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
Mr Martin Dixon
Mr Khalil Eideh
Ms Fiona Patten
Ms Natalie Suleyman
Mr Murray Thompson

Witnesses

Mr David Ruschena, General Counsel, and
Dr Helen Stergiou, Emergency and Trauma Physician, Alfred Health.

Necessary corrections to be notified to executive officer of committee

The DEPUTY CHAIR — Welcome to the public hearings for the Law Reform, Road and Community Safety Committee's inquiry into drug law reform. So far the committee has received over 220 submissions since releasing the terms of reference and calling for submissions. The purpose of these hearings is to obtain further evidence from selected witnesses.

Thank you for giving your time today at this public hearing. Hansard will be recording today's proceedings, and within a fortnight of the public hearing a proof version of transcripts will be sent to you for correction of any typographical or factual errors. The corrected transcripts will then become a matter of public record and be published on the committee's website.

The committee hearings are usually held in public; however, in special circumstances the committee can decide to hear evidence in private. So please advise us if you wish to present all or part of your evidence confidentially. If the committee approves a request, the public gallery will be cleared and none of the confidential evidence will be published on the committee's website or quoted in the committee's report. To help Hansard out, can you ensure you identify yourself when speaking so they can know which of you is speaking.

On that note, again thank you for providing this committee with your time and no doubt for the advice and information you are going to provide the committee. Over to you.

Mr RUSCHENA — Thank you very much, Deputy Chair. It should be relatively easy to tell the difference between Helen and me — I am hoping!

Dr STERGIOU — Although if I get upset, you do not know what I sound like.

Visual presentation.

Mr RUSCHENA — On behalf of Alfred Health we are grateful for the opportunity to appear before the committee to discuss this issue. Our submissions originate in the recognition that the mere act of telling somebody that something is bad for them or will cause harm is often insufficient to prevent them from undertaking that act again and again and again. Even if people agree that their poor choices aggregate, they often lack the resources to make difficult choices. This is not just true for people using prescription or illicit drugs; it is also true for doctors and for health professionals. We also recognise that Australia already has a series of extensive and very successful systems to reduce harm in other areas of human activity, and we think that those systems provide examples that will assist Victoria to deal with this problem to further reduce harm.

So we make submissions applying these recognitions in three ways. Firstly, we believe that hospital stewardship programs that currently apply to antimicrobial use should be expanded and should apply to analgesia. We believe that the drug rehabilitation services should be coordinated by a centralised body similar to the Victorian state trauma system, and we believe that knowledge-brokering services should be created to assist policymakers to improve health policy — and harm reduction policy in this particular instance. We will deal with each of those submissions in turn.

The call for an analgesic stewardship program is based on the evidence that the overuse of analgesia causes harm in its own right and leads to the use of illicit substances. There are a number of causes, but two of the most important are patient expectations and clinical skills, and to prevent the overuse of prescription analgesia we need to address these issues. Let me give an example of how this works in practice.

About three weeks ago a patient came into Alfred Health's emergency department at 6 o'clock on a Friday afternoon with a blocked nose. It was a partially blocked nose, so she could still breathe through it, but she could not sleep well at night and she demanded to see a doctor. When it was explained to her that an ENT consultant was not available at 6 o'clock on a Friday night to deal with a blocked nose, she demanded Stilnox. When she was told she was not going to get Stilnox — which is a very powerful sleeping tablet — she called her lawyer, and her lawyer showed up. So I, as general counsel at Alfred Health, and the ED consultant were standing in a cubicle in the emergency department debating the need for Stilnox for a partially blocked nose at 6 o'clock on a Friday evening.

Now, the easiest thing in the world would have been for the consultant to simply write a script and get back to the other situations, but that was not the appropriate thing and he knew it, and I daresay the lawyer kind of knew it, and I certainly knew it as well. He was lucky because he had the skills and support that are necessary in order

to do the right thing, and we believe that that is an appropriate analogy to draw in relation to the antimicrobial stewardship program.

