LAW REFORM, DRUGS AND CRIME PREVENTION COMMITTEE

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

Traralgon — 28 January 2014

Members

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Witnesses

Mr Mark Allen, Team Manager, Morwell Mobile Intensive Care Ambulance (MICA) Unit and Single Response Unit (SRU), Ambulance Victoria.

Mr Dave Rice, Manager Sale Advanced Life Support Unit and Bairnsdale and Sale Single Responder MICA Units, Ambulance Victoria.

The CHAIR—I'll reconvene the public meeting and ask that the next two witnesses, Mr Mark Allen and Mr David Rice, come to the table, please. Welcome to this public hearing of the Law Reform, Drugs and Crime Prevention Committee, of which I am chair and also the state member for Western Victoria. From the notes here, Mark, you are the team manager of the Morwell Mobile Intensive Care Ambulance Unit and Single Response Unit.

Mr ALLEN—Correct.

The CHAIR—Welcome.

Mr ALLEN—Thank you.

The CHAIR—And, Dave, you are the manager, Sale Advanced Life Support Unit and Bairnsdale and Sale Single Responder MICA Units.

Mr RICE—Yes, that is correct.

The CHAIR—Thank you very much, both, for your time. We have allocated till 1.45 for this session of the public hearing. In the deputy chair's absence, I will read the conditions under which you are presenting to this committee this afternoon and then hopefully we will have full introductions of the committee and then we will ask you to make a presentation.

Mr ALLEN—Okay.

The CHAIR—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. However, it is important that you note that any comments you make outside the hearing, including effective repetition of what you have said in evidence, may not be afforded such privilege. Have you received and read the guide for witnesses presenting evidence to parliamentary committees?

Mr ALLEN—Yes, I have.

Mr RICE—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. You understand this inquiry is looking into the supply and use of methamphetamines, particularly ice, in Victoria, as requested by the parliament. We are due to report back in August of this year.

Committee members introduced themselves to the witnesses

The CHAIR—Sandy Cook you have met, who is our executive officer, and, in his absence, the deputy chair Johan Scheffer is somewhere in the building, soon to join us hopefully. Again thank you, and I look forward to hearing your contributions, and I certainly encourage the committee to ask questions about matters that they may wish to get some fuller answer on from issues that you have raised.

Mr ALLEN—I would just like to thank you for the invitation to attend today. I think it is really important to have an on-the-ground Ambulance Victoria perspective on the issue that you are dealing with through these hearings. I had the opportunity recently to do a brief presentation at what was referred to as a Latrobe Community Safety Forum, which was hosted by Latrobe City. In conjunction with police and other healthcare workers I had the opportunity to do a presentation there and talk about ambulance perspectives around the same issue. Breaking the Ice was the name of the forum.

Most of the information that I have got is largely anecdotal, based on 20 years experience in ambulance and seeing this as a growing problem and, I suppose, as team manager, looking at case reviews and so forth, you get a bit of an idea about the nature of the problem. I think Dave and I both, in discussing it over the last week or so, agree that what we see is an increase in anecdotal evidence of methamphetamine or amphetamine use.

I noticed one of the questions was 'Do you believe it's been reported as being at crisis point?' I think it is a serious and growing issue in terms of our area, this particular area, which is what I am really talking to. It is very hard to say whether many of the cases that we go to are driven by methamphetamine use or whether it is a polypharmacy issue. It is very hard for us to actually pin down specifically that 'This patient was taking methamphetamines' so it is hard for us to comment in a really concise way about its prevalence, but we will do our best to provide what information we can around it.

Mr RICE—We looked at a number of branches across Gippsland and looked at some of the data that comes from our VACIS, our electronic patient care records. The problem with this type of data is that a lot of patients do not actually tell us what they are on. We get the jobs listed as an overdose, an assault of some type or bizarre, erratic behaviour, or psych-affected patients.

So that is the data when we looked at a group patients which were basically aged from 15 through 45, because they seem to be the key ones that we hear about. The spread of jobs is not massive. For Sale in October we looked at three confirmed cases of ice usage and bizarre, erratic behaviour. For November—this is the Sale cluster itself, which is a 24-hour location with a MICA unit attached—we had one case confirmed of someone using ice and in December of 2013 two patients. But if you speak to staff across Sale and various other areas like Lakes Entrance, Bairnsdale et cetera, they will tell you about numerous cases where people were probably drug affected and most likely using amphetamines, because it was that type of behaviour that we see quite commonly with that type of drug.

