



Health and wellbeing for lesbian, gay, bisexual, trans, gender diverse, intersex, queer and other sexual orientation, gender and bodily diverse people (LGBTIQ+)

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## Submission on drug and alcohol program redesign

**LGBTIQ+ Health Australia has lodged a submission on Phase 1 of the Drug and Alcohol Program redesign, calling for LGBTIQ+ populations to be recognised as a priority population and for services to be culturally safe and affirming.**

The submission emphasises the need for stronger partnerships with community-controlled organisations, the inclusion of lived experience, and consistent collection of data using the ABS 2020 Standard to ensure LGBTIQ+ populations are visible in planning and funding decisions. It also highlights the importance of harm reduction, workforce capability, and ensuring smaller specialist organisations are not disadvantaged.

### 1. Do you have any comments on the proposed program objectives in the Program Logic?

- The Prevention and Early intervention objectives should refer specifically to target populations, not just potentially risky behaviours.
- Treatment, recovery and management should refer to the safe, affirming services.
- System enablers objective is confusing. Suggest reworking.

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

Partnerships should not just exist across governments. Partnerships with community-controlled and specialist organisations that provide population-specific expertise and engagement pathways, service provision organisations and peer workers are also key to the logic of this program.

Data infrastructure inputs should also refer to specific data standards. Digital enablement of collection and reporting on sex, gender, variations of sex characteristics and sexual orientation in alignment with the *Australian Bureau of Statistics Standard for Sex, Gender, Variations of Sex Characteristics and Sexual Orientation Variables, 2020* is integral for the effective representation of LGBTIQ+ communities.

### 3. Do you have any comments on the proposed key activities in the Program Logic?

The activities are not specific enough to allow for targeted feedback.

The themes currently presented should capture the following key activities:

- targeted outreach and community engagement for populations that experience barriers to mainstream services
- partnership activities between mainstream AOD services and community-controlled or specialist organisations
- improving quality of service design and delivery, especially for target populations such as LGBTIQ+ communities
- considering intersectionality in the design and provision of services (i.e. mental health, housing instability and social isolation).

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



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The proposed outcomes appropriately focus on reduced harmful AOD use and improved health and wellbeing but lack logic and are thus difficult to follow and do not demonstrate a clear pathway to the long-term outcome. Outcome logic should follow the below structure with comments on each type of outcome:

- Short-term outcomes should focus on changes to knowledge
  - Consider limiting short-term outcomes to changes in knowledge or access to information.
- Mid-term outcomes should focus on changes to attitudes, understanding or beliefs (as a result of increased knowledge)
  - Consider moving all changes in attitudes, understanding or beliefs to medium-term outcomes.
- Long-term outcomes should speak to the change in behaviours.
  - The long term outcome should be: Reduced harmful AOD use including AOD related deaths.
  - The prevalence of this is a measure of this outcome – not the outcome itself.
  - This will also resolve the logical issue in Treatment, recovery and management with the short-term outcome mirroring the long term.
  - Consider moving the correct long-term outcome Reduced prevalence of harmful AOD use including AOD related deaths to Impact (not currently listed) and listing all changed behaviour that will result in this impact as long term outcomes.

Outcomes should also include themes of client safety, engagement and retention. Outcomes should also reflect the change over time in different participants (clients, providers, supporters etc).

#### **5. Do you have any general comments on the draft Program Logic?**

LGBTIQ+ populations experience disproportionately high rates of alcohol and other drug (AOD) use and AOD-related harm, alongside elevated rates of co-occurring mental health conditions. These disparities are driven by minority stress, stigma, discrimination, violence and social exclusion. LHA recommends that LGBTIQ+ populations be explicitly recognised as a priority population within the program objectives. Explicit recognition will support improved needs assessment, service planning and equitable funding allocation.

To further strengthen the effectiveness of the program logic, LHA recommends:

- stronger emphasis on culturally safe and inclusive practice across all pillars, especially through the engagement of safe and affirming peer workforce for LGBTIQ+ communities
- including activities to enhance of digital platforms and online care provision
- harm reduction as a core component of the DAP
- bringing forth the embedding of this work in a human rights framework
- recognition of the critical role of community-controlled and specialist organisations such as drug user organisations in prevention, early intervention and system navigation
- centralising lived and living experiences across the Program Logic
- alignment with national policy frameworks, including the National Action Plan for the Health and Wellbeing of LGBTIQ+ People 2025–2035.

#### **6. Do you have any comments on the proposed prevention KPIs?**



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LGBTIQ+ Health Australia is grateful for the embedding of priority groups in the KPIs and reiterate that this field should form part of the minimum data set for this activity.

LHA recommends that prevention reporting include:

- demographic data that allows analysis by sex, gender, variations of sex characteristics and sexual orientation, using the ABS 2020 Standard
- measures of reach and engagement for priority populations
- indicators of culturally appropriate and community-led prevention activities.

