ANSWERS TO QUESTIONS FOR THE INQUIRY – Emergency Department

1. In relation to Emergency room attendances has the number of patients attending with methamphetamine related issues been increasing in recent years? How does this compare to attendances resulting from the use of other drugs, including alcohol?

Yes.

Whilst there has been a chronic background of patients attending the ED specifically with medical or mental health issues relating to amphetamine use these are generally low in numbers. The past 2 years have seen a notable rise in attendances due to acute behavioural issues or their consequences related to ‘ice’ use. A number of individuals increase these numbers due to multiple presentations, often within short periods of time. The experience in Geelong is relatively modest compared to anecdotal reports from colleagues working in some emergency departments in metropolitan Melbourne.

Despite this, these attendances are far outnumbered by attendances resulting directly as a consequence of acute alcohol use (as opposed to the long-term medical effects of alcohol use). It is difficult to give exact numbers of each group, but the feeling of ED clinicians would be that alcohol related problems would outnumber methamphetamine related problems by a factor of 4 or more.

Other drugs, particularly heroin, are less prevalent in ED attendances than in past years. Emergency attendances due to heroin use are usually due to the effects of acute overdose and in the past 10-20 years the ability of ambulance paramedics to treat these events in the community, combined with reduced supply or user preference has led to a decrease in these attendances to the ED.

There remains a small number of patients presenting with medical issues relating to other opiate use, particularly the injection of oral opiate preparations. Other users present ‘drug seeking’ for a variety of prescription medications including opiates and benzodiazepines.

2. How serious is the issue of crystal methamphetamine (‘ice’) use amongst those patients attending the Emergency Department hospital? How does this compare to the prevalence and harms caused by other drugs including alcohol that bring patients to the hospital? Is the harm caused by methamphetamines as has been stated in some sections of the media, at a ‘crisis’ point or is this an exaggeration?

Whilst the numbers of patients presenting with problems directly related to methamphetamines is modest, their impact upon resource use, staff time, clinical risk and safety is enormous.

Physical strength can increase following methamphetamine use and when combined with increased confidence or self-belief and agitation or paranoia this can lead to an increase physical aggression or violence towards family, friends, bystanders or Emergency Services workers. It is not uncommon for methamphetamine users who present to the Emergency Department to have engaged in acts of physical violence or become violent towards staff in the Emergency Department.

If the potential for violence, prolonged restraint, constant supervision, security and the involvement of multiple team members from the hospital and community is considered over the prolonged time they are in the ED, each occasion tends to consume resources far outweighing any other presentation, including critically ill or injured patients. These patients tend to remain in the ED for prolonged periods (sometimes in excess of 24 hours) and they are often not suitable for admission to general wards, or other specialist areas.
They divert resources from the ED and from the hospital in general and delay the care of other patients. They cause distress to other patients and visitors and are a source of risk to their families, other patients and visitors as well as staff.

Whilst lower levels of alcohol may lead to disinhibition and aggressive behaviour/violence in some patients, leading to some of the same management and safety issues, the physical effects of higher levels of alcohol tend to be depressant and lead to inco-ordination and reduced functioning. This often results in trauma.

Use of other drugs such as heroin or opiates does not generally lead to severe behavioural problems, although patients seeking these drugs can be quite demanding.

Prescription drugs such as benzodiazepines generally have a sedating effect whilst other recreational drugs such as ecstasy or GHB may cause patients to present with dysphoric symptoms or in the extreme, unconsciousness and respiratory arrest.

3. **Is poly drug use a problem in the context of methamphetamine use amongst presenting patients? If so, what other drugs including alcohol are being taken in association with methamphetamines? What are the consequences of this and what challenges does this present for staff, the treatment of patients and their case management?**

Yes. In addition to methamphetamines, these patients are frequently taking other drugs, in particular drugs to ‘bring them down’ from the effects of methamphetamine use. These drugs include significant amounts of marijuana and benzodiazepines, particularly diazepam (valium) and alprazolam (Xanax), far in excess of the amounts other ‘recreational’ users might consume.

Patients may present drug seeking for these prescription drugs and we are aware that users find GP’s who may prescribe benzodiazepines for the treatment of ‘anxiety’ and then use social media and other networks to inform other users of the GP and their apparent willingness to prescribe alprazolam and diazepam in particular.

