LAW REFORM, DRUGS AND CRIME PREVENTION COMMITTEE

Inquiry into the supply and use of methamphetamines, particularly ice, in Victoria

Bendigo — 25 October 2013

Members

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Mr D. Eltringham, Drug and Alcohol Care Coordinator, Emergency Department, Bendigo Health.

Ms C. Lever, Nurse Unit Manager, Emergency Department, Bendigo Health.

Mr B. Jacobs, Nurse Manager, ECAT/Triage/PARC, Psychiatric Services, Bendigo Health.

Mr W. Daly, Nurse Unit Manager, Alexander Bayne Centre, Psychiatric Services, Bendigo Health.

The CHAIR — I welcome from Bendigo Health: Daniel Eltringham, drug and alcohol care coordinator, emergency department; Carol Anne Lever, nurse unit manager, emergency department; Brian Jacobs, nurse manager, ECAT/triage/PARC, psychiatric services; and Wayne Daly, nurse unit manager at the Alexander Bayne Centre, which I assume is the psychiatric part of the hospital.

Mr DALY — Yes, the acute adult inpatient psychiatric unit.

The CHAIR — Welcome to this public hearing of the Law Reform, Drugs and Crime Prevention Committee. I will just read the conditions under which you are presenting to this hearing this morning, and then I will ask you to make a presentation to the committee. We request that you make a short presentation and then allow time for committee members to ask questions. All evidence taken at this hearing is protected by parliamentary privilege as provided by the Constitution Act 1975 and is further subject to the provisions of the Parliamentary Committees Act 2003, the Defamation Act 2005 and where applicable the provisions of reciprocal legislation in other Australian states and territories. However, it is important that you note that any comments you make outside the hearing, including effective repetition of what you have said in evidence, may not be afforded such privilege. Have you received and read the guide for witnesses presenting evidence to parliamentary committees?

Mr ELTRINGHAM — Yes.

The CHAIR — It is also important to note that any action which seeks to impede or hinder a witness or threaten a witness for the evidence they would give or have given may constitute and be punishable as contempt of Parliament. We are recording the evidence and will provide you with a proof version of the Hansard transcript at the earliest opportunity so that you can correct it as appropriate. As you have been informed, this is an inquiry into the supply and use of methamphetamines, particularly ice, in Victoria. Welcome to the public hearing. I invite Brian to start.

Mr JACOBS — Thank you very much for the opportunity. I will probably talk more from a mental health perspective, and the others in attendance will probably include some comments around ED and the impacts across the Bendigo Health organisation more generally.

From the mental health perspective the research has been done by Nicole Lee, an associate professor at Flinders University, and also the Turning Point Researcher Belinda Lloyd, flagging this pending sort of wave with regard to ice and its effect on people. We are starting to see that. Belinda was the Turning Point researcher looking at ambulance attendances involving methamphetamines. From an ECAT perspective for ED, looking at our ECAT contact book from September 2012, about 11.8 per cent of our ECAT presentations for that month had ice as an issue. For September 2013 that figure is up to 22.5 per cent. There could be some issues with that, because previously people were hooked in under the heading of 'polysubstance abuse' or 'substance abuse'. We are now focusing more on that, so it could have been an underreported figure. The other thing is that those figures do not catch direct admissions to the ABC — that is, the Alexander Bayne Centre, which is our acute psychiatric unit — because there will be people directly admitted to there who may have ice as a part of their presenting problem.

The other thing that perhaps I will mention with regard to ED is we have different databases capturing different bits of information. It is linked to reporting to government et cetera, but to get information we have to go to each one, which is very problematic because it is not integrated. There is a lot of work in drawing out which people may have ice as a part of their presentation.

Mr ELTRINGHAM — In regard to patients who do present to the emergency room, I will give a little bit of background. My position as a drug and alcohol care coordinator has been in place since July this year. The Department of Health has funded 21 different emergency departments across the state with some sort of drug and alcohol positions. They were discussed very briefly in the drug and alcohol reform document. It was literally just a sentence, so there has not been a lot of structure around the positions. Brian has already talked about the limitations of our systems to collect the data. As far as drug and alcohol data is concerned, we only introduced a

field in our triage intake for everyone who comes through ED in June this year to capture substance use data. There are a lot of limitations around how we capture the data. I do have some figures, but I am almost reluctant to report on them, because they are not robust figures.

