Australasian College
for Emergency Medicine

# Position Statement

## Alcohol Harm

This document outlines the Australasian College for Emergency Medicine's (ACEM) position on alcohol-related harm and its impact on emergency departments (EDs) throughout Australia and New Zealand.

This statement on Alcohol Harm provides recommendations for EDs and the broader community to comprehensively address the scale of alcohol-related harm.

ACEM considers alcohol-related harm to be one of the largest preventable public health issues facing EDs in Australia and New Zealand. Alcohol-related presentations impact on the volume of patients who present to the ED, particularly during peak public alcohol consumption hours. In addition, such patients are commonly resource and time intensive.

ACEM supports adopting a harm minimisation approach to alcohol. ACEM supports strategies that regulate the availability, price and marketing of alcohol to reduce supply. In addition, ACEM supports demand-reduction approaches through brief interventions in the ED and broader public health messaging and education. Consistent and routine data collection on alcohol-related presentations in the ED are needed to measure the impact of policy reforms.

**July 2020**

## Document Review

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| Timeframe for review: | every five years, or earlier if required. |
| Document authorisation: | Council of Advocacy, Practice and Partnerships |
| Document implementation: | Council of Advocacy, Practice and Partnerships |
| Document maintenance: | Department of Policy and Strategic Partnerships |

## Revision History

| Version | Date | Pages revised / Brief Explanation of Revision |
|---|---|---|
| V1 | July 2006 | Approved by Council |
| V2 | Jul 2012 | Approved by Council |
| V3 | Jul 2016 | S43 combined with Alcohol Harm in Emergency Departments (AHED) Project Alcohol Policy Statement.<br>'Purpose" was edited to remove dot points. Additional content added to 'Background'.<br>'Policy' updated to include AHED Project policy position. |
| V4 | July 2020 | Substantial revision and application of new publication style |

# 1. Purpose

This document outlines the Australasian College for Emergency Medicine's (ACEM) position on alcohol-related harm and its impact on emergency departments (EDs) throughout Australia and New Zealand.

This Statement on Alcohol Harm provides recommendations for EDs and the broader community to comprehensively address the scale of alcohol-related harm.

# 2. Background

Alcohol-related harm is one of the biggest preventable public health issues facing EDs across Australia and New Zealand. Alcohol has never been cheaper, more heavily promoted, or more readily available.

The harmful use of alcohol is a major cause of preventable, non-communicable disease and injury worldwide. Globally, alcohol contributes to 3.3 million deaths every year.[1] Whilst the levels of risky alcohol consumption have been in decline in recent years, one in five New Zealanders and one in six Australians drink at a level that increases their lifetime risk of alcohol-related disease or injury.[2,3] Approximately 2 in 5 Australians (39%) 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.[2]

The consequences of such levels of risky drinking are regularly seen in the ED with people presenting with injuries as a result of alcohol use, clinical intoxication, medical conditions from long-term risky alcohol consumption misuse (liver disease, withdrawal or dependence) or mental health conditions arising from alcohol-related harm.[4] Other people may also be subjected to harm as a result of someone's risky drinking, resulting in serious injury, domestic violence, assaults or sexual abuse.[5]

Alcohol-related harm presentations also contribute to the volume of presentations. One in 12 (8.3%) presentations to Australasian EDs are alcohol related.[4] Snapshot surveys conducted by ACEM at peak times (Friday and Saturday nights) show that alcohol-related presentations account for one in every seven patients. However, EDs in New Zealand have a higher prevalence of alcohol-related presentations compared to Australian EDs (17% and 13% respectively).[4] In addition, compared to other patients, alcohol-affected patients are more likely to arrive via police or ambulance rather than private transport.6,7 Such presentations represent a significant financial cost to the healthcare system, with one study finding that the estimated annual cost to one ED was approximately $7.5 million.[8]

Intoxicated patients can put clinical staff, other patients and the people accompanying them at risk of harm. For example, 98% of ED clinical staff have experienced verbal aggression from an alcohol-affected patient and 92% of ED clinical staff have experienced physical aggression.[9] As a result, alcohol-affected patients are more likely to require security codes being called and/or some form of restraint being used.[7,9] 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.[9]

Alcohol use and associated harms are 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[10] or broader social issues such as homelessness.[11-13] Other systemic factors such as pricing, availability and marketing have also been shown to influence drinking patterns and associated ED presentations.[14]

# 3. Recommendations

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.

