KPMG

The University Of Queensland
AUSTRALIA

Drug and Alcohol Program

Final Evaluation Report

Department of Health, Disability and Ageing

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Acknowledgement of Country

KPMG acknowledges Aboriginal and Torres Strait Islander peoples as the First Peoples of Australia. We pay our respects to Elders past, present, and future as the Traditional Custodians of the land, water and skies of where we work.

At KPMG, our future is one where all Australians are united by a shared, honest, and complete understanding of our past, present, and future. We are committed to making this future a reality. Our story celebrates and acknowledges that the cultures, histories, rights, and voices of Aboriginal and Torres Strait Islander People are heard, understood, respected, and celebrated.

Australia's First Peoples continue to hold distinctive cultural, spiritual, physical and economical relationships with their land, water and skies. We take our obligations to the land and environments in which we operate seriously.

We look forward to making our contribution towards a new future for Aboriginal and Torres Strait Islander peoples so that they can chart a strong future for themselves, their families and communities. We believe we can achieve much more together than we can apart.

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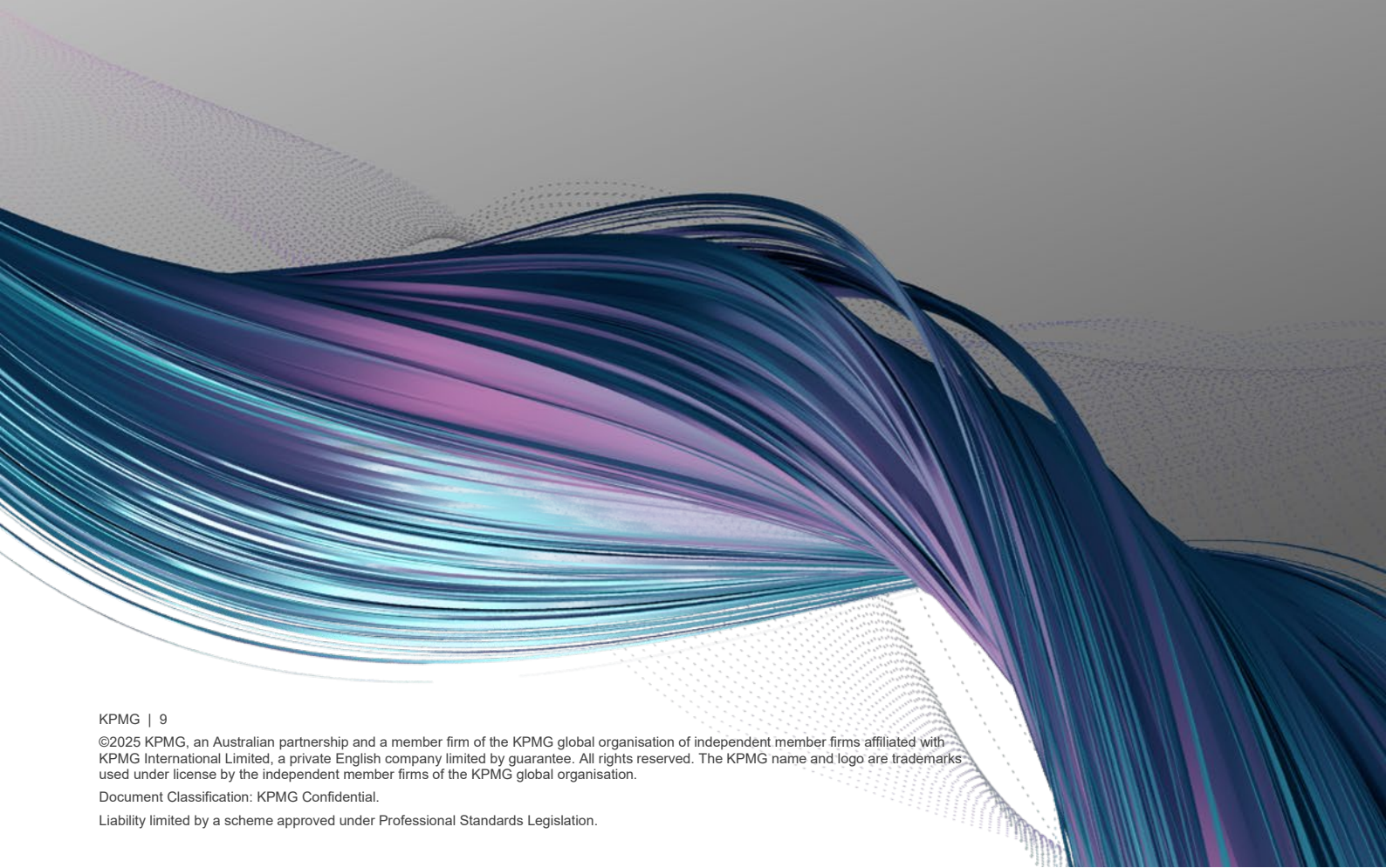
Glossary

Abbreviation	Definition
ACT	Australian Capital Territory
AIHW	Australian Institute of Health and Wellbeing
ANACAD	Australian National Advisory Committee Alcohol and Other Drugs
AOD	Alcohol and Other Drugs
AODTS NMDS	Alcohol and Other Drug Treatment Services National Minimum Dataset
ATOP	Australian Treatment Outcomes Profile
BBVSS	Blood Borne Viruses and Sexually Transmissible Infections
CALD	Culturally and Linguistically Diverse
DAP	Drug and Alcohol Program
DAP Services	Refers to all Department funded DAP initiatives including prevention programs and treatment services
DSS	Department of Social Services
FASD	Fetal Alcohol Spectrum Disorder
GP	General Practitioner
GOG	Grant Opportunity Guideline
HILDA	Household Income and Labour Dynamics in Australia
KEQ	Key Evaluation Questions
KPI	Key Performance Indicators
K10	Kessler 10
LGBTIQ+	Lesbian, gay, bisexual, transgender and/or intersex
LLE	Lived and living experience
MDAF	Ministerial Drug and Alcohol Forum
NADA	Network of Alcohol and Other Drug Agencies
NDARC	National Drug and Alcohol Research Centre
NDS	National Drug Strategy
NGO	Non-government organisations
NHMRC	National Health and Medical Research Council
NHRA	National Health Reform Agreement
NIAA	National Indigenous Australians Agency
NSW	New South Wales
NT	Northern Territory
PHN	Primary Health Network
Qld	Queensland

Abbreviation	Definition
QoL measures	Quality of Life measures
SA	South Australia
Tas	Tasmania
The department	Department of Health, Disability and Ageing
Vic	Victoria
WA	Western Australia
WHO QoL	World Health Organisation Quality of Life

1 Executive Summary



1.1 Drug and Alcohol Program context and background

The Drug and Alcohol Program (DAP) is a national program delivered by the Department of Health, Disability and Ageing (the department). The DAP's objectives are to prevent and minimise health, social, cultural and economic harms of alcohol and other drug (AOD) use among individuals, families and communities. Funding is delivered through DAP direct funding and through Primary Health Networks (PHNs) and is supplementary to the funding provided by states and territories.

Through the DAP, the Australian Government has invested in treatment, prevention, research, data and international activities to reduce the impact of harmful AOD use (excluding tobacco, smoking and vaping-related programs) across targeted streams. Six sub streams of the DAP are in scope for this evaluation, including:

- Prevention Programs
- National Prevention Projects
- Fetal Alcohol Spectrum Disorder (FASD)
- Withdrawal Management and Rehabilitation Services
- AOD Treatment Services in Areas of Identified Need
- PHNs.

Two important trends characterise the AOD landscape in Australia: increased demand for services and increased complexity of client needs. This growing need increases the impetus for governments to ensure funded AOD initiatives address identified need and demand.

1.2 Overview of the evaluation

KPMG and the University of Queensland (UQ) (the Evaluation Team) were commissioned by the department to undertake an evaluation of the DAP from March to July 2025. The primary objective of the evaluation was to assess the impact and overall administration of the DAP. This included determining whether the DAP achieved its intended objectives, for whom and under what circumstances and identifying improvement opportunities for its administration and implementation. Specific objectives of the evaluation were to:

- Thematically describe the types of services and programs delivered within DAP-funded services, and their extent of alignment to program objectives.
- Describe how services commissioned through the DAP are used and accessed.
- Describe, to the extent possible, the effectiveness of DAP-commissioned services in the Australian context.
- Support the DAP to meet broader government expectations in terms of providing evidence-based justification for future grants, aligned with the role of the Commonwealth within the health and AOD sectors.
- Support the department and broader AOD sector to provide the right balance of services, based on contemporary evidence about what works, for the people and communities who need them.
- Recommend opportunities to strengthen data collection and monitoring activities to improve the evaluability of the DAP in the future, including recommended updates to the future program logic and its use.

An Evaluation Steering Committee was convened to provide governance and oversight of the evaluation processes and reporting. An Advisory Committee was also convened to provide sector advice to the evaluation to ensure insights were tested and validated with PHN, provider peaks and lived and living experience (LLE) representatives. More detail on each of these groups is provided in Section 3.1.4.

The evaluation included two core pieces of analysis which were completed concurrently:

- Process evaluation (examining appropriateness and implementation of the DAP).
- Outcomes and impact evaluation (examining effectiveness, efficiency and sustainability of the DAP).

Five Key Evaluation Questions (KEQs) were developed to guide the evaluation across the following domains of implementation, appropriateness, impact, efficiency and sustainability. The KEQs were developed by the department for the evaluation and are provided in Table 1 below.

Table 1 Evaluation domains and KEQs

Domain	KEQ
Implementation	How well is the program being delivered in terms of fidelity, quality and outcomes?
Appropriateness	Is this program the right response to the identified needs and priorities of target populations?
Impact	What difference is the program making?
Efficiency	To what extent has the program delivered value for money?
Sustainability	How can the commissioning and implementation of the program be best supported going forward to maximise impact, ensure value for money and sustainability?

Source: Evaluation Team

This document is the final report for the evaluation of the DAP. It reports against the implementation, appropriateness, impact, efficiency and sustainability of the DAP between 1 July 2021 and 31 March 2025. To answer the KEQs, the report triangulates and synthesises new and existing qualitative and quantitative data, including program documentation, service utilisation data, population health data, stakeholder views from a survey and consultation interviews and evidence from contemporary literature. This final report makes recommendations that support the DAPs future sustainability.

1.3 Evaluation methods

The evaluation report explores the five KEQs and the findings collected across various data sources. Qualitative and quantitative data provided a sound evidence base for understanding the processes' implementation and appropriateness as well as providing an indication of the effectiveness and efficiency of the outcomes and impacts of the DAP. Table 2 provides an overview of each data collection method. Analysis of data informs the development of the key findings for each domain and the development of the sustainability considerations and recommendations.

Table 2 Data Sources and Data Collection Approaches

Data source	Data collection approach
Literature review findings	Developed a rapid targeted review of evidence relevant to the prevention and treatment services funded by DAP to inform the evaluation (n=246)
Provider survey	Designed and disseminated two online surveys to the following recipients: • Direct recipients of DAP grants (n=76) • PHN recipients of DAP grants (n=22)
Discovery consultation outputs	Conducted stakeholder interviews and focus groups with the department, peak bodies, research institutions and professional organisations (n=46)
Provider consultations outputs	Conducted stakeholder focus groups with a sample of providers (n=28)
DAP documentation including grant agreements, activity workplans and guidelines	Analysed the grant agreements, guidelines, performance reporting data and outcomes measurement data (n=1379)
Quantitative data including Australian Institute of Health and Welfare (AIHW), Household Income and Labour Dynamics Australia (HILDA) and the Network of Alcohol and other Drugs Agencies (NADA) NADAbase data	Analysed and collated available datasets to present the key trends in AOD use, associated harms, service utilisation and outcomes to support the considerations and findings

Source: Evaluation Team

1.3.1 Literature review

The literature review was a rapid targeted review of evidence relevant to the prevention and treatment services that are funded by DAP to inform the evaluation. It drew on 246 pieces of national and international literature to identify existing reviews of best practice interventions in the AOD field. The review adopted a pragmatic umbrella review approach to ensure findings could be reached within evaluation timeframes. The outcome of the review betters the understanding of the appropriateness and effectiveness of interventions.

1.3.2 Stakeholder consultation

Survey

A provider survey was developed to capture a breadth of perspectives and collect qualitative and quantitative data aligned to the DAP program logic. The survey provided a holistic measure of the appropriateness, impact and efficiency of DAP.

The questions sought insight into the types of services provided across DAP grants, the experiences of DAP service providers and PHNs and perceived impacts of DAP funding. The survey questions were approved by an Evaluation Steering Committee and Advisory Group prior to distribution.

The survey was voluntary, questions were optional and organisations were asked to respond to the survey once. The analysis for the evaluation assumes this, however as the organisations were not required to self-identify, it is possible that there were multiple responses from the same organisation. Reminder emails were sent to encourage participation and completion of the survey.

The survey was distributed to providers by the Department of Social Services (DSS) grants hub for direct DAP grant recipients. For PHN commissioned providers, the survey was sent to all PHNs with express directions on distributing the survey to all DAP commissioned providers. The survey for PHNs to respond to was distributed through the department's PHN Branch policy team. Potential limitations associated with this distribution method are outlined in Section 3. The survey achieved an estimated response rate of 39.2% from the 273 organisations invited to participate, with 107 total responses. This comprised of 76 responses from providers (an estimated 31.4% response rate) and 31 responses from PHNs (representing 22 PHNs, a 71% response rate).[1]

Semi-structured interviews

Semi-structured interviews were conducted with a range of government and non-governmental stakeholders. A series of 46 discovery consultations were conducted with policy makers, funders, peak representatives, LLE representatives and researchers. These consultations provided insight into the broader AOD sector, emerging trends and needs and system considerations. These consultations sought to answer both process and outcome evaluation questions and primarily focused on:

- Observed impact of the DAP for participants
- Observed impact of the DAP on the organisation
- Observed implementation barriers and enablers
- Perceived appropriateness of DAP funding distribution
- Evidence of DAP accessibility for priority cohorts
- Opportunities to strengthen evaluation and data collection of the DAP
- Evidence of synergies between the DAP and broader AOD service system.

A further 28 service provider organisations were consulted to capture a deeper understanding of the experience of providers, the changes within the AOD sector and the impacts of DAP funding. These consultations augmented the insights gathered from the survey.

All consultations were supported by consultation materials including a semi-structured consultation guide which was distributed to providers prior to the session. More detail on the method used to identify and engage with stakeholders is available in Section 3, Appendix B.2 and Appendix C.

1.3.3 Program document analysis

Analysis of 1379 existing program documents provided insights for developing the findings for each KEQ. The key documents and data analysed were:

- Grant Agreement Guidelines
- Activity Work Plans
- Financial statements
- Reporting and measurement data
- Individual program evaluations
- Australian Government strategies and reviews.

Program document analysis contributed to an understanding of the strengths of the DAP and the opportunities to make it more sustainable.

[1] While a response rate was able to be calculated for PHNs (who were required to identify their organisation), this information was not required from provider respondents and therefore each provider response has been assumed to represent a unique provider. Available data suggests duplicative provider survey responses were minimal.

1.3.4 Quantitative data analysis

This evaluation included exploratory analysis of population level data to understand the patterns and trends of AOD usage across a representative sample. Population level data was also examined to understand patterns and trends of AOD related harms. Data was analysed from the HILDA Survey, Alcohol and Other Drug Treatment Services National Minimum Dataset (AODTS NMDS) from the AIHW and the NADABase. NADABase is a central platform for collecting and reporting treatment outcomes for New South Wales (NSW) non-government organisation (NGO) providers. These analyses supported in aligning the key findings, sustainability considerations and recommendations to the trends and changes in harmful AOD use across Australia**.**

1.3.5 Evaluation constraints and limitations

Despite both qualitative and quantitative data limitations, the triangulation of evidence across data sources creates confidence that the evidence provides a sound basis for decision making. Key limitations are described below. Detailed description of the limitations of the evaluation is provided in Section 3.2 and Appendix B.

Qualitative data limitations

Qualitative data was collected for the evaluation via stakeholder interviews and a survey. Both methods are likely to have introduced biases. These biases were controlled for where possible.

The evaluation sought to draw insights from key areas of interest for the evaluation and the breadth of services delivered through the DAP. Recognising the size of the sector and the constrained timeframe, the evaluation drew a sample designed to ensure that perspectives from across jurisdictions, DAP streams, service types, priority populations and length of engagement with DAP were included. Interviews held towards the end of the evaluation period did not reveal substantively new perspectives, giving confidence that saturation had been reached.

The evaluation timeframes also limited opportunities to engage directly with DAP clients or individuals who may be eligible to access DAP initiatives. The evaluation sought alternative mechanisms to consider client and community perspectives. The Evaluation Team is confident that a sufficiently diverse set of stakeholders was included to capture a broad range of perspectives. However, given that the survey did not cover every stakeholder the limitation that not all perspectives were gathered remains.

Quantitative data limitations

The quantitative data analysis was affected by several constraints, including limitations in data availability, accessibility, quality and consistency across sources. These constraints influenced both the feasibility of certain analytical approaches and the robustness of findings. Limitations included:

- Access to participant linked data limited by evaluation timeframes
- Gaps in completeness of program data collection
- Limitations in the quality of program data
- Challenges in evidencing attribution and causation
- Limitations of proxy measures to estimate outcomes.

These challenges limited the extent to which DAP appropriateness, impact and efficiency could be evaluated. In particular, consideration of participant and population health outcomes was limited, which then reduced the ability to fully consider the cost effectiveness of DAP initiatives.

Further details on these limitations and considerations for interpreting the evaluation findings are included in Section 3.2.

1.3.6 Strength of evidence

This evaluation has applied the following guide in assessing the strength of evidence informing the findings for each of the evaluation domains:

- **Sufficient evidence**: The evidence is sufficient to draw a largely unqualified conclusion regarding the evaluation question because either there is a single source of quality data or multiple sources of data, which have no major quality issues and that consistently support the conclusion reached.
- **Some evidence**: The evidence suggests the finding is reasonable and there is a supporting theoretical rationale but there are data limitations, such that the finding is qualified and further and/or different data (which may have been unavailable to this evaluation) would need to be sourced to be more confident in the conclusion reached.
- **Weak evidence**: The evidence is indicative of a finding but there are major shortcomings in the data, such that limited confidence can be placed on the conclusion.
- **No evidence**: No data exists upon which to make any finding. Note that there are no such examples of this in this Review.

1.4 Evaluation findings

This evaluation report provides key findings against each evaluation domain, which are implementation, appropriateness, impact and efficiency. Key considerations for sustainability have been provided throughout each of these sections of this report, providing a basis for recommendations.

A summary of evaluation findings is outlined below.

Table 3 Summary of evaluation findings and strength of evidence

Evaluation Domain	Findings	Strength of Evidence
Implementation	• The department is funding services that are intended to meet the DAP objectives, however there are opportunities to improve the program's implementation • Aligning the DAP Grant Opportunity Guidelines (GOGs) to national AOD policy and strategy will strengthen the Australian Government's investment • Stronger leadership and coordination from the Australian Government in convening funders and providers will enhance a collaborative approach to addressing the harms of AOD use in Australia • Australian Government leadership and investment in workforce capability and capacity building across the DAP has the potential to strengthen service implementation	There is **sufficient** evidence to support these findings
Appropriateness	• The need for DAP services is continually growing and clients are presenting with increasingly complex needs • DAP initiatives target various priority populations with opportunities to enhance support for people with co-occurring needs and groups with emerging needs • DAP service delivery models can and do learn from best practice and evidence-based approaches • DAP service funding exists alongside AOD funding from other funding bodies within the sector, presenting an opportunity to clarify and define key roles • More collaborative relationships between the Australian Government, states and territories, PHNs and providers is an enabler of delivering localised and adaptable responses through DAP	There is **sufficient** evidence to support these findings
Impact	• DAP funding improves access to AOD services but does not fully meet need • DAP funded services have contributed to positive outcomes for individuals and communities • Population-level outcome data provide useful context but could not be used to evaluate DAP • Strengthening existing data collection and measurement strategies will improve the evidence of DAP impacts and inform service and system planning	There is **weak** evidence to support these findings
Efficiency	• A more streamlined organisation of DAP funding streams, linked to service categories, can support increased efficiencies in commissioning and managing grants • Understanding the costs and avoided costs of certain treatment types can guide investment in the DAP to ensure value for money • Sustainable funding arrangements create opportunities to improve the efficiency and productivity of DAP services • Improving transparency and coordination of reporting requirements can support a more streamlined and efficient delivery of DAP initiatives	There is **some** evidence to support these findings

The below section provides further detail regarding each of these findings.

Several activities were highlighted as having potential to support ongoing DAP sustainability, but which sit outside of the scope of DAP alone. They generally require significant influence and agency from other actors within the AOD sector and beyond. These were identified as key sustainability considerations and are listed alongside the findings below.

1.4.1 Implementation

The implementation domain analysed whether the DAP has been implemented as intended and the extent to which the DAP is aligned to AOD policy objectives, including the National Drug Strategy (NDS). These findings also explore future opportunities to strengthen ongoing implementation of the DAP.

The department is funding services that are intended to meet the objectives of DAP, but opportunities exist to improve implementation processes

It was evident that DAP grants aim to meet the intended objectives as outlined in the program logic. However, the evaluation identified gaps in documented DAP implementation planning. The DAP would benefit from better articulation and monitoring of implementation processes through a DAP workplan which clearly sets out annual objectives, associated activities, indicators of completion, responsible parties and regular (e.g., quarterly) progress updates.

Aligning the DAP grant opportunity guidelines to national AOD policy and strategy will strengthen the Australian Government's investment

Whilst grant objectives were compelling and aligned with good practice in addressing the harms associated with AOD use, the GOGs lack a direct link to Australian Government strategy. Direct connection of GOG objectives with relevant national AOD strategy will provide greater alignment of investment with the Australian Government priorities while also providing desired guidance to grant recipients on delivery of their initiatives.

Stronger leadership and coordination from the Australian Government in convening funders and providers will enhance a collaborative approach to addressing the harms of AOD use in Australia

The recent inquiry into the health impacts of AOD in Australia highlighted the complex AOD policy landscape in Australia.[2] This complexity is replicated within DAP funding with various streams made up of legacy funding. Moreover, the sector is lacking coordinated policy planning across the system, with identified opportunities to strengthen ministerial and governmental leadership in this area. Consultation with the AOD sector, including funders and DAP grant recipients, demonstrated a strong desire from the sector for greater leadership and coordination. The NDS also calls for leadership across the sector to encourage innovation, development of new approaches and to support holistic, systems-based partnerships between both government and non-government agencies. Examples are provided within the report for consideration including enhanced AOD system governance. From a DAP perspective, the evaluation highlighted opportunities to encourage stronger leadership from the department in driving coordinated planning with other funders, including the National Indigenous Australians Agency (NIAA), PHNs and states and territories to ensure DAP funding is complementary to the broader AOD system. DAP grant recipients also emphasised the benefits of embedding provider and LLE voices within any governance mechanism.

Australian Government leadership and investment in capability and capacity building across the DAP has the potential to strengthen service implementation

Evidence demonstrates various workforce and capability challenges facing the AOD sector. These include recruitment and retention of skilled and capable staff, which is impacted by skills shortages, stigma and discrimination facing the AOD workforce. The evaluation identified the need for a strong policy position on the

[2] Commonwealth of Australia. House of Representatives. (2025). *Issues paper relating to the health impacts of alcohol and other drugs in Australia*. Retrieved from https://parlinfo.aph.gov.au/parlInfo/download/committees/reportrep/RB000565/toc_pdf/IssuespaperrelatingtothehealthimpactsofalcoholandotherdrugsinAustralia.pdf

benefits of peer workforce, supported by guidance for the AOD sector and DAP grant recipients on best practice in engaging the peer workforce in governance, planning and delivery.

With growing demand for services that support individuals with co-occurring needs, particularly mental illness, the evaluation identified the need to enhance service integration through training and system development. Opportunities were identified to enhance opportunities for knowledge sharing regarding best practice at a DAP planning and system level.

Sustainability considerations to support ongoing DAP implementation

The following sustainability considerations will support the implementation of DAP:

- Improving documentation of planning and program guidance will support DAP implementation.
- Updating DAP GOGs to directly align with the NDS and its relevant sub-strategies will provider stronger strategic direction for the DAP.
- Strengthening leadership and coordination will improve the governance across the AOD sector.
- Building the future workforce will support the delivery of AOD funding and improve service integration.
- Embedding peer workforce into DAP and the AOD sector will enable more client centred practice.

1.4.2 Appropriateness

The findings in this section explore the extent to which the DAP is an appropriate way of addressing clients' needs and needs of the sector more broadly. It highlights the opportunities available to align prevention program and treatment service delivery models with best practice and evidence-based approaches. These findings also set out considerations for developing more collaborative relationships to strengthen the sustainability of the DAP. The detailed key findings for this section include the following:

The need for DAP services is continually growing and clients are presenting with increasingly complex needs

Demand for AOD services in Australia continues to surpass the available supply supported through existing funding models. This unmet need leads to increased numbers of people seeking information and support for their AOD use as well as longer episodes of care and wait times. Providers also reported growing complexity of needs in clients presenting to their services, most commonly in the form of co-occurring mental health conditions but also in social issues such as employment, housing and justice involvement that impact on their ability to navigate or sustain treatment. Analysis of the activities being delivered through DAP grants demonstrates that across DAP, treatment support represents the largest share of services, at over half (56%) of PHN commissioned services and 38% of direct funded services. Whilst investment in treatment services play an important role in addressing the harms of AOD use, there is a growing body of evidence and policy direction necessitating greater investment in evidence-based community education and prevention campaigns as well as harm reduction services.

DAP initiatives target a range of priority populations with opportunities to enhance support for people with co-occurring needs and groups with emerging needs

Analysis of self-reported data and program documentation highlighted that a range of initiatives delivered through the DAP specifically aim to target AOD use in priority populations, with 45% of grants targeting a priority population. First Nations people are targeted in over half of these services, with young people the next highest group. Women and families and people who inject drugs were recognised as groups with emerging needs requiring more targeted support. Noting the growing co-occurring mental health needs of DAP participants and the relatively small proportion of services targeted to this cohort, there are opportunities to enhance targeted services for these individuals.

DAP service delivery models can and do learn from best practice and evidence-based approaches

DAP providers utilise evidence-based approaches to varying degrees, with different levels of maturity regarding the use of data and research to inform service design. Evidence of best practice in AOD prevention and treatment is constantly evolving, necessitating providers to regularly consider the efficacy of their activities. Incorporating

current research and knowledge sharing practices is key to ensuring that DAP services are evidence informed and appropriate for their intended objectives. Contemporary evidence suggests an effective AOD system needs services to adopt a flexible stepped-care approach that is similarly multidirectional, with supports available prior to (including prevention and harm reduction) and following on from formal treatment episodes to promote ongoing recovery.[3] In particular, DAP models should consider longer term support which meets individuals where they are at. With this in mind, DAP prevention efforts should be adapted to suit the needs of the target audience and vary by setting. Treatment and support modalities should be offered over a range of options, to maximise engagement opportunities.

DAP service funding exists alongside AOD funding from other funding bodies within the sector, presenting an opportunity to clarify and define key roles

The AOD service system in Australia is multifaceted with various funders and stakeholders responsible for making policy and funding decisions. Comparison of DAP funding data with funding information provided by some states and territories, highlighted that funding for AOD services is shared across each of the analysed jurisdictions at varying levels. Notably, all funders, including Australian Government and states and territories, commissioned treatment services, prevention and education activities and workforce and sector capacity building initiatives. While there is no evidence to suggest duplication in services, there is evidence to suggest overlap in commissioning roles. Stakeholders reported a lack of clarity regarding the roles and responsibilities of funders. This presents an opportunity to more clearly define the roles of key funders in the AOD sector, and DAP specifically.

More collaborative relationships between the Australian Government, states and territories, PHNs and providers will enable delivery of appropriate, localised and adaptable responses through DAP

Engaging across multiple levels of AOD delivery, including states and territories, PHNs and providers, allows the Australian Government to better understand both what is being delivered and where there are opportunities to adapt existing initiatives or deliver place-based responses. Existing relationships between the Australian Government and PHNs are reported as supporting the identification of local needs in some instances. However, there are calls for greater consistency in best practice planning and commissioning processes across DAP funders. While examples of integration were evidenced through the evaluation, stakeholders, including DAP providers, expressed a desire for more investment in supporting DAP services to deliver cross sector care, supported by departmental leadership.

Sustainability considerations to support appropriateness of DAP

The following sustainability considerations will support the appropriateness of DAP:

- There is scope to shift the balance of DAP funding to enable greater investment in early intervention approaches.
- Best practice calls for enhanced and adaptive services which continue to meet the needs of those they support, particularly as new trends and evidence emerge.
- Supporting knowledge sharing regarding best practice will enhance good practice.
- The sector would benefit from clearly defining and documenting roles and responsibilities of all funders.
- Enhance coordinated and responsive service planning between providers and funders.
- Drive enhanced cross sector integration.

[3] Ho, C, & Adcock, L. (2017). *Inpatient and Outpatient Treatment Programs for Substance Use Disorder: A Review of Clinical Effectiveness and Guidelines [Internet].* Canadian Agency for Drugs and Technologies in Health.

1.4.3 Impact

The impact findings explore the impact of DAP funding for providers in meeting changing demands and local community needs and in improving access to AOD services. These findings also highlight opportunities to strengthen existing data collection and measurement strategies. The detailed key findings for this section include the following:

DAP funding improves access to AOD services

Stakeholders consistently reported that DAP funding positively impacts the AOD service system, improving the viability of services and enabling providers to continue to deliver services to meet the needs of their local communities. Various flagship evaluations of DAP prevention programs demonstrated increased reach, particularly where barriers exist to accessibility. Prevention program evaluations also reported increased uptake of information and resources. Analysis of treatment utilisation data also demonstrated increased utilisation of AOD services since DAP implementation and a corresponding increase in DAP services.

DAP funded services have contributed to positive outcomes for individuals and communities

Comprehensive analysis of the outcomes resulting from DAP initiatives is limited by the available data. However, some insights were able to be gained throughout the evaluation, with results to be interpreted with caution. DAP prevention programs use a variety of media to enhance reach and uptake of information and resources to minimise harms of AOD use. Flagship evaluations of various DAP prevention initiatives demonstrated a variety of impacts including increased community awareness through access to resources, reported intention to change behaviours and promising return on investment. FASD initiatives saw similar impacts including increased community awareness of FASD, increased provision of FASD information and promising return on investment for FASD diagnostic services. Similarly, analysis of a sample of treatment service reports indicated general improvements in clients psychological distress and improved in Quality of Life (QoL) measures. The degree of service quality and impact appears to vary across providers.

Population-level outcomes data provide useful context but could not be used to evaluate the DAP

While some trends were observed within population level data such as AOD consumption levels, visual inspection of the data suggests no obvious change in these trends after the introduction of the DAP in 2017. Although, it is important to note that the DAP represents a continuation of some previously funded initiatives so potential attribution of the DAP unable to be measured.

Strengthening existing data collection and measurement strategies will improve the evidence of DAP impacts and inform service and system planning

The maturity and ability of providers to use data and evidence to understand their own performance and in seeking to continuously learn and apply better practice varies. While this evaluation has drawn on a range of available data sources, significant limitations in data quality, availability and structure have constrained the ability to assess DAP outcomes and impacts, particularly through quasi-experimental methods. There is need for consistent application of best practice performance measures across DAP to improve policy accountability, streamline reporting requirements and support sector-wide quality improvement. Critically, a robust monitoring and evaluation framework is required which sets out key evaluation elements and leverages data linkage will also improve evaluability of DAP in the future. An evaluation framework which incorporates capability building will also promote greater consistency in service provider approaches to monitoring their service quality and impact.

Sustainability considerations to support DAP impact

The following sustainability considerations will support the impact of DAP:

- Designing a fit-for-purpose monitoring and evaluation approach is crucial to future evaluability of DAP.
- Harmonise reporting Key Performance Indicators (KPIs) to support consistent and reliable DAP data.

1.4.4 Efficiency

The efficiency findings explore the efficiency of the DAP in commissioning and managing grants and in creating cost effective investment in the DAP. These findings also highlight the future-focused opportunities to strengthen the sustainability of funding arrangements and to improve transparency and coordination in reporting requirements. Detailed key findings for this section include the following:

A more streamlined organisation of DAP funding streams, linked to service categories, can support increased efficiencies in commissioning and managing grants

Currently DAP streams largely reflect the previous grants from which they evolved. There are administrative and service delivery legacies because of this consolidation of former grants. Notably, some of the initiatives that are funded within a DAP stream do not align strongly with the intended type of activities within that stream. There is also apparent overlap in activities delivered across multiple DAP streams. There is an opportunity to review the current organisation of streams to enhance administrative efficiencies.

Understanding the costs and avoided costs of DAP initiatives can guide investment in the DAP to ensure value for money

Current gaps in the data collected by DAP services creates challenges in attributing the causality of the DAP to specific outcomes and in turn, assessing the cost effectiveness of DAP initiatives. However, findings from literature were applied to demonstrate the potential value for money produced by DAP funding. The evaluation found that based on available evidence, it can be reasonably inferred that the DAP investment into prevention and treatment services is likely to create value for money into the future for the Australian Government.

Sustainable funding arrangements create opportunities to improve the efficiency and productivity of DAP services

Several challenges were identified as impacting the efficiency of DAP. In particular, there is a need for more sustainable funding through longer term DAP contracts and more appropriate funding envelopes for providers that adequately recognises the costs of delivering DAP initiatives. The evaluation also identified the opportunity to provide stronger and clearer guidance to providers on recording and reporting on the costs of their services, to help inform future DAP modelling and planning.

Improving transparency and coordination of reporting requirements can support a more streamlined and efficient delivery of DAP initiatives

DAP providers are often required to report to multiple funders and in varying ways which creates inefficiencies in reporting processes. There is a clear opportunity for aligning reporting requirements across all providers to increase efficiencies. While this would ideally include the whole AOD sector, for DAP providers, streamlining and harmonising the reporting requirements within DAP streams will go a long way to building efficiencies and enabling more meaningful reporting.

Sustainability considerations to support DAP efficiency

The following sustainability considerations will support the efficiency of DAP:

- Consolidating DAP streams may contribute to increased efficiencies for DAP services.
- Supporting providers to collect and report data on operational costs will facilitate a greater understanding of the costs of delivering services.
- Updating the business and costing models for AOD services will ensure funding remains appropriate and cost-effective.
- Providing a sustainable funding environment for the DAP and across the AOD sector, is crucial.
- Streamlined reporting process will support the efficient administration of DAP services.

1.5 Recommendations

The findings within this report, along with the sustainability considerations, have informed a set of clear and actionable recommendations to support the future of DAP. While the sustainability considerations noted previously will support DAP's development within the context of the broader AOD system, they rely heavily on actors external to the DAP. The evaluation recommendations outlined below are informed by the findings and sustainability recommendations and focus on actions directly tied to DAP and its delivery.

The below table summarises the evaluation recommendations, including the parties responsible for actioning the recommendation as well as a proposed timeline for implementation. These timeframes include short term (one year), medium term (one to three years) and long term (four to five years) timeframes. Implementation considerations are further detailed in Section 5.3 along with more detailed descriptions of each recommendation.

Table 4 DAP evaluation recommendations

#	Recommendation	Timeframe	Responsible Parties
1	**Update DAP GOGs to strengthen alignment with a refreshed national AOD strategy.** Updated GOGs should set out the clear link between DAP initiatives and the achievement of the strategy. Consideration should be given to how this alignment can be measured for monitoring and evaluation.	SHORT to MED 1-3 years	AUS GOV The department
2	**Support initiatives which address emerging needs, including harm reduction strategies, prevention programs and initiatives that target individuals with co-occurring needs.** When considering the balance of funding across DAP initiatives, the Australian Government should consider areas of identified need. There is a need for greater investment in prevention initiatives including evidence-based community education and prevention campaigns as well as harm reduction services. There is also a demonstrated need to enhance support for people with co-occurring mental health needs, women and families and/or people who inject drugs.	SHORT to MED 1-3 years	AUS GOV The department
3	**Develop and implement approaches to enhance coordinated and responsive DAP service planning and drive enhanced cross sector integration in the delivery of the DAP.** This includes collaborating with providers, peaks, PHNs, people with LLE, and state and territory governments when developing DAP policy. The Australian Government should also clarify PHN GOGs to support a consistent approach for PHN local area needs assessment, planning and commissioning of DAP initiatives. Formalising the connection between the research programs and national AOD strategy and policy that is constantly evolving over its lifecycle will further support DAP service planning. The maintenance of the current DAP service mapping will also help inform future funding decisions.	MEDIUM TERM 2-3 years	AUS GOV The department

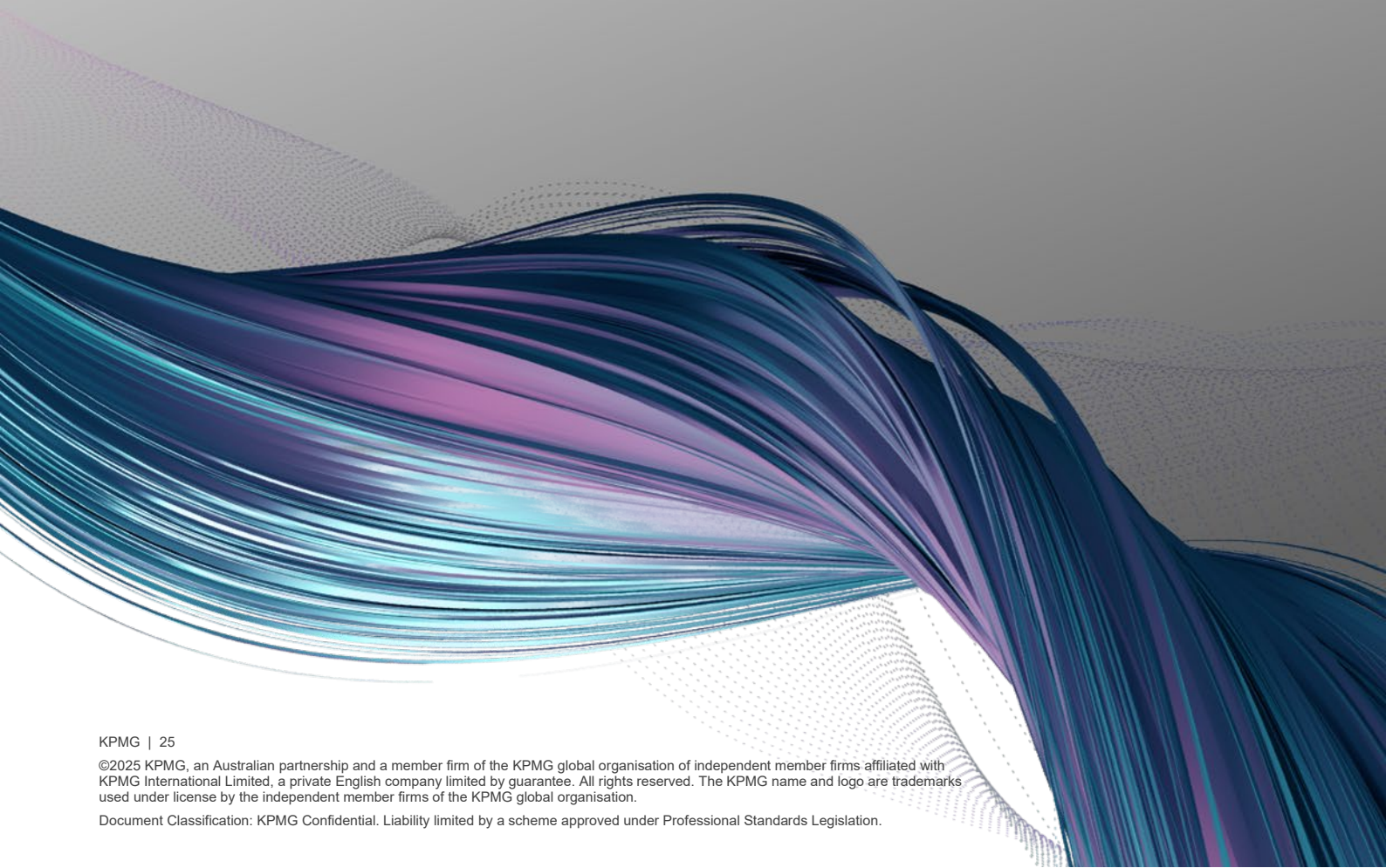
#	Recommendation	Timeframe	Responsible Parties
4	**Update the Monitoring and Evaluation Framework for DAP to ensure it is fit-for-purpose and promotes a consistent approach to quality improvement across DAP services.** The development of the updated framework will require a considered approach and deep sector engagement to ensure impact and efficiencies of DAP can be suitably measured into the future. This might include: • Convening an evaluation advisory group to provide expert advice during the framework's development. • Development of evaluation elements including an updated program logic and nested logics for each DAP stream, theory of change, key evaluation questions, evidence-based indicators and data sources. • Completing a data quality audit and development of a data matrix in collaboration with data custodians. • Undertaking evaluability assessments to determine methodological approaches. • Incorporating capability building to ensure providers can deliver on data collection requirements as well as promoting a more consistent approach to evidence informed service improvement.	MEDIUM TERM 2-3 years	The department
5	**Harmonise reporting KPIs across DAP to streamline processes and increase reliability of reporting.** In the first instance, this should involve consolidating existing reporting KPIs to understand areas of duplication and opportunities available to enhance efficiency in the reporting process. It will also be important to determine any recommended new evidence-based KPIs and Performance Measurement tools and providing clear guidance to providers on a consistent approach to collect and report the data to ensure comparability and quality monitoring practices.	SHORT to MED 1-3 years	The department
6	**Consolidate DAP streams to reduce overlap.** Consolidation of the existing DAP funding streams provides opportunities to increase efficiency for DAP grant administration. The streams that would particularly benefit from consolidation include: • National prevention and prevention streams • Withdrawal and rehabilitation services and the AOD treatment services in areas of identified need stream. In consolidating DAP streams, the department may also wish to explore how the new consolidated streams align with categorisation of contemporary AOD initiatives. Once streams are established, the Australian Government, with support of the department, should clearly outline the terminology used to define streams and their respective activities.	MEDIUM TERM 2-3 years	AUS GOV The department

#	Recommendation	Timeframe	Responsible Parties
7	**Update the DAP funding model and grant agreements process to support improved cost-effectiveness and support the ongoing sustainability of DAP providers.** This can be achieved by addressing key challenges identified during this evaluation, including: • Implementing longer funding cycles of at least three to four years, or longer, for the grant agreements for DAP. • Reviewing the funding model for DAP and considering the most appropriate model and adjustments required to recognise increased cost of service delivery in different contexts (e.g., rural and remote areas). • Development of a mature commissioning process that is based on an agreed costing model. This costing model would provide clarity for funders and providers on the types of services included in the DAP, and estimated funding on service location and type. There would be benefit in applying this same tool/model across the department and PHN commissioned initiatives, to enable consistency in funding approaches.	MEDIUM TERM 2-3 years	AUS GOV The department

Source: Evaluation Team

2 Evaluation context and background

This section provides a brief overview of the purpose of this document and background to the evaluation, including the policy context in which the DAP is delivered.



2.1 Purpose of this document

This document is the final report for the evaluation of the DAP. It analyses the implementation, appropriateness, impact, efficiency and sustainability of the DAP between 1 July 2021 and 31 March 2025. The report answers the KEQs using program documentation and data regarding service utilisation, population health, stakeholder views as well as evidence from contemporary literature. This final report makes recommendations that support the DAP's future sustainability.

The report incorporates feedback from the project governance groups, an Evaluation Steering Committee and Evaluation Advisory Group, that provided perspectives on all key evaluation deliverables. Further information on the project governance is provided in Section 3.1.4.

The report references recent and ongoing reviews highlighting the challenges faced by the AOD and adjacent sectors, including:

- Issues paper relating to the health impacts of alcohol and other drugs in Australia, released in March 2025 by the Standing Committee on Health, Aged Care and Sport[4]
- Report on Australia's illicit drug problem: Challenges and opportunities for law enforcement, released in 2024, by Commonwealth of Australia[5]
- Report on the 2024 NSW Drug Summit, released in 2024 by the NSW Ministry of Health[6]
- Australian National Advisory Council on Alcohol and Other Drugs (ANACAD) Report July 2023 – December 2024, released in 2024 by ANACAD[7] and
- Evaluation of the National Ice Action Strategy (NIAS), released in July 2021 by the department.[8]

The department's Review of Primary Health Network Business Model & Mental Health Flexible Funding Model was in progress at the time of this evaluation and preliminary findings were not available to inform the evaluation. The outcomes from this review support the implementation of recommendations.

2.2 Drug and Alcohol Program: Context and objectives

More than 3,500 people died from their AOD use excluding deaths from tobacco in 2022. The total social and economic cost of AOD including tobacco was $257.1 billion in 2021-2022.[9] Two trends characterise the AOD landscape in Australia: increased demand for services and increased complexity of client needs. Addressing the harms associated with AOD use is a critical public health issue. Improving the health and wellbeing of Australians affected by substance use supports public health. It reduces the burden on the healthcare system and contributes to improved mental health and safer communities.

The NDS 2017-2026 is the Australian Government's 10-year commitment to building safe, healthy and resilient Australian communities through minimising alcohol, tobacco and other drug-related health, social, cultural and economic harms. The Strategy outlines priorities across the three pillars of harm minimisation: demand reduction, supply reduction and harm reduction. The Strategy identifies seven priority population groups, including First Nations people, people experiencing mental health conditions, young people, older people, people in contact with

[4] Commonwealth of Australia. House of Representatives. (2025). *Issues paper relating to the health impacts of alcohol and other drugs in Australia*. Retrieved from https://parlinfo.aph.gov.au/parlInfo/download/committees/reportrep/RB000565/toc_pdf/IssuespaperrelatingtothehealthimpactsofalcoholandotherdrugsinAustralia.pdf

[5] Commonwealth of Australia. (2024). *Australia's Illicit drug problem: Challenges and opportunities for law enforcement*. Commonwealth of Australia. Retrieved from https://parlinfo.aph.gov.au/parlInfo/download/committees/reportjnt/RB000042/toc_pdf/Australia%e2%80%99sillicitdrugproblemChallengesandopportunitiesforlawenforcement.pdf

[6] Tebbutt, C, & Brogden, J. (2024). *Report on the 2024 New South Wales Drug Summit*. NSW Health. Retrieved from https://www.health.nsw.gov.au/aod/summit/Documents/2024-nsw-drug-summit-report.pdf

[7] Australian National Advisory Council on Alcohol and Other Drugs. (2024). *ANACAD Final Report*. Retrieved from https://www.health.gov.au/sites/default/files/2024-12/anacad-final-report-july-2023---december-2024.pdf.

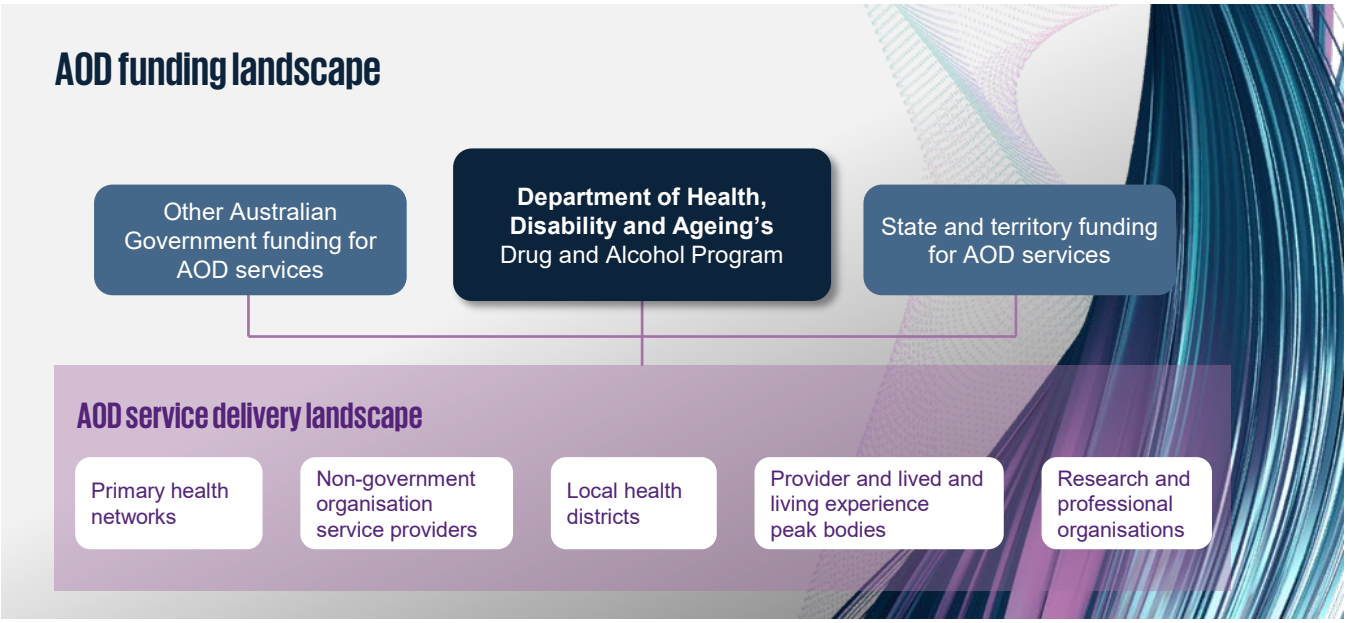
[8] Cash, R, Johnston, J, Bothwell, S, Clancy, B, Demant, L, & Lee, N. (2021). *Evaluation of the National Ice Action Strategy ('NIAS')*. 360 Edge. Retrieved from https://www.health.gov.au/resources/publications/evaluation-of-the-national-ice-action-strategy-nias?language=en.

[9] Chrzanowska, A, Man, N, Sutherland, R, Degenhardt, L, & Peacock, A. (2024). *Trends in Overdose and Other Drug-Induced Deaths in Australia, 2003-2022*. National Illicit Drug Indicators Project. Retrieved from https://www.unsw.edu.au/content/dam/pdfs/medicine-health/ndarc/research-reports/2022-08-ndarc-reports/NIDIP_Drug%20induced%20deaths_2003-2022_Report%20DOI.pdf; Gadsden, T, Craig, M, Jan, S, Henderson, A, & Edwards, B. (2023). *Updated Social and Economic Costs of Alcohol, Tobacco, and Drug Use in Australia, 2022/23*. The George Institute for Global Health. Retrieved from https://www.georgeinstitute.org/sites/default/files/documents/cost-of-alcohol-drug-use-in-aus-report.pdf

the criminal justice system, culturally and linguistically diverse (CALD) communities and people identifying as lesbian, gay, bisexual, transgender and/or intersex (LGBTIQ+).[10]

The DAP is a national program delivered by the Australian Government, within the context of the NDS (see Figure 1). It delivers both direct funding to providers and funding through PHNs and supplements funding from state and territory governments, which hold primary responsibility for funding AOD treatment services. The AOD sector is also funded by the NIAA and NGOs and is informed by the perspectives of peak bodies and advocacy groups, people with LLE and research and professional organisations.

Figure 1 Location of DAP in Australia's AOD sector



Source: Evaluation Team

2.2.1 DAP objectives

The aim of the DAP is to prevent and minimise health, social, cultural and economic harms of AOD use among Australians. The DAP supports the following objectives:

1. Supporting prevention and early intervention activities and promoting evidence-based information about alcohol and other drugs through education.
2. Supporting drug and alcohol treatment services across Australia to reduce the impact of substance use on individuals, families, carers and communities.
3. Strengthening the AOD evidence base through the commissioning of research and data (out-of-scope for this evaluation).
4. Supporting collaboration and coordination between the Australian Government, state and territory governments and service providers.

[10] We note that since the Strategy was published this term has expanded to include people from the queer community or who are questioning their gender identity or people who are asexual. The communities are often referred to collectively and abbreviated to LGBTIQ or LGBTIQ+.

2.2.2 DAP in-scope streams

Activities funded under the DAP are intended to broadly align with the three harm minimisation pillars and the priority populations identified in the NDS. While supply reduction is not a direct DAP target, prevention and treatment are funded through sub-programs. Six of the program streams are in scope for the evaluation and are described in Table 5:

- Prevention programs
- National prevention projects
- FASD
- Withdrawal management and rehabilitation services
- AOD treatment services in areas of identified need
- PHNs.

These streams are designated by the Australian Government. Several DAP streams are out of scope for this evaluation (research and sector coordination, international, AOD Peak, and Community Health and Hospitals streams). While out of scope for the analysis, the evaluation findings may be informed by insights across streams.

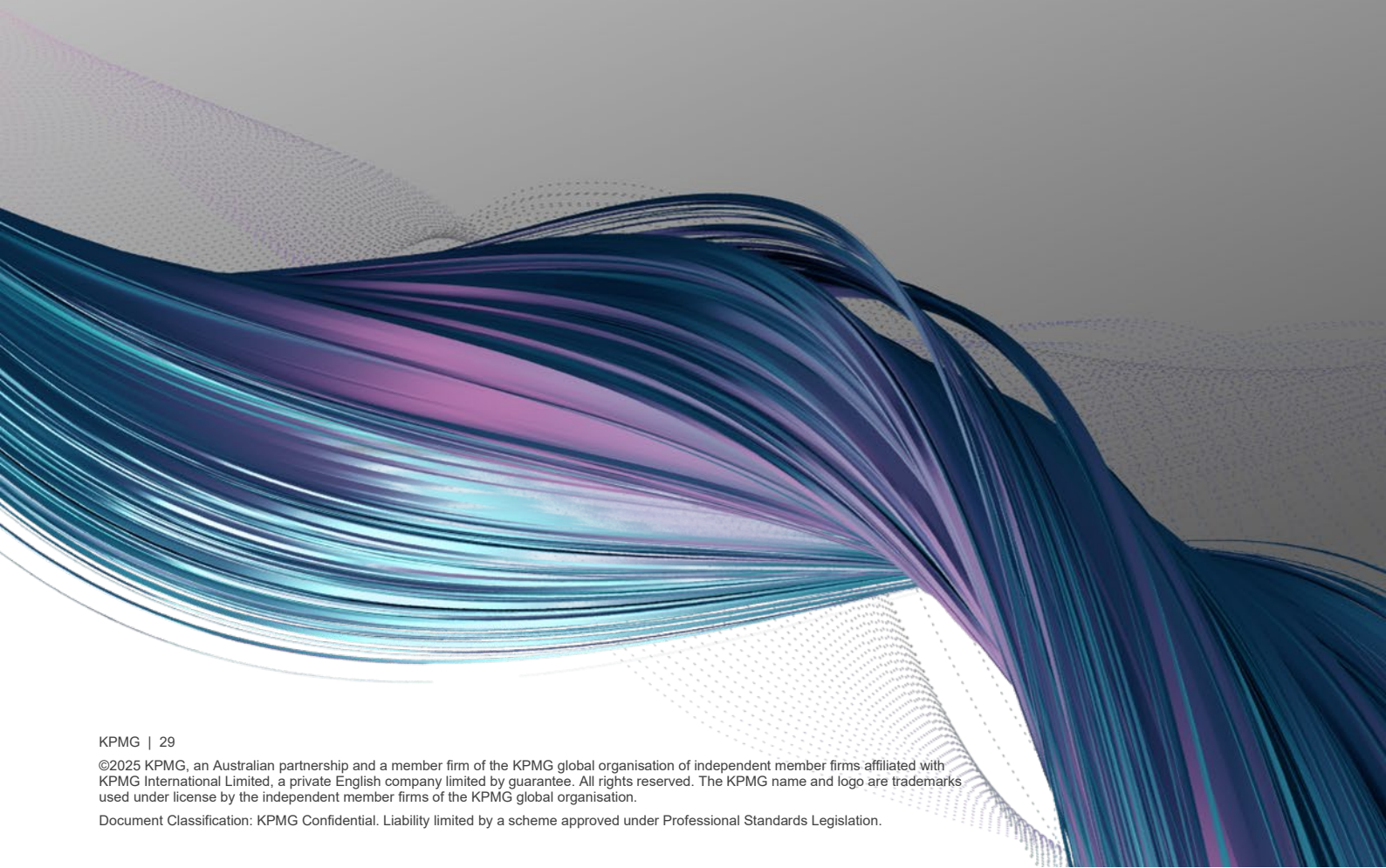
Table 5 Description of in-scope streams

Stream	Description of scope
Prevention Programs	• Population-level and local community-level programs including early intervention, primary prevention, information and education resources, resource dissemination and behavioural change resources. • Sub-programs are attached to a range of budget measures and the NIAS. • May include prevention initiatives and activities, harm reduction work and treatment programs, noting a level of crossover exists between these program types.
National Prevention Projects	• Specified early intervention and brief counselling supports and therapeutic community services, which sit outside the prevention programs stream.
FASD	• Prevention and treatment activities relating to FASD, including diagnostic services, training and educating health professionals, awareness raising and information resource dissemination, data and monitoring activities. • The investment for the FASD stream was driven by the National FASD Strategic Action Plan 2018-2028.
Withdrawal Management and Rehabilitation Services	• Inpatient and in-home withdrawal and rehabilitation, post-residential aftercare, assertive in-reach, outreach activities, therapeutic community programs, counselling and specialist needs assessment and case management. • This includes, but is not limited to, programs targeting priority groups (such as First Nations people and people living with a mental health condition).
AOD Treatment Services in Areas of Identified Need	• Treatment, withdrawal management and rehabilitation services which were previously funded through other budget measures, such as the Support for Alcohol and Drug Abuse in South Australia (SA), former Community Health and Hospitals Program and the Lives Lived Well Caboolture program. • This stream also included sector facing initiatives such as workforce development and capacity building.
PHNs	• Grant funding provided to each of the 31 PHNs to commission services based on their local community needs, including a range of different prevention programs and treatment services. • Includes funding through the NIAS.

Source: Evaluation Team adapted from Department of Health, Disability and Ageing information

3 Evaluation design and methods

This section provides a high-level summary of the approach to the evaluation, including data collection and analysis. More detailed methods are included in Appendix B.



3.1 Overview of evaluation design and methods

The department commissioned the Evaluation Team to evaluate the DAP from March to July 2025. The purpose of the evaluation was to assess the impact and overall administration of the DAP. This included determining whether the DAP achieved its intended objectives, for whom, and under what circumstances. The report identifies opportunities to improve administration and implementation.

Following advice from the Evaluation Steering Committee (described in Section 3.1.4), it was agreed that the evaluation would:

- Describe thematically the types of services and programs delivered within DAP-funded services and their extent of alignment with the program objectives.
- Describe how services commissioned through the DAP are used and accessed.
- Describe, to the extent possible, the effectiveness of DAP-commissioned services in the Australian context.
- Support the DAP to meet broader Government expectations in terms of providing evidence-based justification for future grants, aligned with the role of the Australian Government within the health and AOD sectors.
- Support the department and broader AOD sector to provide the right balance of services, based on contemporary evidence about what works, for the people and communities who need them.
- Recommend opportunities to strengthen data collection and monitoring activities to improve the evaluability of the DAP in the future, including recommended updates to the future program logic and its use.

3.1.1 Key evaluation questions

This evaluation addressed the domains and associated KEQs listed in Table 6. A full list of the KEQs and sub-KEQs is found in Appendix A. The KEQs were developed by the department for the purposes of the evaluation. During the evaluation framework design, the KEQs remained consistent while the sub-KEQs were iterated and refined in consultation with the department and the Evaluation Steering Committee. This process ensured the sub-KEQs were fit for purpose in the context of available data and constrained timelines.

Table 6 Evaluation domains and key evaluation questions

Domain	Key evaluation questions
Implementation	How well is the program being delivered in terms of fidelity, quality and outcomes?
Appropriateness	Is this program the right response to the identified needs and priorities of target populations?
Impact	What difference is the program making?
Efficiency	To what extent has the program delivered value for money?
Sustainability	How can the commissioning and implementation of the program be best supported going forward to maximise impact, ensure value for money and sustainability?

Source: Department of Health, Disability and Ageing

The KEQs and sub-KEQs were informed by the DAP program logic. In 2022, the department developed a program logic for the DAP, which describes how the DAP will achieve its goals and objectives. The program logic also defines the assumptions that must hold and the external factors that might affect the DAP's success. It outlines the investment and activities required to achieve the department's deliverables and outcomes. While the program logic provides a basis for designing the evaluation methodology and KEQs, there is an opportunity to update the program logic to ensure it remains aligned with contemporary policy and measurable outcomes directly tied to the DAP.

3.1.2 Methods and data sources

The analysis utilised a mixed method evaluation approach,[11] drawing on a range of primary and secondary qualitative and quantitative data sources to answer the key process, outcomes and impact evaluation questions. Figure 2 outlines the evaluation framework, including the key domains of inquiry and KEQs, data sources and methodology. The indicators associated with each question and the data sources used to answer them are provided in Appendix B, with a strength of evidence assessment.

The key quantitative data sources included:

- Program and performance monitoring data provided by the department and the DSS Grants Hub.
- Drug and alcohol consumption data from the HILDA Survey.
- Drug and alcohol use data from the National Drug Strategy Household Survey (NDSHS).
- Treatment episode data from the AODTS NMDS collected from services across Australia, as well as a DAP-funded specific sample for three anonymous states and territories.
- A sample of outcomes data from consenting NSW NGOs, made available from NADABase.[12]

The qualitative data provides a sound evidence base for understanding the processes, outcomes and impacts of the DAP. The analysis includes a review of the provided documents (n=1379 documents) and best practice policy and research literature (n=246 documents). The evaluation was augmented by stakeholder interviews (n=74) and a survey (n=76 responses). The qualitative findings were thematically analysed to provide insights against the domains of inquiry.[13]

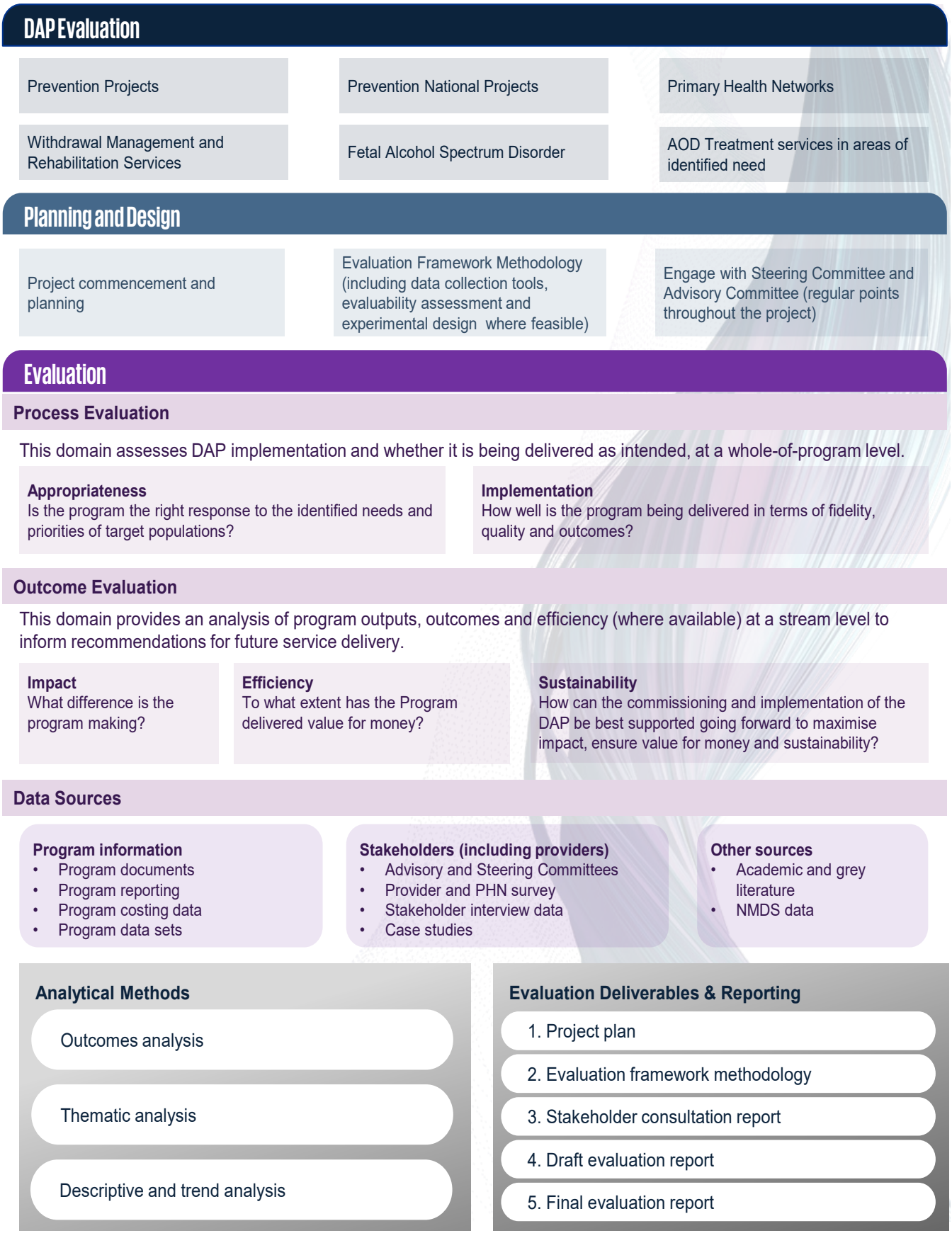
A detailed evaluation methodology is provided in Appendix B.

