AODCCC
Alcohol and Other Drug
Consumer & Community Coalition

13th March 2026

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AODCCC response to Drug and Alcohol Program Consultations - Stage 1 - Program Logic.

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 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 Phase 1 of the Drug and Alcohol Program (DAP) feedback process.

1. Do you have any comments on the proposed PROGRAM OBJECTIVES in the Program Logic?

The AODCCC supports the four proposed program objectives as a strong foundation for a more compassionate, equitable, and person-centred Alcohol and Other Drug (AOD) system. But to be effective, objectives must move beyond existing service framings to meaningfully embed Lived and Living Experience (LLE) expertise across all levels of policy, design, delivery, and evaluation. Only through genuine inclusion of the AOD LLE communities most affected will objectives translate into measurable outcomes.

There is a significant risk that existing policy frameworks continue to draw on narrow and outdated causal theories, failing to capture the perspectives and priorities that LLE communities consistently identify as meaningful and necessary for genuine reform. Partnerships should prioritise communities disproportionately impacted by stigma, discrimination, and criminalisation. Prevention must shift away from narrow behaviour change messaging and fear based or moralistic approaches. People do not develop risky substance use in isolation; they do so within environments shaped by stigma, trauma, poverty, discrimination, and exclusion.

Prevention that frames substance use as personal failure is ineffective and harmful. Community led, grounded initiatives designed with LLE leadership offer more credible pathways. Effective harm prevention promotes safety, agency, and informed choice rather than abstinence only narratives. Early intervention is only possible when people feel safe to seek help. Stigma, discrimination, and fear of punishment consistently delay help seeking. National policy and legal reforms are urgently required to enable better access to evidence-based harm reduction, including supervised consumption environments, drug checking services, and public education initiatives. Early engagement often involves supporting safer AOD use, stabilisation, housing security, and family/community connection long before treatment is discussed. A person-centred system honours goals, whether that's for reduced harm, safer use, abstinence, or an improved quality of life.

Treatment and recovery must not only privilege abstinence as the sole marker of success. Wellbeing can increase while continuing to use substances more safely, or though reducing risk through peer led harm reduction, stabilisation, maintenance, and community connection. LLE expertise strengthens treatment systems by ensuring services are trauma informed, culturally safe, and grounded in autonomy rather than coercion. Ongoing support must extend beyond clinical outcomes to include shelter, social connection, and longer-term stability.

Workforce capability therefore must include genuine integration of AOD peer workers at all levels, with fair pay, career pathways, and governance roles. Data systems must evolve to measure long term, community defined outcomes, not just abstinence or service utilisation. These proposed Program Objectives are a strong start, but they must further evolve to be inclusive and welcoming of the lived realities of those most affected by AOD to determine whether objectives succeed as truly measurable change.

2. Do you have any comments on the proposed INPUTS in the Program Logic?

The AODCCC understands these inputs as foundational materials within this policymaking process signify the demands, pressures, expectations, and resources that flow through society into government.

The DAP Program Logic inputs will shape how people who use drugs (PWUD) and their families, carers and significant others (FCSO) gain attention, how they are framed, and which future solutions are considered legitimate. The policy inputs informing the DAP Program have evolved through a combination of voting, consultation processes and collective action, supported by the contributions of interest groups, peak bodies, political advocacy, research, and media organisations that influence and frame public discourse. Collectively, they will signal where our systems are failing and where policy responses need recalibration, adjustment or braver transformative change. A Department that truly understands and responds meaningfully will produce decisions that align with community priorities, and leading to safer, more equitable outcomes.

The five proposed inputs represent a positive shift recognising that government alone cannot prevent the harms associated with alcohol and other drug use. AODCCC strongly supports moving away from short term, crisis driven responses towards multi-year funding and commissioning models that prioritise continuity and system stability in the longer term.

Building and retaining a skilled multidisciplinary AOD workforce is essential. As is elevating AOD lived and LLE leadership into decision making, policy formation, and design of long-term outcome measures. Embedding AOD peer roles across all levels of the workforce strengthens service delivery and acknowledges the diverse contributions of LLE across education, research, advocacy, management, and governance. Safety, stability, and wellbeing for PWUD and FCSO is dependent on consistent improved access to education, healthcare, housing, justice, and strong community supports.

Robust governance structures inclusive of AOD LLE leadership will enable systems to respond more effectively to community realities and reduce AOD related harm

sustainably. Shared accountability to reduce AOD stigma across all levels of government is vital, as is strengthening data infrastructure and digital tools to support monitoring, evaluation, and service integration.

