CONSULTATIONS STAGE 2 – VICTORIAN AOD STRATEGY

Consumer and family, carer and supporter views

February 2025

sharc

Self Help Addiction Resource Centre

Executive summary

The Mental Health and Wellbeing Division of the Victorian Department of Health engaged the Association of Participating Service Users (APSU) to gather perspectives from people with lived and living experience (LLE) of alcohol and other drugs (AOD), including family members and supporters.

Our community's feedback will inform Stage 2 of the Victorian AOD Strategy development, focusing on ideas and recommendations for improving the experience, access, and outcomes of treatments, approaches and services.

All the consultation participants, including family and supporters, are actively or previously engaged with services. This means that the feedback in this report is from people whose alcohol and drug challenges have significantly impacted their lives.

A complementary report expressing the views LLE workers in designated roles should be read alongside this report.

Access, choice and agency

Participants tell us that the Victorian AOD Strategy must address waiting times, the confusing intake system, service costs, and the fragmented and crisis-driven service model.

They say it is hard to find information about treatment and support options. They want a centralised digital information system that includes both federal and state-funded programs.

A narrowly focused and stretched AOD service system also hinders choice. We were told that after significant waiting times participants are generally only offered one option for treatment. People say that if they turn it down, they risk losing their spot on the list and being labelled ‘non-compliant' by clinicians. Some participants told us it was years before they were offered a treatment that met their and addressed their AOD challenges.

People also said that most GPs and general health professionals lack AOD training and don’t have the skills or information to support people seeking help for an AOD challenge. Peer-led walk-in and mobile services are options that participants recommended for improving access.

Support the whole person

The current service system is described as one-size-fits-all and "vanilla". Participants said they want services that better support co-occurring needs such as mental health challenges, ADHD and chronic pain.

More place-based, population specific and socially and culturally inclusive options are also required to support the diversity of people who use drugs, access services or are in recovery.

People said supports are required for addressing access barriers such as maintaining rental payments during treatment, arranging childcare or not having pet care while in residential rehabilitation.

Build community connection

Funding initiatives that help people build connections and community is considered a key priority.

> *"I heard somewhere where, you know, the opposite of addiction is connection. And so we need the government to get on board with that as well and, and not just throw more forms at us."*

Participants see peer led, community-based interventions such as supported housing, opportunities to discover new interests and hobbies, life skills support, family and individual therapy and assistance accessing training and employment as critical to rebuilding lives and ensuring treatments and supports, as having long-term health impacts.

> *“Once I left detox, I didn't have a drug problem anymore. I had a life problem.”*

Lived and living experience led navigation

Participants believe that LLE must be central to all aspects of AOD system reform.
This includes ensuring that our communities voices inform policy and service design and that people seeking services can connect with peers in designated roles who understand their journey firsthand.

A key recommendation is building peer navigation systems that provide consistent support from pre-contemplation through intake, while receiving treatment, and then when reestablishing lives back in the community. The approaches should also extend to people in the justice system. Parallel support for family and supporters also needs to be resourced and promoted.

Intervene early

Participants emphasised that the system must shift from crisis-driven to prevention-focused approaches. Early intervention opportunities in places such as workplaces and schools require evidence-based resources and education that include harm reduction strategies.

Health led public education campaigns are needed, alongside culturally specific community-designed initiatives. Youth prevention demands dedicated approaches, with families requiring better support tools.

Improving regulations for alcohol advertising and sales is also considered an essential early intervention strategy.

Most critically, treatment must be immediately accessible when help is sought. LLE led approaches are essential for dispelling myths, building understanding and supporting people to take the first step.

Tackle stigma and discrimination

The strategy needs to address stigma and discrimination in the community, services, workplaces, and schools. The dialogue must shift from treating AOD use as a moral failing towards ensuring people experiencing AOD challenges can exercise their right to receive a health response to a health issue.

> *"Our health issues are just as critical as people with diabetes, heart disease or cancer."*

Decriminalising the system and shifting resources to build better health and other supports is seen as an evidence-based approach to moving towards a health-led AOD service system that addresses stigma and improves outcomes.

Methodology

APSU recruited AOD service users in regional and metropolitan areas, their families and supporters. Three focus groups were conducted over the week of 3-7 February 2025 via Microsoft Teams.

