NATIONAL INQUIRY INTO THE HEALTH IMPACTS OF ALCOHOL AND OTHER DRUGS IN AUSTRALIA

Submission to the House Standing Committee on Health, Aged Care and Sport from the Self Help Addiction Resource Centre (SHARC)

December 2025

Contact: Clare Davies, CEO

E: info@sharc.org.au

T: 03 9573 1708

W: SHARC.ORG.AU

APSU
ASSOCIATION OF PARTICIPATING SERVICE USERS

sharc
Self Help Addiction Resource Centre

Acknowledgement of Country

SHARC acknowledges the Traditional Owners of the land on which our work is undertaken. Our office stands on the Land of the Bunurong people of the South-Eastern Kulin Nation. We pay our respects to Elders, past and present, and acknowledge them as the Traditional Custodians.

We also acknowledge the Aboriginal people who provided valuable insights in support of our submission to this inquiry.

Contents

About SHARC

Established in 1995, SHARC is a community of people impacted by alcohol, drugs and gambling, including family, friends and supporters. We transform lives, services and society through our community's lived experience.

We envision lived expertise at the heart of inclusive communities and services, where people proudly share their experiences and support one another in a society free from stigma and discrimination.

We create change by being ourselves, supporting one another, sharing our stories, exchanging knowledge, advocating, and building allyships.

Our programs are as follows:

- **Residential Support Services** provides peer-led housing and education models for adults and young people
- **Family Drug and Gambling Help (FDGH)** delivers practical peer support for family and friends including a phoneline, support groups and training
- **The Association of Participating Service Users (APSU)** is the Victorian peak body for Alcohol and other Drugs (AOD) service users and their family, carers and supporters; we train people to use their voices to change the alcohol and other drug and related systems and to work with organisations to safely and meaningfully engage with our 800 community members
- **Peer Projects** provides support to Victorian AOD peer workers. The Victorian Government funds us to deliver peer worker training, a Community of Practice, and supervision to peer workers. We also run organisational readiness programs to build the capacity of organisations to create safe, productive and enabling environments for workers
- **Peer Mentors in Justice** provide direct, one-on-one and group support to Victorian Drug Court participants. Drawing on their lived experience, our peer workers mentor participants throughout the program.

We also:

- Lead **The Collective**, a new consortium that provides workforce development opportunities for Victorian lived and living experience (LLE) workers across mental health and AOD. Other collaborators are Harm Reduction Victoria, Tandem, the Carer Lived Experience Workforce Network, and the Victorian Mental Illness Awareness Council (VMIAC)
- Auspice **Big Feels Club**, an informal peer support group of over 7000-plus folks described as a "discussion space … not therapy", and **the Australian Hub for Intentional Peer Support (IPS)**, internationally recognised training to examine and practice what is necessary to build mutual support. IPS is funded training offered to the Victorian Peer Workforce.

Voices Reflected in This Submission

This submission reflects the views of the following Victorians:

- **58 APSU community members**, through a consultation commissioned by the Victorian Department of Health to inform Stage 1 and Stage 2 of the drafting of the Victorian Alcohol and Other Drugs

Strategy. These consultations included people with experience accessing or attempting to access AOD services, family members, and supporters[1], and members of the LLE workforce in designated roles[2]

- **13 SHARC workers** employed in designated lived experience roles

All contributors bring lived expertise, either as LLE workers or as APSU consumer participants who receive training, support, and opportunities to intentionally use their experiences to inform policy, influence service design, and drive system change.

Language Notes

For clarity, consistency, and shared understanding, below are our definitions of key terms that have different meanings across the sector.

Recovery

Throughout this submission, we use the term recovery. It is a term many in our community often use to define ourselves. To us, recovery is a self-defined process of meaningful life change, which may or may not always mean abstinence from substance use, and we don't define recovery as finding a 'cure'. The essence of recovery is an experience of improved life quality and a sense of empowerment, with a focus on the central ideas of hope, choice, freedom, and aspiration.

Lived Experience and Lived Expertise

The terms lived experience and lived expertise are often used interchangeably in the AOD sector. At SHARC, we are intentional in how we use these terms and distinguish between them as follows.

Lived experience in the AOD context refers to direct, first-hand experience of alcohol and/or other drug use, harm reduction, withdrawal, treatment, recovery, including experiences as family members and supporters. Lived experience is shaped by social, cultural, legal, health, and service system contexts, and commonly includes experiences of stigma, discrimination, and barriers to service access.

Lived expertise refers to lived experience that has been intentionally reflected upon and applied to inform, influence, and improve peers' experiences, systems, services, policy, and practice. In the AOD context, lived expertise is developed through purposeful roles, training, reflective practice, peer support, participation in governance or advisory structures, and collective learning. It involves the ethical and safe use of lived and living experience to drive system change or support people to navigate the AOD system, rather than simply recounting personal stories.

Overview: What We Are Calling For

We are people with experience accessing or trying to access AOD services, as well as family and supporters. We are the ones navigating intake, waiting lists, treatment, relapse, recovery, housing instability, stigma, and system gaps—often at the most critical moments of our lives.

Our experiences make clear that Australia does not currently have a coherent, health-led AOD system. Instead, we see fragmentation, chronic under-resourcing, excessive waiting times, limited choice in treatments, supports and services. We are also impacted by a persistent reliance on punitive responses that cause preventable harm.

Too often, decisions about policy, funding, and service design are made without us, even though we are the people most affected. Nothing about us without us is not just a slogan—it is a necessary condition for effective, ethical, and evidence-based reform. National leadership must ensure that the full diversity of lived and living experience is represented, including people who rely on harm reduction supports, people seeking treatment and recovery-oriented supports, and the families, friends and supporters who walk alongside us.

The themes and recommendations that follow reflect what we know works because we have lived it. We are calling for a national AOD approach that recognises lived and living expertise, embeds peer leadership at every level, and ensures that both harm reduction and treatment and recovery perspectives are visible, distinct, and complementary at a national level.

We are calling for sustained investment, national governance reform, peer-led navigation and a supported and respected lived experience workforce. We also want systems and services that prioritise connection, housing, dignity, and choice. Our recommendations in this submission set out a practical pathway to build an AOD system that is accountable, inclusive, and capable of supporting long-term health and wellbeing. We urge governments to work with us—genuinely and in partnership—to design a system that reflects the realities of our lives and delivers better outcomes for all Australians affected by challenging alcohol and other drug use.

A full list of recommendations is provided in Appendix 1 on Page 35.

Theme 1: Nothing About Us Without Us

Who is better placed to inform, guide, and implement strategies to address alcohol and other drug–related harms than those with lived or living experience of them? Yet people with experience of using drugs and alcohol, and their family and supporters, rarely have a seat at the decision-making table.

> *"What is important is looking at what governance needs to look like over alcohol and drug in Australia and making sure that the right voices and the right people are around the table. We've never had a spot there to put forward what people with a lived experience are actually experiencing and what we know to work and what doesn't work."*

Effective solutions must start with—not simply include—consultation with LLE communities. Too often, policy and service design are developed *for* people rather than *with* them. For lasting change, LLE expertise must shape reform from problem identification through design, implementation, and evaluation.

We deserve a seat at the decision-making table, with the power to meaningfully influence the policies and services that affect our lives. Our strength lies in connection and trust, enabling innovation in recovery, harm reduction, workforce development, and systemic advocacy across community, service, and system levels.

Achieving this requires commitment to partnership and investment that recognises lived and living experience, used intentionally, as professional expertise. Doing this properly requires investment, co-planning, partnership, capacity building, and power-sharing.

To avoid tokenism, governance processes must elevate diverse LLE voices, including people engaging with different service models, at different stages of AOD engagement, and from diverse backgrounds and locations across Australia.

Lived and Living Perspectives are Missing Nationally

SHARC's contribution to this inquiry provides a unique LLE perspective within the national AOD system. Our community includes people who experience AOD use as challenging, and who have accessed, or attempted to access, withdrawal, treatment, rehabilitation, and recovery-oriented services, alongside their families, friends, and supporters.

This perspective is distinct from harm reduction, which is currently represented nationally by the Australian Injecting and Illicit Drug Users League (AIVL), the peak body representing people who use illicit drugs and people on medication-assisted treatment.

Both perspectives are necessary and often complementary, and it is essential that each is meaningfully represented in national policy and system-level decision-making. In Victoria, for example, across significant reforms including the recent consultations to inform the Victorian AOD strategy, both APSU and Harm Reduction Victoria were funded to consult their respective communities to inform the strategy.

Case Study: The Association of Participating Service Users (APSU) is the peak Victorian consumer body for people who use, have used, or are eligible to use alcohol and other drug (AOD) services. We include family and significant others impacted by AOD challenges. Established 25 years ago, we currently have over 800 members.

We believe that our community's needs, expertise and strengths should underpin the policies, systems, and services designed for us. That's why we provide opportunities for our members to advocate for the issues that matter. Through our training, resources, and peer-led activities we empower our community to shape the debate around AOD and create change for all of us.

APSU also enables organisations to embed lived and living experience safely and meaningfully by connecting them with trained and supported consumer participants and supporting inclusive, well-designed participation processes. APSU also provides organisational readiness support, facilitates co-design and consultation, prepares participants to share their expertise safely, and manages participant payments, including advice on fair remuneration.

Defunding the National Indigenous Drugs and Alcohol Committee (NIDAC)

NIDAC had been part of the Australian National Council on Drugs, providing leadership on Aboriginal and Torres Strait Islander (ATSI) perspectives on AOD at senior levels of government. While the former Commonwealth Government ultimately included the Chair of NIDAC on the Australian National Advisory Council on Alcohol and Drugs (ANACAD), defunding this important peak body reduced community representation on ATSI issues.

National Governance Needs Reform

The absence of key LLE perspectives from national decision-making is reinforced by the lack of a coherent national governance structure for AOD. There is currently no mechanism to sustain dialogue among LLE leadership, the AOD sector, different tiers of government, funding and commissioning bodies, and other intersecting systems. This void in national governance has been particularly evident since the Council of Australian Governments (COAG) and its subgroup, the Ministerial Drug and Alcohol Forum (MDAF), ceased in 2020. We support the many submissions to this inquiry calling for the reinstatement of a national governance structure.

Any renewed national governance framework must meaningfully embed lived and living experience. This includes strong LLE representation at the national table and the establishment of a standalone LLE advisory committee with formal representation on a ministerial advisory committee. Such a structure would enable a diversity of LLE voices to inform policy and system reform, rather than relying on the common approach of a single, tokenised lived experience position within predominantly clinical or professional committees.

We also support the establishment of a dedicated ministerial portfolio for alcohol and other drugs. This portfolio should carry explicit responsibility for ensuring AOD policy and practice are inclusive of diverse lived and living experience perspectives and are health-led, rather than justice-led, and grounded in human rights.

Recommendation 1.1 In partnership with the states and territories, invest in the establishment and sustainable resourcing of a national LLE AOD peak body that represents people who experience AOD use as challenging. This includes people who have experienced addiction, and who have accessed, or attempted to access, withdrawal, treatment, rehabilitation, or recovery-oriented services, including their families and supporters. This investment should sit alongside existing harm-reduction representation, ensuring both perspectives are visible, distinct, and complementary within national AOD policy, system reform, and service design. Dedicated state-level funding for LLE-led consumer participation peak bodies—both AOD and harm reduction—should also be supported. This would ensure safe, supported, and meaningful engagement that moves beyond consultation toward shared decision-making in AOD policy, system reform, and service design.

Recommendation 1.2 Work with Aboriginal and Torres Strait Islander AOD leaders and communities to re-establish a national voice on AOD and harm reduction guided by truth telling and self-determination principles.

Recommendation 1.3 Adopt a new national AOD governance framework that supports integration of activity between levels of government and the AOD sector. The model must include an LLE advisory function where power is shared and a broad representation of LLE perspectives is accommodated.

