LAW REFORM, DRUGS AND CRIME PREVENTION COMMITTEE

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

Geelong — 28 October 2013

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Dr C. Peake, Clinical Coordinator, Drugs and Alcohol Services, Barwon Health.

Mr SCHEFFER — David Eddey, Nic Reid and Cath Peake from Barwon Health, thank you very much for coming to present to the committee's inquiry into the supply and use of methamphetamines in Victoria today. We have around 45 minutes. I am the deputy chair. Our chair, Simon Ramsay, is unable to be here for this hearing at the moment. One formality I need to go through before we can get started and that is to read the following to you. All evidence taken at this hearing is protected by parliamentary privilege as provided by the Constitution Act 1975 and further subject to the provisions of the Parliamentary Committees Act 2003, the Defamation Act 2005 and, where applicable, the provisions of the reciprocal legislation in other Australian states and territories. However, it is important that you note that any comments that you make outside of the hearing, including effective repetition of what you have said in evidence, may not be afforded such a privilege. You have received a copy of the guide for witnesses presenting evidence to parliamentary committees, I understand? Yes, okay. The last part of it is that it is also important that you note that any action which seeks to impede or hinder a witness or threaten a witness for evidence that they would give or have given may constitute and be punishable as a contempt of parliament. We are recording the evidence and we will provide you with a proof version of the Hansard transcript at the earliest opportunity so that you can make any appropriate changes to it. The way we will run this, as I said before, we will hand it over to you to give an oral presentation for however long you wish really, but we would like some time to ask you some follow up questions if that is possible.

Dr EDDY — I might start. We have generally responded to the list of questions that we were provided with and that is probably a good place to start.

Mr SCHEFFER — Yes.

Dr EDDY — Nicole and I are emergency room doctors. Cath is a drug and alcohol specialist. We can talk to the effects that we see on a reasonably frequent basis in the emergency department. The first question was in relation to emergency room attendances, 'Has the number of patients attending with methamphetamine related issues been increasing in recent years, and how does this compare to attendances resulting from the use of other drugs, including alcohol?' In short the answer is yes. The chronic background of patients attending the ED specifically with medical or mental health issues relating to amphetamine use is generally low in numbers. But the past two years have seen a notable rise in attendances due to acute behavioural issues or their consequences related to ice use. A number of individuals increase these numbers due to multiple presentations within short periods of time. The experience of Geelong is relatively modest compared with anecdotal reports of colleagues working in some emergency departments in metropolitan Melbourne.

Despite this, attendances are far outnumbered by attendances resulting directly as a consequence of acute alcohol use as opposed to long-term effects of medical effects of alcohol use. It is difficult to give exact numbers of each group but the feeling of ED would be that alcohol related problems would outnumber methamphetamine related problems by a factor of 4 or more. Other drugs, particularly heroin, are least prevalent in ED attendances than in past years. Emergency attendances due to heroin use are usually due to the effects of acute overdose, and in the past 10 to 20 years the ability of ambulance paramedics to treat these events in the community, combined with reduced supply or user preference has led to a decrease in these attendances to ED.

There remains a small number of patients presenting with medical issues relating to other opiate use, particularly the injection of oral opiate preparations. Other users present drug seeking for a variety of prescription medication, including opiates and benzodiazepines. That was our response to the first question.

Mr SCHEFFER — Yes.

Dr EDDY — I will continue. The second question was, 'How serious is the issue of crystal methamphetamine, ice use to this patient attending the emergency department? How does this compare to the prevalence of harm caused by other drugs, including alcohol, that bring patients to the hospital? Is the harm caused by methamphetamine, as has been stated in some sections of the media, at a crisis point or is this an exaggeration?' I might get Nic to talk to that. Nic has a

particular experience also in a custodial setting as well where some of these patients either end up or originate from—

Dr REID — As David has said, the numbers are not high but the impact on the emergency department is quite significant. As we have outlined, these patients can take up a large amount of resources in emergency. They can present for a number of reasons. They can present with physical complaints or psychological complaints or a combination of the two, but the chaos that often comes with ice, or either intoxication withdrawal in the emergency setting is quite high. They often require staff from a number of areas in the emergency department. It will often involve staff members from the mental health team, as well as security staff, and often require large numbers of staff and often for protracted periods of time. We have certainly seen a significant increase in ice use within the custodial (indistinct) as well. The very full Geelong cells, at the moment most of the people there have some history of ice use, and a lot of the time alleged crimes have been committed in a setting of ice intoxication.

