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Submission to The House of Representatives Standing Committee on Health, Aged Care and Disability Inquiry into the health impacts of alcohol and other drugs in Australia – October 2025

Introduction

The Australasian College for Emergency Medicine (ACEM; the College) welcomes the opportunity to provide a submission to the House Standing Committee on Health, Aged Care and Disability (the Committee) *Inquiry into the health impacts of alcohol and other drugs in Australia*.

ACEM is the peak body for emergency medicine in Australia and Aotearoa New Zealand and has a vital interest in ensuring the highest standards of emergency medical care for all patients. The College is responsible for the training and ongoing education of emergency physicians and the advancement of professional standards in emergency medicine in Australasia.

Alcohol and other drug (AOD) related harm is one of the biggest public health issues facing EDs and the wider healthcare systems in Australia. AOD-related harm places a significant and preventable burden on EDs in Australia. Alcohol contributes to the volume of ED presentations, particularly during peak periods, and is associated with higher resource demands, safety risks for staff and patients, and substantial costs to the health system.

ACEM has long advocated on the issue of AOD-related harm in Australia and Aotearoa New Zealand. The impact of alcohol and methamphetamine use in the community places extreme pressure on acute care settings, especially in the emergency departments (EDs) where our members work. ACEM's full catalogue of research and advocacy resources relating to AOD harm can be found on our website.

This submission has been informed by the advice of Fellows of the Australasian College of Emergency Medicine (FACEMs), whose experience and expertise provides crucial insights into the causes and effects of alcohol and other drug harms. It provides insights into AOD-related ED presentations and makes recommendations to address the issues raised.

1. A summary of the key issues

1.1 Alcohol and drug-related harm accounts for a significant number of avoidable emergency department presentations

The consequences of risky drinking and illicit drug use are regularly seen in the ED with people presenting with a broad spectrum of short- and long-term conditions, including injuries as a result of use, clinical intoxication requiring intensive care treatment, medical conditions from long-term risky alcohol consumption misuse (liver disease, withdrawal or dependence) or mental health conditions arising from AOD-related harm and comorbidity. Other people may also be subjected to harm as a result of someone's impairment resulting in serious injury, family and domestic violence, assaults or sexual abuse.

Limited access to acute treatment services, poor service integration and inadequate after-hours support contributes to people presenting to EDs. Since 2013, ACEM has conducted research across Australia and Aotearoa New Zealand to quantify the burden of AOD harm on EDs. A 2019 snapshot survey found that in Australia, between 11 and 13 per cent of ED presentations were due to methamphetamine or alcohol use.

AOD-related ED presentations increase significantly during peak public drinking hours, with data showing that alcohol is an underlying factor in one in seven ED cases on Friday and Saturday nights. These presentations are often more resource- and time-intensive to manage due to both medical and behavioural factors.[1] Patients presenting with alcohol issues can experience longer wait times and more serious patients take priority to situations where a patient may need to 'sober up' so treatment can commence.

Compared with other patient groups, alcohol-affected individuals are more likely to arrive at the ED via police or ambulance rather than private transport.[2] Alcohol-related presentations also impose a significant financial burden on the health system, with one study estimating the annual cost to a single ED at approximately $7.5 million.[3]

1.2 Alcohol and drug-related harm impacts emergency department safety

A recent meta-analysis found that around 36 in every 10,000 ED presentations involve violence, with alcohol and/or drugs implicated in nearly half of those cases. [4] While not all violence stems from intoxication, the correlation is clear as intoxication impairs cognition and increases the likelihood of violent or aggressive behaviour.[5] Violence in the ED is a key advocacy issue for ACEM.

ACEM's *Alcohol-Related Harm in Australasian Emergency Departments* highlighted the detrimental impact that alcohol has on ED staff, patients and the care provided: [6]

- 70.5 per cent of ED staff say they experienced alcohol-related verbal or physical abuse, threats, intimidation, or harassment from patients frequently (one or more times per week) or often (a few times a month).
- 68.2 per cent of staff believed that incidents of alcohol- related violence had become worse in their ED over the last five years.
- 87.3 per cent of staff reported that they had felt unsafe due to the presence of an alcohol-affected patient while working in the ED.
- 82.4 per cent of ED staff reporting that alcohol-affected patients had negative impacts on staff wellness.
- 93.1 per cent of ED staff reported that alcohol-affected patients had negative impacts on their workload.
- 86.1 per cent of ED staff reported that alcohol-affected patients had negative impacts on waiting times for other patients.
- 94.6 per cent of ED staff reported that alcohol-affected patients had negative impacts on other patients in the waiting room.

