



STATEMENT ON ALCOHOL HARM

1. PURPOSE

This document outlines the Australasian College for Emergency Medicine's (ACEM) position on alcohol harm in Australia and New Zealand.

2. BACKGROUND

Alcohol harm is one of the biggest preventable public health issue facing our emergency departments (EDs). Alcohol has never been cheaper, more heavily promoted, nor more readily available.

The harmful use of alcohol is a major cause of preventable, non-communicable disease and injury worldwide. Alcohol contributes to 3.3 million deaths annually. [1] One in five Australians and New Zealanders drink at a level that increases their lifetime risk of alcohol-related disease or injury. [2] Almost half of Australians (44.7%) over the age of 18 reported consuming alcohol on a single occasion in the preceding year that put them at increased risk of acute injury. [3]

EDs deal with high volumes of alcohol-related presentations, and this has a detrimental effect on clinical staff, other patients and the functioning of the ED. This situation is increasingly unsustainable, given that emergency department presentations have increased by 3.4% on average each year in the last five years. [4] By comparison, Australia's population grew by 1.4% in the last year. [5]

There is no routine collection of alcohol-related presentation data to Australian EDs. Official datasets significantly underestimate the number of alcohol-related presentations.

Research conducted by ACEM has shown that:

- One in 12 (8.3%) presentations to Australasian EDs are alcohol-related. This translates to more than half a million alcohol-related presentations each year in Australasia. [6]
- At peak times one in eight presentations are alcohol-related. [7,8]
- At peak times all regions have EDs where one in three presentations are alcohol related. [7,8]
- 98% of ED clinical staff have experienced verbal aggression from an alcohol-affected patient. [9]
- 92% of ED clinical staff have experienced physical aggression. [9]
- The majority of clinical staff report that alcohol-affected patients impact on the care of other patients and the functioning of the ED in general. [10]
- The large majority of ED clinicians want to provide health promotion interventions, including for risky drinking, but lack time and resources. [11]
- An ultra-brief screening and intervention to reduce risky drinking delivered in an ED setting has a small individual effect size, but the potential for a larger population effect. [12]

ACEM's research makes a strong case for interventions to address this serious public health problem.

3. POLICY

ACEM advocates for the following measures to be implemented in emergency departments:

- The collection of alcohol-related ED presentation data.
- Funded Screening, Brief Intervention and Referral for Treatment Programs in EDs (SBIRT).
- The establishment of an independent regulatory body for alcohol advertising, sponsorship and promotions, and increased regulation to protect young audiences up to 25 years from alcohol advertising.

A. Compulsory collection of alcohol-related ED presentation data

ACEM recommends the introduction of alcohol harm data elements to the National Minimum Data Set for Non-admitted Patient Emergency Department Care (NAPEDC).

The collection of this data would provide:

- A clearer picture of the extent of alcohol-related presentations to hospital.
- An evidence base to inform and evaluate policy decisions.

B. Government-funded Screening, Brief Intervention and Referral for Treatment Programs in EDs (SBIRT)

The World Health Organisation (WHO) recommends the introduction of SBIRT in EDs to identify, reduce and prevent problematic use, abuse, and dependence on alcohol and other drugs. [13]

SBIRT involves:

- A healthcare professional assessing a patient for risky drinking and/or drug taking using a standardised screening tool;
- Conducting a structured conversation about risky alcohol and/or drug use;
- Providing feedback and advice; and
- Referring the patient to a brief therapy or additional treatment if appropriate.

C. The establishment of an independent regulatory body for alcohol advertising, sponsorship and promotions, and increased regulation to protect young audiences up to 25 years from alcohol advertising.

Alcohol is one of the most heavily promoted products in the world. Young people are regularly exposed to advertisements depicting alcohol consumption as a positive experience that is social, fun and inexpensive.

Alcohol advertising in Australia is currently self-regulated by the alcohol and advertising industries through the Alcohol Beverages Advertising Code (ABAC) Scheme. There are numerous deficiencies with this scheme, including:

- The scheme is voluntary.
- Advertisers who breach the code cannot be penalised.
 - Only the content of advertisements is covered by the Scheme – not their placement (i.e. time of day, where they appear during a program).

- Social media advertisements are not adequately regulated.
- The complaint process is difficult and confusing.

Alcohol advertising in New Zealand is also self-regulated through the Alcohol Regulatory and Licensing Authority. Deficiencies with this arrangement include:

- No enforceable penalties for advertisers who breach the code.
- A focus on the content and placement rather than the volume of exposure of young people to alcohol advertising and sponsorship.
- A time consuming complaints process.

