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Inquiry into Drug and Alcohol Treatment – Hearing Follow-up Questions

The Australasian College for Emergency Medicine (ACEM) thanks the New South Wales (NSW) Legislative Council for the opportunity to appear as a witness for the Inquiry into Drug and Alcohol Treatment.

ACEM's is pleased to provide the following information, in response to the Committee's follow-up questions.

Is there any information from other jurisdictions where statistical data is collated and would it be possible to implement a standardised data collection system to provide this in NSW, including with social organisations?

Within New South Wales:

- New South Wales hospitals collect data on alcohol related illnesses through the electronic medical record application FirstNet. However information entered into this system is based on *diagnosis* or the *injury sustained*, rather than its relationship to alcohol, as the primary data recorded.
- Drug and Alcohol (D&A) services within each health network also collect data on patient referrals and waiting times, however this information is not standardised.
- The New South Wales Police Force will likely have data on alcohol related violence and/or injuries, however ACEM is not aware of the specific data collected.
- The NSW Roads and Traffic Authority will collect data on motor vehicle injuries involving alcohol; however ACEM is not aware of the specific data collected.

Other jurisdictions:

- The Victorian Department of Health collects morbidity data on all admitted patients from Victorian public and private acute hospitals via the Victorian Admitted Episodes Dataset (VAED).
    - The Victorian alcohol statistics series is commissioned by the Department of Health and produced every year from work conducted by the Population Health Research Program at Turning Point Alcohol and Drug Centre.

Each of these agencies collects data pertinent to their respective roles; however this still only represents a proportion of the impacts of D&A. ACEM believes many more incidents of alcohol related physical harm would not present to a hospital Emergency Department (ED). Similarly many incidents of alcohol related violence would not come to the attention of the police.

These issues all limit the utility of attempts to collect data in a multi-agency fashion. ACEM recommends that any multi-agency standardised data collection system would need to have its purpose clear from the outset, to ensure appropriate datasets are identified by relevant agencies, and data definitions developed to ensure accurate and meaningful interpretation of the collated information.

Would it be beneficial to prescribe that alcohol testing is required on all Emergency Department patients.

ACEM recommends that prescribed alcohol testing of all patients presenting in all EDs would not be beneficial. The primary role of the ED is to provide medical assessment and treatment. The numeric alcohol level is of limited utility to this role, as there is a poor correlation between alcohol level and clinical intoxication. ACEM also notes that the collection of these samples would also impose an enormous financial and resource burden on already overburdened health facilities. Furthermore, NSW legislation already mandates routine blood alcohol testing for drivers, cyclists and pedestrians involved in motor vehicle accidents, who present to EDs. NSW police also have power to attend EDs and request such samples be taken from uninjured drivers, if they have reason to believe these drivers are alcohol affected.

Do you have information relating to the delay in accessing detox places and are there a set number of positions available in NSW?

Detox is offered by public and private hospitals, as well as a number of non-government organisations (NGOs). Within the public sector, withdrawal may be managed either as an in-patient or out-patient.

ACEM understands that there is data on D&A beds available within each health network; however exact figures are not readily available. ACEM also notes that most available D&A health beds are suitable only for non-medical detoxification, due to the absence of after-hours on-site medical staff and (frequent) physical isolation from adjacent medical services.

Waiting times for detox places can vary, and patients can experience significantly delays with regards to accessing detox. The waiting times for the Concord Hospital Drug Health Service were able to be obtained, and showed that the current waiting time for an acute detoxification bed was approximately two weeks for self-referred patients from the community, and 8 – 12 weeks for a rehabilitation bed for low-priority patients. Patients admitted directly from the ED are generally admitted urgently, and this can subsequently impact on waiting times for detox places to community patients. This information is indicative only, and further information should be sought via each drug health network.

Is there any information available about the number of D&A nurses assigned to ED, and is there evidence that the need for them would be later in the evening and in the early hours of the morning?

ACEM believes that over the last 10 years, there has been a reduction in both inpatient and outpatient detox services for D&A affected patients. Whilst some private hospitals do offer private detox programs for alcohol dependence, the majority of patients would be unable to afford this treatment.

ACEM understands that most larger/tertiary hospitals would have one D&A nurse available during business hours, providing D&A health consultations to both the ED and the hospital as a whole. ACEM notes that NSW Health was funding after-hours D&A nurses (at Royal Princes Alfred and Liverpool Hospitals). However this position employed a junior nurse rather than a specifically trained D&A nurse. In addition, NSW Health also funded a trial for an extended hours nursing liaison role at Royal Prince Alfred hospital (RPA), which included after hours. However this did not continue, as funding was considered insufficient to recruit the appropriately qualified staff.

ACEM provides the following example of D&A nursing availability, from Royal Prince Alfred Hospital:

- One nurse and physician full time Monday – Friday, 8am – 5pm, who cover the ED and the whole hospital.
    - Additional nurse on during Friday evenings
    - Additional nurse on Saturday and Sunday mornings.
- There are no dedicated nurses or physicians for only the ED.

With regards to peak times, indicative data from the Concord and Royal Prince Alfred Hospitals (January – April 2013) showed that there were approximately four patients per day (approximately 1-2% of all ED presentations) with a primary alcohol or drug related discharge diagnosis i.e. the main identifiable issue following investigation of these patients was directly attributable to alcohol or drug effects. Of these patients, only one quarter presented during business hours. The highest number of presentations was during the evening and very early hours of the morning.

Do you have any data in relation to patients presenting with injury levels associated with alcohol and drugs, including injury that is identified as alcohol and drug related but the patient i.e. secondary?

A 2010 study[1] using nursing triage text to detect D&A related ED presentations found just over 5% were alcohol-related, while 2% were drug related.

ACEM Fellows have reported that the Royal Prince Alfred Hospital in Sydney, routinely collects blood alcohol levels on all trauma patients, and found that approximately 30% of patients have a blood alcohol level of >0.05%. However ACEM is not aware of any systematic strategies of obtaining information on secondary injuries, as defined in the question.

Would there be the capacity to support standalone ED type stations provided at events if they were funded by the event organiser?

ACEM understands that at present, such services do not exist outside of events such as the Sydney City to Surf fun run (which is used as a disaster training exercise and staffed by public hospital clinicians). Many large events will have some form of on-site emergency medical service – most frequently either a St John's ambulance (to provide basic first aid) or a cardiac arrest team with defibrillators and advanced life support equipment. ACEM believes that if the provision of a medical treatment area was required at major events, it is very likely that the private companies providing the cardiac arrest teams would be able diversify to cater to this demand. The cost of such services would not be likely to be prohibitive at larger events, but may not be warranted and/or affordable for smaller events.

Thank you for the opportunity to provide additional feedback to the NSW Legislative Council Inquiry into Drug and Alcohol Treatment. If you require any clarification or further information, please do not hesitate to contact the ACEM Director of Policy and Research,

Yours sincerely,

A/PROF RICHARD PAOLONI
CHAIR NSW FACULTY

[1] Indig D, Copeland J, Conigrave K, Acrcuri A. *Characteristics and comorbidity of drug and alcohol-related emergency department presentations detected by nursing triage text.* Addiction 2010:105: 898 - 906