T R A N S C R I P T

LAW REFORM, ROAD AND COMMUNITY SAFETY COMMITTEE

Inquiry into drug law reform

Melbourne — 19 June 2017

Members

Mr Geoff Howard — Chair
Mr Bill Tilley — Deputy Chair
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Ms Fiona Patten
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Witness

Mr Michael Stephenson, Executive Director, Operations, Ambulance Victoria.

Necessary corrections to be notified to executive officer of committee

The CHAIR — Thank you for coming along today on behalf of Ambulance Victoria to speak to our inquiry. You would be aware that our discussion this morning is being recorded and a transcript of the discussion we have will come back to you in the next couple of weeks for you to verify that it is a correct appraisal of the discussion we had, and then it will become part of the public record. I note too that Ambulance Victoria has provided a brief overview — a submission — to us, and we welcome that. In the time we have available to us we would welcome you providing further commentary in regard to Ambulance Victoria's experience in regard to drugs across the state, and we will obviously have some questions to follow up with. So over to you, Mick, if you would like to share the experiences of AV.

Mr STEPHENSON — Thanks very much, Geoff. I will start with a very brief introduction, and then I will leave it to you to ask me the questions that you think relevant. From our point of view the issue of illicit and pharmaceutical drug misuse in this state is really a patient-focused issue, so this is about the care of Victorians and us providing people with good-quality health outcomes. So that is the focus from which we work. We are very interested of course in the reduction of harm, such that we are not dealing with the consequences of drug misuse, and there is the benefit therefore from that of also reducing demand on ambulances. This does pose quite a significant demand problem for us and provides an unpredictable variation in demand. Also the issue of drug misuse in the community presents a very significant risk to our paramedics as well in terms of their exposure to occupational violence, but also the risk of blood and bodily fluid exposure and so on.

To the extent that the problem is known, we work, as you will know, with Turning Point, the agency that is part of Eastern Health, and they basically take a data feed from us and provide back to us the information in terms of alcohol and other drug-related exposure in ambulance. That is what we know. Obviously the problem is much greater than that in the community, given that we only see some of the people who use these substances, and we are probably seeing many patients in circumstances where it is not identified that they have either used or misused drugs and alcohol but have got themselves into strife in some other way — for example, in motor vehicle accidents we know that there is a very significant rate of drug and alcohol use in that cohort that is presenting to the major trauma centres in Melbourne, but they would not necessarily present to us as drug misusers at the time.

I want to start by saying that. That is the framework we are within, and I will answer your questions if you like.

Mr DIXON — Obviously you are the frontline service and you are dealing with all sorts of issues. What are the trends in terms of drug-related incidents that you are attending at the moment?

Mr STEPHENSON — We know that, in terms of the volume we are seeing, the trend is trending upwards constantly. If you are talking about illicit drugs, the trend over the last four years that we have reported — or the last four financial years that we have got reporting for — the trend is about a 19 per cent average increase in attendances per year. In terms of pharmaceutical misuse it is increasing at about 2 per cent a year. So in terms of the total workload now we are seeing about 11 000 cases or more a year of illicit drug use and about 11 000 of pharmaceutical misuse. So there are about 20 000 cases per year, which constitutes about 4 per cent of our emergency workload.

Mr DIXON — Four?

Mr STEPHENSON — About 4 per cent. Drug and alcohol combined is about 8 per cent of our total workload, so it is a very significant impost on us in terms of being able to provide a service. In terms of the types of drugs we see, I think it is well known in the community what the pattern of drug use is per se. Despite the fascination with it, there tends to be a waxing and waning of the types of drugs that are around at any particular time, but for us over recent years we have seen a very significant increase obviously in methamphetamines and other stimulants, and also less so but still significant increases in the use of heroin, cocaine and cannabis as well. So we are seeing, as I say, an increasing trend in the misuse of all of those substances. As I say, in terms of pharmaceuticals there is steady growth in pharmaceutical misuse but less so than there is in the illicit drugs.

Ms PATTEN — As you might know, I have been fairly actively supporting a pilot program for a medically supervised injecting centre in Yarra, and I know some of your colleagues have been supportive of that. Does Ambulance Victoria have a position on the proposed trial?