[11] Bazeley, P. (2018). *Integrating Analyses in Mixed Methods Research.* Sage Publications; Greene, J, C. (2007). *Mixed Methods in Social Inquiry*. Josey-Bass, 2(2), 190-198; Teddlie, C, & Yu, F. (2007). *Mixed Methods Sampling: A Typology with Examples*. Journal of Mixed Methods Research, 1(1), 77-100; Creswell, J, & Plano Clark, V, L. (2017). *Designing and Conducting Mixed Methods Research*. Sage Publications, 3.

[12] Network of alcohol and other drugs agencies (n.d.) *NADAbase.* Retrieved from https://www.nada.org.au/about/what-we-do/nadabase/, NADA, accessed 17 July 2025.

[13] Castleberry, A, & Nolen, A. (2018). *Thematic analysis of qualitative research data: Is it as easy as it sounds?* Currents in Pharmacy Teaching and Learning, 10(6), 807-815; Creswell, J, W. (2013). *Qualitative Inquiry & Research Design: Choosing Among Five Approaches.* Sage Publications; Mackenzie, N, & Knipe, S. (2006). *Research dilemmas: Paradigms, methods and methodology*. Issues In Educational Research, 16(2), 193-205; Punch, K, F. (2009). *Introduction to Research Methods in Education.* Sage Publications, 169-209; Verdinelli, S, & Scagnoli, N, I. (2013). *Data display in qualitative research*. International Journal of Qualitative Methods, 12, 359–381; Willis, J, W. (2007). *Foundations of Qualitative Research: Interpretive and Critical Approaches*. Sage Publications.

Figure 2 High-level evaluation approach



Detailed alt text available at Appendix E - Figure 2. Source: Evaluation Team

3.1.3 Ethics approvals

The evaluation received ethics exemption from the UQ Human Research Ethics Committee registered with the National Health and Medical Research Council (NHMRC) with no changes required (2025/HE000742 and 2025/HE000885).

The evaluation is compliant with the Australian Research Council's Australian Code for the Responsible Conduct of Research, the NHMRC guidelines and the University of Queensland's Guidelines for the Ethical Review of Research Involving Humans.

The evaluation accessed aggregate deidentified data from administrative datasets and high-level summaries that are in the public domain. Composite service-level data is used where service users had given prior consent. The report does not use individual-level data. Consultations were held with consenting stakeholders who deliver the various DAP activities and no consumers were involved.

3.1.4 Project governance

The department convened an Evaluation Steering Committee and Evaluation Advisory Group to support the project governance. These groups met regularly throughout the evaluation and provided perspectives on evaluation deliverables, including this final report. Specific membership and roles of each group are outlined below.

Evaluation Steering Committee

The Evaluation Steering Committee was responsible for advising the Evaluation Team's methodology. The evaluation findings and recommendations were tested with the Committee. The Steering Committee was responsible for authorising all evaluation activities and deliverables.

Steering Committee members from the department included:

- Assistant Secretary Alcohol and Other Drugs Branch (chair)
- DAP Prevention and Treatment Section stream lead and team members
- DAP Drug and Alcohol Prevention Services stream lead and team members
- DAP Evidence and Evaluation Director and team members (secretariat)
- Health, Economics and Research Division team members.

Evaluation Advisory Group

The Evaluation Advisory Group operate externally to the Evaluation Team and provided advice to ensure the evaluation approach, findings and recommendations considered the views of DAP grant recipients and people with LLE. The Advisory Group did not hold any decision making authority.

Advisory Group members included:

- Three provider peak representatives across prevention programs and treatment services
- Two PHN representatives
- One LLE peak representative
- Assistant Secretary Alcohol and Other Drugs Branch (chair), the department
- DAP Prevention and Treatment Section stream lead, the department
- DAP Drug and Alcohol Prevention Services stream lead, the department
- DAP Evidence and Evaluation Director (secretariat), the department.

3.2 Constraints and limitations

There are limitations to both the qualitative and quantitative data available to the evaluation. However, the evaluation findings are based on triangulation of evidence across a range of data sources and the Evaluation Team is confident the evidence provides a sound basis for decision making.

3.2.1 Primary data collection

New qualitative data was collected for the evaluation using key stakeholder interviews and a survey. Both methods are likely to have introduced biases.

3.2.2 Service provider consultations

The evaluation engaged broadly with the AOD sector, including direct- and PHN-funded service providers, government and sector stakeholders, such as peak bodies (see Appendix C for a list of stakeholders included). When engaging DAP providers, the sample was intended to draw insights on the key areas of interest for the evaluation and the breadth of services delivered through the DAP and was further informed by the scope and timeframe for the evaluation. The sampling frames were developed collaboratively with the Steering Committee and the Advisory Committee (see Appendix B).

A limitation of this approach meant that a focus was placed on engaging treatment providers and PHNs, given the majority of funding is provided here. However, recognising the size of the sector and the limited evaluation timeframe, the evaluation drew a purposive sample designed to ensure that perspectives from across jurisdictions, DAP streams, service types, priority populations and length of engagement with DAP were included. The proposed sample size meets research standards for saturation (i.e., gathering sufficient data so that no new insights or themes are emerging). Interviews held towards the end of the evaluation period did not reveal substantively new perspectives, giving confidence that saturation was reached. The Evaluation Team is confident that a sufficient number and diversity of stakeholders were included to capture a broad range of perspectives. Recommendations can be applied broadly and are heavily driven from a service delivery point of view. However, some perspectives may be missing.

In particular, the evaluation timeframe was too short to support engaging ethically and in a trauma informed way with people with LLE of AOD use. The evaluation did not engage extensively with First Nations people, or people from other priority groups (e.g., CALD, LGBTIQ+, young or older people). Rather than through direct consultation, these perspectives were sought through consultation with state and territory peak bodies. The department also made its prior service user research available to the evaluation, which was considered as part of the desktop review and during synthesis of the evaluation findings. The Advisory Group supported interpretation of the evaluation findings through the lens of people with LLE.

Given the length of time over which DAP was implemented, there is potential for recall bias. While the evaluation endeavoured to engage with stakeholders who were involved with the DAP over longer periods, known limitations due to staff turnover (and associated gaps in institutional memory) may have introduced biases, including recall bias, into findings reached based primarily on this evidence.

3.2.3 Service provider survey

Providers and PHNs were invited to respond to a survey to capture both qualitative and quantitative data on the perceptions of DAP grant recipients. The survey was voluntary, and organisations were requested to only complete it once. The analysis for the evaluation assumed this, however as the organisations were not required to self-identify, it is possible that there were multiple responses from the same organisation. Possible biases that may have occurred in the survey are included in Appendix B.2.4. Some survey data was also excluded from the analysis due to incompleteness or inconsistency of responding.

The survey achieved a response rate of 39.2% from the 273 organisations invited to participate, which is comparatively strong in social research.[14] This includes a 71% response rate for PHNs that commission services and 31.4% response rate for service providers. While the survey was not designed to generate a statistically representative sample, the results provided valuable insight into the views of a broad cross-section of stakeholders that reflected the breadth of services funded under the DAP. Nevertheless, care should be taken in generalising insights, as some organisational types may be over- or under-represented in the responses received. More detail regarding the survey response rates and representativeness can be found in Appendix B.2.3.

3.3 Quantitative data limitations

The scope and nature of the quantitative data analysis in this project was affected by several constraints, including limitations in data availability, accessibility, suitability, quality and consistency across sources. These constraints influenced both the feasibility of certain analytical approaches and the robustness of findings. A detailed discussion of data and methodological limitations is provided in Section 3.3.3 and Appendix B, including specific issues related to individual data sources and variables.

3.3.1 Access to participant and linked data

To meet the evaluation timelines, the evaluation did not access individual level outcomes data, nor did it seek to link individual records across datasets. While possible, the time required for the necessary approvals from data custodians and linkage authorities to access and link these datasets exceeded the time available for this evaluation. This limited the extent to which impact and efficiency could be evaluated based on participant health outcomes (outside of those included at an aggregated level in sampled service data, where available).

3.3.2 Gaps in program data collection

While analysis of available program reporting data was conducted as a key evaluation activity, there were known gaps in this data from the period prior to Financial Year 2021-22. The evaluation therefore prioritised detailed analysis of data from Financial Year 2021-22. Reporting data prior to this period was only examined at a high level and to the extent it was available. There were still some gaps identified in data available for the in-scope period 1 July 2021 – 31 March 2025. Identified gaps were monitored throughout the evaluation and are noted throughout the report where potential limitations to the interpretation or validity of findings exist.

3.3.3 Program data quality

There was variability in the quality (completeness, accuracy and coverage) of available program data and documentation (such as performance reporting and activity workplans) across DAP-funded services. These inconsistencies impacted interpretability and validity of findings. It is also noted that performance reporting requirements include output data such as episodes of service, but not participant level outcome data. As such, any participant outcome data that was included in performance reporting was variable, limiting the extent to which comparisons could be made across services.

3.3.4 Challenges in attribution and causation

While the evaluation aimed to demonstrate where links did or did not exist between the DAP-funded activities and a range of outcomes, there were challenges in establishing causality because:

- It is not possible to study what would have happened in the absence of DAP (that is, there was no counterfactual or control group). In addition, there was no individual-level data. This ruled out use of quasi-experimental methods.
- Whole-of-program participant outcome data was not available to the evaluation and any outcome data which had been collected through the program was not always measured using consistent tools or measures (either within or between streams, noting acknowledged challenges in measurement of prevention stream outcomes).
- Whole-of-program baseline data was not collected prior to the commencement of DAP.

[14] Dillman, D, A, Smyth, J, D, & Christian, L, M. (2014). *Internet, phone, mail and mixed mode surveys: The tailored design method*. John Wiley & Sons, 398-449.

- Broader population datasets with individual outcome variables cannot be definitively linked to the DAP, as participation in the DAP (and in other concurrent AOD programs not within the scope of this evaluation) was not included as a variable within the available data.

Moreover, because any change in population outcomes over time can also be attributable to a range of factors outside of the DAP, there will be limitations in the extent to which any finding can be attributed to the DAP alone.

Finally, as noted above, providers (both DAP funded and PHN-commissioned) are likely to receive funding from multiple sources including the DAP, states and territory governments and other sources, rendering it difficult to isolate the effects of DAP funding.

This evaluation intended to provide findings about the DAP's role in generating the observed outcomes (that is, contribution) rather than the extent to which the DAP has caused the observed outcomes (that is, attribution).

3.3.5 Limitations of proxy measures to estimate outcomes

The above data constraints meant that the evaluation needed to use service activity and output measures (such as attendance and resource utilisation) to examine the program's impact. As the links between service activity and participant outcomes are not always clearly defined, these are not ideal proxies and must be interpreted cautiously. The qualitative data available to the evaluation was used to strengthen the interpretations.

3.4 Strength of evidence

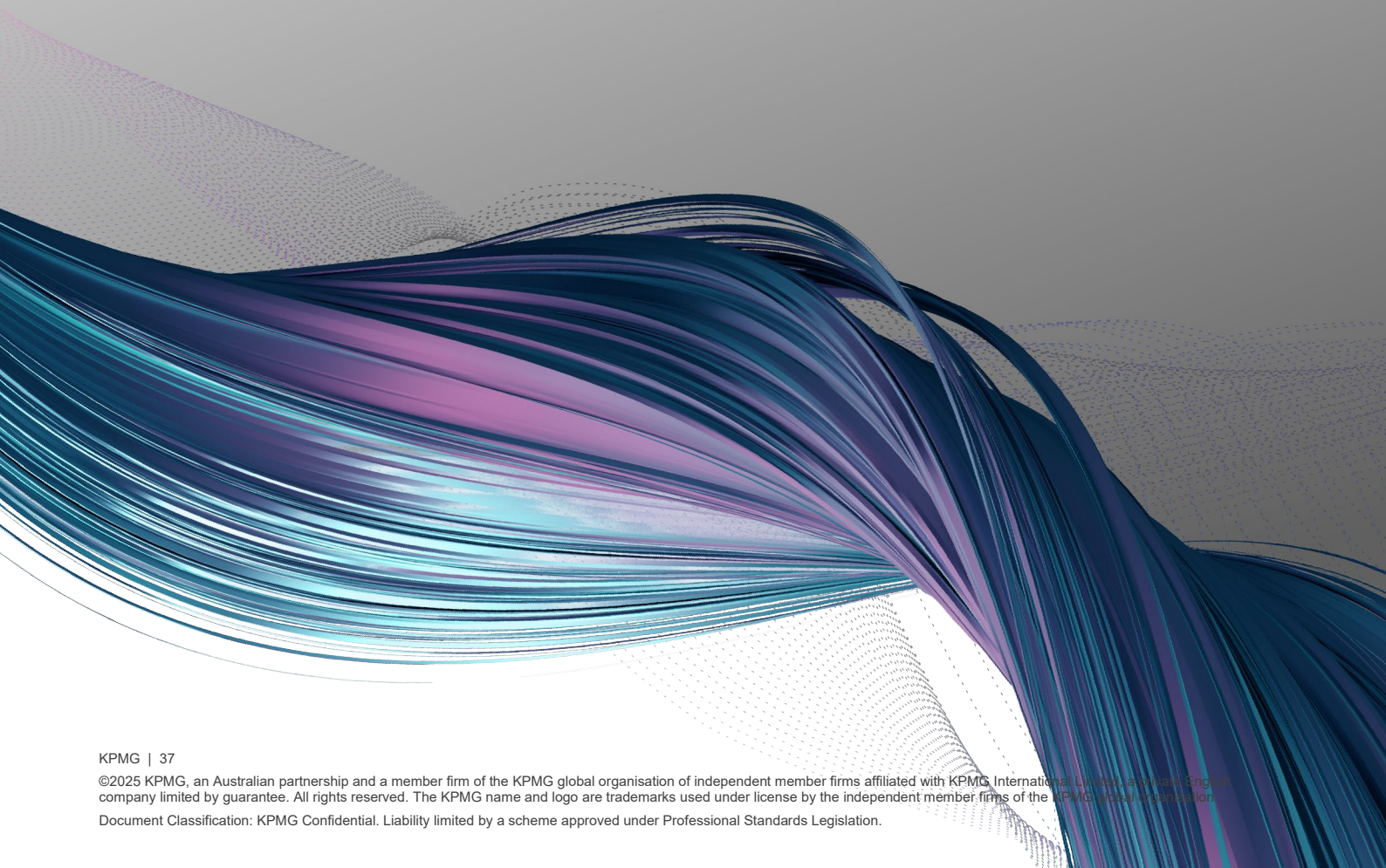
This evaluation has applied the following guide in assessing the strength of evidence in determining the findings for each of the evaluation domains:

- **Sufficient evidence**: The evidence is sufficient to draw a largely unqualified conclusion regarding the evaluation question because either there is a single source of quality data or multiple sources of data, which have no major quality issues and that consistently support the conclusion reached.
- **Some evidence**: The evidence suggests the finding is reasonable and there is a supporting theoretical rationale but there are data limitations, such that the finding is qualified and further and/or different data (which may have been unavailable to this evaluation) would need to be sourced in order to be more confident in the conclusion reached.
- **Weak evidence**: The evidence is indicative of a finding but there are major shortcomings in the data, such that limited confidence can be placed on the conclusion.
- **No evidence**: No data exists upon which to make any finding. Note that there are no such examples of this in this Review.

The assessment of strength of evidence only relates to those evaluation questions that require a conclusion to be drawn and not to evaluation questions that require facts to be stated.

4 Evaluation findings

This section summarises the evaluation findings. A mix of qualitative and quantitative data sources – including peer reviewed literature, program documents, a provider survey, stakeholder consultation and administrative datasets – were triangulated to inform the evaluation findings. The methods for data collection, synthesis and triangulation are described in detail in Appendix B.



4.1 Navigating this section

Section 4 of this report describes findings against the **implementation, appropriateness, impact and efficiency** domains**.** Considerations relating to the **sustainability** of the DAP (KEQ 5) are also provided in call out boxes throughout this section.

Table 7 provides a high level summary of the location of each KEQ within this section. Table 19 located in Appendix A provides further detail on where each sub-KEQ is explored within the report.

Table 7 Location of findings in the document against KEQs

KEQ and sub-KEQs	Location in document
KEQ 1. How well is the program being delivered in terms of fidelity, quality and outcomes?	**Implementation - Section 4.2**
KEQ 2. Is this program the right response to the identified needs and priorities of target populations?	**Appropriateness - Section 4.3**
KEQ 3. What difference is the program making?	**Impact - Section 4.4**
KEQ 4. To what extent has the program delivered value for money?	**Efficiency - Section 4.5**
KEQ 5. How can the commissioning and implementation of the DAP be best supported going forward to maximise impact, ensure value for money and sustainability?	**Sections 4.2, 4.3 and 4.5**

Source: Evaluation Team

4.2 Implementation

This section assesses how well the program is being delivered in terms of fidelity to policy and quality of program outputs. The extent to which DAP funding streams have been able to meet the objectives outlined within their grant guidance and the program logic is explored, with consideration of implementation barriers and enablers. Implementation challenges are also explored in more detail in later sections. The sub-KEQs explored when evaluating the DAP's implementation include:

- To what extent do program guidelines, documentation and reporting requirements enable or hinder high quality program implementation?
- To what extent have the funded organisations delivered outputs according to their grant agreements?
- To what extent has implementation of each DAP stream considered the needs of priority populations, as identified in the NDS (First Nations, CALD, LGBTIQ+, older persons, youth, people with mental health conditions, people in contact with the criminal justice system)?
- What are the other barriers and enablers to effective implementation of the DAP and its ability to achieve positive client outcomes?

4.2.1 Findings

The DAP grants are delivering activities and outputs in line with the DAP policy. However, there are opportunities to strengthen the DAP policy to better align it with Australian Government objectives and to clarify guidance given to DAP providers.

The contemporary DAP is a consolidation of various AOD grants, resulting in some administrative and service delivery legacies. There is no strong and centralising strategic focus guiding its implementation. Stakeholders, including providers, peaks, researchers and governments, all advocated for greater leadership from the department to enable stronger alignment of the DAP with national AOD strategy and to support coordinated implementation.

Key findings in the implementation domain include:

- The department is funding services that are intended to meet the DAP objectives, however there are opportunities to improve the program's implementation.
- Aligning the DAP GOGs to national AOD policy and strategy will strengthen the Australian Government's investment.
- Stronger leadership and coordination from the Australian Government in convening funders and providers will enhance a collaborative approach to addressing the harms of AOD use in Australia.
- Australian Government leadership and investment in workforce capability and capacity building across the DAP has the potential to strengthen service implementation.

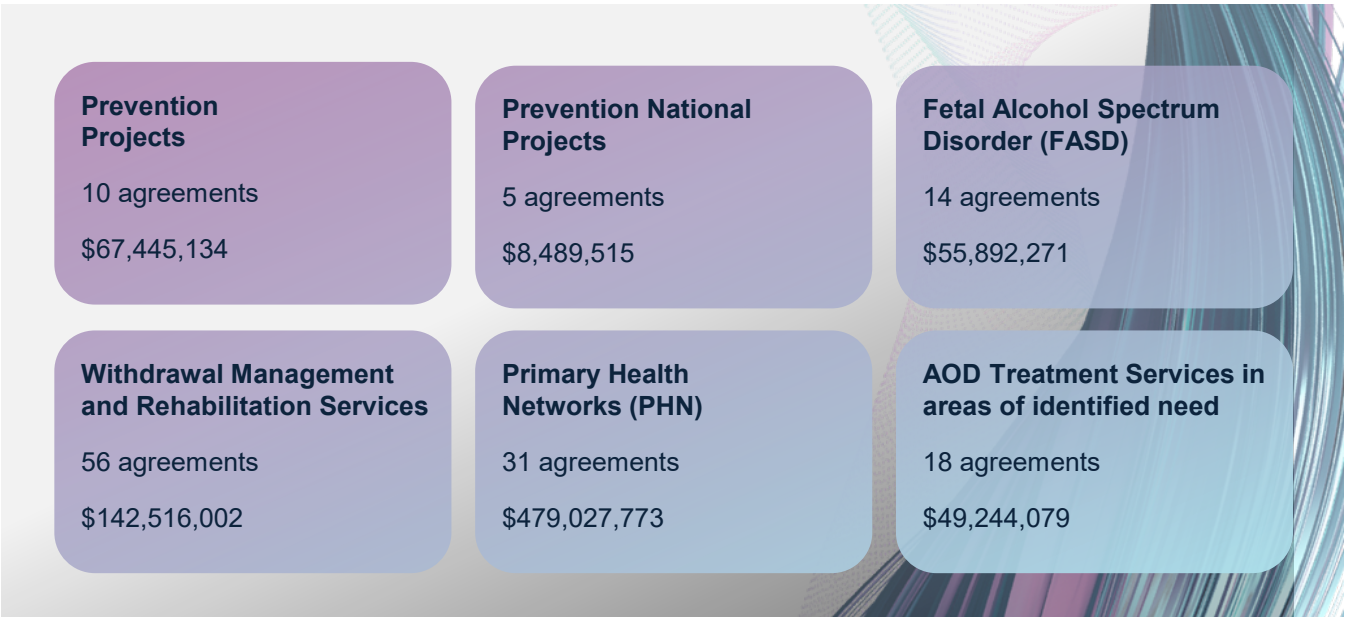
Strength of evidence – Sufficient

Evidence to assess implementation of the DAP drew on consultation feedback, a review of DAP program documentation, relevant strategies, reviews and literature on AOD policy implementation, and analysis of DAP administrative data. These multiple sources provided consistent findings and were further supported by a DAP service mapping exercise to understand the DAP landscape. Findings in this domain relate to the DAP as a whole, rather than to individual funding streams or grants.

4.2.2 The department is funding services that are intended to meet the DAP objectives, however there are opportunities to improve the program's implementation

The Australian Government is committed to building safe and healthy communities by reducing the impact of drug and alcohol use. Through the DAP, the Australian Government invested over $800 million across 819 activities over the period 2021-22 to 2024-25, from prevention and early intervention through to intensive treatment and aftercare. From 2016-17, DAP funding has been delivered in six distinct streams (Figure 3). Within Figure 3, PHN funding is often referred to as a stream comprising 31 PHN grants. However, it is important to note that this funding is used by PHNs to commission initiatives across the full spectrum of support, including prevention, withdrawal and treatment and capacity building.

Figure 3 Overview of in-scope DAP funded streams including number of grants and cumulative total funding over the period 2021-22 to 2024-25



Detailed alt text available at Appendix E - Figure 3. Source: Department of Health, Disability and Ageing

There are stream-specific GOGs, which outline the intended objectives and set out monitoring and reporting obligations.

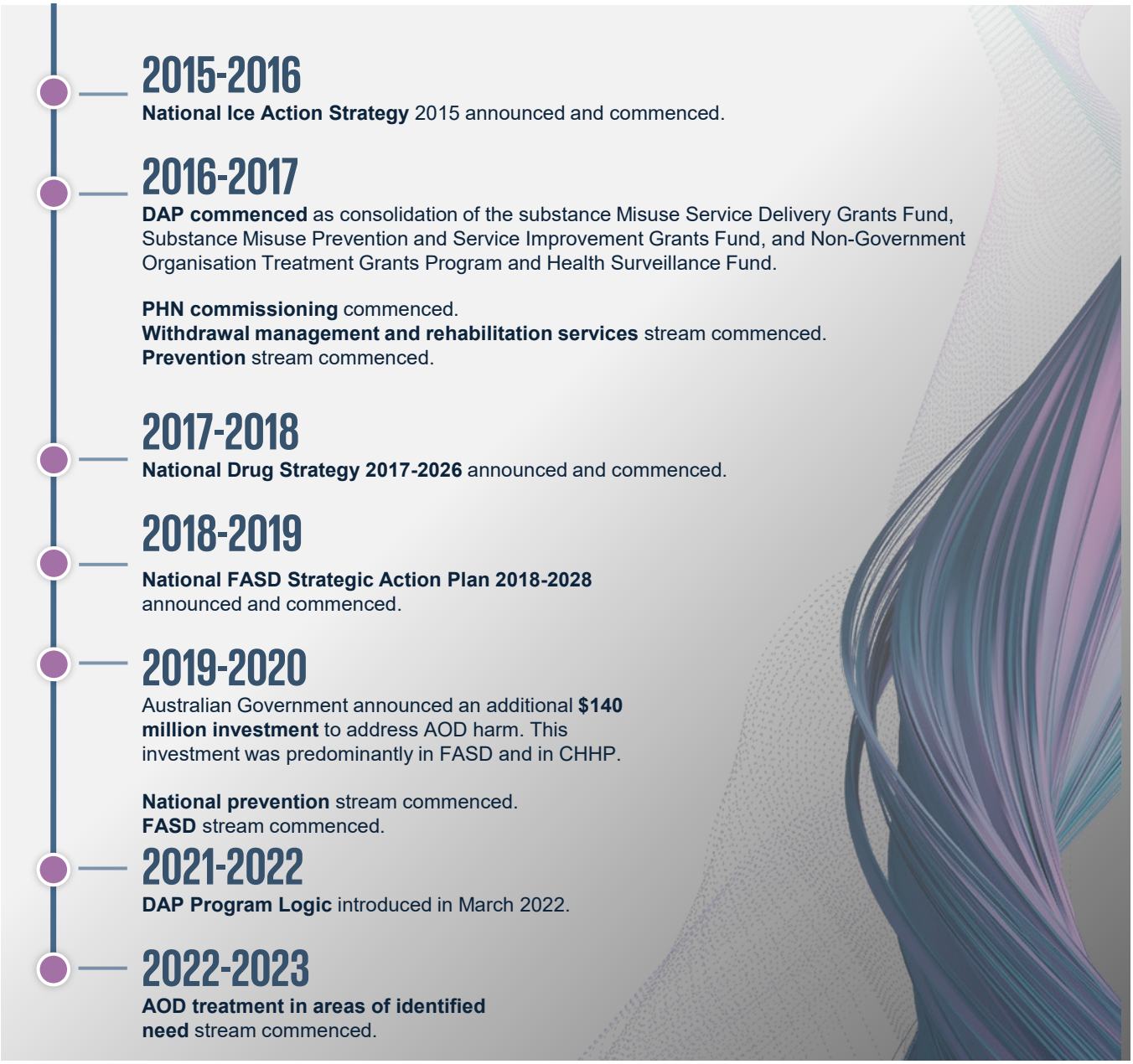
The DAP grants are distributed using two different mechanisms:

1. Grants provided to PHNs to commission services, and
2. Directly funded DAP grants managed through the DSS.

The evolution of DAP

The DAP was launched in 2016-17 as a consolidation of the former Substance Misuse Service Delivery Grants Funds, Substance Misuse Prevention and Service Improvement Grants Fund and the Non-Government Organisation Treatment Grants Program and Health Surveillance Fund. The consolidated program included only three program streams: withdrawal management and rehabilitation services, prevention and PHN commissioned services. New Australian Government investment allowed three more streams (national prevention, FASD and AOD treatment in areas of identified) to be added (see Figure 4).

Figure 4 Timeline of the DAP's implementation



Detailed alt text available at Appendix E - Figure 4. Source: Evaluation Team

Some administrative and service delivery legacies exist within the DAP because of the consolidation of former grants. Notably, some initiatives are funded within a DAP stream that does not clearly align with the type of program or service they deliver. For example, some grants within the Areas of Identified Need stream may be better suited to the Withdrawal Management and Rehabilitation Services Stream. Similarly, this staggered approach to DAP implementation appears to have led to overlap in the types of grants funded across streams. Further detail on this overlap is provided in Section 4.5 where the evaluation considers administrative efficiencies across DAP grants.

DAP implementation planning

There is no overarching implementation planning or operational planning documentation for DAP and therefore, the stream-specific GOGs lack clarity and clear alignment to Australian Government objectives. Additionally, the DAP program logic was developed retrospectively and lacks direct alignment with broader AOD strategy (see Section 4.2.3). These documents have limited use for the ongoing implementation, monitoring and evaluation of DAP.

Considerations for DAP sustainability

Develop and utilise improved documentation to support DAP implementation

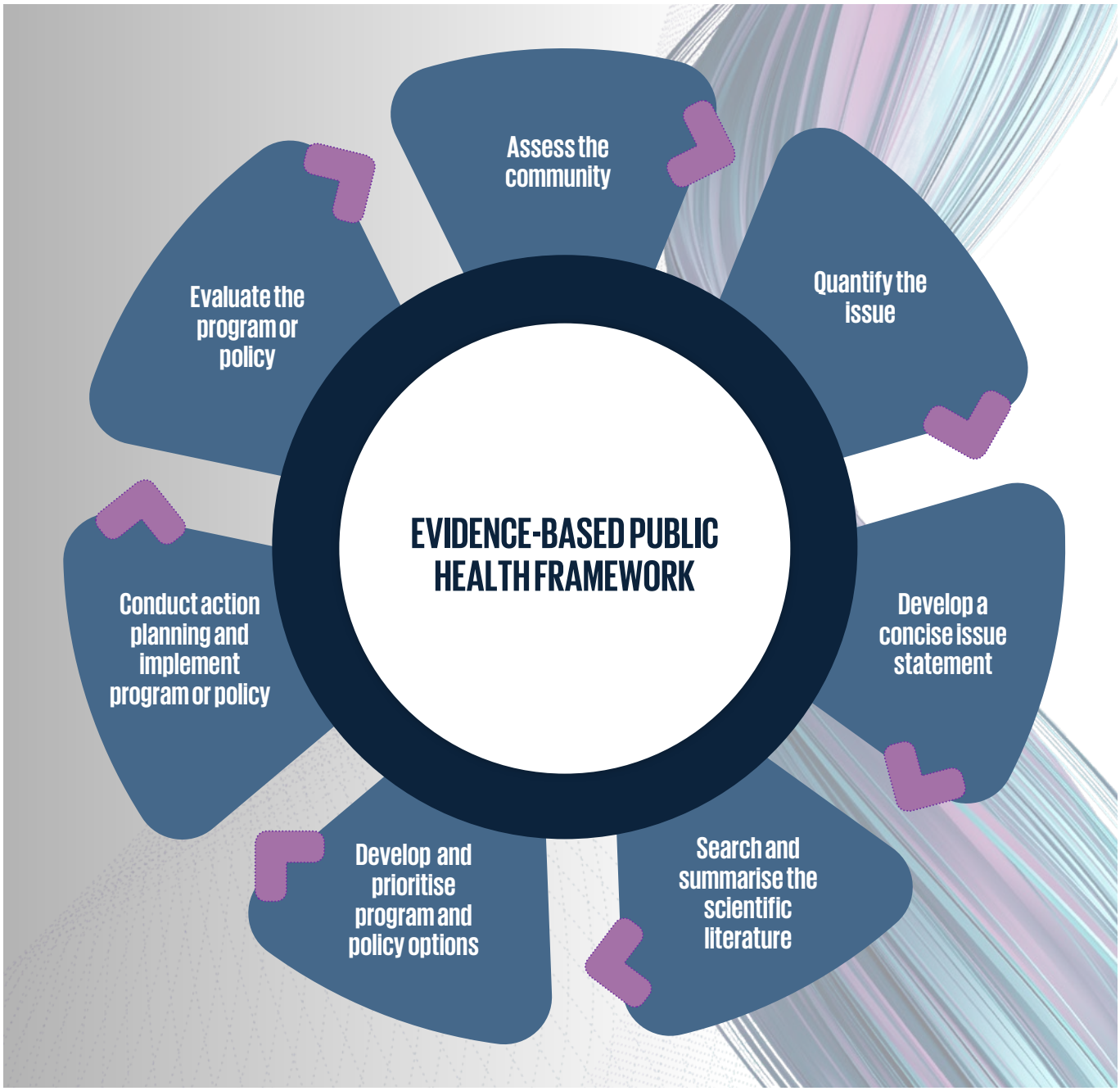
There is an opportunity for the department to develop new documentation that reflects stronger alignment with the Australian Government priorities for AOD and coordination with public health more broadly. An evidence-based approach is summarised in Figure 5.[15]

The department would benefit from establishing an implementation or annual operation plan to drive its key work and the ongoing commissioning of DAP services. Considerations and recommendations within this evaluation may provide a useful basis for setting out the intended activities, proposed timeframes, allocating responsibility and monitoring progress.

A refreshed DAP program logic is also required, along with nested program logics for each DAP stream. This will help to solidify the activities to be delivered, outputs and their connection to the program's intended objectives. This consideration is also detailed in the impact section of the report.

[15] Jacob, R, R, Duggan, K, Allen, P, Erwin, P, C, Aisaka, K, Yang, S, C, & Brownson, R, C. (2018). *Preparing Public Health Professionals to Make Evidence-Based Decisions: A Comparison of Training Delivery Methods in the United States.* Frontiers in Public Health, 6, 257-261.

Figure 5 Framework for training public health professionals in evidence-based decision making



Source: Preparing Public Health Professionals to Make Evidence-Based Decisions: A Comparison of Training Delivery Methods in the United States[16]

Evidence that DAP services have been implemented as intended

While the lack of clear implementation planning makes it difficult to measure implementation progress, there is evidence to suggest that the Australian Government has funded initiatives that are intended to meet the objectives of DAP. Specifically, the Department funded DAP initiatives span the activities specified in the DAP program logic, including prevention, treatment and capability and capacity building services. Table 8 summarises the investment made across the DAP streams, by funding and number of grants. The greatest proportion of DAP funding is directed to PHNs which then commission a range of AOD initiatives. Across remaining streams, the proportion of funding allocated to withdrawal management and rehabilitation services is the largest.

[16]Jacob, R, R, Duggan, K, Allen, P, Erwin, P, C, Aisaka, K, Yang, S, C, & Brownson, R, C. (2018). *Preparing Public Health Professionals to Make Evidence-Based Decisions: A Comparison of Training Delivery Methods in the United States*. Frontiers in Public Health, 6, 257-261.

Table 8 Allocation of funding across DAP streams (including grants to PHNs)

DAP Stream	Number of grants	Proportion of total DAP grants	Cumulative funding for 2021-22 – 2024-25	Proportion of total DAP funding for 2021-22 – 2024-25
Prevention	10	7.5%	$67,445,134	8.4%
National prevention	5	3.7%	$8,489,515	1.1%
FASD	14	10.4%	$55,892,271	7.0%
Withdrawal management and rehabilitation services	56	41.8%	$142,516,002	17.8%
AOD treatment in areas of identified need	18	13.4%	$49,244,079	6.1%
PHNs	31	23.1%	$479,027,773	59.7%
Total	**134**	**100 %**	**$802,614,774**	**100 %**

Source: Data from the Department of Health, Disability and Ageing, analysed by the Evaluation Team

Table 9 provides a summary of how this DAP investment has been implemented to align with the intended activities outlined in the DAP program logic. As noted above, the program logic was developed retrospectively and lacks direct alignment with broader AOD strategy.

Table 9 Activities outlined in DAP program logic

Intended activities as outlined in the DAP program logic	Activities funded through DAP
Prevention • Education and raising awareness of the impact and harms of AOD use • Delaying and preventing the uptake of AOD use	Ten prevention grants and five national prevention grants are funded through DAP with a total investment of over $75 million towards prevention programs since 2021-22. This represents 23.5% of direct funded grants. Prevention initiatives account for 21% of PHN commissioned initiatives.
Treatment and diagnostic and support programs • Treatment providers deliver appropriate services • PHNs commission services based on local need • Funding FASD diagnostic and support services	The other 76.5% of direct funded grants target treatment and diagnostic programs, totalling an investment of over $247 million. Approximately one fifth (22.6%) of this funding targets FASD diagnostic and support services with the remaining 77.4% allocated to withdrawal and treatment services. More than half (59.7%) of the total DAP funding since 2021-22 is directed towards PHNs, which are responsible for assessing and commissioning services that respond to local community needs. Across the 31 PHNs, a further 713 activities are commissioned (including prevention).
Stakeholders to be engaged • Inter-governmental • Inter-jurisdictional • Sector experts and Advisory groups • Service providers and PHNs with state and territories, NGOs and peak bodies	While stakeholder engagement is included as an activity in the program logic, there is no specific funding in the in-scope grants for this activity. More detail on the need for enhanced stakeholder engagement is outlined in Section 4.3.

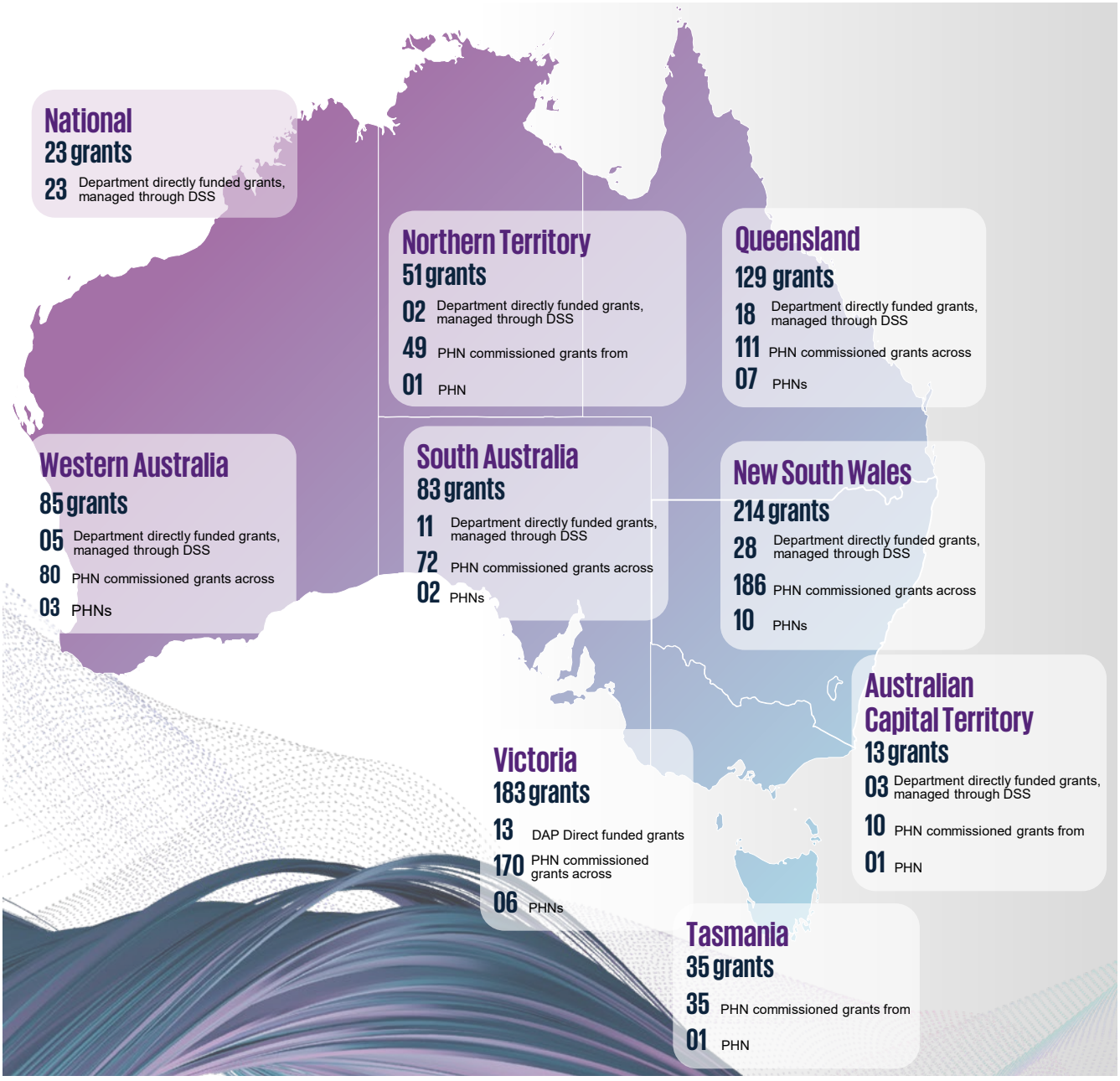
Source: DAP program logic and AOD Funding Contracts and Funding Arrangements

Australia-wide coverage of DAP services

One of the DAP's key intentions is to make AOD initiatives available across Australia. This intention is being realised, with grants provided in each state and territory and some grants with national coverage (Figure 6). Each

of the 31 PHNs also receive DAP funding from the department to support them to identify and address needs within their region.

Figure 6 Breakdown of DAP services by state and territory for the period 1 July 2021 to 31 March 2025



Detailed alt text available at Appendix E - Figure 6. Source: Evaluation Team

The DAP funding model is not formally population-based, however the largest proportion of direct funded DAP grants are in the most populous states of NSW, Queensland (Qld) and Victoria (Vic). Overall, approximately 12.6% of the total number of DAP grants are commissioned directly compared with the other 87.4% commissioned through PHNs. This demonstrates the significant role PHNs currently play in commissioning AOD services on behalf of the Australian Government. Tasmania (Tas) is the only state to receive DAP funding through a PHN alone.

The appropriateness of rural, regional and remote coverage of DAP services is discussed in Section 4.2, and the effectiveness of the DAP commissioning process is detailed in Section 4.2.4.

4.2.3 Aligning the DAP GOGs to national AOD policy and strategy will strengthen the Australian Government's investment

Within Australia, the NDS provides an overarching framework for government, in partnership with providers and community, to build safe, healthy and resilient communities through preventing, reducing and responding to AOD related harms. It outlines three priorities, supported by sub-strategies targeting areas of need (Figure 7). The Strategy guides jurisdictions' and providers' development of their individual responses to alcohol, tobacco and other drug issues. It is important to note that several of the sub-strategies have expired.

Figure 7 Summary of the National Drug Strategy strategic priorities

Detailed alt text available at Appendix E - Figure 7. Source: Evaluation Team

There is unequivocal evidence from stakeholder consultation and service outputs (see Section 4.2 and 4.3) that DAP funded services play an important role in delivering AOD prevention and treatment in Australia. However, there is unclear strategic alignment between the DAP and the NDS. None of the 134 grant agreements (including those between the department and PHNs) or the objectives within the agreements, explicitly reference the NDS or related national strategies.

Providers included in the consultation were keen for clearer and more explicit alignment between national strategy and the initiatives they deliver. They suggested that the GOGs, for both the program and specific streams, should articulate a clear link between national strategy and the DAP, and that this link should be operationalised in individual grant agreements.

> "The NDS and DAP are inherently related although it's not always clear how it happens."
> **- Government Representatives**

Considerations for DAP sustainability

Update DAP GOGs to directly align with the NDS and its relevant sub-strategies

As noted through initial scoping activities to help inform options for a future iteration of the NDS, stakeholders identified a need for the NDS, or an associated implementation plan, to outline clear actions and priorities to guide national efforts. This provides a timely opportunity to focus on aligning DAP grants with national AOD policy and strategy, such as future iterations of the NDS.

Further detail on actions to support this consideration are included in Recommendation 1.

4.2.4 Stronger leadership and coordination from the Australian Government in convening funders and providers will enhance a collaborative approach to addressing the harms of AOD use in Australia

The recent inquiry into the health impacts of AOD in Australia highlighted the multiplicity of AOD strategies with varied timeframes leading to a complex AOD policy landscape in Australia.[17] The NDS recognises the need for all levels of government to work collaboratively through coordinated, multi-agency approaches to develop and deliver jurisdictional responses that seek to prevent and minimise the harms from alcohol, tobacco and other drugs.[18] It further emphasises the need for leadership across the sector to encourage innovation, development of new approaches and to support holistic, systems-based partnerships between both government and non-government agencies. As noted above, there is an opportunity to strengthen the alignment between DAP grants and national AOD policy and strategy, such as a new NDS. In addition to making this link explicit in funding agreements, this alignment can also be strengthened through enhanced leadership and coordination across the DAP sector and the broader AOD sector.

> "This includes partnerships between both government and non-government agencies in areas such as education, treatment and services, primary health care, justice, child protection, social welfare, fiscal policy, trade, consumer policy, road safety and employment. It also includes partnerships with researchers, families and communities, peer educators, drug user organisations, Aboriginal and Torres Strait Islander communities and other priority populations."
> **- NDS**

While the responsibility of funding AOD services sits jointly with all levels of government, coordination and collaboration at the national level and within jurisdictions has the potential to improve client outcomes, catalyse innovative responses and improve efficiency.[19] Stakeholders reported that a lack of consistent national-level needs assessment, strategic planning and coordination by the Australian Government limits the ability to ensure that need is being met across the AOD system. It also limits the ability to ensure DAP is contributing in an appropriate, efficient and effective manner.

> "We need to have a national governance framework guiding the priorities in AOD funding as the DAP can't happen in isolation from state and territory funding stream. We want to look at the whole picture and make sure it's covering all the needs and is positioned to plan for future needs."
> **- State and Territory Peak**

[17]. Commonwealth of Australia. House of Representatives. (2025). *Issues paper relating to the health impacts of alcohol and other drugs in Australia*. Retrieved from https://parlinfo.aph.gov.au/parlInfo/download/committees/reportrep/RB000565/toc_pdf/IssuespaperrelatingtothehealthimpactsofalcoholandotherdrugsinAustralia.pdf
[18] Department of Health, Disability and Ageing. (2017). *National Drug Strategy 2017-2026*. Retrieved from https://www.health.gov.au/sites/default/files/national-drug-strategy-2017-2026.pdf.
[19] Commonwealth of Australia. House of Representatives. (2025). *Issues paper relating to the health impacts of alcohol and other drugs in Australia*. Retrieved from https://parlinfo.aph.gov.au/parlInfo/download/committees/reportrep/RB000565/toc_pdf/IssuespaperrelatingtothehealthimpactsofalcoholandotherdrugsinAustralia.pdf

The ANACAD was established in 2014 as the principal national expert advisory body to the Australian Government on alcohol and other drugs. The need for greater leadership and coordination across the AOD sector is a view supported by ANACAD. In their December 2024 report, ANACAD noted that AOD is a whole-of-government, whole-of-life matter that requires coordinated and collaborative effort across all governments and portfolios.[20] In their report, ANACAD identified several key principles for enhanced governance, including:

- Joint decision-making capacity
- Shared responsibility across jurisdictions and across portfolios
- Transparency and accountability
- Ability to deliver effective policy design (access to appropriate expertise)
- Reduction of duplication and waste through co-ordinated investment.

Similarly, a 2021 evaluation of the NIAS also recognised the value of strong strategic governance for the sector, recommending an expansion in central coordination for the remainder of the life of the strategy, for future programs delivered under NIAS and for similar strategies.[21]

The call for enhanced leadership and governance

The DAP program logic reflects the DAPs objective to 'support collaboration and coordination between the Australian Government, states and territories and providers' and makes it explicit that an assumption underpinning the logic is having appropriate leadership and governance arrangements in place. The logic also makes clear that cohesion between the Australian Government, states and territories and providers must be 'functional' for the DAP to reach its objectives.

In the past, the Ministerial Drug and Alcohol Forum (MDAF) not only endorsed the NDS but was responsible for monitoring and reporting to Council of Australian Government on progress against NDS activities, providing a joint vehicle for ministers across government (including law enforcement/justice and health portfolios) to consider emerging issues at jurisdictional and national level and to consider and recommend potential approaches or solutions. The MDAF membership included two ministers from each jurisdiction: one minister each for health/community services portfolio with AOD policy responsibilities and one minister from justice/law enforcement portfolios.[22] The MDAF was disbanded when the Council of Australian Government was dissolved in 2020.[23] In the MDAF's absence, the two key portfolio areas operate separately, with no formal avenue for regular focused collaboration, decision making and joint advice to government. The opportunity for consideration of AOD issues across both contexts, to address all three pillars of the NDS, is lost.

The key bodies currently engaged to provide advice and coordination on national AOD policy include ANACAD and the Alcohol Tobacco and Other Drugs policy officers group, the latter of which brings together key state and territory Alcohol Tobacco and Other Drugs policy officers. These groups provide complementary expert advice and guidance to the department. While these two groups play a vital role in advising on national AOD policy, stakeholders highlighted two key limitations.

First, while ANACAD provides direct advice to the Minister for Health and Ageing, neither group brings ministers from other areas of government to the table. This limits their ability to influence whole-of-government approaches to addressing the causes and harms of AOD. Second, while both groups are made up of highly respected AOD experts, there are opportunities to incorporate formal mechanisms or pathways for information exchange from a broader range of AOD sector representatives, including providers, peak agencies and LLE representatives.

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[20] Australian National Advisory Council on Alcohol and Other Drugs. (2024). *ANACAD Final Report*. Retrieved from https://www.health.gov.au/sites/default/files/2024-12/anacad-final-report-july-2023---december-2024.pdf

[21] Cash, R, Johnston, J, Bothwell, S, Clancy, B, Demant, L, & Lee, N. (2021). *Evaluation of the National Ice Action Strategy ('NIAS')*. 360 Edge. Retrieved from https://www.health.gov.au/resources/publications/evaluation-of-the-national-ice-action-strategy-nias?language=en.

[22] Department of Health, Disability and Ageing. (2016). *Ministerial Drug and Alcohol Forum Communiqué.* Retrieved from https://www.health.gov.au/sites/default/files/mdaf-communique-16-december-2016.pdf

[23] Parliament of Australia. (2021) *Public Communications Campaigns Targeting Drug and Substance Abuse, Chapter 1*. Retrieved from https://www.aph.gov.au/Parliamentary_Business/Committees/Joint/Law_Enforcement/CommsCampaignsDrugAbuse/Report/section?id=committees%2freportjnt%2f024398%2f75478; Queensland Government Department of the Premier and Cabinet. (2024). *Government relationships.* Retrieved from https://www.premiers.qld.gov.au/about-us/what-we-do/relationships.aspx

The Parliamentary Inquiry into the health impacts of alcohol and other drugs in Australia reported that multiple AOD sector bodies expressed the need for the re-establishment of a national governing body. This national governing body could oversee the implementation of a future iteration of the NDS, coordinate federal and state and territory-level AOD strategies and facilitate cross-sector collaboration.[24] Many reinforced the finding that this absence of national coordination impedes the ability of the sector to function at its full potential.

> "The abolition of the MDAF deprived the sector of the ability to act proactively in response to new issues such as, for example, vaping, the online sale and delivery of alcohol, emerging contaminants in the drug supply, or responses to opioid dependence treatment."
> **- Inquiry submission**

Through the evaluation, almost all stakeholders expressed a keen interest in being more connected to national level AOD strategy and having opportunities to influence or drive AOD policy using their unique insights as providers, peaks, advocates and researchers. In particular, providers noted that this involvement would give them a vehicle for contributing to future AOD sector strategies and ensure that programs such as the DAP align with these strategies. Stakeholders' advocacy for greater connection between policy makers, the service delivery sector and the DAP is also reflected in the National Health Reform Agreement (NHRA), which acknowledges the important role that private providers and community organisations play in delivering services. The Agreement also emphasises the need to continue to strengthen partnerships between government and these stakeholders.[25]

Shared responsibility

While there is a clear interest from DAP stakeholders to see the department enhance its leadership and coordination of the DAP and the broader AOD sector, there is also recognition that addressing AOD harms is not the sole responsibility of the Australian Government. The NDS calls for collaborative approaches to system planning which promote shared accountability across governments, providers, clients and the wider community. During consultations, all groups of stakeholders, including government and non-government stakeholders, expressed a strong willingness to share responsibility for the planning and delivery of AOD services through formal mechanisms.

Recent learnings from attempts to do this within the mental health and suicide prevention sector may be valuable in informing consideration of shared responsibility within the AOD space. The Productivity Commission Interim Report for the Mental Health and Suicide Prevention Agreement Review (June 2025) identified the following areas for improvement:

- The need for stronger accountability and greater transparency, including clear designation of roles and responsibilities for different levels of government. This can be supported by a governance framework.
- Meaningfully embedding people with LLE, their supporters, families, carers and kin in the governance arrangements and in the service design, planning, delivery and evaluation.
- Including dedicated funding for collaboration and joint commissioning of services.[26]

[24] Commonwealth of Australia. House of Representatives. (2025). *Issues paper relating to the health impacts of alcohol and other drugs in Australia*. Retrieved from https://parlinfo.aph.gov.au/parlInfo/download/committees/reportrep/RB000565/toc_pdf/IssuespaperrelatingtothehealthimpactsofalcoholandotherdrugsinAustralia.pdf
[25] Commonwealth of Australia. (2020). *Addendum to National Health Reform Agreement ('NHRA')*. Retrieved from https://federalfinancialrelations.gov.au/sites/federalfinancialrelations.gov.au/files/2021-07/NHRA_2020-25_Addendum_consolidated.pdf.
[26] Productivity Commission. (2025). *Mental Health and Suicide Prevention Agreement Review, Interim report, Overview.* Retrieved from https://www.pc.gov.au/inquiries/current/mental-health-review/interim

Embedding lived and living experience voice in governance

Through consultation, research organisations and peak bodies highlighted the need for meaningful engagement of LLE within DAP planning and governance, noting a current absence of LLE representation in current DAP structures. LLE peaks highlighted the desire to have a coordinated approach to creating opportunities for LLE advice to reframe DAP policy and support reduction of the stigma and discrimination associated with AOD use. They shared examples of doing this through various formats such as open forums and discussions with peaks across other sectors.

However, LLE peaks expressed that a cultural shift is required to achieve genuine engagement of LLE representatives in system planning. Specifically, there is a strong interest in developing a documented framework or guidance that defines the role of LLE in planning and best practice. An LLE framework or guidelines would provide a basis to evaluate and evidence the impacts of LLE on the DAP initiatives and outcomes. This also aligns with contemporary practice in the mental health and disability sectors, with LLE frameworks driving best practice.

This view is supported by literature. A review of frameworks to inform responses to substance use issues noted that the inclusion of people with LLE of substance use in planning and governance was essential to ensure that services and policies were relevant, respectful and grounded in the realities of those most affected by them.[27] In Australia, the National Mental Health and Suicide Prevention Evaluation Framework also refers to this.[28]

> "Lived experience voice is absent the whole way up and down and through, even though they are there and willing to contribute to bring that information to the forefront."
>
> **- State and Territory Peak**

Best practice example - National mental health lived experience peak bodies

The mental health sector has long recognised the benefits of embedding LLE into strategic decision making and policy. More recently, the Australian Government took this one step further, commissioning the co-design and delivery of two dedicated LLE peak bodies for the mental health sector – one for consumers and the other for families, carers and kin. These peak bodies will ensure people with LLE of mental ill-health can contribute to improving the mental health system and services.[29] They will play an integral role in ensuring future strategy and planning is genuinely informed by LLE.

[27] Wallace, B, MacKinnon, K, Strosher, H, Macevicius, C, Gordon, C, Raworth, R, Mesley, L, Shahram, S, Marcellus, L, Urbanoski & Pauly, B. (2021). *Equity-oriented frameworks to inform responses to opioid overdoses: a scoping review.* JBI Evidence Synthesis, 19(8), 1760-1843.
[28] Department of Health, Disability and Ageing. (2025). *National Mental Health and Suicide Prevention Evaluation Framework*. ARTD Consultants. Retrieved from https://www.health.gov.au/resources/publications/national-mental-health-and-suicide-prevention-evaluation-framework?language=en.
[29] Department of Health, Disability and Ageing. (2025). *National mental health lived experience peak bodies*. Retrieved from https://www.health.gov.au/topics/mental-health-and-suicide-prevention/what-were-doing-about-mental-health/national-mental-health-lived-experience-peak-bodies.

Best practice example - Blood Borne Viruses and Sexually Transmissible Infections Standing Committee (BBVSS)

The BBVSS is a key advisory body on social issues, programs and policies related to bloodborne viruses and sexually transmissible infections. It brings together members from the Australian Government, state and territory governments, New Zealand government, key expert organisations, peak bodies and national research centres. In doing so, the BBVSS includes LLE members from the Australian Injecting & Illicit Drug Users League, National Association of People with HIV Australia and the Scarlet Alliance, Australian Sex Workers Association. Inclusion of these LLE members in this forum with government, peaks and researchers raises the voice of LLE individuals when planning BBVSS policy.

Considerations for DAP sustainability

Improving the governance of the AOD sector through leadership and coordination

Stakeholders identified that a service system that is strongly driven by proven governance mechanisms and strategy can align service delivery with this strategy, ensuring services are meeting identified community needs. The department should consider establishing a national, sector inclusive governance structure with the ability to support integrated planning between tiers of government.

This governance framework could include opportunities for engagement across the whole sector, seeking input from government (the Australian Government, states and territories and local governments), providers, peaks, First Nations people and LLE representation. To ensure influence, the governance framework could also consider engagement at decision making levels, such as ministerial participation.

While the governance framework will enable shared responsibility across all stakeholders, it should be driven by the department policy team, solidifying their leadership role across the AOD sector. This may include supporting cross sector collaboration with DAP, driving national needs assessment and planning in collaboration with states and territories and building capability across the DAP sector, such as embedding LLE.

4.2.5 Australian Government leadership and investment in workforce capability and capacity building across the DAP has the potential to strengthen service implementation

The need for health services, including AOD services, to acknowledge and address the social determinants of health is well established. Promoting equitable access to care is essential and systems should address socioeconomic barriers such as poverty, education and healthcare disparities to ensure that harm reduction, prevention and treatment initiatives are available and accessible for underserved and historically marginalised populations.[30] Integrated, trauma informed and harm reduction-oriented care that addresses the social determinants of health has been found to be more effective in supporting people using AOD.[31] Functionally, this involves AOD services having the capacity and capability to also address co-occurring mental and physical health issues, social concerns such as housing and income and involvement with the criminal justice system.

Through consultation, stakeholders highlighted various opportunities to strengthen the capability and capacity of the DAP and broader AOD sector. This included investment by the Australian Government in funding capacity building initiatives through DAP, along with the provision of strong leadership from the Australian Government in addressing systemic barriers to capability and capacity of the sector.

Supporting workforce recruitment and retention

Stakeholders described a highly skilled and qualified workforce currently operating across DAP and consistently highlighted the value of a skilled AOD workforce in achieving DAP implementation objectives. They also noted several workforce challenges facing DAP providers, including:

- Recruitment of skilled staff in rural and remote locations.
- Limited bulk-billing General Practitioners (GPs) with experience in supporting people who use AOD.
- Shortage of Opioid Dependence Treatment Program prescribers.
- Staff turnover in the sector due to wage constraints, instability of employment and short contracts.
- Workforce capability challenges, particularly in treatment of co-occurring mental illness.
- Stigma and discrimination associated with engaging a peer workforce.

A number of these workforce challenges are systemic challenges that may be difficult for the department to influence. While stakeholders also acknowledged that these workforce challenges are not unique to the DAP or even the AOD sector, this evaluation points to an opportunity for renewed investment in workforce capacity and capability building.

All stakeholders emphasised the important opportunity for the Australian Government to address wage constraints and role uncertainty through review of the grant agreement processes. Providers noted the importance of building a DAP sector which demonstrates innovation and excellence, to attract a skilled AOD workforce. Attracting a skilled and qualified workforce is difficult for many DAP services who report that funding constraints hamper their ability to compete with state and territory government health services, who reportedly offer more appealing employment benefits. Withdrawal providers specifically highlighted this workforce challenge, with staffing shortages impacting their ability to fully deploy withdrawal services. Further detail on workforce considerations and opportunities to improve the efficiency of DAP services through sustainable funding arrangements is provided in Section 4.5.5.

[30] Voss, M, W, Smid, M,C, Herrick, J,C, Cleveland, A, Komen, A, V, Johanson, J, Huntington, M. (2025). *A Scoping Review of Community Harm Reduction Strategies for Maternal and Fetal Opioid Impacts: Implications for Policy*. Substance Use & Addiction Journal, 46(3), 722-734.

[31] Henderson, R, McInnes, A, Mackey, L, Head, M, B, Crowshoe, L, Hann, J, Hayward, J, Holroyd, B, R, Lang, E, Larson, B, Leonard, A, J, Persaud, S, Raghavji, K, Sarin, C, Virani, H, Wadsworth, I, W, Whitman, S, & McLane, P. (2021). *Opioid use disorder treatment disruptions during the early COVID-19 pandemic and other emergent disasters: a scoping review addressing dual public health emergencies.* BMC Public Health, 21(1), 1471-1479; Blais, E, Brisson, J, Gagnon, F, & Lemay, S. (2022). *Diverting people who use drugs from the criminal justice system: a systematic review of police-based diversion measures.* International Journal of Drug Policy, 105(4); Bhuvan, K, C, Alrasheedy, A, A, Ibrahim, M, I, M, Paudyal, V, Christopher, C, M, Shrestha, S, & Shrestha, S. (2024). *Combatting opioid misuse, overuse and abuse: a systematic review of pharmacists' services and outcomes.* Pain Management, 14(9), 519-529.

Providers also expressed the value of offering longer term contracts which provide more job certainty to the DAP workforce and their employers. It suggested that this would have flow on effects for service outcomes that result from retention of more experienced staff.

Rural and remote providers stressed the need for grant arrangements to recognise the unique workforce barriers experienced in regional Australia, with thin labour markets. For example, chronic shortages of opioid dependence treatment prescribers in Australia, particularly in regional areas, restricts availability of maintenance therapies, which then creates pressure on other forms of support, which may not always be the best option for the person and can lead to relapse or early exit from care.

