LAW REFORM, DRUGS AND CRIME PREVENTION COMMITTEE

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

Warrnambool — 3 March 2014

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Dr R. Brough, Drug and Alcohol Physician, South West Healthcare.

Dr T. Baker, Emergency Department Physician, South West Healthcare.

Dr A. Pant, Director of Psychiatry, South West Healthcare.

The CHAIR—Good morning, and thank you for your time this morning. For the record we have Dr Rodger Brough, who is a drug and alcohol physician; Dr Tim Baker, an emergency services physician, and Dr Anshuman Pant, director of psychiatry, all from South West Healthcare.

As you know we are conducting an inquiry referenced by the parliament in relation to the supply, distribution and use of methamphetamines in Victoria, particularly, ice. We have held regional meetings all across the state from Geelong, Colac, Bendigo, Traralgon, Mildura, Wodonga, Shepparton, and obviously today. There is no doubt that crystal meth is certainly having an impact particularly to regional areas and the indigenous population. We are looking forward to hearing about what impact this particular drug is having to the Warrnambool region. We have allocated until quarter to 11 in relation to this session. We do invite a brief verbal submission and obviously questions we would like to ask of you that are of interest to us. Are you all making opening statements, or is it a partnership team?

Dr BAKER—I think we have all come separately but I have a brief opening statement.

The CHAIR—Okay. I will read you the conditions under which you are presenting, and do it collectively. 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 evidence to parliamentary committees.

Dr BAKER—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 *Hansard* transcript at the earliest opportunity so you can correct it as appropriate. I would now like to invite you to make a verbal submission and then we will respond with questions.

Dr BAKER—My name is Tim Baker, I am an emergency physician who works in Warrnambool emergency department, and I am also the director for Deakin University's Centre for Rural Emergency Medicine. I wish to address two questions about this issue. The first is the relative impact of amphetamines and alcohol on our department, and the second is the difficulty of collecting methamphetamine data from rural emergency departments.

Firstly, the emergency department of South West Healthcare, Warrnambool, does manage confused, agitated, aggressive patients that we believe have taken methamphetamines. We do not have accurate accounts for reasons I will mention shortly, but staff members are able to recall cases in recent months. Currently, the number and impact of these cases is not great. It is certainly less than I have experienced in urban emergency departments with methamphetamines and other types of amphetamines, and certainly less than I have heard about in other Victorian towns. I could say that we are lucky, but I imagine there has been a great deal of hard work by other agencies that are shielding us from the impact of this problem so far.

Alcohol-related injury, particularly, on the other hand is a daily problem. Over summer we have worked with Dr Peter Miller from Deakin University School of Psychology on a project that asks every injured person presenting to the emergency department questions about their recent alcohol consumption. Over summer there has been approximately 150 alcohol-related injuries, including traffic accidents, life-threatening injuries and assaults. For us, the impact of

alcohol dwarfs the impact of amphetamines in our department.

Secondly, I will address the difficulty of collecting methamphetamine data from rural emergency departments. Basically, I think it is important but not easy. Emergency departments can play an important role in surveillance of injuries caused by drugs and alcohol. Many assaults—injuries, that result in treatment in the emergency department—are not reported to police, and with a little extra effort, emergency departments can identify problem areas. The most well-known example of this is the Targeting Alcohol-Related Street Crime Project from Wales where emergency department statistics were shared with Cardiff police which helped decrease the rate of violent assaults.

Information about patients treated in Victorian emergency departments is collected in the Victorian Emergency Department Minimum Dataset—or VEMD. It can identify drug and alcohol patients in three ways. On arrival, clerical and nursing staff can record a cause of injury as poisoning. On leaving, the same staff can record a final diagnosis of some kind of poisoning. There are a number of subcategories. The problem with both of these methods is that the patient may not identify what they have taken. Also the staff may record an alcohol-related injury as, say, a fall and a fractured leg, rather than a fall, a fractured leg and poisoning, and so cases are missed.