The other patients looked at were the patients who were unconscious for unknown reasons and also just your key common overdose patients. Overdose is actually broken down into a number of things. A lot of them were just over-the-counter types of drugs like you would get from your doctor through a script. There were not many using opiates as such, like heroin—that seems to have dropped quite significantly across this region—but we did see a couple with bizarre and erratic behaviour or in unconscious states attributed most likely to methamphetamine usage.

Mr ALLEN—Those numbers do not sound particularly large, but I think it is a mistake to assume that, 'Oh, is that the extent of the problem?' Clearly it is not. Clearly they are the patients that we get called to. There are plenty of other patients who perhaps are not presenting in the way that Dave has described and may not trigger the kind of notion, 'Well, there could be methamphetamine involved here.'

I am sure there are many other people who are using methamphetamine for whom an ambulance is not called, and I think that is a really salient point. Whilst the numbers do not look that big—and those numbers were probably slightly larger in the Latrobe Valley, and I have not done a breakdown in the manner that Dave has—there would be a lot more people using methamphetamine than those solid figures would dictate, and it is partly because people are having, I guess, their version of the desired effect from the drug, so why would you call an ambulance for that? They are not displaying any particular bizarre outward behaviours or physiological negative impacts of the drug, so an ambulance does not get called.

There is also that notion of, 'There is a problem, but if I call I'm then implicated,' and that was very much the thrust of the community safety forum when I presented there. They were very keen for me to convey the message that it is important for people to call if they have any concerns. It is not our role as paramedics and intensive care paramedics to actually ring the police, unless there are issues of public safety or your own personal safety or other considerations. So I think the figures are vastly larger than our data.

Mr RICE—Definitely. Anecdotally—because we audit all the cases that come in—if you speak to staff they will say, 'Oh, the patient was drug affected. We're not sure what type of drug it was, but they were definitely not their normal selves.' We tend not to get blood tests or results back as a matter of course, so we do not often find out who our patients were or what they were actually on. We say, 'Yeah, there's a good chance they're on speed or methamphetamine or ice, basically, but we cannot prove it.'

Just for East Gippsland, I went through each branch and I spoke to staff at each branch, and this is anecdotal, obviously. Lakes Entrance said that ice use is apparent across the community, but there is a minimal increase in ambulance workload. These are quieter branches across this area. In Bairnsdale ice use is apparent, with a mild to moderate increase in workload. In Maffra there is minimally apparent ice usage. In Sale there is a minimal increase in workload, as you saw by the stats there. In Fulham Prison, believe it or not, anecdotally there is a fair amount of ice coming out of the prison at this stage, or patients affected by it, and that is shown in some of the PCRs and the workload we get, and violence. In Heyfield, which is a smaller branch that only runs five days a week, apparently ice is common. We have a lot of issues in that area with methamphetamine usage, and always have, and that is causing a mild to moderate increase in workload.

The CHAIR—Why is that?

Mr RICE—The community itself is, I guess, reasonably isolated in some ways. It has a large timber industry and a lot of workers come into that industry. There seem to be a fair amount of depressive type cases that we get, with patients with either mental health illness or with addiction problems. I think it is a low socio-economic group of people in the area. I cannot pinpoint a reason why it is high but it always has been, so we tend to get called to a lot of drug-affected patients around that area for the amount of cases that come out of a small town with a small population.

Looking at the stats, alcohol is still the biggest factor that we come across and alcohol related violence. Amphetamine usage is coming up, and sometimes it will be a mix of both, but once again it is very hard to pinpoint which one is the driving factor. I would say alcohol, but you could explain this.

Mr ALLEN—In discussions over the last couple of days with Dave—and it was one of the questions actually from the list that was provided by Sandy that led us to discuss this point—we felt that if you have someone who is alcohol affected, to an extent you can actually still reason with that person and you can actually settle them off, and paramedics are exceptional at those kinds of interventions. They are used to dealing with people, they are used to dealing with patients who are agitated or upset. There might be a social reason or drugs or alcohol. They are particularly good at calming off those situations.

With alcohol, generally speaking, you can still bring that element of control and try and just placate things off. The problem with ice—methamphetamine generally—is that they become generally much more irrational to deal with. 'Unpredictable' is certainly a word that is bandied around quite a lot with patients who are affected by ice, and you just do not know what you are going get. They will be lying quietly one minute on your stretcher. You have been to the scene, you have carried out your interventions, and the next minute they are in the back of your vehicle and they are up and going—out of the blue, unexpected. Again, if it is purely alcohol, most paramedics would feel like they had some element of, 'Okay, I think I can deal with this. I think I can manage it.' That feeling is much less with people who have been taking ice and methamphetamines.

