**LAW REFORM, DRUGS AND CRIME PREVENTION COMMITTEE**

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

**Mildura — 5 December 2013**

Members

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Witnesses

Dr D. Turner, Medical Director of Emergency, Mildura Base Hospital.

Ms L. Dellar, Nurse Unit Manager, Emergency, Mildura Base Hospital.

Mr D. Kirby, Director, Mental Health Services, Mildura Base Hospital.

Ms J. Gleeson, Dual Diagnosis Consultant, Mildura Base Hospital.

**The CHAIR** — Good morning, and welcome to this joint parliamentary Law Reform, Drugs and Crime Prevention Committee's inquiry into the supply and use of methamphetamines, particularly ice, in Victoria. I welcome as witnesses Dr Dan Turner — just quickly putting a face to the name — medical director of emergency; Ms Leanne Dellar, nurse unit manager, emergency; Mr David Kirby, director, Mental Health Services; and Ms Jill Gleeson, dual diagnosis consultant. Welcome to you all. I invite the committee members to introduce themselves.

I would like to read to you the conditions under which you are providing testimony to this public hearing. Welcome again to 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 have said in evidence, may not be afforded such privilege. Have you received and read the guide for witnesses presenting to parliamentary committees?

**Dr TURNER** — Yes.

**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 transcript at the earliest opportunity so you can correct it as appropriate. I am very mindful that when there are a significant number of witnesses we have time overruns, and we do not have that luxury this morning. If you could keep your comments brief, because the committee would like the opportunity to tease out some of the issues that we have had experience of in other regional hearings, and I suspect there will be some similar themes to your own. We do not need that overlap, but we do want to draw out your experiences particularly in the Mildura region in relation to the departments you are responsible for. I invite Dr Turner to present first.

**Dr TURNER** — We have already met and talked about this a bit amongst ourselves. We are presenting two perspectives from the hospital. I will be talking about the acute care services and the emergency department and what we see, and then David will talk more about the community engagement and the mental health side, which sees a fair bit of this as well.

In regard to ice in the emergency department, although it is quite prevalent in the community we are just not seeing a lot of it in the emergency department. Certainly other drugs like alcohol, smoking, cannabis, marijuana and those sorts of things are still much more common for us. We see a small collection of these patients probably on Friday and Saturday nights in the 18 to 25-year-old age group who come in very sympathomimetic — turned on, very excited, very agitated — often with the police and the ambulance. They require a lot of resources from our point of view in terms of having to chemically and physically restrain them and then maintain them in that safe environment until the effects of the drug wear off, which can be anywhere from 3 to 4 hours to 6 to 8 hours. Then usually they are discharged back home or into the community. That has really been our experience.

Certainly five years ago we would not have seen any of it; now we are probably seeing, I think we worked out the other day, maybe one or two cases a month, but they might be clustered on a particular weekend when we see three or four and then we might go for two or three weekends without seeing anything. In terms of the stereotypical very aggressive, rampant patient we are seeing a couple a month and that is about it. That is our emergency department experience with those sorts of patients.

We see patients with alcohol and marijuana-related problems every day around the clock. I tend to work 9.00 a.m. to 5.00 p.m. or 3 .00 p.m. to 11.00 p.m. Monday to Friday, Saturdays and Sundays, and I see a lot more alcohol-related problems in any given shift. I have not seen a sympathomimetic ice patient in the last two years. Other drugs are still big problems from a health perspective. These patients, when they do come in, obviously present a safety issue for the

health-care workers and for themselves and for the people who bring them in — the police and the ambulance as well — because they are often very aggressive, disinhibited and psychotic and they really have no concept of what they are doing. You see them the next morning and they do not remember anything. They are very meek, placid and apologetic. They are completely different people.

**The CHAIR** — Do we take it then, apart from the more extreme cases, that the ice users who require some response from police end up in the cells rather than in the emergency department, because the information given to us is that there has been a significant increase in its use and in antisocial behaviour?

**Dr TURNER** — Yes.

**The CHAIR** — If you are not seeing so much in the hospital, obviously they are not heading in that direction; they are being put in police cells or being detained in some way.

**Dr TURNER** — The police are pretty good at identifying anyone who is drug affected, whether it is ice, marijuana, speed, cocaine, ecstasy or whatever, and when they do they bring them to us. They will clear them through us first before they put them in cells, because obviously they will not take someone who is high and put them in a cell. It is a danger to the patient. I am not aware that we are seeing a large number of ice patients coming in.

