AODCCC

Alcohol and Other Drug
Consumer & Community Coalition

Membership Survey Report 2026-2027

...beyond stigma

Acknowledgement of Country

AODCCC acknowledges that we are on Nyoongar country and extend our respect to the Traditional Custodians, the Wadjuk people, their Elders past and present. We recognise the strength, resilience, and wisdom of all Aboriginal, Torres Strait Islander and First Nations cultures. We acknowledge and respect their continuing culture and the contribution they make to the life of this city and this region.

Recognition of Lived and Living Experience

We would like to acknowledge the individual and collective expertise of those with a lived or living experience of alcohol and/or other drug use. We acknowledge the emotional labour and vulnerability that is present in this space. We also recognise the work of those who came before us to build the foundations to enable this work to take place.

About AODCCC

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. Our aim is to empower the voices of consumers, their families and supports, ensuring the health and wellbeing of our community. The AODCCC was incorporated in June 2018 in response to the need and support for an alcohol and other drug specific, consumer and community informed advocacy body. We have received funding from the Mental Health Commission of Western Australia in order to progress our establishment. The AODCCC would like to acknowledge the ongoing support from the Mental Health Commission of Western Australia in providing the vital funds that enable this work to take place.

Contents

Suggested citation:
Alcohol and Other Drug Consumer and Community Coalition (AODCCC), 2026. *AODCCC Membership Survey Report 2026-2027*. Western Australia. Alcohol and Other Drug Consumer and Community Coalition.

Executive Manager's Message

Welcome to the AODCCC Membership Survey Report 2026–2027.

This report marks the 5th year of AODCCC engagement with a highly diverse, experienced, resilient, and insightful membership. We appreciate the generosity of those members that have come forward to share their lived and living experience of alcohol and other drug use in Western Australia.

Our intent this year was to dedicate a portion of our survey to Families, Carers and Significant Others (FCSO). We understand this often overlooked, yet crucially important group of our community present many significant insights and are essential partners in addressing a whole range of intersecting issues. They face considerable challenges, often alone and overlooked within health and social service systems. We are grateful to have captured insights into this experience and will continue to ensure FCSO's have a platform at AODCCC, as we advocate for change.

Our exploration into stigma and discrimination continues, as we gather further insight into the impact of Self-Stigma, Public Stigma and Structural Stigma. Collectively, these three categories of stigma reinforce one another, creating a cycle that not only impedes access to care and health equity, but also diminishes individuals' dignity, trust, and sense of hope. Our work continues.

You will also see examples of hope throughout this report, signs of resilience and accounts of holistic, person-centred approaches to care, which have made a significant difference to people in need.

We trust this report will provide valuable insights for the broader community, policy and law makers, service providers, and systems, while reaffirming the significant influence of our members' voices in shaping our collective way forward.

Sincerely,

Alex Arpino
AODCCC Executive Manager

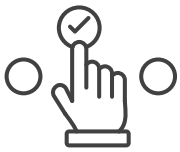
How we created the survey

The AODCCC Membership Survey offers a vital platform for all members to actively inform our priorities, ensuring that everything we do is grounded in lived and living experience of alcohol and other drugs (AOD). We continue to be guided by our monthly Reference Group (RG), comprising a small group of dedicated members who provide passionate input, feedback, and participation in our ongoing systemic discussions. Prior to its release, this survey was evaluated and finalised by the members of our RG, where they assisted in the design and formulation of the questions, all underpinned by our strategic plan 2024-2027.

This year, we had **85** members complete our (anonymous) survey across a **seven-week period.** The annual engagement we receive through this survey reflects the powerful momentum and passion of our membership to contribute to community-led systemic advocacy, and have their experiences and perspectives heard as part of our ongoing collective action towards achieving systemic change in Western Australia (WA).

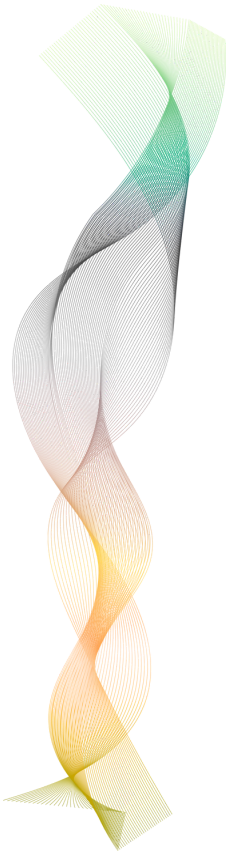
Acknowledgement of "prefer not to say"

The AODCCC would like to acknowledge that even in anonymous surveys, people might choose the option "prefer not to say" for several thoughtful reasons. Time or lack of relevance can often be a reason to select this option, along with psychological and emotion factors, such as privacy, fear of judgement and uncertainty or ambiguity, along with ethical or political considerations, including distrust or resistance to categorisation. We acknowledge that "prefer not to say" is a powerful option that gives people control over their data and acknowledges that not every question fits every person.



In the 2025-26 AODCCC Membership Survey, we asked our members to comment on Health Canada's Substance Use Spectrum and whether a WA focused version of this model, or something similar, would be a helpful tool to educate and inform on the complexities of substance use. A vast majority of last year's responses expressed clear support for a WA-tailored version of the model, citing its many potential positives.

This year, we modeled our first survey question on this topic, to further establish our hope for the development of a health-focused Spectrum of Substance Use within the WA community. **We asked our members to place themselves on the spectrum in relation to their current health.** The following categories were provided:



Non-use
(Avoiding the use of any substances prescribed or non-prescribed, abstinent)

Beneficial use
(Substance use, prescribed and or illicit that can have positive health, social or spiritual effects)

Lower-risk use
(Substance use that has minimal impact to a person, their family, friends and others)

Higher-risk use
(Substance use that has a harmful and negative impacts to a person their family, friends and others)

Addiction
(A condition that affects the brain and involves compulsive and continuous use despite negative impacts to a person, their family, friends and others)

Prefer not to say

(www.canada.ca/en/health-canada)

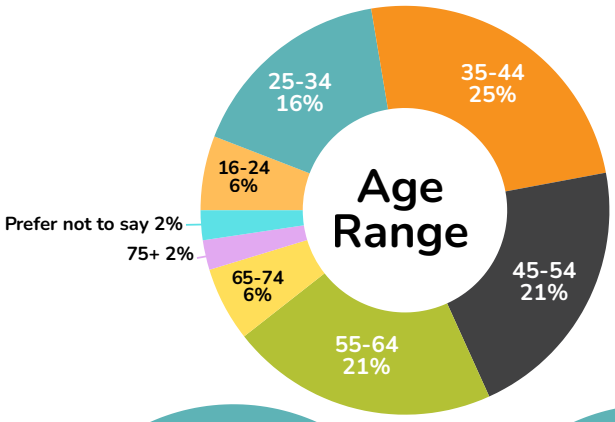
Implementing a Spectrum of Substance Use tool would be a helpful asset for WA as it reflects the reality that people's experiences are diverse and fluid; a continuum rather than a binary state. This was reflected in our members responses which show a diverse selection and that majority located themselves in categories outside of crisis or dependence.

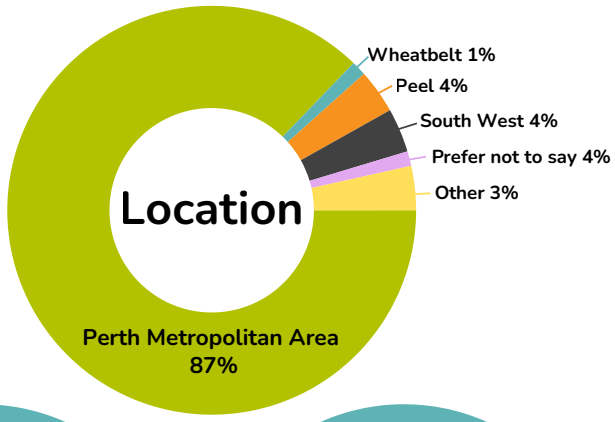
27% identified as non-use, 38% as beneficial use, 21% as lower-risk use, 4% as higher-risk use, and 7% as addiction, and 3% responded with prefer not to say.

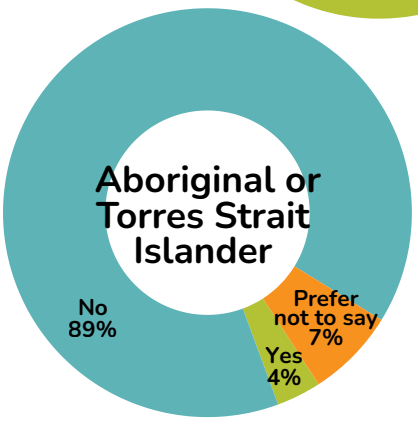
Framing substance use in this way provides a more practical, respectful and health-focused foundation for policy, service design and community conversations in WA. This reduces stigma, supports early intervention, and aligns with person-centred, harm reduction and lived and living experience informed approaches that better respond to people's different needs and goals.