> "There are 4 million+ people using drugs – the investment needs to reflect that. The sector needs more investment for workforce and for programs to do the work they are good at. Every cent invested in programs saves money and changes lives."
> **- Peak Organisation**

Enhancing integration through training and system development

Co-located, wraparound services that integrate supports for other areas of need were identified as foundational to quality of care and success.[32] Integrative and multidisciplinary care models can also enhance engagement with treatment, particularly in remote settings where services are constrained, but must be adequately resourced.[33] It is recognised that supporting an individual's relationship with AOD does not happen in isolation from other social determinants of health and providers are increasingly needing to adapt their services to better support clients with multi-dimensional needs. The most recent national AOD workforce survey revealed that more than 60% of AOD workers seek additional training to address clients with co-occurring mental health needs.[34]

Training and workforce development were repeatedly highlighted by stakeholders as an important component for enabling and improving AOD intervention delivery. Integration across other sectors may also involve upskilling of other-discipline staff such as GPs, mental health staff, corrections and social workers to identify AOD issues.[35] This has proven successful for emergency department clinicians, pharmacists and social workers.[36] Similarly, upskilling of the AOD workforce to identify and respond to multiple social and health concerns is required. Inter-professional education also provides opportunities to develop collaborative referral or care pathways to facilitate access to the range of supports required. Involvement of other professions in identifying AOD needs allows for opportunistic engagement of people who may otherwise not seek specialist AOD treatment.[37] The existing Comorbidity Guidelines funded through DAP provide an example of this in practice.

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[32] Lyall, V, Wolfson, L, Reid, N, Poole, N, Moritz, K, M, Egert, S, Browne, A, J, & Askew, D, A. (2021). *"The Problem Is that We Hear a Bit of Everything…": A Qualitative Systematic Review of Factors Associated with Alcohol Use, Reduction, and Abstinence in Pregnancy.* International Journal of Environmental Research and Public Health, 18(7); Puzhko, S, Eisenberg, M, J, Filion, K, B, Windle, S, B, Hébert-Losier, A, Gore, G, Paraskevopoulos, E, Martel, M, O, & Kudrina, I. (2022). *Effectiveness of Interventions for Prevention of Common Infections Among Opioid Users: A Systematic Review of Systematic Reviews.* Frontiers in Public Health, 10.

[33] Hoppe, D, Ristevski, E, & Khalil, H. (2020). *The attitudes and practice strategies of community pharmacists towards drug misuse management: A scoping review.* Journal of Clinical Pharmacy and Therapeutics, 45(3), 430-452; Bhuvan, K, C, Alrasheedy, A, A, Ibrahim, M, I, M, Paudyal, V, Christopher, C, M, Shrestha, S, & Shrestha, S. (2024). *Combatting opioid misuse, overuse and abuse: a systematic review of pharmacists' services and outcomes.* Pain Management, 14(9), 519-529; Chen, Y, Wang, Y, Nielsen, S, Kuhn, L, & Lam, T. (2020). *A systematic review of opioid overdose interventions delivered within emergency departments.* Drug and Alcohol Dependence, 213.

[34] Commonwealth of Australia. House of Representatives. (2025*). Issues paper relating to the health impacts of alcohol and other drugs in Australia*. Retrieved from https://parlinfo.aph.gov.au/parlInfo/download/committees/reportrep/RB000565/toc_pdf/IssuespaperrelatingtothehealthimpactsofalcoholandotherdrugsinAustralia.pdf

[35] Blais, E, Brisson, J, Gagnon, F, & Lemay, S. (2022). *Diverting people who use drugs from the criminal justice system: a systematic review of police-based diversion measures.* International Journal of Drug Policy, 105(4); Henderson, R, I, McInnes, A, Mackey, L, Head, M, B, Crowshoe, L, Hann, J, Hayward, J, Holroyd, B, R, Lang, E, Larson, B, Leonard, A, J, Persaud, S, Raghavji, K, Sarin, C, Virani, H, Wadsworth, I, W, Whitman, S, & McLane, P. (2021). *Opioid use disorder treatment disruptions during the early COVID-19 pandemic and other emergent disasters: a scoping review addressing dual public health emergencies.* BMC Public Health, 21(2), 1471-1479.

[36] Gugala, E, Briggs, O, Moczygemba, L, R, Brown, C, M, & Hill, L, G. (2022). *Opioid harm reduction: A scoping review of physician and system-level gaps in knowledge, education, and practice.* Substance Abuse, 43(1), 972-987; Drake, E, Patha, S, Rivera, K, & Jimenez, R, A, Lozano, A, Johnson, K, Crockett, K, B, Zapata, I, Henderson, M, & Zhong, Q. (2025). *Integrating Training in Opioid Overdose Response in Medical Schools' Curricula: A Systematic Review.* Medical Science Educator, 35(1), 541-553; Hoppe, D, Ristevski, E, & Khalil, H. (2020). *The attitudes and practice strategies of community pharmacists towards drug misuse management: A scoping review*. Journal of Clinical Pharmacy and Therapeutics, 45(3), 430-452.

[37] Voss, M, W, Smid, M, C, Herrick, J, C, Cleveland, A, Komen, A, V, Johanson, J, & Huntington, M. (2025). *A Scoping Review of Community Harm Reduction Strategies for Maternal and Fetal Opioid Impacts: Implications for Policy.* Substance Use & Addiction Journal, 46(3), 722-734; Hoppe, D, Ristevski, E, & Khalil, H.

Several recent reviews noted the need for this to be led through policy and system-level governance. A number highlighted the need for policies that expand system-level support by endorsing comprehensive care models that integrate medical, social and community services. This includes cross-sector coordination and improved access to adjunct services such as childcare and transportation, as well as substance use treatment.

Policy recommendations to support integration also emphasise workforce training, inter-agency collaboration, expanded service access and reforms like universal screening and updated insurance protocols. The need for legislative and structural support to resource AOD initiatives and reduce systemic barriers was also underscored.[38]

Enhancing knowledge sharing

DAP services are currently managed through either the DSS Grants Hub or commissioned through individual PHNs. Stakeholders noted advantages and disadvantages with these approaches. From a governance perspective, while providers generally reported constructive working relationships with DSS and PHNs, providers suggested that they would benefit from more connection points with the department's policy team. They particularly noted that this desire is amplified when contract managers (DSS or PHNs) have limited AOD sector knowledge and expertise. Providers shared that greater connection with the department's policy team would expedite sharing of knowledge and support informed DAP policy planning.

Consultations highlighted that information exchange is further complicated as it extends to the governance arrangements between providers and PHNs within the DAP. Stakeholders again expressed that mechanisms that brings these stakeholders together would help to enable provider involvement with insight into high-level AOD strategy. While stakeholders acknowledge the efforts made by the department to support knowledge sharing, particularly through DAP funding for peaks, they expressed that more knowledge sharing opportunities were vital to ensuring DAP funding is addressing emerging needs and is aligned with best practice.

> "There is currently information sitting in lots of different places so just information sharing among people can create efficiencies."
> **- Government Representatives**

> "I think it's really important there are more governance structures that allow greater dialogue between government and states and territories and structures to plan and share information."
> **- Provider**

When considering these insights in the context of DAP leadership and information sharing, it is important to note that there are 319 providers across the DAP. It may be unreasonable to expect each of these providers to be engaged directly with the department or at ministerial levels on a regular basis. However, mechanisms that bring together provider representatives, beyond only peak organisations, will add value.

(2020). *The attitudes and practice strategies of community pharmacists towards drug misuse management: A scoping review.* Journal of Clinical Pharmacy and Therapeutics, 45(3), 430-452; Bhuvan, K, C, Alrasheedy, A, A, Ibrahim, M, I, M, Paudyal, V, Christopher, C, M, Shrestha, S, & Shrestha, S. (2024). *Combatting opioid misuse, overuse and abuse: a systematic review of pharmacists' services and outcomes.* Pain Management, 14(9), 519-529; Chen, Y, Wang, Y, Nielsen, S, Kuhn, L, & Lam, T. (2020). *A systematic review of opioid overdose interventions delivered within emergency departments.* Drug and Alcohol Dependence, 213.

[38] Crowther, D, Curran, J, Somerville, M, Sinclair, D, Wozney, L, MacPhee, S, Rose, A, E, Boulos, K, & Caudrella, A. (2023). *Harm reduction strategies in acute care for people who use alcohol and/or drugs: A scoping review.* PLoS One, 18(12); de Ternay, J, Leblanc, P, Michel, P, Benyamina, A, Naassila, M, & Rolland, B. (2022). *One-month alcohol abstinence national campaigns: a scoping review of the harm reduction benefits.* Harm Reduction Journal, 19(1), 24-26; Rose, C, G., Kulbokas, V, Carkovic, E, Lee, T, A, & Pickard, A, S. (2023). *Contextual factors affecting the implementation of drug checking for harm reduction: a scoping literature review from a North American perspective.* Harm Reduction Journal, 20(1), 124-127; Grella, C, E, Ostlie, E, Scott, C, K, Dennis, M, L, Carnevale, J, & Watson, D, P. (2021). *A scoping review of factors that influence opioid overdose prevention for justice-involved populations.* Substance Abuse Treatment, Prevention, and Policy, 16(1), 19-21; Gugala, E, Briggs, O, Moczygemba, L, R, Brown, C, M, & Hill, L, G. (2022). *Opioid harm reduction: A scoping review of physician and system-level gaps in knowledge, education, and practice.* Substance Abuse, 43(1), 972-987.

There are various mechanisms in which knowledge sharing and best practice can be enhanced across DAP. Some examples for consideration include:

- Collaborating with researchers to design and develop KPIs and reporting measures.
- Enhancing the current service offering of peaks, in supporting enhanced sector capacity to ensure the national consistency for promotion of approaches to treatment and workforce development.[39] This may involve leveraging existing mechanisms such as peak conferences and PHN collaborations as mechanisms for the department to engage with more DAP providers.
- Creating communities of practice which bring together providers to build expertise collectively.
- Developing formal governance mechanisms that enable influence at all levels of government and community.
- Creating regular forums for providers and peaks to connect with key funders and decision makers to share emerging trends and collectively problem solve.
- Supporting training opportunities for DAP service providers' staff as well as parallel sectors to support cross-sector collaboration. This may involve cross training programs which allow the workforces to learn from each other.
- Leveraging digital technology to connect stakeholders.
- Implementing informal learning such as mentoring and peer-to-peer learning.

CASE STUDY - PHN case study – Creating a forum for community-level collaboration and capacity building

As part of consultation with a PHN, representatives described the Community of Practice that currently exists within their region and its contribution to building a collaborative environment for those delivering AOD services. The Community of Practice is co-sponsored by the PHN and Local Health District and includes providers of AOD services in the region. Representatives shared that the value of the group is in the network it facilitates between providers and the forum it creates for sharing information and upskilling across those providers in non-government and primary care environments. Providers can work closely with representatives from the PHN and Local Health District to coordinate responses to identified local priorities. Providers also get to know other providers working within the region and increase their ability to link clients with other providers to best support their needs. The Community of Practice allows providers to share examples of what is working well across different program types and support the training and development that underlie them.

The forum enhances integration between providers, the PHN and Local Health District to best address emerging trends in a collaborative and coordinated manner. It represents the potential role of system-level governance in supporting development and upskilling within the sector and across integrated services on a smaller scale.

[39] McDonald, D, & Stirling, R. (2019). *Evaluating the capacity building roles of the state and territory peak bodies in the Australian alcohol and other drug sector.* Evaluation Journal of Australasia, 19(1), 39-48.

In addition to implementing mechanisms for information sharing, stakeholders also stressed utility of more broadly promoting capability uplift as part of DAP grants. There may be benefit in applying approaches to enhance integration across other areas, such as justice and social services. Past Australian Government funded initiatives such as Improved Services for Dual Diagnosis (Mental Health and AOD) (2007-2010) and Amphetamine-Type Stimulants Grants Program (2008-2011), supported organisational capacity building and workforce upskilling. There is an interest from providers in continued and increased investment in programs of this nature that prioritise capability building.

Considerations for DAP sustainability

Building partnerships between the department, PHNs, state and territory governments and the AOD sector

Stakeholders expressed interest in more knowledge sharing across the DAP sector, supported by the department. Greater collaboration and information sharing was noted as creating opportunities for providers to share lessons learned, learn about how to incorporate innovation and improve awareness of best practice examples and evidence.

Improving partnerships and collaboration within the sector further supports in creating a systemised and strategic approach to future funding planning and delivery and supports in strengthening the governance between the Australian Government, state and territory governments and providers. This may include a mix of more localised approaches to support operationally focused information sharing, alongside national mechanisms designed to inform higher-level policy planning.

Building the lived and living experience workforce

Stakeholders repeated raised the stigma of AOD use as a systemic challenge for DAP services. In stakeholders' view, this stigma is evident as underfunding of the sector. This limits the sectors' capacity to support people who use AOD and reinforces negative perceptions about them. Stakeholders were clear that AOD use is a national priority, which needs to be backed by ongoing government investment that strengthens the sector.

> "Working in the AOD sector seems to have a stigma or 'guilt by association' that doesn't seem to happen in other sectors like mental health services."
> **- PHN**

Stakeholders also described the impacts of stigma on workforce recruitment and retention. The LLE peaks commented that the existing policy systems sustain existing stigma and can facilitate harm for individuals with AOD issues. They emphasised the need to reframe AOD policy from the perspective of reducing existing stigma and discrimination, beginning with a robust and endorsed peer workforce strategy.

The evidence demonstrates that embedding peer workforce into the DAP service system will facilitate engagement with service users and improve service outcomes. For example, providers acknowledged that for individuals, existing stigma decreased health seeking behaviours when it comes to an individual's AOD use. It was suggested that peer workforce models for entry and intake services would go a long way to addressing this.

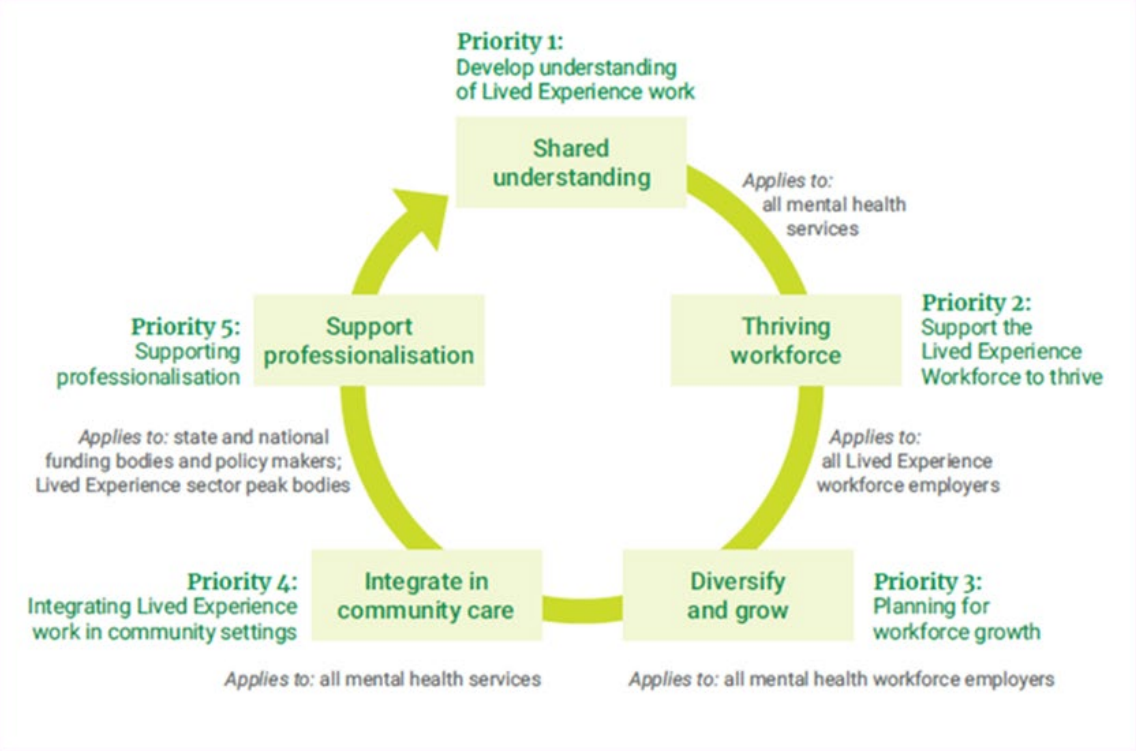
The inclusion and support of peer workers in service delivery is emphasised as critical throughout the literature. Peer workforce models have the potential to reduce systemic stigma, improve engagement and enhance client outcomes. Reviews found that to maximise their contributions, peer roles must be formally integrated into organisational structures with dedicated training, supervision, mentorship and equitable pay. They also recommended recognising peer work as a billable, core part of service delivery. Without structural integration, there

is a risk of the peer workforce being tokenised or underutilised.[40] LLE peaks referenced the mental health sector as an example of a peer workforce forging forward and creating impact.

Best Practice Example - National Lived Experience (Peer) Workforce Development Guidelines

In 2021 the National Mental Health Commission released the National Lived Experience Workforce Development Guidelines as an action under the Fifth National Mental Health and Suicide Prevention Plan. The Guidelines aim to improve understanding of the benefits of peer workers across the mental health sector. They are intended to provide a roadmap for decision makers, employers and funding bodies to establish policies and practices that support a sustainable peer workforce, as per Figure 8.[41]

Figure 8 National Lived Experience Workforce Development Guidelines – priorities for lived experience workforce development



Source: National Lived Experience (Peer) Workforce Development Guidelines

In addition to promoting recovery-oriented practice and enhancing return on investment, the guidelines anticipate multiple service user benefits, including:

- Improved engagement and retention in treatment
- Reduction in critical incidents or restrictive practices
- Improved self-management
- Reduced need for re-admission or acute care.

[40] Chen, Y, Yuan, Y, & Reed, B, G. (2023). *Experiences of peer work in drug use service settings: A systematic review of qualitative evidence.* International Journal of Drug Policy, 120(4); Lavilla-Gracia, M, Pueyo-Garrigues, M, Pueyo-Garrigues, S, Paradavila-Belio, M, I, Canga-Armayor, A, Esandi, N, Alfaro-Diaz, C, & Canga-Armayor, N. (2022). *Peer-led interventions to reduce alcohol consumption in college students: A scoping review.* Health and Social Care in the Community, 30(6), 3562-3578.

[41] National Mental Health Commission. (2023). *National Lived Experience (Peer) Workforce Development Guidelines, A shared agenda for change*. Retrieved from https://www.mentalhealthcommission.gov.au/lived-experience/lived-experience-workforces/peer-experience-workforce-guidelines/national-lived-experience-%28peer%29-workforce-develop/a-shared-agenda-for-change.

Considerations for DAP sustainability

Building the future workforce will support the delivery of AOD funding and improve service integration

Stakeholders emphasised the opportunity to develop future DAP workforce planning and policy in line with contemporary health care reform. With a focus on embedding a peer workforce, enhancing capacity through recruitment and retention and developing skills to support co-occurring needs, targeted workforce planning has the potential to create opportunities to improve DAP service delivery and promote service integration.

Stakeholders also noted the opportunity to include cross-sector development as a key component of any future workforce planning. One example provided was standardising training and programs to support GPs in assessing and managing harmful AOD use and referring to specialist services. While this is already occurring at a local level, standardising resources and programs that could be applied nationally will enhance the reach. Such cross-sector investment may help to address the changing complexities in client needs, including the increasing presentations of co-occurring needs. Increasing the capacity of non-AOD services in treating and supporting AOD clients will further enable the AOD sector to focus on providing targeted AOD treatment and support to those who need it most. It is important to caveat that any future investment in this should be through additional funding and not through a redistribution of existing DAP funding.

Embedding peer workforce into DAP

Professional organisations highlighted that “without LLE voices at the table we won’t know where we’re falling short in the experience of individuals with the AOD sector.” The need for more engagement of LLE across DAP planning and delivery was consistently voiced throughout the evaluation. It is also supported by literature demonstrating the impact of the peer workforce on client outcomes. There are opportunities to enhance the engagement of a peer workforce across DAP.

4.2.6 Implementation recommendations

Within the implementation domain a broad set of considerations and findings were identified. Acting on these considerations and findings will require collaborative effort by governments, providers and the broader sector. The key considerations are summarised below:

- Develop and utilise improved documentation and guidance to support DAP implementation.
- Update DAP GOGs to directly align with the NDS and its relevant sub-strategies.
- Improve the governance of the AOD sector through leadership and coordination.
- Build the future workforce to support the delivery of AOD funding and improve service integration.
- Embed peer workforce into DAP.

The considerations and findings give rise to one recommendation that is directly within the control of the department.

Table 10 Implementation Recommendations

#	Recommendation
1	**Update DAP GOGs to strengthen alignment with a refreshed national AOD strategy.** Updated GOGs should set out that the clear link between DAP initiatives and the achievement of the Strategy. Consideration should be given to how this alignment can be measured for monitoring and evaluation. This should include establishing KPIs which measure the contribution of individual initiatives in supporting the achievement of the strategy. **Implementation considerations** Implementation of this recommendation is dependent on the finalisation of a refreshed NDS. However, for the DAP contracts which are due to expire in June 2026, the department may consider whether action can commence to more closely align GOGs to the current NDS. **Timing** – Short to medium term (1 to 3 years). **Responsible Parties** – Australian Government and the Department of Health, Disability and Ageing.

Source: Evaluation Team

4.3 Appropriateness

This section assesses whether the DAP is the right response to the identified needs and priorities of the target populations. It describes trends emerging in the Australian AOD landscape and considers best-practice and evidence-based service delivery. Analysis of the funded services, including their location, service category and targeted populations, is fundamental to understanding appropriateness. The sub-KEQs explored when evaluating the DAP appropriateness include:

- Are the funded activities the appropriate response based on current data, research, societal and emerging trends, state and territory services, and evidence?
- Based on current needs and available evidence, is there an appropriate balance between funded prevention and treatment services?
- How do the funded programs complement or synergise with existing jurisdictional services?
- To what extent are DAP funded programs delivered in a way which is appropriate for specific priority groups, as identified in the National Drug Strategy (First Nations, CALD, LGBTIQ+, older persons, youth, people with mental health conditions, people in contact with the criminal justice system)?
- Are there any examples of services that might be considered as models of future approaches to commissioning?

When considering the appropriateness of DAP investment, the evaluation sought to understand if the program offers a range of modality options, in a range of geographic areas, at low/manageable cost for people with the socio-economic challenges that commonly accompany dependence and with measures in place to minimise the stigma that prevents people from accessing supports they need.

4.3.1 Findings

Services funded through the DAP provide coverage across various locations, service categories and priority populations. When considering the role that the DAP initiatives play alongside other AOD initiatives funded from other bodies within the sector, including states and territories, duplication was not identified as a critical issue. However, there is an opportunity to better clarify roles and responsibilities across DAP and the broader AOD sector, to reduce potential overlap and support enhanced system planning.

More collaborative relationships between the Australian Government, states and territories, PHNs and providers are an enabler to delivering localised and adaptable responses through DAP.

Key findings in the appropriateness domain include:

- The need for DAP services is continually growing and clients are presenting with increasingly complex needs.
- DAP initiatives target various priority populations with opportunities to enhance support for people with co-occurring needs and groups with emerging needs.
- DAP service delivery models can learn from best practice and evidence-based approaches.
- DAP services exist alongside AOD funding from other funding bodies within the sector, presenting an opportunity to clarify and define key roles. Duplication was not identified as a critical issue.
- More collaborative relationships between the Australian Government, states and territories, PHNs and providers is an enabler to delivering localised and adaptable responses through DAP.

Strength of evidence – Sufficient

Evidence to assess appropriateness of the DAP drew on service mapping information, including program information provided in grant agreements, activity workplans and performance reporting. These sources were triangulated with evidence on best practice identified through the literature review and complemented with stakeholder consultations and analysis of sector inquiries.

4.3.2 The need for DAP services is continually growing and clients are presenting with increasingly complex needs

Insights from sector-wide research and policy documents, alongside consultations with a selection of DAP providers, highlighted two trends characterising the contemporary Australia AOD landscape: a growing demand for treatment services and increasing complexity of clients' needs.

Responding to growing demand for services

Demand for AOD services in Australia continues to surpass supply, a shortfall that has changed very little in the decade over which the DAP has been delivered. In 2023, 198,731 Australians were estimated to be receiving treatment for AOD use issues. The estimated unmet demand for AOD treatment services (which includes people who need and would seek treatment) was between 207,966 and 469,767 people.[42] Similar research completed over 10 years prior found almost the same estimations, with approximately 200,000 people receiving treatment in a year and an additional 200,000 to 500,000 people in unmet demand.[43]

Stakeholders across the continuum of AOD supports were clear that additional investment is required to meet the need. Both prevention and treatment service providers described increasing unmet demand. An analysis of DAP 2023-24 performance reports shows substantial variation in wait times across the 51 withdrawal and treatment providers required to report against wait times.[44] More than half (55.8%) of clients waited between zero and four weeks, while 66% reported zero to six week waits and 4% reported two to eight weeks waits. This overlapping date ranges makes it difficult to fully monitor DAP wait times. The department should provide clearer guidance to providers on reporting to a consistent set of wait periods so that data is comparable for future monitoring. It is also important to note that many people reaching out for AOD support will not register for a wait list. Hence, reported wait times likely underestimate the true demand.

> "There needs to be more early intervention/prevention stopping people from presenting acutely unwell. We see high use of AOD in regions."
> **- PHN**

DAP coverage across the spectrum of care

The issues experienced by people who use AOD can vary greatly in terms of nature, complexity and severity, meaning access to a range of initiatives, intensities and modalities is essential to meet an individual where they are at in their journey.

Spread of DAP service types

The evaluation categorised the types of supports and services funded by DAP into eight categories. These are consistent with the NDS, World Health Organization guidance and the Australian AOD Treatment Framework.

- **Whole of community information and education** – including provision of resources and programs which aim to prevent or delay the uptake of AOD use, reduce misuse and support recovery. This may include, for example, school and family-based education programs, mass media campaigns, internet campaigns and information clearinghouses.
- **Prevention** – including targeted prevention programs for at risk groups which aim to prevent or delay the uptake of AOD use, reduce misuse and support recovery. This may include, for example, assessment and brief intervention programs, screening in brief intervention settings, motivational interviewing, digital programs and apps and school and family-based programs.

[42] Ritter, A, & O'Reilly, K. (2025). *Unmet treatment need: The size of the gap for alcohol and other drugs in Australia.* Drug and Alcohol Review, 44(3), 772-782.
[43] Ritter, A, Berends, L, Chalmers, J, Hull, P, Lancaster, K, & Gomez, M. (2014). *New Horizons: The Review of Alcohol and Other Drug Treatment Services in Australia*. National Drug and Alcohol Research Centre. Retrieved from https://www.health.gov.au/sites/default/files/new-horizons-review-of-alcohol-and-other-drug-treatment-services_0.pdf.
[44] Of the 51 providers required to report against wait times, 47 were providers of withdrawal management/treatment services (92.2%) and four were providers in the Areas of Identified Need Stream (7.8%).

- **FASD** – includes FASD specific programs which aim to reduce the risk of FASD and reduce ongoing harms. This may include information and resource sharing, prevention and screening programs and support programs for individuals and family.
- **Harm reduction** – focuses on reducing the harms and risks that individuals, families and communities are exposed to relating to AOD. This may include community based outreach, harm reduction interventions (e.g., needle and syringe programs, drug checking services, medically supervised injecting centres, blood borne virus testing and treatment etc) and overdose identification and management.
- **Withdrawal services** – also known as detox, includes provision of supervision and management whilst an individual reduces or ceases their AOD use. Withdrawal services can be delivered in residential and hospital settings, or through home based withdrawal services. Withdrawal support can include medication-assisted treatment (including pharmacotherapy) and supervision and may also incorporate counselling or case management support.
- **Treatment services** – include support to cease, reduce or manage an individual's harmful AOD use and continued recovery. This includes a range of intensities according to need and can be delivered in residential settings, clinics or as outreach into communities. Examples may include counselling, case management, pharmacotherapy treatments and therapeutic communities.
- **Post treatment support services** – aim to support an individual's continued recovery, including support to maintain cessation or less harmful use. This may include pharmacotherapy (e.g., opioid agonist therapy), counselling, case management, contingency management, peer recovery coaching and refusal skills training.
- **Capability and capacity building –** including the development of skills, knowledge, resources and abilities of the AOD sector and parallel sectors, to support good practice delivery. This may include workforce training, education and resource distribution.

Figure 9 below illustrates the breakdown of these service categories being delivered across DAP direct funded grants and PHN commissioned grants in the period 2021-22 to 2024-25, respectively. The PHN data used to inform this graph was self-reported while the data for direct funded DAP initiatives was derived from review of DAP grant agreements. As such, there may be some variation in how services have been defined.

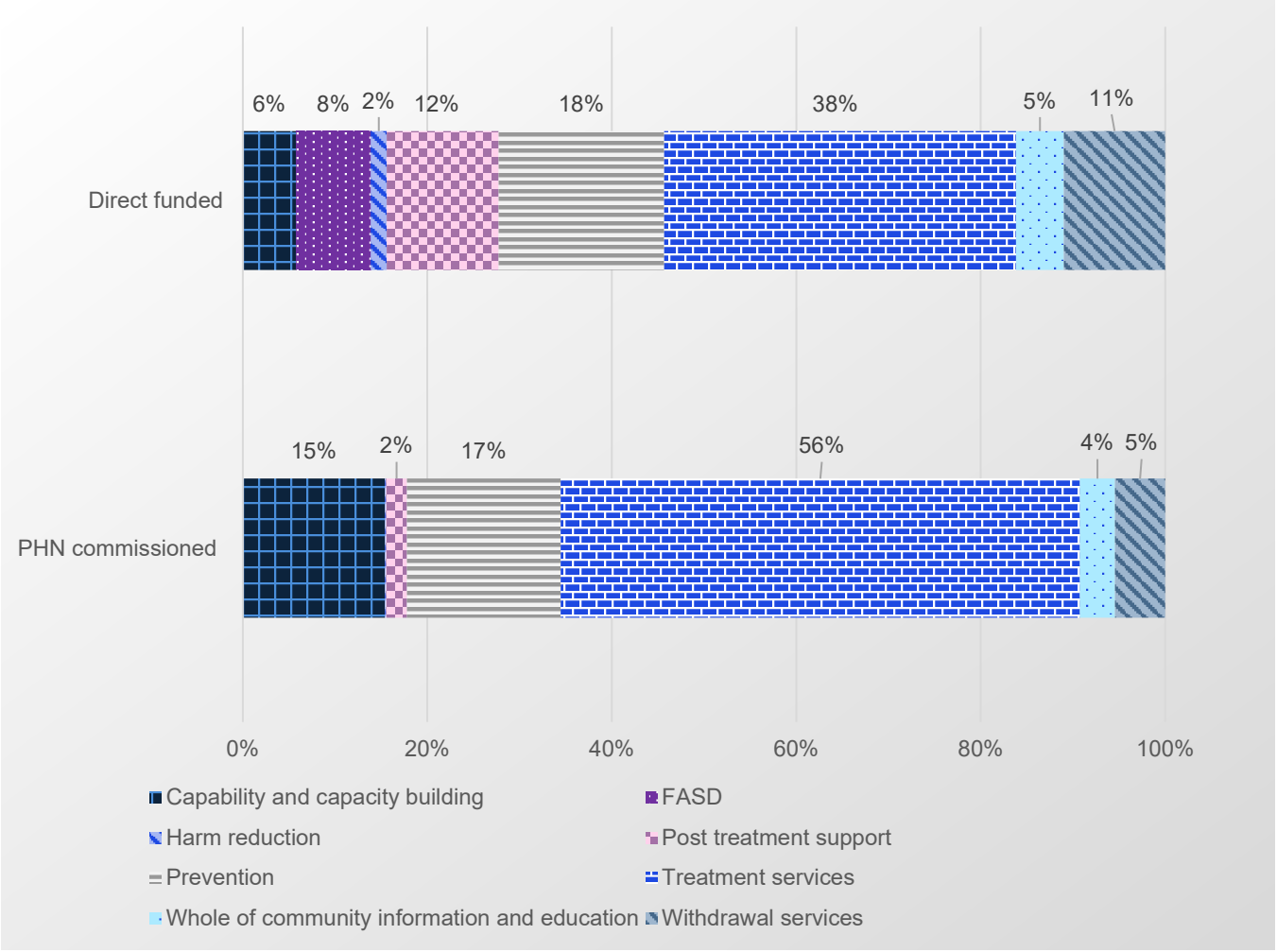
Direct funded and PHN commissioned grants together comprise the DAP service delivery landscape and illustrate a broad prevention and treatment system. Treatment services represent the largest share of services, at over half (56%) of PHN commissioned services and 38% of direct funded services. Prevention services, including information and education and FASD specific services, represent a greater proportion of initiatives across direct funded grants (31%) than in PHN-commissioned grants (20%). This reflects the broader, national scale that is typical of prevention activities.

PHNs appear to target prevention programs (17%), treatment services (56%) and capability and capacity building initiatives (15%). While the direct funded initiatives appear to have a greater spread across the various categories, with treatment services being the most commissioned grants (38%), followed by prevention programs (18%), post-treatment support (12%) and withdrawal services (11%). This aligns with evidence which suggests that withdrawal and post treatment supports, such as maintenance and contingency management programs, complement an individual's engagement with treatment services and increase the positive health and social outcomes.[45]

[45] Brooks, H, L, Kassam, S, Salvalaggio, G, & Hyshka, E. (2018*). Implementing managed alcohol programs in hospital settings: A review of academic and grey literature.* Drug Alcohol Review, 37(1), 145-155; Leidl, D, Takhar, P, & Li, H. (2023). *Prescription psychostimulants as a harm reduction and treatment intervention for methamphetamine use disorder and the implications for nursing clinical practice: A scoping review of the literature.* International Journal of Mental Health Nursing, 32(5), 1225-1242.

Capability and capacity building services represent a larger proportion of service categories delivered (15%) in PHN commissioned grants as compared to direct funded grants (7%). However, this difference may reflect that at the national and state and territory level, capacity and capability building largely occurs through funding to peak bodies, which is out of scope for this evaluation.

Figure 9 Percentage of DAP grant agreements aligned to service types in the period 2021-22 to 2024-25



Source: Grant performance reporting and PHN Funding Summary spreadsheet

Whilst there is variance between the focus of the two commissioning processes, Figure 9 highlights that overall, the department and PHNs are commissioning similar types of initiatives. There may be opportunities to explore where efficiencies may be gained from greater differentiation between the two commissioning processes, potentially reducing duplication in commissioning and contract management processes.

Notably, harm reduction and information and education programs make up smaller proportions of the DAP grants across both PHNs and direct funded initiatives. Harm reduction mechanisms such as needle and syringe programs, drug checking and supervised consumption are critical components of the system, particularly as a means of engaging those not inclined or able to take up structured treatment and support options.[46]

[46] Kennedy, M, C, Karamouzian, M, & Kerr, T. (2017). *Public Health and Public Order Outcomes Associated with Supervised Drug Consumption Facilities: a Systematic Review.* Current HIV/AIDS Reports, 14(5), 161-183; Giulini, F, Keenan, E, Killeen, N, & Ivers, J. (2023). *A Systematized Review of Drug-checking and Related Considerations for Implementation as A Harm Reduction Intervention.* Journal of Psychoactive Drugs, 55(1), 85-93; Sawangjit, R, Khan, T, M, & Chaiyakunapruk, N. (2017). *Effectiveness of pharmacy-based needle/syringe exchange programme for people who inject drugs: a systematic review and meta-analysis.* Addiction, 112(2), 236-247.

Lived and living experience perspectives - Opportunities to increase harm reduction initiatives

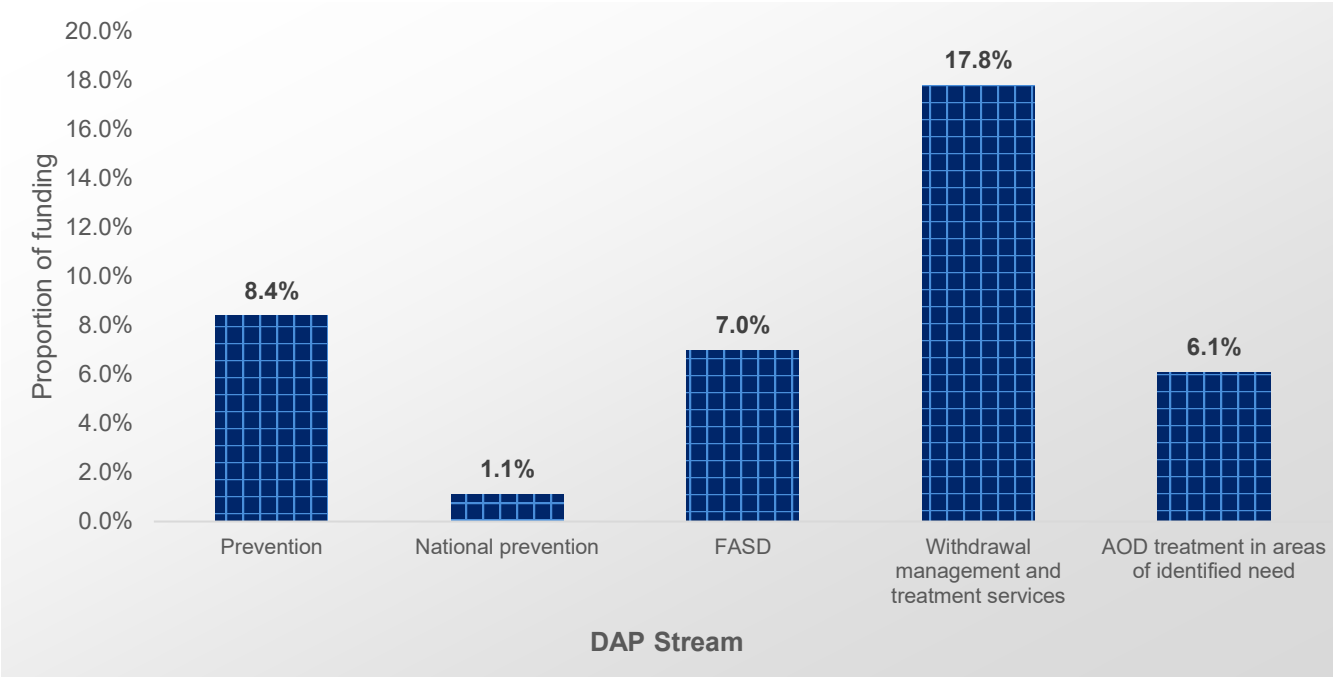
A range of stakeholders commented on the potential to include a greater focus on incorporating harm reduction and peer support services within DAP funding. Both LLE peaks and research organisations acknowledged there is lack of focus on funding harm reduction and peer support models of care within the DAP, despite it being one of the three pillars within the NDS and the "sector currently recognising the importance of lived experience." Including people with lived experience throughout the AOD service delivery landscape ensures individuals feel connected and supported through each phase of their journey in a way that cannot be achieved without having experienced it themselves.

Some PHNs and providers who have incorporated elements of harm reduction and peer support services shared the value they have seen within these services. It was suggested that increased harm reduction earlier on in an individual's journey alleviates the capacity pressures placed on services later on in the treatment system by making sure the "need does not become an emergency". Stakeholders expressed interest in new and emerging approaches to harm reduction which show promise and have potential for application in the DAP context.

DAP funding

It is equally important to consider the distribution of funding across DAP when considering its appropriateness. Figure 10 provides a summary of the funding across DAP streams. For the purpose of this comparison, PHN funding has been removed as it covers a mixture of service types. Figure 10 demonstrates that, as with grants distribution, direct DAP funding investment clearly prioritises withdrawal management and treatment services and treatment services in areas of identified need (23.9% collectively). In comparison, the prevention streams equate to 9.5% of overall DAP funding and FASD an additional 7.0%.

Figure 10 Proportion of funding across DAP streams



Source: Direct funded DAP grants

Considerations for DAP sustainability

There are opportunities to increase DAP funding for early intervention approaches

Investing in treatment services plays a fundamental role in addressing the harms of AOD use, but there is a growing body of evidence and policy direction for increasing investment in evidence-based community education and prevention campaigns. Despite the evidence base, only a small proportion of DAP funding is for harm reduction activities. Stakeholders called for greater investment in harm reduction and additional prevention campaigns.

A recent analysis of the unmet need across the AOD system in Australia found that less intensive interventions may assist with addressing the gap.[42] In particular, investing in interventions at earlier stages of a person's AOD use can prevent the need for later, more intensive interventions. This may include screening and brief interventions programs (including in primary care), prevention interventions (e.g., education and social supports) and harm reduction activities. Such services may also engage people who do not perceive a need for treatment, despite experiencing AOD related harms.

This is consistent with the recent Productivity Commission interim report which recommends a National Framework to support government investment in prevention.[47] The report emphasises the important role of prevention initiatives in improving health outcomes and slowing the escalating growth in demand for acute care and treatment services. This recommendation comes off the back of Australia's National Preventive Health Strategy 2021-2030 which sets out ambitious targets for increasing investment in prevention across the health system.[48] Specifically, the Strategy aims to see an increase in Commonwealth investment in preventive health initiatives by 5% of total health expenditure. While more analysis would be required to determine how this target may apply to the balance of funding within DAP, it does provide guidance for consideration.

The Strategy sets out specific objectives relevant to the role of DAP including reducing AOD harm. In particular, the Strategy outlines the need for prevention initiatives in the AOD space which:

- Build consumer awareness of the National Alcohol Guidelines
- Prevent harm through evidence-based and credible mass media campaigns which are adapted to localised need
- Aim to reduce risk factors and enhance protective factors
- Aim to reduce the onset of AOD use, such as evidence-based and age-appropriate school programs
- Prioritise priority populations
- Upskill the broader health workforce to increase their confidence in evidence-based screening, brief intervention and referral.

Data suggests unmet demand across the spectrum of AOD services. Noting this, it is important to consider how rebalancing funding will impact service delivery organisations and clients. Careful transition planning should underpin any change to minimise disruption.

[47] Productivity Commission. (2025). *Delivering quality care more efficiently, Interim report*. Retrieved from https://www.pc.gov.au/inquiries-and-research/quality-care/interim/.

[48] Department of Health, Disability and Ageing. (2021). *National Preventative Health Strategy 2021-2030.* Retrieved from https://www.health.gov.au/sites/default/files/documents/2021/12/national-preventive-health-strategy-2021-2030_1.pdf.

4.3.3 DAP initiatives target various priority populations with opportunities to enhance support for people with co-occurring needs and groups with emerging needs

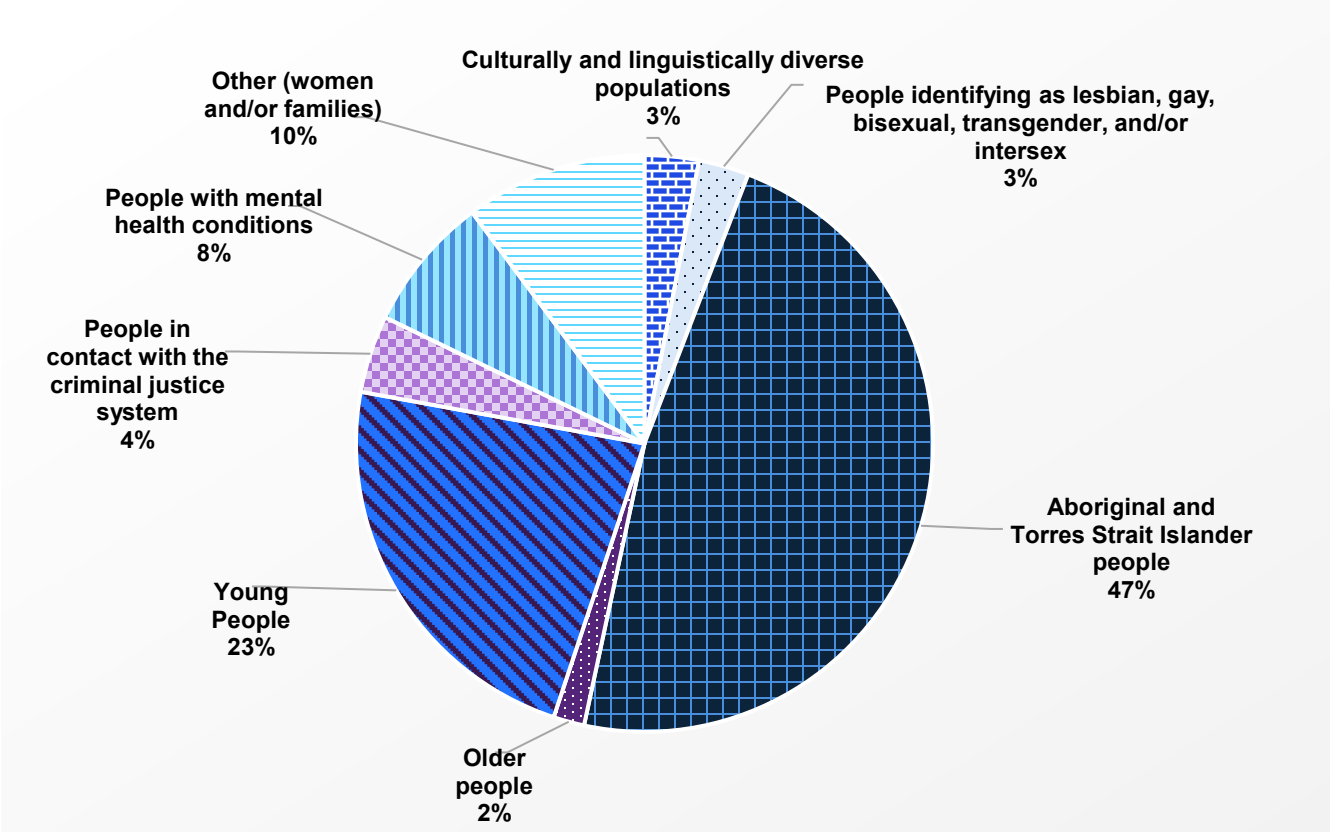
The NDS identifies seven groups of people who experience disproportionate AOD related harms:

- First Nations people
- People with co-morbid mental health conditions
- Young people
- Older people
- People in contact with the criminal justice system
- CALD populations
- People identifying as LGBTIQ+.

Proportion of priority populations targeted by DAP services

Analysis of the available providers' self-reported data and program documentation indicates that almost half (45%) of DAP grants are specifically tailored for people in priority populations.[49] A further 3% of grants are tailored to a priority group not identified by the NDS, but who are identified as having a disproportionate risk of harm from AOD use (such as women, families and people injecting drugs). As shown in Figure 11, more than half (51%) of the providers offering tailored support are working with First Nations people and one-fifth (22%) are working with young people. The remaining priority populations each represent less than 10%.

Figure 11 Breakdown of priority populations targeted by DAP grants in the period 2021-22 to 2024-25



Source: Grant performance reporting and PHN Funding Summary spreadsheet

[49] As this is self-reported data, there are limitations to its reliability as it required providers to accurately report on their delivery models with limited standardisation of how targeting priority populations is delivered across services.

Enhancing DAP supports for priority populations and people with complex needs

There was a clear understanding among interviewed stakeholders, including DAP providers, that to appropriately and effectively support people from priority populations requires shifts in service design and delivery. Two thirds (65%) of provider survey respondents expressed confidence in their ability to tailor initiatives to meet the needs of priority groups to a great extent.

Table 11 summarises the considerations for supporting people from priority groups. Accessibility is a key service design consideration for people in all priority groups. For example, providers shared how assertive outreach and engagement can reduce barriers and facilitate access for specific priority groups.

Table 11 does not include considerations for older people or CALD population groups as services targeting these groups were not consulted with. Support for older people will require even more focus on holistic health, with additional consideration of chronic conditions and potentially limited use of technology-focused supports, but is not well reflected in current literature. However, recent literature does suggest that cultural adaptation approaches similar to those for First Nations people are relevant for culturally diverse population groups.[50]

Table 11 Considerations for delivery of the DAP for priority populations

Priority population group	Considerations for appropriate delivery
First Nations people	• Incorporating local community languages into delivery methods, particularly in remote First Nations communities or for consideration in local prevention campaigns. • Utilising and supporting local community staff within service delivery models. • Incorporating community and family as central to an individual's way-of-life and wellbeing when designing appropriate delivery models. • Co-designing services to encompass a holistic social and emotional wellbeing model of care. • Adapting services to include culturally appropriate delivery including modes of engagement like yarning circles and smoking ceremonies. • Targeting prevention campaigns to prevalent drugs of choice for First Nations people (e.g., Tackling Indigenous Smoking campaign).
People in contact with the criminal justice system	• Commencing treatment/support during the period of incarceration. • Facilitating engagement of individuals with external services prior to exiting the justice system and in transition from the justice system to an AOD facility. • Allowing for extended periods of support to reduce the likelihood of repeat contact. • Collaborating with state justice departments to address increased pressure on services from higher rates of diversion to treatment services.
People identifying as gay, lesbian, bisexual, transgender or intersex	• Addressing the historical lack of safety and the unsuitability of mainstream residential services for LGBTIQ+ individuals. • Understanding the unique social and relational contexts of AOD use for LGBTIQ+ groups and how that impacts engagement with prevention initiatives and the effectiveness of treatment models.
People with co-occurring mental health conditions	• Understanding that AOD use may be driven by underlying mental health issues and vice versa. • Designing services that concurrently support mental health alongside treatment for AOD use. • Continued investment in sector capability building to support the mental health sector (prevention through to treatment) to identify AOD risk and refer as needed.
Young people	• Adapting service delivery models to increase access for young people by meeting them where they are at. • Incorporating early intervention and prevention support in existing forums such as including AOD education in schools.

Source: Stakeholder consultation

[50] Tan, W, J, Larance, B, Walter, E, E, Haynes, C, J, & Kelly, P, J. (2025). *Mutual-Support Groups for Alcohol and Other Drug Use in East, South and Southeast Asia: A Scoping Review.* Drug and Alcohol Review, 44(6), 1711-1755.

Evidence within the literature further highlights some additional considerations for priority populations. Cultural safety in all its dimensions should be a major priority, with language, images and practices echoing those of the community being served. Future funding can support providers in their capacity to strengthen existing practices, such as including smoking ceremonies and Welcome to Country, which enhances cultural safety and healing for clients. Applying cultural knowledge to improve AOD services, treatment and programs and de-stigmatising AOD treatment in addition to working closely with non-Indigenous clinicians will help to achieve the best outcomes for First Nations clients. Co-design with target communities, including people with lived-living experience, can help ensure this is addressed. Acknowledgement and inclusion of families is also important, as the impacts of substance use are not felt by the individual alone.[51]

It is clear, both in emerging research evidence and from stakeholder consultations, that there is increasing complexity amongst people experiencing AOD related harms. Stakeholders described an increasing proportion of clients who present with co-occurring mental health conditions, such as depression or bipolar disorder. Increasingly, people require support for homelessness, disability, financial distress or domestic and family violence alongside their AOD use. Others are in contact with the justice or child protection systems. To appropriately and effectively support people in priority populations and people with complex needs will require greater coordination with other relevant sectors or specialist organisations.

> "There's opportunities from the ground where each group has their own nuances, each area has different needs, we can target those needs in a broader AOD sector."
> **- Service Provider**

Best Practice Example – National Best Practice Unit Tackling Indigenous Smoking Initiative (NBPU TIS)

The Tackling Indigenous Smoking (TIS) program works with First Nations communities to reduce tobacco use and plays an important role across governments, the health sector and NGOs. Ninti One manages the National Best Practice Unit (NBPU) with the Health Research Institute at the University of Canberra and the Australian Indigenous HealthInfoNet at Edith Cowan University. The NBPU provides valuable support to TIS organisations:

- Sharing evidence-based research
- Information and resources
- Delivering TIS workforce training and development activities
- Providing guidance support TIS planning and performance reporting responsibilities under the program.[52]

The NBPU demonstrates an approach which fosters deep cross sector collaboration. Its success relies heavily on the funded TIS teams to set aside competitive advantage and focus on collaborating together through knowledge sharing to collectively enhance capacity and capability across the sector. The DAP would benefit from similar approaches that encourage providers to share knowledge and expertise for the benefit of the sector. Peaks have potential to play a key role in supporting this sector collaboration.

[51] Lyall, V, Wolfson, L, Reid, N, Poole, N, Moritz, K, M, Egert, S, Browne, A, J, & Askew, D, A. (2021). *"The Problem Is that We Hear a Bit of Everything…": A Qualitative Systematic Review of Factors Associated with Alcohol Use, Reduction, and Abstinence in Pregnancy.* International Journal of Environmental Research and Public Health, 18(7); Mathias, H, Foster, L, A, & Rushton, A. (2024). *Programs and practices that support pregnant people who use drugs' access to sexual and reproductive health care in Canada: a scoping review.* BMC Pregnancy Childbirth, 24(1); Milaney, K, Haines-Saah, R, Farkas, B, Egunsola, O, Mastikhina, L, Brown, S, Lorenzetti, D, Hansen, B, McBrien, K, Rittenbach, K, Hill, L, O'Gorman, C, Doig, C, Cabaj, J, Stokvis, C, & Clement, F. (2022). *A scoping review of opioid harm reduction interventions for equity-deserving populations.* Lancet Regional Health Americas 12(1); Tan, W, J, Larance, B, Walter, E, E, Haynes, C, J, & Kelly, P, J. (2025). *Mutual-Support Groups for Alcohol and Other Drug Use in East, South and Southeast Asia: A Scoping Review*. Drug and Alcohol Review, 44(6), 1711-1755; Colledge-Frisby, S, Ottaviano, S, Webb, P, Grebely, J, Wheeler, A, Cunningham, E, B, Hajarizadeh, B, Leung, J, Peacock, A, Vickerman, P, Farrel, M, Dore, G, J, Mickman, M, & Degenhardt, L. (2023). *Global coverage of interventions to prevent and manage drug-related harms among people who inject drugs: a systematic review.* Lancet Global Health, 11(5), 673-683.

[52] Department of Health, Disability and Ageing. (2024). *Tackling Indigenous Smoking.* Retrieved from https://www.health.gov.au/our-work/tackling-indigenous-smoking.

Additional population groups recognised as benefiting from tailored support

Both DAP providers and key non-government AOD sector bodies suggested there are people other than those listed in the NDS who are at risk of disproportionate harm from AOD use. Sector-wide documentation, including AOD strategies in Tas and the Australian Capital Territory (ACT) and the Issues Paper Relating to the Health Impacts of Alcohol and Other Drugs,[53] also acknowledged the need to consider additional population groups as priority when designing and delivering AOD services.

Women and families

Increasing reach, ease of access and engagement with services for women and families was recognised as a priority. There are a range of reasons why women may be less likely to seek AOD supports. Women who care for children may be concerned that they will lose access to them as the consequence of seeking support. Co-gendered services—particularly residential services—are often a barrier to women who are escaping violence. It was widely acknowledged that additional women-only services, or services that can keep parents and their children together during treatment would encourage the engagement of women and parents in DAP services. This is supported by literature which suggests that holistic, wrap-around services that recognise the multiple responsibilities of women and families are most effective.[54]

Similarly, the families of those seeking treatment were identified as another group that would benefit from greater support in the current DAP service delivery landscape. Multiple providers recognised the need to actively support and engage with the people surrounding an individual receiving treatment. Families were acknowledged as being a critical support system to an individual as they addressed their AOD use. Some providers have incorporated support for families into their service delivery model through targeted counselling and group programs, however, have found themselves limited by funding and resource constraints.

People who inject drugs

Stakeholders noted inherent risks for people who inject drugs, including discrimination, overdose and blood borne viruses. Stakeholders highlighted the need to explore specific policy to support access to and engagement with DAP services for people who inject drugs, including harm reduction services. The literature notes the value of agonist therapies, psychosocial supports and support to address injection-related health challenges.[55]

[53] Commonwealth of Australia. House of Representatives. (2025*). Issues paper relating to the health impacts of alcohol and other drugs in Australia*. Retrieved from https://parlinfo.aph.gov.au/parlInfo/download/committees/reportrep/RB000565/toc_pdf/IssuespaperrelatingtothehealthimpactsofalcoholandotherdrugsinAustralia.pdf

[54] Mathias, H, Foster, L, A, & Rushton, A. (2024). *Programs and practices that support pregnant people who use drugs' access to sexual and reproductive health care in Canada: a scoping review*. BMC Pregnancy Childbirth, 24(1).

[55] Platt, L, Minozzi, S, Reed, J, Vickerman, P, Hagan, H, French, C, Jordan, A, Degenhardt, L, Hope, V, Hutchinson, S, Maher, L, Palmateer, N, Taylor, A, Bruneau, J, & Hickman, M. (2017). *Needle syringe programmes and opioid substitution therapy for preventing hepatitis C transmission in people who inject drugs.* Cochrane Database of Systematic Reviews, 9(9); Chen, Y, Lin, Y, Wu, M, Kuo, J, & Wang, C. (2024). *Prevention of Viral Hepatitis and HIV Infection among People Who Inject Drugs: A Systematic Review and Meta-Analysis.* Viruses, 16(1); Fernandes, R, M, Cary, M, Duarte, G, Jesus, G, Alarcao, J, Torre, C, Costa, S, Costa, J, & Carneiro, A, V. (2017). *Effectiveness of needle and syringe Programmes in people who inject drugs - An overview of systematic reviews*. BMC Public Health, 17(1).

Considerations for DAP sustainability

There are opportunities to enhance and adapt services to continue to meet the needs of those they support, particularly as new trends and evidence emerge

As the use of AOD across Australia continues to change and evidence emerges, DAP initiatives will need to be able to continually adapt and enhance their delivery accordingly, to ensure identified needs are appropriately addressed. In targeting flexible and innovative initiatives, the department should look to models which:

- Deliver services that appropriately and effectively meet the changing needs of the groups they target.
- Adapt and manage external shifts to their operating environment with minimal disruption.
- Coordinate their services with other sectors and services (e.g., mental health) and strengthen cross-sector service integration to deliver person-centred services.
- Balance a consistent set of KPIs which support evaluability.

While flexibility and innovation can expand the range of service delivery options and enhance responsiveness, they can also pose challenges for evaluability, particularly if service models and activities vary substantially across contexts or change over time. Regular monitoring and in-depth evaluation can help to assess the extent to which innovative service designs influence outcomes and to better understand appropriateness, effectiveness and mechanisms of change. Stakeholders stressed that innovation requires long term and consistent funding that enables continued evaluation, monitoring and assessment of initiatives to ensure alignment with evidence, needs and resources required to deliver the services on an ongoing basis.

Considering the emerging needs and existing reach of DAP noted in this section, areas to consider as focus of future DAP grants may include innovative approaches to addressing groups with emerging needs including (but not limited to) people with co-occurring mental health needs, women and families and/or people who inject drugs.

4.3.4 DAP service delivery models can and do learn from best practice and evidence-based approaches

Evidence on the impacts of AOD use and modalities of support (i.e., telehealth, face-to-face engagement) is constantly evolving as a result of a dynamic AOD research environment. Incorporating current research and data is key to ensuring that DAP services are evidence informed and appropriate for their intended objectives. Consultation on the models delivered through DAP initiatives identified varying levels of maturity across DAP providers in using data and research to inform evidence-based service design. For the most part, providers described models that align with evidence-based practice in AOD prevention and treatment. For example, a number of prevention providers demonstrated good practices in using contemporary research to inform the design of their initiatives as well as investment in evaluations to inform continuous improvement. However, there was not consistent evidence of this practice across all providers. This variability of practice suggests an opportunity to increase the maturity of providers in using contemporary evidence and research to enable best-practice model design and continuous improvement.

Long term support to improve outcomes

To achieve an optimally functional AOD sector, services need to be available to span the continuum of needs, from universal prevention and early intervention through to tertiary treatment/care and then ongoing follow up or aftercare. It is also important to note that recovery is not a unidirectional journey. Services need to adopt a flexible stepped-care approach that is similarly multidirectional, with supports available prior to and following on from formal treatment episodes to promote ongoing recovery.[56]

To achieve this, engagement pathways need to be clear and non-stigmatised, so that entry is possible at more than one point. This acknowledges that AOD issues are often accompanied by multiple other social issues or determinants of health, such as mental and other physical health concerns, poverty, exposure to the justice system, experience of domestic and family violence and homelessness. Ideally, services will communicate clearly, be coordinated in the care they provide, be co-located wherever possible and staffed by multi-disciplinary teams who understand the multi-dimensional nature of AOD issues and the resulting needs of people seeking support. This approach also provides a range of 'entry options', promoting the 'no wrong door' approach. Resourcing should be flexible to meet these varying needs, including the use of assertive outreach and brokerage funds, so that physical access to services does not create a barrier to support.[57]

Meeting individuals where they are at

Current evidence highlights the importance of meeting individuals where they are at in their AOD journey by providing services across a range of modalities and intervention levels. Each of the DAP streams will be appropriate for different individuals, given their individual circumstances and context of engagement. The summary below provides examples of contemporary evidence for prevention initiatives and treatment focused support.

Prevention initiatives

Prevention initiatives include a range of strategies that address the environment (including regulatory and programmatic approaches to this), protective and risk factors (including social determinants of health) and increased awareness to support behaviour change. Universal prevention initiatives demonstrate effectiveness in some arenas such as raising awareness and knowledge, particularly for those not yet involved in substance use and potentially for shaping community norms around issues such as consumption by young people, while driving and during pregnancy. Initiatives that directly engage individuals or that build into existing educational systems are

[56] Ho, C, & Adcock, L. (2017). *Inpatient and Outpatient Treatment Programs for Substance Use Disorder: A Review of Clinical Effectiveness and Guidelines [Internet].* Canadian Agency for Drugs and Technologies in Health.

[57] Glover-Wright C, Coupe, K, Campbell, A, C, Keen, C, Lawrence, P, Kinner, S, A, & Young, J, T. (2023). *Health outcomes and service use patterns associated with co-located outpatient mental health care and alcohol and other drug specialist treatment: A systematic review.* Drug Alcohol Review, 42(5),1195-1219; Schwarz, T, Horvath, I, Fenz, L, Schmutterer, I, Rosian-Schikuta, I, & Mardh, O. (2022*). Interventions to increase linkage to care and adherence to treatment for hepatitis C among people who inject drugs: A systematic review and practical considerations from an expert panel consultation.* International Journal on Drug Policy, 102(9); Kennedy, M, C, Karamouzian, M, & Kerr, T. (2017). *Public Health and Public Order Outcomes Associated with Supervised Drug Consumption Facilities: a Systematic Review.* Current HIV/AIDS Reports, 14(5), 161-183; Magwood, O, Salvalaggio, G, Beder, M, Kendall, C, Kpade, V, Daghmach, W, Habonimana, G, Marshall, Z, Snyder, E, O'Shea, T, Lennox, R, Hsu, H, Tugwell, P, & Pottie, K. (2020). *The effectiveness of substance use interventions for homeless and vulnerably housed persons: A systematic review of systematic reviews on supervised consumption facilities, managed alcohol programs, and pharmacological agents for opioid use disorder.* PLoS One, 15(1).

more effective and targeted approaches are more effective for population groups at risk.[58] With this in mind, DAP prevention efforts should be adapted to suit the needs of the target audience and vary by setting.

