Att: Committee Secretary
Senate Standing Committee on Community Affairs
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Canberra ACT 2600
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18 August 2011

Dear Secretary,

The Australian Injecting & Illicit Drug Users League (AIVL) welcomes the opportunity to provide the Senate Standing Committee on Community Affairs with our views on the review of the Disability Support Pension (DSP) Impairment Tables. This is a joint submission prepared by AIVL and its national network of peer-based drug user organisations (see details below).

Before outlining our specific views on the Revised *DSP Impairment Tables* however, we would like to briefly explain why AIVL has a unique and important voice to add to this review process and take the opportunity to place our comments in a broader context.

Who does AIVL represent?
The Australian Injecting & Illicit Drug Users League (AIVL) represents issues of national importance for people who use or have used illicit drugs including people currently in drug treatment and is the national peak organisation for state and territory drug user organisations. AIVL and its members are 'peer-based' organisations which mean they are run *by* and *for* people who use/have used illicit drugs. The current state and territory member organisations of AIVL are:

- ACT: Canberra Alliance for Harm Minimisation & Advocacy (CAHMA);
- VIC: Harm Reduction Victoria (HRVic);
- SA: SA Voice for IV Education (SAVIVE);
- WA: WA Substance Users Association (WASUA);
- NT: NT AIDS & Hepatitis Council (NTAHC);
- QLD: Qld Intravenous AIDS Association (QuIVAA) and Qld Injectors Health Network (QuIHN); and
- NSW: NSW Users & AIDS Association (NUAA).

Although AIVL and its members provide a range of programs, activities and services in relation to health, legal and social issues, unlike other non-government organisations, AIVL and its members have direct experiences of many of the issues we seek to represent and in this sense, act as a

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'voice' for people who use and have used illicit drugs in Australia. In this context, AIVL and its member organisations represent the needs and issues for some of the most marginalised and socially excluded people in the community such as:

- people who inject drugs;
- people with drug dependencies;
- people on opioid substitution programs; and
- people with drug-related comorbidities including mental health issues, hepatitis C, HIV/AIDS, etc.

The level of disadvantage experienced by many of the people the AIVL national network represents inevitably means they also have a high degree of contact with the welfare support system. Research into drug treatment programs in Australia have highlighted that the majority of people on opioid pharmacotherapy treatment such as methadone and buprenorphine are reliant on income support[1] with many on the DSP. This is also supported by anecdotal and data collection within the AIVL member organisations with support services targeting people on opioid pharmacotherapies reporting approximately 80-90% of clients on income support with at least 50% being on DSP.

The needs and issues of people who use/have used illicit drugs are often complex and associated with extreme levels of stigma and discrimination. Research evidence has shown that a significant amount of the discrimination and poor treatment experienced by people who use/have used illicit drugs occurs at the hands of government and non-government services in the health, employment and education sectors including Centrelink.[2]

How People Who Use/Have Used Illicit Drugs Experience the Social Welfare System?

Although we are aware this review is focused specifically on the DSP Impairment Tables, we would like to place our comments in context by outlining some of our broader concerns with how people who use/have used illicit drugs experience the welfare system and income support programs in particular.

Like all members of the community, people who use/have used illicit drugs come from diverse backgrounds and experiences. Many people, whether they are on income support or not, live highly functional lives, are engaged in paid and unpaid employment and make significant contributions to their communities. For those people in receipt of government income support however, AIVL believes there are a range of inequities and barriers that specifically affect people who use/have used illicit drugs.

The combined impact of drug dependency, poverty, social isolation, stigmatisation and chronic health problems can have an extremely debilitating effect on a person's capacity to engage with the system. A spokesperson for the Family & Community Services Minister recently said that "work provided dignity and sense of purpose" and that "the Government believes we can do better than a lifetime on income support for Australians who have some capacity to work."[3]

[1] Ritter, A. & Chalmers, J. (2009). Polygon: the many sides to the Australian opioid pharmacotherapy maintenance system. ANCD Research Paper 18. Canberra: Australian National Council on Drugs.

