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Mapping the ecosystem of addiction strategy, support, and service provision in Australia:

Towards better care for those harmed by addiction

DECEMBER 2025

Mapping the ecosystem of addiction strategy, support, and service provision in Australia: *Towards better care for those harmed by addiction*

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Suggested citation:

Long JC, Churruca K, Pagano L, Ellis LA, Sheriff S, Schroeder T, Dalal U, Levy A, Braithwaite J, and Lubman DI. Mapping the ecosystem of addiction strategy, support, and service provision in Australia; Australian Institute of Health Innovation, Sydney, 2025.

Acknowledgement:

This work was supported by a philanthropic grant, and we sincerely thank the funder for their generous support.

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List of Abbreviations

AOD	Alcohol and other drugs
AUD	Alcohol Use Disorder
CAS	Complex Adaptative System
ED	Emergency Department
GP	General Practitioner
LGBTQIA+	Lesbian, gay, bisexual, transgender, queer, questioning, intersex, asexual +
MERIT	Magistrates Early Referral into Treatment
NGO	Non-Government Organisation
NSW	New South Wales
QLD	Queensland
SUD	Substance Use Disorder
VIC	Victoria

Executive Summary

This report presents an analysis of the ecosystem surrounding people with alcohol and other drug (AOD) use disorders in Australia (alcohol, illicit drugs and prescription medications, such as opioids and benzodiazepines). The analysis was achieved through the development of a rich graphic. Based on the concept of health care as a Complex Adaptive System, we sought to capture a range of interest holders, organisations and formal and informal services in the Australian setting relevant to the provision of treatment and support for a person with a substance use disorder, as well as a detailed mapping of issues, influences, interdependencies and barriers to accessing care. This work aims to inform future development of interventions for treatment and support of people with addiction by demonstrating the complex interplay of factors; that is to say, the multiple variables, interrelationships and systems at work. This includes highlighting siloed initiatives that are poorly integrated with other parts of the system, differences and disconnects across state boundaries, systemic cultural issues and areas of unmet need.

The graphic was co-produced with key informants. We used a qualitative, multistep and iterative process to build the graphic. In the first step, the core researchers' conceptualisation of the system was drafted, then the graphic was presented to key informants to critique. Participants across Australia were identified by Turning Point (n=10) with backgrounds in addiction research, clinical practice, management, policy and governance, health economics, and lived experience.

Eight iterations of the Ecosystem graphic were developed. The penultimate version of the graphic was sent to the same key informants in a validation exercise. Informants were asked to fill out a REDCap survey that asked them to review the graphic they worked on and answer structured questions.

The ***Ecosystem graphic*** shows the interplay of seven sectors: Government, Health Services, AOD Services, Community, Social Services, Criminal Justice, and Research. It shows overarching and pervasive influences in Australian society of (1) stigma of people with a substance use disorder and (2) drivers of demand and supply (e.g., regulation that favours the hospitality / liquor industry over people with a substance use disorder). Community-based harm mitigation strategies are prominent, as are community-based treatment, support and self-help services (e.g., Alcoholics Anonymous [AA]). Issues around waitlists for services and workforce shortages are shown. Unclear pathways into treatment continue to be a barrier to accessing care. Implicit but hard to portray in the graphic is the lack of governance at the national level, the chaotic, opportunistic nature of the system due to the impact of ubiquitous stigma associated with addiction, and a lack of data on treatment outcomes.

Key Facts

Impact of substances

- *Alcohol*: Alcohol remains the leading contributor to substance-related harm in Australia. Alcohol-related harm costs the community at least $3.2 billion per year, while Australians spent approximately $26 billion on alcohol consumption in 2019–**20**, reflecting both widespread use and population-level harm (Rethink Addiction and KPMG 2022).
- *Opioids*: Opioids continue to be the most commonly involved drug class in overdose deaths in Australia. While opioid-related mortality rose sharply between 2007 and 2016, opioids remain implicated in around half of all unintentional drug-induced deaths, with pharmaceutical opioids historically accounting for a substantial proportion of these deaths, alongside more recent increases in heroin involvement (AIHW; Penington Institute, 2024).
- *Illicit Drugs*: An estimated 10.2 million Australians have used illicit drugs in their lifetime. Recent national data indicate around 2.8 million people used cannabis, ~237,000 used amphetamines, and ~113,000 used cocaine in the past year, underscoring the scale and diversity of illicit drug use in Australia (Australian Institute of Health and Welfare 2024c).
- *Overdose:* Unintentional overdose deaths involving alcohol and other drugs have increased by approximately 70% over the past two decades, reflecting escalating complexity of substance use, poly-drug exposure, and delayed access to care (Penington Institute, 2024).

Affected Population

- *Alcohol risk:* Around 18% of Australians exceed lifetime risk guidelines for alcohol consumption, placing them at increased risk of chronic disease, injury, and social harm (Australian Institute of Health and Welfare 2024c).
- *Population exposure:* Substance use is highly prevalent across the population, with harms disproportionately concentrated among people experiencing social disadvantage, mental illness, and barriers to early intervention.

Recovery and Services

- *Treatment demand:* In 2022–23, more than 37,000 people accessed publicly funded AOD treatment services in Victoria, while approximately 28,000 people received alcohol-specific treatment in New South Wales, highlighting sustained demand across jurisdictions (Australian Institute of Health and Welfare 2024a; Turning Point 2024).
- *Justice pathways:* Programs offering alternatives to traditional custodial sentencing, including diversion and treatment-based responses, are associated with improved engagement in care and reduced recidivism, particularly for people with complex AOD and mental health needs.

AOD treatment agencies

- In 2022–23, there were approximately 1,280 publicly funded AOD treatment agencies nationally, with the majority of services delivered by non-government organisations, reflecting the central role of the NGO sector in Australia's AOD system (Alcohol and Other Drug Treatment Services in Australia Annual Report, Victoria 2024; Australian Institute of Health and Welfare 2024a).

Alcohol and other drug (AOD) workforce

- Australia faces a significant and persistent AOD workforce shortfall. It is estimated that 200,000–500,000 people each year seek or require help for AOD use disorder but do not receive treatment, in part due to workforce capacity constraints, maldistribution, and limited specialist capability (Howard, 2020).
- Workforce shortages are most acute in regional and rural areas, and among specialist roles such as addiction medicine, dual diagnosis care, and peer and lived experience workers.

Introduction

Alcohol and other drug (AOD) use disorders are a significant problem globally and have well documented negative impacts at the individual, family, health service, community, economic and societal levels. Timely, high-quality support is challenging to deliver due to increasing demand, workforce shortages, geographic inequality, limited service options and the persisting negative impact of stigma and refusal of service (Cheetham et al. 2022; Katayama et al. 2023). Addiction services are diffuse, varied, often overlapping with acute, subacute, primary and mental health services as well as a range of online, telephone or walk-in support services.

