LAW REFORM, DRUGS AND CRIME PREVENTION COMMITTEE

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

Ballarat — 18 November 2013

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Dr Andrew Crellin, Director of Emergency, Ballarat Health Services.

The CHAIR — Welcome, Dr Andrew Crellin. I understand you are deputy director of the emergency department at Ballarat Hospital.

Dr CRELLIN — Yes.

The CHAIR — You are very kindly replacing Dr Jaycen Cruickshank, who is the director of emergency medicine at Ballarat, who I understand has got an emergency himself.

Dr CRELLIN — Yes.

The CHAIR — We appreciate your time this morning. We had allotted this part of the hearing till 10.45. I hope you are able to fulfil that time frame.

Dr CRELLIN — Yes, I have time. I am not sure we will fill that time.

The CHAIR — We might, with questions. You do not have to fill the time. We are very keen to ask questions.

Dr CRELLIN — Yes.

The CHAIR — Thank you. Obviously this is a public hearing of the Law Reform, Drugs and Crime Prevention Committee into a reference that the parliament provides the committee, which is an inquiry into supply and use of methamphetamines, particularly ice, in Victoria. I understand you have the full reference. Just prior to this I actually did adjourn this public hearing, so for the record I am recommencing it, for want of a better term. Just before you start, Dr Crellin, I would like to read you the conditions under which you are providing evidence to this public hearing this morning and again welcome you to this committee and its work.

Dr CRELLIN — Yes.

The CHAIR — 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 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. I am hoping you have received and read the guide for witnesses presenting evidence to parliamentary committees or have an understanding of it.

Dr CRELLIN — I have got an understanding. I had all the information sent to me over the weekend, so I have had little time to prepare. I spent more time trying to answer the questions.

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 a proof version of the Hansard transcript at the earliest opportunity so you can correct it as appropriate. As I said, we do invite you to make a brief submission and then obviously the committee would be keen to ask questions of you. Thank you and welcome this morning.

Dr CRELLIN — Thank you. I sent I think 14 questions, which I will attempt to address as best I can. The nature of emergency medicine statistics makes it difficult to ascertain exact details of presentations. We have interrogated what is known as the Victorian Emergency Medicine Dataset to get data to the best of our ability, but some of the data is quite non specific.

In relation to emergency room attendances in the last four years, our best estimate is that relating to amphetamines and other drugs, not including alcohol, we have had an increase in the presentation rate of around 30 per cent over that time period. The presentations related to alcohol seem to have been stable or static in that period. There are a couple of marked differences between the presentation rates. Alcohol has a weekend preponderance, so approximately double the number of patients appear in the emergency department on Saturday and Sunday—

Mr SCHEFFER — Could I just interrupt you. When you said 30 per cent, just to give us some idea of what the figures are, what is the number of human beings you are talking about?

Dr CRELLIN — Off the top of my head, this financial year, which is not complete, we will be looking at somewhere around 450 presentations in a calendar year.

Mr SCHEFFER — So that is the 30 per cent increase.

Dr CRELLIN — Yes.

Mr SCHEFFER — Four hundred?

Dr CRELLIN — Four hundred and fifty, so it would have been about 380, 370 four years ago.

Mr SCHEFFER — Okay.

Dr CRELLIN — The numbers are roughly equal, so drugs have now overtaken alcohol as a presentation. With alcohol there is a weekend preponderance, so roughly double the number of people have an alcohol related incident on Saturday and Sunday versus any other day of the week. So if it was 50 Monday to Friday, it is 100 Saturday and 100 Sunday. There is a sharp peak in the age group 15 to 24, which is basically double any other age group, and then it is quite consistent up until the age of around 65, although the upper age limit over the past four years appears to have increased. It has gone from 55 to 65, so there is an extending of alcohol related presentations.

With regard to all other drugs, including methamphetamines, it is steady across all days of the week except Wednesday, which is about 20 per cent lower. So these patients occur Monday to Sunday at a steady rate. There is a much more even age spread, although there remains a peak in the 15 to 24 year-olds, and it tapers earlier than alcohol related incidents. It tapers in the 50s rather than the 60s.