There is a comprehensive strategy for the reduction in the use of antibiotics across Australia. It was created by the Australian Commission on Safety and Quality in Health Care, and it was created to give doctors the skills and support they need to respond to inappropriate patient demands and inappropriate clinician expectations relating to prescriptions for antibiotics. There is a comprehensive series of interventions, and this slide shows some of the publications that have been created in relation to hospital governance structures, including clinical champions; education of clinicians, patients and carers; internal and external benchmarking and auditing; quality improvement programs; and targeted research.

We believe — and in fact we have shown at Alfred Health — that these programs can apply very easily to analgesia, and in fact all we needed to do was change the word 'antimicrobial' into 'analgesia' and we knew exactly what we were doing. In fact what we have actually been able to show is some fairly significant reductions in two of the most important opioid analgesics. The top line is morphine and the second line is oxycodone, and in a period of seven years we were able to reduce the use of those by one-third — they have flattened out now, but we think we can still get it down a little bit further — while the prescription rates across the rest of Australia were stagnant. There was no meaningful change one way or the other.

We believe that these programs can be applied across hospitals, but we also believe that they can be applied in the community, specifically with the addition of a real-time prescription monitoring program.

Ms PATTEN — Just to interrupt, is that the number of people who have been prescribed or is that the amount? So they might just be on for shorter times.

Mr RUSCHENA — It is called the defined daily doses, and that is the total number of days of the prescription across each of those years. So, no, we do not give out 90 000 scripts for oxycodone. We believe those programs are a worthwhile opportunity to improve the delivery of health care and improve the use of analgesia across Victoria and across the Victorian health system, including but not limited to hospitals. The second application of these recognitions involves support available to people who overdose, and I will hand over to Helen.

Dr STERGIOU — I guess from a more clinical perspective, just to give an example, this could be one specific patient or this could be a constellation of patients. My credibility, for want of a better word, is nearly 25 years in medicine, around 20 of those in emergency and trauma both north and south of the Yarra — at Alfred, Sandringham, Northern for a number of years, so different demographics, which I think is an important part of all of this.

But if you look at this case, you have a 28-year-old male. Life has not been perfect, and often we know — and I guess from where we sit, it may be the socially marginalised, the vulnerable population — there are challenges with families, challenges growing up, and then what do you have? You have a bit of a way out. That is obviously simplifying, and we all have examples within our personal lives and certainly in the demographics where I have worked of kids who are from good backgrounds or people who have got great supports, and yet the choices they make are challenging.

So for this young man, again a constellation perhaps of patients, there may be a progression of what they have taken, and part of what we have now seen over the last number of years — and they often certainly identify that as an issue — is also the legally, if you like, prescribed medications. From an emergency perspective we are starting to see that with oxycodone particularly, a proportion of those patients are then progressing to needing to use this down the line, and how can they obtain it? By either pushing their clinicians to prescribe or to seek it from less licit sources.

So this patient presents initially and they have got a number of symptoms. My reality as a clinician, whether I am a new, junior consultant in this game or whether someone of many years experience, is I can treat them acutely. I have got resources in that acute setting, but then my hands are tied somewhat. So whether it is the 6 o'clock on the Friday evening or the 10 o'clock on the Monday morning, which we are seeing more and more now. People are having the so-called big weekend, they are in our department acutely on the Sunday night and they are still under the influence. And then it is really by the Monday morning that there is some clarity in their thinking, so that we can start to understand what we can offer them. But my hands are tied.

I have maybe my internal services from a psychology, a social work, a psychiatry resource, but in terms of drug and alcohol do I have a number which I can ring and say, 'Look, with this young man these are the issues. We have dealt with such and such overnight but they've now presented with an ongoing need requiring further resource input'? I do not have that phone number.