Also, in regard to my particular position, with the people I see who present to ED we did not have any systems to capture those statistics. We are still working on developing those, so I have been using my own systems, and I have not specifically recorded the substances that people have been presenting with. My statistics have mostly been around the type of interventions we have provided. I can report on the figures we do have, if you like, but I will stress that they are very limited.

From the period 1 June through to around 20 October this year we have had a total of almost 19 000 people present to the emergency department — it was 18 891. Of those patients who presented to the emergency department, approximately 300 were identified at triage as having some sort of substance use issue. I do not have the data to back it up, but I would say that is definitely an underreporting. The sort of data that they capture at triage is quite limited, and they focus on the main presentation. For example, if you have a patient — and this is an example that I have seen — who presents with lesions and a contributing factor has been their methamphetamine use, depending on who works as the triage nurse, they may or may not record that ice is a factor. It depends on who is on triage, on the sorts of questions they ask and the sorts of responses that patients will provide to them.

Of those 300, we identified that 122 were female and 178 were male, so that is about 41 per cent female to 59 per cent male. I broke the figures down as much as I could into amphetamine type substances that were reported, and of those we had approximately 22 of the 300 where amphetamine type substances were identified as a substance that the person was using.

Mr SCHEFFER — How was it identified?

Mr ELTRINGHAM — Basically the field on the triage database asks the question around substance use, and the nurse who is working triage will note down the substance. It is a free text field, so what the person — —

Mr SCHEFFER — What they tell you?

Mr ELTRINGHAM — Yes. Since this position has been established we have been working on more robust ways to capture that data. We are also looking at introducing screening of patients when they come into the emergency department. We will have a number of points where we will try to capture that information, so we are working on the triage field being, 'Is this presentation directly related to substance use'. We are training our staff to ask that question. Once a person gets into ED we are looking at introducing screening. That will be a voluntary thing. Some patients may decline that, but we are going to ask questions around illicit substances and alcohol use. Some well recognised tools have been developed by organisations like the World Health Organisation that we will use to screen for that information.

That is around the sorts of presentations we are having, but there are a lot of limitations to that data. When I looked through the amphetamine type substance presentations that we did identify, there were a number of people I know who I have seen who are using amphetamine type substances who were not identified at triage, so there are a lot of limitations to those. Talk to me in about 18 months, and we will probably have much better data for you, but unfortunately they are the limitations of our system currently.

The CHAIR — Of the 300, what percentage would be alcohol? Have you got any data?

Mr ELTRINGHAM — I broke it down. I was looking mostly at amphetamine type substances, so 22 of those were out of the 300, which is about 7 per cent. About 7 of the 22 were identified as amphetamine type substances used with other drugs. Of the presentations where alcohol was identified — and that could be with or without the use of other substances — 185 of the 300 were alcohol, which is about 62 per cent of that group.

Mr SCHEFFER — When you talk about screening, do you mean blood testing?

Mr ELTRINGHAM — No.

Mr SCHEFFER — What does 'screening' mean?

Mr ELTRINGHAM — Asking questions.

Mr SCHEFFER — So it is all oral, on the basis of what the person tells you they have used?

Mr ELTRINGHAM — Yes.

Mr SCHEFFER — Is there an error potentially in that?

Mr ELTRINGHAM — It is a self report tool. They are validated tools that have been used for a number of years. Of the tools we are looking at using, there is one called AUDIT — the alcohol use disorders identification test — which is around alcohol use disorders. The other one is the DUDIT, which has been developed from the AUDIT, which is around drug use. It is a self report tool. We are looking at how we are going to introduce it. We have got to fit all the screening into a busy emergency department, so we are looking at ways of perhaps doing self screening, where patients will be given the tools to fill out themselves, and then they will be scored by the staff. The scoring allows you to identify low, moderate or high risk around the person's alcohol use or use of substances, and then we are going to have treatment pathways that will link to those.

As far as doing blood testing and that sort of stuff, if there is a need for that to occur, you would appreciate that there is a lot of cost involved in that sort of stuff. If there is a need for that to occur, it could occur. Sometimes it takes a long time for the results of tests to come back, and by the time you get the results back the patient has already left or moved on to other areas. We do things like breath testing and blood testing for alcohol, of course, but as far as other substances go, we are limited by how long it will take for those to come back from the lab.

