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# Submission to the WA Mental Health Commission – Mental Health and Alcohol and Other Drugs Strategy 2025 – 30 December 2024

## Introduction

The Australasian College for Emergency Medicine (ACEM; the College) welcomes the opportunity to respond to the Draft Western Australian Alcohol and Other Drug Strategy 2024 – 2030 (the draft strategy).

As the peak body for emergency medicine, ACEM 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 welcomes the intention of the Western Australia government to develop a strategy that provides guidance to and recognises the interconnected web of services where mental health and alcohol and other drugs (AOD) treatment and support is delivered.

Our submission primarily addresses the consultation materials contained in *Strategic Pillar 6 – Hospital-based services* and is informed by the experience and expertise of emergency physicians working in Western Australian emergency departments (EDs).

## 1. ACEM Position on Mental Health and Alcohol and Drug-Related ED Presentations

All people presenting to the ED are entitled to receive high quality care, regardless of whether they are physically ill and/or mentally unwell or distressed. When patients present with a condition requiring emergency care, the role of the ED is to assess, stabilise and refer to definitive care as necessary.

Patients presenting to the ED who are experiencing psychological distress should receive culturally responsive and trauma-informed care as soon as possible. Those with an acute mental and/or behavioural condition requiring admission should be transferred to an in-patient ward promptly, following a clinical decision to admit.

ACEM considers alcohol-related harm to be one of the largest preventable public health issues facing EDs in Australia and Aotearoa New Zealand. AOD-related presentations impact on the volume of patients who present to the ED, particularly during evenings and weekends – considered peak alcohol consumption times. In addition, treating these patients is typically resource and time intensive.

The ED environment is anti-therapeutic for the ongoing care of patients with an acute condition who require inpatient admission, including patients attending the ED with an acute mental and/or behavioural condition or intoxication. The ED is a high stimulus environment, often loud and crowded and confusing. The environment can be overwhelming, particularly to patients experiencing a mental health crisis.

## 2. Recommendations

Recommendation 1 – The strategy must include goals and actions beyond prevention and treatment, for example, addressing the social determinants that impact upon mental health i.e. poverty, homelessness, access to affordable health and dental care.

Recommendation 2 – The strategy must include principles regarding physical health and another about the external factors that impact an individual's wellbeing i.e., address the social determinants of health.

**Recommendation 3 –** Remove the phrase "rebalance" investment in mental health and AOD systems from the strategy. The investment in systems must emphasise a need for investment in acute care settings, step-up/step-down services, short stay units and community-based services that is commensurate with the burden of disease.

**Recommendation 4** – The strategy must include a set of actions to undertake a needs assessment to scope the requirement for inpatient mental health beds in line with international best practice evidence and standards.

**Recommendation 5 –** The strategy must emphasise engagement with clinicians to address the access and flow issues affecting acute care services. This must include developing better data to correctly identify the true burden of mental health and AOD presentations to EDs.

**Recommendation 6 –** The strategy must include provisions pertaining to the design of acute care facilities to optimise the management of patients with mental health and/or AOD-related care needs.

**Recommendation 7 –** The strategy must contain a set of actions regarding the exploration of innovative diversion or non-hospital alternative care models, underpinned by robust research and evaluation.

**Recommendation 8 –** The strategy must support initiatives such as the Emerging Drugs Network of Australia (EDNA), the WA Model for Violence Prevention, Minimum Unit pricing for alcohol, and the development of Addiction Medicine services, to better serve the WA community. This must include efforts to reduce stigma.

# 3. Background

## 3.1 Mental Health in the ED

All people presenting to the ED are entitled to receive high quality care, regardless of whether they are physically ill and/or mentally unwell or distressed. 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, for example, homelessness.

Demand for mental health care is outpacing the availability of acute mental health services, particularly after-hours, which has created a situation where EDs have become a major and often default entry point for people seeking access to mental health care, often when in crisis – put simply, there is nowhere else to go.

Further, mental health in-patient units' capacity is inadequate to meet community needs, particularly presentations of drug-induced psychosis. This can often require longer stays, resulting in less availability and throughput of patients to mental health wards. This also has devastating impacts on access block, as mental health patients experience some of the longest wait times in ED.[1] This is anti-therapeutic and poses a considerable risk of harm to both patients and staff.