Within Alfred — it is a fairly mature service and obviously has had many patients over many years — we have tried to develop an internal drug and alcohol service. The hours are limited. It is almost a context of 9 to 5. We know these issues are clearly not 9 to 5. So as a clinician you are then in a situation of what do you offer. You may have a discussion, you may engage the family, you may talk about a rehabilitation or a detox-type scenario. I can tell you the number of times that we have gotten on to talk about detox and then it is a waiting game of another four weeks or six weeks. That is not helping me on Monday morning or Tuesday morning or Wednesday morning.

So if we proceed to the next slide. In thinking about that from our perspective, it is very much look at what has worked already. Now, I mentioned before I am in emergency and trauma. So it is seeing patients up-front in emergency setting at the Alfred — as I say, you watch the 6 o'clock news and you see what we do — and then following them through their journey through the hospital. It is only 17 years since the Victorian state trauma system was established. The RoTES report came out in the late 1990s. There was a lot of passion, there was a lot of decision-making and I dare say some difficult meetings, and then the work that has been done over the years to achieve what we now have, which is a world-leading trauma system. The Alfred basically now deals with China, with India, we have only just had a group from Myanmar, the Philippines, and obviously Sri Lanka after the Boxing Day disaster a number of years ago now. Within that time frame, by establishing an integrated system, that looks at the prehospital, acutely within hospital, and rehabilitation, and underpins that with good education and with obviously the appropriate research, we have been able to establish that.

As a clinician, this for me is not about interesting theoretical constructs; it is what we see every day. Yet with drug and alcohol — because it culturally that is obviously such an important part of it — there are bits of work that we do, but there is not that sense of integration. The clinical example I have provided is just that: we see the patient, we do all of the acute interventions that we need to, and then we are stuck. From a perspective of different emergency departments around town — I have my colleagues at Royal Melbourne and my colleagues at the Northern, with whom I have worked for a number of years — we are not sharing those data. We are not looking at what we are offering our patients; we are not looking at what we could potentially be doing. Instead there is a degree of fatalism. I think on one of our slides we feature the concept of the revolving door. And there is a fatalism to it. As clinicians in emergency, people are there for many reasons. You have to enjoy what you do to be doing it after a long time, clearly, but there is often a fatalism with this group of patients. 'This is what they always do' or 'This is what he always does on a Sunday; I can't really offer much more'. I think that is fatalism that is really not based on fact.

I look at the trauma system. Our mortality rates with trauma — with car accidents, with falling off a ladder, with all those sorts of things — back in the 1990s were percentage X. Within about seven or eight years of instituting the trauma system, our mortality rates of trauma dropped by about 30 per cent. So it was a lot of good work fairly acutely and also some fairly time-critical decisions to manage some of those time-critical patients, those deemed in trauma. We certainly have the same scenario now in our drug and alcohol situation. These are time-critical patients. I do not need to tell the committee, I am sure, and people in the room our suicide rates. If we actually put our suicide rates up next to our road traffic deaths per year, this number is so much higher. Yet with our resources there are great pieces of work, but where is that integration across the board?

Talking about this with David last week, from my perspective as a clinician it is: what is that dream, what is that challenge for me to say to my junior colleagues, who are only coming in and they are wide-eyed and they are loving emergency because of all the bells and whistles, but they are also gently starting to see 'Hang on, there are patients for whom we don't have as many resources', whereas other patient groups, the minute they hit the door, this is their trajectory. They will have all of these resources, they will have the doors open for the acute length of stay, for the rehabilitation, for the ongoing resolution of their issues over the next year or two. With these issues here in our, I guess, patients subjecting themselves to these sorts of choices, they have the same needs and yet we are not providing that same level of input. In my mind and certainly for a few of us around town perhaps the thought is that we can; we just need to make some of those really hard decisions up-front.

