Drug Sub 42

Submission 42

Government of **Western Australia**
Department of **Health**
South Metropolitan Area Health Service

ROYAL PERTH HOSPITAL
ABN 13 993 250 709

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29th September, 2009

Dr J Woollard
Education and Health Standing Committee
Legislative Assembly
Parliament House
PERTH WA 6000

Dear Dr Woollard

Re: Inquiry into the Adequacy and Appropriateness of Prevention and Treatment Services for Alcohol and Illicit Drug Problems in WA

Thank you for your request for the RPH Clinical Staff Association (CSA) to make a submission to the Education and Health Standing Committee on the above subject. As you are aware the Emergency Department (ED) at RPH sees a significant number of alcohol and drug related issues which require input from a range of clinicians including Drug and Alcohol Nurses, Clinical Toxicologists, ED Medical and Nursing Staff, and Mental Health Clinicians.

The Emergency Department at Royal Perth Hospital is one of the busiest in Australasia, with an annual census of 61000 and an admission rate of 42%. It is estimated that one third of all attendances are alcohol related. (This may be up to two thirds late on Friday and Saturday nights, likely to be related to our proximity to Northbridge). In addition, survey data has revealed that 62% of our 18-25 year olds have used illicit drugs (average age of first use was 16 yrs; one in eight of these have injected illicit drugs). (See attached poster, being presented at the national conference of the Australasian College for Emergency Medicine in November, Melbourne). It is then clear that patients presenting with alcohol and drug related complaints are a dominant issue for us.

In addition to the large numbers of drug and alcohol presentations we provide in-patient care to the sickest cohort of these cases. This involves high acuity admissions to areas such as ICU under the Clinical Toxicology Service. In conjunction with the Emergency Department the clinical toxicology service provides initial in-patient alcohol detoxification during the most acute phase of this potentially life threatening illness where hospital admission is required. From this point there are attempts to integrate the care of these cases into less acute but more specialized rehabilitation centres (such as Next Step).

In our view the Drug and Alcohol Service at RPH is under resourced. Currently we have 2.0 FTE Drug and Alcohol Nurse positions providing a 9-5 weekday service. In contrast SCGH has 2.5 FTE and runs 6 days per week. Please find in Appendix 1 a summary of the Drug and

Alcohol Services provided at RPH which is inadequate to meet the growing demand of this patient group both at the Wellington Street and Shenton Park Campuses. Furthermore our clinical toxicology service is a consultant only service at RPH with no registrar support. This is in contrast to the services of Sir Charles Gairdner and Fremantle hospitals.

We would like to make special comment on the recurrent problems with integrating patients into ongoing medical detoxification and rehabilitation centers. The Next Step service is a vital service from the perspective of the hospital system as it has the potential to provide essential post hospital care and rehabilitation in a medically supervised and comprehensive service.

There are ongoing issues with this service relating to difficulty in referring cases, lack of transparency with referral and refusal criteria, inconsistent practice relating to these issues, no feedback, and more recently lack of face to face patient assessment (now done over the phone). This has lead to this service being difficult to access and it has become a less reliable disposition route for cases following acute hospital care.

On behalf of the RPH CSA, we make the following **Recommendations:**

1. **Recognition that an acute hospital presentation is a strategic opportunity in terms of the potential for intervention.**

There needs to be a multidisciplinary approach to this intervention including improved access to community detoxification and rehabilitation centres.

2. **Improved resourcing for the care of Drug and Alcohol presentations to RPH**

    a. Additional 1.0 FTE in Drug and Alcohol nurse staffing at RPH, aiming for a 7 day a week service. We currently have 2.0 FTE in the hospital.

    b. Funding for a Clinical Toxicology Registrar.

        The Toxicology Service at RPH currently is a Consultant only service. It is the only Toxicology service in the state that does not have a registrar. The registrar would not only provide inpatient and ED care of patients, but also be a part of the advocacy group in prevention. They would provide a resource in terms of education to junior medical staff and more broadly to community groups and schools with the aim of reducing alcohol and drug related attendances to hospitals.