These inputs will only achieve the policy aims, as in prevention and minimisation that our communities value if the scope of understanding recovery as abstinence or service utilisation is broadened. For instance, evidence from comparable jurisdictions, such as Canada or Portugal demonstrate how integrated, human rights based, and harm reduction aligned approaches can lead to improved long-term outcomes for people who use AOD, their families, carers, and communities.

Overall AODCCC believes the five inputs are a welcome step toward a more effective, community aligned AOD systems. However, as a peak body we advocate further embedding AOD LLE expertise at every stage.

3. Do you have any comments on the proposed KEY ACTIVITIES in the Program Logic?

The AODCCC supports the direction of these proposed Key Activities and recommends strengthening further through embedding harm reduction principles, measurable stigma reduction practices, and AOD LLE leadership across all levels and domains. Recognising drug use as a spectrum within public health requires evidence-based approaches, which are more person-centered and non-judgmental. This ought to be more prominent throughout the draft DAP Program Key Activities.

Education, awareness, and prevention activities, including school, community, and sports-based programs must be delivered in ways that actively reduce stigma and support safer environments. Stigma remains a major barrier to disclosure, help seeking, treatment retention, and wellbeing. To be effective, education and workforce development should strengthen understanding of what AOD stigma is, how it forms, and why it persists; supporting an approach which recognises personal, social, and systemic impacts of AOD stigma; and builds skills in identifying biases, stereotypes, and harmful narratives. These Key Activities should be further designed and delivered in partnership with strong AOD LLE leadership to ensure authenticity and relevance.

At a systems level the proposed data infrastructure must also be inclusive of connected care, commissioning of research, and cross system governance as appropriate and necessary. However, this requires further articulation how AOD LLE leadership representation will be included in the governance structures, performance monitoring, and decision making. These are essential for accountability measuring of how AOD LLE expertise informs DAP policy, service design, and ongoing quality improvement.

For treatment, withdrawal management, assessment, harm reduction, digital monitoring, and aftercare activities, it is critical that DAP funded services operate without compounding stigma whilst acknowledging many people have used, currently use, or will in future use drugs, and many people have family members or peers who do so. Honest recognition supports emotional safety, reduces shame, and fosters genuine engagement. Routine assessments, targeted screening for at risk groups, brief interventions, and referral pathways must reflect person-centered care and prioritise emotional, as well as physical safety by adopting transparency, and continuity of supports when desired.

Overall, the proposed Key Activities form a strong foundation, the DAP Program Logic would benefit from explicitly linking how activity addresses and reduces stigma via measurable KPI's. This proposed alignment would further ensure the DAP Program delivers measurable improvements in safety, inclusion, and outcomes across the continuum, as in whole journey of lifetime.

4. Do you have any comments on the proposed OUTCOMES in the Program Logic?

The terminology 'Reduced Stigma' appears only once in the whole DAP Program Logic as a Short-Term Outcome. Yet addressing and reducing AOD related stigma is a fundamental determinant of safety, access, and wellbeing. To be effective, the entire suite of DAP Outcomes must explicitly and further integrate stigma reduction, advocacy capacity, and LLE leadership across its short, medium, and long-term outcomes.

As the state peak body, the AODCCC has consistently shown that our members (85% in the 2025–26 Annual Membership Survey) have experienced stigma or discrimination related to AOD use. This demonstrates that stigma is not peripheral, it is central to the barriers and harms faced by people who use drugs, their families, carers, and significant others.

Traditional AOD KPIs often privilege what is easiest to quantify rather than what is meaningful. This mismatch shapes DAP Program priorities and narrows what is considered 'success.' Such top-down indicators have repeatedly failed to measure 'stigma reduction' or the relational outcomes that matter most, by omitting the complex realities and evidence-based solutions identified within AOD LLE expertise. The proposed outcomes risk reinforcing this pattern by favouring quantitative coverage over meaningful qualitative impact, it risks privileging 'what meets funder expectations' instead of 'what drives sustainable improvements for individuals, families and communities most impacted.'

DAP Program Logic as it stands today overlooks insight from those who experience the systems firsthand. The current measures will struggle to capture Outcomes such as reduced stigma and discrimination, which will impact ability for engagement within the future DAP Program funded key activities. Embedding LLE leadership within service provision strengthens awareness of current AOD risks, harm minimisation, and supports entry pathways by providing relevant, non-stigmatising messaging grounded in lived AOD realities.

