LAW REFORM, DRUGS AND CRIME PREVENTION COMMITTEE

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

Bendigo — 25 October 2013

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Mr K. Strachan, Group Manager, Ambulance Victoria.

Mr R. Marchingo, Ambulance Paramedic, Ambulance Victoria.

The CHAIR — Welcome, both of you, to the joint parliamentary Law Reform, Drugs and Crime Prevention Committee and its public hearing in Bendigo this afternoon. This is an inquiry into the supply and use of methamphetamines, particularly ice, in Victoria. Richard, I understand you are the lead speaker.

Mr MARCHINGO — I think Kerry is going to lead.

The CHAIR — Just before you do, I will read the conditions under which you are providing evidence to this committee this afternoon. 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. 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 MARCHINGO — Yes.

Mr STRACHAN — Yes.

The CHAIR — It is also important to note that any action that seeks to impede, hinder 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 we will provide a proof version of the Hansard transcript at the earliest opportunity so you can correct it as appropriate. Welcome again. As I have said to other witnesses presenting at this committee, we do like to ask questions, so it will not be 45 minutes of presentation but a short presentation, and then I will invite the committee to ask questions of you. Thank you for attending this afternoon.

Overheads shown.

Mr STRACHAN — Thank you. We have prepared a presentation, which you may have seen before. I will try to precis it down a little bit to keep the time going, so we can have more time for questions. Initially, AV commenced in collaboration with Turning Point in 1997 looking at non fatal heroin overdoses, and that was funded by DH. We started collecting data on crystal meth in 2002, when we started keeping data on it with our electronic patient care record equipment, so we can actually trace the amount of cases where we actually did — —

The CHAIR — Kerry, can I just ask you to move your microphone closer? I am having a bit of trouble hearing you. While we have stopped there, Kerry, I should have said that you are a group manager at Ambulance Victoria.

Mr STRACHAN — Group manager, Campaspe, yes.

The CHAIR — And, Richard, you are an ambulance paramedic.

Mr MARCHINGO — I am a paramedic, yes.

The CHAIR — Thanks, Richard, and thanks, Kerry.

Mr STRACHAN — We have started to expand data collection to include mental health issues. With the use of crystal meth in Victoria, we have experienced an increasing number of calls regarding ice. We deal with approximately 650 to 700 cases per year for ice and approximately 11 000 cases for alcohol per year. The total number of cases when compared to alcohol and prescription opioids is actually at a lower rate at this stage. Just remember that this data is only up to 2012. We do not have 2012–13 data at this stage, so this is data we have only captured at that stage.

We have had an increase of 27 per cent for alcohol cases we attend; that was 11 458 cases. All amphetamines are up 49 per cent, which is 1048 cases. With ice we have had an increase of 109 per cent, with the 671 cases we attended. For other inhalants there has been a 27 per cent increase,

and there has been a 25 per cent increase for cocaine. For other heroin users there has been a 0.4 per cent increase, and for GHB there has been 2.3 per cent increase.

Mr SCHEFFER — Can I just ask, what do you mean by 'other heroin'?

Mr STRACHAN — Derivatives of heroin.

Mr SCHEFFER — So where does heroin fit into that chart?

Mr STRACHAN — It would probably come under 'other heroin' as well. On our records there is just the one word. It does not have other types of heroin, so it all comes under the one heading.

Mr SCHEFFER — Thank you.

Mr STRACHAN — In the local government areas — and I will just talk about it as we go, because most of the other areas will speak for themselves — we have seven cases we know of. Richard might talk about that a little bit later for us, about the actual cases. We know there are other cases that might include ice or result from ice. It is very hard to nail it down to that particular case. Our electronic system does not nail it down to that particular drug at this stage.

Just on the age and gender, we have had a number of attendances. There are 671, as I mentioned before. I will just cruise down to this. The mean ages that we have targeted are between 25 and 27. Of those, 46 per cent are males, and of patients found in public spaces there were around 18 cases. With police attendance, there were 5 cases. There were 65 cases that were transported to hospital and 35 cases with alcohol involvement that we know of. I have just included in the presentation the name of the group that we are involved with, Turning Point. It has a website as well, which has a full complement of all this data that our group has provided here. I will hand over to Richard now.