The other issue is that we do not necessarily ask. We can ask them, but they may not tell us what they are on or what they are using. They may be psychotic and a bit off, and we manage that. We will see those patients whether it is related to ice or whether it is related to alcohol or to other drugs. Unless they specifically tell us they have been using ice, we may not get that story either.

**Mr SCHEFFER** — Just on that, does this suggest there is a discrepancy between what we are hearing and seeing in the media and what the police are telling us and what you are telling us? The Chair tried to explain what the difference might be.

**Dr TURNER** — There is a spectrum of disease with anything. At the far end you have the psychotic, raging bull-type patient, and at the other end you have the patient with social and economic problems and with a home life that is completely disruptive, and they are addicted. We do not see 95 per cent of the spectrum in the emergency department; we see 5 per cent of that spectrum. We are only seeing the bad and really aggressive tip of the iceberg. David, mental health, GPs, community practice and regional community health are the sorts of people who see the other 95 per cent.

**Mr SCHEFFER** — Thank you.

**Mr SOUTHWICK** — Maybe we should hit the 95 per cent.

**Mr KIRBY** — I am not sure about the 95 per cent. I just want to put our situation in context. Obviously our emergency department and our hospital is remote, regional and rural. We take patients in the emergency department from a very broad area. We have small emergency departments, which are essentially GP-run, through Robinvale and Ouyen, but essentially we are the only tertiary facility that has 24-hour-a-day, seven-day-a-week care. We have approximately 30 000 presentations to the emergency department, and the hospital has 146 beds.

My role at the hospital is that I am the director of mental health services. We are the Northern Mallee area mental health service, and we cover about 25 000 square kilometres along the river down to almost Swan Hill and along the Mallee track, including Ouyen, and across to the South Australian border. We also take admissions from the population that Paul was referring to just over the border as well. The nearest mental health inpatient unit is in Broken Hill; other than that it is through Bendigo. Essentially we are the one-stop-shop for mental health services around this area. We provide a CAT — or crisis assessment and treatment — service seven days a week through the emergency department, and we have telephone triage running 24 hours a day.

We are seeing an overall increase in presentations for ice. That being said, the data is not specific. For anybody coming through to our service we do a screening, which includes seeing what substances are being used. As Dan was saying, those acute presentations through the emergency department are basically handled within the medical model, and I should also say the security model within the hospital due to the risks presented there. For us, I think the difference we are seeing with ice compared to the more traditional-type substances, if you like, is the intensity and the acuity of the onset of symptoms. That means we are seeing people having overall social and physical dysfunction happening for a number of months, whereas in the past with cannabis and alcohol et cetera that onset could be over a number of years. We are seeing people presenting to us with depression and suicidal ideation over a number of weeks rather than a chronic major depressive episode, which is usually six months plus, and also the onset of psychotic features. Very rarely do we see people who are only taking ice and no other substances; it is generally a combination of different substances. With the addition of ice we are seeing more acute psychotic features with those patients.

The other change is that we are seeing a change in the demographic of the people who are presenting with substance abuse and ice use. Traditionally for us it has been males; now we are seeing younger females in the 18 to 25-year-old demographic presenting to our service. We are also seeing a slight change in the demographic of the people who are coming through to our service as well. They are not so much the lower socioeconomic group, they are more the nutritioned middle-class presentations; and again it is anxiety, depression and suicide ideation, and acute onset of those symptoms as well. So there is that shift for us as well.

The accessibility of ice in the community is something that we are putting this down to as well. It seems that it is a lot more accessible and much more social. Anecdotally — I was going to try to avoid using that word today — it is more available in pubs and nightclubs and such, and therefore it is much more accessible. But also it is an extremely expensive drug as well. I will stop talking at this stage.

**The CHAIR** — David, it is almost an oxymoron there in that it is very expensive and highly profitable in the supply chain. We understand that. Unless you are engaged in criminal activity in relation to being able to fund that habit, you would expect it would only be accessible to a certain demographic, given the price. Also, with its use in nightclubs, I assume the most popular way is smoking it — that is what we understand.

**Mr KIRBY** — That is my understanding.

**The CHAIR** — So there are not a lot of opportunities to do that in nightclubs, whether they are doing it before or they are doing it outside, assuming they go in and out to get the hit. I just thought from an ease of use perspective it would be quite difficult. We have spoken to nightclub owners who assure us that there is not a lot of trade or use going on in their establishments, but what you are saying is contradictory to that.

