LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON THE DRUGS OF DEPENDENCE (PERSONAL USE) AMENDMENT BILL 2021
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Submission Cover Sheet

Inquiry into the Drugs of Dependence (Personal Use) Amendment Bill 2021

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Inquiry into the Drugs of Dependence (Personal Use) Amendment Bill 2021 - ACEM Submission
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1. Introduction

The Australasian College for Emergency Medicine (ACEM, the College) welcomes the opportunity to provide its submission to this consultation, which has been prepared in collaboration with our Australian Capital Territory (ACT) members. ACEM is responsible for the training and ongoing education of emergency physicians and the advancement of professional standards in emergency medicine (EM) in Australia and New Zealand. As the peak body for EM, ACEM has a vital interest in ensuring the highest standards of EM care for all patients, including those impacted by drug-related harm.

1.1 The burden of drug-related harm in the emergency department

The practice of EM is concerned with the prevention, diagnosis and management of acute and urgent aspects of illness and injury among patients of all ages presenting with a spectrum of undifferentiated physical and behavioural disorders. By default, emergency departments (EDs) act as frontline harm reduction services, with specialist emergency physicians at the forefront of responding to the direct and indirect health consequences of drug use and related harm. Responses range from treating acute drug intoxication and reversing overdose and poisonings, to managing acute and serious complications of chronic drug-related conditions. Fellows of ACEM (specialist emergency physicians) report that drug-related presentations significantly impact ED waiting times and resources, contributing to ED overcrowding and rates of violence against staff. In this context, the specialist emergency physicians' role comprises not only the provision of care for acute illness and injury, but also engagement with other organisations to implement evidence-based primary and secondary prevention as well as harm reduction strategies.

The most recent Australian Burden of Disease Report in 2015 recorded that drug use accounted for 2.7 per cent of the disease burden in Australia including substance abuse disorders, communicable diseases (such as Hepatitis B, Hepatitis C and HIV/AIDS), overdose, and injury[1]. Illicit drug use is also associated with mental illness, which creates more complex treatment needs. In 2016, one in four people who had recently used drugs reported high or very high levels of psychological distress, and one in five had been diagnosed or treated with a mental illness in the last 12 months[2].

Data from the annual ACEM Snapshot Survey of Alcohol and Other Drug Harm in the ED in 2019[i] recorded methamphetamine presentations as accounting for 3 per cent of all presentations to an ED in Australia at the time of the snapshot[3]. Methamphetamine-related presentations are of particular concern to Australasian EDs and have been increasing in recent years. In the past decade methamphetamine has become more potent, cheaper and easier to obtain, possibly explaining some of the increases in harm observed in ED settings[4,5]. The ED does not see the full scale of the burden that methamphetamine and opioids cause the community; many overdose cases do not present to the ED and other drug users may wish to avoid the ED due to the illegalities involved in their situation.

[i] Data from the 2020 snapshot has not been published due to the impact of COVID-19 on the data.

1.2 ACEM recommendations

ACEM considers that investment in effective, innovative and evidence-based harm reduction initiatives will contribute to ameliorating the harms associated with drug use in the community and ultimately assist with reducing the burden of drug-related ED presentations. We support an evidence-based approach that centres on people-focused policies and interventions which recognise the socioeconomic and cultural context of drug use, rather than extending ineffective prohibitionist and punitive approaches.

A number of recommendations are provided through this submission based on the expertise of the ACEM ACT Faculty and Public Health and Disaster Committee.

1.3 Alcohol-related harm

In the medical sphere, policy on drug use and drug-related harm is often combined with, or presented alongside, policy on alcohol use and alcohol-related harm. In the ACT, as with other Australian jurisdictions, specialist services on the prevention and treatment of AOD related harm are categorised together. While the inquiry is not taking evidence on alcohol issues, there will be several instances in this submission where it is referred to due to this overlap. As with approaches to drug use and minimising drug-related harm, ACEM supports effective and evidence-based initiatives to tackle the significant burden placed on the ED by alcohol-related presentations to the ED.

