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Family & Community Affairs Committee

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6th February 2003

Ms Kay Hull,
Chair,
Standing Committee on Family and Community Affairs,
House of Representatives,
Parliament House,
Canberra,
ACT 2600

House of Representatives Standing Committee on Family and Community Affairs
Submission No: 285.
Date Received: 10 Feb 03
Secretary:

Dear Ms Hull

Re: Inquiry into Substance Abuse in Australian Communities: Private Briefing

Thank you for your letter dated 12/12/02. It was a pleasure to be able to talk about our work. I thought I should take the opportunity to emphasise some points I hope the Committee will take into account. This occurred to me over the last 3 days as I did assessment interviews with two new candidates for detoxification from Methadone.

In the first case a young man of 36 became addicted to heroin in a short time following the failure of his marriage. He only used for few months and was then put on Methadone when he sought treatment. He had been on Methadone for 4 years when I saw him. He was living with his parents, he worked full-time as an Enrolled Nurse in a Nursing Home, he suffered from Anxiety, which dated from a sexual assault, when he was 14 years old, other wise he was a very stable and decent person. He felt profoundly humiliated and depressed by the fact he had to line up daily for Methadone, he felt he was treated with great disrespect by the staff and other medical people when they became aware of his status (ie. A junkie) and he was constantly fearful that colleagues at work would find out about his past problems. He said he was well liked at work and loved his job.

He thanked me for treating him "like a human being". Both he and his mother were in tears at the prospect of him being able to resume a normal life. He had previously spoken to his Methadone doctor who told him that Naltrexone "does not work" and he felt that without our help he might have been on the drug for the rest of his life. I believe he has an excellent chance, with counselling and support, to make a full recovery.

The other case I saw a yesterday was of a 33 year old mother with 5 children under five, including twins. She brought the lot of them with her for the interview! They were delightful children, well behaved (although they asked a million questions) and obviously well cared for. She had a history of early abuse and had only started heroin use some three years before for a short time. She had been on Methadone since then and felt she would never be able to get off it and resume her life. Again she was told that she should stay on the drug and was given no support from any medical authorities to seek treatment. Her husband was drug free (he had managed to detox from Methadone on his own) and had left work to help her care for the children. He was clearly devoted to the children and had stuck by her and was applying for release of Superannuation money on the grounds of hardship to pay for her detoxification and counselling. Again I believe that she has every prospect of not returning to opiate use and of maintaining a full recovery.

In your recommendations to Parliament it is important that any proposal to provide treatment using Naltrexone be accompanied by the need for thorough assessment and preparation, social support and counselling. Naltrexone should be used as a maintenance medication to prevent relapse and to provide time to make significant changes in their lives for at least six months. It should be given orally under

supervision from a support person to ensure compliance or as an implant. It should only be seen as an adjunct to a comprehensive treatment approach and not as a cure in itself.

It is also very important that we are able to have access to some funding to verify the efficacy of our model through clinical trials which can be done as part of my doctoral studies and therefore provide treatment for people such as those I have described above.

I suppose the most important point I would like to make, as exemplified by the examples above, is that much of our success is attributable to our attitude toward those who seek our help. People must be treated with respect and they should feel worthy of care. Often their sense of despair and depression is fuelled by their encounters with the health system, which treats them as 'lepers'.

The training of counsellors, which is so vital to the after-care program needs to incorporate these values and should be made a priority in any proposal. It is also very important that detoxification numbers do not exceed the capacity to deliver after-care treatment including counselling. Again training of people who understand our approach and who have knowledge of addiction theory and treatment practice is essential to the process and needs to be properly set up and funded.

I look forward to hearing from you and thank you again for inviting us to speak with your committee,

Yours faithfully,

Ross Colquhoun, B Sc Hons (psych). MAPS, MACCP, MAPSAD
Cc: Alan Cadman