

# **AIVL**

**Australian Injecting &  
Illicit Drug Users League  
(AIVL)**

## **‘NEW RECOVERY’, HARM REDUCTION & DRUG USE POLICY STATEMENT**

**June 2012**

## Introduction:

This paper has been developed by the Australian Injecting & Illicit Drug Users League (AIVL) which is the peak national organisation for the state and territory peer-based drug user organisations and represents issues of national importance for people who use or have used illicit drugs. It aims to outline AIVL's key policy stance on the major issues relating to recent and ongoing discussions on "recovery" and "new recovery". It has been developed in consultation with AIVL's member organisations and some individuals who use or have used illicit drugs and represents an emerging policy position on a rapidly evolving issue within the Australian AOD, harm reduction and BBV sectors.

In reaching the positions articulated in this paper, AIVL was seeking to clearly express our support for a range of generic principles that are being claimed by some as being exclusive to a 'recovery-based approach'. These principles include that AIVL supports all people having access to the types of services, programs, supports and systems they need to ensure overall health and wellness, to live fulfilling and self-directed lives, to achieve their full potential and to be valued members of their communities. While we fully support calls to improve upon and expand access to our current AOD treatment system in Australia, we do not support attempts to convince the general community, politicians, families and drug users themselves that a shift to a 'full recovery approach' is the only way to provide people with health, wellness and personal fulfilment. For those who genuinely choose it, a recovery-based approach can be one way for people to achieve their treatment and personal goals, but it is not the only way for an individual to reach their aspirations.

It is not difficult to see why people (particularly many highly marginalised drug users and their families) might respond very positively to promises of self-empowerment, freedom from pharmacological dependence, social inclusion, fulfilment and happiness – such principles are easy to support. But we must also ask how such promises will be delivered in real, practical terms, and at what price? We should also consider whether it is really fair to ask people who have been forced to accept a largely inflexible, restrictive and at times, even punitive treatment program whether they would like a life free from such restriction. If people answer "yes" to such a question does it mean that long-term opioid pharmacotherapy consumers are really ready to come off their treatment and become 'drug-free' or is it just that they want and need a far more flexible, responsive and humane pharmacotherapy program? If these same people were to have a far more positive experience while on pharmacotherapy maintenance, it is quite likely that remaining on the program would not be considered so personally and professionally limiting – so morally questionable.

Even if people genuinely decide they would like to come off their pharmacotherapy treatment, AIVL believes we need to be absolutely sure that a system based on the principles of 'new recovery' - can deliver the promises of stable housing, meaningful and long-term employment, inclusion and being welcomed back into general society. In particular, we are concerned about people finding themselves morally pressured or even personally driven to come off pharmacotherapy treatment (and if experience in the UK is anything to go by, potentially their mental health medications as well) because of a belief that 'freedom from pharmacological dependency' alone will transform their lives. Further, we are also concerned about what happens if the system is unable to deliver on such promises and people are left alone to confront the fact that being 'drug free' has not 'fixed' a lifetime of disadvantage and exclusion. There are many people who have tried a range of treatment approaches including abstinence based treatment, but have found it is pharmacotherapy that has

kept them alive, supported them to stabilise their drug use and eventually achieve their treatment goals. Under such circumstances, we do not believe it is appropriate for the choice to remain on pharmacotherapy treatment to be characterised as a morally inferior one if it is the right choice for the individual concerned.

AIVL believes people should be supported to make the treatment choice that is right for them. This includes being continually supported to make changes to their treatment choice, to maintain their treatment choice (for the remainder of their life if they so choose) or to leave treatment or choose no treatment in response to their individual needs and circumstances. Genuine choice involves full and informed consent. On this basis, we reject any approach to AOD treatment that seeks to impose a 'one-size' fits all regime. We also do not support a treatment system that requires a predetermined outcome of total abstinence and a 'drug-free lifestyle' without the full and informed consent of the individuals concerned and without the provision of genuine treatment choice. We are not 'anti-abstinence' and refuse to be characterised as not wanting people to achieve fulfilling lives simply because we believe the option of long-term pharmacotherapy treatment should be available to those who wish to access it.

In this context, AIVL has developed the following policy discussion points to encourage discussion and debate on the proposed 'new recovery' agenda. This paper does not claim to represent the individual views of every person who uses or has used illicit drugs in Australia. It is a statement of position from AIVL on some of the key issues that we believe need further discussion and consideration. In this regard it is not written in an academic style, nor is it intended as an evidence-based or 'objective' exploration of the pros and cons of a 'recovery approach'. It is important to note that AIVL occupies a unique position in the 'new recovery' debate. The main reason is because we represent one of the groups that stand to be most affected by any major changes to current drug policy and treatment services. And, it is for this reason we believe our paper makes an important additional contribution to the national discussion on this issue. As the current debate on the 'new recovery' approach is a dynamic process, this paper will remain a 'living document' to allow us to respond and even amend our position as required on key issues as the national dialogue develops.

Finally, we believe it is important to acknowledge that this paper has a major focus on the potential implications of Australia moving to a 'new recovery' approach for those currently on long term opioid pharmacotherapy maintenance programs. This has been a conscious choice and does not mean that we have not focused on the issues and needs of those who use other illicit drugs and/or access other treatment modalities as appropriate throughout the paper. It does mean however that we wish to highlight the fact that it is those currently on opioid pharmacotherapy maintenance programs who we believe stand to potentially lose and suffer the most from a shift to a 'new recovery' approach as it is currently being promoted. It also needs to be said, that people who genuinely choose recovery are well catered for and represented within the 'new recovery' approach. In this regard, they do not need AIVL's limited advocacy resources as their needs are already taken into account. Those on opioid pharmacotherapy maintenance however, have no-one other than AIVL to protect their needs and rights, specifically from a consumer perspective, in a national debate on 'new recovery'. In short, there are a significant number of highly marginalised people with little or no power or voice in this process who need continued access to opioid pharmacotherapy maintenance and who are absolutely relying on AIVL to ensure their needs and rights are protected. This paper attempts to honour that obligation.

## The Disease Model & Genetic Theories of Drug Use:

AIVL does not support taking a 'disease-based' approach to understanding drug use (licit or illicit), nor to the people who use or have used drugs. We do not support the notion that drug dependency is a 'chronic relapsing brain disease expressed in the form of compulsive behaviours'. Rather, AIVL views drug use (whether it involves dependency or not) as a social phenomenon that is characterised by a high level of diversity, not 'sameness'. We view drug use as something where the extent of difference, in terms of people's individual experiences, 'journeys' and outcomes, in themselves contradict theories of genetic predisposition and/or disease-based models. Such theories and approaches simply do not explain why people can experience drug use (and drug dependency) so differently depending on a vast array of social, economic, legal, political and cultural factors. Many human beings engage in behaviours repeatedly, despite the apparent risks, because it gives them pleasure/they enjoy it and myriad other reasons – some high risk sports are good examples of this. We do not rush however to characterise such 'compulsive behaviour' as a disease. All human activities affect and change the brain, in our view calling certain changes, and not others 'damage' is highly problematic and almost entirely subjective.