I will also say, perhaps provocatively, it is not a sexy area. The patients are challenging at times and there is so much in the media of late. The Alfred at the moment is dealing with a number of cases of potentially tragic outcomes, where it has been a combination of drug usage and mental health, but are we doing the drugs to therefore deal with our mental health challenges? Irrespective, we now have behaviours of concern and our behaviours of concern are manifesting with outcomes which are certainly potentially tragic outcomes.

If you drive past the Alfred at the moment, on Commercial Road you will see renovations — fantastic. There are all these banners saying, 'We're going to treat the public' and 'We're open day and night' et cetera, et cetera. A number of the new cubicles are what we call BOC — behaviours of concern — rooms. They will not be a purely clinical space in terms of 'I'll help the patient with asthma for that next thunderstorm asthma episode'. We will have a new trauma cubicle — we will have a fifth trauma cubicle, which will be great — but a number of those clinical spaces will be BOC rooms, to deal with what we are seeing. Again, we need to go pre-hospital to look at that issue and we need to also go post-hospital to look at that issue. It is not just about having that new BOC room, which is great, and the acronym gives it a legitimacy, perhaps. But the reality of what goes on in there is something that at a systems level we are not measuring, we are not targeting, we are not really looking at. Again, that, from my perspective as a clinician of years in this space, is how I would look at it.

Mr RUSCHENA — The last of the submissions we will make very, very short. It is simply to note that there is a gap between the research that is being produced. I am sure the committee is aware of the tsunami, the glacier, the overwhelming body of research and argument that exists in this area, but the fact is that there is a gap between understanding what that research says and what is needed in order to expect appropriate policy and create appropriate systems. The example that we use in our submission I think is appropriate in relation to safe injecting houses, which do reduce overdoses, but only in a very, very small geographic area. So the problem is not a nimby problem; it is not about not in my backyard. It is actually a nieby problem; it is now in everyone's backyard. Until that recognition is made by policymakers and by society generally, a lot of time is spent and a lot of discussions are had that are not necessarily as productive as they might be in order to properly reduce harm.

The translation of existing research and evidence into health policy and practices takes somewhere between 10 and 17 years, according to the current research. We think that time has to come down, and the only way in which it can come down is by the creation of an appropriate body to assist researchers to understand what is necessary and policymakers to understand what already exists.

So we believe these three areas constitute a significant series of opportunities to meaningfully improve the delivery of health care. Each of these systems takes a lot of work, and the antimicrobial stewardship program is a great example of that, but they can deliver extremely effective outcomes. And yet all that is necessary is the time, the will and the money.

The DEPUTY CHAIR — Over to us and we will work our way through it. Thank you. Can I just confirm that the presentation has been provided to the committee?

Mr RUSCHENA — Yes.

The DEPUTY CHAIR — In addition to the submission?

Mr RUSCHENA — Yes.

The DEPUTY CHAIR — I understand — and I will talk very quickly before I hand over to my colleagues — and can relate absolutely to the trauma centre at the Alfred. Being stationed at St Kilda Road, I spent a lot of time there. Back in those days it was exactly what you were talking about Helen — the mid to late-1990s. It was very busy, and to all those professionals there who have given great service to those who need it, it is fantastic. It is an interesting place; you could make a movie about it.

On that note, what you were saying in relation to the fact that your hands are tied, I suppose there is not one thing we can point to that is contained within what you are telling the committee, as well as in your submission, in relation to looking for a solution. But is there a priority, in simple layman's terms, that you see for a solution to get us through that?

Dr STERGIOU — Giving the example, if we continue with the 28-year-old male, we have done what we need to acutely. It is 10 o'clock on a Monday morning. What do I have in front of me? So let us think about a resource. Let us think about a drug and alcohol system that is 24/7, funded and staffed. From that we can link them then into continuing an acute stay in hospital, but not under a general medical unit with our elderly patients with cognitive impairment issues, but in a specific space with some specific brief interventions. There has been work to show that appropriately timed and targeted brief interventions do have an outcome, but then let us see what the rehab or detox options are.

