State Budget Submission 2026

Building a Sustainable, Accessible, and Person-Centred AOD System for Victoria

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Acknowledgement of Country

VAADA acknowledges the Traditional Owners of the land on which our work is undertaken. Our office stands on the country of the Wurundjeri people of the Kulin Nation. We pay our respects to all Elders past and present and acknowledge their continuing and ongoing connection to land, waters and sky.

About VAADA

The Victorian Alcohol & Drug Association (VAADA) is a member-based peak body and health promotion charity representing organisations and individuals involved in prevention, treatment, rehabilitation, harm reduction or research related to alcohol or drugs. VAADA aims to support and promote strategies that prevent and reduce the harms associated with alcohol and other drug (AOD) use across the Victorian community. Our vision is a Victorian community in which AOD-related harms are reduced and well-being is promoted to support people to reach their potential. VAADA seeks to achieve this through:

- Engaging in policy development
- Advocating for systemic change
- Representing issues our members identify
- Providing leadership on priority issues
- Creating a space for collaboration within the AOD sector
- Keeping our members and stakeholders informed about issues relevant to the sector
- Supporting evidence-based practice that maintains the dignity of those who use alcohol and other drugs and related services

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VAADA acknowledges and celebrates people and their families and supporters who have a lived and living experience of alcohol, medication and other drug use. We value your courage, wisdom and experience, and recognise the important contribution that you make to the AOD sector in Victoria.

Executive Summary

Victoria's Alcohol and Other Drug (AOD) sector is at an important juncture. With the imminent release of the Victorian AOD Strategy, the 2026 State Budget presents a tangible opportunity to realign service delivery with client needs, strengthen system design, invest in a sustainable workforce, and improve integration across sectors. It also creates an opportunity to capitalise on the gains made under the AOD Statewide Action Plan (Victorian Government, 2024) and support the vision for better integration across the mental health and wellbeing system (VAADA, 2025a).

Current AOD funding and service models prioritise system requirements over person-centred care, leaving too many people navigating fragmented services, facing long wait times, and with insufficient support at critical points - such as treatment entry and transition between modes of care. Overdose deaths have reached record levels (11 deaths per week in 2024), highlighting the urgency of investment in intake, harm reduction, pharmacotherapy access, and system "surge protection" against emerging risks like synthetic opioids. Dedicated services remain under-resourced, particularly for First Nations people, women with AOD treatment needs, diverse communities, and regional Victorians.

Sustainable reform requires redesigning funding and service models, including replacing the outdated Drug Treatment Activity Unit, investing in infrastructure, and strengthening data systems to improve service planning and delivery. Innovation is already underway—through initiatives such as VAADABase and new residential treatment models—but it requires dedicated investment to sustain real change.

A capable, resilient workforce is essential to the success of the AOD Strategy. Expanding training platforms such as Elevate!, investing in additional traineeships, creating pathways for lived experience roles and opportunities for leadership development, along with improved access to supervision, are critical to retaining staff, reducing burnout, addressing regional workforce shortfalls, and building the workforce of the future (VAADA, 2025c). These workforce measures should be consolidated as part of an AOD Industry Plan.

In addition, effective responses must extend beyond AOD to intersecting service systems —mental health, justice, family violence, and hospitals. Codesigned, culturally safe programs for communities experiencing disproportionate harms, integrated models of care to address co-occurring needs, and strengthening intersectional practice will help ensure the AOD system is equitable, inclusive, and person-centred.

To realise the vision of the forthcoming AOD Strategy, a funded implementation plan is necessary. Without it, the AOD treatment and harm reduction systems in Victoria

will continue to be hampered by outdated systems architecture, rising demand, and growing harms; with it, Victoria can begin developing a more responsive and sustainable system that ensures all Victorians can receive the right care where and when they need it.

Following extensive consultation with the Victorian AOD sector and allied community services, VAADA's 2026 State Budget submission identifies **10 key priorities** addressing urgent community needs and structural challenges to build long-term sustainability. These priorities provide strategic guidance for future programs and system development. The submission also outlines a suite of complementary initiatives that together provide a comprehensive blueprint to reduce harms and improve wellbeing for Victorians seeking help for their AOD use.

