The Opioid Dependence Treatment Program in Australia

Participants' Expectations and Visions for the Future

AIVL Australian Injecting & Illicit Drug Users League

Executive Summary

This statement brings together many years of discussions about the need to reform and improve the opioid dependence treatment program (ODTP) in Australia. The statement design process was led by ODTP participants and allies involved in the Australian Injecting and Illicit Drug Users League (AIVL) and its member organisations. Its purpose is to synthesise a statement on the aspects of the program that need to change to fulfill the expectations and the vision that ODTP participants have for their treatment.

It is hoped that this statement will provide support to program participants who are often confronted and challenged by the difficulties associated with accessing and engaging with the ODTP in Australia. It may also form a useful advocacy tool for those participants who work within peer-based harm reduction and drug treatment to support the ongoing telling of their stories and experiences as they advocate for changes that are far too long in being achieved.

Lastly, this statement is being made to support a multidisciplinary consensus building event called the ODTP National Consensus for Action: a roundtable for opioid treatment in Australia, which will be held at Parliament House on the 7th of September 2026. This event has the aim of advocating to prioritise reform of the ODTP in Australia. The consensus building event is being led by members of the Australasian Professional Society for Alcohol and Drugs (ASPAD), the Australian Alcohol and other Drug Council (AADC) and member organisations, Harm Reduction Australia (HRA), AIVL and member organisations and the Monash Addiction Research Centre (MARC).

The statement sets out the background and process for how the statement was completed, followed by a preamble describing the state of ODTP in Australia and participants understanding of their treatment environment. The statement is split into 9 priority areas which describe important areas where change is required and which are all underpinned by the central premise:

"Healthcare is a human right, which must be delivered equitably and without moral judgement"

Nine key principles for design and delivery of the ODTP in the statement are set out in a cascade, with number one being a universal principle which affects all others and the following principles set out as per the importance given by participants. For each of the principles, examples are given of current practice and how these impact program

participants. Each section then ends with a reform opportunity for decision makers to consider. It should be noted that a key principle is the inclusion of program participants in decision making forums throughout the ODTP system. A summary of principles and overarching reform opportunities is given to end the executive summary below.

1. **Care and dignity, not suspicion and punishment** - Implement stigma-reduction measures across healthcare, pharmacy, child protection, hospitals, aged care, emergency departments and community services, and ensure meaningful mechanisms for reporting instances of stigmatising and discriminatory practice.
2. **Access, wherever we live, whenever we need it** - Establish national expectations for access, flexibility, emergency pathways and continuity of treatment, regardless of geography or individual provider.
3. **Real choice, genuine consent** - Ensure participants can choose between appropriate treatment options, define their own goals and make decisions based on clear, accessible and evidence-informed information.
4. **Partnership, not control** - Shift from a culture of control to one grounded in rights, trust, partnership and health equity.
5. **Respect our privacy and confidentiality** - Information collected about our health should only be used to support and improve our care, not as a tool of surveillance or punishment
6. **Whole-person care** - Integrate ODTP into mainstream primary healthcare.
7. **Parents and families supported, not punished** - Treat engagement with ODTP as a potential protective factor and support parents through consistent, trauma-informed and family-centred approaches.
8. **Meet our different needs** - Design ODTP around each person's actual circumstances, culture, identity, responsibilities and needs.
9. **ODTP peer leadership, not just peer consultation** - Embed drug user organisation and peer leadership in ODTP governance, policy, service design, service delivery and clinical review.

Background

In September 2026, a Roundtable about Australian Opioid Dependence Treatment will bring together a diverse range of stakeholders seeking to form consensus on how the Opioid Dependence Treatment Program (ODTP) should evolve and improve. In preparation for this event, the Australian Injecting and Illicit Drug Users' League (AIVL) resourced a process to build a statement of consensus by people across Australia with lived-living experience of the program.

Consultations were held with all Drug User Organisations (DUOs) across the country, with some DUOs extending invitations to community members to participate. A record of organisations and participant make-up is included at **Appendix 1**. DUOs play a vital role in representing and advocating for program participants, and this process gave people a safe space to discuss what they want from the future of their treatment.