Recommendation 1.4 Establish a ministerial portfolio focused on drug and alcohol policy with responsibilities that include ensuring alcohol and other drug policy and practices are inclusive of LLE, health-led, and human rights-based.

Theme 2: Chronic Under-Resourcing and Policy Failure

There is no coherent AOD ‘system’. What we have today reflects years of policy neglect and the persistent under-prioritisation of alcohol and other drug challenges as health issues. The result is a fragmented, underfunded sector struggling to meet the needs of Australians who deserve better.

Within current funding settings, implementing evidence-based models of care is impossible: as funding reduces, so does integrity to the evidence-base. What we know works; we often can't fund correctly because funding is unavailable. There is no funding to trial new approaches, scale successful models, or rigorously evaluate and improve existing programs. As one sector leader put it:

> *"The system is currently very vanilla. We keep doing the same things over and over again because there is no funding for innovation, and no funding to evaluate the same programs that we have been rolling out year after year."*

Meanwhile, the AOD sector faces mounting financial pressure from inflation, award wage increases, and the urgent need to invest in service infrastructure. Yet long-term, sustainable funding remains elusive, and current arrangements fail to keep pace with rising costs. Services are forced to do more with less, patching together funding from multiple sources, including scarce philanthropic contributions constrained by stigma and discrimination towards people who use drugs.

Cost-driven, clinically dominated decision-making continues to prioritise the cheapest options—such as day programs and Cognitive Behavioural Therapy (CBT)—at the expense of people without safe housing or social support. These approaches fail those who need intensive, flexible, and relational models of care, where secure housing and community connection are often the essential first steps.

As the real value of investment in AOD treatment declines, access to support is reduced for Australians who need it most. The LLE workforce reports growing pressure, job insecurity, and burnout. The cumulative impact is a system that too often fails to provide continuity, dignity, cultural safety, or the conditions required for sustained recovery and wellbeing.

Recommendation 2.1 Commit to long-term, sustainable funding arrangements for AOD services, including multi-year contracts of at least five years, transparent and timely indexation linked to CPI, Fair Work wage determinations, and streamlined renewal processes to ensure continuity of support. Funding models must keep pace with the actual cost of service delivery.

Recommendation 2.2 Establish a dedicated national AOD innovation, evaluation, and translation fund to enable trialling, scaling, and rigorous evaluation of evidence-based and peer-led models of care, including community-led recovery and harm reduction initiatives.

Theme 3: Intake for the Resourced, Not Those in Crisis

The current intake model in Victoria is confusing, inflexible, and resource-heavy, favouring those with time, literacy, confidence, and support while excluding many of us with the highest needs.

> *"I was just kind of handed off from one stage to the next with no idea what was going to happen, but more importantly, no idea what was expected of me. I'd finish with one worker and say goodbye to them forever before showing up somewhere new at my 'next stage' where I would meet a new set of people to process while they process my demographic information. You have to really want something to sit through the hours of forms and assessments required, especially when the assessment becomes invalid because you've been waiting so long for a space in your next environment."*

Access to AOD services is often determined by whether you have a family member, advocate, or outreach worker who can help you navigate the system.

> *"Because of the hoops and steps that people have to navigate, you essentially needed to have the resources or support or phones or the time to remember appointments to call, or answer the*

phone and then go to the next one and then the next one to be referred somewhere, which just means the accessibility of our services for people who most need access to them in the AOD sector has been so challenging."

"Those without support are too often denied equitable treatment because the system demands repeated engagement, complex administration, and persistence at the exact moment when someone may be in crisis."

"If you don't have a supportive family or network or an outreach worker from a community service, it is near impossible to navigate the process when your AOD challenges are at their peak."

These barriers are especially harmful for those of us facing intersectional disadvantage, including financial hardship, homelessness, and criminalisation.

"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."

Social, psychological, and economic conditions in our lives—relationships, housing, work, and health—impact access to AOD treatment in ways that aren't acknowledged by services or policymakers.

People need support to address access barriers, such as maintaining rental payments during treatment, arranging childcare, or arranging pet care while in residential rehabilitation.

Excessive Waiting Times and Missed Windows for Change

Accessing services such as withdrawal and rehabilitation programs is met with long waiting times. Our community reports delays of up to three months for withdrawal services and six months for rehabilitation.

Service use statistics in Australia support our communities' claims. A recent analysis estimates that in 2022-23, only 30 per cent to 49 per cent of those who could benefit from treatment received it[3]—a gap that leaves up to half a million people without essential support every year.

The impacts of not getting access to services were described by our community as severely detrimental to their health and wellbeing:

"I waited approximately ten months for a bed. This protracted wait time was traumatic when I was at my most desperate. When I relapsed, the wait times for detox were similarly distressing. Given what we know about the stages of change, reducing [barriers to] access to these and all types of intervention is required so that a person can turn readiness for change into recovery. Motivation is not infinite, and people die on these wait lists."

"It is bad to make people [wait] months to get into one, and the risks of not getting in include: severe health problems, possibly fatal, people continue using and get sicker and/or die, they need to get a supply of the drug they are withdrawing from which makes people very vulnerable to extremely poor health/mental health, poverty, homelessness, violence, crime (doing crime and/or being the victim), etc."

We know these access issues are not just experienced in Victoria, and we are also aware that people regularly uproot their lives and travel interstate to access treatment when nothing is available in their own state. Intake and waiting times are a national crisis that requires a national approach. Yet one of the key national mechanisms, the National Alcohol and Other Drug Hotline, is never mentioned as a resource that our community accesses and has been described as ineffectual by our workforce.

Learning from the 2014 Reforms in Victoria

Our community also wants to ensure that any national approaches to AOD service delivery learn from the reforms introduced in Victoria in 2014, which have had long-term detrimental impacts.[4]

Through these reforms, a centralised intake assessment system was introduced, reducing 30 funded treatment types to six, significantly impacting program diversity and choice for service users—especially for community-led and peer-based programs. The reforms also led to a consortia model for intake management, 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.

With the intent of streamlining intake processes, the reforms significantly reduced funded treatment options, resulting in smaller peer-led programs being subsumed. According to our community, the key impacts of these reforms include:

- Limiting in-community support: supported accommodation models and community-led programs were defunded, creating a considerable risk of relapse for those re-entering the community after leaving rehabilitation without secure housing and/or family support.
- Reducing in-service choice: funding for residential rehabilitation models was decreased due to cost considerations, with government funding favouring less expensive options such as CBT in day programs and pharmacotherapy.

"While day programs provide a more flexible model for people with strong community support, others need more intensive residential support, such as those detoxing from methamphetamine and those without support networks."

Recommendation 3.1 In partnership with the states and territories, prioritise redesigning AOD intake, assessment, and referral systems, including the National Alcohol and Other Drug Hotline, so they are functional and effective, and accessibility is improved during periods of crisis. The redesign should focus on simplifying pathways, increasing assertive outreach, peer-led navigation, and reducing administrative burden. This must include practical supports that enable access and continuity of care—housing and tenancy stability, income support continuity, childcare, pet care—so engagement is not dependent on personal resources, system literacy, or informal advocacy.

Recommendation 3.2 Set national benchmarks and accountability mechanisms to reduce waiting times for withdrawal and rehabilitation services, recognising that delays result in preventable harm, relapse, and death, and readiness for change is often time limited.

Recommendation 3.3 Ensure any national approach to AOD service delivery learns from and avoids replicating the Victorian AOD reforms introduced in 2014, which significantly reduced service diversity, undermined community-led and peer-based programs, and weakened in-community supports.

In particular, national reforms should:

- Reject overly centralised intake and assessment models that limit treatment pathways and concentrate funding within large consortia, at the expense of smaller, community-based, and peer-led services.
- Protect and fund a diverse mix of treatment models, including supported accommodation, community-led programs, and residential rehabilitation, recognising that different people require different levels and types of support.

- Ensure funding settings do not only privilege low-cost interventions, such as short-term day programs or pharmacotherapy, where more intensive residential or in-community supports are clinically and socially necessary.
- Embed safeguards for innovation, choice, and continuity of care, particularly for people without stable housing and family support.

Theme 4: The Missing Link is Peer-Led Navigation

A consistent theme across all our consultations is calls for LLE navigation models. People want flexible, non-time-bound, peer-led support at every stage of their journey, from when the need for support is first identified, to during intake, while waiting, in treatment, and after exit. Families, friends and supporters also need LLE-informed tools and guidance for navigating the system.

Access to workers who will not judge, and who can help navigate the system, can be the difference between giving up when services are unavailable, and staying connected when feeling isolated, unsupported, or at risk of relapse.

> "There can be an interim of six weeks where we're waiting … that's when you think you've made the wrong decision and start using again."

The AOD peer workforce community also strongly advocates for flexible peer navigation models that allow long-term engagement across service transitions.

> *"Relationships are more important than KPIs … focusing as peers on the relationship rather than on KPIs."*

They describe frustration with short service episodes that disrupt trust and continuity.

> *"We build such a rapport and then they move on … it's sort of broken."*

There is a desire to continue supporting people beyond discharge, including during relapse and re-engagement.

> *"I want to help people if they leave our service and relapse. I want to be able to continue supporting people when they are back in the community. That is a hard time."*

Access could also be improved through better communication and support for people waiting for services that address the complex access needs of those with AOD challenges.

Misconceptions and rumours about treatments and services can also hinder access. Access to peer navigators who have used a service and can provide advice on what treatment will be like is 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."*

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

Case study: Flat Out Inc's Beyond Bricks and Bars[5] *is a peer-led, trauma-informed project providing continuous support to trans and gender diverse people before, during, and after incarceration—shared by community members as an example of the kind of long-term LLE scaffolding they want to see adapted for AOD navigation.*

Recommendation 4.1 Update national AOD strategies and review the National Treatment Framework to embed LLE-led peer navigation. The National Drug Strategy, National Alcohol Strategy, and National Framework for Alcohol, Tobacco and Other Drug Treatment must formally recognise and fund flexible, peer-led navigation models as a core component of harm minimisation and treatment systems.

Recommendation 4.2 Include non-time-limited peer navigation and warmline services that support people, families, and supporters across intake, wait periods, treatment, discharge, relapse, and re-engagement. These should operate across AOD, mental health, housing and justice systems and be governed by people with LLE experience.

Theme 5: Choice, Flexibility and Self-Determination in Treatment

Choice is essential to effective AOD support, yet the current system offers too few options and often forces people into models that don't meet their needs or reflect their circumstances.

"It was years before I was offered something that finally met my needs."

A survey with 29 community members highlighted a wide range of services that were helpful in the past. The results show clearly that no one-size-fits-all model exists, and that people need different supports at different times, including:

- Long-term government-funded residential rehabilitation
- Peer-led supported accommodation
- Day rehabilitation for people with family or work responsibilities
- Harm reduction: naloxone, drug checking, supervised injecting rooms and overdose phonelines
- Peer-led abstinence programmes (AA, NA) and SMART Recovery
- Integrated mental health and trauma therapies such as EMDR and access to psychologists beyond the 10 sessions funded through mental health treatment plans
- Outreach and drop-in centres that do not rely on appointment-based access
- Bilingual and culturally specific programmes

Across all settings, a consistent theme emerged: peer-led or peer-supported services were preferred for their relevance, empathy, and trustworthiness.

"I listened to her because I trusted her and knew she had similar experiences to mine."

Limited choice can often be due to encountering a GP, clinician, or intake provider who prefers a particular approach, not knowing about available treatment options, or failing to consider specific access barriers. 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 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 were 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 their recovery
- Harm reduction strategies not being offered alongside abstinence programs—discovering this option was described as a "gamechanger" for some people

Many express concern that the lack of resourcing also leads people to accept a treatment type or service model they know does not suit their needs. A key issue is people being placed on pharmacotherapy or being offered it due to the absence of available rehabilitation beds. If they refuse treatment, it is often seen as noncompliance. According to our community, this approach undermines self-determination and potentially breaches human rights.

