Reducing AOD-related stigma in primary care

Research-informed strategies for change

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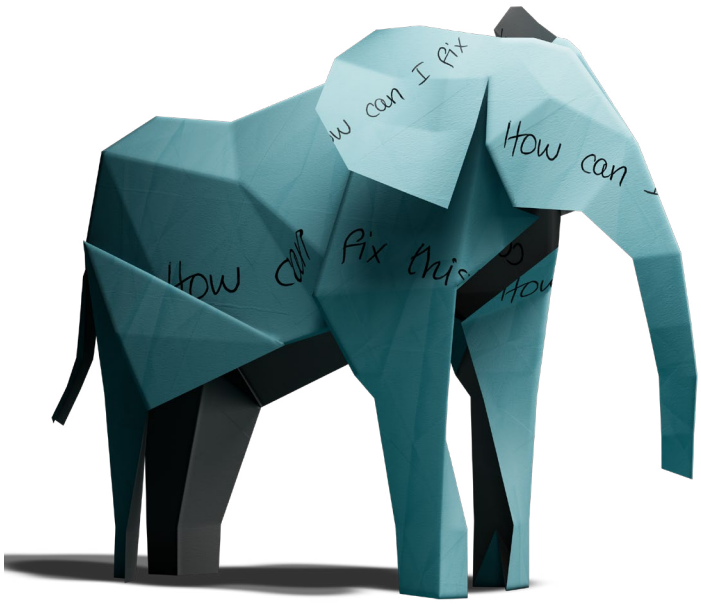
NWMPHN partnered with research, creative and behaviour change experts ICON Agency and Kris White, KWC Agency, to find out more about stigma, and how it affects the experience of primary care providers.

This research required the time of many AOD experts, primary care providers and people with lived experience.

We sincerely thank all who were involved.



Executive summary

Project vision

Research indicates that stigma and discrimination experienced by people who use alcohol and other drugs (AOD) are barriers to primary care.

This North Western Melbourne Primary Health Network (NWMPHN) project explores ways to identify and reduce these barriers.

It progresses NWMPHN's vision for a health care system that is person-centred, comprehensive, coordinated, accessible, high-quality, and safe.

Research program

A comprehensive four-month research program engaged over 20 participants through more than 14 hours of interviews, focus groups and workshops. This was complemented by a review of academic papers and documents, consultations with NWMPHN's Expert Advisory Groups, and insights shared by people with lived experience of alcohol and other drug use.

This mixed-method approach ensures that the findings provide a comprehensive understanding grounded in real-world practice.

Key findings

The research highlights that AOD-related stigma in primary care is a systemic issue, present not only in individual attitudes, but embedded in organisational practices, regulatory and funding structures, and broader societal narratives. Addressing this stigma requires coordinated action across multiple levels. The findings indicate that meaningful change occurs when interventions align across systems, when team culture, practice environments, funding models, training, and patient engagement strategies reinforce one another.

Crucially, stigma reduction is not a one-off initiative, but a sustained process of embedding accessible, person-centred care throughout the primary care system.

To support this, the research identifies 13 strategic themes that together provide a practical and comprehensive framework for strengthening person-centred primary care in the context of AOD-related stigma.

Strategic themes

1. Transform organisational culture through whole-of-practice approaches
2. Address systemic practice constraints
3. Reinforce framing of AOD as primary health care
4. Build sustainable practitioner networks and support systems
5. Strengthen skills and self-efficacy for meaningful care
6. Support practitioner wellbeing and sustainability
7. Invest in early career formation
8. Create systematic exposure to recovery
9. Partner with lived experience voices
10. Support referral and care coordination systems
11. Embed person-centred communication and environments
12. Ensure culturally safe and responsive care
13. Build accountability through measurement and feedback

Note: Throughout this report, the terms "health care professional" and "practitioner" refer collectively to general practitioners, practice nurses, and pharmacists. However, administrative staff are also considered part of the broader primary care team.

Contents

Section 1: Research background and methodology

Building the evidence base to tackle AOD stigma in primary care

Project vision

North Western Melbourne Primary Health Network (NWMPHN) has a vision for a primary care system that is person-centred, comprehensive, coordinated, accessible, high-quality, and safe.

Research indicates that stigma and discrimination experienced by people who use alcohol and other drugs (AOD) create significant barriers to accessing primary care in communities across the NWMPHN region.

This project progresses NWMPHN's vision for people who use alcohol and other drugs to receive the same high-quality care as all other community members across the region.

While the project focused on the NWMPHN region, it is hoped that the insights and strategies developed will inform efforts to address these barriers across Australia and globally.

Methodology

This research involved:

- **Literature review:** Systematic analysis of published peer-reviewed academic sources, focusing on healthcare professional behaviour change, stigma reduction interventions, and primary care delivery models.
- **Stigma reduction audit**: Systematic scan of Australian and international health organisation strategies addressing stigma in healthcare, identifying common practices, communications and engagement strategies.
- **Stakeholder interviews**: Nine 45-90 minute in-depth interviews with health care professionals (general practitioners, practice nurses, reception or administrative staff, pharmacists) as well as AOD researchers and specialists.
- **Co-creation workshops:** Three structured 90-minute sessions with nine participants; one multidisciplinary primary health care group, one practice nurse group and one general practitioner group.
- **Lived experience review**: Analysis of wide-ranging resources and self-reported experiences to understand behavioural impacts of stigma.
- **Theoretical framework:** Analysis grounded in the established Capability, Opportunity, Motivation-Behaviour model (COM-B).
- **Validation process**: Findings tested and refined through NWMPHN expert advisory groups and iterative feedback loops.
- **Behaviour change framework development:** Development of comprehensive framework outlining potential behavioural approaches for target audiences.

Section 2: Research-informed strategic themes

1: Transform organisational culture through whole-of-practice approaches

Create unified practice environments where every member contributes to equitable health care access through coordinated support and shared understanding.

> "We had training as a group about how to have conversations when people are heightened (due to substance use) and the conflict resolution skills helped. Feedback was that the staff understood why people would be aggressive and could use different techniques so they were less scared and more confident." Practice manager

Research insights - *findings from the research about what drives or prevents behaviour change*

- **Individual efforts benefit from team alignment** - Health care professionals working within aligned teams report greater confidence and effectiveness compared to those attempting change in isolation.
- **Front-line staff need enhanced support** - Reception, assistant and administrative staff manage most initial patient interactions while often having limited access to education about AOD.
- **Concentrated expertise creates pressure points** - When AOD knowledge sits with one or two team members, it creates unsustainable workloads and limits practice capacity.

