LAW REFORM, DRUGS AND CRIME PREVENTION COMMITTEE

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

Wodonga — 24 February 2014

Members

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Witnesses

Mr M. Fuery, Paramedic, Ambulance Victoria.

The CHAIR—I might take this opportunity now to reconvene the public hearing of the Law Reform, Drugs and Crime Prevention Committee. We have our witness at the table, Mr Mike Fuery, a paramedic from Ambulance Victoria. We have allocated a sessional time from 1.30 to 2 o'clock this afternoon to hear from Mr Fuery. I will read the conditions under which you are giving evidence this afternoon to this inquiry.

Welcome to the public hearing of the Law Reform, Drugs and Crime Prevention Committee. 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. It is important that you note that any comments you make outside the hearing, including effective repetition of what you said in evidence, may not be afforded such privilege. Have you received and read the guide for witnesses presenting to parliamentary committees.

Mr FUERY—Yes.

The CHAIR—Thank you. It is also important to note that any action which seeks to impede or hinder a witness or threaten a witness for the evidence they would give or have given may constitute and be punishable as contempt of parliament. We are recording the evidence and will provide you with a proof version of the *Hansard* transcript at the earliest opportunity so you can correct it as appropriate. We normally ask if you wish to make some opening statements and then the committee will want to ask some questions of you.

Mr FUERY—Sure.

The CHAIR—Thank you, Mike.

Mr FUERY—Insofar as a general comment, from our perspective, stipulating or detecting ice as a problem—or methamphetamine—as a particular problem that we are attending is very difficult to do in the field. Our greatest indicator, I suppose, the treatment is to observe behaviour. Unless we have someone at the scene who says they have taken ice or they have taken some drug, or there is other evidence at the scene, we are flying by the seat of our pants a lot of the time and watching behaviour. I do not know if that helps to frame the questions but that is probably the only thing I would like to say at this stage.

The CHAIR—That was short and sweet.

Mr FUERY—Yes.

The CHAIR—We have collected a lot of evidence, particularly from Ambulance Victoria themselves centrally in Melbourne and also locally. Some of the evidence we have collected is already about the impact of crystal meth particularly to frontline officers like yourself, paramedics, how you have to change your behaviour and method, I guess, in relation to dealing with particularly those affected by methamphetamine. You might want to make a comment about that. I would invite the committee to ask questions and they might well draw that out.

Mr FUERY—Certainly, yes.

The CHAIR—As distinct from other drugs. We are trying to work out what we can possibly recommend to parliament that is related to the fact that this drug is significantly different to other drugs where frontline officers have to deal with it.

Mr SCHEFFER—Thank you for that opening remark which was a good beginning. Given that you do deal with a range of incidents in the streets, the city's nightlife, and having to collect people who are in trouble, in some of those incidents people would indicate that either the person in trouble has been using ice or they might say it themselves. When you look

at those circumstances where you are reasonably clear from what people tell you that ice is involved, what is the process and what are the difficulties and issues of bringing a person like that into care?

Mr FUERY—To be completely frank with you, that scenario is more likely to be a case where we see the aggressive behaviour or we see abnormal behaviour for which we are required to intervene, whether that be through using our clinical practice guidelines or whether to use behavioural. We do not often have people saying they have taken ice or, 'I've taken ice.' In many ways we are in the dark. We can suspect it, certainly, but as for our intervention, like most of what we do, we base our intervention on what we see or what we can measure—their vital signs, conscious state, all of those clinical things we can measure. Whether ice is involved I am not sure whether there is anything specific. We would look at the degree of agitation, the degree of aggression perhaps and make a judgment on that. It is not often we get to have a definite flag that goes up that this person has had ice.

That is peculiar to this area, I would say, because I was speaking to a colleague recently who works in Mansfield and she said—I think it was January 2013—they had one particular week where the local police officers came to visit the station and said, 'We've had some cases of ice, apprehending people who have had ice administered. Have you heard anything?' Her response was no. Then in the subsequent days they had a string of people who were identified as having used ice. Then it died away, there were no other incidents related to that. It seemed to be a well-defined and discrete period of time where a supply came into Mansfield and then there was nothing. As far as here goes, Albury-Wodonga, I have no doubt that it is here.

Mr SCHEFFER—Why do you have no doubt it is here?

Mr FUERY—From the fact that it is well publicised and people have come out and said that it is here. We have had evidence of other substances being used. For instance, narcotics, heroin, differences I have experienced between working with narcotic affected people in Melbourne to narcotics here. It was not as dramatic, we did not have the overdoses. We certainly suspected it was up here and we have had some people that we have encountered who were—I will not say sub-clinical—just on the border of becoming clinically significant.

Mr SCHEFFER—Do you have ways that assist you to identify what is wrong with somebody who is in a state of extremity? Like, you can work it out.

Mr FUERY—Sure.

