LAW REFORM, DRUGS AND CRIME PREVENTION COMMITTEE

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

Traralgon — 28 January 2014

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Dr Simon Fraser, Chief Medical Officer, Latrobe Regional Hospital.

Ms Cayte Hoppner, Director of Mental Health, Latrobe Regional Hospital.

Dr Tony Chan, Emergency Department Director, Latrobe Regional Hospital.

The CHAIR—Good morning and thank you for your time this morning. This is a public hearing of the Law Reform, Drugs and Crime Prevention Joint Parliamentary Committee of Victoria and we are investigating an inquiry into the supply and use of methamphetamines in Victoria.

Today obviously we are meeting in Traralgon and we certainly welcome the public to attend this public meeting, and also we welcome our second lot of witnesses for this morning. On my left I have Ms Amanda Cameron, who is the acting chief executive officer. We have Dr Simon Fraser, who is the chief medical officer. We have Ms Cayte Hoppner, and please tell me if I have not got the name right, director of mental health; and Dr Tony Chan, who is the ED director. They are all from the Latrobe Regional Hospital. Thank you again this morning for your time and for presenting evidence to this committee. We have allowed from 10 to 10.45. I appreciate we are running a bit late, so my apologies to you all. Hopefully we will be able to get through this.

I understand Dr Tony Chan will be leading in presenting to the committee. We also like to provide some time, more time perhaps than the presentation to the committee, to ask questions because it is important for us to extract information we can use in putting together this report which we are tabling to parliament in August.

I welcome you all 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 have said in evidence, may not be afforded such privilege. Have you received and read the guide for witnesses presenting evidence to parliamentary committees?

Dr CHAN—Yes, I have.

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. I now invite you to make your submission. Thank you.

Dr CHAN—Thank you very much. By way of introduction, my name is Dr Tony Chang. I am the co-director of the emergency department of Latrobe Regional Hospital. I am the hospital representative to give evidence at this public hearing into the supply and use of methamphetamines from the front-line experience at the hospital. Latrobe Regional Hospital is Gippsland's regional specialist referral and trauma centre, serving a population of more than 240,000. Our emergency department dealt with slightly more than 31,000 presentations in the years 2012 and 2013.

As an acute hospital, we are in a position to provide the committee with information regarding presentations at the hospital emergency department which involve alcohol or drug intoxication. I am also able to provide information regarding the level of admissions to hospital which are complicated by or involved in the use of alcohol or drugs. I am not in a position to respond to questions related to the manufacture, trafficking, crime and long-term treatment of the chronic user, nor to comment on the adequacy of existing state and federal strategies for dealing with methamphetamine use.

In relation to question 1, by way of background to interpreting the data I am about to give you, it is important to note the limitations of the data. It is not possible to give an accurate reflection of the number of patients who present to the emergency department where methamphetamines are involved. This is because the primary information collected relates to their diagnosis and condition on discharge from the emergency department. The use of methamphetamines which might be causally related to the reason for presentation or admission may be short-lived and unrelated to the reasons for presentation to the emergency department. For example, a person on methamphetamines may be aggressive and involved in a fight but is admitted for the injuries

caused by the fight. Another reason for the limitations of this data is that testing for the type of drug ingested is not usually done and it is difficult to determine from behaviour which drug was ingested, although anecdotal evidence suggests that users of methamphetamines are usually more aggressive than other drug users.

There are difficulties in relation to that data collected because there is a specific discharge coding for methamphetamine use, as well as codes in groupings—for example, psychoactive substances, opioids, cannabinoids, alcohol and so on—as well as the effects, such as harmful use, acute intoxication, withdrawal states and so on. This means that a presentation involving methamphetamine could be coded to the methamphetamine code or to another code of a similar class—for example, psychoactive drugs.

The specific coding in the emergency department for methamphetamine use, F151, is fairly limited in relation to the type of presentation—acute intoxication or harmful use, dependent syndrome and so on—and hence it is more flexible to code under the general psychoactive coding which has divisions for the type of presentation. The data also reflects under-reporting of methamphetamine involvement, as the primary code would often be the diagnosis. For example, violent injury, confusing, delirium, mental illness, even if recognised to be related to drug use would be coded with the primary diagnosis.