1.3 Emergency departments lack the infrastructure to safely manage patients with acute AOD and co-occurring conditions

There is substantial overlap between mental health and substance use disorders, yet there are significant inconsistencies in acute care services across Australia. Patients presenting with mental health disorders related to psychoactive substance use are often complex and resource-intensive to manage in the ED, with co-occurring symptoms that may be substance-induced and resolve over time. Psychiatric assessment cannot occur while patients are intoxicated and (potentially) have reduced decision-making capacity, often resulting in extended ED stays (frequently beyond eight hours) while they sober up.

[1] Australasian College for Emergency Medicine. 2018 alcohol and other drug harm snapshot survey. Melbourne: ACEM; 2019.
[2] Mclay S, MacDonald E, Fatovich D. Alcohol-related presentations to the Royal Perth Hospital emergency department: a prospective study. Emerg Med Australas 2017;29(5):531-538.
[3] Lingamanaicker K, Geelhoed E, Fatovich D. Direct cost of alcohol-related presentations to Royal Perth Hospital emergency department. Emerg Med Australasia, 2019;31(6):1045-1052.
[4] Nikathil S, Olaussen A, Gocentas R, Symons E, Mitra B. Workplace violence in the emergency department: A systematic review and meta-analysis. Emergency Medicine Australasia. 2017;29:265-75.
[5] Australasian College for Emergency Medicine. Violence in emergency departments. Melbourne: ACEM; 2024.
[6] ACEM, 2023. ACEM Report Impact of Alcohol harm on Emergency Care: https://acem.org.au/getmedia/ee86d4d9-6378-4f3a-99ed-b523495f730c/ACEM-Report-Impact-of-Alcohol-harm-on-Emergency-Care-FINAL

The management of these patients increases ED workload due to the often chaotic and volatile behaviours exhibited by intoxicated patients, which increase the safety risks to patients and staff, requiring risk management, security, and regular observation. ACEM's *Breaking Point: An Urgent Call to Action on Emergency Department Safety* report highlighted the link between AOD presentations and violence in EDs.[7] The report highlighted that ED design was a common contributing factor negatively affecting safety.

2. Recommendations

EDs are there to help the community at the time of greatest need and ED staff will continue to do their best to support every patient who seeks care. However, responding to AOD-related harm cannot rest with EDs or even the health system alone. A lasting reduction in harm requires a whole-of-system and whole-of-society approach that combines regulation, service reform, and effective public health communication.

ACEM strongly believes evidence-based harm-minimisation approaches should be adopted in programs and initiatives to improve prevention and reduction of AOD harms.[8] Harm minimisation initiatives should be implemented with a multipronged approach, 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 alcohol and drugs and reducing production and supply).

2.1 Strengthen the acute care response

EDs play a critical role in identifying and responding to alcohol-related harm.[9] They are often the first point of contact for people experiencing acute alcohol intoxication, withdrawal or associated mental and physical health crises. Embedding AOD specialists in EDs can enhance continuity of care by initiating treatment and supporting transitions to ongoing specialist management.

Emergency department resourcing, staffing and referral pathways

The effectiveness of ED-based responses relies on strong system-level support, including appropriate governance structures and service integration across health, mental health, and addiction services. Improved integration between inpatient and community-based treatment and support services and consistent referral pathways in metropolitan and RRR areas are essential.

Reforms are needed to improve the acute service response to patients with co-occurring AOD and mental health conditions, including the establishment of dual diagnosis units to manage these complex emergency presentations. Ideally, a dedicated Behavioural Assessment Unit (BAU) within the ED, supported by a multidisciplinary team spanning emergency medicine, psychiatry, addiction medicine and toxicology, would provide appropriate observation and care. Purpose-built BAUs offer low-stimulus environments that reduce behavioural escalation, enhance patient privacy and dignity, and minimise disruption to others, with evidence showing improved time to psychiatric assessment and reduced overall ED length of stay.[10]

Screening and surveillance

Screening, Brief Intervention and Referral to Treatment (SBIRT) models enable ED clinicians to assess substance abuse risk, provide targeted advice and refer patients to appropriate inpatient or community-based treatment and support services.[11] While implementation can be challenging due to workforce and ED workload pressures, evidence suggests even brief screening and interventions can reduce harmful drinking and deliver meaningful population-level benefits.[6,16] Ongoing evaluation of ED-based interventions, including SBIRT and other embedded specialist models, is essential to determine their feasibility, cost-effectiveness and long-term impact on patient outcomes and service demand.

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[7] Australasian College for Emergency Medicine. Breaking Point: An Urgent Call to Action on Emergency Department Safety. Melbourne: ACEM. 2024

[8] Australasian College for Emergency Medicine, 2020. Statement on Harm Minimisation Related to Drug Use. Melbourne. Available from: https://acem.org.au/getmedia/b59faddc-5185-465d-b598-b3a6ea3bc7c9/S769_Statement_HarmMinimisation

[9] World Health Organization. Alcohol and injuries: emergency department studies in an international perspective. Geneva (CH): World Health Organisation; 2012.