Group 1 – Consumers living in regional areas: 10 participants

Group 2 – Consumers in Metropolitan Melbourne: 7 participants

Group 3 – Families and supporters (statewide): 7 participants

More detail about participant demographics is available in Appendix 1.

Participants were asked to comment on key questions to capture problems with the current system, examples of good practice, and ideas for improvement – See Appendix 2. Responses were captured and grouped into primary response themes.

Some ideas for improving policy and practice across the sector were gathered through the Questionnaire undertaken in Stage 1.

Focus groups with LLE workers were also conducted. These findings are included in a separate report.

Findings including ideas for change

There are six headline themes emerging from the consultations. They include:

- Tackle stigma and discrimination
- Intervene early
- Access, choice and agency
- Build community connection
- LLE navigation
- Support the whole person

Each section poses the problems outlined by the consultation participants and suggests actions and ideas for change.

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1. Tackle stigma and discrimination

> *"People with AOD challenges are still people, they just need help"*

Stigma and discrimination are consistently described as barriers to seeking and accessing AOD healthcare and other support. They are described as underlying causes AOD challenges as they impact on a person's ability to fully engage in community life, including finding work and accessing housing. They also contribute to social isolation.

Family and supporters are also impacted by stigma and discrimination, and people in regional and rural communities describe further impacts due to their privacy being compromised through living in a small community.

Stigma and discrimination are reinforced by a damaging public and media discourse. When government, legal systems, schools and other organisations attempt to approach AOD from any perspective other than strict abstinence and punishment for associated crimes, they are criticised as being “soft on drugs”. Participants express a strong desire to end the public moralising about AOD. Moving from a punitive response to a health response is consistently raised as a mechanism for addressing stigma and discrimination.

There are calls for public health campaigns to address stigma and discrimination. However, participants caution that past campaigns about AOD impacts often used language and imagery that perpetuated negative stereotypes. To avoid these mistakes, campaigns must be designed and developed by and feature people with lived and living experience. Real stories that dispel the myths must be featured.

GPs and other health professionals with the mindset to provide a health-led response are seen as a critical first step for reducing stigma. Addressing stigma and discrimination in schools and workplaces is also seen as a priority.

Being connected to LLE workers in designated positions, with a shared experience is also seen as important for confronting the stigma and discrimination people often feel when talking about their substance use challenges and accessing supports.

Ideas for change

1.1 Enact a cross-sectoral public policy response ensuring AOD dependency is viewed as a health issue, not a choice or moral failing. General and mental health; justice; jobs, skills and industrial relations; education; families, fairness and housing departments should be targeted. Recognise the role of regulatory settings in the AOD strategy as an enabler to address stigma and discrimination across the AOD sector.

1.2 Fund public health campaigns like those undertaken in mental health to reduce the stigma and discrimination associated with AOD challenges and build understanding that AOD dependence is a health issue. Schools, sports clubs, faith-based organisations and workplaces are important sites to target.

1.3 Embed stigma and discrimination education and training opportunities for health professionals and workers across general and mental health; justice; jobs, skills and industrial relations; education; families, fairness and housing.

1.4 At every point of engagement with AOD and other services and systems, offer people opportunities to engage with an LLE worker to assist with breaking down barriers to stigma and discrimination.

1.5 Develop a strategy to address stigma and reduce discrimination reduction strategy for Victorian health services and ensure people with experience of AOD challenges are meaningfully engaged in the drafting process.

1.6 Improve funding for peer-led organisations, programs and services so there is an alternate non-clinical relationally and socially focused support system.

1.7 Resource LLE organisations to empower people with LLE to advocate for addressing stigma and discrimination at system, service and community levels. This will ensure that real stories are available to dispel the myths.

2. Intervene early

Concerns were expressed that the Victorian AOD system is crisis-driven and not grounded in preventative models.

Workplaces and educational settings, including schools, TAFE colleges, and universities, are seen as important sites for early intervention. Evidence-based training and resources that can support sound policy and culture change and help people recognise, intervene, and offer support to someone experiencing an AOD challenge early are required in these settings. Recruitment and job agencies were also seen as important places for building awareness.