## 3.2 Alcohol and Drug Use and the ED

Australian research[2] has found that 10% of ED presentations are alcohol related, and up to 7% of ED presentations are illicit drug related[3]. The consequences of risky alcohol and/or drug use are regularly seen in the ED with people presenting with injuries as a result of use, clinical intoxication, medical conditions from long-term risky alcohol consumption misuse (liver disease, withdrawal or dependence) or

[1] 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

[2] Egerton-Waburton D, Gosbell K, Wadsworth A, Richardson D, Fatovich DM. Alcohol-related harm in emergency departments: a prospective, ,multi-centre study. Addiction. 2018;113(4):623-632

[3] Dawson J, Remke S, Fatovich D. Snapshot audit of illicit drug-related presentations. Emergency Medicine Australasia. 2020;32(3):530-532.

mental health conditions arising from alcohol and drug related harm and comorbidity[4]. 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.[5]

AOD use presents a growing challenge for ED staff, particularly as some drugs may increase a person's risk of violent or aggressive behaviours. Intoxicated patients can put clinical staff, other patients and the people accompanying them at risk of harm. For example, 98% of ED clinical staff have experienced verbal aggression from an alcohol-affected patient and 92% of ED clinical staff have experienced physical aggression[6]. As a result, AOD affected patients are more likely to require security codes being called and/or some form of restraint 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.[7] [8]

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.[9] [10] 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.[11]

### 3.3 Co-occurring conditions

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.

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.

There is a serious lack of dual diagnosis services in the system, meaning people with coexisting AOD and mental health problems have very significant access problems to help as they are deemed ineligible due to services lacking the capability to manage the co-occurrence of disorders under the care of one multidisciplinary team. 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. In summary, ACEM believes that there needs to be a 'no wrong door' approach by community services.

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[4] Australasian College for Emergency Medicine. 2024. Alcohol-Related Harm in Australasian Emergency Departments Sobering new data that shows how alcohol impacts emergency departments in Australia and Aotearoa New Zealand. Melbourne: ACEM;2024. Available from: https://acem.org.au/getmedia/ee86d4d9-6378-4f3a-99ed-b523495f730c/ACEM-Report-Impact-of-Alcohol-harm-on-Emergency-Care-FINAL

[5] 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.

[6] Australasian College for Emergency Medicine. Position statement Alcohol Harm (S43). 2020. Melbourne: ACEM.

7 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.

[8] 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.

[9] 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.

[10] 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

[11] 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.

## 4. ACEM Feedback

### 4.1 Vision, Aims and Principles

The College is broadly supportive of the vision, aims and principles outlined in the discussion paper. We note in the discussion paper that there is a recognition of the socioeconomic factors that contribute to poor mental health and substance misuse. 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. The strategy needs to include principles regarding physical health and another about the external factors that positively or negatively impact an individual's wellbeing included for the vision to be achievable.

### 4.2 Balancing the System

The discussion paper demonstrates a comprehensive understanding of the myriads of challenges that impact on the provision of services and support – however, ACEM is concerned by the phrase that appears in the discussion paper to "rebalance" the investment between acute and community-based services. This framing has the potential to be misconstrued as reducing the funding available for acute services, when we know that there is an ever-increasing demand for acute services and a lack of resourcing and capacity to meet the demand for care. Maintaining the current level of investment by "rebalancing" is not the answer – funding across the spectrum of systems needs to be increased, commensurate with the burden of disease.

### 4.3 Framing the Issue

Whilst the consultation paper promotes Western Australians to experience optimal wellbeing, ACEM believes the draft strategy would be strengthened by framing addiction as a health issue, clearly articulating an understanding of why addiction occurs, and acknowledging that more needs to be done to support people living and lived experience of AOD problems.

### 4.4 Reducing Stigma

Stigma is pervasive, creating a major barrier to help-seeking and effective intervention. Structural stigma refers to systemic barriers that limit access to care, including discriminatory policies, practices and funding, which impact the availability of addiction treatment options within primary and acute care systems, resulting in a fragmented addiction treatment sector that is difficult to navigate. The combination of public stigma, structural barriers, and social disadvantage means that many individuals do not seek help until they are experiencing acute harms related to their use (e.g., withdrawal complications, infection, injuries, overdose, psychosis). This approach is resource-intensive, costly, and highly inefficient, and disproportionately reliant on emergency services.

The Global Commission on Drug Policy argues for humane and effective policies shaped by scientific evidence, public health principles and human rights standards. The main measure that could be taken to address this would be to reframe the issue of illicit drugs as a health and social issue. The current paradigm is that this is a law enforcement and criminal justice issue. That paradigm inevitably results in stigma. If the issue can be reframed into a health and social issue, then the likelihood of improved treatment services is increased. It would also begin to address the social determinants of health. The WA Methamphetamine Action Plan Taskforce Final report, published on 2 August 2019 made a number of recommendations to the Mental Health Commission on de-stigmatising methamphetamine use. ACEM defers to the expertise within this report and encourages the WA Mental Health Commission to revisit and incorporate a focus on reducing stigma into the 2025-2030 strategy.