Treatment and focused support

Treatment and support modalities should be offered over a range of options, to maximise engagement opportunities. These include lower-intensity community-based supports and counselling either as stand-alone or prelude to engagement in more structured programs, longer term or more intensive supports. These higher-intensity support options may include approaches such as withdrawal management, medicated and psychosocial treatments and supported residential options. As explored below, online, virtual or telehealth options can increase accessibility where distance, stigma, local service availability and other responsibilities such as family or employment create barriers to face-to-face engagement.[59]

Mode of delivery

Alongside the range of service categories delivered through DAP initiatives, there are also variations in how these initiatives are delivered, including face-to-face and non-traditional modes like telehealth and online delivery. Many programs funded under prevention appear to be leading the way with digital engagement options, such as online and phone support.

Best practice example – Cracks in the Ice Project

The Cracks in the Ice Toolkit was launched in 2017 to provide non-stigmatising, evidence-based resources and information about crystal methamphetamine, to the Australian community. In 2018 a mobile app was developed in response to the need for access to offline resources in regional and rural communities. An additional five online programs for families and friends of people using AOD, including a dedicated crystal methamphetamine program have also been introduced and in 2021 a suite of co-designed culturally appropriate resources for First Nations people was launched. Cracks in the Ice utilises a strategic multi-pronged dissemination approach including targeted social media and leveraging partnerships to extend its reach and resource dissemination (>1.4 million website visitors to date).

Since launching, the Cracks in the Ice webinar program has received greater than 71,000 combined attendees and on-demand views across just 33 webinars. The mobile app also boasts 9,900 clicks to download and over 4,000 site users for the family and friend's online programs. These statistics demonstrate the reach that can be achieved with online engagement mechanisms for prevention and education programs.

[58] Mewton L, Visontay, R, Chapman, C, Newton, N, Slade, T, Kay-Lambkin, F, & Teesson, M. (2018). *Universal prevention of alcohol and drug use: An overview of reviews in an Australian context.* Drug Alcohol Review, 37(1), 435-469; de Ternay, J, Leblanc, P, Michel, P, Benyamina, A, Naassila, M, & Rolland, B. (2022). *One-month alcohol abstinence national campaigns: a scoping review of the harm reduction benefits.* Harm Reduction Journal, 19(1), 24-26; Bates, G, Jones, L, Maden, M, Chochrane, M, Pendlebury, M, & Sumnall, H. (2017). *The effectiveness of interventions related to the use of illicit drugs: prevention, harm reduction, treatment and recovery: A 'review of reviews'.* Health Research Board; Yeh, J, Niederdeppe, J, Lewis Jr, N, A, & Jernigan, D, H. (2023). *Social Media Campaigns to Influence Alcohol Consumption and Related Harms, Attitudes, and Awareness: A Systematic Review.* Journal of Studies on Alcohol and Drugs, 84(4), 546-559; Yadav, R, & Kobayashi, M. (2015). *A systematic review: effectiveness of mass media campaigns for reducing alcohol-impaired driving and alcohol-related crashes.* BMC Public Health, 15(857).

[59] Schwarz, T, Horvath, I, Fenz, L, Schmutterer, I, Rosian-Schikuta, I, & Mardh, O. (2022*). Interventions to increase linkage to care and adherence to treatment for hepatitis C among people who inject drugs: A systematic review and practical considerations from an expert panel consultation.* International Journal on Drug Policy 102(9); Sibley, A, L, Colston, D, C, Vivian, F, G. (2024). *Interventions to reduce self-stigma in people who use drugs: A systematic review.* Journal of Substance Use Addictions Treatment, 159; Krawczyk, N, Fawole, A, Yang, J, & Tofighi, B. (2021). *Early innovations in opioid use disorder treatment and harm reduction during the COVID-19 pandemic: a scoping review.* Addict Science & Clinical Practice, 16(1); Sumnall, H, Bates, G, & Jones, L. (2017). *Evidence review summary: drug demand reduction, treatment and harm reduction.* European Monitoring Centre for Drugs and Drug Addiction.

In contrast, treatment services tend to favour face-to-face engagement. It is important to note that not all face-to-face services can simply and effectively be transitioned to online services, with challenges such as digital literacy and access to be considered. For example, residential services are typically more constrained to face-to-face treatment, but many are working to include virtual aspects where possible.

Stakeholders acknowledge that increased online engagement has the potential to extend the reach and coverage of existing services, particularly where barriers exist to in person accessibility. Many service providers reported a willingness to deliver flexible modes of support including traditional face-to-face and newer technologies including telehealth and digital engagement. All stakeholder groups expressed a commitment to enhancing their capacity to offer varying engagement modes to make services more accessible.

Adapting to COVID-19 restrictions – DAP services incorporating new technologies where possible

Restrictions on face-to-face service delivery during the COVID-19 pandemic impacted the delivery of existing AOD services, many of which had previously relied solely on face-to-face delivery. Stakeholders commented on the need for AOD services to quickly and effectively adapt their delivery models to include virtual service delivery where possible. While some providers had difficulties in transitioning to virtual approaches due to the nature of the services they deliver, a number of providers shared their positive experiences in incorporating virtual delivery models. This included utilising telehealth for counselling or support groups and / or adapting their face-to-face delivery models in response to changing restrictions. Many providers that incorporated digital approaches to their service delivery during this time maintained **this capability beyond the end of COVID restrictions and into business-as-usual processes.**

Considerations for DAP sustainability

There is an opportunity for DAP providers to consistently apply contemporary evidence-informed practice

Evidence included in this section highlights the value of ensuring that a range of support options are available, with flexibility for individuals to engage at multiple points, at different levels of intensity and in several formats. However, the dynamic nature of AOD research means that what is considered best practice is constantly evolving and service delivery must follow this evolution. Whilst DAP providers demonstrate efforts to keep abreast of contemporary evidence, there are opportunities for providers to increase their capability to consider the efficacy of their activities and ensure their models are informed by evidence and research.

The Australian Government can support this capability uplift through knowledge sharing on best practices

Like the funding provided to services to deliver AOD initiatives, DAP funding is also provided to research organisations (out of scope for this evaluation) to continue building the AOD evidence base. The capacity building grants for peak bodies focus on supporting the application of evidence in practice. There is opportunity for the department to strengthen pathways for enhanced information sharing between research organisations, peaks and service providers. An additional opportunity exists for a more formal connection between the research programs and a new dynamic and adaptive national drug strategy that evolves over its lifecycle, informed by ongoing monitoring, stakeholder feedback and emerging evidence.

When combined, these strategies will enable service delivery to remain appropriate to identified need, informed by best practice evidence and responsive to changing demands. Increasing the shared understanding of best practice will guide providers when designing and delivering services and support the department's evaluation of the effectiveness and potential impact of existing services.

4.3.5 DAP service funding exists alongside AOD funding from other funding bodies within the sector, presenting an opportunity to clarify and define key roles

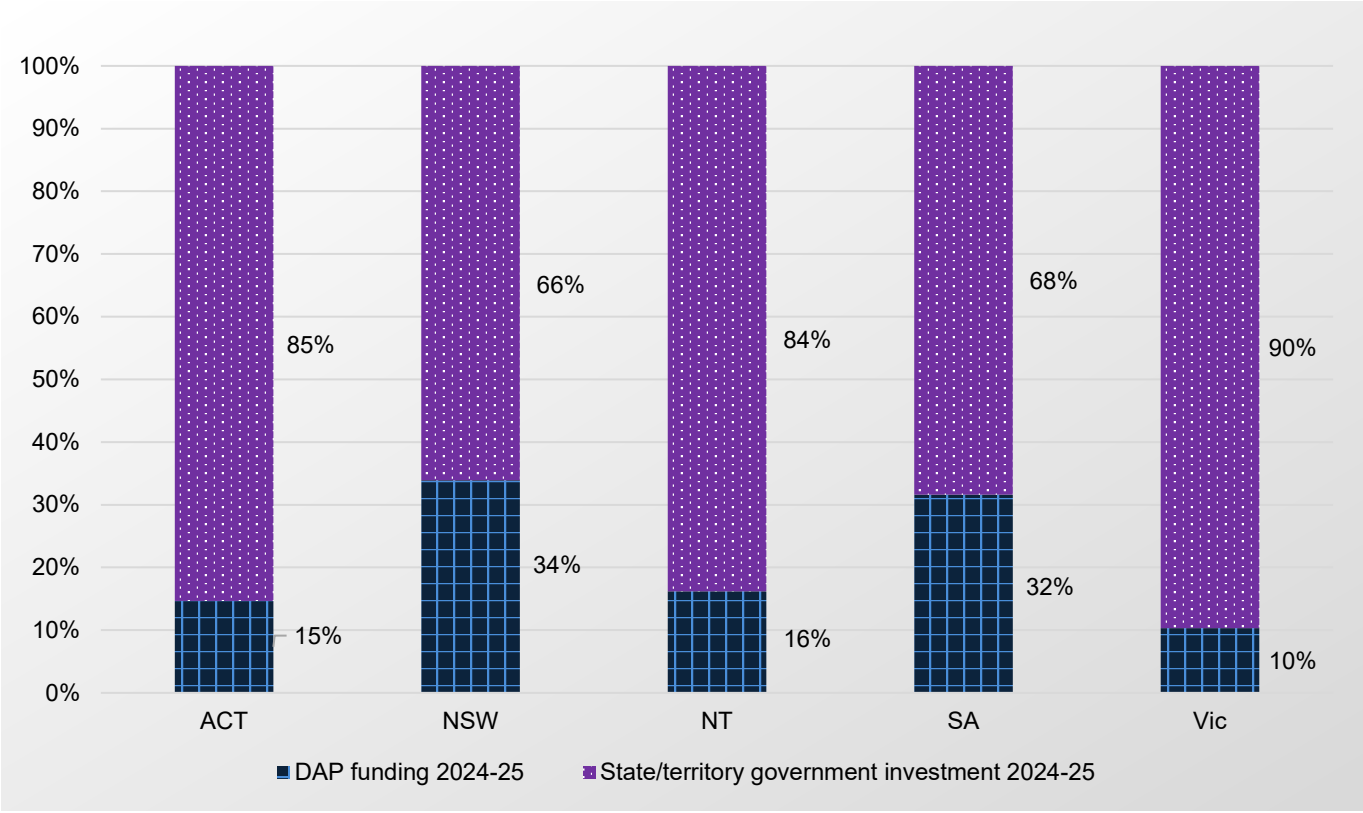
The AOD service system in Australia is multifaceted. Policy making is led by both the Australian Government and jurisdictions, with influence from peak bodies and research organisations. Services are funded by the Australian Government through the department, PHNs and NIAA and by state and territory governments. As such, the appropriateness of DAP funding must be considered alongside the funding in the sector from state and territory governments and the NIAA. Currently, these funders operate alongside each other without visibility of how much funding is being provided by each and to whom it is being provided.

AOD funding landscape within states and territories

To bring clarity to the extent of DAP funding within the broader AOD system, the evaluation requested funding from all relevant state and territory governments for 2024-25. Five jurisdictions agreed to provide data (ACT, NSW, Northern Territory (NT), SA and Vic). Jurisdictions provided their data in different formats, limiting its comparability. Further, the evaluation did not have access to AOD funding data from the NIAA or private services.

Figure 12 shows the proportion of DAP funding relative to jurisdiction funding is highest in NSW (34% DAP funding). In the ACT, NT and Vic, DAP funding represents less than 17% of total AOD funding in each of the jurisdictions.

Figure 12 Proportion of DAP investment compared to state and territory government investment across jurisdictions in 2024-25



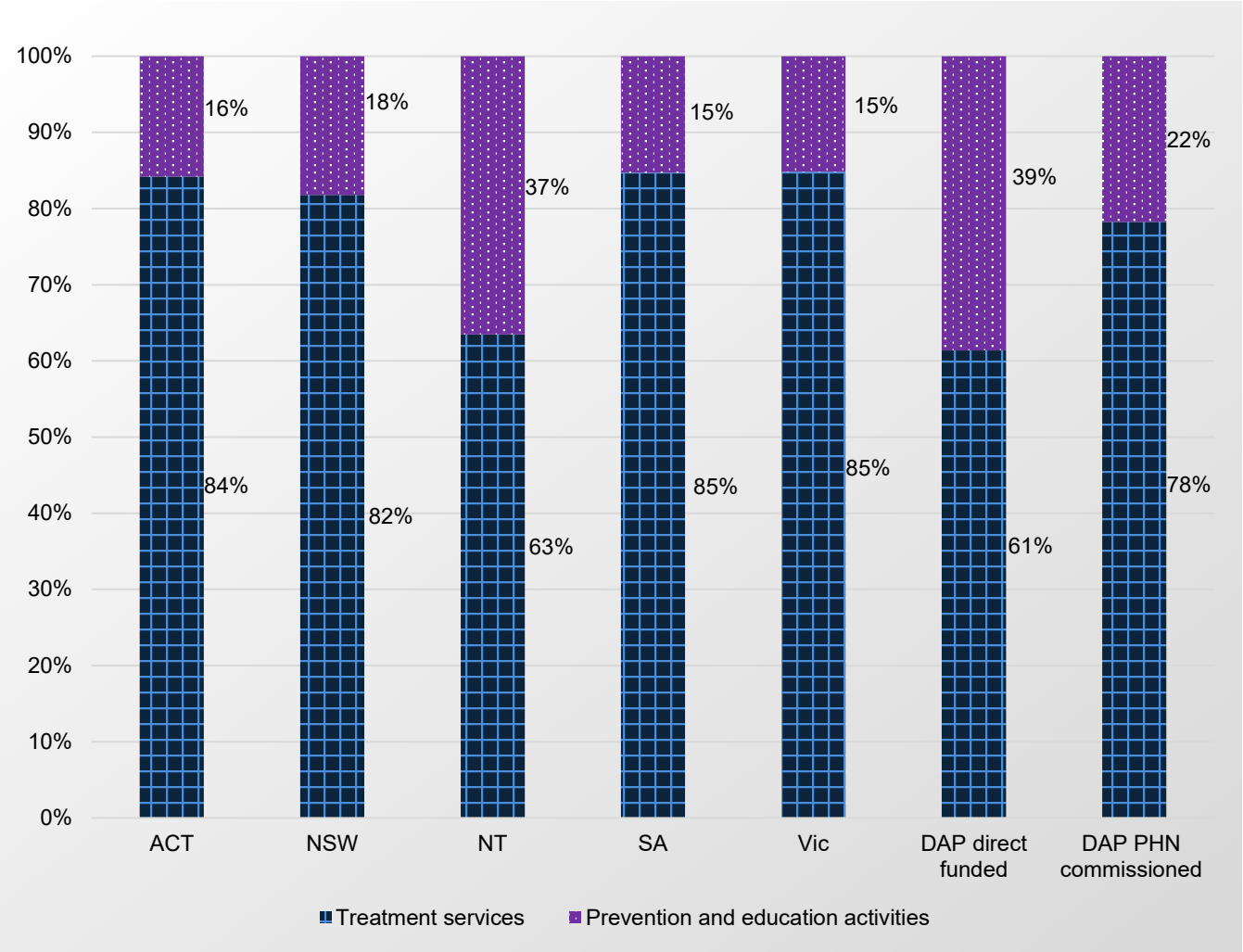
Source: Funding data provided by ACT, NSW, NT, SA and Vic, and AOD Funding Contracts and Funding Agreements

It was possible to explore five state and territory governments' AOD funding by service category (ACT, NSW, NT, SA and Vic). Figure 13 illustrates the breakdown of service category funding from state and territory governments compared to that of DAP direct funded grants and PHN commissioned grants for 2024-25.

Notably, the DAP and all represented states and territories, commission initiatives across both treatment services and prevention and education activities. Across the DAP and each of the jurisdictions, treatment services (including withdrawal services, non-residential and residential services) represent the largest share of funding. In the ACT, NSW, SA and Vic, treatment services represent over 80% of state and territory AOD funding.

For direct funding provided by the DAP, the share of funding going towards prevention and education activities is larger than in any of the states or territories included in the analysis. This may reflect the national scale and scope of most prevention and education activities, which are typically not funded by individual jurisdictions. It may also be representative of differing definitions of AOD initiatives which may have impacted the split.

Figure 13 Breakdown of state and territory government funding and DAP funding by service categories in 2024-25[60]



Source: Funding data provided by ACT, NSW, NT, SA and Vic, and analysis of PHN Funding Summary spreadsheet and AOD Funding Contracts and Funding Agreements spreadsheet

[60] For the data provided by state and territory governments, analysis was undertaken to categorise funding to service categories. Where there were instances where funding contributed to both treatment services and prevention and education activities, the funding was attributed to the predominant activity.

The roles and responsibilities of key AOD funders

The roles of distinct funders across the AOD sector are unclear. As demonstrated in Figure 13, both the department and state and territory governments fund AOD services across the full spectrum of care in broadly similar proportions. Whilst this might result in duplication of effort across government in administering grants, this does not necessarily mean there is duplication of service delivery. Instead, the significant unmet demand across the AOD sector suggests that all available services are likely being utilised and that current service capacity may be insufficient to meet population need.[42]

> "The federal funding is so important, with no DAP funding there would be many gaps in service provision. With the way it's been deployed, it's not duplicating services, instead it's a different value add that would be noticed if taken away."
> **- State and Territory Peak**

However, this overlap in commissioned services may be a symptom of broader systemic issues. It was evident that the specific roles of the Australian Government, states and territories and PHNs were unclear to providers, peaks, researchers and even to the government stakeholders consulted in the evaluation. All stakeholders suggested clearer definition of the unique roles of each key funder would limit duplication and support identify any system gaps.

Stakeholders acknowledged that best practice AOD service delivery spans settings and addresses various levels of acuity, which can complicate a clear definition of roles and responsibilities. Many stakeholders understand state and territory governments' role as providing 'core' AOD supports. Although stakeholders applied different definitions of 'core' supports, their definitions suggest localised AOD prevention and treatment services.

There was far more consistent understanding amongst stakeholders of the DAP, including its potential to:

- Enhance access to AOD programs and services by addressing identified gaps
- Provide flexibility to respond to emerging needs
- Enable national prevention initiatives
- Support coordination with primary health interventions through the Commonwealth's role in primary healthcare
- Enable innovation to become core business
- Build capability and capacity, including workforce development and stigma reduction (through the peer workforce)
- Address cross-border issues
- Deliver cross sector models.

Whilst this description appears aspirational and would need further testing, it does emphasise the need for a process which brings together key funders to consider and agree on their respective roles and responsibilities and inform shared planning. The capacity for service planning is inhibited without a clear picture of what is funded across all the funders and how that aligns with outcomes and populations intended to be targeted by DAP funded services. Concerns were shared that without this visibility across the sector there is strong potential for a misalignment with state and territory funding in the AOD sector.

Role clarity and transparency would also support new opportunities for shared funding models within DAP in the future, with the Australian Government and state and territory governments co-investing in AOD initiatives. This was a sentiment expressed by stakeholders, including government and aligns with the NHRA which encourages co-investment to support improved outcomes. This is further supported by the mid-point review of the NHRA which emphasises the need for a more collaborative and whole-of-system approach which drives co-commissioning through collaboration requirements, flexible funding and data sharing.[61]

Closing the gap

State and territory governments and the Australian Government have a joint responsibility for closing the gap in First Nations disadvantage and life expectancy. The Australian Government also has responsibility for managing AOD funding for First Nations people through the NIAA. Stakeholders stressed the need for greater alignment between DAP funding and AOD funding administered by the NIAA. This can reduce confusion across the sector regarding the roles of the DAP and NIAA in funding AOD services for First Nations people. Government stakeholders reported that there is some informal consultation between the department's policy team and NIAA for the coordination of AOD funding, however there is opportunity to include NIAA in any formal overarching governance forums to better coordinate funding across the two agencies.

Considerations for DAP sustainability

The need to clearly define and document roles and responsibilities of all funders

This will enhance shared planning processes and reduce role duplication.

As described so far, there is an opportunity for the department to implement agreed practices that improve information sharing across government so that states and territories and the various parts of Australian Government better understand what and how much each party funds. This should include close collaboration with other funders to clarify and agree on roles and responsibilities of key funders. Defining how each of these funders relate to the broader AOD sector and the role of each stakeholder in delivering a joined up AOD system, will enable more coordinated and complementary funding decisions and efficient use of resources. It must be noted that significant reform that might result from this, may lead to a fundamental shift for DAP funding. It would be important that any such reform work be done in close collaboration with the sector and transitioned in a way that ensured existing funding remained within the AOD sector.

Where a process to agree on roles and responsibilities is not possible, the department should consider how it can more clearly articulate the role of DAP within the sector.

[61] Department of Health, Disability and Ageing. (2023). *Mid-Term Review of the National Health Reform Agreement Addendum 2020-2025 Final Report.* Department of Health, Ageing and Disability. Retrieved from https://www.health.gov.au/sites/default/files/2023-12/nhra-mid-term-review-final-report-october-2023.pdf

4.3.6 More collaborative relationships between the Australian Government, states and territories, PHNs and providers is an enabler of delivering localised and adaptable responses through DAP

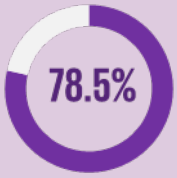
Central to ensuring that DAP initiatives are appropriate and effective in their intended delivery is the ability of the Australian Government to both identify where needs exist within the sector and commission initiatives that respond to the identified need. There is no 'one size fits all' approach when responding to issues with AOD use and the challenge for the Australian Government is tying together the existing AOD landscape, the changing needs and emerging evidence while also ensuring that initiatives are an appropriate response to the target population.

Identifying and responding to local needs

Engaging across multiple levels of AOD delivery, including states and territories, PHNs and providers, allows the Australian Government to better understand both what is being delivered and where there are opportunities to adapt existing initiatives or deliver place-based responses. Existing relationships between the Australian Government and PHNs are reported as supporting the identification of local needs and setting an example of where further collaboration with other funding bodies can improve the coordination and appropriateness of commissioned initiatives.

The incorporation of PHN commissioning of DAP initiatives was identified in consultations as a mechanism to provide a localised approach to identifying and responding to community needs, with the flexibility to reallocate funding where required. Stakeholders noted that PHNs are designed to have a strong understanding of the needs and considerations for their region with visibility of a level of detail that the department's policy team cannot achieve. This is evident in the mandatory needs assessment completed by PHNs as part of their grant requirements, which provide a clear and timely view of what needs exist within their region.

Central to including PHNs in the DAP model, is the relationship building they are designed to facilitate within a region. Local contract managers can engage closely with providers on the ground and effectively understand the implementation and impact of their services commissioned within a region. During consultations, providers commissioned through PHNs commented that this engagement with their PHN allowed information sharing and collaboration which in turn supported the effective allocation of commissioned services based on demonstrated need.



of PHNs responding to the survey felt that their DAP funded services had a positive impact on individuals '**to a great extent'.**

Source: Evaluation Team Survey

Commissioning through the PHN was described as providing some flexibility such that service models could adapt in minor ways within a contract to better target identified gaps. An example of this is the shift towards providing more outreach-based treatment and support services to address accessibility challenges within a particular region.

> "Need to change the whole view of people having to leave their families and communities to go to treatment, treatment needs to come to communities."
> **- PHN**

While PHNs were described as enablers for identifying and flexibly responding to local need in some cases, this is not the case with all PHNs. Stakeholders noted varying performance of PHNs in this area, with a smaller number of stakeholders noting poor support and coordination from their respective PHN. More needs to be done to ensure that there are clear standards for delivery and consistent performance across all PHNs. Greater collaboration between the Australian Government, PHNs and providers can support the early identification and reconciliation of inconsistencies across PHN commissioning and support PHNs in their role in traversing the divide between the Australian Government and jurisdictional policy makers and enabling localised assessment, planning and commissioning approaches. Importantly, any future effort in this area should be informed by insights captured through the current PHN review which is underway.

Driving enhanced cross sector integration

Noting the growing complexity of the needs of clients engaging with AOD services, there is a need to support closer integration with sectors that often intersect with AOD initiatives, including mental health services, primary health services, social services and the justice system. This cross-sector integration is required across all DAP streams. Collaborative relationships between the various levels of funders within and beyond the AOD sector will enable providers to adapt and deliver this integration.

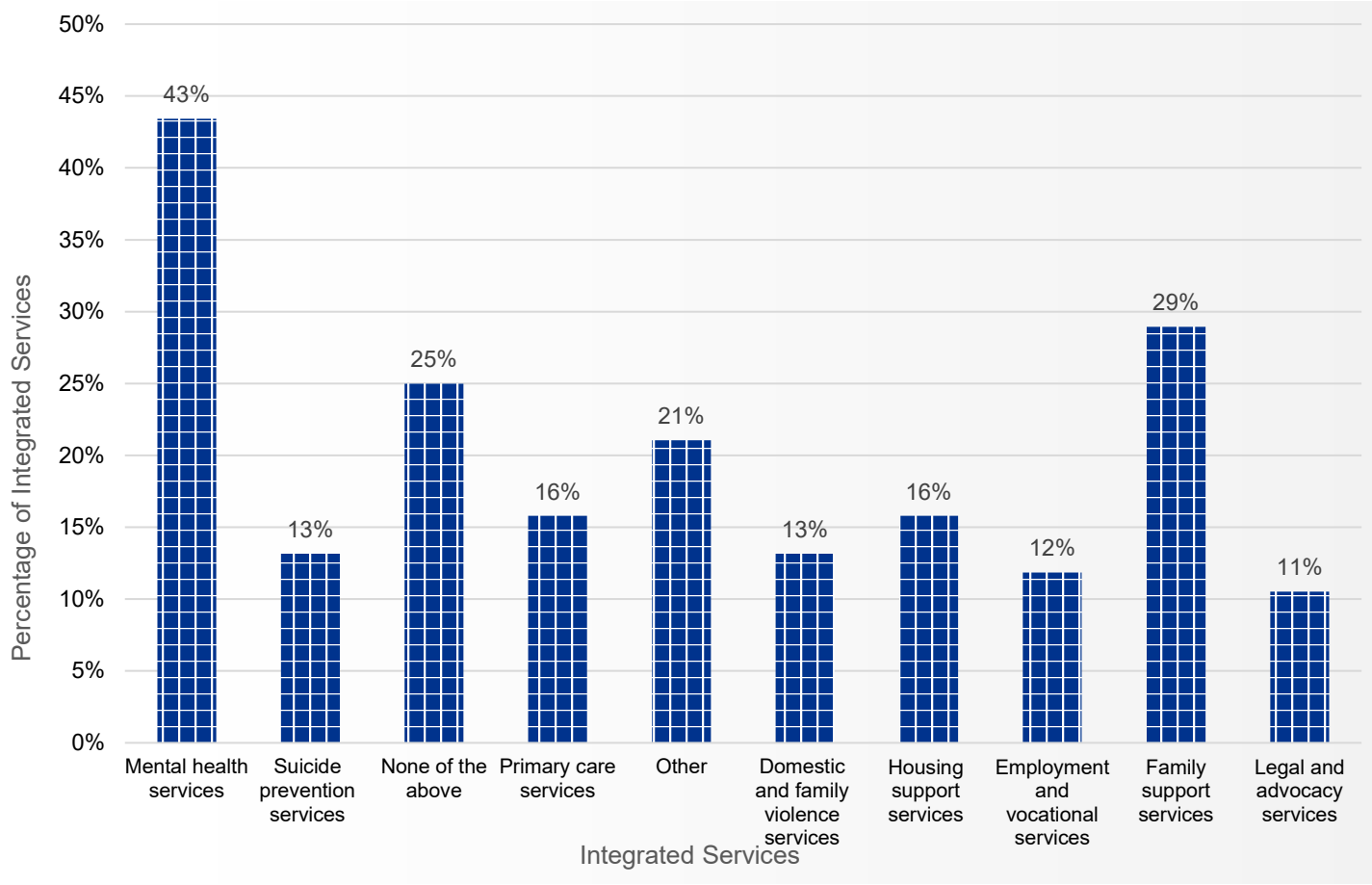
Consultations highlighted the intersectionality of these different systems and the impact they have on clients seeking AOD support. One example highlighted was that individuals experiencing homelessness may be ineligible to receive AOD treatment and services due to their housing instability. Conversely, individuals who use alcohol and other drugs are often excluded from accessing homelessness services, creating accessibility barriers. In a second example, providers also reported a growing demand for AOD support for individuals in contact with the justice system, particularly court ordered individuals.

> “A lot of people present at AOD services who haven’t engaged in the health service for a long time. People will often present and have a range of other impacts including the social determinants of health that impact their ability to access care.”
> **- PHN**

Examples of existing cross sector integration

Treatment and withdrawal providers reported that through their DAP funding, they have been able to develop cross sector partnerships to strengthen collaborative service delivery and holistic care in their region. This ensured that the services they are providing are appropriate and respond to the needs their clients are presenting with.
As shown in Figure 14, 75% of providers who responded to this survey question reported integrating with another service, with mental health services being the most common partner types. This indicates a significant level of integrated service delivery is occurring within DAP funded services.

Figure 14 Percentage of survey respondents (providers) reporting they have integrated with another service type (n=76 responses)



Source: Evaluation Team survey

Stakeholders shared examples of where cross-sector integration already worked well in delivering AOD services, particularly in regional areas where the volume of services was limited. An example provided was a hub model where AOD and other cross-sector services were specifically brought together in one location so an individual could access various services in a single venue. One regional provider reported that co-location of their DAP funded service with both mental health and disability services, enhanced referral pathways between the three separate individual organisations.

While examples of integration were evidenced in consultations and the survey results, stakeholders, including DAP providers, expressed a desire for more investment in supporting DAP services to deliver cross sector care, supported by departmental leadership. An opportunity exists for greater coordination and collaboration across the Australian Government, states and territories and providers, to facilitate enhanced cross-sector integration. As described in AADC's online event on forging new partnerships and pathways to achieve better outcomes,[62] this work would begin with the ability of providers to work closely with their funders to report back on what they are experiencing on the ground, what is working and where they need greater support. This could then progress to shared development of professional skills, co-ordinated care arrangements and full service integration where feasible.

[62] The Australian Alcohol & Other Drugs Council. (2023). *Alcohol and other drugs, disability and overrepresentation in the criminal justice system: forging new partnerships and pathways to achieve better outcomes.* Retrieved from https://www.youtube.com/watch?v=VF85dTIyHM8.

"Huge opportunity for DAP to provide a leadership role, clinical guidelines, best practice models of care and training."

- Research Institution

Considerations for DAP sustainability

Enhancing coordinated and responsive service planning between providers and funders

Opportunities exist to leverage insights captured by providers, peaks and PHNs to inform high level DAP policy planning that meets the needs of the Australian people. This begins with a consistent approach to collaborating with DAP providers and regional peaks for PHN local needs assessments, planning and commissioning. This may also include triangulating these insights with state and territory representatives and their expertise.

There is then an opportunity to elevate these insights to inform higher level DAP planning and policy through engagement and information sharing with the department's DAP policy team to inform and support coordinated national planning.

An opportunity exists for the Australian Government to drive enhanced cross sector integration

Stakeholders emphasised that endorsing a cross-sector approach to service delivery will help to address the increasing complexity being experienced by DAP clients. Various approaches were highlighted to enhance cross-sector collaboration from high level policy advice to practical tools and support for providers, all of which could be driven by the Australian Government in collaboration with states and territories and PHNs. Some considerations include:

- Providing clearer guidance to PHNs on conducting their AOD needs assessments and activity panning, to ensure DAP funding is allocated to greatest areas of AOD need.
- Leading the development of strategic direction and policy which aims to align the efforts of all areas of government in relation to addressing AOD harm.
- Funding targeted services which deliver innovative approaches to addressing co-occurring needs.
- Providing support (i.e., through resourcing/funding) to enhance the capacity of all DAP services to be able to support co-occurring needs, including training for the DAP workforce training in managing co-occurring needs.
- Formalising connection between research programs and a new dynamic and adaptive national drug strategy.

Similarly, collaboration between funders at each of the levels and their respective cross sector counterparts could enhance the capability of other sectors (mental health, disability, homelessness, justice) to be able to support co-occurring needs, including breaking down barriers to access for people who use AOD.

4.3.7 Appropriateness recommendations

Considering the findings described within this section and the identified considerations for sustainability of the DAP, a number of recommendations have emerged. These appropriateness recommendations are outlined in Table 12 below.

Table 12 Appropriateness Recommendations

#	Recommendation
2	**Support initiatives which address emerging needs, including harm reduction strategies, prevention programs and initiatives that target individuals with co-occurring needs.** When considering the balance in funding across DAP and states and territories, there is a demonstrable need for increased investment in prevention initiatives including evidence-based community education and prevention campaigns as well as harm reduction services. Currently, there is minimal DAP funding provided towards harm reduction activities, despite a growing evidence base endorsing such services and a commitment from the Australian Government to increase prevention investment by 5% of total health expenditure.[48] DAP investment in prevention initiatives should aim to align with objectives within the National Preventive Health Strategy which calls for prevention initiatives to reduce AOD harm and sets out a number of priority areas including awareness raising, delaying onset of use, prioritising priority populations and upskilling the broader health workforce. Considering the emerging needs and existing reach of DAP noted in this section, there is also a demonstrated need to enhance support for people with co-occurring mental health needs, women and families and/or people who inject drugs. Any rebalance of DAP funding will require careful transition planning to minimise disruption for DAP service delivery organisations and clients. **Timing** – Short to medium term (1 to 3 years). **Responsible Parties** – Australian Government and the Department of Health, Disability and Ageing.
3	**Develop and implement approaches to enhance coordinated and responsive DAP service planning and drive enhanced cross sector integration in the delivery of the DAP.** This could include: • Ensuring development of DAP policy includes contribution from providers, peaks, PHNs, people with LLE and state and territory governments. • Establishing clear GOGs, supporting a consistent approach for PHN local area needs assessment, planning and commissioning of DAP initiatives, including local area AOD needs assessment and collaboration with DAP providers, regional peaks and state and territory governments. The department should require PHNs to report against these objectives so that improvement can be consistently measured. • Formalising the connection between the research programs and a new dynamic and adaptive national drug strategy that evolves over its lifecycle, informed by ongoing monitoring, stakeholder feedback and emerging evidence. • Implementing practices to maintain current DAP service mapping to help inform future funding decisions. The department should also consider expanding the service mapping to include funding provided by states and territories and NIAA. **Timing** – Medium term (2 to 3 years). **Responsible Parties** – Australian Government and the Department of Health, Disability and Ageing.

Source: Evaluation Team

4.4 Impact

This section assesses the impact of the DAP by drawing on insights from across the range of data sources available for the evaluation, including stakeholder consultations, provider performance reports, evaluation reports and a sample of treatment outcome data for NSW. These data sources are used to explore individual and community-level benefits emerging from DAP funding and the opportunities available to strengthen how these impacts are measured through data and reporting tools. The section also explores changes in the service delivery landscape resulting from the DAP, as well as opportunities for improvement.

Trends in population level data related to treatment episodes and the intended long-term AOD impacts identified in the DAP program logic are also provided. While these population data provide useful contextual information, they do not enable an assessment of the specific impact of DAP; as such, there is no attempt to interpret these trends against the implementation of the DAP.

The sub-KEQs explored when evaluating the DAP impact in this section include:

- What effect do DAP services have on resource utilisation by program participants?
- How does resource utilisation vary across different demographic groups who participated in the program? What explains these differences?
- Which elements of DAP may be associated with achieving positive outcomes?
- Are there service improvement models in some settings that could be promoted for broader implementation?
- How have population-level AOD outcomes changed since DAP implementation?

4.4.1 Findings

DAP funding improves access to AOD services. Whilst it is difficult to measure the extent of DAP impacts and to tie a causal link to DAP, the evaluation did find examples of positive outcomes demonstrated across DAP initiatives. Evidence also demonstrated that DAP enables providers to deliver targeted services to meet the needs of their local communities.

Strengthening existing data collection and measurement strategies will improve the evidence of DAPs impacts and inform service planning.

Key findings in the impact domain include:

- DAP funding improves access to AOD services.
- DAP funded services have contributed to positive outcomes for individuals and communities.
- Population-level outcome data provide useful context but could not be used to evaluate DAP.
- Strengthening existing data collection and measurement strategies will improve the evidence of DAP impacts and inform service planning.

Strength of evidence – Weak

Evidence to assess the impact of DAP initiatives primarily drew on review of DAP performance reports, flagship evaluations available from various DAP providers, as well as analysis of numerous quantitative data sets, including the population level AODTS NMDS and HILDA survey datasets. Some evidence was available to inform the presentation of case studies used to demonstrate reported impacts. However, there are significant limitations in the reliability and availability of outcomes data across the DAP that limits the evaluation's ability to draw broad, definitive conclusions regarding the DAPs impact. Causal links were also unable to be drawn from population data analysis, reducing the strength of evidence available for the first two findings above.

4.4.2 DAP funding improves access to AOD services but does not fully meet need

This section examines the impact of DAP on service availability, access and utilisation. Drawing on stakeholder consultations and analysis of provider performance data, it highlights how DAP funding has enhanced the availability of services and enabled more people to access AOD treatment and prevention initiatives. These insights are presented alongside population level treatment data to help contextualise the qualitative insights.

Increased access to AOD services

When exploring DAP outcomes, stakeholders consistently reported that DAP funding positively impacts the AOD service system, improving the viability of services and enabling providers to continue to deliver services to meet the needs of their local communities. For example, for providers delivering services in rural and remote health care settings, DAP funding has reportedly enabled them to reduce gaps in service delivery and contribute to increasing equity of access to AOD services in an environment where services are scarce.

> "A lot of services that would otherwise be unviable with only state and territory funding are made viable with this program. Any reduction in the quantity of funding would mean many services become unviable. The Australian Government investment is critical in this space to maintain the current level of coverage."
>
> **- Peak Body**

DAP prevention initiatives delivered through various modalities were noted as driving increased access. Access to services may be constrained by distance and privacy, especially for regional and rural clients where services can be limited. These issues can be alleviated by accessing services via telehealth modalities and online services. It was reported that the introduction of these modalities has been effective, affording earlier, more informal access, removing some of the power imbalances experienced and reducing some of the stigma attached to physical attendance at a specialist AOD facility. However, the accessibility of these modalities can be hampered by factors such as access to technology, digital, language and cultural literacy and online providers' limited awareness of the experiences of people living in regional/remote locations, including their referral options.[63]

Some providers whose services included elements of a peer workforce shared the accessibility benefits they had observed from incorporating peer workers into their service delivery. Including a peer support setting was identified as being valuable in providing individuals with an alternate setting of receiving support, aside from typical treatment and rehabilitation services. It allowed individuals "to go in and out of both styles of service" and increase access to support that was right for them.

Increased service utilisation

The stakeholder insights regarding improved access are supported by evidence of DAP utilisation which shows an increase in the number of people accessing DAP services. During consultations, providers reported an increase over recent years in demand for services and complexity in presentations and co-morbidities. A review of DAP provider performance reports between July 2021 and March 2025 highlighted these changes in service demand.

Within the performance reporting data analysed, 31 DAP treatment providers consistently reported changes in client admissions rates identifying an admissions growth rate of 32% from 2021 to 2024.

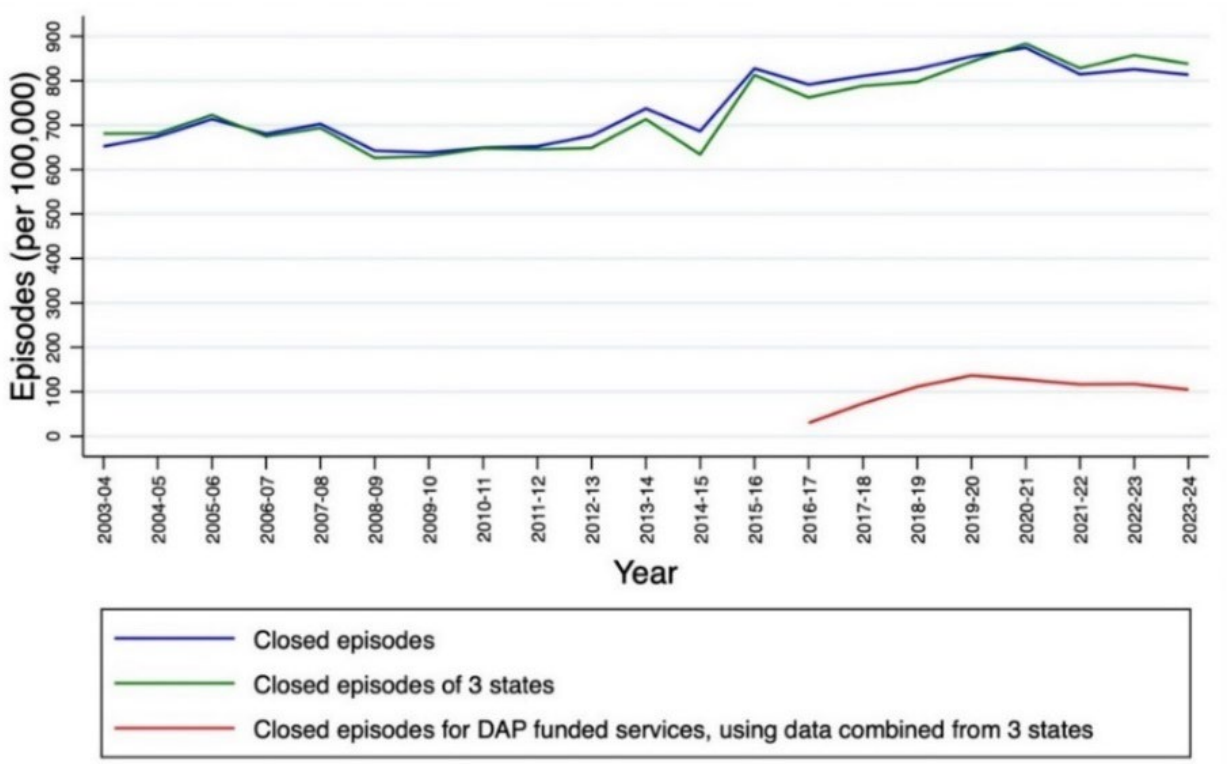
Population level data on treatment episodes provide a comprehensive overview of treatment utilisation across Australia. These data help to contextualise the perspectives shared by stakeholders regarding service access. Specifically, the AODTS NMDS records data on every completed treatment episode within participating

[63] Fomiatti, R, Shaw, F, & Fraser, S. (2022). *It's a different way to do medicine: exploring the affordances of telehealth for hepatitis C healthcare.* International Journal on Drug Policy, 110(1); Kavanagh, B, E, Corney, K, B, Beks, H, Williams, L, J, Quirk, S, E, & Versace, V, L. (2023). *A scoping review of the barriers and facilitators to accessing and utilising mental health services across regional, rural, and remote Australia.* BMC Health Services Research, 23(1); Dilkes-Frayne, E, Savic, M, Carter, A, Kokanovic, R, & Lubman, D, I. (2019). *Going Online: The Affordances of Online Counselling for Families Affected by Alcohol and Other Drug Issues.* Qualitative Health Research, 29(14), 2010-2022; Haylock, P, A, C, Carter, A, Savic, M, & Lubman, D, I. (2022*). Regional and rural clients' presenting concerns and experiences of care when engaging with an online substance use counseling service*. Addiction Research & Theory, 30(5), 330-339.

organisations,[64] including the drugs of concern and treatment types used.[65] However, the dataset has several key limitations to note. First, the data captures closed treatment episodes rather than unique clients, preventing tracking of individual treatment pathways and inflating episode counts. Second, the data are incomplete, covering only a subset of services across three jurisdictions, with suppressed and pooled figures limiting geographic analysis. Finally, there is currently no nationally agreed outcome measure within the AODTS NMDS. Treatment goals and the extent to which they are met (i.e., outcomes) are not captured by the AODTS NMDS, nor is the intention of treatment types captured as part of the treatment episode. 'Reason for cessation' where the 'treatment is completed' is problematic because there is no record of the original intention for that episode or detail of client outcome. These caveats mean that AIHW figures for DAP-funded services — from episode counts to reasons for ceasing treatment — should be interpreted as broad, anonymised snapshots of service activity rather than exhaustive, client-level census data. Any inference about treatment access, client populations or state-specific trends must acknowledge these constraints.

Analysis of AODTS NMDS shows increases in treatment episodes per 100,000 people from 2003-04 to 2023-24 (Figure 15). For DAP-funded services (aggregated data for 3 states available only), episodes increased between 2016-17 and 2019-20 before slightly declining to 2023-24. This increase in service utilisation corresponds with DAP inception in 2016-17, suggesting improved access corresponding with DAP investment. The plateau that occurs in treatment episodes from 2020 also aligns with the last significant funding investment in DAP, which occurred in 2019-20. While it is not possible to directly tie DAP investment to increased utilisation across the broader sector, this trend is promising.

Figure 15 Rate of treatment episodes, 2003-04 to 2023-24



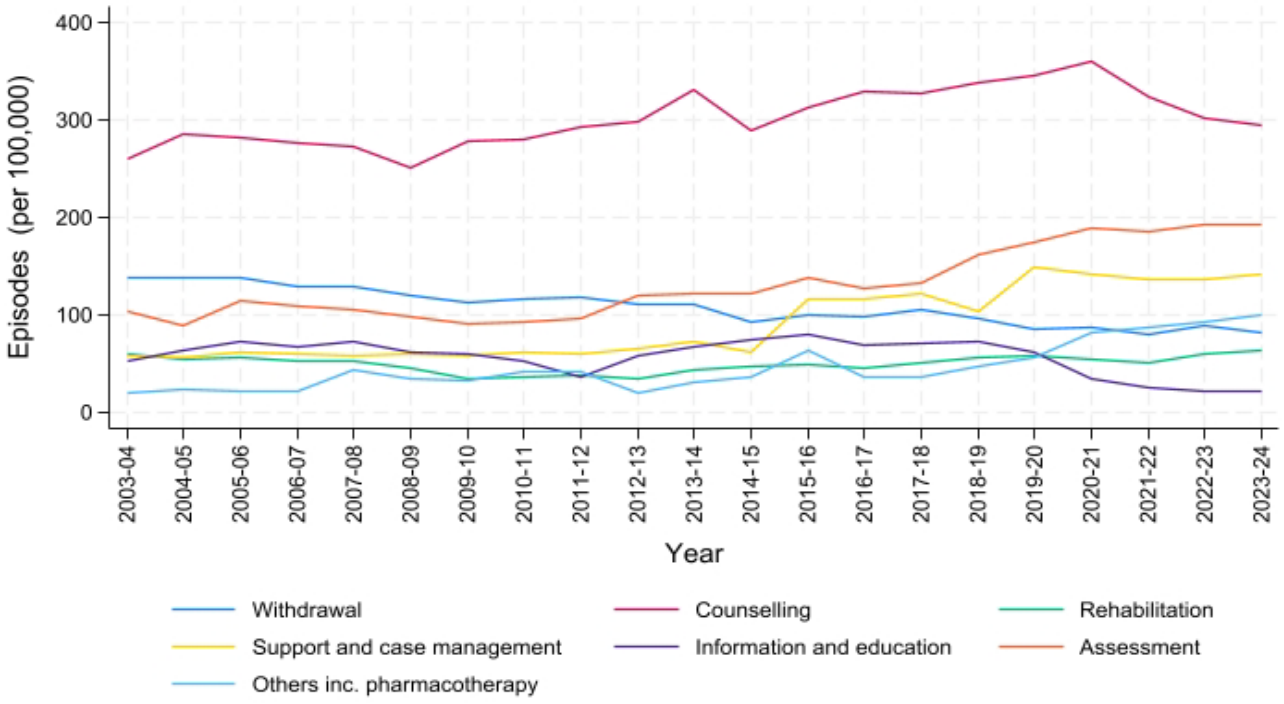
Source: Population adjusted closed episodes, NMDS, AIHW

[64] Publicly funded government and non-government agencies providing alcohol and/or drug treatment services. This includes community-based ambulatory services and outpatient services.

[65] Australian Government Australian Institute of Health and Welfare. (2024). *Alcohol and other drug treatment services NMDS, 2021-22; Quality Statement.*

When examining service utilisation across treatment service types, counselling represented the largest proportion across the time period analysed. The overall increase in treatment episodes shown in Figure 16 as largely driven by increases in counselling, support and case management, assessment and others (including pharmacotherapy). This aligns with stakeholder feedback suggesting that the introduction of NIAS funding via DAP has supported the introduction of more outpatient-type services to address shortages in bed-based services, and to address treatment needs that do not require bed-based services.

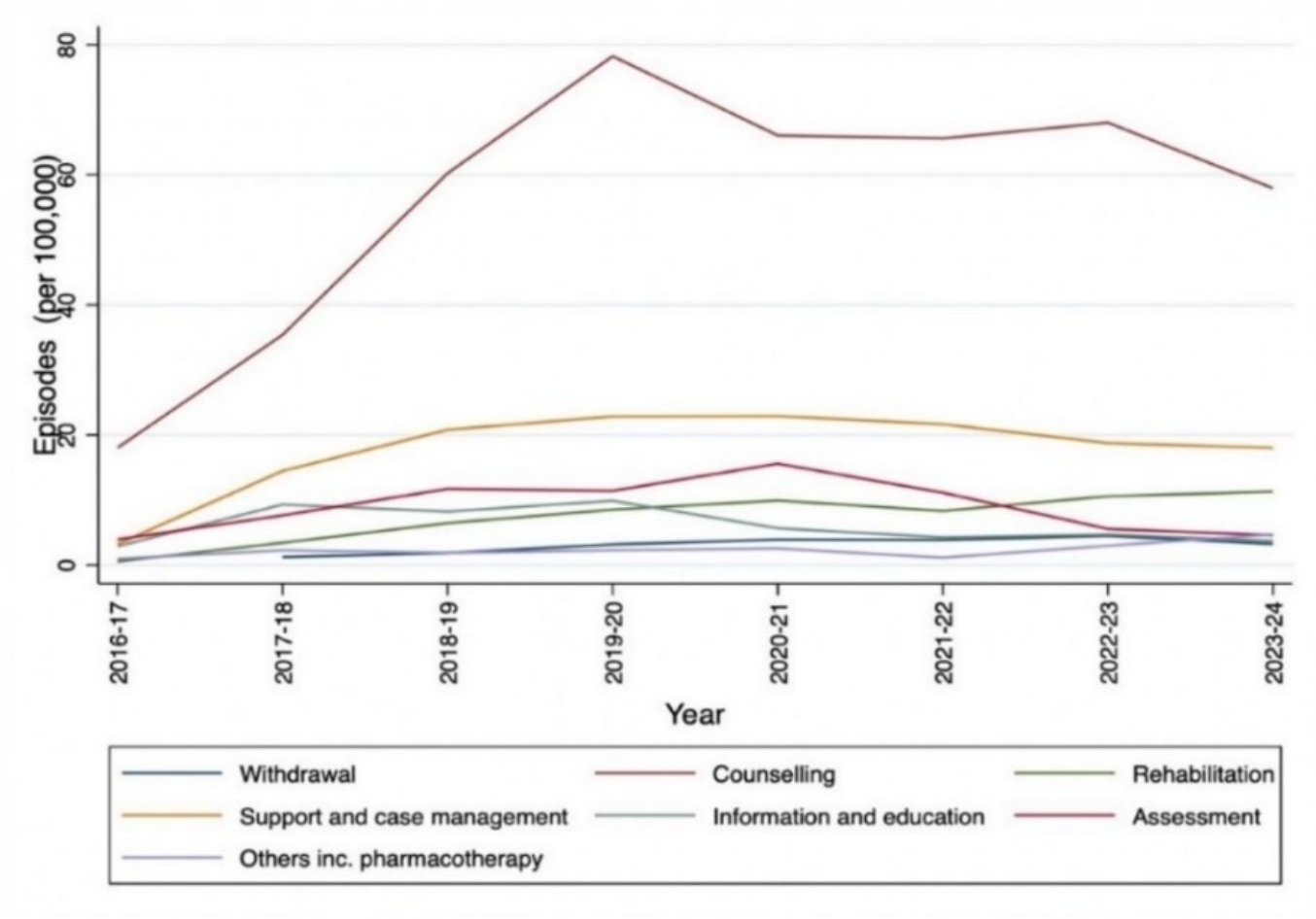
Figure 16 Rate of treatment episodes, by main treatment type, 2003-04 to 2023-24



Source: Population adjusted closed episodes, NMDS, AIHW

For DAP-funded services, counselling treatment episodes have accounted for the largest share of treatment types in the 3 states for which data were available. There was a large increase from DAP introduction in 2016-17 to a peak of 80 per 100,000 by 2019-20. This was followed by a decrease of approximately 25% to around 60 per 100,000 by 2023-2024. This trend in counselling provision across DAP may relate to the proportion of funding commissioned through PHNs who don't traditionally fund residential-based services. It may be useful for the department to explore this trend further to understand the drivers and what it might mean for future DAP planning.

Figure 17 Rate of DAP-funded treatment episodes, by main treatment type, 2016-17 to 2023-24



Source: Population adjusted closed episodes, NMDS, AIHW

4.4.3 DAP funded services have contributed to positive outcomes for individuals and communities

Impacts and outcomes vary greatly across the DAP streams due to the varied nature of support provided from prevention through to treatment and aftercare. The outcomes also vary from individual level outcomes (i.e., impacts on the health and behaviour of clients accessing DAP initiatives) through to community and population level outcomes (impacts on the community or a population of people, such as increased awareness or safety). Noting that limitations exist in the availability of outcomes evidence across DAP, the DAP outcomes that were evidenced through the evaluation are summarised below, presented by stream and level of outcome (individual and community).

Community level outcomes in prevention projects and national prevention projects streams

In the prevention stream, DAP funding enables the continued delivery of prevention activities across the AOD sector and presents future opportunities to expand these services. Providers across the consultations shared the importance of prevention activities in improving community-level health and wellbeing outcomes. Because of the distinct nature of prevention campaigns, often targeting different cohorts or needs, it is difficult to measure prevention initiatives collectively. For the purposes of understanding the impact of DAP prevention initiatives, the evaluation examined distinct impacts of various projects, including a detailed analysis of flagship evaluations available across the stream. This analysis demonstrated that, in general, DAP prevention initiatives are increasing reach of AOD information and resources, increasing AOD knowledge and awareness and contributing to behaviour change.

This is evidenced, for example, by the evaluation of Cracks in the Ice, which found that the website's online toolkit resources improved knowledge about methamphetamine and reduced stigmatising attitudes (across 2110 Australians).[66] These findings show that information and non-judgemental digital resources such as those delivered through Cracks in the Ice can change community knowledge and attitudes, which in turn can reduce barriers to care access. These impacts are rarely assessed within the context of real-world implementation of digital public health initiatives but demonstrate the role digital health tools have in stigma reduction. Across the stakeholder consultations conducted as part of this evaluation, there was also appetite among providers for shifting investment into prevention and early intervention, to further enhance these impacts.

> "Invest more money into prevention. There is good evidence it returns at least $14 to $1. Politically it's a hard one as treatment is more pressing but the more we can invest into prevention takes the pressure off the back end."
> **- Service Provider**

Prevention initiatives aim to improve community health outcomes through use of digital interventions. Examples of the digital interventions used include the following:

- Websites
- Online resources
- Apps
- Social media engagement and posts.

[66] Cash, R, Johnston, J, Bothwell, S, Clancy, B, Demant, L, & Lee, N. (2021). *Evaluation of the National Ice Action Strategy ('NIAS')*. 360 Edge. Retrieved from https://www.health.gov.au/resources/publications/evaluation-of-the-national-ice-action-strategy-nias?language=en.

The use of digital interventions is known to provide increased community access to resources that can improve understanding of the harms associated with AOD use and the information and services available to support individuals. The following case studies demonstrate that these digital interventions enabled broad dissemination of resources within communities. In addition, evidence identified in the literature review highlighted that personalised advice using computers or mobile devices may help people reduce heavy drinking better than doing nothing or providing only general health information.[67] There are also further opportunities to strengthen community knowledge and awareness of prevention programs and the resources available by increasing the use of digital interventions.

Best Practice Example – Positive Choices Program, Matilda Centre for Research in Mental Health and Substance Use, The University of Sydney

The Positive Choices Program is an initiative to address the gap in implementation of evidence-based alcohol and other drug (AOD) prevention approaches in Australia. The program was launched in 2015 and since its launch has provided evidence-based resources to over 4.5 million people.[68] Positive Choices has supported school communities in understanding the facts around AOD use, and to implement best practice prevention strategies to reduce AOD use and related harms. The resources for the Positive Choices Program has enhanced availability of effective prevention resources for implementation within school communities to reduce AOD harm.[69]

The Positive Choices portal is available digitally and has promoted the reach and accessibility of AOD prevention resources to:

- 4,527,000 website visitors
- 8,224,000 page views
- 32,000+ webinar views
- 9 years+ of monthly growth in site users.[70]

The Positive Choices Program has strengthened community awareness of AOD prevention approaches and increased access to evidence-based resources. A study completed by the program found that 100% of participants intended to implement effective AOD prevention programs and strategies after they completed the Positive Choices Program.[71]

[67] Kaner, E, F, Beyer, F, R., Garnett, C, Crane, D, Brown, J, Muirhead, C, Redmore, J, O'Donnell, A, Newham, J, J, de Vocht, F, Hickman, M, Brown, H, Maniatopoulos, G, & Michie, S. (2017). *Personalised digital interventions for reducing hazardous and harmful alcohol consumption in community-dwelling populations.* The Cochrane Database of Systemic Reviews, 9(9).
[68] The University of Sydney, Matilda Centre. (n.d.). *Project Evaluation Framework for Positive Choices, an award winning Matilda Centre translation and dissemination portal.*
[69] The University of Sydney, Matilda Centre. (n.d.). *Project Evaluation Framework for Positive Choices, an award winning Matilda Centre translation and dissemination portal.*
[70] The University of Sydney, Matilda Centre. (n.d.). *Project Evaluation Framework for Positive Choices, an award winning Matilda Centre translation and dissemination portal.*
[71] The University of Sydney, Matilda Centre. (n.d.). *Project Evaluation Framework for Positive Choices, an award winning Matilda Centre translation and dissemination portal.*

Best Practice Example – Good Sports Program, Australian Drug Foundation

The Good Sports Program is Australia's largest community health sports program and was designed as an alcohol management program for community sporting clubs. As a preventative service, the program supported community sporting clubs and provided over 9,500 resources. Almost 10,000 Good Sports Clubs are using the program's resources and the social and economic benefits of the program were estimated at $11.04 million in 2014.[72]

For every dollar invested in the program, there has been an estimated return of $3.10 and $4.20 to the Australian economy.[73] The impact of the program has demonstrated strong behavioural changes for individuals and the community. Outcomes from the program include a reduction in risky drinking by 37% and a reduction in the overall harms by 42%.[74] For the clubs involved in the Good Sports Program there was an 8% reduction in the likelihood of drink driving compared to sports clubs that weren't involved in the program.[75] The Good Sports Program also reported that 89-95% of clubs had an increased knowledge and confidence in developing a policy for illegal drugs.[76]

Community-level outcomes in the FASD stream

Survey respondents reported that through their programs, providers were able to strengthen community knowledge and awareness of AOD harms (100% of survey respondents in the FASD stream) and reduce the stigma associated with AOD use (71.4% of survey respondents in the FASD stream). Analysis of the performance reporting data also suggests that there was improved community awareness and knowledge of FASD as a result of these programs. Examples of how organisations achieved this include expanding service delivery, refining their model of care and improving access to the evidence base. Other examples of how DAP funding has been used within the FASD stream:

- Delivering training and e-learning modules to help health professionals recognise symptoms of FASD.
- Developing educational resources to support in the long-term screening of FASD.
- Providing accessible diagnostic services to individuals at no cost.
- Providing early intervention and promotion services.

> "Having people who are interested in the FASD space has been pivotal, people do see Australia as being one of the leading countries around the world for FASD. Good to see the government has led the way in a campaign in that space too."
> **- Peak Body**

[72] Alcohol and Drug Foundation. (2023). Celebrating 25 Years, A report on the impact of the Good Sports Program. Retrieved from https://goodsports.com.au/celebrate25/

[73] Alcohol and Drug Foundation. (2023). Celebrating 25 Years, A report on the impact of the Good Sports Program. Retrieved from https://goodsports.com.au/celebrate25/

[74] Kingsland, M, Wolfenden, L, Tindall, J, Rowland B, C, Lecathelinais, C, Gillham, K, E, Dodds, P, Sidey, M, N, Rogerson, J, C., McElduff, P, Crundall, I, & Wiggers, J, H. (2015). *Tackling risky alcohol consumption in sport: a cluster randomised controlled trial of an alcohol management intervention with community football clubs.* Epidemiol Community Health, 69, 993-999.

[75] Rowland, B, Toumbouro, J, & Allen, F. (2012). *Drink-driving in community sports clubs: Adopting the Good Sports alcohol management program.* Accident Analysis & Prevention 48, 264-270.

[76] Alcohol and Drug Foundation. (2023). Celebrating 25 Years, A report on the impact of the Good Sports Program. Retrieved from https://goodsports.com.au/celebrate25/

FASD programs demonstrate outcomes associated with their programs, as evidenced in performance reporting and publicly available reviews. DAP funding for providers in the FASD stream has enabled the development of measurement tools and outcome measures. FASD reports showed various improvements across the FASD programs. The following includes a snapshot of some of the reported outcomes from providers in the FASD stream:

- One provider shared that 100% of people who sought FASD information and referral pathways were provided with support for their questions.
- Increased awareness of FASD through marketing campaigns including the Every Moment Matters Campaign, where there was an increase of 52.3% in 2022 to 63.5% in 2023 in the proportion of individuals who had heard of FASD.[77]
- Changed behaviours in response to the Every Moment Matters Campaign, where there was an increase in abstaining from alcohol during current/recent pregnancy from 68.8% in 2022 to 80.3% in 2023.[78]

Across consultations, stakeholders shared that increased funding for FASD initiatives would allow ongoing contributions to improved community-level outcomes.

Individual level outcomes in the withdrawal management and rehabilitation services and AOD treatment services in areas of identified need streams

The programs and services provided through DAP funding were described by stakeholders as creating positive impacts for individuals using the services. It was explained that the services and programs support the delivery of holistic care to individuals receiving treatment and provide support to those individuals to address their drug and alcohol use. For priority populations, DAP funding was described as enabling the delivery of services that positively affect outcomes for these cohorts. Examples of the positive impacts for priority cohorts, as reported by stakeholders, include:

- Providing support to individuals in contact with the justice system in receiving treatment and in navigating integrated services to support them in reducing offending behaviour and thus staying out of prison.
- Supporting individuals in keeping their families and children together, reducing the impacts of family separation and supporting family reunification for those engaged in the care and protection system.
- Delivering culturally safe and place-based care for First Nations people.

Providers consulted in the evaluation expressed agreement that funding delivered through the DAP has contributed to meaningful improvements for individuals in their health and wellbeing outcomes. Figure 18 below highlights the proportion of providers that reported improved outcomes in response to the survey. More detailed survey responses can be found in Appendix D.