In these online sessions, participants were presented with a summary of themes synthesised from desktop research and invited into a discussion about what resonated and what was either missing or inadequately represented. Participants were then asked to ideate on the future of the program, expressing their hopes for realistic change. Discussions were captured in real time on a collaborative whiteboard so that participants could be sure their ideas were correctly understood, and sessions were recorded and transcribed so that nothing was lost.

After nine consultations were completed, the whiteboard data and transcripts were analysed and synthesised to formulate eleven draft themes with associated key challenges and opportunities for reform. These were then presented for consideration at an in-person workshop that brought together sixteen consultation participants from across the country. A record of the workshop logistics and attendance is included at **Appendix 2.**

Over the course of one day, participants:

- reorganised the themes bringing the number from 11 to 9
- considered the wording of challenges, reform opportunities, and opening/closing sections to reach agreement on the most salient points as well as tone for their statement
- ordered the themes to reflect urgency and ensure a coherent story
- agreed on the language of 'program participant' to describe themselves, over 'patient', 'consumer' or 'a person on ODTP', on the basis that 'program participant' is humanising and signals agency.

The nine principles below are ordered to tell a coherent, cumulative story, as agreed by workshop participants, rather than as a strict ranking. That said, the first principles are care and dignity, punitive treatment, and access, because these were the concerns raised most consistently, and with the greatest apparent impact on day-to-day experience, across all nine consultations.

Preamble

We are people with lived-living experience of Australia's Opioid Dependence Treatment Program (ODTP). We come from every walk of life and community across Australia. We are ordinary people with healthcare needs.

This statement brings together our experiences of the ODTP and our vision for the future of this essential health program. It is a standalone advocacy document, designed to speak collectively about our experiences. It sits alongside a broader national consensus being developed by clinicians, researchers and program leaders who share responsibility for this program.

We bring something others cannot: the daily experience of ODTP access in Australia and how the program affects our lives. It is only by actively listening to our stories, respecting our expertise and experience and acting on our feedback and recommendations that we can meaningfully improve the ODTP in Australia. We support the core purpose of the ODTP program, to provide stability, improve health and wellbeing, and reduce harm. However, the current program incorporates too much surveillance, punishment and control for a modern-day healthcare program.

Australia's National guidelines for the medication-assisted treatment of opioid dependence are now unacceptably out of date and do not accurately reflect contemporary practice. Despite these guidelines recognising that when people are treated respectfully with regard to their dignity, autonomy and privacy, treatment outcomes are likely to improve[1], this respect is inadequately reflected in the clinical advice and hence how the program is structured and delivered. Outdated guidance has significant ramifications for program participants and allows for restrictive, stigmatising practices across the country that participants experience as discriminatory.

In practice, each Australian jurisdiction regulates its own ODTP program, causing significant variation in available treatments. Outdated national guidance sits on top of these programs, stifling progressive jurisdictions and supporting outdated practice in

[1] Australian Government Department of Health, Disability and Ageing 2014, *National Guidelines for Medication-Assisted Treatment of Opioid Dependence*, https://www.health.gov.au/resources/publications/national-guidelines-for-medication-assisted-treatment-of-opioid-dependence?language=en (viewed August 2026).

others. This patchwork system means that some program participants are able to access better care than others, making health equity a real and serious issue.

These differences have been exacerbated since the Covid-19 pandemic where clinical guidelines were relaxed in many jurisdictions to allow participants to isolate and quarantine in line with emergency health orders and public expectation. Despite fears around increased harms, none were seen as noted by the Victorian Coroners Court[2],[3] and the changes were broadly supported by caregivers. Post-Covid, some jurisdictions have embedded this extra flexibility in their practice while others have reverted to pre-Covid practice causing significant trauma to participants and increasing jurisdictional inequity and feelings of discrimination.

We applaud recent changes to the payment architecture of ODTP which place it on an equitable footing with other PBS medications. However, this has simply brought the financial burden of ODT into line with other treatments and has not solved issues of program experience and access.