Clearly underpinning all of that is the patient's motivation, but that is also about 'Let's have the conversation. Let's have the discussion'. I am not saying that this is the panacea, but we do not even have that now for the patients who do show one iota of motivation to try and change the direction of their choices. Their social situations can be so complex that sometimes they look at me and say, 'I just need to stay in hospital overnight'. And yet unless they currently fit a specific medical diagnosis I can no longer do that. In the 1990s I could arrange a social admission — purely that. They need a roof over their heads. You cannot do that anymore. You have got to push very hard.

So for me it is continuing, if you like, that up-front work. Call it drug and alcohol and find a lovely acronym, which has a 24/7 basis and has the appropriate staff, which would be a combination of drug and alcohol workers, psychologists, psychiatrists, acute medicine and clearly social work — those sorts of groups — and then be riding this patient's journey over the next few days as a team, until such time as they make another decision. It is almost analogous to the safe injecting rooms — —

The DEPUTY CHAIR — I was about to go there.

Dr STERGIOU — I will stop.

The DEPUTY CHAIR — No, keep going.

Dr STERGIOU — The analogy with the safe injecting rooms is the number of consumers who will start seeking assistance in their choices. So it is not just safe injecting rooms or medically supervised, reducing the number of overdoses, number one, but no deaths. For example, in Sydney at the King's Cross centre since 2001-ish when it was established, for the group of consumers who are accessing it, there is a growing body who are then after once or twice or the third time saying, 'Okay, let me try and make some life choices here'. We do not have that currently, and that is what I would like to see — a canopy group, an umbrella group, that are happy. It is not in a sense of, roll the eyes, this is what he does every Friday. That is a little bit of the culture that needs to shift.

Ms PATTEN — Thank you, that was really interesting. I really like this analogy of the trauma system. Much to my surprise, I thought we always had that.

Dr STERGIOU — No.

Ms PATTEN — So what were those hard questions? I am trying to think how we would see that. We had Ambulance Victoria in earlier today who talked about some of the issues that they are facing with the pre-hospital and the heavy sedation that is becoming practice so that it makes it more difficult when they get them to hospital. I suppose it is the rehab, it is the third section, is it not — —

Dr STERGIOU — That constantly fits into that first section as it were — constantly.

Ms PATTEN — So when you were setting up the trauma system how did that come to be and how can we mirror that in this?

Dr STERGIOU — The one difference, I guess, in looking at this analogy is that trauma happens, there are obviously risk-taking behaviours as part of it, but it is also wrong place, wrong time, the gods above, twisted sense of humour, bad things happen, whereas here it is maybe a determined choice at times, not always but often. At that point they are not absolutely equivalent, but you have got a base of behaviour and choices and risk-taking pre-hospital. Let us really look and understand that.

It is all about empowering the groups that are disempowered. I will go back as a 51-year-old and say that it is parenting as well. All of those things are so important in the choices that we all make. What can we do? How

far back can we drill there? But we obviously have to draw a line, and we have to say, 'Okay, people make choices that will get them into these situations'. They need Ambulance Victoria. This occasion will be dealt with, but let us really target them and look at what we are doing in terms of them understanding the behaviour.

After our Myer music bowl adventure earlier this year, where there were a number of patients taken to a number of emergency departments around town, Alfred Health featured. There were a few discussions with the media, and one of the very simple thoughts was, 'Let's think about filming these patients at the time that they are intubated, and they are looking less than presentable'. There are clearly some issues around that, but let us look at getting some images for them in the world now where people are so visual and our attention span is so brief. 'Here's your Snapchat of what you looked like at 3 o'clock in the morning on Sunday'. Let us think about that.

Ms PATTEN — That sounds like an incredibly effective scenario.