A greater focus on harm reduction is seen as critical to prevention. Early intervention support for people seeking to minimise harm is suggested as either a first step or a positive choice for managing risks and staying healthy. Improving regulations for alcohol advertising and sales was considered essential.

Public education programs are also seen as critical. Some pointed to high profile campaigns for problem gambling as an example of public education campaigns that emphasises the availability and desirability of seeking help.

It was also seen as important to consider population-specific programs that are designed by and target specific groups. These initiatives must be place based and target the nuanced needs of these communities.

Prevention for younger people is seen as key, and programs must be designed by and for that audience, with information that incorporates underlying causes such as anxiety, depression and isolation that can be the catalyst for AOD use. Participants noted there is a strong emphasis on sex education and career planning in schools, but little about AOD use. Families reported having trouble when supporting a young person with AOD challenges, recognising that forcing young people with AOD challenges into treatment won't work. Programs that support parents to understand and respond to AOD challenges in a young person from a harm reduction and recovery perspective that offers alternatives beyond abstinence were highlighted. Strategies for families and supporters to address their needs must be included.

Another strong theme was the need for access to treatment when a person identifies they need help and not having to wait for a crisis before a service is available.

Improving regulations for alcohol advertising and sales is considered an essential early intervention.

Having access to a lived and living experience worker who can provide support and advocacy is an important link in assisting someone to navigate the system, particularly if there is a waiting period to access withdrawal and or rehabilitation services.

Ideas for change

2.1 Develop and fund evidence-based education and training opportunities alongside population specific activities to build awareness, address stigma, and support people to access services. Building awareness of harm reduction strategies alongside recovery options was seen as critical, especially for families and supporters and educational facilities. Models such as Mental Health First Aid were provided as examples. Programs should target diverse audiences, including:

- GPs and health professionals
- Festivals and music and entertainment venues
- Educational settings

- Faith-based organisations
- Place based communities
- Prison and justice setting
- Community service providers such as homeless programs
- Job agencies
- Workplaces
- Justice and legal organisations and services

2.2 Increase focus on harm reduction activities. Suggestions for action include:

- Increasing access to Naloxone and needle and syringe exchanges
- Increasing the scope and impact of drug-checking services
- Providing more medically supervised injecting rooms
- The Department of Health (DOH) working in partnership with the Victorian Liquor Commission to improve regulation and compliance for alcohol advertising and sales and community access

2.3 Increase resourcing for the AOD system to ensure people can access services as soon as they request support rather than having to wait for their situation to become a crisis.

2.4 Resource and promote peer led training and supports for families and supporters assisting someone experiencing AOD challenges to recognise and respond to their own needs. Programs for parents in schools are seen as critical ensuring that they encourage parents to take a health led approach and understand how to communicate about harm reduction alongside understanding how to access services.

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3. Access, choice and agency

A complicated intake system, long waiting lists, and a fragmented treatment model further exacerbate challenging substance use. A shortage of public services has resulted in the growth of a private system that is expensive and significant growth in unregulated and unscrupulous un-registered private providers. These factors challenge people's ability to identify legitimate services offering evidence based care.

Services to address specific needs

Participants are clear that new and innovative programs are needed, but they also want increased funding for greater access to public services and greater scrutiny of non-evidence-based providers, whom they perceive as exploiting gaps in public services.

Diverse service types and place-based approaches are critical, particularly for people with AOD challenges who identify as First Nations, are from diverse religious or cultural backgrounds, or are gender diverse. More women-only services were also recommended.

A SHARC consultation undertaken with older Victorian service users was mentioned. The consultation highlighted that the existing service model in Victoria is designed for younger people and does not meet older people's specific, health, access and psychosocial needs. More access to specialised youth services is also considered a priority.

Consumers in regional areas express frustration at the lack of services available to them, noting that already limited spaces are often taken by people from Melbourne with AOD challenges, presumably because services in Melbourne are over-subscribed.

Participants note that, due to long waiting lists, they often have to take any services available, even when unsure the option suits their needs. Sometimes this means:

- going into considerable debt for a private service
- travelling away from supportive networks to access a service
- opting for a day program when they didn't have secure housing, making successful completion difficult, or only being offered a residential program that made it hard to meet their family responsibilities or risked them losing their rental property or getting into arrears on their mortgage while accessing services.
- accessing a service near a site where drug use is easily accessible, creating a risk for their recovery.

