Answers to questions on notice: The Royal Australasian College of Physicians (RACP)

Question 3

Hansard page reference: p. 28.

Senator KAKOSCHKE-MOORE: Just finally, Professor Reynolds, you mentioned little while ago that money is being spent on low-value and harmful medical interventions. Can you provide us with some examples of what you mean by a low-value and harmful medical intervention?

Senator KAKOSCHKE-MOORE: Just for clarification, was that comment more to do with treatment for a condition rather than treatment for an addiction? Are you not concerned that there are some inappropriate treatments taking place for an addiction?

Senator KAKOSCHKE-MOORE: Perhaps, on notice, you could provide some more information on those interventions?

Answer

Background on low-value care

Low-value interventions are clinical practices that may be overused, inappropriate or of limited effectiveness in a given clinical context. Growing attention is being paid by the medical profession in research to evidence of benefit, risk and harm arising from clinical interventions. With most clinical practices there is some level of cost or potential harm. For example, every x-ray gives a low-dose of radiation; if a patient is having unnecessary x-rays, then they are being exposed to these harms without gaining any benefit. The weighing of benefit versus harm is central to the advice and discussions that clinicians have with their patients in determining treatment.

Low-value care can arise due to changes in evidence not being widely known; systems and processes designed around or incorporating the intervention (e.g. a test might be included in a check list of other tests for a condition); patient demand (e.g. antibiotic prescription for a cold); where there is a culture of wanting to do everything possible (even when this might not be beneficial, such as during end-of-life care); and where the system inadvertently has perverse incentives (e.g. where one type of treatment is incentivised over another).

Potential low-value care in drug & alcohol services

Alcohol and other drug (AOD) treatment services are delivered in a variety of settings – public and private, clinical and non-clinical – with a significant proportion of services contracted to the non-government sector. Instances of low-value care and systemic low-value practices may occur in any of these settings.

A significant concern relating to low-value care in the AOD sector is the lack of regulatory standards and oversight of treatment clinics and services delivered by providers in the private and non-government sectors. Robust frameworks and oversight of services is critical to ensuring good clinical governance, as are rigorous incident management reporting and evaluation systems, and ensuring an appropriately credentialed, well-trained and supported workforce.

These services also often operate without appropriate and specialised medical assessment, advice and intervention, which can lead to the use of ineffective and potentially unsafe clinical practices. This was highlighted in the Four Corners' September 2016 report Rehab Inc., which examined non-evidence based treatment and therapies in unregulated private drug and alcohol rehabilitation clinics. Such services may admit patients who are unwell and at risk from co-occurring medical and mental health co-morbidities, without staff with the necessary medical expertise to assess and identify such risks or manage them safely and effectively.

Perverse incentive funding models in the private health system are also of concern. For example, private health insurance policies which provide for up to 21 days of inpatient drug or alcohol treatment can encourage inpatient admission where it is not warranted, or a length of stay that may not be clinically indicated.

Contracting services in a local area requires consultation with, and input from, clinical experts to inform the services being contracted to ensure they are what is required and they are effectively designed and established. Local data about waiting lists is also vital. For example, there have been instances where the focus has been on increasing counselling services as this is what the NGO was able to provide, whereas the real need in the area was for other forms of evidence informed treatment including medically supervised withdrawal services and medically assisted treatment of opioid dependence. Similar issues have arisen in resource allocation towards residential rehabilitation (where the evidence base is yet to be built) – at the expense of evidence based treatment services and funding for population coverage of these services.

Specific examples of clinical practices relating to addiction that are considered to be low-value (i.e. ineffective or potentially harmful) by RACP members, based on their clinical opinions, professional expertise and current research include:

- Withdrawal (or "detoxification") as a stand-alone treatment without a structured dependence treatment plan.
- Naltrexone implants for alcohol, opioid and methamphetamine dependence (these require more research on both safety and efficacy and are currently recommended for use only in experimental conditions - see www.nhmrc.gov.au/your-health/naltrexone-implants).

Addressing low-value care in Addiction Medicine

The RACP's Evolve initiative is working to identify and address low-value interventions in the field of Addiction Medicine. Preliminary work includes the following examples:

- Inpatient detoxification should not be undertaken without a post discharge follow up plan –recognising otherwise generally poor clinical outcomes.
- Opioid detoxification should not be offered without commencement of opioid substitution therapy or an alternative appropriate and arranged treatment pathway (such as admission to a therapeutic community), recognising the significant risks of opioid overdose and death in the event of relapse to opioid use.
- The prescription of pharmaceutical products to treat alcohol use disorders needs to occur as part of a package that includes the provision of psychosocial support.
- Benzodiazepines should not be prescribed other than in the clinical management of specifically identified acute medical conditions or medical procedures.
- Current evidence does not support opioid therapy for long term management of chronic non-cancer pain.
- Administration of thiamine via parenteral route and in adequate doses should be used in preference to oral thiamine as prophylaxis for Wernicke Encephalopathy during alcohol withdrawal management.

Question 4

Hansard page reference: p. 28.

Senator SIEWERT: Professor Reynolds, you referred to other reports besides the one that we were talking about with Professor Ritter.

Senator SIEWERT: Are you able to take on notice providing further information on we could find those reports?

Answer

Please note below the reports that we are aware of relating to this question:

1. Drug and Alcohol Clinical Care Packages (DACCP) / Drug and Alcohol Services Planning (DASP) – Alison Ritter, 2013.
   - Submitted to the IGCD for consideration in April 2013, approved in July 2013.
   - Approved by the Mental Health, Drug and Alcohol Principal Committee in August 2013.
   - Reviewed by the Australian Health Ministers' Advisory Council (AHMAC) in September 2013.

2. Development of a Quality Framework for Australian Government Funded Drug and Alcohol Treatment Services – Turning Point, July 2014.

3. Opioid Substitution Treatment Pharmacotherapies: Analysis of current arrangements – Siggins Miller, January 2015.
   - The RACP understands this now sits with the Australian Health Ministers' Advisory Council for its consideration.