Viewing the health system as a complex adaptive system (CAS) is an effective way to grapple with such multidimensional issues resistant to change (Braithwaite et al. 2015; Plsek and Greenhalgh 2001). A complex systems approach takes a holistic view, paying attention to influences and constraints from a broad perspective. It is very different to the reductionist approach that sees systems as linear processes made up of individual parts, which, as a result, lead to predictable outcomes (Braithwaite et al. 2018; Plsek and Greenhalgh 2001). Instead of focusing on individual components, a CAS approach allows an exploration of the relations and interdependencies between multiple interest holders across differing levels (e.g., team, ward, organisation, state) that are constantly adapting over time. While useful as an approach, it can also be daunting for designers of change initiatives (Greenhalgh and Papoutsi 2018).

Soft Systems Methodology employs a tool known as "rich pictures" to visually represent and analyse intricate human situations using drawings, for example of people, objects, places and events in detailed graphical depictions (Checkland 1981; 2000; Checkland and Poulter 2006). Rich graphics is an extension of this method and relies on group sensemaking and a visual not literal understanding of the whole structure and how components and agents interact. Consequently, a rich graphic is an ideal tool to represent elements of a CAS as it shows the system as a whole as opposed to analysing each element in isolation (Augustsson, Churruca, and Braithwaite 2019). This view also enables a targeted approach to interventions and informs scale-up and spread.

The aim of this study was to develop a graphic, with an accompanying narrative, to illustrate the broader ecosystem of AOD efforts in Australia. We sought to expose the dynamics of AOD services and the landscape of circumstances inherent in providing them. The work will describe in detail the context across the macro, meso and micro levels of the system.

Methods

Overview

An iterative, exploratory, qualitative design was used drawing on multiple sources of data to build and refine the graphic. **Stage 1** involved the research team listing all interest holders, resources, issues (and influences relevant to each issue) the graphic sought to represent. Relationships and interdependencies of interest holders and additional factors were added to the graphic, informed by peer-reviewed and grey literature. Quantitative data was included wherever possible (e.g., workforce statistics). The graphic was drafted by hand, then created electronically in Microsoft Visio drawing software. **Stage 2** involved interviews with representatives from key interest holder groups. The graphic was shown to participants who were asked to “think out loud” about what they saw and then answered structured questions about what was missing, present but in the wrong place or not accurately portrayed. The graphic was then amended in response to interviewees’ suggestions. Data from all stages was collated and interrogated as to where they fit on the graphic, relationships with other elements they impact or influence and other features of note. Data was integrated into the graphic and added to the accompanying narrative. While this was partly an inductive process, known

features were given special attention, including funding, workforce capacity, acute and mental health services, infrastructure, equity, influence of geography, professional and regulatory bodies, and policy at the state and national level.

An overview of the methods is provided in Figure 1.

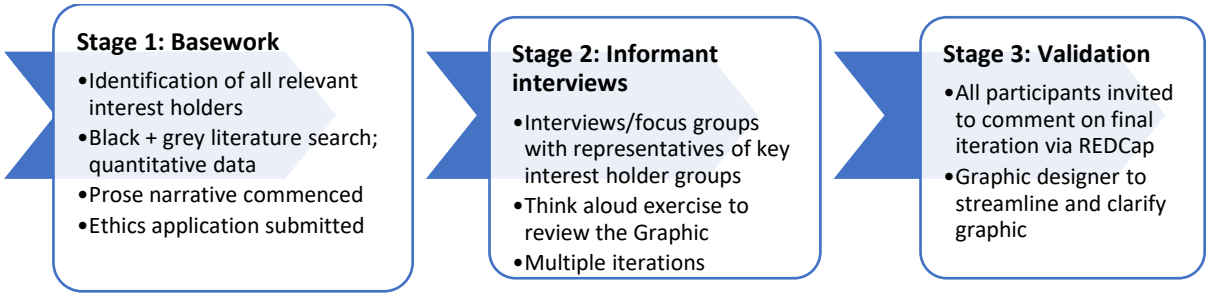

Figure 1: Overview of the development of the rich picture.

Ethics

This work received ethical approval from Macquarie University Human Research Ethics Committee (Ref: 16167).

Results

We drew on, and reviewed, multiple literature sources to develop and contextualise the graphics (Table 1). Ten key informants were interviewed. Table 2 shows their characteristics. They were experienced and represented three Australian states and multiple additional perspectives. Interviews lasted 20-90 minutes with informants tending to focus on areas of the graphics with which they were most familiar. For example, Non-Government Organisation (NGO) service providers and people with lived experience spoke at length about the value of peer support, policy experts on strategies. Some participants cited studies that illuminated particular issues or a part of the patient journey. These were also considered and incorporated into the graphic where appropriate. Seven iterations of the Ecosystem graphic were generated with the final version being approved by all participants and the full research team. The final graphic is shown on page 20.

Table 1: Sources of data used to inform the graphics.

Source
Peer-reviewed literature (PubMed searches and snowballing)
Selected Websites including: Australian Institute of Health and Welfare Australian Bureau of Statistics *Addiction Statistics in Australia* website Turning Point State Health Departments, e.g., NSW Health Alcohol and Drug Foundation

Table 2: Key Informants involved in the development of the rich graphics.

No.	Primary role	State of residence	Years of experience
1	AOD treatment provider, researcher	VIC	~25 years
2	Director of a community based AOD program	VIC	+20 years
3	Policy advice and advocacy on workforce development and harm reduction service delivery	NSW	~14 years
4	Consultant on government policy programs, justice, community programs. Strategy and policy	VIC	~14 years
5	Lived experience with substance use; peer support worker at an NGO	VIC	~11 years
6	Manager at NGO AOD treatment service	QLD	+8 years
7	Clinician researcher	VIC	~22 years
8	GP and addiction specialist	NSW	~15 years
9	Clinical psychologist; drug policy advisor; researcher	NSW	+30 years
10	Addiction specialist; Local and international, public and NGO treatment services	NSW	~20 years