In relation to the specific questions raised, I make the following comments. Anecdotally, nursing staff believe there has been a slight increase in presentations where methamphetamines have been ingested by the patient. However, it is important to note that data specifically for methamphetamine presentations is not collected. Methamphetamines would be coded as a psychoactive substance, along with others such as other amphetamine derived substances—for example, ecstasy, toxic mushrooms, glue-sniffing and so on. However, we consider that in the category coded 'psychoactive drugs', the majority of these presentations would be methamphetamine. Internal emergency department data confirms that the number of alcohol, psychoactive and other drug involvement presentations in 2013 remain relatively static, with a slight increase in the presentations of each category.

The figures for the patients admitted to the various wards of the hospital with a coding reflecting psychoactive substances, alcohol involvement or other drug use are as follows. Hospital admissions for psychoactive substances in 2012 was 159. In 2013 it was 152. Hospital admissions for alcohol in 2012 was 382 and in 2013, 391. Hospital admissions for other drugs for 2012 was 174 and in 2013, 197. This brings the total of all psychoactive, alcohol and other drugs admitted to hospital in 2012 to 715 and in 2013 to 740.

The percentage of hospital admissions that are related to psychoactive substances, alcohol and other drugs has remained pretty much the same over the last two years. These total hospital admission figures reflect the magnitude of the drug and alcohol involvement over the last two years. For example, in 2012, 73 patients were admitted to the Flynn Unit, which is our mental health inpatient unit, with a diagnosis involving psychoactive substances. In 2013 this increased to 97. Alcohol and drug related admissions are relatively equal if psychoactive substances and other drugs are combined.

Question 2: although the numbers of methamphetamine presentations were not as high as that of other drugs and alcohol, methamphetamine presentations take up more hospital resources due to the violent nature of presentations. This is in the form of increased need for physical and chemical sedation and subsequent need for close monitoring required by security, medical and nursing staff. This impacts negatively on general waiting, assessment and discharge times of other patients in the department and there is the potential for injury to staff in physical confrontation. This extends beyond the emergency department, particularly in the Flynn Unit, the mental health inpatient unit.

The harm caused by other drugs, including alcohol and tobacco, is also serious, and because of its greater use and by a wider social demographic, I regard alcohol to be a bigger problem for our emergency department. In my view, a person affected by alcohol is more likely to present him or herself to an emergency department because the consumption of alcohol is legal, whereas the use of methamphetamines is not. Patients who have ingested methamphetamines are more likely to be

brought to the emergency department by police because they need treatment after a violent confrontation in public, or bizarre behaviour in public.

I do not consider the emergency department figures reflect the usage of methamphetamines in the community and it would not surprise me if police or court figures are much higher. We only see those persons who have been injured, appear physically ill or are behaving as if they have a mental illness. Our data does not reflect the usage in the community.

Question 3: in our experience, polydrug use is very common amongst methamphetamine users. The majority of the other drugs would be alcohol, cannabis and ecstasy. We do not have any data on this.

The consequence of polydrug use would be the additional harm posed by other drugs. The fact is that polydrug use is common, so the general approach in the emergency department is that of vigilance to that possibility. The detection of harm from another substance would enable any additional management to be implemented. In the long term, counselling, withdrawal management, support and case management would need to address the differences with multiple substance use.

Question 4. In our experience, methamphetamine presentations are not limited to any particular group, except that they are generally young—under age 30.

Question 5. I pointed out the difficulty with data collection in my introduction. Suffice to say there is no emphasis in our data collection on this specifically. In addition to my comments above, it is important to note that the coding is done by individual health information managers. Coders rely on the documented notes, and interpretation may vary. Some presentations that are methamphetamine related are coded elsewhere, such as injury from violence or accidents, arrhythmias—that is, abnormal heart rhythm—unsafe sexual behaviour and so on. For these reasons, it would not be easy to pinpoint the actual the actual methamphetamine presentation from the hospital discharge coding.

Question 6. Persons who are affected by methamphetamines present at hospital with various medical conditions. These include seizures, stroke, hypertensive crisis, mental health problems—such as psychosis, anxiety, depression, panic, mood swings, mania, suicidal thoughts, particularly on withdrawal—injury as a result of violent confrontation or accident. Commonly these presentations appear in an atmosphere of violence, aggression and agitation.

Question 7. The major problem when dealing with a methamphetamine presentation is that due to violence and aggression. The safety of emergency department staff, the patient, the attending police members and that of other patients is of concern. Chemical and physical restraint is commonly used. Friends and family of the affected person may find it difficult to cope with the situation. All of these factors require additional resources for support. The resources required for managing such a patient can be intensive.