Key Priorities

1. **Deliver a funded implementation plan for the Victorian AOD Strategy**
   Develop and resource a clear plan to translate the Victorian AOD Strategy into action.
2. **Develop contemporary, flexible funding and service delivery models**
   Ensure the pricing review is informed by the AOD sector, replacing the Drug Treatment Activity Unit (DTAU) with evidence-informed models that enable flexibility, innovation and person-centred care across both adult and youth services, while ensuring funding keeps pace with delivery costs, workforce requirements, client complexity and growing demand.
3. **Develop a Victorian AOD Industry Plan**
   Establish a coordinated plan to strengthen workforce attraction, retention and capability by expanding traineeships, embedding designated lived and living experience roles, and investing in sector leadership and supervision.
4. **Extend key harm reduction initiatives**
   Provide further funding for the Public Intoxication Response and the Victorian Pill Testing Service, securing these key harm reduction initiatives for the long term, while expanding access to the pharmacotherapy grants program.
5. **Support the AOD sector to meet the aspirations of Treaty**
   Deliver on the goals of the Yoorrook Justice Commission and the Victorian Aboriginal Health and Wellbeing Partnership Agreement by investing in culturally safe, First Nations models of care for AOD, focused on healing, community and culture.
6. **Redesign the Victorian AOD Intake system**
   Increase place-based intake and assessment capacity as an interim measure to address current community access issues, while a plan is finalised for a redesigned AOD intake system.

7. **Strengthen data capability**
   Fund the expansion of *VAADABase* to meet a critical gap in evidence-based decision-making around service and treatment planning.
8. **Establish a recurrent AOD capital infrastructure grants program**
   Create a $30 million AOD Capital Infrastructure Fund over three years to urgently upgrade facilities, improve accessibility and ensure treatment environments are safe and fit for purpose.
9. **Expand withdrawal bed capacity and mental health–AOD hubs**
   Increase withdrawal capacity across AOD services, community settings and public hospitals—particularly in rural and regional areas—and expand mental health–AOD emergency department hubs across Victoria.
10. **Improve coordination at key service intersections**
    Resource peak bodies to facilitate cross-sector engagement as system stewards, supporting sector capacity and better system integration between aligned service systems.

1. Service Delivery and Client Need

In Victoria, accessing and navigating the AOD system remains complex, fragmented, and inconsistent across regions. The state's AOD intake system, introduced in 2014, illustrates these challenges. While designed to improve coordination, it is no longer fit for purpose. Lack of clear and transparent pathways into treatment has created regional bottlenecks and inconsistent availability of services (Victorian Alcohol and Drug Association, 2024a). **The intake system requires redesign** to ensure that, wherever someone enters treatment, *the first door is the right door.* As a first step, **increasing place-based intake and assessment capacity** should be supported alongside the centralised intake route. This should be complemented by a broad uplift in treatment resourcing to meet current demand[1] and ensure the system is ready to support the implementation of the Victorian AOD Strategy.

Continuity of service also needs to be strengthened at key transition points—such as when individuals are waiting for treatment, moving between services, or leaving care. These transition points are associated with increased risk of disconnection from support, AOD lapse, overdose and premature death. Expanding the **Care and Recovery Coordination** model and establishing **Peer Navigator roles** would provide more consistent support across these transitions, improving engagement and outcomes.

Access to Medication Assisted Treatment for Opioid Dependence (MATOD) remains a significant challenge in Victoria. The current program is under strain from a lack of prescribers and is at constant risk of failure. This is particularly so in regional Victoria. The pharmacotherapy grants program, while welcomed by the sector, has only had a modest impact, with high rates of unmet need[2]. Expansion of the grants program to include specialist AOD services, community health services and Aboriginal Community Controlled Health Organisations (ACCHOs) is essential. Scaling up **nurse practitioner and telehealth models to reduce pressure on the lack of prescribers**[3] and **scaled incentive payments for GPs** who support patients requiring MATOD must be examined. State and Commonwealth governments need to work more closely together to provide better access to this life-saving medication.

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[1] On any given day, around 4,550 people are waiting for AOD treatment in Victoria (Victorian Alcohol and Drug Association, 2025b).