We expect and deserve an ODTP in line with other modern health programs and services; one that is contemporary, progressive, equitable, accessible, genuinely person-centred and founded in human rights. We recognise that access to treatment is connected and supported by a series of rights centred around these principles and is also supported by domestic and international law, including anti-discrimination legislation.

We ground this statement in those domestic and international laws, as well as the Australian Charter of Healthcare Rights[4], the International Guidelines on Human Rights and Drug Policy[5], and one simple, non-negotiable premise:

Healthcare is a human right and must be delivered equitably, and without moral judgement.

What follows are nine key principles for the design and delivery of the program. Each describes aspects of our lived-living experience and identifies vital strategies for reform. These are concrete and achievable changes that would improve the program and the lives of those who rely on it.

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[2] Coroners Court of Victoria 2021, *Victorian Overdose Deaths 2011-2020,* https://www.coronerscourt.vic.gov.au/sites/default/files/2021-07/CCOV%20-%20Overdose%20deaths%20in%20Victoria%202011-2020%20-%2029Jul2021.pdf, (viewed August 2026).
[3] Coroners Court of Victoria 2023, *Victorian Overdose Deaths 2013-2022,* https://coronerscourt.vic.gov.au/sites/default/files/2024-01/CCOV%20-%20Overdose%20deaths%20in%20Victoria%202013-2022%20%28revised%29%20-%2020240125.pdf, (Viewed August 2026).
[4] Australian Commission on Safety and Quality in Health Care, *Australian Charter of Healther Rights (second edition),* https://www.safetyandquality.gov.au/resources/australian-charter-healthcare-rights-second-edition-a4-accessible (Viewed August 2026).
[5] United Nations Development Program 2020, *International Guidelines on Human Rights and Drug Policy,* https://www.undp.org/publications/international-guidelines-human-rights-and-drug-policy, (Viewed August 2026).

1. Care and dignity, not suspicion and punishment

We are stigmatised, discriminated against and treated as morally suspect. This is our number one concern and pervades all aspects of our treatment experience. We recognise that most caregivers deliver compassionate care and support system reform. However a small minority directly add to our mistreatment, and all work inside a system of regulation and risk management that enables stigma and discrimination and ignores our human rights.

We are:

- Surveilled in pharmacies and clinics (e.g. subjected to supervised dosing).
- Treated as 'less than' across the healthcare system, including in hospitals, clinics, pharmacies, waiting rooms and custodial settings.
- Treated punitively if we miss a supervised dose, or if we use drugs or are perceived to have used drugs, with no consideration of the circumstances or context.
- Required to attend clinics and services that can feel more custodial than therapeutic. Forensic characteristics like security doors, bulletproof glass and guarded entry points are often found in clinics and dispensaries.

"It's got heavy metal doors, bulletproof glass. It's forensic, isn't it? It's a forensic setting."

The reform opportunity

- Eliminate stigma and discrimination across all systems. Implement stigma-reduction measures across healthcare, pharmacy, child protection, hospitals, aged care, emergency departments and community services, and ensure meaningful mechanisms for reporting instances of stigmatising and discriminatory practice.
- Ensure physical environments reflect therapeutic, respectful and person-centred care.
- Re-evaluate the assumptions that lie at the heart of the ODTP (such as supervised and unsupervised dosing) and ensure that the system is built on human rights and equity principles and not fundamentally discriminatory and stigmatising.

2. Access, wherever we live, whenever we need it

Too few clinicians and pharmacies deliver ODTP, especially outside major cities. Those clinicians who do see us can be seeing hundreds of participants, or even more, making it impossible to get time with them. Getting onto the program can take months and require enormous effort. Staying on the program can be just as difficult. We sometimes travel for hours to access prescribers and/or pharmacies. These gaps are particularly serious for those of us transitioning from custodial settings and those of us who live in rural and regional areas.

Continuity of care is also fragile. When prescribers retire, take leave or resign from a workplace, we can be left in precarious situations, often without service altogether.

"The prescriber falls ill, the script expires, and the pharmacy won't dose. We spend so much of our time dealing with these situations."

