EDUCATION AND HEALTH STANDING COMMITTEE

INQUIRY INTO THE ADEQUACY AND APPROPRIATENESS OF PREVENTION AND TREATMENT SERVICES FOR ALCOHOL AND ILLICIT DRUG PROBLEMS IN WESTERN AUSTRALIA

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
THURSDAY, 2 SEPTEMBER 2010

SESSION THREE

Members

Dr J.M. Woollard (Chairman)
Mr P. Abetz (Deputy Chairman)
Ms L.L. Baker
Mr P.B. Watson
Mr I.C. Blayney

Hearing commenced at 11.04 am

CARRUTHERS, DR SUSAN,
Research Fellow, National Drug Research Institute, Curtin University, examined:

The CHAIRMAN: On behalf of the Education and Health Standing Committee, I would like to thank you for your interest and your appearance before us today. The purpose of this hearing is to assist the committee in gathering evidence for its inquiry into the accuracy and appropriateness of prevention and treatment services for alcohol and illicit drug problems in Western Australia. You have been provided with a copy of the committee's specific terms of reference. This committee is a committee of the Legislative Assembly. This is a formal procedure of Parliament. Even though we are not asking you to provide evidence on oath or affirmation, any deliberate misleading of this committee is a contempt of Parliament. As a public hearing, Hansard is providing a transcript so we would appreciate you providing the full title for Hansard of any document you refer to. Before we proceed to your submission, I need to ask you if you have completed the "Details of Witness" form.

Dr Carruthers: I have.

The CHAIRMAN: Do you understand the notes at the bottom of the form about giving evidence to a parliamentary committee?

Dr Carruthers: I do.

The CHAIRMAN: Did you receive and read the information for witnesses briefing sheet?

Dr Carruthers: Yes.

The CHAIRMAN: Do you have any questions in relation to being a witness at today's hearing?

Dr Carruthers: No.

The CHAIRMAN: Please state the capacity in which you appear before the committee today.

Dr Carruthers: I am a research fellow at the National Drug Research Institute and chair of the WA Viral Hepatitis Committee.

The CHAIRMAN: Thank you. I believe you have seen the full terms of reference.

Dr Carruthers: Yes.

The CHAIRMAN: We are looking at alcohol and drugs. We thank you for your submission. This inquiry has now been going on for 12 months. I am sure you have looked at some of the submissions that have come to the committee. The committee has had hearings in regional WA and in the metropolitan area. You might like to add to your submission, and the committee will ask you some questions. Committee members may well interject during your submission with some additional questions.

Dr Carruthers: Thank you for asking me here today. I need to point out that my area of speciality is quite narrow; it is illicit drugs only—illicit drugs other than cannabis. I work in a very specific area, and most of my work is done among injecting drug users. The focus of that work is harm reduction, in particular, the prevention of the spread of blood-borne viruses through needle sharing and other injecting practices.

It is very difficult to comment on school education because the majority of school education takes place in terms of alcohol and cannabis. We are not yet able to predict which students or which children will go on to drug use, although it is associated with social disadvantage and lower

education; therefore, it is extremely hard to target illicit drug use at school students. One of the problems is the suggestion that if we talk about illicit drugs we will encourage students to experiment; we might rouse their curiosity and, therefore, they will try something they would not ordinarily try.

The second point is that among the number of people who use illicit drugs, in particular injecting drugs, in WA, illicit drugs are a very small part of the major problems with alcohol and drugs. I happily acknowledge that the majority of our problems are to do with alcohol. There is, however, a subgroup of people who go on to experiment with illicit drugs, and some of those will go on to inject them, and that introduces a whole new level of harm reduction in terms of crime, unemployment and many health problems, but the blood-borne virus one is one of the most serious ones.

The CHAIRMAN: In the UK now, rather than supplying needles and syringes, they are looking at supplying aluminium foil. Are you aware of that? Is that being considered in Australia?

Dr Carruthers: I am aware of that, and no, it is not being considered in Australia, if you are talking about a heroin user, for the prime reason that the type of heroin we have access to across Australia is not suitable for smoking. It comes in the salt form rather than the base form and it is much easier to mix and inject. It would be very difficult to change the market so that we could actually encourage people to smoke as opposed to inject, which comes with a whole lot of problems.

Mr P.B. WATSON: Has the heroin trade dropped over the past 10 years?