Mr MARCHINGO — I do not have a formal presentation. I will just give you a bit of background about myself. I was raised in Bendigo and educated in Bendigo. I have spent 27 years on the road as a paramedic, doing two nights a week and two days a week, working six weekends out of eight. I have a pretty good rough idea of what is happening around town. I have put together a little bit of information from speaking to my other colleagues at the branch, and that is around 20 people.

Obviously there have always been drugs and alcohol in Bendigo. I have been here for 27 years. It is difficult to assess how dramatic it has got of late, but it has increased in the last couple of years, there is no doubt about that. I surveyed the staff. All the staff have concerns about the increase of drugs in the area. There is no doubt about that. With ice we are experiencing probably around two cases a week where we are not sure what type of drug they are on. We presume it is ice when we are getting the types of aggressive, agitated, irrational behaviour in patients. Feel free to pull me up at any stage.

Why we get concerned about this is we are getting patients spitting at us, punching, pummelling and threatening, and it is becoming more common. Over the years the heroin type addict patients were more sedate, but the ice patients are just difficult for us to deal with. They present as homicidal, suicidal — those types of symptoms. It varies. As the ambos on the road we have put them into two basic categories. Initially the one that is on ice is the aggressive, agitated, irrational patient that is difficult to deal with. The second one is the one who has been on ice and has symptoms of things like elevated temperature, diarrhoea, tachycardia, crawling skin, depression and all those sorts of things. We have categorised them into those two sorts of areas.

The other concern we have now is that we do not get police backup. We respond. If we feel like we are in danger or threatened once we are at the scene, then we call for backup. A lot of staff are concerned about that.

Mr CARROLL — Is that a policy change that you do not get police backup?

Mr MARCHINGO — That is a policy change, yes; it has been recent. Kerry?

Mr STRACHAN — Yes, there has been a directive from Victoria Police that they will only come when there is a known activity. If we have an address of interest that we have to go to they may not come to that straightaway. We have to physically see that there is an activity or be involved in it, and then they will come, because obviously they are resource hungry with all their staffing as well.

Mr MARCHINGO — Probably my next point is that when you get dispatched you are told that the patient is aggressive but not violent. That is the type of case we are sent on.

There is pressure with these jobs, there is no doubt about that. There are long delays at scene. With regard to case management, where someone is irrational you have to get them to the point where you get services around, whether it is us, police or psych services. It definitely takes time, so it drags out our work time. I have been back from annual leave for the last eight weeks, but I have three or four examples that I can outline here quickly — you know, like a family on it. The first example is that of a tradesman. It is 6 in the morning and he has not been sleeping for the last three nights. On Sunday morning he has got up to go to work and just realised he could not function. A second is a 19 year old male who says he is not on any medication, there is nothing wrong with him, he has abdo pain and diarrhoea, but he has taken ice. Another one in the area who presented totally irrational behaviour and aggression was running along the street. Police turned up; he ended up on the roof, ripping off tiles, pitching tiles at us.

It is probably more interesting to note that these people have a background of being stable people in the community; they have been working and they have been functioning people who have families. That is probably more surprising of late. We had five young blokes the other week where one of them had taken meth and had a respiratory arrest just as we got there, but the other four were just agitated and pushing us and grabbing us and all that type of stuff. We transported him, but then suddenly the other four realised that they had taken the same drug and the symptoms had not yet kicked in, so in the end we had another one or two ambulances out there to transport them. They are difficult jobs. It is difficult to focus on the job when you have aggressive people pushing you and you are under the pump.

Another case occurred at a new subdivision in Bendigo the other week. We turned up and the boss said, 'What's wrong with these two blokes?'. There was no doubt they had been on the meth over the weekend. These are the common sorts of cases we are getting. They are not people that you necessarily think are drug addicts or low lifes of the community. We are seeing more of the middle class types of people.

We do not get surprised any more at the workload. Kerry's statistics are accurate. At casualty the security people I see have at least two definite ice cases a week. We spoke about it during the day with Kerry. There is a lot more around it. People that have symptoms of ice use, as in the diarrhoea, vomiting and the like, are not logged down as ice cases, but we are actually doing ice related cases; they are not direct. So the workload is probably a lot higher for us in that area. That is about all I have to say.

The CHAIR — All right. Thank you. We have some questions. Can you just tell me what makes a sane person want to inject or smoke a substance that is made up of bleach, brake fluid, battery acid and other substances, as a quick fix for alertness or pleasantness? Do people fully understand what is actually in the drug they are injecting into themselves or smoking?