Mr SCHEFFER — Okay.

Mr JACOBS — And you are right: the reliability of the informant will affect the accuracy of the data.

Mr SCHEFFER — You mentioned the World Health Organisation had a toolkit around that. Is that all premised on oral information?

Mr ELTRINGHAM — Yes. These tools are used by drug and alcohol services. I am not sure if you are aware that drug and alcohol services obviously are going through a lot of reform at the moment. Part of that reform was developing a new statewide tool. The DUDIT and the AUDIT, which are the tools that we are looking at using, are used in the new statewide tools. We are trying to be consistent with that as well.

Mr SCHEFFER — Okay. Thank you.

Mr JACOBS — The other thing I need to flag is that polysubstance abuse. As we have already mentioned, it is a bit of a catch all. So if a person comes in and they are under the influence of a drug or alcohol — they may have said they have smoked THC — they could be labelled poly substance abusers. To then work out whether they have used ice et cetera we have to either have them identified or find some other means of identifying it. It is a really challenging picture of trying to accurately find out what they are on because they use multiple drugs, including Endone et cetera.

Mr DALY — Again we have not been collecting a lot of stats so a lot of it is anecdotal, but from an inpatient psychiatric point of view we have noticed over the last couple of months that on any given day at least half of our patients — we have a 24 bed unit, so that would be 12 — would have some kind of substance abuse as an issue. One day last week I think we had 22 out of the 24. We have had days when up to 15 of them have been identified as being ice users as well. Certainly a lot of the ones who come through the ED get filtered through to the inpatient unit. We

take a lot of admissions that do not come through the ED, and a lot of those are via police and ambulance, so they have quite significant substance abuse issues as well.

The difficulty with mental health patients is that a lot of them take these substances because it helps to alleviate the symptoms. They may hear voices that are telling them to harm themselves, telling them to harm other people or telling them to kill other people. They may be derogatory voices. Quite often when they take these substances, whether it be alcohol, amphetamines or whatever, they help to alleviate the symptoms so they help them to get through. Then we have the people who come in with a drug induced psychosis. They may not have had any previous mental illness, but the effects of the substance abuse cause them to have some kind of psychotic or other mental health issue.

Mr ELTRINGHAM — Just from my perspective, when I assess people in the ED, and the majority of my assessments will be people who actually present to the ED within my working hours — I work Monday to Friday, 7 to 3.30 — we offer a follow up if people would like a telephone assessment and I have the ability to follow up people in the wards, the majority of people we are seeing are poly substance users. If they are using ice, they are often using other substances. They will either be other stimulant type substances when they cannot get access to the ice, or on most occasions they will be depressant type substances, which they are essentially using to overcome the effects of the ice.

As you would have heard from the many presentations on ice, it can affect things like sleep and it can affect things like mood. People can become highly agitated and people will actually self medicate that, usually with depressant substances like cannabis, alcohol, benzodiazepines or illegally obtained antipsychotic medication — Seroquel or quetiapine is a big one with people — and they will use those sorts of medications so that they can sleep, so that they can come down from the effects of the ice. It is very common.

Mr SCHEFFER — Do they work?

Mr ELTRINGHAM — Do they work for them?

Mr SCHEFFER — No. You said that what we have also been told is that there is not a substance analogous to methadone. There is not something like that.

Mr ELTRINGHAM — Essentially when a person comes to the ED they are acutely intoxicated with ice. The sorts of treatments that we would use would be sedative type medications, usually benzodiazepines, and sometimes the management model might also involve mechanically restraining people. Essentially the benzodiazepines are given to try to counteract the stimulating effects. Ice is a stimulant; it stimulates everything. A depressant type drug like a benzodiazepine will depress everything.

Mr SCHEFFER — That is why I am asking whether that works, because what we have been told previously is that nothing works and people are empty handed in terms of some remedy.