Efforts to reduce stigma are evidenced as more effective, for instance as seen when shaped by AOD LLE storytelling or through delivery of co designed training materials to challenge stereotypes, strengthening non stigmatising AOD language use & humanise lived experience.

Evaluation capacity increases when community led data systems capture outcomes traditional measures overlook, such as trust, or reduced stigma. Stronger referral pathways and improved cross system coordination emerge when guided by people who have directly navigated system gaps.

For more responsive policy, stronger outcomes, and longer-term system effectiveness the AODCCC advocates for outcomes to be more grounded in equity, accountability, and social justice whilst shifting away from narrow performance metrics. AOD LLE participation ensures that affected communities help define what we measure, how AOD impact is understood, and how relevant decisions are made.

5. Do you have any GENERAL COMMENTS on the draft Program Logic?

The AODCCC welcomes this opportunity to provide general feedback on the development of the DAP Program Logic. As the peak body for alcohol and other drug consumer and community informed systemic advocacy in Western Australia, we remain committed to elevating the expertise of people with LLE and ensuring their insights meaningfully shape reform.

The AODCCC supports the direction of the proposed key activities; however, we recommend strengthening them by clearly embedding harm reduction principles, stigma reduction practices, and LLE leadership across all domains of the DAP Program Logic. As an established and respected policy actor, the AODCCC is well positioned to leverage our networks, advocate, provide through co-design, and participate in further ongoing policy implementation to help ensure the DAP Program Logic becomes an effective, contemporary, and community centred initiative. To achieve this, we call on the Department to be courageous and adopt approaches that genuinely reflect the growing body of evidence.

We promote the interests, education, and wellbeing of people affected by alcohol and other drug use, as the only member informed AOD consumer body in the state where diverse views are shared openly, without stigma and judgment. We take courageous steps toward meeting community needs by looking beyond AOD stigma and addressing the structural conditions that reinforce inequity. Every response, insight, and story shared which contributed to this process is more than feedback, it is a catalyst for transformation. Together, we are not simply moving beyond stigma; we are rewriting the policy narrative to become more inclusive and effective for current and future generations. The AODCCC fosters human connection and holds a deep collective understanding of the complexities surrounding AOD use. Through collaborative projects and inclusive programs, we address stigma, elevate LLE perspectives, and create environments where LLE stories spark empathy, the understanding to drive policy and agitate for service reform. Education and training remain central to our work, including the co designed, peer led AOD Stigma Reduction Training program (2026).

To support the Department in building a contemporary, evidence informed, and community led DAP Program Logic, the AODCCC recommends prioritising:

- Stigma reduction training and education.
- AOD Language Literacy and practice reforms across the AOD sector.
- Peer led models of care, support, and service delivery.
- Inclusion of Lived and Living Experience representatives in policy, service design, and evaluation.
- Expansion and embedding of Lived/Living Experience leadership roles.

These recommendations are essential for ensuring the DAP Program Logic delivers activities, outputs, and outcomes that genuinely reflect the needs, strengths, and aspirations of the communities it seeks to serve.

Key Performance Indicators

6. Do you have any comments on the proposed PREVENTION KPIs?

To hold meaningful value within a prevention context, GOGs future service provision with KPI measurements must further embed harm reduction principles, stigma reduction practices, and AOD LLE leadership. These are additional measurable indicators essential to achieving short-term outcomes and for providing the foundation for meaningful medium-term prevention impacts.

At present, these Prevention KPIs remain heavily output focused, which may not reflect the systemic adjustments required for AOD prevention activities to be effective, equitable, and sustainable.

Counting materials or programs delivered is an administrative measure, not a prevention indicator. These metrics overlook core determinants of quality such as cultural relevance, evidence strength, workforce capability, stigma aware practice, and fidelity of delivery. Output metrics do not tell us whether resources are understood, trusted, or used by priority populations. Without indicators of stigma reduction, engagement, comprehension, and early behavioural change, the KPIs risk overstating system performance.

Digital analytics reflect exposure rather than meaningful engagement.
Downloads and impressions provide only surface level insight. AOD Prevention requires understanding whether people engaged with materials, found them useful, or experienced shifts in attitudes, knowledge, or confidence. Without complementary measures such as direct feedback from priority groups with AOD LLE, digital analytics can reinforce compliance focused reporting rather than continuous improvement.

Current these KPIs rely on the assumption that the DAP Program possesses adequate capacity to identify and support people experiencing stigma, marginalisation and complex social determinants. In reality, this capability remains inconsistent and under-developed.
Reporting 'people reached by priority group' will be ineffective unless DAP Programs are codesigned with the AOD LLE input, as reporting may reinforce inequities rather than addressing them.