Mr STRACHAN — No.

Mr MARCHINGO — I think you have to realise that ice initially is a good drug, there is no doubt about that. You only have to look at the side effects of it: there is raised alertness, it gives you good euphoria, it is good for weight control, you are up and about. That is what people initially use ice for, or any type of drug. It is the consequences of the regular use and the side effects that kick in that take control of their life. People want to perform. We have seen it lately with football clubs. I am tied up in sporting clubs myself, and you see people there on Ventolin pumps before the start of the race, and if you ask them why they are on it, you learn they are not asthmatics but they are trying to dilate their lungs and they think they can get the equivalent of an extra lung out

of it and get the extra percentage over their competitors. I think initially that is where drugs start: people looking for the edge.

The CHAIR — But do people fully understand what they are made of? If they knew they were injecting or smoking brake fluid or a bleach or a detergent — —

Mr STRACHAN — I do not think they do.

Mr MARCHINGO — You have to understand, though, it is about how it is sold, and whether it is pure ice, as in the pseudoephedrine, or it is cut down in exactly the way you say, with Drano, battery acid, talcum powder and all these substances.

Mr STRACHAN — I think it is the word 'ice'. They say, 'I'm going to buy some ice', but they do not know what substance is in it. Of course people sell it to anybody because they will make money, and people buy it because of peer pressure and all the other stuff that goes with it. They think 'I'm going to spot some ice', but they have no idea of the ingredients and the circumstances of what happens after you take it. It is like any drug: that is what they do.

Mr SCHEFFER — Mr Marchingo, I want to come back to some of the comments you made. You spoke about the generally increasing incidence of violence in relation to the work that ambulance officers do. By way of background, this committee did a whole inquiry on violence in emergency departments of hospitals, so we are across the issues that you are talking about generally.

You describe the kind of behaviour of people who you indicate were on ice as 'punching, pummelling, threatening, agitated and aggressive'. From that do I infer that you are saying that ice actually causes these behaviours or are they contextual and associated with polydrug use of which ice is a component but cannot actually be identified? That is a particular concern for me. We did something completely fair. When we spoke to Bendigo health earlier today I put the same question to them, and to paraphrase their answer it was that you could not say that ice directly caused it but that ice often is associated contextually with the way an agitated person is being handled and how they were being dealt with that could cause them to behave in a violent way ultimately. I am just asking you to reflect on whether you are saying to us that ice causes that behaviour or you are saying it is associated with it because of the context.

Mr MARCHINGO — It would vary from case to case. In one of the cases I just mentioned that person was only held in Bendigo ED for 8 hours overnight and he was aggressive towards us — punching, pinching, pushing, targeting; the whole lot — but the next morning I was back on day shift and he was there. He came up and apologised and shook my hand. He was regretful at what had happened.

Mr SCHEFFER — But that does not enable you to say that ice caused it. Another expression you used was 'no doubt they'd been on meth'. When you say something like that, 'no doubt they'd been on meth', do you know that or do you infer it from their behaviour? How do you know these things?

Mr MARCHINGO — From gathering their history. Quite often there are family or friends there and you are told that they have been using meth or another type of drug.

Mr SCHEFFER — And that it causes the violent, aggressive, pummelling, threatening behaviour?

Mr MARCHINGO — We assume it does.

Mr SCHEFFER — Okay. Thank you.

Mr STRACHAN — It is hard to tell which drug is causing the problem.

Mr MARCHINGO — We have patients for only a short period of time. Obviously they call 000 and an ambulance arrives. In Bendigo you are probably going to have the patient for a

maximum of 20 minutes, so in that period of time we have to package the patient up, vital signs, assessment, gather a history and transport them to ED.

Mr SCHEFFER — Absolutely, and I have nothing but the utmost respect for the work you do. I am not in any way calling that into question. It is part of my job to ask you about how conclusions are drawn.

Mr MARCHINGO — Quite often down the line the accuracy of our history might not be substantiated, but it is difficult to package these people up.

Mr SCHEFFER — Of course it is.

Mr McCURDY — Is it more difficult than with alcohol affected patients? When you look at the numbers, are the percentages higher for alcohol or is the number of people that you assess are on ice and who are aggressive greater? As we know, the numbers for alcohol are much higher than for everything else.

