Australasian College
for Emergency Medicine

Position Statement

Harm Minimisation Related to Drug Use

This document outlines the Australasian College for Emergency Medicine's (ACEM) position on reducing harm from drug use. This statement provides recommendations for emergency departments (EDs) and the broader community to comprehensively reduce harm.

For the purposes of this Statement, the term drugs refers to both illicit drug use and the misuse of prescription medications. Tobacco use is out of scope (see S42 Statement on Tobacco Smoking).

ACEM supports evidence-based approaches to harm minimisation. Harm minimisation is considered to be a multi-pronged approach to drug use 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 drugs and reducing production and supply).

Harm minimisation does not condone drug use and recognises that some people will choose to use drugs.

Drug use presents a growing challenge to emergency departments particularly as some drugs may increase a person's risk of violent or aggressive behaviours. Emergency physicians have a significant role in minimising harm from drugs through the identification and referral of patients with drug problems, through responsible prescribing and advocating for harm reduction measures.

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Document Review

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1. Background

Drug use is mediated by a person's social, economic, physical and cultural environment. Additionally, the health of people who use drugs is affected by the same environmental determinants.[1] There are variety of potential factors behind an individual's drug use such as peer pressure, experimentation, escapism or as a form of self-medication.[2]

According to the Australian National Health Survey in 2016, 16% of people aged over 14 reported using illicit drugs in the last 12 months.[3] Cannabis was the most commonly used substance (10.3%), followed by cocaine (2.5%), ecstasy (2.2%), and methamphetamine (1.4%). While methamphetamine use declined from 3.4% in 2001, deaths from methamphetamine were four times higher in 2017 than in 1999.[3] The majority of deaths due to stimulants such as methamphetamine are recorded as intentional and attributed to recreational drug use.[4]

Drug use accounted for 2.7% of the total burden of disease in Australia in 2015 including substance abuse disorders, communicable diseases (such as Hepatitis B, Hepatitis C and HIV/AIDS), overdose, and injury. In addition, illicit drug use is also associated with mental illness. 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.[3] Similarly, in New Zealand illicit drug use accounts for 2.3% of disability adjusted life-years (DALYs) however this increases to 6.5% amongst youth.[5]

Compared to alcohol-related emergency department presentations, drug-related presentations are comparatively low.[6,7,8,9] Data from ACEM's Snapshot Survey of alcohol and other drug harm in the ED methamphetamine presentations were higher in Australia (3%) compared to New Zealand (0.7%). Alcohol-related presentations were substantially higher in both countries (13.3% and 17.2% respectively).[10] Western Australia had the highest percentage of methamphetamine related presentations (6%). 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 such as those observed in ED settings.[11,12]

In 2017-18 there were 78,175 mental and behavioural disorders due to psychoactive substance use which accounted for 27% of all mental health related ED presentations in Australia.[13] In addition, people experiencing homelessness are also frequent attenders of ED due to co-occurring issues of mental illness and alcohol and other drug (AOD) use.[14,15]

Patients attending EDs due to substance use are a diverse cohort mediated by the type of drug consumed, the regularity of such consumption and the context in which drug use occurs.[9] For example, a study comparing presentations due to ecstasy, gamma hydroxybutyrate (GHB) and amphetamine found that ecstasy related presentations were more likely to result in an admission.[16] GHB presentations were more likely to arrive via ambulance and be categorised as Category 1 according to the Australasian Triage Scale, however, they were more likely to be discharged home.

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.[8,17] 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]

Prescription drug misuse and overdose are rising problems both in Australia and internationally. In Australia oxycodone and benzodiazepines account for the largest proportion of drug-induced deaths and disproportionately occur amongst older age groups.[4] EDs regularly prescribe medications such as opioids for pain management upon discharge from the ED. As a result, the ED has been identified as a critical location to limit opioid prescribing and identify and treat patients presenting with addiction.

One study found that one-quarter of patients discharged to the community with a prescription were prescribed opioids.[19] In addition, patients were regularly prescribed with more than three days' worth of opioid analgesia.

2. Recommendations

ACEM supports an approach to harm minimisation that centres on people-focused policies and interventions which recognise the socioeconomic and cultural context of drug use rather than extending prohibitionist and punitive approaches.