Mr ELTRINGHAM — Again, it depends on the individual, it depends on how much they have taken, but generally — —

Ms LEVER — We have probably only had a couple that it has not worked on. In the emergency department we are pretty good at settling people down. It depends on the person, but sometimes it is with mechanical restraints so we can get IV access to give them the medication. Then once that has kicked in we can remove the mechanical restraint, and that is when we can hopefully get them across to the inpatient unit. I would say, Wayne, that there have been a couple of people the chemicals have not worked on.

Mr DALY — Yes, and they can remain in that aggressive or disinhibited state for up to 24, 36 or 48 hours. Quite often it does not matter what type of medication you use to try to calm them down; it does not have any effect. We also have to physically restrain people. We use seclusion, which is under the Mental Health Act. So we have those measures available to us, which those in ED do not have.

Mr ELTRINGHAM — You are really talking about the medical management of people, and things like antipsychotics and benzodiazepines are used. We do not like to overuse them obviously, because they can themselves have negative effects. But that is our only line of treatment apart from using seclusion or mechanical restraint to manage some of these people — and these are people who are acutely intoxicated, presenting with high levels of risk to themselves and others.

Ms LEVER — These are also people for whom we cannot assume that it is only the illicit drug that is causing their presentation. From our point of view in emergency we need to make sure that they have nothing organic going on, so nothing medical like a tumour or something that is causing them to act out like this. We cannot just assume that it is only the ice, so until we clear them medically that is where they stay in our environment. Once we rule out any other issues, that is how we go.

The CHAIR — Have you seen an increase in the non traditional type user presenting at the ED? I guess we are trying to get an understanding of whether there has been an increase in those who traditionally have not used drugs but are now using ice because of its purity and its immediate — —

Ms LEVER — I would say there has been no difference, because at the presentation last night it was said that they are from all walks of life. It is no more or less any type of person I guess. That is from what I have observed.

The CHAIR — The difference I am trying to understand, though, is whether ice is being used now by non traditional drug users rather than those who have been using a variety of drugs for a variety of reasons over a long period of time.

Mr DALY — I suppose one issue with that is that in the past a lot of what we see as the non traditional drug users we do not know about. People will drink at home, they will drink when they are out socially or they will use marijuana. They are drugs that people can use for years and years and not come to our attention — to the attention of health services or drug and alcohol services. The difference is that with things like ice and that, it causes extremes of behaviour and, as I said, they become very disinhibited, therefore the police become involved or family and friends become concerned. If you are smoking marijuana, for example, you might fall asleep, and the same with alcohol and things like that. Whereas with these, it tends to cause behaviours that bring them to the attention of others, whether that be self harm or harms to others and those sorts of issues.

Mr SCHEFFER — My question relates to the Chair's question. A few times you have said in different ways in your presentation and you hear it said more widely that ice causes aggression and violence and psychotic type behaviours. Of course there is another proposition that ice is associated with those, and one of the factors in the association is the poly drug use and the mix or the circumstances of their detainment or the event that occurred that brought them into the emergency ward. There are a lot of factors that can produce aggression, but that is a different proposition to saying it is caused by the methamphetamine. Can you talk about that, about what we know scientifically about that causal connection?

Ms LEVER — I think it is that noradrenaline response. It is that response coming from the receptors that really hypes you up and makes you a bit agitated and so on: this is how I present and I am like this. It depends on who they are like this in front of, because if it is an experienced drug and alcohol worker or someone in the emergency department or a mental health worker, you know that you do not necessarily have that fear or agitation, or you might be able to talk that person around. But if it is somebody on the street who notices something like that with a member of the public, they are likely to call the police and say, 'This person is acting aggressively' or, 'I'm frightened'. The police will come and, depending on what the police response is, that behaviour may escalate or they may be able to settle down that behaviour. I think what you are asking is: does ice cause the aggression? I think ice causes the behaviour that can sometimes be interpreted as aggression and then that can escalate, depending on the response that that person gets.

Sometimes police will bring someone into the emergency department. Depending on who is on, we will actually take a hands off approach and that might settle that person. Sometimes that does not work; sometimes they are in such a heightened state that nothing else but actually knocking them out with chemical restraint will do. Does that make sense?

Mr SCHEFFER — That is very clear.

Mr DALY — The other thing, too, is that certainly in mental health it is very rare to see someone who has taken just ice and nothing else. It is almost always associated with alcohol, marijuana or other types of drugs. It is very rare if you have someone in that they have taken just ice only.