Strategic enablers - *conditions required to facilitate change*

- **Leadership commitment that positions AOD care as core practice** - Practice leaders who actively champion AOD care through policies, resource allocation, and consistent messaging that this work is central to quality health care delivery.
- **Aligned team culture with role-specific skills** - Common foundational understanding of AOD as a health condition, combined with tailored competencies that recognise each role's unique contribution to care.
- **Shared knowledge embedded across the team** - AOD-related knowledge and understanding are shared across all staff, not concentrated in one or two specialists. This includes reception, nursing, and administrative roles, helping to avoid bottlenecks and ensure more consistent, sustainable care.
- **System-wide structures, not individual dependence** - Clear protocols, defined roles, and team-based workflows ensure AOD care is supported by the system, not reliant on a few passionate or skilled individuals carrying the load.

Implementation examples - *approaches that demonstrate enablers in practice*

- **Whole-of-practice AOD education programs** - Simultaneous training for entire teams covering foundational AOD health concepts, followed by role-specific workshops for GPs, nurses, reception staff, and practice managers.
- **Practice environment enhancement** - Systematic reviews of physical spaces, signage, and patient flow processes to create welcoming environments, including removal of stigmatising materials and addition of recovery-affirming resources.
- **Peer practice partnerships modelled on Strengthening Care for Children** - Formal connections between practices and AOD specialists to share experiences, problem-solve challenges, and provide mutual support for AOD service development.
- **Practice wide AOD care policy development** - Facilitated sessions where practices create written policies covering everything from language standards to crisis management, ensuring consistent approaches across all staff.

Address systemic incentives and practice constraints

Health care professionals operate within systemic constraints where regulatory factors, funding structures, and commercial pressures actively discourage comprehensive AOD engagement.

2:

> "There is an understandable defensiveness that comes from healthcare professionals when feeling they are held responsible for the individual's outcomes, even when it is multilayered and involves housing, financial support and a whole system." Researcher

Research insights - *findings from the research about what drives or prevents behaviour change*

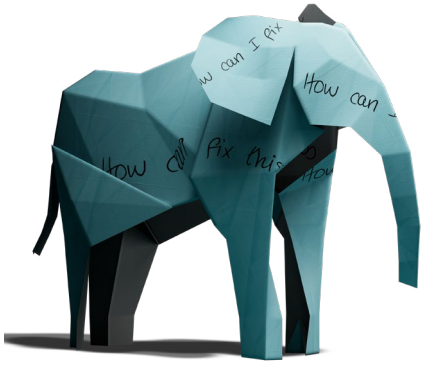
- **Current funding structures shape care possibilities** - Fee-for-service models that dominate primary care funding create time pressures that disincentivise addressing complex health presentations requiring extended engagement.
- **Commercial pressures shape service provision** - Pharmacies operate as businesses within healthcare, while also facing perceived concerns from neighbouring businesses and co-located services who fear AOD services will "attract" unwanted clientele.
- **Professional uncertainty affects clinical confidence** - Questions about appropriate prescribing practices, concerns about prescribing surveillance and regulatory expectations influence how practitioners approach AOD care.
- **Training competes with financial and time constraints** - AOD education often requires unpaid after-hours attendance, competing with other CPD priorities and personal time.

Strategic enablers - *conditions required to facilitate change*

- **Financial structures that reward comprehensive care** - Payment models that allow practices to provide extended consultations and build multidisciplinary teams for complex health presentations, rather than fee-for-service models that create time pressures.
- **Professional development systems that prioritise access to AOD competency** - Training requirements and funding mechanisms that position AOD education as essential rather than optional, with protected time and financial support for skill development.
- **Business environments that support AOD services** - Commercial and regulatory contexts where practices and pharmacies can provide AOD care without fear of losing clientele, facing neighbourhood opposition, or experiencing regulatory scrutiny.
- **Clear regulatory frameworks that encourage engagement** - Professional guidelines and oversight systems that provide clarity about appropriate prescribing practices and reduce anxiety about surveillance or professional consequences.

Implementation examples - *approaches that demonstrate enablers in practice*

- **Blended payment model trials** - Pilot programs allowing practices to combine fee-for-service with capitation payments, enabling longer consultations and care coordination for people with complex AOD presentations.
- **CPD-accredited micro-learning with completion incentives** - Short online modules that count toward mandatory professional development requirements, with practice incentive payments for team-wide completion.
- **Medical precinct and retail centre AOD service agreements** - Formal partnerships between property managers and pharmacy/practice tenants that explicitly support and promote AOD services as essential health care.
- **Business case toolkits with local evidence** - Ready-to-use resources showing successful AOD service integration, including revenue data, patient satisfaction scores, and community health outcomes from similar practices in the region.



Reinforce framing of AOD as primary health care

3:

Position substance use as a health condition requiring the same compassionate, evidence-based care as any other chronic health issue.

> "Why don't they just stop' is the fundamental chestnut that we need to crack. The 'War against drugs' has shown punishment doesn't work. It is slowly improving when it is being seen as a health issue." GP

Research insights - *findings from the research about what drives or prevents behaviour change*

- **Moral framing drives avoidance for some** - When AOD is viewed through a purely moral or legal lens rather than through a health lens, some health care professionals feel it is outside their professional scope.
- **Attribution beliefs shape care quality** - Health care professionals who believe people have "autonomous control over their addictions" demonstrate more negative attitudes, while those understanding the biopsychosocial nature of addiction show greater compassion.
- **Comparison with other conditions transforms practice** - Practitioners who frame AOD alongside chronic diseases such as diabetes or hypertension report greater confidence and willingness to provide ongoing care.

Strategic enablers - *conditions required to facilitate change*

- **Clinical evidence frameworks that demonstrate treatment effectiveness** - Access to recovery statistics, treatment outcome data, and evidence showing AOD care achieves similar success rates to other chronic disease management.
- **Regular exposure to recovery narratives and positive outcomes** - Ongoing contact with success stories that demonstrate the effectiveness of primary care interventions and challenge deficit-based assumptions.
- **Professional education that emphasises biopsychosocial understanding** - Training that covers neurobiological mechanisms of addiction, reducing moral attributions and increasing understanding of substance use as a health concern with complex causation.
- **Integration with familiar chronic disease management models** - AOD care positioned within existing frameworks that practitioners already use confidently, such as care planning, regular monitoring, and multidisciplinary approaches.

Implementation examples - *approaches that demonstrate enablers in practice*

- **Patient journey mapping tools** - Resources showing how AOD care mirrors chronic disease management like diabetes or hypertension, from screening, to ongoing care, to recovery milestones.
- **Recovery outcome data integration** - Regular sharing of local success statistics through practice newsletters, professional networks, and team meetings, highlighting the tangible impact of primary care AOD interventions.
- **Clinical education modules embedded in existing CPD** - Brief online learning integrated into mandatory professional development requirements, presenting addiction neuroscience and evidence-based treatment outcomes alongside other chronic disease content.
- **Chronic disease management framework adaptation** - Modified care planning templates and protocols that position AOD within systems practitioners already use confidently for other ongoing health conditions.

4: Build sustainable practitioner networks and support systems

Connect practices and practitioners to provide ongoing peer support, shared learning, and collective problem-solving to reduce isolation, build confidence and resilience.