Developments in neuroscience which have allowed a greater understanding of the uptake and effect of repeated opioid use on certain neurotransmitters and receptors in the brain have also been used by some to argue that dependent opioid use is a 'disease'. The principle problem with such theories is that there is a massive, and unsubstantiated, leap from identifying the mechanisms by which opioids (or other substances) work on the human brain to then labelling the ingestion of those substances as a 'disease'. Definitions of 'addiction' as a disease are highly controversial among leading academics and even diagnostic tools such as the DSM definitions of 'addiction' are largely focused on behavioural not physiological phenomena. From this perspective, AIVL believes at best, it may be possible to characterise dependent drug use as a set of behaviours that can have physiological effects, but not as a disease, and certainly not as something that is experienced in the same way by every person or has the same origins. You could even say that some people (by no means all) may find it hard to stop using certain drugs but that hardly rates as a "chronic relapsing brain disease". As an organisation representing people who use/have used illicit drugs, AIVL values new areas of neurological research into the post-facto physiological effects of long-term and dependent drug use but this does not and cannot amount to an evidence base for theories of genetic predisposition or 'disease models of addiction'.

AIVL also believes it is contradictory to refer to people with drug dependence and 'addiction' [sic] as having a genetic disorder or a chronic disease and that recovery is a never ending and lifelong process. One of the main reasons we believe this is contradictory, is because so many people seem to overcome these 'genetics' and 'chronic disease' states to achieve long term abstinence (i.e. for many individuals 25-30 years plus). We believe, such long term periods of sustained abstinence suggest a social phenomenon, rather than the presence of a disease or some type of genetic vulnerability. People who use drugs are not passive victims simply awaiting a predetermined 'disease' that is chronic and never-ending. They are active participants in their physical and social existence who are limited (and so often harmed) not by genetic or disease-based predictors, but by the social and legal determinants of health and rights such as the conditions in which they are born and live and by a system that appears, in many cases, deliberately designed to harm and fail them at almost every turn.

As people who use or have used illicit drugs, we will continue to demand to be recognised in all our diversity and to have our health and human rights restored through a commitment to systemic social change. We reject characterisations of us as people who are fundamentally ‘diseased’ and simply too ill to recognise it. We are concerned that such depictions can have the effect (even if it is unintentional) of silencing and discrediting us as a group resulting in the removal of organisations of active drug users and pharmacotherapy consumers - in both a physical and intellectual sense - from the critical debate on these important issues facing the Australian AOD sector.

### **‘Active Users’ Vs. ‘People in Recovery’:**

AIVL does not support the artificial distinction between ‘active’ or current drug users and ‘those in recovery’. Not only are these types of false distinctions unhelpful, we believe they may promote the continued social exclusion of, and stigma and discrimination against current drug users who are too often cast as ‘selfish’, ‘sick’ people who are not ‘doing enough’ to ‘help themselves’ and to ‘make’ themselves into ‘better people’. This is supported by AIVL’s recent Anti-Discrimination Market Research Report undertaken by an independent marketing and communications agency. This research with members of both the general public and health professionals clearly identified a sense of compassion for those in drug treatment who were perceived as ‘trying to make themselves into better people’ and to be ‘doing something to fix themselves’. Drug users who were not seen to be ‘doing something to fix themselves’ were considered ‘fair game’ for discrimination and deserving of poor treatment. Indeed, there was a feeling that discriminating against people currently using illicit drugs was a form of ‘community service’ that has a ‘demand reduction’ impact – that is, if we shame, stigmatise and harm enough, people will stop using drugs and commence the process of making themselves ‘better and more productive members of society’ – by becoming ‘people in recovery’.

These same principles have been articulated by key members of the ‘new recovery’ paradigm both here in Australia and particularly in the UK where the policy transformation to a “full recovery” approach is all but complete. There is no role identified for the voice, ideas and needs of ‘active’ or current users in the ‘new’ agenda. Only those who are viewed and view themselves as part of the “full recovery community” – as “recovery champions” - are seen as having positive and constructive contributions to make. In the Australian context, the obvious question then becomes “where does that leave drug user organisations that are run *by* and *for* people who *use* and/or *have used* illicit drugs including current users and long term pharmacotherapy consumers?” In fact, many of the senior leaders within the international drug users movement and established national drug user organisations are people on opioid pharmacotherapy maintenance programs who are living the types of lives and contributing to their communities in a way that only ‘full recovery’ is meant to deliver. If the claims of the ‘new recovery movement’ are correct, how can this be the case? How is it that people who have seemingly been “left to languish or drift” on pharmacotherapy maintenance are doing so well, both personally and professionally?

And it is not just people involved in drug user organisations. There are many thousands of people on pharmacotherapy maintenance programs in Australia, the UK and across the world who are gainfully employed, good parents and active members of their families and communities. This can also be said of people who have used pharmacotherapy programs to achieve their treatment goals and are no longer in drug treatment. It is simply a natural outcome of the process that people who have achieved their treatment goals through pharmacotherapy treatment will not be visible within

the community but just ordinary people getting on with their lives. The fact that they are not immediately visible should not lead to an assumption that no-one successfully transitions off pharmacotherapies or that remaining on pharmacotherapy equals an incomplete or ‘unsuccessful’ outcome. At the end of the day, perhaps all we really need is a greater investment in and expansion of our current approach in order to improve access to a broader range of treatment options and to support people already in treatment to more effectively achieve the goals they have identified for themselves – regardless of their treatment choice.

AIVL does not believe it is accurate to depict the core concepts and principles being promoted in the ‘new recovery agenda’ as ‘new’. Recovery-based services and programs have always been a major feature of the Australian drug treatment sector – a situation that continues to this day. Depending on where they live, people who wish to access recovery-based approaches can do so. Of course, as with all other forms of drug treatment, including opioid pharmacotherapy, in many parts of the country people wishing to access drug treatment experience insufficient services, long waiting lists and a lack of treatment options. Unfortunately people seeking treatment for amphetamine/ATS issues have little or no genuine treatment choice in that ATS pharmacotherapy treatment is not available in Australia and there is also insufficient access to other drug treatment services (including recovery-oriented services) specifically designed for dependent long-term ATS users.