In the custodial setting patients requesting drugs such as alprazolam and valium are known to exert significant pressure on medical practitioners even in close proximity to police, and it is possible that patients seeking these drugs from medical practitioners exert significant pressure upon isolated GP’s to provide these medications.

4. **Are there particular groups that present for treatment that are at (high) risk from problematic methamphetamine use?**

Heavy users and long-term users appear to present more frequently.

5. **How difficult is it to collect data on emergency department and hospital admittances related to methamphetamine use?**

Whilst medical records may record the specific drug used by a patient, these are not readily searchable to extract data. All ED attendances record a diagnosis in the ‘VEMD’ (Victorian Emergency Minimum Dataset). Currently there is no specific data item for amphetamines or methamphetamine, the closest descriptor being ‘stimulant’. There is a lack of consistency regarding the terminology used. In Geelong the term “speed” was used for amphetamine whilst “ice” indicated methamphetamine however with recent increased availability of methamphetamine both terms are used as colloquial expressions for methamphetamine. In recent months the term “shard” has become increasingly popular.

The coding of this would most likely only occur if ‘stimulant’ use is the primary problem as opposed to being the cause of, or related to the primary problem. Presentations to the Emergency Department following use of methamphetamine can result due to the physical or psychological effects of the drug. Due to the varied nature of the presentations it is difficult to collect accurate data on methamphetamine related Emergency Department presentations. Information related to the presentation often related to the symptoms experience rather than the underlying cause. For example a patient experiencing anxiety may be coded as anxiety or palpitations, when in fact the primary problem is due to methamphetamine use.
6. **What medical conditions are people who are affected by methamphetamines presenting to the hospital with?**

Physical symptoms that have been observed at Geelong Hospital Emergency Department include complaints such as palpitations (a sensation of a racing heart), tachycardia (fast heart beat), chest pain, shortness of breath, hyperventilation, fevers, abdominal pain, movement disorders such as teeth grinding and complications of pregnancy.

Psychological effects can range from anxiety and hypervigilance, increased confidence, elevated mood, agitation, paranoia and psychosis.

Behavioural disturbance is frequently the reason for police being called to attend these patients in the community and they are subsequently brought to ED as a ‘Section 10’ patient.

7. **What particular problems do medical and allied staff working at Barwon Health Geelong Hospital especially the emergency room staff face when dealing with patients affected by methamphetamines and their friends or families?**

- Injuries related to violence and aggression. Some patients have been found with weapons.
- Damage to hospital property related to violence and aggression.
- Risk of blood contact and infectious disease (particularly Hepatitis C)
- Personal threats (including death, rape, assault) to family and property.
- Professional risk if adverse outcome for patient.

8. **How is methamphetamine induced aggression and violence dealt with in the hospital?**

- Permanent security presence in ED and hospital.
- Code ‘grey’ or code ‘black’. Multiple person response from within hospital.
- Physical restraint to prevent injury to patient and staff and others.
- Pharmacological restraint to prevent injury to patient and staff and others. Barwon Health has a guideline for this specifically used in ‘ice’ affected patients due to the need for high potency medications.
- Occasionally police involvement if already present in ED or severe threat.

The system is multi-disciplinary and is resource intensive, often repeatedly or for prolonged periods of time.

Attempts are always made at early de-escalation, but due to the unpredictable nature of the behaviour of these patients, our response is frequently escalated
BACKGROUND INFORMATION – Mental Health, Drug and Alcohol Services

Barwon Health provides an integrated model of specialist mental health and drugs and alcohol services (MHDAS). All adult and youth mental health teams deliver integrated mental health care, including for substance use problems.

Barwon Health Drugs and Alcohol Services

Barwon Health’s Drugs and Alcohol Services (DAS) provides integrated clinical treatment and other interventions for people aged 26 years and above who have moderate to severe substance use disorders and co-morbid mild to moderate mental health disorders (e.g., depression, anxiety, trauma). Private community GPs are also located on site at DAS and provide opioid replacement therapies (e.g., methadone, suboxone, buprenorphine) to clients with opioid dependence.