Mr SCHEFFER — When you are talking about people who have been or are in custody, these are people that come to the emergency department from the general community or do they come from the prison?

Dr REID — I have a role with Victoria Police providing medical care for people in custody within the Geelong Police Station cells where we have approximately 25 detainees in custody at the moment due to other issues, such as crowding or overcrowding within the prison system. We have a lot of people who are held police cells across the state at the moment, anywhere between—200 people, so they have medical needs and a lot of those relate to drug and alcohol issues. Whereas the last 10 years we have seen a lot of oxycodone misuse. There is a preference in Geelong for oxycodone, whereas heroin, we have seen that really change in the last 18 months to two years where ice has become more prevalent, making it very difficult to manage in custody because they are intoxicated, they aggressive. When they are intoxicated in the emergency department they are aggressive as well. They can have a number of health complaints.

Due to the physical effects of ice, patients often have increased confidence, they have a sense of invincibility so they will take on less (indistinct) in that setting in the community. In the emergency department they will take on—sometimes they come in with police under section 10 of the Medical Health Act if police are concerned about someone who has the appearance of a mental illness will be accompanied to the emergency department by police, and so they will often be physical aggression towards members of Victoria Police or the security staff or other staff in the emergency department—a wide range of physical elements, often from chronic ice use but also the lack of self-care that occurs in people who are dependent on substance abuse, but also because they tend to, due to their lack of sound decision-making, instigating high risk behaviours, the sequence of an event as a result of motor vehicle collisions because they are driving under the influence, or they are jumping off roofs of buildings or with assaults and they will often fight on with serious injuries, including fractures, because of ice's effect on the perception of pain, as well as increases the effect on their own perceptions of the environment and the situation.

Dr EDDY — I have written down here what our response is. The resources they consume would be considerable, not that they always require a high level of medical care, just the resources of the supervisory care they require would probably consume a far more critically ill patient who I will see for a much shorter period of time, but they have the power to disrupt the functioning of the emergency department and that is quite distressing for our staff, our patients. For example, we have a team—which I will cover later on—a code grey team. There is a professional security staff in hospital 24 hours a day but one or two of those gentlemen may not be sufficient to retain or control one of these patients. We have a code grey team which may be half a dozen or more male staff members but they are usually the orderly staff in the hospital. If we have these teams tied up for hours, the whole functioning of the hospital can be adversely affected.

Mr SOUTHWICK — What numbers are we talking about that you would have people present and how many of those would be readmitted, like, you have seen them before and they have come back?

Dr EDDY — There are a number of people—

Dr REID — We had a gentleman last week who presented three times in two days. Often there is a period where people will re-present a number of times and we will see them in a crisis, in a setting of escalating psychosis as a part of that.

Dr EDDY — There are a group of frequent flyers, we would call them, and at the moment the chief behavioural (indistinct) may be two, three or four a week and it comes and goes. Part of the question was, how does it compare to alcohol. Alcohol, as numbers, would be a far bigger effect, not so much the acute violence and aggression associated with alcohol because if they are purely related to intoxication they are often dealt with by the police in the community, but alcohol contributes, from a much higher point of view, to personal injury and injury to others—motor vehicle accidents, domestic violence. Numbers of patients affected or turning up to ED because of alcohol would be much higher, but not necessarily as resource (indistinct) with threatening—

Mr SOUTHWICK — Just extending from that, if you are getting two or three a week, we heard from the paramedics there were about 18 cases a year. Does that mean a lot of people are self-presenting? They are turning up, police are bringing them in, where are they coming from?