At any rate, even if access to an individual’s choice of treatment was to be equally limited across all treatment model types (i.e. recovery or abstinence, therapeutic communities, pharmacotherapy, peer support, counselling, etc.) the answer is to provide greater investment across the range of treatment modalities, not present one as more effective, more deserving of support or ‘morally superior’ than others. This is the situation Australia is potentially facing and a sector-wide conflict over policy and philosophical paradigms is not going to do anything to increase access or to meet the needs of people seeking treatment for drug dependency – regardless of the treatment approach they wish to access. In this regard, the only genuinely ‘new’ element within the ‘new recovery’ agenda is that key new recovery advocates are seeking to replace our current pragmatic and evidence-based philosophy and practice with a focus on a largely ideological and moralistic agenda. AIVL does not support such an agenda and believes that before any steps are taken to re-orient the Australian AOD sector towards a UK-styled “full recovery agenda” there needs to be a full and frank exploration of the core principles and potential implications of such a shift. AIVL strongly believes the full implications of the moral (rather than evidence-based) agenda at work beneath the policy framework currently being implemented in the UK and proposed by some for Australia, needs to be both acknowledged and discussed in a frank and honest manner. The blog commentary below from an individual in the UK gives voice (in a way that few have been willing to do) to some of the real concerns and fears about the possible implications of the “full recovery agenda”. It is emotional in its tone. Some might claim it is an over-reaction. Despite this however, AIVL has included this statement in our paper, not to further divide an increasingly divided sector, but to highlight that there are genuine concerns about the potential for increased social exclusion and harm and a desire to have an open discussion about those concerns. The statement starts with a direct quote from the UK Government’s ‘roadmap’ for building a new treatment system “Putting Full Recovery First” and is followed by reflections on that statement from the blog author:

*"Our ultimate goal is to enable individuals to become free from their dependence, to recover fully and live meaningful lives."(quote from Lord Henley)*

*“What this document - and in fact what the demarcation of medically assisted recovery and full recovery - primes us to do, is discount those unworthy of our sympathy. “They don't want 'Full Recovery'? - to hell with them then... don't say we didn't try”.*

*And so when our drug related deaths begin to rise, when the numbers with BBVs increase, when the problems of people who have difficulties with drugs are multiplied by government policy, we really don't have to care. We will have recovery champions. We will be living in communities that actively celebrate recovery. We will all be recovery friendly. Except of course those of us who are dead. We won't be very friendly to anything at all.”*

<http://crow7.blogspot.co.uk/2012/03/putting-full-recovery-first.html>

## **Harm Reduction:**

Harm reduction is not and can never be reduced to a ‘by the way’, ‘side thing’ we do while we get on with the ‘real’ job of reducing the supply of, and demand for illicit drugs and getting people on the ‘road to recovery’. Harm reduction is about active drug use. Harm Reduction is the goal – not a step along the ‘road to recovery’ or the path to ‘freedom from dependence’. It is not, cannot and was never meant to be a point on a ‘continuum’ towards the ‘real’ goal of abstinence and a drug-free lifestyle. Of course, individuals who choose to work towards being abstinent may find harm reduction services or approaches helpful in reaching their goal. Indeed, there is a good deal of data reflecting the important role that harm reduction services such as NSPs and safe injecting rooms play in referring people to appropriate drug treatment programs and linking them with other health and social services.

There is also recognition, that people’s engagement in drug use is often fluid and that people frequently move in and out of active drug use over long periods of time even if their ultimate goal is to quit using. It is critical during this process, that people have access to harm reduction services that they can access without fear of exposure or shame. Where they can feel safe accessing harm reduction services without potentially threatening their access to drug treatment services (including abstinence based programs such as NA or counselling) or live in fear of losing their children, their job, their housing, etc., because they are scared of the potential to be reported for or seen accessing the NSP. One of the main reasons why harm reduction services are so effective in supporting people in this way is due to the core principles that sit at the very heart of harm reduction as a concept including that:

- a. **It meets people where they are, not where we might like them to be;**
- b. **It is tailored to the needs of the individual;**
- c. **It is non-judgmental in its approach; and**
- d. **It saves lives – millions of them and counting...**

Harm reduction is our primary, frontline response to reducing the potential harms associated with active drug use particularly injecting drug use including: BBVs, overdose, bacterial infections, etc. It is a specific public health response supported by an over-whelming international evidence-base showing extremely high levels of both effectiveness and cost-effectiveness. In over 20 years of harm reduction practice in Australia, no other health promotion activity has come even close to

demonstrating the levels of effectiveness and return on government investment achieved by harm reduction.

What is harm reduction? Harm reduction includes but is not limited to: needle and syringe programs (NSP) in the general community and prisons, peer education run by and for people who use drugs, peer distribution of all drug using equipment, opioid pharmacotherapy programs including heroin prescription & ATS substitution, overdose prevention, abscess management, vein care, user empowerment, safer injecting rooms and IDU primary health care, etc. There is a significant body of literature supporting the fact that the majority of harms and problems commonly experienced by people who use illicit drugs *do not* come from the substances themselves, but rather, are a result of the social and legal context in which they are used. In the face of this data, AIVL believes there is an obligation upon governments to focus on addressing the systemic factors that create drug related harm, and therefore adverse outcomes for the individual and the broader community. This involves providing a range of appropriate, non-judgmental and accessible AOD & BBV prevention services and programs across the full spectrum of service models and approaches including harm reduction.

### **“Treatment Works”:**

AIVL also believes the discussion about the ‘new recovery’ approach provides a good opportunity to review the use of simplistic slogans such as “treatment works”. While we fully acknowledge that the “treatment works” slogan has not only been used in the ‘new recovery’ context, it is its profiling in this context that highlighted for us the need to encourage some public discussion of this commonly used statement. Even when considered on face value, we believe simply stating that “treatment works” lacks meaning and substance because; in the first instance the vast majority of people who use illicit drugs are not in treatment (for many different reasons). Secondly, such slogans fail to address the complex nature of the issues involved, the diversity of need among people contemplating drug treatment, and the well-documented problems associated with the larger social, legal and political system. Perhaps most importantly of all, it fails to acknowledge the problems within the AOD treatment system itself which are also well-documented in the available literature. When it comes to making statements such as “treatment works”, AIVL believes we need to ask some very basic questions:

- a. **What do we mean by “treatment”** – are we only referring to abstinence-based or ‘recovery-oriented’ services or do we mean ALL drug treatment services including pharmacotherapy-based maintenance programs, counselling, peer support, etc? Do we all mean the same thing when we talk about ‘treatment’?
- b. **What do we mean when we say it “works”** – how is such an outcome measured? Is it measured in terms of health outcomes only (physical and mental)? Is it about how long a person is retained in treatment? Is treatment only seen to ‘work’ if it involves the person achieving abstinence and maintaining a drug-free lifestyle? Or is reducing or eliminating illicit drug use and staying on pharmacotherapy in order to achieve and maintain ‘stability’ in a broader lifestyle sense a sign that treatment ‘works’? Or are we talking about all of the above?
- c. **Under what circumstances is “treatment” claimed or deemed to “work”** – is it achieving a drug-free lifestyle and if so, is that because the person says they are drug-free or does

there need to be independent monitoring? Is it when an individual ceases all illicit drug use 'on top' of their pharmacotherapy? Or is a significant reduction in 'using on top' enough to claim treatment is 'working' for some individuals? If a person achieves abstinence is that a sign treatment has 'worked' or is it only if abstinence is maintained for a certain amount of time and if so, how long is long enough? Can treatment be claimed to 'work' simply because a client completes the 'required' number of sessions for a particular form of treatment? Or should treatment be deemed to 'work' because the person on treatment says it is/or has worked for them?

- d. If “**treatment works**” does that mean **ALL** drug treatment – what about compulsory drug treatment centres? Forced labour camps? Prisons - which are said to be a form of 'drug treatment' in many countries including Australia that claims to have 'drug free' prisons for the purpose of rehabilitation? What exactly are we talking about – what type of 'treatment' and under what conditions is it reasonable to claim that it has 'worked' for an individual or group?

### **Stigma & Discrimination:**

Another claim being made is that the “full recovery approach” will lead to an elimination of the stigma and discrimination experienced by people who have used drugs. It is claimed, the elimination of such treatment is a necessary part of welcoming people with a history of drug use “back into society”. While AIVL unconditionally supports the elimination of stigma and discrimination against people who use/have used illicit drugs, we do not believe an approach, that fundamentally categorises some people as 'more deserving' of fair and humane treatment simply on the basis of whether they are abstinent or not, will result in a genuine reduction or elimination of drug use-related stigma and discrimination. While the principle of aiming to reduce stigma and discrimination against a highly marginalised group within our community will appeal to many on the surface and is hard to argue against, the problem is that the 'new recovery agenda' fails to recognise the major role the health system itself, including AOD services, continue to play in promoting and perpetuating the very stigma and discrimination under discussion. Once again, this is not a matter of opinion but a reality that has been well-documented in the available literature.

AIVL has recently launched a new online survey for people with a history of injecting drug use inviting them to tell us about their experiences of stigma and discrimination. We have had an overwhelming response to the survey from a group of people who are acknowledged as being extremely reluctant to come forward to report such treatment through formal complaint systems. One of the major issues highlighted in the first assessment of the data is the degree to which “micro-aggressions” impact on both the behaviour and decision making of people who use drugs.” Micro-aggressions” are the daily, seemingly minor infractions that may not meet the legal definition of 'discrimination' yet demoralise and destroy people's self-esteem and capacity to view themselves as people deserving of fair or equitable treatment. It is more than interesting to note that drug treatment services, have been identified as one of the main sites of such discriminatory treatment and micro-aggressions. In this regard, claims of 'welcoming drug users back into society' are little more than rhetorical window-dressing unless they are backed-up with actual law reform and genuine changes in attitudes and values including among AOD treatment services themselves. We believe one of the central questions remains: “how do you achieve *real*, meaningful reductions in stigma and discrimination against drug users while certain substances remain illegal?” Or, are we

only looking for reduced stigma and discrimination for those already in, or genuinely seeking 'recovery' – those who are viewed as trying to 'help' or 'fix' themselves?

Some advocates in the 'new recovery movement' have suggested that society "wants addicts back". The obvious admission within this statement is that "addicts" [sic] are not actually considered part of society at the moment and hence people who choose to continue to inject drugs will remain 'outside' of society until they become or are deemed to be 'people in recovery' - people, who have 'earned the right' to be treated with basic dignity and respect and live their lives free from stigma and discrimination. From this perspective, it is important to review the language, practices and goals of the 'new recovery movement' carefully. In particular we are concerned about governments potentially supporting an approach to addressing drug dependency issues that could entrench, not reduce stigma and discrimination against 'certain' drug dependent people purely on the basis of whether they choose a pharmacotherapy treatment or an abstinence-based treatment approach. Given that pharmacotherapy-based treatment is a legal, evidence-based health service, it is possible such distinctions could be judged in breach of basic rights and obligations at both international law under the Universal Declaration of Human Rights and at domestic law in Australia under Anti-Discrimination legislation. We need to ask ourselves, are we potentially seeking to treat people differently on the basis of an irrelevant characteristic and in a way that could potential result in significant harm to certain individuals?

### **Is there an Agreed Definition of 'Recovery'?**

AIVL is concerned about the implied meaning of the term 'recovery'. One of the most obvious questions from the drug user perspective is "what is it that we are meant to be 'recovering' from and who defines it?" As it currently stands, there are almost as many different existing definitions of 'recovery' as there are individuals in the process of 'recovering themselves'. As a starting point, there are the more traditional recovery statements and definitions associated with groups such as Alcoholic Anonymous (AA) and Narcotics Anonymous (NA) with their origins largely in the U.S. but their acceptance and impact global in nature. There are also the numerous 'recovery' definitions that have been produced by other groups within the U.S. such as the Substance Abuse & Mental Health Services Administration (SAMHSA) Recovery Principles, the Betty Ford Institute Consensus Definition and the work of the Connecticut Community for Addiction Recovery (CCAR) – or the "you are in recovery if you say you are" school of thought. More recently, the concepts and definitions being espoused by the UK Government through their "Drug Strategy 2010" and "Putting Recovery First" policy statements, as well as the consensus principles developed by the UK Recovery Federation, have added to the vast array of statements and definitions on this issue.

With so many definitions of 'recovery' – and so many of these claiming to have broad based consensus – it is very difficult to know exactly what is being proposed by the various recovery proponents currently active within Australia. This fact alone should encourage people to pause for reflection and consider the potential consequences of introducing a potentially ill-directed and confused approach into the Australian context which until now, has been highly regarded internationally for our pragmatic and consistent approach to public health issues over the past 20-40 years. As many commentators on the 'new recovery' have pointed out, there seems to be a distinct lack of any agreed definition on what 'recovery' actually means. Even those who advocate a 'recovery' approach admit that the lack of a standard definition has hindered research and this in

turn, has acted as a significant barrier to assessing the efficacy and cost-effectiveness of ‘recovery’ approaches, as well as comparative assessments against other forms of AOD treatment.