Prevention success relies on program consistency, sustainability, quality, and workforce stability, none of which are measured in the proposed KPIs. A system level prevention approach requires indicators that reflect workforce capability and support, inclusive of AOD LLE expertise as evidence-based methods, and stigma reduction competence. The best way to achieve this is meaningful codesign with AOD LLE peak bodies, AOD LLE led/informed research and PWUD.

To improve prevention measurement, the KPI framework should incorporate indicators relating to:

- Quality and evidence base of stigma aware prevention programs.
- Engagement metrics beyond attendance or exposure.
- Co-design with First Nations, CaRM, and marginalised populations.
- Co-design with LLE AOD communities, peer workers, and FCSOs of PWUD.

- System enablers such as LLE workforce capacity and community partnerships.

Incorporating these measures would move the KPIs beyond counting outputs towards demonstrating genuine prevention progress, equity outcomes, and systemic change.

7. Do you have any comments on the proposed EARLY INTERVENTION KPIs?

Whilst Early Intervention KPI's must further address the barriers that prevent people from engaging with AOD support including structural stigma, internalised stigma, and the pervasive justice system lens that discourages people from seeking help due to fears of criminalisation, employment consequences, family judgement, or child protection involvement.

The proposed early intervention KPI omit any measurements for improving AOD literacy across the lifespan, which is an essential component of early intervention and critical for reducing barriers for engagement, enabling earlier, safer engagement with support.

Understanding and measuring reasons for help seeking, previous attempts to access support, and whether people had to wait for help is essential to strengthen early intervention and prevention pathways.

KPIs that measure changes in help seeking patterns over time, such as a shift from crisis driven contact towards earlier information seeking provide essential insight into whether early intervention approaches are functioning as intended.

Collecting demographic characteristics of family and friends seeking help (including age, gender, identity, cultural or language needs, and locality) is vital for identifying inequities, tailoring services, and ensuring future GOGs funded supports are accessible and responsive.

The KPIs require further input to be relevant and adequate in measuring whether services are delivering accurate, no stigmatising information and meaningfully involving AOD LLE and FCSO in program design, delivery and evaluation.

Finally, it is essential to recognise that substance use is not inherently harmful, and responses must prioritise the health and wellbeing of individuals and their family, carer, significant others and support networks.

Approaches grounded in stigma, criminalisation, and punitive measures have consistently failed to reduce substance use. Evidence from Portugal illustrates this clearly: decriminalisation did not reduce the number of people using substances

because that was not the policy goal, however it significantly increased help seeking behaviour contributing to increasing access to health services, reduced harms, and improved rehabilitation uptake. Outcomes that demonstrated that early interventions which reduce stigma and remove punitive barriers, support earlier help seeking and better engagement with healthcare.

Despite strong evidence for early intervention through harm reduction interventions, several Australian jurisdictions, including Western Australia, continue to resist pragmatic measures such as drug testing. The research remains clear; drug testing reduces harm, facilitates earlier contact with AOD information and support, and creates opportunities for real time early intervention education and engagement. These benefits align directly with prevention goals and with the intent of the proposed KPIs, but will require the Department to advocate for brave, evidence informed legislative change.

8. Do you have any comments on the proposed TREATMENT, RECOVERY AND MANAGEMENT KPIs?

The proposed KPIs as stands provide a limited administrative snapshot and will not fully capture treatment quality, stigma awareness or reduction, or AOD LLE defined outcomes. Without major strengthening, these KPIs risk reinforcing existing system failures rather than improving treatment and recovery.

Counting clients entering treatment tells us nothing about the far larger number who cannot or will not access services due to stigma, criminalisation, long waitlists, cultural unsafety, or fear of child protection involvement. Priority group reporting is useful, but it ignores the systemic barriers that keep these populations out of DAP funded services.

Likewise, counting treatment plans without assessing their quality, collaboration, relevance, or harm reduction alignment can reduce person centered care to compliance. A treatment plan that is not trauma informed, flexible, or co created with AOD LLE should not be treated as a quality indicator.

Volume alone cannot demonstrate adequacy, appropriateness, or continuity. Long identified gaps in aftercare will not be revealed through simple service counts. KPIs must measure whether aftercare is available, culturally safe, timely, and aligned with client defined goals, otherwise this KPI risks masking ongoing system failures.