Alcohol advertising promoting positive messages around alcohol consumption continue to be widely viewed by children, with alcohol advertising permitted during live broadcasts of sporting events on weekends and public holidays. In one study, 76% of Australian children aged 5 to 12 years were able to match at least one sport with its relevant sponsor. [14]

ACEM recommends the Australian and New Zealand Governments introduce legislation to phase out alcohol sponsorship of sports teams, as well as alcohol advertising during televised sport.

4. PROCEDURES AND ACTIONS

ACEM will, where appropriate, act in partnership with the relevant stakeholders in national and state governments, as well as the community to address alcohol harm.

EDs are well placed to identify alcohol related problems in presenting patients. Utilisation of validated, standardised screening tools is encouraged. Mechanisms should exist to refer at-risk patients to an appropriate community resource for culturally sensitive and appropriate education/intervention. If possible, referrals should be made directly while in the ED.

Where possible, EDs should contribute to the ongoing assessment of efficacy and quality improvement of SBIRT programmes. As appropriate and feasible, EDs should also contribute to state and national research into alcohol harm.

5. REFERENCES

1. World Health Organisation. Global status report on alcohol and health. 2014.
2. Australian Bureau of Statistics, (2013) Australian Health Survey: First Results (2011-12) Publication Number: 4264.0.55.001; Ministry of Health. (2013). Hazardous drinking in 2011/12: Findings from the New Zealand Health Survey. Wellington: Ministry of Health.
3. Australian Bureau of Statistics, (2013) Australian Health Survey: First Results (2011-12) Publication Number: 4264.0.55.001.
4. Australian Institute of Health and Welfare 2015. Emergency department care 2014–15: Australian hospital statistics. Health services series no. 65. Cat. no. HSE 168. Canberra: AIHW.
5. Bureau of Statistics: Retrieved 3/12/2015 from: <http://www.abs.gov.au/ausstats/abs@.nsf/mf/3101.0>.
6. Egerton-Warburton D, Gosbell A, Moore K, et al. Prospective, multi-centre, seven-day study of alcohol-related harm in Australasian emergency departments. 2016. Unpublished manuscript.
7. Egerton-Warburton D, Gosbell A, Wadsworth A et al. Survey of alcohol-related presentations to Australasian emergency departments. *Med J Aust* 2014; 201: 584-587.
8. Egerton-Warburton D, Gosbell A, Wadsworth A et al. Survey confirms alcohol-related presentations to Australasian emergency departments are under-reported [abstract]. 31st Annual Scientific Meeting of the Australasian College for Emergency Medicine, 7–11 December 2014, Melbourne, Australia. *Emerg Med Australas* 2015; 27 (Suppl 1): 6.
9. Egerton-Warburton D, Gosbell A, Wadsworth A et al. Perceptions of Australasian emergency department staff of the impact of alcohol-related presentations. *Med J Aust* 2016; 204 (4): 155.
10. Egerton Warburton D. Gosbell A. Moore K. Jelinek G., Attitudes, barriers and current practice regarding public health in Australasian Emergency Departments. *Emergency Medicine Australasia*. 2015 Sep 7. doi: 10.1111/1742-6723.12475.
11. McGinnes RA. Hutton, J. Egerton-Warburton, D. Weiland TJ, Fatovich D. Effectiveness of Ultra-Brief Interventions in the Emergency Department to Reduce Alcohol Consumption: a systematic review.
 - a. ACEM Annual Scientific Meeting: Brisbane, 25 November 2015.
12. World Health Organisation. 2009. Alcohol and injuries: emergency department studies in an international perspective.
13. Pettigrew S, Rosenberg M, Ferguson R, Houghton S, Wood L. Game on: do children absorb sports sponsorship messages? *Public Health Nutr*. 2013 Dec; 16(12):2197-204.

6. DOCUMENT REVIEW

Timeframe for review: Every five (5) years, or earlier if required.

6.1 Responsibilities

Document authorisation: Council for Advocacy, Policy and Partnership

Document implementation: Public Health Committee

Document maintenance: Policy and Research Department

6.2 Revision History

| Version | Date | of | Pages revised / Brief Explanation of Revision |
|---------|-----------|---------|---|
| | | Version | |
| V1 | July 2006 | | Approved by Council |
| V2 | Jul 2012 | | Approved by Council |
| V3 | Jul 2016 | | S43 combined with AHED Project Alcohol Policy Statement. 'Purpose' was edited to remove dot points. Additional content added to 'Background'. 'Policy' updated to include AHED Project policy position. |

© Copyright – Australasian College for Emergency Medicine. All rights reserved.