[2] Despite broadly comparable needs, Victoria has around 10,000 fewer people in pharmacotherapy treatment than New South Wales (Victorian Government, 2023)

[3] Noting the long-standing challenges of clients in regional Victoria accessing Addiction Medicine Specialists, especially for pharmacotherapy, at least two regional services have adopted a remote telehealth model allowing for the assessment and treatment of patients for issues related to opioid use. The use of telehealth to deliver MATOD is a well-established intervention and is known to increase access and, in some cases, improve attendance. (Garry et al., 2025). This model should be adopted more widely to help remedy the pharmacotherapy crisis in Victoria. See: https://www1.racgp.org.au/ajgp/2025/may/provision-of-a-remote-telehealth-opioid-substitutition

Two key harm reduction initiatives—the **Public Intoxication Response** and the **Pill Testing Service**—are currently only funded as implementation trials and lack a commitment of further funding beyond their trial period. The Public Intoxication Response, established through decades of Aboriginal community advocacy, provides outreach support and sobering-up services in metropolitan Melbourne and regional Victoria. It embeds a major shift from a criminal justice approach to public intoxication to a health-led response, while also addressing the disproportionate (and tragic) impact public intoxication laws have had on Aboriginal people.

The 2024-25 Pill Testing trial engaged more than 1500 people during the summer festival season. For 65% of service users, it was the first time they had ever spoken to a health professional about AOD safety. More than 30% said they would take a smaller amount after having this conversation. The Victorian Pill Testing Service now includes a fixed site in Fitzroy, issuing timely alerts about high-risk or unknown substances. This service is on the frontline of supporting **improved real-time drug surveillance** in Victoria, providing timely information about emerging risks and unknown threats in the illicit drug market. The Public Intoxication Response and the Pill Testing Service must continue to be funded as part of the long-term shift in the way that we address AOD harms in Victoria. Another critical and effective response to the harms of injecting drug use is the North Richmond Overdose Prevention Facility (Victorian Government, 2023). With heroin overdose deaths increasing by 20% in 2024 (Coroner's Court of Victoria, 2025), the expansion of this model, where needed, must be supported. There is also a pressing need to **strengthen peer-led outreach** to better engage and support people at the highest risk.

While men represent the majority of AOD service users, the treatment system continues to underserve other groups, particularly women, gender-diverse people and First Nations peoples. Those in rural and regional areas also face significant access inequities. Ongoing **shortages of place-based withdrawal beds persist across much of the state and require urgent attention**. Developing On-Country Aboriginal residential detox and treatment services, including a women's service, guided by the Victorian Aboriginal Community Controlled Health Organisation (VACCHO), should also be prioritised (VAADA 2024c). There also remains **unfinished business connected to the AOD goals in the Victorian Aboriginal Health and Wellbeing Partnership Agreement Action Plan 2023-2025**. These goals have been jointly developed through the Partnerships Forum and must be delivered through

further commitment[4]. Similarly, the Yoorrook Justice Commission (Yoorrook Justice Commission, 2025) called for an increase in funding to First Peoples-led health services to ensure they are sufficiently resourced to deliver First Peoples AOD services. More specifically, Recommendation 80 calls to establish First Peoples Women's Centres for First Peoples Women affected by family violence, including a comprehensive suite of culturally safe supports such as AOD support.

Mainstream AOD services must also be equipped to embed cultural safety as a structural feature of practice. Developing **an Aboriginal AOD training package for Victorian mainstream AOD services**, led by the Aboriginal Community Controlled Health sector with VAADA, will help ensure cultural safety is applied consistently—from organisational leadership through to frontline service delivery. This is a critical step toward enhancing approaches between mainstream AOD treatment and First Nations ways of being, knowing, and healing. The commitment to **Treaty** requires no less.

Together, these initiatives set out a path toward a more responsive, equitable, and coordinated AOD service system. These should be approached in line with the pending **Victorian AOD Strategy**, providing solutions for the long term to improve service delivery and meet community needs. Critically, the **AOD strategy will require a clearly articulated and funded implementation plan**—reiterating a recommendation from the 2025 VAADA State Budget Submission, to ensure the sector can meet the vision of the strategy once it's released.

2. System Planning and Design

Ensuring the long-term sustainability of the Victorian AOD sector will require **changes to both funding and service delivery models**. The current funding model for most adult services — the Drug Treatment Activity Unit (DTAU) — is no longer fit for purpose and does not adequately reflect or fund the full range of activity undertaken (VAADA, 2024a). The DTAU is widely regarded as rigid, limiting flexibility and innovation.

