Australasian College
for Emergency Medicine

Statement on Alcohol Harm

Document review

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Version	Date	Pages revised / Brief explanation of revision
V5	Nov-2025	Comprehensive update of alcohol-related harm and more detailed consideration of its specific effects within EDs.

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1. Purpose

This is a position statement of the Australasian College for Emergency Medicine (ACEM; the College), which describes alcohol-related harm, its impact on emergency departments (EDs) and recommendations to mitigate risk of harm in Australia and Aotearoa New Zealand.

2. Background

Alcohol-related harm is one of the biggest public health issues facing EDs and the wider healthcare systems in Australia and Aotearoa New Zealand. Alcohol has never been more affordable, more heavily advertised, or more readily available.[1,2]

Alcohol is one of the leading causes of chronic diseases, family and domestic violence, injury, self-harm and suicide. In 2019 alone, alcohol contributed to 3.3 million deaths globally.[3] One in four adults in Australia and Aotearoa New Zealand drink at a level that increases their lifetime risk of alcohol-related disease or injury.[4,5] Alcohol-related mortality has climbed to its highest level in two decades, reflecting a concerning trend.[3]

Alcohol use and associated harms are largely driven by the social determinants of health. While patients may present for alcohol intoxication or injuries alone, for others, alcohol use may be a co-morbid condition related to mental illness or broader social issues such as homelessness.[6,7] Other systemic factors such as pricing, availability and marketing have also been shown to influence drinking patterns and associated ED presentations.[8]

3. Alcohol-Related Harm in Australasian Emergency Departments

Alcohol-related harm places a significant and preventable burden on EDs in Australia and Aotearoa New Zealand. 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.

Since 2013, ACEM has conducted research across Australia and Aotearoa New Zealand to quantify the burden of alcohol and other drugs (AOD) on EDs. A 2019 snapshot survey found that in Australia, 13 per cent of ED presentations were alcohol-related, while in Aotearoa New Zealand, 16 per cent of ED presentations were alcohol-related.[9]

Alcohol-related ED presentations increase significantly during peak public drinking hours, with data showing that alcohol is a 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.[10]

Alcohol-affected patients can pose safety risks to staff and other patients, as intoxication impairs cognition and increases the likelihood of violent or aggressive behaviour.[11] A survey of ED staff found that 70.5 per cent had experienced verbal or written abuse, threats, intimidation or harassment from alcohol-affected patients, and 94.6 per cent reported that alcohol intoxication negatively affected care delivery and ED functioning.[12] ACEM's Breaking Point: An Urgent Call to Action on Emergency Department Safety report highlighted the link between such presentations and violence in EDs.[13] The report also highlighted that ED design was a common contributing factor negatively affecting safety.

Compared with other patient groups, alcohol-affected individuals are more likely to arrive at the ED via police or ambulance rather than private transport.[14] 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.[15]

4. ACEM Position

- ACEM considers alcohol-related harm to be one of the main preventable public health issues facing EDs and the wider healthcare systems in Australia and Aotearoa New Zealand.
- ACEM supports ongoing public health campaigns and education initiatives addressing harmful alcohol use. These should be implemented alongside broader policy measures such as pricing, taxation and availability controls to influence drinking behaviours and reduce alcohol-related harm.
- ACEM recommends greater investment in prevention and harm minimisation measures for problem alcohol use, as it is more beneficial to prevent harm than treat it.
- ACEM supports a harm minimisation approach to alcohol. Harm minimisation is a multi-pronged approach addressing alcohol harm through three fundamental pillars of demand reduction, supply reduction and harm reduction.

5. Recommendations

5.1 Increase public health messaging and awareness campaigns

Responding to alcohol-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.

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.

- 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.

5.2 Improve data collection and research

Accurate, consistent data on alcohol-related harm in EDs is essential to understanding the true scale and impact of alcohol on health systems and communities. Currently, there is no standardised mechanism across Australia or Aotearoa New Zealand to capture alcohol 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.

- ACEM recommends the introduction of alcohol-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.

5.3 Reduce alcohol supply and demand

Reducing population-level alcohol consumption is the most effective way to decrease alcohol-related harm.[16] Strategies addressing both supply and demand can significantly reduce community consumption, ED presentations and associated social impacts.