Mr RICE—We pulled two cases. One was a 21-year-old female who four of us actually went to, and she was quite irrational, at home with her parents. It took 35 minutes just to calm her down and actually get her to come into an ambulance. Even then her behaviour was quite irrational. The normal things you do with patients who are just intoxicated through alcohol is to get eye contact and slowly get a bit of rapport going. That was not working with this girl, so we had to continually get her focused. She was biting her arm, scratching incessantly, picking things up—would lose focus in about three seconds—so it was really hard to actually get any level of trust and rapport going and get some information. She could barely speak.

Yes, and they are quite difficult as a result, because you cannot get a history out of them either, whereas with drunk people, 'What have you had?' 'I've had five stubbies,' or, 'I've drunk X amount of whisky.' These patients either do not tell you anything or cannot tell you anything. So to work out exactly what is happening with them is fairly difficult, plus there are the medical conditions that come about from the use, which could be a decreased level of conscious state or hypothermia, tachycardias et cetera. They are quite hard to deal with sometimes.

We have some good guidelines in place. Mark will go through the guidelines shortly. Most of our staff have gone through a degree of training. They have that ability of paramedics where they have had years and years of dealing with irrational people or people that are in crisis. But there are odd cases where you have to go and sedate some of these patients, because their behaviour is just a danger to themselves or others. There are also patients who are in such a decreased level of conscious state that we need to actually sedate them further and look after their airways and some of their other medical problems.

Mr ALLEN—There was a national drugs strategy—it was in 2006, I understand—and on the back of that there was a recommendation that came out for ambulance services around psychostimulant overdose. As I say, it was part of a national strategy and on the back of that certainly Ambulance Victoria, which I can talk to, in 2007 or 2008—I am not certain of the year—came out with a new clinical guideline around the agitated patient, and it was very much aimed at the increased prevalence of agitation and violence associated with psychostimulant overdose. That has been really successful and used quite broadly since then. As a paramedic, it gives you freedoms, if you like, and protection from the patient and also protects them from themselves in some instances. It is a sedative, if you like. It is midazolam and it is an intramuscular administration for the patient that you have been unable to placate.

Just to paint a brief picture, you turn up at a scene and they are uncontrollable. The police may be involved at that point and are holding them down because of their behaviours. You do the best you can, but they are already in that heightened state. You have choices. You can then try and weave some of your magic and talk them down out of that state, which is often difficult, or you can see clearly they are a risk to themselves, they are certainly a threat to the police, and then if you become engaged in that in the back of your ambulance, they are certainly a threat to you. The guideline was introduced to enable you to lightly sedate them to the point where you can manage them and protect them from themselves. I think the fact that we had that introduced into ambulance practice a relatively few years ago was a recognition that this was going to be a growing problem.

I used the guideline myself probably four months ago. There was a young fellow found naked inside a house. Someone found him in the house, didn't know him from a bar of soap, and chased him and he leapt out of the window. The police had been called, obviously. They arrived at the scene and they had a naked 20-something-year-old, in the dark, standing behind a shed, trying to put a sock on. That was the best effort he could make at getting dressed. Now, clearly something was going on there, very likely psychostimulant abuse. He started to get really agitated with the police there and tried to physically attack one of the police. The two of them there at the time jumped on and held him down to protect themselves, and him really, and then another couple of police members turned up and they were able to adequately hold him down.

He was agitated the whole time, he was eating mouthfuls of grass in the backyard, and that was a perfect application for that new guideline that we have, because we were able to settle him down, manage him, get a set of observations on him, get his blood pressure, check his heart rate, put the cardiac monitor on, none of which would have been possible in any meaningful way without the application of that guideline.

The other consequence sometimes of people using psychostimulants is that they will overheat and become hyperthermic—will have a very high body core temperature—and ambulance now has the capacity to do a number of things with patients in that category. We can provide active cooling with cool fluids if we are unable to, through more passive measures, reduce their core temperature, and there are also some really significantly advanced airway management issues if their conscious state has been affected to the point where they are deeply unconscious.