Figure 18 Percentage of responses received in the survey outlining positive outcomes from DAP

Source: Evaluation Team Survey

[77] Foundation for Alcohol Research and Education. (2023). *Every Moment Matters Impact Snapshot.* Retrieved from https://fare.org.au/wp-content/uploads/EMM-Impact-Snapshot.pdf.
[78] Foundation for Alcohol Research and Education. (2023). *Every Moment Matters Impact Snapshot.* Retrieved from https://fare.org.au/wp-content/uploads/EMM-Impact-Snapshot.pdf.

Performance reporting outcomes

In DAP performance reporting, DAP treatment providers are invited to provide details of outcomes achieved as a result of their services. Pre- and post-scores for the Kessler-10 (K10) and QoL measures are collected by some providers to assess changes in client's psychological distress and quality of life. Of the 65 organisations that reported collecting these measures, only 18 provided pre- and post-K10 data for 2023-24 and only eight organisations provided QoL data for this period. A decrease in K10 score represents an improvement in severity of a client's psychological distress. Conversely, an increase in QoL score represents an improvement in a client's quality of life. Of the providers who reported against K10 scores, they identified an overall improvement in clients' psychological distress. Of the eight providers that reported against QoL measures, there was a demonstrable improvement in client's quality of life.

It is important to note the limitations in this analysis, particularly in relation to the smaller sample. Across the 65 organisations there were inconsistencies and variances in the data, specifically the performance reporting outcomes used, the ways in which the data was collected and how it was reported in performance reports. There would be benefit in providing advice to DAP treatment providers on the most appropriate evidence-based measures to be used, with clear direction on how they should be collected and reported. This will help to ensure consistent data is available to be used for comparative purposes in the future.

The benefits of holistic and person-centred service delivery

Stakeholders acknowledged that AOD issues do not exist in isolation from other social and health aspects of an individual's life and that opportunities exist to improve the measurement of holistic and person-centred service delivery and client outcomes. Many providers commented on the importance of either incorporating related services within their service delivery models or linking individuals to related services, such as mental health, primary health or housing support. A 'whole-of-person' approach was highlighted as being effective to address the presenting AOD issues, as well as supporting other areas of an individual's life that may influence AOD use and affect the person's recovery.

Supporting all aspects of an individual's life was seen to be beneficial to preventing the relapse of AOD issues and facilitating longer term benefits. Stakeholders noted that there was an opportunity for DAP funding to better support the delivery of holistic and person-centred service delivery.

These perspectives align with the evidence from the literature review that highlighted the need for system-level policy support to enable comprehensive care models that integrate medical, social and community services.[79] This includes improving cross-sector coordination and access to enabling supports such as childcare, transport and substance use treatment. Such integrative and multidisciplinary models were considered especially important in remote settings and must be adequately supported to enhance engagement and recovery outcomes.[80]

Aggregated data from NSW suggest most DAP service users experience positive treatment outcomes

As noted above, outcomes data collection and reporting is inconsistent across DAP providers nationally. In an attempt to address this within NSW, the NSW NADA developed an outcomes database (NADAbase) which allows exploration of clients' improvements. The evaluation analysed this data to understand trends in outcomes across DAP, and for DSS-managed DAP grants compared to PHN commissioned DAP grants. These data show that almost all clients across funding streams who were treated for heroin or amphetamine use achieved at least a one-day reduction in substance use from baseline levels (or maintained their abstinence), with improvement rates often exceeding 95% for DSS and PHN sites. Improvement in alcohol use are also high at between 80 and 85% overall. PHN-commissioned services reported lower and more variable results compared with DSS and DAP funded services, although this may reflect differences between residential and non-residential services. Cannabis improvement rates showed substantial year on year fluctuations across all funding streams, ranging from 63 to 72% improvement.

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[79] Voss, M, W, Smid, M, C, Herrick, J, C, Cleveland, A, Komen, A, V, Johanson, J, & Huntington, M. (2025). *A Scoping Review of Community Harm Reduction Strategies for Maternal and Fetal Opioid Impacts: Implications for Policy.* Substance Use & Addiction Journal, 46(3), 722-734.

[80] Schwarz, T, Horvath, I, Fenz, L, Schmutterer, I, Rosian-Schikuta, I, & Mardh, O. (2022*). Interventions to increase linkage to care and adherence to treatment for hepatitis C among people who inject drugs: A systematic review and practical considerations from an expert panel consultation.* International Journal on Drug Policy, 102.

Improvements in psychological health are also evident in the NADAbase. The improvements, as measured by the K10 self-report remain stable at around 71 to 75% each year, while the Australian Treatment Outcomes Profile (ATOP) clinician assessments were more variable (between 50 and 63%). The most volatility in self-reported improvements were in PHN-funded sites (noting that ATOP is not used in residential services). Quality of life (assessed by the World Health Organisation Quality of Life (WHO QoL) self-report tool) show consistent improvement for around two thirds of clients, whereas clinician-rated ATOP QoL ranged from 50 to 60%.

These improvements, while encouraging, should be cautiously interpreted. While the NADAbase outcome data provide a broad snapshot of client improvement across streams for selected DAP-funded services in NSW, interpretation is constrained by selection bias, data gaps, minimal improvement thresholds and service heterogeneity. As such, any conclusions about relative performance must be made cautiously. Further analyses using raw counts, standardised follow-up periods and case-mix adjustment would help strengthen confidence in the findings.

Community-level outcomes in the withdrawal management and rehabilitation services and AOD treatment services in areas of identified need streams

Stakeholders reported that DAP funding reduces the stigma associated with AOD use and enables the delivery of services to improve community health and wellbeing outcomes. In particular, stakeholders consistently emphasised that investment in the DAP represents the Australian Government's acknowledgement of AOD as a health issue within Australia. In the survey, 58% of providers identified that DAP funding supported in reducing stigma against people with lived experience of AOD use. Providers also shared during consultations that funding enables them to meet local community needs through increasing access to local services. As noted in Section 4.2, this includes enabling providers to deliver services in rural and remote areas to reduce the gaps in the AOD service delivery. Additional community-level benefits include reducing AOD related harm to the community and individuals.

DAP funding enables the delivery of services to provide wrap-around care that is needed to reduce AOD harms. Across consultations, stakeholders shared how harm reduction (which may include, for example, community-based outreach, needle and syringe programs and drug checking services), is included as part of providing treatment services, and highlighted the role of holistic and wrap-around care. Across consultations there was significant interest from stakeholders for further investment in harm reduction activities. These insights are further supported by the literature review which highlighted the importance of harm reduction and wrap-around services to reduce AOD harm, as outlined in the appropriateness section of this report.

Providers also noted system level impacts, explaining, for example, that by increasing access to specialist AOD services, DAP funding has the potential to reduce the demand on primary health care services. In strengthening the delivery of AOD services, DAP funding was also reported to enhance partnerships and relationships within the health services sector that contribute to and facilitate holistic, wrap around service delivery. Through Australian Government funding, DAP funding supports providers to create improvements in community health and wellbeing outcomes.

> "Really effective providers are acting as coordinators in their services."
> **- Service Provider**

Community- and individual-level outcomes for PHN commissioned DAP initiatives

Community level outcomes

Through DAP funding, PHNs have continued to commission services that are responsive to local health needs. DAP funding requires PHNs to undertake regular health needs assessments to identify gaps in AOD service delivery within their local areas. Based on these needs assessments, PHNs are able to commission services to help meet service delivery gaps within the AOD sector and contribute to strengthening the delivery of services. Stakeholders identified the important role PHN Regional Needs Assessments play in ensuring that localised and flexible approaches are designed to meet the specific needs within and across regions.

Survey responses identified a high level of confidence that services commissioned by PHNs were making a positive impact on individuals. Based on the responses received, 72.7% of providers selected that their PHN commissioned services have had a positive impact on individuals "to a great extent", with 27.3% of respondents selecting "to some extent." Survey respondents reported the following positive changes as a result of PHN commissioned services:

- Improved access to services for priority populations
- Strengthened delivery of integrated and holistic care
- Increased available services and resources for individuals
- Improved the community awareness and knowledge of harms associated with AOD use.

Opportunities exist, however, to further strengthen this service delivery by refining the mechanisms for commissioning of services and reporting on this process, discussed further in Section 4.4.5.

First Nations' Perspectives

Providers emphasised that an opportunity exists to strengthen the delivery of culturally safe care that is responsive to local health needs. To strengthen the delivery of culturally safe care, there is a role for cultural knowledge and clinical knowledge in delivering care. Providers suggested that future funding could support improved data collection to better understand and respond to outcomes for First Nations peoples. They also emphasised the importance of ensuring that data sovereignty principles are upheld when balancing the collection of output and outcome data and in reporting against funding requirements. The Social, Emotional and Wellbeing Framework recognises the holistic understanding of wellbeing and the importance of culture and history in better healthcare for First Nations People and could be leveraged to enhance culturally safe outcomes measurement and reporting across DAP.[81]

[81] Transforming Indigenous Mental Health and Wellbeing. (2021). *Fact Sheet: Social and Emotional Wellbeing*. Retrieved from http://timhwb.org.au/wp-content/uploads/2021/04/SEWB-fact-sheet.pdf

4.4.4 Population-level outcome data provide useful context but could not be used to evaluate DAP

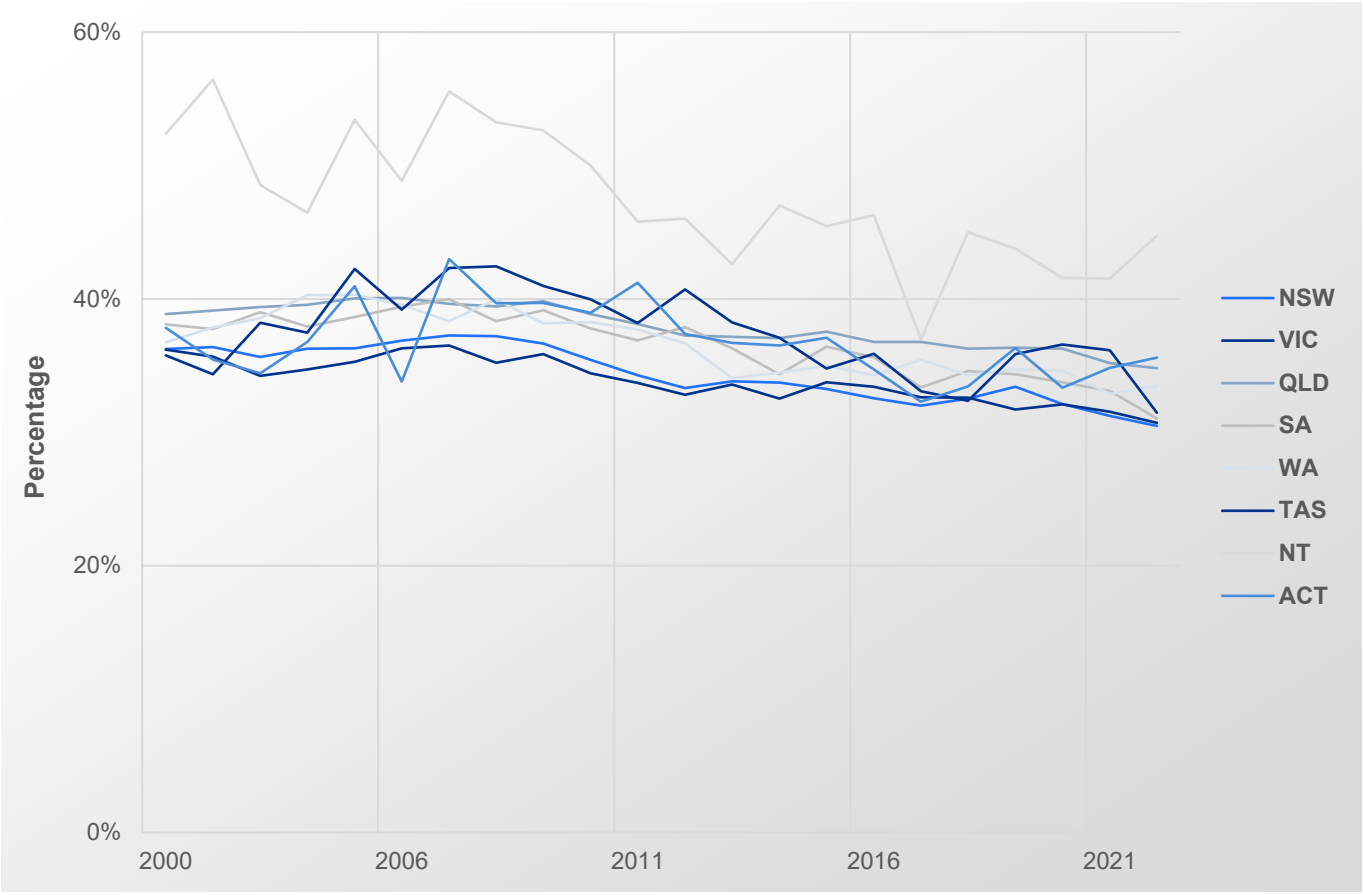
This section presents trends in population-level data on long-term AOD outcomes described in the DAP program logic. However, these data were not considered suitable for attributing changes specifically to DAP and no attempt has been made to draw causal links to the program's implementation. A detailed description of the limitations of the available data for assessing DAP's impact is also provided.

Consumption

The HILDA survey can be used to assess trends in AOD use in Australia for a time before and after DAP funding was implemented. The HILDA data provides useful contextual information but cannot be used to infer DAP impacts as it is unknown whether respondents to the HILDA have accessed DAP-funded services. Nonetheless, it provides valuable information on patterns of AOD use among a representative sample of the Australian population across all states and territories from 2002 onwards.

Overall, there has been a decrease in the prevalence of respondents who consume risky levels of alcohol (defined according to NHMRC Guidelines as either more than four standard drinks per drinking occasion, or more than 10 standard drinks per week), from 37.1% in 2002 to 32.1% in 2023. Levels of risky alcohol use vary by jurisdiction, with the NT consistently showing the highest rates of risky drinking, though there has been a downward trend over time (Figure 19). The prevalence of risky alcohol use is lowest in Vic and NSW. Visual inspection of the data suggests no obvious change in the prevalence of risky alcohol use after the introduction of the DAP in 2017 although, as noted earlier, the DAP represents a continuation of some previously funded initiatives.
The NDS Household Drug Survey shows that rates of risky drinking dropped from 47.1% in 2010 to 40.5% in 2022-23.

Figure 19 Prevalence of risky alcohol consumption over time and across jurisdictions



Source: HILDA

Hospitalisations and deaths

Alcohol-related deaths and hospitalisations are defined as those where the underlying cause or principal diagnosis is directly attributable to alcohol use. This includes acute conditions such as alcohol poisoning and chronic conditions such as alcoholic liver cirrhosis. Drug-related deaths and hospitalisations are defined as those where the underlying cause or principal diagnosis is directly attributable to drug use (excluding alcohol and tobacco). Drug-related deaths refer to cases such as overdoses where drug use is the direct cause of death, not where drugs played only a contributory role. Many drug-related hospitalisations involve multiple substances; if no single primary drug is identified, the case may be recorded as multiple drug use and not attributed to a specific substance.

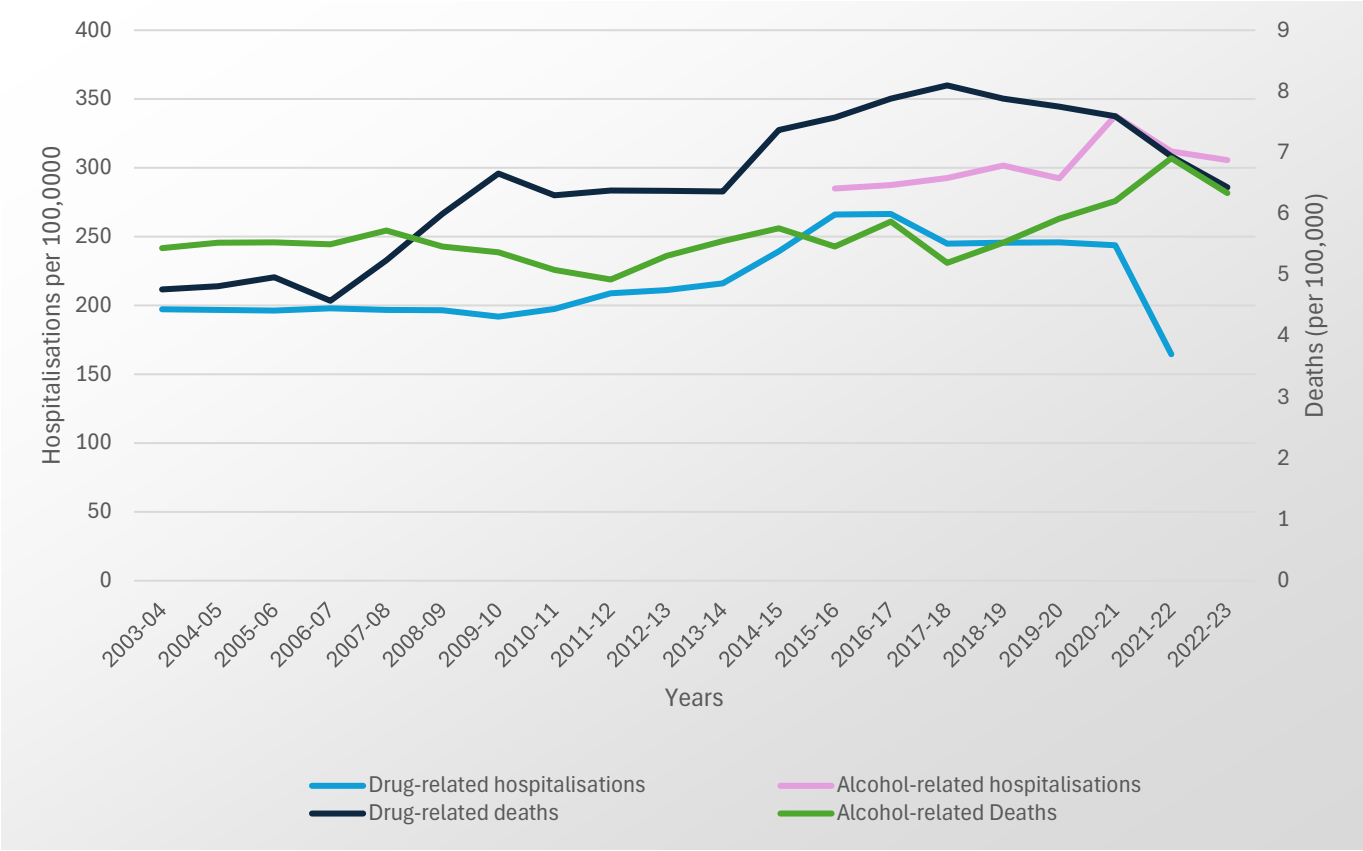
Figure 20 presents trends in drug- and alcohol-related hospitalisations and deaths per 100,000 population from 2003–04 to 2023–24. Drug-related hospitalisation data are from the National Drug and Alcohol Research Centre (NDARC), while alcohol-related hospitalisation data and all mortality data are from AIHW.

Drug-related hospitalisations rose steadily from 192 per 100,000 in 2009-10 to a peak of 266 per 100,000 in 2015–16 before declining by 39% to 164 per 100,000 in 2022–23. Alcohol-related hospitalisations increased from 285 per 100,000 in 2015/16 to a peak of 334 in 2020–21, before falling to 306 per 100,000 in 2022–23.

Drug-related deaths, shown on the right axis, rose gradually from the late 2000s, peaking in 2017–18 at around 9 per 100,000, before declining by about 20% to 2023–24. Alcohol-related deaths were relatively stable until 2017–18, then increased to a high of nearly 7 per 100,000 in 2021–22, followed by a modest decline.

Overall, both drug and alcohol harms increased markedly from the early 2010s to their respective peaks in the mid to late 2010s (for drugs) and early 2020s (for alcohol). Since then, hospitalisations have declined more sharply than deaths. This divergence may suggest improvements in acute care or earlier intervention efforts.

Figure 20 Trends in drug- and alcohol-related hospitalisations and deaths, 2003-04 to 2022-23



Source: AIHW and NDARC

4.4.5 Strengthening existing data collection and measurement strategies will improve the evidence of DAP impacts and inform service and system planning

Robust quantitative data collection and analyses are critical for assessing the effectiveness of the DAP and for informing service planning and improvement. While this evaluation has drawn on a range of available data sources, significant limitations in data quality, availability and structure have constrained the ability to assess DAP outcomes and impacts, particularly through quasi-experimental methods. This section outlines key methodological and data-related limitations that affected the scope of the analysis and presents a set of considerations for strengthening outcome measurement, performance reporting and data infrastructure to support future evaluations and continuous improvement across the sector.

Existing data and methodological limitations

Initially, there was an interest in including experimental or quasi-experimental approaches in the evaluation design. These methods, recommended by the Australian Centre for Evaluation, are often viewed as providing the strongest evidence for establishing causal attribution with quantitative data and determining whether observed changes in outcomes can be directly linked to a specific intervention. However, through a detailed evaluability assessment and review of available data sources, it became clear that the conditions necessary to support such approaches were not present for this evaluation.

This section summarises the main methodological and data-related limitations that constrained the ability to apply such designs (further detail is provided in Appendix B). Given these limitations, the evaluation has necessarily relied on descriptive analyses and proxy indicators to describe trends in relevant indicators of service utilisation and AOD use over the time period that DAP has been funded. These analyses provide useful insights into trends and patterns but fall short of demonstrating program impact.

Lack of a well-defined ‘evaluand’

A foundational requirement for causal inference is a clearly defined exposure (or ‘evaluand’), i.e., an intervention or program that is sufficiently discrete and temporally bounded to be isolated analytically. In the case of the DAP, the evaluand comprises hundreds of sub-programs, implemented at different time points, targeting diverse populations and often overlapping with other Australian Government, state or territory-funded initiatives. The boundaries of these programs are often blurred, with some representing continuations of earlier initiatives and others being new interventions without a clear implementation start date. In this context, isolating the causal impact of any single program (or of the DAP as a whole), is extremely difficult.

This lack of specificity in the definition of the evaluand also creates problems for analysis at the aggregate level. For example, some DAP grants ceased during the period under review, while others continued from earlier funding arrangements, complicating the construction of a meaningful pre-post analytic framework. These issues limited our ability to explore the attribution of AOD-related outcomes specifically to the DAP.

Absence of a suitable comparison group

Quasi-experimental methods such as difference-in-differences, interrupted time series, propensity score matching and synthetic control methods all require some form of counterfactual, referring to an estimate of what would have happened in the absence of the intervention. For a national program such as the DAP, a key challenge is that individuals who received support through DAP-funded services cannot be reliably identified in the available datasets, making it impossible to distinguish a ‘treated’ group. Similarly, there is no readily identifiable comparison group of people experiencing AOD-related harm who did not receive DAP-funded services, limiting the ability to construct a suitable counterfactual.

A staggered rollout could, in theory, have supported causal inference using difference-in-differences or Interrupted time series methods, but the rollout of the DAP was not sufficiently consistent across jurisdictions or time to enable this. Furthermore, available data from AIHW were considered incomplete and unreliable for the pre-2016 period, making it difficult to establish a stable baseline against which to assess change. Even if baseline data were available, the concurrent implementation of multiple overlapping programs would introduce substantial confounding, further undermining causal inference.

Data fragmentation and lack of linkage

As highlighted through the stakeholder consultation, the data available for this evaluation are fragmented across multiple sources and are not linked at the individual or service level. This limits our ability to track participants' journeys through treatment and assess changes in outcomes over time in relation to program exposure. While the AODTS NMDS provides some episode-level treatment data, this dataset does not include and is not liked to, data on treatment outcomes, thereby preventing robust analysis of effectiveness.

Key population datasets that capture data on AOD use, such as HILDA and the NDSHS, cannot be linked to the DAP or to specific treatment services. As such, they can only be used to describe broad population level trends in AOD use and are not suitable for establishing program level effects.

In summary, while experimental and quasi-experimental approaches were considered and initially planned for, the nature of the DAP and limitations in the available data, particularly around treatment definition, comparison groups and linkage, meant these approaches were deemed infeasible. These methodological considerations, detailed further in Appendix B, highlight the challenges of evaluating complex, multisite, multiservice programs operating in dynamic policy environments. Nevertheless, the evaluation has delivered valuable findings through service mapping and the triangulation of multiple data sources. Recommendations are offered below for how future program designs and data collection efforts could better support causal evaluation approaches.

Strengthening outcome measurement and performance reporting

Measuring outcomes across a diverse and evolving program like the DAP is inherently challenging. Legacy funding mechanisms and variability in service types make consistent measurement difficult. Stakeholders emphasised the value of KPIs and performance reporting for understanding service impacts but noted inconsistencies in reporting processes and the time burden involved. The evaluation identified variability in the maturity and ability of DAP providers to monitor their own performance through evidence collection and in seeking to continually apply better practice. Some providers demonstrated the ability to use data to evidence impacts, such as through evaluations and service reviews. While the evidence suggested that some DAP providers would benefit from capability uplift in this area, to enable consistent and robust evidence collection across DAP.

Providers described a lack of clear guidance on appropriate indicators, particularly for prevention activities and priority populations such as CALD and First Nations communities. Literature findings echoed these concerns, citing heterogeneity in outcome measures and inconsistent use of validated tools (e.g., Alcohol Use Disorders Identification Test, World Health Organisation Alcohol, Smoking and Substance Involvement Screening Test , K10), limiting comparability across services.[82] Providers across the DAP expressed a desire for clearer guidance on data collection and evaluation, including agreed monitoring frameworks and reporting expectations tailored to different service types. While treatment services are more amenable to outcome tracking, prevention-focused providers face

[82] Sumnall, H, Bates, G, & Jones, L. (2017). *Evidence review summary: drug demand reduction, treatment and harm reduction.* European Monitoring Centre for Drugs and Drug Addiction; Bates, G, Jones, L, Maden, M, Chochrane, M, Pendlebury, & M, Sumnall, H. (2017). *The effectiveness of interventions related to the use of illicit drugs: prevention, harm reduction, treatment and recovery: A 'review of reviews'*. Health Research Board; Miler, J, A, Carver, H, Foster, R, & Parkes, T. (2020). *Provision of peer support at the intersection of homelessness and problem substance use services: a systematic 'state of the art' review.* BMC Public Health, 20(1); Pussig, B, Vandelanotte, S, Mathei, C, Pas, L, Aertgeerts, B, & Vermandere, M. (2022). *Mapping key components of community-oriented strategies to facilitate alcohol-related early identification and brief intervention in general practice: a scoping review.* Family Practice, 39(4), 701-709; Smith-Bernardin, S, M, Suen, L, W, Barr-Walker, J, Cuervo, I, A, & Handley, M, A. (2022). *Scoping review of managed alcohol programs.* Harm Reduction Journal, 19(1); Perrin, S, Fillol, A, Moriceau, S, Tirant, L, L, Allache, A, Serre, F, Stevens, N, Auriacombe, M, Cambon, L, & Martin-Fernandez, J. (2024). *Exploring and describing alcohol harm reduction interventions: a scoping review of literature from the past decade in the western world.* Harm Reduction Journal 21(1); Donnell, A, Unnithan, C, Tyndall, J, & Hanna, F. (2022). *Digital Interventions to Save Lives From the Opioid Crisis Prior and During the SARS COVID-19 Pandemic: A Scoping Review of Australian and Canadian Experiences.* Frontiers in Public Health, 10; Crowther, D, Curran, J, Somerville, M, Sinclair, D, Wozney, L, MacPhee, S, Rose, A, E, Boulos, L, & Caudrella, A. (2023). *Harm reduction strategies in acute care for people who use alcohol and/or drugs: A scoping review.* PLoS One, 18(12); Klimas, J, Fairgrieve, C, Tobin, H, Field, C, O'Gormhlyan, C, S, Glynn, L, G, Keenan, E, Saunders, J, Bury, G, Dunne, C, & Cullen, Walter. (2018). *Psychosocial interventions to reduce alcohol consumption in concurrent problem alcohol and illicit drug users.* Cochrane Database of Systematic Reviews, 12.

challenges in identifying suitable indicators. Current metrics (e.g., web engagement, workshop numbers), while useful, offer limited insight into impact.

The lack of harmonisation in reporting, especially for services funded by both the department and PHNs, adds administrative burden and hinders the ability to demonstrate outcomes. There is strong sector appetite to improve and harmonise measurement tools. Best practice examples exist in jurisdictions where peak bodies support consistent use of a core set of validated measures. This is consistent with recent studies in Australia highlighting the need for best practice performance measures in the AOD sector to improve policy accountability, streamline reporting requirements and support sector-wide quality improvement.[83] Stirling et al. (2022) developed an agreed set of measures for assessing the performance of AOD treatment services, spanning outputs and processes through to outcomes for individuals.[84]

A program logic is a fundamental tool to identify appropriate indicators and to inform a broader monitoring and evaluation framework. Noting the recommendation to more strongly align the DAP with national AOD policy and strategy, the DAP program logic should also be refined. Given the diversity of the DAP, stream-specific program logics, which clearly link to the broader program logic, are likely to be necessary. Funded services' objectives and associated performance indicators should map to a stream-specific program logic. It is important to meaningfully engage stakeholders, including funded providers, the AOD sector and people with LLE, in developing the monitoring and evaluation framework and its associated components. This will support a framework that is credible and useful, as set out in the Australian Government evaluation principles. DAP providers should also be engaged in this process to enhance their capability for consistent data and evidence collection and quality improvement practices.

Leveraging data linkage for improved evaluation

Data linkage allows sophisticated quantitative techniques, such as those described in Appendix B4, to be applied by combining information from multiple sources to provide a richer, more comprehensive view of individuals' health and welfare. The AIHW routinely carries out customised data linkage projects that deliver tangible benefits to the community. However, accessing these linked datasets requires the approval of data custodians and ethics committees, which can be a complex and time-consuming process.

Including DAP-related service records in a broader linkage framework and allocating sufficient lead time for custodial and ethical approvals would enable researchers to conduct more detailed analyses and draw stronger causal inferences. This would, in turn, support more informed policy development and improved service delivery.

[83] Stirling, R, Ritter, A, Rawstorne, P, & Nathan, S. (2020). *Contracting treatment services in Australia: Do measures adhere to best practice?* International Journal of Drug Policy, 86.

[84] Stirling, R, Nathan, S, & Ritter, A. (2022). *Prioritizing measures to assess performance of drug treatment services: a Delphi process with funders, treatment providers and service-users.* Addiction,18(1),119-127.

Considerations for DAP sustainability

Designing a fit-for-purpose monitoring and evaluation approach

In considering the future of the DAP, it is essential to develop a monitoring and evaluation framework for the DAP that aligns with national AOD policy and strategy, such as a new NDS. This framework is a key factor in ensuring the Australian Government is making well-informed, evidence-based commissioning decisions and that funded providers continue to effectively deliver against objectives of the program and assess and report on the outcomes they are achieving. Such a framework would support more consistent evaluation of drug and alcohol programs funded under the DAP, including approaches to measuring effectiveness and efficiency. The monitoring and evaluation framework should be consistent with the Australian Government evaluation principles, including that it is fit for purpose and useful, robust, ethical and culturally appropriate. There would be additional merit in the DAP monitoring and evaluation framework providing a basis for a national outcomes framework across the AOD sector, to ensure consistent and comparative data on sector impacts.

A monitoring and evaluation framework which incorporates capability building will promote greater consistency in service provider approaches to monitoring their service quality and impact. It is also important to note that adequate funding is required to enable providers to engage with this level of monitoring and evaluation, beyond their core DAP funding.

Harmonising reporting KPIs

Stakeholders are eager to see reporting KPIs harmonised across all levels of funding to avoid the duplication of effort in reporting on the same indicators in different ways. Ideally, this would involve consultation with the sector to determine the appropriate KPIs and ensure that the approach to reporting is appropriate and suitable to those delivering services. Investment in national quality improvement mechanisms for the DAP could support in harmonising reporting KPIs. Examples of National Quality Improvement Mechanisms include the National Quality Framework for Drug and Alcohol Treatment Services and the Queensland Safety Quality Improvement Framework: Mental Health Alcohol and Other Drugs Care.[85,86]

Additional detail on both of these considerations can be found in recommendations for the impact domain.

[85] Department of Health, Disability and Ageing. (2019). *National Quality Framework for Drug and Alcohol Treatment Services.* Retrieved from https://www.health.gov.au/resources/publications/national-quality-framework-for-drug-and-alcohol-treatment-services?language=en.
[86] Queensland Health. (2024). *Queensland Safety and Quality Improvement Framework, Mental Health Alcohol and Other Drugs Care.* Retrieved from https://www.health.qld.gov.au/__data/assets/pdf_file/0019/1362304/safety-quality-improvement-framework-mhaod.pdf.

4.4.6 Impact recommendations

Considering the findings described within this section and the identified considerations for sustainability of the DAP, several recommendations have emerged. These impact recommendations are outlined in Table 13 below.

Table 13 Impact Recommendations

#	Recommendation
4	**Update the Monitoring and Evaluation Framework for DAP to ensure it is fit-for-purpose and promotes a consistent approach to quality improvement across DAP services.** While this evaluation can provide a basis for future DAP evaluation, there are a number of limitations to the current approach, such as time constraints and data availability, that would be addressed in an updated monitoring and evaluation framework (framework). The development of the updated framework will require a considered approach and deep sector engagement to ensure impact and efficiencies of DAP can be suitably measured into the future. Key activities to include are detailed below. • Convening an Evaluation Advisory Group to provide expert advice on development of the framework. This may include representation from the department DAP policy team, the departments Health, Economics and Research Division, AIHW, a service provider peak, a PHN peak and an LLE peak. This steering committee would provide guidance and advice to the following activities: • Developing a strategy logic specifying the intended outcomes and impacts of DAP, with consideration of broader national drug and alcohol strategies and stakeholders' expressed needs. • Development of evaluation elements including a theory of change, key evaluation questions, indicators and data sources. This will need to consider evidence-based tools and approaches for measuring DAP impacts and efficiency. • Ensuring these key framework elements are implementable and link closely to the Australian Governments objectives outlined in a future national AOD strategy. • Completing a data quality audit to confirm the availability, quality and structure of the qualitative and quantitative data sources that contribute to measuring the outcomes articulated in the framework. • Undertaking evaluability assessments to determine what methodological approaches are likely to be feasible with the available data and resources. The extent to which quasi-experimental design can be included is dependent on the extent and quality of data collected. To enhance the opportunity to incorporate these approaches, the process should include: • Collaborating with the AIHW to advocate for and enable data linkage to better evidence the direct impacts of DAP. • Designing a detailed data matrix in collaboration with key stakeholders including (but not limited to) providers and the AIHW that incorporates quasi experimental approaches where data availability can be reached. **Implementation considerations** The effectiveness of this framework will be contingent on the engagement with key stakeholders to ensure the availability and reliability of key data components, including: • Co-designing the framework with stakeholders across all levels of the DAP system including providers, PHNs, states and territories, the Australian Government, peak bodies and LLE representatives. • Engaging with stakeholders to align data collection and monitoring approaches to the capacity and capability of those delivering services. The framework should seek to incorporate capability building and upskilling to enhance capacity of the sector to reliably capture the required data may. This will promote greater consistency in service provider approaches to monitoring quality and impact. • Engaging with the AIHW will be essential to collaborate on data linkage opportunities to better evidence the full impacts of the DAP services. • Timing of the framework updates will need to consider dependencies on other recommendations. In particular, the updated framework would be best completed once the DAP streams have been consolidated and GOGs have been updated to align with any new strategy. **Timing** – Medium term (2 to 3 years). **Responsible Parties** – Department of Health, Disability and Ageing.

#	Recommendation
5	**Harmonise reporting KPIs across DAP to streamline processes and increase reliability of reporting**. This may include: • Collaborating with DAP providers to determine the appropriate KPIs required for reporting and align the recommended KPIs and Performance Measurement tools to best practice evidence. • Consolidating existing reporting KPIs to understand areas of duplication and opportunities available to enhance efficiency in the reporting process. • Providing clear guidance to providers on the reporting measures to provide and the methods to collect this data, including clear guidance on a consistent approach to collect and report the data to ensure comparability across services. Section 5.3 of this report provides a more detailed description of the types of performance indicators which may be considered across DAP, outlining universal KPIs along with examples of prevention and treatment specific KPIs. **Implementation considerations** • The NSW trial may provide a basis for beginning this work. • It would be beneficial to align this work with the efforts to update DAP GOGs as well and update of the monitoring and evaluation framework. There may be an opportunity to incorporate greater guidance for a smaller set of KPIs and updated KPIs in the immediate instance, with more significant updates to occur as each of these other pieces of work occur. • The department may benefit from leveraging existing work, including the KPI pilot conducted throughout NSW. The department may also take a leadership role in driving this piece of work further, encouraging and supporting a consistent approach to harmonising KPIs across the whole AOD sector, including Australian Government and state and territory funding. This will ultimately create significant efficiencies across the sector and build robust service system monitoring. It will, however, require strong engagement with and buy-in from PHNs, NIAA and states and territories. **Timing** – Short to Medium term (1 to 3 years). **Responsible Parties** – Department of Health, Disability and Ageing.

Source: Evaluation Team

4.5 Efficiency

This section assesses the extent to which the DAP delivered value for money. This is explored through the efficiencies created in streamlining the organisation of the DAP funding streams and in aligning services to best practice evidence to reduce service delivery costs. Additional opportunities to enhance efficiency are also discussed, including improving the sustainability of funding reporting requirements. The sub-KEQs explored when evaluating the DAP efficiency include:

- How have resources been allocated and utilised?
- To what extent is the relationship between inputs, outputs and outcomes timely and to expected standards?
- Are the reporting arrangements required from funded organisations proportionate to the level of funding and program objectives?
- Are there gaps or areas of duplication in the DAP? How can these be addressed?

4.5.1 Findings

It can be reasonably inferred that the DAP investment into prevention and treatment services is likely to create value for money into the future for the Australian Government. More streamlined organisation of DAP funding streams can support increased efficiencies in commissioning and managing grants. Various inefficiencies were identified, including impacts of administrative practices and inconsistent reporting and grant uncertainty. Sustainable funding arrangements will create opportunities to improve the efficiency of services in the AOD sector. Improving transparency and coordination over reporting requirements can also support a more streamlined and efficient approach to reporting.

Key findings in the efficiency domain include:

- A more streamlined organisation of DAP funding streams, linked to service categories, can support increased efficiencies in commissioning and managing grants.
- Understanding the costs and avoided costs of certain treatment types can guide investment in the DAP to ensure value for money.
- Sustainable funding arrangements create opportunities to improve the efficiency and productivity of DAP services.
- Improving transparency and coordination of reporting requirements can support a more streamlined and efficient delivery of DAP initiatives.

Strength of evidence – Some

Evidence to assess the efficiency of DAP was sourced through a review of DAP documentation, including grant agreements and performance reports, as well as recent relevant reviews across the AOD sector. Cost-effectiveness considerations relied heavily on findings from the literature. The stakeholder survey and consultations provided useful insights regarding the efficiency of DAP policy and practices. While some evidence was available, DAP cost-effectiveness could not be calculated due to a lack of outcomes data. Findings in this domain relate to DAP as a whole, rather than to individual funding streams or grants.

4.5.2 A more streamlined organisation of DAP funding streams, linked to service categories, can support increased efficiencies in commissioning and managing grants

Section 4.2.2 described the evolution of DAP and its transition from various grants, into one program of AOD support. This transition saw the organisation of DAP grants into streams, which largely reflect the previous grants, as well as the transition to commissioning through PHNs. As a result, there are administrative and service delivery legacies because of this consolidation of former grants. Notably, some of the initiatives that are funded within a DAP stream do not align strongly with the intended type of activities within that stream. There is an opportunity to review the current organisation of streams under which initiatives are funded to avoid duplication and drive efficiencies for both the department when commissioning and managing grants and the services in reporting and acquitting grants.

Current organisation across in-scope DAP streams

The organisation of grants into the six in-scope DAP streams provides structure and direction in determining the objectives, outcomes and measures for the different initiatives. Individual streams outline their own stream-specific objectives and outcomes, which are built into the GOGs and grant agreements that support the broader DAP-level objectives outlined in the program logic. Within some streams, there are multiple GOGs that are relevant to specific initiatives and providers within the stream. The GOGs are built into individual grant agreements and guide both the delivery of activities and their administration, including how performance is measured and reported.

Table 14 below outlines the breakdown of grants across the six in-scope streams and describes the categories of initiatives funded within each stream. The table highlights overlap of service categories delivered across streams.

Table 14 Organisation of DAP streams with a description of service categories

Types of initiatives	Prevention Stream	National Prevention	FASD	Withdrawal management and rehabilitation	AOD treatment in areas of identified need	PHNs
Early intervention	Yes	Yes	No	No	No	
Primary prevention	Yes	Yes	No	No	No	Yes
Whole of community information and education	Yes	Yes	Yes	No	No	Yes
Capacity and capability building	Yes	Yes	Yes	No	Yes	Yes
Specific prevention and treatment activities relating to FASD	No	No	Yes	No	No	No
Training and educating health professionals	Yes	No	Yes	No	No	No
Diagnostic services	No	No	Yes	No	No	No
Harm reduction	No	No	No	Yes	Yes	
Detoxification/withdrawal	No	No	No	Yes	Yes	Yes
Inpatient rehabilitation	No	No	No	Yes	Yes	No
Post-residential aftercare	No	No	No	Yes	No	No
General treatment (counselling, case management, pharmacotherapy, therapeutic communities)	Yes	Yes	No	Yes	Yes	Yes
Assertive in-reach	No	No	No	Yes	No	No

Types of initiatives	Prevention Stream	National Prevention	FASD	Withdrawal management and rehabilitation	AOD treatment in areas of identified need	PHNs
Post treatment support	No	No	No	Yes	Yes	Yes
Outreach activities	No	No	No	Yes	No	No

Source: Information from DAP GOGs and service mapping analysed by Evaluation Team

Duplication within current prevention and national prevention streams

As demonstrated in Table 14, there is overlap between grants funded under the current prevention and national prevention streams, which both deliver prevention, whole of community information and education and capacity and capability building services. As Section 4.2.2 explains, the prevention stream commenced as one of the initial grant streams following the transition of the DAP from the previous grant programs. The services funded as part of this stream include a variety of AOD resources, brief and early intervention services and preventative programs, all of which are national in their scale. Grants within the national prevention stream commenced later in 2019-20 under different GOGs but with similar objectives, scope and intentions. The five grants that are funded under this stream also include a range of different prevention-focused delivery models that are nationally delivered. There is opportunity to consolidate the two grant streams into a single prevention-focused stream. In doing so, this would present an opportunity to better define prevention activities so there is clear understanding from policy makers, funders and the sector regarding what prevention means in the context of DAP. This synthesising would potentially reduce the administrative effort required to manage two sets of grants while also increasing clarity for providers in the expectations of the services and activities they deliver.

Duplication within the 'AOD treatment in areas of identified need' stream

The 'AOD treatment in areas of identified need' stream is another example of where legacy administration processes have continued into the DAP and created inefficiencies. The stream commenced in 2022-23 with 18 grants that were formerly funded through the Community Health and Hospitals Program, Support for Alcohol and Drug Abuse in SA and Lives Lived Well. The stream does not represent a specific point in the spectrum of AOD support, instead including services that deliver a range of delivery models across the cycle of care. As such, the GOGs are broad to ensure they encapsulate the services included. Reallocating some of the grants included in this stream to alternate streams, that better align with the service categories they deliver, could enhance clarity on what types of services are being delivered and how much funding is invested in specific service categories.

Limited clarity on the organisation of DAP streams affects providers' understanding of the DAP streams

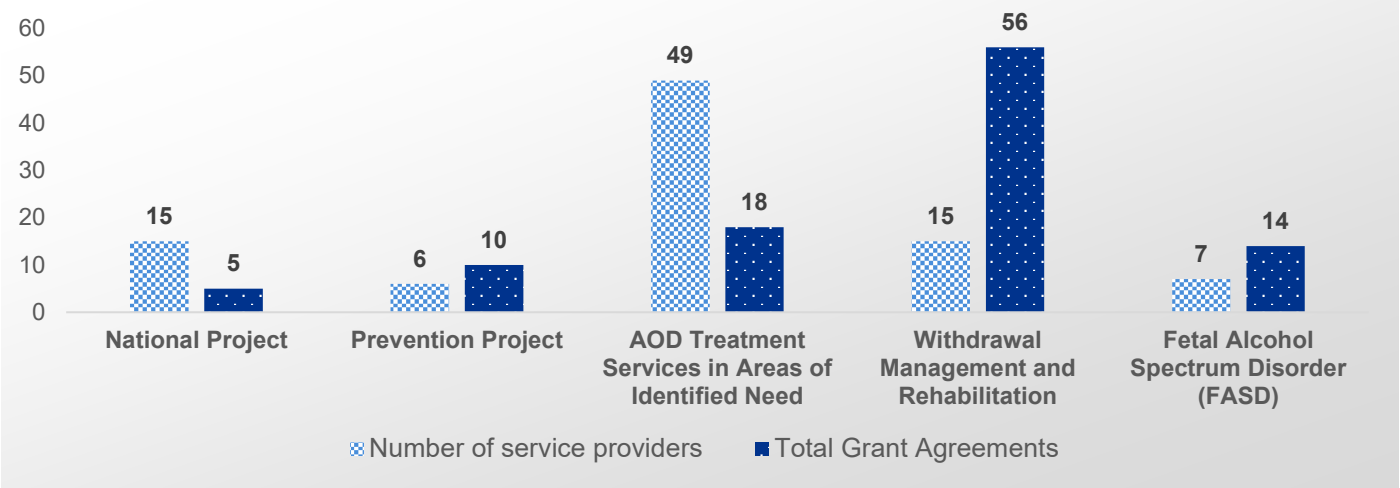
There is also misalignment between how grants are organised under the six DAP streams and how providers understand these grant streams. In the survey of providers, responses showed there is ambiguity as to which stream their services fall under. Figure 21 shows the spread of survey responses to the specific question that asked which DAP grant stream their organisation received funding from. Although the sample is not representative of the whole selection of DAP providers, it does depict an indicative proportion of providers and their understanding of DAP streams. When compared to Table 14 above, there are clear differences evident across the AOD treatment services in areas of identified need stream, withdrawal management and rehabilitation stream and national prevention stream. Key areas of difference include:

- Through the survey, 15 providers indicated that they receive funding under the national prevention stream, yet only five grants are funded through this stream. This reflects that prevention initiatives across both national prevention and prevention streams are delivering prevention activities nationally. It also reflects a lack of understanding as to the origin and intent of DAP prevention funding. This may also reflect variance in the way providers define prevention initiatives.
- Similarly, more survey respondents identified that they were funded by the AOD treatment services in areas of identified need stream (n=49) than the actual number of possible grants (n=18).

- In contrast, fewer survey respondents identified as being funded in the withdrawal management and rehabilitation stream (n=15) than the number of grants included in that stream (n=56), but this may reflect survey respondents not being representative of the full group of funded services.

The comparisons across these streams suggest that many providers are not aware of what stream they receive funding through and potentially believe that their services align better to an alternate stream. Another seven respondents selected 'unsure' for this question, further highlighting the misunderstanding of DAP streams. Ensuring initiatives are appropriately organised across DAP streams according to the types of activities and services they deliver ensures that the expectations of delivery and reporting are relevant and accurately based on stream objectives.

Figure 21 Summary of responses to survey question: Under which DAP grant stream(s) does your organisation receive funding?



Source: Evaluation Team survey

Considerations for DAP sustainability

Consolidation of DAP streams may contribute to increased efficiencies for DAP services

The current organisation of DAP streams leads to inefficiencies for the department and DSS in commissioning and managing funding agreements and a lack of clarity over delivery and reporting expectations for providers.

Consolidation of the existing funding streams, particularly the national prevention and prevention streams and the reallocation of services within the AOD treatment services in areas of identified need stream, provide opportunities to increase efficiency for both DAP funded services and the processes for managing this funding. Clearly defining the terminology used to define streams and their respective activities will also assist. Benefits from streamlining DAP streams include:

- Reducing misunderstanding of providers within DAP and increasing clarity of the objectives and expectations as laid out in GOGs.
- Improving alignment between what service providers perceive they deliver and the DAP stream they are located within.
- Reducing administrative requirements of the department and DSS when commissioning and managing grants by reducing duplication of administration functions in current streams that deliver similar service types.

4.5.3 Understanding the costs and avoided costs of certain treatment types can guide investment in the DAP to ensure value for money

Current gaps in data collected by DAP services creates challenges in attributing the causality of the DAP to specific outcomes and in turn, assessing the relationships between inputs, outputs and outcomes. However, findings from the literature review and other sector-specific documentation on the cost-effectiveness of similar AOD services can be applied to demonstrate the potential for DAP services to produce value for money.

Aligning to evidence on cost-effectiveness from AOD interventions

A study completed by the Australian Institute of Criminology found that, on average, the return on investment (ROI) of demand reduction programs was $5.40 (AUD) for every dollar spent.[87] Demand reduction programs include prevention and treatment service types which collectively make up the DAP activities. As health departments in some states and territories fund justice-based demand reduction programs, it is interesting to note that investments in such youth-focused programs can demonstrate greater ROI than those for adults (Benefit-Cost Ratio (BCR) of 53.66 vs 2.82). The National Preventative Health Strategy reports that prevention initiatives in Australia can create significant savings by offsetting the costs of interventions provided downstream as well as generating other social and health benefits.[48]

FASD providers also reported strong cost effectiveness of prevention and diagnostic interventions. Despite these services being costly to implement and maintain, the reduction of indirect costs on health, social and justice systems and the positive impacts of increased community integration lead to the positive social return on investment found within the study (SROI of 1:9 meaning that for every dollar invested in the service, $9 is created in value).[88] As such, it can be reasonably inferred that the DAP investment into prevention and treatment services is likely to create value for money into the future for the Australian Government.

Insights from the literature review conducted for the evaluation similarly found that most modalities of AOD treatment generate a positive BCR, seen below in Table 15. A BCR is used to identify cost-effectiveness of programs and provides a measurement that accounts for both the tangible and intangible impacts of a program as compared to the costs of delivery. For all treatment types listed in the table (brief interventions, psychosocial treatments, therapeutic communities, outpatient treatment in community / incarceration, opioid agonist treatment), there is a positive BCR for all treatment types and the distribution of benefits was observed across a range of recipients (taxpayers, participants, reduction in crime victimisation). These findings suggest that the positive impacts of these treatment types outweigh their delivery costs. While the calculations are based on cost data in Washington State and may not directly reflect the Australian context, they draw on international program reviews and provide an indication of the potential for positive BCRs in Australia.

All six of the treatment types listed below as having positive BCRs are included within services funded by the DAP. Section 4.3 demonstrated that treatment services, many of which incorporate a therapeutic community model, represent 51% of DAP services and post treatment services represent 4% of DAP services. In addition, 4% of all DAP services support people in contact with the justice system, providing AOD support prior to and after release from incarceration. As over half of DAP services align with treatment types shown to have positive BCRs, there is evidence base to support continued investment in these models of care to ensure value for money.

Studies focusing on ROI from Canadian First Nations healing programs show that such programs, with strong parallels to those implemented in Australia, estimated BCRs of 3.1 and 3.2 (i.e., for every dollar invested in the initiative, there is an expected return of approximately $3 in benefit) when including avoided costs from both health and justice domains.[89] A study of Australian First Nations programs, although older, showed that community

[87] Voce, A, & Sullivan, T. (2022). *What are the monetary returns of investing in programs that reduce demand for illicit drugs*. Trends & Issues in Crime & Criminal Justice. Retrieved from https://www.aic.gov.au/sites/default/files/2022-09/ti657_what_are_the_monetary_returns_of_investing_in_programs.pdf.
[88] Jackson, A, Saunders, C, Blane, N. (2024). *National FASD Program Social Return on Investment.* Impact Economics and Policy. Retrieved from https://fare.org.au/wp-content/uploads/SROI-report.pdf
[89] Aboriginal and Torres Strait Healing Foundation. (2014). *Prospective cost benefit analysis of healing centres*. Canberra, ACT. Retrieved from https://healingfoundation.org.au/app/uploads/2017/01/CBA-final-SINGLES-for-screen.pdf

residential treatment was associated with better outcomes compared to incarceration, with estimated savings of about $81 000 per offender.[90]

Table 15 Benefit to cost ratios for various treatment types

Treatment type	Benefit-to-cost ratio
Brief intervention in primary care	$23.57
Motivational interviewing and CBT	$24.66 - $25.61
Therapeutic communities	$1.77
Outpatient treatment in community	$7.40
Outpatient treatment in incarceration	$32
Opiod agonist treatment	$1.88 - $2.42

Source: Washington State Institute for Public Policy[91]

As detailed below, several Australian studies (identified subsequent to our review of reviews) provide more Australian context on BCRs. An analysis of treatments for young people identified that delivering community-based counselling and group AOD treatments would be significantly more cost effective than the provision of residential youth AOD treatment but acknowledged that some key groups benefit more from residential treatment, despite the increased costs.[92]

A recent cost-benefit review of harm reduction services in the ACT demonstrated the value of investing further in harm reduction.[93] It estimated that maintaining the current package of harm reduction interventions (needle and syringe programs, drug consumption room, take-home naloxone, opioid agonist treatment, safer opioid supply, drug checking service and technological interventions) would have a BCR of 10.8, compared to no interventions. Financial gains were from avoided costs of overdose-related deaths, emergency responses, injection-related infections and hepatitis C infections. The highest BCRs were found for take-home naloxone (BCR=17.8) and opioid agonist treatment (BCR=10.9). For technological interventions such as overdose monitoring apps and hotlines for people who use opioids, BCRs varied widely according to estimates of reach, which are hard to confirm. These calculations do not include avoided costs related to reduced involvement with justice or social services and so may underestimate the benefits, further supporting the calls from stakeholders for investment in harm reduction programs under the DAP.

Leveraging existing evidence on business costs for AOD treatment models

In 2020, NSW Ministry of Health commissioned a Business and Funding Model Study of NGOs delivering AOD treatment in NSW in order to adequately understand what level of funding is appropriate to deliver effective AOD services. This was undertaken in partnership with NADA. The study included NGOs in NSW only and is not representative of the costs of delivering services in all jurisdictions; however, findings from the study are likely applicable to the DAP context.

The study found:

- There is substantial variation in costs for NGOs delivering AOD treatment services, largely driven by activity levels, scale and maturity of services, client complexity and staffing requirements.
- In residential rehabilitation services, the average cost per bed per day is $296.
- In residential withdrawal management services, the average cost per episode of treatment is $11,266.

[90] Deloitte Access Economics (2012). *An economic analysis for Aboriginal and Torres Strait Islander offenders: prison vs residential treatment.* Australian National Council on Drugs. Retrieved from https://www.indigenousjustice.gov.au/resources/an-economic-analysis-for-aboriginal-and-torres-strait-islander-offenders-prison-vs-residential-treatment/

[91] Washington State Institute for Public Policy. (n.d.). *Benefit Cost Results.* Retrieved from Washington State Institute for Public Policy.

[92] Meumann, N, Allan, J, & Snowdon, N. (2019). *Evaluation of the value for money of residential rehabilitation compared to the model for the delivery for community based alcohol and other drug interventions for young people.* Lives Lived Well. Retrieved from https://www.coordinare.org.au/public/assets/19b65bc2c9/Residential-rehabilitation-and-AOD-interventions-in-young-people-April-2019.pdf

[93] Bowring A, Olsen A, Tidhar T, Bourke K, Bailey C, Keane H, Dietze P, & Scott N. (2025). *Australian Capital Territory harm reduction cost-benefit analysis.* Canberra ACT: Australian National University and Burnet Institute. Retrieved from https://www.act.gov.au/__data/assets/pdf_file/0008/2864285/ACT-harm-reduction-cost-benefit-analysis-harm-reduction-review-final-report-March-2025.pdf

- In non-residential rehabilitation services (including counselling, case management and day rehabilitation programs), the average cost per episode of treatment is $7,311 with significant variation between the three service types.
- These costs should be used as a benchmark for future commissioning; however, there may be additional considerations for speciality services delivered in certain locations or contexts.[94]

The survey shared with providers as part of the evaluation included an optional question asking for the cost per bed per day for providers of residential services. Response rates for this question were low and of the responses received, there was substantial variation, indicating that providers use various formulas for calculating and managing their bed costs. There may be opportunities to collaborate with DAP providers and peak bodies to agree on key processes for calculating bed costs. Given the lack of existing benchmark costs within the DAP, findings from the NADA and NSW Ministry of Health study listed above may be used by the department as guidance when determining average costs per bed per day and how that relates to funding allocations for DAP services, noting the data would need to be indexed to reflect present-day costs.

Considerations for DAP sustainability

Supporting providers to collect and report data on operational costs will facilitate a greater understanding of the costs of delivering services

The department should provide clear guidance to providers on how data should be collected and reported. This will make sure data is up to date, accurate, comparable and meaningful.

Current reporting for DAP services includes a requirement to submit both a budget and a financial acquittal each year. However, this data is not used to inform understanding on the costs to deliver services, including indicators such as cost per bed per day. Providing clear guidance on what data should be collected, and how, will allow for regular monitoring of the costs of delivery and continuous feedback to the department on the appropriateness of funding. Alongside consolidation of reporting which includes improved measurement of service outcomes, improved costs data will also create a picture of the cost-effectiveness of DAP services. The interpretation of data designed to measure cost effectiveness should be sensitive to the drivers of cost including client complexity and rurality. Providers should be given an opportunity to explain these cost drivers.

Regular updating of business and costing models for AOD services will ensure funding remains appropriate and cost-effective

There is currently limited understanding within the department of the costs to deliver AOD services, and in particular the cost per bed per day for residential services. Previous studies are useful in providing guidance of baseline funding levels for current service commissioning through the DAP but may not be accurate for present day costs in delivering services. Opportunities exist to better understand the additional impact on costs from services delivering in particular locations, or to specific population groups. An improved data set will support an evidence informed cycle of updates to the business and cost modelling. This will drive funding allocation which appropriately considers the cost to deliver AOD services.

[94] Network of alcohol and other drugs agencies (NADA). (2023). *NADA Position: Business and Funding Model Study*. Retrieved from https://nada.org.au/wp-content/uploads/2023/11/NADA-Position_BAFM-Study_1123.pdf.

4.5.4 Sustainable funding arrangements create opportunities to improve the efficiency and productivity of DAP services

Improving the sustainability of existing funding arrangements can occur at both the overarching DAP system-level and at the service provider-level to enhance efficiency. Existing commissioning processes, including how funding is allocated and its consideration of the operational context of providers, can be improved to enhance the relationship between inputs, outputs and ultimately outcomes.

The cost of funding local responses

Stakeholders value the importance of adapting DAP services to respond to identified local need and the positive impacts this creates for individuals and community. However, many providers reported increased delivery costs associated with localisation and identified opportunities to improve DAP funding mechanisms to sustain local responses.

Opportunities to improve commissioning arrangements

PHNs are the primary vehicle for identifying local need and commissioning services within a region and are a key component of delivering health and social services beyond AOD-specific services. There is opportunity for this localising approach to be better integrated with the broader funding and policy environment to improve consistency in commissioning processes across PHNs.

With a whole-of-DAP perspective, the inclusion of PHNs as a commissioning source alongside the department creates challenges and inconsistencies in how the limited DAP funding is used, particularly given the absence of a national strategic approach to service commissioning. While Section 4.2.4 expressed the value of PHNs as key drivers of identifying and responding to local need, stakeholders identified associated efficiency and sustainability challenges. Various peak bodies and sector-specific organisations raised challenges with having multiple commissioning organisations for the DAP, including a lack of consistency in commissioning approaches amongst PHNs.

Stakeholders considered whether a localising approach could be strengthened using additional mechanisms, perhaps through a strong governance and planning framework. This could include improving the coordination and efficiency of the commissioning processes for DAP to ensure that service gaps are identified and managed in a coordinated manner and better alignment with the broader AOD policy direction.

Impacts of variation in service maturity, scale and infrastructure

A significant cost for providers in designing and implementing services that respond to local needs is utilising limited funding to establish or adapt services as required by the changing landscape. For existing services, maturity and scale impacts a provider's ability to adapt how funding and other resources are used for service delivery.

Physical co-location with other health and wellbeing services was identified by stakeholders as a key driver to holistic, wrap around care for DAP clients. This is particularly relevant given the increasing complexity of client presentations explored in Section 4.2.1. Many spoke of the benefits of co-location models in driving efficiency and delivering longer term outcomes. For example, South Eastern NSWs' PHN's Hub Model brings together in one location providers from various social and health services and operates in regional areas where services otherwise do not exist or require large travel distances. It was noted that while co-location does require additional establishment costs, these costs are often outweighed by improvements in service efficiency and the outcomes achieved for clients. Enhancing the efficiency of how DAP funding is allocated and utilised requires consideration for service delivery models that may need an additional upfront investment of resources.

The need for targeted and more sustainable funding

A consistent message across the sector and within stakeholder consultations was the need for a more targeted and strategic funding approach, given the current levels of DAP investment. DAP funding has been vital in increasing access to AOD services, yet there remains a substantial level of unmet demand.[95] Similarly, as noted above, there is sector-wide acknowledgement of the shifting service delivery landscape, including that providers are increasingly

[95] Ritter, A, & O'Reilly, K. (2025). *Unmet treatment need: The size of the gap for alcohol and other drugs in Australia.* Drug and Alcohol Review, *44*(3), 772-782.

needing to address more complex client presentations. This places additional pressures on making sure that funding is being allocated to best support providers in an already stretched delivery system.

Supporting service sustainability with appropriate funding

There was an indexation freeze on DAP funding from 2016-17 to 2020-21. Insights from consultations suggest providers are continuing to feel the impacts from this indexation freeze, with an increasing need to deliver services to a growing client base with rising costs of delivery.

Providers noted that it is becoming increasingly difficult to sustainably deliver outputs at existing levels without funding that appropriately reflects the operating context of AOD services. In AOD treatment services, staff represent a significant input to activities and wages, representing up to 75% of costs for providers. As such, external increases to award-level pay rates place a greater impact on the costs to deliver services, often without corresponding funding support from the Australian Government.[96] Supplementary payments, including the Drug and Alcohol Treatment Services Maintenance, Wage Cost Indices and Community Sector Organisation, were introduced to broadly address issues with increased costs and inconsistent indexation and reduce the load placed on providers to supplement these increased costs themselves. However, these payment arrangements are not ongoing and are likely to leave gaps once ceased. Additionally, the delivery of supplementary funding arrangements creates inefficiencies for the department and the DSS policy team through the increased time required to administer and manage these additional measures.

> "The indexation doesn't come anywhere near meeting the CPI. The issue that happens is that there is an increase of need and people trying to access services, but funding hasn't changed so FTEs are dropping."
> **- PHN**

> "Can't have an efficient service where it is chronically underfunded."
> **- State and Territory Peak**

Impacts of short-term funding cycles on service delivery

Alongside the existing challenges associated with limited funding amounts for DAP services, the short nature of funding cycles places additional pressures on providers and inhibits their ability to efficiently plan and deliver services. An overwhelming sentiment shared in consultations across providers and sector representatives was the inefficiencies associated with short term funding cycles. Current DAP funding cycles, which are often less than three years, or in some cases yearly, drives instability for services that are dependent on DAP funding to remain viable. Similarly, there are difficulties for providers who are only able to plan for the present and lose the ability to invest in service improvements, like system and process updates, that would create efficiencies in the future.