Of all the patients attending the emergency department, the 15 to 24 year old age group actually accounts for 20 per cent of our emergency presentations in Ballarat and it is the highest proportion of ED patients except in the nought to four year old age group, so we divided 15 to 18 and 19 to 24. That is about 10 per cent each. Nought to four is about 11½ per cent. So that gives you an idea that there is a big preponderance of presentations in that age group, as well as the drug and alcohol related presentations.

In relation to question 2—how serious is the issue?—it is the resources within the emergency department that these patients consume. They are generally managed as very high acuity patients. They require multiple members of staff—nursing, medical and often security staff—to attend when they initially present. They spend long periods of time in the emergency department waiting for assessments, so we have to wait for drugs to wear off before we can adequately complete psychiatric assessments. Often they require sedation to make them manageable during their stay in the emergency department and they are very often not admitted to the hospital as a result of that. They often remain in the emergency department for prolonged periods of time.

In comparison, alcohol related patients tend also, when it is profound intoxication, to stay for a long period of time until they are recovered enough to go, but when you deal with their trauma related injuries, they are often able to go because they are still able to get out on their own two feet, so they probably consume more resources from that point of view than the alcohol related presentations.

With regard to question 3, yes, I think polysubstance use is very prevalent in these groups. However, this is an issue that we really have little information about, because it is a screening problem. We do not screen all of our drug presentations, and one of the reasons for that is because it has very little impact on the immediate management of their presentation. If we send off a urinary drug screen, it can often be 48 hours before we get a turnaround. If the patient is only in the department for six or eight hours, getting a test result two days later does not help us. So we often do not screen these patients.

It is my understanding that the psychiatric units screen their patients more, but I cannot speak for them. So we do not screen all of these patients and we are not resourced to do so, because we would have to follow up the screening results. So some of the information that goes into our computer is based on what the patient tells us when they arrive or what their friends tell us, and there are often people who turn up who are clearly under the influence of multiple substances who will only tell you about one or two of them and not necessarily all the other things that they have used prior to coming in.

I would suggest that people who get intoxicated on alcohol are more disinhibited and therefore are more likely to experiment with a drug like ice or amphetamines, but I do not have any evidence or actual numbers to support that.

In relation to question 4—other groups that are at high risk—certainly there is a preponderance of young people, so 15- to 24-year-olds, low socioeconomic, and we would suggest that vulnerable people—people with pre existing psychiatric illnesses or pre-existing intellectual problems—also tend to present more frequently in this category.

With regard to how difficult it is to collect data, it is really very difficult. I do not think we would be the only emergency department that would say that in the state. We rely on the history from the patient to collect the data. We rely on multiple different staff members to input the data. There is no centralised input. It is all input by individual doctors. There are multiple categories in which you can file these in the dataset, and some will choose poisoning, some will choose the toxic effect of the drug, and it is quite difficult to nail down which drugs have been taken.

We look at the patients as they come through the door in terms of what toxidrome they have, and by 'toxidrome' I mean what sorts of signs and symptoms they have. That will tell us which group of drugs they may have taken but it will not tell us the exact drug that has caused that toxidrome, and there are multiple drugs that can cause the same toxidrome in amongst the illicit substances.

In relation to what medical conditions people who are affected by methamphetamines are presenting to hospital with, we certainly have seen a number of strokes or intracerebral haemorrhages related to amphetamine use. We would see withdrawal not uncommonly as probably the next most common presentation. If you include psychiatric presentations in medical illnesses, then that is certainly very high up on the list, but they can present with all sorts of different medical conditions. They certainly come in with heart and other problems, particularly those in the older age groups who are using, which can precipitate cardiac events and things like that. Those patients become very difficult to deal with because not only do they have an active medical condition going on but they have also got a toxidrome related to the substance that they have used going on, so they are often uncooperative and violent to staff and they pose a big management problem when they actually present with a medical condition whilst intoxicated.