Frequently, there are no contingency arrangements for natural disasters and other emergencies, creating additional stress at a time of crisis, when stability matters most. Examples are:

- We are often left out of existing emergency health provision efforts and considered too complex or high-risk.
- When un-supervised doses are lost, spilt or leak there are no replacements.
- When our bodies process the medications faster than prescribed, there are often no options to change our dosing arrangements and ensure our comfort.
- We are unable to access third-party forms or delivery of medications even when we have issues with mobility, or are ill or injured.
- Gaps across jurisdictions mean our ability to travel interstate is restricted, and blanket regulations concerning access to takeaway medications mean that international travel is either heavily restricted or not accessible at all.

These gaps in access result in lost opportunities in employment, study, family life, travel and activities others take for granted, preventing us from moving forward with our lives - a reason many of us access ODTP in the first place.

The reform opportunity

- Ensure equitable access and continuity of care nationwide.
- Establish national expectations for access, flexibility, emergency pathways and continuity of treatment, regardless of geography or individual provider.
- Ensure people leaving custodial settings can transition directly and safely into community-based care without interruption.

3. Real choice, genuine consent

The range of ODTP medications available to us is too narrow. Treatment options are not always presented equally, and our choices may be restricted due to assumptions about potential risk and/or ease of service delivery. Treatment matching is often secondary to these considerations and this can leave us feeling coerced into accepting a treatment that is ineffective or unsuitable for us. There are only three medication options available in Australia, with only one – methadone – being a full opioid agonist. In many services and sometimes across entire regions, these options are restricted to one or two.

These issues are exacerbated in custodial settings where fears about diversion and issues of staff resourcing mean choice is further reduced.

The current approach to the program restricts not only the types of medications available to us, but also our routes of administration, self-management and engagement with the program. These restrictions, many of which come from fears about risk, have very real consequences for participants, sometimes leaving us without access to the ODTP at all.

The reform opportunity

- Guarantee meaningful choice, autonomy and informed consent.
- Deliver flexible, person-centred care that reflects the complexity of people's lives.
- Ensure participants can choose between appropriate treatment options, define their own goals and make decisions based on clear, accessible and evidence-informed information.
- In some European countries a broader range of medications including injectable short acting opioids and oral long acting and slow-release medications are available giving program participants choice[6],[7]. In Australia, the recent 'Feasibility of Opioid Injectable Treatment' (FOpIT) hydromorphone trial showed promising results and there are other initiatives afoot to increase choice to medications such as Slow-Release Oral Morphine (SROM)[8]. Increase in choice should be viewed as a priority especially given the removal of Sublocade from Australia and the potential for the removal of other medications in the future.
- Treatment should be something done **with** us, not **to** us.

[6] International Network on Health, Hepatitis and Substance Use, *Connecting with Care – Zurich, Switzerland,* https://inhsu.org/what-we-do/advocating-for-change/innovative-models-of-hcv-care-films/connecting-with-care-switzerland/, (Viewed August 2026).
[7] H. Alho, M. Dematteis, D. Lembo, I. Maremmani, C. Roncero, L. Somaini, Opioid-related deaths in Europe: Strategies for a comprehensive approach to address a major public health concern, *International Journal of Drug Policy,* Vol. 76, 2020.
[8] J. Rance, V. Belackova, J. Bell, A. Dunlop, N. Ezard, M. Jauncey, N. Lintzeris, E. Ovedio-Joekes, A. Ritter, D. Roberts, C. Rodgers, K. Siefried, J. Strang, W. van den Brink, C. Treloar, Hydromorphone Hopes, A Qualitative Study of People Initiating Supervised Short-Acting Injectable Opioid Treatment in Australia, *Drug Alcohol Review,* Vol 44, 2025.

4. Partnership, not control

The program is too often rooted in fear-based risk management. We are dictated to rather than partnered with.