Mr STEPHENSON — As I said at the start, our focus is really on the reduction of harm to the patient and obviously the health of the community generally. So from our point of view we would say that if the research supports these sorts of things, the evidence is such that they should be undertaken, the evidence is such that harm would be reduced for the patient and in fact the rate of death, for example, would go down, then we would follow the lead of the government of the day. So should that be implemented, of course we would work with them.

I suspect that for us in many ways it would make our work somewhat easier if the large majority of patients who overdosed in a drug injecting centre would be able to be managed by the drug injecting centre. At the moment, as you know, if you overdose in a laneway or in an alley or a public toilet or whatever, the risk is considerably greater. There is some published science on this matter and, as I said, we would follow the lead of the government of the day and work with those safe injecting rooms should they exist. We are very interested in things that could reduce harm and reduce risks to patients — yes.

The CHAIR — As a follow-on, then, in terms of naloxone availability, clearly it is available at a number of sites across town, but of course it is not available as broadly as it could be. I wonder whether you want to make any comment on whether it should be able to be made more available.

Mr STEPHENSON — For a narcotic overdose naloxone is obviously the antidote and, if it is available at the time of overdose, by and large you can have the overdose reversed, and the risks of respiratory depression and respiratory arrest and death are obviously reduced very significantly, and from our point of view again if it were widely available to the community and it reduced harm and improved outcomes for patients, then we would be supportive of it.

Clearly I would think that in many of the overdoses we attend, in terms of narcotic overdose, if someone with that patient at the time had naloxone and was trained to use it, then we probably would not be there. There is no great risk with that item. A large majority of patients that are resuscitated from narcotic overdose with naloxone do not need ongoing care.

Ms SULEYMAN — Your submission explains that there is an increasing use of illicit drugs. We have heard from your submission as well of public events causing deaths and overdoses. In your submission you suggest there should be an increased responsibility on event organisers to run safer events. Can you talk a little bit more about how that can be achieved?

Mr STEPHENSON — This is of grave concern to us. This is an unregulated environment, and the event organisers are essentially unregulated. There are some rules obviously they have in place for themselves in terms of insurance and medical care and other bits and pieces, but the variations in practice at these events are marked. As a consequence it can have a very significant impact on us and obviously a very significant impact on people who use drugs at those events.

There are a couple of things I suppose that we perceive would make things better in that environment. One is that the experts in our environment who work in this area daily inform me that where there is a form of policing on entry to these events — not necessarily by Victoria Police but a form of policing — then the risk of overdose is reduced dramatically and we see far less overdoses at those events than we do where policing is not in place.

Given that this is unregulated, the risk to patients is grave where there is not the appropriate level of medical care. There is no obligation on an event organiser, for example, to have us, Ambulance Victoria, at their events. But clearly given the gravity of the consequences of some of the overdoses, it is absolutely sensible that we would be there — so some form of insistence that at least the level of medical care that Ambulance Victoria or another agency could provide to a patient who is critically ill. These patients are often patients who require intensive care, and your first aid provider for the largest part is not able to provide that level of care.

From Ambulance Victoria's point of view, regulation in this area is very, very important, understanding that at most of these events we would see on average five or six significant overdoses. You have seen in the recent media where we had an event where there were 30, and more than 20 of those patients were critically ill. It is a complex matter.

It is also compounded by the fact that the organisers seek to put these events on often outside of the public eye, so they are often outside of areas where you would have good quality medical support. If you have a rave party

out in the middle of the bush, there is not a big hospital nearby, there is not an intensive care nearby. Ambulance resources will obviously be limited in those areas. Understand that when we are working at these events and if we are resuscitating four, five or six people, then that ambulance will not be available for the general community at that time either, so it is a very complex matter for us in terms of resourcing.

We engage with the event organisers as best we can in an unregulated environment to see that they have our services, but that is not always the case. Certainly the quantum of service that we would like to provide for many would not be provided because there is a cost to it.

Ms SULEYMAN — That is very interesting. Just to follow up on that, there has been a lot of public debate in relation to the proposal of pill testing at these events. There are pros and cons. I am interested to hear your view.