[11.10 am]

Dr Carruthers: It has. As I am sure you are aware, it has dropped significantly in the 2000–01 period. The reason for that remains unknown. There are a lot of myths about droughts and what was going on in Burma—the junta tightening up on heroin and opium growth. The same in Afghanistan. It was not a worldwide slowing down; it really was associated mostly with Australia and partly with New Zealand. But the heroin that makes its way to Australia comes from a different part of Asia. Most of the Afghanistan opium goes to the northern hemisphere in paste form—in the base form. That which comes from South East Asia goes through another production step, which makes it into the salt, which means that it can be injected. Those sorts of markets are impossible to shift—they are set. That was a good question. Yes, the heroin market has declined greatly but, unfortunately, the methamphetamine and crystal methamphetamine markets have grown to take over the place of heroin. In terms of hepatitis C and its prevention, that makes our job easier because that drug is efficiently smoked. When it is smoked, users get an instant effect, which is what they want. Although it can be injected, people prefer to smoke it and, in terms of the problems that come with injecting, that is good. It is smoked through a pipe. I am not aware that it can be smoked on foil. It is a different type of chemical from heroin. A water pipe is needed to smoke crystal methamphetamine. However, it can be powdered and smoked in a cigarette. They are very different drugs. In terms of both treatment and the prevention of the harm, they need to be treated very differently.

Mr P. ABETZ: In light of that, has there been a decline in the number of fit packs that have been handed out?

Dr Carruthers: It has not declined, but it has stabilised. We need to understand that although heroin is no longer as easily available, it comes in fits and starts. A lot of people who were using heroin have swapped to other drugs, mostly pharmaceutical drugs. There is a strong market for morphine tablets.

The CHAIRMAN: That they get from their GP now?

Dr Carruthers: Some are got illicitly; they are bought and sold on the open drug market. Some people go to doctors to get prescriptions for them. That happens and not infrequently. It is a bit like the story with benzodiazepines in that people “doctor shop”. They go from one doctor to the next to

the next in order to score a certain number of morphine tablets. If they are supplying their own habit, they will sell half and retain the other half. There is a strong market in those drugs.

Mr P.B. WATSON: Do addicts know of certain doctors in town from whom they can get a prescription?

Dr Carruthers: There have always been certain doctors who are more sympathetic to drug users. There are national controls on the amount of drugs that are prescribed. If one doctor is seen to be prescribing far more than what would be expected from his practice, he would be cautioned or someone would talk to him. I am not sure whether that person would be someone from the Therapeutic Goods Administration or the Pharmaceutical Benefits Scheme. There are a few checks and balances. There are other hints that people who are legitimately on pain killers sometimes sell their pain killers.

The CHAIRMAN: What are the ages of those who develop viral hepatitis? Has there been a trend? For example, is the average age 30; and, if so, has it been 30 for the past 20 years or has it gone up or down?

Dr Carruthers: The average age is between 21 and 25. That is associated with starting to inject and then going forward and developing a problem so that they are injecting more frequently. Many, many people experiment with drugs but only a few will go on to have major problems. Once a person is injecting daily and his injecting networks become wider—that is, he is injecting with more people—his risk of getting hepatitis C skyrockets. Within three years of first starting to inject drugs, between 25 and 30 per cent of injectors are infected. For those who have been injecting between four and five years, we are up to about 50 per cent and by the time someone has been injecting for 10 or more years, around 75 per cent will be infected.

The CHAIRMAN: If the average age is between 21 and 25, how many people who develop hepatitis will require a liver transplant by the age of 40?

Dr Carruthers: A very small number. I am not sure what your knowledge base of hepatitis C is. Most people—75 per cent—who have an acute infection go on to have a chronic infection. Of those who have a chronic infection, about 40 per cent will live with hepatitis C quite happily, especially if they modify their lifestyle by restricting their alcohol use and generally living a healthy lifestyle away from drugs.

Mr P.B. WATSON: Does alcohol use affect hepatitis C?

Dr Carruthers: Yes, especially heavy alcohol use. It speeds up the process of hepatitis C damage to the liver. That is a message we need to get across.

About five per cent of those infected will go on to have either cirrhosis of the liver, liver failure or hepatocellular cancer. Those diseases are life threatening and cost many hundreds of thousands of dollars to treat. In fact, the majority of liver transplants occur as a result of hepatitis C. That is a really important thing to remember. We do not have enough livers.

The middle group of about 30 to 50 per cent will suffer the ill-effects of hepatitis C, which are very insidious. A person feels tired all the time, has elevated liver enzyme test results and loses cognitively. Chronic hepatitis C sufferers do not think as sharply as they used to. They feel tired and have abdominal pain. Those are very vague symptoms, but they may mean that someone has to give up full-time work or that they cannot care for their children. That middle group, while not having a life-threatening illness, still suffer a great deal.

[11.20 am]

Mr P. ABETZ: I used to run a drug rehab support group in the early 2000s. One of the things that I became aware of was that many drug users, even though they get fit packs from a pharmacy, still share needles. To what extent—given that after 10 years, 75 per cent of people or thereabouts have

hepatitis C, presumably through sharing needles—has the free needle program actually been successful, if one can use the word "successful"?