## 3.1 Data Collection and research

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 New Zealand.

The collection of this data would provide:

- a clearer picture of the extent of alcohol-related harm presentations to EDs
- an evidence base to inform and evaluate the impact of policy reforms on alcohol harm.

## 3.2 Alcohol supply reduction

### *Brief interventions in the ED*

The World Health Organization has identified that EDs are well placed to identify alcohol-related problems in presenting patients.[15] Screening, Brief Intervention and Referral to Treatment (SBIRT) models have been developed for use in healthcare settings, including EDs, to identify, reduce and prevent problematic use and abuse of, and dependence on, alcohol and other drugs.[15]

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 while in the ED (mechanisms should also exist to refer at-risk patients to an appropriate community resource for culturally sensitive and appropriate education/intervention).

However, some EDs have reported difficulties in implementing SBIRT particularly without appropriate personnel and time.[6] Research has shown that even 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.[16] Further evidence is needed to examine the feasibility and effectiveness of these interventions in the ED so where possible, EDs should contribute to the ongoing assessment of efficacy and quality improvement of SBIRT programmes. As screening and early intervention are specialised skills, the success of brief interventions will depend on EDs being appropriately resourced with dedicated alcohol and other drugs (AOD) staff who possess the skills and knowledge required to accurately use SBIRT models.

### *Pricing and taxation*

Alcohol pricing has a direct impact on alcohol-related harm and ultimately the extent of alcohol-related ED presentations. Research following the introduction of taxation on 'alcopops' found a reduction in acute alcohol-related ED presentations amongst both males and females, especially amongst people aged 18-24 years old.[17]

Similarly, in the Northern Territory a raft of measures including Minimum Unit Pricing (MUP), that prevents alcohol from being sold at a discounted rate, were implemented in 2018. Following MUP's introduction, there has been a noticeable reduction of alcohol-related ED presentations, intensive care hospital admissions and assaults.[18-19]

ACEM supports measures to introduce a volumetric tax and establish minimum unit pricing (MUP).

### *Availability*

Data from the 'Last Drinks' project as well as other research shows most patients requiring treatment after consuming alcohol have consumed packaged liquor purchased from outlets such as supermarkets and bottle shops.[7,20] This enables people to purchase large amounts of cheap alcohol, when compared to licenced venues, and consume offsite where no 'safe service' levels apply.

ACEM supports measures which restrict the trading hours and the number of liquor outlets in a community.

## 3.3 Alcohol demand reduction

### *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 continues to be 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 alcohol sponsor. [21]

Alcohol advertising in both Australia and New Zealand is currently self-regulated by the alcohol and advertising industries through the Alcohol Beverages Advertising Code (ABAC) Scheme (Australia) and the Alcohol Regulatory and Licensing Authority (New Zealand). There are numerous deficiencies with both schemes as there are no enforceable penalties, they focus solely on the content of advertisements and have difficult complaints processes.

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.

### *Public health messaging and awareness campaigns*

ACEM supports broader public health messaging around harmful use of alcohol including through awareness campaigns and education. However, ACEM acknowledges that these interventions need to be used in conjunction with other strategies to influence harmful drinking behaviours.[14]

## 3.4 Harm Reduction

### *Alcohol and other drug treatment services*

ACEM supports integrated and multidisciplinary services which comprehensively address AOD use as well as other co-morbid physical and psychiatric conditions. At present the limited availability of acute treatment services, and lack of service integration and community assistance means that people requiring support for AOD use often seek support from EDs in crisis. In addition, there may also be significant delays between ED referral to outpatient community rehabilitation services. Improving access and availability to acute treatment services and altering the community provision of services available after-hours would likely prevent many of these ED presentations.

ACEM supports initiatives to embed AOD clinical specialists in EDs to initiate optimal therapy and provide continuity of care as patients transition from ED to AOD specialist management, whether on an outpatient or inpatient basis. Integrated models of care that co-locate AOD patients and emergency mental health clinicians enable timely referral and access to services so should be central to any reforms of the mental health care system. In addition, further exploration of such models is needed in rural and regional areas where there is a higher burden of AOD use and fewer services to address this burden. ACEM recognises the potential benefit of teleconsultation to increase both geographical reach of support services, and access to after-hours care.

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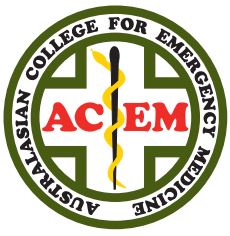


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