Question 8. Methamphetamine-induced aggression and violence is a threat to the patient's own safety, as well as others. Verbal de-escalation and decreased environmental stimuli is not effective in the severely agitated. Sometimes immediate sedation is necessary to prevent fatal physiological collapse from exhaustion. Generally this would require physical restraint by staff to allow chemical sedation. Any physical restraint would be removed as soon as it is safe to do so. The patient is monitored very closely during this period in terms of the depth of sedation and the need for supporting vital physiological processes.

Question 9. It is well established that methamphetamine use can cause mood and anxiety disorders during intoxication and withdrawal states and has its own diagnostic category in DSM-IV. It is also recognised that methamphetamine use can cause an acute psychosis which is self-limiting or could trigger a psychotic state in someone with a previous diagnosis or predisposition. The challenge for treatment and rehabilitation, therefore, is to establish whether there is any underlying mental health disorder which would require long-term mental health treatment in addition to the drug rehabilitation.

The number of patients to the Flynn Unit—that is the inpatient mental health unit—with drug-induced psychosis has increased, with increasing pressure on the need for more high-dependency unit beds—currently three—longer length of stay and risk of readmission due to recommencing lifestyle on discharge, as most do not want to stop using.

Question 10. We have a formal agreement with Latrobe Community Health Service for drug and alcohol services, primarily withdrawal. Inpatients in the Flynn Unit admitted due to intoxication of illicit substances or alcohol can be referred to Latrobe Community Health Service drug and alcohol withdrawal service. When this occurs, assessment is completed during their admission. The Latrobe Community Health Service worker will make recommendations for management of withdrawal, refer for residential rehabilitation and follow the person up on discharge for ongoing counselling.

The Latrobe Community Health Service drug and alcohol withdrawal nurse attends the mental health meetings weekly, on Mondays, at Latrobe Regional Hospital with the mental health ED clinician, consultation liaison psychiatry service and mental health triage service to discuss presentations to the emergency department, admissions to the acute wards and to the Flynn Unit to ensure that patients are linked to drug and alcohol services. On discharge the mental health community case manager supports the person in accessing drug and alcohol services, assists the person through the stages of change—that is, pre-contemplative and contemplative. The role of community mental health case managers is to monitor mental state and assess risk for the associated mental illness, including pre-existing mental illness, drug-induced psychosis and alcohol-induced depression.

Latrobe Community Health Service drug treatment services attends the local community mental health teams weekly, clinical reviews for joint discussions and a detox nurse attends the clinic to see clients. Latrobe community mental health case managers also receive referrals from the local drug and alcohol services to see clients in the local drug and alcohol centres. Case managers also work with the client's general practitioner, who has admission rights for accessing admission of their client for detoxification of alcohol, cannabis, ice, amphetamines and benzodiazepines.

Latrobe Regional Hospital has formal relationships with Victoria Police and Ambulance Victoria through the Emergency Services Liaison Committee across Gippsland. That is four committees. These committees actively identify and manage key issues in relation to people with mental health and alcohol and other drug issues that use police, ambulance, acute health or mental health services. The Emergency Services Liaison Committee also supports joint education and training to build capacity for all organisations to work together.

Question 11. Latrobe Regional Hospital does not provide treatment specifically for chronic or problematic methamphetamine use. However, a large number of clients have a mental illness with a coexisting substance use problem. The focus of treatment is treating the associated symptoms, including paranoia, hallucinations and anxiety. Aside from our close linkage with Latrobe Community Health Service, which provides drug and alcohol counselling as well as withdrawal services, we can refer to Depaul House attached to St Vincent's Hospital Melbourne for a five- to 10-day voluntary inpatient program, or Windana located in St Kilda.

There are waiting lists for these services. Referral for residential rehabilitation in the private hospital sector is easier. However, it requires private hospital cover. There is no residential rehabilitation service in Gippsland. Persons wishing to access residential rehabilitation services have to go out of the area, and there is also a cost. Most of the programs are for six to 12 months. There are also specialist groups for children and young people up to the age of 21 and for Indigenous people.

Latrobe Community Health Service, which operates across Gippsland, has strong links with general practitioners for medication management. However, there is a shortage of general practitioners experienced in pharmacotherapy and opiate replacement therapy. Latrobe Regional Hospital delivers the dual-diagnosis program for people who have a mental illness and an alcohol or drug issue. This program provides primary and secondary consultations and professional development across the health and community sector in Gippsland to support people with a dual

diagnosis. The program provides advice and consultation through experienced clinical staff, supported by visiting addiction medicine specialists.