Participants also advise that intake providers often don’t consider barriers to access, noting that declining an opportunity led to being perceived as resisting treatment, often resulting in losing 'your place in the queue’. Several participants also raise the issue of having a pet to care for as a barrier to accessing residential programs.

Complicated intake and access

The intake process for AOD services is complicated and requires you to fill out forms, attend appointments and continually follow up services. This is hard for people in the depth of an AOD challenge.

Some suggested that access could be improved through better communication and support for people waiting for services. For example, people often miss follow-ups by service providers due to a reliance on phone calls that are often made at a time of day a person with AOD challenges is unlikely to respond to or from “no caller ID” numbers that a person with AOD challenges may not want to answer. Some participants may also not have access to a phone or credit.

The option for face-to-face intake options via walk-in services that don't require an appointment were suggested. Mobile service model options were recommended for regional areas.

A strong theme is the importance of services working together and sharing information, with participants reporting being re-traumatised having to tell their story multiple times at different stages of treatment, recovery and support. Participants also raise that at each of these stages people must have the opportunity to update their records to address any bias or outdated information that exists on their files.

There are also suggestions that removing the need for referral, and enabling the person with AOD challenges to self-refer, the process could be simplified providing greater choice and agency.

Limited information, limited choices

Participants highlight a dearth of accessible information on how to get support and the treatment options available. Some described accessing services for many years before hearing about or being offered programs and services that successfully addressed their AOD issues.

These access issues are often because the GP, clinician or intake provider they encounter preferences a particular approach to their AOD challenge, doesn’t know about treatment types or options available, or doesn’t consider specific access barriers for that individual.

Examples include:

- A young person only being offered harm reduction programs, when the program that had the most significant impact on their recovery was an abstinence-based rehabilitation program and Narcotics Anonymous.
- People getting dual diagnosis and treatment for their ADHD and substance use or their mental health and substance use after years of only receiving support for their AOD challenges.
- Someone only being offered pharmacotherapy when previously they had suffered from debilitating side effects and being told they were being non-compliant for refusing this treatment.
- A person requesting access to treatment close to family and community or in other locations to protect their privacy, or to move away from people who may impact on their recovery.
- Harm reduction not being offered alongside abstinence programs; discovering this option was described as a game changer for some people.

A centralised digital information system that includes both federal and state-funded programs is required.

Participants emphasise the need for options, not instructions, and for choice to be provided as early as possible. A “binary” response to a request for help is seen as not helpful and further removes agency, compounding feelings of powerlessness and marginalisation.

Participants highlight a critical need to educate clinicians across general practice, primary and tertiary hospitals, mental health and emergency services to identify AOD challenges, understand the treatments and supports available and provide person centred and stigma free support.

Knowing what to expect

Misconceptions and rumours about treatments and services can also hinder access. Not knowing what to expect from a treatment option or program can result in people not seeking support. Visiting and trying a program without committing to an extended stay is seen as beneficial, recognising that service providers would need to be remunerated for this to occur efficiently. Access to designated LLE workers who have used the service and can provide advice on what treatment or service will be like is also suggested.

> *"I definitely would have liked to have had some idea of what to expect. Answers from people who have been through their own related experiences would be ideal."*

> *"I was nervous to commit to a rehab which was maybe six months, It seemed too long and detox is not enough to recover, maybe like a shorter program like a rehab, maybe a four-week trial rehab where people can go and try it out."*

Participants also advise that it is important to know that treatments and programs don't always work the first time, and that dropping out or being removed from a program does not indicate a personal failing or should not be, a barrier to re-entry when circumstances change. They advise that sometimes the service offered does not address a person’s current needs, address the underlying causes of their AOD challenges or their circumstances may have changed.

Ideas for change

3.1 Strengthen regulation and compliance of private AOD treatment providers to ensure evidence-based care, transparent pricing, and ethical practices. Require accreditation, financial accountability, and integration with public services.

3.2 Increase public funding to improve access to treatment and reduce reliance on private providers and prevent exploitation of system gaps.

3.3 Undertake a population-specific and place-based gap analysis of Victoria's AOD system and services, and work with the LLE community to design new approaches for communities with specific needs that meet their access and other requirements.