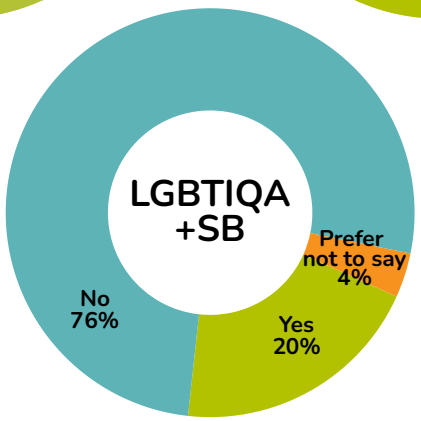
Demographics

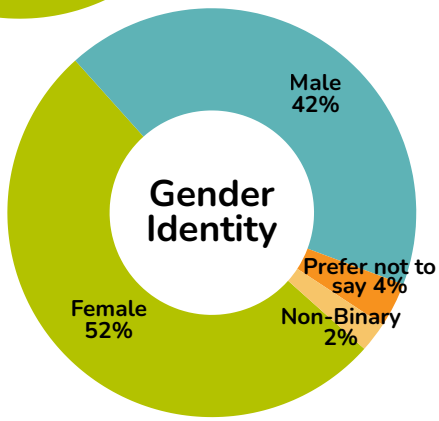
AODCCC strives to authentically engage our community, providing space to share the unique and highly nuanced experiences of each person beyond the demographic. We actively work to safeguard from any bias, stigma and stereotyping that is often associated when approaching the community as groups. As such, demographics are utilised as a general snapshot, while acknowledging that diverse views and experience come in many forms, regardless of cultural backgrounds, genders and sexual orientation.

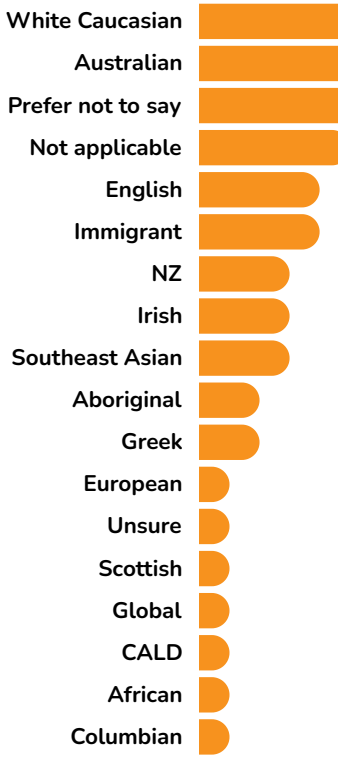








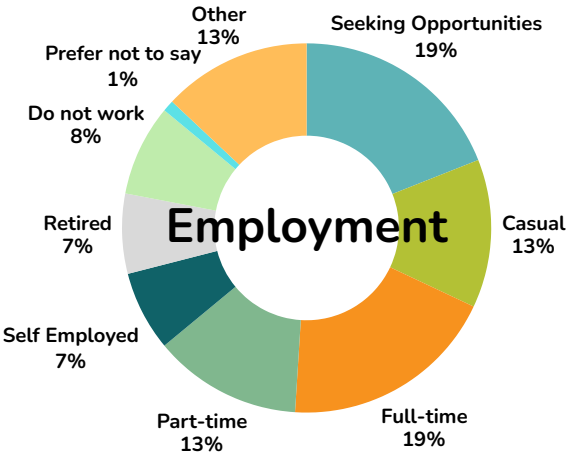




To capture the diversity within our membership **we asked participants to share what they perceive their cultural and racial identities to be.**

The data reveals a rich tapestry of backgrounds that extend across many countries, each contributing to the organisation's unique cultural fabric.

Importantly, nearly 12% of members chose not to disclose their identity, and others selected broader or more fluid identifiers such as Immigrant, Global, and CALD, highlighting that identity is both personal and multifaceted.



We asked participants how their lived or living experience of AOD influences, or has impacted, their employment status.

Approximately 34% of members described positive employment outcomes, particularly where lived and living experience is recognised as a professional strength. This supports action to expand the peer workforce and career transition pathways across AOD, mental health and community service sectors.

Roughly 48% reported negative employment impacts, with the strongest concerns relating to stigma and discrimination (17%), job loss (8%), police clearance barriers (7%) and medication or treatment access issues (5%). This reinforces the need for employer education, police clearance reform, and more flexible, employment-friendly treatment access.

Approximately 21% reported no current impact on employment, although many noted earlier barriers. This suggests community action should not only address crisis points, but also strengthen long-term recovery, retention and inclusive workplace practices.

A smaller but equally important group (5%) were family members or carers whose work was affected by supporting loved ones experiencing AOD issues, highlighting the need for workplace flexibility and targeted supports for carers as part of a broader community response.

Throughout the survey responses, AOD use was described as having a profound and often lasting impact on employment, shaping not only people's capacity to obtain and maintain work, but also the kinds of roles they feel able to pursue. Many felt that their AOD use impacted reliability, concentration, and attendance, and working while unwell meant being unable to function effectively in the workplace. In some cases, members described losing jobs altogether due to active use, hangovers, relapse, or extended periods away from work.

Others described longer-term structural barriers, such as gaps in employment history, criminal records and police clearances, loss of licence, and the stigma and judgement attached to past or current AOD use, all of which limited opportunities and made job applications, disclosure, and workplace conversations difficult and distressing. For members in regional areas, treatment requirements such as pharmacy dosing, transport constraints, and medication side effects, added further challenges to sustaining regular employment.

At the same time, the responses show that the relationship between AOD and employment is not solely negative. For a significant number of people, lived and living

experience has become a source of insight, purpose, and vocational direction, particularly within peer work, counselling, community services, homelessness roles, and the broader AOD sector, where personal experience can strengthen connection, empathy, and credibility.

Overall, the survey suggests that **AOD impacts employment in complex ways, with harm driven not only by substance use itself, but also by stigma, inflexible systems, criminalisation, and limited employer understanding. Supportive workplaces and settings that recognise and value lived and living experience, create meaningful pathways towards sustainable and valued employment.**

The following points summarise the key themes and priorities identified in relation to AOD and employment. They reflects areas where members indicated a need for action or system improvement, highlighting how individual experiences are shaped by broader structural factors, including stigma, policy settings, and workplace practices. The identified priorities represent potential directions for further exploration, rather than a confirmed advocacy agenda or endorsed position.

Police clearance reform

Recommended Action: Advocate for spent convictions legislation and flexible National Police Clearance policies.
Target: Government/ Employers
Reform and address existing police clearance processes to reduce barriers for people with AOD histories, including fairer assessment of minor or historical offences and greater transparency in decision-making. This should be applied across recruitment, onboarding, and screening processes within government organisations, moving beyond compliance-driven approaches towards more equitable access to employment for people with lived and living experience.

Workplace stigma reduction

Recommended Action: Develop employer education programs on AOD lived experience.
Target: Business/ Service/ Health sector
Implementation of stigma reduction training and education programs to challenge misconceptions about AOD use and foster inclusive, psychologically safe workplace cultures.

Peer workforce expansion and Lived and Living Experience pathways

Recommended Action: Promote peer worker roles and lived and living experience transition pathways into health/ community sectors.
Target: AOD/ health sectors and training/ education
Expanding WA's peer workforce capacity, acknowledging lived and living experience as valuable professional expertise, and systematically develop and embed structured employment pathways for people with lived and living experience.

These must be appropriately resourced and underpinned by formalised structures to support participation, progression, and advancement into leadership roles, and be aligned with existing policy frameworks, and governance requirements. This creates an opportunity to support organisations to adopt practices which improve opportunities, equity and alignment with lived and living experience peer workforce principles, relevant frameworks and legislation.

Medication access

Recommended Action: Advocate for flexible pharmacy hours and regional access.
Target: Health services
To improve access to pharmaceutical treatments by tackling barriers to affordable, flexible, pharmacotherapy, including enhanced regional access and the development of lived and living experience-informed pharmacy models.

Supportive employment

Recommended Action: Create best practice guidelines for AOD-inclusive workplaces.
Target: Employers/ HR departments
Embed AOD-inclusive workplace policies that enable equitable workforce participation for people with lived and living experience, inclusive of family, carers and significant others with 'hands on' caring responsibilities. Organisations may move beyond minimum compliance by integrating supportive practices such as flexible scheduling, non-punitive responses, equitable access to leave, and clear pathways to support services into standard workforce systems. These approaches are essential to sustaining employment, supporting wellbeing, and addressing structural barriers across workplaces.