Dr EDDY — The really disturbed, violent patients are relatively small numbers. This gentleman that has been here three times last week, three times in three days, so there is a spike in attendances. The severely disturbed ones are relatively infrequent, but commonly people presenting with symptoms of intoxication, that is they are panicky, they have medical conditions masquerading - a bit like medical conditions presenting as a result of their intoxication. They present with anxiety, palpitations, chest pain, all sorts of things. Then it turns out when you take a history they have been using amphetamines or ice.

Mr SOUTHWICK — They are getting themselves there?

Dr EDDY — They get themselves there or family bring them.

Mr SOUTHWICK — Family.

Dr EDDY — Some are acute. They are concerned because they are unwell, they are behaving strongly, they are not looking after themselves, they have some acute symptoms. The police clearly obviously bring a number in as section 10 patients that have the appearance of having mental health issues and they are behaving strangely in the community. The ambulance would be involved in a number of, I guess, high end presentations that require paramedic care to start with, but a lot do self-present.

Mr SOUTHWICK — Thank you.

Dr EDDY — Some present relatively calmly but escalate for a whole lot of reasons. That is another issue as well. They are largely unpredictable sometimes.

Mr McCURDY — In terms of data collection—I am trying to get my head around when you ticked a box to say that someone has been presented because of drugs or alcohol, is there any difference between that person who has presented with an injury—let's say they have done an injury to themselves as a result of alcohol, they have been fighting or whatever. Is that an alcohol—or they have presented because they have other health issues related to the alcohol, the same with drugs?

Dr EDDY — If they present purely with a mental health issue related to drugs or alcohol it might be coded as a mental health symptom. It might be anxiety. We have explored that a little bit in our—

Dr REID — There is no box to tick in terms of—a lot of our patients present with chest pain. A 32 year old (indistinct) and says to the triage nurse, 'I've got chest pain and palpitations.' Now it may not be recorded clearly but buried within the medical notes, that person has (indistinct)

so that is where a lot of the data issues. There was a lady with facial injuries on Thursday night who had been assaulted by ice users in a carpark. That ice use is not recorded and so we do not know. We see a lot of people who have been affected by ice use and others but we would have no way of quantifying that data.

Dr EDDY — If someone had slipped over in the street intoxicated and broken their ankle or wrist, the primary problem would be fractured ankle or fractured wrist, and not specifically recorded anywhere—I mean, in the medical notes they would probably record, 'Intoxicated, fell over,' but on a surgical database, particularly the Victorian Emergency Minimum Dataset, that may not be recorded as an alcohol related—there is an injury surveillance part of Victorian Emergency Minimum Dataset which is run by Monash University. My feeling is that is inconsistently completed and that would probably be common across emergency departments. There is no one box. The other issue with ice and amphetamines is there is no—even within that minimum dataset, there are questions, 'Does this relate to the mental behavioural effects of alcohol?' But there is nothing specifically that relates to methamphetamine and ice, but there was a stimulant box but nothing that says ice. Certainly the ice or alcohol or any other drug's involvement in any one presentation might be unreported or under represented because the primary diagnosis is what is important.

Mr McCURDY — Thank you.

Mr SCHEFFER — Maybe we will let you go on with what it was you wanted to say.

Dr EDDY — Okay. The next question is, 'Is polydrug use a problem in the context of methamphetamine use amongst presenting patients? If so, what other drugs, including alcohol, have been taken in association with methamphetamines? What are the consequences of this and what challenges does this present to staff, the treatment of patients and their case management?' Cath might speak about the case management but, yes, in addition to methamphetamines these patients are frequently taking other drugs, in particular drugs to bring them down from the effects of methamphetamine use. These drugs include significant amounts of marijuana and benzodiazepines, particularly diazepam, Valium and alprazolam, also known as Xanax, fair in excess of the amounts other recreational users might consume. Patients may also present drug seeking for these prescription drugs and we are aware that users find G Ps who may prescribe benzodiazepines for the treatment of so-called anxiety, and then used social media and other networks to inform other users of the GP and their apparent willingness to prescribe alprazolam and diazepam in particular.