Question 12: as we are a regional service, we consider it appropriate to leave treatment interventions to the experts through agents' experts, though agencies need to work together. Treatment interventions are best met through joint partnerships with health, community, social and legal organisations. They should be based on the best available evidence and delivered through established programs accessible across all of Gippsland. Due to isolation and remoteness across the region, interventions need to meet the needs of the entire community, not just those able to access a service in a major town.

Lastly, question 13: strategies to best address methamphetamine abuse in the community must focus on health, social and legal pillars. A key focus on community awareness of methamphetamine use and its consequences is needed, along with stronger legal consequences for use and distribution and adequate treatment for those impacted by methamphetamine use. The lack of a purpose-built detoxification facility in Gippsland presents significant problems for treatment and rehabilitation. Addiction medicine specialists to lead coordinated and evidence based treatments are not readily available in the region. A specialist-led, coordinated treatment facility that provides accessible care to the local community is a major health service gap. A facility that focuses on residential day programs and telemedicine and virtual clinics is required to meet the full spectrum of treatment options for the Gippsland region.

Managing methamphetamine related violence in the emergency department is a complex issue and requires an organisational approach to jointly introduce measures to minimise harm but also to reduce the use of restrictive interventions that have been shown to cause injury and, in some cases, death. Strict protocols for appropriate pharmacological approaches, along with verbal de-escalation skills, have been useful in some circumstances. However, the specific management is often related to individual presentations and circumstances, including the level of intoxication and comorbidities. Reducing the number of presentations to the emergency department through diversion to appropriate and accessible drug treatment services should be considered. Specialist addiction medicine services in emergency departments would also provide additional advice and treatment for management of all alcohol and drug presentations.

The CHAIR—That was a very thorough response to the questions that we provided. Thank you very much. We appreciate that and we would ask if we could perhaps have a copy of those notes. I appreciate there are three other contributors here today. Is there something you wanted to add before I open it up for the committee? No? Can I just quickly ask, did you see our previous inquiry in relation to security arrangements in emergency departments?

Dr CHAN—No, not specifically.

The CHAIR—We did an inquiry. It is just that I noticed some of your information was referring to responses by, particularly, triage in relation to security for your staff in volatile situations. We did an in-depth inquiry looking at providing recommendations in relation to security arrangements in emergency departments. I know that some of those recommendations are still filtering through, so perhaps it might be useful for you to have a look at that. We can provide you with the report that we tabled.

Dr CHAN—Yes, I will have a look.

The CHAIR—I invite the committee now to ask questions of our presenters.

Mr SCHEFFER—Thank you, Dr Chan, for that presentation. It was very comprehensive and I only have a very small question. You outlined the complexities of data-gathering, which we appreciate, but I think you summarised it by saying that generally the position was stable, with a slight increase. Is that fair?

Dr CHAN—That is correct.

Mr SCHEFFER—I just want to ask you whether that was in line with the general population increase for the area that one would expect?

Dr CHAN—The slight increase is two to three per cent from our own internal data. I am not sure what the population increase over the 12 months is for Gippsland, so it is a bit difficult to answer that question.

Mr SCHEFFER—I guess it is probably similar.

Dr CHAN—Okay. So if that is the case, then that is in line with the population increase.

Mr SOUTHWICK—I wanted to firstly put on record my thanks to you. We have had a lot of hospitals present, but one particular point that I think you have made today is about the difficulty in data collection, and the information that you have does not present the issues that necessarily are going on in the community, because we have been hearing a lot about the issues of alcohol, and you have just said people present because alcohol is legal, so it is a more likely presentation, but we really do not know the depth of this particular issue with ice.

In terms of treatment, there was discussion about this detox centre that you were suggesting is needed for Gippsland. Do you have a model that you would like to see, something like that that exists in other jurisdictions? Also, what is your view on ensuring that people have compulsory treatment when it comes to an addiction, particularly if they are frequently visiting or frequently being requested for servicing in hospital care?

Dr CHAN—The first question relates to a model of a detox facility?

Mr SOUTHWICK—Yes.