Without demographic visibility, it will not be possible to assess whether prevention efforts are reaching populations at higher risk.

### **7. Do you have any comments on the proposed early intervention KPIs?**

The language around who is the recipient of targeted activities is confusing - will it be at-risk groups or at-risk individuals? The terms seem to be used interchangeably.

LHA recommends:

- demographic data collection using the ABS 2020 Standard
- indicators of timely access and referral pathways for priority populations
- measures of engagement and completion rates, disaggregated where possible
- inclusion of client experience or perceived safety measures.

These indicators will support early identification of access barriers and service gaps.

### **8. Do you have any comments on the proposed treatment, recovery and management KPIs?**

Treatment and recovery KPIs should reflect both clinical outcomes, quality and equity. There are no quality KPIs whether patient-reported or independent. It is difficult to understand the timing as it relates to these KPIs - suggest KPIs such as Number and proportion of clients who report a decrease in

AOD use, by priority group is time bound.

LHA recommends:

- collection of demographic data aligned with the ABS 2020 Standard
- analysis of treatment access, retention and outcomes for priority populations
- inclusion of clinical quality, quality-of-life and social participation measures
- consideration of client-reported experience and cultural safety indicators.

For populations such as LGBTIQ+ people, perceived safety and inclusion are key determinants of treatment engagement and success.

### **9. Do you have any comments on the proposed system enablers KPIs?**

System enablers should include measures of workforce capability and culturally safe service environments outside of Aboriginal and Torres Strait Islander cultural competency.



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LHA recommends inclusion of indicators relating to:

- workforce training in culturally safe and inclusive practice for priority populations
- partnerships with community-controlled and specialist organisations
- implementation of inclusive policies, intake processes and service environments
- capability to collect and report demographic data aligned with the ABS 2020 Standard.

These system-level measures will support sustainable improvements in service accessibility and quality. **10.**

#### **Do you have any general comments on the draft KPIs?**

LHA supports the development of a core, consistent KPI set. To ensure the KPIs support equitable outcomes, it is essential that demographic visibility is embedded across the framework.

The consistent collection of data on sex, gender, variations of sex characteristics and sexual orientation will:

- enable monitoring of access and outcomes for priority populations
- inform the development of the needs-based funding model
- strengthen the evidence base for future policy and investment.

Consideration should also be given to implementation timeframes and support for services to build data capability.

Without consistent demographic data, the needs-based funding model will not be able to accurately assess demand or unmet need for some priority populations, which may lead to misallocation of resources.

To support consistent national data and comparability across services, the Department should require the use of the ABS Standard for Sex, Gender, Variations of Sex Characteristics and Sexual Orientation Variables across DAP-funded services.

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

There are several logical leaps in the Program Logic, most notably in the “Cross-system partnerships and governance” activity. The Output of this activity “Sector forums established and maintained, including representation from people with lived and living experience” does not indicate clear partnership intent. In addition the associated KPIs at the bottom of page 17 do not have a quality measure, do not describe priority populations, and do not speak to intersectionality.

To further strengthen the effectiveness of the program logic, LHA recommends:

- stronger emphasis on culturally safe and inclusive practice across all pillars, especially through the engagement of safe and affirming peer workforce for LGBTIQ+ communities
- including activities to enhance of digital platforms and online care provision
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- bringing forth the embedding of this work in a human rights framework
- recognition of the critical role of community-controlled and specialist organisations such as drug user organisations in prevention, early intervention and system navigation
- centralising lived and living experiences across the Program Logic



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- alignment with national policy frameworks, including the National Action Plan for the Health and Wellbeing of LGBTIQ+ People 2025–2035.-controlled organisations and lived-experience expertise.

These measures will support more effective targeting of resources and improved outcomes for populations experiencing disproportionate harm.

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

Key considerations include:

- The risk that priority populations will remain invisible in needs-based funding models if demographic data are not collected consistently.
- The capacity of services to implement new reporting requirements, including the need for system upgrades, workforce training and transition time.
- The importance of ensuring that smaller community-controlled and specialist organisations are not disadvantaged by increased reporting burden or competitive funding processes.
- The need to balance performance measurement with administrative burden to ensure resources remain focused on service delivery.

Ensuring proportional reporting requirements and appropriate implementation support will be critical to sector sustainability.

Community-controlled organisations that provide population-specific expertise are often small and under-resourced. Increased reporting and competitive processes may unintentionally exclude these organisations unless proportional requirements and dedicated support mechanisms are in place.

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

- How will the needs-based funding model incorporate the needs of priority populations where current national data are limited?
- Will the department require the use of the ABS Standard for Sex, Gender, Variations of Sex Characteristics and Sexual Orientation Variables across DAP-funded services?
- What transition support will be provided to services to implement new data collection and reporting requirements?
- How will the department ensure that smaller specialist and community-controlled organisations are able to compete effectively in future grant processes?