Increasing discussions on the potential for the ‘new recovery’ approach to be adopted in Australia have led some to suggest we need to develop a “consensus definition of recovery” – something unique to the Australian context. While some in the AOD, harm reduction and BBVs sectors have shown some interest in such a definition (on the basis that it has the potential to cherry pick the ‘best’ aspects of recovery-based principles and combine them with best practice, evidenced-based harm reduction approaches) AIVL has serious reservations about our ability to reach a genuine consensus on such a ‘hybrid’ approach. What’s more, we also have concerns about whether a commitment to ‘giving harm reduction a place within a recovery-based approach’ would be ultimately honoured in principle and practice. What has generated our concerns?

Once again, the UK experience is instructive in that the very same discussions about the need for compromise and seeking to bring together the best of recovery and harm reduction approaches also occurred. It should be noted, that these discussions (both here and in the UK) were driven by the desire to avoid an unnecessary and potentially harmful philosophical split within the AOD and BBV sectors. While admittedly such discussions in the UK succeeded in creating new partnerships between some representatives of active drug users, some harm reduction and recovery-oriented advocates and other key stakeholders, it has not resulted in the government adopting a ‘best of both worlds’ or ‘hybrid’ approach at the level of policy and practice. Wording taken directly from the policy “roadmap” that accompanies the UK Government’s National Drug Strategy – “Putting Full Recovery First” – outlines the real aims of the new recovery approach and the ‘place’ of harm reduction within it. It states:

*“All our work on combating blood borne viruses amongst service users will be conducted in line with and assessed against a strategic recovery objective. It is self-evident that the best protection against blood borne viruses is full recovery.”*

So what does this mean exactly, and most importantly, what does it mean to say that something is “self-evident”? “Self-evident” to whom? Is it proposing to replace scientific evidence with the wholly subjective concept of testing public health approaches to see if they meet the standard of being ‘self-evident’? Surely this is not consistent with the successful and proven Australian approach of using high-quality, available evidence and properly designed needs assessments to develop AOD and BBV policies and services that are relevant to the identified needs of the local population. In this context, one could ask “why should we care what the UK “roadmap for a new recovery based treatment system” says?” AIVL would argue we should care because despite commitments by both harm reduction and recovery oriented advocates to preserve the best elements of both approaches, it is the elimination, not incorporation of evidence-based harm reduction approaches that is now at the heart of UK drug policy. In short, we cannot assume that the best efforts and motivations of some will automatically result in best practice outcomes for all.

AIVL believes we should also care about the developments in the UK drug policy because an increasing number of Australian Governments are openly using the UK ‘New Recovery Paradigm’ as the blueprint for policy change in Australia. But Australia is not the UK, and there are many important differences in our systems, populations, patterns and types of drug use, people’s needs and aspirations and importantly, in the range of programs and services both available now and

required into the future. There is also increasing anecdotal evidence from the UK that the lack of the fundamentals such as: an agreed definition, an established evidence base and clear protocols and metrics to guide practice and measure outcomes is already resulting in increased harm and problems for some of the most vulnerable drug dependent individuals. In this context, AIVL would argue that rather than seeking to dismantle or replace the current Australian approach, we should be focused on increasing investment in and thereby improving the relevance, effectiveness and flexibility of our existing AOD and BBV sectors.

### **Combining Mental Health ‘Recovery’ & Drug-Use Related ‘Recovery’:**

AIVL has major concerns about universally combining or meshing ‘mental health recovery’ and ‘drug use related recovery’. Over the past 20 years, the adoption of harm reduction based frameworks led to an important shift in the way that evidence-based treatments for drug dependency (particularly opioid pharmacotherapy) have been delivered in Australia. It signalled a shift away from pharmacotherapies being predominately prescribed by psychiatrists to a more community-based model focused in general practice, community pharmacy and AOD specialist services. One of the main aims of this shift was to ‘normalise’ pharmacotherapy and other AOD treatment and to provide people on treatment with greater flexibility and convenience.

Over the past 5 years however, Australia has witnessed a major shift away from the above commitment to harm reduction based frameworks with responsibility for AOD issues (particularly AOD treatment issues) being returned to the mental health sections of Health Departments. Where once AOD issues had their own departmental sections or branches, in 2012 if governments are focused on issues relating to illicit drug use at all, it is almost entirely in relation to supply and demand reduction with all drug use increasingly characterised as ‘problematic’ and ultimately mental health related. The increasing conflation of AOD and mental health issues are also underlined by the new national mental health initiative “Partners in Recovery”. While AIVL wishes to be very clear that we support this important initiative for people with mental health issues, we believe the title of the program “Partners in Recovery” potentially takes on new meaning in the context of the ‘new recovery’ debate currently occurring in relation to AOD issues. Specifically, we are concerned that the very different principles that underpin the concept of ‘recovery’ under the mental health initiative are being inappropriately co-opted by ‘new recovery’ advocates in the AOD area. The principles behind and the potential outcomes associated with the use of the term ‘recovery’ are quite different in the two areas and AIVL believes there needs to be a frank discussion about how and why they differ.

Some have claimed that the AOD sector will benefit, particularly in terms of resourcing from being subsumed into the mental health sector. Despite this optimism, AIVL has not seen any evidence of increased resourcing for drug treatment, even though responsibility for AOD issues has been part of mental health for some years now in many jurisdictions. Although it is claimed that mental health as a sector has led the way in relation to health consumer participation and involvement, there has been little to celebrate by way of increased consumer participation for drug treatment service users as a direct result of the return to the mental health paradigm. Any work that is being conducted in the area of consumer participation in drug treatment settings tends to either pre-date the shift of AOD issues back into mental health or they are plagued by the fact that mental health consumer participation models cannot simply be transposed onto drug treatment consumer participation

initiatives. The latter is not surprising of course, due to the simple fact that the needs and issues of mental health and drug treatment consumers are not one in the same.

AIVL believes services for people with mental health issues and drug dependency issues should operate in a way that is tailored to meet the needs of each individual – recognising a person’s stage in life, the issues that are relevant for them at that time, the context in which they live, etc.

Combining these services and implying that people who have a drug dependency issue *must* by definition have a co-existing mental illness, or vice versa may work for the system, but is unlikely to work for the individual. Recently there have been calls from organisations in the U.S. such as SAMHSA to “simply combine mental health recovery and substance abuse recovery services and approach” because (in their opinion), the same issues and principles can be applied. AIVL believes this viewpoint ignores the complexity of both mental health and drug dependency issues and wrongly assumes that ‘recovery’ (however it is defined) is what everyone is or should be seeking from drug treatment. Such an approach fails to recognise important distinctions between the two issues, the diverse needs of the individuals concerned, as well as the different tools, skill sets and approaches that may be required to effectively address such conditions either in tandem or alone. When combining these services in such a manner, AIVL is concerned about the risk of alienating the very people such services should be trying to reach. While AIVL fully acknowledges that people with co-existing mental health and drug dependency issues too often ‘fall between the gaps’ in AOD and mental health service delivery models, and that this situation needs to be urgently addressed, we do not believe that simply ‘relocating’ responsibility for AOD issues into mental health will provide an effective solution.