Drug testing policy

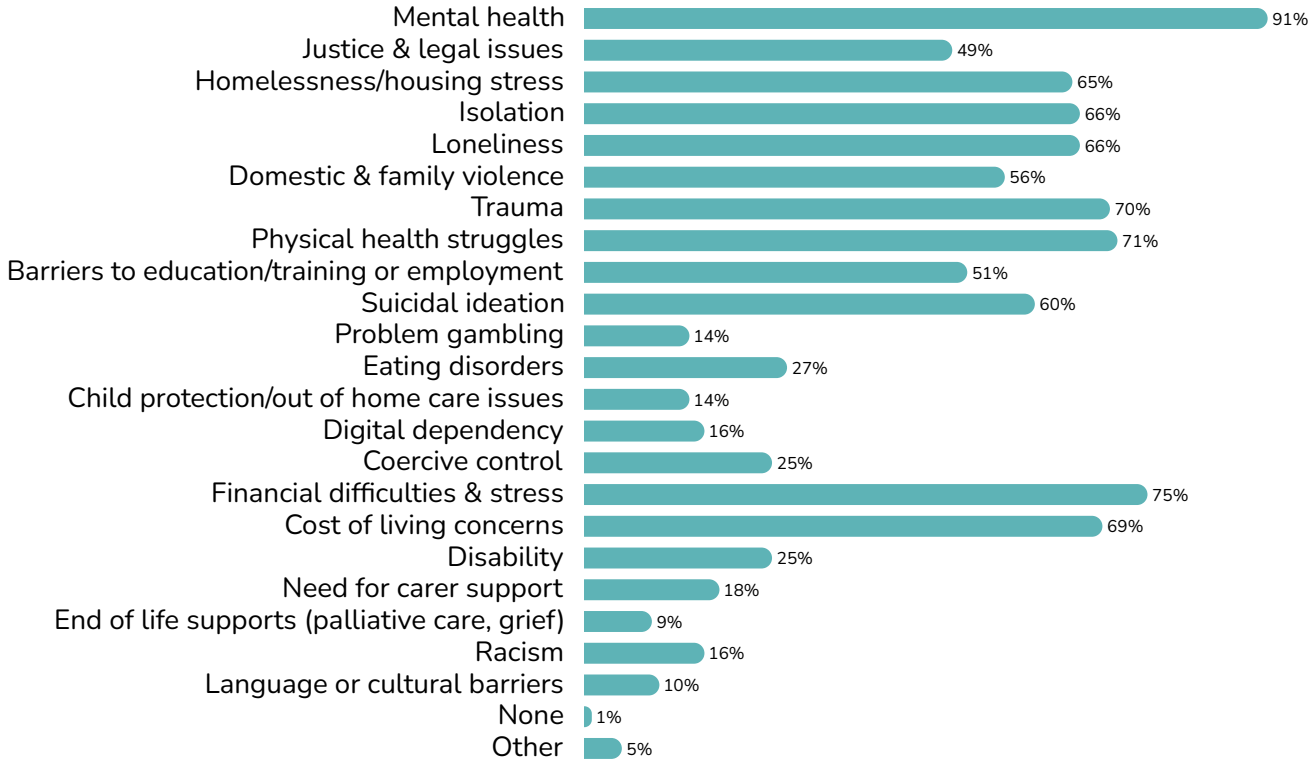
Recommended Action: Challenge unnecessary workplace drug testing policies.
Target: Industry/ Government
Review workplace drug testing policies and processes to ensure they are evidence-based, proportionate, non-discriminatory. These must be focused on whole of workplace safety, rather than individual workers or punishment and exclusion practices that reinforce stigma.

Family and Carer Support

Recommended Action: Develop workplace supports for AOD-affected family carers.
Target: Employers/ Policy
Despite the well-established link between employment and improved social and wellbeing outcomes, caring responsibilities create significant structural barriers to workforce participation. The level of dissatisfaction and declining capacity to engage in both voluntary and paid work among family and carers, highlight persistent systemic gaps. These impacts are compounded by the insufficient integration of family/ carer lived and living experience expertise in policy, service design, and workforce systems, thus limiting the effectiveness of responses to family and carer needs.

Beyond Stigma

Co-occurring experiences in addition to alcohol and other drug use are broad and diverse. Below is a breakdown of the co-occurring experiences reported by our members.



We asked participants, **when seeking support to address your alcohol and other drug use and co-occurring circumstances, have the services you accessed met your needs?**

Responses highlight mixed experiences of accessing services. Some individuals reported life-changing and effective care, particularly through specialised programs, peer support, and trauma-informed practitioners, where outcomes such as achieving sobriety, learning coping tools, feeling supported, and life-saving interventions were experienced.

On the contrary, other responses described significant systemic shortcomings. A dominant theme was the fragmentation of services, with mental health, AOD, and social supports often operating in silos, resulting in people being repeatedly referred on without receiving holistic care.

Structural barriers such as long waitlists, strict eligibility criteria, affordability, and geographic access further limit support, often preventing people from accessing services altogether or delaying help until crises deepen.

Experiences of stigma and discrimination, especially in mainstream healthcare settings, were widespread contributing to distrust and, in some cases, the withholding of important information. There was emphasis on the lack of person-centred, culturally safe, and inclusive care, particularly for those with complex needs or diverse identities.

Members identified severe gaps during crisis, with the high cost of private care a major barrier in crisis situations. There were particularly concerning accounts of suicide risk being dismissed, inability to access hospital care, and over-reliance on family due to system failure.

There is a consistent call for access to peer and trauma-informed support, with emphasise on this type of support being more empathetic, effective, and better at addressing the 'whole person'.

Overall, while pockets of high-quality and compassionate support exist, the broader system is perceived as inconsistent, difficult to navigate, and insufficiently equipped to respond to the complexity of AOD and co-occurring challenges. Service options need to operate with compassion, understanding and flexibility to ensure that the diverse needs of the community can be met.

Alcohol and other drugs stigma is the negative attitudes, beliefs, behaviours, policies and systems directed towards people who use (or are perceived to use) substances, as well as their families, carers and significant others.

We asked participants, **how and where have you experienced AOD-related stigma, and what impact has it had?**

Direct quotes to this question have been grouped into the 3 levels of stigma as defined in the *AODCCC Alcohol and Other Drugs Stigma Position Paper: Moving Beyond Stigma.*

Self-Stigma

Occurs when people internalise the negative messages they hear about AOD use [4].
People may:

- Believe harmful stereotypes about themselves.
- Feel guilt, shame or failure.
- Hide their substance use.
- Avoid seeking help or support.
- Experience isolation and declining self-worth.
- Be at an increased risk of self-harm or suicidal ideation.

Public Stigma

Occurs in everyday interactions and community attitudes [4]. This includes:

- Being described with dehumanising labels such as 'junkie' or 'addict'.
- Seeing harmful stereotypes reinforced on TV, in films and on social media.
- Being judged or denied goods or services.
- Receiving harsh or dismissive treatment from healthcare professionals, police and other service providers.

Structural Stigma

Occurs when institutions and systems disadvantage or exclude people who use substances [4]. This includes:

- Avoiding healthcare due to fear of judgement and confidentiality concerns.
- Receiving lower quality or delayed care
- Policies that punish, exclude or reduce opportunities.
- Institutional rules that limit access to housing, employment, education or services.

AODCCC Alcohol and Other Drugs Stigma Position Paper: Moving Beyond Stigma: https://aodccc.org/

Experiences of Self-Stigma and its impacts

Self-stigma is often experienced as shame, guilt and a collapse of identity, with many people internalising feelings of failure and unworthiness before any external judgement occurs.

"I have personally felt guilt, shame and failure... even self-doubt and anxiety about coming forward."

"Feeling worthless... without hope."

"I approached help... already persuaded of my own unworthiness."

Fear of disclosure and hiding identity often lead people to conceal their AOD use to avoid judgement, which reinforces isolation and reduces access to support.

"I have to hide my history... too scared to be stigmatised."

"Not being able to disclose personal information."

"I became adept at self-editing... presenting a simplified version."

Self-stigma can cause people to withdraw from help-seeking, leaving them feeling too ashamed or unworthy to engage, even when they are in crisis.

"I was afraid of asking for help as I believed I would be judged and felt I was not worthy of assistance."

"Made me feel embarrassed and deterred me from seeking support again."

"It's just easier to not engage at all."

Self-stigma can deepen distress over time, contributing to isolation, relapse, suicidality and other serious harms.

"[stigma] leads to isolation and loneliness and if that goes on too long, suicidality is not far behind."

"Threatens suicide... low self-esteem."

"Made me feel isolated, so I used more drugs."

Experiences of Public Stigma and its impact

Public stigma often labels and dehumanises people, viewing substance use as a moral failure rather than recognising a person's full humanity. It can often lead to social isolation, costing people relationships and a sense of community connection.

"I was looked at as just a drug addict."

"I have been treated as a less than person because of presenting to [health services] to try and get medical help."

"As soon as someone finds out that you are a drug user they look at you in a completely different way, which is where the stigma badge comes into affect."

"Lost many friends and family because I was a 'junkie'."

"Shunned and isolated... no support system."

Public stigma often frames AOD use as a personal choice, placing blame on individuals and families rather than recognising the vast complexities and contexts.

"I was [seen as] a 'junkie' that didn't care enough to help myself. I wanted to help myself, I just didn't know how at the time."

"As parents we have experienced stigma [by association]. Comments like 'you must have not been tough on him'."

"Is it stigma, or is it the harsh truth."

Public stigma is reinforced by stereotypes with simplistic narratives that obscure the reasons why people use substances, which leads to judgement and shame.