3.4 Using codesign principles, develop a website and other promotional information designed for and by people with lived and living experience that provides clear, up-to-date information about Victoria's AOD system to help people living with AOD challenges, their family, carers and supporters, and clinicians and other support services to understand a person's needs and challenges, and to find out what treatment and supports are available. Ensure that the information includes both state and federally funded programs.

3.5 Review the current intake system to allow for a broader option of treatment types, more diversity of providers, improved information about what to expect when accessing a treatment or service, and more choice and autonomy for service users. Consider introducing options for self-referral.

3.6 Simplify intake, reducing the number of forms, and creating a 'tell us once' information system shared across systems that allows a person to access and update the information in their file. Create an online consumer portal allowing people to view and update information in their records and authorise sharing with other services, including with family and supporters.

3.7 Train clinicians across primary care, mental health and emergency services to be able to identify and respond to AOD challenges.

3.8 Introduce a peer led program where people seeking services can learn more about the treatment types available including harm reduction approaches. Opportunities to visit or try a service to see if it will meet their needs was also suggested. This could be delivered via a self-paced online program with videos of people describing the different treatment types available.

3.9 Introduce mobile and walk-in models for intake and information sharing that are LLE led, allowing people to discover treatment options, engage with peers, undertake intake to AOD services, and be referred to services in the AOD system and beyond.

3.10 Introduce a housing support program that helps people to maintain their rent or mortgage while they are receiving residential or day program treatment.

3.11 Offer options for residential supports where a person can bring their pets. Consider a grant program for day and residential programs to upgrade their facilities to accommodate animals.

3.12 Train AOD workers to help service users to unpack the narrative of ‘a treatment didn’t work and therefore I failed’. Ensure workers have the skills to support individuals to recognise that the model of support may not have been appropriate for where a person is at in their recovery and provide other options for support including harm reduction, other treatments or recovery models.

4. Build community connection

> *"there's an analogy I like to use where, you know, you can take a fish out of a dirty fish tank and put it in a clean tank and get it well again. But you put it back into the same dirty fish tank, it's going to get sick again."*

Housing insecurity and a lack of social support and community connections are identified as key risk factors for relapse, subsequent service contact and overdose.

The period after exiting withdrawal and rehabilitation programs and on release from a correctional facility are identified by our community and in current Australian and international literature as times of exceptionally high risk for people with AOD challenges. As such, the success of treatments including long stay rehabilitation and pharmacotherapy are compromised by a lack of supports in the community.

Participants described the challenges related to rebuilding their lives after treatment or on release from prison, especially if their old networks are unsafe or no longer supportive. Many have lost connection with family, stable housing, and the interests or friendships that once gave their lives meaning. They described long-term AOD challenges as often narrowing their worlds to finding, using, and being affected by drugs or alcohol, leaving little space for hobbies, work, family, wellbeing activities or community connection.

Community stigma and discrimination are further isolating factors making people feel reticent to engage in civic life. They also describe the need for supports to address stressors such as debt, health issues and family conflict, that could result in them not being able to maintain their life goals after treatment.

Without secure housing and a strong, supportive community, there is a risk of social isolation and relapse. Safe, stable accommodation and connection to new social networks and community activities and supports are essential to help rebuild lives and ensure that treatment programs have positive long-term outcomes.

Family and supporters also talked about the social isolation that they experienced, with little or no support offered or available to them. They advised that not unlike the person experiencing AOD challenges they need to rebuild their lives once the stressors of supporting someone with AOD challenges has been removed. It was noted that Carers Victoria is often the only option made available to families and supporters. Family and supporters said that they didn't feel like they qualified for the support of mainstream carer services.

Ideas for change

4.1 Fund peer led supported housing models that provide access to safe housing within a community of people seeking to change their lives and help each other. Additional supports such as life skills and counselling should also be part of the model. Ensure that the reforms related to the Royal Commission into Victoria's Mental Health Services Recommendation 25.3 which calls for 2,000 dwellings assigned to Victorians living with mental health challenges to be delivered as supported housing models are inclusive of people living with AOD challenges.

