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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Witnesses

Mr Grant Hocking, Clinical Support Manager, Grampians Region, Ambulance Victoria.

Mr Sam Caldow, Advanced Life Support Paramedic, Ballarat Branch, Ambulance Victoria.

The CHAIR — I welcome our next two witnesses, Sam Caldow, who is the advanced life support paramedic at the Ballarat branch—I hope I got that right, Sam—and Grant Hocking. Your title is, sorry?

Mr HOCKING — I am the clinical support manager for the Grampians region.

The CHAIR — Thank you. Welcome, Grant. You are filling in for Julian Cofield.

Mr HOCKING — Correct.

The CHAIR — Thank you. Welcome to the Law Reform, Drugs and Crime Prevention Joint Parliamentary Committee of Victoria and specifically to our inquiry into supply and use of methamphetamines in Victoria, particularly ice. I just have to read you the conditions around which you are presenting at this inquiry this afternoon, if you would bear with me just for a minute.

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. Have you received and read the guide for witnesses presenting evidence to parliamentary committees?

Mr CALDOW — Yes.

The CHAIR — That's 1½ nods! 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.

We have allotted time till 1.35 for this section of the hearing, and I have indicated to Grant and Sam that we have had PowerPoint presentations from Ambulance Victoria which have a familiar theme about the information, so they understand that, and will move fairly quickly across the PowerPoint so we can get to a point where we can ask questions of them in relation to a local sense. Thank you.

Mr HOCKING — No worries, thank you. I will go through this fairly quickly. You are familiar with our collaboration with Turning Point, who provide all our data on drug use and non fatal heroin overdoses. They provide us information back in response to that and we are expanding the data collection to include mental health presentations.

We are experiencing an increasing number of calls regarding crystal methamphetamine, attending approximately 700 cases per annum, but in contrast to that, about 11,000 for alcohol related cases. This is a quick snapshot here. I will just go through the highlights. It shows increases since 2010-11 and the number of attendances in 2011 12. With specific reference to crystal methamphetamine, there has been more than a 100 per cent increase since 2010 11. Specifically in relation to the Ballarat area, there have been eight attendances for ice related cases in the 2011 12 report.

In relation to crystal methamphetamine, this is just a generic breakdown of the types of cases. The mean age of our patients is around 27. About 60 per cent are male. We transport about 80 per cent of those patients to hospital. About 30 per cent have an alcohol component to them as well. Are you happy for us to comment on the local scene or would you rather have us respond to questions?

The CHAIR — A bit of both, actually. If you would like to spend a couple of minutes just giving us an overview of what is happening in the Ballarat region in relation to your responses and attendances and presentations, then we will ask questions.

Mr HOCKING — All right. I might hand over to Sam for that.

Mr CALDOW — I obviously am a front line paramedic and, as such, see probably more than what Grant does. Those figures indicate eight attendances within a 12 month period. I would argue that that is probably not an entirely accurate reflection of the numbers. Quite often these patients present with polypharmacy, so have multiple agents on board, whether it be ice, alcohol, prescription and other non prescription medications.

I also think that we tend to see them not because of their use of ice—rather, the complications because of the use. One specific incident springs to mind: a young bloke who was involved in a motor vehicle collision, where he ran into a tree. He was ice affected. He believed that he was somewhere completely different, had no idea that he had been involved in a car accident, and thought that I as a paramedic attending to him was one of his best mates and they were still driving to Melbourne.

We were not called because he had taken ice. We were obviously called because of his traffic collision, and then obviously we get there and find that they are substance affected as well, which adds another degree of complexity to the management of the case, being that we have to manage that stimulant that they have on board, in conjunction with the injuries that they have suffered. Quite often the drug ice will mask or create difficulty in assessing exactly what is going on, whether it is because of their mental state or because of their physiological changes, so an increase in their heart rate, their rest rate. It is very difficult to determine exactly what is causing what we are seeing.

Mr HOCKING — I would like to make another statement there. With some of the festivals that we have in and around this area—music festivals and the like—we tend to see an increase in cases out of the festivals, but a lot of those are managed on site by first aid or other healthcare providers. We do not necessarily see them directly or transport them, but we do sometimes have a presence at those scenes, and there is a high increase at those locations.

I have worked at some in the past, and it is a constant stream throughout the day and night of people coming through. We do not necessarily treat them. They are treated by the on site people if they are well enough and they are just looked after for a few hours and then sent back out into the festival and on their way. We would not have those recorded in our statistics.

The CHAIR — Are you happy if we ask questions now?