Medication schedules, access to takeaway doses and everyday decisions about our treatment are controlled by others. Basic trust and autonomy are treated as privileges we must earn, rather than a right we already hold. Inflexible regulations restrict our access to and experience of ODTP and leave no room for partnership based on our individual circumstances. Jurisdictional and national clinical frameworks provide maximum unsupervised dose limits, creating impassible glass ceilings, regardless of stability or length of time on the program. For many people, these insurmountable restrictions, which often require attendance at dosing points multiple times per week, result in:

- Ongoing impacts on capacity to be involved in other aspects of life such as employment, education and family responsibilities, with compounding implications for overall health and well-being
- Disempowerment and psychological injury caused by experiences of stigma and discrimination
- Disengagement with the program
- Fundamental human rights issues with regards to surveillance, privacy, autonomy and agency.

Person-centred care trusts program participants and their prescribers to make decisions about the person's care based on their life circumstances, clinical needs and ODTP experience. The best system of clinical risk management would allow program participants to safely access the program, beginning with supervised doses where necessary, before transitioning to complete removal of supervised doses after assessment, regardless of medication type. The current system is inequitable with other medications and erodes trust between program participants and providers. If we do have a prescriber and pharmacist who understand our needs, they are restricted by a system of regulation which doesn't allow person centred care.

'As a young female, my doctor didn't believe that 'a child' could be using that much, so my initial dose was nowhere near enough and I had to keep using. I felt powerless'.

The reform opportunity

- Embed human rights, dignity and respect across the ODTP system.
- Shift from a culture of control to one grounded in rights, trust, partnership and health equity.
- Manage risk in ways that are proportionate, transparent and based on individual circumstances rather than assumptions about people who use drugs.

5. Respect our privacy and confidentiality

Our privacy and confidentiality are routinely compromised across the system.

This includes:

- Our personal information being recorded on permanent or long-term registers.
- Our private information being disclosed to other people or services without our knowledge or consent.
- Supervised dosing arrangements that publicly identify us as participants in the program, for example because only ODTP participants are required to use a particular space.
- Despite complying with identification procedures, program participants are confined to a single access point to obtain medication.

These practices can have profound consequences. They can affect our employment, relationships, ability to obtain or retain a driver's licence, access to insurance and ability to obtain visas and other services. They can discourage us from accessing or staying on the program.

The reform opportunity

- Respect our privacy and safeguard our personal information.
- Information collected about our health should only be used to support and improve our care, not as a tool of surveillance or punishment.
- Identification and registration processes within ODTP should be designed to support flexible, person-centred care, for example enabling program participants to access medication wherever they choose.
- Registers of drug dependence should be abolished.
- Any collection, use or sharing of ODTP data should be through informed consent and be necessary, proportionate, transparent and subject to strong privacy protections.

6. Whole-person care

Our general health is often not considered by our prescribers and other healthcare professionals. We can struggle to access treatment for co-occurring health conditions, and some of us are turned away from hospitals or have health problems overlooked, misdiagnosed or diagnostically overshadowed.

We are often denied adequate pain relief for genuine medical needs because clinicians see the program before they see the patient. During the consultation process, participants shared many shocking stories of program participants receiving acute medical care or even end-of-life care without any pain relief.

Other health conditions can go untreated because our participation in ODTP becomes the defining feature of how we are perceived.

We should not be expected to endure unnecessary pain, live with untreated conditions or die without dignity because we participate in this program. We need equitable access to all healthcare including pain management and palliative care.

The reform opportunity

- Integrate ODTP into mainstream primary healthcare.
- Ensure equitable treatment in all health settings, including pain management, mental healthcare, aged care, palliative care and hospital-based care.
- Ensure healthcare professionals are trained and provided with processes that support assessment and treatment of the whole person and their clinical needs rather than making assumptions based on ODTP participation.
- Healthcare professionals should be trained to understand the difference between ODTP and pain relief and how pain relief interacts with ODTP including issues of tolerance.

7. Parents and families supported, not punished

All too often, parents and pregnant women participating in ODTP feel treated as a risk to be managed. Pregnant people accessing the ODTP can care for their children like any other parent. They and their families should not be punished because of it.

Our experiences include:

- Pregnant people being dehumanised or treated as incapable of making decisions about their own healthcare.
- Children and infants being viewed primarily as needing protection from a parent accessing ODTP, rather than as members of a family receiving healthcare and support.
- Participation in ODTP triggering child protection notifications.
- Experiences of extended child removal associated with entering or participating in treatment.
- Participants being pressured onto the program in order to keep their children in their care, with others being told their children would only be returned to them if they came off the program.