**Mr KIRBY** — That is certainly my understanding.

**Ms GLEESON** — That is my understanding.

**Mr KIRBY** — You will hear more from the Project Ice people later on. They have done more work on the ground in that respect, but that is where I am hearing — that a lot of people are usually introduced to the drug.

**Mr SOUTHWICK** — What about people who present on a regular basis? Is there any trending there to indicate that there are people who are finding themselves regularly needing assistance, getting support and then coming back? How are they treated and managed?

**Mr KIRBY** — I suppose the difference for us is that we will not have people presenting to us for withdrawal from a substance. People will come to us for a mental health issue, be that psychosis and/or depression or suicidal thoughts — that type of presentation is what we will see. Then it is a matter of teasing out the reasons behind that, and quite often it is drug use, alcohol use et cetera, but we are seeing people coming in who have been using multiple substances in the past

and then they have the addition of ice. For people who have been using some ice, because of the chemical changes associated with that, the down afterwards is extreme. Instead of seeing somebody with an acute depression over a number of months, they will come in after a number of days on ice — a few days after use.

**Mr SOUTHWICK** — You mentioned that there has been a change in demographic in the sorts of people who are presenting. Over what period has that become more evident, and can you put that down to anything? I do not want to go anecdotally, but do you have any suggestions as to why it has been targeted particularly at, say, a middle-class younger female?

**Mr KIRBY** — I would not be able to give you specific reasons for it. But just from some data that we have been running for the purposes of this inquiry they are the changes that we are seeing. It is a shift to probably 60 per cent males and 40 per cent females — sort of reverse — and younger in that demographic as well.

**Mr SCHEFFER** — Dr Turner is very clear on saying he sees one or two people on average a month, with some ups and downs. Can you give a similar quantification, because we have a lot of trouble trying to get a sense of the figures?

**Mr KIRBY** — No. It would take a lot of drilling down, and I would not have that specific data to be able to give you the actual numbers. That being said, the coexistence of alcohol or THC is still by far the most dominant issue.

**Mr SCHEFFER** — We get a lot of percentages of increase, and it can be distorting if you do not have the raw numbers.

**Mr KIRBY** — Sure. We did a sample. We do approximately 1100 assessments a year, so that means someone has called through to our triage service that they are requiring a response and our crisis assessment team will then assess them.

**Mr SCHEFFER** — They are unique records? The 1100 are not multiples? They are not the number of calls coming through; each one is a human being?

**Mr KIRBY** — Yes. Again, around 150 of those people throughout the last 12 months have presented with amphetamine use. In the previous year it was around 130, so that is what we are looking at. But again, it is not specific data.

**The CHAIR** — That is the issue for us, because emergency departments indicate that they have presentations with amphetamine and methamphetamine but they cannot break down the ice or the crystal meth as against the amphetamine, which has been around for as long as Hades. I am sorry, I am taking up the time. I invite Ms Dellar and Ms Gleeson to make brief contributions, and then we will open it up to the committee for questions.

**Mr KIRBY** — Can I just add one other thing? Leanne will probably go into this as well, but I will mention some of the challenges that we face. I think one of the reasons that we are not going to get that specific data is because of the challenges of managing people within the emergency department. If someone comes in in an acute aggressive state, the guys there have to treat them symptomatically, if you like, which is essentially going to be physical, mechanical and medicinal restraint within the emergency department in order to maintain a safe environment for the staff working in that place. Within the Mildura Base Hospital we have limited security. We have a designated security officer on overnight and that is all. The rest of our code black or personal response throughout the day is essentially going to be provided by our PSEs — cleaning and domestic staff — and/or the medical staff.

The infrequency of these presentations also makes them extremely difficult to manage in that respect, and we have been trying to find solutions to how to maintain the safety of our staff. But because they do occur so infrequently and at different times of the day, it is very difficult to predict. The challenge within the emergency department — and I do not want to put words into your mouth, Leanne — is maintaining the safe environment.

**The CHAIR** — Which is interesting for us too, because this committee conducted an inquiry into security in emergency departments. We interviewed a number of hospitals in relation to their security arrangements and how we could best make recommendations to improve security in emergency departments. That report has been tabled, and the government has responded in part. Feel free, if you wish, to make comments about security in EDs as well.