4.2 Build a framework for peer-based community activities for people who have experience of AOD challenges across Victoria that are affordable and accessible. The following activities and opportunities were suggested:

- Introductory sessions for people to try out new hobbies, interests or sports in a safe and supportive environment. When you find something, you like there are supports to join the club or class
- Opportunities to get back into nature and to visit new places
- Health and wellbeing support such as meditation, yoga, counselling, fitness and dental treatment.
- Supports to build life skills, achieve life goals or address psychosocial needs such as :financial counselling, learning to drive and cooking classes
- Supports to engage in education, find work or volunteer
- Introductions to and maintenance of recovery supports such as SMART Recovery and 12-Step Programs
- Skills building in consumer participation and opportunities to use your lived experience to change the system.
- Animal-based therapies that do not require pet ownership which is often unaffordable

4.3 Establish drop-in venues, both fixed and mobile, that provide a place to go for social connection, supports, and respite.

4.4 Expand and properly fund supports, structured activities and training for family and supporters in the community. Activities that run in parallel with the person they support's participation in rehabilitation and withdrawal programs was specifically highlighted. The programs should focus on:

- Respite
- Health and wellbeing activities such as complimentary therapies, yoga and meditation
- Recognising trauma and mental health impacts
- Building self-supporting community connections with other family and supporters
- Developing skills to support the person post-treatment with a focus on communication skills
- Providing psychosocial supports such as financial and general counselling, family therapy and housing support

One idea was a retreat-style program in nature. There were also suggestions for expanding the AOD supports offered through the North East Mental Health and Wellbeing Connect Centres to the other seven Connect Centres across the state.

Note: The importance of these programs being designed specifically for people with experience of AOD challenges and facilitated by people with LLE was emphasised. One participant described not wanting to be the "elephant in the room" when engaging in a group activity.

Some model examples

WA Recovery College - A self-directed, democratic approach to learning that fosters a sense of belonging and provides pathways to further education and employment. For more information click here

Banyule Council - A program to build connections beyond recovery. For a description of the program click here.

Oxford Houses - A supported housing model from the USA. SHARC have operated this model in Australia for the past 25 years. A 2017 evaluation of the program is available. Click here

Residential Support Services – An alcohol and other drug treatment service offering community-based housing and a day program for young people aged between 16-25 years who want to learn to live without using drugs. A program evaluation is available here.

The Forest - A model for a safe place where people leaving prison with experience of AOD challenges can go to access a comprehensive network of services, engage in meaningful activities, and find care and community. Information about the proposed model is available here.

Family, Drug and Gambling Help - A program of SHARC that provides a phone service, training and support groups for family and supporters of people supporting someone with an AOD challenge. More information is available here.

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5. LLE navigation

> *"I knew how to book a flight or buy a fridge but not where to get help [for AOD]!"*

As a result of the underfunding and system fragmentation described above, access to AOD services is often determined by whether individuals have an advocate, support person, or outreach worker. People without resources or representation are denied equitable treatment because the intake system is poorly designed, hard to navigate, and requires a person to engage with it consistently.

Due to this complexity, the people most in need of services often struggle to access support, and current funding models do not allow for the intensive support that people most at risk or in the greatest level of crisis require to navigate the system.

Other participants, particularly those with experience of the justice system, described the inability to access supports as a precursor to incarceration and sometimes overdose because of the desperation experienced through not being able to access services when they needed them most.

> *"By the time you wait for a government bed, it could be too late. You could be in prison, you could be dead by then."*

Participants identified the risks associated with not being able to get support you need when you are ready to take action. They identified a need for LLE navigators across the system to provide vital peer support, understanding, and guidance, helping people with AOD challenges navigate services, reduce stigma, and build hope for recovery.

Having access to someone to keep in contact with while waiting to access the system is described as a critical harm avoidance response. Continuing consistent support while people are accessing treatment, and then when you leave a service was also recommended. Having a similar support for family and supporters is seen as equally as important.

One participant cited the example of Beyond Bricks and Bars, an LGBTIQA+ peer led program service that provides direct support to trans and gender diverse people in prison, at risk of incarceration and those returning to their communities from prison as a model of LLE navigator support. According to the participant, having access to peer support for an indefinite period before they entered prison, while they were in prison and after release provided the scaffolding they required to heal.

Participants highlighted that peer-to-peer support is not the only priority for effective LLE navigation. Lived and living expertise must also inform the design, delivery, evaluation and improvement of all services and systems to ensure accessibility at every stage.