[4] These goals include:

- Design the service model of a culturally safe, gender-specific residential detoxification and rehabilitation facility for Aboriginal and/or Torres Strait Islander women with the aim of this service being operational by 2030.
- Ensure the government is adhering to commitments made on the decriminalisation of public intoxication.
- Review the current AOD care mechanisms to ensure they are culturally appropriate and safe, prioritising intake and assessment processes.
- Ensure that mainstream AOD organisations embed a consistent cultural safety practice in their models of care. Undertake whole-of-system Aboriginal-specific AOD service demand and planning assessment.

While **reform of the DTAU is needed**, adjusting prices alone will not achieve meaningful change. A new funding model is required — one informed by the AOD sector and incorporating expertise in health economics, data and evaluation, system design, and public policy. It should be underpinned by First Nations knowledge and the perspectives of people with lived and living experience. **Future models must provide services with greater flexibility and autonomy to respond to person-centred needs, and must more accurately reflect the real cost of service delivery**, including currently unfunded mental health activity (VAADA, 2025d), professional development, supervision, and community and cross-sector engagement. Further, and as per VAADA's submission to the Yoorrook Justice Commission (VAADA, 2024c), there must be **investment in the development and implementation of First Nations models of care for AOD**, focused on healing, community and culture.

The Department of Health has acknowledged that a funding review cannot occur without rethinking how services are delivered. This approach is supported but should extend beyond adult DTAU-funded services. **The forensic service system** — described as "mind-bogglingly complex" — must also be included[5]. Similarly, the **specialist youth AOD system**, established in 1996, has seen little change in the way interventions are funded for young people in three decades. Youth services must be in scope in any future system and funding redesign to meet the challenges faced today by young people including from evolving AOD markets.

Effective service planning and design also depend on the availability of high-quality data. Many organisations continue to struggle to access and interpret their own AOD data through the Victorian Alcohol and Drug Collection (VADC) (VAADA, 2025c). Most recommendations from the 2022 Victorian Auditor-General's report (Victorian Auditor General's Office, 2022) remain unimplemented. *VAADABase*, a sector-led data collaboration piloted with 16 agencies, offers a genuine solution. It provides user-friendly data dashboards at both service and sector levels, enhancing data visibility and analysis. **With proper resourcing, *VAADABase* could substantially improve planning, identify system gaps, and strengthen service delivery.**

System planning also extends to the built environment. Many AOD facilities are ageing and require major upgrades or replacement. VAADA's 2025 submission to Infrastructure Victoria recommended establishing a **recurrent AOD capital infrastructure grants program** (VAADA, 2025e). Thirty million dollars over three years is required to address urgent infrastructure needs. Such a program would also enable upgrades that improve accessibility and create more welcoming, therapeutic

[5] In 2019, the Collaborative Practice Framework (Victorian Government, 2019) was developed to strengthen coordination between Community Correctional Services (CCS), the AOD sector, and the Community Offender Advice and Treatment Service (COATS). Developed with key cross-sector stakeholders, it established a shared understanding of collaborative practice to better support forensic clients with AOD treatment needs. It should now be revisited as a framework to renew cross-sector collaboration and improve outcomes for people involved in both systems.

environments for people seeking support. In early 2025, the Victorian Government funded the development of a model of care for a new residential AOD treatment approach focused on supporting working Victorians. Led by the Health and Community Services Union (HACSU) and supported by other unions, ***The Crossing*** **aims to offer greater flexibility than traditional AOD residential models, with an explicit focus on gambling-related harms**. Given the significant investment in its design, the Government should commit to operationalising this model, creating more flexible and responsive residential treatment options for Victorian workers.

Research and evidence must continue to inform system planning. Since its launch in 2019, the **Alcohol and Drug Research Innovation Agenda (ADRIA**) has supported innovative, sector-led research, enabling agencies working directly with communities to produce impactful, translational outcomes (see ADRIA webpage). Now in its final funding round, ADRIA is widely recognised by leading AOD researchers as a unique and effective model for generating sector-driven evidence. **Continued investment is essential to build on this momentum and ensure that research continues to inform and improve practice** across a changing landscape of AOD-related threats and harms.