**Ms DELLAR** — I am just being mindful of the time, because David and Dan have probably covered most of it. The security issue is probably one of the biggest issues for staff in the emergency department, as David said, because of the infrequent number of presentations that we have. We do have limited security staff, being one overnight. These patients are often extremely heightened, aggressive, paranoid and unable to be reasoned with, which is I guess one of the key features of a methamphetamine presentation as opposed to a cannabis and alcohol presentation. Their physical and chemical state obviously poses a risk to patients and staff. Pretty much all of the heightened patients are brought in under section 10 with the police, and so we do have their assistance with the extremely heightened patient for the most part. But the risk still remains to staff. Conversely, there is the risk to the patient who we are having to heavily sedate to maintain a safe environment. They then also have an increased physical risk to maintaining airways and those sorts of things. It just absorbs so many resources, and they are very resource-intensive patients to care for.

**Mr SCHEFFER** — So that is when an incident actually occurs, but given that we have heard both Mr Kirby and Dr Turner talk about the relative infrequency, generally it is not an issue, but when it occurs it is highly resource intensive and dangerous.

**Ms DELLAR** — Yes. I have five staff on any emergency department overnight, and all of those five staff could be maintained for up to an hour with that patient ongoing until they are able to be adequately chemically restrained.

**Mr SCHEFFER** — Yes; understood. Thank you.

**Mr CARROLL** — Leanne, can you go on to section 10 — how that works — which you just referred to before?

**Ms DELLAR** — That is the police powers to bring any of us in under the Mental Health Act.

**Mr CARROLL** — So health professionals are empowered under that, as well as the police?

**Dr TURNER** — No.

**Ms DELLAR** — No. It is just police authority to transport to the nearest designated health authority, where a mental health practitioner or a medical practitioner can then continue the care of that patient. It just gives police powers to transport.

**Mr McCURDY** — And you are saying that these are more likely to be the higher maintenance clients coming in rather than those who have come in by ambulance or have been admitted with friends?

**Ms DELLAR** — Yes, because they are the patients the ambulance officers or the friends have called the police for, because they are unable to be managed safely and adequately. I do not want to use 'anecdotally' either, but anecdotally they are the larger of the small volume of patients who do present. The other group of presenters are the naive users or the one-off users or the party users whose friends become very concerned with the response they get from the drug usage, and they bundle them up and bring them into the emergency department. We do not have self-presenters.

**Ms GLEESON** — I guess I would like to just go back a little bit to the people we have coming into the mental health ward. No doubt this committee has heard a lot about the ice masking or mimicking the mental health symptoms or even exacerbating them, but the clinical picture is

very blurred and very difficult. On top of that there is often the reason people do not want to tell us or reveal to us what they have been taking. I think that is something we probably have not thought about and discussed — that people are not always identifying what they have been using, and they may or may not have known what they were using. They can be out and using substances and not really knowing exactly what they have used, and there could be numerous different substances. I guess that clinical picture is always very blurred when you have people coming in or accessing our service.

**The CHAIR** — Can I ask you collectively: is this the biggest social and health issue in Mildura? Is this an epidemic of a drug that is running rife and that requires an immediate response? If we read the papers, particularly here in Mildura, the papers have been very polarised in identifying the issue around ice and the local community as a social and health issue. What we are hearing from you is, 'Look, in the more extreme cases there are a small number of presentations to ED. There are small numbers of cases in relation to a mental health response requirement'. It is not really mirroring what we are hearing in the present media. Can you just make comment about that?

**Dr TURNER** — From an emergency department point of view, which is the pointy end of acute care, in the last fortnight I have not seen one case of ice. I have basically had two people die — a 45-year-old male and a 45-year-old female — because of complications of alcohol. We see lots more issues with smoking and alcohol. Those are the epidemic things facing society in my department right now. I have not seen any ice in the last fortnight.

**The CHAIR** — That is not to say it is not out there — just that you have not seen it.

**Dr TURNER** — That is right. We are at the acute care pointy end. There are a lot of socioeconomic, mental health and other sorts of issues we do not see, and that is where David and Jill see those sorts of things, and the community would see that. It does not mean it is not there; it just means the acute health care side effects we are not seeing in the emergency department, like with other drugs.