2. Data collection and research

Current data collection and coding systems do not accurately capture the true burden of drug-related ED presentations, leading to systematic underreporting of this issue. Indeed, the lack of appropriate ICD-10 (International Classification of Diseases version 10) diagnostic codes for acute recreational drugs means that only one in 10 AOD ED presentations can be accurately captured[6]. Likewise, in NSW it has been shown that only 1 per cent of AOD related ED presentations are identified as having a primary diagnosis related to alcohol, with identification or reporting of secondary diagnoses related to alcohol also under reported[7].

Implementation of consistent, routine AOD ED presentation data collection is required to establish a clearer picture of the extent of AOD-related harm presentations to EDs and to help governments and stakeholders inform and evaluate the impact of policy reforms on AOD-related harm.

The current data collection actions detailed in the ACT Drug Strategy Action Plan 2018–2021 do not recommend that data is collected on AOD related presentations to the ED, which will limit the effectiveness of surveillance and monitoring and evaluating future AOD strategies.

Recommendation one

That the data gathering actions detailed in the ACT Drug Strategy Action Plan 2018–2021 and any future plans are strengthened to include all data on AOD-related harm and presentations in ACT EDs.

3. Harm reduction

3.1 Brief interventions in the ED

SBIRT models have been developed for use in healthcare settings, including EDs, to identify, reduce and prevent problematic use and abuse of, and dependence on, AOD[8]. SBIRT involves a healthcare professional:

- assessing a patient for drug taking using a standardised screening tool;
- conducting a structured conversation about drug use;
- providing feedback and advice; and
- referring the patient to a brief therapy or additional treatment if appropriate while in the ED (mechanisms should also exist to refer at-risk patients to an appropriate community resource for culturally sensitive and appropriate education/intervention).

However, some EDs have reported difficulties in implementing SBIRT particularly without appropriate personnel and time[9]. Further evidence is needed to examine the feasibility and effectiveness of these interventions in the ED, so where possible, EDs should also contribute to the ongoing assessment of efficacy and quality improvement of SBIRT programmes.

As screening and early intervention are specialised skills, the success of brief interventions will depend on EDs being appropriately resourced with dedicated AOD staff who possess the skills and knowledge required to accurately use SBIRT models.

Recommendation two

That all ACT EDs are provided with the funding and resourcing to first implement, and then to monitor and evaluate the performance of, SBIRT models.

3.2 Drug treatment services

ACEM supports integrated and multidisciplinary services that comprehensively address AOD use as well as other co-morbid physical and psychiatric conditions. At present the limited availability of acute treatment services in the ACT, and lack of service integration and community assistance, means that people in crisis requiring support for drug use often seek support from EDs. In addition, there may also be significant delays following ED referral to outpatient community rehabilitation services. Improving access and availability to acute treatment services and altering the community provision of services available after-hours would likely prevent many of these ED presentations and result in better outcomes for patients.

ACEM supports initiatives to embed addiction medicine clinical specialists in EDs to initiate optimal therapy and provide continuity of care as patients transition from ED to AOD specialist management, whether on an outpatient or inpatient basis. Integrated models of care that co-locate AOD patients and emergency mental health clinicians enable timely referral and access to services. They should be central to any reforms of the AOD/mental health care system. ACEM also recognises the potential benefit of teleconsultation to increase both geographical reach of support services and access to after-hours care.

Recommendation three

That the ACT Government works with the Aboriginal Community Controlled Health Organisation Sector and Culturally and Linguistically Diverse Communities to ensure that all AOD services in the ACT are culturally appropriate and accessible for all.

Recommendation four

That the ACT Government increases resourcing for community-based dual diagnosis AOD services that offer comprehensive medical and psychosocial care and support.

Recommendation five

That the ACT Government resources increased specialist AOD treatment options, including methamphetamine-related harm and psychosis. Specialist services could include in-hospital withdrawal services and access to specialist psychiatric support.

Recommendation six

That ACT Health provides integrated care pathways out of EDs and into specialist treatment programs, so that health professionals can offer assertive interventions to people whose drug use has come to a crisis point. The pathways should start with an immediate publicly-funded appointment for those in need of care and support.

Recommendation seven

That ACT Health further investigates integrated models of care in communities where there is a higher burden of AOD use and fewer services to address this burden. The potential benefit of teleconsultation should be explored to increase both geographical reach of support services and access to after-hours care. Funding for this should be undertaken in addition to, rather than at the expense of, emergency medicine.