The third way drug and alcohol presentations can be identified is by searching for particular phrases in what the nurses and doctors enter into the computer. Unfortunately lots of different terms can be used which make searching difficult—for instance, ice, meth, crystal—and a lot of irrelevant cases are also picked up this way also. For instance, if we searched for 'ice' we would pick up a case where 'a 13-year-old girl twisted ankle at school, teacher supplied ice', which gives entirely the wrong impression. The experts in this are the Victorian Injuries Surveillance System at Monash University and they could best provide the committee with practical options to collect data from the VEMD database and other hospital databases.

One further point regarding the collection of information in rural areas, all urban emergency departments record VEMD data and record it. In rural areas, only the largest emergency departments do, which means that if 50 rural emergency departments do not collect any of this data at all, they only record the total number of patients they treat because they see approximately 150,000 patients a year, which is nine per cent of all Victoria's emergency patients. This is a significant blind spot. For instance, it is impossible to collect any emergency department that would identify an emerging drug problem in Portland, Colac or Benalla. The emergency department in Warrnambool is seeing patients who have taken methamphetamine but we believe the local actions of other agencies have protected us from the worst of this problem so far, and we have a greater problem with alcohol-related attendances, and emergency department can be an important adjunct to police but in rural Victoria there are important blind spots where no data is available at all.

The CHAIR—Thank you, Dr Baker. Any other verbal submissions?

Dr BROUGH—I am happy to make one. One of the reasons why I was not actively pursuing appearing before this committee was that we do not see very much of it at all. My main contact with patients is through the hospital's withdrawal service. Whilst we have some patients who present with usually alcohol, cannabis or opiate withdrawal, we do have one or two patients in the last 12 or 18 months that have also listed ice as one of the drugs they are using. But I think we might have had one patient only in the last 12 months presenting with wanting help with their ice problem. The rest, it has been a coincidental problem from their perspective and not an issue of real importance to them.

By the same token we are well aware—and we have been for the last 12 months approximately—that there is ice around the district, and we are certainly hearing that. I have made some inquiries amongst some of my longstanding patients around availability and the use of ice. I have had a couple of my older patients talk to me about the ice that they have tried what is around now, and they relate to it as not wanting to touch it again, it gives them a

horrible effect, not like the after-effect, the afterglow, that they used to get from speed when they used that back in the 80s, early 90s.

I am aware that the police too are concerned about ice in the south-west. I am also aware that Medicare Local has been working with ANEX to offer train the trainer programs down here. We are not getting a lot of interest in that offer here. We were reluctant to go to the public meeting sort of offer because we have seen before a lot of people get very worried about something that we are not noticing is a very big problem on the ground from a health perspective. Certainly we are concerned about the issues, as much about policing as about health, with the frequency with which we are seeing them but, like Tim, our data collection systems, as far as the state government is concerned, our withdrawal service is not a withdrawal service, although it is only one of two intra-hospital withdrawal services in the state. The Western General Hospital is the only other one that has the similar type of capacity that we have. St Vincent's has Depaul House which is very close to St Vincent's but it not within the hospital and does not have ready access to the emergency department, the intensive care, the psych unit et cetera, that we are very fortunate to have here.

Although our data has been passed back to the department for the 17 or 18 years we have been running the withdrawal service—some inpatient, some outpatient—our data is not reflected in a lot of the statistics. Because we run a rural withdrawal service, it is the funding stream under which we have been historically funded and we do not get our data collected and looked at in the same way. As Tim was saying, the metropolitan hospitals and other hospitals get their data looked at. It is not a great encouragement for us to keep forwarding data to the department. We are hoping that the restructure currently under way is going to make it easier in the long term but that is some way off before it brings practical changes as far as our service is concerned. Yes, we are concerned about it.

