LAW REFORM, DRUGS AND CRIME PREVENTION COMMITTEE

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

Warrnambool — 3 March 2014

Members

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Witnesses

Mr G. Castledine, Group Manager South West, Ambulance Victoria.

Mr P. Benbow, Acting Team Manager, Warrnambool, Ambulance Victoria.

The CHAIR—Phil and Gary, welcome. We are conducting a public hearing into the supply and use of methamphetamines in Victoria, particularly ice, which was given to us by the Victorian Parliament. We are due to table a report at the end of August and we have been collecting evidence right across regional Victoria of which Warrnambool was our last regional hearing at this stage anyway, unless there is a request for another hearing. We have been particularly referenced in relation to the impact to the indigenous communities, but also looking at what role outlaw bikie clubs and organised crime play to the supply end which is probably not so much your expertise but certainly we are keen to hear from those at the front line of which you are. It is important that you be here today and I thank you for your time. I will read you the conditions under which you are providing evidence to this inquiry this afternoon. Bear with me for a second.

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 have said in evidence, may not be afforded such privilege. You have received and read the guide for witnesses presenting evidence to parliamentary committees. 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.

Again, welcome. I understand you would like to make a verbal submission and then we will ask some questions of you.

Mr CASTLEDINE—My name is Gary Castledine and I am currently the Ambulance Victoria group manager for south-west. I have been in this role for two and a half years. With me is Phil Benbow, the acting team manager at the Warrnambool branch. As part of my research for today I have reviewed 17 months of data from August 2012 to December 2013 for the south-west district from the Victorian Ambulance Computer Information System, or VACIS. From approximately 15,500 cases reviewed during that period I have identified six cases which specifically make reference to methamphetamine and/or ice, and six cases which sound suspiciously like the patient may have consumed this illicit drug. That is a total of 12 cases over 17 months amounting to a percentage .07 per cent.

I need to qualify the meaning of that data by saying that Ambulance Victoria's computer aided dispatch system does not identify cases by the drug consumed but rather by the particular symptoms identified during the call-taking process using the Ambulance Medical Priority Dispatch System. For example, the case may be dispatched as an assault based on injuries received by the patient during an altercation. However, when the paramedics arrive they may discover covertly or by admission that the patient has taken ice. This will not necessarily be reflected in our data as the assault and associated injuries may still be the primary issue.

The second issue is that from the cases reviewed AV was called to patients who experienced an adverse effect; that is, they are reporting feeling unwell—nausea or pain, for example. For those who experienced the effect that they are chasing after using ice, we are unlikely to be called to them. These patients often call some time after the initial event to report these symptoms.

Finally, paramedics respond to the limited information they are presented with. Often it will be many hours at A and E where various tests have been completed and/or significant rapport developed before the true nature of the situation is known. In addition, most of the 12 cases identified revealed overdose by poly pharmacy which further clouds any assessment. Given the data may not provide the entire picture I addressed the issue with a number of operational staff who reported that the problem was an insignificant one in the south-west generally.

While most paramedics spoken to could recall having been to a case of ice, they were not concerned about its prevalence.

The data revealed eight of 12 patients were aged 20 to 25 years, with nine of 12 being male; that is, the ice patients attended by AV in the south-west are best characterised as young adult males. Our data does not reveal any other salient personal characteristics. There are clearly other significant drug use issues in the community with greater than 90 per cent of the overdose cases that I reviewed relating to alcohol. This would appear to be used far more regularly by people within the south-west and is significantly more likely to need an ambulance to respond. Often these patients were young adults, both male and female.

With regard to violence perpetrated against paramedics in the south-west it is an extremely rare event, arguably a reflection of the excellent training and professionalism of AV's paramedics. Safety is always the first priority. On the data reviewed, while it was clear that patients were agitated they did not direct violence towards the paramedics. Paramedics are trained to deal with agitated patients, both chemically and mechanically, using the assistance of other agencies, such as Victoria Police.

In summary, ice use in the south-west is not currently considered an overwhelming problem from Ambulance Victoria's position. Thank you for this opportunity to provide the submission.

The CHAIR—Thank you. Phil?

Mr BENBOW—No, I have nothing further to add to the submission.

The CHAIR—Okay. Mr Scheffer, would you like to ask any questions?

Mr SCHEFFER—No, not really. I think it is fairly generally the case that your colleagues across the state are reporting a very similar story but yet we are getting evidence from other quarters of the community—agencies, for example, that support people who are using drugs and substances like this, that there has been a great upsurge in it, and you have explained in your presentation about why you do not pick that up. In your interactions with some of those other agencies are you aware of this apparent disparity, people working in the profession.

Mr CASTLEDINE—With the poly pharmacy, you mean?

Mr SCHEFFER—Well, we are getting on the one hand you people saying 17 people over 18 months; that you say agitated patients do not direct their violence towards you, and I think you said also that you are not particularly concerned about its prevalence which you are saying is from your experience, while we are hearing in other areas in communities there is a great concern and there is an upsurge and there are a lot of very stressed parents and family members around the use. You must be hearing that as well, you must be seeing it in the newspapers. How do you put all this together?

Mr BENBOW—I think as Gary explained in the first part of his submission that one of the things for us is they are often poly pharmacy overdoses, especially with a load of grog on board. But even anecdotally, leaving to come here this afternoon, around the table at the branch one paramedic said he has had two this week. I asked him how did he put that on his PCR, his case sheet. As I would you describe the presenting problem, and he would put in there 'poly pharmacy overdose', because although you could say the person is perhaps using meth, whether they have admitted it or you can see certain signs, this particular individual was severely drunk as well as having taken other drugs. They may not have taken the meth today, it might be prescription drugs to go with alcohol. The patients we come across we tend to be treating them holistically with the presenting problem rather than delving down into what they are using.