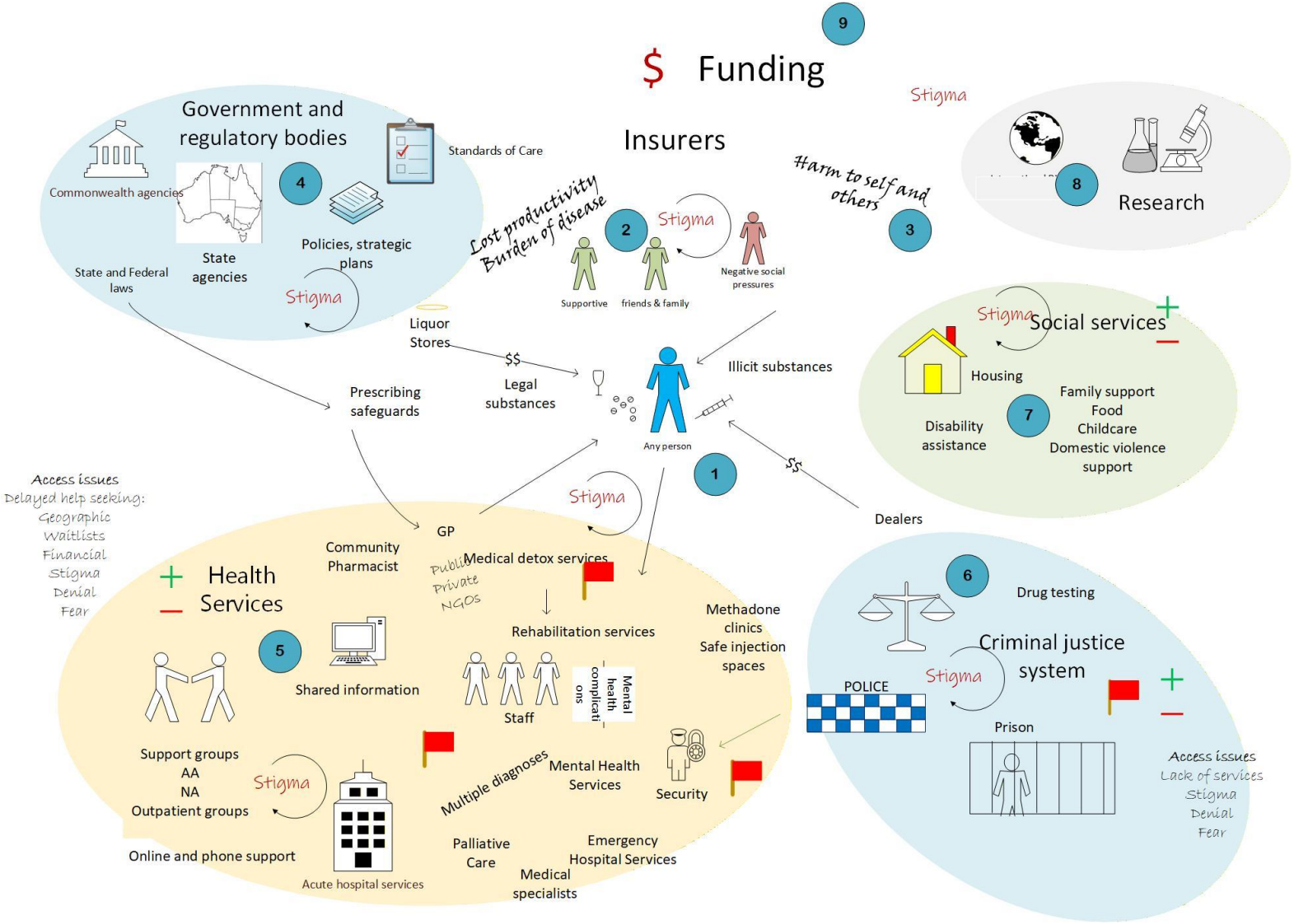

Figure 2: Version 1 of the Ecosystem of AOD efforts in Australia graphic used in interviews

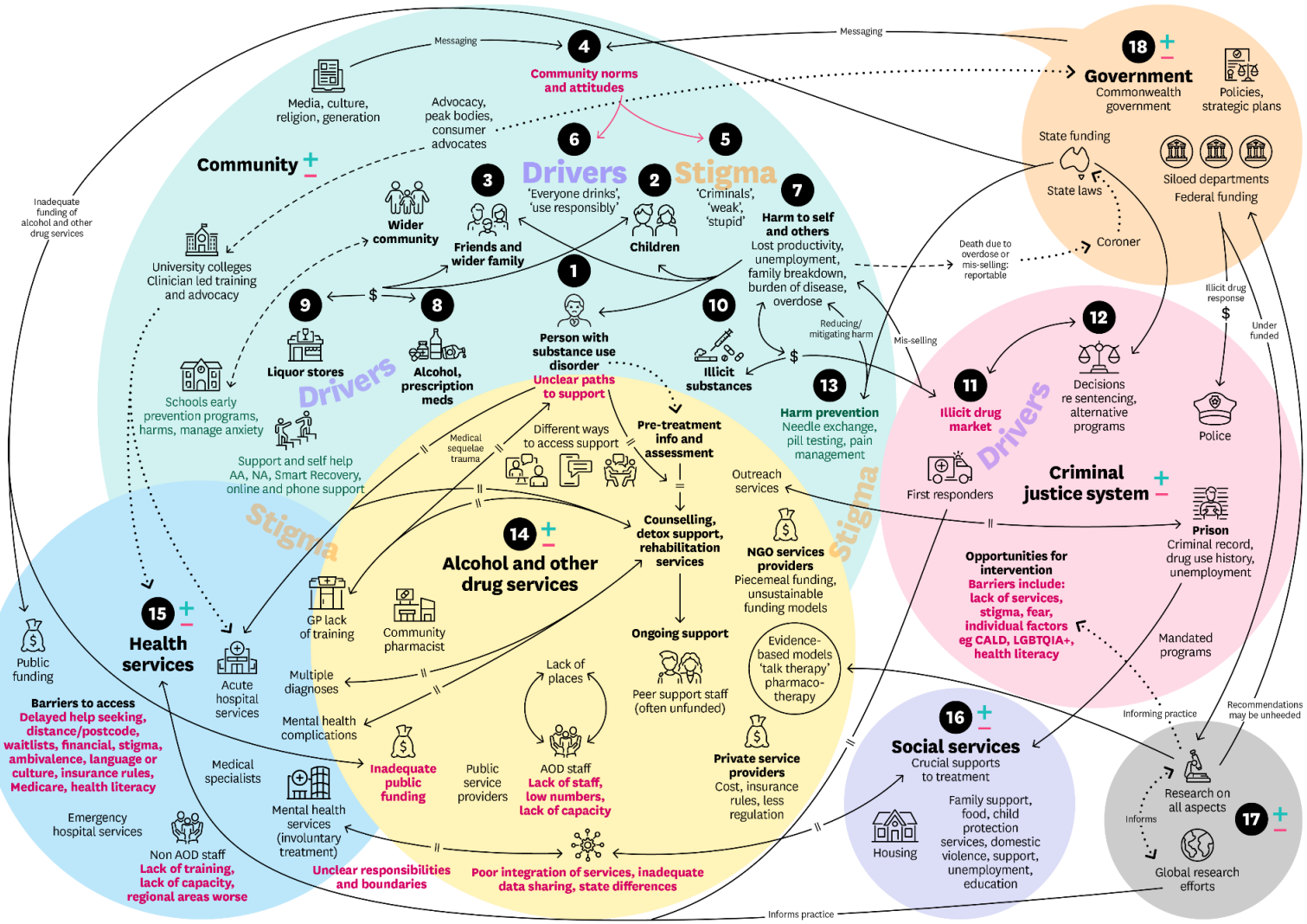

Figure 3: Final version of the Ecosystem of AOD efforts in Australia graphic

Overview of the graphic: Full commentary to accompany the graphic is provided in Appendix 1

The ecosystem of AOD efforts is characterised as seven interest holder groups that surround a central blue figure, representing the person with an AOD use disorder. The seven sectors are (clockwise from top right corner) State and Commonwealth Governments, the Criminal Justice System, Research sector, Social Services, AOD services, Health services, and Community. Each sector has a + and a – symbol, showing that in different contexts they can be enablers or barriers to a person engaging with AOD support. Vectors between interest holders represent flow of resources (e.g., data or funding), relationships (e.g., referral pathways, advocacy) or associations (e.g., between lack of staff and lack of beds in residential AOD services). Darker lines represent stronger influences. Green fonts refer to enablers while red refer to barriers. **Appendix 1** provides details of each of the numbered points on the graphic and should be read side-by-side with it.