As Section 4.2.6 mentioned, many state and territory governments are increasingly adopting longer contract lengths as a result of the inefficiencies of service delivery created by short-term funding cycles. Providers from jurisdictions where funding cycles have been increased shared their wish for the DAP funding to follow suit.

Managing the administrative requirements of short-term funding

An unintended impact of short funding cycles on DAP providers is the requirement to regularly undertake the administrative processes associated with applying for and receiving grant funding. Providers shared that in applying for new grants and managing existing grant rollovers, staff are continuously taken away from service delivery to instead complete administrative processes that aim to ensure their funding continues, without the guarantee that it will.

Many providers also shared the impacts on efficiency and productivity in service delivery when notice of funding renewal or extension was last minute and the execution of funding delayed. In these situations, there is an expectation on providers that services will continue as normal without incoming funding or contractual security for

[96] Australian Alcohol & Other Drugs Council. (2024). *Submission to the Inquiry into the health impacts of alcohol and other drugs in Australia.* Retrieved from https://aadc.org.au/download/submission-to-the-standing-committee-on-health-aged-care-and-sport-inquiry-into-the-health-impacts-of-alcohol-and-other-drugs-aod-in-australia-september-2024/

months.[97] In these cases, providers are working only to continue delivery and not with the mindset of identifying opportunities for improved efficiency and productivity.

This sentiment has been echoed across the community services sector with many state and territory governments moving towards longer term commissioning. For example, the ACT government has recently moved to longer-term (up to 10 years) contracts as part of their commissioning reform. In a recent report they cite that the reform is designed to promote workforce stability, reduce costs associated with frequent procurement and improve service quality through better planning and implementation.[98] The Australian Government's Not-for-profit Sector Development Blueprint further highlights the opportunity to integrate flexibility into longer term contracts.[99]

Challenges of funding uncertainty in retaining and recruiting staff

Part of the challenge of short funding cycles in terms of efficiency is the uncertainty it creates for providers and their workforce. Short-term funding arrangements inhibit providers' ability to recruit and retain skilled staff, which itself creates inefficiencies where providers are required to manage vacancies and divert time away from delivering services to hire new staff. Section 4.2.5 highlighted the significance of workforce recruitment and retention in supporting the implementation of the DAP and the challenge that short funding cycles have on providers in being able to recruit a workforce that their services depend on for implementation. As a result, there is additional expenditure on regular recruitment and time lost while positions are vacant, meaning providers are unable to operate to their full capacity.

Multiple sector-wide reports raise a similar sentiment, noting the significant short supply of a specialist AOD workforce throughout Australia, exacerbated by an insecure funding environment. *The Issues Paper relating to the health impacts of alcohol and other drugs in Australia* reported that challenges in recruiting and retaining the workforce creates inefficiencies not just for providers, but also for the health care system as a whole. The lack of capacity within the AOD sector leads individuals seeking AOD crisis support to present to hospital emergency departments. Emergency department staff are already under significant capacity and resourcing strain and feel increased pressure from treating AOD patients who are resource and time intensive.[100]

> "The way that it is set up all we've been able to do is budget and plan services based on 12-month funding extension."
> **- State and Territory Peak**

Challenges associated with funding uncertainty for maintaining a workforce are particularly evident in rural and remote areas, where recruiting and retaining staff to deliver services is an added challenge given the location of services. Consultations with providers and sector representatives raise the difficulty of competing with metropolitan services for attracting staff, including the need for increased wage levels that will attract staff away from metropolitan areas. For the staff themselves, the uncertainty of short funding cycles makes it difficult to justify the investment in relocation to rural and remote areas.

Using strategic funding decisions to target efficient service delivery

Providers reported that the pressures of limited existing funding mean that the design and delivery of services needs to be strategic and targeted, as not all activities may be feasible. Much like the department's need to be intentional in how DAP funding is used to support providers given current funding amounts, providers are having to make the same strategic decisions on a smaller scale regarding how they use their funding to maximise outcomes. In particular, marketing, campaign and promotional activities were identified as valuable aspects of service delivery to increase reach and engagement, yet were often reduced given funding and resource constraints. Marketing campaigns are also ineligible expenditure under the GOGs for Withdrawal Management and Rehabilitation and

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[97] Australian Alcohol & Other Drugs Council. (2024). *Submission to the Inquiry into the health impacts of alcohol and other drugs in Australia*. Retrieved from https://aadc.org.au/download/submission-to-the-standing-committee-on-health-aged-care-and-sport-inquiry-into-the-health-impacts-of-alcohol-and-other-drugs-aod-in-australia-september-2024/.

[98] ACT Government. (2023). *ACT Government Response to the Counting the Costs: Sustainable funding for the ACT community services sector Report*. Retrieved from https://www.act.gov.au/__data/assets/pdf_file/0018/2422080/ACT-Government-Response-to-the-Counting-the-Costs-Report.pdf.

[99] Department of Social Services. (2024). *Not-for-profit Sector Development Blueprint*. Retrieved from https://www.dss.gov.au/panels-and-other-groups/resource/not-profit-sector-development-blueprint.

[100] Commonwealth of Australia. House of Representatives. (2025*). Issues paper relating to the health impacts of alcohol and other drugs in Australia*. Retrieved from https://parlinfo.aph.gov.au/parlInfo/download/committees/reportrep/RB000565/toc_pdf/IssuespaperrelatingtothehealthimpactsofalcoholandotherdrugsinAustralia.pdf.

AOD Treatment Services in Areas of Identified Need. This has diminished providers' ability to target key populations and connect their service to communities. This is particularly relevant for prevention and promotion services, which are dependent on the ability to reach whole population groups.

From consultations, there is sector-wide acknowledgement that the current funding model is not strategically designed to consider how limited funding can be targeted with the most efficient use of resources. Enhancing efficiencies across service delivery requires targeted and evidence-informed decisions about allocated funding in response to an evolving operating context. Directly funded DAP services are allocated using an informal population-based funding model, a model that had also been intended for PHN-commissioned services. While a useful starting point for planning, a strictly proportional approach may disadvantage regional and remote communities, which often experience higher per capita prevalence of AOD-related harms and have more limited access to both general and specialist healthcare. Rural and remote service providers also report higher operating costs often associated with providing attractive staff wages and higher infrastructure and travel costs. As such, a 1:1 population ratio may not adequately reflect DAP service need. A more nuanced funding model could consider both population size and additional factors such as geographic access and service vulnerability. For example, data from PHN needs assessments could play a greater role in informing regional funding needs. While currently mainly used for local commissioning, there may be benefit in exploring how these assessments could be pooled and shared to inform planning across the AOD sector, including the DAP. This aligns with broader considerations mentioned elsewhere in the report around strengthened governance and coordinated national oversight of emerging evidence and service planning.

Considerations for DAP sustainability

Providing a sustainable funding environment for the DAP

There are opportunities for increased efficiency at both the whole-of-DAP level and for individual providers as a result of the current funding arrangements for the DAP. In particular, there is a need to adjust the DAP funding model to best support providers and ensure sustainability of DAP services so that they can continue to work towards improved outcomes. Considerations for addressing DAP funding constraints include:

- Identifying the costs of DAP initiatives, agreeing benchmarks and ensuring funding reflects the operating contexts of providers, especially for those in rural and remote areas where more resources are required for delivery compared to services in metropolitan areas.
- Creating longer funding cycles of at least three to four years, or longer, to allow services to strategically plan and reduce the pressures of regularly funding administrative processes. Increased funding cycles will also support providers in recruiting and retaining staff and enhance productivity within DAP services.
- Ensuring that funding mechanisms and grant agreements reflect the emerging trends and changing landscape of AOD service delivery. Providers shared that the shifting service delivery landscape requires agility to deliver holistic and person-centred care, which requires a larger investment of time and resources into upskilling staff and delivering services.
- To the extent possible within government dependencies, aiming to renew DAP funding in a timely manner to create certainty for providers and support the continuity of their services.
- Transitioning the Drug and Alcohol Treatment Services Maintenance measures into existing, ongoing contracts.

4.5.5 Improving transparency and coordination of reporting requirements can support a more streamlined and efficient delivery of DAP initiatives

DAP service providers are required to provide annual reporting as part of their grant agreements, with some variation over what that reporting includes, dependent on whether service providers are directly funded by the department, managed through DSS, or commissioned through their PHN.

For DAP initiatives funded directly by the department, the required reporting includes an activity work plan and performance report. These are provided to the DSS Grants Hub who are responsible for managing the grant activity. Activity Work Plans include information on objectives and performance indicators of service delivery, specific activity deliverables, risk and governance processes and delivery budget. Performance reports include opportunities for providers to report on service delivery, including challenges that have impacted their delivery over the performance period, case studies, performance against objectives, deliverables and performance measures, workforce development activities and financial outcomes.

For PHN-commissioned DAP services, reporting is provided to the contract managers within the PHN, who use the data for their own performance report. This reporting does not include specific performance data for individual services but of the PHN's performance in commissioning appropriate services based on the health needs assessment they complete. It is the responsibility of contract managers within PHNs to monitor the services they commission.

Inefficiencies of managing multiple funding streams for providers

Service providers receiving DAP funding also receive funding from other funders to deliver AOD services. Analysis of survey responses from DAP providers, including PHN commissioned services, showed that 68% of providers reported using other funding sources to supplement DAP delivery. This high prevalence of dual funding is not only specific to DAP services; multiple reviews and reports across the sector have highlighted the high occurrence of piecemeal funding for AOD services.

Section 4.2.3 demonstrated that, in most cases, states and territories provide a larger proportion of funding for AOD services than the Australian Government through DAP. This was reinforced during consultations with stakeholders, where participants reported that the most common additional source of AOD funding was from states and territories. Stakeholders noted that limited coordination between states and territories, DAP and other Australian Government funding creates challenges for providers who use multiple funding sources to deliver their services, including the requirement to report against each funding source separately.

In addition to the multiplicity of reporting against different funding sources, there is a lack of consistency of what data is collected and how it is measured. Multiple stakeholders shared examples of where they were required to report on the same data source using different measures, which occasionally required multiple systems of data collection. Much like the administration of managing short funding cycles mentioned in Section 4.4.3, providers reported the need to redirect time and resources away from service delivery to complete duplicative administrative tasks.

While the department is not in control of the reporting requirements for other funding sources, there is an opportunity to understand that the DAP operates within a broader sector where multiple funders are present. An increased leadership role for the department, as was discussed in Section 4.2.4, could support the increased coordination of reporting efforts across the sector and lead to improved efficiency for DAP services. Similarly, Sections 4.3.5 highlighted the opportunity to improve role clarity and clarify funding responsibilities between the Australian Government and states and territories. Strengthening these arrangements could reduce the need for providers to rely on multiple funding sources. In practice, progressing this work would require senior-level leadership and ministerial support.

> "Then the bureaucracy of reporting, you could have 6-7 different requirements for how you develop plans and report on outcomes. It's putting pressure on people administering the programs."
> **- Research Organisation**

Streamlining reporting requirements for efficient program monitoring

Within the DAP itself there is also variation between how services are required to report on their performance against intended activities, despite these services operating towards the same broader program objectives (see the program logic in Section 3.2). Similar to the challenges of duplicative reporting efforts from multiple funding sources across the sector, there are examples of where services receive DAP funding directly and through a PHN and are required to provide multiple reports that do not always align in expectations. In addition to the inefficiencies this creates for providers who are required to redirect limited time and resources away from service delivery, there are inefficiencies created for the department and its ability to monitor and evaluate service performance.

Key challenges within this complex reporting environment outlined by providers included:

- Templates and measures vary across PHNs and DSS which means they are duplicating effort to complete multiple reports which measure outputs and impact in slightly different ways.
- The measures required for DAP reporting do not consistently align with evidenced output and outcome measures. For example, prevention providers shared that their reporting templates don't tend to include measures and frameworks to report on evidenced outcomes.
- DAP funding does not provide adequate funding to support data collection, monitoring and evaluation activities.

There are variations in reporting requirements between direct funded and PHN-commissioned DAP services. The limited alignment of DSS and PHN reporting requirements create challenges for providers in collecting, reporting and sharing performance data. Providers shared during consultations that different templates and expectations for PHNs and the DSS Grants Hub results in duplicative processes, particularly where different measures of performance are required.

Desire for more meaningful reporting

Both providers and representatives from the department shared a desire for a more informed use of reporting to ensure quality improvement is at the heart of reporting requirements. Currently, performance reports are provided to the DSS Grants Hub where they are assessed against Activity Work Plans and the relevant GOGs. If all the required data points are present and there are no further points for consideration, no follow up response is shared with providers. As such, there is no feedback to providers or the department on how DAP services are driving improved outcomes or where there are opportunities to enhance service delivery. Multiple providers highlighted challenges in engaging with the DSS Grants Hub regarding performance reporting, noting that contract managers often lacked expertise in the AOD sector and a clear understanding of best practice.

Current reporting includes the requirement for providers to report on specific treatment data to the NMDS, including the number and length of treatment episodes. This data is largely outputs-based, as opposed to outcomes-based, meaning providers feel they are being assessed on the volume of activity rather than the impact of their services on individuals' AOD use. In 2023-24, an updated performance report template was piloted for providers in NSW and the ACT with a specific focus on reporting on client outcomes. The template includes a section for providers to report on specific outcome measures (Table 16), using a data collection tool of their choice.

Table 16 Performance Report Outcome Measures

Outcome measure	Definition
Severity of dependence	Reductions in severity of dependence, as a marker of good treatment outcome.
AOD use	Reductions in the amount of AOD use per use occasion (quantity) or reducing the number of days of use (frequency).
Risk behaviour	Harms associated with use have been reduced for clients during treatment.
Quality of life	Broader social, psychological and physical wellbeing of clients' outcomes compared at entry, during treatment and at exit.
Mental health	Identifying mental health issues of clients and supporting clients to address those needs to achieve successful treatment goals.
Treatment plan in place	Tailored, individualised, collaborative tool developed between clinicians and clients.
Treatment goals achieved	Clients perceive they have achieved their treatment goals.

Source: Activity Work Plan and Performance Report Template (2024-25), Department of Health, Disability and Ageing

The NSW AOD peak body, NADA, which is supporting the pilot of the updated reporting template, shared that most providers already measure these outcomes in some way and have found limited challenges to reporting according to the outcomes-based template. For those providers who do not already collect this type of data, there is a willingness to improve data collection processes to be able to do so. NADA did acknowledge that additional guidance and support, including funding, would be required to support providers in improving data collection methods.

There is an opportunity for the department to design DAP reporting requirements that are meaningful and useful for program monitoring and continuous quality improvement. Limited feedback to providers on how their reporting is being used can make the process seem meaningless and more of a compliance exercise than a tool for enhancing service delivery. Providers described being more inclined to contribute to reporting processes if they knew the information was being used in a meaningful way to inform DAP planning and design. Likewise, a more purposeful use of performance reporting by the department could facilitate a greater understanding of emerging trends in the service delivery landscape and the benefits of different delivery models. Ensuring that reporting is valuable and supports effective service delivery means providers are not spending their limited time collecting and collating data that is not being utilised. This, in turn, will increase efficiencies at the provider and whole-of-DAP level.

Ensuring reporting is appropriate to First Nations' service delivery models

Providers highlighted that future funding could support them in improving their ability to collect data for First Nations peoples and on the outcomes that they report. Current templates and frameworks do not consistently enable providers of First Nations services to report on their preferred outcome measurement tools including, for example, the Social and Emotional Wellbeing Framework. In delivering holistic and person-centred care, First Nations-specific measurement tools and frameworks should be incorporated into reporting requirements and when collecting outcomes data. Sector representatives and providers recommended that current templates could be adapted to better reflect the different way individual outcomes are measured with First Nations people.

Considerations for DAP sustainability

Streamlining reporting process to support the efficient delivery of DAP services

Existing inefficiencies created by funding arrangements across the sector are exacerbated by challenges in completing reporting requirements for providers. Providers expressed a willingness to report on the impact of their services but desire a more streamlined and evidenced approach which makes reporting more efficient and meaningful.

Specifically for DAP services, the department could consider how it can streamline existing reporting requirements across directly funded and PHN commissioned DAP services. Coordination across what is reported and how can support services by decreasing the time and resources required to compile reporting. In doing this, the department could further consider how reporting can be meaningful for program monitoring and useful for continuous quality improvement.

Through a stronger leadership role across the sector, the department can also drive greater coordination in reporting requirements across other funding sources. Coordination across the multiple funders has the potential to create a system where providers collect one set of data that is applicable to all funders across a given period. Ideally, the development of a national performance or outcomes framework would support this and provide the ability for the Australian Government to assess progress against a national AOD strategy.

At all levels, any reduction in the current reporting requirements can be expected to create efficiencies for providers who can reinvest time and resources into service delivery.

4.5.6 Efficiency recommendations

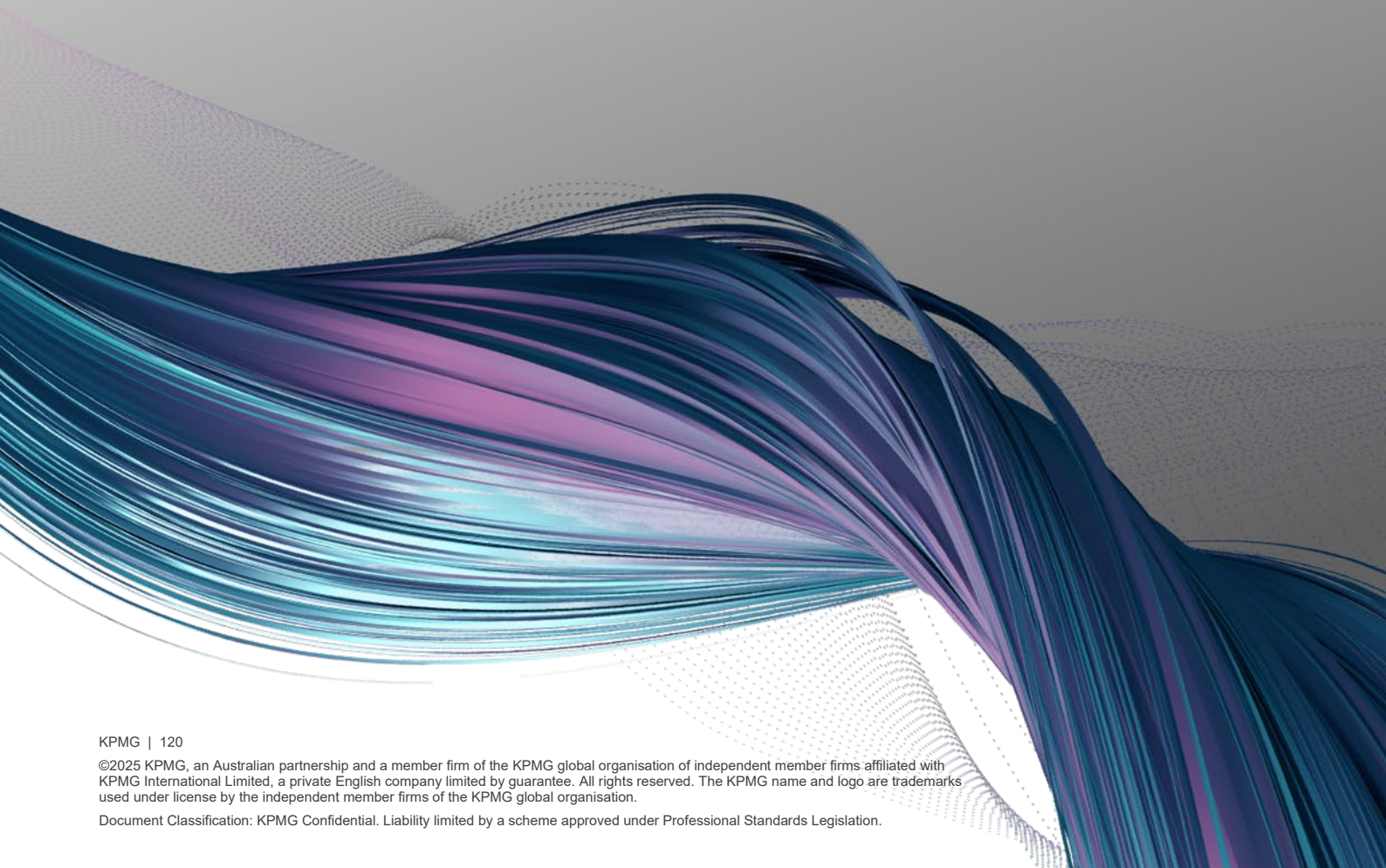
Considering the findings described within this section and the identified considerations for sustainability of the DAP, a number of recommendations have emerged. These efficiency recommendations are outlined in Table 17.

Table 17 Efficiency Recommendations

#	Recommendation
6	**Consolidate DAP streams to reduce overlap** Consolidation of the existing DAP funding streams provides opportunities to increase efficiency for DAP grant administration. The streams that would particularly benefit from consolidation include: • national prevention and prevention streams • withdrawal and rehabilitation services and the AOD treatment services in areas of identified need stream. There may be value in exploring potential benefits or risks in also merging FASD grants with the prevention stream, noting that there is existing overlap of activities. However, maintaining a separate stream for FASD may also be beneficial due to its unique focus. The Australian Government should explore this opportunity with key FASD stakeholders. In consolidating DAP streams, the Australian Government may also wish to explore how the new consolidated streams align with categorisation of contemporary AOD initiatives. The service categories outlined in Section 4.3 may provide a basis for further consideration. Once streams are established, the Australian Government, with support of the department, should clearly outline the terminology used to define streams and their respective activities. **Timing** – Medium term (2 to 3 years). **Responsible Parties** – Australian Government and Department of Health, Disability and Ageing.
7	**Update the DAP funding model and grant agreements process to support improved cost-effectiveness and support the ongoing sustainability for DAP providers.** The Australian Government should consider implementing longer funding cycles of at least three to four years for the grant agreements for DAP. This would improve the ability of services to strategically plan, reduce pressure on regular funding administrative processes and enhance recruitment and retention of staff. The Australian Government should also review the funding model for DAP and consider the most appropriate model required to recognise the increased cost of service delivery in different contexts (e.g., rural and remote areas). This should include transitioning the Drug and Alcohol Treatment Services Maintenance measures into existing, ongoing contracts. The business and costing models for AOD services should be regularly updated by the department to ensure the allocation of funding appropriately considers the costs required to deliver AOD services. This would include the development of a mature commissioning process that is based on an agreed costing model. This costing model would provide clarity for funders and providers on the types of services included in the DAP and estimated funding on service location and type. For treatment services, this process may be supported through the use of an agreed costing model/tool which could be applied across DAP treatment services. The department may consider leveraging the previous work completed within NSW as a basis for this work, with a project to be commissioned to explore its application across Australia. There would be benefit in applying this same model/tool across the department and PHN commissioned initiatives, to enable better consistency in funding approaches. **Implementation considerations** The actions under this recommendation are likely to be influenced by those outlined in Recommendation 6 regarding the consolidation of DAP streams. It would therefore be logical for Recommendation 5 to be actioned first. However, longer funding terms and the application of indexation should be implemented more quickly. **Timing** – Medium term (2 to 3 years). **Responsible Parties** – Australian Government and Department of Health, Disability and Ageing.

Source: Evaluation Team

5 Conclusion and recommendations



5.1 Summary of evaluation findings

5.1.1 Implementation

The DAP evaluation has identified a strong commitment from across the AOD sector to the shared vision of reducing the harms of AOD use in Australia. The creation of DAP in 2016-17 was influenced by various drivers and since then the program has evolved in response to emerging need rather than by design.

There were various challenges identified throughout the implementation review which informed numerous system enhancement opportunities including the desire for greater leadership and governance from the department. Stronger leadership and coordination from the department in convening funders and providers will enhance a collaborative approach to addressing the harms of AOD use in Australia. Additionally, there is benefit in the DAP guidelines being tied directly to national AOD strategy to greater align the outcomes with the objectives of the Australian Government.

Stakeholders also identified the need for investment in DAP capability and capacity building to strengthen integration across the AOD sector and other intersecting areas. In particular, workforce capacity building was identified as an area of future focus, along with opportunities to reduce stigma and discrimination through embedding a peer workforce within the DAP.

5.1.2 Appropriateness

Review of stakeholder insights and service utilisation data demonstrated that the need for DAP services is continually growing and clients are presenting with increasingly complex needs. Co-occurring needs, particularly co-occurring mental ill health, were identified as key drivers for this reported rise in complexity.

The evidence demonstrated that services funded through the DAP provide coverage across various locations, service categories and priority populations. This is particularly the case when considering the role that the DAP services play alongside other AOD services funded from other bodies within the sector, including states and territories. While duplication was not identified as a critical issue across DAP, there is an opportunity to better clarify roles and responsibilities across DAP and the broader AOD sector, to reduce potential overlap and support enhanced system planning.

There is a need for an increased role for government to support the sector and individual providers to design and implement evidence-based interventions and to share better practice approaches. More collaborative relationships between the Australian Government, states and territories, PHNs and providers is an enabler of delivering localised and adaptable responses through DAP.

5.1.3 Impact

DAP funding has the potential to improve access to AOD services and create positive impacts for individuals and communities but does not fully meet existing need. Whilst it is difficult to measure the extent of these impacts and to tie a causal link to DAP, stakeholders provided examples and service data which demonstrates positive outcomes. Evidence also demonstrated that DAP supports providers in utilising their resources to meet the changing demands within their communities. In particular, DAP funding enables providers to deliver targeted services to meet the needs of their local communities.

Strengthening existing data collection and measurement strategies will improve the evidence of DAPs impact and inform service planning. There is an opportunity for the department to strengthen the evidence available for future assessments of the DAP's implementation and effectiveness in line with the direction of the Commonwealth Evaluation Policy and the DSS Evaluation Strategy.[101,102]

[101] Australian Government. (2025). *Public Governance, Performance and Accountability Act 2013*. Retrieved from https://www.legislation.gov.au/C2013A00123/asmade/text

[102] Commonwealth of Australia. (2024). *Evaluation Strategy 2025-2027*. Australian Government Department of Social Services, Canberra. Retrieved from https://www.dss.gov.au/system/files/documents/2025-07/evaluation-strategy-2025-2027.pdf

5.1.4 Efficiency

While cost effectiveness was unable to be measured through this evaluation due to data limitations, opportunities exist to enhance efficiencies across the system. There is recognition from providers and other stakeholders that understanding the costs and avoided costs of certain treatment types can guide cost-effective investment in the DAP. More streamlined organisation of DAP funding streams can support increased efficiencies in commissioning and managing grants.

Various inefficiencies were identified, including impacts of administrative practices and burden on services, such as reporting and workforce turn-over. Additional cost drivers were also identified, particularly for regional and remote providers where delivery costs are increased. Sustainable funding arrangements, which consider cost drivers, will create opportunities to improve the efficiency and productivity of services in the AOD sector. Improving transparency and coordination over reporting requirements can also support a more streamlined and evidenced approach to reporting.

5.2 Sustainability considerations

A number of activities were highlighted as having potential to support ongoing DAP sustainability, which may not be substantial enough to require a recommendation. Alternatively, some considerations may sit outside of the scope of DAP alone. In these instances, they generally require significant influence and agency from other actors within the AOD sector and beyond. These were identified as key considerations to support the sustainability of DAP.

While a number of these considerations have closely informed the development of DAP recommendations, there are several considerations that aren't included in the recommendations. These considerations are outlined below.

5.2.1 Develop and utilise improved documentation and guidance to support DAP implementation

There is an opportunity for the department to develop new documentation that reflects stronger alignment with the Australian Government priorities for AOD and coordination with public health more broadly. This includes the establishment of a DAP implementation plan or annual planning document to drive the departments key work across DAP. It also includes the development of a refreshed DAP program logic.

5.2.2 Improve the governance of the AOD sector through leadership and coordination

The department should consider establishing a national, sector inclusive governance structure with the ability to support integrated planning between tiers of government. This governance framework could include opportunities for engagement across the whole sector, seeking input from government providers, peaks, First Nations people and LLE representation. To ensure influence, the governance framework could also consider engagement at decision making levels, such as ministerial participation.

While the governance framework will enable shared responsibility across all stakeholders, it should be driven by the department policy team, solidifying their leadership role across the AOD sector. This may include supporting cross sector collaboration, driving national needs assessment and planning in collaboration with states and territories and building capability across the AOD sector, such as embedding LLE.

5.2.3 Build partnerships between the department, PHNs, state and territory governments and the AOD sector to enhance knowledge sharing and coordinated planning

The dynamic nature of AOD practice means that what is considered best practice is constantly evolving and service delivery must follow this evolution. There is opportunity for the department to strengthen pathways for enhanced information sharing between research organisations, peaks and service providers. An additional opportunity exists for a more formal connection between the research programs and a new dynamic and adaptive national drug strategy that evolves over its lifecycle, informed by ongoing monitoring, stakeholder feedback and emerging evidence.

Greater collaboration and information sharing was noted as creating opportunities for providers to share lessons learned, learn about how to incorporate innovation and improve awareness of best practice examples and evidence. Improving partnerships and collaboration within the sector further supports in creating a systemised and strategic approach to future funding planning and delivery and supports in strengthening the governance between the Australian Government, state and territory governments and providers. This may include a mix of more localised approaches to support operationally focused information sharing, alongside national mechanisms designed to inform higher-level policy planning.

5.2.4 Build the future workforce to support the delivery of AOD funding and improve service integration

The is an opportunity to develop future DAP workforce planning and policy in line with contemporary health care reform. With a focus on embedding a peer workforce, enhancing capacity through recruitment and retention and developing skills to support co-occurring needs, targeted workforce planning has the potential to create opportunities to improve DAP service delivery and promote service integration.

Cross-sector development should also be considered a key component of any future workforce planning. Standardising resources and programs that could be applied nationally will enhance the reach. Cross-sector investment may also help to address the changing complexities in client needs, including the increasing presentations of co-occurring needs. It is important to caveat that any future investment in this should be through additional funding and not through a redistribution of existing DAP funding.

5.2.5 Embed peer workforce into the AOD sector and DAP

There is a need for more engagement of LLE across DAP and the broader AOD sector, planning and delivery. This is supported by literature demonstrating the impact of the peer workforce on client outcomes. There are opportunities to enhance the engagement of a peer workforce across the AOD sector and at all levels, from planning and governance, through to service delivery. The evaluation identified the need for a strong policy position on the benefits of peer workforce, supported by guidance for the AOD sector and DAP grant recipients on best practice in engaging the peer workforce in governance, planning and delivery.

5.2.6 Enhance and adapt services to continue to meet the needs of those they support, particularly as new trends and evidence emerge

As the use of AOD across Australia continues to change and evidence emerges, DAP initiatives will need to be able to continually adapt and enhance their delivery accordingly, to ensure identified needs are appropriately addressed. In targeting flexible and innovative initiatives, the department should look to models which:

- Deliver services that appropriately and effectively meet the changing needs of the groups they target.
- Adapt and manage external shifts to their operating environment with minimal disruption.
- Coordinate their services with other sectors and services (e.g., mental health) and strengthen cross-sector service integration to deliver person-centred services.

Innovation requires long term and consistent funding that enables continued evaluation, monitoring and assessment of initiatives to ensure alignment with evidence, needs and resources required to deliver the services on an ongoing basis.

5.2.7 Define and document roles and responsibilities of all funders

This will enhance shared planning processes and reduce role duplication. There is an opportunity for the department to implement agreed practices that improve information sharing across government so that states and territories and the various parts of Australian Government better understand what and how much each party funds.

This should include close collaboration with other funders to clarify and agree on roles and responsibilities of key funders. Defining how each of these funders relate to the broader AOD sector and the role of each stakeholder in delivering a joined up AOD system will enable more coordinated and complementary funding decisions and efficient use of resources. It must be noted that significant reform might result from this which may lead to a fundamental shift for DAP funding. It would be important that any such reform work be done in close collaboration with the sector and transitioned in a way that ensured existing funding remained within the AOD sector.

5.2.8 Streamline reporting processes in the AOD sector to support the efficient delivery of DAP services

Existing inefficiencies created by funding arrangements across the sector are exacerbated by variances in reporting requirements across multiple funders. There is an opportunity for a more streamlined and evidenced approach which makes reporting more efficient and meaningful.

Through a stronger leadership role across the sector, the Australian Government can drive greater coordination in reporting requirements across the various funding sources. Coordination across the multiple funders has the potential to create a system where providers collect one set of data that is applicable to all funders across a given period. Ideally, the development of a national performance or outcomes framework would support this and provide the ability for the Australian Government to assess progress against a national AOD strategy.

At all levels, any reduction in the current reporting requirements should create efficiencies for providers who can reinvest that time and resources into service delivery.

5.3 Recommendations and considerations for implementation

The findings within this report, along with the sustainability considerations, have informed a set of clear and actionable recommendations to support the future of DAP. While the sustainability considerations noted previously will support DAP's development within the context of the broader AOD system, they rely heavily on actors external to the DAP. Instead, the evaluation recommendations outlined in this section centred on actions directly tied to DAP and its delivery.

The below table has compiled the recommendations from within each section of this report and include the parties responsible for actioning the recommendation as well as a proposed timeline for implementation. The timelines are as follows:

- Short Term – 1 year
- Medium Term – 1 to 3 years
- Long Term – 4 to 5 years.

A number of the recommendations require time to fully address. With this in mind, the department may choose to consider potential impacts on expiring DAP grants in 2026, with a potential view to roll over grants to accommodate sufficient time to fully implement the recommendations.

Table 18 Detailed Recommendations

#	Recommendation	Timeframe	Responsible Parties
1	**Update DAP GOGs to strengthen alignment with a refreshed national AOD strategy**	SHORT to MED 1-3 years	AUS GOV, The department
2	**Support new initiatives which address emerging needs, including harm reduction strategies, prevention programs and initiatives that target individuals with co-occurring needs**	SHORT to MED 1-3 years	AUS GOV, The department
3	**Develop and implement approaches to enhance coordinated and responsive DAP service planning and drive enhanced cross sector integration in the delivery of the DAP**	MEDIUM TERM 2-3 years	AUS GOV, The department
4	**Update the Monitoring and Evaluation Framework for DAP to ensure it is fit-for-purpose**	MEDIUM TERM 2-3 years	The department
5	**Harmonise reporting KPIs across DAP to streamline processes and increase reliability of reporting**	SHORT to MED 1-3 years	The department
6	**Consolidate DAP streams to reduce overlap**	MEDIUM TERM 2-3 years	AUS GOV, The department
7	**Update the DAP funding model and grant agreements process to support improved cost-effectiveness and support the ongoing sustainability of providers**	MEDIUM TERM 2-3 years	AUS GOV, The department

Source: Evaluation Team

The pages overleaf include further detailed guidance on implementing these recommendations, including implementation considerations and interdependencies.

Recommendation
01

Recommendation 1: Update DAP GOGs to strengthen alignment with a refreshed national AOD strategy

The evaluation identified that here is unclear strategic alignment between the DAP and the NDS. There is a need for clearer and more explicit alignment between national strategy and the initiatives they deliver. Specifically, the GOGs, for both the program and specific streams, should articulate a clear link between national strategy and the DAP, and that this link should be operationalised in individual grant agreements.

The DAP GOGs should be updated to set out the clear link between DAP initiatives and the achievement of the Strategy. This should include:

- Consideration to how this alignment can be measured for monitoring and evaluation.
- Establishing KPIs which measure the contribution of individual initiatives in supporting the achievement of the strategy.

Implementation considerations and interdependencies

Implementation of this recommendation is dependent on the finalisation of a refreshed strategy. However, for the DAP contracts which are due to expire in June 2026, the department may consider whether action can commence to more closely align GOGs to the current strategy.

Responsibility

AUS GOV The department

Timeframe

SHORT to MED
1-3 years

Recommendation
02

Recommendation 2: Support initiatives which address emerging needs, including harm reduction strategies, prevention programs and initiatives that target individuals with co-occurring needs

There is growing impetus for government to invest in prevention programs that improve outcomes and reduce demand on other parts of the treatment system.[47] A recent analysis of demand and unmet need across the AOD system in Australia found that less intensive interventions may assist with addressing the gap.[42] In particular, investing in interventions at earlier stages of a person's AOD use can prevent the need for later, more intensive interventions. This may include screening and brief intervention (including in primary care), prevention interventions (e.g., education and social supports) and harm reduction activities.

When considering investment in less intensive programs across states and territories and DAP, there is a demonstrable need for increased investment in evidence-based community education and prevention campaigns as well as harm reduction services. Currently, there is minimal DAP funding provided towards harm reduction activities, despite a growing evidence base endorsing such services. The Australian Government should consider shifting the balance of funding within DAP to enable a greater investment in these prevention initiatives. Australia's National Preventive Health Strategy 2021-2030 sets an ambitious target to increase Commonwealth investment in preventive health initiatives by 5% of total health expenditure.[48] Whilst more analysis and consultation is required to determine the exact proportion shift within DAP, this target provides useful guidance for consideration.

The Strategy also sets out specific objectives relevant to DAP including reducing AOD harm. Recommendations of interest and consideration for future DAP investment include initiatives which:

- Build consumer awareness of the National Alcohol Guidelines.
- Prevent harm through evidence-based and credible mass media campaigns which are adapted to localised need.
- Aim to reduce risk factors and enhance protective factors.
- Aim to reduce the onset of AOD use, such as evidence-based and age-appropriate school programs.
- Prioritise priority populations.
- Upskill the broader health workforce to increase their confidence in evidence-based screening, brief intervention and referral.

Considering the emerging needs and existing reach of DAP noted in this section, there is also a demonstrated need to enhance support for people with co-occurring mental health needs, women and families, and/or people who inject drugs.

Implementation considerations and interdependencies

Rebalancing the focus of DAP funding to increase investment in prevention and early intervention initiatives, even slightly, has the potential to impact treatment service providers and their clients. This will require deep planning and collaboration with key stakeholders to ensure minimal impact on DAP providers and service users. Ideally, any shift of funding from a treatment provider should only be considered where the service is underperforming. As opposed to decommissioning important and necessary treatment services, alternative approaches may include:

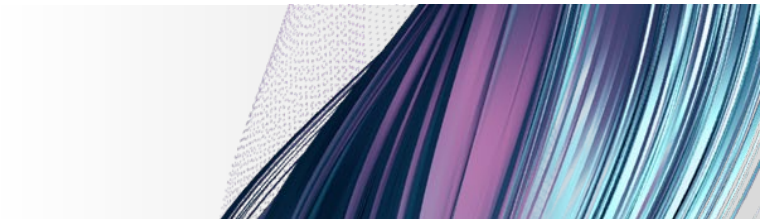
- Promoting opportunities for DAP treatment providers to consider how they could re-direct a proportion of their funding to prevention or early intervention activities.
- Promoting opportunities for prevention providers and treatment providers to partner in promoting engagement with early interventions and harm reduction.

These options are not exhaustive and their feasibility has not been considered in depth. It will be important for this to be explored further with policy teams and providers.

Responsibility

Timeframe

Recommendation
03



Recommendation 3: Develop and implement approaches to enhance coordinated and responsive DAP service planning and drive enhanced cross sector integration in the delivery of the DAP

It is important to enable a DAP system that funds and supports a range of services that work across the spectrum from community based information and education, through prevention, brief/early intervention and harm reduction activities to lower-intensity community based treatments and then into withdrawal and higher intensity treatment services, which then connect into post-treatment supports such as maintenance, harm reduction and recovery support programs. This will mean that DAP initiatives will target each stage of AOD use from contemplation to initiation, experience of harm and recovery.

The actual strategies/activities used to target each stage need to be driven by well-investigated local needs and able to be tailored to meet the needs of priority populations to ensure equity of access. Coordinated and responsive service planning will be key to ensuring this continuum of care is enacted across DAP.

This could include:

- Ensuring development of DAP policy includes contribution from providers, peaks, PHNs, people with LLE, and state and territory governments.
- Establishing clear GOGs, supporting a consistent approach for PHN local area needs assessment, planning and commissioning of DAP initiatives and collaboration with DAP providers, regional peaks and state and territory governments. The department should require PHNs to report against these objectives so that improvement can be consistently measured.
- Formalising the connection between the research programs and a new dynamic and adaptive national drug strategy that evolves over its lifecycle, informed by ongoing monitoring, stakeholder feedback and emerging evidence.
- Implementing practices to maintain current DAP service mapping to help inform future funding decisions. The department should also consider expanding the service mapping to include funding provided by states and territories and the NIAA.

Implementation considerations and interdependencies:

This recommendation requires investment in time needed to do this work and also collaboration with key partners, including other AOD funders, to establish information sharing agreements. It will be crucial to implement practices that improve information sharing across government so that states and territories and the Australian Government (including the department and NIAA) better understand what and how much each party funds. This will enhance shared planning processes and reduce role duplication.

Responsibility

AUS GOV The department

Timeframe

MEDIUM TERM
2-3 years

Recommendation
04

Recommendation 4: Update the Monitoring and Evaluation Framework for DAP to ensure it is fit-for-purpose and promotes a consistent approach to quality improvement across DAP services

Developing a Monitoring and Evaluation Framework consistent with the advice included in the Commonwealth Evaluation Toolkit will provide structured, coordinated guidance for collecting and analysing credible evidence for policy making, continuous quality improvement and resource allocation.[103] While structured, it should also be flexible enough to respond to emergent policy and program directions. It is imperative that the Framework is informed by a review of the relevant literature, policy and practice documents and key needs expressed by stakeholders.

It should also recognise the complexity of the DAP, noting that the funded grants (and the stream the grants are funded within) are designed to individually and collectively achieve outcomes for individuals, communities and the service system more broadly. Since the DAP is seeking to influence a system, its impact will be determined by the extent to which the problem condition (that is, AOD use) changes. This necessitates a monitoring and evaluation approach that leverages, but is somewhat different to, the approach used for program evaluation.[104]

For complex, multi-level interventions such as the DAP, it is more appropriate to evaluate the overall performance, using monitoring and evaluation data to document the extent of implementation, as well as changes in the problem conditions at different levels of the system. This can be used to make decisions about modifying existing actions or implementing new ones.[105]

The centrepiece of the Framework should be a **strategy logic** specifying the intended outcomes and impacts of the DAP. It is ideal that the logic aligns with broader national drug and alcohol strategies to support collective impact measurement. Reflecting the complex interactions between the components of the program and the service system, a logic can provide a line of sight between inputs, resources, outputs and the intended strategic outcomes, but should not attempt to draw causal links. A useful approach is contribution analysis, which uses multiple sources of evidence to assess the extent to which the logic holds up against the evidence. It does not seek to 'prove' that a particular policy, program or organisation has brought about a change, but instead supports development of a plausible, evidence-based narrative (contribution 'story') to answer causal questions about its influence.[106]

The framework should also include an outcomes matrix, which specifies the full range of information needed to assess the achievement of outcomes and impacts and where the information can be sourced from.[107] It includes attributes of success (what outcomes should look like when they are achieved) as well as metrics for attributes of success. Some outcomes specified in the matrix will not be directly observable or easily measured, necessitating the use of proxy measures. It should also identify the data sources and comment on the availability of data in terms of cohorts and frequency with which the data can be obtained.

As evidenced in this evaluation, it is not always possible to measure the attributable impacts of each of the component actions of the program, particularly in the absence of a carefully designed monitoring and evaluation framework. While there is a substantial amount of data available and associated with the DAP, much of it is not fit for purpose, is not available within a timeframe that is useful for monitoring and evaluation or may not be comparable across streams.

[103] Australian Centre for Evaluation. (n.d.). *Evaluation Toolkit: Templates, tools and resources.* Retrieved from https://evaluation.treasury.gov.au/about/commonwealth-evaluation-policy
[104] Patton, M, Q, & Patrizi, P, A. (2010). *Strategy as the focus for the evaluation.* New Directions for Evaluation, 2010(128), 5 – 28.
[105] Kurtz, C, F, & Snowden, D, J. (2003). *The new dynamics of strategy: Sense-making in a complex and complicated world.* IBM Systems Journal, 42(3), 462–483.
[106] Mayne, J. (2008). *Contribution analysis: An approach to exploring cause and effect.* ILAC Brief.
[107] Australian Centre for Evaluation. (n.d.). *Evaluation Toolkit: Templates, tools and resources.* Retrieved from https://evaluation.treasury.gov.au/about/commonwealth-evaluation-policy

This evaluation provides a strong foundation for developing the Monitoring and Evaluation Framework. However, the department should undertake a data quality audit to inform the Framework's development. The audit will confirm the availability, quality and structure of the qualitative and quantitative data sources that contribute to measuring the outcomes expressed in the Framework. It will identify potential issues and gaps and ascertain how they might be offset or addressed. This audit will link closely with recommendation five which recommends improved reporting against KPIs. For prevention services, this may also call for prevention-specific monitoring and evaluation measures, including proxy indicators (e.g., help-seeking behaviour, awareness, engagement) and longitudinal tracking of digital and community-based interventions.

An important aspect of the audit is being clear about the availability of linked administrative data to strengthen the monitoring and evaluation evidence base. It is expected that the data sources identified during this evaluation are not the only available data for performance monitoring and evaluation. Further, it is anticipated that new data sources will become available as the DAP continues to be implemented.

A formal data quality audit will support a longer term and strategic data development agenda to continue building the evidence base for the DAP. This agenda will enhance the quality, availability and useability of data collected by the department or on the department's behalf (for example, in the National Minimum Dataset) and identify areas for improvement. These potential data development areas should support development of a more strategic evidence base to better understand peoples' journeys through the AOD system, and the systems adjacent to it.

The Framework should make a distinction between monitoring and evaluation. These data are mutually reinforcing over the lifetime of a program and can be used together to shape decisions about the strategic design, implementation, outcomes and possible redesign of a program to achieve its intended outcomes.

Monitoring leverages readily available data used to understand the extent to which the program, its sub-streams and individual grants are being implemented as intended. This data can also support understanding of the extent to which the program, its sub-streams and individual grants are achieving their intended outcomes. Performance monitoring data is credible information for program management and resource allocation decisions. It is one source of evidence for evaluation, but on its own does not constitute an evaluation.

Evaluation provides a more detailed understanding of the merit or worth of specific funded grant activities, their value to the overall program and whether these activities should be retained, modified or scaled up. We suggest the Framework includes a series of mixed-method, process and outcome **flagship evaluations** of a select number of grants within each program stream should be delivered to develop an understanding of how these generate outcomes, for which people and to what extent. These evaluations will generate the evidence needed to be able to scale up or replicate any successful actions in new contexts. These evaluations should be chosen according to predefined criteria, which may include the magnitude or maturity of the funded grant activity, the priority population it supports, the level of innovation, and/or the availability of data that supports a quasi-experimental approach. Evaluability assessments should be undertaken to determine what methodological approaches are likely to be feasible with the available data and resources.

If, in future, the DAP is to be implemented in discrete time periods (for example, as an Action Plan associated with a broader national drug and alcohol strategy), it will be important to consider evaluating each implementation phase separately. This supports clear understanding of the extent to which each Action Plan delivered the intended outcomes, and to identify what actions need to be taken in subsequent plans to achieve the overall objectives of the program.

An overall evaluation, which supports an assessment of the extent to which the program has delivered its expected impact, should be done as the implementation period ends. The overall evaluation could involve a synthesis of all the evaluations completed to date, drawing together all relevant monitoring and evaluation data to answer overall evaluation questions.

This piece of work will require a number of key components to ensure impact and efficiencies of DAP can be suitably measured into the future. Key activities required when developing the monitoring and evaluation framework include:

- Coordination of an evaluation steering group to provide expert advice in the development of the Framework. This may include representation from the department DAP policy team, the departments Health, Economics and Research Division, AIHW, a service provider peak, a PHN peak and an LLE peak.

- Revision of the current program logic in collaboration with stakeholders and development of nested program logic for DAP streams.
- Development of evaluation elements including a theory of change, key evaluation questions, indicators and data sources. This will need to consider evidence-based tools and approaches for measuring DAP impacts and efficiency.
- A detailed data matrix designed in collaboration with key stakeholders including (but not limited to) providers and AIHW.
- Incorporation of quasi experimental approaches where data availability can be reached.
- Collaboration with AIHW to advocate for and enable data linkage to better evidence the direct impacts of DAP.
- Incorporation of capability building for service providers to ensure they can consistently deliver on data collection requirements and to promote evidence informed service monitoring and improvement.

Implementation considerations and interdependencies

The effectiveness of this framework will be contingent on the engagement with key stakeholders to ensure the reliability of key data components. Where feasible, the framework could be co-designed with stakeholders across all levels of the DAP system including providers, PHNs, states and territories, the Australian Government, peak bodies and LLE representatives. Engagement with stakeholders will align data collection and monitoring approaches to the capacity and capability of those delivering services. Upskilling to enhance capacity of the sector to reliably capture the required data will be needed.

This work should closely align with the recommendation five which explores opportunities to harmonise reporting and KPI's across DAP. That process will provide a solid basis for the monitoring of DAP through performance reporting.

The extent to which quasi-experimental design can be included is dependent on the extent and quality of data collected. Engagement with AIHW will be essential to collaborate on data linkage opportunities to better evidence the full impacts of the DAP services.

Responsibility

Timeframe

Recommendation
05

Recommendation 5: Harmonise reporting KPIs across DAP to streamline processes and increase reliability of reporting

The department should work to streamline existing reporting requirements and KPIs across directly funded and PHN commissioned DAP services. Coordination across what is reported and how it is reported, can support services by decreasing the time and resources required to compile reporting. In doing this, the department could further consider how reporting can be meaningful for ongoing program monitoring.

This may include:

- Collaborating with DAP providers to determine the appropriate KPIs required for reporting and align the recommended KPIs and performance measurement tools to best practice evidence. This should include consolidating existing reporting KPIs to understand areas of duplication and increase efficient processes.
- Providing clear guidance to providers on the reporting measures and the methods to collect this data, including clear guidance on a consistent approach to collect and report the data to ensure comparability across services.

Universal KPIs

There are a core set of universal KPIs which have utility across all DAP performance reporting, from prevention through to treatment. These KPIs relate predominantly to program inputs and structure and are outlined in Table 19. Some of these indicators have been adapted from the NSW AOD performance reporting trial.

Table 19 Example performance measures for all DAP initiatives

Measurement type	Performance measure
Input	• Provision of annual audited financial statement • Actual expenditure against annual budget
Structural	• Organisation holds current and valid accreditation relevant to their service type (e.g., treatment providers hold accreditation against approved health and community service standards) • Number and percentage of staff trained in Aboriginal cultural competence • Number and percentage of staff who have undertaken relevant continuing professional development

Source: Adapted by KPMG from NADA Position Paper: Measuring performance of NSW non-government AOD treatment services[108]

Prevention Specific KPIs

As noted throughout this report, prevention providers face challenges in measuring impact, especially for one-off engagements. For prevention programs, thinking should be done to consider where a small set of overarching and consistent KPIs may be applied for all prevention providers, noting that program specific KPIs will still be required given the unique nature of the DAP prevention programs. Some of these overarching KPIs for prevention programs may include measures which evidence reach and awareness raising outputs and outcomes. Behaviour change measures such as knowledge change, intended actions and health behaviours, may be more specific to each prevention campaign. Table 20 provides examples of prevention KPIs which may be considered in consultation with DAP providers. Given the diverse models applied across DAP prevention programs, not all of these KPIs will be relevant to all programs. It will be important for the Department to engage in a co-design process with prevention providers to agree on a set of common KPIs where possible and as well as implementing any additional KPIs unique to individual programs.

[108] Network of Alcohol and Other Drugs Agencies. (2022). *NADA Position Paper: Measuring performance of NSW non government alcohol and other drug treatment services.* Retrieved from https://nada.org.au/wp-content/uploads/2023/02/NADA-Position-Paper_Performance-measurement-2022.pdf.

Table 20 Example performance measures for AOD prevention programs

Measurement type	Performance measures
Access	• Types of program activities and settings • Use of available resources and materials (e.g., number of people accessing websites - number of links clicked, reactions, comments and shares - average time spent looking at website pages) • Average wait times (e.g., for phone support services)
Process	• Number of new clients engaging with the program • Number and types of educational material distributed • Number of brief intervention sessions (e.g., support provided through a crisis line) • Number of partners involved • Mode of program delivery (phone-line, website, app) • Marketing and communications plan developed
Outcomes	• Number and percentage of people that report increased awareness of AOD risks and harms • Number and percentage of people that report improved attitudes towards AOD risks and harm • Number and percentage of people that report intention to change their behaviours regarding AOD use or risk • Number and percentage of people that report improved AOD related behaviours or risk
Experience	• Number and percentage of people that report the program was culturally safe and appropriate • Number and percentage of people that report they were linked up with other services to support them

Source: KPMG

Treatment KPIs

Treatment services have a stronger base of validated measures which can be used to demonstrate impact. The challenge for DAP is that these measures are not applied consistently across all treatment services, which reduces comparability or analysis. The department may benefit from leveraging existing work, including the AOD performance measure trial conducted throughout NSW. KPIs which would have utility for monitoring DAP performance, are outlined in Table 21. This table reflects the performance measures included in the NSW trial with additional measures for access, such as mode of delivery.

Table 21 Example performance measures for AOD treatment services

Measurement type	Performance measures
Output	• Provision of an electronic extract of the Minimum Data Set data report
Access	• Number of people that were eligible and suitable that couldn't be accepted for treatment due to capacity issues • Average waiting time (days) per treatment type for eligible and suitable people Residential treatment capacity during reporting period: • Bed capacity • Occupancy rate • Average length of stay Non-residential treatment: • Use of available counselling or group sessions • Average episode length • Proportion of sessions delivered in person, on the telephone or online
Process	• Number of new clients assess and accepted into the service that have a treatment plan
Outcomes	• Number and percentage of people that report an improvement in overall quality of life • Number and percentage of people with reduction in severity of dependence • Number and percentage of people that report a reduction in AOD use • Number and percentage of people that report a reduction in risk behaviour related to AOD use

Measurement type	Performance measures
	• Number and percentage of people that report that they achieved their own treatment goals
Experience	• Number and percentage of people that report the service was culturally safe and appropriate • Number and percentage of people that report they were linked up with other services to support them when they leave the program

Source: Adapted by KPMG from NADA Position Paper: Measuring performance of NSW non-government AOD treatment services108

The above measures will require providers to report against client outcomes. There are various validated outcomes measures for AOD treatment which may be used for this purpose. Table 22 provides a summary of these measures which also have a precedent of being used across the QLD and NSW AOD sectors. In addition to evidencing outcomes, these measures also play an important role in the treatment process, helping to inform individual treatment planning and review.

Table 22 Validated AOD outcomes measures

Outcome Measures	Definition
Australian Treatment Outcomes Profile (ATOP)	ATOP is a 22 item client reported tool used to assess client's substance use, general health, wellbeing, and related risks over the past four weeks. In NSWs the NADAbase context, ATOP is an agreed tool for reporting against changes in substance use, physical health, psychological health and quality of life.
Kessler Psychological Distress Scale (K10)	K10 is a brief, non-specific screening tool to identify levels of psychological distress, particularly anxiety and depression, over the past seven days. It is often used in the AOD context to assess a client's need for referral for further mental health support.
World Health Organisation Quality of Life instrument (WHOQOL)	WHOQOL assessment tools are used to measure an individual's perception of their quality of life across various domains over the past four weeks. Domains include physical health, psychological health, social relationships and environment (e.g., finances, safety, housing).
Severity of Dependence Scale (SDS)	SDS is a short scale which measures the degree of a dependence experienced by an individual for different types of drugs. It particularly measures risky and problematic use of substances.

Source: KPMG

These measures could be considered for use across DAP reporting to support regular monitoring of program outcomes. A key learning from the NSW performance measure trial has been the importance of equipping providers with an agreed set of guidelines for collecting and reporting on measures to ensure that the data is comparable. For example, if asking DAP providers to report on clients' improvement in ATOP results, it is important to provide clear guidance regarding:

- What interval the measure should be completed at
- How often is it reported against
- What amount of change in scores represents increase/decrease
- Over what period of time should the change be sustained to qualify as improvement.

Reporting on service costs

The department should provide clear guidance to providers on how cost data should be collected and reported to ensure that it is comparable and meaningful. Current reporting for DAP services includes a requirement to submit both a budget and a financial acquittal each year. Providing clear guidance on what data should be collected, and how, will allow for regular monitoring of the costs of delivery and continuous feedback to the department on the appropriateness of funding. Alongside consolidation of reporting to include improved measurement of service outcomes, this will also create a picture of the cost-effectiveness of DAP services. In providing this guidance, the department should ensure it also enables for tailoring to consider client complexity in costs, specifically for priority populations, which may require differing workforce or structural components of care.

Implementation considerations and interdependencies:

It would be beneficial to align this work with the efforts to update DAP GOGs and an updates monitoring and evaluation framework. There may be an opportunity to incorporate greater guidance for a smaller set of KPIs in the immediate instance, with more significant updates to occur as part of a larger co-design project with providers and peaks.

The department may take a leadership role in driving this piece of work further, encouraging and supporting a consistent approach to harmonising KPIs across the whole AOD sector, including Australian Government and state and territory funding. This will ultimately create significant efficiencies across the sector and build robust service system monitoring. It will, however, require strong engagement with and buy-in from PHNs, NIAA, and states and territories.

Responsibility

Timeframe

Recommendation
06

Recommendation 6: Consolidate DAP streams to reduce overlap

Consolidation of the existing DAP funding streams provides opportunities to increase efficiency for DAP grant administration. The streams that would particularly benefit from consolidation include:

- National prevention and prevention streams
- Withdrawal and rehabilitation services and the AOD treatment services in areas of identified need stream.

There may be benefit in exploring potential benefits or risks in also merging FASD grants with the prevention stream, noting that there is existing overlap of activities. However, there may benefit in FASD remaining separate due to its unique focus area. The Australian Government should explore this opportunity with key FASD stakeholders.

In consolidating DAP streams, the department may also wish to explore how the new consolidated streams align with categorisation of contemporary AOD initiatives. The service categories outlined in Section 4.3 may provide a basis for further consideration.

Once streams are established, the Australian Government, with support of the department, should clearly outline the terminology used to define streams and their respective activities.

Implementation considerations and interdependencies:

When considering the sequencing of this recommendation, the department may consider how any revised DAP streams also align with a refreshed AOD strategy. Clearly alignment of the streams with a new strategy will also create greater positioning to support the strategy.

Responsibility

AUS GOV The department

Timeframe

MEDIUM TERM
2-3 years

Recommendation
07

Recommendation 7: Update the DAP funding model and grant agreements process to support improved cost-effectiveness and support the ongoing sustainability of DAP providers

This can be achieved by addressing a number of challenges identified during this evaluation, including:

The Australian Government should consider implementing longer funding cycles of at least three to four years, or longer, for the grant agreements for DAP. This can support services to strategically plan, reduce pressure on regular funding administrative processes, and support improved recruitment and retention of staff.

The Australian Government should review the funding model for DAP and consider the most appropriate model and adjustments required to recognise increased cost of service delivery in different contexts (e.g., rural and remote areas). This should include transitioning the Drug and Alcohol Treatment Services Maintenance measures into existing, ongoing contracts.

The department should also regularly update the business and costing models for AOD services to ensure the allocation of funding appropriately considers the costs required to deliver AOD services. This would include the development of a mature commissioning process that is based on an agreed costing model. This costing model would provide clarity for funders and providers on the types of services included in the DAP, and estimated funding on service location and type. For treatment services, this process may be supported through the use of an agreed costing model/tool which could be applied across DAP treatment services. The department may consider leveraging the previous work completed within NSW as a basis for this work, with a project to be commissioned to explore its application across Australia. There would be benefit in applying this same tool/model across the department and PHN commissioned initiatives, to enable consistency in funding approaches.

Implementation considerations and interdependencies:

Actions carried out as part of this recommendation will likely be influenced by actions included in Recommendation 6 – consolidation of DAP streams. As such, it would make sense for Recommendation 5 to be actioned in the first instance. However, longer funding terms and indexation increases are options that can and should be more readily applied.