Ms HOPPNER—We have not had any discussions around a model, but there are certainly a number of models out there that have proven to be successful. The issue for this region is that there is no access to residential rehab, so the accessibility of health services is somewhat difficult, so to try and engage someone in who is contemplating change is very difficult if they have to move out of the region and cannot access that care. There is a lot of evidence around clinical models, but for rural and remote services we would need a model that would fit the region in terms of accessibility, so in terms of having telemedicine, telepsychiatry, virtual clinics where people can actually access day programs and treatment services but not necessarily be in a residential facility. They may come through a day program but also a virtual program so that services are accessible in their local region. I guess that is the pattern of thinking.

Mr SOUTHWICK—And what are you views on compulsory orders for treatment services?

Ms HOPPNER—We have actually used the Severe Substance Dependence Treatment Act, minimally, in the mental health service. We have had a couple of people where we have used that because of the significant risk to those people and to the community in terms of their ongoing substance use and use of services. It is extreme cases that we would use that in, but there is definitely a need for that in terms of risk management for some people.

Mr CARROLL—Thank you for your presentation, Dr Chan. I was just trying to get more of a grip on the data collection issues. I think you said methamphetamine use comes under the F151 category.

Dr CHAN—Yes. There are actually different sets of data that have been collected and it has been complicated by the fact that there has been a transition to how emergency departments are funded. The data that is collected since 1 July 2013 has changed in preparation for the different funding model. It is called activity based funding.

Mr CARROLL—That was the federal government?

Ms CAMERON—That is right.

Dr CHAN—Prior to that there was a different code, which is ED presentations, which is collected in a dataset. We call it iPM, which is a central—

Ms CAMERON—Admitted patient master dataset.

Mr CARROLL—Okay.

Dr CHAN—That is right. During this period of time the coding that is in the iPM, they have specific coding, and ED presentations are included in the admissions. Anyone who has a complex admission in ED or has a long admission in ED can be admitted under ED and those figures will be reflected in the hospital dataset. Now, since 1 July, there is no category of ED admissions. That is reported elsewhere, so there are actually different codes of ED admissions.

Mr CARROLL—If we are looking to make recommendations, if we were to target a recommendation in terms of a better system for categorising ED admissions, that would help your job and just help everyone's job in the health profession with intelligence and things like that?

Dr CHAN—I think the problem would be, just in relation to 2012-13, that we are unable—because now that we are transitioning over, we recognise that there are two different coding systems. We can allow for that by collecting data from both and then just—

Mr CARROLL—Does it increase your workload, collecting data from both, or is it just done systematically?

Ms CAMERON—The data is actually entered onto a system for the admissions but the collating of it is not done in the emergency department. It is done in the health information unit. It is a particular unit for collating that data. They are different software systems, so to be able to make it easier than one coding system you would have to have one emergency department software system for the whole of Victoria's emergency departments. They all have their own individual preference. You would also have to have the same admission data for the inpatients. I think you will find the government tried that with HealthSMART.

Mr CARROLL—A universal one across the whole state, though, would very much help with resources issues et cetera.

Ms CAMERON—It would not help with resources issues. The resources issues around the methamphetamine presentations to the emergency department are around the physical resources that are required to treat that person.

Mr CARROLL—If the data shows there is a higher prevalence of people presenting at Latrobe Medical Health Centre versus the Benalla Medical Health Centre, the Department of Health could then say, 'We need to perhaps target Latrobe more in terms of assistance, more beds et cetera.' That is what I am getting at with the data collection.

Ms CAMERON—We have just heard from the presentation and from Cayte, our director of mental health, that the treatment of these types of patients, clients or individuals with these complex conditions is a matter of coordination between inpatient, community, mental health. So just making that one change is not going to solve that problem. This is a very complex problem.

Mr CARROLL—I think I heard you have three high-dependency beds.

Ms CAMERON—Yes. We are just about to go to six. It is already being built.

Mr CARROLL—Will the demand on those six be taken up almost immediately?

Ms HOPPNER—We suspect so.

Mr CARROLL—So what I am getting at is more resources to increase the number from six onwards and upwards if that is what the emergency department statistics are showing.

Ms HOPPNER—They are mental health inpatient unit beds, so we would have people who have a mental health issue and often a co-occurring drug and alcohol issue as well. I guess the gap in the service system is rehab and residential.

Mr CARROLL—Yes.