[2] ADBNSW, *C-Change: Report of the Inquiry into Hepatitis C Related Discrimination*, Anti-Discrimination Board of NSW, Sydney, 2001.

[3] The Australian: *"Pension Overhaul: Thousands to Lose Out"*, 8 August 2011.

While AIVL understands the broad intention of the above statement, we are concerned that within the Government's reform agenda, there is insufficient acknowledgement that some people will never be in the position to participate in the workforce or have such complex vulnerabilities that many aspects of the current system are inadequate to assist them in a meaningful and dignified way on a path towards workforce participation. This is the reality for some of the people the AIVL network seeks to represent.

In a democratic society one of our most fundamental principles must be that participation in the workforce is a matter of choice and that principles of 'fairness' and 'equity' should underpin our social support systems. Forcing people into low-pay/unpaid and/or unfulfilling jobs is not about choice, empowerment, equity or justice. It neither serves employee nor employer and has resulted in an 'under-class' of Australian citizens who can be forced into employment at the risk of their livelihood and in many cases their ongoing health and wellbeing. In the case of people who use/have used illicit drugs, they may even be forced into undertaking drug treatment under the guise of policies and programs aimed at making people 'work ready'. We would ask at what cost do we pursue such ends? Is it acceptable to threaten, even violate basic health and human rights in the name of 'workforce participation'?

Ultimately, the Australian welfare system should be judged against how effectively it addresses the needs of the most vulnerable and marginalised in our community. That is, a system that is compassionate and guarantees a basic 'liveable' income to those who require it and a system that is flexible and responsive to the needs of those who seek employment and vocational assistance. Australia has a long-standing ethos of 'egalitarianism' and part of this, people in employment are required to pay taxes to, among other things, fund a social security 'safety net'. These principles need to be at the foundation of any process of review or reform in relation to the DSP.

Background to Review:

"A nation's greatness is measured by how it treats its weakest members."
Mahatma Gandhi

There has been a good deal of media attention on the review of the DSP Impairment Tables. While some of this has opened the door to the usual attacks on welfare recipients including disparaging remarks about the "ease of getting on to the DSP" and its' relative "generosity" in comparison to the Newstart Allowance, there has also been a focus on the potential impact of the changes. A number of welfare-focused NGOs have commented on the decision to introduce "Revised Impairment Tables" questioning both the central aim and likely impact of the new criterion.

According to the Australian Government, the review and changes to the DSP Impairment Tables seek to save some $35millon over the next 12 months. The potential impact on the federal budget was also highlighted in an editorial in *The Australian* on 1 August titled: *"Welfare Reforms Welcome"*. The editorial stated: *"The economic benefits of moving people from welfare to work are felt directly on the budget by removing unnecessary welfare payments and increasing the number of people who might pay tax".* For many individuals and organisations however, this issue goes to the heart of concerns about the rationale and/or possible impact the proposed changes. The Australian Council of Social Service (ACOSS) has been one of the groups with significant expertise in the welfare sector that have highlighted the importance of the Government taking steps to ensure *"that any changes to the rules do not just result in pushing more people onto lower paying allowances"*.[4]

The inadequacy of the Newstart Allowance is well recognised with people being asked to live and cover all the necessities of life on approximately $34 per day. The AIVL network is extremely concerned that a potential dramatic reduction in the number of people receiving the DSP including thousands of highly vulnerable people, many of whom are struggling with issues such as long-term

[4] Pro Bono News: *"Major Crackdown on Disability Support Pension",* 1 August 2011.

drug dependency and other complex health issues will be expected to manage not just the basic cost of living but often costly medications and treatment expenses on an allowance that is not designed for people with such ongoing needs. This concern has also been highlighted by the CEO of ACOSS, Dr. Goldie who has said: *"… unless there is a dramatic improvement in the job prospects of people with disabilities, all the tightening of access to the DSP will achieve is to leave people with disabilities $128 per week poorer."*[5] There is considerable agreement that there is a very real risk these changes could simply result in more people living in poverty.