Meta problems

I. Lack of overarching national governance and coordination, resulting in different models of care in each jurisdiction;
II. Inertia from society and government to effect change, partly driven by stigma;
III. Lack of high quality data on outcomes, workforce and waitlists;
IV. Chaotic nature of the system and chaotic nature of people accessing services.

Key issues by sector

Government, governance and regulation sector

Key players

- Commonwealth government
- State and territory governments
- Legislative bodies
- Coroner
- Government departments and policy-making organisations

Role within the system

- Introducing, enacting and amending laws, policies, strategies, rules and regulations related to alcohol and drug use in Australia.
- Making determinations about which drugs are “legal” for adults, compared with those that are “illicit”.
- Providing messaging around illicit drug use (e.g., framing it as criminal behaviour).
- Funding law enforcement to reduce supply
- Funding prevention and treatment to address demand reduction and harm reduction

Current initiatives, plans, policies or interventions

- Federal

    - National Drug Strategy 2017-2026: aimed at reducing demand, supply and the harms of alcohol, tobacco, and other drugs. (Commonwealth of Australia, Department of Health, 2017)
    - National Alcohol Strategy 2019-2028: aimed at preventing and minimising alcohol-related harms among individuals, families, and communities. (Commonwealth of Australia 2019)
- New South Wales
    - NSW Alcohol and Other Drugs Workforce Strategy 2024-2032: focuses on developing cross-sector partnership to enhance capacity and capability of the AOD workforce. (NSW Health 2024)
- Victoria
    - Victoria's Alcohol and Other Drug Workforce Strategy 2018-2022: guides workforce development in AOD treatment sector. (Victorian Government (Department of Health and Human Services) 2018)
- Queensland
    - Queensland Alcohol and Other Drugs Action Plan 2022-2025: Focuses on prevention, treatment, and harm reduction. (Queensland Mental Health Commission 2022)
    - Queensland Mental Health, Alcohol and Other Drugs Strategic Plan 2018-2023: Integrates mental health and substance use treatment. (Queensland Mental Health Commission 2018)
- Western Australia
    - Mental Health and Alcohol and Other Drug Strategy 2025-2030: currently in development, will take a whole-of-system approach to improve leadership, collaboration and coordination of the mental health and alcohol and other drugs systems. (Mental Health Commission, Government of Western Australia 2024)
- Northern Territory
    - Northern Territory Alcohol Action Plan: New plan being drafted. Focuses on reducing alcohol-related harm. (Northern Territory Government 2024).

Issues in this sector

- Government departments often work in siloed ways.
- Considerable variability in AOD response (policing, harm reduction measures, treatment) from across Australia due to the federated system of government.
- Decisions and strategies are typically devised with limited consultation with those working in the AOD sector or those with lived experience.
- Government determinations around drug legality and subsequent messaging contributes to the stigmatisation of people with substance use disorders.

Health services sector (not including AOD services)

Key players

- Primary care including General Practice or allied health clinics and community pharmacies
- Secondary services (i.e., medical specialists outside of hospitals)
- Acute Health Services, including inpatient services
- Emergency Departments (EDs)
- Acute Mental Health Services (inpatient)
- Community Mental Health Services

Role within the system

- Primary care settings may be the first place people seek help for their AOD use disorder
- Acute services deal with medical harms from AOD use
- Emergency Departments see and treat people harmed from direct or indirect effects of AOD use (e.g., opioid overdose, trauma due to accidents)
- Primary, secondary and tertiary services can refer the person to AOD services in the community

Current initiatives, plans or policies

- NSW Health have addiction coordinators in acute health services to ensure appropriate access to AOD services
- Involuntary admissions where available, are overseen by boards in each state and territory and have varied criteria and processes
- There can be long waitlists for services. Mitigation strategies include harm minimisation strategies and bridging services (e.g., telephone check-ins)
- Harm minimisation is a priority to manage waitlists, which can include bridging services

Issues within this sector

- GPs may not be skilled in counselling a person with AOD disorders or linking them to appropriate support
- Pathways into AOD services may not be clear
- People with AOD disorders may not disclose information such as the extent of use or harms already experienced
- Integration between primary, secondary or tertiary health services may be poor with a lack of clear referral pathways and limited patient data sharing
- Patients in ED who are acutely intoxicated need to be kept somewhere safe while the alcohol leaves their system which can be perceived as a drain on resources
- Patients who present with an AOD overdose may also be seen as a drain on resources in EDs
- Medical issues may be prioritised over mental health or addiction issues meaning these latter conditions may not be addressed in a timely way
- Stigma from health professionals is reported, leading to a refusal or limitation of services provided, or a shaming experience for the person seeking help. This can reinforce the person's reluctance to engage with services

Alcohol and other drug services

Key players

- Publicly-funded (government) AOD services attached to district acute and community health services
    - *Addiction specialists, psychiatrists, psychologists, counsellors, nurses*
- Privately-funded, for-profit (non-government) AOD services
    - *Varies – Addiction specialists, psychiatrists, psychologists, nurses, counsellors (GPs in residential programs)*
- Not for profit services (largely non-government) AOD services

- *Varies – predominantly peer support workers/counsellors, (+/- psychologist, GP in residential programs), education, policy and advocacy programs*

Role within the system

- Publicly-funded AOD services: harm reduction programs, education, assessment, counselling, medically supervised detox services, residential rehabilitation, community rehabilitation support, advocacy
- Privately-funded, for profit AOD services: assessment, counselling, residential rehabilitation programs, outpatient programs, education, support, advocacy
- Not for profit services: assessment, counselling, residential rehabilitation, day programs, education, support, advocacy

Current initiatives

- Harm reduction strategies:
  - outreach into school programs
  - community education
  - public health campaigns
  - targeted approaches to priority populations
- Guidelines and standards of care

Issues within this sector

- Waitlists
- Geographic barriers
- Staff shortages (addiction health professionals)
- Lack of funded places
- Unclear pathways into services from other parts of the health system

Justice system sector

Key players

- Police and Law Enforcement Agencies
- Courts and Tribunals
- Prisons and Corrective Services (e.g., in prison treatment programs)
- Probation and Parole Officers

Role within the system

- Police and Law Enforcement: enforce drug laws, conduct investigations, and refer offenders to AOD diversion programs
- Courts and Judiciary: offer alternative sentencing focused on rehabilitation through specialised drug courts and mandated treatment
- Prisons and Corrective Services: provide AOD treatment programs to reduce substance use and support inmate rehabilitation
- Probation and Parole Officers: monitor offenders in the community, ensure compliance with court orders, and connect them to AOD services

Current initiatives, plans or policies

- These vary markedly across the states
- NSW Drug Court Program: aims to break the cycle of drug dependency, criminal activity, and imprisonment
- MERIT (Magistrates Early Referral into Treatment): court-based diversion program which allows arrested defendants with substance use issues to be assessed for treatment suitability
- EDDI (Enhanced Drug Diversion Initiative): allows NSW Police to issue on-the-spot fines for low-level drug offences instead of court appearances e.g., the individual has the option to pay the fine or complete a drug education/treatment program.
- CRC Pathways Home (AOD Prison Transition Program): managed by the Community Restorative Centre, this program supports individuals transitioning from prison back into the community.