"Judgement and complete misunderstanding of why we use, from police, hospital, community."

"When I sought support... the counsellors expressed that my drug use didn't seem to impact me significantly and that I appeared put together and didn't fit the stereotype. It made me feel embarrassed and deterred me from seeking support again."

"People get their information from media... against drugs."

Public stigma can be intensified within cultural and community settings, where shame, exclusion and intergenerational harm may be shaped by racism, trauma, displacement or rigid social expectations.

"Muslim community... always [AOD] stigma there, isolating this type of people."

"We have been excluded... for generations."

"My parents use alcohol because of racism, trauma and displacement."

Experiences of Structural Stigma and its impact

Structural stigma exists within healthcare settings, including discrimination, neglect, dismissal, denial of care, and harmful assumptions.

"They just dismissed me... didn't give me the help I needed."

"Dr said 'I suppose you want Valium, do you?!'"

"...I witnessed a nurse in ED saying to the person 'oh, you used XX drug, no sympathy for you then."

"Doctors not wanting to provide adequate care due to alcohol use."

"Everything blamed on drugs."

Structural stigma can contribute to trauma within healthcare settings with experiences described as dehumanising, unsafe, and retraumatising.

"They just dismissed me, didn't give me the time of day... I needed a safe place and they made me feel unsafe."

"Appalling... berated in full view of the ED."

"I left without follow up... during a crisis."

"Loss of trust in the system."

Structural stigma contributes to policy and system design failures, services which are not built for complexity or lived and living experience, and unsupportive priorities.

"...Systemic neglect I experienced because I was 'too complex'."

"Policies... embedded disadvantage."

"Refused help while homeless."

"Detox centres not keen to take me in because I'm looking at giving my body a rest from the drugs and not wanting to go into longer term treatment."

"Justice system treating AOD issues as criminal rather than medical."

"Imagine as many rehab beds as prison beds."

Structural stigma exists beyond healthcare.

"Turned down life insurance because of my medical history."

"Excluded from decision making and citizenship."

It is evident that the impact of stigma is not confined to a single experience or setting; rather, self-stigma, public stigma and structural stigma operate together to produce deep and compounding harm.

The result is a pattern of profound social disconnection, delayed or avoided care, worsening health risks including relapse and overdose, and ripple effects that extend to families and communities.

Together, these three categories of stigma form a mutually reinforcing cycle that not only undermines access to care and recovery, but also strips people of dignity, trust and hope.

> ***"They constitute an ecology... Self-stigma makes one less likely to challenge public stigma. Public stigma legitimises structural stigma. Structural stigma confirms self-stigma."***

Stigma Divides. Compassion Connects.

We asked participants to tell us about a time when they had experienced compassion in relation to their (or a family members) lived and living experience of AOD.

Responses highlight the profound and transformative role of compassion in the lives of members navigating AOD use. Across a diverse range of experiences, **compassion was consistently described as a critical factor in reducing stigma, fostering connection, and supporting pathways to recovery.**

Members reported experiencing compassion in a variety of settings, including rehabilitation services, healthcare environments, peer support groups, and within personal relationships. These experiences were often characterised by non-judgemental attitudes, active listening, and an authentic recognition of each person's humanity beyond their substance use.

The responses frequently emphasised the importance of being accepted "where they were at," noting that this form of unconditional regard created a sense of safety and belonging that is often absent in stigmatising environments.

For many, engagement with peer-based and community-led services provided particularly meaningful encounters with compassion, where shared lived experience helped to reduce shame and foster mutual understanding. One response reflected on the impact of such environments, stating that ***"everyone at these services were non-judgemental and so accepting of where I was at on any given day. It was such a breath of fresh air."***

This sense of acceptance was echoed across numerous responses, reinforcing the value of person-centred, trauma-informed approaches to care.

Compassion was described as an active and relational practice, rather than a passive sentiment. Members highlighted the significance of being truly seen and heard without judgement or urgency to "fix" their situation.

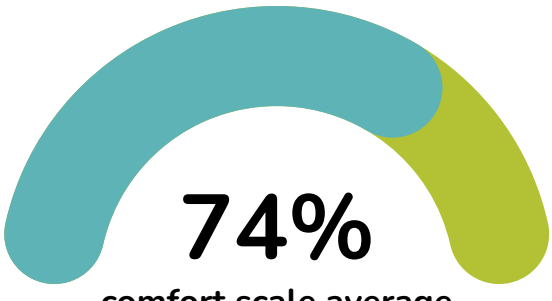
In one particularly powerful account, the impact of a peer support interaction was explored, ***"they witnessed. And in being [fully] witnessed without condition, something in me that had long been braced for judgment, slowly released its grip."*** Such experiences underscore the importance of presence, empathy, and genuine human connection in fostering trust and facilitating personal change.

Importantly, acts of compassion were not limited to formal service settings. Many members described meaningful moments of care from healthcare workers, family members, and even brief interactions with community members. These gestures, while sometimes small in nature, had lasting emotional impact. Simple acts of kindness and attention can reinforce an individual's sense of worth and dignity, as one member recalled, ***"the nurse didn't have to talk to me or anything, but she gave me the time and day...I'll never forget that."***

Overall, we observe that compassion plays a central role in shaping positive experiences for people affected by AOD use. It serves not only to counteract stigma, but also to strengthen engagement with support systems, promote wellbeing, and inspire individuals to extend compassion to others. These insights reinforce the importance of embedding compassion as a foundational principle across all services, systems, and community responses to AOD-related challenges.

How comfortable do you feel calling out or challenging AOD stigma?

People challenge AOD stigma through a combination of drawing on their lived and living experience, education, language change, advocacy, and interpersonal strategies, while also navigating significant emotional, social, and structural barriers that shape when and how they call out or challenge stigma.



A central approach to challenging AOD stigma involves the **sharing lived and living experience**, **with the goal to humanise AOD use and counter stereotypes.** This reframes AOD use as part of a broader life story rather than a defining identity, positioning lived and living experience as a form of expertise and a tool for stigma reduction.

Education and context-setting emerge as one of the strongest strategies. Members challenge stigma by **explaining the complexity of addiction and the reframing of AOD use** away from being viewed as a moral failing. By emphasising links to trauma, mental health, and structural disadvantage, often drawing on evidence-based or trauma-informed perspectives, members promote more compassionate and nuanced understandings of substance use. This educational work can be delivered both gently and assertively, depending on the audience and situation.

Closely linked to this is the **active challenging of stigmatising language**, with many members expressing they correct terms such as "addict" or "junkie" **by promoting person-first, non-stigmatising language**. This functions both as a form of education and as a boundary-setting practice that reshapes how AOD use is discussed. Some members extend their efforts into advocacy and structural change, working within professional, community, or policy contexts to address stigma at institutional levels.

Stigma operates at both interpersonal and systemical levels, requiring responses and call-out efforts across multiple domains. Interpersonally, members adopt gentle questioning and perspective-shifting strategies, using curiosity and reflective dialogue to challenge assumptions without escalating conflict. Others engage in bystander intervention, standing up for individuals experiencing judgement and reinforcing their humanity in social or community settings.

At the same time, the survey responses reveal important reasons why people choose not to challenge stigma. These include fear of judgement, shame, unwanted disclosure of personal experiences or potential ineffectiveness, safety concerns, or professional constraints (particularly in healthcare settings). These barriers highlight the significant emotional labour involved and the role of power dynamics and context in shaping any stigma-challenging actions.

"I explain to whoever, that addiction has many underlying issues."

"I am always open to telling my own experiences with AOD... to help in stigma reduction."

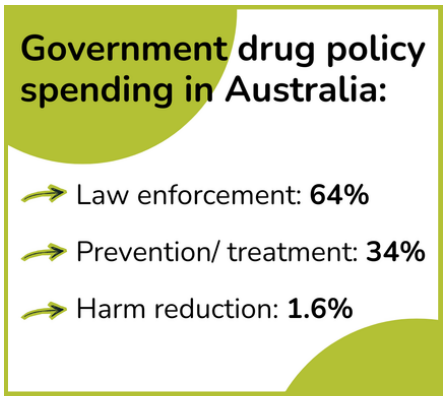
"I generally ask questions with curiosity... about the evidence behind their discriminating statement."

"Depends on the risk of harm/violence. Sometimes it simply ain't safe."

Systemic Advocacy

The AODCCC believes that meaningful and sustained harm reduction and prevention efforts must address long-term structural drivers such as poverty, trauma, deprivation, housing insecurity and mental health inequality.

Within the survey, we shared the adjacent image depicting the current government drug policy spending allocations in Australia.