Dr Carruthers: It is successful. We can only look at these figures retrospectively, and I will send the committee a copy of the projections and estimates report, completed every three years, which looks at predicting how many people would have been affected. We have prevented a lot of hepatitis C cases. More importantly, our needle and syringe program has prevented and kept HIV extremely low. While we still work towards preventing hepatitis C, HIV is still very much in the background and we must never, ever forget that. In cities in Canada and the United Kingdom that did not have needle and syringe programs, or closed them after they thought that HIV was no longer a problem, there were explosions in HIV, and that could well happen here as well. It is not just hepatitis C, it is also HIV.

The CHAIRMAN: Could I ask you to send us that report by way of supplementary information?

Dr Carruthers: I shall, yes.

Mr P. ABETZ: Is the hepatitis C virus much more robust in that sense?

Dr Carruthers: It is much more infectious, yes.

Mr P. ABETZ: Can it withstand not being at the right temperature more so than the HIV virus? If a shared syringe has not been used for X number of hours, the HIV virus is often not active anymore and will die, whereas hepatitis C continues to be virile—is that right?

Dr Carruthers: Hepatitis C is more robust in terms of living in that environment for a longer period of time, in certain conditions. By being more infectious, what it means is that the amount of blood required to transmit the virus is far, far smaller than what is required for HIV. That is purely to do with the infectiousness and the number of active live particles in the blood. The amount of blood that would transmit hepatitis C would not be sufficient for HIV; that is the difference in the viruses. One is a retrovirus; that is what "infectiousness" actually means.

The CHAIRMAN: Susan, could you tell us about hepatitis C in Indigenous communities, and problems in Indigenous communities? Is it more or less of a problem?

Dr Carruthers: It is a growing problem. Compared with non-Aboriginal populations, the rate of infection amongst Aboriginal people is higher. That is partially to do with their uptake of injecting drug use, which has been slowly on the increase for quite a long time, although we do not have very good data on that. There are other ritual practices, especially amongst Aboriginals of the far north, that are very risky in terms of hepatitis C, but again, we do not know the scope of that.

The CHAIRMAN: Is that cultural practices and rites of passage?

Dr Carruthers: Rites of passage, yes, but again, we cannot say what the size of that problem is, although it is likely to have an effect. One area where we have very, very poor data is amongst Aboriginal injectors. It is sometimes not easy to collect data from Aboriginal populations; we pick them up as part of standard surveys, but we really need much more close examination of that data for urban as well as rural and remote Aboriginal people. We have to remember that most Aboriginals actually live in the urban areas.

Mr P.B. WATSON: Susan, can I just ask you about heroin again? When I talk to Palmerston in Albany I am told that heroin is too expensive in the bush. Is that an issue in the city too?

Dr Carruthers: It waxes and wanes. It is expensive in terms of its purity at the moment. The heroin we had when the city was well supplied was quite pure; the purity now is low and the price is high, and that is purely a market factor.

The CHAIRMAN: Susan, could you tell us a little bit about the needle and syringe exchange program and the vending programs in both metropolitan and regional areas?

Dr Carruthers: We have only two fix site needle exchanges in WA; one is in Perth and the other one is a sub office of the Western Australian Substance Users' Association. It is also the process of opening one up in Bunbury, which is another region where drug use is quite high. Availability of needles and syringes other than those fix sights are through pharmacies, and the majority of pharmacies in rural and urban areas have a needle and syringe program, although they are not an exchange; they just sell fit packs.

The government has recently installed six vending machines in major rural areas—Esperance, Kalgoorlie, Geraldton, Port Hedland and Albany; that is five. We have another four or five to negotiate. It has actually provided access to needles and syringes that is no longer via hospitals. A lot of hospitals would operate needle programs and would hand out fit packs.

Mr P.B. WATSON: Yes, Albany hospital used to do that.

Dr Carruthers: Yes. The staff in hospitals are often not happy about doing that; they say it takes them away from their everyday work and they are already busy enough. In those places we have actually installed machines. It gives them access to needles and syringes, which is critically important, but the problem is that it takes away the human element of somebody coming in and saying, "You look awful today; are you okay?", and starting a conversation or passing on information about where they might get treatment and where they might get help and what-have-you. It becomes purely a monetary transaction. However, in terms of providing needles and syringes, it is absolutely critical.

Mr P.B. WATSON: Susan, can I ask you what your opinion is about providing clean needles in prisons?

