naltrexone oral tablets 50 mg from streamlined authority to restricted access.
- Include disulfiram oral tablets and thiamine oral tablets on the PBS to improve affordability and access.
- Provide funding, education and support for GPs to undertake ongoing conversations with women of childbearing age about the risks of alcohol use during pregnancy and breastfeeding, helping to prevent FASD.

Tobacco and nicotine dependence

Nicotine dependence drives ongoing use of both tobacco and nicotine products. While national daily smoking rates have declined, rates remain disproportionately high among disadvantaged communities and people who use AOD.⁵ These groups are likely to be highly nicotine dependent and need significant support to change their use. Many have a history of unsuccessful quit attempts and low confidence in their ability to change their use. GPs have a central role in asking about, advising on and assisting people with nicotine use, including providing behavioural support and prescribing pharmacotherapy.

Nicotine dependence in pregnancy and post-partum has significant risks to the foetus and baby, including exposure to second hand smoke from household members. This is an ideal time for behaviour change, acknowledging that pregnant people and their families need specific and ongoing support to successfully make and maintain this change. Supporting GPs with funding, training and referral options would have significant health benefits.

Evidence shows that smoking cessation is more successful with combined nicotine replacement therapy (NRT), using both short and long-acting products (ie patch and gum), when accompanied by behavioural support, compared to NRT monotherapy.⁶ Currently short acting nicotine replacement products are not available through the PBS. As a result, the cost of accessing combination NRT is prohibitive for the most vulnerable in the community.

Cytisine, a plant-delivered medication used internationally for smoking cessation is not yet approved by the TGA or available in Australia. Supporting TGA approval and PBS listing would broaden the armamentarium options available to support smoking cessation. The RACGP supports cytisine as an effective and generally safe prescription-only option for smoking cessation, noting moderate evidence for its success and mainly mild side effects.⁷

The use of vaporised nicotine liquid is an emerging issue in Australia. There is currently limited evidence to guide cessation strategies for vaping. It is possible that existing tobacco cessation options may have similar effectiveness, however this is currently unknown. Continued research and clinical guidance in this area is needed.

Recommendations and opportunities

- Support GPs with funding, training and referral options to address nicotine dependence in pregnancy and post-partum for pregnant people, parents and all householders.
- Subsidise short-acting NRT through the PBS to enable ease of access to combined therapy.
- Investigate the utility of cytisine for smoking cessation and support TGA and PBS approval as an additional smoking cessation medicine.
- Support from research into the efficacy and effectiveness of treatments for vaporised nicotine cessation.

Cannabis access

Medicinal cannabis use in Australia has increased significantly, in large part due to the proliferation of vertically integrated telehealth businesses. While some individuals may benefit, evidence for the effectiveness and efficacy across many conditions remains unknown. Medicinal cannabis is accessed by people with considerable overlap between medical and recreational use, with many using it as harm-reduction to reduce legal risk or to manage symptoms of dependence. There is a wide range of cannabis medications available, with varying potencies, making it difficult for GPs to assess the impact of specific products.

The current quasi-medicinal model for cannabis is not working. The Pennington Institute recently released a plan for the sensible reform of cannabis access in Australia.⁸ Such reform could help reduce the burden on the health system and medical products could be limited to those prescribed for evidence-based medical indications.

Recommendations and opportunities

- The current quasi-medicinal model for cannabis is not working. Consider changing the approach to cannabis access with more regulated supply to adults that ensures separation of dispensing from the prescribing, prescribing limited to evidence-based clinical indications, and requirements for face to face prescribing .

Opioid dependence treatment and access

Opioid dependence is a low prevalence but chronic and relapsing condition, yet it can be effectively managed through long-term treatment. In Australia, the main medications for opioid dependence include oral liquid methadone and high-dose buprenorphine formulations including Subutex, Suboxone, Sublocade, and Bupival. These medications, together with welfare and psychological therapies when needed, are highly effective. Even individuals with chronic pain who develop opioid dependence benefit significantly from these options. For treatment to be effective, it often needs to be prescribed long-term, often for many years.

Opioid dependence treatment can positively impact people's lives, yet many continue to experience other morbidities and social welfare issues. Programs that support reintegration training and long-term treatment are important. GPs play an important role in supporting long-term treatment and reintegration, and there is potential for broader involvement across the profession. This requires investment in training, leadership, and education, throughout secondary and tertiary education through to postgraduate levels, to build awareness of the multifaceted issues affecting people with opioid dependence.

GPs are successfully using virtual care to treat opioid dependence among patients in rural, regional, and remote areas, significantly improving access and outcomes. Under current Medicare arrangements, GPs are only funded for virtual consultations if the patient is seen in person once annually or is being treated for hepatitis C or sexual health. This forces many patients to travel long distances, sometimes several hours, for a single consultation. Many individuals with opioid dependence also face multiple health conditions that could be managed virtually. Even when opioid dependence is the sole focus, virtual care remains important and beneficial. The success of this approach was clearly demonstrated during the COVID-19 pandemic.

Patient engagement in opioid dependence treatment can be further supported through initiatives that make treatment easier to access and maintain. In 2018, the introduction of long-acting injectable Buprenorphine (Sublocade and Bupival) has supported increased access to treatment for a vulnerable group of people who were previously not able to access it. Many GPs have incorporated these injections into their practice, maintaining therapeutic relationships and enabling opportunistic care. However, while community pharmacists were funded in 2023 to dispense and administer opioid dependence medications, GPs remain unfunded to do so in their own settings.

Isolated cases of harm associated with potent opioids have begun to emerge. Unlike Europe and North America, which have experienced substantial increases in overdose deaths, Australia has not yet seen comparable rates. However, thousands of Australians die from overdose each year, highlighting the need to prepare and strengthen approaches to manage any future increase in opioid-related harm. Australia should learn from the experiences of other countries to develop models of care and improve access to medications that minimise harm from high-risk medicines, including potent opioids.

Naloxone is a safe effective emergency treatment for opioid overdose. It is available through the PBS and the National naloxone program as both injectable and intranasal formations. Currently only naloxone injections are available in the [PBS prescriber bag](#). The addition of intranasal naloxone to the prescriber bag, encourages GP access to this and flags this medication as a core emergency medication for GPs.

Recommendations and opportunities

- Review how Medicare can better support the long-term management of opioid dependence treatment in the general practice setting

- Allow opioid dependence treatment to be exempt from the 12 month telehealth rule, similar to how hepatitis C and sexual health are exempt.
- Fund the administration of long-acting injectable Buprenorphine within general practice for GPs who choose to provide this treatment in their setting.
- Ensure vulnerable people experiencing opioid dependence can continue to access long-acting injectable buprenorphine in supportive settings by allowing access to funded medications outside the current PBS model
- Learn from international experience to develop models of care and access to opioid dependence treatment that minimise harm from high-risk medicines, including potent opioids.
- Include intranasal naloxone in the PBS prescribers bag list.

Conclusion

GPs are central to Australia's health system and play an important role in addressing AOD-related harms. Strengthening general practice through sustainable funding, education and evidence-based clinical support will enable more equitable, coordinated, culturally safe, and effective care that meets patients where they are and draws on the full expertise of GPs. By embedding general practice at the centre of Australia's AOD response, governments can build a more integrated health system that supports the health and wellbeing of all Australians.

Thank you again for the opportunity to provide this supplementary submission to this important inquiry. For any queries, please contact qualitycare@racgp.org.au.

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