> "Reflective practice and Balint groups, people who go to them swear by them. It provides some support to be with other practitioners with shared experiences." GP

Research insights - *findings from the research about what drives or prevents behaviour change*

- **Isolated practitioners experience burnout** - Those with AOD expertise often become the "go-to" for peers and people who use AOD alike, creating unsustainable workloads without adequate support structures.
- **Pharmacists experience unique isolation** - Unlike GP practices with multiple practitioners, pharmacists often work alone or in small teams, lacking immediate peer support when managing complex AOD presentations.
- **Peer learning builds confidence** - Health care professionals report that discussing challenging cases with colleagues and sharing experiences significantly improves their willingness to engage.
- **Small group formats enable vulnerability** - Small group sessions in trusted settings can support psychological safety, allowing practitioners to discuss difficulties, learn from mistakes, and develop new approaches.

Strategic enablers - *conditions required to facilitate change*

- **Expert mentorship access without creating dependency** - Connection to experienced AOD practitioners who can provide guidance and case consultation while building local capacity rather than ongoing reliance.
- **Cross-sector collaboration that includes isolated practitioners** - Networks that specifically include pharmacists and solo practitioners who lack immediate peer support, connecting them with broader primary care communities.
- **Facilitated discussion frameworks that create psychological safety** - Structured approaches that allow practitioners to discuss challenges, admit uncertainties, and learn from mistakes without judgment or professional risk.
- **Protected time for peer connection** - Regular, scheduled opportunities for practitioners to engage in case discussion and mutual support without competing clinical or administrative pressures.

Implementation examples - *approaches that demonstrate enablers in practice*

- **Communities of practice with case discussion focus** - Monthly forums combining brief education updates with structured case discussions, peer problem-solving, and experience sharing, building on successful special interest group models.
- **Balint group establishment for AOD care** - Regular facilitated groups where practitioners reflect on challenging patient interactions, focusing on the therapeutic relationship and emotional aspects of care.
- **Extension for Community Health Care Outcomes (ECHO) network expansion** - Scaling existing ECHO AOD models (for example AOD Connect - Project ECHO) where specialists and generalists discuss cases via video conferencing, making specialist expertise accessible across the region.
- **Mentorship matching programs with clear boundarie**s - Structured connections between experienced and developing AOD practitioners, with defined timeframes and expectations to prevent mentor burnout while building capability.
- **Pharmacotherapy Area Based Network** – Supports GPs, pharmacists, and practice staff in treating opioid dependence through training, mentoring, and access to specialist resources.

5: Strengthen skills and self-efficacy for meaningful care

Build confidence and competence across all roles by developing practical skills while reinforcing the significant positive impact practitioners can have.

> "Someone I treated years earlier came back to me years later and said, 'you really helped me and shook my hand and showed respect and said good luck'. He reminded me of that. It's so disarming. It's rewarding ... there is not a week I don't come away not thinking 'I have saved a life'."
> GP

Research insights - *findings from the research about what drives or prevents behaviour change*

- **Understanding impact drives sustained engagement** - Practitioners who recognise their role in recovery report finding the work deeply meaningful and professionally rewarding.
- **Skills without confidence don't translate to action** - Many practitioners have technical knowledge but lack the self-efficacy to apply it, particularly when facing complex presentations.
- **Practical application builds competence** - Theoretical knowledge alone doesn't create behaviour change; practitioners need opportunities to practice skills in supported environments.

Strategic enablers - *conditions required to facilitate change*

- **Recognition of meaningful impact on recovery outcomes** - Regular reinforcement of how primary care interventions contribute to successful recovery, helping practitioners understand their role's significance beyond crisis management.
- **Practical skill development that builds on existing competencies** - Training that enhances current clinical skills rather than requiring completely new approaches, showing how AOD care extends familiar practices.
- **Graduated learning pathways that build confidence incrementally** - Progressive skill development from basic screening through complex care management, allowing practitioners to build competence step-by-step.
- **Safe practice environments for skill rehearsal** - Opportunities to practise challenging conversations, screening techniques, and clinical skills before implementing with patients, reducing anxiety about real-world application.

Implementation examples - *approaches that demonstrate enablers in practice*

- **Recovery story integration in professional development** - Including people with lived experience as speakers in training programs, showing the transformative impact of compassionate primary care and practitioner significance in recovery journeys.
- **Simulation-based training programs** - Interactive scenarios where practitioners can rehearse AOD conversations, de-escalation techniques, and screening approaches in supportive environments with immediate feedback.
- **Micro-learning modules integrated into practice systems** - Brief, focused skill-building resources such as short videos on effective CAGE screening or motivational interviewing techniques, accessible during practice hours.
- **Competency-based progression programs** - Structured learning pathways where practitioners advance from basic AOD awareness through intermediate screening skills to advanced care coordination, with recognition and credentialing at each level.

Support practitioner wellbeing and sustainability

6:

Address vicarious trauma and prevent burnout through structured support systems that acknowledge the emotional complexity of AOD care."

"A GP colleague returned from retirement and reflected that we are traumatised from decades of work working with this patient population. It doesn't make for a great advocate for the work." GP

Research insights - *findings from the research about what drives or prevents behaviour change*

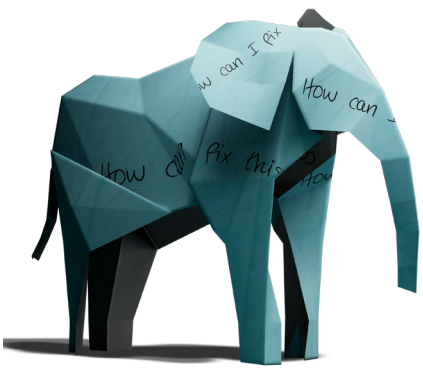
- **Long-term exposure can create cumulative trauma** - Some health care professionals report experiencing vicarious trauma from years of complex AOD work without adequate support structures.
- **No formal support systems exist** - Research suggests an absence of support groups or structured debriefing for practitioners managing emotionally challenging AOD presentations.
- **Burnout concentrates in committed practitioners** - Those most engaged in AOD care often carry disproportionate emotional burden, leading to eventual withdrawal from this work.
- **Disengaged practitioners discourage others** – Burnt-out clinicians who feel unsupported may become sceptical or cynical, inadvertently acting as negative advocates and dissuading peers from entering or continuing in AOD work.

Strategic enablers - *conditions required to facilitate change*

- **Normalised discussion of emotional impact** - Practice cultures that acknowledge AOD work can be emotionally challenging without stigmatising the work itself or practitioners who need support.
- **Structured debriefing and processing opportunities** - Regular, facilitated spaces for practitioners to process difficult experiences, emotions, and ethical dilemmas arising from complex AOD presentations.
- **Peer support networks with shared understanding** - Connections with other practitioners who understand the unique challenges of AOD care, reducing isolation and providing mutual support.
- **Professional supervision models adapted for primary care** - Supervisory frameworks that provide emotional support and professional guidance, similar to mental health practice models but tailored for general practice contexts.