As already outlined above however, this is not only an issue in the United States. There are growing concerns that changes within Australian AOD and mental health policy frameworks, funding approaches and service delivery models are increasingly seeking to simply subsume AOD issues within a mental health paradigm. Rather than reaffirming drug use as a social phenomenon with a diverse range of potential implications depending on contextual factors, people who use drugs are being increasingly pathologised and forced within a narrow disease-based approach. Seeking to use a mental health framework to describe drug dependency purely in terms of pathology and disease is not only inaccurate, but also inconsistent with evidence-based practice and accepted clinical definitions within both mental health and AOD treatment approaches.

In this context, AIVL is particularly concerned about approaches that require people to be ‘drug-free’ to the extent that they must cease any prescribed mental health medications in order to meet or maintain eligibility for particular programs or services. An evidence-based approach to clinical practice in mental health would not support people being ‘effectively forced’ off their medications to suit the structure of a program or a particular ideological approach. We believe we should ask ourselves, would we accept people with mental health conditions who are stabilised on long-term or life-long medical treatment having that medication withdrawn in order to be seen by others (and even themselves) as ‘recovered’? Anyone advocating such an irresponsible position would rightly be accused of being unethical, uncompassionate, and even medically negligent. For this reason, AIVL believes that any programs or proposed approaches for people with co-existing mental health and drug dependency issues must meet accepted standards of evidence-based, ethical and humane clinical practice. This includes ensuring genuine informed consent and adherence to basic human rights currently protected at law.

## **Payment by Results or ‘Incentivising Recovery’:**

Although there are many aspects of the UK ‘recovery roadmap’ – “Putting Full Recovery First” – that are very concerning, AIVL believes one of the most concerning proposals within this document is the concept of “Payment by Results” (PBR). The PBR model is primarily designed to ‘incentivise recovery’ by directly linking the funding of services to whether they are judged as delivering ‘recovery outcomes’. If services are deemed not to be providing such outcomes, they will not get paid. The PBR-type approach is already well-established in the Australian context as it is essentially the backbone of how employment assistance programs are now provided through the Job Network structure. There is already significant evaluative work that has been undertaken to highlight the problems associated with taking a PBR-type approach in the employment assistance context, particularly for some of the most vulnerable unemployed – who are frequently people living with long term drug dependence issues.

A variant of the PBR-type approach is already making its way into the Australian AOD treatment sector in so far as services being funded under and/or linked to various initiatives that involve structured treatment programs for payment ‘upon delivery’ of agreed services. Such programs can involve requiring people to attend a set number of counselling sessions at the end of which, if the patient attends all sessions, the service is paid for their ‘results’. Admittedly, this approach is more often referred to as an “Episodes of Care (EoC)” model than PBR but for all intents and purposes, AIVL believes the process and outcomes are similarly dangerous and concerning. While all models and approaches have their pros and cons, AIVL does not believe an EoC approach is in the best interests of people with drug dependency issues. In a recent presentation to a Sydney conference, researcher David Moore suggested the EoC approach may be problematic in the AOD treatment area in that it relies on a predetermined concept of an ‘addiction’ that is best ‘treated’ by an EoC approach. Each EoC involves the delivery of an agreed range of services or programs. Once these services/programs are delivered the ‘treatment’ is deemed to be ‘successful’. The needs and treatment goals of the individual and an assessment of progress towards these needs and goals do not drive what defines a ‘successful treatment outcome’ – success is the delivery of the EoC and subsequent payment for services rendered.

Under an EoC approach therefore, services are almost inevitably motivated towards ensuring individuals complete the ‘funded’ EoC in order to get or retain government funding contracts and keep their service open. In the AOD context, unless the individual is lucky enough for the services available under the EoC approach to precisely match their needs and treatment goals (i.e. that they just happen to need the exact number of CBT sessions on offer through their local AOD service) then they are likely to return to illicit drug use following ‘treatment’ and/or they will seek to return to ‘treatment’ at the same or another service for another EoC. Either way, they will be characterised as having ‘failed the treatment program’ rather than the ‘treatment program having failed them’. This gives the impression of ‘addiction’ or drug dependency as a ‘chronic relapsing condition’ because people seem to keep returning to drug use and/or needing repeated treatment episodes. In his conference presentation referred to above, David Moore also raised these issues and questioned the role of the AOD treatment system itself in both defining and creating our understandings of concepts such as ‘addiction’ rather than just responding to ‘addiction’ as a pre-determined state. The parallels between the Episodes of Care (EoC) and Payment by Results (PBR) approaches are clear – it is only the words used to describe the process that differ.

Based on the above analysis, one of AIVL's most serious concerns about EoC or PBR-type approaches is the obvious negative implications for opioid pharmacotherapy maintenance programs. Under the "full-recovery" approach, PBR focuses on government defined 'recovery outcomes'. Long-term or life-long opioid pharmacotherapy treatment is not seen as a 'recovery outcome' but rather, short-term substitute prescribing is viewed, at best, as a 'first step on the recovery journey' but certainly not a 'recovery destination' or 'outcome'. Utilising a PBR approach would therefore result in pharmacotherapy prescribing services not being paid until someone is seen as achieving the defined 'recovery outcome' – that is - transitioning people already on pharmacotherapy programs off those programs as soon as possible and not commencing people on pharmacotherapy unless it is used under rare circumstances as a brief withdrawal based program towards a 'drug free' outcome. The devil, as they say, is in the detail and despite rhetoric to the contrary, AIVL believes the PBR approach exposes the primary agenda of the 'new recovery' movement as total abstinence for all with the PBR approach used to 'incentivise' services to adopt certain treatment approaches and 'disincentivise' the provision of others.

