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for Emergency Medicine

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Submission to The House of Representatives Standing Committee on Health, Aged Care and Sport Inquiry into the health impacts of alcohol and other drug use in Australia – October 2024

Introduction

The College welcomes the opportunity to provide a submission to the House Standing Committee on Health, Aged Care and Sport inquiry (the Committee) into the impacts of alcohol and other drugs in Australia.
For more than a decade our members have expressed concern not only about alcohol harm, but also methamphetamine's impact on the acute health system, particularly in the EDs where our members work.

The Australasian College for Emergency Medicine (ACEM; the College) is the peak body for emergency medicine and has a vital interest in ensuring the highest standards of emergency medical care for all patients. ACEM is responsible for the training and ongoing education of emergency physicians and the advancement of professional standards in emergency medicine in Australia and Aotearoa New Zealand.

ACEM's response has been informed by the advice of Fellows of the Australasian College of Emergency Medicine (FACEMs), whose experience and expertise provides crucial insights into the causes and effects of alcohol and other drug harms. This submission provides insights into alcohol and other drug (AOD) presentations to EDs in Australia, issues EDs face due to these presentations, and how healthcare to patients that present alcohol and/or drug affected can be improved.

ACEM has been a vocal advocate for public policy changes and specific measures to address AOD harm in the Australian and New Zealand communities, particularly in relation to alcohol. A number of ACEM's research and reports on alcohol and other drug harms in relation to emergency departments (EDs) can be found here.

1. ACEM Position on Alcohol and Other Drugs

The identification and response to alcohol and drug-related harm accounts for a significant proportion of ED workload, as EDs are often the default entry point into the healthcare system. Emergency physicians are responsible for providing the initial response during the acute intoxication phase and have a significant role minimising harm from AOD through the identification, assessment and referral of patients with AOD problems, through responsible clinical practice and advocating for harm reduction measures.

ACEM strongly believes evidence-based harm-minimisation approaches should be adopted in programs and initiatives to improve prevention and reduction of AOD harms.[1] Harm minimisation initiatives should be implemented with a multipronged approach, through harm reduction (reducing risk behaviours from drug use or creating safer settings), demand reduction (preventing uptake or providing appropriate drug treatment to people) and supply reduction (regulation of alcohol and drugs and reducing production and supply).

ACEM also supports strategies that regulate the availability, price and marketing of alcohol to reduce supply. In addition, ACEM supports demand-reduction approaches through brief interventions in the ED and broader public health messaging and education. Consistent, accurate and routine data collection on AOD-related presentations in the ED are needed to measure the impact of policy reforms.

1 Australasian College for Emergency Medicine, 2020. Statement on Harm Minimisation Related to Drug Use. Melbourne. Available from: https://acem.org.au/getmedia/b59faddc-5185-465d-b598-b3a6ea3bc7c9/S769_Statement_HarmMinimisation

2. Alcohol and Drug-Related Presentations in the ED

EDs experience a surge in patient presentations and alcohol and drug-related incidents, overdoses, injuries and mental health crisis during peak times, typically on weekend nights and public holidays. These higher presentation numbers add strain to ED capacity, resourcing and staff stress. Treating these patients is resource and time intensive. ACEM considers alcohol harms to be one of the largest preventable public health issues facing EDs in Australia and Aotearoa New Zealand.

Extended wait times: patients presenting with alcohol issues can experience longer wait times and more serious patients take priority to situations where a patient may need to 'sober up' so treatment can commence. Due to the volume and nature of presentations, AOD harm can have detrimental effects on ED staff, other patients and accompanying persons. Intoxication is a primary factor represented in the data on verbal and physical abuse against frontline healthcare workers and represents a significant workplace health and safety risk. This adversely impacts the way EDs function.[2]