Mr STEPHENSON — If the science suggested that it reduced the use of drugs at these events or indeed improved the safety of drug taking at the events, then Ambulance Victoria would be supportive of it. I know the science is a little divided on it. My understanding is that what you are testing for is certain known compounds, not always for things that are unknown, so the predominant agent in the drug will be identified. It does not make that pill safe to take. I think if we are guaranteed that people were safe or guaranteed that drug taking was going to be reduced, then I think we would be supportive. As it stands at the moment, I think the science is uncertain, but if the science were definite, then I think we would be supportive.

Ms SULEYMAN — There is also, as I think we heard in the previous submission, the issue of not knowing what the person has taken, whether it is prescribed and other known or unknown drugs within that person as well that are not tested on the spot, so that is another challenge.

Mr STEPHENSON — These compounds are often complex anyway. From our point of view, as you have probably heard repeatedly, there is no quality control in illicit drug manufacture for the largest part, and as a consequence most people do not know what they are taking. They certainly do not know what dose they are taking, and that will vary from pill to pill, supplier to supplier and so on.

In terms of our work, when these patients are critically ill we manage people based on the problems we find. It matters little somewhat in terms of what they are taking in terms of the treatment that we offer, because we provide the necessary resuscitation required, although there will be times when you have taken substances that have an effect that you are not expecting or it is so grave that it cannot be resolved and no matter what level of symptomatic care or what level of supportive care we offer, what level of treatment is provided, the patient will still die. That is a reality.

Ms SULEYMAN — Thank you.

Mr THOMPSON — Mick, I recently was working with a constituent family where there were three ambulance presentations at hospital within 48 hours or thereabouts in relation to a family member who had a synthetic cannabinoid addiction. Have you seen an increase in that level of addiction in the last five years?

Mr STEPHENSON — I do not know if I could comment on addiction per se, but we have seen an increasing level of use in the synthetic cannabinoids. It has probably not been at the level of increasing use in other substances. As I said, methamphetamine has been the drug that we have noticed the greatest increase of use in. In saying that, remember we would see about 2500 cases of methamphetamine abuse a year compared to 20 000-odd of alcohol misuse, so it is a much lesser problem for us than alcohol is. But often, as you know, these things are used in combination, and that is where some of the strife arises.

We have certainly seen an increase in use. My personal experience with this is that I have not seen it grow at the rate I thought it might, although a few years ago when we first noticed synthetic cannabinoids being the norm amongst drug users to some extent, there were some very significant spikes in presentation to us and to hospitals as a consequence — very significant spikes. I certainly know that when I was working in rural Victoria we saw very sudden and unexpected spikes in synthetic cannabinoid use. It is an increasing problem, although it seems to have plateaued to some extent. That is my understanding of it at the moment.

Mr THOMPSON — Does the treatment of someone with those presenting symptoms require the full backup of Ambulance Victoria? Are there greater priorities for Ambulance Victoria in terms of meeting its

call-out demands for heart attack, strokes, other emergencies, accidents et cetera? Are there other better measures to deal with people who may suffer from addictions, noting that when they get to the hospital they may only be there a short time before they are turfed back out into the community?

Mr STEPHENSON — From Ambulance Victoria's perspective, irrespective of the cause of someone's illness, if they are critically ill, then we are interested — very interested — and we would respond accordingly. Our drug and alcohol problem in this state consumes about 8 per cent of our ambulance resources, and if we were not doing that, we would have considerably better performance. At the moment I would suggest that if we did not have that demand, we would probably meet our performance targets that have been set for us. To that extent, it is an impost. Although at this point in time we have had our best performance effort for many, many years, and that includes our performance for stroke and heart attack. Our cardiac arrest survival is better than it has ever been. It would only be better if we were not consumed with preventable illness — evidently preventable illness as we are in this case.

To that extent, it is important to understand that these patients are often critically ill and require life-saving intervention. Many people, as you would well understand, are cured of their drug addictions, so the resuscitation or the saving of life — once, twice or more often if need be — often is of significant benefit because a life is saved and later turned around to lead a productive life and so on. So it would be perhaps negligent of me to say that we would prioritise one sick patient over another, irrespective of the cause of the illness. As I say, we are very interested and would provide everyone with the same level of care.