[10] Braitberg, G. et.al. Behavioural assessment unit improves outcomes for patients with complex psychosocial needs. Emergency Medicine Australasia. 2018 Jun;30(3):353-358.

[11] Rodgers C. Brief interventions for alcohol and other drug use. Aust Prescriber. 2018;41(4):117-121.

ACEM endorses the Emerging Drugs Network of Australia (EDNA), which captures data from patients presenting to EDs after using illicit or novel psychoactive substances. These presentations provide critical insights into substances causing acute harm in the community. Traditionally, intoxications are assessed based on self-report and symptoms, without objective identification of the agent. EDNA has improved clinical, forensic, and public health responses, and delivered Australia's first national ED data on novel psychoactive substances to the UNODC Global SMART Forensics program – strengthening Australia's role in global surveillance. EDNA aligns with the *National Drug Strategy 2017–2026* and is funded by the National Health and Medical Research Council (GNT2001107) until 2025–26.[12]

Recommendation 1: ACEM recommends that governments work with hospitals and health services to build a comprehensive web of referral pathways to better understand and respond to service demand and availability.

Recommendation 2: ACEM recommends that all EDs are equipped with purpose-built behavioural assessment rooms (or preferably units) to manage patients to manage patients experiencing acute behavioural disturbance or intoxication.

Recommendation 3: ACEM recommends embedding AOD specialists in EDs to provide screening, early intervention and coordinated follow up.

Recommendation 4: ACEM recommends ongoing funding to implement SBIRT programs as part of regular ED services.

Recommendation 5: ACEM recommends extending National Health and Medical Research Council funding for the Emerging Drugs Network of Australia (EDNA) beyond 2025–26 to sustain national surveillance, support harm reduction, and maintain Australia's contribution to global drug monitoring initiatives.

2.2 Increase public health messaging and awareness campaigns

Public health messaging plays a vital role in shaping community attitudes toward how alcohol is consumed and to improve safety. Both Australia and Aotearoa New Zealand have demonstrated that evidence-based public education campaigns, when delivered consistently alongside regulatory action, can influence societal attitudes and contribute to measurable reductions in alcohol-related harm. For example, both the Transport Accident Commission in Australia and the Public Health Agency (formerly Health Promotion Agency) in Aotearoa New Zealand have run successful campaigns specifically aimed at reducing drink driving.

Recommendation 6: ACEM recommends that governments make greater investments into public health messaging by developing and maintaining research-informed public health campaigns that target specific alcohol-related risks, and evaluate their effectiveness to inform continuous improvement.

2.3 Reduce alcohol supply and demand

Reducing population-level alcohol consumption is the most effective way to decrease alcohol-related harm.[13] Strategies addressing both supply and demand – through pricing, availability and advertising can significantly reduce community consumption, ED presentations and associated social impacts.

Recommendation 7: ACEM recommends implementing pricing and taxation measures such as a volumetric tax and minimum unit pricing.

Recommendation 8: ACEM recommends introducing measures that restrict the trading hours and the number of liquor outlets in a community.

Recommendation 9: ACEM recommends reforms to restrict hours of alcohol delivery to between 10am-10pm, with mandatory two-hour safety pauses between order and delivery.

[12] Fatovich, D. M., et al. 2024. "'You mean you're not doing it already?' A national sentinel toxico-surveillance system for detecting illicit, emerging and novel psychoactive drugs in presentations to emergency departments." Emerg Med Australasia

[13] Gilmore W, Gilmore I. Preventing alcohol-related harm: effective strategies and role of health professionals. Br J Hosp Med. 2025;86(8):1-12.

Recommendation 10: ACEM recommends strengthening advertising regulations in Australia and Aotearoa New Zealand.

2.4 Improve data collection and research

Accurate, consistent data on alcohol-related harm in EDs is essential to understanding the true scale and impact of AOD harm on health systems and communities. Currently, there is no standardised mechanism across Australia or Aotearoa New Zealand to capture alcohol and drug use and related harm in ED presentations, limiting the ability to monitor trends, allocate resources, and evaluate the effectiveness of policy reforms on alcohol harm.

Recommendation 11: ACEM recommends the introduction of AOD-related harm data elements to the National Minimum Dataset for National Non-admitted Patient Emergency Department Care (NNAPEDC) in Australia and the National Non-admitted Patient Collection in Aotearoa New Zealand.

3. Conclusion

The prevention and reduction of AOD-related health, social, and economic harms requires a multiprong approach. All governments need to commit to consistent and coordinated interventions to reduce alcohol and drug-related harm in the community.

The College urges the Committee to consider this submission in its final report to ensure future system reforms related to AOD improve how healthcare is delivered in EDs as a safe workplace.

Thank you again for the opportunity to provide this submission. If you require any further information about any of the above issues or if you have any questions about ACEM or our work, please do not hesitate to contact Hamish Bourne, Manager, Policy (hamish.bourne@acem.org.au).

Kind regards,

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