If you would just allow me to use some lay terms, for a deeply unconscious patient who does not have the capacity to look after their own airway, intensive care paramedics now can put in a breathing tube or intubate the patient and, if necessary, we can give them paralysing agents to enable that to happen. That was not developed specifically for those psychostimulant overdoses but it is an adjunct that we have been known to use with patients who have overdosed. That is how we go about managing them at the high end.

Mr RICE—The point that is concerning for us is that we see a lot of patient groups or groups of people that normally would not have used speed or methamphetamines or any type of drug of that sort. It is almost acceptable now. I asked some of the younger ones around our area and they said it is actually cheaper than alcohol, so if they are going to a nightclub for the night they can buy ice fairly cheaply and there are a number of ways to use it, compared to buying drinks for the night which cost $8 to $10 each, and they said that is the biggest factor—that they can walk around with a bottle of water or two and have a fairly cheap evening. These are people who, if you had asked, I reckon, in my generation or the generation of the last couple of years, 'Would you use speed or methamphetamines?' would have answered a definite 'No', but now it seems to have become almost acceptable as a drug of choice, which I think is fairly horrifying.

Mr SOUTHWICK—Are you being called out to the nightclubs and public premises as opposed to people's homes?

Mr ALLEN—I think mostly you get called out after the nightclub. You get the odd one in nightclubs, where patients have taken too much and haven't drunk enough water or they have had an effect from the drug which is stronger than what they expected. A lot of the time it is calls from parents or concerned friends later on. The trouble with trying to get a history out of them—what have they taken, what have they done—is that there is a lot of reticence in regard to doing that because people do not want to admit that they have used drugs or that their friends have used drugs, and a lot of friends have often taken the drugs as well but have not had those effects.

Yes, we get calls to nightclubs—and in some of these areas the nightclubs are fairly small compared to inner Melbourne—but it seems to be a few hours later when they get them home, or friends bundle them up into the car or a taxi and get them home, the patient does not get better and they get to crisis point and say, 'We need to call an ambulance,' and we get called. In a lot of cases hopefully they are recovering, but sometimes they continue to get worse. They are the ones we need to work fairly hard on to get a better response out of the patient.

Then you have the ongoing issue of getting them into an emergency department. For irrational behaviours, you need police involved. You have got areas where you have got limited resources in regard to ambulance and police at certain times, so that makes it reasonably difficult as well, and emergency departments as a whole are not the most secure area. You have got a lot of patients, nurses, sharp instruments, expensive equipment, so they are difficult to manage in that case, hence why often, if we have to, we will sedate the patient reasonably early to try and make them more manageable.

I have been doing this and a few other jobs—the police force, for example—for 20 years. I have never had a problem dealing with drunken people just intoxicated through alcohol. They are quite easy. You can normally get them down and you can see if they start to escalate and get angry. It tends to be a slower fuse. I was dealing with heroin in Melbourne years ago. It was quite rife when I was down there. It was very cheap and used. They were the same—normally fairly placid. With ice and methamphetamine, they are quick to fire up. There will be no signs that it is going to happen, or they are already fired up when you get there, and that is the scary part about them. They take a lot of work to control, if you can.

Mr RICE—Associated with that behaviour, often in the case of young, fit males, with an old bloke like myself in the back of the ambulance, is that they are strong. They are very, very strong, and once they fire up and you are dealing with someone who is strong and who you cannot reason with, you can see the apparent dangers. That is one of the concerns, certainly, as a manager of staff at your branch. We have had instances—they are not every week, but they are not isolated—where paramedics have been assaulted in those kinds of settings out of the blue.

The CHAIR—I was going to ask the hospital. There does not seem to be any cause for alarm for particularly the young about what they are putting in their bodies. It has been described to us that part of the ingredients of crystal meth is some quite volatile chemicals—bleaches and battery acid and whatever else. Chlorine, is it?

Mr RICE—Powders, yes.

The CHAIR—Yes, all pretty nasty stuff, all mixed into a concoction that they seem to readily smoke, and in this day and age, with young people always demonstrating concern about what goes in their bodies, I would have thought an intervention program that actually describes the ingredients of some of these drugs would probably be enough to allow people to sit and think for a minute, 'Well, is this good for me long term in my body?' to try and overcome the natural quick fix of creating wellbeing superficially by the use of the drug. Is there any concern by your patients about what they are actually taking?

Mr RICE—No, not at all. I have not seen it, and I think it has always been that way. When the patients were injecting amphetamines they did not seem too concerned. They are just after that drug itself.

The CHAIR—The big buzz, yes.