Implementation examples - *approaches that demonstrate enablers in practice*

- **Clinical supervision programs for AOD-engaged practitioners** - Regular one-on-one or small group supervision sessions focusing on emotional processing, ethical decision-making, and skill development for those providing complex AOD care.
- **Team debriefing protocols after challenging incidents** - Structured approaches for practices to debrief as a team following difficult situations, focusing on emotional processing, learning, and preventing secondary trauma.
- **Practitioner wellbeing integration in practice meetings** - Regular check-ins about emotional impact and support needs integrated into standard practice meetings, normalising discussion of wellbeing alongside clinical matters.
- **Peer support circles for AOD practitioners** - Regular confidential gatherings where practitioners share experiences, discuss challenges, and provide mutual emotional support in safe environments.



Invest in early career formation

7:

Shape positive attitudes and build confidence during training and formative professional years when approaches to AOD care are still developing.

> "Only once trainees have had some placement in AOD do they gain interest." AOD Expert

Research insights - *findings from the research about what drives or prevents behaviour change*

- **Early exposure transforms attitudes** - Practitioners who encounter AOD care during training (for example, placements) report more positive attitudes and greater willingness to engage throughout their careers.
- **Current education treats AOD as afterthought** - AOD is sometimes "just thrown in" to training after other priorities like diabetes, signalling it's less important or legitimate.
- **Younger professionals show more openness** - Research suggests less negative attitudes among younger health care professionals who've had recent AOD training and exposure.

Strategic enablers - *conditions required to facilitate change*

- **Mandatory meaningful AOD exposure during training** - Structured placement and learning experiences that ensure all health care trainees encounter AOD care in supportive, well-mentored environments.
- **Integration across the curriculum rather than isolated modules** - AOD content woven throughout training programs rather than treated as a separate, optional, or low-priority topic.
- **Positive role models demonstrating effective person-centred care** - Access to experienced practitioners who model compassionate, evidence-based AOD care and can challenge negative stereotypes through direct mentorship.

Implementation examples - *approaches that demonstrate enablers in practice*

- **GP registrar rotation programs with experienced AOD mentors** - Partnerships with training providers ensuring all registrars complete dedicated AOD-focused placements with practitioners recognised for excellence in person-centred care.
- **Extended student placement programs in AOD-capable practices** - Increased medical, nursing, and pharmacy student placements in practices with established AOD programs, providing sustained exposure rather than brief encounters.

- **University partnership programs with integrated curriculum** - Collaboration with health faculties to embed AOD content throughout degree programs, including patient speakers, practical skills sessions, and reflective learning components.
- **Young practitioner mentorship networks** - Structured support systems connecting early-career practitioners with experienced AOD advocates, providing ongoing guidance during formative professional years.

8: Facilitating positive contact with recovery

Facilitate positive contact between health care professionals and people in recovery outside crisis moments to reduce fear and transform stereotypes.

> "Crucially, when the health care professional comes into contact with the person engaging in AOD use outside of the clinic it can humanise them. It provides the health care professional with positive experiences they would not otherwise be exposed to. Just having personal exposure can help." GP

Research insights - *findings from the research about what drives or prevents behaviour change*

- **Fear drives avoidance** - Perceived dangerousness and unpredictability create barriers, with practitioners reporting fear of violence to self and others.
- **Crisis exposure reinforces stereotypes** - Some health care contact occurs during acute presentations, reinforcing negative associations rather than showing recovery potential.
- '**Ideal contact' transforms attitudes** - Structured exposure outside clinical settings, where groups work together on shared goals, creates lasting stigma reduction.
- **Recovery narratives create empathy** - Understanding patient journeys and recovery processes builds identification and positive attitudes that persist over time.

Strategic enablers - *conditions required to facilitate change*

- **Facilitated positive contact experiences outside clinical settings** - Structured programs that create safe, meaningful interactions between practitioners and people in recovery, moving beyond crisis-focused encounters.
- **Multiple exposure opportunities that build familiarity** - Regular rather than one-off contact to develop comfort, understanding, and positive associations that persist over time.

- **Non-hierarchical interactions that focus on shared humanity** - Contact that reduces power imbalances and emphasises common experiences rather than provider-patient dynamics.
- **Emphasis on recovery journeys and successful outcomes** - Exposure that highlights recovery potential and positive life changes rather than acute presentations or crisis situations.

Implementation examples - *approaches that demonstrate enablers in practice*

- **Structured recovery story sessions during practice meetings** - Regular presentation by people in recovery during regular practice meetings, following established "Recovery Speaks" protocols with facilitator support and structured Q&A.
- **Cultural learning through recovery narratives** - Practice-wide engagement with recovery-focused books or films, followed by facilitated discussions about insights and attitude changes.
- **Recovery community partnership events** - Joint activities between practices and recovery organisations, such as community health fairs or awareness events, creating positive contact in collaborative rather than clinical contexts.
- **Peer mentor integration in practice settings** - Regular presence of people in recovery as volunteers or advisors within practice environments, normalising their presence and providing ongoing positive contact.

Partner with lived experience

9:

Integrate people with lived experience as equal partners in system design, training delivery, and service improvement.

> "We have a saying, 'nothing about us, without us', but it's not just about having someone there, there needs to be structure for it." Researcher

Research insights - findings from the research about what drives or prevents behaviour change

- **Authentic voices transform understanding** - When people with lived experience share their perspectives directly, it challenges assumptions more effectively than professional education alone.
- **Credibility comes from experience** - Health care professionals respond differently to insights from those who have navigated the system themselves.
- **Partnership requires infrastructure** - Successful integration of the lived experience into practices needs formal processes, frameworks, and appropriate compensation.

Strategic enablers - *conditions required to facilitate change*

- **Formal structures that recognise lived experience as valuable expertise** - Position descriptions, governance roles, and decision-making authority that treat lived experience as professional expertise deserving appropriate compensation and respect.
- **Infrastructure that supports meaningful partnership** - Training, mentoring, and peer networks that enable people with lived experience to thrive in health care settings and contribute effectively to system improvement.
- **Cultural shift toward authentic co-design** - Organisational commitment to "nothing about us, without us" that extends to multiple aspects of service development and delivery.
- **Professional recognition and career pathways** - Formal acknowledgment of lived experience work as legitimate professional expertise with opportunities for advancement and specialisation.

Implementation examples - *approaches that demonstrate enablers in practice*

- **Lived experience workforce development programs** - Formal positions for peer workers within practices with clear role descriptions, professional development opportunities, and integration into clinical teams.
- **Co-design partnerships in service development** - Inclusion of people with lived experience as equal partners in developing new AOD services, from initial planning through implementation and evaluation.
- **Co-facilitated training delivery** - Partnerships between professional educators and lived experience trainers for all AOD-related professional development, ensuring authentic voices inform practitioner learning.
- **Consumer advisory groups with decision-making authority** - Formal advisory structures where people with lived experience have genuine influence over practice policies, service design, and quality improvement initiatives affecting AOD care.