The National Welfare Rights Network (NWRN) has said *"two thirds of people who apply for a disability support pension from January will be rejected when they fail an obstacle course of tough new tests designed to rein in pension numbers"*. [6] Those who will be affected are among the most vulnerable members of our society. Injured workers and people living with ongoing illness and disabilities are among those who experience significant barriers to gaining stable, reasonably paid employment. A recent media report also stated that *"according to the ABC, a Centrelink test of the new tables found that 4 out of every 10 people who qualified for the Disability Support Pension earlier this year would not qualify under the new regime".* [7]

Decisions by government to change the social welfare system have a huge impact on the quality of life and opportunities afforded to large sections of our community. The Henry Review of the Australian tax system examined the impact of policy decisions to make Newstart even less attractive. In his report Henry states: *"Decisions to target payment increases to particular groups has increased incentives for some people to remain on and for others to seek to qualify for higher rate, non- activity tested payments, such as the Disability Support Pension".* These decisions are, of course, driven by political imperatives. *"Categorical distinctions such as 'single parenthood', 'disability' or 'unemployment' assist in targeting support to those with varying need and capacity to support themselves. Such distinctions also give effect to various social judgments about who should receive assistance".* [8]

The media and popular culture generally is filled with stereotypes about 'people on welfare'. Many employers believe that people with a disability are not productive. People who use or have used illicit drugs in particular experience extreme levels of stigma and discrimination and stereotyping in the employment context. In this regard, it will take more than exhortations by politicians for employers to get behind the government's agenda to provide new job opportunities for those currently on DSP. This stereotyping extends to the policy debate: that anyone on a Disability Support Pension who doesn't sit in a wheelchair is not "really disabled".[9] In its discussion paper on the myths and realities of people on income support, ACOSS argues that *"the goal of employment participation policies should be to improve the job prospects of people with disabilities, not merely reduce the numbers of people on one payment (DSP) by shifting them to another (Newstart)"*.[10]

There is recent evidence of the impact of similar policy 'reforms'. The Howard government in July 2006 introduced a "Welfare to Work" policy which included a DSP component. Less than 1 in 5 of those people diverted to Newstart through 2006/07 obtained employment and left income support

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[5] Pro Bono New, above n.4.

[6] The Australian, above n.3.

[7] Pro Bono News, above n.4.

[8] Henry Review Final Report accessed at: http://taxreview.treasury.gov.au/content/Content.aspx?doc=html/pubs_reports.htm on 18 August 2011.

[9] ACOSS: "Beyond Stereotypes: Myths and Facts about People of Working Age who Receive Social Security" ACOSS Paper #175

[10] Ibid.

that year. The rest remained on the lower payment. Journalist Adele Horin put it this way: *"Labor's new impairment rules will make it harder for people with disabilities to qualify for a pension… Support for these work-focused initiatives, in themselves not bad policy, is always tempered for those who understand the realities. In practice they mean a transfer of disadvantaged people from a frugal payment such as Parenting Payment (single) to the pitiable Newstart, or parking thousands of new disability support pension applicants on the lower payment. The government will make significant savings but a lot of poor people will be even poorer"*.[11]

General Comments on Definitions and Tables

a) Introduction to the Impairment Tables

There is a large and growing body of evidence demonstrating the enormous health and social impacts the "war on drugs" has had on people who use and have used illicit drugs.[12] In the context, we believe the introduction to Impairment Table 6 is needs to be reviewed to ensure it does not unintentionally discriminate against those who have experienced the majority harm under the current approach to illicit drugs. As it currently reads, we believe it expresses a narrow "disease model" approach to drugs and limits the rules solely to "diagnosed medical conditions" validating impairment. Yet having opted for highly medical approach to the impact of illicit drug use, the rules only require diagnosis by someone "preferably with experience in this area" rather than someone with clear evidence-based harm reduction expertise which would be in line with Government drug policy and practice. We are concerned that under these circumstances, people who use/have used illicit drugs may be subjected to lesser protection from arbitrary diagnosis and treatment than other applicants. Another inconsistency is the statement that the "tables are function based rather than diagnosis based" and yet Table 6 is predicated on a person having a "diagnosed medical condition".