The reform opportunity

- Treat engagement with ODTP as a potential protective factor and support parents through consistent, trauma-informed and family-centred approaches.
- Participation in healthcare should not be treated as evidence that a parent is incapable of caring for their child.
- Ensure all hospitals and birthing centres have standardised, evidence-based processes for assessing the clinical needs of babies born to people on ODTP, and the training to use them without judgement.
- Increase resourcing for peer-based services that support parents to engage with child protection services (specifically services that are staffed by parents with lived-living experience of engaging with child protection services and regaining custody of their children).

8. Meet our different needs

Aboriginal peoples and Torres Strait Islander peoples, women, gender-expansive people, LGBTQIA+ people, people who are culturally and racially marginalised, Disabled people, people in custodial settings, younger and older people can experience the challenges described in this statement more profoundly. For example:

- People with mobility or access issues who are forced into daily dosing and who struggle with public transport, are disincentivised to remain on the program. Additionally lack of third-party pickup provisions and delivery options further pressurises older people, people who are unwell, and people with mobility issues.
- People with co-occurring mental health are often treated in a punitive manner if their mental health deteriorates. For example, they might be sent back to public clinics and only allowed to dose in limited hours when a security guard is present.
- Aboriginal and Torres Strait Islander people may find challenges related to their communities' understanding of ODTP as well as face culturally unsafe practice from mainstream health providers.
- Residential aged care providers are not equipped to deal with ODTP participants and participants can be forced to change medications to expensive, non-PBS listed alternatives.
- Where ODTP medications are available, people in custodial settings face significantly increased challenges in almost every area of priority identified in this statement including choice, access, whole person care, partnership and care with dignity. Unlike many other medications, police holding cells and watchhouses often do not offer dosing of ODT to people in custody.

These overlapping forms of disadvantage require deliberate and urgent attention.

This is not a hypothetical concern: of the 45 people who took part in our consultations, 26 were women, at least 9 identified as LGBTQIA+, 5 as living with disability, 2 as culturally and linguistically diverse, 1 as Pasifika and 1 as a First Nations person (a further 4 participants' information was not recorded). See Appendix 1.

The reform opportunity

- Design ODTP around each person's actual circumstances, culture, identity, responsibilities and needs.
- Ensure services are culturally safe, accessible and responsive to different communities and experiences.
- Involve ODTP program participants from the communities most vulnerable to stigma and discrimination and negative health outcomes in the ongoing development and implementation of the program.

- Provide training for residential aged care providers to allow quality provision of and engagement with the ODTP. Consider placing physeptone on the PBS for ODT to increase access to people living in residential aged care and review regulations related to provision of ODTP in residential aged care facilities.
- Review ODTP in all custodial settings with a view to ensure equity of care with programs in non-custodial settings.

9. ODTP peer leadership, not just peer consultation

We remain largely absent from the rooms where decisions about this program are made.

Peer-led and drug user organisations are often stretched far beyond their funding to provide the support, advocacy and navigation that program participants often need.

Consultation alone is not enough. We are essential players in the decision-making process.

The reform opportunity

- Embed drug user organisation and peer leadership in ODTP governance, policy, service design, service delivery and clinical review.
- Ensure clinical guidelines and program reforms are co-developed with people who have lived-living experience of ODTP and drug user organisations.
- Establish properly funded peer navigation and advocacy supports across the treatment journey that centre the person at the heart of the service system.
- We should have meaningful decision-making power over the systems that affect our lives.

Final Remarks

We are not asking for anything extraordinary, only for what anyone accessing healthcare should expect: to be trusted, treated with dignity, and welcomed as a genuine partner in our own care.

We have the right to access an Opioid Dependence Treatment Program built on trust, respect, dignity, autonomy and genuine partnership; one that sees the person before the diagnosis, the family before the risk, and healthcare before surveillance and control.