What problems do medical and allied health staff face? Our main problem is aggression. These patients are often very violent. They are often very uncooperative. They often require high levels of restraint in the initial stages of their management and, as a duty of care, you are often forced to restrain these people for prolonged periods, either with chemicals, so sedation, or contact restraints, so point restraints.

Once we have dealt with the issues, the contact resources and accommodation options locally in terms of disposition of these patients are very poor. We end up sending a lot of these patients to guesthouses if they don't have other accommodation options, where they are again just re exposed to more alcohol use, drug use et cetera, and the resources Monday to Friday, nine till five, in terms of counselling and support services are fantastic, but outside of those hours the contact resources for helping these people in the community are not there, so if someone presents Friday night, it may be Monday before a referral can be made. The nature of our workplace is shift work predominantly, so someone who is working Friday has to put something in the pipeline for Monday, which may be overlooked, and it can become difficult.

How is the induced aggression and violence dealt with? These patients, as I have already said, are managed as high-acuity patients. They require, often, a large response. We have an extra security

staff member designated to the ED on Friday and Saturday nights, but otherwise we have two security staff in the hospital 24/7 and they are responsible for the entire campus, including Psych, so they can often be spread very thin. We often require these patients, once they have been sedated, to be nursed one-on-one, so they require a high degree of nursing resources. Our usual nursing ratio on the emergency department is one to three, so one nurse for three patients. These patients can require one on one nursing.

They are often extremely disruptive to patients around them. They are often very loud, very aggressive, very noisy. The nature of the emergency department is that there is no safe room or anywhere that you can put them that is closed, so they disturb multiple other patients. If we have got a patient in one of our moderate acuity bays going off, so to speak, he could disturb 15 other patients quite easily.

I cannot really answer question 9, about methamphetamine use and comorbid mental illness. I suspect there are patients—so the vulnerable group that have a pre-existing mental illness—over represented in the drug using population, but the converse is that most of these patients, when they are violent and aggressive, actually present as if they have got a mental illness, so it is often chicken-and-egg for us in the emergency department to work out what came first. Is it exposing an underlying tendency or is it actually creating? We know that the amphetamines group of drugs cause psychiatric disturbance. It is a very difficult question to answer.

In terms of the challenge for treatment and rehabilitation, it is making that differentiation as to whether the drugs cause the illness, because if the drugs cause the illness then theoretically if you withdraw the drug the illness might go away, but there are patients who get psychosis from these drugs and the psychosis does not go away. But certainly in patients who have active mental illness, the treatment of their drug addiction or drug use can be much more difficult.

I am trying to restrict to my knowledge and that is mostly the ED. Do we work in partnership with other organisations to address harms and challenges? We do have an ED care coordinator who is rostered on the weekends who is also a drug and alcohol counsellor. That is of limited utility because counselling these people while they are acutely intoxicated is often not particularly useful. The emergency department does participate actively in a program run jointly with, I think, the Ballarat Community Health—I may be wrong. Certainly there is police and ambulance involvement. It is called Partysafe, where we get children from secondary schools in the area, particularly disadvantaged children, to come in small groups and they are given talks by doctors, nurses, paramedics, police, about party drugs, party safety, and I think that's quite an effective program from the reports that we get back from the people who have gone through that program, but that is more about looking after their mates when they are out partying rather than us having a prevention strategy.

The other thing that comes into that in terms of partnership is the referral issues. They are not open on weekends and evenings and that is predominantly when our patients arrive, and there are no detox facilities in this area, so there is nowhere where we can say, 'You can have detox.' Ballarat Community Health runs community detox which is in the community, in the home, but there are no detox beds in the Ballarat region.

I cannot really answer question 11 in terms of strategies. My best guess is that prevention of use and prevention of getting addicted in the first place would be high on my list, but certainly accommodation options that were safe for our patients in terms of not re-exposing them immediately to drugs and alcohol would be useful.

I cannot answer the programs provided by the health service. I can answer what we have done in the ED, which I already have, for question 12.

Treatment interventions? Again I can't answer that, but prevention strategies I think must be very high up on the agenda. I think educational strategies in the latter years of high school or even the early years of high school would be extremely important as an intervention to prevent rather than actually deal with it once it has started, and in terms of specifically what interventions address

methamphetamine violence in the hospital sector, we are very active in our department about pursuing criminal charges against anyone who assaults a staff member.