**The CHAIR** — Do you wish to comment?

**Mr KIRBY** — I was just going to say that I think we have a new phenomenon and a new drug coming into Mildura that has not been here before. I think there is an acute spike at the moment, given the fact that it is a new phenomenon. As I said, the acute nature of this drug has highlighted it to a lot of people, and also there are changing demographics, I think, as well. It appears to be more mainstream.

That is another thing I wanted to touch on regarding our treatment options in Mildura. We will see and admit people to our acute psychiatric unit for a number of detoxes, and we have in the past. We work closely in partnerships with community services, such as Sunraysia Community Health Services and their drug and alcohol counselling services, in order to stitch together a response — that is, agreements to bring people into the general wards at the hospital for alcohol withdrawals and having counsellors coming to the psychiatric unit for drug and alcohol withdrawals, which traditionally do not sit within the psychiatric system, but these are the types of responses we require in Mildura to support people who have drug and alcohol problems.

We do not have a residential facility nearby, and we have a lot of trouble accessing those services at the point where the person would like to access them. Particularly with ice we need the response quickly. Drug and alcohol services will be presenting later in the day, but we certainly would like that response more quickly at the time the patient or person requires it. Community-based counselling and drug and alcohol counselling are extremely stretched. I am not sure if you wanted to say anything more on that.

**Ms GLEESON** — We have an example of a person coming in to our service today we are working with — the alcohol and community drug services. This is a young lady. We have had to organise respite care for her little one. She is going to spend some time in the wards to give her an opportunity to come off ice and other substances. It is a polysubstance withdrawal we are doing. We are supporting her through so that we can actually enable her to get to Melbourne for a

rehabilitation centre, obviously. For her it is a huge thing because not only has she been separated from her child for the time in our ward but that child has to go 80 kilometres away for some respite care. We have to organise and juggle the beds, the detox, the child, her access to Melbourne, the cost to go to Melbourne and her leaving her community. It is a huge thing, not just on the service sector but on the individuals. It is massive — them actually having to access a service that is away — and that is the best we can juggle for this lady at the moment.

**Mr CARROLL** — Is there a waiting list for her in Melbourne?

**Ms GLEESON** — She has had to wait only a period, and not for a great period of time, a short period of time — a couple of weeks. That has been one good thing, but there have been integration services supporting her too. We have respite services, we have child protections services, we have mental health and we have the AOD services working together and the Aboriginal services as well. So we have quite a number of services having to actually work together to make this woman's journey into rehab possible.

**Mr CARROLL** — Which is part of the debate, I think. When you cut up all those services and you see the cost to the taxpayer, if you can actually help that person once and get them right on the path to a productive life, the benefit not only to them but to the broader community with them not having to access all those services for such a long-term period I think is something we need to be mindful of. That investment and getting them right pays off dividends for everyone down the track.

**Ms GLEESON** — Yes, and especially for her. This lady has a history of mental health as well. It is very much a dual-diagnosis approach.

**Mr SOUTHWICK** — In terms of a broader sense, do any of you have any recommendations you think we should be looking at as a committee going forward on how we can be tackling this issue from a mental health perspective or from a patient care perspective? What are the sorts of things you think we should be looking at?

**Ms DELLAR** — I would just like to comment on Mr Carroll's question, which sort of ties in a bit with that question. There is only a small window of opportunity for most of these clients to actually access the service. It takes some time for them to be willing and physically able to come forward and say, 'I need to access the service', and to be accepting of that. The waiting lists are things that often are at odds with those sorts of decisions once the clients make them. To refer someone locally to our drug and alcohol services is not an immediate referral. Oftentimes they will not be seen this week, let alone next week or, sometimes, the week after, depending on the availability of staff. So that very small window of opportunity that you have when a client determines that they are ready for treatment is oftentimes at odds with what we can do for them, purely because of the lack of resources that are available to refer them to. One of the best things we could have as an outcome is that referral services were more resourced to provide response in a timely fashion.

**Mr SOUTHWICK** — In the first instance, in the early part?

**Ms DELLAR** — If I am an ice addict and you tell me to go to rehab tomorrow, I am not going to go. They have to be ready themselves; they have to come to the realisation themselves. There is nothing we can do to force them into rehabilitation, but when they are ready and able, if we cannot get them in in that very small window of opportunity when they are ready and able, it is often lost, and it might be lost for months or years afterwards.