Ideas for Change

5.1 Establish an AOD peer warm line that can be accessed during the intake process, while waiting to access services, when people are receiving treatment, and when they have been optioned out and/or exited from services.

5.2 Establish a peer navigation program for people with limited resources or representation that can provide consistent navigation support for accessing AOD and other services supports, before, during and after treatment. The support should not be time bound, allowing people to access the program at any point in their journey when support is required.

5.3 Increase support to APSU at SHARC and Harm Reduction Victoria to build skills and broad representation in consumer participants outside LLE workforce. Ensure members are informed about opportunities to participate, and build both organisations' policy, co-design, and research capabilities to respond more effectively to consultation requests and resource a sector wide campaign to promote the APSU, VMIAC and Tandem Participation Registers. Provide peer-led education and training for departmental staff and partner organisations to improve the safety and quality of commissioned co-design activities.

Model examples

Beyond Bricks and Bars - a peer led community project that provides direct support to trans and gender diverse people in prison, at risk of incarceration and those returning to their communities, for more information - Click here

Q Life - Anonymous and free phoneline with webchat for LGBTIQ+ peer support and referral for people wanting to talk about sexuality, gender, bodies, feelings or relationships – Click here.

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6. Supporting the whole person

Participants are clear that AOD challenges cannot be fixed in isolation, and most advocated for person-centered and integrated responses.

Skilled AOD teams understand that a person with AOD challenges or addiction has a health issue and treats them accordingly. Unfortunately, many people with AOD challenges experience insensitive treatment and judgement from health professionals. This requires education, training and service standard changes to overcome.

A focus on addressing co-occurring health and social issues, such as homelessness, mental health challenges, trauma, neurodiversity, financial pressures and family violence was seen as important.

Access to psychologists, and trauma-informed practice specialists are provided as examples of impactful services for both consumers and family members and supporters. Yet, some respondents advised that the out-of-pocket expenses are prohibitive and unsustainable and many of the providers you are referred to do not understand AOD.

Some participants reported that if they had been listened to when they first sought help and issues beyond their AOD dependence were explored they might have avoided problematic AOD use later. A number of participants mentioned the importance of an earlier diagnosis of neurodiversity could have avoided years of self-medication to deal with symptoms.

Others suggested that having both a mental health challenge and an AOD challenge is a barrier to accessing comprehensive support with healthcare providers viewing you as too complex and resulting in you being passed between services.

A more appropriate response would be for services to meet with the person and work out what they need to support their wellbeing. This includes removing barriers to access medication for other conditions such as chronic pain, ADHD etc. Requests for medication can be viewed with suspicion by those prescribing out of a poor understanding of the difference between medication for a condition versus a drug of dependence.

Another participant outlined the problems associated with Medicare rebates that can take several weeks to process. For a person on a low or fixed income this presents a barrier to accessing treatment when there are insufficient funds to pay for the next treatment session while waiting on the refund from the previous one. It can also mean missed rental payments, or restrictions on food or energy use.

> *"I can't afford to wait two to three weeks for that [Medicare] money to come back"*

A model example

The Mental Health and Wellbeing Locals in Bendigo provide free mental health and well-being treatment, care, and support that does not require a medical practitioner's referral. People with AOD challenges can speak with a peer worker before engaging with services.

Justice and AOD

Participants consistently stated that criminalisation and incarceration are not the answer, and rather than a prison sentence, more people should have the option of accessing treatments such as long-term rehabilitation.

> *"Don't be so quick to lock people up. When someone goes to prison, that's it, you're building a criminal there!"*

Some participants who had experience of the justice system noted that remand and prison are opportunities to provide AOD treatment and support, but they are most often not available.

> *"So you could be linked in with AOD, youth, work, mental health, all the stuff and things in the world and be starting to move really far in your recovery. And then suddenly you do the wrong thing and you get locked up and then everything stops, everything drops off. And then when you get released, you have to start from square one."*

Victoria's Drug Court is cited as having a positive impact. The support of peer workers within this program is mentioned as a key factor in its ongoing success. It was suggested that AOD peer workers should be more available across the court systems.

Ideas for Change

6.1 Develop person-centred, trauma-informed approaches across treatment, recovery services and health and social care services which work with people with AOD challenges. Ensure funding is available for other supports including psychologists, family therapists and financial counsellors for people experiencing financial barriers.