Dr STERGIOU — The analogy is what we call the P.A.R.T.Y. program, which is a program, essentially, around youth, developed in Canada and which we have imported here. Certainly at the Alfred and at a couple of other centres around town, kids are brought in — 15, 16, 17-year-olds — and they have some lectures and some didactic elements. They meet patients in intensive care. They are taken through the trauma centre. They don the clothes, they look at the bells and whistles and listen to them. It is what we call the teachable moment. One of those kids, next time they are about to get into a car and they have had a few too many, will stop and think. There is literature to show that that makes a difference.

So coming back to your initial question — that pre-hospital — you almost have to draw a line and say, 'Okay, it will happen, but let's really follow them into that rehab space so they have some choices when they again find themselves back there'. That is the fundamental difference with trauma — driving down the street, bang, it has happened. You were not necessarily a party to it; in these choices, you generally are. Does that make sense?

Ms PATTEN — It does. I suppose it is: how do we make that happen? I think from the acute to the rehabilitation, it is that connect. How did we make that happen in the 1990s and how do we make it happen today?

Mr RUSCHENA — There were two hard choices that needed to be made in relation to the Victorian state trauma system. It shifted a bit further to the right of this situation. The first is there was the designation of three specialist trauma hospitals — that is, the Royal Children's Hospital for paediatrics, the Royal Melbourne Hospital and the Alfred. Those are the primary centres of trauma care. Then there are a series of additional hospitals — I will not say underneath — that provide a different type of service for a different level of care: the Austin, which provides great care for spinal injuries, but also Box Hill Hospital and Dandenong Hospital and so on.

Then there were a series of triage discussions that needed to take place as to who to send where. Effectively if you are going to do something analogous with drug overdoses, you are in that space, but for detox and rehabilitation facilities you are working out who to fund and how much to fund and on what basis you are funding them. So you are having some fairly hard discussions about, 'Does your service work more or less than other services? Why does that service work more or less than other services?'. If there can be an evidence basis for improved efficacy, whether it is because they have a better service or because they select a different group of patients, then government can resource that in a better way. That is how that process works as a system, as well as the centralised series of rules for where you send everyone.

Ms SULEYMAN — Previously we heard from the Victorian Institute of Forensic Medicine. In their submission they have called for a 24/7 rapid clinical toxicology service to assist hospitals and patients. What would be your view on that particular point?

Dr STERGIOU — It is a matter of what we need immediately to understand what the patients have taken versus then looking at the datasets and coming back to this concept of the system across the board integrated and then using that information to understand what is out there. The 24/7 toxicology service is very much about, 'This young man/young female has come in. This is what they have taken', and how many times when we have looked they are unconscious. One of the first things is exposure — 'Let's remove the clothing'. Nursing staff become so adept at looking through pockets to understand what is in there — 'Oh! Here's a little bit of green powder. What is that?'. If we had a 24/7 service, let us expeditiously get that over there or have them come to us. Let us look at what the constituents are, and then let us do a little bit of quick epidemiology. Where were

they, what is the geography and what was the population there? We are seeing this. We are behind the eight ball currently.

Again I refer back to the Myer music bowl episode earlier this year, where we did not have a sense of what it was they had taken. Our ideas were it was a certain substance, but we had no data to back that up to therefore then be able to target perhaps some of the education a little bit more specifically, so we would be very keen for something like that. It would be, I think, the acute usage, but also let us look at the data and let us go back a few steps to understanding the reasons around why those medications are being used at this point in time.

An example as I am talking: currently there is a push to lace marijuana with things such as fentanyl. Fentanyl is a medication which is a very strong pain-relieving medication used in what we call procedural sedation. So you come in, you have broken your arm, and I want to put it back into place fairly swiftly. Without giving you a general anaesthetic as such, I will give you a little bit of sedation, get you just right to be able to manipulate your arm. The 16-year-old who is trying marijuana with his mates will now potentially be subjected to that being laced with fentanyl. If you get that dose wrong, you stop breathing. No-one there to help you? You are dead. A toxicology service would assist us clinically with making those judgments fairly swiftly.