Planning for the future requires **preparedness for emerging challenges, including the rise of high-risk new psychoactive substances such as potent synthetic opioids**. These substances are increasing rapidly worldwide (UNODC, 2025), and in Victoria, novel psychoactive substances contributed to 48 overdose deaths in 2024. Between 2015 and 2024, 59 different individual novel psychoactive substances were identified as contributors to overdose deaths (Coroner's Court of Victoria, 2025). VAADA has previously highlighted the risks posed by potent synthetic opioids such as Nitazenes (VAADA, 2024b) and **the need for 'surge protection' capacity** allowing services to scale up rapidly in response to new threats. **Victoria needs a Potent Synthetic Opioid Plan** to ensure a coordinated, evidence-based, and rapid response—including joined-up early warning systems, cross-sector collaboration, workforce training, and improved access to harm reduction and treatment services. **Eliminating Naloxone 'black spots' across Victoria must also be a priority.**

3. Workforce Training and Development

The Victorian AOD workforce supports individuals and families navigating complex, multifaceted, and long-term challenges. Effective service delivery requires not only expertise in AOD practice, but also multi-disciplinary capability. It also requires a **purposeful and strategic approach to workforce development.** Despite this, workforce development initiatives are often reactive and available training is frequently oversubscribed. Competing demands and limited resourcing can prevent

staff from attending professional development (VAADA, 2025c)[6]. These factors mean that, although opportunities exist, access remains uneven across the workforce.

The **Elevate!** training platform has helped to address these challenges. In 2024/25, 646 attendees participated in 26 professional development sessions funded through Elevate!. The sector regards it as a highly effective and accessible platform, providing valuable training for AOD professionals. Interest in AOD training is also increasing in adjacent sectors, including organisations such as National Disability Services and the Asylum Seeker Resource Centre. To meet this demand, **Elevate! should be maintained through a long-term commitment and expanded, both to increase opportunities for the AOD sector and to deliver tailored programs for adjacent sectors**.

The **AOD Traineeship Program** has been instrumental in attracting early-career workers to the sector. However, recent changes to the eligibility criteria excluded many smaller organisations, particularly in regional and rural Victoria. In 2025/26, only ten traineeship places were funded. While the program provides an important pathway into the workforce, there is no structure to transition trainees into ongoing roles, and the future of the program is uncertain. **Expansion of the traineeship program** to include smaller, place-based services—supported by an industry-wide workforce plan—would contribute to strengthening sector sustainability.

The Victorian TAFE sector continues to deliver AOD qualifications, supporting staff to meet the requirements of the Minimum Qualification Strategy. However, pathways from these qualifications into ongoing sector employment remain limited, setting up graduates for disappointment. **This needs to be addressed as part of an industry plan to continue to replenish our workforce.** Similarly, barriers for employing people with lived and living experience (LLE) continue. **Police checks and other compliance criteria can exclude people with lived experience.** Without compromising client safety, these barriers must be addressed to enhance participation and strengthen the workforce. Evidence from government and academic research confirms the importance of LLE roles, yet there remain **too few designated LLE roles**, a situation that fails to build on the incredible strength of LLE leadership that has founded and sustains the AOD sector.

There is also a need to support **increased addiction medicine capacity** in Victoria. This could be via incentive payments for GPs (GPs get paid significantly less for seeing patients living with addiction due to inadequate Medicare funding) and/or a mentorship program to bridge the gap between MATOD training and real-world

[6] VAADA's 2025 biennial workforce survey results showed financial costs to employers were cited as the most common barrier to training access, doubling from 13.1 per cent in 2023 to 25.9 per cent in 2025.

practice to strengthen addiction medicine workforce capacity and expand access to patient care (in consultation with the RACGP).

Leadership development is another critical gap. Staff seeking senior or leadership roles report limited access to relevant training, despite leadership capability consistently being identified as a top workforce need. Investment in programs such as the **AOD Leadership Accelerator Program** is essential in developing the sector's future leaders. The six-month pilot equipped emerging leaders with practical and theoretical skills for leading teams in complex AOD settings, and received outstanding participant feedback in the independent evaluation.