In this context, we are concerned that the section entitled 'Reasonable Treatment' contains statements which could be interpreted by an assessor to justify coercing a person into unwanted drug treatment. For example, point 13 in this section states that: *"It is assumed that a person will generally wish to pursue any reasonable treatment that will improve or alleviate impairment".* If drug dependency is recognised as an impairment then accessing drug treatment such as opioid pharmacotherapy, detox, rehab, etc., could be recognised as 'reasonable treatment options'. Under point 14 it states that: *"The question that must be answered by the assessor is "Am I satisfied that there is a reason that compels, in this case, the person not to undertake the treatment"*. We believe this is entirely subjective to the interpretation of the assessor as to whether or not a drug user has an 'acceptable' reason for not entering into drug treatment. If a drug user has no interest in accessing opioid pharmacotherapy, detox or other drug treatment options, they may feel compelled to access these unwanted treatment options in order to fulfil the DSP impairment criteria, or may lose their entitlements.

AIVL does not believe the complexities and impacts of licit and illicit drugs in relation to impairment can be reduced to a brief introduction to a highly empiricist-based system. In our opinion, the descriptors make a range of value judgements about a person's lifestyle, hygiene, nutrition, behavioural skills and social skills, etc. We are unclear about the evidence to support making such blanket determinations on the basis of individual

[11] Adele Horin, Sydney Morning Herald: "Labor Learns Limits of Toughness", 13 August 2011.

[12] AIVL's '*Hepatitis C Models of Access & Service Delivery for People With a History of Injecting Drug Use'* has a good overview and summary of some of the latest evidence in relation to stigma and discrimination and the impact of criminalisation and illegality on the lives of people who use/have used illicit drugs. This paper can be found at: http://www.aivl.org.au/database/sites/default/files/resources/Hep%20C%20Models%20of%20Access%20%20Service%20Delivery%20Paper.pdf

circumstances. This includes what constitutes a "harmful amount of alcohol, drugs and other substances" which under the proposed descriptors has no evidence-based from which to make an appropriate assessment.

A statement is made in the introduction, that the tables represent an "empirically agreed set of criteria for assessing the severity of *functional limitations* for work related tasks and do not take into account the broader impact of a *functional impairment* in a societal sense". The obvious response to this statement is "agreed" by whom and based on what evidence? Given the overwhelming evidence of the negative impact of stigma and discrimination on both the health and wellbeing of people who use/have used illicit drugs, we cannot be satisfied with a social support system that does not take account of or have the capacity to understand the disadvantage suffered by this group in our community. In short, the social security system and the assessors involved in providing access to it cannot simply 'wash their hands' of a responsibility to address the health, social and legal consequences of our current approach to illicit drugs in the Australian community.

An impairment assessment is to be undertaken by an assessor, being "a person trained and experienced in applying the Tables". The February 2008 "Submission on the Job Capacity Assessment Program" by the National Welfare Rights Network highlighted problems with the Job Capacity Assessment process not delivering accurate assessments of work capacity "in a significant proportion of cases."[13] Under these circumstances, the AIVL network would continue to have a range of serious concerns about the specific training and expertise of assessors and their capacity to fulfil their required roles under the revised Impairment Tables particularly for people who are or have been illicit drug users.

b) *Assessment of Impairment*

1. Appropriateness of Assessor Skills:

Central to eligibility for the DSP is the assessment process or *Job Capacity Assessment (JCA)* whereby individual applications are assessed and an impairment rating is determined. To be eligible for the DSP you must be assessed as having an impairment rating of 20 points or more across the impairment tables – each of an individual's 'permanent' conditions is given an impairment rating and these ratings are added together to make up a total impairment rating.[14] In this context, both AIVL and the NWRN (among other organisations) raised in their 2008 submissions to the review of the JCA system, concerns about the expertise and skills of assessors to make decisions about an individual's capacity to work.