The consequences of risky drinking and illicit drug use are regularly seen in the ED with people presenting with injuries as a result of use, clinical intoxication requiring intensive care treatment, medical conditions from long-term risky alcohol consumption misuse (liver disease, withdrawal or dependence) or mental health conditions arising from AOD-related harm and comorbidity.[3] Other people may also be subjected to harm as a result of someone's consumption resulting in serious injury, family and domestic violence, assaults or sexual abuse.[4]

2.1 Alcohol-Related Presentations

Alcohol is one of the biggest drivers of violence in the ED, and has major consequences for workforce operations, care and safety to patients and the community.[5] It is detrimental to other patients to who may experience longer wait times due to resources being diverted to manage aggressive or violent patients, and it impacts the patient experience, causing frustration and anxiety about their health and safety. This is particularly anti-therapeutic for mental health patients.

Between 2013-2018, findings from the ACEM Alcohol Harm Snapshot Survey (AHSS) have typically shown that between one in seven and one in eight patients presenting to Australian-based EDs do so in relation to alcohol. The survey is conducted on a weekend night in December, in more than 100 EDs based in Australia and New Zealand. The primary aim of the AHSS is to quantify alcohol's burden on EDs and further our understanding of its contribution to the ED workload.

The percentages of alcohol and methamphetamine ED presentations per Australian jurisdiction were between 11% and 13% of all ED presentations. Of the Australian states and territories, Western Australia had the highest percentage of alcohol presentations on the AHSS survey night, with almost one in five ED patients presenting in relation to alcohol.[6]

Alcohol-related presentations also have significant adverse impacts for staff. ACEM's 2024 report on Alcohol Related Harm in Australasian Emergency Departments found some sobering statistics from staff working in EDs. Noting that 79% of respondents worked in Australian EDs, and 21% of respondents worked in Aotearoa New Zealand EDs.

- 70.5% of emergency department staff say they experienced alcohol-related verbal or physical abuse, threats, intimidation, or harassment from patients frequently (one or more times per week) or often (a few times a month).

[2] Australasian College for Emergency Medicine. Statement on Alcohol Harm (S43). Melbourne: ACEM; 2016 [updated Jul-16; cited 2019 Jan 30]. Available from: https://acem.org.au/getmedia/ceaf21fd-fedb-46e3-bcab-333b58f63c13/S43_Alcohol_Policy_Statement_Jul-16.aspx.
[3] Australasian College for Emergency Medicine. 2018 alcohol and other drug harm snapshot survey. Melbourne: ACEM; 2019. Available from: https://acem.org.au/getmedia/3e940b76-3215-4b6f-a6ae-97b4d30d1d95/2019- Alcohol-and-methamphetamine-snapshot-survey_R2
[4] Lam T, Laslett AM, Ogeil R, Lubman DI, Liang W, Chikritzhs T, et al. From eye rolls to punches: experiences of harm from others' drinking among risky-drinking adolescents across Australia. Public Health Res Pract. 2019;29(4):2941927.
[5] As above.
[6] Australasian College for Emergency Medicine 2019. 2018 Alcohol and Other Drug Harm Snapshot survey. Available from: https://acem.org.au/News/June-2019/Burden-of-alcohol-and-methamphetamine-harm-reveale

- 68.2% or over two-thirds of staff believed that incidents of alcohol- related violence had become worse in their emergency departments over the last five years.
- 87.3% of staff reported that they had felt unsafe due to the presence of an alcohol-affected patient while working in the emergency department.
- 82.4% of emergency department staff reporting that alcohol-affected patients had negative impacts on staff wellness.
- 93.1% of emergency department staff reported that alcohol-affected patients had negative impacts on their workload.
- 86.1% of emergency department staff reported that alcohol-affected patients had negative impacts on waiting times for other patients.
- 94.6% of emergency department staff reported that alcohol -affected patients had negative impacts on other patients in the waiting room.[7]

The community deserves clear communication about the impact that alcohol-related harm is having on the health of ED staff, and the health of their loved ones. Expressly acknowledging the impact that alcohol-related aggression is having on the people who are there to provide emergency care to the community when it is most needed is important. Crucially, it is important to communicate the challenges these harms have on EDs without stigmatisation of addiction, trauma, and mental health issues that may be corelated with these types of presentations.