Mr TILLEY — Just off the back of that, Mick, you mentioned that you are turning out at a critically ill patient and there are no differences. I wanted to just talk to you about the dispatch system if we could — you know, how we determine this stuff. Through ESTA there is a telephone call put in, going through a number, can you just talk me through the formula that determines the dispatch?

Mr STEPHENSON — We use a system called the medical priority dispatch system. So you ring 000, Telstra takes the call — 'Police or ambulance?' — you get through to us and ESTA takes over that call. They use a call-taking discrimination system or algorithm that works through a series of structured questions to assign an event type, and from that Ambulance Victoria determines in relation to that event type the type of ambulance that is responding — so the type, the number and the type of response, whether it be a lights and sirens response or a less urgent response. Indeed you may be referred to a referral service where the call is then secondarily triaged, and then we provide a different level of response which might be telehealth — a GP comes to your home, nursing care — or you might come back into the emergency system.

That MPDS system has got about 1100 lines of code, so there are about 1100 different case types that can be derived from the call. Of course it starts with questions around threats to life, and if there are immediate threats to the patient's life, it is categorised as a priority 0 event and you get an immediate advanced life support level ambulance response and an intensive care level MICA-level response. If it is not as life-threatening but is serious, then you get what is called a code 1 response, which is a lights and sirens response. The large majority of these patients that we are talking about would invariably see a priority 0 response because they have got an immediate threat to life or they are indeed in cardiac arrest. About 5 to 6 per cent of our total cardiac arrest population in Victoria is drug related. The large majority of patients otherwise would receive, which is the majority of these patients, ultimately a lights and sirens response — for example, if their conscious state was impaired and if they had had an overdose and their behaviour was unusual or there were just less specific symptoms or less grave symptoms, then they would get an urgent but not lights and sirens response.

Mr TILLEY — I know it has been problematic for probably 20-plus years, the transfer and treatment of patients presenting with mental illness, and a bit of argy-bargy has gone on there with AV and police. Putting aside mental illness, is it getting out your concerns in relation to those that are exacerbated by the presence of a substance of some sort?

Mr STEPHENSON — Mental illness is a very significant issue in the community generally and, as you understand, drug and alcohol misuse is very common in that population, so it is often very clouded in terms of what the specific problems of the patient are at the time. These cases tend to be resource intensive, and if you look now in particular at the misuse of psychostimulants and methamphetamine in particular, we often find ourselves in the company of very violent, very aggressive patients, very hard to manage, certainly not compliant such that you could get them to hospital where they can receive the treatment they require. Of course that will often require a significant number of police resources. I mean, you see six or eight police at a case and two to

four paramedics for one patient. That is an extraordinary burden on the system, and it goes on for some time because the case times tend to be quite lengthy by the time you restrain a patient so that they are safe, sedate them and care for them after the sedation.

They will often have a police presence in the transport, so at least a couple of police tied up and a couple of paramedics — and often three or four paramedics. So they are very resource intensive, labour intensive and very difficult, and, as you would imagine, on any given night, particularly on busy nights in Melbourne, our case load in relation to drug and alcohol use would add 10 per cent to our total case load for the day. So where we might see normally about 8 per cent of our case load being this, it might grow by another 10 per cent. So it is not unusual to see another 150 or 160 jobs stacked onto our normal case load in relation to this sort of work over a weekend in particular. Add six or eight police at a whole lot of those jobs, and you start to deplete the state's resources pretty quickly.

Mr TILLEY — Do you have any indication of what is the loss to the workforce through WorkCover, WorkSafe, of those sorts of injuries that paramedics are experiencing owing principally to the incidence of substance?

Mr STEPHENSON — About 4 per cent of our total injury rate is occupational violence related. More than 40 per cent of the cases of occupational violence towards paramedics are related to drug and alcohol misuse — often both. It is very often both, and about 3 per cent of that case load relates to blood or body fluid exposure in the midst of occupational violence. So this is a very significant issue for us. We can talk about the numbers, and the numbers are high, but in reality we have people who are injured in the workplace as a consequence of this who have been assaulted or have been harmed in another way — for example, trying to restrain a patient for the patient's safety — who never return to work, either through the mental injury that occurs as a result of dealing with this sort of work or as a consequence of the physical injury. So it is a very significant impost to us.