In the custodial settings, patients requesting drugs such as alprazolam are known to exert significant pressure on medical practitioners, even in close proximity to police, and it is possible that patients seeking these drugs from medical practitioners exert significant pressure upon isolated GPs to provide these medications. It is not only the amphetamine use, there is huge use of other drugs to either tide them over between methamphetamine or to reduce the anxiety of other mental effects of methamphetamines. That is our feeling. I mean, certainly from personal experience there are patients who present to ED masquerading with symptoms to try and acquire prescriptions for medications. The ED would be reasonably aware of these patients and their tactics but like we have alluded to, we suspect that in the community in general there is a lot of drug seeking going on to general practitioners from these patients.

Mr SCHEFFER — Cath, were you going to add something to that?

Dr PEAKE — I can add later but I would reiterate that people coming for treatment, it is rarely for a single substance. By the time they get to a tertiary treatment service like ours, whether it is poly substance dependence or dependence on one but used in many others, it complicates the treatment regime around withdrawal and ongoing psychological—

Mr CARROLL — Some of them, are they almost self-medicating?

Dr PEAKE — Absolutely.

Mr CARROLL — Yes. They are taking the ice, and the polydrug use is not so much to add to the high, it is actually, 'I'm taking the ice but when I get to this level I'm going to take this to bring me down a bit so I can then function.'

Dr REID — I find this is a quite honest problem about the fact that they are taking a mixture, so you can take an upper or a stimulant and then you take something to help you sleep. The quantities of alprazolam, in particular, which fortunately is moving to a schedule 8 regime where it is permit based in February, I see people taking fistfuls of—they will get a bottle of 100 tablets of alprazolam, which is a very potent, short acting benzodiazepine, and they will take multiples, eight to 10 tablets in one go and then divert some of the others and share with their friends in a caring, sharing way, or using large amounts of marijuana to allow them to sleep. I saw a gentleman late, or early on Friday morning who had been up for three days who had had a small fistful of alprazolam, partly because he was in a police pursuit and he needed to get rid of the medication because it did not belong to him, but also for an effect. He slept quite well for six hours and then was reassessed before the police could interview him on Friday morning. They give themselves what they believe they need and the problem is that ice is addictive but so is alprazolam, it is highly addictive. The poly substance or polydrug dependence in this is so complex because it is not a single problem, it is multifaceted, and everything works together.

Dr PEAKE — In terms of self-medication, the onset of the drug may be a form of self medication around whatever the purpose of the initial use has been. Sometimes it may be social but sometimes it is to medicate against social anxiety, so people feel more confident, particularly with the amphetamines they feel more confident going out, or they are using it to enhance their work capacity, whether it is driving or, for example, tradesmen say initially they would use it because they work better but, of course, the consequences are dire under certain circumstances.

Mr SOUTHWICK — On that, are you finding that the profile of the ice user is in some cases different from other drug users that are presented?

Dr REID — There is no one profile. A lot of my patients identify—there are people who smoke ice and they often identify in a very different group. If you ask them if they are injecting they will say, 'I'm not a junkie,' but they are smoking large quantities of ice. They see themselves as weekend recreational users, they use it for a reason, and they might identify with why they started and not that they have ended up highly drug dependent and that has had such a huge influence on their life. They do not identify with where they are now. There are other people who are injecting. I mean, there is not one profile.

Mr SOUTHWICK — But there are the people that are using ice to get by on a day-to-day basis, or the party drug user, as opposed to, say, somebody that might be presenting with heroin or cocaine that might be different—

Dr REID — I do not think again locally—

Dr EDDY — I think the traditional view of a heroin addict is someone who is pretty scruffy, down and out, not particularly functional. In methamphetamine use there is a whole range. There are clearly people who would fit that group but there is clearly reasonably well-off, middle-aged, almost professional people who would be using this maybe on a recreational basis, but I think it tends to cross age groups and socioeconomic groups a bit too.