UNSW Sydney: https://doi.org/10.26190/unsworks/30075

We asked participants, **what long-term government actions/ spending allocations do you believe should be considered or implemented to better protect people who use substances?**

The responses paint a clear and compelling picture of what people want our government to fund, with **harm reduction being the strongest and most unifying priority.**

Members emphasised the links between AOD use and co-occurring challenges such as, trauma, mental health challenges, violence, poverty, and unmet emotional needs, highlighting that substance use is often ***"a way of coping... to block out our past traumas"*** and that ***"addiction isn't a choice and is like a physical and mental illness."***

There is a collective **call for government investment in services that keep people safe, reduce preventable harm, and meet individuals where they are at**, rather than punishing or moralising their circumstances. There is a clear **call for trauma-informed, person-centred supports** that recognise the depth and complexity of reasons why people use substances, alongside expanded access to mental health care, domestic violence support, housing stability, and culturally safe services. Members also **call for prioritising safer environments and practical supports to be available at a community level**, such as needle and syringe programs, overdose prevention, drug checking facilities and non-policing responses.

Members also highlight the essential role of peer workers and lived and living experience leadership, noting that sharing lived and living experience "*disrupts the narrative*" and builds trust in ways traditional services often cannot. Members **call for government to properly fund peer roles, training pathways, and lived and living experience-led models of care.**

Stigma remains a major barrier to safety and help-seeking, with many members describing discrimination in healthcare and community service settings. This fuels a strong **call for government-funded stigma reduction initiatives** that focus on values-based education strategies, embedding lived and living experience voices to inform public awareness campaigns, and training for clinicians and service providers.

Such strategies can help to foster environments where people are treated and supported with dignity and respect.

Taken together, the community's message is consistent and urgent. **The WA government must invest in harm reduction, trauma-informed care, peer-led services, stigma reduction initiatives, and service system reform to create a compassionate, effective, and evidence-based AOD system that genuinely supports people and saves lives.**

The AODCCC believes government and community must invest in community-led solutions to ensure the WA AOD system is inclusive, compassionate and responsive to those it serves.

We asked participants, **what community led solutions have you experienced in relation to your lived and living experience of AOD, or what could/ should they look like?**

Community-led solutions in the AOD sector are not widely experienced or clearly understood by many of our members. A significant number indicated that they have had little to no exposure to these kinds of approaches, often stating they were unsure what community-led solutions look like in practice. This highlights a strong gap in awareness, access, and communication relating to such models.

A recurring theme across the responses gathered was the experience of isolation and disconnection. Many expressed a desire for stronger community connection, describing the **need for spaces where individuals can come together, share experiences, and realise they are not alone in facing challenges related to AOD use.** The idea of community gatherings, open conversations, and peer support environments was seen as important in building understanding and reducing stigma. Members made frequent reference to informal, grassroots activities as meaningful examples of community-led approaches, including creative workshops, community sports, volunteer-led initiatives, and outreach work. Such activities are seen to foster connection, provide positive alternatives, and create safe and inclusive environments where people feel a sense of belonging.

The importance of lived and living experience is one of the most consistent and strongly expressed themes, with members emphasising that **people who have lived and living experience of AOD should play a central role in designing, delivering, and leading services.**

Peer workers were widely valued for their ability to relate, build trust, and provide hope, and many responses highlighted that lived and living experience should be recognised as a form of expertise and embedded not only in frontline roles but also in leadership and decision-making positions.

There is also a strong call for **holistic, person-centred approaches to care**, particularly the need for supports that acknowledge without limitation, the full range of an individual's circumstances. Continuity of care, consistent support workers, and relationship-based approaches were identified as key elements for effective support.

Cultural safety and local ownership were also highlighted as essential. Some members, particularly those from Aboriginal or culturally diverse backgrounds, emphasised the importance of **services being designed and led by the communities they serve**. There was clear concern about tokenistic inclusion in mainstream services and a strong preference for approaches that genuinely transfer power and decision-making to communities.

Practical harm reduction strategies were identified as effective and necessary components of support. Examples such as needle exchange programs and opioid replacement therapy clinics, were recognised for their role in providing realistic and non-judgemental assistance. These approaches were valued for meeting people where they are and prioritising safety and wellbeing. Significant gaps were highlighted in the current system and called for greater investment. There were repeated mentions of the need for **more rehabilitation services, counselling, outreach programs, housing support, and accessible resources.** Accessibility and availability of services were seen as ongoing challenges, particularly for people in regional or disadvantaged areas.

Some members shared negative experiences with existing services, including feeling judged, disrespected, or unsupported. In certain cases, interactions with staff were described as harmful or triggering. These experiences reinforce the aforementioned importance of trauma-informed care, compassion, and the inclusion of lived experience in service delivery. **Long-term and stable funding** was identified as essential to sustain these models, along with evaluation approaches that reflect community priorities rather than externally imposed measures.

Overall, the responses indicate that while community-led solutions are highly valued in principle, they are not yet widely embedded in practice. **People are seeking approaches that are inclusive, locally driven, and built on trust, connection, and lived and living experience. There is a clear desire to move away from systems that are designed externally and instead support communities to define and lead their own solutions.**

Responding to the harms associated with drug use and the illicit drug trade is one of the greatest social policy challenges of our time. All aspects of this challenge have human rights implications. The AODCCC believes people who use substances should have the right to respect, health, safety, dignity and participation when seeking assistance with their health.

We asked participants, **do you believe that WA should adopt a human rights approach to substance use policy and practice?**

Responses strongly demonstrate overall support, with many emphasising dignity, respect, and access to care as fundamental principles. Responses echo the common view that substance use is closely linked to health and wellbeing and should be treated primarily as a health issue rather than a criminal or moral failing. Many members described addiction as complex and therefore deserving of compassionate and multidisciplinary support in line with a human rights approach.

Members expressed that a human rights approach could reduce the evident stigma experienced by people who use substances. By promoting understanding, compassion, and non-discriminatory treatment, people would feel safe and respected when accessing services. Opinions of current justice approaches echo this, as members stated the prioritisation of punishment and criminalisation were ineffective and can often worsen outcomes. There was a clear call to shift away this, toward approaches focused on harm reduction, early intervention, and ongoing support. Being treated with respect and compassion means a person is more likely to engage with services and make positive changes in their lives, whereas judgement and criminalisation were seen as pushing people further away from help.

The importance of dignity and being treated as a person rather than being labelled or defined by substance use was a strong theme amongst responses. Many emphasised that individuals who use alcohol or other drugs should have equal rights to healthcare, safety, and participation in society. This includes being listened to, having their choices respected, and being provided with appropriate care without prejudice. Responses highlighted that denying these rights contributes to further harm, reinforcing cycles of shame and disconnection.

A human rights approach was seen as one that fosters connection, community, and inclusion, recognising that people are more likely to heal when they feel valued and supported. This aligns with broader calls for supportive environments that encourage participation and recognition of individual complexities.

Amongst the responses there was also recognition that human rights approaches must balance the safety of others, particularly frontline workers, with the rights of individuals using substances. While most members supported a rights-based framework, some emphasised the need for safeguards to ensure that harmful behaviour toward others is still appropriately addressed.

Several responses highlighted the importance of autonomy and the right to make decisions about one's own body and life. This perspective included recognising that not all substance use is problematic and that individuals should not be automatically stigmatised or controlled. Respecting personal choice, while still offering support when needed, was seen as part of a fair and balanced approach.

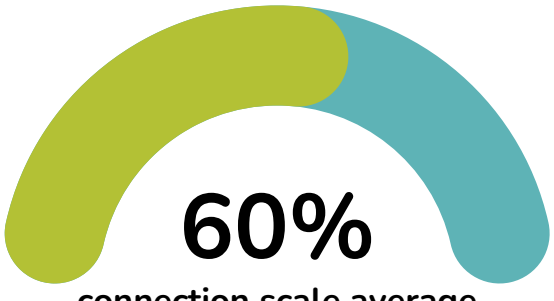
Some members linked their response directly to broader human rights frameworks, including international standards, arguing that equal treatment and dignity should already be guaranteed regardless of a person's circumstances. They suggested that failing to provide respectful and unbiased care may constitute a breach of those principles. There was also a strong sentiment that people who use substances are members of the community first and should not be excluded from rights and protections. A human rights approach was seen as more realistic, humane, and effective over time compared to current models that rely heavily on enforcement and judgement.