In their submission the NWRN stated that the JCA has not delivered accurate assessments of work capacity in a significant number of cases and raised concerns about:

- An over-emphasis on the secondary component of "impact of impairment on capacity to work";
- Assessors disagreeing with or ignoring medical or other specialist reports despite a lack of relevant training to support such decision making; and
- A lack of recognition of how the JCA process itself often leads to insufficient or defective medical evidence – particularly insufficient timeframes for applicants to gather such evidence.[15]

[13] National Welfare Rights Network (NWRN). Submission on the Job Capacity Assessment Program. February 2008.

[14] Welfare Work Wills, Centrelink Entitlements: 2.3 Disability Support Pension, accessed at: www.chronicillness.org.au

[15] National Welfare Rights Network (NWRN), above n.13.

Similar concerns were also raised by AIVL specifically in regard to people who use/have used illicit drugs. Although this review was undertaken a number of years ago, we do not believe the concerns have been adequately addressed and indeed the proposed revisions to the impairment tables may only serve to exacerbate the problems within the current system.

Other organisations such as the National Association of People Living with HIV (NAPWA) and the Australian Federation of AIDS Organisations (AFAO) have also identified the issue of relevant skills and expertise in the JCA program in relation to the application of the DSP impairment tables. In relation to the role of allied health professionals, in their submission NAPWA & AFAO state: *"If it has been identified that allied health professionals are experiencing difficulties using or applying the Tables, this may point to issues regarding the appropriateness of allied health professionals from some disciplines playing a part in DSP assessments and/or the need for training in proper use of the Tables"*.[16] Such sentiments have also been supported by the Legal Aid Commission of NSW and the Commonwealth Ombudsmen who has recommended that the "JCA Assessor allocation should where possible align with the DSP claimant's primary medical condition."[17]

In relation to specific issues for people who use/have used illicit drugs (including those on opioid pharmacotherapies) there is an extensive evidence-base that documents a broad range of health, social and legal issues with potential to impact on a person's ' job capacity'. While not specific to the area of 'job capacity assessment' or disability income support, the experience and practice of Portugal in relation to their Commissions for the Dissuasion of Drug Addiction (CDATs) may be somewhat instructive in this context. The Portuguese CDAT's are a central component of the country's shift to a model of decriminalisation in relation to the personal use of illicit substances. The CDAT's refer people who are using illicit drugs to regional panels made up of 3 people including lawyers, social workers and medical professionals reflecting the multi-disciplinary approach necessary to work with and support people who use drugs.

While AIVL recognises there needs to be a designated assessor whose main skill is likely to be a comprehensive understanding of these Tables, we do not believe this is sufficient for complex assessments of people who use/have used illicit drugs. While we are aware that 'supporting documents' including the contributions of health professionals etc., are considered in the process, we still have concerns about the particular complexity inherent in matters of illicit drug use.

2. Self-Report & Evidence:

From AIVL's perspective, the 'evidence' seems to have an over-emphasis on medical based evidence with self-report and personal experience having little or no value. This is also supported by the NWRN in their submission on the JCA program where they refer to *"a focus on medical evidence ONLY to determine a person's capacity to work"* rather than a proper investigation into individual circumstances.[18] The introduction to the revised tables also refers to the 'objective' evidence of the assessor on issues which we believe, particularly in relation to the use of illicit drugs and/or opioid pharmacotherapy

[16] NAPWA/AFAO. Review of the Tables for the Assessment of Work-related Impairment for Disability Support Pension (DSP Impairment Tables): Joint Submission of National Association of People with HIV/AIDS and Australian Federation of AIDS Organisations. August 2011.