Mr CALDOW — Absolutely, yes.

The CHAIR — I might lead off. We have seen the data before, to be honest, and some of those figures we have to question, because we are getting conflicting evidence of presentations to emergency departments, as with the drug agencies.

Mr CALDOW — Yes.

The CHAIR — I notice that is a year old report, so ice certainly would appear to be in greater use in the community since that report was done.

Mr CALDOW — Yes, absolutely.

The CHAIR — Not that I am trying to over-sensationalise the figures in any way. We have been told that with ice—and it might be the more extreme cases—there are a whole lot of resources needed to respond to someone that is significantly impacted by coming off ice.

Mr CALDOW — Yes.

The CHAIR — The aggressive, violent behaviour requires a different way to respond, and the police have indicated that they cannot use tasers, or they do not want to use tasers because of the mental aspect of the response, and we understand that paramedics are also having to treat the way they respond to someone who is physically violent that has been affected by ice differently than they normally do other patients, even heroin and other drugs.

There is a view that there is a different way to deal with responses to ice users and different resources have to be applied in different ways. I would love it if you could provide a snapshot in perhaps the more acute cases of how you deal with an ice user in relation to a resource and tactical response so we can have an understanding of what is so different about this drug compared to other drugs that it is actually impacting on the way that you do your business.

Mr HOCKING — If it is okay, I will start from the initial call and then I will let Sam complete the picture from a direct patient care perspective. Our Emergency Services Telecommunications Authority—so ESTA—is where we have our call taking and dispatching processes coordinated. We have a clinician and a duty manager on staff there as well. When a case comes in, they will identify through the call—the question and answer process—what specific type of case it is and how severely unwell the patient is and then the response, depending on the level of critical illness of the patient, will be an advanced life support ambulance and, if there is any airway or cardiovascular compromise, it is then also supported by an intensive care ambulance. They will, in a lot of cases, both be dispatched simultaneously to attend the patient. Without the airway and cardiovascular compromise, it will probably generally just be an advanced life support paramedic unit that we will send. I will give it to Sam to finish the picture.

Mr CALDOW — That is obviously where I come into the picture, or ALS guys come into the picture. On our arrival we are typically presented with, depending on what the origin of the call is, someone that is normally quite distressed—a family member, a friend, a bystander—that has encountered this person that is behaving exceptionally abnormally, very agitated and very bizarre behaviours, from seeing things to trying to do really quite strange things like jumping off a roof, trying to fly and those sorts of bizarre behaviours that I am sure you have heard lots of stories about.

Obviously from our perspective our first priority is to make sure that we are safe, and that quite often is where the police become involved. I am sure you have heard from them as well. The great difficulty in assessing and looking after these patients is quite often they do not recognise who you are and that you are trying to provide them with assistance. As a result, they see you as a threat and we deal with aggression and violence towards as us as well. Once we have established our own safety, we need to try and form some sort of assessment. As I touched on before, quite often they have multiple substances on board as well as the ice, with the ice obviously being the key factor in their behaviour.

Depending on what their behaviour is and how compliant they are, we can have a conversation with them, assess their wellbeing, perform some vital signs, assess their heart rate, their respiratory rate, their blood pressure and so forth, then also assess what is going on today: if they are having some mental health issues, thoughts of suicide or self-harm, or have engaged in dangerous behaviours, like they have jumped off a roof, being involved in a car accident or such, and assess what injuries they may have sustained. Another case jumps to mind. A particular person jumped off a roof and broke both lower legs. They were oblivious to the pain they were in, walking around at the scene, effectively on their ankles with their feet sort of kicked out sideways. It is quite gruesome at times to turn up to that and they did not perceive there to be any injury or anything wrong. With that complexity of a case you have to convince them.

Unfortunately, a lot of the time they are not willing to come to hospital or have engaged in behaviours that mean they do not have a choice, so with the involvement of police we have to restrain them and sedate them, using some of the medications that we have, in order to provide that transport to hospital.

Mr HOCKING — A lot of our clinical practice guidelines are modified for patients with drug or other effects of alcohol, for example. You mentioned before about heroin users. We have specific guidelines to treat specific types of patient presentations. Often, as Sam has mentioned, because they may not be aware of painful stimuli, we then modify our normal approach to patients in those sorts of situations without drugs on board, without ice. Our paramedics are highly trained. They work to the guidelines but they often need to modify those, depending on the patient presentation.

The CHAIR — Do you call for police assistance when you arrive at the scene to ascertain that in fact your workplace could be put in jeopardy because of the violent nature of the ice user?