Mr SCHEFFER—Whether it is their heart or whether they are drugged?

Mr FUERY—Yes.

Mr SCHEFFER—But you do not have a tool at your disposal that tells you whether or not a person is having these symptoms because they have been using ice?

Mr FUERY—That is right, we do not.

Mr SCHEFFER—Therefore it would then stand to reason—and I am not trying to put words in your mouth—that neither would the police or anybody in the emergency ward?

Mr FUERY—Perhaps that would be the case, yes. Again if we are suspecting it—and unless there is evidence from someone else saying they have used ice, that is the only way we can know. We do not know most of the time.

Mr SOUTHWICK—A blood test?

Mr SCHEFFER—Yes. Would the emergency ward know?

Mr FUERY—Again the emergency ward would suspect unless, of course, someone says—either the patient themselves says, 'I've had some ice,' or some relative or friend said, 'They've had some.' It is all based on what people suspect. Looking at the symptoms they might see some of those symptoms that we would tick off the list and think, 'It's probably likely that they've had some but we don't know for sure.'

Mr SOUTHWICK—Following on from that, if a blood test is administered by police, as opposed to an alcohol test, would the actual blood test pick up the use of ice?

Mr FUERY—I do not know anything about that, but if that is one of the drugs it tests for then that would be a good measuring tool.

Mr SCHEFFER—The police would have it. It is a bit of three-way conversation.

Mr FUERY—No, that is all right.

Mr SCHEFFER—I am wondering if the police would have a tool available to them to identify it through a test, why wouldn't you have it?

Mr FUERY—It is a good question. We do not have breathalysers so we do not measure blood alcohol content. We suspect it and we can certainly smell it, and there is evidence—

Mr SCHEFFER—Okay.

Mr FUERY—Because also society's attitude towards alcohol is very relaxed and very comfortable that will often have information given to us that they have had 'a couple', and we go, 'A couple of dozen,' or we can smell it or there are broken bottles. There is ample evidence for us to make that assessment.

Mr McCURDY—Would a level of admission assist you?

Mr FUERY—Probably. Any information that we could gather would be of value to us. We really do benefit from any information in terms of a clinical history. When we are asking people in general, we say, 'What medication are you on? What allergies do you? What is your past history?' In the case of people we have never met before, in the field we would be saying, 'Have you taken anything?' If they do not tell us then they do not tell us, we do not know. We can suspect but we do not know. But if they were to say, 'Yes, I've had some ice,' that would be great, but that is rational conversation. If we are meeting someone who is irrational and aggressive, it is very hard to make the distinction between alcohol and ice.

Mr SOUTHWICK—Following on from that though, if you suspected that somebody is on something and it is not being disclosed to you by the patient, would that be helpful if there was a drug test available to be able to give you more information as part of that treatment as to what that person might be using?

Mr FUERY—Well, it could be, although our priorities are to try and assess a patient's clinical state as quickly as we can and then initiate any treatment to protect them. So if we see someone who was aggressive or perhaps requiring some restraint or some sedation, then we would do that, and we could suspect in the back of our minds there might be other substances involved that is provoking that behaviour. Whether we would see it as necessary to do some sort of test, it would be very difficult because we would be looking for compliance as well, whether that be a saliva test or whatever. It is easy to do a blood glucose test, we can jab a finger and there is a drop and we know. There are certain things we can test for relatively quickly but I do not know whether a drug test would be that helpful.

Mr SOUTHWICK—What about people that are presenting with, say, an alcohol-fuelled violence episode, are you seeing those?

Mr FUERY—For 30 years I have seen them, absolutely. That is the problem.

Mr SOUTHWICK—That is the problem. In more recent times, is it possible that some of those are also using ice or something else? Have you seen a recent spike?

Mr FUERY—No. It is possible and I cannot exclude it, but alcohol has always been the problem. It is the biggest problem for society, policing, health care, family, relationships and finances et cetera. It is the biggest problem.

Mr McCURDY—In weight of numbers you are saying it is the biggest problem in terms of the level of violence or trauma involved or is it the weight of numbers, because we have heard around Victoria that alcohol does seem to be, by volume, the largest issue that we have.

Mr FUERY—Absolutely, without doubt.

Mr CARROLL—Alcohol-fuelled violence or the drug ice, evidence suggests, with ice, it makes people very strong. You spoke before of having to restrain people. Where is the threshold with having to get the police involved, and how do you work with the police?

Mr FUERY—It is about the way we manage a scene. Our priorities are safety to ourselves and then safety to the patient and safety to those at the scene. If we have someone who is physically aggressive, violent, irrational and threatening, we would request police attendance. If that person can be safely restrained then we would like at strength of numbers to do that, and then we would look at using our approved restraints or sedation—a chemical restraint as well. Those are the options available to us.

Mr CARROLL—How often would you need to get the police, or is that a rarity?