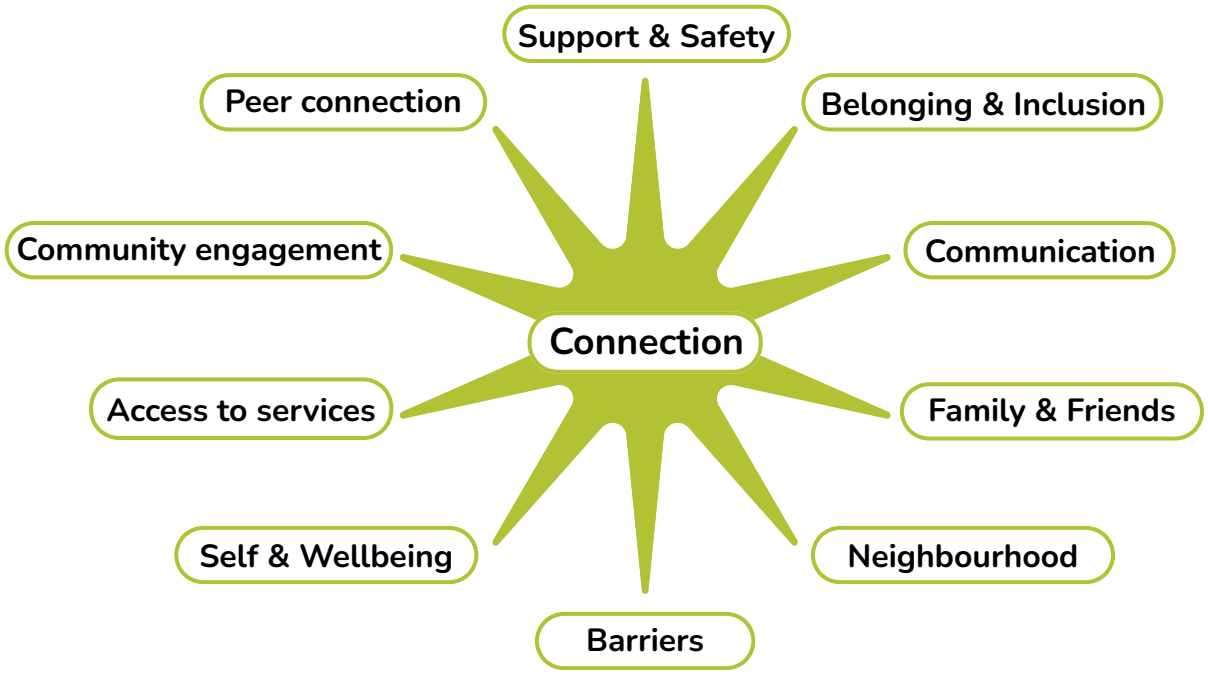
A smaller number of responses expressed uncertainty or disagreement, suggesting that substance use itself should not be considered a human right. However, even among these responses, there was often an implicit acknowledgement that people experiencing substance-related challenges still require care and support.

Overall, the **responses indicate strong support for adopting a human rights approach in WA.** Such an approach is seen to shift the system toward health, dignity, respect, and inclusion, while reducing stigma and encouraging people to seek help earlier. **It reflects a broader desire for policies and practices that recognise the humanity of individuals and respond to substance use in a compassionate, evidence-based, and socially responsible way.**

How connected & included do you currently feel in your community?

The AODCCC advocates for healthy and connected communities. Throughout the responses, connection was described as a holistic and interconnected experience shaped by relationships, belonging, support, and access.





Connection is grounded in meaningful ties with family, friends, peers, and community, while also depending on environments and settings that foster inclusion, safety, and non-judgement. Connection is also seen and felt on a personal level, with responses encompassing individual wellbeing, identity, and a sense of purpose.

Responses also highlight the presence of significant barriers to achieving connection, such as stigma, isolation, judgement and limited access to opportunities. Such responses demontrate how fragile achieving positive connection can be when many of the elements above are absent.

Connection is best understood not as a single condition, but as a dynamic system where authentic relationships, shared experiences, and equitable opportunities come together to enable individuals to feel seen, supported, and able to participate fully in their communities and lives.

To our members, connection looks like...

"Having equal access & a sense of belonging to my community of choice without prejudice or discrimination."

"Accessing services without judgement so I feel like I am no different."

"...connection in my community looks like people actually seeing you as a person, not just your past or your use. From my own lived experience, real connection was when someone didn't judge straight away, and didn't treat me like I was "less than" because of what I was going through."

Governance & Sustainability

To date the AODCCC has provided free training for our members. In the interest of increasing our ability to build our training options and bring onboard and compensate more lived and living experience co-facilitators to help deliver our trainings, we are considering the implementation of a fee.

We asked participants **what do you believe would be a fair fee for members and non-members to attend co-designed and co-facilitated training with the AODCCC?**

Responses indicate that while there is general recognition of the need for AODCCC to introduce a fee in order to sustainably fund and appropriately pay lived and living experience co-facilitators, there is also a very strong and consistent concern that any cost must not create a barrier to participation. Responses highlight the importance of recognising that a significant proportion of members are experiencing financial hardship, are on low incomes, or rely on income support.

Most responses gravitate toward a low, affordable contribution, typically within the $10 to $20 range for members. There was a clear resistance to higher fees, unless applied to professionals, organisations, or non-members, who were widely seen as more capable of contributing financially. A reoccurring theme across responses was the preference for a flexible and equitable pricing approach, including income-based fees, concessions, pay-what-you-can options, and free access for those unable to pay, alongside a strong expectation that introductory or community-focused sessions should remain free.

Alongside this, there is notable support for differentiated pricing that allows higher-paying participants, such as professionals and organisations to subsidise access for members with lived experience, suggesting that a tiered, cross-subsidised model would be both acceptable and strategically effective.

Overall, members supports a pricing strategy that balances sustainability with inclusion, by introducing modest member fees, higher non-member and organisational rates, and embedded safeguards to ensure no one is excluded due to cost. This positions the AODCCC to expand its training capacity while maintaining its core values of accessibility, equity, and lived and living experience leadership.

A **Reconciliation Action Plan** (RAP) is a guide that helps organisations take meaningful steps toward reconciliation. It focuses on building respectful relationships with Aboriginal and Torres Strait Islander peoples and supporting their self-determination.

With approximately 10% of our membership identifying as Aboriginal we believe that now is the time to genuinely begin our journey to develop an authentic RAP plan.

As we start our collaborative journey into developing an AODCCC RAP, we asked our members, **what do you believe would be the best approach for our organisation to build respectful relationships and support reconciliation in a meaningful and authentic way.**

Responses encompass the following key themes:

- **Listen first**, particularly to Elders and Aboriginal and Torres Strait Islander people.
- **Engage and consult meaningfully** through ongoing dialogue.
- **Co-design and share power,** focusing on Aboriginal-led or guided decision-making.
- **Build genuine relationships** that are long-term, trust-based, not 'tick-box'.
- **Ensure inclusion and representation** across Elders, youth, peers, and communities.
- **Avoid tokenism.** Actions must be authentic and followed through.
- **Create safe spaces for voices** with a focus on accessible and respectful participation opportunities.
- **Invest properly**, including payment, roles, and employment of Aboriginal people.

The strongest message across responses can be seen as both simple and powerful...

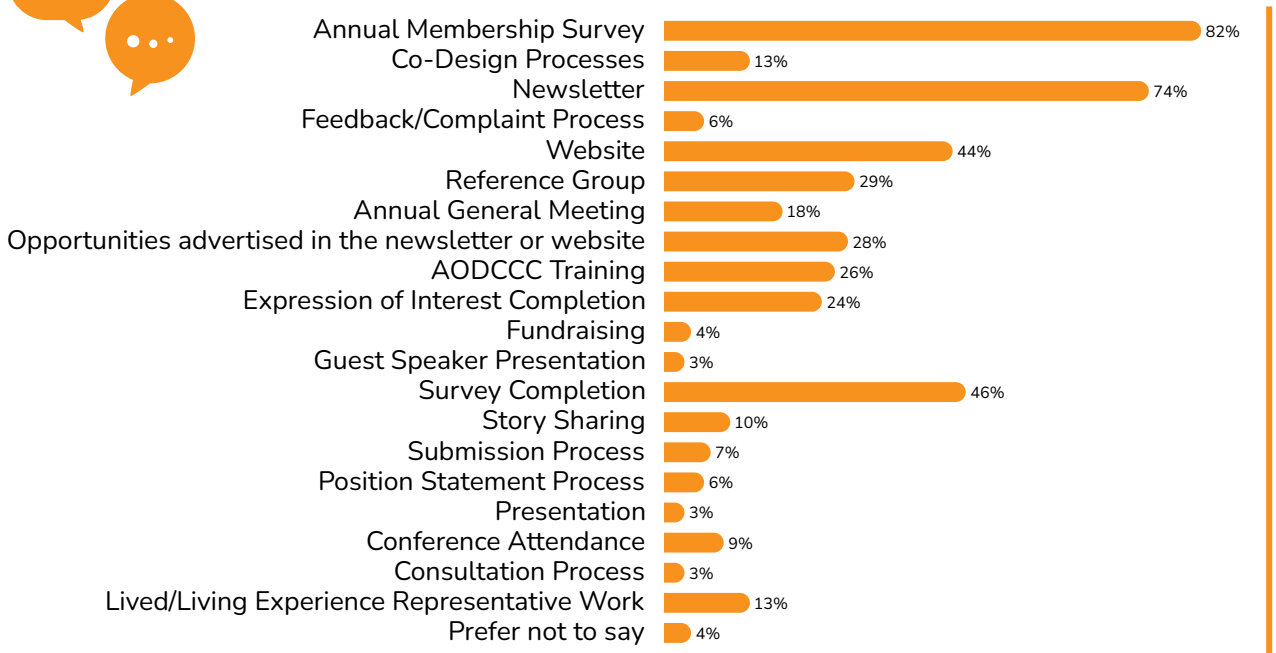
"Nothing about us without us - and not just once, but ongoing."

The AODCCC RAP plan should therefore prioritise listening, relationship-building, shared decision-making, and accountability, ensuring reconciliation is lived practice and not just a document.