Another key driver of poor access and choice is the limited information available to both service providers and service users about treatments and services across Australia. A centralised information system is required to provide information on harm reduction, treatment types and services across federal- and state-funded programs.

Recommendation 5.1 Embed choice, flexibility, self-determination, and innovation as core requirements of AOD treatment commissioning and practice. AOD funding, commissioning, and intake processes must support genuine choice across harm reduction, treatment, and recovery pathways, including peer-led, culturally specific, and place-based options. This must include dedicated funding for innovation, piloting and scaling diverse service models, safeguards against default or coerced treatment due to system constraints, recognition of people's right to refuse or change treatment without penalty, and support for blended and staged approaches that respond to people's changing needs over time.

Recommendation 5.2 Fund a national, publicly accessible digital database that provides clear, current, culturally appropriate and non-stigmatising information on alcohol and other drug (AOD) use, harm reduction, treatment, and recovery and psychosocial and community supports. The database—co-designed and governed with people with LLE—should clearly describe what services offer, how to access them, costs, who they are for and the quality standards they meet.

Theme 6: AOD Recovery Without Connection is a Systemic Blind Spot

Loneliness is a national issue connected to challenges with alcohol and drug use. Peer-reviewed evidence supports this,[6] with estimates suggesting loneliness costs the economy $2.7 billion per year.[7] Research indicates our community is more likely to be lonely than others.[8] Isolation is associated with chronic disease, mental health issues and lower quality of life[9] as well as suicide.[10]

"Once I left detox, I didn't have a drug problem anymore. I had a life problem."

Current AOD services prioritise narrow clinical outcomes while neglecting what truly strengthens us—community connection. After treatment, we are often left to navigate complex recovery journeys alone, without sustained support for housing, employment, learning, and social engagement.

"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 not just throw more forms at us."

Our community faces isolation when we need connection most. Isolation directly impacts our health, increasing risks of overdose, relapse, chronic disease, mental health issues, suicide, and service contact.

"Where are the supports to transition back into the community when the government has just spent a bomb supporting me in rehab? Where's the safe, affordable accommodation? Where's the community and peer support around me?"

Investing in Peer-Led Places and Activities

When we talk about community connection, what we mean is having people around us who understand us. It's about finding our place within our communities —joining activities, building skills, and developing relationships.

"I'm a big fan of groups—find an activity that you believe will bring some people out and make it happen! Having something to do and someone to do it with is possibly the most underrated weapon against poor mental health and the often-resulting substance dependency."

Ensuring opportunities for community connection is a well-established funding priority for governments at all levels; for example, men's sheds, community houses, youth programs, and sports. However, these mainstream services can be hard for us to access due to the stigma and discrimination we often experience when accessing mainstream programs.

That's why access to programs that target people with experience of AOD use and are facilitated by people with lived and living experience is important. Yet in Victoria, funding for community connection programs has been systemically defunded over decades. And nationally, the National Framework for Alcohol, Tobacco and other Drug Treatment 2019–2029 does not include community connection programs as part of the service system.[11]

Through consultations, the following peer-led activities and opportunities are identified as critical:

- Introductory sessions to try new hobbies, interests, or sports in safe and supportive environments, with support to join clubs or classes once interest is established
- Opportunities to reconnect with nature and visit new places
- Health and wellbeing supports, including meditation, yoga, counselling, and fitness
- Support to build life skills, achieve personal goals or address psychosocial needs, such as financial counselling, learning to drive and cooking classes
- Support to engage in education, employment, or volunteering
- Introduction to, and ongoing connection with, recovery supports such as SMART Recovery and 12-step programs
- Skill-building in consumer participation and opportunities to use lived experience to influence system change
- Animal-based therapies that do not require pet ownership, which is often unaffordable

"The thing that helped me most on my recovery journey was a session with peers that included boxing and creative journal writing. The boxing helped me deal with my anger, the writing helped me express my trauma, and the people I met with every week helped me overcome my isolation. They are still my close friends."

Recommendation 6.1: Include initiatives to rebalance AOD policy towards community connection in the next iteration of the National Drug Strategy. Prioritise fostering strong social networks and inclusive LLE led environments as vital components of prevention, harm reduction, and recovery. Explicitly grounded in a human rights-based and peer-led approach, the initiatives should feature:

- Funding for peer-led social connection activities
- Emphasis on the role of family, friends, peer support groups, and local community organisations in providing practical and emotional support
- Establishment of key indicators for government policy and services to measure community connection outcomes
- Strong links to existing lived experience initiatives
- Provision of new models of care to guide future investment in peer-led initiatives
- Strategies to reduce stigma and facilitate meaningful engagement

Theme 7: Recovery Needs a Home

Without a home and meaningful connection, people are left isolated, at high risk of relapse and overdose and, for some, incarceration. Many people in our community describe being abandoned after treatment without safe places to recover and heal.

"In my own experiences, I found the complete lack of aftercare made it almost necessary to return to my old habits. Because I had no other connections, the only alternative was to be completely alone all of the time."

A safe home, alongside people who can support recovery goals, is widely recognised as essential to sustained recovery following withdrawal and rehabilitation programs. For this reason, our community consistently describes the lack of safe, secure, peer-led housing and community support after treatment as one of the most critical failures of the AOD system. Community members report that when they have access to peer-led supported accommodation with others in recovery, they gain not only safety and accountability, but also a strong sense of belonging and purpose.

"I've always found the sober living residences to be an effective stepping stone for people coming out of rehab or incarceration. These residences not only add a clear level of accountability to a person's recovery plan, but they also add social connections, community and a place to belong which I often cite as my main reasons for relapse."

Research supports these insights: housing insecurity and social isolation are proven risk factors for relapse, repeat service contact, and overdose.[12] Risks are described as exceptionally high during the transition periods after withdrawal, rehabilitation, or release from justice settings.

"Where are our supports to transition back into the community? Where's our safe, affordable accommodation? Where's our peer support community around us?"

Yet peer-led supported residential models remain almost entirely unfunded in Australia, despite their proven impact. In Victoria, there are no government funded adult peer-supported residential programs, and only two youth programs remain—both at risk due to their reliance on philanthropy. High demand and limited resources means providers are stretched, and essential models go underutilised or unevaluated. There is limited data on their success, so they are often not considered when assessing treatment models.

Case Study: How Safe, Supported Housing Changed Jim's Life

SHARC's Recovery Support Services (RSS) is an alcohol and other drug support service offering community-based housing and a day program for people aged 16 to 25 who want to learn to live without using drugs. Jim is a recent participant in the program.

Jim entered RSS at 23, an experience he says changed his life. He left home at 12 due to family violence and experienced homelessness from then on, alongside escalating substance use, involvement with the juvenile justice system, and placement in residential out-of-home care. By 14, methamphetamine use had led to drug-induced psychosis and multiple psychiatric admissions. He had not seen his family since leaving home.

After hearing from peers in juvenile justice that SHARC was a place of support, Jim contacted the service and entered RSS with little hope for change—his primary goal was to feel safe. During his time at SHARC, he lived in safe, affordable accommodation. He participated in a five-day weekly program, including peer support groups, case management, and access to professional mental health support.

Jim gradually built strong recovery relationships with his peers, engaged in 12-step groups, and took on increasing responsibility. After six months, he became a senior resident and enrolled in a Certificate III in Horticulture. After nine months, with the support of his peers and his key peer worker, he began reconnecting with his siblings.

Jim now lives with recovery peers in transitional accommodation through SHARC's Oxford Houses Program.

**Name has been changed*

Providing Housing Stability During Withdrawal and Rehabilitation

People entering withdrawal and rehabilitation programs are often required to step away from employment and income or utilise their government payments to access services for extended periods, placing pressure on their ability to maintain rent or mortgage payments. Without targeted housing assistance during treatment, people often make the choice to refuse treatment or are forced to relinquish stable housing at the very point they are seeking to stabilise their health. This creates a predictable pathway from treatment into housing insecurity or homelessness.

Housing instability on exit from treatment significantly undermines recovery outcomes. For some, returning to unsafe or unstable accommodation increases exposure to previous networks, environments and stressors associated with substance use, heightening the risk of relapse and disengagement from ongoing care. As one family member shared:

> *"When my son entered rehab, he had to give up his rental accommodation because he didn't have enough money to maintain the lease. When he left rehab he didn't have secure housing so he went back to his old networks who offered him a couch to sleep on. This accommodation wasn't safe, so he relapsed."*

Providing rental, mortgage and housing assistance during treatment is a preventative intervention that protects recovery gains, reduces demand on crisis services, and supports safer transition back into the community.

Recommendation 7.1 Ensure supported housing programs providing safe and affordable accommodation are included in national housing strategies, the next iteration of the National Drug Strategy, and future iterations of the National Framework for Alcohol, Tobacco and other Drug Treatment. These programs should enable people to transition from treatment or justice settings into stable homes within peer-supported communities that reduce isolation and support recovery. Effective models must include wraparound

supports, such as life-skills development, education and training, psychosocial and mental health supports, and opportunities for community connection.

Recommendation 7.2 Establish nationally consistent rental, mortgage and housing assistance for people undertaking alcohol and other drug withdrawal and rehabilitation programs to prevent loss of housing during treatment.

Theme 8: Recovery Is Relational

Many families and supporters experience social and emotional isolation and financial challenges, alongside the person they support. These are often experienced alone due to limited access to peer-led safe spaces where they can speak openly and gain validation. Our community tell us they often feel uncomfortable in mainstream carer services due to the stigma and discrimination they experience.

> *"The person I support has experience of co-occurring mental health and AOD challenges. When I attended support groups for mental health carers, I was consistently confronted with people making the distinction that the person they supported was 'not on drugs'. In one group, a person claimed that her son couldn't get support because the mental health system was 'clogged up with druggies' these days. When I finally found the Family Drug and Gambling Help support group, I finally felt I could talk about my experiences"*

Family members and supporters also tell us that they:

- Are shut out of treatment and discharge discussions, even when they are expected to provide ongoing support
- Experience stigma and blame from the wider community, which compounds grief and distress
- Struggle to navigate fragmented and underfunded systems alone
- Face postponed employment, reduced income, and social isolation as they coordinate and support the person
- Don't have access to information and training in supporting someone with an AOD challenge that includes information about harm reduction and using health-led approaches to supports

Our community of family and supporters also carries deep expertise. This expertise is rooted in navigating stigma, service gaps, systems failures, emotional distress, advocacy, and ongoing uncertainty. Yet their knowledge, needs, and voices are often excluded from AOD policy, service design, and treatment planning, despite their critical roles.

> *"Engage us in designing the treatment journey. We have insight, we have experience, and we need support too."*

The lived expertise of our family and supporter community is essential to:

- Designing realistic, relational treatment pathways
- Informing crisis response and aftercare models, especially during overdose, system gaps or transition out of care
- Breaking down structural stigma directed at families and supporters
- Creating systems that acknowledge grief, complexity, and resilience across family networks

Yet family leadership funding remains minimal in Australia's AOD system.

"The family system needs to be seen as part of the recovery system. You can't have one without the other."

Case Study: Family Drug and Gambling Help (FDGH), a program of SHARC, provides essential support to families impacted by alcohol, drug, and gambling harm. Through peer-led support groups, educational workshops, and a 24/7 helpline, FDGH empowers families to navigate complex challenges with compassion and understanding. Our approach is grounded in lived experience, fostering resilience and reducing stigma while connecting families to culturally responsive care.

Recommendation 8.1 Fund community-based, co-designed and peer-led supports for families, friends, and supporters affected by AOD use. These programmes should include:

- Peer-to-peer connection and shared learning and supports
- Respite and wellbeing activities (e.g. meditation, creative arts, yoga)
- Skill-building to strengthen communication and rebuild relationships
- Bereavement support for people who have lost someone to overdose
- Partnerships with rehabilitation programs to ensure a person's designated support people have the skills and confidence to support their recovery on exiting a service
- Harm reduction and drug education

Recommendation 8.2 Invest in family and supporter perspective leadership across the AOD system. This includes investment in the workforce and building the capacity of and opportunities for family and supporters to use their voice and expertise to change the system.