Using employment as a recovery indicator is reductive and reinforces stigma. Workforce participation is shaped by discrimination, housing instability, criminal records, racism, disability, and socio-economic conditions not treatment engagement. Employment must not be imposed as a universal outcome, as FCSO's providing caregiving is often

unpaid, but has immense value to individuals, families, communities. Linking “social inclusion” to detention rates risks incorrectly assuming all justice system contact results from individual behaviour rather than punitive drug laws, over policing, and systemic discrimination. This KPI risks pathologising clients without recognising that criminalisation itself is a major barrier to help seeking and recovery. KPIs must measure access to diversion, non-punitive pathways, and harm reduction options.

To be meaningful, the KPI set must include measures of:

- Cultural safety, trauma informed care, and active stigma reduction.
- Involvement of AOD LLE and FCSO in planning, delivery, and evaluation.
- Adequacy and continuity of aftercare.
- Client defined outcomes rather than employment-based expectations.
- Equity of access and identification of structural barriers.
- System enablers such as workforce stability, training, partnerships, and safe referral pathways.

As drafted, these KPI prioritise activity counting over outcomes and fail to capture whether treatment, recovery and management' is safe, equitable, culturally responsive, or aligned with harm reduction. The framework needs substantial revision to measure what truly matters: quality, dignity, equity, and lived experience informed recovery definitions as appropriate.

9. Do you have any comments on the proposed SYSTEM ENABLERS KPIs?

The proposed KPI and the broader system fall short because they neither measure nor address the need for genuine LLE leadership. Reducing LLE involvement to 'representation' fundamentally misunderstands what is required for system reform, safety, and accountability.

Western Australia provides clear evidence that progress occurs only when LLE leadership, not tokenistic participation is embedded structurally. For instance, the Western Australia Government response to the 2022 Independent Review demonstrated a strong commitment to Lived Experience Leadership across the mental health and AOD system. Key reforms included establishing a Ministerial Advisory Panel with lived experience representation, creating a dedicated Lived Experience Advisory Group, and implementing new lived experience, First Nation, and AOD leadership roles. Together, these measures elevate lived experience into governance, strategy, and commissioning processes, strengthening system accountability, integration, and practice.

The KPI measuring the “proportion of services with at least one peer worker” is inadequate. Having one peer worker per service does not demonstrate meaningful integration, cultural change, or organisational readiness. Peer workers are too often under resourced, siloed, and treated as an add on rather than as essential contributors. This subject is addressed within the *WA Lived Experience (Peer) Workforces Framework*, which outlines best practice across mental health, alcohol and other drug, and suicide prevention contexts. The framework provides a nuanced and highly appropriate contribution to support and strengthen the policy context.

The KPI on 'proportion of sector forums with regular supported LLE participation' is essential, yet currently underdeveloped. LLE participation is meaningful only when it is paid, resourced, valued, and influential. The sector has a long history of symbolic consultation, often without decision making power or adequate support for participants.

Overall, the KPIs acknowledge the importance of LLE roles but fail to measure the conditions that enable safe, empowered, non-tokenistic involvement. Peer workers and LLE representatives are critical for stigma reduction, cultural safety, accessibility, and system accountability. KPIs must therefore go beyond presence and measure role quality, influence, safety, and structural support.

Without these improvements, the KPIs risk legitimising tokenism rather than embedding the meaningful, system level LLE leadership required to improve AOD treatment and recovery outcomes.

10. Do you have any GENERAL COMMENTS on the draft KPIs?

A core failure of the proposed DAP Program Logic KPI framework is that that it overlooks stigma as the most pervasive barrier in the broader systems. Stigma and discrimination are not incidental; they are drivers of harm. These determines who seeks help, who receives support, and who is excluded. Any KPI framework that does not explicitly measure stigma reduction will continue to reproduce the very inequities it claims to address.

Stigma shows up at every level:

- Self-stigma, internalised shame that stops people seeking help.
- Public stigma judgement and stereotyping that shapes community attitudes.
- Structural stigma policies and systems that punish, exclude, or criminalise.

- Stigma by association the discrimination experienced by families, chosen supports and carers.

These forms of stigma are visible across media, healthcare, services, family systems, workplaces, and community spaces, shaping how people who use drugs, and their families and supporters are treated.

AODCCC members consistently report avoiding service and care due to fear of judgement or confidentiality breaches, receiving delayed or lower quality care, and being denied housing, employment, education, or service access because of institutional rules and punitive policies. These are not theoretical harms; they are daily realities for people with AOD LLE.