This approach appears to have little to do with valuing people's choices, supporting people to meet their treatment goals and outcomes, improving people's quality of life or even encouraging people to celebrate and acknowledge meeting their own goals. The PBR approach is designed to ensure that AOD services focus on the end outcome, rather than the treatment 'process'. Given the overwhelming evidence supporting the fact that addressing long term drug dependency issues is a highly individualised process requiring access to a broad-range of treatment and support options including long-term pharmacotherapy-based programs, the PBR system is not evidence-based. In the final analysis, a PBR approach that emphasises "full recovery for all" and at any cost, can only be interpreted as a way to disincentivise support for harm reduction approaches. If services will not be paid until they have delivered a "full recovery outcome" (read – total abstinence) then no services will be encouraged or supported to deliver harm reduction based programs as these 'will not pay' in financial terms even though they have shown over 20 years that they 'pay' in terms of health outcomes and health economics.

The "full recovery" approach promises better value for money for taxpayers because by enforcing a PBR model, ultimately services will be paid by the government for "full recovery only". But where does this leave people who cannot achieve or do not want "full recovery" - arguable some of the most marginalised and long-term dependent of drug users. In particular, AIVL is concerned about the impact on both the individuals concerned and the broader community when people continue to use and inject illicit drugs but no longer have access to evidence-based harm reduction services to prevent them from contracting HIV or hepatitis C, or overdosing or losing the employment, housing and stability they managed to accumulate while on long-term pharmacotherapy. What will a promise of 'full recovery' mean to these people? And where is the peer-reviewed evidence, that is available now, that demonstrates that as a community we should abolish current harm reduction-based services that we know can effectively respond to the needs identified above in favour of 'new recovery' approach?

### **What is the Evidence Base for 'New or Full Recovery' Approaches:**

Harm reduction programs in Australia have a history of effectiveness that spans over 25 years and a substantial, internationally recognised, peer-reviewed evidence base to demonstrate why governments should continue to invest in an approach with a proven beneficial track record. Harm

reduction initiatives within and outside Australia have successfully and repeatedly demonstrated their capacity to save lives and improve health while maintaining an unprecedented cost-effectiveness profile. The evidence base to support the effectiveness of opioid pharmacotherapy maintenance programs in the Australian context is also supported by an extensive, internationally recognised, peer-reviewed literature that includes comparative analyses, clinical trials, cohort studies, needs assessments, program evaluations and longitudinal data collection and review.

Against this backdrop, the recently released UK “roadmap for building a new treatment system based on recovery” titled “Putting Full Recovery First” admits that over the coming months and years the UK Government:

*“... will ensure that open-ended substitute prescribing in the community is only used where absolutely necessary, and only on the basis of a rigorous, multidisciplinary review of a patient’s ongoing needs and even so with recovery as the eventual goal.”*

The above is contrary to available international evidence in relation to best practice and ethical approaches to drug treatment and/or, to addressing AOD issues generally. It is interesting to note the degree of rigour and “multidisciplinary review of a patient’s ongoing needs” that will be required under the new UK recovery approach in order for an individual to be maintained on their pharmacotherapy prescription. By contrast, there appears to be no equivalent standard of requirement to remove an individual’s pharmacotherapy prescription or indeed, to take a decision that an individual is ‘ready’ to move to a ‘drug-free lifestyle’. Further, evidence-based approaches such as the importance of people being supported to remain on long-term pharmacotherapy treatment are dismissed as “ineffective”, not because there is no evidence to support the effectiveness of such approaches, but because they do not seek to move people to “full recovery quickly enough”.

As already stated above, AIVL has focused on the policy and programmatic developments towards a “full recovery” approach in the UK within this paper because it is being used by both ‘new recovery’ advocates and some state governments here in Australia as a basis for changes to the Australian AOD sector. In this context, it is very important to highlight that the UK Government itself has acknowledged the need to create a new evidence base to support a full recovery system. In this context, AIVL is concerned about how it has been possible to evaluate the full recovery approach as effective and as better value for money than the current evidence-based approaches without the existence of a strong evidence-base. It is equally unclear as to how it has been possible to undertake a complete overhaul and reorientation of the UK drug treatment system without a rigorous existing evidence-base to inform policy development, service planning and action. One of the main new and developing sources of evidence cited by the UK Government is the National Drug Treatment Monitoring System (NDTMS). It is of interest to note, that in 2010/11 the NDTMS has identified an almost 20 per cent increase in what is termed “people leaving treatment having successfully overcome their dependency”.

What the above data, in such a short timeframe, does not and cannot tell us is whether those individuals have maintained their “successful recovery outcome” or whether they have returned to illicit drug use and/or to the treatment system. Only time and rigorous and independent monitoring can show this. But, AIVL believes the ‘new recovery’ approach will experience a good deal of difficulty creating such rigorous and independent evidence of long-term outcomes. Long-term

outcomes can be monitored effectively in pharmacotherapy programs because people are continuously engaged with the system. There has been and continues to be much scrutiny of opioid pharmacotherapy programs but the same scrutiny and standards of evidence must be applied to the so-called 'new recovery' approaches. Simply monitoring treatment exit data or even conducting follow-up with people 6-12 months after leaving treatment should not be accepted as evidence of "full recovery" or that people have "successfully overcome their dependency".

It is important to stress, that nothing AIVL has said in this statement should be taken as a wholesale endorsement of the way that opioid pharmacotherapy programs or other drug treatment programs are currently delivered in Australia. The current Australian opioid pharmacotherapy system is not perfect and many consumers have concerns and problems about the design and delivery of the program including concerns about lack of real support to exit the program and to plan and meet their treatment goals. Indeed, research conducted by AIVL in 2005 (with 500 consumers from public pharmacotherapy programs in NSW) highlighted the need for major reforms in relation to program flexibility, social and welfare support, housing, financial advice, family issues, employment, etc. Other research has also highlighted these concerns. What is important to understand here however, is that the above data should not be interpreted as people calling for the *removal* of opioid pharmacotherapy programs and the physiological benefits that they derive from such programs but rather that they want more, not less say in how these programs are designed and delivered.

Some people want and need long-term and/or lifetime pharmacotherapy treatment. In the context of an ageing population, it is crucial that we address the needs of clients who will be on the program for many years and/or for the remainder of their life. It is entirely possible to build and deliver programs that ensure quality outcomes including high quality of life without having to force people off pharmacotherapy medications or other medications when they do not wish to choose a 'drug-free lifestyle'. To do so is contrary to available evidence and arguably could be construed as cruel, unusual and inhumane treatment. Indeed, if any other part of the health system in Australia was to arbitrarily and without genuine informed consent, remove a person's access to an essential medication resulting in significant distress and suffering, there would rightly be condemnation and potential legal consequences. AIVL is unclear as to why we seem to be discussing a potentially different standard when it comes to opioid pharmacotherapy treatment - particularly when the World Health Organisation has listed methadone and buprenorphine as essential medicines?