Through my role with DACAS—on the DACAS line—I have had as many calls from the south-west as I have had from any other rural areas on the days when I am on. I do tend to be on a fair bit on Fridays which are the times when the HMOs are left holding the bag for the weekend patients. I have certainly noticed that there have been more inquiries about ice. I cannot remember having had any in the first 10 years or so, but certainly there have been more inquiries, and the ones that I have had from the south-west have been from Portland. My impression is that Portland is seeing more of the ice problems presenting to doctors and the hospital than we are here, but you would have a better idea of that than I would, Tim.

Dr BAKER—I work at Portland also and certainly I think drug-taking results in a higher percentage of presentations to Portland than Warrnambool but for a mixture of agents, especially opiates. We suffered from the fentanyl patches being injected, as other areas of Victoria did, but there have been some amphetamine cases recently too.

The CHAIR—Thank you. Dr Pant, do you want to make any opening remarks?

Dr PANT—One of the issues perhaps why maybe the patients are not seen in the inpatients in rural settings is because the setting itself is more geared towards opioid, benzodiazepine, alcohol withdrawal, as opposed to addressing methamphetamine withdrawal, which usually do not require that kind of detox program, as opposed to drugs like opioids, benzodiazepine and alcohol. Certainly in my experience working both in addiction settings in England, and mental health settings, one of the issues an inpatient in rural units is that you do not see much amphetamine users. Perhaps they go more to the community agencies which are geared for community treatment. Maybe the experience of WRAD in this area and the Community Drug and Alcohol Treatment might also be useful to take in mind as to what are they seeing, because I think in terms of the inpatient perhaps that might not be representative of the population we are seeing.

Mr SCHEFFER—Why would that be so?

Dr PANT—The reason is that in terms of pharmacological detox from drugs like the

opioids, benzodiazepines and alcohol, the key strategy for the dependent user is pharmacological detox because otherwise you can get into serious trouble, for example, sedative drugs, alcohol and benzodiazepine, there are risk of seizures, for example, the DTs; whereas in opioids, it (withdrawal) is very nasty. We have a very good strategy to address opioid withdrawal by pharmacological measures. With stimulant drugs, like cocaine, to a lesser degree cannabis, there is withdrawal, there may be physiological withdrawal, but that is not serious in terms of requiring pharmacological treatment. Having said that, for heavy meth users pharmacological strategies can be given to prevent dysphoria, a short dose of benzodiazepine, for example. But the inpatient is not really geared for that kind of an issue and this is more the community thing—and Rodger will correct me if I am wrong. He has obviously been working in this area for a very long time. An inpatient detox unit number as proxy for the problem in the community may not be very representative of the real problem. With amphetamine users, the inpatient detox may not really be the key strategy as this is for opioid dependent users or benzodiazepine or alcohol dependent users which is really what they (ie. impatient detox units) are geared for. That was my observation.

In terms of methamphetamine and mental health, yes, I was quite alarmed. I had been working as an authorised psychiatrist and also the consultant for the early intervention and dual diagnosis team for South West Healthcare, and I was quite alarmed to see the number of patients who come in through to our service. It was quite alarming to see patients on ice which— even whilst working in tertiary centres in the UK and I never came across patients using crystal meth, it was more speed use and cocaine use. Here I am seeing crystal meth use. In terms of our early intervention and dual diagnosis team, this is a team to address high-risk mental states in young client groups. I do not have any robust audit finding, it is something we are working towards; but two-thirds of my early intervention dual diagnosis patients—we have more than 50 patients on our books—would have a comorbid drug or alcohol use. No. 1 would be cannabis, No. 2 would be alcohol. Speed and meth probably number 3.

The issues that we see in the mental health team, one is of intoxication, patients that come to ED with amphetamine intoxication. If the symptoms are not resolving they will probably pass them on to us, to the mental health unit. The second is amphetamine induced psychosis. There is some data which I can share but the global prevalence of amphetamine induced psychosis which is around eight per cent to 46 per cent in regular users. There are several studies which are quite robust in this area. Eight per cent to 46 per cent of regular users have a risk of developing a psychotic episode. Most of the psychotic episodes are self-limiting or they limit within two weeks of treatment. However, about five to 10 per cent, maybe 15 per cent can get chronic and then it is difficult to tease out what is going on, whether it is an amphetamine induced psychosis or a functional psychosis like schizophrenia. We do have a few clients in the early intervention teams where it is very difficult to tease out what is going on. In fact some of them have not been abstinent enough for a month for us to tease out what is going on. It (methamphetamine use) is a comorbid condition, is something which I am seeing in our mental health settings.