Mr FUERY—That would be a rarity, yes—probably a couple of times a year—for something to escalate to that degree, but we certainly encounter a lot of aggression and violence due to alcohol along the way.

Mr CARROLL—I was reading your biography, you have done quite a bit in terms of how to manage things in ambulance services and paramedic services and obviously forward-thinking with some of the technological advances you think could be adopted. What recommendations could the committee make to assist paramedics in relation to crystal meth?

Mr FUERY—I gave this question a lot of thought, and I am not sure, to be honest with you. I am not sure I can be that specific. We have a number of organisational practices, such as flagging locations of interest. If there are regular events that happen from one address we can flag that within our computer aided despatch system at Ballarat and in Melbourne. When a call comes from that address it will be flagged. Then we can enter that location with some forewarning. As you know some of these cases appear at pubs and there is no pattern to them. It is very difficult to predict. Often the frequent cases are identified over a mess room table discussion. Someone will say, 'I went there last week,' and someone else will say, 'I went there yesterday.' 'Oh, really, same thing?' Then a discussion starts up and then I get told and I do a search through our database and suddenly we discover there is a pattern of contact.

The CHAIR—A quick question of clarity. This morning we have heard a lot of evidence about the increasing prevalence of the use of crystal meth in this region. Your evidence is suggesting that you have seen no increase in responses by Ambulance Victoria—in your case, the service here—to methamphetamine antisocial behaviour or a requirement for a paramedic.

Mr FUERY—An increase in it?

The CHAIR—Yes, an increasing response to drug-related antisocial behaviour or medical attention.

Mr FUERY—Yes. I could not be so specific to say it is related to methamphetamine but I could say that we certainly see behaviour—

The CHAIR—Assuming it is not alcohol, it is some other drugs.

Mr FUERY—If it is not alcohol. You see that is the difficulty again because of the poly pharmacy aspect that sometimes alcohol is taken with other things as well, not only methamphetamine but other substances that provide confusing symptoms sometimes. It is difficult to be that specific.

The CHAIR—If I can put it another way.

Mr FUERY—Yes, sure.

The CHAIR—The evidence this morning from different stakeholders indicated there was an increased use of crystal meth in this region, but your evidence is suggesting that you have not seen it at the coalface in relation to response or medical attention.

Mr FUERY—Correct.

The CHAIR—Which indicates either the evidence this morning was not perhaps a true reflection on what is happening in society, or in fact there is an increasing prevalence of the use of the drug but it is not seen at your level.

Mr FUERY—Yes, that is right. As I said before, I have no doubt that it is out there, from what we know, and the publicity, but I would suspect that we get called in health crises. When a situation becomes out of control we get called. I have no doubt that to individuals and their families it is a huge problem, but we are not being called a lot of the time to that.

The CHAIR—Thank you. Any closing statements you would like to make, Mr Fuery?

Mr FUERY—As I said, I gave this a fair bit of thought and I would have to say the ongoing issue for me and for a lot of my colleagues, and I daresay other agencies as well, is alcohol. I suppose at a family and at an individual level, the introduction of these drugs—ice—certainly has a profound impact. But I think as a society, alcohol is the big one.

The CHAIR—All right. Given that you are in the box seat we have had new laws introduced in New South Wales in relation to reducing access to those facilities that sell alcohol. A good piece of legislation, a bad piece of legislation? What can we do to control the abuse of alcohol in our society?

Mr FUERY—Change of attitudes. Educate. I put a proposal together to Tony Robinson back in 2007 for creating a TAC style advertising campaign that would help to change attitudes. I am not advocating, of course, abstinence or prohibition or anything like that, but the attitude needs to be changed. It is a slow process to get people to think a little bit more carefully about quantities and amounts.

Mr SOUTHWICK—In terms of alcohol being the big issue for you—and I am certainly not taking that away in terms of what was suggested—but would you also consider the fact that alcohol being a legal drug, if you like, people are more likely to call an ambulance for an alcohol problem than they are for an illegal drug? Therefore you are not seeing the types of presentations that you would of somebody that had overdosed or taken a drug?

Mr FUERY—Yes, absolutely. The corollary to that would be the reluctance of some

people to call us for narcotic overdoses because they would assume that we would have some communication with the law enforcement agencies. We would make it quite clear to them that we are here as a health agency, as a health service, and we do not routinely share that information. If we suspected trafficking or a bigger issue, we certainly would consider sharing that information, but for the individual—

Mr SOUTHWICK—The perception would be there but you would possibly be sharing that information—

Mr FUERY—Yes, that is right.

Mr SOUTHWICK—And therefore it would be unlikely for them to call, say, a paramedic as opposed to dealing with it themselves.

Mr FUERY—Yes.

The CHAIR—Thank you very much for your time this afternoon.

Mr FUERY—Thank you.

The CHAIR—I will officially ask Mr Fuery if he would table his written submission to the committee.

Mr FUERY—Yes.

Witness withdrew.