Support referral and care coordination systems

10:

Create clear, accessible pathways that reduce practitioner burden and ensure seamless connections to appropriate services.

> "What helps is a network. I know where to refer them to housing etc The NEDDY connect service works with health care professionals bringing a case study. It is practical and tangible and helps service system navigation for HCPs, whether welfare, courts, family violence or ED." GP

Research insights - *findings from the research about what drives or prevents behaviour change*

- **Networks reduce burden** - Practitioners with established referral relationships report greater confidence and willingness to engage with AOD presentations.
- **Unclear pathways create avoidance** - Lack of awareness about referral options leads practitioners to feel overwhelmed with sole responsibility for complex cases.
- **Missing safety nets increase anxiety** - Practitioners report feeling "stuck" without clear escalation pathways, particularly for complex presentations.
- **Pharmacists lack clear escalation pathways** - Pharmacists sometimes feel people dispensed methadone or accessing needle exchange need additional support, but they lack clear escalation or referral pathways.
- **Safety concerns without back-up** - The absence of clear protocols for managing complex presentations leaves pharmacists feeling vulnerable and unsupported and ultimately hesitant to engage.
- **Current tools lack practical information** - Existing referral and pathway resources often missing crucial details like wait times, costs, eligibility criteria, and contact information.

Strategic enablers - *conditions required to facilitate change*

- **Real-time pathway information that supports clinical decision-making** - Up to date details on service availability, wait times, costs, eligibility criteria, and specific contact information that practitioners can access immediately.
- **Secondary consultation access without full referral burden** - Ability to access specialist advice and guidance easily while maintaining primary care management, supporting practitioners to manage cases flexibly.
- **Warm handover processes that ensure successful transitions** - Facilitated connections between services that prioritise continuity of care and reduce the risk of people falling through gaps between providers.
- **Reciprocal communication systems that support ongoing care** - Feedback loops between referring practitioners and specialist services that enable coordinated care planning and shared responsibility.

Implementation examples - *approaches that demonstrate enablers in practice*

- **Enhanced HealthPathways Melbourne platform with real-time updates** - Expansion of HealthPathways Melbourne to include searchable, localised referral information with current wait times, costs, and direct booking links updated regularly.
- **Telehealth consultation expansion across the region** - Scaling successful models like Northern Hospital's telehealth service to provide real-time specialist support for primary care practitioners managing complex presentations.
- **Digital referral integration with practice management systems** - Direct connection of referral pathways with practice management systems for seamless workflow integration.
- **Pharmacy safety net and rapid response systems** - Dedicated support lines and rapid response protocols specifically for pharmacists needing immediate clinical guidance or escalation options for complex presentations.

11: Embed person-centred communication and environments

Create welcoming spaces and interactions that affirm dignity through language, physical environments, and every patient interaction.

> "Technical language helps us be specific but also there is euphemistic and less humanised language for example, 'Lost to therapy' means they stopped turning up to the doctors but didn't say why. There are then assumptions." Researcher

Research insights - *findings from the research about what drives or prevents behaviour change*

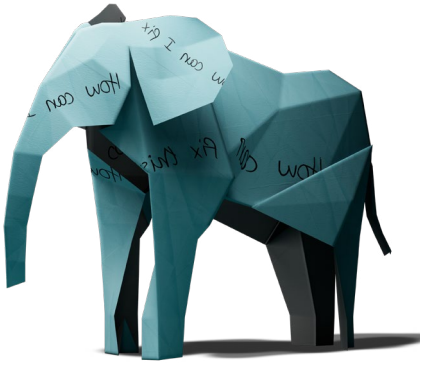
- **Language shapes attitudes and outcomes** - Clinical and stigmatising language reinforces negative perceptions for both practitioners and people who use AOD, creating barriers to care.
- **Environmental cues communicate values** - Physical spaces, signage, and processes send powerful messages about who is welcome and valued.
- **First impressions determine engagement** - Initial interactions, particularly at reception, set the tone for whether people who use AOD feel safe to disclose and seek help.
- **Current terminology dehumanises** - Technical language like 'non-compliant' or 'drug-seeking' positions people who use alcohol or drugs as problems rather than individuals needing care.

Strategic enablers - *conditions required to facilitate change*

- **Organisational language standards that prioritise dignity** - Clear policies requiring person-first, strengths-based communication across all documentation, signage, and interpersonal interactions.
- P**hysical environments that communicate welcome and safety** - Spaces, signage, and processes that send positive messages about who is valued and welcome, removing stigmatising elements while promoting therapeutic relationships.
- **Communication competence that extends beyond terminology** - Skills in tone, body language, therapeutic communication, and trauma-informed approaches that create genuine connection and safety.
- **Patient voice integration in communication approach design** - Regular input from people with lived experience in reviewing and improving communication practices, ensuring approaches genuinely meet patient needs.

Implementation examples - *approaches that demonstrate enablers in practice*

- **Power of Words implementation with regular reinforcemen**t - Training using the Alcohol and Drug Foundation (ADF) Power of Words resource integrated into staff onboarding, with refresher sessions and peer coaching to maintain standards.
- **Communication audits with lived experience involvement** - Systematic reviews of all patient-facing materials, signage, and documentation templates led by people with lived experience to identify and remove stigmatising language.
- **Practice environment enhancement projects** - Systematic reviews of physical spaces, signage, and patient flow processes to create welcoming environments, including removal of stigmatising materials and addition of recovery-affirming resources.



12: Ensure culturally safe and responsive care

Develop approaches that honour diverse experiences and cultural contexts while avoiding demographic stereotyping.

> "Limitations of the ability of health care providers to identify problematic AOD use amongst CALD populations is a challenge. Some cultural behaviours may not be able to be delineated from cultural norms." AOD expert

Research insights - *findings from the research about what drives or prevents behaviour change*

- **Fear of misidentifying creates avoidance** - Some health care professionals report lacking confidence to intervene in AOD use among culturally diverse populations, leading to missed opportunities for care.
- **Cultural norms influence presentation** - Different cultural contexts shape how AOD concerns are expressed, requiring nuanced understanding rather than assumptions.
- **Demographic stereotyping increases harm** - Associating AOD with specific populations based on age, gender, or ethnicity reinforces stigma and creates barriers.
- **Historical experiences affect trust -** Past health care discrimination has affected various communities differently, including Aboriginal and Torres Strait Islander peoples, creating ongoing barriers requiring culturally informed approaches.