The CHAIR—Thank you.

Mr SOUTHWICK—I am wondering—coming back to your point, Tim—about the local providers doing the work for you, what role do you see the health care providers playing in this particular space, seeing on one hand we are hearing someone calling it an epidemic, someone saying there is a huge growth in this particular space of this drug. We have also heard evidence to suggest that for a whole range of reasons, users are not choosing the hospital networks to present, and possibly one is because it is an illegal substance and it is the last place they will end up turning up. Ambulances are saying that they are not being picked up there either. What is the role of the health care providers?

Dr BAKER—I think we have two roles. Our main role is to provide care for the people who are affected, whether they come by themselves or are brought by others, or whether they are coming just with intoxication, or whether they have been intoxicated and involved in some other kind of injury. That is our main role and it fits very well into health

care. We can also have a role in providing statistics to other agencies to identify problems and help with a more community approach to things as well. We have a lot of important concerns about privacy, but we have identified data in general statistics about, 'We are seeing a lot of this problem or that problem,' which can be provided to the local agencies.

Mr SOUTHWICK—At the moment we are having difficulty in getting statistics on this particular drug. Can you elaborate?

Dr BAKER—I think so, for the reasons that I said, that the Victorian Emergency Department Minimum Dataset is set up for recording the work that emergency department do, not for surveillance of injury. An injury surveillance system works much better for working out, are we having more quad bike injuries or scooter injuries or falling off ladder injuries than for specifically identifying drug and alcohol issues. Normally to find the impact of alcohol we have had to do a specific study asking specific questions about alcohol for that to happen, and that kind of thing could be done with methamphetamines as well.

Mr SOUTHWICK—Rodger, your work with Turning Point, as a board member, do you see any—

Dr BROUGH—I am no longer a board member. Was a board member for about 18 months in the last stages when Turning Point was an independent organisation, but I have not been on the board since the amalgamation with Eastern Health.

Mr SOUTHWICK—But you would be in contact with obviously other regions and seeing—

Dr BROUGH—Yes, I certainly talk to my colleagues on the DACAS lines and those sorts of things. We have meetings every quarter.

Mr SOUTHWICK—In terms of the prevalence of the problems, say, here compared to other regions, is there any evidence to suggest that this is about the same as everywhere else or a little bit more—taking Portland into account as well.

Dr BROUGH—What we do not have is other representatives from other rural areas. My colleagues that I work with through DACAS are all metropolitan based. What I hear is what is happening for them in their hospitals and their communities. Certainly that is pretty uniform and it certainly sounds as though it is more problematic than it is down here. It is interesting that the emergency departments in rural areas, I cannot remember having had a DACAS call about amphetamines from a metropolitan hospital when I have been on DACAS but certainly it is the rural GPs and the rural doctors that are asking. I think one of the reasons why—sometimes users are under-appreciated for what they know, they are not stupid. One of the things they know is that we do not have specific medications and drugs that are going to be helpful for amphetamine withdrawal specifically or for longer-term management. That is one of the reasons why they do not front up. I suspect too that it is associated with the party scene and the younger age groups who are perhaps a little more reluctant to seek out help from traditional medical services too.

The other thing I was going to say is over the 30 or 40 years I have been working with an interest in alcohol and drugs, the epidemiology of a number of drugs in our area is not what it is in Melbourne. It is quite different. When amphetamines were giving us problems with a lot of amphetamine psychoses back in the late 80s, my colleagues were all concerned about the rising toll of heroin overdoses and those types of things, and they would look at me sideways. When we noticed in 1999-2000 that prescription opioids had replaced the long trips for people to go to Melbourne or to Adelaide to get their supplies, my colleagues were looking at me as though I was from another planet, it did not jell with their experience. Marijuana, similarly, there is a different pattern here where we see people who just use cannabis and nothing much else.