In our workplace at the moment this is probably the thing of greatest interest to us. It has grown exponentially over recent years, particularly with the rate of psychostimulant use growing, but it is certainly a very significant problem just with alcohol alone, for example. We have invested an enormous amount in education and training for our paramedics in terms of managing these sorts of situations. We have had to adjust our clinical practice guidelines so that we revert to what would be considered very assertive levels of sedation in these patients so that they are safe for us to transport and restrain. So with clinical practice, risk to our paramedics has grown and our clinical practice has had to change.

Then of course if you sedate a patient who is extremely is aggressive from, say, methamphetamine use, they are unconscious when they arrive at hospital. It requires an extra level of care in hospital. It would mean the patient is in the resuscitation area of the emergency department and may become an intensive care patient, so it compounds. But in terms of us practising safely and assuring the safety of our paramedics, it is absolutely fundamental that we behave in that way, so this has changed our practice and changed our practice just over the last couple of years.

Mr TILLEY — Is it having any impact or effect on retention?

Mr STEPHENSON — There is no doubt it would. I will go back a little. Our return rates to work from mental health injury are very high; they are much better than the state generally, which is surprising, and much better than the entire WorkSafe cohort — through the insured entities. So we return our people back to work at a much greater rate than other places, but we lose people because of the environment they are working in. There is no doubt about it. So we will lose people through physical injury, through mental injury, and we will lose people who find that the work is not what they came to do.

Invariably I would think most paramedics when they join Ambulance Victoria joined for the purposes of helping people who are sick and giving back. It is very difficult when you are working in an environment where your efforts to do that are impeded and where you are constantly put at risk, and for our people generally, if you think about the incidence of occupational violence towards our staff, there is more than one episode per paramedic per year, so almost everyone will be exposed to it.

Clearly based on the human disposition some people will cope with it and some will not. Those that do not cope will invariably leave us, I think, or in fact be staying in work where they are feeling very uncomfortable or unsure about themselves. Hence the reason for our significant investment in training and the protection of our

staff, and we have got more coming. This week we will start our trial of body-worn cameras in the midst of all the other training we have done. We have done a lot of virtual reality training this year, and we intend to expand that further, and we have had every paramedic and every volunteer that works for us off the road for a day basically to reinvigorate the conversation around occupational violence. You can imagine that with 4600 staff that is a fairly costly venture.

Mr TILLEY — So have you run any trials rolling out the cameras?

Mr STEPHENSON — The cameras are about to start in the west of Melbourne, which is where statistically we are at the greatest risk of occupational violence, and certainly it is where very significant drug misuse occurs — in the city and in the west. So that pilot will start now, and if it proves to be effective, then we will roll it out to all of our staff.

Mr TILLEY — We will probably be finished, but certainly we will come up with some findings and recommendations. I think it would be important to know for this committee that for people generally human behaviour is, if they know they are being observed, recorded — putting aside that owing to the presence of substance they might not be well aware — if the message gets out there that they are being recorded, that it may go some ways to preventing some of these incidents that are facing our paramedics.

Mr STEPHENSON — Bill, we certainly hope so. That is why we are entering into the program. The state government have very generously sponsored that program. I think the findings will be interesting, because many people that we are talking about in terms of drug misuse and psychostimulant misuse are beyond considering the outcomes of their actions and in fact are beyond being capable of doing so. Very often in terms of occupational violence towards our staff it will not be the patient; it will be the patient's family and friends. So it will certainly help with those who have their faculties about them and who are able to make clearer decisions.

The risk of the severely agitated patient with something like a psychostimulant overdose will always be there, and body-worn cameras will not help with that, but there will be people who are moderately affected, moderately impaired or mildly impaired who are aggressive and who might make a decision to do otherwise. But as I said, I certainly think bystanders and so on — people who are connected to that patient — are likely to behave differently.

Mr TILLEY — Just in closing on that, when it comes to evidence value and reporting to police, is that type of information going to be available to police for prosecution, or are you just using it for diagnostics, the way you provide the service?

Mr STEPHENSON — It will certainly be useful for us in terms of training our paramedics in the future. We will identify, perhaps, patterns of behaviour on our behalf in terms of the way we manage these cases that we might be able to rectify. We are working through the final processes of the legalities of what we do with the information, but the information will be stored. If there are certain triggers met — one of those would be, for example, a prosecution or serious harm to one of our staff and so on — then the information will be used, yes.