Mr MARCHINGO — There is no doubt that there are a lot more alcohol cases, but as far as aggression is concerned, probably not. It is probably pretty similar.

Mr STRACHAN — You can actually handle an aggressive drunk a lot easier than you can handle an aggressive ice patient, because you can deflect all that sort of stuff. They are a bit slower. Ice patients actually terrorise you. We have had one staff member off work because of being attacked. It does impact on our service and our staff and their wellbeing, and there are a whole lot of other ramifications not only for the actual user but from telling their family and the domino effect it has on everybody else. It is a whole of community type problem that we have.

Mr MARCHINGO — The other problem we find too is that people have a lot of knowledge about the drug. There is no doubt you can google it and find information on how to cook ice and the whole lot — signs and symptoms, reactions. It is interesting.

Mr CARROLL — This committee is looking at best practice strategies to deal with methamphetamine use. The question I have is: what could be done to assist paramedics when they are dealing with methamphetamine affected patients?

Mr STRACHAN — We have a better understanding of the whole thing with ice, and because within the ambulance service it is so widespread we need to get out to all the small rural and remote areas where staff are a bit more isolated and have not been exposed to that sort of thing. We have a lot of involvement now with hospitals and psych services and all that sort of stuff, and Richard has been involved in a few forums now about that sort of stuff. So we have a bigger understanding statewide really.

Mr MARCHINGO — I think it is similar to the road toll. The road toll in the 70s was up around 1000, and the only reason that has been reduced has been through education and more scrutiny of it.

Mr CARROLL — Do you get training to deal with patients who just generally are aggressive? You do?

Mr STRACHAN — Yes. We have regular training on combative or aggressive type patients. If someone is really aggressive, it takes a fair bit of work to get organised.

The CHAIR — Can I just take you back to the stats you gave us? Ambulance Victoria in Melbourne gave us very similar stats the other day at a hearing we held in Melbourne. In Greater Bendigo you have seven as the number of ice attendances back in the 2011–12 report. Can you just give us a figure now? You may well have said it, and if so, I am sorry, I must have missed it. I am trying to work out what the exponential increase in attendances for ice related cases is with seven in 2011–12.

Mr STRACHAN — That is probably my fault, the reason being in Kerry's fleet there is a VACIS machine. Do you know what a VACIS machine is? It is the data we put into the system. When you are called to a patient, you treat the signs and symptoms of that patient. They might be on ice but they are coming off it and they have abdo pain or are in an altered consciousness state. It is a drop down box system, so I drop my information into those categories from which the data is dragged off. In my history taking I write up evidence of the case, and I would mention ice or methamphetamines, but that is probably a poor reflection of the difference between what I am seeing in case workload to what is probably showing up on the data.

The CHAIR — The police, from memory, gave us a different picture of the responses to ice related cases that they attend, which was significantly more than the data is suggesting here. Have you got a figure for what the most recent data is in relation to ice related attendances?

Mr MARCHINGO — I do not know the exact numbers, but it is going to be a lot. As I said, I have spoken to security at the Bendigo Hospital. They are seeing two direct cases a week, and there have been three or four cases there in the last eight weeks that I have been involved in. Again, they are ice related cases that are not affected at the time because of the drug. They are affected with the signs and symptoms of diarrhoea and abdo pain, so it is an indirect workload.

Mr STRACHAN — I think the other thing you will find with these statistics is that in a lot of the cases we are called to the police actually attend, and they may present to the hospital without even coming through us. They will go to an incident down the street and just take them off to hospital and deal with it, because they are violent, and we actually do not get involved. They will have a different number of people that they pick up from us, so that will skew the figures.

Mr MARCHINGO — Also if you are dispatched on to a job and police attend, I will use the drop down information on the VACIS to put in that I was cancelled on arrival, so I do not put all the details in that it was a methamphetamine case.

The CHAIR — All right. Do you have any parting words you would like to leave with us?

Mr STRACHAN — I hope this has a really good outcome for everybody, because at the end of the day — I am a parent; I have kids — we are all going to suffer financially or emotionally or whatever. If we can get a good outcome from all your hearings, we will greatly appreciate it.

The CHAIR — Thank you both very much.

Mr MARCHINGO — Thank you.

Witnesses withdrew.