The other comment I would make about the amphetamines in the current milieu of drug use is that poly substance use is the accepted norm now, whereas back in the 70s and 80s there were more people who were more alcohol, more opiate or even the hallucinogens, stimulants, and there is a much more homogenous population now of poly substance users. 'I might use a bit of this, a bit of that,' depending on what is available, what they can afford, and their preference for drug use.

Mr SCHEFFER—Rodger, partly I am asking you to kind of recap some of the things you have touched on but going back a decade when this committee did its inquiry into amphetamines and party drugs which was a bit before my time on the committee but I understand you presented on that, and you said at the time that amphetamines was a considerable concern, that it was a hidden problem. I think I also saw that you said there were specific challenges facing this phenomenon in a rural setting that I know you touched on. I want to ask you now to reflect back on that and tell us about how you think the problem is the same now but more visible and instance some of those ways that you knew more about it before or whether it has escalated, and again just to revisit what are the challenges in providing these services whether they have improved or the historical view of how it was then and how you are seeing it now.

Dr BROUGH—I guess we used to see in the late 80s pretty much textbook amphetamine related psychoses and we did not see the type of gross agitation, people becoming quite behaviourally disturbed. Those things were not prominent in the presentations that I saw back in the late 80s. I am not sure, Tim, whether you are seeing the same type of presentations that they see in the Melbourne hospitals with the bizarre behaviours, jumping out of windows and doing crazy things with the ice.

Dr BAKER—I find that with speed that people were very aggressive but clearer in the head than with ice where people are more confused and harder to predict.

Dr BROUGH—That is what it seems to be, although I do not see the acute effects the way that Tim does.

The CHAIR—We have all identified alcohol as being perhaps from a legality point of view the most abused substance and there have been copious inquiries into impacts of alcohol abuse, even through our parliament, over many years of which probably some of you have been involved in. I posed the question to a superintendent of Victoria Police here this morning about how or what we might introduce to try and curb that antisocial problem which has been with us for decades, and other states are looking at different ways to do that. Given all your experience—and this is off reference, and Sandy is going to give me a slap because she is going to say, 'This isn't part of the reference of the committee,' which is fair enough. I thought we might be able to kill two birds with the one stone in relation to the use of alcohol and methamphetamine. What do you see is a way that we can change the cultural behaviour, not only methamphetamine use but particularly alcohol given it is the worst social problem in relation to the impact it is having to our communities, whether it is from advertising or whether it is from lockouts. Do you have a view one way or another?

Dr BROUGH—From my perspective I think we can learn some lessons from what is happening with smoking. It is a much harder task to be changing the public's perception of alcohol, it is so ingrained in the Australian culture as being acceptable at almost any level of consumption that it is a really difficult ask. Persuading people about the health-related issues that are there is difficult; more difficult than it is with tobacco, but I suspect that it has to be a multifaceted approach targeting the community generally and getting the community behind it. Seeing as scientific interest in alcohol and drugs has really only been around for the last 30 or 40 years—the smoking literature goes back at least to the 50s and 60s when the surgeon-general's report came out, drawing attention to the harmful effects from a health perspective—while that data has been around it gets lost in the beneficial effects, the promotion effects, the ubiquitous presence of alcohol right throughout our society. It is education, it is advertising, it is taxation—we know there are measures that will work but the lobbies are very strong against

that. We know that taxation on alcohol volume is a very effective measure but it is getting the political support to follow through with those things.