Workforce stress and wellbeing remain significant concerns. The 2025 VAADA workforce survey has found that high stress and burnout are the leading reasons staff consider leaving the sector (52%), while 26.2% rated their mental health as fair to poor—an increase from 17.5% in 2023. Quality clinical supervision is fundamental to employee wellbeing and effective service delivery. To address these pressures, the sector has proposed a **"supervision bank"**—a pool of experienced clinical supervisors skilled in both individual and group supervision, as well as mentorship. This initiative would improve access to supervision, particularly for regional services, and help services to meet their obligations under the imminent Victorian psychosocial hazard legislation. Beyond this initiative, a future funding model must build in sufficient resourcing to allow services to purchase quality supervision and better support their staff.

Communities of Practice (COPs) are important spaces for professional development, knowledge sharing and capacity building. Network meetings are an opportunity to identify common issues and work up shared solutions. Regional forums bring staff and services together to consider place-based issues and opportunities and plan collaboratively. Despite the value of these groups, very few are funded for the AOD sector. This leaves a number of these at risk of discontinuing[7], and sees services working on the same issues but duplicating effort[8], resulting in an absence of coordinated strategic planning[9]. **Targeted, purposeful and well-constituted COPs, network meetings and forums** can strengthen workforce capability, stay ahead of

[7] Including the Sex, Sexuality and Gender Diverse network, a network for AOD sector leaders, and an AOD youth network. In addition, the AOD sector has increased calls for new CoPs, including an Aboriginal AOD COP and potentially a CALD network.

[8] Too often services face similar issues and challenges, yet they frequently do so in isolation from one another, which is inefficient and leads to duplication. One example relates to GHB. GHB is increasingly prevalent in overdose death data (Coroner's Court of Victoria, 2025). GHB withdrawal is also complex to manage and can present with mild symptoms like alcohol withdrawal up to severe delirium and psychotic features that sometimes require intensive care. However, there is a lack of coordinated response and sharing of intelligence and resources, limiting the capacity to respond quickly and in a coordinated way.

[9] What forums exist are typically self-funded and rely on clinicians giving up their time to organise them. The former Catchment Planner's Network was undervalued and under-resourced, yet it was the only local AOD strategic planning mechanism and produced genuine local plans.

emerging critical issues, share intelligence, and support a more strategic, coordinated and responsive sector. They are also cost-effective—collectively reaching large proportions of the workforce. The ad hoc approach to these groups needs to be replaced by a coordinated suite of resourced networks. This should extend to **resourcing VAADA and adjacent peaks to facilitate cross-sector engagement as system stewards**, supporting better system integration between aligned service systems.

A coordinated approach to workforce planning requires the development of a **Victorian AOD Industry Plan**. This plan would articulate a shared vision for the workforce of the future and outline strategies to grow, retain, and upskill staff. Complementing the Victorian AOD Strategy and Workforce Capability Framework, the plan would identify skill gaps, promote innovation, grow the workforce, and anticipate legislative and industrial changes. It should also include **ongoing resourcing for VAADA's biennial workforce survey**, which provides critical insights into workforce composition, capability, and wellbeing needs, informed by workers in the field.

An industry-based reference group should underpin the governance of the industry plan, providing sector-informed oversight, quality assurance, and leadership. Strengthened collaboration between training providers, industry bodies, and government would facilitate systemic assessment of workforce needs and enable coordinated strategies for recruitment, retention, professional development, and wellbeing.

By addressing training access, leadership development, supervision, LLE participation, and strategic workforce planning, the sector can strengthen both capability and resilience. A comprehensive workforce approach is essential to ensure that Victoria's AOD sector is equipped to meet current and future demand while supporting the health, wellbeing and development needs of its workforce.

4. Intersecting Systems, Settings and Supports

People seeking AOD treatment often move between multiple service systems, including mental health, justice, hospitals, and family violence services. Notwithstanding the progress made under the mental health and family violence Royal Commissions, the need for **effective integrated care** has not diminished.

Recommendation 35 from the Royal Commission into Victoria's Mental Health System emphasises the importance of services providing integrated treatment, care and support to people living with mental illness and substance use. One mechanism to support integration is the **VICC audit tool**—a locally tailored adaptation of the Comprehensive Continuous Integrated System of Care (CCISC). The CCISC has been

recognised as a best-practice model for improving the delivery of integrated care (Minkoff and Cline, 2005). The tool allows agencies to assess the quality of integration, identify gaps in service coordination, support shared decision-making with clients and support coordinated care across providers. This ready-to-go tool, adapted for Victoria, can support the implementation of Recommendation 35 and improve the quality of integrated care in mental health and AOD treatment services.