EDs are there to help the community at the time of greatest need and ED staff will continue to do their best to support every patient who seeks care. However, when it comes to alcohol-related presentations, coordinated early intervention is needed to prevent harm escalating.

2.2 Drug Related Presentations in the ED

Illicit drug-related ED presentations represent up to 7% of ED workload. The main area of research ACEM has published on drug-related presentations is regarding methamphetamine.

Methamphetamine-related presentations are typically of high acuity. Among other factors, frequent and heavy methamphetamine use is associated with psychosis, major depression, higher levels of health service utilisation and frequent ED presentation. Patients attending EDs due to methamphetamine use have complex needs and require active care, greater clinical resources, and longer ED lengths of stay for stabilisation. Since 2018, the AHSS has also examined the burden of methamphetamine-related presented on EDs and ED workload.

In the past decade methamphetamine has become more potent, cheaper and easier to obtain, possibly explaining some of the increases in harm such as those observed in ED settings. For instance, among patients seeking help from EDs for mental health crises, almost a third have substance use recorded as a feature of their presentation, and long ED stays are widespread. A sizeable proportion of toxicology presentations also involve methamphetamine intoxication. [8]

State governments and hospitals have begun to invest in reorienting EDs to include models of care that integrate specialist expertise in mental health, emergency medicine, and drugs and alcohol. Some examples include the Psychiatric and Non-prescription Drug Assessment (PANDA) Unit at St Vincent's Hospital Sydney, in NSW; the Mental Health Observation and Assessment (MHOA) Units and Urgent Care Centres (Toxicology) in WA; and the Alfred Mental Health Service at the Alfred Hospital in Victoria. These models are multidisciplinary in their staffing mix, targeted to manage the health effects of drug and alcohol use and reduce the risks related to aggression and violence in the ED.

Of particular note, ACEM has strongly endorsed the Emerging Drugs Network of Australia (EDNA). Patients presenting to the ED after using illicit drugs, including novel psychoactive substances, are a unique source of information on substances that are directly causing acute harm in the community. Conventionally, illicit drug intoxications are assessed and managed in EDs based on self-report and presenting symptoms, with no objective data on the causative agent.

[7] ACEM, 2023. ACEM Report Impact of Alcohol harm on Emergency Care: https://acem.org.au/getmedia/ee86d4d9-6378-4f3a-99ed-b523495f730c/ACEM-Report-Impact-of-Alcohol-harm-on-Emergency-Care-FINAL

[8] Bunting P, Fulde G, S F. Comparison of crystalline methamphetamine ("ice") users and other patients with toxicology-related problems presenting to a hospital emergency department. Med J Aust. 2007;187(10):564-6.

EDNA is a national toxico-surveillance system that provides analytic data on these drugs, from sentinel EDs. It is a collaborative national network of emergency physicians, toxicologists, forensic laboratories and public health authorities. The key benefit of EDNA is the capacity to provide timely laboratory-confirmed toxicology data on emerging drug-related threats in the community which acts as an Early Warning System. This has led to improvements in clinical, forensic laboratory and public health harm reduction responses, EDNA has made Australia's first contribution of national ED data on novel psychoactive substances to the United Nations Office on Drugs and Crime Global SMART Forensics program. It has strengthened Australia's contribution to global surveillance networks. EDNA aligns with the National Drug Strategy 2017-2026. Funding for EDNA is from the NHMRC (GNT2001107) and ceases in 2025-26.[9]

ACEM recommends:

1) that EDNA should serve as an ongoing early detection and reporting system beyond the current NHMRC funding.