Key statistics

- In 2022–23, police proceeded against 347,742 offenders nationally, many of whom experience co-occurring alcohol and other drug use, mental ill-health, and social disadvantage (Australian Bureau of Statistics 2024b)
- Number of illicit drug offenders increased for the first time in seven years, with 52,315 offenders in 2022-23 (Australian Bureau of Statistics 2024b)
- The youth offender rate for illicit drug offences decreased from 138 to 130 offenders per 100,000 persons aged 10-17 years in 2022-23, marking the lowest recorded rate since 2008-09 (Australian Bureau of Statistics 2024b)

Interventions

- Again, we note that these vary markedly across and within the states
- Needle and Syringe programs: operate within and outside prisons to reduce the spread of infectious diseases such as Hepatitis C and HIV among people who inject drugs
- Therapeutic Communities: residential programs within correctional facilities that offer a structured, drug-free environment
- Diversion programs: aim to redirect individuals away from the Criminal Justice system and into treatment services
- Drug Courts: provide an alternative to traditional sentencing by focusing on rehabilitation for offenders with substance use disorders
- Opioid Substitution Therapy (including methadone and buprenorphine): is provided in some prisons to manage opioid dependence, reduce overdose risk, and improve health outcomes
- Health education and harm reduction programs: workshops, one-on-one counselling, and peer support
- Post-release support programs: provide continuity of care as individuals transition from prison back into the community

Issues within this sector

- Lack of integrated care/services
- Stigma, discrimination, fear
- Limited access to AOD treatment
- Inadequate harm reduction services

- Resource constraints
- Data gaps and inconsistent monitoring of data
- High rate of co-occurring mental health disorders
- Cultural appropriateness
- Post-release challenges

Social services

Key players

- Department of Social Services (DSS):
    - Families and Children: programs to support families, including parenting support and child protection
    - Housing Support: assistance with housing and homelessness services
    - Seniors: services and support for older Australians
    - Women's Safety: initiatives to protect women from domestic violence
    - Mental Health: support services for mental health issues

- Non-Government Organisations (examples)
    - The Salvation Army: provides a wide range of social services, including emergency relief, homelessness support, and addiction recovery programs
    - St Vincent de Paul Society: offers support for the homeless, disadvantaged, and those in crisis
    - Mission Australia: provides services for homelessness, mental health, and employment

Role within the system

- State and Territory Health Departments: develop and implement policies and programs related to AOD treatment and harm reduction; emergency and transition housing; long-term-housing support; counselling and therapy for the family; parenting support; child protection services; domestic violence support; employment services and financial assistance
- National and Local Public Health Services: collaborate with AOD services to offer integrated care, outreach, and harm reduction initiatives
- Public health and community health services: offer integrated care, focus on vulnerable populations

Issues within this sector

- Funding constraints
- Resource allocation
- Social stigma
- Discrimination
- Fragmented services
- System navigation
- Geographic barriers
- Cultural and linguistic barriers
- Staffing shortages
- Training and professional development

- Complex needs
- Inconsistent policies and regulatory barriers

Examples of interactions, interdependencies, and feedback loops inherent in the system

- Interdependencies between AOD staff capacity, funding and the number of people they can support
- Structural and organisational stigma lead to the creation of policies and community attitudes that marginalise people with AOD use disorder, reinforcing internalised stigma. Internalised stigma leads to treatment becoming a source of shame and reduces an individual's willingness to seek help
- Reducing stigma may increase demand for services and drive unmet need due to limited supply of services
- Siloed government departments lead to fragmented services and poor coordination of care, creating difficulties in navigating available treatment options and supports
- Lack of provider training or the inability of services to manage issues outside the parameters of their specialisations exacerbate service access and capacity issues
- AOD use disorder is complicated by comorbid mental health issues where siloed approaches to treatments often require individuals to address substance use before being accepted into treatment programs
- Siloed approaches between the healthcare system and other services result in unmet needs, for example, initiatives to address housing insecurity or stress helps to improve substance use outcomes, but there is limited capacity to facilitate referrals in the healthcare sector.

Discussion

A rich graphic depicting the context of AOD use disorder efforts in Australia was developed through an iterative process. Eight versions of the Ecosystem graphic were drawn. The penultimate version of the graphic was presented to all the participants, who validated the version with some refinements. We note that there was robust discussion about language (e.g., “addiction” or “dependence” or “use disorder”) and that some less prominent elements were not able to be included due to the limits of two-dimensional graphics.

Our graphic was immediately engaging to participants and suggestions to make it more easily navigable were incorporated into later versions where possible. The “think out loud” instructions provoked comments such as “I like this bit”, “No – you’ve missed out things here” or “You’ve made this part too prominent/not prominent enough”. As a general trend, organisations, interest holders, issues and interactions were added rather than subtracted.

The main change to the early graphic in response to the key informant interviews was increasing the prominence of the community sector over inpatient services, making home and surrounding community services the scene for the most effort, especially harm mitigation and prevention strategies. Treatment services also were changed to be mostly delivered in community settings, with or without formal services. While only a small number of people are represented in the pathway to acute health services for treatment of alcohol-induced medical issues for example, they represent a huge human and economic cost. Over 1,000 people die each year in Australia from alcohol-induced conditions (Australian Institute of Health and Welfare 2024a).

Nearly all participants spoke first about the central figure of the graphic which was interpreted by some as only representing a white male. The narrative was expanded to emphasise the intended universality of the figure while noting the broad range of barriers and issues faced by different people. For example, older adults face concurrent physical issues and online support strategies such as telehealth may be inappropriate or unacceptable to them. The need for tailored prevention, harm mitigation and treatment protocols to different individuals and distinguishable groups about the importance is apparent.

Several participants spoke at length about the importance of peer support in providing non-judgmental and appropriate care. This was in contrast to the stigma which people with substance use disorder often faced, reportedly from a range of people including generalist health professionals, family and friends. Stigma not only made asking for help difficult, but it was also commonly reported as being the reason that people did not truthfully disclose their actual level of substance use or its associated harms to health professionals. This could become a negative feedback loop where judgmental or dismissive responses from health professionals made future rapport and engagement with the system less likely.

Lost opportunities to engage with supports were identified in several places in the graphic. Failure of generalist health professionals to explicitly refer to AOD services or talk about community-based self-help opportunities means that people are left unsupported and associated harms may continue to accrue. Unclear pathways into services meant that without the advocacy and advice of a health professional, many people may not find their way to help. Not-for-profit organisations play a major role here as their services and support may be seen as more accessible and acceptable to those in need. Lost opportunities were also identified in the Criminal Justice sector where inappropriate sentencing, or lack of local programs while incarcerated, can perpetuate problems.