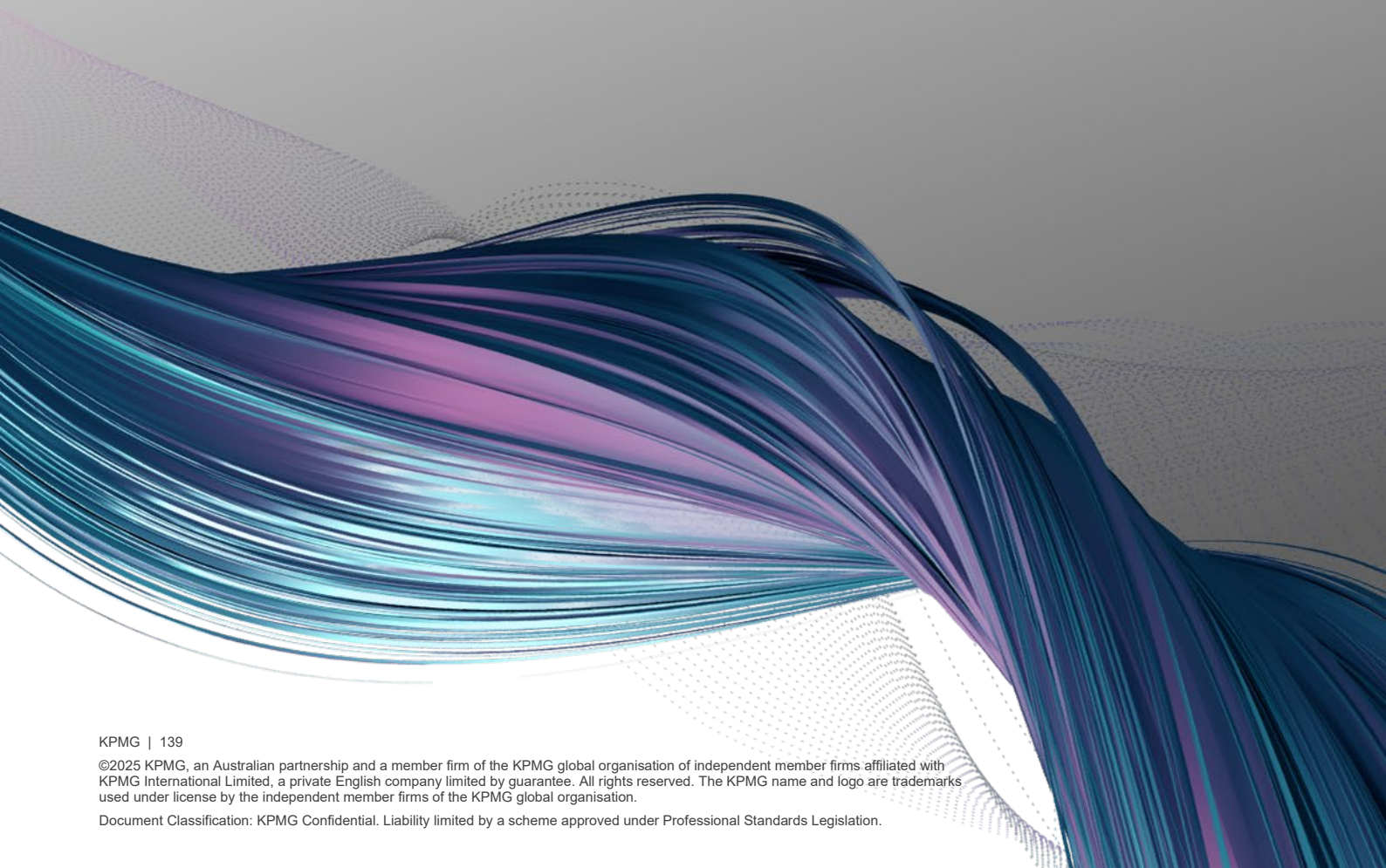
Responsibility

AUS GOV The department

Timeframe

MEDIUM TERM
2-3 years

6 Appendices



Appendix A Key evaluation questions

Table 23 Key evaluation questions and the location of relevant findings within the report

Domain	KEQ and sub-KEQs	Location in document
Implementation	**KEQ 1. How well is the program being delivered in terms of fidelity, quality and outcomes?**	**Section 4.2**
Implementation	A. To what extent do program guidelines, documentation and reporting requirements enable or hinder high quality program implementation?	Section 4.2.1, 4.2.2
Implementation	B. To what extent have the funded organisations delivered outputs according to their grant agreements?	Section 4.2.1
Implementation	C. To what extent has implementation of each DAP stream considered the needs of priority populations, as identified in the National Drug Strategy (First Nations, CALD, LGBTIQ+, older persons, youth, people with mental health conditions, people in contact with the criminal justice system)?	*Findings for this sub-KEQ have been incorporated with sub-KEQ 2D in Section 4.3.2 where analysis on priority populations is explored*
Implementation	D. What are the other barriers and enablers to effective implementation of the DAP and its ability to achieve positive client outcomes?	Sections 4.2.3, 4.2.4, 4.2.5
Appropriateness	**KEQ 2. Is this program the right response to the identified needs and priorities of target populations?**	**Section 4.3**
Appropriateness	A. Are the funded activities the appropriate response based on current data, research, societal and emerging trends, state and territory services, and evidence?	Section 4.3.1, 4.3.4, 4.3.5
Appropriateness	B. Based on current needs and available evidence, is there an appropriate balance between funded prevention and treatment services?	Section 4.3.2, 4.3.4
Appropriateness	C. How do the funded programs complement or synergise with existing jurisdictional services?	Section 4.3.3
Appropriateness	D. To what extent are DAP funded programs delivered in a way which is appropriate for specific vulnerable groups, as identified in the National Drug Strategy (First Nations, CALD, LGBTIQ+, older persons, youth, people with mental health conditions, people in contact with the criminal justice system)?	Section 4.3.2
Appropriateness	E. Are there any examples of services that might be considered as models of future approaches to commissioning?	Section 4.3.5
Impact	**KEQ 3. What difference is the program making?**	**Section 4.4**
Impact	A. What effect do DAP services have for program participants?	Section 4.4.1, 4.4.2
Impact	B. How does resource utilisation vary across different demographic groups who participated in the program? What explains these differences?	Section 4.4.1
Impact	C. Which elements of the DAP programs may be associated with achieving positive outcomes?	*Findings for this sub-KEQ have* been included in Section 4.3.4 where DAP alignment to best practice is explored
Impact	D. Are there service improvement models in some settings that could be promoted for broader implementation?	Section 4.3.5, 4.4.2, 4.4.3
Impact	E. How have population-level AOD outcomes changed since DAP implementation?	Section 4.4.2
Efficiency	**KEQ 4. To what extent has the program delivered value for money?**	**Section 4.5**
Efficiency	A. How have resources been allocated and utilised?	Section 4.5.2, 4.3.6
Efficiency	B. To what extent is the relationship between inputs, outputs and outcomes timely and to expected standards?	Section 4.5.2, 4.5.3, 4.4.4

Domain	KEQ and sub-KEQs	Location in document
Efficiency	C. Are the reporting arrangements required from funded organisations proportionate to the level of funding and program objectives?	Section 4.5.4
Efficiency	D. Are there gaps or areas of duplication in the DAP? How can these be addressed?	Section 4.5.1, 4.5.3
Sustainability	**KEQ 5. How can the commissioning and implementation of the DAP be best supported going forward to maximise impact, ensure value for money and sustainability?**	**Where relevant in Sections 4.1 – 4.4**
Sustainability	A. What best practices in AOD prevention and treatment could be adapted to the DAP context to improve outcomes?	Where relevant in Sections 4.1 – 4.4
Sustainability	B. What mechanisms and metrics can be used to regularly and effectively evaluate performance and impact of contracted providers in delivering DAP services?	Where relevant in Sections 4.1 - 4.4
Sustainability	C. What should be included in a more effective data set for DAP funded programs?	Where relevant in Sections 4.1 - 4.4
Sustainability	D. What are the major opportunities to improve future DAP activity mix?	Where relevant in Sections 4.1 - 4.4

Source: Evaluation Team

Appendix B Detailed evaluation methodology

This section includes a detailed evaluation methodology, including the principles that guided all aspects of the evaluation and an explanation of the various data collection methods.

B.1 Evaluation principles

Table 24 outlines the evaluation principles that informed the evaluation.

Table 24 Evaluation Principles

Principle	Description	How the evaluation will deliver
Pragmatic	Insights are pragmatic and tailored to the realities of service delivery	The evaluation examined implementation and outcomes based on the in-scope elements of the DAP program logic. The evaluation prioritised high-quality available program data for analysis and supplemented this with existing national data sources where required to contribute to findings. A pragmatic rapid literature review approach (review of reviews) was used to identify supplementary data sources.
Evidence-based	Insights are evidence-based and designed to maximise our current understanding of what works	A data matrix outlined how each KEQ and sub-question was based on relevant available evidence sources. As part of the literature review, Evaluation Team experts contributed to a gap analysis which further informed the understanding of the baseline evidence.
Actionable	Insights are actionable and achievable in the everyday context of the program	Impact and Outcomes findings were synthesised (or triangulated) at the stream level to ensure they were tailored to the context of underlying sub-programs. Findings were used to inform recommendations to enhance the sustainability (commissioning and implementation) and future evaluability of the DAP.
Responsive	Insights are responsive to the needs of providers and participants, with consideration given to their lived experiences	Primary data collection was undertaken through a survey of providers. A sample of these providers were directly consulted to contribute explanatory data about implementation and effectiveness. These providers were invited to provide service-level outcomes data which contributed to findings about participant outcomes, in addition to existing department research into AOD consumer experience.
Cultural Safety	Insights are pursued in a way which is ethical and culturally appropriate	Cultural safety was a key consideration in both the consultation approach and interpretation of findings, aligning with the Australian Government Evaluation policy guidance on culturally appropriate evaluation.[109] This was accomplished through tailored consultations for First Nations stakeholders and internal validation of insights coming from these consultations.

Source: Evaluation Team

B.1.1 Culturally safe approach

Further to the evaluation principles outlined above, the evaluation was underpinned by a set of agreed principles relating to cultural safety, which were maintained across the evaluation period and all stages of reporting. Cultural safety and respect were at the heart of the evaluation approach during the consultations used to gather First Nations insights.

The following guiding principles are based on the UN Declaration on the Rights of Indigenous Peoples, and underpinned all work undertaken with First Nations stakeholders during consultation processes.

[109] Australian Centre for Evaluation. (n.d.). *Indigenous evaluation.* Retrieved from https://evaluation.treasury.gov.au/about/indigenous-evaluation.

Table 25 Principles for creating a culturally safe approach to the evaluation

Principle	How it applies in the Evaluation
Self-determination First Nations people are best placed to make decisions about their own health and wellbeing. Centring self-determination as a key principle in the way the Evaluation Team work through leadership, culture and community will enable First Nations organisations to work in partnership with mainstream organisations to deliver culturally responsive and culturally safe services.	• Throughout the evaluation process the rights of First Nations peoples will remain central to evaluation activities. • This included incorporating styles of consultation specific to First Nations communities such as Yarning Circles. • Prioritising First Nations stakeholders in the deep dive sample, and including First Nations organisations in initial discovery consultations, will help to ensure that the Evaluation reflects the views of communities. • Specific KEQ sub-questions will seek to understand the experiences and observations of First Nations participants and organisations in the DAP, as a priority group. These will be adapted into tailored consultation questions within consultation guides.
Cultural safety The Evaluation Team commit to creating an environment that is safe for First Nations peoples. A recognition that First Nations culture enables individuals and communities to feel respected and safe.	• The evaluation will consider the cultural needs of First Nations participants as part of the overall evaluation planning approach. This includes considerations for cultural safety in the proposed data collection approaches. • A culturally safe response will embed knowledge of cultural connections and cultural preferences as a protective factor for addressing intergenerational trauma, understanding of local context, and acknowledgement of the diversity and uniqueness of First Nations peoples.
Rights, respect and trust The Evaluation Team will undertake and encourage actions that build trust and credibility for the process among all the participants and will follow through with what is outlined. The Evaluation Team will provide feedback on how the evaluation informs decision making and ensure there are appropriate feedback loops.	• Our approach will be flexible and responsive to the diversity across the different First Nations communities and organisations that the Evaluation Team will engage with. • The evaluation will acknowledge that First Nations peoples are experts in their own experiences, and that each individual will have different experiences and needs. • The qualitative analysis process will note where stakeholder insights represent First Nations perspectives. This will enable final evaluation findings to highlight the voices of First Nations stakeholders and prioritise their observations of the program. The final evaluation reporting will integrate First Nations perspectives throughout and include a separate consolidated summary of distinct findings.
Responsive and timely The Evaluation Team will progress the work in a responsive and timely way, whilst maintaining our commitment to all other guiding principles. The Evaluation Team will speak up early if our commitment to partnership and collaboration may impact our ability to be responsive and timely.	• The Evaluation Team will provide the community with transparent information about the timing and scope of activity and the way in which information will be used and treated. • The Evaluation Team will provide a feedback loop process which provides First Nations stakeholders with key documents prior to consultations, works through an approach of explanation and questions, and provides an opportunity to play back our interpretation of findings for validation (see data sovereignty, below).
Data sovereignty The Evaluation Team will align to the Framework for Governance of Indigenous Data to manage all data (primary and secondary) relating to First Nations peoples collected through this evaluation, partnering with First Nations people to approach the use of data in a respectful and self-determination-led way.[110]	• The Evaluation Team will engage closely with any First Nations organisations included in the sample for deep-dives, to ensure a thorough understanding of why the Evaluation Team are requesting service-level data, how it will be used, and that they have the option to opt out of providing data. • The Evaluation Team will provide First Nations consultation participants with the opportunity to review and validate consultation notes they have participated in. • The Evaluation Team will ensure data serves the interests of First Nations people, rather than reinforcing colonial power structures. As part of the above process, the Evaluation Team will provide First Nations organisations with a further opportunity to offer recommendations for the program and will prioritise these perspectives in formulating final evaluation recommendations.

Source: Evaluation Team

[110] National Indigenous Australians Agency (NIAA). (2024). *Framework for Governance of Indigenous Data.* Retrieved from https://www.niaa.gov.au/resource-centre/framework-governance-indigenous-data

B.2 Stakeholder engagement approach

B.2.1 Discovery consultations

The first phase of stakeholder consultations involved a range of key internal and external government and non-government stakeholders. The discovery consultations prioritised high-level policy insights from the AOD sector and provided contextual insights on the DAP within the broader sector. These consultations sought to answer both process and outcome evaluation questions, and primarily focused on:

- Observed impact of the DAP
- Observed and perceived implementation barriers and enablers
- Perceived appropriateness of DAP funding distribution
- Alignment of DAP to best practice
- Evidence of DAP access barriers and enablers for priority cohorts
- Opportunities to strengthen evaluation and data collection of the DAP
- Evidence of synergies between the DAP and broader AOD service system.

Forty-six (46) stakeholders were consulted as part of the discovery consultations and included representatives from the following stakeholder groups:

- The department policy teams
- Relevant Australian Government agencies
- State and territory AOD policy representatives
- Peak bodies for consumers and providers
- Research institutions
- Professional organisations.

Consultations were conducted as focus groups using a semi-structured interview style with tailored consultation guides. The focus of specific consultations was tailored based on the target stakeholder group to capture the unique insights of each stakeholder group.

Consultation guides were provided to stakeholders prior to the consultation and are in Section C.2. Separate consultation guides were provided for government and non-government stakeholders, as well as those groups with a specialised role within the sector.

B.2.2 Provider consultations

Following the discovery consultations with key governmental and non-governmental stakeholders, a series of targeted focus groups was conducted with a sample of DAP service/program providers and PHNs to gain a deeper understanding of DAP barriers, enablers and future considerations. These consultations sought to answer both process and outcome evaluation questions, and primarily focused on:

- Observed impact of the DAP for participants
- Observed impact of the DAP on the organisation
- Observed implementation barriers and enablers
- Perceived appropriateness of DAP funding distribution
- Evidence of DAP accessibility for priority cohorts
- Opportunities to strengthen evaluation and data collection of the DAP
- Evidence of synergies between the DAP and broader AOD service system.

Twenty-eight (28) stakeholders were consulted as part of the provider consultations and included a combination of:

- Providers receiving direct DAP grant funding from the department
- Providers commissioned by PHNs to deliver DAP services
- PHNs receiving DAP funding to commission services.

The sample of providers and PHNs was selected to draw insights on key areas of interest for the evaluation and the breadth of services delivered through DAP. The sample of providers included for the consultations was not intended to be fully representative of all DAP services but rather representative of the distribution of funding streams across providers.

The following criteria were used in selecting the sample of DAP providers for consultation:

- Each stream was represented across the sample, in approximate proportion to the number of grants allocated to each stream.
- Both PHN-commissioned and non-PHN commissioned services were included in the sample, in line with the above.
- Consideration of key factors including program size, operating model, maturity, mix of regional and metro providers, population diversity and expertise/specialty areas.
- Services delivering multiple DAP-funded programs (e.g., across multiple streams) and receiving large grants were prioritised for selection to provide a greater breadth of service information, however this is not a requirement for services to be selected. A smaller number of single providers was also considered to provide insights on whether provider scale influences outcomes.

Table 26 below shows the breakdown of providers consulted with across the six DAP funding streams and commissioned through PHNs.

Table 26 Breakdown of providers consulted

DAP Stream	Total number of grants in stream	Proportion of total DAP grants	Number of providers consulted	Number of grants represented	Proportion of stream represented in consultations (based on number of grants represented)
Prevention	10	7.5%	2	6	11.5%
National Prevention Projects	5	3.7%	2	2	3.8%
Withdrawal Management and Rehabilitation	56	41.8%	8	24	46.2%
AOD Treatment Services in Areas of Identified Need	18	13.4%	7	10	19.2%
FASD	14	10.4%	2	2	3.8%
PHN	31	23.1%	8	8	15.4%
Total	*134*	*100%*	*29*	*52*	*100%*
PHN-Commissioned Services	443	*N/A*	14	98	*N/A*

Source: Department of Health, Disability and Ageing analysed by the Evaluation Team

Consultations were conducted individually with providers using a semi-structured interview style with tailored consultation guides. In many cases, multiple representatives from a provider attended the consultation to ensure that multiple perspectives from within the organisation were captured.

Consultation guides were provided to stakeholders prior to the consultation and can be found in Appendix C. Separate consultation guides were provided for providers receiving direct DAP funding and providers commissioned through PHNs.

B.2.3 Survey

The survey was developed with tailored questions for PHNs that commission services and providers that receive funding to deliver services.

The survey was voluntary, and participants were able to respond to some or all of the questions asked. Organisations were requested to respond once to the survey. The analysis for the evaluation assumes this, however as the organisations were not required to self-identify, it is possible that there were multiple responses from the same organisation.

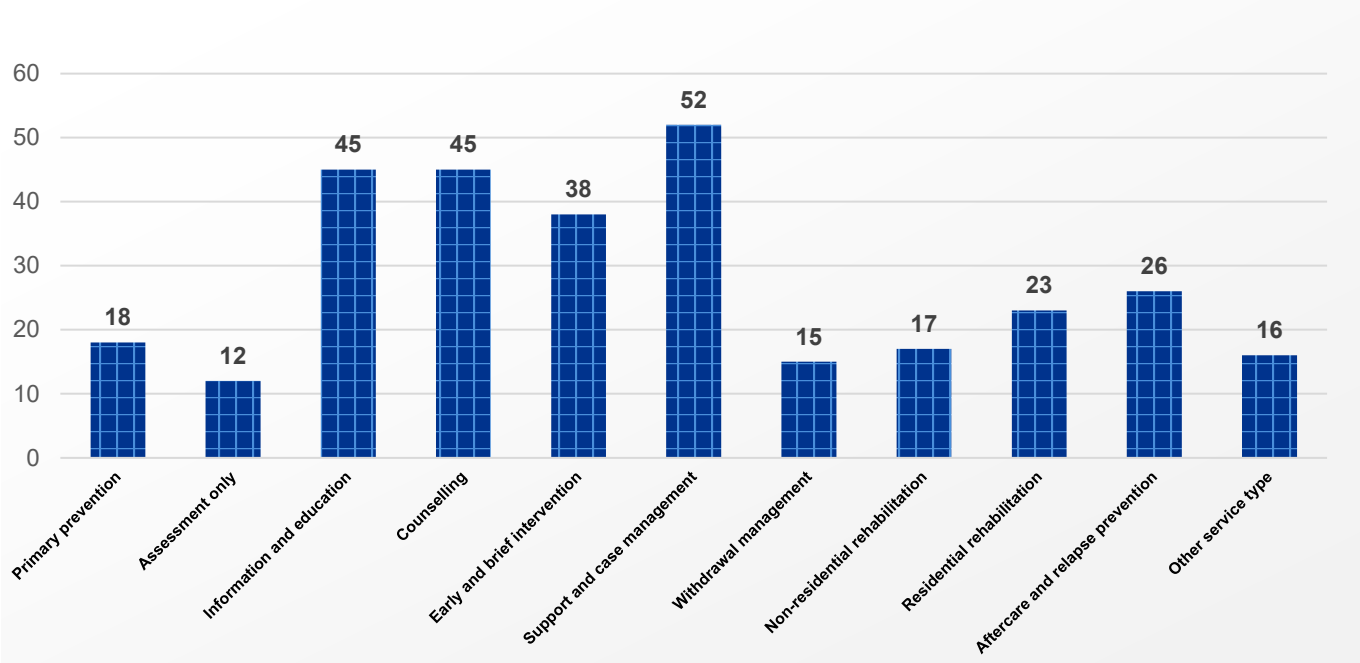
A summary of the number of responses received is provided below, with analysis of the survey included through Appendix D.

Summary of the number of responses received

This analysis uses the responses received from the providers and PHNs to create high-level insights around the experience of providers and PHNs with the DAP. In disseminating the survey, the Evaluation Team tried to ensure that the survey was received by all providers through multiple levels within the organisation. Reminders were also sent to providers to encourage completion and participation in the survey. There is a limitation that it cannot be confirmed that all providers received the survey, and all analysis should be viewed through the lens of this limitation and its impact on the results and insights included.

Within the survey, survey respondents and PHNs were asked which service types they provide as part of their services. Figure 22 illustrates the number of respondents who identified themselves as delivering services within each of the service categories. Respondents were able to select more than one category, and most respondents did select more than one. The survey did not include a description of service categories, see Appendix C3 for the survey questions. The figure illustrates a spread of service categories that mirrors the distribution of grants across the DAP funding streams.

Figure 22 Number of respondents per service category as self-reported in the survey



Source: Evaluation Team Survey

Table 27 below provides the breakdown of responses received by funding arrangement. This was self-reported and providers could select more than one option. There was a distinct difference between services only receiving DAP grant funding via a PHN and the services receiving direct grant funding through the DAP and DAP grant funding via a PHN. This is likely due to the sample of service providers that responded and their grant structures. The table should be viewed through this limitation.

Table 27 Organisation's DAP funding arrangement

Organisation	Number of organisations receiving funding in DAP	Total survey respondents [111]	Response rate (* = estimated)
Service only receiving direct grant funding through the DAP	50	33	66.00% *
Service only receiving DAP grant funding via a PHN	173	29	16.76% *
Service receiving direct grant funding through the DAP and DAP grant funding via a PHN	19	14	73.68% *
Total providers	**242**	76	31.40% *
PHNs	31	22	70.97%
Total	**273**	**107**	**39.19%**

Source: Evaluation Team Survey

Table 28 below provides a summary of the providers that operate in each state and territory. In Table 28, the total number of responses received is 107 responses. The number of responses received for service providers (n=85) is higher than the total number of service providers funded through DAP (n=76). This is due to some providers providing multiple responses because they operate out of more than one location. Three (3) provider respondents operate in two jurisdictions (one in the ACT and NSW, and two in NSW and Qld), and one service provider respondent operates in five jurisdictions (all jurisdictions excluding ACT, Tas and Vic). The difference between the total number of providers and the provider responses was attributable to the following:

- Five (5) service providers operate from two or more jurisdictions, which means there is an additional five responses.
- One (1) service provider operates from five or more jurisdictions, which means there is an additional four responses.

These nine additional responses account for the difference between the number of service providers responses received and the number of service providers operating that responded to the survey.

Table 28 Organisational survey responses (service providers and PHNs), by jurisdiction

Jurisdiction	Total (Service Providers)	Total (PHNs)
ACT	2	1
NSW	20	9
NT	4	1
Qld	15	3
SA	13	2
Tas	4	
Vic	15	6

[111] A response rate was able to be calculated for PHNs (who were required to identify their organisation). However, for other provider responses, the response rate is an estimate only because provider respondents were not required to identify their organisation. To calculate estimated response rates, each provider response has been assumed to represent a unique provider. Available data suggests duplicative provider survey responses were minimal. Total responses from PHN representative were n=31 total, however the figure in this table shows the total number of PHNs who responded (n=22) as more than one response was received from some PHNs.

Jurisdiction	Total (Service Providers)	Total (PHNs)
Western Australia (WA)	4	
National	8	
Total	85	22

Source: Evaluation Team survey

B 2.4 Consultation Limitations

This section details the limitations of the stakeholder consultations. Limitations to the stakeholder consultation emerging insights, for example, includes biases existing in the sample and insights collated from the stakeholder engagement. We are confident that the evidence represents a sound basis for decision making. We do note the potential impact of biases, including:

Selection Bias

- **Selection bias** could occur due to sampling inclusion/exclusion decisions or if providers with more favourable or more critical views and/or certain characteristics self-selected in or out of the process (i.e., if they accepted or declined the invite because of this). This possible bias may have skewed the results and led to middle-ground or nuanced perspectives being overlooked.
- **Non-response bias** may occur as non-respondents' views may have differed in important ways, potentially impacting results.
- **Bias caused by single-person response**, for example, may reflect dominant voices within an organisation.
- **Bias linked to organisational role** could skew findings. For example, responses may reflect the views of senior leaders rather than frontline staff, which could skew findings toward strategic or administrative perspectives rather than day-to-day implementation challenges.

Social desirability bias

- **Social desirability bias** may occur due to providers tailoring their responses based on perceived expectations and/or fears (i.e., fear of funding being impacted).
- **Self-interest bias/conflict of interest** may arise due to one's own professional interests (i.e., such as desire for continued funding, job security), influencing their portrayal of the program through inflating claims of effectiveness, and underreporting risks.
- **Fear of repercussions,** even with an independent evaluator**,** may result in providers avoiding overly critical feedback due to the potential for negative consequences (i.e., funding cuts).

Recall bias

- **Recall bias** relates to biased or inaccurate recollections, particularly when asking staff to comment on past program decisions/aspects.
- **Confirmation bias** may arise by focusing on data or narratives aligning with beliefs about effectiveness and potentially only highlighting successful outcomes.

B.3 Literature review

B.3.1 Objective

The purpose of the review was to summarise evidence from systematic reviews that examine best practice AOD interventions aligned with programs currently funded under the DAP, in relation to effectiveness and access (including by target populations) and return on investment.

Although the NDS 2017-2026 takes a balanced approach across the three pillars of demand reduction, supply reduction and harm reduction, the DAP does not include supply reduction activities. As such, the review will focus on demand reduction and harm reduction only. These two areas include activities in prevention, harm reduction, treatment and long-term recovery support to address harmful AOD use and dependence. These are aligned with activities funded under the DAP.

The review provides evidence to support decision making in line with the key evaluation questions and to inform answers to the key evaluation questions.

B.3.2 Approach to searches

This was not a systematic review. Rather, given the condensed evaluation timeline, the review used a targeted approach consistent with the Cochrane Overviews of Reviews (Overviews) approach and methodology.[112] Consistent with the Overview methodology, only systematic reviews (with or without meta-analyses) were included.

The search strategy was divided into three categories:

- Prevention
- Treatment and recovery
- Harm reduction.

These categories align with the funded DAP streams, the three pillars of Australia's NDS and a prior comprehensive review of AOD interventions.[113]

B.3.3 Information sources

The Cochrane Review database was the primary source of information for this review. This database uses strict guidelines to maintain quality of studies in its database and hence is considered one of the most credible sources of evidence.

To ensure sufficient coverage of published articles, a secondary search was done in the PubMed database. This database was chosen because it provides the most comprehensive coverage of evidence on AOD issues, regularly yielding more relevant findings than other databases (such as MEDLINE, Scopus or PsycINFO).

Current guidance for rapid reviews advises the use of a small number (but at least two) of carefully selected databases based on the study type and subject matter.[114] We have identified these two bibliographic databases as most relevant to the review topic and likely to yield the majority of pertinent literature. This strategy reflects a balance between ensuring adequate coverage and maintaining feasibility within the time and resource considerations of the project.

Consistent with the Overviews methodology, the review did not include primary studies identified through searches of either the Cochrane Review or PubMed databases.

However, to support the review's policy relevance, it included a grey literature search (see Section 4) to identify relevant publications (for example, research or evaluation reports) that sit outside the peer reviewed literature.

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[112] Pollock, M, Fernandes, R, M, Becker, L, A, Pieper, D, & Hartling, L. (2023). *Chapter V: Overviews of Reviews – V,7 Chapter information.* Cochrane. Retrieved from https://www.cochrane.org/authors/handbooks-and-manuals/handbook/current/chapter-v

[113] Bates, G, Jones, L, Maden, M, Chochrane, M, Pendlebury, & M, Sumnall, H. (2017). *The effectiveness of interventions related to the use of illicit drugs: prevention, harm reduction, treatment and recovery: A 'review of reviews'.* Health Research Board.

[114] Garrity, C, Hamel, C, Trivella, M, Gartlehener, G, Nussbaumer-Streit, B, Devane D, Kamel, C, Griebler, U, & King, V, J. (2024). *Updated recommendations for the Cochrane rapid review methods guidance for rapid reviews of effectiveness.* BMJ; King, V, J, Stevens, A, Nussbaumer-Streit, B, Kamel, C, & Garritty, C. (2022). *Paper 2: Performing rapid reviews.* Systematic Reviews, 11(1).

Searches were limited to articles published from 2016 until the date of search. This ensured the review focused on the most contemporary evidence, whilst also aligning with the implementation of the DAP in its current structure. It also means this review builds on the above-mentioned prior review of the effectiveness of interventions for illicit drugs.[115]

B.3.4 Eligibility criteria

The following criteria were applied to the searches to screen for eligibility.

Table 29 Literature review eligibility criteria

Category	Inclusion criteria	Exclusion criteria
Prevention	• Written in English • Published from 2016 onwards • Full-text available • Reviews only: systematic review, meta-analyses, umbrella review, scoping review (exclude primary studies, rapid review and traditional literature reviews) • Focuses on AOD prevention programs (universal or selective, primary or secondary) • Western countries only • Human studies	• Not written in English • No full text available • Not a review: Original study, protocol only, editorial, commentary conference proceedings • Primary study, rapid review or traditional literature review only • Not focused on AOD prevention programs • Non-human studies • Non-western studies only
Treatment and recovery	• Written in English • Published from 2016 onwards • Full-text available • Reviews only: systematic review, meta-analyses, umbrella review, scoping review (exclude primary studies, rapid review and traditional literature reviews) • Focuses on AOD treatment and recovery interventions (excluding supplements) • Human studies only • Western countries only	• Not written in English • No full text available • Not a review: Original study, protocol only, editorial, commentary conference proceedings • Primary study, rapid review or traditional literature review only • Not focused on AOD treatment and harm reduction interventions • Non-human studies • Non-western countries
Harm reduction	• Written in English • Published from 2016 onwards • Full-text available • Reviews only: systematic review, meta-analyses, umbrella review, scoping review (exclude primary studies, rapid review and traditional literature reviews) • Focuses on AOD harm reduction interventions • Human studies only • Western countries only	• Not written in English • No full text available • Not a review: Original study, protocol only, editorial, commentary conference proceedings • Primary study, rapid review or traditional literature review only • Not focused on AOD harm reduction interventions • Non-human studies • Non-western countries

Source: Evaluation Team

[115] Bates, G, Jones, L, Maden, M, Chochrane, M, Pendlebury, & M, Sumnall, H. (2017). *The effectiveness of interventions related to the use of illicit drugs: prevention, harm reduction, treatment and recovery: A 'review of reviews'*. Health Research Board.

B.3.5 Search terms

Databases were searched using a combination of keyword search terms, as shown in Table 30. The search terms were built with consideration of the terms used by Bates et al (2017), the Cochrane Review database's suggested fields and a recent review of evidence for male health interventions undertaken for the department (Gap Analysis of Evidence for Male Health).[116] In a preliminary pilot of the terms, the lead reviewer undertook a high-level check of the title and abstracts returned for each of the search terms to confirm their suitability for ongoing use.

Table 30 Literature review search strategies

Intervention type	Intervention type search terms	AOD search terms	Review search terms
Prevention search strategy	"primary prevention" OR "secondary prevention" OR "universal prevention" OR "selective prevention" OR intervention OR "health promot*" OR campaign* OR adverti* OR "health education" OR "drug education" OR "early intervention"	"substance use" OR "substance abuse" OR "substance-related disorder" OR "substance depend*" OR "substance addict*" OR "drug use*" OR "drug abuse" OR "drug-related disorder" OR "drug addict*" OR "illicit drug*" OR "recreational drug*" OR drug* OR "drug rehab*" OR "drug addict*" OR drug*, non-prescription OR "street drug*" OR "intravenous drug*" OR substance abuse, intravenous or inhalant OR cannabis* OR stimulant* OR "methamphetamine" OR amphetamine OR opioid* OR benzo* OR hallucinogen* OR sedative* OR hypnotic* OR (poly drug*) OR (poly substance*) OR "people who use drugs" or "persons who use drugs" or pwud OR "people who inject drugs" or "persons who inject drugs" OR "alcohol*" OR "Binge drinking" OR "drink*" OR FASD	review OR "meta analysis" OR meta-analys* OR "meta analys*" OR "metaanalys*" OR "systematic review" OR "systematic review*"
Treatment Search Strategy	"Residential rehab*" OR "therapeutic communit*" OR outpatient OR "substance use treatment" OR "drug and alcohol treatment" OR "alcohol and other drug treatment" OR "demand reduction" OR detoxification OR withdrawal OR aftercare OR "continuum of care" OR "continuity of care" OR "peer support" OR "brief intervention" OR "smart recovery"	"substance use" OR "substance abuse" OR "substance-related disorder" OR "substance depend*" OR "substance addict*" OR "drug use*" OR "drug abuse" OR "drug-related disorder" OR "drug addict*" OR "illicit drug*" OR "recreational drug*" OR drug* OR "drug rehab*" OR "drug addict*" OR drug*, non-prescription OR "street drug*" OR "intravenous drug*" OR substance abuse, intravenous or inhalant OR cannabis* OR stimulant* OR "methamphetamine" OR amphetamine OR opioid* OR benzo* OR hallucinogen* OR sedative* OR hypnotic* OR (poly drug*) OR (poly substance*) OR "people who use drugs" or "persons who use drugs" or pwud OR "people who inject drugs" or "persons who inject drugs" OR "alcohol*" OR "Binge drinking" OR "drink*" OR FASD	review OR "meta analysis" OR meta-analys* OR "meta analys*" OR "metaanalys*" OR "systematic review" OR "systematic review*"
Harm reduction search strategy	"harm reduction" OR "harm minimis*" OR "harm minimiz*" OR "overdose prevent*" OR "needle exchange" OR "clean needle" OR "syringe exchange" OR "needle syringe"	"substance use" OR "substance abuse" OR "substance-related disorder" OR "substance depend*" OR "substance addict*" OR "drug use*" OR "drug abuse" OR "drug-related disorder" OR "drug addict*" OR "illicit drug*" OR "recreational drug*" OR drug* OR "drug rehab*" OR "drug addict*" OR drug*, non-prescription OR "street drug*" OR "intravenous drug*" OR substance abuse, intravenous or inhalant OR cannabis* OR stimulant* OR "methamphetamine" OR amphetamine OR opioid* OR benzo* OR hallucinogen* OR sedative* OR hypnotic* OR (poly drug*) OR (poly substance*) OR "people who use drugs" or "persons who use drugs" or pwud OR "people who inject drugs" or "persons who inject drugs" OR "alcohol*" OR "Binge drinking" OR "drink*" OR FASD	review OR "meta analysis" OR meta-analys* OR "meta analys*" OR "metaanalys*" OR "systematic review" OR "systematic review*"

Source: Evaluation Team

[116] Bates, G, Jones, L, Maden, M, Chochrane, M, Pandlebury, & M, Sumnall, H. (2017). *The effectiveness of interventions related to the use of illicit drugs: prevention, harm reduction, treatment and recovery: A 'review of reviews'.* Health Research Board; Dublin; Miler, J, A, Carver, H, Foster, R, & Parkes, T. (2020). *Provision of peer support at the intersection of homelessness and problem substance use services: a systematic 'state of the art' review*. BMC public health, 20(1).

MeSH Terms

AOD: "alcohol related disorders"[MeSH Terms] OR "Alcohol Drinking"[MeSH Terms] OR "Alcoholic Beverages"[MeSH Terms] OR “Alcoholism” [MeSH Terms], cocaine [MeSH Terms] OR MDMA, heroin, methamphetamine, amphetamine-related disorders, amphetamine, substance-related disorder, alcohol-related disorders, amphetamine-related disorders, cocaine-related disorders, heroin dependence, inhalant abuse, marijuana abuse, opioid-related disorder, intravenous substance abuse, oral substance abuse, drug misuse, drug users

Prevention: Primary prevention OR Secondary prevention OR prevention and control OR Drug and Narcotic Control

Harm reduction: Harm reduction

B.3.6 Grey literature

Experience from the Evaluation Team indicated that policy relevant articles (for example research or evaluation reports) were likely to sit beyond the peer-reviewed literature, particularly where they have been commissioned by government agencies or peak bodies. To ensure these were captured, the review included a targeted search of the following websites. It also included reviews that were pre-identified by the department and other evaluation stakeholders, and a snowballing methodology. There was no minimum threshold for the number of sources to be included in the grey literature; the final number of selected grey literature articles was determined by ensuring the overall literature review was policy relevant and sufficient to answer the key evaluation questions within the evaluation timeframe.

Table 31 Search websites for literature review

Organisation	Website
National Drug and Alcohol Research Centre	https//ndarc.ned.unsw.edu.au
European Union Drugs Agency (EUDA)	https://www.euda.europa.eu/index_en
Lenus	https://www.lenus.ie/
National Institute on Drug Abuse (NIDA)	https://nida.nih.gov/
National Drugs Library	https://www.drugsandalcohol.ie/
Washington State Institute for Public Policy (WSIPP)	https://www.wsipp.wa.gov/

Source: Evaluation Team

B.3.7 Screening

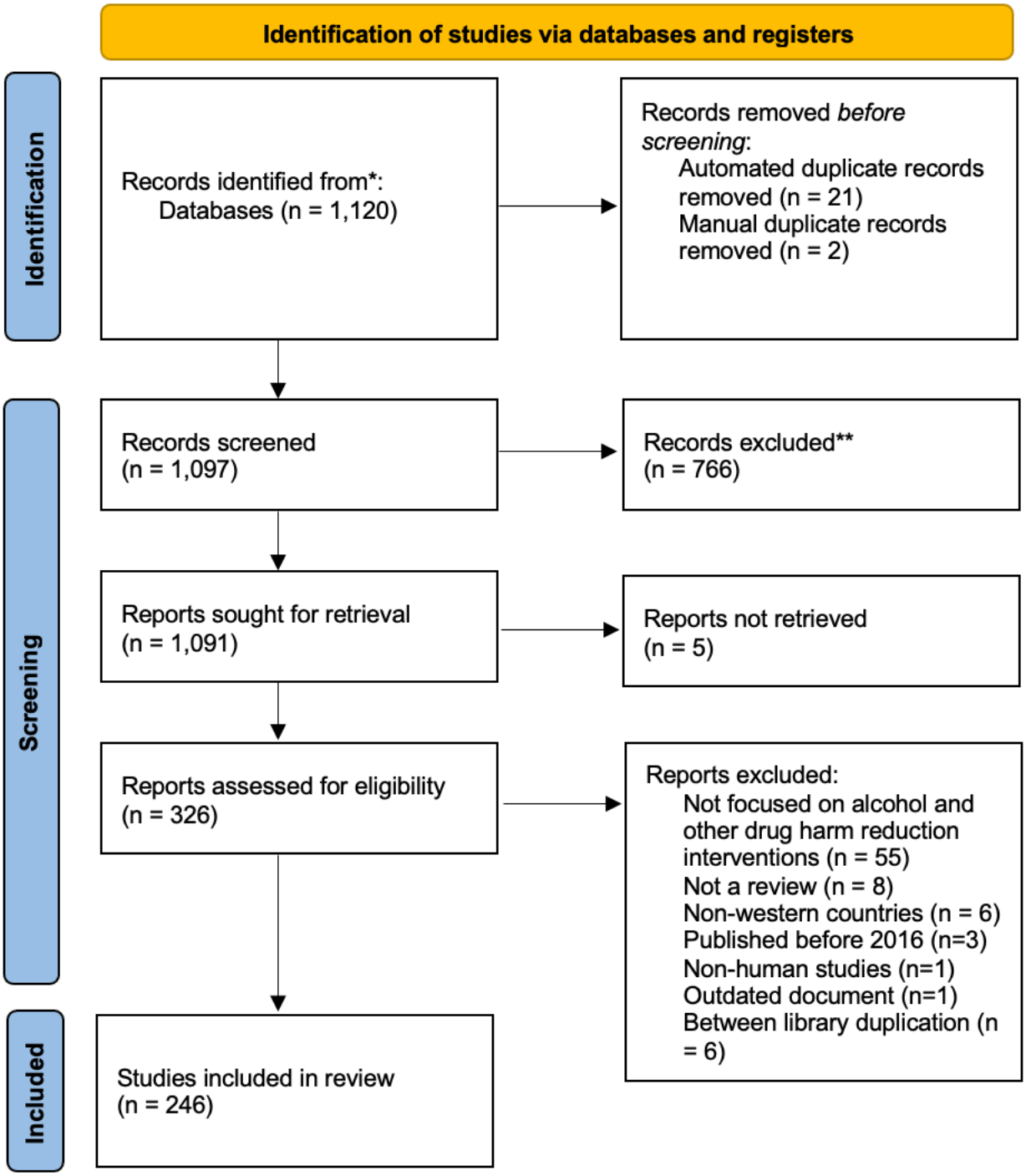
All search results were imported into Covidence for screening. Three separate review screening processes were undertaken in Covidence for each of the three search areas: 1. Prevention; 2. Treatment and recovery; 3. Harm reduction.

After duplicate removal, one reviewer per search stream screened title and abstract citations retrieved during the initial searches for relevance against the inclusion criteria, with guidance from the senior researchers. The full texts of articles identified as potentially relevant to the review were obtained and reviewed against the eligibility criteria by one reviewer.

A second reviewer screened 10% of the title and abstract and full text results to ensure inter-rater reliability. Any discrepancies were resolved by the senior researchers. Screening was reported using the PRISMA guidelines (see Figure 23 below).

A total of 1119 records were identified through the searches described above. After removal of duplicates, 1096 records were screened, with 1091 retrieved and 325 assessed for eligibility, with a final total of 248 records included in the review and data extracted.

Figure 23 Results of literature searches for DAP Evaluation



Detailed alt text available at Appendix E - Figure 23. Source: Evaluation Team

B.3.8 Data extraction

Data were extracted from all reviews relating to prevention, treatment and harm reduction.

While harm reduction is not currently funded under the DAP, we note that harm reduction focused programs may become relevant in the future as policy settings and priorities emerge. We anticipated these studies could contribute to understanding appropriate program models, delivery mechanisms and outcomes that may later inform the expansion or adaptation of the current approach.

Data extraction fields were iteratively developed to align with the key evaluation questions and using prior relevant research.[117] The criteria were piloted on three included studies.

Consistent with the Overviews approach (and as distinct to a meta-analysis) where effect sizes were reported in the included studies, these were extracted. Where the data was missing, it was reported as such. In line with the evaluation timeline, we did not attempt to close these gaps by reviewing the primary studies in detail or contacting the authors.

While it is likely that the systematic reviews that are included in this Overviews include some of the same primary articles, we did not attempt to create a citation matrix or to calculate the corrected coverage area. Where substantive overlaps exist, these may be qualitatively expressed in the review findings.

Review characteristics

- Published review information (authors, year of publication, publication title, DOI/ journal/publication)
- Review type (systematic review, umbrella review or scoping review)
- Review aims and hypotheses
- Number of relevant studies included in review
- Search dates
- Databases searched
- Included study designs/types
- Locations of included studies
- Review methodology (including study type [quantitative], qualitative(?) or mixed)
- JBI (Joanna Briggs Institute) critical appraisal fields for scoring review quality (including 12 scaled items).

Participant characteristics

Target population group/s reviewed details (identify priority populations: First Nations, CALD, LGBTIQ+, older persons, youth, rural and remote communities, people entering/leaving the criminal justice system).

Interventions reviewed

- Prevention intervention types (e.g., prevention, harm reduction, treatment and recovery, FASD)
- Intervention settings
- Intervention details/features
- Barriers and enablers to implementation.

Outcomes

- Types of outcomes (quantitative and/or qualitative, AOD health issue)
- Participant outcomes (self-reported and/or verified)
- Results: data relevant to the DAP project's review selection criteria
- Evidence quality for each outcome examined (High-quality review-level evidence, moderate quality review-level evidence, low-quality review-level evidence).

[117] Bates, G, Jones, L, Maden, M, Cochrane, M, Pendlebury, M, & Sumnall, H. (2017). *The effectiveness of interventions related to the use of illicit drugs: prevention, harm reduction, treatment and recovery: A 'review of reviews'.* Health Research Board; Miler, J, A, Carver, H, Foster, R, & Parkes, T. (2020*). Provision of peer support at the intersection of homelessness and problem substance use services: a systematic 'state of the art' review*. BMC public health, 20(1).

B.3.9 Assessment of review quality and bias

Consistent with the Overviews approach (and as distinct to a meta-analysis) evidence for the review authors' assessments of bias was extracted from each included review during the data extraction phase. In line with the evaluation timeline, primary assessment of bias in studies included by each review was not attempted.

This review does not assess clinically defined outcomes due to the variability in the activities currently being funded, and the variation in the acceptable outcomes regarding recovery and treatment across substances, cohorts and approaches.

B.4 Quantitative data collection and analysis

B.4.1 Quantitative data collection

Quantitative data was collected from a variety of sources outlined in Table 32. The primary data collection period was 1 July 2021 – 31 March 2025. Where historical examples and data existed for a greater time range, the time period was extended to include data from the time of DAP inception, as agreed with the department.

Table 32 Approach to quantitative data collection

Data source and time period	Area of analysis and examples of relevant factors	Data collection approach & specific considerations
DAP data including summary of program grants, performance reporting, activity work plans 1 July 2021 – 31 March 2025	• Program characteristics and parameters (size, location, scope, time of operation, resources employed, other intermediate inputs, funding received) • Service utilisation information (e.g., service access, participation, retention, engagement with online resources, treatment engagement, episode duration) • Service user characteristics (where available) (e.g., target cohort, age, gender, postcode, health status) • Outcomes evidence where available (e.g., changes in awareness and service accessibility, harm, AOD use, stability, consumer satisfaction)	• Provided by department • Variance in information collected based on the service type and stream • Data reported inconsistently across providers and grants, meaning comparison was limited • Service user characteristics and outcomes information were limited within performance reporting • Where available, this included additional sub-program level information such as risk assessments, existing evaluation reporting, and existing internal review reports
PHN summary data for DAP funded programs 1 July 2021 – 31 March 2025	• Program characteristics and parameters • Service utilisation information • Service user characteristics (where available) • Outcomes evidence where available	• Provided by PHNs
NMDS AOD data 1 July 2021 – 31 March 2025	• Service utilisation information • Service user characteristics	• Requested via AIHW, aligned with Human Research Ethics Committee approval • Challenges existed in separating out data for in-scope DAP streams. AIHW have also identified data gaps and inconsistency which limited potential analysis. See a more detailed description of these limitations below • Where possible and necessary, data was adjusted for sociodemographic characteristics. The potential effects of external factors were considered in interpretations
AIHW population health/AOD data 1 July 2011 – 31 March 2025[118]	• Population level characteristics for people who use AOD (age, gender, SES, health status, rates of harm, burden of disease/mortality, rates of AOD use)	• Publicly available data • Linked data was unavailable so could not make a direct link to DAP consumer cohort
Publicly available police and crime statistics 1 July 2011 – 31 March 2025	• Population level data on drug related crime (offence types, offence rates, incarceration rates, costs of incarceration, victim impact)	• Publicly available data • Linked data was unavailable, so could not make direct links to DAP consumer cohort

[118] Period of interest for specific datasets will depend on data availability/limitations as reported by AIHW.

Data source and time period	Area of analysis and examples of relevant factors	Data collection approach & specific considerations

Provider survey (quantitative questions)
1 July 2021 – 31 March 2025
	• Provider and program characteristics and parameters (other intermediate inputs, alignment with other funding sources)
	• Service utilisation information that is not available through performance reporting
	• Outcomes evidence where available
		• Designed and disseminated an online survey to:
		  • Direct recipients of DAP grants
		  • PHN recipients of DAP grants
		  • PHNs
		See Appendix C3 for details of the survey

Source: Evaluation Team

Limitations of NMDS AOD data for treatment episodes

The AIHW dataset used to present trends in treatment episodes at aggregate level and for DAP-funded services in this report has several important limitations. First, the episode-level data capture every closed treatment episode rather than unique clients, so one individual who re-enters care multiple times a year appears as multiple records. Since a single person may have multiple closed episodes in a given year, potentially involving different treatment types or drugs of concern, the episode counts do not equate to distinct individuals. Because all figures reflect discrete episodes, any attempt to infer client counts or to track individual pathways through treatment is impossible.

The DAP data is aggregated across three states and only covers the period from 2016–17 to 2023–24. As these represent an unknown proportion of all DAP-funded episodes, the figures may not reflect the full extent of service activity. Since the AIHW adheres to a strict de-identification policy, any cell containing five or fewer episodes is suppressed, and further suppression or category collapsing is applied where necessary to prevent re-identification. As the DAP data are not reported at the individual state level, it is not possible to conduct any geographic analysis within each state or territory; all statistics represent a pooled sample for the three included jurisdictions. Furthermore, the data include only closed treatment episodes rather than unique clients.

Not all DAP-funded services appear in the data. Dual-funded services continue to submit their data through state or territory channels and cannot be identified within the AODTS NMDS and hence the AIHW-reported sample. Similarly, Australian Government-only services that have not transitioned to direct AIHW reporting remain invisible, particularly during the program's early years when resourcing or system barriers prevented full data submission. Brief intervention programs that are out of scope and any service that fails to collect the majority of mandatory AODTS NMDS variables are also excluded entirely from the annual dataset.

Finally, there is currently no nationally agreed outcome measure within the AODTS NMDS. Treatment goals and the extent to which they are met (i.e., outcomes) are not captured by the AODTS NMDS, nor is the intention of treatment types captured as part of the treatment episode. ‘Reason for cessation’ where the ‘treatment is completed’ is problematic because there is no record of the original intention for that episode or detail of client outcome.

These caveats mean that AIHW figures for DAP Services — from episode counts to reasons for ceasing treatment — should be interpreted as broad, anonymised snapshots of service activity rather than exhaustive, client-level census data. Any inference about treatment access, client populations or state-specific trends must acknowledge these constraints.

Limitations of NSW treatment outcomes data

Several limitations should be considered when interpreting the figures in this section. First, the dataset includes only services that have agreed to and consistently use the NADAbase outcome-reporting tools. Not all DAP-funded services contribute outcome data, and figures at the DSS and PHN levels are based on just 41 and 28 consenting sites, respectively. This introduces the risk of selection bias as participating services may differ systematically from non-participants, potentially leading to upward bias in observed improvement rates. For instance, smaller or resource-constrained services may be underrepresented.

Second, the four-year observation window limits meaningful trend analysis. Some outcomes are missing or inconsistently reported across years, and key indicators, such as ATOP psychological health and QoL data for DSS-funded services, are unavailable for 2021–22, impeding direct comparison across streams and time.

Third, the definition of improvement includes both reductions in use and maintained abstinence, without distinguishing between clients who were already abstinent and those who achieved change. This masks heterogeneity in outcomes and may overstate clinical progress, especially for substances with high baseline abstinence.

Fourth, while the thresholds for improvement are pragmatic (any change in a positive direction), they are minimal. For example, a one-point change on the K10 or ATOP scale, or a one-day reduction in use, is considered improvement, even though it may not represent a clinically meaningful change. Moreover, follow-up intervals vary across services and years, including post-episode assessments, reducing comparability.

Finally, cross-stream comparisons assume similar service models, yet program structures, clinical protocols, and staffing levels differ across DAP, DSS, and PHN services. For example, DSS-funded sites may offer integrated care with built-in follow-up, while PHN-funded sites may focus on shorter-term support. Similarly, as noted previously, DSS primarily funds residential rehabilitation services, while PHNs primarily fund non-residential services.

In summary, while the outcome data provide a broad snapshot of client improvement across streams, interpretation is constrained by selection bias, data gaps, minimal improvement thresholds, and service heterogeneity. Any conclusions about relative performance should be made cautiously. Further analyses using raw counts, standardised follow-up periods, and case-mix adjustment would help strengthen confidence in the findings.

B.4.2 Approach to quantitative analysis

Quantitative analysis established attribution and causation of outcomes to the DAP, noting the limitations listed above. Table 33 describes the different quantitative analysis methods used in the evaluation.

Table 33 Description of quantitative data analysis methods

Analysis Type	Description
Descriptive analysis	Descriptive analysis using outputs such as histograms and density plots: • Analysis of the key dataset for the DAP, the AODTS NMDS. • AIHW national data, for example trends in substance use, drug-related incidents and mortality. • Australian Criminal Intelligence Commission data, including number of police arrests for drug possession and criminal activity related to drug use or intoxication. • NADABase outcomes data, for outcome trends for providers in NSW reporting to NADABase.
Activity analysis	Desktop review of program data and documentation included: • Mapping delivery of the DAP over time, by stream, to show which sub-programs were delivered and when, using grants and activity data. This mapping included direct grant recipients and PHN-commissioned programs. • Which services/programs were delivered by the DAP that would otherwise not have been possible, based on triangulation with qualitative evidence (such as stakeholder consultation and analysis of grant agreements).
Outcomes analysis	Outcomes analysis considered the following outcomes: • The analysis assessed the impact of the DAP across different types of treatment. Since individual-level patient outcomes could not be linked to specific treatments or DAP participation, and given access to AODTS NMDS episode-level data, resource utilisation was a primary outcome of interest due to its comparative availability for DAP sub-programs (noting limitations of interpretability of proxy output measures to estimate program effectiveness). The analysis examined variations in treatment types over time. • The possibility of examining national trends in drug and alcohol use over time (using national-level datasets) as program outcomes was explored, i.e. to test whether any correlation between the population-level outcomes and the DAP could be established. However, it is important to note that this relationship was influenced by numerous confounding factors that could not be fully controlled for, such as the presence of other programs or individual reasons for discontinuing participation. There was therefore an inherent bias and limitations in the interpretability of this data as an outcome of the DAP. Therefore, these outcomes were used in descriptive analysis to understand the trends in Australia.
Efficiency analysis	• The approach to the efficiency analysis focused on understanding the allocation of funding expenditure for each DAP grant stream. • This included a description of the activities being funded, and whether this was spent to reduce an identified gap and/or duplication in services. This was undertaken through bringing together grant agreement and expenditure data, provided by the department. AOD funding data was also provided from state and territory governments where possible for inclusion in the analysis. • The findings were triangulated with the activity and outcomes analysis to consider DAP efficiency.

Source: Evaluation Team

Other quantitative methods explored

The feasibility of additional analytical methods was explored, via an evaluability assessment, with feasibility based on data availability, quality and consistency. The evaluability assessment determined that these methods were not feasible given the quantitative data available for the evaluation. Additional methods included:

- Interrupted time series analysis to assess whether the DAP has had an impact on resource utilisation, enabling a comparator. The feasibility of this approach depended on the availability of sufficient pre-interruption data to establish a stable baseline trend before the DAP's implementation. Limitations in this approach resulted from a lack of formally established baseline data collected through the DAP itself.

Other quasi-experimental methods (Difference-in-Differences, propensity score matching, synthetic controls) were considered as part of the evaluability assessment. They were deemed infeasible given insufficient data for selection of

appropriate control groups, data limitations for a treatment group, and the inability to establish a counterfactual, see Table 34 to Table 37 below.

Table 34 Methodological Choices Explanation - Difference-in-Difference method

Requirements for Methodology	Challenge to Applicability for DAP Evaluation
Requires **outcome** data for two groups (**treatment** and **control** groups) over at least two time periods (**before** and **after** treatment). • Assumes that the treatment and control groups would have followed similar trends in the outcome variable if the treatment hadn't been implemented. • The treatment status of a unit (individual, firm, etc.) can only vary between two states: treated or not treated. This means there cannot be any intermediate or multiple levels of treatment within the same unit over the period of analysis.	Two options considered for outcome data: NMDS as a widely-required reporting mechanism, and individual service-collected data. **NMDS data** • NMDS contains only a 'treatment' sample (cannot provide a group of persons not receiving any intervention). • NMDS does not allow for disaggregation of DAP-funded and non-DAP-funded clients (difference between 'DAP treatment' and 'other treatment'). • NMDS does not currently contain outcomes measures and is not linked with other data sources that provide outcome measures or enable control groups to be identified. Linkage with other data sources that may provide outcome measures, or enable control groups to be used, is not possible within the timeframes for this project. **Data reported by programs** • Outcome data from funded programs are unlikely to be consistent in measures. • Outcome data from funded programs will contain only 'treated' samples. • Exploring specific grants. • The evaluation considered using Indigenous people as 'treated' for grants related to them while non-Indigenous as control groups, or grants given to certain population subgroups versus those who are not given certain grants. However, the remaining groups are also 'treated' by other grants. This limitation renders any such result non-meaningful. **Isolating the impact of DAP** • Multiple grants are awarded during the same period, making it challenging to clearly distinguish between treatment (receiving DAP funding) and control (no DAP funding) groups of services. The Difference-in-Differences method relies on a well-defined distinction between those who are 'treated' and those who are 'not treated.' The overlap in timing across various grants complicates this distinction. Access to information on recently active but completed programs is essential for identifying which groups or individuals have received treatment. • The structure of the NMDS dataset at the service level (i.e., episodes are not individualised) means it will not be possible to distinguish clients whose engagement is unique from those who have previously engaged with that service (i.e., it becomes impossible to separate exposed/unexposed to treatment at entry, to determine before/after treatment) DAP funding has been in place under other program names prior to the evaluation period; this renders before/after allocation unclear for establishing pre-intervention trends. • Numerous services that receive funding under DAP also receive funding under multiple other schemes, including state/territory governments. This makes isolation of the impact of DAP funding (i.e., attribution) unclear. • Funded programs operate across multiple geographic locations, which may make comparison across locations unclear. The level of population characteristics required to adjust for variation may not be contained in administrative data sets (e.g., NMDS). • The evaluation explored defining Indigenous populations as the treated group for Indigenous-specific grants, with non-Indigenous populations serving as a control group. We also considered comparing grant recipients and non-recipients. As previously noted, many of these organisations have also received other grants, meaning it is not possible to isolate the effect of any single intervention. This limitation significantly undermines the interpretability and policy relevance of the results. • While the NMDS dataset offers national-level insights, the AIHW recommends using the data only from 2016 onwards. This constraint restricts the availability of sufficient pre-treatment data, further limiting the ability to conduct robust evaluations. • For future analysis, linking NMDS data with complementary sources such as HILDA or the Drug and Alcohol Consumption Survey could provide a more complete picture and strengthen evaluation efforts. Although overlapping grant timelines and the absence of distinct treatment periods limit the ability to draw firm causal conclusions, exploratory analysis remains possible where treated and comparison groups can be reasonably defined.

Source: Evaluation Team

Table 35 Methodological Choices Explanation - Synthetic Control method

Requirements for Methodology	Challenge to Applicability for DAP Evaluation
The synthetic control method is a useful tool for evaluating the impact of a policy or intervention by constructing a weighted combination of control units to create a "synthetic" version of the treated group—essentially providing an estimate of what would have happened in the absence of the intervention. Even though this method is called synthetic controls, it requires controls to be used to define weights. However, this method requires a well-defined intervention with a clear treatment group, a sufficient number of comparable control units, and along enough pre-treatment period to establish baseline trends. This method also: • requires outcome data for two groups (treatment and control groups) over at least two time periods (before and after treatment) • requires a defined study population which is not exposed to treatment, for selection of a control group.	In this case, the synthetic control method is not feasible due to: • non availability of control group • no well-defined control group • the overlapping and non-specific nature of multiple grant programs, which makes it difficult to clearly define treatment and control groups, and limits availability of pre-treatment data.

Source: Evaluation Team

Table 36 Methodological Choices Explanation - Propensity Score Matching method

Requirements for Methodology	Challenge to Applicability for DAP Evaluation
Propensity Score Matching **Interrupted time series** Propensity score matching (PSM) aims to estimate the impact of a treatment by matching treated and untreated individuals with similar characteristics, thereby mimicking the conditions of a randomised experiment. For PSM to produce valid results, it requires two key conditions: 1 a well-defined treatment and control group 2 comprehensive data on observable characteristics that influence both treatment assignment and outcomes. • Requires outcome data for two groups (treatment and control groups) over at least two time periods (before and after treatment). • Requires a defined study population which is not exposed to treatment, for selection of a control group. • Requires data for **both treatment and control groups** for **characteristics** to which matching can be applied.	In this context, PSM is not feasible because there is no clearly defined untreated group-most individuals or groups are exposed to some form of grant, making it difficult to identify a suitable control population. In addition, the available data may not capture all relevant factors that influence both grant receipt and outcomes, leading to biased estimates (there are no feasible control variables). As a result, the assumptions necessary for the reliable use of PSM are not met.

Source: Evaluation Team

Table 37 Methodological Choices Explanation - Interrupted Time Series method

Requirements for Methodology	Challenge to Applicability for DAP Evaluation
• Outcome data pre- and post- intervention • Clarity of intervention population • Clarity in intervention timing	To make casual inferences from an interrupted time series design, several key assumptions and requirements must be met. First, a main assumption is that no other changes around the same could affect the outcome. This assumption is most likely violated due to the potential for other programs, e.g., grassroot organising that are not recorded by the department as well as the COVID-19 pandemic. There could be other unobserved confounders, such as changes in prices or regulation. In the absence of a control group in this kind of method, it is not possible to infer causality from the approach to evaluate the DAP. Second, the intervention or event must have a clearly defined implementation date. This assumption is also violated, since there is no information on respondents' location in HILDA other than the SA4 level. Because SA4 levels do not perfectly align with PHNs it is not possible to differentiate those individuals who are `treated` from those who are not. The AIHW dataset only includes individuals who received treatment, with no identifiable untreated group. Moreover, multiple grants were implemented concurrently, and there is no visibility of when some grants were completed while others were ongoing. This overlap makes it impossible to isolate the effect of any single intervention, undermining the construction of liable counterfactual trend. This also means it is not possible to assess whether there was a stable pre-trend, the third assumption in ensuring that any estimates from an interrupted time series can be attributed to the programs. Finally, the intervention should be exogenous to the outcome, i.e., not caused by trends in the outcome itself. It is likely that programs are to some extent determined by the usage of drugs and alcohol in a certain area or population, that is, it would not make sense to implement such a program in a region or targeted at a population who do not use drugs or alcohol. Considering that ***several*** key assumptions are violated it was implausible to claim weak/limited causal inference using Interrupted time series for the DAP evaluation.

Source: Evaluation Team

B.5 Synthesis of data

The outputs from both the qualitative and quantitative analysis, as well as the findings from the literature review, were synthesised and triangulated into findings against each of the evaluation domains.

For each of the evaluation domains, the evaluation considered relevant literature review evidence as a key secondary data source to supplement primary evaluation evidence, or to supplement where there were gaps in data able to be collected through the evaluation. This was particularly important to answer sub-questions related to alignment of the DAP with best practice, establishing a comparison to the extent possible, see Table 38 to Table 39 below.

Table 38: Strength of evidence key for Data Matrix

Rating	Description
High	There is likely to be strong evidence from quantitative data sources and contemporaneous evidence describing actual program delivery. Data is likely to be available from multiple sources, e.g., enabling mixed-methods triangulation to answer the sub-question. The findings are likely to be attributable to the DAP.
Medium	Contemporaneous evidence describing actual program delivery is likely to be available, but is likely to be predominantly qualitative rather than quantitative in nature. Triangulation may be possible between this evidence and primary stakeholder consultation evidence and/or secondary literature review evidence. There may be limitations in the attribution of outcomes to the DAP, e.g., presence of confounding factors.
Low	There is unlikely to be strong contemporaneous evidence (either quantitative or qualitative) and findings are unlikely to have a quantitative basis. Triangulation between data sources may not be possible, or may be based on inferences made through reference to literature review findings. There are limitations in the attribution of findings to the DAP, e.g., strong presence of confounding factors or reliance on secondary or population-level evidence not specifically associated with the DAP.