Mr ELTRINGHAM — Ice is certainly a contributing factor, though. It is the sort of hard to narrow it down to one particular thing. If you have an everyday person and you deprive them of sleep for 72 hours, people will start to develop psychotic type symptoms there. With ice, as we heard in the presentation last night and you hear from ice users themselves, people can go without sleep for seven days and sometimes up to almost a couple of weeks. A lot of changes happen in their brain when that occurs — psychotic type symptoms develop, that sort of stuff.

The other issue that you do have with ice and something that I have seen a lot in my position is people who are experiencing suicidal and self harm thoughts and their mood is just so low. The way that the ice affects the different chemicals like dopamine and that sort of stuff, they cannot feel pleasure in anything and they feel just completely worthless. With a lot of the people we are seeing, at one end you have a lot of agitation and aggression and that sort of stuff and at the other you are seeing a lot of people who have really depressed moods and self harm type behaviours. There is a mixture of those who will come through to you.

Mr DALY — I think the other thing, too, is that sometimes there is a bit of hysteria around ice use. We might get someone in who is quite destructive and that and immediately people start saying, 'Oh, they've taken ice. It's the ice that's doing this'. When you look into it further, once they have settled down, it may not be the ice; it may be their mental illness. I think there is sometimes a certain amount of hysteria, that when somebody comes in who is aggressive, it must be ice. I think you need to take that into account as well, that just because someone says they have been taking ice or it is ice, we cannot actually prove that that is what it is. Sometimes I think it becomes trendy for people to say, 'Yes, I've had ice; that's why I am like I am' sort of thing.

Mr SCHEFFER — That relates back to the reliability of the — —

Mr DALY — Yes, and you need to take all those things into account as well.

Mr JACOBS — In terms of the diagnostic groups that come into the ABC, they can include drug induced psychotic presentations, they can include people with personality type disorders with associated drug use or they could include people who have other psychiatric conditions where they have had access to the drug. People with schizophrenia, as Wayne pointed out before, could be using the drug to help manage some of the symptoms of their illness.

The other thing I probably need to point out is that every day I check to try to get a sense of who is in the ward with ice as an issue. Today we had eight, and of those people who are in currently, a number have accommodation as an issue, so they are very hard to place back in the community and manage in the community because they do not have that as an option.

Another thing that is an issue for us is that recently we have attracted some pretty negative press about people going over our courtyard fence. The majority of those people who are going over the courtyard fence have drug linked behaviours that have caused them to get in there. I have sat on the ward and seen people going around checking with a couple to make up the shopping list. So they try to get over the fence to go and get drugs and bring them back. It is a real issue for us. We do searches and other things to try to manage it, but with these people the habit does not stop at the door, so to speak. So that becomes an issue.

You also observe some predatory behaviours, for want of a better term, with some of them, in that they try to hook onto others to get money, share the cost — 'I'll go and get it for you but we'll share it' sort of stuff.

Mr ELTRINGHAM — Really there are limitations in the emergency department in the hospital, the health care setting in general, to actually manage these sorts of patients. That is often why they will end up in somewhere like the Alexander Bayne Centre, because of the behaviours, the psychotic sort of features or the depressive features. Sometimes those things will resolve quite quickly but it is very difficult to manage those sorts of people when they are in that very excited, agitated sort of state or when they are very depressed and have suicidal type behaviours.

Mr DALY — Yes, and we are finding that 24 to 36 hours later they are discharged, once the effects have worn off and they do not actually have a pre existing psychiatric illness; it is just the effects of the ice. In effect, they are taking up valuable beds that could be better used in treating people with a mental illness sort of thing.

The other big issue, too, that we have not touched on is the safety aspect of it — Brian sort of touched on it briefly — for the other patients in our unit, for example, but in particular for the staff. We have seen the staff assaults increase quite dramatically. I am sure that has been in ED as well as in patient psych services. That is another issue that we have to manage.

Mr McCURDY — Is that greater than with alcohol, in terms of safety in the workplace?

Mr DALY — Yes.

Mr McCURDY — Do you think that ice users are a greater risk in the ED?

Mr DALY — Drug users in general.

Mr McCURDY — Drug users in general, but not necessarily ice users?