Because stigma is systemic, reduction efforts must also be systemic. This requires:

- LLE led research which reframes causal narratives and drives evidence-based reform.
- Strong lived experience advocacy embedded in governance, not operating from the margins.
- Community and political leadership committed to non-stigmatising, accurate language.
- Meaningful LLE leadership that has relevance throughout all levels of design, policy, evaluation and governance, not tokenistic “representation”.

To be more meaningful, the draft KPI must be expanded to address and record:

- Whether peer workers are embedded, supported, and safe.
- Role types of LLE peer workers: variety of AOD, MH, Disability, Family Domestic Violence, Suicide, Family/Carer, First Nation, CARM, ELD & LGBTIQA+SB. Peer work is not a one size fits all approach.
- Equitable pay and role parity, access to clinical and peer supervision.
- Clear role structures, progression pathways, leadership opportunities.
- Use of peer workers across treatment, prevention, aftercare, and community engagement.

Without such, peer worker presence risks becoming a compliance checkbox rather than evidence of system level adoption of LLE expertise. The evidence is unequivocal; systems only change when people with lived and living experience lead and participate in the change. For this KPI framework to drive real improvement, it must centre stigma reduction as a measurable outcome, embed LLE leadership across every domain, and

commit to dismantling the structural barriers that perpetuate harm. Without this shift, the system will continue to fail the very people it is designed to support.

11. Do you have any further comments on the draft Program Logic and KPIs?

AODCCC assumes and explicitly expects that the final DAP Program Logic will recognise, integrate, and address the interconnected AOD realities with Mental Health, Justice, Child Protection, Disabilities, and Family & Domestic Violence.

A genuine no wrong door approach must ensure people are never excluded or redirected simply because their needs cross system boundaries.

The Program Logic must also meaningfully respond to alcohol and other drug use as co-occurring with cost-of-living pressures, homelessness, wealth inequality, and the broader social determinants of health.

Turning people away from AOD support for instance due to mental health issues or identifying homelessness as a barrier to restrict consumers entering residential/therapeutic services is unacceptable and harmful.

We advocate for a system where every door is the right door, every pathway maintains dignity and continuity, and every person can access the support they need without stigma, discrimination, displacement, or structural neglect.

12. Are there any issues which you consider the department must be aware of when redesigning the DAP?

The Department must be aware of power imbalances arising from the socio-political context in which these documents were produced. AODCCC hold the view that AOD LLE expertise is not adequately visible throughout the draft DAP Program Logic design. This lack of visibility increases the risk that the current draft Key Outputs will become performative, functioning only as statements within documents rather than driving meaningful and transformative change.

At the Key Activity and Key Output DAP Program levels, AOD LLE involvement has the potential to address stigma, improve overall care quality, increase accessibility and safety, enhance understanding of service impacts, support innovation, and ensure policy responses reflect the needs of our communities.

The decentring of PWUD and FCSO in the framing of the draft DAP Program Logic is a concern. Historically when policy documents write about PWUD and FSCO, rather than

write policy documents with PWUD and FCSO any future policy outcomes will typically omit complexities, replicate the current complex power imbalance, and allow stigma and discrimination to prevail. The Department needs to show increased awareness, as not supporting the current evidence informed AOD LLE paradigm simply promotes a bureaucratically paternalistic view of 'helping' PWUD rather than improving health and social outcomes and reducing economic harm as intended.

13. Do you have any questions you would like considered for inclusion in the Key Information and Q&As document?

In conclusion, the Alcohol and Other Drug Consumer and Community Coalition (AODCCC) emphasise the need for explicit confirmation that the Q&A's document, and consultation process will meaningfully embed the expectations articulated through stakeholder feedback. This must include:

- Genuine, decision shaping Lived and Living Experience (LLE) expertise, particularly AOD LLE embedded across all stages of program design, governance, and implementation.
- Safe, confidential, culturally appropriate, and trauma aware feedback mechanisms that protect People Who Use Drugs (PWUD) and Family, Carer, and Significant Others (FCSOs) from any risk or repercussion, ensuring their contributions are respected and valued.
- Rigorous and transparent systems for capturing, responding to, and acting upon feedback, including clear "you said, we did" processes and escalation pathways when insights are not adequately addressed.

The AODCCC reiterates that genuine reform requires more than consultation; it requires structural adoption, accountability, and measurable follow through across the entire DAP Program and its associated services. We therefore urge the Department consultation team to clearly demonstrate how these commitments will be operationalised in practice.

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

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