Dr Carruthers: As a prevention tool I think it is essential. None of us condone drug use, but we know that it happens in prisons. Why and how the drugs get in is not my concern; that is something for somebody else to deal with. But while prisoners are injecting, even though it is illegal behaviour, I think we have a duty of care to provide them with clean needles. The evidence in other countries, particularly in Europe, is overwhelmingly that there has never been an attack in a prison using a needle and syringe where they are actually distributed in prisons. It also cuts down on prison officers being accidentally injured by needles when searching through bunks, under clothes and in little nooks and crannies. The rule in Europe is that if a prisoner has a needle and syringe, it is on a shelf, in full sight all the time. On the other hand, if people are still injecting in prisons, we need to do something about providing them with treatment, and good treatment—detoxification and ongoing treatment, not necessarily methadone. Methadone is very efficient, but if someone has a problem with amphetamines, methadone is not going to help. We need very good programs in prisons.

Mr P.B. WATSON: We also have to stop it getting in in the first place.

Dr Carruthers: Absolutely, but as I said, that is something for the Department of Corrective Services to handle.

Mr P.B. WATSON: Yes, but people just say, "Oh, they are in the prisons". We have all these tests, but with the modern technology we have today, it should never get in.

Dr Carruthers: Yes, that would be my first recommendation—to stop the drugs from getting in, but in the meantime we need harm reduction measures.

The CHAIRMAN: Are there some places where you do still have staff who hand out needles and syringes?

[11.30 am]

Dr Carruthers: Yes, most community health centres in the rural and remote areas stock needles and syringes. That becomes a personal transaction.

The CHAIRMAN: What training do they get and is it sufficient?

Dr Carruthers: The health department provides annual training for needle and syringe programs. It is also combined with education on sexually transmitted diseases. The department brings rural workers from these community centres down to Perth for one or two-day training. I have been involved in that training for a while and it is very good. For people who have quite minimal contact with drug users, it is probably sufficient. I think the medical profession is underresourced and undereducated. Specific people have very good training. It is difficult to get doctors in for training as well.

The CHAIRMAN: We are looking at the whole impact of alcohol and drugs. Do you think the social impact of alcohol and drugs has got worse or better over the past 10 years?

Dr Carruthers: In terms of illicit drugs, it has been quite stable, helped in part by the downturn in the heroin market. However, we have replaced that with amphetamines, which bring a different set of problems. In terms of illicit drugs, it has probably stayed relatively stable. I would not say the same for alcohol, but then I am not an alcohol expert. The National Drug Research Institute has put in a very hefty submission on alcohol.

Mr P.B. WATSON: What is worse, amphetamines or heroin, as they relate to viral hepatitis?

Dr Carruthers: In terms of risk, heroin, because it tends to be a drug that is used on a daily basis and the heroin we get must be injected because it cannot be used in any other way. Amphetamines are more likely to be smoked. While people stay away from injecting, there is no risk of hepatitis C. The other problem with amphetamines is that they have quite a profound effect on sexual activity. Amphetamine use is associated with high-risk sexual activity—unprotected but also multiple partners. While there is no evidence that hepatitis C is a sexually transmitted disease, it has been reported, and multiple partners is one of the risk factors.

The CHAIRMAN: Because alcohol is such a problem and the drugs that are on the market at the moment are a problem, what new initiative do you think the government could introduce to limit the impact of drugs and alcohol?

Dr Carruthers: I do not know that any new initiatives are left. We are doing all the initiatives but whether we are doing them in sufficient quantity is another factor. Treatment is available for alcohol problems and treatment is available for heroin use. We are less successful in treating amphetamine use because there is not a substitute drug as there is with heroin; we put them on methadone and we can maintain them long term on that drug. There are too few detoxification facilities and the waiting time to get into treatment for an amphetamine-related problem is three to four months, which is too long. If someone has a problem with amphetamines, that person needs to detoxify now and go into treatment. A three or four-month waiting period is sometimes too long. In terms of alcohol, we have to change the culture and I do not know that a government can do that. We can persuade people to drink sensibly. As I said, alcohol is not my strong point.

Ms L.L. BAKER: Your evidence has been really interesting and very insightful.

Mr P.B. WATSON: I learnt a lot this morning.

Dr Carruthers: I will come back any time.

The CHAIRMAN: Is there anything that you would like to add?

Dr Carruthers: No.

The CHAIRMAN: Thank you for your evidence before the committee today. A transcript of this hearing will be forwarded to you for correction of minor errors. Any such corrections must be made and the transcript returned within 10 days from the date of the letter attached to the transcript. If the transcript is not returned within this period, it will be deemed to be correct. New material cannot be added via these corrections and the sense of your evidence cannot be altered. Should you wish to

provide additional information or elaborate on particular points, please include a supplementary submission for the committee's consideration when you return your corrected transcript of evidence. Again, thank you very much for coming in this morning.

Mr P.B. WATSON: Keep up your great work.

Hearing concluded at 11.35 am