Submission to the

Inquiry into severe substance dependence: a model for involuntary detoxification and rehabilitation

Health and Disabilities Committee
Queensland Parliament

14 February 2012

Thank you for the opportunity to provide comment to the Inquiry into severe substance dependence: a model for involuntary detoxification and rehabilitation by the Health and Disabilities Committee of the Queensland Parliament. This is a joint submission with the Public Health Association of Australia (PHAA) in support of the submission to the Inquiry by Dr Alex Wodak.

ADCA is the national peak body representing the interests of the Australian non-government sector for alcohol and other drugs. It works collaboratively with the government, non-government, business and community sectors to promote evidence-based, socially just approaches aimed at preventing or reducing the health, economic and social harm caused by alcohol and other drugs to individuals, families, communities and the nation. The PHAA provides a forum for the exchange of ideas, knowledge and information on public health and is involved in advocacy for public health policy, development, research and training.

ADCA and the PHAA appreciate that the proposal by Queensland Health to introduce involuntary detoxification and rehabilitation is aimed at achieving better health outcomes for a particularly vulnerable group in our society. The question though is whether the evidence supports this approach to achieve the outcomes being sought. In an era of fiscal restraint and where evidence based decision making underpins Australia's National Drug Strategy, this is an important question to ask. Dr Wodak argues that there is little evidence to support the effectiveness, safety and cost effectiveness of involuntary detoxification and rehabilitation and indeed, Queensland Health itself acknowledges this in its supporting document to the Inquiry. It begs the question then why this proposal is being considered at all.

ADCA and PHAA agree that the money spent on establishing and running an involuntary detoxification and rehabilitation program would be better spent on providing services to the community that are known to be effective and address fundamental issues that contribute to alcohol and drug related harm. For example, while governments continue to allow the growth of liquor outlets, they perpetuate a growth in violence.

As members of the National Alliance on Action on Alcohol, the three key priorities for ADCA and PHAA to address alcohol related harm remain as access and availability of alcohol and alcohol products, pricing and taxation, and advertising and marketing (including alcohol sponsorship). Until governments seriously address these drivers of consumption, Queensland and the other states and territories in Australia will continue to see high levels of alcohol related harm in their communities.

Evidence based approaches are critical for success in dealing with the use of illicit drugs and the growing problem of pharmaceutical misuse. Clients should have access to high quality treatment and be able to choose from a range of treatment options. Treatment services should be more attractive to engage with, more flexible and more affordable to meet client needs. Furthermore, there should be enough services to accommodate all users who want access to effective, evidence-based treatment. Currently, the capacity of drug treatment in Australia is too small.

On a practical level, the current inadequacy in treatment capacity creates some significant impracticality associated with involuntary detoxification and rehabilitation. There is no sense in forcing more people into detoxification and rehabilitation when services and facilities are currently unable to cope with the demand for treatment from people who want to access it voluntarily. Greater access and funding would address some of the existing barriers to treatment for people in the target group. This means that if more people are able to access treatment that meets their needs in a timely fashion, there may not be the need to force people into treatment. The current inadequacy in treatment capacity would also be a significant practical problem in implementing any involuntary scheme. it would make no sense to take places away from people who voluntarily seek treatment and give them to those who are being forced into treatment that they don't want.

Worth remembering is that treatment of alcohol and drug (AOD) dependence cannot be done in isolation. AOD treatment needs a holistic approach to address the underlying causes of the dependence and to support people post treatment. An increase in funding levels and capacity in areas of service provision related to AOD is needed to improve outcomes from episodes of treatment. For example, access to housing, employment, education and training and mental health support services are critical following treatment and support is needed to ensure that these things are addressed before the client leaves treatment.

If someone gets out of treatment and then has nowhere to live, they are likely to be exposed to environments where drug-taking is rife, significantly increasing the likelihood of relapse to drug use. If someone gets out of treatment and can't access gainful employment or education/training options and benefits, they are unlikely to be able to support themselves, have lots of time on their hands and again, will be more likely to relapse. If someone with a history of prior abuse leaves treatment without access to counselling services, they won't be able to address the reasons why they turned to drugs and again, relapse is likely. Increased funding/capacity for these complementary areas of service provision are likely to significantly enhance success rates for episodes of treatment, create a pathway to long-term recovery and reduce the rates of relapse to problematic drug use among the target group.

The likelihood of relapse to drug use is significantly increased if someone gets out of treatment and has nowhere to live and can't access gainful employment or education and training options and benefits. Without housing, they are likely to be exposed to environments where drug-taking is rife and without employment or education or some other kind of purpose, will have time on their hands. If someone with a history of prior abuse leaves treatment without access to counselling services, they won't be able to address the reasons why they turned to drugs and again, relapse is likely. Increased funding and capacity for these complementary areas of service provision are likely to significantly enhance success rates for episodes of treatment, create a pathway to long-term recovery and reduce the rates of relapse to problematic drug use among the target group.

Consumer advocacy groups should be supported and consulted to gain genuine insight to the issues of drug use and be involved in developing and implementing strategies that can lead to better outcomes. They support individuals to improve their health and wellbeing, and advocate on behalf of all drug users on issues affecting their health and human rights.

For real success in addressing alcohol and drug related harm, governments need to remove the politics around the issue and concentrate on ensuring good practice in service provision. The policy emphasis by governments on law enforcement should be redirected towards a health and human rights approach to achieve better outcomes for individuals, families and the community. The social harm from a heavy law enforcement approach is substantial for both the individual and their family. Arrest can lead to personal and family embarrassment and stigmatisation and a criminal conviction can limit the choice of jobs available to individuals. These in turn can lead to other problems.

Prisons are an area of real concern and by way of example, ADCA and PHAA have indicated their support for a trial of a needle and syringe program at the Alexander Maconochie Centre in the ACT. The NSP would operate alongside other harm minimisation activities to reduce the spread of blood borne viruses within the prison. It would supply clean equipment but would not supply any drugs.

Once again, ADCA and the PHAA are pleased to support Dr Wodak's submission to the Inquiry. Please contact Meredythe Crane at meredythe.crane@adca.org.au or on 02 6215 9808 if you would like to discuss this response in more detail.

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