We have very prominent signage, which is often missed by the patients who are acutely unwell because they come in the back door, but we have very prominent signage in the waiting rooms that physical and verbal violence and aggression will not be tolerated and that we will pursue appropriate avenues, and we have done so on many occasions. I do not think this is a widespread, consistent practice and even within our department it is not particularly consistent, so there are still people who are verbally abused or physically assaulted in their workplace who take it no further than within the workplace and, until we get widespread uptake, the problem is probably partly hidden, because the statistics would suggest that there is far more violence and aggression incidents in the emergency department in our hospital than in fact we pursue with the police at any given time.

The CHAIR — Thank you, Dr Crellin. It is interesting that you finish on that note, because in fact this committee did a report in relation to violence in emergency wards of hospitals which you no doubt probably read. We made a number of recommendations to the parliament in respect of the issues that you raised.

Dr CRELLIN — Yes.

Mr SCHEFFER — Thanks very much, Dr Crellin, for that.

Dr CRELLIN — You can call me Andrew. I feel like I am in trouble when you call me 'Dr Crellin'!

Mr SCHEFFER — Okay, I will not.

Dr CRELLIN — Andrew is fine.

Mr SCHEFFER — Andrew. Fine. I appreciate what you said in the beginning about the stats being difficult. They are even more difficult when they come orally in the way that they did.

Dr CRELLIN — Yes.

Mr SCHEFFER — And I do not quite understand, because they seemed a bit out of proportion to other stats that people have indicated to us, so I have probably misunderstood what you said. Did you say between the range of 400 and 450, which represented a 30 per cent increase in the people who are using illegal drugs that have come to you? Does that mean that there are about 1,200 that come a year? Is that the proportion we are talking about?

Dr CRELLIN — No. The data that we have suggests that there are about 1,000 patients a year with drugs and alcohol and it is roughly a fifty-fifty split, with alcohol staying static. So it started as roughly 350, 380 each in 2009 and it is now up to 450, we estimate probably, so the estimate for this year would be just over 500.

Mr SCHEFFER — That is the total that you see?

Dr CRELLIN — That is the total for the drugs, but that is reliant on the VEMD coding. If someone comes in with a stroke and they have not coded the amphetamine use or they have used the amphetamine use as a secondary code, we do not pick it up, so there are presentations, I am sure, that are hidden, because the data is very user dependent, it is often not completed at the time of the presentation, and we are very reliant on a patient telling us that they have taken drugs. So there are three ways that it is hidden from us and so I think that to some extent that will be an underestimate, but our best estimate is that we have grown 30 per cent from 2009 to the current year.

Mr SCHEFFER — That is the whole collection?

Dr CRELLIN — No, that is the illegal drugs. The alcohol numbers stayed stable. The alcohol number is basically 380, 380, 380, 380, 380, stable. The illegal drugs number is growing,

so therefore the overall number is growing, but we think about 30 per cent.

Mr SCHEFFER — But given all that complexity you mentioned, insofar as it is sensible to talk about an increase in the use of methamphetamines, ice, is it possible to get a sense of a quantum of that, how that has increased?

Dr CRELLIN — No.

Mr SCHEFFER — It is not?

Dr CRELLIN — No, because the patients can look the same if they have taken ice, if they have taken amphetamines, if they have taken ecstasy, if they have taken 20 Red Bulls. They can look the same.

Mr SCHEFFER — So we need to be very careful in talking about an increase in uptake of ice, from your emergency department's point of view?

Dr CRELLIN — I do not know what the usage is in the community. I could not tell you what the usage is in my emergency department. What I can tell you is that the numbers that are on our system suggest that the number of times our doctors code something as an illegal drug effect has gone up 30 per cent in the last five years, from 2009 to current.

Mr CARROLL — Thanks, Andrew, for your presentation. You did say there are no detox beds in Ballarat, so how much does that then contribute to just the cycle and the repeat of people being admitted to the emergency department?