2.1 Data collection

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.[20] Implementation of consistent, routine drug-related ED presentation data collection is required to help governments and stakeholders better understand the burden of drug and alcohol use across the Australian and New Zealand acute health systems and the associated resourcing needs.

ACEM recommends that alcohol and drug use is captured within the National Non-admitted Patient Emergency Department Care Database (NNAPEDC) in Australia and the National Non-admitted Patient Collection in New Zealand. Further work is also needed to determine the optimal coding method to ensure that data collection accurately captures drug-related ED presentations.

2.2 Demand reduction

Brief interventions in the ED

EDs are recognised as providing opportunities to identify drug-related problems in presenting patients.[21] Screening, Brief Intervention and Referral to Treatment (SBIRT) models have been developed for healthcare settings to identify, reduce and prevent problematic use and abuse of, and dependence on, alcohol and other drugs.[22]

SBIRT involves a healthcare professional:

- assessing a patient for risky drinking and/or drug taking using a standardised screening tool;
- conducting a structured conversation about risky alcohol and/or 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).

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.[21, 22] Further research and resourcing is needed to ensure implementation of effective modes of intervention.

2.3 Supply reduction

Prescription opioids are commonly provided upon discharge, so the ED plays a critical role in stemming the supply and overprescribing of opioids. Regulatory changes were implemented by the Therapeutic Goods Administration (TGA) in 2020 to prompt prescribers to reflect on their opioid prescribing practice and ensure that prior to initiating or continuing to prescribe an opioid, they consider whether patients will benefit from opioid treatment and how to manage risks and harms.[23] Specific to the ED context, ACEM recommends that timely and accessible referral pathways to acute pain services should also be available to refer patients for comprehensive pain management.

For patients with chronic pain, ACEM recommends a model of multidisciplinary management with clear pathways and resourcing to reduce the number of patients who are re-presenting and comprehensively address patients' pain. Similarly, emergency physicians should also advocate for the enhanced regulation of prescription medicines, centralised mandatory databases for prescription medicine scripts, and improved use of information technology (IT) to communicate patient histories directly to health care providers.

2.4 Harm reduction

Public health messaging

ACEM supports public awareness and education initiatives that promote safer behaviours regarding drug use. Examples of such approaches include helping peers to identify when a friend is deteriorating and where to seek help.

Safer settings

ACEM is supportive of measures which seek to create safer environments to reduce harms from drug use such as needle and syringe exchange programs, community prescribing of naloxone (opiate antidote), medically supervised safe injection rooms and drug checking services (i.e. 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.[24,25] Importantly, research has shown that drug use does not increase with the presence of such programs.[26]

Alcohol and other drug treatment services

ACEM supports integrated and multidisciplinary services which comprehensively address alcohol and other drug use as well as other co-morbid physical and psychiatric conditions. At present the lack of service integration and community assistance means that people requiring support for AOD use often seek support from EDs in crisis. Appropriate community provision of such services available 24-hours a day may prevent many of these ED presentations. In addition, for those who do present to EDs there is a need for integrated care pathways into specialist treatment programs such as opioid replacement therapy, as well as other social support services to comprehensively address patients' needs.

ACEM supports models that co-locate AOD patients and emergency mental health clinicians, enabling timely referral and access to services. Such integrated models of care should be central to any reforms of the mental health care system. In addition, further exploration of such models is needed in rural and regional areas where there is a higher burden of AOD use and fewer services to address this burden. ACEM recognises the potential benefit of teleconsultation to increase both geographical reach of support services, and access to after-hours care.

References

1 Galea S, Vlahov D. Social determinants and the health of drug users: socioeconomic status, homelessness, and incarceration. Public Health Rep. 2002;117(1):S135-S145.

2 Ritter A, King T, Hamilton MA, editors. Drug use in Australian society. 2nd ed. Victoria: Oxford University Press; 2017.