DAS has:

- An Addiction Psychiatrist who provides assessment and treatment advice to the team and Pharmacotherapy General Practitioners (GPs) and consultation and liaison with mental health services and the general hospital. A Psychiatric Registrar will also commence with the team from February 2014.
- Nurses who work closely with GPs in the community and provide targeted intervention and treatment, and advice and support around alcohol and other drugs (AOD) withdrawal. This team also includes an acquired brain injury (ABI)/AOD clinical consultant.
- Allied health clinicians (psychologists, social workers and community development workers) who provide targeted psychological interventions and psychosocial support services (including housing). This team also provides treatment services for forensic clients.
- An injecting drug users team who provide assessment for people wishing to enter the pharmacotherapy program, outreach case management and support to complex needs consumers, a Needle and Syringe Program (mobile and on site), and a GP Mental Health Nurse (who receives referrals from the pharmacotherapy GPs via mental health care plans).

Barwon Health Jigsaw

Jigsaw provides specialist community mental health services to young people aged 12 to 25 years. The service includes specialist early intervention for young people with or at risk of developing a psychotic disorder and treatment services for young people with drug and alcohol and/or high prevalence disorders.

Prevalence of methamphetamines presentations to MHDAS 2012 - 2013

As shown in Graph 1, of the 5388 presentations1 to MHDAS from 1 January to 31 December 2012, methamphetamines were cited as the primary reason for referral in 35 cases (0.65%). Methamphetamines were cited in the history of the presenting problem in 201 cases (3.73%).

Of the 4173 presentations to MHDAS in 2013 to date (i.e., 1 January to 22 October 2013), methamphetamines were cited as the primary reason for referral in 42 cases (1.00%). Methamphetamines were cited in the history of the presenting problem in 265 cases (6.35%).

N = 5388 does not represent 5388 individual people, but rather the number of new or re-presentations. Some people will present to MHDAS more than once or numerous times during the course of a year.
Compared with 2012, the figures for 2013 thus far represent increases of 65% where methamphetamines use is the primary reason for presentation, and 59% where methamphetamines use is a factor in the history of the presenting problem.

Across 2012 – 2013, when methamphetamines use was cited as the primary reason for presentation, in nearly half of cases (46.75%) people first presented at the Emergency Department/Triage service at Geelong Hospital. (It should be noted that these figures will not represent the total number of presentations to the Emergency Department/Geelong Hospital related to methamphetamines use as not all people are referred on to MHDAS).

Graph 2 shows the primary drug types used by people accessing community based services at DAS and Jigsaw in the financial years 2011-12 and 2012-13.

The data shows that for people seeking AOD treatment at DAS and Jigsaw from June 2011 to July 2013 there has been a slight decrease in the use of alcohol, cannabis and opiates as the primary drug of choice and a slight increase in amphetamines as the primary drug of choice. (Further, poly-substance abuse is typical of people seeking treatment).

Anecdotally speaking, the DAS Addiction Psychiatrist and Clinical Coordinator agree that problematic methamphetamine use (either alone or in conjunction with other substances) is increasingly featuring in new referrals to the service, particularly in the past 6 months. People seeking assistance for methamphetamines dependence at DAS tend to be male, in the age range of 30 to 40 years, typically employed (e.g., in trades), and report that their initially controlled, social use of “ice” has increased to be problematic or dependent, including quickly progressing to injecting as the route of administration. They are also using other substances (primarily cannabis and alcohol), their poly-substance abuse has resulted in psycho-social problems such as relationship difficulties and social isolation, and they also report co-morbid depression and anxiety problems.

ANSWERS TO QUESTIONS FOR THE INQUIRY – Mental Health, Drug and Alcohol Services

8. How is methamphetamine induced aggression and violence dealt with in the hospital?

The Swanston Centre Acute Psychiatric Admissions Unit (SCA) at The Geelong Hospital is a 32 bed in-patient unit that offers short term treatment for people from the Barwon region with a severe episode of mental illness. The SCA Nurse Unit Manager reports that the number of people being admitted to SCA who are acutely affected by methamphetamines has “increased markedly” over the past few years. Presentations also seem to “spike” for a few weeks at a time here and there, presumably reflecting the availability of ice in the community at that time.

