AODCCC
Alcohol and Other Drug
Consumer & Community Coalition

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Australian Government
Department of Health, Disability and Ageing
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AODCCC response to Drug and Alcohol Program Consultations - Stage 2 - briefing on data inputs to a needs-based funding model.

The following content is an extract from an online survey; we have included responses that are pertinent to our members.

The Alcohol and Other Drug Consumer & Community Coalition (AODCCC) is the peak body for alcohol and other drug consumer and community informed systemic advocacy in Western Australia. With more than 990 members onboard, the AODCCC is a conduit for individuals and families with living & lived experience of alcohol and other drugs to have their voice heard. Our aim is to empower the voices of consumers, their families and supports, ensuring the health and wellbeing of our community. The knowledge, insights and expertise of lived & living experience is integral not only to the work of the AODCCC but also plays a vital role for communities all over WA.

This written submission draws on insights, expertise and experiences shared by AODCCC members through multiple engagement mechanisms, including our annual membership survey, training events, community forums, reference groups, and through direct conversations with members. This ongoing engagement ensures that the perspectives of people with lived and living experience (LLE) are consistently represented in both state and national reform discussions.

As part of our systemic advocacy focus, the AODCCC is pleased to contribute these member-informed insights to Stage 2 of the Drug and Alcohol Program (DAP) feedback process.

1. Do you have any general comments on the updated draft logic?

The AODCCC acknowledges the outcomes of the DAP consultation process and recognises both what has been incorporated, the constraints that have been applied and the overall complexity of the DAP policy environment, including the political and fiscal factors shaping this work. We therefore appreciate the Department's openness throughout the process and its willingness to clearly articulate where changes have been made and where limitations remain. This transparency is critical to maintaining trust with the sector and the wider community.

We note the progress achieved through good-faith engagement, while also recognising that further participation is unlikely to materially shift outcomes, particularly in relation to harm reduction. The limitations now evident reflect broader government policy settings, rather than shortcomings in consultation design or engagement processes. AODCCC has articulated this position in greater detail at the public hearing House Standing Committee on Health, Aged Care and Disability | Perth, WA | 14/04/2026

The AODCCC generally supports the Department's efforts to reflect stakeholder feedback in the revised program logic and KPIs, including reframing the problem statement, and clarifying key concepts raised during Stage 1 consultation. We also recognise that a number of priorities identified by our communities sit outside the scope of the current DAP reform process.

As DAP implementation progresses, we encourage the continued grounding of policy development in principles of human rights, equity, and social justice. Harm minimisation is not simply a set of techniques; it is a public health and ethical framework grounded in respect for the dignity, autonomy, and rights of people who use drugs, recognising them as people deserving of healthcare, rather than stigma and punishment.

2. Do you have any general comments on the updated KPIs?

The AODCCC supports the development of clear, outcome-focused KPIs within the DAP as an important mechanism for assessing whether the system is reducing preventable harm and improving population health. However, we urge the Department to apply caution in how the DAP KPIs are interpreted and used. KPIs should not be treated as definitive measures of success, but as partial indicators within complex social and health systems.

Future compliance with and reporting to these KPIs without incorporating LLE expertise and leadership is more likely to prioritise what is easiest to measure rather than what matters most to people directly affected by alcohol and other drug (AOD) systems, including safety, dignity, trust, accessibility, and sustained stigma reduction.

Effective mechanisms for embedding LLE perspectives include LLE-led advisory and governance structures with real decision-making authority; co-design processes that involve LLE from the earliest stages of KPI and program development; paid LLE roles across policy, commissioning, research, and evaluation; and formal LLE representation on boards, steering committees, and compliance mechanisms. It is far more that the existing DAP KPI's to integrate peer workforces, as qualitative measures.

Embedding LLE in broader ways improves the validity, equity, and effectiveness of KPIs, ensuring they guide policy and service decisions that genuinely reduce harm, save lives, and respond to real-world complexity. In addition, we see that KPI trends show correlation, not causation; assuming that changes in indicators directly reflect the effectiveness of specific policies or programs can result in misguided decisions. Without being complemented by qualitative evidence, lived experience, and contextual analysis, KPIs as they stand in phase 2 risk narrowing policy focus, distorting future priorities, and driving decisions that do not reflect real-world complexity or community need.

3. Are there any issues the department must be aware of when redesigning the DAP?

When redesigning the DAP, the Department must be alert to several key risks. Over-reliance on narrow or activity-based KPIs can oversimplify complex systems and misrepresent performance, particularly if KPIs are treated as definitive measures rather than partial indicators of real-world outcomes. This can distort policy and funding decisions away from long-term harm reduction and equity.

The meaningful involvement of people with LLE of AOD use must be embedded at all stages of policy design, commissioning, implementation, compliance, and evaluation. Without LLE leadership, the DAP risks prioritising what is easiest to measure over what matters most to people who use services, including safety, dignity, accessibility, and trust.

The Department must also address ongoing stigma and political sensitivity that limit uptake of evidence-based harm reduction approaches. Harm reduction should be recognised as a core function of the AOD system, not a discretionary add-on.

Finally, such program settings and aggregated data risk masking regional and population inequities. The redesigned DAP must retain sufficient flexibility to respond to diverse community needs and levels of risk.

4. Do you have any questions you would like considered for inclusion in the Key information and Q & A documents?

How will the DAP address, measure, track, and reduce stigma for people who use AOD?

How will the DAP address, measure, track, and reduce stigma for families, carers and significant others of people who use AODs?

Thank you for your consideration and commitment to inclusive policy development.

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