Mr CALDOW — Yes.

The CHAIR — Do you do that as you get the call to say there is an ice addict who is behaving violently in a setting? Do you then immediately call the police to say, 'We'll need backup support,' or do you call them later?

Mr CALDOW — It can come from one of two ways, and both ways as you have just described. Initially, if there is threat of violence or aggression at the scene or assaults taking place, police will be co dispatched with us so they will arrive before us, secure the scene and ensure it is safe for us to enter. The other one is that if there is no violence at the scene, we will attend. If we can establish that it is safe to enter, we will; then, depending on the discussion or conversation we have with the patient or the affected person, determine their requirement. If we arrive and it is not safe then we are able to retreat, withdraw and wait for police to arrive and assist us in our assessment of the patient.

The CHAIR — I would like to question you further about resources because police are ongoingly being asked to provide support for what we see as more violent cases of drug abuse. It draws resources away from their normal functions but, as well, it is important to provide the security of a workplace for yourselves.

Mr HOCKING — As Sam mentioned, during the initial call, if there is any risk or threat of violence, the call takers will determine that and ask a specific series of questions. Then, as I mentioned also, our own staff—our duty managers and clinicians—become involved and will make further calls to assess the level of the risk. If it is deemed high then they will call the police to co-respond. But if it is not a high-risk grading, they will send the ambulance on its own. It is up to the crew then to determine the level of risk once they are on the scene.

Usually—I would say the majority of times—if there has not been a phone pick-up from the initial call that there is high risk, there is usually not. It is only in unusual circumstances that they arrive and it has not been predetermined. Normally we would know beforehand that there was violence and risk, and quite infrequently send a crew into a dangerous situation. But you are right, the police have become acutely aware and we are aware of that as well. So we try to limit the number of times we call them out in the first instance, and it is only for those who are at high risk that we will do that.

Mr SCHEFFER — I am just going back, Sam, to your account of that dangerous and worrying scenario that you sketched for us, which is clearly at the extreme end of what a call-out might be. Then there would be a variation, and I think Grant was indicating where it is not quite so extreme, but in all those situations, when you keep your records, you need to put down the primary cause or the primary drug that the person was on. How do you make an assessment about whether it was ice or whether it was ecstasy or alcohol? How do you form that view, other than people telling you?

Mr CALDOW — At times that can be quite difficult. That is where we rely on physical signs and symptoms and assessment of their vital signs: the heart rate, their conscious state, their blood pressure and such. It often gives us an indication of whether it has been a stimulant or a depressive they have taken, with ice being a stimulant. Obviously there are a number of ways they are able to ingest ice, from smoking it to injecting it as well. That leaves visible signs, so obviously injection marks—track marks, as we call them—where they have injected it into veins. Then also there is the residue of smoking it and paraphernalia that is at the scene, so sharps and the pipes that they use to smoke it.

Very rarely do these drugs get used in isolation. By that I mean we find that people do not sit at home by themselves and use ice. It is a very social drug and it drives people to be social, and the social pressure of it leads to them using as well. It is a bit of a spiral there. Once they are with friends who are using it they will try it and it continues to escalate in that manner.

Mr SCHEFFER — So in summary, it is fair to say if someone tells you they have taken what they believe to be ice—and that in itself is a question because it might not be—

Mr CALDOW — Yes.

Mr SCHEFFER — but if they tell you and the physiological effects tell you it is a stimulant, you would not actually know whether it was ice or another kind of stimulant.

Mr CALDOW — No.

Mr SCHEFFER — Then the external things that are around would point towards whether it was ice or if there was ice actually there in unused form.

Mr CALDOW — Yes.

Mr SCHEFFER — So that is the range of indicators you would use?

Mr CALDOW — Yes.

Mr SCHEFFER — But there is some room for doubting whether it is actually ice.

Mr CALDOW — You talked about the resources required and it seems that obviously there is a fairly large component of the police being required to make these patients safe. In the more extreme circumstances where we have to intervene with pharmacological interventions, quite often they will then, as you have alluded to, require other resources at the hospital but also require other ambulance resources in the form of our intensive care paramedics. Someone who has taken an overdose of ice or of multiple drugs will quite often require airways support, what we call intubation, and also sedation and paralysis as well. These patients are very complex to manage and because of the drug on board as well, it can often alter the dynamics of the medications we administer.