Waitlists are shown nearly everywhere on arrows depicting engagement with services. A clear mismatch was identified between the number of people requiring support and the capacity of services to meet that need. Number of trained AOD staff was low, with lived experience members reporting unfilled staff vacancies and high staff turnover in some public and private services. Peer support workers or trained counsellors were reportedly in much less demand and were seen by some as an untapped resource. Interventions aimed at people with AOD use disorders that sought to mitigate barriers to access such as addressing stigma or strengthening the "no wrong door" strategy, may not be able to support increasing demand. Reported lack of funding, insufficient number of places in programs or beds in residential services, and inadequate staffing levels imply the current suboptimal demand is barely being met by supply. This complex interdependency was considered in many of the state AOD strategic plans by structuring a multifaceted plan to address demand and supply of substances, workforce issues, targeted schemes for priority populations and linking up of services and supports across sectors.

A positive and negative sign was placed in every sector as participants reported the beneficial and the negative aspects of each. For example, the Social Services sector could provide vital income, or education and employment support for people returning to the community after time in prison, or providing stable housing for someone moving into "life in recovery". However, there were reports of onerous mandatory testing, or check-ins to be eligible to receive support. This was another driver of the stigma feedback loop, ultimately deterring people with a genuine need for support to seek it.

Importantly, the informants talked about the lack of a coherent national structure for AOD governance in Australia. Previous national governance structures, the Intergovernmental Committee on Drugs and the National Drug Strategy Committee were dissolved, and the Council of Australian Governments and the Ministerial Drug and Alcohol Forum was disbanded in 2020. The Australian Government advises on a framework and strategic directions for AOD efforts through the Australian National Advisory Committee on Alcohol and Drugs. Each state and territory has its own department or agency embedded in their state health departments responsible for delivering AOD services, such as NSW Health's Alcohol and Drug Unit and Queensland Health's Alcohol and Other Drugs Branch. Added to this are a range of public, private and not-for-profit organizations delivering on-the-ground services. Despite of efforts to collaborate and ensure coordination of frameworks, priorities and service delivery, it remains a fragmented, complex and multidimensional field.

Limitations

No graphic can fully capture the detail and dynamism of a CAS. Our graphic, while rich in the data it has incorporated, does not claim to be definitive. Not all issues we identified from the literature could be depicted graphically, and some issues were not discussed by our participants. The research team focussed on the aspects that were discussed by our informants and this introduced an element of bias. For example, there were a number of treatment or harm mitigation interventions still in the piloting stage that were not discussed. Moreover, expertise in the research team was skewed somewhat to AUD. As a result, some aspects of the AOD sector are not fully reported. For example, unique issues around cannabis use have not been teased out, and some details around opioid use disorders are missing. Drugs deemed illicit are dealt with all together, without reference to the unique issues arising from each.

Conclusion

This report presents the development of a rich graphic that provides a holistic view of the ecosystem of AOD efforts in Australia. Based on the concept of the health system as a Complex Adaptive

System, we sought to capture the range of interest holders, organisations and formal and informal services in the Australian setting relevant to the provision of treatment and support for a person with an AOD use disorder, as well as a detailed mapping of issues, influences, interdependencies and barriers to accessing care. The interplay of sectors and overarching and often overwhelming issues or stigma and community attitudes dominate the graphics. Simplistic fixes such as increasing funding to build more infrastructure to extend AOD services are shown by the network of vectors (lines of influences, barriers) surrounding the sector to be insufficient to solve issues we identified. Workforce, infrastructure, equity and access issues for priority populations, appropriate restrictions on drivers of supply, and support where and when it is needed must all be addressed.

Continue to Appendix 1: Commentary to accompany the graphic

Appendix 1

Ecosystem of Alcohol and other Drug efforts in Australia

The ecosystem of AOD efforts is characterised as seven interest holder groups that surround a central blue figure that represents the person with an AOD use disorder. The seven sectors are (clockwise from the top right corner) State and Commonwealth Governments, the Criminal Justice system, the Research sector, Social Services, AOD services, Health services, and Community. Each sector has a + and a – symbol, showing that in different contexts they can be enablers or barriers to a person engaging with services. Vectors (lines between interest holders) represent flow of resources (e.g., data or funding) or relationships (e.g., referral pathways, advocacy) or associations (e.g., between lack of staff and lack of beds in residential services). Darker lines represent stronger influences. Green fonts refer to those issues that are typically enablers while red fonts refer to barriers.

1 At the centre of the graphic is a human figure representing people in Australia who are living with an AOD use disorder (647,900 (3.3%) of Australians aged 16-85 years; Australian Institute of Health and Welfare 2024a).

The figure bears a tear over their heart representing trauma or emotional pain that often precedes AOD use disorders. Relief from this pain can often be the impetus for continued substance use.

While only a single human figure is shown, the icon represents multiple people in multiple circumstances including:

- Women: a minority in AOD services, who often have different issues to men around their use disorder (e.g., child caring responsibilities, pregnancy, additional stigma, trauma and domestic violence).

- Young people: approximately 28% of young people aged 15-24 have used substances for non-medical purposes in the past year, an increase from 22% in 2012-13. Young people are particularly vulnerable to substance misuse, with males more likely to engage in substance use compared to females (Australian Institute of Health and Welfare 2024b).

- Older adults: people aged 70 years and over continue to be the most likely to drink daily (11.7%), followed by people in their 60s (8.5%) and 50s (6.5%]. Older adults have different issues to younger people (e.g., higher numbers of medical comorbidities; Australian Institute of Health and Welfare 2024b).

- People from different ethnicities, religions, languages, traditions, and migration experiences: range of issues related to cultural norms; language barriers; socioeconomic barriers (Chartier and Caetano 2010).

- Aboriginal and Torres Strait Islander people: range of issues including intergenerational trauma, stigma, cultural dislocation, socioeconomic disadvantage (Australian Bureau of Statistics 2019). Indigenous Australians experience higher rates of substance misuse compared to non-Indigenous Australians. In 2018-2019, about 29% of Aboriginal and Torres Strait Islander people aged 15 and over had used substances for non-medical purposes in

the past year (Australian Institute of Health and Welfare and National Indigenous Australians Agency 2020).

- People who identify as Lesbian, Gay, Bisexual, Transgender, Intersex, Queer/questioning, Asexual+ (LGBTQIA+): range of issues including stigma, social isolation, discrimination and marginalisation. Alcohol use and alcohol-related problems are higher in the LGBTQIA+ community compared to the general population (Hughes, Wilsnack, and Kantor 2016). Some subgroups of the LGBTQIA+ community have even higher rates of misuse. The group with the highest drinking rates in the LGBTQIA+ community were bisexual women, 25% of whom reported heavy drinking (Hughes, Wilsnack, and Kantor 2016; Green and Feinstein 2012; Rehab Spot 2023).

- People who are homeless:In 2022-23, about 8.6% of clients of specialist homelessness services reported an AUD. A large majority (75%) of these clients were under 45 years of age, and 43% had a current mental health issue (Australian Institute of Health and Welfare 2024e).

- People who live in rural or remote areas. People living in very remote areas have a higher rate of receiving treatment (1,412/100,000) than those living in major cities (487/100,000). This was despite having the smallest number of clients and the smallest average number of episodes per client (Australian Institute of Health and Welfare 2024a).