Unfortunately, the son of a friend of mine is using meth. Where they go to, like, social work and support services through DHS or whatever, they then are specifically aware of that one problem and they will say, 'Let's discuss and handle your meth addiction or your meth abuse,' whereas for us we tend to treat the presenting problem at the time.

Mr SCHEFFER—Of those 17 over 18 months—

Mr CASTLEDINE—No, sorry, 12 over 17 months.

Mr SCHEFFER—Well, that is even lower—12 over 17 months, thanks for putting me right. Those 12 were they home calls, were they street events, were they in venues?

Mr CASTLEDINE—Yes, all of those areas.

Mr SCHEFFER—I know it is a very small number of cases you are talking about but is more one than the other?

Mr CASTLEDINE—No, I would say there was an even spread.

The CHAIR—Can I ask, in relation to an increase in call-outs for alcohol-related required assistance, as against drug related, have the ratios gone up? You might well have said this and I might have missed it, I am sorry, but I guess Mr Scheffer was probably trying to find out, has there been an increase in call-out for particularly meth or crystal meth type assistance as against your normal business which probably is alcohol related more so than anything else. Has there been a change in requirement or call-out to drug rather than alcohol, or has it consistently been similar in increases?

Mr CASTLEDINE—From the data I reviewed, alcohol was the most prominent and most common, and there has really been no changes. Across the 17 months those 12 cases were spread fairly evenly, and the number of alcohol cases were far in excess of anything to do with this particular issue.

The CHAIR—Do I take it then the responses for medical assistance in the region that you are covering has not increased either through the legal drug alcohol, or through illicit drugs like methamphetamines?

Mr CASTLEDINE—No, I would not say it has increased from the data I reviewed. In actual fact our case load across the district that I look after has dropped by approximately 10 per cent over the last couple of years, and that is due to a couple of initiatives that we have introduced, and not directly related to the issue of alcohol or drugs, but the numbers of those cases would have been maintained at a similar proportion or level through the 17 months that I reviewed.

The CHAIR—Can we take it then the incidence of street violence is reduced also in relation to those stats?

Mr CASTLEDINE—If I go on incident reporting to me, specifically about violent events that our people go to and are exposed to that violence, there certainly has not been an increase. There are occasionally events where our paramedics have to work their way through that situation but there has definitely not been an increase.

The CHAIR—It is interesting, given all the evidence we have collected so far indicates an increase in use of methamphetamines. I suppose you could say that because it has not been presented at a paramedic level required assistance, does not mean it is not increasing, it is the fact that you are not seeing it through your responses.

Mr CASTLEDINE—That is right. I live in this area and I am aware that it is out there, but from a professional point of view I am looking at the data I have. I cannot make any

other comment than what I have presented today really. That goes back to specifically on our VACIS, the computerised reporting system we use. There is no specific box which area you put down, like, if you believe the patient is on amphetamine or ice, unless it is specific that someone in a psychotic state and someone will say, 'He's having an ice withdrawal,' that is when you may have put that down. But generally, as I said earlier, you are treating an assault which is post-alcohol overdose and probably combined with potentially ice.

In reference to the deputy chair's question regarding other services, I am part of the Mental Health Liaison Committee that works the south-west area, and certainly while it is reported in that committee that drug use—and we are not specifically talking about ice—is an issue in that particular community, in the next few months we are reducing some parts of our service which is suggestive to me that the issue we are talking about today is not as prevalent as you might have been told in other areas of the state. With regard to VicPol, again I have not been approached about any particular issue. Yesterday Phil spoke to workers at the emergency department and they had a similar view that the prevalence was not overwhelming.

The CHAIR—That is good news because part of our report was looking at what protection we might need to recommend for paramedics at the front line, if in fact they felt somewhat threatened by erratic and violent behaviour which has been told to us that emanates out of those that are badly affected by crystal meth.

Mr CASTLEDINE—Yes.

The CHAIR—You are indicating to us from a paramedic's point of view that (1) the situation is not as perhaps dire as what we have heard from other regions and (2) that your safety does not seem to have been compromised by the few call-outs that you have had in relation to that drug.

Mr CASTLEDINE—That is the evidence I have before me, yes.

The CHAIR—Okay. Mr Scheffer?

Mr SCHEFFER—I think that probably covers it really from my point of view.

The CHAIR—Is there anything else you would like to say? I guess if in fact your job and your role as paramedics at the front line are not being unduly impacted by methamphetamines, but perhaps more so by alcohol-related activity, then there is not much more, as far as this inquiry, in asking for additional information.

Mr BENBOW—Sure. I am generally working on road on a roster and I know in Warrnambool there are probably—and this is really anecdotal—four patients we are regularly called out to, twice a week, three times a week, and we will frequently have the police at that scene for our safety, but at least three of those four are alcohol related. They have probably done other drugs in the past which would give them some type of acquired brain injury but generally it is usually always alcohol that causes the problems.

The CHAIR—Which is pretty consistent.

Mr BENBOW—But that is not discounting ice. If you get someone on an ice-related psychoses they are difficult to handle. It is potentially quite dangerous and difficult to handle, and your normal de-escalation procedures, you do struggle.

The CHAIR—With a new paramedic, does he or she have specific training in relation to dealing with someone on meth?

Mr BENBOW—Yes. Well, not specifically meth but stimulants psychoses. Cocaine can produce similar effects. New paramedics, when they come out as gap students—they do part of it in their university training. When they come out and do that first gap year they are

with a clinical instructor for the first 12 months, it is something which is talked about a lot.

The CHAIR—Thank you both very much for your time this afternoon. We appreciate it.

Mr CASTLEDINE—Thank you.

Witnesses withdrew.

Hearing suspended.