Mr RICE—And, yes, you are correct. Once again, there is more anecdotal evidence for us from sporting groups that it is becoming more prevalent. It is just accepted that people use it. Even people that are fairly health-conscious and fit will still have their weekend bender as such and use some of these drugs.

Mr ALLEN—One of the questions alluded to 'Okay, what do you think the solutions are?' I certainly think that there needs to be high-profile, ongoing education to the public about exactly those kinds of things: 'You need to understand what the potential consequences of what you are doing are, because these drugs are often cut with other products and made with chemicals.'

It is only the one who is cooking the drugs who has any idea of what has gone into it. The range of effects can be from the supposed desired effect right through to the obvious other end of the spectrum. We have all been to those jobs. Again, at the acute end they are the ones that we tend to see but there is a whole raft of other people who are probably suffering some kind of physiological effect. It may even be a long-term effect: strokes, high blood pressure, cardiac arrhythmias. The list just goes on and on.

The unpredictable nature of the outcome is well researched and well documented. Two people can take the same drug at the same time and both have vastly different responses to it, depending upon their mental state. They might be on a natural high, so they will have this heightened response to it. The other person may not get that same reaction. Person A might have an effect lasting sometimes days, and this other person might have an effect that will last them hours. It is that unpredictable nature of it; there is just no way of saying, 'I've seen them take it and be safe. I should be right.'

The CHAIR—The same as the happy drunk and aggressive drunk, I suppose.

Mr ALLEN—Yes.

Mr CARROLL—I was going to ask Dave, just when you were talking about the 21-year-old girl that was biting her arm and scratching, was she saying anything? We hear evidence that ice can make you suspicious, paranoid, you think there are bugs under your skin. What she doing any of that?

Mr RICE—She would keep flinching away from us. You would talk to her for a while and then she would lose focus for a period of time. Then she would come back to focus and say, 'Who are you?' That is quite common. They are almost shocked to see you, even though they have been speaking to you 20 seconds ago. Something was happening. There was something on her body—to her—and there was something in her mouth. She was pulling her lips apart and biting; just bizarre irrational behaviour. It is really hard to say. I honestly cannot remember the exact

conversations that she had but she did make a lot of statements throughout when she did speak. She would say, 'I have to run. I have to go. I have to run.' We would ask her what she had taken and she could not tell us. She would say, 'I haven't taken anything. I haven't taken anything.' She would just pick on one sentence and repeat it constantly.

We have seen a few patients like this lately and she was probably one of the worst affected that was not actually unconscious. She was right on that cusp of being unconscious or so dangerous to herself that we would have sedated her. So biting her arm, the skin, she would lift things up and look at things. We put her in the ambulance. When we finally got her in there she just wanted to touch everything and check everything out. It was almost like a newborn trying to find stuff. Evidence later came through that her boyfriend or a friend had brought some drugs around and provided ice to her, which they smoked.

Mr CARROLL—If I can just follow up with Mark, the Breaking the Ice forum that you were involved in, how beneficial—you spoke about it being important for education but did young people turn up to that?

Mr ALLEN—Yes.

Mr CARROLL—Can you just shed a little bit more light on it?

Mr ALLEN—The forum was organised by Latrobe City as part of their annual community safety forums and they invited Ambulance Victoria, who I represented, the police and a drug squad member who was fascinating in terms of his depth of knowledge of the drug. I can get you his name afterwards. It just does not come to mind at the moment—John. He spoke in detail about the drug and the effect and the networks, and how they go about their policing methods around all of that. There were healthcare workers as well who deal in drug intervention programs and rehabilitation programs. They were equally interesting. The audience were paramedics, nursing staff, healthcare workers and a lot of young people, some of whom seemingly had parents there with them. In the end there were 350 people at this thing. For Latrobe Valley that is a big turnout for something like that.

Afterwards there were a lot of people who were actually quite keen to talk to each of the presenters, myself included. They did not want to ask a question because there was an open forum at the end, question and answers, and there were a lot of people who came up to me afterwards and asked a question more discreetly. There was a lot of interest and I thought it was terrific. They had had one earlier in the day that centred around alcohol issues and then the evening session went for about three hours. It was specifically about amphetamines.

Mr SOUTHWICK—I am just wondering if you could elaborate a little bit further about the different type of user that you are seeing more with ice: the tradie, the person that would not normally fit the drug profile we have seen in the past with other users.

