Australasian College for Emergency Medicine

acem.org.au

Alcohol and Methamphetamine Harm in Emergency Departments

Findings from the 2019 Snapshot Survey

Table of contents

Executive summary

Background

As part of its Alcohol Harm in Emergency Departments (EDs) Program, the Australasian College for Emergency (ACEM) conducts an Alcohol Harm Snapshot Survey (AHSS). The AHSS, conducted on a weekend night in December since 2013, aims to quantify alcohol's burden on EDs and further our understanding of its contribution to the ED workload. Since 2018, the AHSS has also examined the burden of methamphetamine-related presentations on EDs and ED workload.

Findings

Of the 167 EDs that were eligible to participate in the AHSS across Australia and New Zealand in 2019 (147 and 20 EDs, respectively), 79% completed the AHSS (113 EDs in Australia; 19 EDs in New Zealand).

At the national level in 2019:

- 13% of ED presentations were alcohol-related and 2.8% of ED presentations were methamphetamine-related in Australia;
- 16% of ED presentations were alcohol-related and 1.9% of ED presentations were methamphetamine-related in New Zealand;
- Alcohol-related ED presentations have remained constant at 13% in Australia from 2016-2019, whereas in New Zealand they have decreased from 23% in 2016 to 16% in 2019; and
- Methamphetamine-related presentations decreased slightly in Australia (3.0% in 2018 versus 2.8% in 2019), and increased in New Zealand (0.7% in 2018 versus 1.9% in 2019).

At the jurisdictional level in Australia:

- Western Australia consistently had the highest percentage of alcohol-related ED presentations, with more than one in five (22%) ED patients there in relation to alcohol in 2019;
- There were minimal changes in the percentage of alcohol-related ED presentations across jurisdictions from 2016-2019; the largest change was in South Australia, where alcohol-related presentations reduced by 5% (15% in 2016 to 10% in 2019);
- All jurisdictions had similar percentages of methamphetamine presentations in 2019 (ranging from 2.0-3.8%); and
- Western Australia reported the largest difference in methamphetamine-related ED presentations in 2019 compared to 2018, reducing from almost 5.9% to 3.3%.

Conclusions

Emergency physicians are at the forefront of responding to and treating the consequences of alcohol and other drug (AOD)-related harm. ACEM's 2019 findings show that 13-16% of ED presentations are alcohol-related across Australia and New Zealand, with 1.9-2.8% methamphetamine-related. AOD harm represent significant challenges for the acute health system, affecting ED function, significantly impacting staff wellbeing, and exerting a negative impact on the care of other patients. Additionally, current data collection and coding systems do not accurately capture the true burden of drug-related ED presentations so harms are likely to be underestimated in current figures.

Given that all these presentations would not have occurred without the influence of alcohol or drugs, there is great potential to prevent these cases and the associated cost of care provided by the ED through appropriate public health action. Action should focus on evidence-based approaches to harm minimisation through the multi-pronged approach of harm reduction, demand reduction and supply reduction. ACEM supports an approach to harm minimisation that centres on people-focused policies and interventions which recognise the socioeconomic and cultural context of AOD rather than extending prohibitionist and punitive approaches.

Background

To inform our advocacy, each year since 2013 as part of the Alcohol Harm in Emergency Departments program, ACEM has conducted the Alcohol Harm Snapshot Survey on **a weekend night in December in more than 100 Australian and New Zealand EDs**.

The Australasian College for Emergency Medicine (ACEM, the College) is the not-for-profit organisation in Australia and New Zealand with responsibility for training emergency physicians and advancing professional standards in emergency medicine. Fellows of ACEM (FACEMs) – our members – are specialist emergency physicians working in Australian and New Zealand emergency departments (EDs), and internationally.

As the peak professional organisation for emergency medicine, the College is the trusted authority for ensuring the highest standard of quality, patient-focused medical care is provided and maintained in EDs across Australia and New Zealand.

Based on the clinical experiences of our members, the College believes alcohol and other drug (AOD) harm is one of the largest, preventable public health issues facing EDs in our region. Due to the volume and nature of presentations, AOD harm can have detrimental effects on ED staff, other patients and accompanying persons, adversely impacting the way EDs function.[1]

ACEM has been a vocal advocate for public policy changes and specific measures to address AOD harm in the Australian and New Zealand communities, particularly in relation to alcohol.[2]

To inform our advocacy, each year since 2013[i] as part of the Alcohol Harm in EDs (AHED) program ACEM has conducted the Alcohol Harm Snapshot Survey (AHSS) on a weekend night in December in more than 100 Australian and New Zealand EDs. The primary aim of the snapshots has been to quantify alcohol's burden in EDs and better understand its contribution to the ED workload.

Over time, findings have typically shown that between one in seven and eight Australian patients presenting to EDs on Snapshot nights do so in relation to alcohol; across New Zealand, the highest proportion recorded has been one in four.[2] During peak patient presentation times (Friday and Saturday nights), further research by our members has shown that all regions have EDs in which one in three patient presentations are associated with alcohol, representing a third of the ED workload.[3] Not only does this affect ED function, it significantly impacts staff wellbeing and has a negative impact on the care of other patients; in a recent survey, almost all (98%) ED clinical staff had experienced alcohol-related verbal aggression from patients in the past 12 months, with nine in 10 (92%) experiencing physical aggression. More than 80% of ED clinical staff also felt that alcohol-related presentations adversely affected patient wait times, other patients waiting to be seen, and the care of other patients within the ED.[4]

In addition to alcohol, for more than a decade ACEM members have simultaneously expressed concern about methamphetamine's impact in the acute health system, particularly in the EDs where they work. In 2015, to better understand these concerns the College explored ED staff perceptions of recent trends in AOD related ED presentations. Seventy-two per cent[ii] of Australian Directors of Emergency Medicine (DEMs) reported a perception that amphetamine-type stimulant (ATS) ED presentations increased between 2014 and 2015, and more than half of DEMs[iii] identified rising ATS ED presentations as an emerging trend.[5]

Feedback from our members – together with the lack of nationally consistent data quantifying the extent and impact of AOD harm in EDs in Australia and New Zealand – led the College to explore the issue further by including methamphetamine in the 2018 AHSS.