3 Australian Institute of Health and Welfare. Alcohol, tobacco and other drugs in Australia. Cat. no. PHE 221. Canberra: AIHW; 2020. Available from: https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia/contents/interactive-data/illicit-drugs

4 Australian Bureau of Statistics. 3303.0 - Causes of death, Australia, 2016. Drug induced deaths in Australia: a changing story. Canberra: ABS; 2018. Available from: https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/3303.0~2016~Main%20Features~Drug%20Induced%20Deaths%20in%20Australia~6

5 Ministry of Health, New Zealand Government. Health loss in New Zealand 1990-2013. A report from the New Zealand burden of diseases, injuries and risk factors study. Wellington: Ministry of Health; 2016. Available from: https://www.health.govt.nz/system/files/documents/publications/health-loss-in-new-zealand-1990-2013-aug16.pdf

6 Australian Institute of Health and Welfare. National drug strategy household survey 2016: detailed findings. Cat. No. PHE 214. Canberra: AIHW; 2017. Available from: https://www.aihw.gov.au/reports/illicit-use-of-drugs/2016-ndshs-detailed/contents/table-of-contents

7 New Zealand Drug Foundation. State of the nation 2019: A stocktake of how New Zealand is dealing with the issue of drugs. Wellington: NZ Drug Foundation; 2019. Available from: https://www.drugfoundation.org.nz/assets/uploads/2019-uploads/Policy-pages/State-of-the-Nation-2019.pdf

8 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.

9 Bunting P, Fulde G, Forster SL. 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.

10 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

11 Scott N, Caulkins J, Ritter A, Quinn C, Dietze P. High-frequency drug purity and price series as tools for explaining drug trends and harms in Victoria, Australia. Addiction. 2015;110(1):120-8. 22.

12 Australian Institute of Health and Welfare. Trends in methylamphetamine availability, use and treatment, 2003-04 to 2013-14. Cat. No. HSE 165. Canberra: AIHW; 2015. Available from: https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/trends-in-methylamphetamine-availability-use-and/contents/table-of-contents

13 Australian Institute of Health and Welfare. Mental health services in Australia. Hospital emergency services. Canberra: AIHW, 2020. Available from: https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/hospital-emergency-services

14 Davies A, Wood L. Homeless healthcare: meeting the challenges of providing primary care. Med J Aust. 2018; 209(5):230-234.

15 Salhi B, White M, Pitts S, Wright D. Homelessness and emergency medicine: a review of the literature. Acad Emerg Med. 2017;25(5):577-593.

16 Horyniak D, Degenhardt L, Smit DV, Munir V, Johnston J, Fry C, et al. Pattern and characteristics of ecstasy and related drug (ERD) presentations at two hospital emergency departments, Melbourne, Australia, 2008-2010. Emerg Med J. 2014;31:317-322.

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 Stanley B, Collins L, Norman A, Karro J, Jung M, Bonomo Y. Opioid prescribing in the emergency department of a tertiary hospital: a retrospective audit of hospital discharge data. Emerg Med Australas. 2019;32(1):33-38.

20 Dawson J, Remke S, Fatovich D. Snapshot audit of illicit drug-related presentations. Emerg Med Australas. 2020;32(3):530-2.

21 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.

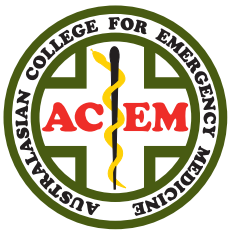
22 Rodgers C. Brief interventions for alcohol and other drug use. Aust Prescr. 2018;41:117-121.

23 Therapeutic Goods Association (TGA). Prescription opioids: information for health professionals. Department of Health; 2020. Available from: https://www.tga.gov.au/prescription-opioids-information-health-professionals

24 Department of Health, Australian Government. Review of methadone treatment in Australia. Canberra: Department of Health; 1995. Available from: https://www1.health.gov.au/internet/publications/publishing.nsf/Content/drugtreat-pubs-methrev-toc

25 Fernandes R, Cary M, Duarte G, Jesus G, Alarcão J, Torre C, et al. Effectiveness of needle and syringe programmes in people who inject drugs – an overview of systematic reviews. BMC Public Health. 2017; 17(309):1-15.

26 Harm Reduction Australia. What is harm reduction?. Harm Reduction Australia; 2018. Available online: https://www.harmreductionaustralia.org.au/what-is-harm-reduction/



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