### **Is 'New Recovery' Really 'New'?:**

It is a myth to promote the idea that recovery or abstinence-based services are not an already well-established part of the Australian AOD sector. AIVL is concerned this myth is being deliberately promoted in order to create a belief that there is a need for a total change or re-think in relation to current drug policy and practice in Australia. As highlighted above, just because the UK has felt the need to revise their approach to the design and delivery of drug treatment policy and practice, it does not mean that this is relevant in the Australian context. If there is a need for change, we believe it is to create more access to more flexible and relevant treatment options – not less choice and removing access to treatment options that are currently working for people. In this context, AIVL does not accept the characterisation of people on pharmacotherapies as universally dissatisfied or as having been 'left to drift on methadone'. Equally, we would've thought that those who are responsible for the funding and delivery of such programs for over 40 years in Australia would have serious concerns about such negative depictions of the current treatment system.

The truth is that there are currently plenty of recovery-focused or abstinence-based options within the Australian drug treatment system for those who wish to choose or try that approach. This has always been the case. We agree that we need to expand access across the full range of treatment options currently available and abolish waiting lists, but this should not be done by setting one treatment modality up against another. Further, we do not support tactics such as those being employed under the UK “recovery roadmap” including people being forced through punitive measures off their long-term pharmacotherapy scripts, being offered only withdrawal based programs or linking social security benefits to pre-determined treatment targets. It is clear from the policy documents that becoming “drug-free and recovered” is now the primary aim of drug policy and treatment programs in the UK. AIVL objects in the strongest possible terms against any shift in Australian government policy and practice that could result in the levels of fear, distress and harm that are already being documented in the UK.

If recovery based approaches were all we ever needed in Australia (and elsewhere for that matter), why do we have in excess of 45,000 people on opioid pharmacotherapy programs in Australia and are unable to meet the growing demand for those services? AIVL finds it offensive that people who have made such choices are too often characterised in UK Government policy and by those promoting the same approach in Australia as passive victims of a system that has become too focused on reducing drug related harms at the expense of supporting people to choose recovery as a way out of their dependency. AIVL believes such views are patronising and fail to recognise that many thousands of drug dependent people have ‘tried and tested’ the various forms of available drug treatment and have ultimately ‘voted with their feet’ to choose the program that best provides them with the outcomes THEY are looking for in THEIR lives. This choice must be respected. There is a big difference between people having a particular approach forced upon them (either by coercion or because of a lack of other options) and people being supported to genuinely choose what’s right for them and their individual treatment goals.

Not everyone wants a drug-free lifestyle or is concerned about having an ongoing dependency on a drug if that drug is safe, affordable, continuously available through a flexible and responsive system, without punitive outcomes, etc. Many people must live with ongoing dependencies to medications and drugs for various reasons. Australia is at an important cross-road. On the one hand we can choose to listen to those who are currently dealing with drug dependency issues and their desire for greater flexibility and more options in a drug treatment system that already has a good deal of merit. Or, we can decide to throw out the entire drug treatment system in favour of “putting full recovery first” – because that is what it will take, a redesign of the entire system. But we must understand that the latter option comes with the very real risk that many people who are currently stable will potentially end up disengaged with the treatment system, at much higher risk of BBVs and overdose deaths and alienated from the very health system that should be providing them with responsive and appropriate treatment options. Such an outcome would not be safe, evidence-based or cost-effective but more importantly, it would not be compassionate, right or just – the choice is ours to make!

### **Summary of the Key AIVL Policy Positions in this Paper:**

- 1. AIVL is not anti-abstinence we support people being able to choose the drug treatment approach that is best for them and their particular circumstances.**

2. AIVL does not support ‘disease-based’ models or ‘genetic theories’ of drug use.
3. AIVL believes that false distinctions between ‘active users’ and ‘people in recovery’ are unhelpful and may promote continued social exclusion and stigma and discrimination against current drug users.
4. AIVL advocates the harm reduction approach as an essential element of an evidence-based, ethical and effective response to addressing licit and illicit drugs.
5. AIVL rejects the use of simplistic slogans such as “Treatment Works” and supports a more sophisticated analysis of when, how and why we would claim that treatment is working for those in treatment or those who have been in treatment.
6. AIVL only supports AOD and/or BBV approaches or models that involve genuine informed consent, treatment choice, consumer participation and respect for fundamental human rights.
7. AIVL believes people on opioid pharmacotherapy maintenance potentially stand to lose and suffer the most from any shift towards a ‘new recovery’ approach that advocates the removal of opioid pharmacotherapy maintenance or in any way resembles the current UK Government endorsed “full recovery” paradigm.
8. AIVL does not support the use of the term “recovery”, “new recovery”, “full recovery” or any other variation of the above to replace “harm minimisation” as the way to describe the overarching philosophy or policy framework underpinning the Australian AOD and BBV sectors.
9. AIVL believes if “new recovery” advocates are actually seeking a commitment to abstinence-based approaches alone, then it should be said openly and we should have a full and frank discussion about the implications and relevance of such an approach in the Australian context.
10. AIVL does not believe it is necessary to attempt to ‘cherry pick’ the best of ‘new recovery’ and harm reduction approaches to create a uniquely Australian ‘recovery-based’ approach. The current Australian AOD treatment approach already offers a range of treatment modalities.
11. AIVL questions whether the ‘new recovery’ approach is actually ‘new’ as the current Australian AOD drug treatment system already includes a range of services and programs based on a ‘recovery’ oriented approach.
12. AIVL does not support the use of “Payment by Results” type funding models for the delivery of AOD services or programs when a “successful result” is defined exclusively as a “recovery-based outcome”.
13. AIVL supports greater investment in appropriate, evidence-based and tailored services for those who are experiencing co-existing mental health and drug dependency issues.

- 14. AIVL does not believe it is possible to simply mesh or combine the issues or principles underpinning ‘mental health-related recovery’ and ‘drug use-related recovery’ approaches.**
- 15. AIVL is seriously concerned about the apparent lack of a rigorous, peer-reviewed evidence base and/or an agreed definition to support the ‘new recovery’ agenda.**
- 16. AIVL does not believe there is a need to redesign or reorient the current Australian AOD treatment sector towards a ‘new recovery’ approach.**
- 17. Instead, AIVL believes we should be focused on reviewing the current AOD treatment system with the view to:**
  - a. retaining those aspects of the system with merit;**
  - b. increasing investment and resourcing levels;**
  - c. improving treatment quality, affordability and flexibility;**
  - d. increasing access to a greater range of evidence-based treatment options;**
  - e. reducing punitive and judgemental treatment approaches;**
  - f. increasing genuine consumer participation and involvement; and**
  - g. improving support for people to identify and achieve their treatment goals and outcomes within a treatment setting that best meets their individual needs.**