Mr DALY — Yes, they present a greater risk. Usually with people who are affected by alcohol there is some degree of restraint. I am not sure why, but just from the point of view of managing a person, it is easier to manage someone who is drunk or affected by alcohol only. They still retain some sense of their personality. At times they still know what is right and wrong. They know it is wrong to hit a staff member; they know it is wrong to hit someone else. With amphetamines, a lot of those drug users do not have that control.

Mr ELTRINGHAM — I think you need to look at the type of drug that alcohol is. It is a depressant drug, whereas ice excites everything. It actually depresses; their coordination goes out, so in some ways they are actually easier to manage because they do not have those sorts of presentation that ice users do.

Mr CARROLL — I am interested to know when people present to the emergency department. Is it when the drug is in the stages of wearing off? From what I can tell, there are different stages. From evidence presented last night, I understand that when you take the drug, you feel fantastic. You are basically limitless, you are 6 feet 10 and the world is perfect. Then, perhaps when the drug starts to wear off, that is when you can get agitated. It is a big high and then a big come down and you can get that sort of erratic behaviour. Are they coming to you when the drug is starting to wear off?

Mr ELTRINGHAM — It is the whole spectrum.

Ms LEVER — All stages.

Mr ELTRINGHAM — You will get people who will go a little bit too far, that flight or fight response. They become extremely agitated, there are strange behaviours and they will be picked up by police. They will be roaming the neighbourhood, yelling at people. Last night you heard about someone who had an ice user on their roof. They can be picked up in that acute intoxication stage, they can also be picked up a few days later because they have started to develop

psychotic type symptoms and they are attracting attention that way, or you can see the other side of it where essentially what they have done is burnt out everything in their brain and they are so depressed they will come in with overdoses, self harm attempts and that sort of stuff. There is a whole spectrum.

Mr CARROLL — Are you seeing people present differently they have inhaled the drug versus those who have injected it?

Ms LEVER — No.

Mr DALY — No, and usually it is hard to get that information out of them, anyhow. They do not afford that.

Mr ELTRINGHAM — I suppose the common way to take it is smoking and injecting. People do sometimes start with swallowing, but essentially what happens is that you lose a lot of the drug in your gut. Smoking or injecting gets it straight into your bloodstream and you get the biggest high from it. You would have heard in presentations that often people will start maybe swallowing, something like that. They will then often graduate to smoking and then to injecting because that tolerance to ice builds so quickly that they have to find ways to get the most bang for their buck, sort of.

Mr DALY — One of the other issues which is perhaps something that could be done about this issue is the legal products you buy. They sell us incense and things like Chronic. I know that a lot of our inpatients come back and have been down to the shop in Bendigo and bought things like Chronic. I am not sure what the other names are. You can buy them over the counter; they are legal. They are not sold as drugs; they are sold as, as I said, incense or a different range of things. They are really quite destructive as well.

Ms LEVER — And talking about a community response, at the forum last night it was really interesting because I have a son in year 8 who told me that he is doing a project on drugs at school. He knew two shops in Bendigo where he could purchase synthetic cannabis — 'Is that true, Mum?'. This is a 13 year old boy who already knows that.

Mr SCHEFFER — Where did your son hear this?

Ms LEVER — At school.

Mr SCHEFFER — I do not want to ask a leading question, but one of the things we are interested in is what strategies could be employed. Your son hears this at school; is that because it is in the media? How does he pick that up?

Ms LEVER — I think it is a bit of that, and maybe because kids at school are talking about it. He has been given an assignment to look at drugs in society, so he gets on Google, he does this sort of thing and he talks to kids at school. They get information given to them at school. He asked me, 'Is it true, Mum? If I wanted to, could I buy this particular type of drug at this particular shop in Bendigo?', because that is what he had heard at school, which is really disturbing.

Mr DALY — Especially seeing as it is true, I think.

Ms LEVER — I was really glad he asked me, but to me, that has to be part of the community response, doesn't it? It has to have that. I am happy that he is doing that stuff in school — very happy that he is looking at that thing and asking me questions.