## 5. Additional Comments

### 5.1 Addiction medicine

There is a shortage of Addiction Medicine specialists in WA. The Addiction Medicine team has a key role in early engagement, assessment and management of patients with drug and alcohol related conditions upon ED presentation and/or during admission. Specialist motivation enhancement skills are utilised in addition to providing expert pathway navigation through to appropriate community AOD treatment and support services. These interventions result in enhanced patient safety, reduced complications (including

mortality), increased treatment engagement, and overall improved quality and efficiency of services for patients with substance use-related conditions. Hospital clinicians benefit through formal and informal education, mentorship and capacity building. Research demonstrates reductions in length of stay, premature discharges, re-presentations, re-admissions, behavioural incidents, and hospital costs. A visionary approach would be to establish a Centre of Excellence in Addiction Medicine. Yet it is notable that the WA Mental Health Research Framework 2024-28 does not mention the word addiction.

### 5.2 Research Evidence

ACEM advocates for good quality Emergency Medicine Research, noting that this strategy would be strengthened by exploring research options to greater support ED interventions. ACEM believes that the strategy should include reference and funding to research into standard emergency care to greater support patients as well as the emergency department.

Many routine standard treatments in emergency care are not supported by high level evidence but are based upon consensus. Consequently, the effectiveness of these routinely administered treatments is uncertain; some may in fact even be harmful. This would not be considered acceptable in other clinical fields such as heart disease, diabetes or cancer treatment.

ACEM endorsed innovations such as the Emerging Drugs Network of Australia (EDNA) help to identify new illicit drugs and their clinical effects, while supporting emergency clinicians by giving them knowledge on treating overdoses. The key benefit of EDNA is the capacity to provide timely laboratory-confirmed toxicology data on emerging drug-related threats in the community. This leads to improvements in clinical, forensic laboratory and public health harm reduction responses, reflecting rapid translation of the research[12]. Research efforts such as these have a very real beneficial impact and the strategy would benefit from acknowledgment of, and consideration of existing and potential research. It is worth noting that EDNA aligns with recommendations 52 and 53 of the WA Methamphetamine Action Plan Taskforce. The framework and systems established serve as a valuable blueprint for future initiatives aimed at reducing drug-related harms and enhancing public health via harm minimisation.

Accurate development of a mental health strategy should rely on accurate data[13]. Unfortunately, there are multiple research papers that demonstrate current coding systems, especially in EDs, do not accurately reflect ED workload; i.e., they heavily under-report mental health and AOD workload[14]. The strategy should make every effort to improve data capture from EDs.

### 5.3 WA Model for Violence Prevention (WA MVP)

ACEM has been involved in efforts to introduce the Cardiff model to reduce alcohol related violence in the eastern states. ACEM is delighted that the WA MVP has been established and looks forward to supporting and promoting the program.

### 5.4 Facility Design and Resourcing

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. This would also improve the occupational safety of our ED workforce, which is a key organisational responsibility.

[12] Fatovich D, Dessauer P, Ezard N. “You mean you’re not doing it already?” Developing a national sentinel toxico-surveillance system for detecting illicit, emerging, and novel psychoactive drugs in presentations to Emergency Departments. *Emerg Med Australas* 2024;36:990-992.

[13] Dawson J, Remke S, Fatovich D. Snapshot audit of illicit drug related presentations.
Emerg Med Australas 2020;32:530-532.

[14] Goyal N, Proper E, Lin P, Ahmad U, John-White M, O'Reilly G. M, et al. Using emergency department data to define a 'mental health presentation' - implications of different definitions on estimates of emergency department mental health workload. Australian Health Rev 2024;48 (4): 342-350.

### 5.5 Coding systems

Accurate development of a mental health strategy should rely on accurate data[15]. Unfortunately, there are multiple research papers that demonstrate current coding systems, especially in EDs, do not accurately reflect ED workload; ie they heavily under-report mental health and AOD workload[16]. The strategy should make every effort to improve data capture from EDs.

### 5.6 Minimum unit pricing of alcohol

ACEM strongly supports the efforts by the Cancer Council in WA to introduce a minimum unit price for alcohol. We can dramatically reduce alcohol-related harms in WA, by introducing a minimum floor price for cheap alcohol below which these dangerous products cannot be sold. This is something communities around the world have been introducing in recent years with great success. This may also contribute to efforts to reduce family and domestic violence.

## 6. Contact

Thank you for considering the feedback provided by ACEM to support the development of the Western Australia Mental Health and Alcohol and Other Drug Strategy. If correctly funded and resourced, it has the potential to significantly improve the health and wellbeing of Western Australians.

To discuss any of the issues raised in this submission or to learn more about the College's work, please contact Hamish Bourne, Manager, Policy and Advocacy (policy@acem.org.au).

Yours sincerely,

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[15] Dawson J, Remke S, Fatovich D. Snapshot audit of illicit drug related presentations. Emergency Medicine Australasia 2020;32:530-532.

[16] Goyal N, Proper E, Lin P, Ahmad U, John-White M, O'Reilly G. M, et al. Using emergency department data to define a 'mental health presentation' - implications of different definitions on estimates of emergency department mental health workload. Australian Health Rev 2024;48 (4): 342-350.