The CHAIR — Can I just follow up? If I heard you right, you said that, of the drug issues you are called out for, 50 per cent might relate to illicit drugs and 50 per cent to prescription drugs.

Mr STEPHENSON — That is right. They are almost identical numbers.

The CHAIR — We have not talked much about prescription drugs. If the government was to help reduce workload in that area, I presume Ambulance Victoria would welcome some system that ensured that information about prescriptions that one GP or one doctor might prescribe is shared with others and that further education is shared with both the medical profession and more broadly across the community about the danger of prescription drugs.

Mr STEPHENSON — The answer to that is yes; we would be very welcoming of that occurring. Prescription pharmaceutical misuse is tied up with illicit drug misuse, as you know, but it does often occur on its own. As I said, prescription medication misuse constitutes about 2 per cent of our workload — so again, it is a significant impost on what we do. You would invariably think that better education and better efforts in this regard would reduce that load, reduce patient risk and clearly reduce the impact on AV.

Ms PATTEN — I just wanted to follow up on talking about the festivals and the duty of care of the organisers, which is something that has not been raised with us before, so it is very interesting. You mentioned that on average you would see five or six incidents. How would that compare to the incidence of problems with alcohol at the same events? Do we see 20 alcohol-related incidents and five drug ones or — —

Mr STEPHENSON — In terms of illicit drug use and alcohol misuse in this community, it is about two to one in terms of the call-outs to us. We will see twice as many alcohol-related calls as we will calls about illicit drug misuse. At these events alcohol misuse is not a predominant feature, not by any stretch. Alcohol at some of these events is almost unseen, which suggests that there is a lot of drug use, I suspect.

Ms PATTEN — Or they are just having cups of tea and fresh air.

Mr STEPHENSON — That is right. It could be that. The alcohol spectrum is spread right across the community. If you look at the work that Turning Point did in the 2014–15 financial year, the growth in alcohol misuse was actually in an older population that would not be the population at these sorts of events. So alcohol has not been a significant issue for us.

The thing about alcohol — and I will sound old in a moment — in a younger generation is that it is often consumed before the event, and then the drug taking occurs after that. Of course the two combined are incredibly dangerous. There are a number of reasons for that. The cost of alcohol at home, as you know, is much cheaper than it is when you are out.

Ms PATTEN — Preloading.

Mr STEPHENSON — That is right. They do preload. That is well known. Alcohol at these sorts of events is unusual. We would generally see at parties — rave parties and so on — probably five or six overdoses. It is reported to us that, if the policing is good or if the security is good up-front at the event, those numbers will often be cut down to one or two.

Mr THOMPSON — You have impressively run through the statistics of your call-out data across the categories of unwellness or emergency need. Are you able to give a brief overview of those categories, if that is possible now or later on, and of the varying demand? Noting that alcohol and drugs was about 8 to 10 per cent of your call-out, what is the predominant area of AV's call-out demand?

Mr STEPHENSON — The big case load will come in things like pain — so people call for pain. They might have a specific cause of the pain. Often it is just pain they are calling for. But if you think about our predominant work, it is in medical conditions. Often older people with multiple medical conditions, including things like heart disease, brain disease — cerebrovascular disease — lung disease, abdominal conditions, abdominal pain and so on, constitute the large majority of our workload. Mental health is a very significant load for us as well. We do a lot of mental health patients.

Mr THOMPSON — What percentage in mental health?

Mr STEPHENSON — Do not quote me, but I think it is 13 per cent at the moment. It is relatively high, and it has grown over recent years from 6 per cent to 13 per cent, I think. I can check for you, Murray, if you like, but I think it is around about that mark. It is a significant impost to us, and as I said, it is clouded with drug and alcohol misuse as well.

By and large we are a service to older people with medical conditions. That would be the predominant focus of our work. There is a sense that we are out seeing a lot of trauma and so on. Trauma is a much lesser load for Ambulance Victoria than those other problems.

The CHAIR — Thank you, Mick. It has been very useful to have your contribution today too.

Mr STEPHENSON — Thanks very much for having me. I appreciate it.

Witness withdrew.