Theme 9: Data, Research and Quality Measures

It is impossible to assess whether services across the AOD sector are delivering equity for all Australians, value for money, and the best outcomes for individuals, their families, and society. This is due to a lack of comprehensive data collection, consistent standards, and agreed outcome measurements across the sector.

"There's no way you would be getting equity, value for money or best outcomes because … we can't actually measure any [outcomes] … There's no data … But the fact that we don't know would suggest that we're wasting a lot of money … It's all anecdotal … But the anecdotes are pretty strong for the negative … You do hear people having positive outcomes, but you hear them more on an individual level rather than across the board."

What Success Should Measure: Outcomes That Matter to Our Community

Current data collection remains inconsistent, clinically focused, and largely fails to measure what truly matters.

"Gathering information about alcohol and drug use and how it has changed (or not) is a good place to start but it is not the full picture. I think you have to get more holistic data on how service users' lives have changed as a result of engaging with a service, whether they are more or less

engaged in their community, whether they are a better, calmer parent, whether they feel they have a better quality of life."

Outcome measures continue to prioritise treatment episodes and abstinence rates—metrics that offer only a partial, and at times misleading, picture of what creates meaningful change. An emphasis on setting measures through the lens of harm caused by substance use is also critiqued. These measures risk reinforcing stigma and excluding our voices and realities. Our perspectives are essential to understanding what works and why.

We know that recovery is not a single destination or defined solely by abstinence. It is a nuanced, deeply individual, and non-linear process grounded in connection, meaning, and improved quality of life. When systems define "success" without the input of those who live it, they fail to capture the full story of change.

These shortcomings stem from the absence of LLE leadership in the design of outcome measures. While expert partners bring valuable clinical and policy insight, they cannot meaningfully measure the outcomes of communities they do not fully understand.

"It is neither reasonable nor ethical to expect those outside our communities to define what support looks like for us."

This is not a rejection of collaboration, but a call for care, humility, and balance in deciding whose knowledge is valued and applied. Actual progress depends on shared spaces of decision-making where LLE is not an afterthought, but the foundation upon which policy, data, and reform are built. Our community is calling for a shift from clinical to more meaningful measures such as:

- Community connection
- Rebuilding relationships
- Access to opportunities for work and leisure
- Housing and financial security
- Reduction in overdose
- Better health and wellbeing

Data Gaps in Measuring LLE Program and Initiatives Impacts

A significant data gap in the Australian AOD system is the lack of consistent evidence on the impacts of LLE AOD initiatives and the LLE workforce. As a result, the effectiveness of LLE initiatives is frequently questioned by funders and policymakers, despite strong community endorsement and long-standing practice evidence[13].

We need data measuring tools that help shift peer-led recovery work from being anecdotally "known to work" to being measurable, demonstrable, and more readily recognised within policy, commissioning, and funding frameworks.

Case Study: Faces & Voices of Recovery is a recovery advocacy organisation in the United States and developer of the Recovery Data Platform® (RDP)[14] .This cloud-based data collection and reporting system enables peer-led services to capture service activity and outcomes data in real time, strengthening visibility, accountability, and fundability.

RDP functions as an electronic recovery record infrastructure, capable of storing large volumes of structured data—often described as "thousands of unique data points"—and supporting longitudinal tracking of recovery outcomes.

Recommendation 9.1 Invest in a nationally consistent, peer-appropriate data and evaluation framework to measure the impacts of LLE-led AOD initiatives and the LLE workforce. The design of the framework should be LLE led, include fit-for-purpose digital tools for peer-led and non-clinical services, and support longitudinal outcome tracking. It should draw on international examples such as Faces & Voices of Recovery's Recovery Data Platform.

Lack of Independent Oversight Undermines Quality and Choice

Effective independent oversight of the quality and outcomes of AOD services is perceived as lacking by many community members. This was described as preventing the community from making informed choices about services that meet our health, social, and financial needs, as well as our cultural and social requirements.

> *"There's no quality measure associated with any of the services. Individual services might give you an idea of the quality of their own service, but you'd query whether someone critiquing the quality of their own service is the right person to be giving you that information."*

This lack of transparency is frequently identified as an issue in the private sector. Limited regulation and the absence of publicly available quality measures are perceived to contribute to the proliferation of costly, non-evidence-based service models.

Services are also out of step with contemporary drug use. Data and quality measures are often focused on the wrong outcomes, or there are no quality measures that reflect the impact of service models against many of the current drugs on the market. See Theme 10 for more information.

Recommendation 9.2: Review the National Quality Framework for Drug and Alcohol Treatment Services in partnership with people with LLE. Determine whether it supports an enabling environment for people to make informed decisions about the quality of programs and treatments.[15]

Research Created by Us: Building LLE Led Evidence and Capability

SHARC's experience of working with research bodies, consultants and policy makers is that these groups usually don't have the resourcing or expertise to meaningfully and safely work with the diverse experiences of our community. Due to experiences of stigma and discrimination, many in our community will not engage with mainstream organisations. As a result, the majority of voices in our community go unheard.

To create meaningful change, we must build our community's capacity and skills to research, advocate, and inform policy ourselves, rather than always having others do it on our behalf. We need dedicated funding for peer research models. We also need to ensure people are adequately remunerated for their expertise.

Case Study: The Forest is a research project led by people who use drugs, for people who use drugs, conducted by the Burnet Institute.[16] It provides a model for a safe place where people leaving prison with experience of AOD challenges can access a comprehensive network of services, engage in meaningful activities, and find care and community. The research methodology incorporated leadership and mentorship from LLE, resulting in a research output that is accessible and grounded in lived expertise.

Recommendation 9.3 Build AOD LLE research capability through:

- Creating AOD LLE research pathways through partnerships with universities and services for formal qualifications, mentorship programmes, and plain-language research toolkits

- Developing peer-led research funding streams that enable those with lived experience to lead projects, not just participate in them
- Building peer researcher networks, collectives, and events to provide ongoing support, knowledge sharing, and collective bidding power for research grants
- Mandating co-production in federally funded AOD research with people with lived experience having genuine decision-making power from design through to dissemination
- Streamlining ethics processes for peer-led research while maintaining rigour, recognising the unique expertise peers bring

Theme 10: Services out of Step with Contemporary Drug Use

The service system still largely reflects models designed over 20 years ago for opioids (in particular, heroin) and alcohol. A high proportion of people now present with poly-substance use, frequently combining sedatives, stimulants, and depressants. This has significant implications for safety, withdrawal management, and program design.

> *"You don't really get people who just drink or are just using heroin anymore. You get people who are on GHB, meth and some benzos. That's the combination most people are on."*

In particular, our community is concerned that withdrawal programs are not long enough to support people and that they are often entering rehabilitation programs while still in withdrawal. As a result, people are frequently asked to leave programs because they cannot participate due to being in active withdrawal, or worse, denied service because they are defined as a "risk" for the organisation.

The sector is also seeing increasing incidences of overdose and a rise in potent synthetic opioid adulteration in substances like MDMA, cocaine, methamphetamine, and diverted pharmaceuticals—echoing trends in North America and Europe. There is an urgent concern in our community that Australia is underprepared, as it has no dedicated national overdose response.[17] A robust system for harm reduction services across Australia is required. Our partners, VAADA and Harm Reduction Victoria, are also calling for a national synthetic opioids plan that allows for rapid implementation to mitigate the harms associated with potent synthetic opioids.[18]

Positive developments in Victoria include the Medically Supervised Injecting Room (MSIR), Take-Home Naloxone Program, trials of both drug-checking and naloxone vending machines and plans to trial an overdose prevention and response phone line. These demonstrate the policy appetite for sensible, evidence-based, peer-led, and harm-reduction strategies. Yet political backlash[19] and stigmatising media coverage[20] show how vulnerable these interventions are without national leadership.

> *"The government also needs to reconsider its position on medically supervised injecting rooms and work harder to communicate the benefits of these services for both individuals and the broader community."*

Any approach to reducing overdose must also include strategies to support safe transitions back to community living following withdrawal and rehabilitation programs or time spent in prison—periods associated with a heightened risk of overdose—particularly given that community-based aftercare supports, such as supported residential services, remain grossly underfunded.

Recommendation 10.1 Undertake a comprehensive national review to ensure the National Framework for Alcohol, Tobacco and Other Drug Treatment 2019–29 and the new National Drug Strategy address the

impacts of a rapidly changing drug market. These include rising poly-substance use, synthetic opioid contamination, and increasing overdose risk. This review should assess current withdrawal and rehabilitation models—program length, safety, and transitions between withdrawal, rehabilitation, and community living—and embed harm-reduction approaches as core components of the treatment continuum. This review must be co-designed and led in partnership with people with LLE of accessing treatment services.

Recommendation 10.2 Develop a national overdose prevention strategy in partnership with people with LLE. This should include a national synthetic opioid preparedness plan and a coordinated national response to harm reduction initiatives. It must cover support for people exiting prison, rehabilitation and withdrawal services and harm reduction education for family members and supporters.

Theme 11: Meeting Diverse Needs

Decades of research—and lived testimony—make it clear that mainstream AOD services continue to fail to meet the needs of many diverse communities. These include, but are not limited to, Aboriginal and Torres Strait Islander people, culturally and linguistically diverse communities, LGBTQIA+ people, people living in rural and regional areas, people living with disabilities, mental health challenges and neurodivergence, people in contact with the justice system, and young and older people.

Whole-Person, Integrated Responses

AOD challenges cannot be addressed in isolation. Many in our community advocate for person-centred, integrated responses that recognise AOD use as a health issue shaped by social, cultural, and structural factors.

> *"When I first went for help, they basically just gave me antidepressants and then sent me on my way. Which isn't super helpful because obviously later on, like my mental health, I turned to substances to try to fix that because there were no other services given. Was just 'here's a script'."*

> *"People with lived experience who engage with service delivery differently, for example, people who engage in abstinence and people who find harm reduction strategies or pharmacotherapy helpful. People who have experienced problematic prescription drug use, alcohol, gambling and illicit drugs should all be at the table. We all have different experiences, and different things work for each of us."*

Addressing Diverse Needs and Financial Barriers

A consistent theme in our consultations is the importance of addressing co-occurring health and social issues, including homelessness, mental health challenges, trauma, neurodiversity, financial pressures, and family violence.

Access to psychosocial supports is identified as particularly impactful, yet out-of-pocket costs are frequently described as prohibitive and unsustainable, and many report being referred to providers who lack an understanding of AOD.

Community members state that if they had been listened to when they first sought help—and if broader issues beyond AOD dependence had been explored—they may have avoided later problematic AOD use. Early identification of neurodiversity is repeatedly identified as critical, with some noting that years of self-medication could have been avoided if their needs had been recognised earlier.

People also describe having both a mental health challenge and an AOD challenge as a barrier to support, with individuals frequently passed between services due to being viewed as "too complex."

A more appropriate response is for services to meet with the person and work collaboratively to identify what is required to support their wellbeing. This includes removing barriers to accessing medication for other conditions, such as chronic pain or ADHD, where requests are sometimes treated with suspicion due to a poor understanding of the difference between medication for a condition and a drug of dependence.

Financial barriers further compound access issues. One community member outlines the impact of Medicare rebate delays, noting that waiting several weeks for reimbursements creates significant hardship for people on low or fixed incomes, including missed rent payments or reduced spending on food and energy bills.

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

Culturally Safe, Place-Based and Age-Appropriate Services

There is strong agreement that more place-based, population-specific, and socially and culturally inclusive service options are required. The AOD workforce—including the peer workforce—must also reflect the diversity of communities experiencing AOD-related harm to provide culturally safe and responsive care.

"AOD interventions must be led by the impacted communities."