Ms HOPPNER—We have community based and home based withdrawal and the drug treatment services will certainly talk to you about that when they present. But in terms of accessibility to a residential rehab, we do not actually have that in Gippsland. I guess that is a significant issue in terms of resources. The full treatment options are not available.

Ms CAMERON—Which then could possibly decrease the reliance on those high-dependency beds because the rehab program and treatment is more effective. People are actually accessing and using it because it is here.

The CHAIR—I think we are hearing that loud and clear. It was very succinct by Dr Tony Chan.

Mr McCURDY—In terms of behaviour in the emergency departments, I have this assumption that in many presentations family support is there in an emergency situation. You spoke about alcohol being legal and that people will present differently. Is it different when someone is dragged in by the police, or is it a different situation because of drugs? Are they on their own? Would you treat them any differently? Are there any different behaviour patterns because they do not have that family support around them, or is that not an issue?

Dr CHAN—The alcohol presentations sometimes are brought in by a family member as well. The ones that are brought in by police are generally associated with domestic violence and bizarre behaviour so that the police have become involved. When they are brought in they can be extremely agitated. The difference is that we actually need to control their agitation.

Mr McCURDY—Because it is against their will, rather than coming in voluntarily?

Dr CHAN—Yes, they are brought in under a section 10.

The CHAIR—Do you have a view about early intervention in relation to public events education? In this region you have had a couple of forums, as I understand—ice forums—and in other regions where we have taken evidence there has been some high-profile ambassador, if you like, sort of talking to young children about the dangers of drugs and particularly methamphetamine. I am reminded of the grim reaper ads. There are opposing views about how successful that was in relation to HIV or AIDS related things. Given you have indicated to us your admissions are not really reflective of what is happening out there in relation to use of methamphetamines, a way to educate the public of dangers of particularly crystal meth, because there is, as I understand it, no medicinal drug to help with coming off it like there is with heroin.

Dr CHAN—No, there is not. There is no replacement drug for withdrawal. My view is that education is always—I do not know what the effectiveness has been from previous studies but that is one method, and a method that can be put in place, educating target groups, particularly the young, because the use of ice or methamphetamines usually is among younger people. When educating, we need to understand what the whole background to drug use is, not just the actual drug use but also the causes of the drug use. Is there any background of mental illness or social problem? There are a lot of complexities that need to be understood in order to educate our target group.

Ms HOPPNER—I would kind of go back to mental health where we have done a lot of work in early intervention, particularly in young people, because we know that the majority of mental health issues occur before someone turns 25, so there have been significant targets set in terms of early interventions and the effectiveness of those programs. Anything that targets early intervention and looking at some robust studies into that would be very useful.

Mr SOUTHWICK—Could I ask your views on compulsory testing, or some form of testing being brought in for any complicated cases that you are having that are hard to detect, whether it be mental health or police custody type issues.

Dr CHAN—In the emergency department we do not routinely test. It actually does not help because the turnaround time, in order to know what the substance is, is not really useful for an ED presentation. I am not sure whether it is going to help to make it compulsory. It certainly will not help the ED but I am not sure whether it is going to help overall.

Ms HOPPNER—It may deter people from presenting for treatment.

Ms CAMERON—The emergency department's focus is actually on clinically treating the patient, not performing the requirements of whether you decide that there is compulsory testing. It is not going to make a lot of difference to their clinical treatment at the time. They want to get on and do the job they have to do and not be complicated by having to fulfil some requirement to test for what type of drug it is.

Mr SOUTHWICK—Is it a pretty simple test, though, just taking a swab?

Ms CAMERON—No, not for amphetamines.

Mr SOUTHWICK—Okay. Thank you.

The CHAIR—Any more questions?

Mr SCHEFFER—Just one point, just to correct myself. It is not three per cent; 1.4 per cent per annum population increase and 7.5 per cent over the next decade.

Ms CAMERON—That is a little bit higher.

Mr SCHEFFER—Yes, that is right.

The CHAIR—I see we have our data—

Mr SCHEFFER—I just took a guess and it was wrong, so I thought I would correct the record.

The CHAIR—All right. Time is against us, so thank you all very much for your time this morning in presenting, and thank you very much for obviously quite a lot of work done in relation to your response to questions. We appreciate that. It has helped us enormously to have that information, which you are going to provide, as I understand.

Ms HOPPNER—I will send it through to Sandy.

The CHAIR—Just for everyone else, we are breaking for 10 minutes and we will resume at five past 11.

Witnesses withdrew.

Hearing suspended.