Mr RICE—This is probably from history with police, ambulance and a few other industries. Probably some of the younger set, so 18 to 30-year-olds that you would not expect to be involved in high-level drugs. Normally that kind of group you might expect to use marijuana or alcohol at the worst, and they are now using what is a heavy drug, which is something you just never used to see. In some of those circles you might have seen some cocaine years ago when it was around; a few of those drugs which were seen as more of a trendy drug as such, and probably ecstasy, which is seen as a party drug. Now you are seeing something that has always been seen as a lower-end hard drug, which is used as a last resort, now becoming commonplace. That is my view. I do not know if you agree.

Mr ALLEN—I agree with that. The nature of the drug, and it is well documented, is it is so highly addictive, much more than many other illicit substances that are known to be addictive. Users build a tolerance for it very quickly, so hence that escalation that you get. Each proceeding time it takes a larger dose to get that same effect. Therefore I guess that's how the people supplying it build the market. Most of the patients that I have been to and seen written up on case sheets do tend to be younger. That is my experience; that it tends to be a younger cohort of patients.

Mr SOUTHWICK—Do those patients that you are seeing tend to be the first-time user, be it they are not able to manage their drug use?

Mr RICE—Not really. It is such a volatile drug that you can never be sure what dose level you are going to get with the drug, depending on who manufactured it and what is actually involved in the drug itself. You can get patients who have used it for the first time. We get quite a few of those amongst the younger party type set at night clubs and so forth, as we were talking about before, but sometimes we get long-term users that obviously take something and this time they have had an effect that they never really expect. Once again, these patients are the ones that five years ago, if you said, 'Would you use speed?' they would go, 'No, I wouldn't use speed. There's no way I'd ever touch speed.' Now they are quite happy to go and use ice.

Mr SCHEFFER—They are different people though, aren't they? Are they different cohorts coming through?

Mr RICE—I think the same groupings of people. I think it's just that society type of change. The perception of the drug itself has changed, so it has become a drug that is acceptable to use in certain groups, where it would not have been five or 10 years ago. That is just something I am seeing. I walk in a house and go, 'They're using amphetamines. I'd never expect it from this kind of person.' We used to get surprised occasionally, with heroin and stuff, that there were people using it you would never expect. We would get teachers and all walks of life using those drugs, but it was not very common.

Mr McCURDY—Very quickly, you spoke about four of you at an incident for that patient before. I am just assuming that is behaviour patterns. At what stage do you think you need to change the way you are equipped when you go to some of these situations? Is it growing at a rate that you say things need to change quickly? Are you still equipped to manage the situations?

Mr RICE—I do not think there is much criminal-wise that we can change that will help us. It is probably more training in regards to de-escalation techniques in dealing with these people. If we walk in a house, it is a house you have probably never been in before, so there are dangers associated with that. Then throw in someone who is agitated and violent, it is quite hard to mitigate any safety risks. On Thursday or Friday at Bairnsdale, one of the paramedics got kicked by someone on methamphetamines. So criminal-wise, probably not; I think it is just us learning, and probably learning fairly quickly better techniques of de-escalating some of these patients or getting a rapport with them or controlling them.

Mr McCURDY—Okay.

Mr RICE—Or maybe escalating the way we manage them with drug intervention a bit quicker sometimes. I know there have been cases where we have tried other techniques and then events have occurred and probably they should have been sedated a bit earlier.

Mr ALLEN—Not to say that age necessarily brings wisdom but there are a lot of young people working as paramedics now. The nature of the paramedic education system is that it is a university based degree, of course, so you tend to get a lot of young people working on the road, some of whom have only ever spoken to their grandad or grandma in terms of elderly patients. Some of the young people perhaps do not necessarily come with the same skills as some of the crusty old paramedics who have been around a bit and had to deal with a lot of different situations. I guess it will be interesting to see, over time, whether that becomes any kind of issue. Having said that, they come out of university very smart, very highly qualified and it is a great system. So there is that experience and that goes back to Dave's point, I think, which is making sure we maintain that education around de-escalation, not put ourselves at risk, and use the guideline that we have been given, wisely.

Mr RICE—I think this will be a high risk for us in coming years. We will see paramedics hurt as a result, unfortunately.

The CHAIR—All right. We might have to leave it there. Thank you very much for your contribution this afternoon to this hearing.

Mr RICE—No worries.

The CHAIR—We appreciate the response you had to the questions, too. Thank you.

Mr ALLEN—Thank you.

Witnesses withdrew.