Dr REID — I saw a 57 year old ice user in police custody on Friday morning who had a number of medical problems, as well as a 22 year old who had not been using for a long time. The one difference I have observed with methamphetamine or ice is that we see people getting into trouble with the police in a very short period of time. Generally what happened with the people in our jurisdiction or are evidenced in the Oxycontin or oxycodone and so people had had a slower period of time losing work, isolating from family due to often the manipulation and theft around getting money to obtain the heroin or oxycodone, because people do not tend to get aggressive, they sleep, relaxed, they are quiet, except there is a huge amount of manipulation and damage to families due to the need to get money to get the substance in the first place. Whereas we see with ice users a very short lead-up time to some significant crimes because of this wonderful

combination of increased confidence, physical strength and aggressive and paranoia—a huge amount of violence on the family around them. There are a few young men in custody for some very significant crimes who are likely to do some long custodial sentences who have only been using for 12 months but have previously never been known to police. That is not the pattern we saw with oxycodone use.

Mr SOUTHWICK — Thank you.

Dr EDDY — The next question, 'Are there particular groups that receive treatment that are high risk from methamphetamine use?' Cath might speak more to it but our experience is heavy—people obviously, the more they use it, the longer they use it for, the more likely you are to turn up to an emergency department at some point. The next question was, 'How difficult was it to collect data?' I think we have covered that. There are coding issues. The next question is, 'What medical condition'—

Mr SCHEFFER — Sorry, on the data collection which so much of our strategies rest on, is the way you described it earlier on where there is a general—what you called the primary cause for the person coming in, and that really stands for a range of other things that might have played around that. Is that the way it is going to stay or can that be more sophisticated to take into account some of the multifactorial elements that Nic was mentioning?

Dr EDDY — I am not sure if it is going to stay that way. The Victorian Emergency Minimum Dataset is constantly added to and edited. The injury surveillance part of it, anything—say trauma, drug related—is coded under the injury surveillance. I am not aware of that being revised for many years.

Mr SCHEFFER — Do you think it should be?

Dr EDDY — I think it would add to clarity if it was. A simple tick box, 'Does this presentation involve alcohol, heroin, methamphetamine?' would be a much more powerful tool. At least you could pull out all the trauma, domestic violence assaults whatever that relate to a particular drug relatively easily rather than the quite cumbersome system it is now.

Mr SCHEFFER — Okay.

Dr EDDY — Individual hospitals do not do that, that is done by Monash University. As I said, I suspect compliance with that is quite a cumbersome thing to fill out and it is in addition to what is already recorded about a patient's presentation. I suspect that compliance with it is not particularly good and there could be a better way of doing it.

Dr PEAKE — On data collection, is separate to the hospital's data collection, currently we have a data recording system called ADIS—Alcohol and Drug Information System—as part of our funding recommissioning that is currently in play at the moment, we are unclear if that data—it seems unlikely that that existing data collection system is going to be retained, and perhaps it is unknown. Separate geographic based catchment areas will have to submit their own data that they have formed their own system for collating. In some ways it might give us an opportunity to collate data more specifically in the existing system.

Mr SCHEFFER — How would you compare like with like across the state then if you were getting different assistance?

Dr PEAKE — The state will give us, I guess, criteria they want reported on. It will be up to us to design our own—

Mr SCHEFFER — You would still be able to aggregate across the state.

Dr PEAKE — They will—

Mr SCHEFFER — Okay.

Dr PEAKE — But it might give us an opportunity with our submissions to receive funding. There are benefits of being more specific. Currently one of the points I made, there has not been, I think, a clear enough delineation. We are catching up but we need to delineate more quickly between different amphetamine type substances. We might just collect data on amphetamine type substance or amphetamine which could mean the old powder form that we rarely see any more that is less damaging, I would say, or the crystal form or other pure kind of ecstasy type forms. I think if we are talking about ice specifically it would be of benefit to have more clarity about the exact substance for the person who is using. The effects and consequences of ice are more serious than we used to see in the powder form.