The sector reports that **significant AOD harms are occurring in diverse communities**, particularly among people with complex trauma histories. Asylum seekers face additional barriers, such as the lack of access to Medicare, leaving highly vulnerable individuals without access to treatment or affordable medication. A scheme to address this inequity is urgently needed.

Two communities currently experiencing significant harms include the African community and the Chin community. More culturally specific AOD support is needed in places like Footscray, where African communities are disproportionately impacted by the harms of AOD. Public intoxication, mental health deterioration and homelessness have reached a crisis point. **Footscray and the western region need a rapid increase in place-based culturally appropriate services, backing recent commitments to introduce more AOD services in the area.** Similarly, members of the Chin community in the city of Maroondah are facing higher rates of alcohol use disorder and alcohol-related liver disease. There are limited culturally tailored programs that combine trauma-informed care with addiction treatment**. More resources are needed to respond to the AOD harms that are occurring within culturally and linguistically diverse communities.** Increasing health literacy, including AOD literacy, would also support communities to prevent and better respond to AOD harms. Racism exacerbates these challenges, increasing fear, reducing help-seeking, and driving isolation. As a sector, it is incumbent on us to **demonstrate greater inclusivity and engagement with migrant and refugee communities through purposeful engagement, programs and partnership development.**

Justice settings are another critical interface. Approximately 23 per cent of AOD clients have a recorded forensic status (VAADA, 2025f). However, in 2024, bail support services moved from local, place-based models to phone-only delivery, reducing engagement, service familiarity, and accessibility. This change also affected AOD service agreements, which include targets for forensic clients. A **codesigned, flexible, place-based model** of AOD support within the Magistrates' Courts is needed, alongside increased funding for forensic treatment programs addressing AOD-related offending. The urgency of this should not be underestimated. Reducing substance use reduces the risk of reoffending.

Emergency Departments are often the first point of contact in a crisis. Despite high AOD presentations and the unsuitability of hospital environments for complex care, not all services are funded to operate mental health and AOD hubs (Mental Health Victoria, 2025). **Expanding these hubs and better integrating them with local mental health and community AOD services is essential**. Further, there are too few dedicated withdrawal beds in Victoria's public hospitals[10]. When patients are discharged from hospitals, it is often without adequate support or referral to community mental health and AOD services. **Investment to better connect the hubs to local mental health and AOD services would improve outcomes.**

AOD service providers are in a unique position to identify family violence, assess the relationship between AOD and family violence and intervene appropriately. The Royal Commission found up to 90% of women in mental health and AOD services had experienced child abuse or family violence, while 30–40% of men in AOD services have used intimate partner violence and/or sexual violence. Programs such as **U-TURN**, a men's behaviour change program addressing both AOD use and family violence, show positive outcomes. U-TURN addresses gendered drivers of violence, emotional regulation, impacts on children, empathy, communication, and personal responsibility. Scaling the program statewide would provide critical support for men engaged in AOD services. Further, integrating family violence content into core AOD training and establishing **dedicated AOD Advisor roles within the family violence sector**—mirroring the Specialist Family Violence Advisor program in the AOD sector—would build AOD literacy, embed intersectional practice, and support consistent cross-sector governance.

A coordinated approach across mental health, justice, hospitals, and family violence systems is essential. By investing in culturally tailored, trauma-informed, and integrated responses, Victoria can improve outcomes for people navigating complex and intersecting systems of care and strengthen the AOD response wherever it is needed.

Conclusion

The forthcoming Victorian AOD Strategy sets the foundation for a health-led, sustainable, and capable AOD system. This State Budget Submission outlines the key investments and reform requirements to support its effective implementation over its 10-year vision. By enhancing access and continuity of care, addressing system planning and design challenges, investing in the workforce, and improving

[10] Because admission to community-based residential AOD treatment often requires completion of an inpatient withdrawal first, increasing the number of withdrawal beds in the system will also help reduce wait times for this treatment type and improve occupancy rates.

integrated care, the proposals in this submission provide a blueprint to strengthen the sector, improve client outcomes, and reduce AOD-related harms in Victoria.

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