Strategic enablers - *conditions required to facilitate change*

- **Cultural safety frameworks that recognise diverse community needs** - Standards and approaches that acknowledge how different cultural contexts shape health care experiences, including Aboriginal and Torres Strait Islander peoples, CALD communities, and other cultural groups.
- **Community partnerships that inform culturally appropriate care** - Ongoing relationships with cultural organisations, community leaders, and cultural liaison services that provide guidance on respectful and effective approaches.
- **Culturally informed understanding rather than demographic assumptions** - Recognition of how historical experiences, cultural norms, and community contexts influence AOD presentations without stereotyping or generalisation.
- **Trauma-informed approaches that acknowledge historical health care discrimination** - Understanding of how past discrimination affects, for example, Aboriginal and Torres Strait Islander people trust in health care, requiring specific approaches to rebuild confidence and engagement.

Implementation examples - *approaches that demonstrate enablers in practice*

- **Multicultural competence training with specific AOD components** - Comprehensive programs covering cultural safety principles for diverse populations, with dedicated modules on culturally appropriate AOD screening and care approaches.
- **Cultural liaison networks for AOD care guidance** - Established partnerships with cultural liaison services across different communities to provide real-time advice on culturally appropriate screening, intervention, and referral approaches.
- **Community co-designed resources with authentic cultural input** - Development of AOD materials with specific cultural communities rather than generic translations, including culturally appropriate screening tools and referral pathways.
- **Cultural responsiveness audits with targeted improvement strategies** - Regular practice reviews using cultural safety assessment tools to identify barriers across different cultural groups, with community-informed improvement plans.

Build accountability through measurement and feedback

13:

Create transparent systems that track progress toward equitable care and drive continuous improvement.

> "What gets measured, gets managed." AOD expert

Research insights - *findings from the research about what drives or prevents behaviour change*

- **Hidden discrimination persists without measurement** - Without systematic tracking, inequitable access patterns remain invisible and unaddressed.
- **Feedback loops drive behaviour change** - When practitioners see data about their practice patterns, it motivates improvement more than education alone.
- **Current systems lack AOD-specific metrics** - Existing quality measures don't necessarily capture whether people who use AOD receive equitable care.
- **Patient voice often missing** - Limited mechanisms for people who use AOD to provide feedback about their care experiences.

Strategic enablers - *conditions required to facilitate change*

- **Embedded measurement systems that capture equity outcomes** - Integration of AOD-specific equity metrics into existing practice management and quality improvement frameworks, making disparities visible.
- **Safe feedback mechanisms that don't risk service withdrawal** - Anonymous and protected ways for people who use AOD to report their care experiences without fear of losing access to services.

- **Regular reporting cycles that drive improvement** - Consistent review of data with teams to identify patterns, celebrate progress, and target areas needing attention.
- **Recognition and celebration systems that maintain momentum** - Acknowledgment of improvements and successful approaches that motivate continued effort and enable sharing of effective strategies.

Implementation examples - *approaches that demonstrate enablers in practice*

- **Patient experience surveys with AOD-specific questions** - Development of survey tools with specific questions about dignity, respect, and access for people who identify as using AOD, integrated into routine patient feedback systems.
- **Practice equity audits with regular review cycles** - Systematic analysis of appointment availability, treatment completion rates, and referral patterns by patient population, with quarterly team reviews and improvement planning.
- **Quality improvement collaboratives for AOD care** - Groups of practices working together to measure and improve AOD care access, sharing data, strategies, and lessons learned across the network.
- P**rogress celebration and learning forums** - Regular opportunities to recognise improvements, share successful approaches, and learn from challenges, maintaining momentum and spreading effective practices.

Section 3: Audience-specific research insights and strategic requirements

Health care professional roles: specific insights and requirements

3.1 General practitioners

3:1

"The perception amongst many GPs is that treating patients with AOD use requires significant time investment and highly specialist skills." GP

Research insights - *findings from the research about what drives or prevents behaviour change*

- **Time constraints and priority of presenting issues drive hesitancy to explore AOD use** - GPs report feeling overwhelmed by the perceived time investment required and burden of responsibility for managing complex AOD presentations, particularly when it is not the presenting issue and they are unclear about next-step referral pathways or specialist support options.
- **Regulatory anxiety creates avoidance** - Concern about AHPRA surveillance (from pharmacotherapy) and concerns about being "notified by patient or colleague" leads some GPs to hesitation to engage with people who use AOD, despite professional obligations to provide comprehensive health care.
- **Clinical framing transforms engagement** - GPs who view AOD use through a health care lens (similar to diabetes or other chronic conditions) rather than a moral or personal choice framework demonstrate significantly more positive attitudes and willingness to provide care.
- **Strategic enablers** - *conditions required to facilitate change*
- **Clear pathways that reduce perceived burden** - Accessible, up-to-date information about local referral options, wait times, and specialist consultation services that reduce GP anxiety about carrying sole responsibility for complex presentations.
- **Professional peer support that prevents isolation** - Networks where GPs can discuss challenging cases, access mentoring, and share responsibility for complex AOD care without feeling overwhelmed.
- **Efficiency tools that enable engagement within existing constraints** - Streamlined screening tools, consultation support, and care coordination resources that help GPs provide quality AOD care within standard appointment timeframes.
- **Reduced regulatory anxiety about professional consequences** - Clear guidance about appropriate prescribing practices and AHPRA expectations that reduce fear about surveillance or professional notifications.

Implementation examples - approaches that demonstrate enablers in practice

- **Enhanced NWMPHN HealthPathways Melbourne with integrated support** - Expansion of the existing HealthPathways Melbourne system with brief interactive AOD modules featuring patient recovery narratives, combined with up-to-date local referral information, wait times, and direct links to specialist telehealth consultation services.
- **Strengthening care model adaptation for AOD** - Replication of the successful "Strengthening Care for Children" approach, creating AOD-focused networks where experienced practitioners provide ongoing case discussion, mentoring, and clinical guidance to colleagues.
- **Integrated CAGE and AUDIT-C facilitation** - Support for practice integration of preferred screening tools that are patient-led, already embedded in practice management systems, or provide clear guidance on next steps for positive screens.
- **Peer mentorship networks with case consultation** - Structured connections between experienced AOD practitioners and those developing skills, with regular case discussion opportunities and accessible specialist backup.

Messaging guidelines - *suggested communication principles to engage the audience*

- **Acknowledge expertise and autonomy**. Frame AOD care as extending existing clinical skills rather than requiring specialist knowledge:

  "You already have the core skills needed - this builds on your existing approach to chronic disease management."

- **Emphasise professional impact and meaning**. Highlight the significant difference GPs can make:

  "Research shows that even brief GP interventions can be life-changing - your role is often the first step towards recovery."