Pricing and taxation

Alcohol pricing directly influences consumption and harm. Lower prices increase drinking, particularly amongst young people and heavy drinkers. Evidence from the 'alcopops' tax and the introduction of Minimum Unit Pricing (MUP) in the Northern Territory demonstrated reductions in alcohol-related ED presentations, hospital admissions and assaults.[17,18,19] While the MUP was repealed in 2025, ACEM maintains the position that reducing demand and supply prevents alcohol-related injury, illness, offending, and adverse impacts on EDs.[20]

- ACEM recommends implementing pricing and taxation measures such as a volumetric tax and minimum unit pricing.

Availability and accessibility

The availability and accessibility of alcohol is a key area of policy reform that can result in tangible change. A series of studies show that increased trading hours for bars and pubs tends to result in higher rates of harm.[21] Most alcohol-related ED presentations involve packaged liquor purchased from outlets such as supermarkets and bottle shops. This enables people to purchase large amounts of cheap alcohol, when compared to licenced venues, and consume offsite where no 'safe service' levels apply. Furthermore, the rapid growth of online alcohol sales and near instant delivery has outpaced existing liquor laws, and is creating significant public health risks, including increases in family violence in the home.[22]

- ACEM recommends introducing measures that restrict the trading hours and the number of liquor outlets in a community.
- ACEM supports the Foundation for Alcohol Research's recommendation to restrict hours of alcohol delivery to between 10am-10pm.[23]
- ACEM recommends that mandatory two-hour safety pauses between order and delivery are introduced to prevent high-risk consumption.

Advertising

Alcohol remains one of the most heavily promoted products, with marketing that encourages consumption amongst young people by depicting drinking as a positive experience that is social, fun and inexpensive. Alcohol advertising continues to be permitted during live broadcasts of sporting events on weekends and public holidays. In one study, 76 per cent of Australian children aged 5 to 12 years were able to match at least one sport with its relevant alcohol sponsor.[24] Self-regulatory schemes such as Alcohol Beverages Advertising Code (ABAC) in Australia and Alcohol Regulatory and Licensing Authority (ARLA) in Aotearoa New Zealand lack enforceable penalties and are ineffective in limiting exposure.

- ACEM recommends strengthening advertising regulations in Australia and Aotearoa New Zealand.
- ACEM recommends that legislation be introduced to ban alcohol sponsorship of sports teams, sporting codes and advertising during televised sport.

5.4 Enhance system design and adequately resource services

Alcohol and other drug services

Limited access to acute treatment services, poor service integration and inadequate after-hours support contributes to people presenting to EDs. Improving access to acute AOD treatment and expanding the availability of after-hours community services would reduce avoidable ED presentations.

Models of care that respond to the co-occurrence of substance abuse and mental health should be central to system design and service planning. These integrated models enable earlier intervention, more coordinated care, and improved patient outcomes.

There must be greater emphasis placed upon ensuring such models are operational in regional, rural and remote (RRR) areas, where the burden of AOD harm is higher and specialist services are limited. ACEM recognises the potential benefit of virtual care services to increase both the geographical reach and access to after-hours services.

- ACEM recommends improving access to integrated, multidisciplinary services that address substance misuse alongside co-existing physical and mental health conditions.
- ACEM recommends expanding after-hours inpatient and community-based support to reduce ED reliance.
- ACEM recommends prioritising the expansion of inpatient and community-based services in RRR areas to ensure equitable access to services.

Emergency department services

EDs play a critical role in identifying and responding to alcohol-related harm.3 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 larger EDs, and providing smaller and outer metropolitan EDs with access to AOD specialists, can enhance continuity of care by initiating treatment and supporting transitions to ongoing specialist management.

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.

Screening

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.[25] 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.

Models of care and supporting infrastructure

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, mental health, AOD, 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.[26]

- ACEM recommends embedding AOD specialists in EDs to provide screening, early intervention and coordinated follow up.
- 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.
- ACEM recommends ongoing funding to implement SBIRT programs as part of regular ED services.
- 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.

6. Related Documents

- P56 – Policy on Public Health
- S769 – Harm Minimisation Related to Drug Use
- P32 – Violence in Emergency Departments
- P41 – Access to Care for Patients with Acute Mental and Behavioural Conditions

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