Mr SCHEFFER — I guess it is a whole other subject with the way that a lot of drugs are being continually modified would create a whole set of other data collection issues. Would that be fair to say?

Dr PEAKE — Yes, and synthetic substances (indistinct) all together and we have—you cannot—

Mr SCHEFFER — Okay.

Dr PEAKE — We do not know what people are using.

Dr EDDY — The other issue is people call it different things. There is a whole evolution of names from ice to shard but if they present, 'I've taken shard,' that might be all that they know it is, when in fact it is methamphetamine. The naming is an issue as well.

Dr REID —Sometimes doctors do not feel comfortable saying, 'Sorry, what is shard?' I am familiar with that term. If I hear a term I do not know, I feel quite comfortable saying, 'Sorry, what is that?' whereas a lot of our doctors do not feel comfortable talking about illicit substances. There may be some judgment on their behalf or they do not want to offend the person or look like they do not know. 'Speed' was the term that we used to see used only for amphetamines locally but now a lot of people when they say 'speed' they mean methamphetamine. That is what is being produced locally and used locally. Terms can mean different things in different areas and people use the same term to mean different things. It is also the fact that the colloquialisms or vernacular can change or mean different things to different people. Unlike drug and alcohol, an individual or a patient expects to say, 'This is what I've been using.' When people come to the emergency department they are often not wonderfully forthcoming. They may not say to our triage nurse, 'I've been using ice or shard or methamphetamine.' They will come and present with the symptoms, so it is part of the way the emergency departments work. We focus on what the problem is or complaint, and maybe the underlying complaint is something else. We are always going to have trouble capturing the data.

Mr SCHEFFER — Yes, I understand. Thank you.

Dr EDDY — I will go on, 'What particular problems do medical allied staff working at Barwon Health, Geelong Hospital, especially the emergency room, face when dealing with patients affected by methamphetamine, and their friends or family?' Specifically, simply the acute behavioural disturbance where all our staff and bystanders are at risk of injuries related to violence and aggression. We have found patients with weapons—that would be knives and blades of some description. There is damage to hospital property relating to violence and aggression, either in the course of restraining people or just from their behavioural issues before they get seen, so holes in walls, broken windows. There is a risk to us of blood contact with infectious diseases, particularly hepatitis C and the injecting drug use group. There is the risk of personal threats and just that emergency department nurse would be able to probably give you a description, but my own experience is personal threats of death, rape my daughters, assault, 'I'll come and find you, I'll burn your house down,' the whole—everyone would probably have a similar story.

Lastly, professional risks. If there happens to be an adverse outcome, the patient absconds and dies by walking in front of a bus which they sometimes threaten to do, a patient dies in our custody, so to speak, as in restrained, either pharmacologically or physically, all these things have risks

attached to them; certainly risks to the patient but certainly professional risks to individuals and to organisations.

Lastly, 'How is methamphetamine induced aggressive and violence dealt with at the hospital?' The hospital, certainly in the last few years, certainly our hospital has increased its security presence. It is now 24 hour a day security presence based in the ED, and when we built our emergency department, which is now almost five years old, we put our hospital security office in the emergency department, moved into the waiting room. There is a code grey or code black which would be common across most hospitals which is a response from - a team response. It is largely a number of male staff to attend a violent or behaviourally disturbed patient. Code grey tends to be the violent response, whereas code black is one where there is a serious threat, as with an armed patient. Code blacks are fewer, but code greys are an everyday occurrence in the hospital in general.

Ways we deal with them is certainly in the short term they often require a physical restraint and that means shackled to hospital trolleys by five points—chest and each limb. That is not without risk and certainly there are quite stringent guidelines across, I would imagine, most organisations over the use of those and the monitoring of patients that is required when patients are in that restraint. The next step is to pharmacologically restrain them, and that is to give them something to control their behaviour and also to help relieve their symptoms, their distress. We have a variety of medications, certainly for patients who have ice induced violence and aggression. We have a specific guideline and drug we use for it which is heavy duty medication to sedate these people.