Research underway at SHARC indicates that, through the success of harm reduction programs, people are living longer and as a result an older cohort of people now require AOD services. Yet our community of older people advise that services are not currently designed to meet their often more complex health conditions and mobility, accessibility, and social needs. Older community members advise that current program structures, service cultures and built environments are not designed with their needs in mind, creating barriers to access and completion of programs.

"I'd been an addict for a long time, and it took a lot to get treatment. I repeatedly fronted up to a hospital-based drop-in service for assessments but got refused quite a few times because of my age and my health. Even services I'd had associations with I felt would look at me and think, 'oh not her again'."

There is a clear need for co-designed service models specifically tailored to older people.

Rural and Regional Access

Rates of AOD-related harm are higher in many regional and remote communities. Yet access to timely, appropriate, and continuous care is constrained by geographic isolation, limited service availability, workforce shortages, transport barriers and fragmented referral pathways.

Our community in rural and regional areas tells us that service systems remain overly reliant on metropolitan, face-to-face models that do not reflect regional realities. Both national AOD and alcohol strategies emphasise the need for equitable, person-centred, evidence-based, and accessible responses across all pillars of AOD policy. To meet these objectives, rural and regional communities require greater access to flexible, low-threshold supports—including telehealth, outreach, digital services, and peer-led community connection—alongside locally responsive, place-based care. Addressing these access gaps is critical to reducing preventable harm, improving continuity of care, and easing avoidable pressure on acute health and justice systems.

Recommendation 11.1 Fund culturally safe, place-based and population-specific AOD services that are co-designed and led by impacted communities. These include Aboriginal and Torres Strait Islander

communities, culturally and linguistically diverse communities, LGBTQIA+ people, people living with disability, people in regional and remote areas, and young and older people. Ensure the AOD workforce, including the peer workforce, reflects the diversity of communities experiencing AOD-related harm and is supported through culturally safe employment practices and organisational cultures.

Recommendation 11.2 Work with the states and territories and across government to invest in integrated, whole-person AOD service models. These should address co-occurring mental health, trauma, neurodiversity, chronic pain, disability, family violence, housing instability, and financial stress, ensuring people are not excluded from care due to perceived "complexity" or their service risk.

Recommendation 11.3 Expand access to affordable, psychosocial care for people with AOD challenges by increasing Medicare-subsidised sessions, reducing out-of-pocket costs.

Recommendation 11.4 Prioritise equitable access to AOD prevention, harm reduction, treatment, aftercare, and recovery supports in rural and regional Australia. This includes sustained investment in flexible and accessible service models such as telehealth, outreach, digital supports, and peer-led community programs. Ensure place-based workforce development and service integration for continuity of care regardless of postcode.

Theme 12: From Punishment to Health and Human Rights

It's time to treat AOD challenges as a health issue rather than a criminal justice one.

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

International evidence shows decriminalisation—when embedded in a rights-based approach that includes investment in drug treatment, harm reduction, mental health supports, housing, employment, and other social services—is significantly more effective in reducing harms.[21] Criminalisation exacerbates stigma, deters help-seeking, and diverts resources away from health-led responses. Pragmatic drug law reform needs to be part of Australia's AOD system.

Despite the evidence, Australia's funding priorities remain heavily skewed toward enforcement. An estimated $3.5 billion annually is directed to illicit drug law enforcement and supply reduction, compared with $2 billion for AOD prevention, harm reduction, and treatment. This represents a near 2:1 imbalance in favour of punitive responses.[22]

"I do think that justice gets a lot of funding, that we can be funding people, creating programs with that money rather than incarcerating them, rather than putting them on orders with a whole lot of ridiculous stuff that makes no sense."

Recent inquiries—including the Joint Committee on Law Enforcement Australia's illicit drug problem: Challenges and opportunities for law enforcement—have recommended urgent reform. Spending must be rebalanced across the pillars of AOD policy: prevention, treatment, harm reduction, and law enforcement.[23]

Community members with lived experience of the justice system emphasise that remand and prison settings represent critical—but frequently missed—opportunities to provide AOD treatment and support.

"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. We need better supports inside."

Case study: Victoria's Drug Court is cited by community members as having a positive impact, with the presence of SHARC's Peer Mentors in Justice workers identified as a key contributor to its success. Working within the Victorian justice system, our peer mentors provide direct one-on-one and group support to court participants. Drawing on their lived experience, they offer empathy, understanding, advocacy, and practical support throughout the program. Community members consistently suggest that AOD peer workers should be more widely available across court and justice systems to ensure continuity of care, advocacy, and culturally safe support.

Recommendation 12.1 Review and rebalance current AOD funding across policy pillars to align with evidence-based need, prioritising treatment, harm reduction, aftercare, and in-community supports over law enforcement.

Recommendation 12.2 Include a timeline for pragmatic drug law reform, supporting legal options for drug decriminalisation across all Australian states and territories in the next iteration of the National Drug Strategy.

Recommendation 12.3 Work with the states and territories to resource AOD treatment and peer-led support within justice settings, including remand and prison. Ensure continuity of care on release through peer workers, care coordination, and immediate access to housing and community supports. Support the expansion and availability of the peer workforce across court, diversion, and justice systems to provide advocacy, continuity, and culturally safe support. Build on evidence from models such as the Peers in Justice Program in Victoria's Drug Court.

Theme 13: Addressing Stigma and Discrimination

We face significant stigma and discrimination. This is found in the broader community's attitudes toward us, shaped and compounded by media, religious, and political discourse and institutions. We confront stigma in the healthcare system[24], the housing system[25], employment settings[26] and in social and community settings. This shapes our perceptions of ourselves and our sense of safety when interacting with services and the broader community.

Stigma and discrimination function as both obstacles to care and key contributors to substance use challenges. Our community describes how stigma undermines dignity, social inclusion, housing, employment, and family and community engagement, while increasing isolation, shame, and substance use.

> *"I just kept hearing from family, the media, health professionals, how **** I was and therefore I just fed into that, you know that. So it's self-fulfilling prophecy. The more I heard it, the more I used. So, for me maybe some education around how it's not a choice. It might be in the beginning, but then after that it's very quickly not and I don't know how you change the community's view on something so big that for me that was the hardest part was with the stigma."*

Fear of judgment often deters help-seeking, and even service engagement can exacerbate shame. Harmful public narratives, moralising of illicit substances, double standards for legal substances, and punitive institutional responses reinforce these barriers.

Stigma and discrimination don't just harm us: when the broader community stigmatises and silences us, they lose the valuable insights, innovative approaches, and meaningful relationships that we can bring.

Our community consistently identifies health-first, peer-led interventions, education, and public messaging as critical for reducing stigma and supporting equitable access to services.

There are calls for public health campaigns to address stigma and discrimination. However, our community cautions 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 people with lived and living experience, and feature people with lived and living experience. Real stories that dispel the myths must be featured.

"Those ads on telly of a drug addict in the gutter wearing a hoodie and ripped jeans just further strengthen the negative stereotypes."

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 necessary for confronting the stigma and discrimination people often feel when talking about their substance use challenges and accessing supports.

Recommendation 13.1 Fund a coordinated, national response to stigma and discrimination related to AOD use, led by people with lived and living experience. Resource LLE-led organisations to deliver peer-led public education, workforce training, and LLE relational supports that reinforce AOD dependence as a health issue across the broader community, services, and systems.

Theme 14: LLE Workers: A Foundation for a Functioning AOD System

LLE-led responses sit at the foundation of AOD services in Australia. Before AOD challenges and the health risks associated with drug use (including overdose) were recognised as issues requiring a health-led response, we were forced to create our own solutions. Peer-led mutual aid, therapeutic communities, and community-based supports emerged not as optional additions to the system, but as acts of survival. They were built by people who knew the harms, risks and pathways to safe drug use and recovery because we had lived them.

In Victoria, the LLE workforce has become increasingly recognised and resourced over the past 10 years through more sustained government investment in LLE leadership. Successive reforms—most notably those arising from the Royal Commission into Victoria's Mental Health System[27]—have affirmed lived experience as an essential discipline within health and human services, including alcohol and other drugs.

Victoria currently leads the country in investing in the structures required to sustain this workforce. Through formal partnerships with government, LLE-led organisations such as SHARC have supported the development of peer workforce strategies, training and supervision models, organisational readiness initiatives, and statewide communities of practice across mental health, AOD and harm reduction.

This work demonstrates a simple truth: we do not need to reinvent the wheel—but we do need national coordination, consistency and leadership that reflects the diversity of lived and living experience across the AOD system. Although there is still a long way to go, these reforms have begun shifting LLE from the margins into the core of system design, governance, workforce development and accountability, recognising that services are more effective, humane, and accessible when shaped by the people who use them.

Nationally, however, LLE workforce leadership remains fragmented. As discussed previously, harm reduction workforces are better represented through the advocacy of the Australian Injecting and Illicit Drug Users League (AIVL). There is currently no equivalent national voice for workforces supporting people who identify as having problematic AOD use seeking withdrawal, treatment, rehabilitation and recovery-oriented supports—or for their families and supporters. This imbalance is evident in the National Framework for Alcohol, Tobacco and Other Drug Treatment 2019–2029[28] where LLE is referenced as peer support in descriptions of harm reduction service provision. Yet across the summaries of screening, assessment, service navigation, withdrawal, treatment, rehabilitation and recovery-oriented care, peer initiatives are not mentioned.

The development of a national peer workforce framework, currently underway, led by AIVL in partnership with and supported by the Commonwealth, represents an important opportunity to strengthen recognition, consistency and sustainability of LLE roles nationally.[29] As this work progresses, we call for a framework that truly reflects the breadth of lived and living experience across the AOD system. It should include workers supporting people with challenging drug use who engage with treatment and recovery services, and the families and supporters who walk alongside them. Nothing about us without us must mean *all of us*.

An APSU[30] consultation with Victorian LLE workers to inform the drafting of the Victorian Alcohol and other Drug Strategy launched in 2025,[31] found despite significant state reform, there is still work to do. Key issues include:

- **Role clarity and stigma:** AOD peer roles are poorly understood, often reduced to storytelling, affected by role creep, and undermined by stigma related to drug use and professional legitimacy.

  "I think that the word 'peer worker' has a stigma against it, which is now holding the discipline back in a way. Clinical staff hear 'peer worker' and do not realise that there is so much more than just sharing a story."

- **Job security, pay, and progression:** Peer roles are commonly short-term, underpaid and treated as entry-level, with limited career pathways and no pay parity with mental health peers. There is strong support for the development of a Certificate IV in AOD peer work, alongside stable, ongoing funding models that enable permanent roles, fair wages, and long-term workforce sustainability.

  "We're asking people to give so much, but then our jobs can just be pulled away."

  "They actually don't hire peer workers after two years … Their model is, if you want to stay, you've got to move into a clinical role."

  "AOD peers are a minority within a minority workforce."

  "Fair wages and job security," with "funding models that support sustainable employment."

- **Supervision and leadership gaps:** There is a lack of peer-led supervision, funded training pathways, and LLE leadership, with peer workers frequently excluded from governance and decision-making.

  "Workers need regular supervision and feedback from people who understand their role."

  "I don't get to have too much input in like the PHN table … I'm out of that loop the whole way."

- **Organisational readiness:** Many organisations are unprepared to embed peer roles, with clinical dominance limiting autonomy, impact and genuine power-sharing.

  "They get the funding for this position because of the recent growth in the discipline, but they're not equipped to have us."

"Getting it past the clinical aspect within the organisation is like pulling teeth … bashing my head up against a rock."

- **Limited flexibility and reach:** Standard business hours and low visibility restrict effective engagement, despite strong evidence that outreach and after-hours peer work improves access and outcomes.

"People are generally not in crisis at 2pm on Tuesday afternoon when I am working. I would have more impact if my shift was 1am on a Saturday."

- **Workforce diversity and family inclusion:** The workforce does not reflect community diversity, and there is a near-absence of funded family and supporter lived experience roles in the AOD sector.

"There are minimal opportunities for family and supporter lived experience workers to access core workforce supports such as communities of practice, discipline-specific supervision, professional development, or clear role pathways. I have worked across both the mental health and AOD family, carer peer workforce. In the AOD sector, I feel quite unsupported."