Education & Training

The AODCCC aims to empower its members and the community through training and knowledge sharing, while promoting the importance and value of AOD lived and living experience representation.

How have you engaged with the AODCCC?



There is a strong and diverse pattern of member engagement with AODCCC activities, demonstrating success in providing multiple entry points for participation. Members are engaging with through a wide range of channels, including systemic advocacy initiatives, sector-wide consultations, training and professional development, working groups, collaborative projects and staying informed and connected through online communications and shared resources.

This spread of engagement reflects a healthy ecosystem where members can interact in ways that suit their capacity, roles and strategic priorities. Importantly, the data shows that engagement is not concentrated in a single area, rather, members are participating across multiple activities, often combining different involvement pathways.

While a significant portion of members report high levels of involvement across several initiatives, others tend to engage more selectively. This variation reinforces the importance of maintaining a flexible and inclusive engagement model. By creating multiple touchpoints for engagement, the AODCCC fosters richer collaboration, more representative systemic advocacy, and stronger sector-wide alignment.

The AODCCC recognises that investment in public education is needed, to shift attitudes on how society views people who use substances.

We asked participants to provide their perspective on how this would be best delivered.

AODCCC members strongly support a multifaceted, lived and living experience-led approach to public education. Initiatives should be tailored for different audiences, age groups and community settings, as responses highlight the ineffectiveness of one-size-fits-all approaches. Significant importance was also placed on education that is co-designed, co-delivered and strongly informed by people with lived and living experience, making it less judgemental and more authentic, relatable and effective in achieving the desired outcome. Here's what our members said...

Lived and living experience voices

Education should centre real stories, peer speakers, consumer representatives and the overall visibility of lived and living experience throughout schools, the media, services and policy spaces.

Harm reduction and realistic education

Education should include practical and realistic information on recognising overdose, mixing substances, identifying tampered drugs, and how to respond safely if something goes wrong.

Schools and early education

Education should start as early as primary school and continue through high school and into tertiary spaces. Material should avoid fear-based messaging and instead build understanding, empathy, realism, and harm reduction awareness. It should form part of the curriculum and be holistic, e.g. involving families so that outdated attitudes can be addressed at home.

Community-based and in-person education

Education should be delivered in various settings, including within community groups, at community events, in local outreach settings, and in accommodation settings, such as hostels. There is strong support for education that happens where people already are, not just in formal systems.

Public campaigns and media

Broader public education should focus on realistic, human experiences that is not fear-based, and should appear through various mediums, such as social media, television, radio, websites, podcasts, digital and print campaigns and newsletters.

Workplaces and professional training

Stigma reduction should target not only the general public, but also the systems and professionals people interact with, particularly medical and allied health practitioners, emergency service staff, police, staff in court setting and those in social services.

Amplify Voices

Family Carers and Significant Others (FCSO) who support a loved one through their substance use journey have their own support needs that are often overlooked.
In 2025 the AODCCC created a FCSO Reference Group, to deepen our understanding of the systemic advocacy work that needs to occur in this space.

As we continue to recognise the unique strengths and insights that FCSO bring, we asked survey participants, **what changes do you believe are needed in the AOD system to better support and utilise FCSO?**

An important contextual note to consider is that a number of responses recorded “not sure”, “unsure”, or similar. This may indicate varying levels of familiarity with the FCSO role, uncertainty about what system change could look like, or the fact that the question may have been easier to answer for people with direct lived or living experience.

Whilst the above is considered, other responses demonstrate thoughoutful and thorough considerations and suggestions.

Recognition of FCSO as partners in care

There is a need for the AOD system to recognise FCSO as active partners in care, rather than peripheral observers. Family members, carers and significant others often hold detailed knowledge of the person’s circumstances, patterns of use, risks, needs and warning signs. Services and health professionals should listen more closely to FCSO and create structured opportunities for their perspectives to inform support planning and service delivery. This reflects a broader call for the system to value FCSO as knowledge-holders with lived expertise, rather than involving them only during times of crisis or treating them as secondary to the therapeutic process..

Dedicated supports for FCSO in their own right

There is a need for services and supports that are specifically designed for FCSO themselves. Members described the emotional, psychological and practical burden carried by family members, carers and significant others , including stress, exhaustion, grief and trauma. There was a clear view that FCSO should not only be considered in terms of the support they provide to others, but as a group with their own independent support needs. Suggested supports included counselling, peer support groups, helplines, psychosocial support, support workers with lived experience, and easier access to family-focused services. Responses highlight a strong expectation that FCSO should be embedded within the AOD system, rather than treated as optional or external.

Education, information and system navigation

Many responses highlighted the importance of providing FCSO with accessible education and information. Members identified a need for greater understanding of substance use, support options, healthy boundaries, self-care, crisis responses and available services. Several comments suggested that families and carers are often expected to manage highly complex situations without being given the knowledge or tools required to do so. This also points to the importance of practical system navigation support, including clearer referral pathways, information about family and carer rights, and guidance on how to engage with services more effectively.

Inclusion of FCSO in policy, service design and co-design

A number of responses went beyond frontline service delivery and called for FCSO to be included more meaningfully in broader policy, advocacy and service design processes. There is concern that the family voice is often "tagged on" rather than genuinely incorporated into co-design, consultation and decision-making forums. There was support for FCSO reference groups, dedicated family representation structures, and more deliberate mechanisms to ensure lived and living experience informs service review, new initiatives and advocacy priorities. Inclusion should occur not only at the point of care, but also at structural and systemic levels.

Stigma, judgment and discrimination

Stigma was a particularly prominent theme. Members described a system in which family members, carers and significant others often experience blame, silence, shame and exclusion. Some comments reflected frustration that families continue to be stereotyped as a source of dysfunction or harm, despite the complexity of people's experiences and the evidence that many families are providing care under extremely difficult circumstances. Several responses highlighted the impact of discrimination in health and community settings, and the need for more compassionate, non-judgmental, trauma-informed responses. This underscores stigma as both a barrier to support and a source of additional harm for FCSO.

Family-inclusive and relational models of care

Several responses pointed to the limitations of a system that focuses primarily on the individual using substances. Members highlight that substance use and recovery occur within the context of relationships, and that the AOD system should better reflect this by adopting family-inclusive and relational approaches to care. This included calls for policy change, more integrated support pathways, and service models that recognise the interconnected impacts of AOD use on individuals, families and support networks. Members advocate for a broader understanding of recovery that includes family wellbeing and relational support.

Peer and lived and living experience support

The value of lived and living experience was highlighted as several responses advocated for peer-led support groups, support workers with direct FCSO experience, and opportunities for families to learn from others who have navigated similar circumstances. Peer support was seen as both validating and practical, offering understanding that may not always be available through clinical or formal service channels.

Privacy, communication and practical service access

Some members stated that confidentiality requirements can prevent FCSO from being meaningfully involved, while others called for more balanced and practical approaches that allow family insights to be heard without breaching privacy. Suggestions included more structured care planning pathways, clearer communication processes, and better opportunities for FCSO to share relevant information with services. In relation to service access, practical suggestions were shared, such as improved hospital screening, better emergency planning, dedicated counsellors in hospitals and emergency departments, and simpler ways for family members to connect loved ones with services.

Increased funding and resourcing

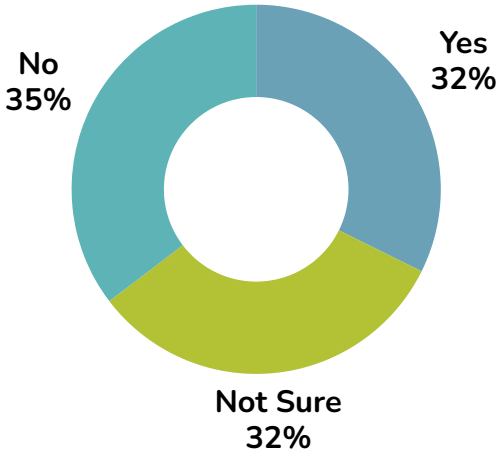
Many responses pointed to resourcing as a fundamental issue. Members called for increased funding for FCSO supports, more trained workers, more support groups, and stronger service availability overall. Some noted that there are fewer family-focused supports available now than in the past. This highlights significant gaps within the sector, where there is insufficient investment in family-inclusive supports and services.

Support for children and young people affected by family substance use

Members highlighted the need to better support children and young people affected by family substance use. Many noted that young people can be overlooked when living with parental substance use, incarceration, instability or unsafe home environments. This suggests an important opportunity for the system to broaden its understanding of who may be impacted and to provide earlier, developmentally appropriate supports for younger family members.

Overall, AODCCC members indicate that **the AOD system would be strengthened by moving toward a more family-inclusive model that recognises Family, Carers and Significant Others as partners in care, experts through lived and living experience, and individuals with their own distinct support needs.**

Do you believe that FCSO voices are meaningfully included in AOD-related decision-making?



When considered alongside the written responses, these figures present an important picture of how family members, carers and significant others are included in AOD decision-making. While there are pockets of progress, the dominant narrative is that inclusion is inconsistent, often superficial, and not yet embedded in a meaningful or systemic way.