Dr BAKER—We have undertaken our research with Deakin School of Psychology because we feel that pattern of problem drinking has changed and that where people once went out and drank large amounts of alcohol at nightclubs and hotels and then got into trouble that everyone would believe that most people pre-load before they go out, and already turn up to town intoxicated. Our interim result show the vast majority of alcohol consumed by people who are injured, or injure others, has been purchased at supermarkets and stand-alone bottle shops. I do not think much has been done in this area where people are still pushing a model of selling as much as you can, you know, a sales model where really I think something should be done there to try and decrease how intoxicated people are, how much they have drunk before they go downtown.

The CHAIR—Thank you. I am mindful of the fact that they are looking at introducing alcohol in service stations, the premise being 'Fill up your car and fill up yourself at the same time,' not a good mix. It is counterproductive.

Dr PANT—I have worked in this area for quite some time and I think a public campaign would be the crucial thing and especially when government guidelines get changed. For example in this country in 2009 with the binge drinking, the acute harms from intoxication was reduced to four standard drinks. Internationally it is eight British units for a man and six British units for a woman. In terms of standard rinks, it was reduced from seven for a man and six for a woman to four for both. Although I can see where the guidelines are coming from, obviously there has been a lot of research around that, (ie. four drinks increases the harm from intoxication, and the huge list of harms from intoxication from interpersonal violence to domestic violence). However, if the public dismisses that message, as Rodger said, this culture where you go and have a good night out drinking; if the public rejects that message, as it is not consistent with what is going on, then I think it is very important that it is followed through, and advise why these recommendations have come by and in keeping with that would be a public health campaign around this area, otherwise the message would get dismissed. That is my observation.

The other thing was the attracting methamphetamine users. We are not really geared up for methamphetamine, the reason being because most of methamphetamine users when they come down and crash, they self-medicate with alcohol and benzodiazepines. They do not really feel the need to have an inpatient detox like opioid dependent users or the benzodiazepine dependent users or alcohol dependent users. There is a lot of stigma within the community. With amphetamine use usually you are seeing younger groups, alcohol is largely older drinkers, mostly older aged persons. There is also a stigma within user groups. I have bed patients saying, 'I don't want to be with junkies,' so there is a stigma within the user group around heroin users attracting the worst kind of stigma. There is in England, for example, specialist services—in fact one service which has come up in London for stimulant users because otherwise the general services would not attract this group of patients because they would not want to go to a standard drug and alcohol service. That is probably my comment around attracting the user and why they are not coming in terms of—they are coming to our service only when there is intoxication issues or psychotic symptoms, but they are not coming to seek help for their abuse or substance use and that is where WRAD and QUAMBY, which have the commissioned agencies, it would be useful to get their opinion. Also if they are not coming their way, then certainly we need to think whether maybe specialist clinics might be useful for stimulant users.

The CHAIR—We will be hearing from WRAD this afternoon.

Mr SCHEFFER—In your knowledge over the decades has there ever been the kind of rolling roadshow that we have seen with the material out in the media on the methamphetamines, all the material in the media, and Department of Justice community forums around alcohol, or is this unique?

Dr BROUGH—I am not sure. I think around the rollout of the 2001 or 2002 got NHMRC guidelines. There was a lot of information around and it was a bit more prominent than it has been with the latest NHMRC guidelines, but there were certainly more attempts to alert professionals to the—

Mr SCHEFFER—But not these large community forums that we have seen run by Department of Justice—

Dr BROUGH—No, no.

Mr SCHEFFER—This avalanche of stuff to the media. We have never seen that.

Dr BROUGH—No, no.

Mr SCHEFFER—That is what my question is, yes.

Dr BROUGH—Not even with the state alcohol campaign that was launched four or five years ago, no, there was not, and I was on the reference for that and that really was not a major push that was looked at. It was more around the licensing issues and things that we were concentrating on them. It really is a hard problem, the alcohol one, because it is not a cut and dried message like the smoking, 'Just stop it,' it is not that simple. It is a complex message to get across to people. If it does not jell with their personal experience it is really hard to sway people.

The CHAIR—All right. Time has lapsed. Can I thank the three of you very much for your time this morning. We appreciate it.

Witnesses withdrew.

Hearing suspended.