3. Early Intervention and Reduction Opportunities from the ED

ACEM's Statement on Alcohol Harm[10] supports the World Health Organization recommendation that EDs be resourced to conduct screening and other brief interventions and referral for treatment (SBIRT) programs. The routine use of validated, standardised screening tools offers an important mechanism for identifying, reducing and preventing problematic use, abuse, and dependence on alcohol and other drugs.

While the use of brief interventions originated in the ED, evidence of the success of SBIRT models in these settings is largely observational, with limited controlled trials conducted and mixed findings depending on the severity of patients' drug use.[11] Further research and resourcing is essential to ensure implementation of effective modes of intervention.

Where possible, EDs should be resourced for the ongoing assessment of efficacy of SBIRT, and quality improvement of SBIRT programs.

ACEM recommends:

2) The Committee's findings recommend investment, evaluation and research in screening and other brief interventions and referral for treatment (SBIRT) models that can be utilised in healthcare settings to identify, reduce and prevent problematic use of and dependence on alcohol and other drugs.

4. Violence in the ED

AOD use may increase a person's risk of violent or aggressive behaviours. A recent meta-analysis 11 found that approximately 36 in every 10,000 ED presentations involve violence, with an estimated 45 in every 100 violent presentations associated with alcohol and/or other drugs. [12]

For example, in a 2016 study, 98% of ED clinical staff have experienced verbal aggression from an alcohol-affected patient and 92% of ED clinical staff have experienced physical aggression. As a result, alcohol-affected patients are more likely to require security codes being called and/or some form of restraint

[9] Fatovich, D. M., et al. 2024. "'You mean you're not doing it already?' A national sentinel toxico-surveillance system for detecting illicit, emerging and novel psychoactive drugs in presentations to emergency departments." Emerg Med Australasia

[10] Australasian College for Emergency Medicine. Statement on Alcohol Harm (S43). Melbourne: ACEM; 2016 [updated Jul-16; cited 2019 Jan 30]. Available from: https://acem.org.au/getmedia/ceaf21fd-fedb-46e3-bcab-333b58f63c13/S43_Alcohol_Policy_Statement_Jul-16.aspx.

[11] Bogenschutz MP, Donovan DM, Mandler RN, Perl HA, Forcehimes AA, Crandall C, et al. Brief intervention for drug users in emergency departments. JAMA Intern Med. 2014;174(11):1736-1745.

[12] Nikathil S, Olaussen A, Gocentas R, Symons E, Mitra B. Workplace violence in the emergency department: A systematic review and meta-analysis. Emergency Medicine Australasia. 2017;29:265-75.

being used. The majority of clinical staff report that alcohol-affected patients impact on the care of other patients and the functioning of the ED in general.[13] [14] [15]

Research consistently shows that despite the relatively low rate of presentations due to methamphetamine, this cohort of patients are highly resource intensive and require complex care in the ED. [16] [17] A 2017 study of presentations to an inner-city Australian ED related to methamphetamine use over one month found that patients were predominantly male, acutely intoxicated, had used methamphetamine in the past 28 days, presented voluntarily, needed physical and mechanical restraint and were aggressive to other patients and staff.[18]

One of ACEM's key priority areas is violence in the ED. ACEM's policy on violence in the emergency department defines its characteristics, consequences, causes, responsibilities and management. Whilst not all occurrences of violence in the ED are associated with AOD use, there is a strong correlation and risk of violence from intoxicated patients.

There are few studies that have monitored trends in ED violence or evaluated the effectiveness of interventions over time. To understand the cumulative effects of violence on ED staff, as well as appropriate prevention and intervention strategies, instituting and supporting a culture of user-friendly reporting of violence is essential. The Cardiff Model is used as a violence prevention tool to reduce alcohol-related violence in a number of Australian EDs in WA, Victoria, and the ACT.[19]

ACEM recommends:

3) The Committee's findings include a recommendation to monitor trends in ED violence and evaluate interventions of violence.