Dr CRELLIN — I do not think that is an answerable question, in that we know that a large number of people fail detox anyway. There are definitely people who want to detox, who tell us that they want to detox, who we cannot refer directly to a service locally. We certainly do our best to refer them through other services who can access these beds in western Melbourne, but we do not have anything locally, so it makes it very difficult for us to make the direct referral. So I think, yes, the people who want to detox, the people who want to come off the medications, certainly would benefit from having those beds available, but how much that contributes to the exact numbers and presentations I cannot—

Mr CARROLL — In Melbourne you have got Odyssey House and various long-term accommodation facilities that seem to be quite effective in treating and rehabilitating people and giving them routine in their lives, and this committee is about trying to make recommendations right across the board to government to facilitate and assist people on the ground dealing with ice as an epidemic. At Ballarat Health, ideally what would you add to your suite of services that would make the biggest impact? Would it be long-term accommodation or would it be another treatment option?

Dr CRELLIN — From the emergency department's point of view, prevention is our best strategy, because not exposing people to the drugs means that the violence and aggression and all of those acute things that happen with the drugs are not there, so not having the drug available would be ideal.

In terms of the longer term management and how that impacts on the emergency department, I think for the individuals, having both a long-term accommodation and then local support that matches with that would be very beneficial for people who are addicted, and not just to amphetamines and speed but alcohol and other drugs as well. Not having the inpatient program then followed up locally, with exactly the same sort of people dealing with the counselling as an outpatient, makes life very difficult. Certainly our patients do go to Melbourne and spend time in these units, but then they come back, and whether the support is there fully when they come back, I don't know. So the combination is really important, of both inpatient and outpatient services.

Certainly the availability of emergency accommodation options, from our point of view, would be really important, so emergency accommodation options that are relatively drug and alcohol free,

rather than back out into a community of drug and alcohol users straightaway, would be very important for us.

Mr SOUTHWICK — Thanks, Andrew. The figures that you have given us this morning indicate that Ballarat has probably a more prevalent rate, particularly when you are looking at alcohol and drugs, than other regions like Geelong and Bendigo. Why do you think we are experiencing that significant increase in Ballarat more specifically?

Dr CRELLIN — I do not know. I do not know if the drugs are more readily available in Ballarat. I do not know whether it is the community in Ballarat, so whether we have got more vulnerable people. From an emergency department point of view I cannot really answer that question. I think our data is as good as it can be across the board in terms of what goes into our dataset and so whether other places' data is not as good I do not know. It has always been my impression locally that there is more of an issue here than there is elsewhere, but I do not have any data that actually supports that.

Mr SOUTHWICK — You see a number of repeat users that are coming in for treatment. How would that equate—and I know it is hard to give an exact percentage, but just an idea of the sort of count, number, of people that are coming in that have been regularly seen by your hospital?

Dr CRELLIN — Often there is a large difference in the way they present. People who are frequent users present with complications because they know what the risks are, whereas people who are infrequent users, who use the drugs in association with being intoxicated on another substance, often turn up with the acute effects that you might expect from the drug. Are they represented in our population? Absolutely. We have lots of frequent re-presenters across all groups that attend the emergency department, but in particular with illegal drug use there are people who attend and attend and attend. I would not say that is isolated to amphetamines. It is all drugs.

Mr SOUTHWICK — Would you have any information in terms of the types of activity you might have during significant events in Ballarat? You have three music festivals. Do you find that there is more activity around the time of those festivals and other types of activities?

Dr CRELLIN — From personal experience, the last rave that was held on Kryal Castle was my on call weekend and I spent the entire weekend resuscitating drug overdoses in the emergency department. I think that reflected the introduction of drugs that were unfamiliar to the people who were using them. They thought, 'I'm going to a rave; I'll just take something.' Having worked in Melbourne, where you tend to see some drugs preponderance on Sunday morning, we were seeing these early on Saturday evening. It was quite high acuity. I have not worked weekends with the other festivals but certainly there is a spike in presentations associated with illicit drug use when you have those sorts of festivals locally.