SCA clinicians are skilled at “talking down” people presenting in distress or experiencing non-drug induced psychosis. However, there is less ability for clinicians to calm a person who is acutely intoxicated by ice. In addition to paranoia and psychosis, aggression and propensity for violence are not uncommon and require responses that can ensure the safety of both consumers and staff. Rapid Sedation and Seclusion procedures and guidelines will then be enacted (if sedation is not successful seclusion may need to follow). Clinicians are MOVIAT trained and also comply with Occupational Violence and Aggression Procedures.
At times it may be difficult to ascertain whether a person is ice affected, as people may deny or minimise their level or use at the time of admission. There is also often a mixed picture of poly-substance abuse and mental health problems in play. Anecdotally, for acute ice intoxication, medications regimes may need to be higher and seclusion periods longer for stabilisation to occur. If this is required it can provide a retrospective indicator that a person was ice affected at admission.

One of the aims of an inpatient admission is to provide a safe environment for consumers (and staff) and allow time for the acute effects of ice to subside. This may take from between one day to one week depending on other co-morbid factors. The admission can also provide an opportunity for discussing linkages and referral to other services for treatment of substance use disorders.

9. What links are there between methamphetamine use and co-morbid mental illness? What challenges does this then pose for treatment and rehabilitation of those using methamphetamines?

Co-morbidity between methamphetamines abuse/dependence and mental health disorders (depression, anxiety and psychosis) is in the vicinity of 50-75%. Despite the research literature establishing the link between methamphetamine use and mental health problems, less is known about the order of onset and thus the implications of this for treatment. A comprehensive and inclusive integrated assessment is therefore required to indicate whether mental health problems pre-date or are a consequence/exacerbated by ice abuse.

However, people with problematic ice use often first present to services (e.g., Emergency Departments) when acutely intoxicated, experiencing behavioral problems, mental health symptoms such as psychosis, medical problems such as cardiac symptoms, and/or significantly distressed. In the event of acute intoxication, medical treatment teams may need to admit people suffering medical complications but it is difficult to manage patients with behavioural issues in a public ward and thus an admission to the psychiatric ward may result. None the less, the acute phases of “crash” and withdrawal require management and treatment before a clear assessment of co-morbid mental health and psycho-social needs can occur. This in turn depends on the person willingly seeking or engaging in further assessment once the crash/withdrawal/crisis phase is over. Cognitive deficits or acquired brain injuries may also be a co-morbid feature in this population, potentially increasing difficulty for accessing services.

It is the generally held view that barriers to accessing or remaining in treatment for people experiencing methamphetamines abuse/dependence include:

- Not seeing their drug use as a problem (until perhaps a crisis occurs)
- Not typically engaging in help seeking behaviours
- Being ashamed of mental health problems
- Not believing that treatment will help
- Difficulty accessing services in business hours due to work/family commitments
- Services not offering specialised interventions for ice use.

Thus, the challenge for services is to engage people who may not yet be ready or willing for treatment, and also to offer treatment services that are specifically targeted, relevant and effective for methamphetamines use disorders.

There are potential implications in terms of the cumulative impact on staff (e.g., “burnout”), particularly those working in inpatient settings, of increasingly having to manage the behavioural problems commonly exhibited by people who are acutely methamphetamine intoxicated.

10. Does Barwon Health work in partnership with other organisations in Geelong to address the harms and challenges caused by methamphetamine use?

Yes, DAS works in conjunction with other parts of Barwon Health and external services to provide holistic treatment and care for people seeking help for problems with methamphetamine use. These services include:

- The Geelong Hospital Emergency Department (including a MHDAS clinical liaison position providing capacity building in the ED and Psychiatric Triage service for dealing with alcohol and drug related hospital admissions and emergency department presentations)
• Community and inpatient mental health services
• GPs
• Residential and medical withdrawal services and residential rehabilitation services
• Other primary care services such as psychology services
• Child and family services, including Child Protection
• Aboriginal services
• Housing and welfare services

11. What strategies should be put in place to best address the harms caused by methamphetamine use in regional communities such as Geelong? What could the Committee recommend in this respect?

Anecdotally, the power form of methamphetamine (“speed”) is now days rarely, if ever, seen. The more potent crystal form (“ice”) is the methamphetamine type primarily available in the community, perhaps in part because it can be relatively inexpensive and easy to manufacture (including people who access information on the internet and are able to produce their own for personal use). Thus, any strategies and treatment approaches need to take into account the particular characteristics of the effects and consequences of this specific form of drug.