4.1 Security in the ED

To support the management of AOD intoxicated patients, ACEM advocates for dedicated, specifically trained and funded hospital security personnel. Security is a vital ED work safety resource that should be adequately funded by jurisdictional health system managers and employed and trained by hospital EDs as an integrated part of the ED clinical team.[20]

Well-trained, experienced hospital security personnel with strong, reassuring, and supportive physical presence, excellent communication skills, an aptitude for learning, a solid understanding of cultural safety and competency, and a positive 'customer service' attitude can be successfully utilised in the ED to problem solve and eliminate unnecessary conflict.[21] Security personnel working under this model within the ED will have the ability to support de-escalation of some intoxicated patients, and communicate with them in a patient-centred way to advise on treatment and care provision within the ED. They are also able to protect safety in instances of escalating violence.

Therefore, ACEM recommends:

4) EDs are funded to employ, and train dedicated security personnel staff – 24 hours a day, seven days a week – to minimise the risk of overall violence experienced in ED, including violence from intoxicated patients.

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[13] Egerton-Warburton D, Gosbell A, Wadsworth A, Moore K, Richardson D, Fatovich D. Perceptions of Australasian emergency department staff of the impact of alcohol-related presentations. Med J Aust. 2016;204(4):155.
[14] Mclay S, MacDonald E, Fatovich D. Alcohol-related presentations to the Royal Perth Hospital emergency department: a prospective study. Emerg Med Australas. 2017;29:531-538.
[15] Sills, R.K., et al. (2020). 'Snapshot of audit of emergency department workplace violence'. Emergency Medicine Australasia. 32 (3): 529-530.
[16] Gray S, Fatovich D, McCoubrie D, Daly F. Amphetamine-related presentations to an inner-city tertiary emergency department: a prospective evaluation. Med J Aust. 2007;186(7):336-9.
[17] Fatovich D, Davis G, Bartu A. Morbidity associated with amphetamine related presentations to an emergency department: a record linkage study. Emerg Med Australas. 2012;24:553-9
[18] Unadkat A, Subasinghe S, Harvey RJ, Castle DJ. Methamphetamine use in patients presenting to emergency departments and psychiatric inpatient facilities: what are the service implications?. Australas Psychiatry. 2019;27(1):14-7.
[19] Mental Health Commission. WA Model for Violence Prevention Pilot. Available at: https://www.mhc.wa.gov.au/about-us/major-projects/wa-model-for-violence-prevention-pilot/
[20] Safe Work Australia. Workplace violence and aggression – advice for workers. Australia
[21] York T, MacAlister D. Hospital and healthcare security. Sixth ed. Oxford: Elsevier Inc; 2015

5. Multidisciplinary Interventions in the ED

State governments need to invest in reorienting EDs to include models of care appropriate to patient demand and case mix that integrate mental health, general medical and AOD/toxicological care. More flexible and integrated care across mental health, substance use, and primary care services is essential, together with a prioritisation of early intervention for methamphetamine-related psychotic symptoms. Changes are needed to the design and resourcing of EDs to better prevent, minimise and manage violent behaviours that often accompany alcohol and drug presentations, including methamphetamine-related psychosis.

6. Improved Integration of AOD Services

A lack of service development and integration means that many people whose presentations primarily involve AOD use and who would be better served in the community seek help from EDs in crisis and with nowhere else to go. Presentations involving methamphetamine-related psychosis are among the most resource intensive in the ED. Frequently, patients discharged from ED with addiction or problematic AOD use, have limited availability of after-care services.

ACEM identified the following actions for greater integration and availability of AOD services that are required:

- Increased resourcing for community-based AOD services that offer comprehensive medical and psychosocial care and support.
- Resourcing for increased specialist AOD treatment options, starting with alcohol or methamphetamine-related harm, including methamphetamine-induced psychosis. Specialist services could include in-hospital withdrawal services and access to specialist psychiatric support.
- The provision of integrated care pathways out of EDs and into specialist treatment programs so that health professionals can offer assertive interventions to people whose drug and alcohol use has come to a crisis point, starting with an immediate appointment for publicly funded care and support.