[17] Ibid.

[18] National Welfare Rights Network (NWRN), above n.13.

treatment medications, involve subjective opinions on their own or at the very least where subjective opinions are likely to have some bearing - for example a person's overall presentation and stereotypes about people who use/have used illicit drugs. This is also particularly important in tables relating to “intellectual function”, “brain function” and “function of consciousness” which we are happy to discuss further with the Committee.

The other issue of general significance is the explicit omission of ‘social factors’ in the consideration of DSP applications which AIVL believes is a particularly salient point for the area of illicit drug use. The AIVL network is very concerned about how issues such as stigma, social exclusion and discrimination, as well as the self-esteem issues that can arise out of these problems, could possibly be considered within the framework of the revised tables. In this context, we believe it is essential to view health not just as an absence of disease, but as having regard to the social, emotional and cultural wellbeing of both individuals and their communities which is also central to understandings of health among Aboriginal and Torres Strait Islander Communities.

The language used in *Table 6: Functioning Related to Alcohol, Drug and Other Substance Use* illustrates a general lack of understanding in relation to the social and legal dimensions of illicit drug use. For example, the statement *"absent from work due to the effects of substance use"* should instead be worded *"absent from work due to the impacts of substance use"* as AIVL would argue that in opioid dependency, the effects of the drug do not necessarily impact on a person's ability to function at work, attend work, etc. Rather, it is the absence of opioids in a dependent person which often has a far greater impact on the person's ability to function at and/or attend work, etc. It is extremely important that the language and principles employed within the impairment tables and the way they are applied are based on a ‘real world’ understanding of the impact of both dependent and non-dependent drug use on a persona’s capacity to function rather than on myths, misinformation and stereotypes.

3. Access to Medical Specialists:

In regard to 'medical evidence' under the drug and alcohol table - it states the evidence needs to be provided in the form of a report from a “psychiatrist or an Addiction Medicine Specialist (AMS)”. In many states and territories within Australia there are very few Addition Medicine Specialists. For example, in Victoria there are approximately 6 AMS for the entire state and it is simply unrealistic for them to be expected to spend significant amounts of time filling out reports for Centrelink. Some jurisdictions have even less AMS than Victoria. This is supported by information provided by the NWRN which states that in 2008 there were significant waiting periods for access to specialists in the public health system waiting periods of not less than 6 months and up to 18 months in metropolitan areas.[19]

By way of example, one of AIVL’s member organisations had a recent case of a pharmacotherapy client who required a truck driver's licence to secure a job. The network provider (who was paying for the truck licence) told the Road Traffic Authority that the person was on pharmacotherapy which resulted in the RTA wanting a report from an AMS to state that the person was safe to drive a heavy vehicle. Without the AIVL member organisation working with specialist colleagues on the ground, the person concerned would not have been able to secure the report required within the timeframe. The reality however is that there are very few AMS across the country and the majority of them do not wish to undertake such work – an issue that must be taken seriously by the review of the DSP Impairment Tables.

[19] National Welfare Rights Network (NWRN), above n.13.

The other issue associated with access to medical specialists for people who use/have used illicit drugs is the ability of people to gather medical evidence in the timeframes required and the general cost of accessing specialist medical reports. It is well recognised that there is a decreasing level of access to affordable medical care in particular access to bulk billing through general practice.[20] Many of the specialists working in the AOD field are based in general practice. The NWRN in their report on the JCA states that*: "… it seems to us that in many cases assessments are rushed, often leaving little or no time for the client to obtain medical evidence to support their claim".*[21] This approach to gaining medical and other evidence to supporting a claim for DSP allowance will not be practical or fair for the majority of people who are managing ongoing and/or long-term drug dependency issues.