Ms SULEYMAN — We have also heard about the potential role of GPs and early intervention and how important that is. With one of the submissions the example was, if you are diagnosed with cancer, your GP has a pretty straightforward path to treatment or referral, and it is very clear. With the role of GPs at the moment, it is extremely challenging. In your opinion, significantly in the early intervention phase and the screening of patients, what would be your view on the role that local GPs have?

Dr STERGIOU — From an acute perspective I guess I am biased. One of the things I would perhaps caution about, because of the behavioural outputs having the patient/client/consumer attend a GP in that acute phase of behavioural disturbance, is that sometimes it would pose challenges because you do not have the security services, you do not have that physical environment perhaps to attend to the acute behavioural concerns.

Once we have come down from that acute phase, a GP connection would be vital. It is again around what the incentive is for the GP. These conversations take time to try and engage someone who is using these substances. Generally life is not great. There may be a number of psychological/psychiatric/mental health concerns. Those conversations take time. They are not a 6-minute review.

So I would feel, yes, fundamental. I would feel it is about, again not unlike within our acute hospital system, changing the culture. It would be about looking at some of the time constraints for GPs, reviewing their funding models, allowing them to have that Monday morning set aside to be able to see four rather than 24 patients, for example, but knowing that if they really hook into what that patient needs, they will be able to refer them, whether it is back into the acute centre or to the rehabilitation. The acute behavioural constraints would be a challenge.

Mr RUSCHENA — It is probably also worth noting that the funding structure for GPs exists to allow intensive engagement, including with the clinical treating team of other clinicians for chronic diseases, but it does not allow it for behavioural issues such as this, so that would have to change as well.

Ms SULEYMAN — That is an important point.

The DEPUTY CHAIR — Colleagues, I am mindful that we have got a teleconference at quarter past 3. We have got three more to go, okay?

Mr THOMPSON — Helen, just for the record, what is your medical background?

Dr STERGIOU — I am an emergency specialist or emergency physician, and trauma consultant. That is an evolving concept in terms of managing the trauma patients on the wards, but I am an emergency specialist in emergency medicine and have been a doctor for 24 years.

Mr THOMPSON — Have you had much experience dealing with people that might have ingested synthetic cannabis?

Dr STERGIOU — Through the emergency department, yes. It is certainly a growing phase.

Mr THOMPSON — What is the adequacy of service delivery options for such people? I will give an example. I have a constituent who was admitted most recently to St Vincent's Hospital, but did have an admission to the Alfred in the last month, where there was a severe addiction issue. There were not really any treatment options for his family other than them self-funding $30 000 for about a month or so.

Dr STERGIOU — No. Synthetic cannabis, again, is a learning phase for the clinicians. At times it is interesting how we need to refer to social media to understand what the adverse effects are and therefore what some of the potential treatments could be acutely and then in a more chronic sense. We do not have an antidote, as it were, so for the effects of synthetic cannabis, it is very much supportive management — the appropriate medications acutely to deal with it, behavioural or cardiac/heart irregularities or breathing irregularities et cetera. But then there is no antidote or medication that can acutely reverse what they have taken.

Then from an addiction, if you like, perspective, it goes back to the description from earlier on. I do not have a system where I can say, 'Now, I can place you into Alfred Health's drug and alcohol' — for want of a better phrase — 'unit for finalising that acute component of your treatment before you then proceed to a rehabilitation or detoxification system'. So, no, there will be some private enterprises certainly. I would also suggest at times caution as to what is perhaps promised as the treatment or panacea that some of these programs will suggest they have.

Mr THOMPSON — I have a second and final question. Do you have a view on pills provided to rave parties and gatherings and whether there should be pill testing at a venue, the reliability of that testing and the ability to detect the range of illicit substances that might be within a pill and whether as a legislature it is something we should promote by offering pill testing or whether we should have a tough policy against it?

Dr STERGIOU — It is one of those interesting questions where there is the professional, perhaps, and the personal.