The task now is to ensure that national frameworks are informed by the same principles that have guided reform in Victoria, as well as continuing to improve the working conditions and impact of our workforce.

Case Study: SHARC's Work Strengthening the Victorian LLE Workforce

SHARC has more than 30 years of experience as a lived experience-led organisation, with deep roots in the AOD sector and long-standing leadership in peer workforce development. Our Peer Projects program is leading and facilitating:

- The development of the Department of Health's **LLE Leadership Strategy**
- **The Lived and Living Experience at Heart (LLEAH)** is a program comprised of two projects. **SOLE (Supporting Organisational Lived Experience),** which provides tailored organisational assessments, supports and one-off grants to help mental health and AOD services embed and sustain LLE roles. **TLC (The Learning Collaborative)** builds networks between AOD and mental health organisations to facilitate mentoring, co-learning, and cultural change, better integrating lived and living experience workforce members; it's delivered in partnership with the Department of Health, Yale University (US), Mental Health Victoria, and lived experience workforce experts.
- The publication of **AOD LLE Workforce Discipline Frameworks** for the AOD consumer workforce[32] and the AOD family carer workforce[33]
- **The Collective**, a new consortium that provides workforce development opportunities for Victorian LLE workers across mental health and AOD. Other collaborators are Harm Reduction Victoria, Tandem, the Carer Lived Experience Workforce Network, and the Victorian Mental Illness Awareness Council (VMIAC). SHARC is the auspice organisation
- **Organisational Readiness Training** to support organisations at all stages of LLE workforce development. More than 60 organisations have participated, including 39 interstate services across AOD treatment, harm reduction, mental health, justice, homelessness, family, and youth services
- **The Victorian AOD Peer Workers Community of Practice**, which has grown from 15 participants in 2017 to 125 in 2026
- **Peer Worker Practice Supervision** to help ensure that peer workers are strategically and meaningfully supported in their role
- **Peer Worker Training** that includes 10 training sessions across a year for people interested in joining the peer workforce and those new to peer work

Is auspicing:

- **Big Feels Club**, an informal peer support group of more than 7000 folks described as a "discussion space … not therapy". Big Feels also has a focus on people working in the system with experience of mental health and AOD challenges who are not in designated LLE roles
- **The Australian Hub for Intentional Peer Support (IPS**) provides the Victorian peer workforce with internationally recognised training to examine and practice what is necessary to build mutual support.

Recommendation 14.1 Establish a nationally coordinated AOD LLE workforce structure in partnership with states and territories initiatives to ensure consistent role clarity, recognition, and sustainability across jurisdictions. The structure should distinguish between harm reduction, AOD treatment, and family and

supporter lived experience workforces, recognising the different practice contexts, ethical considerations, and support needs of each. Ensure the:

- National Framework for Alcohol, Tobacco and Other Drug Treatment 2019–2029 embeds LLE expertise and workforce across all pillars of the AOD system, including prevention, harm reduction, treatment, and recovery. Peer supports should be included in service delivery across screening, assessment, service navigation, and intensive interventions such as withdrawal and rehabilitation. Currently, peer supports are only mentioned in the context of harm reduction.
- Peer Workforce: National Practical Framework for Employing People With Lived/living Experience of Using Drugs as Health, Harm Reduction and AOD Workers, currently under development, is co-designed. This should explicitly include workers with LLE of problematic drug use who have accessed or tried to access AOD treatment and recovery services and supporters.
- National AOD policy and funding mechanisms support discipline-specific workforce development initiatives, including: peer-led communities of practice; funded discipline-specific supervision and reflective practice; workforce development and leadership pathways for experienced LLE workers.
- Targeted investment to ensure peer-led supervision and leadership roles are embedded across AOD treatment, harm reduction, and family support settings.
- Commonwealth requires demonstrated organisational readiness training designed and delivered by LLE experts, as a condition of funding for AOD LLE and peer roles, including: mandatory organisational capability building to support LLE integration; clear governance and power-sharing arrangements; peer-led training for boards, executives, and clinical teams.
- Victorian Government's Workforce initiatives to develop and expand the lived experience workforce inform national reform

Recommendation 14.2 Ensure national AOD workforce and funding frameworks explicitly support flexible, community-based, and outreach-oriented peer practice. They should recognise that peer impact is often greatest outside standard clinical settings and business hours and in services outside the AOD service system, such as emergency, justice, homelessness, education, and community services.

Recommendation 14.3 Use National Cabinet and Fair Work mechanisms to establish nationally consistent employment, classification and funding frameworks that recognise LLE as skilled work across mental health and AOD systems. This must include fair award classifications, secure employment conditions, funded supervision, and explicit recognition of both consumer and family/supporter LLE workforces. These national mechanisms must address inequities within the AOD LLE workforce across jurisdictions by:

- Ensuring parity with mental health peer workforces in pay, security, and recognition
- Supporting culturally safe, inclusive recruitment and retention strategies
- Removing barriers related to justice involvement, housing insecurity, disability, culture, language, and gender

Recommendation 14.4 In partnership with states and territories, develop and nationally accredit a Certificate IV in Alcohol and Other Drugs Peer Work, aligned with—but distinct from—existing mental health peer qualifications.

Theme 15: From Crisis Response to Early Action

The AOD system is reactive, rather than preventative. Current approaches focus on crisis intervention rather than embedding early detection, harm reduction, and proactive health responses into everyday settings.

Workplaces, schools, TAFE colleges, universities, and job agencies are seen as critical sites for early intervention. These spaces must be equipped with evidence-based, health-led training and resources that are co-designed and delivered with LLE leadership. Only then can they foster cultures that encourage early intervention and help-seeking without shame or judgment.

A harm reduction framework is fundamental to the prevention of overdose death and long-term health impacts. Yet, without LLE leadership—built on trust, shared experience, and non-clinical engagement—these approaches are likely to be misunderstood or underutilised. Health and peer led public education also plays a vital role, alongside culturally specific, community-designed, place-based initiatives. Youth prevention demands dedicated approaches, with families requiring better support tools and access to peer- led support services.

Improving regulations for alcohol advertising and sale is also considered an essential early intervention strategy. Our community has raised concerns about:

- The saturation of alcohol advertising across digital, outdoor, and broadcast media
- Inadequacy of self-regulation under the voluntary ABAC code
- Promotion of alcohol on supermarket receipts and in association with sport and entertainment programs and pop-up advertisements for alcohol delivery when ordering on Uber Eats

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. Across all feedback, a consistent message emerges. To be effective, response systems must act earlier—and they must be co-designed with people with LLE.

Recommendation 15.1 Prioritise the development, funding and evaluation of early intervention education that is co-designed and delivered with LLE leadership in national AOD frameworks. These programmes must:

- Be grounded in harm reduction principles
- Build capacity to recognise and respond to AOD concerns early
- Embed lived experience expertise across schools, vocational training, workplaces, and faith-based settings
- Target diverse and marginalised communities through place-based and culturally relevant initiatives

Recommendation 15.2 Investigate the adequacy of self-regulation for companies under the ABAC code. Consider ways to strengthen the regulation of alcohol advertising in digital, outdoor, and broadcast media and in marketing on food delivery apps and supermarket receipts.

Recommendation 15.3 Fund LLE-led training, support, and navigation services for families, friends, and supporters. These supports should:

- Help families engage from a harm reduction and recovery perspective
- Be trauma-informed and anchored in hope, healing, and non-judgement
- Include youth-specific LLE mentors and family services co-designed with parents and young people
- Be embedded in communities where people already are—not just specialist treatment settings

Theme 16: Taking a Rights Based Approach

All people, including those with AOD challenges, should enjoy the highest standard of physical and mental health[34], an adequate standard of living[35], and enjoy full participation in public life.[36] These are rights held under domestic and international law that are often denied to people in our community due to failures in Australia's approach to addressing the health impacts of problematic AOD use. A human rights-based approach is increasingly important in AOD advocacy and policy. Given Australia's international and national commitments to human rights, this should be central to any national AOD strategies and policies developed now and in the future.[37]

Case Study: The Scottish Alcohol and Drug Treatment Strategy, titled Rights, Respect and Recovery, takes a rights-based approach to improving health by preventing and reducing alcohol and drug use, harm, and related deaths.[38]

Recommendation 16.1 Ensure all national AOD policy and reform is centred on a rights-based approach.

Theme 17: An Integrated National Model in Practice

Throughout this submission, SHARC has highlighted the absence of a coherent national approach that brings together: peer-led navigation; evidence-informed treatment and clinical approaches; community connection; and research grounded in LLE. One example of how these elements can operate together at scale is the proposed national recovery centre model being developed by SHARC, Turning Point[39]and the Monash Addiction Research Centre[40].

The proposed approach leverages existing national telehealth infrastructure, integrates peer and treatment workforces, and embeds research capability. The recovery centre model addresses fragmented access, lack of peer navigation, non-existent aftercare supports, limited rural reach, and insufficient evaluation of recovery-oriented outcomes. The model is a practical, scalable example of how peer-led and clinical/treatment approaches can work together through telehealth and research innovation to strengthen Australia's national response to AOD challenges.

The approach is particularly suited to rural and regional communities, where access to face-to-face services is limited, and where telehealth provides a scalable way to extend recovery-oriented support while remaining connected to local services. It also provides an option for people to access services outside their local community helping to ensure privacy and minimise the impacts of stigma and discrimination on service access.

Recommendation 17.1 Meet with SHARC, Turning Point and the Monash Addiction Research Centre to explore the proposed national recovery centre model. This integrated, telehealth-enabled initiative brings together peer-led navigation, clinically based treatment and research innovation to address access, continuity and recovery outcomes—particularly for people in rural and regional Australia.

Appendix 1: Full List of Recommendations

Below is a full list of the recommendations outlined throughout the document.

Theme 1: Nothing About Us Without Us

Recommendation 1.1 In partnership with the states and territories, invest in the establishment and sustainable resourcing of a national LLE AOD peak body that represents people who experience AOD use as challenging. This includes people who have experienced addiction, and who have accessed, or attempted to access, withdrawal, treatment, rehabilitation, or recovery-oriented services, including their families and supporters. This investment should sit alongside existing harm-reduction representation, ensuring both perspectives are visible, distinct, and complementary within national AOD policy, system reform, and service design. Dedicated state-level funding for LLE-led consumer participation peak bodies—both AOD and harm reduction—should also be supported. This would ensure safe, supported, and meaningful engagement that moves beyond consultation toward shared decision-making in AOD policy, system reform, and service design.

Recommendation 1.2 Work with Aboriginal and Torres Strait Islander AOD leaders and communities to re-establish a national voice on AOD and harm reduction guided by truth telling and self-determination principles.

Recommendation 1.3 Adopt a new national AOD governance framework that supports integration of activity between levels of government and the AOD sector. The model must include an LLE advisory function where power is shared and a broad representation of LLE perspectives is accommodated.

Recommendation 1.4 Establish a ministerial portfolio focused on drug and alcohol policy with responsibilities that include ensuring alcohol and other drug policy and practices are inclusive of LLE, health-led, and human rights-based.

Theme 2: Chronic Under-Resourcing and Policy Failure

Recommendation 2.1 Commit to long-term, sustainable funding arrangements for AOD services, including multi-year contracts of at least five years, transparent and timely indexation linked to CPI, Fair Work wage determinations, and streamlined renewal processes to ensure continuity of support. Funding models must keep pace with the actual cost of service delivery.

Recommendation 2.2 Establish a dedicated national AOD innovation, evaluation, and translation fund to enable trialling, scaling, and rigorous evaluation of evidence-based and peer-led models of care, including community-led recovery and harm reduction initiatives.