Because these things are not without risk you cannot put these people in a back room to wait for them to wake up because there is a risk associated with restraint, either pharmacological or physical, they need constant monitoring and they would get probably one-on-one nursing care until such time as they are safe. That is one of the issues around resource consumption. Occasionally we have police involvement. Often the police may already be with a patient, but certainly if there was a severe threat from an armed patient, the police would be called.

Mr SOUTHWICK — What do you do when you have your frequent flyers, as you said before, like the gentleman that came three times within a week?

Dr EDDY — Three times in two days.

Mr SOUTHWICK — Yes. Is there anything you can do—

Dr EDDY — My last line is there is an attempt to always make early de escalation. Often our mental health staff who are pretty much based in the emergency department know these patients well. Obviously there are attempts to de-escalate them. Perhaps medicate them with something a little gentler to calm them down. But they are unpredictable and they can flare up, fire up at a moment's notice and that is the problem. Yes, we do try and de-escalate them. That would be good. I mean, no one wants to restrain someone unnecessarily but I think that is the ultimate thing when we have a duty of care to ourselves, our staff, our patients and the particular patient as well.

Dr REID — That gentleman in particular the first time—I mean, the ED staff get to know them reasonably well (indistinct) mental health, and it is working together. He was allowed to leave the first two times in a state where he was reasonably okay in that he was not a risk to himself, potentially a risk to others when we let him walk out, but he was safe enough to leave the emergency department. Whereas on the third presentation—we had noticed across the three presentations a deterioration in his processing. He was becoming more and more erratic. On the third time he submitted himself (indistinct) I mean, that often is a plan that the concerns are raised on the second discharge but if he comes back again and we are concerned with seeing a deterioration over the last two days, a plan is put in place that if he comes back that is the communication but sometimes you need to let these people walk out because we cannot contain them but there is no easy fix when people are behaving in a disturbed state and often we sedate or restrain them and keep a close eye on them, but there are often those people in the middle ground where we do not—to detain people under the Mental Health Act we have to have reasonable cause.

It is a huge imposition on people's (indistinct) there are people who fall in that grey area where we have concerns about their function in society but we really cannot detain them and it is often just a wait and see situation.

Mr SOUTHWICK — What, do you refer them to other treatment services?

Dr REID — Acutely there is not—I mean, when he was becoming erratic and more and more paranoid, the treatment—we need to get him through the acute stage before he has further treatment. People have to be willing to engage in treatments (indistinct)

Dr EDDY — They are very difficult people to deal with. They are not people who you can sit down and have a rational discussion with, and if you do, you will come back 10 minutes and they would not recall any of that discussion. They are very difficult to even reason with, and certainly to de-escalate someone and talk them into lying down and having a sleep in a quiet room is often pointless.

Dr REID — There is a huge issue of underlying cognitive function. Cognitive function is brain function. We know that methamphetamine is directly toxic to nerve studies. There is the acute intoxication in their mental—agitation, aggression, their heart is racing, they might have palpitations, there might be a range of issues but with longer-term use, not just related to methamphetamine, but we have a few people who have escalated from solvent use who have solvent injuries, acquired brain injuries who are now using methamphetamine. The problem is that when they are well and they are clear of substances, some of the individuals do not function terribly well. To engage in treatment you have to understand there is a problem, whereas they often do not see that. I am sure Catherine—

Mr SCHEFFER — Before you go on, we have just under five minutes left. While we could spend another hour discussing this I think we need to start to think about winding up. Perhaps, David, if you could step us through the remaining things you wanted to say.

Dr EDDY — I have more or less finished, so Cath might—

Mr SCHEFFER — Okay, that is fine.