There is overwhelming agreement that FCSO voices and the lived and living experiences within, are valuable and essential in a right of their own, not simply as an extension of the person using substances.

Members emphasise that FCSO share the burden of AOD impacts, hold critical frontline knowledge and provide ongoing, often unpaid support. Some members acknowledge that progress is occurring in specific areas, while other point out the gaps.

"FCSO are the people at the front lines... and deserve a voice because they are just as much in the struggle."

"Because it affects a whole family. The stress and anxiety... is massive and they need a voice."

"I've been through hell and back... and never been approached."

"The distinction is between being heard and being heeded... inclusion is episodic rather than ongoing, consultative rather than determinative."

"All perspectives are meaningful, this fosters inclusivity."

"Lived experience is only now starting to receive the merits that it deserves... this has not yet included appropriately the voices of FCSO."

"FCSO voices are sometimes included, but often not meaningfully... mainly involved during crises rather than shared planning."

"They are at AODCCC but not in the wider community."

Significant structural barriers and system gaps are acknowledged as contributers to FCSO not being included meaningfully AOD-related decision-making.

"If they are an adult the parents are ignored..."

"No one listens when your child is an adult."

"You are viewed as an enabler... cannot be trusted."

"Stigma still obvious... blame culture etc."

"What capacity-building is given to FCSOs who want to make meaning from their experiences?"

"Currently I don't think the government listens effectively..."

"Men/fathers... given more of a voice. Women... seen as difficult, demanding."

Responses which recorded 'not sure' were often attributed to limited knowledge or mixed experiences, with many members stating they require more information to answer appropriately.

Collectively, the responses to this question reinforce the notion that FCSO inclusion is inconsistent and difficult to clearly assess, pointing again to a lack of system-wide transparency and structure.

The system currently appears to sit in a transitional phase, moving toward further recognising FCSO, but is not yet achieving meaningful, sustained, and influential inclusion.

"Until FCSO inclusion is embedded in governance structures... 'meaningful inclusion' remains more aspiration than reality."

What would reduce AOD related stigma for FCSO?

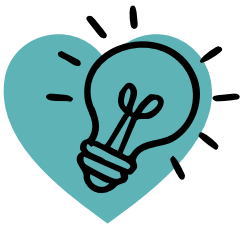
Members identified **education, awareness and understanding** as the most impactful ways to reduce stigma for FCSO, particularly through education that explains the complexity of AOD use, including the role of trauma and the fact that each person's circumstances are different. They also emphasised the need for better support for FCSO, including counselling, peer connection, family-specific support groups and accessible services, so that families feel less isolated and less blamed. The importance of public storytelling and visibility was strongly emphasised, with members calling for real, diverse and hopeful stories from families and carers to be heard more often.

Members highlighted the need for less blame and judgement, more non-stigmatising language and practice from professionals, and greater recognition of FCSO expertise and inclusion in service planning, advocacy and policy.

Reducing stigma for FCSO requires a combination of community education, practical and emotional support, stronger public narratives & structural recognition that acknowledge the importance of FCSO and the vital role they play. FCSO are not secondary to the system, they are central to it. Their experiences reflect resilience, love, and commitment, but also significant unmet needs.

"Seeing and hearing the government take up the challenge on stigma."

What is one thing you wish service providers or policymakers understood about supporting a loved one impacted by AOD?



- The need to be heard, respected, and included.
- The hidden and profound impact on families and carers.
- Exclusion from care and barriers within systems exist and need to be addressed.
- Recognition of the complexity and individuality of experiences as a family member, carer or significant other.
- The need for compassionate, human-centred care that is grounded in empathy and humility.
- Loved ones remain involved out of love, not control.
- Understanding and recognition of the critical role of families, carers and significant others play in recovery.

Community wish list...

Compassionate and respectful practice **Dedicated support for carers**

Improved system navigation and access **Long-term, sustainable support**

Recognition and inclusion **Flexible, person and family centred systems**

Meaningful engagement in policy and design

Addressing these priorities is not only a matter of fairness, but also essential to achieving better outcomes for individuals, families, and communities alike.

The AODCCC advocates for and believes in a system that values lived and living experience as valuable expertise.

We asked participants to share how their lived or living experience of AOD is being utilised and what impact they see it having on the AOD system currently.

A clear theme emerged throughout the responses, demonstrating that lived and living experience is already shaping the AOD landscape in powerful and diverse ways. AODCCC Members are meaningfully contributing to this at personal, community, organisational, and systemic levels.

Supporting others through direct peer work

Many members are working as AOD counsellors, peer workers, and support staff in schools, rehabilitation facilities, and mental health services. Some are facilitating support groups and offering one-on-one encouragement to people, within these settings, while others are providing family peer support by helping loved ones understand addiction and hold hope. These contributions facilitate trust, reduce shame, and create spaces where people feel genuinely understood.

Challenging stigma through storytelling and visibility

Members are contributing to podcasts, social media, and community conversations, along with AODCCC story sharing to humanise the experience of AOD. "*I have a podcast... and I use my lived experience to reduce stigma and psychoeducate.*"

Members explore actions such as speaking openly about addiction to normalise recovery and counter stereotypes, along with representing themselves in everyday settings (like pharmacies) in ways that challenge assumptions about 'what a drug user looks like'. These acts, both big and small, chip away at stigma and create cultural change.

Shaping education and community understanding

Some members expressed taking part in opportunities to co-create and co-facilitate courses on understanding AOD use and topics such as addiction. Others take part in educating families in early psychosis programs, and share insights about drug-induced psychosis, harm reduction, and the realities of addiction in various settings. This work helps communities to respond armed with knowledge and compassion.

Influencing policy and system design

Many members participate in reference groups, committees and advocacy opportunities. Some members recount working with organisations and groups such as, Cancer Council, Opioid Pharmacotherapy Recruitment and Advisory Committee (OPRAC), and AODCCC, to inform policy and contribute to discussions on issues such as pharmacy dosing, harm minimisation, and service accessibility. Others are advocating for change through petitions, social media groups, and community organising. These contributions all help to ensure the system reflects real-world experiences rather than assumptions.

Personal transformation as impact

Members explore personal growth as a result of using their lived or living experience to affect change, particularly through becoming more compassionate, tolerant, and understanding. From using their journey to inspire hope in others, to living openly in recovery to show that change is possible. These personal shifts ripple outward into families and communities.

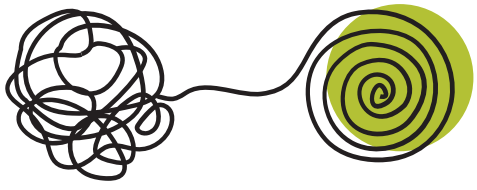
Several members shared that they are not currently using their lived or living experience, don't know how it's being used, or don't feel safe or ready to share. These voices matter too.

They remind us that:

- Not everyone has access to opportunities,
- Some feel excluded (especially regionally),
- Some are still healing or finding their path.

The honesty in these responses helps to highlight gaps that the system still needs to address.

The depth of responses provided to how a persons lived or living experience of AOD is being utilised and the impacts this is having, shows a community that is courageous, generous, and deeply committed to change. **Whether through formal roles, quiet conversations, advocacy, or personal growth, members are already reshaping the AOD system from the inside out.** Lived and living experience is valuable and this collective impact is needed now more than ever, as we see the system slowly becoming more human-centred, more compassionate, and more grounded in real experience.



Experience and Collective Action

As we close the 5th AODCCC Membership Survey Report, we are left with a renewed sense of clarity and recognition that there is plenty of work ahead of us, not only within the AODCCC but across government, social service sectors and the broader community.

We see there has been some progress made, particularly in the peer workforce, however, overall employment challenges continue to exist. Barriers such as the rigidity of employing or engaging those with criminal records exist outside of alignment with the purpose and values of the evolving peer workforce landscape. We implore employers and policy makers to work with people with lived and living experience, to reduce the barriers for engagement and employment, and encourage supportive recruitment policies and practice. Failure to do so will limit the workforce's proven potential and stifle lived and living experience voices.

We would also like to highlight the profound influence and impact of compassion in the lives of individuals, families, carers and significant others, navigating alcohol and other drug use. Regardless of their experiences, participants consistently described compassion as instrumental in overcoming stigma, building a sense of connection, meeting the individual where they are at and supporting their journey. We see this as a key take away from this report, as it presents a way forward for the community. It all starts by seeing the person.

Moving forward, this report marks the end of a cycle, which aligns with our 2024-2027 Strategic Plan. Next year we will be pausing to compile a reflective impact report, responding to the content of our previous Membership Survey Reports, highlighting the work AODCCC has undertaken to achieve outcomes and address the systemic issues brought to light by our members.

We would like to thank each member who completed this year's survey, and thank you to our overall 1044 members, for your engagement, contribution, and support of our cause. A big thank you also to all the stakeholders and those working tirelessly for the health and wellbeing of our community. Change is not possible without you.

Sincerely,

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AODCCC Alcohol and Other Drug Consumer & Community Coalition