6.1 AOD and Mental Health

EDs receive many patients that present with co-occurring substance use disorders and mental health issues. These presentations require comprehensive assessment and treatment and can be some of the most complex and difficult to engage with long-term treatment.

Rates of mental health presentations in EDs are increasing amongst all age groups. People presenting in mental health crisis often have other complex needs including physical health comorbidities, drug and alcohol abuse problems, or require support to address broader social circumstances, including homelessness. This reflects the social determinants of health.

There is a serious lack of dual diagnosis services in the mental health system, where people with co-existing AOD and mental health problems have very significant access problems to help as they are deemed ineligible due to services not acknowledging the co-occurrence of disorders. This contributes to escalations in crisis and people having nowhere else to go except the ED. This also contributes to the revolving door effect of frequent presenters to ED. Notably, coronial inquiries make recommendations that there must be a better integration of mental health and alcohol and other drug services.

Step-up step-down type services can be effective at treating patients with dual diagnosis and admission from the ED to community services is a more patient centred and recovery-oriented approach to mental health and AOD care. However, these services are often at capacity, and admission from ED is inconsistent and problematic around the country.

Further, mental health in-patient units' capacity is inadequate to meet community needs, particularly presentations of drug-induced psychosis can often require longer stays, resulting in less availability and

throughput of patients to mental health wards. This also has significant impacts on access block, where mental health patients experience some of the longest wait times in ED.[22]

ACEM recommends:

5) States and Territories should undertake strategic needs assessments to scope requirements for inpatient mental health beds and that resources are invested for increased bed capacity in line with demand.

6) Additional resources must be invested to increase non-hospital alternatives to mental health and AOD treatment and recovery options, such as step-up step-down services, hospital in the home, Police, Ambulance, Clinician, Emergency Response (PACER), or services tailored to community needs.

7. Improvements to Data Collection

ACEM urges the Australian, State and Territory governments to require reporting on alcohol and drug-related presentations to ED and use this to inform prevalence. Unfortunately, current coding systems result in substantial under-reporting. For example, the New South Wales Special Commission of Inquiry into the Drug 'Ice' found that systematic data collection under-reports methamphetamine ED presentations by 40%. Current coding (i.e. data collection) systems have not evolved sufficiently to adequately represent the complex nature of this issue, as International Classification of Disease codes are not available for most illicit drugs.[23]

Implementation of accurate, consistent, reliable and routine AOD ED presentation data collection is required to help governments and stakeholders better understand the burden of AOD across the Australian acute health systems and the associated resourcing needs.

ACEM recommends that:

7) Governments develop and implement compulsory collection of accurate minimum AOD-related presentation data through addition of AOD data elements to the National Non-Admitted Patient Emergency.

8. Conclusion

Australian EDs need relief from the pressures of managing highly complex, mentally unwell, behaviourally disturbed people whose drug and alcohol use has come to a crisis. All governments need to commit to consistent and coordinated interventions to reduce alcohol and drug-related harm in the community.

The College urges the Committee to consider this submission in its final report to ensure future system reforms related to AOD improve how healthcare is delivered in EDs as a safe workplace.

Thank you again for the opportunity to provide this submission. If you require any further information about any of the above issues or if you have any questions about ACEM or our work, please do not hesitate to contact Hamish Bourne, Manager, Policy and Advocacy (hamish.bourne@acem.org.au).

Kind regards,

Dr Stephen Gourley
President
Australasian College for Emergency Medicine

[22] Australasian College for Emergency Medicine. 2020. Nowhere else to go report. Available from: https://acem.org.au/getmedia/5ad5d20e-778c-4a2e-b76a-a7283799f60c/Nowhere-else-to-go-report_final_September-2020

[23] Dawson, J., et al. (2020). 'Snapshot of audit of illicit drug-related presentations.'. Emergency Medicine Australasia. 32 (3): 530-532.