Mr SCHEFFER — I am asking the question from the point of view that our specific brief is methamphetamines, with focus on ice. Part of what we need to get clear in our work is the data, so that we know what we are talking about and whether we are confusing the use of ice methamphetamines with other kinds of stimulants. That is why we are asking these questions. The unclarity that you work in is an occupational circumstance but, from our point of view, we are just asking those questions, not to diminish what you are saying but to try to get exactly clear what you know and what you do not know in the situation.

Mr CARROLL — Thanks, Sam and Grant, for your presentation and for the work you do. Mine is a broad question which is simply, what more could be done to assist paramedics in dealing with methamphetamine-affected patients? It is a dorothy dixer for you.

Mr HOCKING — At the moment we have a fairly good understanding. Our paramedics are well educated and continually train and do education sessions. We have one of our staff as a member of Turning Point, so he is an ambulance representative as part of Turning Point. I would think that we are pretty well versed in the use and effects of ice in particular. We continually update our clinical practice guidelines that I mentioned earlier, and recently—I would say in the last five years—we have introduced new clinical guidelines to manage those specific patients that have not only ice on board but other drugs as well.

I am not sure that there is a lot more we could be doing, but we are adaptive and we are responsive and we will change where we see it is needed. At the moment I think we are just doing everything we can. We also do not just change on a whim. We actually change based on evidence. That is what we need and that is why we collect a lot of data. I will finish my statement by saying that we do collect a lot of data. We are collaborating with Turning Point on providing them with information, and we get information back so we can use it for our own purposes as well.

Mr CALDOW — I would probably echo Grant's sentiment that at the moment we are quite well equipped from an ambulance/medical perspective to deal with these patients. As we

touched on before, we have pharmacological medications we can give the person if we do need to restrain and transport them to hospital. There is probably not a great deal that can be done immediately to support the paramedics themselves—it is the support structures around them. As Grant has touched on, we have good education. It is making sure that everyone continues to work in a safe environment and can make sure the patients are at the forefront of our—

Mr CARROLL — So you meet with the police. Could that relationship be strengthened, like at the front end when you are going out to the scene? So put that out there with the police, and then also when you are actually driving a patient into the emergency department. Would you change anything, if you could, at either end there?

Mr CALDOW — I think we have a really good working relationship with the police. Certainly the front line guys that we have contact with regularly are more than aware of the limitations that are placed on us with legislation and such. It becomes a bit of a blurring of the lines as to where the responsibility lies. If they are at risk themselves, then ambulance cannot initiate the decision to transport to hospital. That is something that the police do. They rely on our judgement to do that, so that collaboration works quite well.

Mr CARROLL — Yes.

Mr CALDOW — I think that the policy of requesting police to attend as it is at the moment works quite well. They certainly trust and back our judgement, and we bounce ideas off each other as well as to how best to go about managing a patient as appropriate.

Mr CARROLL — Is there a ratio? How many would go in the back of a police car or a divvy van—they are a real risk to themselves—to a hospital emergency department versus an ambulance?

Mr CALDOW — I would say probably the majority of patients that come to ambulance attention are transported by the ambulance, with a police escort, I will say.

Mr CARROLL — Yes.

Mr CALDOW — Normally by that stage we have had to take steps to manage and control that patient, whether it be through medication or restraints. But I would say the majority of them go in the ambulance.

Mr CARROLL — Does a police officer go in the ambulance as well? Does he escort?

Mr HOCKING — Sometimes. If the patient is exhibiting violence or is aggressive, then we will often take a police member. Also if there is any crime and there needs to be a consistent evidence chain maintained, they will often attend for that. But again I would say that the majority of times it is the patient with the paramedics in the ambulance, without police.

Mr SCHEFFER — Do you have more updated figures than the ones from Turning Point? I would be interested to know those.

Mr HOCKING — No.

Mr SCHEFFER — So you cannot tell us how many cases you have had over the last 12 months where people have been affected by ice.

Mr CALDOW — Not in hard data, no. Incidentally again, I would have seen a large increase, going from maybe one or two in a 12 month period to, I would say, one a fortnight to one every three weeks this year alone.

Mr SCHEFFER — Okay, so up to about 25 a year.

Mr CALDOW — Yes.

Mr SCHEFFER — From?

Mr CALDOW — From probably three or four a year.

Mr SCHEFFER — Okay, thanks.

The CHAIR — You mentioned the updated guidelines. Would the committee be able to get a copy of those guidelines?

Mr HOCKING — Certainly.

The CHAIR — They are not just internal use?

Mr HOCKING — I can provide those.

The CHAIR — Thank you. Thank you very much both of you, Sam and Grant, for appearing with us this afternoon.

Witnesses withdrew.