Source: Evaluation Team

Table 39: Data matrix for KEQ 1: How well is the program being delivered in terms of fidelity, quality and outcomes? (Implementation)

Sub-questions	Strength of evidence	Indicators	Data sources
A. To what extent do program guidelines, documentation and reporting requirements enable or hinder high quality program implementation?	High	• Fidelity of program implementation to guidelines • Completion rates for provider performance reporting	• Program-level documentation (guidelines, reporting requirements) • Provider performance reporting
B. To what extent have the funded organisations delivered outputs according to their grant agreements?	High	• Whole-of-program level (aggregated) • Alignment between outputs delivered and outputs in funding agreements	• Current grant agreements • Grant reporting for current programs
C. To what extent has implementation of each DAP stream considered the needs of priority populations, as identified in the National Drug Strategy (First Nations, CALD, LGBTIQ+, older persons, youth, people with mental health conditions, people in contact with the criminal justice system)?	Medium	• Whole-of-program or stream level (aggregated) • Proportion of sub-programs with evidence of tailored service delivery approach for priority populations • Evidence of specific guidelines or implementation processes to meet needs of priority populations	• Program-level documentation • Current grant agreements • Provider survey data • Provider focus group data • Discovery consultation data
D. What are the other barriers and enablers to effective implementation of the DAP and its ability to achieve positive client outcomes?	Medium	• Qualitative evidence of factors which impeded or delayed implementation (distribution of grants, DAP service delivery) • Qualitative evidence of factors which improved or facilitated implementation • Sufficiency of DAP resourcing to deliver Drug and Alcohol programs	• Provider survey data • Provider focus group data • Discovery consultation data • Program-level documentation

Source: Evaluation Team

Table 40: Data matrix for KEQ 2: Is this program the right response to the identified needs and priorities of target populations? (Appropriateness)

Sub-questions	Strength of evidence	Indicators	Data Sources
A. Are the funded activities the appropriate response based on current data, research, societal and emerging trends, state and territory services, and evidence?	Medium	• Alignment of DAP activity streams and service types to good practice evidence (e.g., evidence-based digital programs)	• AODTS NMDS • Literature review • Summary data for DAP • Discovery and provider focus group data • Advisory Committee / internal experts
B. Based on current needs and available evidence, is there an appropriate balance between funded prevention and treatment services?	High	• Alignment of DAP activity streams and service types to good practice evidence	• Literature review • Summary data for Drug and Alcohol programs • Discovery focus group data • AODTS MDS
C. How do the funded programs complement or synergise with existing jurisdictional services?	Medium	• Evidence of simultaneous delivery of DAP and existing jurisdictional services • Evidence of efficiencies gained through blended funding streams • Evidence of services delivered or expanded through DAP funding that could otherwise not be delivered	• Discovery focus group data (states and territories, peaks) • Provider focus group data • Desktop review
D. To what extent are DAP funded programs delivered in a way which is appropriate for specific vulnerable groups, as identified in the National Drug Strategy (First Nations, CALD, LGBTIQ+, older persons, youth, people with mental health conditions, people in contact with the criminal justice system)?	Medium	• Evidence of targeted models of care for priority cohorts • Evidence of service delivery conducted in a tailored way for priority cohorts • Evidence of access challenges for priority cohorts	• Discovery focus group data (peaks, research institutions) • Provider focus group data • Literature review • AODTS NMDS
E. Are there any examples of services that might be considered as models of future approaches to commissioning?	Medium	• Evidence of services tailored to local community e.g., rural and remote • Evidence of co-designed services with lived experience input into design • Evidence of innovation in service delivery	• Grant agreements • Discovery focus group data (peaks, research institutions) • Literature review

Source: Evaluation Team

Table 41: Data matrix for KEQ 3: What difference is the program making? (Impact)

Sub-questions	Strength of evidence	Indicators	Data Sources
A. What effect do DAP services have for program participants?	Medium	Treatment programs (stream-level):[119] • Rates of treatment completion • Vacancy rates (sampled services) • High treatment satisfaction (sampled services) • Aggregate participant health and wellbeing outcomes (from sampled services, if available) • Number of jurisdiction-level AOD-related police reports Prevention programs (stream-level): • Service reach / access • Number of service participants • Retention rates of participants • Evidence of priority group participation / access • Utilisation of online resources / number participating in prevention activities / dissemination of prevention materials • Participant satisfaction	All programs: • Aggregated program data from sample of DAP services • Grant reporting Treatment programs: • AODTS NMDS[120] • Australian Criminal Intelligence Commission data[121]
B. How does resource utilisation vary across different demographic groups who participated in them? What explains these differences?	Low	Stream-level: • Resource utilisation indicators (above) by age, gender, location, First Nations status, drug of use • Qualitative explanatory evidence of drivers of difference between demographics	• Aggregated program data from sample of DAP services • Provider focus group data • Provider survey data • Literature review

[119] Note: Through exploration of the DAP streams, examples of sub-stream groupings of services may emerge as useful to group insights, e.g., specific types of prevention programs may be grouped within the Prevention Programs stream where these address similar issues and/or measure similar outcomes.
[120] Note that the AODTS NMDS may be an incomplete dataset of DAP programs.
[121] Note that while administrative datasets contain whole-of-population outcome data which may enable comparison of population-level outcomes pre- and post-introduction of the DAP, these datasets are unlikely to report DAP participation as a variable, potentially impacting the analytical method to be applied.

Sub-questions	Strength of evidence	Indicators	Data Sources
C. Which elements of DAP may be associated with achieving positive outcomes?	Low	• Stream-level resource utilisation indicators (above) • Literature evidence of AOD service duration correlated with positive participant outcomes • Qualitative explanatory evidence	• AODTS NMDS • Aggregated program data from sample of DAP services • Provider survey data • Provider focus group data • Literature review
D. Are there service improvement models in some settings that could be promoted for broader implementation?	Medium	Stream level: • Evidence of improved health outcomes for sampled services • Evidence of innovative models aligning with best practice	• Literature review • Provider survey data • Discovery focus group data • Aggregated program data from sample of DAP services
E. How have population-level AOD outcomes changed since DAP implementation?	Medium	• Increase in public understanding about AOD issues • Reduction of daily smoking prevalence • Reduction of harmful alcohol consumption • Reduction in illicit drug use • Reduction in the number of victims of drug-related incidents • Reduction in the drug-related burden of disease • Reduction in drug-related mortality	• Population health and AOD use data (AIHW, Drug Trends and Wastewater research programs)[122] • Australian Criminal Intelligence Commission data

Source: Evaluation Team

[122] Note that administrative datasets contain whole-of-population outcome data for comparison pre- and post-program, they are unlikely to report DAP participation as a variable, therefore are unlikely to be suitable to construct a control group for purposes of some quasi-experimental methods which use this technique.

Table 42: Data matrix for KEQ 4: To what extent has the program delivered value for money? (Efficiency)

Sub-questions	Strength of evidence	Indicators	Data Sources
A. How have resources been allocated and utilised?	Medium	• Cost per bed day (Withdrawal Management and Rehabilitation Services and AOD Treatment Services in Areas of Identified Need) • Qualitative evidence of resource allocation aligning with good practice • Qualitative evidence of resource allocation towards priority communities and populations • Qualitative evidence of programs that expanded remit due to receiving DAP grant funding	• Current grant agreements • Grant reporting • Provider focus group data • Provider survey • Discovery consultations (Government)
B. To what extent is the relationship between inputs, outputs and outcomes timely and to expected standards?	Low	• Stream-level • Alignment of outputs to good practice	• Literature review • Grant reporting • Discovery consultations (Government)
C. Are the reporting arrangements required from funded organisations proportionate to the level of funding and program objectives?	Medium	• Completion rates for provider performance reporting • Consistency in performance reporting across streams • Alignment with good practice AOD data collection	• Grant reporting • Provider survey data • Provider focus group data • Literature review
D. Are there gaps or areas of duplication in the DAP? How can these be addressed?	Medium	• Evidence of duplicative service delivery • Evidence of unmet need	• Provider survey data • Discovery consultation data (Government, peaks) • Provider focus group data • Program documentation

Source: Evaluation Team

Appendix C Stakeholder consultation summary

C.1 Consultation summary

Stakeholder consultations were completed in two phases across April – June 2025. Table 43 lists the stakeholders who participated in consultations and their stakeholder category.

Table 43 List of stakeholders consulted

Stakeholder	Stakeholder Group
Department of Health, Disability and Ageing – PATS	Department
Department of Health, Disability and Ageing – DAPS	Department
Department of Health, Disability and Ageing – E&E	Department
Department of Health, Disability and Ageing – PHN Branch	Department
Department of Health, Disability and Ageing – Health Economics and Research	Department
National Indigenous Australians Agency (NIAA)	Other Australian Government agencies
Department of Social Services (DSS)	Other Australian Government agencies
Department of Prime Minister & Cabinet Social Policy Group	Other Australian Government agencies
Tasmania Department of Health AOD Policy representatives	State/Territory government
NSW Ministry of Health AOD Policy representatives	State/Territory government
Victoria Department of Health AOD Policy representatives	State/Territory government
ACT Health Directorate AOD Policy representatives	State/Territory government
NT Health AOD Policy representatives	State/Territory government
WA Mental Health Commission AOD Policy representatives	State/Territory government
SA Health AOD Policy representatives	State/Territory government
Queensland Health AOD Policy representatives	State/Territory government
Australian Alcohol and other Drugs Council (AADC)	Peaks
National Organisation for Fetal Alcohol Spectrum Disorder (NOFASD)	Peaks
Foundation for Alcohol Research and Education (FARE)	Peaks
National Aboriginal Community Controlled Health Organisation (NACCHO)	Peaks
Australian Injecting and Illicit Drug Users League (AIVL)	Lived Experience peaks
NSW Users and AIDS Association (NUAA)	Lived Experience peaks
Canberra Alliance for Harm Minimisation & Advocacy (CAHMA)	Lived Experience peaks
Harm Reduction Victoria	Lived Experience peaks
Queensland Injectors Health Network (QuIHN)	Lived Experience peaks
Peer Based Harm Reduction WA	Lived Experience peaks
Northern Territory AIDS and Hepatitis Council Inc.	Lived Experience peaks
SA Harm Reduction Peer Services	Lived Experience peaks
South Australian Network of Drug & Alcohol Services (SANDAS)	Peaks (State/territory)
Victorian Alcohol and Drug Association (VAADA)	Peaks (State/territory)
Alcohol, Tobacco & Other Drug Association ACT (ATODA)	Peaks (State/territory)
Network of Alcohol and Other Drugs Agencies (NADA)	Peaks (State/territory)
Alcohol, Tobacco & Other Drugs Council Tasmania (ATDC)	Peaks (State/territory)

Stakeholder	Stakeholder Group
Western Australia Network of Alcohol & Other Drug Agencies (WANADA)	Peaks (State/territory)
Association of Alcohol and Other Drug Agencies NT (AADANT)	Peaks (State/territory)
Queensland Network of Alcohol & Other Drug Agencies Ltd (QNADA)	Peaks (State/territory)
National Drug and Alcohol Research Centre (NDARC)	Research
National Centre for Education and Training on Addictions (NCETA)	Research
National Drug Research Institute (NDRI)	Research
National Centre for Youth Substance Use Research (NCYSUR)	Research
Drug Policy Modelling Program	Research
Monash Addiction Research Centre	Research
Australian Drug Foundation (ADF)	Research
Australasian Professional Society on Alcohol & other Drugs (APSAD)	Professional organisations
Australasian Chapter of Addiction Medicine	Professional organisations
Royal Australasian College of Physicians (RACP)	Professional organisations
Royal Australian College of General Practitioners (RACGP)	Professional organisations
Lives Lived Well	Provider
Palmerston Associated Inc	Provider
Mission Australia	Provider
Odyssey House	Provider
Thorne Harbour Health	Provider
Uniting Communities	Provider
University of Sydney	Provider
Alcohol and Drug Foundation (ADF) **ADF were consulted with on two separate occasions as part of both the discovery and provider consultations*	Provider
Baptist Care (SA) Inc	Provider
Ngaimpe Aboriginal Corporation	Provider
Country and Outback Health	Provider
Eastern Health/Turning Point	Provider
Substance Misuses Limestone Coast Incorporated	Provider
Fadiss Limited (Family Drug Support)	Provider
The Salvation Army	Provider
Yaandina Family Centre	Provider
The HIVE Counselling (previously Holyoake Tasmania)	Provider
Holyoake (WA)	Provider
Karralika	Provider
Directions ACT	Provider
Windana Drug and Alcohol Recovery Centre	Provider
South Eastern Melbourne PHN	Provider
Country SA PHN	Provider
Northern Territory PHN	Provider
Western Australia Primary Health Alliance (Perth and Country WA PHNs)	Provider
Western Sydney PHN	Provider

Stakeholder	Stakeholder Group
Brisbane North PHN	Provider
Tasmania PHN	Provider
South Eastern NSW PHN	Provider

Source: Evaluation Team

C.2 Consultation guides

Consultation guides were developed based on the KEQs and tailored to each stakeholder group in order to capture their unique insights. The consultation guides were provided to stakeholders ahead of consultations.

C.2.1 Consultation briefing document

Evaluation Background

The Department of Health and Aged Care (the department) have engaged The Evaluation Team to evaluate the national Drug and Alcohol Program (DAP). The DAP aims to reduce the impact of alcohol and other drug (AOD) use on individuals, families, and communities.

The DAP includes all current Australian Government funding to the alcohol and other drug (AOD) sector by the Department of Health and Aged Care, including funding provided via Primary Health Networks (PHNs). It does not include AOD funding received from state and territory Governments, or funding provided to Indigenous-specific services by the National Indigenous Australians Agency (NIAA).

The DAP is largely administered through grant funding to AOD services nationally to run a series of sub-programs, and grant funding to Primary Health Networks (PHNs) to commission sub-programs that meet local needs. DAP sub-programs typically include client-facing treatment, withdrawal management and rehabilitation, prevention programs, and programs targeted to Fetal Alcohol Spectrum Disorder (FASD).

DAP services align with priorities and guidelines outlined in the National Drug Strategy (NDS). The priority populations for the DAP also align with those in the NDS: First Nations peoples, people with mental health conditions, young people, older people, people in contact with the criminal justice system, culturally and linguistically diverse (CALD) populations, and LGBTIQ+ people.

Purpose of the evaluation

The Evaluation Team are undertaking the evaluation to assess the impact and overall administration of the DAP. The evaluation aims to reach an understanding of:

- To what extent the DAP is achieving its intended objectives, for whom, and under what circumstances.
- Opportunities to improve DAP administration and implementation.

This evaluation will examine the program’s implementation, appropriateness, effectiveness, efficiency and sustainability. This analysis aims to provide recommendations to the government on opportunities for future funding and program design. It will also guide delivery and evaluation activities, contributing to the evidence base for future DAP policy decisions. While not pre-empting the evaluation's insights, several scenarios may be recommended, including changes to grant design and duration, reporting requirements, and how success is measured.

The Evaluation Team will undertake analysis of program documents and data, a survey of DAP-funded providers and PHNs, a rapid literature review, and consultations with key stakeholders (government, peak body, professional organisation, Lived and Living Experience, DAP-funded providers and PHNs).

The combined analysis aims to provide recommendations to the government on opportunities for future funding and program design. It will also guide delivery and evaluation activities, contributing to the evidence base for future DAP policy decisions. While not pre-empting the evaluation's insights, several scenarios may be recommended, including changes to grant design and duration, reporting requirements, and how success is measured. The evaluation insights are intended to be published in a Final Report in July 2025.

Overview of consultations

During the consultation process, the Evaluation Team will meet with key stakeholders to capture insights about the DAP. The Evaluation Team is interested in your understanding of the DAP, its impact and opportunities for enhancement. The format of our consultations will be a focus group using a semi-structured interview style.

Consent and withdrawal

There is no obligation to be part of this consultation. You can participate as little or as much as you wish and can choose to opt out or cease participation at any time before or during the consultation.

[For Provider consultations only:] During the focus group, you may be asked if you are willing for the DAP-funded service(s) you run to be included as **case study** within the Final Evaluation Report. If you agree to this, your organisation will only be referred to by name in the Final Evaluation Report with your express consent. There is no obligation for your organisation to agree for your service(s) to be included as a case study.

[For Provider consultations only:] The Evaluation Team may request **participant outcome data** from your organisation following the consultation. This data must be aggregated and deidentified (no individual-level data) in order to be provided to the Evaluation Team. There is no obligation to provide this data if it is not available.

Privacy and confidentiality

After the focus group, the Evaluation Team will analyse their notes to draw out key insights. These will inform the Final Evaluation Report, which will be made publicly available. None of the observations within the report will be attributed to any individual.

Key Discussion Points

For the purposes of evaluation, the DAP includes current Department of Health and Aged Care and PHN funding to the AOD sector, but not funding from state and territory Governments or the NIAA.

During the consultation, the Evaluation tteam will ask questions about:

- DAP implementation barriers, enablers and areas for improvement
- The extent to which the DAP complements service delivery in the broader AOD and health landscape
- Best practice examples in the DAP or broader AOD landscape
- Perceived appropriateness and efficiency of DAP funding distribution and allocation
- Observed extent of equity, access barriers and enablers for priority cohorts within the DAP
- Opportunities to strengthen DAP data collection, evaluation and monitoring processes
- Impact of the DAP on outcomes for participants.

[For Lived Experience only] Where to get support

A qualified researcher will lead the conversation to make sure that it is respectful and open. Whilst the consultation is unlikely to cause you any distress, sometimes participants may feel upset during a consultation. If you feel this way, you are free to take a break or ask for the interview to be stopped at any time. You don’t have to answer any question that you don’t feel comfortable answering. If you would like to speak to someone following the consultation, you may wish to access one of the following services:

- Lifeline – 13 11 14
- 13YARN
- Beyond Blue – 1300 224 636

Contact

If you have any questions, please do not hesitate to contact the department or the Evaluation Team.

C.2.2 Consultation guide – Government

Implementation

- What level of visibility are you able to have over the DAP program as a whole, and why?
- To what extent do the currently-funded suite of sub-programs provide coverage across the in-scope pillars of the National Drug Strategy (demand reduction and harm reduction)? What areas, if any, may require additional investment to provide coverage?
- Can you describe factors which have hindered or enabled the implementation of the DAP? (e.g., program governance, program guidelines, grant funding allocation, reporting requirements)

For NIAA consultation:

- What is the relationship between the DAP and NIAA-led First Nations-specific AOD services?
- To what extent is there role definition between the department and NIAA in relation to AOD?
- What role should the department be playing in First Nations AOD services?

Appropriateness

- How well do DAP funded programs complement or synergise with other AOD services, e.g., state and territory funded services and/or PHN-commissioned DAP activities?
- To what extent does contemporary evidence, best practice and innovation inform the type and balance of services funded through the DAP?
- To what extent are the programs meaningfully tailored to ensure equity of access?

For state and territory government consultation:

- What role should the department be playing in delivering AOD services?
- To what extent is there role definition between the department and states and territories in relation to AOD?

For NIAA consultation:

- How should DAP grant agreements that fund services specifically tailored for First Nations communities differ from those for mainstream services?

Impact

- What has the DAP funding made possible that would otherwise not have been feasible?
- Can you comment on how this has changed over the lifespan of the DAP or compared to previous iterations of Australian Government AOD funding?
- What has been the most significant change that DAP has contributed to nationally?

Efficiency

- Where can you see key opportunities to improve the efficiency of the DAP?

Sustainability

- What policy enhancements, service improvement or best practice approaches are required for DAP to meet the needs of its target cohort, including priority populations? (First Nations, people with mental health conditions, young people, older people, people in contact with the criminal justice system, CALD populations, LGBTIQ+)

Closing

- Do you have anything else you would like to share about the DAP, which we have not covered already during the consultation?

C.2.3 Consultation guide – Peak bodies, professional organisations and research institutions

Implementation

- Can you describe factors which may have hindered or enabled the implementation of the DAP? (e.g., program governance, program guidelines, grant funding allocation, reporting requirements)
- What level of visibility are you able to have over the DAP program as a whole, and why?

For NACCHO consultation:

- What is the relationship between the DAP and NIAA-led First Nations-specific AOD services?
- What role should the department be playing in First Nations AOD services?
- How should DAP grant agreements that fund services specifically tailored for First Nations communities differ from those for mainstream services?

Appropriateness

- What difference do DAP-funded programs make for the communities or services you represent?
- To what extent are the programs meaningfully tailored to ensure equity of access?
- How should the DAP align to best practice and current evidence in terms of the types and balance of programs funded?

Impact

- What has DAP funding made possible that would otherwise not have been feasible? (e.g., outcomes for participants, for AOD services, and/or for the broader sector)
- What has been the most significant change that DAP has contributed to nationally?

Efficiency

- Where can you see key opportunities to improve the efficiency of the DAP?

Sustainability

- What streamlined measures should be put in place to improve data collection, monitoring and evaluation of the DAP?

Closing

- Do you have anything else you would like to share about the DAP, which we have not covered already during the consultation?

C.2.4 Consultation guide – Lived and Living Experience Peak Bodies

Implementation

- What level of visibility are you able to have over the DAP program as a whole?
- Have you observed any barriers or enablers which have affected how the DAP has been implemented?

Appropriateness

- What difference do DAP-funded programs make for people with Lived Experience?
- How should the DAP align to best practice and current evidence in terms of the types and balance of programs funded? (e.g., between prevention and treatment)
- How should DAP sub-programs and policy be informed by Lived Experience?
- How should the DAP sub-programs be meaningfully tailored to meet the needs of priority populations? (First Nations, people with mental health conditions, young people, older people, people in contact with the criminal justice system, CALD populations, LGBTIQ+)

Impact

- What do you believe DAP funding has made possible that would otherwise not have been feasible?
- What has been the most significant change that DAP has contributed to for people with Lived Experience?

Efficiency

- Can you describe how DAP funding could be better used to achieve outcomes?

Sustainability

- How can the DAP better meet the needs of its target population going forward?

Closing

- Do you have anything else you would like to share about the DAP, which we have not covered already during the consultation?

C.2.5 Consultation guide – Providers (direct funded and PHN-commissioned)

Introduction

- Can you tell us about your role within the organisation and in relation to the DAP?
- Can you tell us about your organisation and the services it delivers with DAP funding?
- Does your organisation consent to inclusion in the Final Evaluation Report as a case study?

Implementation

- Have you observed any barriers or enablers which have affected how the DAP has been implemented?

Appropriateness

- How has your organisation been supported to ensure equity of access for DAP participants?
    - E.g., for identified DAP priority groups (First Nations peoples, CALD, LGBTIQ+ Sistergirl and Brotherboy, older persons, youth, rural and remote communities, people with mental health conditions, people in contact with the justice system).
    - E.g., for socioeconomic status, or other ways of considering equitable access.
- Can you comment on how demand for DAP services has changed over the past three years (e.g., in population size or complexity)?

Impact

- From your perspective as a service delivering DAP funded services, what do you believe has been the most significant change that DAP has led to, and why? (e.g., at an individual level, service level, or for the broader AOD sector)
- What has DAP funding made possible that would otherwise not have been feasible? (e.g., at an individual level, service level, or for the broader AOD sector)

Efficiency

- To what extent are the DAP grant funding arrangements working effectively for your organisation, and why?
- Does your organisation use other sources of funding in addition to DAP funding to support delivery of DAP programs? If so, which other funding streams?

Sustainability

- How can the DAP better meet the needs of its target population going forward?
- Does your organisation collect DAP participant outcome data?

Closing

- Do you have anything else you would like to share about the DAP program, which we have not covered already during the consultation?
- Is your organisation able to provide DAP aggregate, deidentified participant outcome data [if applicable] following this consultation?

C.2.6 Consultation guide – PHNs

Introduction

- Can you tell us about your role within the PHN in relation to the DAP?
- Can you tell us about your organisation and an overview of the services it commissions with DAP funding?

Implementation

- Have you observed any barriers or enablers which have affected how the DAP has been implemented?

Appropriateness

- How does your PHN ensure programs commissioned through the DAP are meaningfully tailored to ensure equity of access?
    - E.g., for identified DAP priority groups (First Nations peoples, CALD, LGBTIQ+ Sistergirl and Brotherboy, older persons, youth, rural and remote communities, people with mental health conditions, people in contact with the justice system).
    - E.g., for socioeconomic status, or other ways of considering equitable access.
- Can you comment on how demand for DAP services has changed over the past three years (e.g., in population size or complexity)?

Impact

- From your perspective as a commissioner of DAP funded services, what do you believe has been the most significant change that DAP has led to, and why? (e.g., at an individual level, service level, or for the broader AOD sector)
- What has DAP funding made possible that would otherwise not have been feasible? (e.g., at an individual level, service level, or for the broader AOD sector)

Efficiency

- To what extent are the DAP grant funding arrangements working effectively for your organisation, and why?

Sustainability

- How can the DAP better meet the needs of its target population going forward?

Closing

- Do you have anything else you would like to share about the DAP program, which we have not covered already during the consultation?

C.3 Provider survey

The provider survey was designed to capture a large breadth of provider perspectives, collecting program-wide qualitative and quantitative data to support understanding of DAP implementation and outcomes. It complemented the stakeholder consultations, providing a holistic measure of the DAP processes and outcomes, from the perspective of providers.

The provider survey was shared with both directly-funded DAP providers by the DSS Grants Hub, including PHNs, and with PHN-commissioned services through their respective PHNs. It was developed with tailored questions that differed for PHNs that commission services and providers that receive funding to deliver services.

The survey was voluntary and participants were able to respond to some or all of the questions asked. Organisations were requested to respond to the survey once.

C.3.1 Provider survey briefing document

About the survey

This survey is asking about the alcohol and other drug (AOD) services funded by the department of Health and Aged Care through the Drug and Alcohol Program (DAP). The DAP delivers funding to AOD services and to PHNs who commission local AOD services.

The DAP includes all current Australian Government funding to the alcohol and other drug (AOD) sector by the department of Health and Aged Care, including funding provided via Primary Health Networks (PHNs). It does not include AOD funding received from state and territory governments, or funding provided to Indigenous-specific services by the National Indigenous Australians Agency (NIAA).

The department have engaged an external consultant (“the Evaluation Team”) to evaluate the DAP. The DAP Evaluation (“the Evaluation”) will assess the impact and overall administration of the DAP, and aims to identify:
The extent to which the DAP is achieving its intended objectives, for whom, and under what circumstances.
Opportunities to improve DAP administration and implementation.

Your views of the DAP are important. The survey will ask questions about the outcomes you have observed from the DAP, barriers and enablers. It also offers you opportunities to identify how the program could be improved.

There is no obligation to participate in this survey. You may respond to some or all of the questions asked.

Please note that the survey should be completed once only on behalf of your organisation.

Privacy Collection Notice

The department and the Evaluation Team are committed to protecting your privacy. Participation in the survey is voluntary. You can exit the survey at any time and, unless you click the ‘submit’ button, the responses will not be used.

All responses will be anonymised. The Evaluation Team will only use your personal information for the purposes of the evaluation and strictly in accordance with the Evaluation Team’s Privacy Policy. The Evaluation Team will only keep survey responses for as long as we need to for the purposes of the evaluation after which it will be de-identified or destroyed.

lease do not provide personal information about yourself or anyone else in your response (including service users), including any sensitive or health information. The Evaluation Team will take reasonable steps to ensure there is no personally identifying information in responses before analysing and using those responses. You will be provided with an opportunity to identify your organisation in your response, however this question is optional.
The Evaluation Team will collect and handle responses. Your answers will be deidentified and summarised and high level themes will be drawn out and used to inform a report for the department. This report is intended to be made publicly available. Your individual survey responses will not be attributed to you in the report.

De-identified survey results will be shared with the department at the conclusion of the project.

Consent for participation

Before beginning the survey, please read the following:

- You agree that you are a representative of an organisation providing a service or services funded by the DAP, or a representative of a PHN which commissions services through the DAP
- You do not have to answer questions if you do not feel comfortable responding to them
- You are free to withdraw at any time during the survey and your participation is voluntary
- Your responses will not be recorded or used by the Evaluation Team if you do not submit your responses at the conclusion of the survey.

This survey is issued in accordance with the Evaluation Team's policies. All information and data collated shall only be used in accordance with these policies (including privacy policy) and applicable laws.

By clicking on the "Next" button below you acknowledge that you have read and understood all of the information detailed in this notification, and agreed to undertake the survey.

C.3.2 Provider survey questions – PHN

Q1. Which of the below best describes your organisation's DAP funding arrangement?

Which of the below best describes your organisation's DAP funding arrangement?

You may select more than one.

- Service receiving direct grant funding through the DAP
- Service receiving DAP grant funding via a Primary Health Network (PHN)
- Primary Health Network (PHN) commissioning services under the DAP

Q2. Which PHN are you responding on behalf of?

Which PHN are you responding on behalf of?

Q3. Which priority populations are the focus of the DAP-funded services your PHN commissions?

Which priority populations are the focus of the DAP-funded services your PHN commissions?

You may select more than one.

- Aboriginal and/or Torres Strait Islander peoples
- Culturally and linguistically diverse (CALD) communities
- LGBTQI+ Sistergirl and Brotherboy
- Older people
- Young people
- Rural and remote communities
- People with mental health conditions
- People in contact with the criminal justice system
- Other (please specify)
- None of these

Q4. To what extent do you believe the services your PHN commissions through the DAP have had a positive impact for participants?

To what extent do you believe the services your PHN commissions through the DAP have had a positive impact for participants?

- To a great extent
- To some extent
- A little
- Not at all

Q5. Which of the following impacts have you observed from the services your PHN commissions through the DAP?

Which of the following impacts have you observed from the services your PHN commissions through the DAP?

- Improved awareness and understanding of AOD harms in the community
- Improved awareness and understanding of AOD harms among priority groups
- Improved access to information and resources about AOD
- Increased access to AOD treatment, diagnostic and support services
- Reduced stigma against people with lived experience of AOD use
- Increase in help seeking behaviour relating to AOD use

- Improved uptake of AOD programs among priority groups
- Improved sustainability of funding for AOD programs
- None of the above

Q6. Can you describe the most significant change you have observed as a result of the services your PHN commissions through the DAP?

Can you describe the most significant change you have observed as a result of the services your PHN commissions through the DAP?

You may wish to reflect on your response to the previous question, or additional program impacts you have observed. Please avoid providing identifiable information in your response.

Q7. Can you comment on how demand for DAP services has changed over the past three years (e.g., in population size or complexity)?

Can you comment on how demand for DAP services has changed over the past three years (e.g., in population size or complexity)?

Q8. For each of the following questions, please select an option.

For each of the following questions, please select an option.

Question	To a great extent	To some extent	A little	Not at all
To what extent are your PHN's commissioned DAP services tailored to priority groups? (Aboriginal and/or Torres Strait Islander peoples, CALD, LGBTIQ+ Sistergirl and Brotherboy, older persons, youth, rural and remote communities, people with mental health conditions and people in contact with the criminal justice system)	□	□	□	□
To what extent have your PHN's commissioned DAP service led to improved outcomes for the above priority groups?	□	□	□	□
To what extent do you believe commissioning of DAP-funded services through PHNs is working effectively?	□	□	□	□
To what extent are reporting and monitoring requirements for DAP funded organisations capturing and presenting meaningful outcomes aligned to program objectives?	□	□	□	□
To what extent are DAP providers able to effectively collaborate and integrate services to improve participant outcomes?	□	□	□	□

Q9. Can you provide a comment on the extent to which commissioning of DAP-funded services through PHNs is working effectively?

Can you provide a comment on the extent to which commissioning of DAP-funded services through PHNs is working effectively?

Q10. Reflecting on your answers above, what do you believe are the main factors which may explain program outcomes? Can you describe any barriers or enablers

Reflecting on your answers above, what do you believe are the main factors which may explain program outcomes? Can you describe any barriers or enablers (e.g., related to program governance, grant guidelines, contract lengths, funding amounts, reporting obligations, workforce or other factors?)

Q11. Can you provide any specific comment on outcomes achieved for priority groups through the DAP services your PHN commissions?

Can you provide any specific comment on outcomes achieved for priority groups through the DAP services your PHN commissions?

Current priority groups as included in the National Drug Strategy 2017-2026 are Aboriginal and/or Torres Strait Islander peoples, CALD, LGBTIQ+ Sistergirl and Brotherboy, older persons, youth, rural and remote communities, people with mental health conditions and people in contact with the criminal justice system.

Q12. Are there additional priority groups you believe should be considered for future delivery of the DAP?

Are there additional priority groups you believe should be considered for future delivery of the DAP?

Current priority groups as included in the National Drug Strategy 2017-2026 are Aboriginal and/or Torres Strait Islander peoples, CALD, LGBTIQ+ Sistergirl and Brotherboy, older persons, youth, rural and remote communities, people with mental health conditions and people in contact with the criminal justice system.

Q13. To what extent have DAP funding allocations to your PHN matched community demand for DAP services, and/or any observed change in the cost of delivering AOD services in your region?

To what extent have DAP funding allocations to your PHN matched community demand for DAP services, and/or any observed change in the cost of delivering AOD services in your region?

- To a great extent
- To some extent
- A little
- Not at all

Q14. Are there any further comments you would like to make about the DAP?

Are there any further comments you would like to make about the DAP?

Thank you for your time and feedback.

C.3.3 Provider survey questions - Providers

Q1. Which of the below best describes your organisation's DAP funding arrangement?

Which of the below best describes your organisation's DAP funding arrangement?

You may select more than one.

- Service receiving direct grant funding through the DAP
- Service receiving DAP grant funding via a Primary Health Network (PHN)
- Primary Health Network (PHN) commissioning services under the DAP

Q2. If you would like to identify the organisation you represent, please do so here. (Note that this information will be seen only by the Evaluation Team for data validation purposes)

If you would like to identify the organisation you represent, please do so here.

Note that this information will be seen only by the Evaluation Team for data validation purposes

Q3. Under which DAP grant stream(s) does your organisation receive funding?

Under which DAP grant stream(s) does your organisation receive funding?

You may select more than one.

- National Project
- Prevention Project
- AOD Treatment Services in Areas of Identified Need
- Withdrawal Management and Rehabilitation
- Fetal Alcohol Spectrum Disorder (FASD)
- Unsure

Q4. Which of the following service type(s) does your organisation deliver using DAP funding?

Which of the following service type(s) does your organisation deliver using DAP funding?

You may select more than one.

- Primary prevention
- Assessment only
- Information and education
- Counselling
- Early and brief intervention
- Support and case management
- Withdrawal management
- Non-residential rehabilitation
- Residential rehabilitation
- Aftercare and relapse prevention
- Other service type (please specify)
- Unsure

Q5. Which priority populations are the focus of your organisation's DAP-funded services?

Which priority populations are the focus of your organisation's DAP-funded services?

You may select more than one.

- Aboriginal and/or Torres Strait Islander peoples
- Culturally and linguistically diverse (CALD) communities
- LGBTQI+ Sistergirl and Brotherboy
- Older people
- Young people
- Rural and remote communities
- People with mental health conditions
- People in contact with the criminal justice system
- Other (please specify)
- None of these

Q6. Does your organisation's DAP service model contain any of the following integrated services?

Does your organisation's DAP service model contain any of the following integrated services?

- Mental health services
- Suicide prevention services
- Primary care services
- Housing support services
- Employment and vocational services
- Legal and advocacy services
- Family support services
- Domestic and family violence services
- Other (please specify)_____
- None of the above

Q7. In which jurisdiction(s) does your organisation deliver DAP-funded services?

In which jurisdiction(s) does your organisation deliver DAP-funded services?

You may select more than one, if relevant.

- ACT
- NSW
- NT
- QLD
- SA
- TAS
- VIC
- WA
- National

Q8. To what extent do you believe your organisation's DAP-funded service(s) have had a positive impact for participants?

To what extent do you believe your organisation's DAP-funded service(s) have had a positive impact for participants?

Response	To a great extent	To some extent	A little	Not at all
Primary prevention	□	□	□	□
Assessment only	□	□	□	□
Information and education	□	□	□	□
Counselling	□	□	□	□
Early and brief intervention	□	□	□	□
Support and case management	□	□	□	□
Withdrawal management	□	□	□	□
Non-residential rehabilitation	□	□	□	□
Residential rehabilitation	□	□	□	□
Aftercare and relapse prevention	□	□	□	□

Q9. Which other impacts have you observed from your organisation's DAP-funded service(s)?

Which other impacts have you observed from your organisation's DAP-funded service(s)?

- Improved awareness and understanding of AOD harms in the community
- Improved awareness and understanding of AOD harms among priority groups
- Improved access to information and resources about AOD
- Increased access to AOD treatment, diagnostic and support services
- Reduced stigma against people with lived experience of AOD use
- Increase in help-seeking behaviour relating to AOD use
- Improved uptake of AOD programs among priority groups
- Improved sustainability of funding for AOD programs
- None of the above

Q10. Can you describe the most significant change you have observed as a result of the service(s) funded through the DAP?

Can you describe the most significant change you have observed as a result of the service(s) funded through the DAP?

You may wish to reflect on your response to the previous question, or additional program impacts you have observed.

Q11. Can you comment on how demand for DAP services has changed over the past three years (e.g., in population size or complexity)?

Can you comment on how demand for DAP services has changed over the past three years (e.g., in population size or complexity)?

Q12. For each of the following questions, please select an option.

For each of the following questions, please select an option.

Question	To a great extent	To some extent	A little	Not at all
To what extent are your organisation's DAP-funded service(s) tailored to priority groups? (Aboriginal and/or Torres Strait Islander peoples, CALD, LGBTIQ+ Sistergirl and Brotherboy, older persons, youth, rural and remote communities, people with mental health conditions and people in contact with the criminal justice system)	□	□	□	□
To what extent have your organisation's DAP-funded service(s) led to improved outcomes for the above priority groups?	□	□	□	□
To what extent are the DAP grant funding arrangements working effectively for your organisation?	□	□	□	□
To what extent are reporting and monitoring requirements for DAP funded organisations capturing and presenting meaningful outcomes aligned to program objectives?	□	□	□	□
To what extent are DAP providers able to effectively collaborate and integrate services to improve participant outcomes?	□	□	□	□
To what extent have DAP funding allocations to your organisation matched community demand for DAP services, and/or any change in your cost base?	□	□	□	□

Q13. Does your organisation use other sources of funding in addition to DAP funding to support delivery of DAP programs?

Does your organisation use other sources of funding in addition to DAP funding to support delivery of DAP programs?

- Yes
- No
- Unsure

Q14. Reflecting on your answers above, what do you believe are the main factors which may explain program outcomes?

Reflecting on your previous answers, what do you believe are the main factors which may explain program outcomes? Can you describe any barriers or enablers (e.g., related to program governance, grant guidelines, contract lengths, funding amounts, reporting obligations, workforce, Peer or Lived and Living Experience workforce, or other factors?)

Q15. Can you provide any specific comment on outcomes achieved through your organisation's DAP-funded service(s) for priority groups?

Can you provide any specific comment on outcomes achieved through your organisation's DAP-funded service(s) for priority groups?

Current priority groups as included in the National Drug Strategy 2017-2026 are Aboriginal and/or Torres Strait Islander peoples, CALD, LGBTIQ+ Sistergirl and Brotherboy, older persons, youth, rural and remote communities, people with mental health conditions and people in contact with the criminal justice system.

Q16. Are there additional priority groups you believe should be considered for future delivery of the DAP?

Are there additional priority groups you believe should be considered for future delivery of the DAP?

Current priority groups as included in the National Drug Strategy 2017-2026 are Aboriginal and/or Torres Strait Islander peoples, CALD, LGBTIQ+ Sistergirl and Brotherboy, older persons, youth, rural and remote communities, people with mental health conditions and people in contact with the criminal justice system.

Note: Questions 17 to 20 should only be answered by providers that deliver DAP funded residential services.

The following questions are intended to provide the evaluators with a better understanding of cost drivers and considerations across DAP-funded residential withdrawal services. These questions are not intended to be used to measure individual performance of services and responses will not be linked to individual providers in evaluation reporting.

Q17. What was your organisation's bed capacity in 2023-24, considering DAP-funded beds only?

What was your organisation's bed capacity in 2023-24, considering DAP-funded beds only?

This refers to the number of beds in your organisation which were funded by the DAP. If this number changed during the year, please indicate the bed capacity on 30 June 2024.

Q18. What was your organisation's average bed occupancy rate in 2023-24, considering DAP-funded beds only?

What was your organisation's average bed occupancy rate in 2023-24, considering DAP-funded beds only?

Please provide the figure as a percentage, e.g., for 80%, insert '80'.

Q19. What was your organisation's cost per bed day in 2023-24, considering DAP-funded beds only?

What was your organisation's cost per bed day in 2023-24, considering DAP-funded beds only?

Q20. Would you like to provide an explanation of the above figures?

Would you like to provide an explanation of the above figures?

For example, factors which influenced bed capacity or cost, or considerations for interpretation of the above figures, such as non-DAP funding sources for the residential beds.

Q21. Are there any further comments you would like to make about the DAP?

Are there any further comments you would like to make about the DAP?

Thank you for your time and feedback.

Appendix D Detailed data findings

This section includes additional detail on findings from the various data analysis activities. The data included in this section has informed findings throughout the evaluation.

D.1 Additional survey response analysis

This appendix provides a summary of the survey responses to key questions not already provided within the body of the report. In particular, it provides response information regarding DAP services to priority populations, service integration and some residential service information.

D.1.1 Priority populations

The provider survey responses identified that most of the DAP funded organisations deliver services that focus on one or more priority populations. Of note:

- Five (5) providers responded that the DAP funded services being delivered do not primarily focus on any priority population group.
- Ten (10) providers noted that they support other priority population groups, including women and women with children, families dependent on prescription medication, and people who inject drugs.

Of the eight priority populations listed in the survey, the following table demonstrates the number of providers who report delivering targeted services to one or more priority populations. It's important to note that this may include services delivered across multiple grants. Notably, more organisations target up to four priority groups.

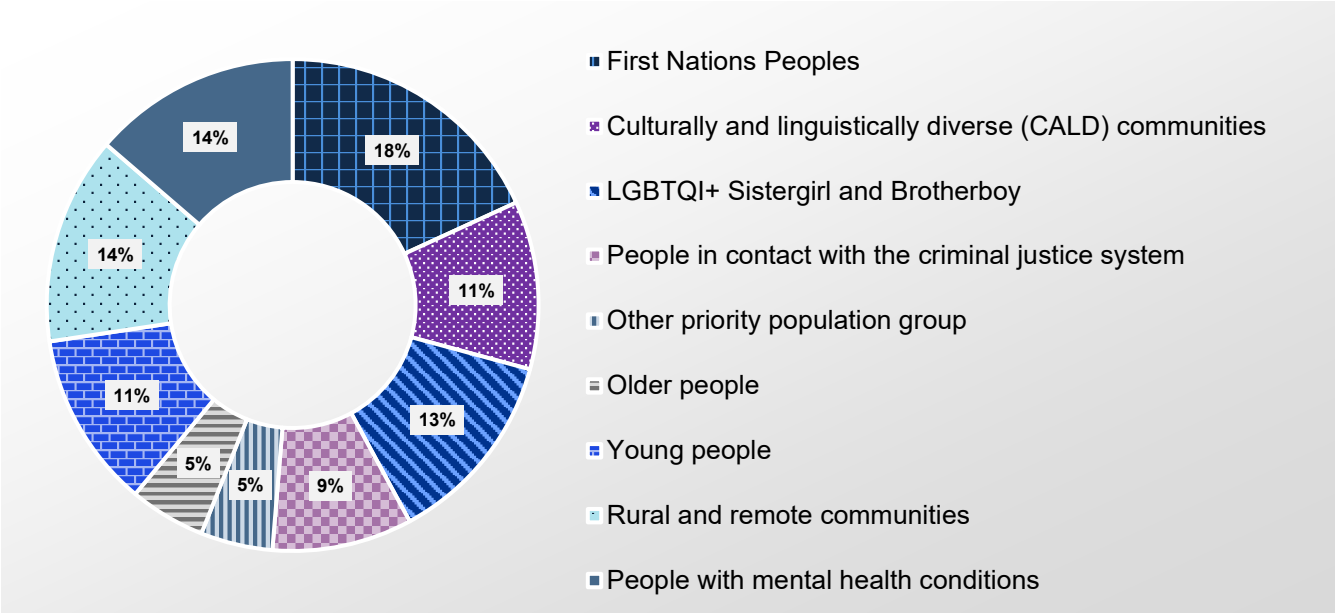
Table 44 Number of Priority Populations that providers focus on

Number of priority populations targeted	Number of organisations targeting one or more priority populations
1	14
2	10
3	7
4	16
5	3
6	6
7	8
8	4

Source: Evaluation Team Survey

For the priority populations, 18.3% of providers selected First Nations peoples, and 14.6% selected rural and remote communities. Figure 24 shows the proportion of providers and PHNs that reported delivering services to specific priority populations.

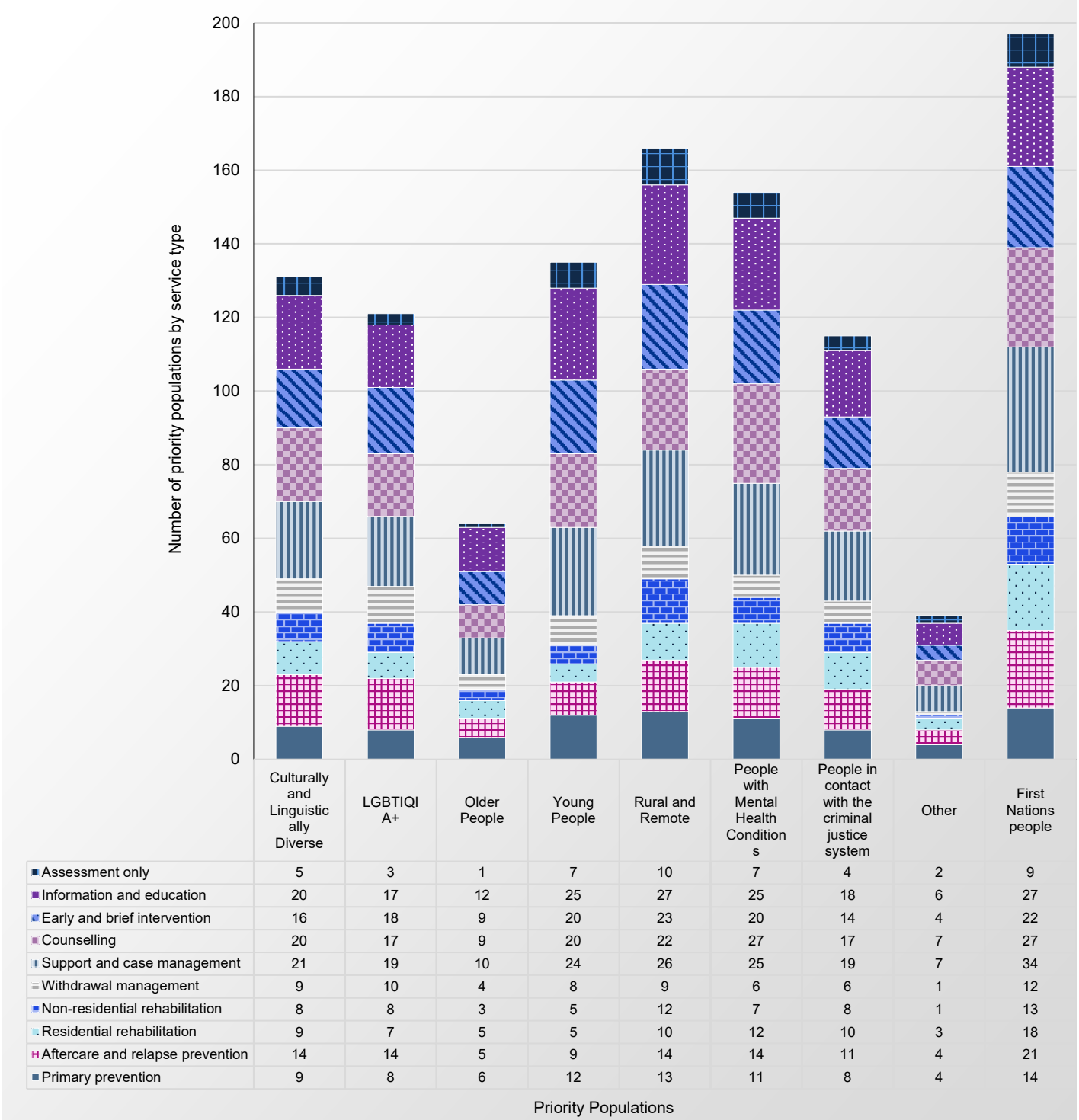
Figure 24 Proportion of providers and PHNs supporting priority populations



Source: Evaluation Team Survey

Figure 25 below highlights the priority populations by service type for the service provider responses. When considering the type of services providers deliver and which services reach priority populations, it appears the majority of priority groups have access to targeted support across all service types. The one exception to this is older people who don't appear to have access to targeted assessment only services.

Figure 25 Priority populations by service type



	Culturally and Linguistically Diverse	LGBTIQI A+	Older People	Young People	Rural and Remote	People with Mental Health Conditions	People in contact with the criminal justice system	Other	First Nations people
Assessment only	5	3	1	7	10	7	4	2	9
Information and education	20	17	12	25	27	25	18	6	27
Early and brief intervention	16	18	9	20	23	20	14	4	22
Counselling	20	17	9	20	22	27	17	7	27
Support and case management	21	19	10	24	26	25	19	7	34
Withdrawal management	9	10	4	8	9	6	6	1	12
Non-residential rehabilitation	8	8	3	5	12	7	8	1	13
Residential rehabilitation	9	7	5	5	10	12	10	3	18
Aftercare and relapse prevention	14	14	5	9	14	14	11	4	21
Primary prevention	9	8	6	12	13	11	8	4	14

Source: Evaluation Team Survey

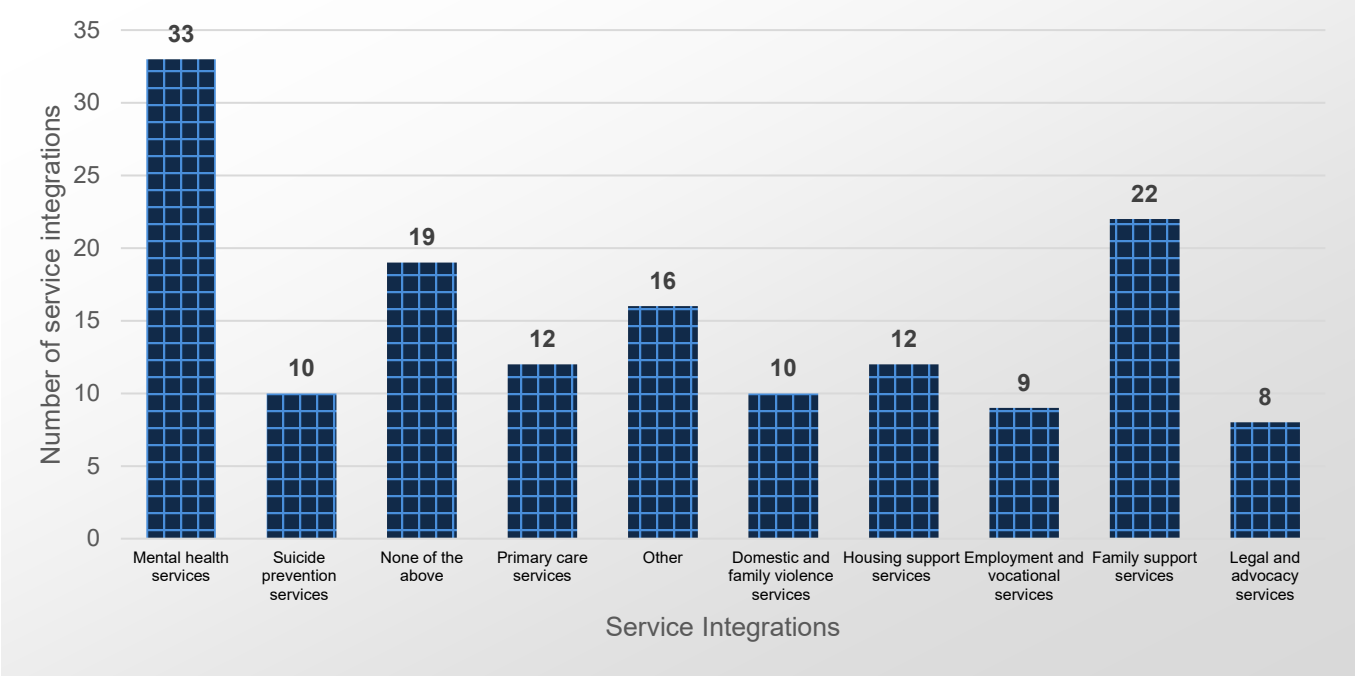
D.1.2 Service integration

From the service providers' responses received, 25.3% of providers only use DAP funding, 68% use other funding sources to support DAP, and 7% were unsure of if they use other funding to support DAP.

For their service delivery, all 87% of respondents responded that their service integrates with other services. These include Mental Health, Suicide, Primary Care Services, Housing, Employment, Legal and Advocacy Services, Family Support Services, Domestic and Family Violence Services, or other.

Figure 26 below shows the number of services that integrates with these additional services. Mental Health was the most commonly integrated service with 33 service providers integrating with mental health support. Family support services were also frequently selected (22 responses) by service providers, with 'none of the above' (19 responses) and 'other' (16 responses) also frequently being selected.

Figure 26 Number of integrated services



Source: Evaluation Team survey

D.1.3 Residential services bed occupancy rates

Of the 23 providers that noted they provide residential rehabilitation services, 15 provided some commentary and data on cost and occupancy rates for residential services.

Three of the 15 organisations noted that they had zero DAP-funded beds in 2023-24, with DAP-funding supporting other services (e.g., pre and post rehabilitation services) and state government funding the residential services. One organisation noted that the funded beds are currently co-funded by the Australian Government and other funding.

Of six organisations that provided complete data, the average bed capacity for DAP-funded beds in 2023-24 ranged from two to 76 beds per provider. Average occupancy rates for these beds was approximately 74.7% (ranging from 7% to 100%). One service provider noted a challenge with managing occupancy rates is the need to coordinate client intake with external withdrawal services, which can result in delayed program intake.

D.2 Additional treatment outcomes in NSW analysis

D.2.1 Heroin

Heroin use exhibited the highest improvement rates across all four years, rising from approximately 92%% in 2021–22 to a peak of approximately 98 in 2023–24 before settling at roughly 94% in 2024–25. Within DAP-funded

services, approximately 96% of clients reduced or ceased heroin use in 2021–22, increasing to 100% in 2023–24, then dipping slightly to roughly 96% in 2024–25. DSS-funded services showed a similar trajectory, from approximately 97% in 2021–22 to 100% in 2023–24 and 99% in 2024–25. PHN-supported services maintained 100% from 2021–22 through 2023–24 before falling to roughly 96% in 2024–25. These figures indicate that nearly all clients in heroin treatment either reduced use by at least one day or remained abstinent throughout their episode.

D.2.2 Amphetamines

Amphetamines also achieved high improvement rates (87–89%). In DAP services, rates rose from approximately 88% in 2021–22 to 90% in 2023–24, then eased to 88% in 2024–25. DSS-funded services climbed from roughly 93% to 100% over the same span before settling at 97%. PHN sites were more variable: approximately 78% in 2021–22, 72% in 2023–24, and rebounding to 84% in 2024–25. Overall, about nine in ten amphetamine clients improved, with DSS achieving the highest and PHN the most fluctuation.

D.2.3 Cannabis

Cannabis outcomes were the most volatile. Total improvement rates ranged from 64% in 2022–23 to 72% in 2023–24, then fell to approximately 66% in 2024–25. DAP services went from approximately 71% in 2021–22 to 75% in 2023–24, dropping to 60% in 2024–25. DSS-funded services rose sharply from 81% to 97%, then declined to 78%. PHN-funded rates climbed from approximately 60% to 77%, then fell to 58%. While most cannabis clients improved, rates fluctuated markedly across funding streams and years, with no stream sustaining high performance throughout.

D.2.4 Psychological health

Psychological health was assessed via the clinician-administered ATOP and the self-reported K10 distress scale. ATOP-measured improvement was lowest in 2021–22 (~50%), rose to approximately 63% in 2022–23, and then declined to 57% in 2024–25. Within DAP-funded services, ATOP improvements climbed from 41% in 2021–22 to 57% in 2022–23 and settled at roughly 54% in 2024–25. DSS-funded services showed a steady increase from approximately 58% in 2022–23 to 69% in 2024–25. PHN-funded services ATOP-measured improvement was approximately 72% in 2022–23, dipped to 24% in 2023–24, and recovered to approximately 53% in 2024–25. By contrast, K10-measured improvement remained high and stable—approximately 71% in 2021–22, 75% in both 2022–23 and 2023–24 and 73% in 2024–25. DAP services reported roughly 71% in 2021–22, peaking at 76% in 2023–24, then easing to 71%. DSS sites rose from 72% in 2021–22 to approximately 82% in 2023–24 before decreasing to 76%. PHN services went from 70.2% in 2021–22 and 72.9% in 2022–23 to 64.2% in 2024–25. Overall, about three-quarters of clients reported reduced distress, whereas clinician-rated ATOP improvements were more variable and generally lower—especially for PHN sites, which exhibited the greatest volatility and data gaps.

D.2.5 Quality of life

QoL was measured via clinician-rated ATOP and the WHO QoL self-report scale. ATOP-measured QoL improvement rose from approximately 53% in 2021–22 to 60% in 2022–23, then declined to 55% in 2024–25. DAP services increased from 38% in 2021–22 to roughly 53% in 2023–24 and remained at 53% in 2024–25. DSS sites went from approximately 44% in 2022–23 to 68 in 2024–25. PHN services had no ATOP QoL data in 2021–22, reported approximately 57% in 2022–23, dipped to 47% in 2023–24, and then rose to 53%. In contrast, WHO QoL improvements stayed in the mid-60% range—approximately 66% in 2021–22, 69% in 2023–24 and 68% in 2024–25. DAP services ranged from roughly 68% to 72%; DSS sites achieved approximately 72% in 2021–22, peaked at 82% in 2022–23 and stabilised at 81% in 2024–25; PHN services recorded approximately 68%, 64%, 66% and 63% across the four years. Self-reported QoL improvements were, therefore, bigger and more stable than clinician-rated measures—about two-thirds of clients improved overall, with DSS sites leading and PHN sites lagging.

Appendix E Alt text for detailed figures

Figure 2 High-level evaluation approach

DAP Evaluation

- Prevention Projects
- Prevention National Projects
- Primary Health Networks
- Withdrawal Management and Rehabilitation Services
- Fetal Alcohol Spectrum Disorder
- AOD Treatment services in areas of identified need

Planning and Design

- Project commencement and planning
- Evaluation Framework Methodology (including data collection tools, evaluability assessment and experimental design where feasible)
- Engage with Steering Committee and Advisory Committee (regular points throughout the project)

Evaluation

Process Evaluation

This domain assesses DAP implementation and whether it is being delivered as intended, at a whole-of-program level.

Appropriateness

Is the program the right response to the identified needs and priorities of target populations?

Implementation

How well is the program being delivered in terms of fidelity, quality and outcomes?

Outcome Evaluation

This domain provides an analysis of program outputs, outcomes and efficiency (where available) at a stream level to inform recommendations for future service delivery.

Impact

What difference is the program making?

Efficiency

To what extent has the Program delivered value for money?

Sustainability

How can the commissioning and implementation of the DAP be best supported going forward to maximise impact, ensure value for money and sustainability?

Data Sources

Program information

- Program documents
- Program reporting
- Program costing data
- Program data sets

Stakeholders (including providers)

- Advisory and Steering Committees

- Provider and PHN survey
- Stakeholder interview data
- Case studies

Other sources

- Academic and grey literature
- NMDS data

Analytical Methods

- Outcomes analysis
- Thematic analysis
- Descriptive and trend analysis

Evaluation Deliverables & Reporting

1. Project plan
2. Evaluation framework methodology
3. Stakeholder consultation report
4. Draft evaluation report
5. Final evaluation report

Return to Figure 2

Figure 3 Overview of in-scope DAP funded streams including number of grants and cumulative total funding over the period 2021-22 to 2024-25

Prevention Projects

10 agreements

$67,445,134

Prevention National Projects

5 agreements

$8,489,515

Fetal Alcohol Spectrum Disorder (FASD)

14 agreements

$55,892,271

Withdrawal Management and Rehabilitation Services

56 agreements

$142,516,002

Primary Health Networks (PHN)

31 agreements

$479,027,773

AOD Treatment Services in areas of identified need

18 agreements

$49,244,079

Return to Figure 3

Figure 4 Timeline of the DAP's implementation

2015-2016

- National Ice Action Strategy 2015 announced and commenced.

2016-2017

- DAP commenced as consolidation of the substance Misuse Service Delivery Grants Fund, Substance Misuse Prevention and Service Improvement Grants Fund, and Non-Government Organisation Treatment Grants Program and Health Surveillance Fund.
- PHN commissioning commenced.
- Withdrawal management and rehabilitation services stream commenced.
- Prevention stream commenced.

2017-2018

- National Drug Strategy 2017-2026 announced and commenced.

2018-2019

- National FASD Strategic Action Plan 2018-2028 announced and commenced.

2019-2020

- Australian Government announced an additional $140 million investment to address AOD harm. This investment was predominantly in FASD and in CHHP.
- National prevention stream commenced.
- FASD stream commenced.

2021-2022

- DAP Program Logic introduced in March 2022.

2022-2023

- AOD treatment in areas of identified need stream commenced.

Return to Figure 4

Figure 6 Breakdown of DAP services by state and territory for the period 1 July 2021 to 31 March 2025

National

23 grants

23 Department directly funded grants, managed through DSS

Australian Capital Territory

13 grants

03 Department directly funded grants, managed through DSS

10 PHN commissioned grants from

01 PHN

New South Wales

214 grants

28 Department directly funded grants, managed through DSS

186 PHN commissioned grants across

10 PHNs

Northern Territory

51 grants

02 Department directly funded grants, managed through DSS

49 PHN commissioned grants from

01 PHN

Queensland

129 grants

18 Department directly funded grants, managed through DSS

111 PHN commissioned grants across

07 PHNs

South Australia

83 grants

11 Department directly funded grants, managed through DSS

72 PHN commissioned grants across
02 PHNs

Tasmania

35 grants

35 PHN commissioned grants from

01 PHN

Victoria

183 grants

13 DAP Direct funded grants

170 PHN commissioned grants across

06 PHNs

Western Australia

85 grants

05 Department directly funded grants, managed through DSS

80 PHN commissioned grants across

03 PHNs

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Figure 7 Summary of the National Drug Strategy strategic priorities

National Drug Strategy 2017-2026

Aim: to build safe, healthy and resilient Australian communities through preventing and minimising alcohol, tobacco and other drug-related health, social, cultural and economic harms among individuals, families and communities.

Demand reduction

Preventing the uptake and/or delaying onset of use of alcohol, tobacco and other drugs; reducing the misuse of alcohol, tobacco and other drugs in the community; and supporting people to recover from dependence through evidence informed treatment.

Supply reduction

Preventing, stopping, disrupting or otherwise reducing the production and supply of illegal drugs; and controlling, managing and/or regulating the availability of illegal drugs.

Harm reduction

Reducing the adverse health, social and economic consequences of the use of drugs, for the user, their families and the wider community.

National Drug Strategy sub-strategies

- National Aboriginal and Torres Strait Islander Drug Strategy 2014-2019
- National Alcohol and Other Drug Workforce Development Strategy 2015-2018
- National Alcohol Strategy 2019-2028
- National Fetal Alcohol Spectrum Disorder Strategic Action Plan 2018-2028
- National Ice Action Strategy 2015
- National Tobacco Strategy 2023-2030

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Figure 23 Results of literature searches for DAP Evaluation

Identification of studies via databases and registers

Identification

1. Records identified from*: Databases (n = 1,120)
    - Records removed before screening:
        - Automated duplicate records removed (n = 21)
        - Manual duplicate records removed (n = 2)

Screening

2. Records screened (n = 1,097)
    - Records excluded** (n =766)
3. Reports sought for retrieval (n = 1,091)
    - Reports not retrieved (n=5)
4. Reports assessed for eligibility (n = 326)
    - Reports excluded:
        - Not focused on alcohol and other drug harm reduction interventions (n = 55)
        - Not a review (n = 8)
        - Non-western countries (n = 6)
        - Published before 2016 (n=3)
        - Non-human studies (n=1)
        - Outdated document (n=1)
        - Between library duplication (n = 6)

Included

5. Studies included in review (n = 246)

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