Theme 3: Intake for the Resourced, Not Those in Crisis

Recommendation 3.1 In partnership with the states and territories, prioritise redesigning AOD intake, assessment, and referral systems, including the National Alcohol and Other Drug Hotline, so they are functional and effective, and accessibility is improved during periods of crisis. The redesign should focus on simplifying pathways, increasing assertive outreach, peer-led navigation, and reducing administrative burden. This must include practical supports that enable access and continuity of care—housing and tenancy stability, income support continuity, childcare, pet care—so engagement is not dependent on personal resources, system literacy, or informal advocacy.

Recommendation 3.2 Set national benchmarks and accountability mechanisms to reduce waiting times for withdrawal and rehabilitation services, recognising that delays result in preventable harm, relapse, and death, and readiness for change is often time limited.

Recommendation 3.3 Ensure any national approach to AOD service delivery explicitly learns from and avoids replicating the Victorian AOD reforms introduced in 2014, which significantly reduced service diversity, undermined community-led and peer-based programs, and weakened in-community supports. The national reforms should:

- Reject overly centralised intake and assessment models that limit treatment pathways and concentrate funding within large consortia, at the expense of smaller, community-based, and peer-led services.
- Protect and fund a diverse mix of treatment models, including supported accommodation, community-led programs, and residential rehabilitation, recognising that different people require different levels and types of support.
- Ensure funding settings do not only privilege low-cost interventions, such as short-term day programs or pharmacotherapy, where more intensive residential or in-community supports are clinically and socially necessary.
- Embed safeguards for innovation, choice, and continuity of care, particularly for people without stable housing and family support.

Theme 4: The Missing Link is Peer-Led Navigation

Recommendation 4.1 Update national AOD strategies and review the National Treatment Framework to embed LLE-led peer navigation. The National Drug Strategy, National Alcohol Strategy, and National Framework for Alcohol, Tobacco and Other Drug Treatment must formally recognise and fund flexible, peer-led navigation models as a core component of harm minimisation and treatment systems.

Recommendation 4.2 Include non-time-limited peer navigation and warmline services that support people, families, and supporters across intake, wait periods, treatment, discharge, relapse, and re-engagement. These should operate across AOD, mental health, housing and justice systems and be governed by people with LLE experience.

Theme 5: Choice, Flexibility and Self-Determination in Treatment

Recommendation 5.1 Embed choice, flexibility, self-determination, and innovation as core requirements of AOD treatment commissioning and practice. AOD funding, commissioning, and intake processes must support genuine choice across harm reduction, treatment, and recovery pathways, including peer-led, culturally specific, and place-based options. This must include dedicated funding for innovation, piloting and scaling diverse service models, safeguards against default or coerced treatment due to system constraints, recognition of people's right to refuse or change treatment without penalty, and support for blended and staged approaches that respond to people's changing needs over time.

Recommendation 5.2 Fund a national, publicly accessible digital database that provides clear, current, culturally appropriate and non-stigmatising information on alcohol and other drug (AOD) use, harm reduction, treatment, and recovery and psychosocial and community supports across commonwealth, state, and territory systems. The database—co-designed and governed with LLE—should clearly describe what services offer, how to access them, costs, who they are for and the quality standards they meet.

Theme 6: AOD Recovery Without Connection is a Systemic Blind Spot

Recommendation 6.1: Include initiatives to rebalance AOD policy towards community connection in the next iteration of the National Drug Strategy. Prioritise fostering strong social networks and inclusive LLE led environments as vital components of prevention, harm reduction, and recovery. Explicitly grounded in a human rights-based and peer-led approach, the initiatives should feature:

- Funding for peer-led social connection activities
- Emphasis on the role of family, friends, peer support groups, and local community organisations in providing practical and emotional support
- Establishment of key indicators for government policy and services to measure community connection outcomes
- Strong links to existing lived experience initiatives
- Provision of new models of care to guide future investment in peer-led initiatives
- Strategies to reduce stigma and facilitate meaningful engagement

Theme 7: Recovery Needs a Home

Recommendation 7.1 Ensure supported housing programs providing safe and affordable accommodation are included in national housing strategies, the next iteration of the National Drug Strategy, and future iterations of the National Framework for Alcohol, Tobacco and other Drug Treatment. These programs should enable people to transition from treatment or justice settings into stable homes within peer-supported communities that reduce isolation and support recovery. Effective models must include wraparound supports, such as life-skills development, education and training, psychosocial and mental health supports, and opportunities for community connection.

Recommendation 7.2 Establish nationally consistent rental, mortgage and housing assistance for people undertaking alcohol and other drug withdrawal and rehabilitation programs to prevent loss of housing during treatment.

Theme 8 — Recovery is Relational

Recommendation 8.1 Fund community-based, co-designed and peer-led supports for families, friends, and supporters affected by AOD use. These programmes should include:

- Peer-to-peer connection and shared learning and supports
- Respite and wellbeing activities (e.g. meditation, creative arts, yoga)
- Skill-building to strengthen communication and re-build relationships
- Bereavement support for people who have lost someone to overdose
- Partnerships with rehabilitation programs to ensure a person's designated support people have the skills and confidence to support someone's recovery on exiting a service
- Harm reduction and drug education

Recommendation 8.2 Invest in family and supporter perspective leadership across the AOD system. This includes investment in the workforce and building the capacity of and opportunities for family and supporters to use their voice and expertise to change the system.

Theme 9: Data, Quality and Research Measures

Recommendation 9.1 Invest in a nationally consistent, peer-appropriate data and evaluation framework to measure the impacts of LLE led AOD initiatives and the LLE workforce. The design of the framework should be LLE led, include fit-for-purpose digital tools for peer-led and non-clinical services, and support longitudinal outcome tracking. It should draw on international examples such as Faces & Voices of Recovery's Recovery Data Platform.

Recommendation 9.2 Review the National Quality Framework for Drug and Alcohol Treatment Services in partnership with people with LLE to determine whether it supports an enabling environment for people to make informed decisions about the quality of programs and treatments.

Recommendation 9.3 Build AOD LLE research capability through:

- Creating AOD LLE research pathways through partnerships with universities and services for formal qualifications, mentorship programmes, and plain-language research toolkits
- Developing peer-led research funding streams that enable those with lived experience to lead projects, not just participate in them
- Building peer researcher networks, collectives, and events to provide ongoing support, knowledge sharing, and collective bidding power for research grants
- Mandating co-production in federally funded AOD research with people with lived experience having genuine decision-making power from design through to dissemination
- Streamlining ethics processes for peer-led research while maintaining rigour, recognising the unique expertise peers bring.

Theme 10: Services out of Step with Contemporary Drug Use

Recommendation 10.1 Undertake a comprehensive national review to ensure the National Framework for Alcohol, Tobacco and Other Drug Treatment 2019–29 and the new National Drug Strategy address the impacts of a rapidly changing drug market. These include rising poly-substance use, synthetic opioid contamination, and increasing overdose risk. This review should assess current withdrawal and rehabilitation models—program length, safety, and transitions between withdrawal, rehabilitation, and community living—and embed harm-reduction approaches as core components of the treatment continuum. This review must be co-designed and led in partnership with people with LLE of accessing treatment services.

Recommendation 10.2 Develop a national overdose prevention strategy in partnership with people with LLE. This should include a national synthetic opioid preparedness plan and a coordinated national response to harm reduction initiatives. It must cover support for people exiting prison, rehabilitation and withdrawal services and harm reduction education for family members and supporters.

Theme 11: Meeting Diverse Needs

Recommendation 11.1 Fund culturally safe, place-based and population-specific AOD services that are co-designed and led by impacted communities. These include Aboriginal and Torres Strait Islander communities, culturally and linguistically diverse communities, LGBTQIA+ people, people living with disability, people in regional and remote areas, and young and older people. Ensure the AOD workforce, including the peer workforce, reflects the diversity of communities experiencing AOD-related harm and is supported through culturally safe employment practices and organisational cultures.

Recommendation 11.2 Work with the states and territories and across government to invest in integrated, whole-person AOD service models. These should address co-occurring mental health, trauma, neurodiversity, chronic pain, disability, family violence, housing instability, and financial stress, ensuring people are not excluded from care due to perceived “complexity” or their service risk.

Recommendation 11.3 Expand access to affordable, psychosocial care for people with AOD challenges by increasing Medicare-subsidised sessions, reducing out-of-pocket costs.

Recommendation 11.4 Prioritise equitable access to AOD prevention, harm reduction, treatment, aftercare, and recovery supports in rural and regional Australia. This includes sustained investment in flexible and accessible service models such as telehealth, outreach, digital supports, and peer-led

community programs. Ensure place-based workforce development and service integration for continuity of care regardless of postcode.

Theme 12: From Punishment to Health and Human Rights

Recommendation 12.1 Review and rebalance current AOD funding across policy pillars to align with evidence-based need, prioritising treatment, harm reduction, aftercare, and in-community supports over law enforcement.

Recommendation 12.2 Include a timeline for pragmatic drug law reform, supporting legal options for drug decriminalisation across all Australian states and territories in the next iteration of the National Drug Strategy.

Recommendation 12.3 Work with the states and territories to resource AOD treatment and peer-led support within justice settings, including remand and prison. Ensure continuity of care on release through peer workers, care coordination, and immediate access to housing and community supports. Support the expansion and availability of the peer workforce across court, diversion, and justice systems to provide advocacy, continuity, and culturally safe support. Build on evidence from models such as the Peers in Justice Program in Victoria's Drug Court.

Theme 13: Addressing Stigma and Discrimination

Recommendation 13.1 Fund a coordinated, national response to stigma and discrimination related to AOD use, led by people with lived and living experience. Resource LLE-led organisations to deliver peer-led public education, workforce training, and LLE relational supports that reinforce AOD dependence as a health issue across the broader community, services, and systems.

Theme 14: LLE Workers: A Foundation for a Functioning AOD System

Recommendation 14.1 Establish a nationally coordinated AOD LLE workforce structure in partnership with states and territories initiatives to ensure consistent role clarity, recognition, and sustainability across jurisdictions. The structure should distinguish between harm reduction, AOD treatment, and family and supporter lived experience workforces, recognising the different practice contexts, ethical considerations, and support needs of each. Ensure the:

- National Framework for Alcohol, Tobacco and Other Drug Treatment 2019–2029 embeds LLE expertise and workforce across all pillars of the AOD system, including prevention, harm reduction, treatment, and recovery. Peer supports should be included in service delivery across screening, assessment, service navigation, and intensive interventions such as withdrawal and rehabilitation. Currently, peer supports are only mentioned in the context of harm reduction.
- Peer Workforce: National Practical Framework for Employing People With Lived/living Experience of Using Drugs as Health, Harm Reduction and AOD Workers, currently under development, is co-designed. This should explicitly include workers with LLE of problematic drug use who have accessed or tried to access AOD treatment and recovery services and supporters.
- National AOD policy and funding mechanisms support discipline-specific workforce development initiatives, including: peer-led communities of practice; funded discipline-specific supervision and reflective practice; workforce development and leadership pathways for experienced LLE workers.
- Targeted investment to ensure peer-led supervision and leadership roles are embedded across AOD treatment, harm reduction, and family support settings.

- Commonwealth requires demonstrated organisational readiness training designed and delivered by LLE experts, as a condition of funding for AOD LLE and peer roles, including: mandatory organisational capability building to support LLE integration; clear governance and power-sharing arrangements; peer-led training for boards, executives, and clinical teams.
- Victorian Government's Workforce initiatives to develop and expand the lived experience workforce inform national reform

Recommendation 14.2 Ensure national AOD workforce and funding frameworks explicitly support flexible, community-based, and outreach-oriented peer practice. They should recognise that peer impact is often greatest outside standard clinical settings and business hours and in services outside the AOD service system, such as emergency, justice, homelessness, education, and community services.