**Mr SCHEFFER** — This is really a follow-up on your question, Chair. In relation to what was said, Mr Kirby, when you wake up in the morning and see the reports in the media on what is happening in Mildura in relation to methamphetamines, do you say, 'Yes, that's the world that I live in. This is true; it's good that that's all going out in that way', or do you think, 'Well, it's a bit of an exaggeration; it's not quite right. Yes, it's an issue, but it's not like that'? Where do you sit in that?

**Mr KIRBY** — I think there is a change in the community and our response is equal to that. I think the Project Ice response has been excellent. It is an interface between the justice system and the health system. It is something that I think the community is actually asking for, and I do not think it has increased the hype about ice. I think there was actually a response required. Before this came into place, I called the local inspector and said, 'What can we do?', because we are seeing changes in the types of crimes that are being committed and changes in the types of presentation to mental health. I think it is another layer on an already resource-poor service through drug and alcohol services and mental health services that requires a greater response. I think that Project Ice was a fantastic response.

**Mr SCHEFFER** — That is fine; I understand that and think that is great. But then there is the proportionality around alcohol, for example, that we have heard about. Is there a commensurate or greater response from the community around alcohol? And would that be appropriate?

**Mr KIRBY** — I think the chronicity of alcohol use and that it is seen as a socially acceptable substance also makes those changes.

**Mr SCHEFFER** — So if ice were socially acceptable, we could respond to it in the same way as we do alcohol?

**Mr KIRBY** — I think the acuity and the onset of the problems associated with ice is the difference, and our response needs to mirror that. On the chronicity of alcohol problems, again the framework associated with responding to it is very similar, but I really do think the time lines are the difference.

**Mr SCHEFFER** — That makes sense. Thank you.

**Dr TURNER** — I think the other thing around alcohol is that we have a couple of thousand years of experience with alcohol. We have had ice around for only two or three years, and it is already having a disproportionate sort of effect on society in terms of disrupting the socioeconomic side of things, whereas alcohol has just been ingrained and it sort of moves along. Yes, it has a slow sort of time frame, whereas ice just seems to get in there and financially and psychologically destroy someone, disrupt their family life and put people in a very precarious situation. And it makes a few people rich.

**Ms DELLAR** — The whole pharmacology effect, the pharmaco-kinetic effect, of ice versus alcohol as far as addiction and onset of addiction is completely different. You can go out, and I am sure you do, and have a red wine on a Friday and Saturday night — or maybe not — and not be addicted. The addictive properties of ice suggest that social uses are not an option.

**The CHAIR** — I suppose the base products of alcohol, like yeast, wheat and barley, are all natural things, as against battery cleaners, acid and other things, which makes it a bit more appealing.

**Mr McCURDY** — Just in terms of time, as ice has been around for only the past two or three years, do any of you have a feel for the rate of change that is going on? Is it exponential growth over weeks, months or years? Is it something that is growing very quickly, or are you just seeing more and more presentations as time goes on, and do you think that they are increasing?

**Dr TURNER** — Again speaking from the emergency department point of view, we only see a select population of patients in any type of health field. We see the sick patients or the unwell patients, so we do not get to see the whole spectrum; we see a small percentage. We have been seeing more of those over the past two or three years, but it is still very small compared to our overall workload. I think from David's perspective — what they are seeing in the community — is a lot of it. It is becoming more and more common, and it is replacing other drugs. David can speak more about what they see.

**Mr KIRBY** — I think essentially the drivers for it, as Leanne was talking about, are the financial gains for the dealers and the ease of access for people. I think they will continue to drive ice unless we intervene.

**The CHAIR** — I appreciate that you have written responses to our questions; I am advised so. I am just wondering whether you would be prepared to submit to the committee those responses that you have in writing?

**Mr KIRBY** — Yes.

**Dr TURNER** — We have written up a document as we were talking about it. I do not know if anyone brought it, but we can certainly get that for you.

**The CHAIR** — Thank you. I appreciate that, because there are obviously a number of questions that we have not asked that may well be covered in your response to the questions that we provided. If you are happy, we will take that as being submitted to the committee.

**Dr TURNER** — Yes.

**The CHAIR** — Given there are no other questions from the committee, I thank you all very much for your time this morning. We appreciate the evidence you have given to the committee, and it will form part of the report. If you feel there are other issues that you would like to flag with the committee, please do so through Sandy Cook, our executive officer.

**Witnesses withdrew.**