6.2 Ensure services respond to the intersectional needs of the community. Provide greater access to dual diagnosis treatment programs such as mental health and ADHD and build supports across the system to address other social determinants such as financial issues, homelessness and family violence.

6.3 Ensure programs are place based and allow for population specific interventions to address the needs of diverse communities. Also ensure that workforces including the lived experience workforce reflect the communities they serve.

6.4 Ensure lived and living experience expertise is central to developing, designing and delivering treatment and recovery services, interventions and approaches.

6.5 Move towards decriminalisation. Divert people with AOD challenges away from the justice system and into treatment and support. Ensure that people with AOD challenges who encounter the justice system are provided with support. Expand access to peer workers in the justice system and expand access to the Drug Court.

6.6 We appreciate that solving the delays in receiving Medicare rebates is outside the scope of the Victorian Government. However, there is an opportunity to take this matter to the Health Ministers Meeting, of which Victoria is currently the co-chair, and seek a resolution through this forum.

6.7 Educate medication prescribers in how to adopt a stigma free approach to identifying whether a person with a medical history of substance use is seeking a prescriptive drug due to an AOD challenge or they require the medication to treat symptoms such as chronic pain, anxiety or ADHD.

Learning from the reforms in 2014

We want to highlight that many of the ideas suggested in this report are not innovations. They were available across the system before 2014 when reforms in Victoria significantly impacted the AOD system for people accessing services and working in the sector—notably smaller grassroots organisations.

Creating a centralised intake assessment system, reducing 30 funded treatment types to 6, significantly impacted program diversity and choice for service users, especially for community-led and peer-based programs. The reforms also resulted in a consortia model for managing intake, with larger, more established providers receiving most of the funding. This has impacted the viability of smaller, more flexible programs that often had greater capacity to innovate.

This long-term underfunding has resulted in a disjointed system patched together with insecure funding that doesn’t allow for:

- access and equity in service delivery
- program growth and innovation
- secure employment and professional development for sector workers
- a strong evidence base, particularly for community-based and lived experience-led programs

Burnout is a constant challenge within the sector, particularly for our lived-experience workforce committed to delivering impact in an underfunded sector. The sector also struggles to secure funding from the community and philanthropy due to the Australian community's entrenched stigmatised views of people who experience AOD health challenges and their family and supporters.

This submission presents a strong case for the need for peer-led, community-based programs. Our community tells us this approach works because access to community supports and workers who understand our experiences is what makes the difference.

Appendix 1: Participant demographics

Consumer/Service Users, Family Members, Partners and Supporters

DEMOGRAPHIC DATA - Individual	
Consumer	17
Family Member, Partner, Supporter	8
Metro/Greater Melbourne	8
Regional/Rural Victoria	8
DEMOGRAPHIC DATA - Identity	
Aboriginal and/or Torres Strait Islander	1
CALD	1
LGBTIQA+	7
Visible or invisible disability	8
Neurodiversity	6
Older person (over 45 years)	12
young person (25 under years)	1
DEMOGRAPHIC DTATE - Experience	
Criminal justice system,	13
Homelessness or housing stress	18
Co-occurring mental health and AOD treatment and support needs	25
TREATMENT HISTORY	
Currently in treatment	10
in treatment within the last 12 months	11
in treatment within the last 5 years	5
Never accessed services	

Appendix 2: Questions for the consumers, families and supporters

Focus area	Details
Prevention & Early Intervention	The people drafting the strategy want to hear your ideas on how to act early and prevent harm. Thinking back to when you first knew things weren't right, what would have made a difference in the lead-up or during this time?
Access to Services	In Phase 1 of the consultations, we constantly heard how difficult it was to access services. What would good access to services look like? What is required to make your ideas a reality?
Treatment & supports	What treatments and supports stand out to you as being effective? It could be something you have experienced personally, a treatment option you have heard about or something you wish existed. Tell us a little about why you chose to share this option/idea.
Community supports	Looking beyond direct treatment, what other supports and programs make a difference in people's lives? How can they best be provided? Note - Q4 was dropped in half way through the discussion so check recording for chat sequencing)
Final thoughts	What would be your number one small or big idea for creating change for you and others?