- **Connect to professional values.** Link AOD care to the humanitarian and social justice values that drew many to medicine:

  "The impact we had was transformational. Most people in general practice are in this practice for this." GP

3.2 Practice nurses

3:2

"We are trusted by patients partly because we have more time with them, but also because we have a slightly different role to the doctors. The doctors might rely on us for the relationship we have for things like screening or follow-ups." Practice nurse

Research insights - *findings from the research about what drives or prevents behaviour change*

- **Unique position enables connection** - Practice nurses have more time with people who use AOD than GPs, fostering personal connections and understanding of the biopsychosocial context of AOD use, with their nurturing role creating psychological safety for disclosure.
- **Capability gaps despite frequent contact** - Some nurses report feeling inadequately prepared for AOD care despite having more consistent patient contact than other team members.
- **Safety concerns impact engagement** - Worry about physical risk or disruption from unpredictable behaviour assumed of people who use AOD, creates hesitancy, particularly when working in relative isolation without back up.
- **Limited autonomy restricts potential impact -** Despite being trusted by people who use AOD and relied upon by GPs for screening and follow-up, nurses' training and patient management decisions often ultimately require GP approval, limiting their ability to implement changes.

Strategic enablers - *conditions required to facilitate change*

- **Skills development that leverages extended patient contact** - AOD competencies that build on nurses' existing therapeutic relationships and whole-person perspective, including screening, brief interventions, and care plan development.
- **Safety protocols that provide confidence** - Clear procedures for managing challenging situations, including de-escalation techniques and immediate support access, reducing fear while maintaining engagement
- **Professional development pathways that recognise AOD nursing specialty** - Formal recognition of AOD care as a legitimate nursing specialty area with appropriate training, certification, and career progression opportunities.
- **Collaborative practice frameworks that maximise nursing contribution** - Systems that utilise nurses' trusted relationships and extended patient contact while working within scope of practice and GP oversight requirements.

Implementation examples - *approaches that demonstrate enablers in practice*

- **Nurse-led AOD consultation sessions** - Dedicated appointment slots where nurses provide extended consultations for AOD screening, health education, motivational interviewing, and care planning.
- **Comprehensive safety-first training programs** - Education combining AOD health knowledge with practical skills in de-escalation, risk assessment, team communication, and self-care strategies.
- **Extended consultation models with nursing focus** - Practice arrangements that allow nurses more time with people who use AOD for comprehensive assessment, health education, and ongoing support.

Messaging guidelines - *suggested communication principles to engage the audience*

- **Recognise existing strengths**. Acknowledge the unique therapeutic relationships nurses build through extended patient contact:

  "Your ability to build trust and see the whole person makes you uniquely positioned to support people who use AOD recovery journeys."

- **Emphasise collaborative impact**. Highlight how nursing care creates the foundation for successful treatment outcomes:

  "Your screening and support often provides the foundation for successful treatment - you're an essential part of the care team."

  Address safety directly. Provide practical solutions rather than minimising legitimate concerns about personal safety:

  "These approaches help you provide compassionate care while maintaining your safety and wellbeing."

- **Professional growth framing**. Position AOD skills as career-enhancing rather than additional burden:

  "Developing AOD care skills enhances your practice and opens new professional opportunities."

3.3 Practice managers and administrative staff

3:3

> "We should have training and more insight into what these people may be like and their context. When we know the types of medications that we prescribe, we can think 'Oh they have got an opioid dependence.' By knowing that, you can gauge their experience and what they're going through."
> Medical receptionist

Research insights - *findings from the research about what drives or prevents behaviour change*

- **First contact shapes the care experience** - Reception and administrative staff sometimes have the most contact with people who use AOD, but receive the least training about AOD as a health issue. Their interactions often shape whether people who use AOD feel welcome and safe to seek help.
- **Fear drives defensive behaviours** - Exposure to challenging behaviours without understanding the health context leads to protective gatekeeping, with staff trying to shield the practice and other people seeking care from perceived risks.
- **High turnover perpetuates knowledge gaps** - Reception positions experience significant turnover, with staff reporting it "takes a year to take it in and also learn the medical aspects," creating ongoing training challenges.
- **Caught between competing demands** - Administrative staff must balance practice efficiency, other people seeking care's comfort, GP preferences, and their own safety concerns often without clear guidance on prioritisation.

Strategic enablers - *conditions required to facilitate change*

- **Role recognition as part of the therapeutic care experience** - Positioning reception and administrative staff as the first step in health care delivery rather than purely administration, acknowledging their crucial role in creating psychological safety.
- **Practical skills for common challenging scenarios** - Specific techniques for de-escalation, appointment management, and responding to distressed presentations with confidence and compassion.
- **Team support structures that prevent isolation** - Clear escalation pathways and back up procedures ensuring staff never feel alone when managing challenging situations.
- **Professional development that addresses high turnover** - Training approaches that account for significant turnover in reception positions and the time required to develop medical knowledge and confidence.
- **Understanding the AOD health context** - Education about AOD as a health concern that helps staff understand challenging behaviours within a therapeutic framework.

Implementation examples - *approaches that demonstrate enablers in practice*

- **Reception as healthcare training with ongoing support** - Comprehensive programs covering AOD as a health condition, trauma-informed communication, and conflict resolution, building on successful examples where staff became "less scared and more confident".
- **Scenario-based skill building with role-play** - Interactive training using realistic situations from appointment scheduling to managing distressed presentations, allowing staff to practise responses in safe environments.
- **Quick reference systems integrated into reception workflows -** Easily accessible guides for common situations built into reception computer systems, including appropriate language, de-escalation phrases, and clear escalation procedures.
- **Administrative career pathways with AOD competency recognition** - Progression opportunities that acknowledge AOD care skills, such as senior reception roles, patient liaison positions, or practice coordinator roles.

Messaging guidelines - *suggested communication principles to engage the audience*

- **Validate current challenges**. Acknowledge the difficult position of managing competing demands without adequate support:

  "We understand you're sometimes managing difficult situations without all the skills you need - this training provides that context."

- **Emphasise safety and support.** Focus on building confidence through skills and back up rather than just courage:

  "These skills help you feel more confident and less vulnerable while creating better outcomes for everyone."

- **Professional skill development.** Frame training as career advancement rather than remedial education:

  "Understanding health contexts makes you more effective in your role and opens new career opportunities."

- **Team contribution focus.** Recognise reception as part of the care experience rather than just administrative:

  "You're the face of the practice - your approach sets the tone for successful health care delivery."

3.4 Pharmacists

3:4

"Pharmacy struggles with scenarios where a person is not well enough to be getting dosed in the community, but there is no referral pathway for us." Pharmacist

Research insights - *findings from the research about what drives or prevents behaviour change*

- **Commercial pressures complicate care** - Pharmacists must balance professional health care obligations with business viability, facing pressure from shopping centres, neighbouring businesses, and co-located medical practices which fear AOD services will "attract undesirable patients to the area".
- **Isolation without safety nets -** Unlike GPs, who may have more established pathways for referring complex cases, pharmacists report having no clear escalation pathways when people who use AOD need additional support, leaving them feeling vulnerable.
- **Prejudice affects service provision -** Stigmatising attitudes held by staff or general public toward people buying injecting equipment or accessing methadone create barriers to providing respectful, professional service.
- **Disconnection from health care networks** - Pharmacists often work outside integrated primary care teams, missing opportunities for case consultation, shared learning, and coordinated care.