DSM-5-TR Substance Use Disorder Criteria (American Psychiatric Association 2013)
Substance use disorders span a wide variety of problems arising from substance use, and cover 11 different criteria:

1. Taking the substance in larger amounts or for longer than you're meant to
2. Wanting to cut down or stop using the substance but not managing to
3. Spending a lot of time getting, using, or recovering from use of the substance
4. Cravings and urges to use the substance
5. Not managing to do what you should at work, home, or school because of substance use
6. Continuing to use, even when it causes problems in relationships
7. Giving up important social, occupational, or recreational activities because of substance use
8. Using substances again and again, even when it puts you in danger
9. Continuing to use, even when you know you have a physical or psychological problem that could have been caused or made worse by the substance
10. Needing more of the substance to get the effect you want (tolerance)
11. Development of withdrawal symptoms, which can be relieved by taking more of the substance

2 Immediately above the person are children representing caring responsibilities. While not all people with AOD use disorders have dependent children or caring responsibilities, those that do have a suite of unique issues as a result. Lost income from missing work, or money to pay rent or

buy food and clothes for dependants may be used to buy alcohol or other substances consequently placing pressures on the household.

3 Beside the central figure are their wider family and friends. Friends may provide support and encouragement but may also be a significant part of the problem, perhaps modelling or enabling ongoing AOD use disorder or contributing to stressors already present.

4 Hovering over the central figure are community norms and attitudes. A ubiquitous and potent influence on every aspect of AOD efforts and the lived experience of AOD use, attitudes and norms fuel drivers for a continuing AOD use disorder. Heavy arrows from Government rhetoric and messaging, and values portrayed in media, culture, religion as well as generational attitudes, indicate the strength of the influence.

5 Community norms and attitudes fuel the ubiquitous influence of stigma. Common beliefs and attitudes from the community that drive stigma are that people with AOD use disorder are weak individuals who lack character, intelligence or will power. Often, their struggles can be reduced to personal or moral failings rather than recognising the complex interplay of biological, psychological, and social factors involved (Cheetham et al. 2022; Kaufmann et al. 2014; Forchuk, Serrato, and Scott 2024). This perception is further amplified by government rhetoric that commonly frames illicit drug users as criminals with malicious and selfish intent towards those in society who are 'innocent'. Public health messaging often fails to address the nuances of addiction and may reinforce harmful stereotypes. For example, the World Health Organization published a statement in 2023 in the Lancet Public Health (Anderson et al. 2023; World Health Organization 2024b) emphasising that there is no "safe" amount of alcohol consumption that does not affect health, as even drinking small amounts increases the risk of developing various cancers. While this information now underpins public health messaging around alcohol consumption in Australian guidelines (Alcohol and Drug Foundation 2023) that aim for risk reduction, they still may unintentionally imply that drinking to a certain level is safe, except when pregnant (Department of Health and Aged Care 2020). Moreover, the lack of regulation in the marketing of alcohol consumption as a fun, light hearted activity may further contribute to confusion (Davies et al. 2023).

This rhetoric is compounded by structural stigma within the criminal justice system, manifesting through aggressive or over-policing of people who use drugs and the criminalisation of drug use, collectively reinforcing negative stereotypes of people with AOD use disorder (Scher et al. 2023; United Nations Office on Drugs and Crime 2021). Punitive school environments with strict disciplinary measures also fail to address the underlying issues related to AOD use (Fisher et al. 2024), further entrenching stigma and failing to focus on the root cause. Structural stigma is pervasive, with many restrictive measures placed over supportive interventions for people with AOD use disorder, such as underfunding of treatment resources or reduced support from government agencies. Restrictive policies and bureaucratic red tape create significant barriers to accessing services, with complex insurance policies and eligibility requirements limiting access to necessary interventions (Cheetham et al. 2022; Giorgi et al. 2023; Luna et al. 2024). Stigma is shown in other places on the graphic to emphasise its influence over all aspects of the ecosystem.

6 Drivers of AOD use disorder are also fuelled by community norms and attitudes. Participants with lived experience report being embedded in communities where "everyone drank too much"

and it was considered normal and appropriate. Messaging from industries that stand to benefit from people's continued use may imply it is the responsibility of the person to control their substance use (Davies et al. 2023)(see also 9).

7 Harms that are associated with the AOD use are noted. Impaired function or a focus on the substance may lead to lost productivity, absenteeism or unemployment. Pressures mentioned at 2 may escalate as the person "prioritises their habit over their family responsibilities" (participant with lived experience). Physical and mental health harms may be present and progressively worsening, adding to the harms. Domestic and family violence is often associated with AOD use, as are car accidents or other trauma associated with substance use and resulting risky behaviour. Death due to overdose is mentioned as a (catastrophic) harm. Such deaths are reportable to the coroner and recommendations arising from some of these investigations have been responsible for changes to State laws (e.g., after the death of a person in custody in Victoria, public intoxication was decriminalised and from that date, individuals who are identified as intoxicated in public will be supported to go to a safe place, rather than being detained in a police cell under criminal or civil powers) (Human Rights Commission 2021).

8 Alcohol and prescription medicines are shown to the left of the central figure, grouped as substances that are legal for an adult to obtain and use. Opioid prescribing in Australia has increased by over 40% between 2010-2019, with the number of opioid prescriptions (10.3 million) in 2010 moving to 14.5 million in 2019 (Dunlop, Lokuge, and Lintzeris 2021). According to the 2019 National Drug Strategy Household survey, approximately 3.3% of Australians aged over the age of 14 (approx. 600,000 individuals) reported misusing prescription opioids (Australian Institute of Health and Welfare 2020; 2018). There were 1,121 drug induced deaths in 2019 in Australia with opioids being the most common substance involved. Of these, 53% were linked to prescription opioids, such as oxycodone, codeine and morphine (Donovan et al. 2020). In terms of alcohol, in Australia more than 1 in 4 (26.8%) Australians aged 18 years and older exceed the lifetime risk guidelines for alcohol consumption. Men were more likely than women to exceed the guidelines with 35.8% of men and 18.1% women (Australian Institute of Health and Welfare 2024b).

9 Liquor stores are shown with a warning, reflecting the fact that alcohol is no ordinary commodity, and the industry has a responsibility for minimising alcohol-related harms across the community (rather than blaming the individual). Yet, the industry drives alcohol consumption through making it easy to access (e.g., extended opening hours, high density of liquor outlets, rapid online delivery). Alcohol sales are highly lucrative, with approximately $26 billion spent by Australians on alcohol consumption in 2019-20 (Deloitte Access Economics 2021). Sources estimate the cost of engaging in harmful consumption of alcohol at $3.2 billion in 2021 (Rethink Addiction and KPMG 2022). Moreover, alcohol promotion can increase emotions and thoughts around drinking alcohol and trigger cravings for vulnerable people (Murray et al. 2022). Use of online promotions has been linked to early and risky alcohol use in young people (Gupta et al. 2016). Online advertisements encouraging instant purchase and rapid delivery of alcohol (linked to excessive and risky use of alcohol) (Foundation for Alcohol Research & Education 2024) have been identified as an area that merit consideration of government-imposed standards and regulations to limit harms due to alcohol.