Recommendation 14.3 Use National Cabinet and Fair Work mechanisms to establish nationally consistent employment, classification and funding frameworks that recognise LLE as skilled work across mental health and AOD systems. This must include fair award classifications, secure employment conditions, funded supervision, and explicit recognition of both consumer and family/supporter LLE workforces. These national mechanisms must address inequities within the AOD LLE workforce across jurisdictions by:

- Ensuring parity with mental health peer workforces in pay, security, and recognition
- Supporting culturally safe, inclusive recruitment and retention strategies
- Removing barriers related to justice involvement, housing insecurity, disability, culture, language, and gender

Recommendation 14.4 In partnership with states and territories, develop and nationally accredit a Certificate IV in Alcohol and Other Drugs Peer Work, aligned with—but distinct from—existing mental health peer qualifications.

Theme 15: From Crisis Response to Early Action

Recommendation 15.1 Prioritise the development, funding and evaluation of early intervention education that is co-designed and delivered with LLE leadership in national AOD frameworks. These programmes must:

- Be grounded in harm reduction principles
- Build capacity to recognise and respond to AOD concerns early
- Embed lived experience expertise across schools, vocational training, workplaces, and faith-based settings
- Target diverse and marginalised communities through place-based and culturally relevant initiatives

Recommendation 15.2 Investigate the inadequacy of self-regulation for companies under the ABAC code. Consider ways to strengthen the regulation of alcohol advertising to address the saturation level across digital, outdoor, and broadcast media and marketing on food delivery apps and supermarket receipts.

Recommendation 15.3 Fund LLE-led training, support, and navigation services for families, friends, and supporters. These supports should:

- Help families engage from a harm reduction and recovery perspective
- Be trauma-informed and anchored in hope, healing, and non-judgement

- Include youth-specific LLE mentors and family services co-designed with parents and young people
- Be embedded in communities where people already are—not just specialist treatment settings

Theme 16: Taking a Rights-Based Approach

Recommendation 16.1 Ensure that all national AOD policy and practice is centred on a rights-based approach.

Theme 17: An Integrated National Model in Practice

Recommendation 17.1 Meet with SHARC, Turning Point and the Monash Addiction Research Centre to explore the proposed national recovery centre model. This integrated, telehealth-enabled initiative brings together peer-led navigation, clinically based treatment and research innovation to address access, continuity and recovery outcomes—particularly for people in rural and regional Australia.

References

[1] Association of Participating Services Users (APSU) (2025) Consultations Stage 2 – Victorian AOD Strategy Consumer and Family, Carer and Supporter Views: Link

[2] Association of Participating Services Users (APSU) (2025) Consultations Stage 2 – Victorian AOD Strategy Lived and Living Experience Workforce Views: Link

[3] Ritter A, O'Reilly K. Unmet treatment need: The size of the gap for alcohol and other drugs in Australia. *Drug Alcohol Rev*. 2025; 44(3): 772–782. https://doi.org/10.1111/dar.14008

[4] Berends, L., & Ritter, A. (2014). The Processes of Reform in Victoria's Alcohol and Other Drug Sector, 2011-2014. Sydney: National Drug and Alcohol Research Centre.

[5] Flat Out Inc's Beyond Bricks and Bars : Link

[6] Mohsen Hosseinbor et al, 'Emotional and Social Loneliness in Individuals with and without Substance Dependence Disorder' (2014) 3(3) *International journal of high risk behaviors & addiction* e22688; Louise C Hawkley and John T Cacioppo, 'Loneliness Matters: A Theoretical and Empirical Review of Consequences and Mechanisms' (2010) 40(2) *Annals of behavioral medicine* 218 ('Loneliness Matters'); Raheel Mushtaq et al, 'Relationship between Loneliness, Psychiatric Disorders and Physical Health? A Review on the Psychological Aspects of Loneliness' (2014) 8(9) *Journal of clinical and diagnostic research: JCDR* WE01 ('Relationship between Loneliness, Psychiatric Disorders and Physical Health?'); Ingemar Åkerlind and Jan Olof Hörnquist, 'Loneliness and Alcohol Abuse: A Review of Evidences of an Interplay' (1992) 34(4) *Social science & medicine* 405 ('Loneliness and Alcohol Abuse'); Stephanie R Dyal and Thomas W Valente, 'A Systematic Review of Loneliness and Smoking: Small Effects, Big Implications' (2015) 50(13) *Substance Use & Misuse* 1697 ('A Systematic Review of Loneliness and Smoking').

[7] Groundswell Foundation and KPMG, *Connections Matter: A Report on the Impacts of Loneliness in Australia* (Groundswell Foundation and KPMG, November 2022) 5 <https://www.groundswellfoundation.com.au/post/connectionsmatter-a-report-on-the-impacts-of-loneliness-in-australia>.

[8] Isabella Ingram et al, 'Loneliness in Treatment-Seeking Substance-Dependent Populations: Validation of the Social and Emotional Loneliness Scale for Adults–Short Version' (2018) 14(4) *Journal of Dual Diagnosis* 211 ('Loneliness in Treatment-Seeking Substance-Dependent Populations').

[9] M Lim, B Smith and K Owen, 'State of the Nation Report–Social Connection in Australia 2023: A Deep-Dive into Loneliness and Social Isolation' [2023] *Analysis and Policy Observatory* ('State of the Nation Report–Social Connection in Australia 2023').

[10] Shane Darke and Joanne Ross, 'Suicide among Heroin Users: Rates, Risk Factors and Methods' (2002) 97(11) *Addiction* 1383 ('Suicide among Heroin Users').

[11] Commonwealth of Australia, Department of Health Disability and Ageing, National Framework for Alcohol, Tobacco and Other Drug Treatment 2019–29, Page 7: Link

[12] Manning, V., Garfield, J. B., Best, D., Berends, L., Room, R., Mugavin, J., … and Lubman, D. I. (2017) 'Substance use outcomes following treatment: Findings from the Australian Patient Pathways Study', Australian & New Zealand Journal of Psychiatry, vol. 51, no. 2: 177–189, https://doi.org/10.1177/0004867415625815

Duff, C., Hill, N., Blunden, H. valentine, k., Randall, S., Scutella, R. and Johnson, G. (2021) Leaving rehab: enhancing transitions into stable housing, AHURI Final Report No. 359, Australian Housing and Urban Research Institute Limited, Melbourne, https://www.ahuri.edu.au/research/final-reports/359, doi: 10.18408/ahuri53211.

[13] Peer support reduces hospital readmissions for mental health crises, shows study
BMJ 2018; 362 doi: https://doi.org/10.1136/bmj.k3405 (Published 03 August 2018)
[14] Faces and Voices for Change, Recovery Data Platform :Link
[15] Australian Government Department of Health, Disability and Ageing (2018) National Quality Framework for Drug and Alcohol Treatment Services: Link
[16] The Burnet Institute (2022): The Forest: Link
[17] Ritter, A., Grealy, M., Kelaita, P. & Kowalski, M. (2024) The Australian 'drug budget': Government drug policy expenditure 2021/22. DPMP Monograph No. 36. Sydney: Social Policy Research Centre, UNSW. https://doi.org/10.26190/unsworks/3007

[18] HRVic and VAADA. 2024. Keeping Victorians Safe: we need a potent synthetic opioids plan. https://www.vaada.org.au

[19]:Wilson, Eleanor (2025) Nine News It's madness': Council renews calls to relocate safe injecting room away from school :Link
[20] Borg, Rebecca (2023) News.com.au Richmond injecting room: MSIR to cost homeowners up to $60k, new research shows | news.com.au — Australia's leading news site for latest headlines: Link
[21] Scheim AI, Maghsoudi N, Marshall Z, et al. Impact evaluations of drug decriminalisation and legal regulation on drug use, health and social harms: a systematic review. BMJ Open. 2020;10:e035148.
[22] UNSW press release (2024) Illicit drugs: government spending lowest on prevention and harm reduction, shows new report: Link
[23] Commonwealth of Australia 2024, Parliamentary Joint Committee on Law Enforcement Australia's illicit drug problem: Challenges and opportunities for law enforcement: Link

[24] Lynda Berends and Dan I Lubman, 'Obstacles to Alcohol and Drug Care: Are Medicare Locals the Answer?' (2013) 42(5) *Australian family physician* 339 ('Obstacles to Alcohol and Drug Care'); Terence V McCann et al, 'Recognition of, and Attitudes towards, People with Depression and Psychosis with/without Alcohol and Other Drug Problems: Results from a National Survey of Australian Paramedics' (2018) 8(12) *BMJ open* e023860 ('Recognition of, and Attitudes towards, People with Depression and Psychosis with/without Alcohol and Other Drug Problems').

[25] Nicola Brackertz et al, 'Trajectories: The Interplay between Mental Health and Housing Pathways' [2020] *AHURI Research Paper, Melbourne, Australian Housing and Urban Research Institute and Mind Australia* <https://www.ahuri.edu.au/sites/default/files/migration/documents/Policy-priorities-for-better-access-to-housing-and-mental-health.pdf> ('Trajectories'); Castan Centre for Human Rights Law and Inner Melbourne Community Legal, *Housing Discrimination: Submission to the UN Special Rapporteur on the Right to Adequate Housing* (2021) <https://www.monash.edu/__data/assets/pdf_file/0007/2582908/Castan-Centre-and-Inner-Melbourne-Community-Legal-Submission-on-Housing-Discrimination-May-2021.pdf>; Joanne Bryant et al, 'Improving Access to Drug and Alcohol Treatment in NSW Australia: The Role of Self-determination and Peer Support' (2022) 30(5) *Health & Social Care in the Community* <https://onlinelibrary.wiley.com/doi/10.1111/hsc.13639> ('Improving Access to Drug and Alcohol Treatment in NSW Australia').

[26] Lynne M Harris et al, 'Perspectives on Barriers to Employment for Job Seekers with Mental Illness and Additional Substance-Use Problems' (2014) 22(1) *Health & Social Care in the Community* 67.

[27] Victorian Department of Health (2025), Lived and living experience workforces (LLEWs) initiatives | health.vic.gov.au, viewed 11th January 2026
[28] Commonwealth of Australia, Department of Health Disability and Ageing, National Framework for Alcohol, Tobacco and Other Drug Treatment 2019–29, Page 7: Link

[29] The Peer Workforce: National Practical Framework for Employing People With Lived living Experience of Using Drugs as Health, Harm Reduction and AOD Workers :Link
[30] Association of Participating Services Users (APSU) (2025) Consultations Stage 2 – Victorian AOD Strategy Lived and Living Experience Workforce Views: Link

[31] Victorian Government Website, Victorian Alcohol and Other Drugs Strategy 2025-35, viewed December 2025: Link
[32] AVIL and NECTA (2025) Peer Workforce: A Practical National Framework For Employing People With Lived-Living Experience Of Using Drugs As Health, Harm Reduction And AoD Workers: Link
[32] Self Help Addiction Resource Centre Inc (2025) Alcohol and other Drug (AOD) Lived Experience Workforce Discipline Framework: Link

[33] Self Help Addiction Resource Centre Inc (2025) Alcohol and other Drug (AOD) Family Supporter Lived Experience Workforce Discipline Framework : Link
[34] *Convention of the Rights of Persons with Disabilities*, opened for signature 13 December 2006, 2515 UNTS 3 (entered into force 3 May 2008), Art 25.

[35] *International Covenant on Economic, Social and Cultural Rights*, opened for signature 16 December 1966, 993 UNTS 3 (entered into force 3 January 1976), Art 11.

[36] *International Covenant on Civil and Political Rights,* opened for signature 16 December 1966, 999 UNTS 171 (entered into force 23 March 1976), Art 25.

[37] Kate Seear and Sean Mulcahy, 'Human Rights and Drug Policy: Summary Report of Project Findings and Recommendations' <https://opal.latrobe.edu.au/articles/report/Human_rights_and_drug_policy_Summary_report_of_project_findings_and_recommendations/28340675/1/files/52114670.pdf> ('Human Rights and Drug Policy').

38 Scottish Government (2018) Rights, Respect and Recovery Scotland's strategy to improve health by preventing and reducing alcohol and drug use, harm and related deaths: Link

[39] Turning Point: Link
[40] Monash Addiction Resource Centre: Link