We recognise the frustration and trauma of ODTP participants striving for healthcare equity, and the ODTP caregivers, politicians and bureaucrats that are working hard to provide contemporary care to their patients. We thank our allies for supporting our efforts to make our treatment program truly reflect equity, human rights and person-centred healthcare practices and principles.

We have shown, through this process, that we are ready to help lead this work. It is time for program reform.

Nothing about us without us.

Appendix 1

Consultation participation

These sessions were designed by Damian Vanderwolf and Ruth Toomey and were facilitated by one or both of them.

When: 5 Aug to 14 Aug 2026

Where: Online

Who: Participants were recruited via Drug User Organisations (DUO) from across Australia. They were either peer workers at the DUOs with personal experience as a program participant, or community members who were program participants (note: two peer workers did not have personal experience as a program participant).

Date	Time	DUO	Invited	Attended
5/08/2026	1230pm to 2pm	AIVL	5 (peer workers)	5 (peer workers)
6/08/2026	11am to 1230pm	SAHrps	9 (6 peer workers, 3 community members)	5 (4 peer workers, 1 community member)
7/08/2026	10am to 1130am	TUHSL	7 (3 peer workers, 4 community members)	5 (3 peer workers, 2 community members)
10/08/2026	230pm to 4pm	CAHMA	11 (7 peer workers, 4 community members)	9 (6 peer workers, 3 community members)
11/08/2026	1130am to 1pm	NUAA	8 (4 peer workers, 4 community members)	7 (3 peer workers, 4 community members)
12/08/2026	3pm to 430pm	NTAHC	6 (peer workers)	5 (peer workers)
14/08/2026	930am to 11am	QuIHN & QuIVAA	2 (peer workers)	2 (peer workers)
14/08/2026	1130am to 1pm	HRVic	6 (4 peer workers, 2 community members)	4 (peer workers)
14/08/2026	2pm to 330pm	PBHRWA	4 (1 peer worker, 3 community members)	4 (1 peer worker, 3 community members)
TOTAL			58 (38 peer workers, 20 community members)	45 (32 peer workers, 13 community members)

(NOTE: Times are based on Australian Eastern Standard Time)

As part of the recruitment process, participants completed a short registration form. The form included a question regarding needs for adjustments to ensure that people could participate at their best. Whilst there were no specific targets to include people from intersecting communities, we wanted to keep track of this. A question was asked about whether people were part of any other intersecting communities. Below is a summary of this:

- 26 women
- 9 LGBTQIA+ people
- 5 People with Disability/Disabled people
- 2 Culturally and Linguistically Diverse people
- 1 Pasifika person
- 1 First Nations Person
- (Note: we weren't able to collect this information from 4 participants).

Consultation agenda

Consultation discussions were for approximately 90 minutes, and included the following activities:

1. Introduction and background
2. Check-in circle (including a conversation about program benefits)
3. Summary of themes from desktop research
4. Discussion about the themes (what resonated, what, if anything, was missing)
5. Discussion about future hopes for the program

Appendix 2

Workshop participation

When: 19 August 2026, 10am to 430pm

Where: WorkIt Boardroom - 34 Burke Road Alexandria NSW

Who: At least one representative from each DUO attended an in-person workshop.

DUO	Attended
AIVL	3 peer workers
SAHrps	1 peer worker
TUHSL	2 peer workers
CAHMA	3 peer workers
NUAA	2 peer workers
NTAHC	2 peer workers
QuIHN & QuIVAA	1 peer worker
HRVic	2 peer workers
PBHRWA	1 peer worker, 1 community member
TOTAL	16 attendees

NOTE: some attendees represented more than one organisation.

Workshop agenda/run sheet

The workshop was designed and co-facilitated by Ruth Toomey and Damian Vanderwolf. Process activities included:

1. Welcome and check-in activity (including a short discussion about hopes for the Program in the next 3 to 5 years)

2. Viewing of 'Dose of Dignity' video and summary of the themes from the consultation activities

3. Activity to refine the wording of the themes relating to the current challenges for program participants

4. Activity to refine 'Reform opportunities'

5. Activity to help set the order of consensus statement principles

6. Activity to refine preamble and closing statement

7. Discussion about naming language

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