Mr THOMPSON — Can you give us a Hellenic viewpoint?

Dr STERGIOU — Yes, indeed, if we bring that into it. If you have the right system, you will achieve the results. It is then again about the motivation. So yes, let us set up a version of the toxicology lab at the front of the dance venue, and let us allow people to volunteer what they have in their pockets. We can suggest, 'This is safe. This one is not. This one has a green component. You don't want the green component'. As a professional, though, in this space I would want to take it a step back and say: is that really where we want to leave it? Shouldn't we be taking it back a step? So there are some conflicting views.

Mr THOMPSON — Take it back where?

Dr STERGIOU — Back to, 'Let's think about why you're taking these pills in the first place'. Let us really take it back to that rehabilitation, if you like, cycle: 'Why were you in that headspace that you needed to take this substance to enjoy what is otherwise an enjoyable afternoon?'.

Mr THOMPSON — So chamomile tea and fresh air is something you would recommend?

Dr STERGIOU — A little bit of fresh air. That is from my point of view being simplistic. With pill testing, as David was saying, we really need to look at the literature around that. Let us create some fairly provocative and creative, rigorous data review. Let us look at some research in this space. Let us be world leading and look at some research in this space, rather than just taking the anecdotal feedback as being useful.

Mr RUSCHENA — Can I also suggest that the assumption that pill testing makes is that it is possible to identify the substance in the pill. With the massive proliferation of new synthetic substances that are not yet identifiable, as well as the accidental creation of synthetic substances from variations in the manufacturing process, the idea that a pill tester will actually be able to accurately identify everything that is brought to a rave is a little bit optimistic. Then the question happens: what if someone at this gig gets the green light from the pill-testing kit and overdoses on a substance that is not known or identified at that particular stage?

Mr EIDEH — Your submission raises issues about the fee structure for dispensing medication with abuse potential. Is this mainly a commonwealth issue, or maybe the Victorian government could address it? What is your view?

Mr RUSCHENA — We might take that one on notice — that is a submission from our director of pharmacy, who is away in Europe at the moment — if that is okay. I think it is a combination of both. I think there is a basic fee through the pharmaceutical benefits scheme, and then there is an additional fee through the community pharmacy scheme, which I think is Victorian. But we will take it on notice if that is acceptable.

Mr EIDEH — I would appreciate it.

Mr DIXON — Can we have some reflections on the real-time prescription monitoring system?

Dr STERGIOU — Let us do it.

Mr RUSCHENA — It is in Tasmania.

Mr DIXON — How would it help you in a practical sense, perhaps?

Dr STERGIOU — If a patient comes in and they are asking for Stilnox on a Friday afternoon at 6.00 p.m., I want to be able to get into a database in a rather George Orwellian, Big Brother way and see when they last received Stilnox. I need that information to do it safely.

Mr DIXON — It is doable, though?

Dr STERGIOU — Absolutely doable.

Mr RUSCHENA — It is actually happening in Tasmania.

The DEPUTY CHAIR — On that note, is there anything further you would like to add?

Dr STERGIOU — No, thank you.

Ms PATTEN — We have been talking about treating drug use as a health issue rather than a criminal one, and that has been a kind of mantra of many of the submissions. Do you find that the criminal aspect of the drugs affects the patient's ability to access treatments or assistance, or their willingness to speak openly and honestly within your health setting?

Dr STERGIOU — No. I would say what affects them is more the effect on their behaviour of the substances. Very occasionally in my 24 years of so many different interactions it has been, 'I shall be penalised or somehow not respected because of the criminal element'. It is more, 'My behavioural output at the moment is what it is, and I can't control what I'm doing'. So no, very rarely in this country have I seen that as an issue.

The DEPUTY CHAIR — Thank you, Helen. Thank you, David. Thank you so much. Your time is important. This committee does certainly appreciate your time.

Dr STERGIOU — Thank you very much.

Witnesses withdrew.