The CHAIR — I am a bit like Deputy Chair Johan Scheffer, trying to sift through the information and data in relation to what is ice specific in presentation to an ED as against other illicit drugs. Obviously our reference is more concerned with use of methamphetamine, particularly ice. I know the hardship of triage and trying to identify someone who is specifically on ice. If a policeman is called to an incident in relation to antisocial behaviour, is there any way to gauge that? We hear in the media, 'He's ice affected', yet from a clinical sign point of view can you tell whether they are on ice or not, as distinct from heroin, ecstasy, speed or something else?

Dr CRELLIN — In terms of toxidrome, heroin is markedly different to the amphetamines and stimulants. Heroin has markedly different effects on the pupils and the respiratory rate and drive. It is a depressant on all of those systems. Heroin is very easy to pick out of that group but the others—ecstasy, ice, speed and any other sorts of amphetamines—present the same way. They present with racing heart, dilated pupils, hyperactivity. The preponderance of violence and aggression tends to be much more prevalent in the ice group. But we rely on the patient's description of what they took, and they do not know because they do not know who made it most of the time. They know what it was sold to them as, but they do not know what they have actually taken.

That is where the difficulty comes in: you are reliant on the patient's history as to, 'I was taking this drug.' They have come in and said, 'I took ecstasy,' but it might have been more speed than ecstasy. 'I came in and I took ice'—well, it might have been all speed. It may not have been ice. It is not clear from the point of view of when the patient presents. There is no way to differentiate between speed and ice because they are exactly the same compounds, just prepared differently. You cannot clinically differentiate. We can differentiate between the stimulants, and heroin is quite different, as are the prescribed drugs of abuse: the narcotics, oxycodone and those sorts of drugs. They have a very different toxidrome to the stimulants.

The CHAIR — In relation to the actual ingredients, it was said to us at a forum we attended in Bendigo that a lot of the constituent of ice—and forget the purity issue—is made up of a whole lot of toxic chemicals, whether they be cleaners or bleaches or battery acid or whatever else. Is that also true of methamphetamine other than ice or amphetamines as well? Is ice so much more caustic because of the ingredients associated with it?

Dr CRELLIN — I have no idea how they make it or what they use to make the stuff. Ice is the advance on speed. What the drug manufacturers want is something that works quicker, gives a bigger high and is going to give them repeat business. Ice is more addictive, quicker acting, more bang for your buck—is my understanding—and creates more problems because it gives more of a high, therefore more deleterious or bad effects as well, and it is much more addictive. The other thing that goes along with it is that more patients get addicted quickly to ice than any of the other amphetamines. That population is probably growing, but would I have a number that supports it? No.

Mr SCHEFFER — The Chair and I are in complete agreement on this. Just coming back to those figures again, the difficulty we have as a committee is that we have experts like you come along and talk about the complexity of it and the difficulty in identifying very specifically what the dimensions of the specific ice issue are, but when we look at the papers the next day, the headline figure—if it comes out—is '30 per cent increase in ice use'. There is something lost in translation, so we are very keen to make sure that complexity is laid before the committee.

Dr CRELLIN — That 30 per cent number that I talk about is across a broad range of stimulants that can be put in the same category as ice.

Mr SCHEFFER — Absolutely.

Dr CRELLIN — The only way you can answer the question as to whether it is ice prevalence is the supply chain for ice. Is there more ice than speed available? Can I walk into a local pub and buy ice more readily than I can buy speed? I do not know the answer to that question and I do not know whether there is police data about the availability of particular substances. As new drugs come on the market they tend to be swept up by the community and the older ones left behind.

The CHAIR — Thank you very much, Andrew, for your presentation this morning. We appreciate our time. Pass our thanks back to the emergency department for allowing you to be here.

Dr CRELLIN — Yes. I would also like to thank Jaycen because he provided me all the data at a time of reasonable angst for him. I would like to thank him for his support in helping prepare all of this.

The CHAIR — Duly noted. Thank you. The committee will adjourn for morning tea until 11 o'clock.

Witness withdrew.

Hearing suspended.