Mr SCHEFFER — We have heard evidence from some who think that broadcasting information and warnings and all that to the general public is not as useful as targeting messages to cohorts that are likely to use it — more under the radar in a way that we became very familiar with the AIDS issues in the 1980s, where the Grim Reaper strategy was not seen as being nearly as effective as targeted information. How would you respond to that?

Ms LEVER — As a parent and as a health worker, I am really happy that kids have information because, one, it makes them safe, and two, they have to make choices, and at that vulnerable age of 13 you are coming in to 14 and 15, where he is going to be less supervised. He is going to be out doing things where I am not there, and you want them to be able to make safe choices. You want the harm to be minimised that they can do to themselves. He has the information. He knows what the stuff does. He has to make a choice at some point, and you just hope he makes the right one. To me, give them information, because if all he is hearing is 'It's fun' from somebody — —

Mr DALY — I have four daughters, three of whom are at primary school and one at secondary school. They come home, and it is not necessarily what they see on television or read, it is what they hear from other kids. I think as a parent you have to be open and prepared to talk to them about it because if you try to hide it, it then becomes something sort of sinister. Kids talk about it at school irrespective of what parents do at home. It is the same with sex and lots of other things. They talk about drugs at school. My daughter is first year at secondary, and there is talk that one or two kids might be doing this, so it is out in the open anyhow.

Mr ELTRINGHAM — I think synthetics is a whole different ball game.

Mr DALY — Yes.

Mr ELTRINGHAM — I know there is a current ban in place around the sale of synthetics. One of the issues with that is that they are not sold as drugs; they are sold as incense, they are sold as herbal treatments or all that sort of stuff. I think one of the big problems with the law is that you can outlaw particular substances or particular chemical structures, but they just change the chemical and put a slightly different chemical in there to get around the law.

Mr DALY — And the other thing with that is that they are easily accessible. It is right that you can go into certain shops and buy it over the counter.

Mr ELTRINGHAM — They are sold as 'legal highs'.

Mr JACOBS — I think the issue we have is that this is a multiheaded problem and you will need a number of different strategies to try to address it. One of the ones I have been online and checked out is the Oklahoma Prevention of Methamphetamine Abuse Project. They have actually come at it from a number of different directions, more of an umbrella approach on some occasions but then at targeted groups on another. I actually have a summary of the stuff here I can hand up, if you like.

The other one was the Too Good for Drugs schools project, where they were trying to look at the resilience of kids and look at what their expectations were and all that and trying to give them strategies to say no — that type of stuff. My son goes out to the discos and that sort of thing, and he is offered it every week; he can say no, but there are others who do not. Some of these are predatory people; they will hook them in with, 'I'll give you something for free', and then before long they have the hooks into you. Next minute you have tens of thousands of dollars worth of debt, you have lost your partner and you have lost access to your kid, and that is just over a couple of years. It is a very dangerous thing, this.

Mr McCURDY — Just some clarification. Is the use of alcohol and cannabis on top of ice a deliberate attempt at a comedown, or is it just a natural progression in the state of mind once you have been on ice for a day or two days, and you just start using alcohol? Is that when the problem kicks in and you get presentations to you?

Mr ELTRINGHAM — I think it really depends on the user and their experience. If you have someone who is trying to hold down a job and that sort of stuff, they will often use depressant type substances so they can get to sleep. Whether that is cannabis or alcohol or whether it is something like a benzodiazepine they picked up — it could be prescribed by a doctor for another reason — drug users get to know these sorts of things. Other times people will actually continue to take ice to maintain that high sort of feeling and to get them through life. It really depends on the user, I suppose. People get to know things. We all have had drinks before. It helps you sort of

relax. It helps you sort of chill out. People get to know that, and if they are thinking, 'I'm feeling highly agitated and I can't sleep', naturally they are sort of drawn to those depressant type drugs.

Mr DALY — You know yourself that if you have a beer, that might be better for you; if you have a wine or a scotch or something like that, that affects you in different ways. It is the same with alcohol and drugs.

Mr McCURDY — And that is when you see the presentations to you — after that?

Mr ELTRINGHAM — Sometimes, yes; not always. Again, it can be the whole spectrum.

The CHAIR — Thank you. We might have to leave it there, given that we have another witness waiting. I thank you all very much for presenting to the inquiry this morning. Thank you.

Mr DALY — No worries. Thank you.

Witnesses withdrew.