3.3 Clinically supervised drug consumption

ACEM would be supportive of a clinically supervised drug consumption site in the ACT. A medically supervised injecting centre (MSIC) opened in Sydney in 2001 and contributed to a decrease in opioid-related presentations at the nearest ED compared to the rest of New South Wales throughout its trial period up to 2010[10]. It is estimated that a similar MSIC facility currently being trialled in Melbourne saved 21-27 lives in its first 18 months of operation[11]. A clinically supervised drug consumption site in Canberra would have the potential to reduce the number of presentations to and pressure on ACT EDs, having benefits for both staff and patients in the ED. We understand that the ACT Government is developing a plan for such a facility and is about to undertake a community consultation to help foster an understanding of how supervised drug consumption rooms work. Improving education around the function and benefits of these facilities will have positive results for both the community and drug consumers.

Recommendation eight

That the ACT Government continues undertaking its exploratory work of developing a clinically supervised drug consumption site and builds understanding in the community of how such facilities work.

3.4 Peer support

Peer support has a strong evidence base for health promotion interventions amongst people who use drugs, for example introduction to MSICs, harm reduction, peer support workers at raves/festivals/other drug use settings, and ongoing rehabilitation support models. Similarly, provision of clean injecting equipment was a pillar of Australia's public health intervention to HIV and continues to be a major reason for low blood borne virus (BBV) spread in these communities. Although HIV is now treatable all efforts at preventing BBV spread, as well as other infectious complications of unclean equipment, should be supported. Injecting equipment needs to be available, accessible and acceptable, and this is likely to be best achieved by peer support workers.

Recommendation nine

That ACT Health establishes an AOD network of peer support workers.

3.5 Other harm minimisation

In addition to medically supervised safe injection rooms, ACEM is supportive of measures that seek to create safer environments to reduce harms from drug use such as needle and syringe exchange programs, community prescribing of naloxone (opiate antidote), treatment of Hepatitis C Virus (HCV) as a means of preventing transmission, real time prescription monitoring, and drug checking services (such as pill testing). Evaluations of these programs consistently demonstrate a reduction of transmission of blood-borne disease, reduced dependence and addiction, and reduced deaths from overdoses[12,13]. Importantly, research has shown that drug use does not increase with the presence of such programs[14].

Recommendation ten

That the ACT Government continues expansion of other known harm minimisation mechanisms such as needle and syringe exchange programs, community prescribing of naloxone, and drug checking services.

4. Violence in the ED

Drug-related harm extends beyond the individual user. A recent meta-analysis[ii] found that approximately 36 in every 10,000 ED presentations in Australia involve violence, with about 45 per cent estimated to be associated with alcohol and other drugs[15]. An ACEM study in 2016 found that in the previous 12 months only 7.8 per cent of respondents reported not experiencing physical aggression from patients, and 92 per cent of ED nurses were made to feel unsafe due to AOD-related behaviour[16]. The same study found that AOD-affected patients also negatively impacted ED waiting times, other patients in the waiting room, and the care of other patients.

[ii] Findings were limited by inaccurate data related to under-reporting and lack of objective evidence.

The safety of patients, visitors and staff in the ED is of primary concern to ACEM. While in the vicinity of the ED and the wider hospital, all people have a right to an environment safe from violence. The College's vision is that no staff, patients or accompanying persons suffer harm due to violent incidents in the ED. The College has a statement on violence in the ED that includes a recommendation to better understand the causes of violence in EDs and in particular its relationship to alcohol, drug use, and mental health[17].

While ACEM is one of many organisations advocating for more preventative measures to reduce the number of presentations that could involve violence, it is also imperative that EDs have adequate resources to deal with such situations so that ED staff feel safe when they work. This should always include adequate security, sufficient training for all ED staff, and sufficient access to police.

Recommendation eleven

That an action is added to the ACT Drug Strategy Action Plan 2018–2021 and any future plan for data to be collected on cases where violence in the ED is related to drug-affected patients.

Recommendation twelve

That ACT Health commissions a review into the effectiveness of each ED in the ACT to respond to and deal with violent incidents.

Thank you for the opportunity to contribute to this inquiry. If you require any further information about any of the abovce issues or if you have any questions about ACEM or our work, please do not hesitate to contact Jesse Dean, General Manager, Policy and Regional Engagement [redacted]

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