Dr PEAKE — I manage the treatment service for adults based in the community. We have been talking about the hospital to date, but I will quickly follow on in terms of managing these people presenting acutely ice intoxicated in the psychiatric unit of the Geelong Hospital. The presentation has increased markedly over the last couple of years, the ones who do go into the mental health inpatient unit, whereas the mental health clinicians in the hospital, in the psych unit, are very skilled and experienced in talking down people having a psychotic episode related to schizophrenia, say, they find it is not possible to talk someone down really that is having an ice induced psychosis. They have to use the rapid sedation pharmacological and the use of seclusion more which is distressing for everyone. The point I would like to make is we do not yet know what the cumulative effect for staff are on having to deal with these much more distressing, violent, greater use of seclusion and restraint. That impacts on staff as well, of course, the person themself. That is something to keep in mind certainly in the emergency department.

I responded to the second set of the questions which we will not have time for but clearly there is very comorbidity between substance use and dependence and mental illness. We presume that there will be a comorbid, at least psychological distress, if not a diagnosable psychiatric condition going along with the substance use. A lot of the people first coming into contact with mental health services at Barwon Health because or related to ice use are seen in the emergency department, and the psychiatric triage team will often also see them. But in terms of then linking them to ongoing treatment—and we know there needs to be long term support in the community in all sorts of ways to address this—it is not possible necessarily to make that linkage into treatment at the point where someone is acutely intoxicated or distressed or they walk out or can leave and think, 'Well, I'm okay now,' and do not see the need for engaging in treatment. Engaging people in treatment in the community is a challenge, working with people to acknowledge that there is a problem with ice

use. The people coming to us for treatment would be a very small proportion of people who are using ice.

There has been a small increase percentage-wise in the number of people presenting to mental health and drug and alcohol services because of ice over 10 months to date, compared to the previous 12 months. We are seeing it trending up. Again it is complicated with all sorts of other substance use and all sorts of other reasons for use. There is not a great deal of research, longitudinal research, into the best form of treatment in the community but we do know the acute withdrawal period is probably longer with ice. People need an opportunity to crash, to sleep, come down and then probably a withdrawal episode that is longer than maybe for other substances. That has implications for how services are funded. We know that long-term residential rehabilitation will be effective while it is running its course but then if people go back into the community without adequate support that the rehabilitation effects are not sustained. Again that has implications of the need for treatment services, not only to link up well but resources to be able to provide long-term care for people.

We know that brief interventions and cognitive behavioural therapy can be effective and again we are working to try to really understand the types of people coming to our service for ice use and to be specifically tailoring treatment. A one size fits all, the same approach we might take for someone who is only alcohol dependent, cannot be the same. We need a lot more support and intervention for these people's families in the longer term, not only psychological but psychosocial support in the long term.

Mr SCHEFFER — Okay, thank you. Any more questions?

Mr CARROLL — I think I am right, except probably echo what Cathie said about the long term. That has been evidence that we have received that you cannot just put them in isolation. It is a month by month type arrangement that is required.

Mr SOUTHWICK — One quick question in terms of the cost. Has there been any work done in terms of what the cost might be of having—again I come back to the frequent flyers in particular—but the treatment and the extended resources that you have suggested is needed for ice patients?

Dr EDDY — The emergency department is a bit of a fire station. It is always open and staffed. If those resources were not being used for a particular patient they would be utilised elsewhere. The cost, I am sure if you could sit down and work out the man-hours involved in looking after a patient it would be significant. I am not aware of that being done but—

Mr SCHEFFER — A really quick question. On the one hand you talked about ice induced violence and aggression and on the other hand there is a view that it causes erratic—people present erratically and there is paranoia and a range of dispositions in that, and that contextually then can precipitate a violent situation. My question to you is does ice cause violent behaviour?

Dr EDDY — I think it has the potential to make normal people violent, yes.

Mr SCHEFFER — Thank you. Finally, we did have to truncate some discussion. It would be helpful if we could have that in the form of a written submission.

Dr EDDY — Okay.

Mr SCHEFFER — Thank you so much, we are very appreciative of your time and that has been a very valuable discussion.

Dr EDDY — Thank you.

Witnesses withdrew.

Hearing adjourned.