4. Defining a "Fully Diagnosed, Treated & Stabilsed" Condition:

In regard to a condition that qualifies for an 'impairment rating', that is, according to the revised impairment schedules, a medical condition that is - "fully documented, diagnosed, treated and stabilised and likely to be ongoing for more than two years" - will almost certainly impact on some of the common AOD treatments such as pharmacotherapy, counselling, detox/rehab and naltrexone implants (the latter of which should not be included due to lack of medical evidence). It would seem that 'pharmacotherapy' would qualify the person to be allocated a score, but possibly not detox/rehab because the treatment is not "ongoing". While unclear, AOD counselling may qualify - but possibly not if the AOD worker is not qualify as a 'medical professional'. It remains unclear where approaches such as peer education based on harm reduction principles, NA and other self-help groups and strategies (that many people choose over expensive and/or unavailable counselling services) fit in relation to the impairment tables.

The situation for a person(s) not engaged in any treatment for their illicit drug use (for example a street based injecting drug user who is homeless or without a permanent dwelling, no mental health diagnosis, heroin dependent but not on pharmacotherapy) is not addressed sufficiently within the introduction or revised tables. A person in this instance may have far more complex issues to manage, and thus far less able to work/look for work/undertake training, etc., than a person who is effectively stabilised on opioid pharmacotherapy or other recognised drug treatment. Nevertheless, it is difficult to see how this person could qualify for the DSP in comparison to somebody who is on pharmacotherapy, who might qualify. To be clear, AIVL is not suggesting there should be preference given to people not on pharmacotherapy vs. those on pharmacotherapy but rather that the system needs to be designed to respond in a flexible, open and non-judgmental way to people who use/have used illicit drugs in all their diversity.

AIVL also wishes to note that although it is stated that treatment has to be "affordable and available", this is no longer the case for the majority of people on opioid pharmacotherapy in Australia. The majority of people pay treatment dispensing fees. A recent Victorian study has shown that pharmacotherapy fees can represent approx. 70% of the weekly income of those on DSP. [22] The same study of income support recipients in pharmacotherapy treatment in Melbourne also highlights the difficulties that clients face in meeting their dispensing fees. *"Clients regard their dispensing fees as a priority due to a range of reasons including physical dependence. Rather than not pay*

[20] AIVL. 2010. Hepatitis C Models of Access & Service Delivery for People with a History of Injecting Drug Use, above n.12.

[21] National Welfare Rights Network (NWRN), above n.13.

[22] J. Rowe. Raw Deal: Cost of Opioid Pharmacotherapies in Victoria. 2008.

these fees, they would sooner go without food or go to emergency organisations for food and accommodation, commit crimes and/or obtain loans from Centrelink, etc."[23]

While there is limited space to adequately explore the issue in this submission, it is important to also recognise the detrimental impact of stigma and discrimination on the likelihood of those who are using or have used illicit drugs to disclose information relating to their drug use. It is critical that social income support systems including the DSP understand the enormous impact of shame and stigma on people's capacity to provide genuine informed consent in issues involving assessment for their income and/or to disclose sensitive issues relating to health conditions and illicit activities.

Conclusion:

AIVL would once again like to thank the Australian Government for the opportunity to provide some insights and recommendations from the perspective of people who use/have used illicit drugs in relation to the review of the DSP Impairment Tables.

Given the unique perspective that AIVL brings and the potential impact that any changes to the current system will have for the people we represent, AIVL would be very pleased to organise one or more focus groups with people who use/have used illicit drugs to discuss any of the issues we have raised in more detail.

AIVL and its member organisations are very willing to provide further information and/or appear before the Senate Committee to allow us to elaborate on the issues and experiences included above. We look forward to discussing our submission with you and want to thank you for your consideration of this matter.

Yours Sincerely,

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Executive Officer
On behalf of the AIVL National Network

In co-authorship with:
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[23] Ritter, A. & Chalmers, J., above n.1.