10 Illicit substances are seen to the right of the central figure grouped as substances that it is not legal for an adult to obtain and use in Australia such as amphetamines, cocaine, heroin and cannabis

(excluding medicinal cannabis which can be prescribed; Therapeutic Goods Administration 2023). According to the 2022–2023 National Drug Strategy Household Survey (Australian Institute of Health and Welfare 2024d), approximately 10.2 million (47%) people aged 14 years and over in Australia had illicitly used a drug at some point in their lifetime. This included both illegal drugs (such as cocaine, heroin, and amphetamines) and non-medical use of prescribed medications (Australian Institute of Health and Welfare 2024c). The most common illicit drug used was cannabis, followed by cocaine and hallucinogens. Specifically, around 2.8 million Australians use cannabis, 283,000 people used opioids, 237,000 people use amphetamines regularly and 113,000 people use cocaine regularly (Australian Institute of Health and Welfare 2024c).

11 The illicit drug market is shown with its links to the Police and Criminal Justice sectors. It is noted that substances may be obtained in other ways than purchase through this market (e.g., sharing or theft of substances prescribed for others). Significant harms including death can occur before AOD use disorder criteria are met (e.g., through experimentation). Import of illicit substances is a major concern for border security. Another focus is mis-selling of drugs (i.e., drugs containing substances other than what the vendors claim is present, including foreign material or contaminants) that can result in death or significant harm. Pill testing is a harm mitigation strategy to reduce this. It is estimated that the largest proportion of Federal funding for drug response goes to law enforcement (Grealy 2024). This is reflected in the statistic that 25% of all frontline police officers' time is spent responding to alcohol related crime (Australian Institute of Health and Welfare 2024c).

First responders are adjacent to the police and the illicit drug market, responding to crimes or incidents involving people with AOD, medical or mental health-related events. This is frequently in the news, and inappropriate responses may occur related to limited training in managing these issues, and community fear and stigma in relation to safety.

12 In the Criminal Justice sector, decisions regarding sentencing can influence AOD service efforts. Any criminal (and particularly custodial) sentences can be harmful for the person and can ruin their reputation, making them ineligible for some jobs or activities. Programs designed to reduce ongoing dependence, harms and crimes while encouraging continuing engagement with AOD services are available in some states. For example, MERIT (Magistrates Early Referral into Treatment) is a court-based diversion program which allow arrested defendants with substance use issues to be assessed for treatment suitability in NSW. Another program, the Work Development Program allows the defendant to pay off their fines and avoid a custodial sentence in NSW. Participants noted a rising problem in the negative cycle of people with Hepatitis C, who have been successfully treated in the community, being re-infected in prison due to lack of clean injecting materials. Better access to AOD services may mitigate this difficult cycle and reduce morbidity.

13 A selection of harm minimisation strategies is noted here, and elsewhere in the community (e.g., school programs promoting coping strategies on far left). Programs include needle exchanges (e.g., WAAC 2024), safe injecting spaces, pill testing at music festivals (Barratt et al. 2018) and public health campaigns. Harm minimisation is a major strategy of all agencies working in Australia.

14 The yellow shaded area shows Alcohol and Other Drug services. States have variations in configuration and integration of services within or alongside the health and mental health sector and

different proportions of publicly or privately funded or NGO services (see more details in Report Results, p.12). The majority of AOD support and services are carried out in the community. Funding and staff capacity and capability are key barriers to timely, high-quality support or treatment. Staff burnout is reportedly high in this sector, with career options being described by some participants as limited and unattractive. The peer support staff are seen as a key part of the workforce. On the far left, community-based AOD support and self-help groups such as AA, NA, SMARTRecovery or NGO helplines, walk-in clinics, or publicly funded groups play an important part. These services are important entry points to more intensive treatments if required.

15 The health sector is shown in the blue shaded area (See also Results p.15-16 for more details). People with AOD may present here first to access support or treatment. This includes GPs and pharmacists who may not have the skills required to deal with people experiencing AOD disorder, stigma and trauma. Prescribing safeguards include real time prescription monitoring tools to identify high risk drug prescribing as well as multiple prescribers, and prescribing guidelines and education for GPs and pharmacists. Unclear pathways and responsibilities are noted at the boundaries between health (e.g., lack of staff training) or mental health services (siloed styles of treatments) into AOD services. Barriers to access AOD support are listed on the bottom left:

- Delays in seeking help for addiction: multiple factors inhibit early help-seeking, including ambivalence, hopelessness, incapacity or shame.
- Challenging behaviours: people with challenging behaviours may find it difficult to make their needs known and may be denied or not offered some services. This can perpetuate harms to the individual.
- Geographic location: there are fewer services in rural and regional areas in Australia making access to services more difficult logistically.
- Waitlists: are ubiquitous in the system, especially for public services. Initial assessment and then being put on a waitlist for support can be traumatising in its own right (Francia, Lam, et al. 2023).
- Financial: some AOD services are offered by private organisations. Charges for residential rehab programs, for example, may be prohibitive for many (e.g., 3 week residential rehab in a private facility in Sydney may cost $21,000 plus extras). Even with private health insurance, wait times are required to be served before benefits can be claimed for pre-existing conditions. Health insurance also does not cover all aspects of private services and there are many out of pocket costs.
- Language or culture may be a potent barrier for some people with AOD use disorders who may feel unable to communicate their needs, or feel judged or ostracised by their community, further isolating them from help.
- Medicare. Many services are rebatable on Medicare but for those individuals without a Medicare Card, or non-residents from countries without reciprocal rights, full fees are charged.
- Health literacy. Unclear pathways into AOD services are widely reported, muddled by the confusing array of options available. Adopting a “no wrong door” strategy that links clients to appropriate AOD services from any other health or mental health service is the soundest policy. More work needs to be done to ensure this happens.

16 Located beneath the Criminal Justice system is the Social Services sector. It is noted that stable housing and income support can be crucial supports to treatment. A criminal or custodial sentence may result in access to some services being unhelpfully conditional on certain behaviours,

resulting in people who are unable to comply, lost to AOD support or treatment (see more details on p.18-19)

17 The Research sector is shown in the bottom right corner. Research is conducted on all aspects of AOD support efforts but is noted to be demonstrably underfunded by Category 1 funders such as the National Health and Medical Research Council and Medical Research Future Fund. Research is noted to influence evidence-based treatments and practice by producing research findings or guidelines (e.g., Haber and Riordan 2021a; Manning et al. 2018). A common lament is that recommendations from research are often unheeded by policymakers.

18 The Government sector is noted for its siloed departments meaning a lack of integration between sectors that result in gaps in services. State governments fund and regulate local services and it was argued by several participants that there is no coherent federal governance structure in AOD. As noted at 17, decisions and strategies appear to be influenced by community sentiment or vested interests rather than listening to input from researchers or those active in the AOD sector. Some government policies and regulations have had a positive effect on harm reduction (e.g., the Alcohol Linking Program has reduced alcohol associated incidents in regional and rural venues in association with police (Wiggers 2007)); lack of tighter regulation of liquor supply, and failure to institute policies recommended by research is said to have a negative impact (Fitzgerald et al. 2024).

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