Strategic enablers - *conditions required to facilitate change*

- **Integration with primary care networks** - Formal connections between pharmacies and GP practices for shared care arrangements, case consultation, and coordinated treatment approaches.
- **Clear escalation pathways that reduce isolation** - Established referral protocols and rapid consultation options specifically for community pharmacies, removing the burden of sole responsibility for complex presentations.
- **Business sustainability models that support professional obligations -** Demonstrated approaches showing how respectful AOD service provision enhances pharmacy reputation, ensures stable revenue, and fulfils professional health care responsibilities.
- **Professional network connection that reduces solo practice isolation -** Forums and support systems specifically for pharmacists providing AOD services, sharing strategies for managing dual health care and business pressures.
- **Commercial environment support for AOD services** - Business contexts where shopping centres, neighbouring practices, and co-located services welcome rather than oppose pharmacy AOD programs.

Implementation examples - *approaches that demonstrate enablers in practice*

- **Pharmacy safety net program with immediate consultation access** - Dedicated phone service where pharmacists can access immediate clinical advice, arrange urgent referrals, or request rapid support for complex presentations requiring escalation.
- **Shared care protocols with local GP practices -** Formal agreements between pharmacies and practices for managing opioid replacement therapy, including regular case conferencing, clear communication pathways, and defined responsibilities.
- **Professional pharmacy networks for AOD service providers -** Monthly forums specifically for pharmacists delivering AOD services to share strategies for managing business pressures, clinical challenges, and community relations while maintaining professional standards.
- **Medical precinct and retail centre AOD service agreements -** Formal arrangements with property managers and neighbouring businesses that explicitly support pharmacy AOD services as essential community health care.

Messaging guidelines - *suggested communication principles to engage the audience*

- **Acknowledge dual pressures.** Recognise the unique challenge of balancing healthcare and business responsibilities:

  "We understand you're balancing professional obligations with business realities - these approaches help you succeed at both."

- **Reduce isolation**. Emphasise connection and support rather than solo responsibility:

  "You're not alone in managing complex presentations - these connections provide the support you need."

- **Professional pride.** Frame AOD services as demonstrating pharmacy's essential health care role:

  "Providing these essential health services demonstrates pharmacy's vital role in comprehensive health care."

- **Community benefit framing.** Link quality AOD care to enhanced business reputation and community trust:

  "Well-managed AOD services enhance community health and pharmacy's reputation as a trusted health care provider."

Appendix: Tools and resources

Clinical screening and assessment tools

- AUDIT-C (Alcohol Use Disorders Identification Test - Consumption) - embedded in MedicalDirector, retained in case notes
- CAGE questionnaire - encourages client engagement by addressing subjective perception of AOD use and intent to change
- BetterConsult - potential partnership for pre-consultation AOD screening tool
- Before During After (BDA) package - contains harm reduction tools
- Reasons for Use (RFU) screening tool

Referral pathways and services

- HealthPathways Melbourne
- Turning Point - valuable referral point for those who've completed AOD training
- Drug and Alcohol Clinical Advisory Service (DACAS) - secondary advice service
- Directline
- SHARC's Peer Projects
- Western Health Drug and Alcohol service
- Nexus Dual Diagnosis Service, St Vincent's Hospital Melbourne
- Harm Reduction Victoria
- Pharmacotherapy, Advocacy, Mediation and Support (PAMS) - 1800 443 844
- The Stigma Project - peer support and best practice

Formal training initiatives

- REACH Project, Department of Health, Victoria
- NEXUS training, St Vincent's Hospital
- RACGP: Medication Assisted Treatment for Opioid Dependence (MATOD)
- Pharmacy Society of Australia: Enhancing Care for People Who Use Alcohol and Other Drugs in Pharmacy
- MDT training at the Alfred Hospital
- RACGP supervised clinical attachment
- GPADD - General Practice in Addiction Conference 2026
- Victorian Pharmacy Pharmacotherapy Training Program
- Pharmacotherapy Area Based Networks (PABN)

Small group learning approaches

- Balint groups
- ECHO networks - technology-based case discussion networks
- Reflective practice groups
- Monthly journal clubs
- North East Dual Diagnosis Youth (The NEDDY)

Community programs

- Youth Support & Advocacy Services (YSAS)
- Muslim Youth and Families (MYAF)
- The Zone - for community engagement

Language guides

- The Power of Words (ADF resource) - practical guide for non-stigmatising language
- AOD Media Watch guidelines
- St Vincents Hospital: Carers Can Ask resource - assists carers in meaningful conversations with service providers

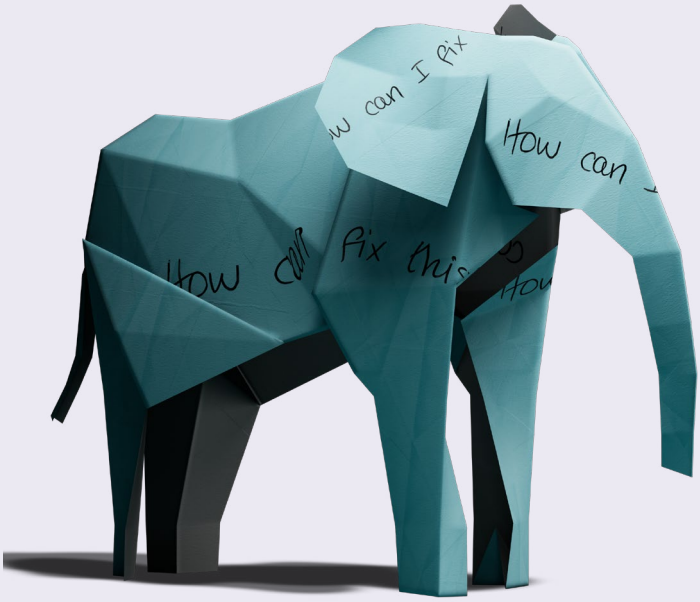
Prescribing and medication

- SafeScript - reinforcement mechanism and messaging
- RACGP - Prescribing drugs of dependence in general practice guidelines
- Drugs of dependence: Responding to requests
- Harm Reduction Australia statistics on recovery outcomes
- Optimising the MBS for people who use AOD who use alcohol and other drugs

Cultural content

- "Unbroken Brain: A Revolutionary New Way of Understanding Addiction" by Maia Szalavitz
- "Fighting the Dragon" documentary
- "In My Skin: A Memoir of Addiction" by Kate Holden

Find more tools,services, resources and support at raiseit.nwmphn.org.au


How can I fix
How can
How can I fix this

Sometimes, alcohol and other drug concerns can feel like the elephant in the room, for you, your patients, and your colleagues.

But it's okay, you're not expected to have all the answers on your own. Whether it's raising a sensitive conversation, knowing what support is available, or guiding someone to the right care, there's help for you too.

There are resources, training, and support available so you can raise it with confidence.

Learn more at raiseit.nwmphn.org.au

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