The route of administration for methamphetamine use is generally either by smoking or injecting. Local anecdotal evidence indicates there can be a quick progression from smoking to injecting for people who have otherwise previously not injected drugs. Additionally, the vast majority of methamphetamine users will also likely never enter formal treatment. Thus, Needle and Syringe Programs (NSPs) could be developed to provide a more specific focus on methamphetamine specific harm reduction advice and education (similarly to how NSPS have developed to focus on steroids use in more recent years and the need has arisen in the community), thus reducing risks of blood borne viruses and injecting related injury and disease in this population. Further, methamphetamine specific education and advice via contact with NSPs could lead to increased confidence in seeking other linkages and/or referral to treatment. More targeted workforce development in this area could be of benefit.

From a clinical perspective, generic AOD treatment services need to develop great confidence and expertise in providing specialist, evidence based treatment for methamphetamine use disorders. Longer residential/hospital withdrawal admissions to manage the more protracted acute “crash” and withdrawal phases associated with ice withdrawal is indicated. This has implications in terms of the need for funding for residential withdrawal services that facilitates longer treatment episodes. There is also evidence that brief interventions and cognitive behavioural therapy (CBT) tailored specifically for methamphetamine use is beneficial. The development of up to date strategies and best practice guidelines would be welcome. Current Victorian strategies and treatment guidelines are useful, however are not necessarily specific to “ice” (but rather all amphetamine type substances including “speed” and cocaine) and do not necessarily reflect the changing population of “ice” users (e.g., increasingly being seen in adults in a range of circumstances, not just social and recreational; increasingly injected).

At a broader level, education and capacity building in the primary care sector, particularly for GPs, for recognising and providing advice and education around methamphetamine use would be valuable, particularly as many people who use ice will never seek treatment from specialist AOD services. On-going public education and health promotion campaigns similar to those for cigarettes and alcohol may also be of benefit.

12. Could you outline the treatment/programme options provided by Barwon Health for people with chronic or problematic methamphetamine use? How effective have these been?

DAS conducts an integrated AOD and mental health intake screening at the point of entry to the service, including ascertaining the consumer’s treatment wishes and goals. Comprehensive advice information, referral and linkages are provided at the point of intake. A multi-disciplinary team comprised of the Addiction Psychiatrist, Clinical Coordinator or Senior Clinicians, and other clinicians review all new presentations and make recommendations about appropriate treatment options and pathways. This is fed back to the consumer for their consideration. DAS also works closely with a person’s community GP and family members/support people in providing care.
If residential or inpatient medical withdrawal is indicated DAS will assist with referral to such services and provide pre and post withdrawal support. DAS also provides home based withdrawal treatment (in conjunction with GPs and the consumer’s support networks), 1:1 psychological interventions such as motivational interviewing, CBT and relapse prevention (using existing treatment guidelines), psycho-educational and therapeutic groups programs, and referral and linkages to other primary care and psycho-social services as needed.

It is difficult to ascertain how effective treatment provided by DAS has been to date for crystal methamphetamine users. Data specifically relating to outcomes and re-presentations for this specific population has not yet been collated. However, it appears that a “one size fits all” approach to community based clinical treatment is not sufficient and a greater degree of specificity with regarding to treatment for different types of substances (and poly-substance use) would be beneficial. The DAS Addiction Psychiatrist and Clinical Coordinator are currently in discussion about developing more specialised and targeted interventions (including perhaps a specialist sub-team) that will be specific to adult crystal methamphetamine users.

13. Can treatment interventions aimed at methamphetamine use be better tailored to specific groups such as young people, Indigenous people or other potentially high risk groups?

The specific needs of each population are likely to need specific approaches. Anecdotally, local Aboriginal people sometimes prefer to access mainstream public health services (rather than Aboriginal services) citing that that their treatment and care will be more confidential from their own community.

14. What strategies should be put in place to best address the issue of amphetamine abuse in Geelong, particularly amongst young people, Indigenous people and people from rural communities? Specifically what interventions could be put in place to address methamphetamine related violence in the hospital sector?

As per Question 11.

Unable to answer specifically in relation to violence in the hospital, however hospital settings can provide an opportunity for effective brief interventions and linkages/ referral for other treatment and support.