3. **Recognition of the vital role of a residential post hospital medical detoxification facility**. With respect to Next Step we suggest:

    a. Improved transparency regarding admission criteria for Next Step Services
    b. Improved access for outpatient assessment
    c. Improved integration and communication with hospital services.

4. **Improved resourcing for Drug and Alcohol research.**

    There is a lack of evidence for the effectiveness of acute Emergency Department intervention strategies for drug and alcohol rehabilitation. Research in this area needs to be promoted and funded. Recommend 0.5 FTE Drug and Alcohol research nursing position be created at RPH.

The RPH CSA would like to thank you for the opportunity to make a submission to the Education and Health Standing Committee. We would be happy to meet with the Committee to discuss these matters further.

Yours Sincerely

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ROYAL PERTH HOSPITAL EMERGENCY DEPARTMENT SCREENING PROJECT FOR CHLAMYDIA TRACHOMATIS:
a comparison of nurse initiated vs patient initiated screening

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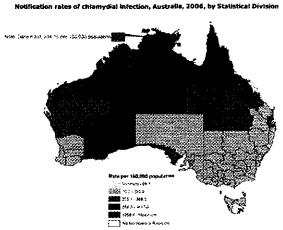
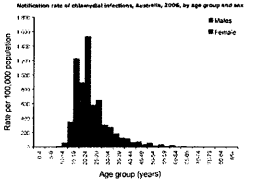
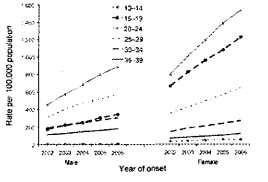
Royal Perth Hospital
Department of Health
South Metropolitan Area Health Service

Background

- Chlamydia, a sexually transmitted infection, is the most frequently reported notifiable disease in Australia
  - N=58513 (2008)
- Chlamydia screening programs often miss hard to reach groups
  - Young men
  - Indigenous
  - Homeless
- Hard to reach groups may be difficult to contact







Aim

We undertook a Chlamydia screening program to assess two different recruitment strategies.

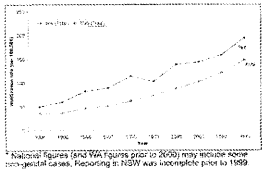
Methods

Urinary screening for Chlamydia was offered to people aged 18-25 years who attended the RPH Emergency Department (ED), including visitors, with no genital symptoms. Recruitment via a **nurse initiated** strategy was compared to a **patient initiated** strategy. A resource package (including brochure and DVD) was designed to facilitate recruitment and screening. Options for notifying patients of their results were evaluated. A detailed patient survey was completed. Approved by RPH ethics committee.

- Patients given a choice in mode of contact
- Contact tracing was undertaken
- Recruitment was for 34 wks
  - July 2007 - March 2008
- Thurs- Mon
  - 1300 - 2200 hrs
- 1 day in 5 was randomly allocated to patient initiated recruitment, using a DVD and brochure (see below)
- Detailed survey data collected

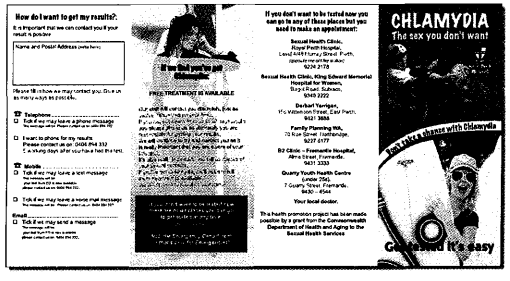
Exclusion criteria

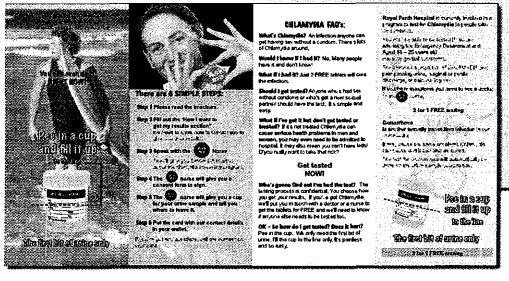
- Symptoms consistent with Chlamydia
- Critically ill
- Altered mental state



* National figures (and WA figures prior to 2000) may include some non-genital cases. Reporting in NSW was incomplete prior to 1989

References. http://www.health.gov.au/internet/main/publishing.nsf/Content/cda-cdi3202a9.htm

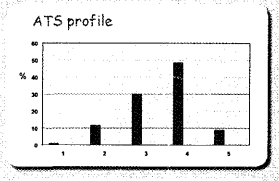


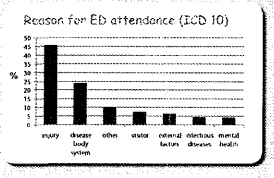


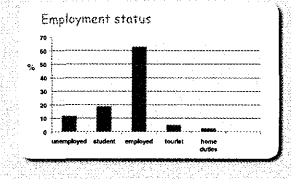
Results

- 1987 attendances within age range
- 1584 approached
- 882 (56%) agreed to participate
  - Including 61 visitors
- 59 excluded
  - Did not provide urine
  - Not within age group
  - Previous recruitment
- Final n = 823 (male 532, 65%)

Patient Profile

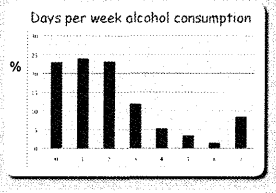


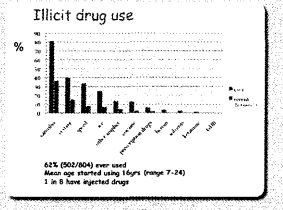




These were a hard to screen/contact population:

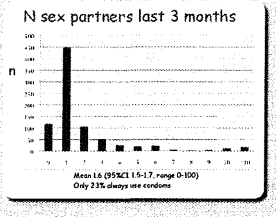
- 10% no permanent address
- 35% had a residential move in last 3 months
- 49% had not visited a doctor in last 6 months
- 38% do not have a regular doctor





Drug use and Chlamydia

- 'Ice' users less likely to have Chlamydia (OR 0.39)
- Cocaine users more likely to have Chlamydia (OR 2.7)
- Ecstasy use unrelated to Chlamydia.



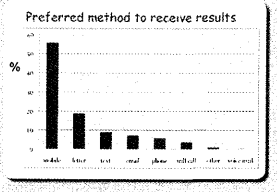
- Sexual preferences
  - 92.8% heterosexual
  - 3.7% lesbian
  - 2.4% homosexual
  - 1.1% bisexual

Chlamydia detection

- N=45 (5.4%)
  - 42 (93%) were notified of their infection
- Male 6.2%
- Female 4.1%
- Aboriginal 5.2%
- No age relationship
  - Other studies suggest rate higher in younger

Yield of nurse initiated vs patient initiated ... Yield 7.9 per screening occasions per ED attendance

	Nurse initiated n=330		Patient initiated n=13		Total	
	mean	95%CI	mean	95%CI	mean	95%CI
ED attendance	11.6	11.0-12.3	11.3	9.2-13.8	11.6	11.0-12.2
Chlamydia study assessments	5	4.4-5.6	3.2	0.2-44.1	4.9	4.4-5.5
Positive contacts	1.13	1.03-1.24	0		1.12	1.02-1.16
Negative contacts	4.7	4.2-5.3			4.7	4.2-5.3
Yield	0.45	0.40-0.50	0.08	-0.02-0.18	0.43	0.38-0.47



Chlamydia & having a GP

- Less likely to have Chlamydia if you have a regular doctor (p=0.02)
- Less likely to have Chlamydia if they have a stronger relationship with a doctor (p=0.009)

Conclusions

- 5.4% of our 18-25 year old cohort had Chlamydia
- Patients need human contact to initiate screening
  - This provides educational opportunities
  - We recommend a nurse led approach for screening
  - This requires specific personnel in the ED
- Almost two thirds have ever used illicit drugs
- Patients prefer modern means to obtain results
  - Mobile phone most preferred
- This is a mobile population with limited contact with health services
- On average, one asymptomatic person aged 18-25 yrs with Chlamydia attends our ED per day

Acknowledgements: S Aranzig, K Broadbent, A West, M Phillips, I Kay & Dept of Health and Aging, Australian Government.