[i] With the exception of 2015.
[ii] 58 Australian DEMs and eight New Zealand DEMs responded; 72% cf. 14% in New Zealand.
[iii] 56% of 48 DEMs who responded.

Survey

Purpose

As part of its Alcohol Harm in Emergency Departments (EDs) Program, the Australasian College for Emergency conducts an Alcohol Harm Snapshot Survey (AHSS). The AHSS, conducted on a weekend night in December since 2013, aims to quantify alcohol's burden on EDs and further our understanding of its contribution to the ED workload. Since 2018, the AHSS has also examined the burden of methamphetamine-related presentations on EDs and ED workload.

Methodology

On Saturday 21 December 2019 at 2.00am local time (i.e. effectively Friday night), the AHSS was undertaken to estimate the point-prevalence of alcohol and methamphetamine harm in Australian and New Zealand hospital EDs. As with previous years, the survey was a point-in-time snapshot of ED presentations.

Definitions

For the purposes of the snapshot, ED clinicians were required to identify the number of patients in their departments who were clinically intoxicated due to alcohol or methamphetamine, or who had presented directly or indirectly in relation to either drug. The criteria used to define alcohol and methamphetamine presentations were broad and included the following, based on ED clinician judgement and/or patient self-report.

Injuries as a result of alcohol or methamphetamine use

- Unintentional, including motor vehicle accidents and road traffic injuries, drowning, burns, poisoning and falls
- Intentional, such as those resulting from acts of violence against self or others

Intoxication

- Alcohol and/or methamphetamine involvement as determined by relevant measures, e.g. blood alcohol content
- Clinical intoxication determined by clinician assessment, including ED triage staff if not yet seen by a doctor
- Intoxication, but unrelated to the clinical presentation

Medical conditions as the result of alcohol or methamphetamine use

- Degeneration of nervous system
- Polyneuropathy (damage to muliple nerves)
- Myopathy (muscle damage) due to other toxic agents
- Cardiomyopathy
- Gastritis
- Liver disease
- Withdrawal state

- Dependence syndrome
- Other medical condition(s) that the treating doctor believed was attributable to or exacerbated by either drug

Mental and behavioural conditions due to alcohol or methamphetamine use

- Mental health presentations due to intoxication
- Mental health presentation due to harmful use
- Overdose

Underlying AOD use

- Lifestyle problems due to AOD use

Indirect harm

- Unintentional or intentional injuries caused by an affected third party

Data

Data collected included a count of the number of patients waiting to be seen at 2.00am local time, the number of patients being seen and, where applicable, the number of patients in observation and/or short stay units. No individual level patient information was collected.

Emergency departments provided estimates on the number of:

- all patients;
- patients with alcohol-related presentations (clinically intoxicated or presentation due to alcohol); and
- patients with methamphetamine-related presentations (clinically intoxicated or presentation due to similar drug).

Patient presentations that were both alcohol and methamphetamine related were classified clinically by the predominant effect. No information was collected on ED length of stay.

Data is presented as percentages, which were rounded up or down in the report body to the nearest whole number unless below 10%.

Limitations

- Data presented is provided in aggregate form only, which prevents more in-depth analysis of variation at individual hospital, jurisdictional and ED delineation levels
- The findings for SA should be interpreted with caution, both due to low ED participation rates and the very small numbers of patients in those EDs at the snapshot time
- Data for the ACT, NT and TAS is combined so that individual hospitals cannot be identified
- The 2016, 2017 and 2019 AHSS were conducted at 2am on a Saturday morning but in 2018 the AHSS was conducted on a Sunday at 2am. Anecdotal reports from EDs suggest that patient presentation numbers are lower at 2am on Sunday morning than the night before, an inherent limitation of point-in-time data collections. Findings in 2018 may therefore be an underestimate

Findings

Across Australia and New Zealand, 167 EDs were invited to participate in the AHSS. Of these eligible EDs, 132 (79%) participated in the survey. In Australia, 113 out of 147 eligible hospital EDs (77%) participated and 19 out of 20 (95%) New Zealand hospital EDs provided data.

Australian data were submitted by 39 (93%) eligible hospital EDs in New South Wales (NSW), 24 (73%) in Queensland, 26 (74%) in Victoria, and 11 (85%) in Western Australia (WA).

Five (71%) eligible hospital EDs provided data in South Australia (SA), and eight (89%) EDs combined provided data from the Australian Capital Territory (ACT), Northern Territory (NT) and Tasmania.[IV] Data for these jurisdictions should be interpreted with caution due to small numbers.

Presentations in Australia and New Zealand

At the time of the 2019 snapshot 3,255 patients were attending Australian EDs, with 422 patients attending New Zealand EDs. Of the Australian ED attendances, 407 (13%) were alcohol related while 90 (2.8%) were in relation to methamphetamine. In New Zealand, 66 (16%) ED attendances were alcohol related, with 8 (1.9%) being methamphetamine related.

In Australia, alcohol-related ED presentations have remained relatively consistent between 2016-2019 (Figure 1). In contrast, alcohol-related ED presentations have varied in New Zealand, ranging from a high of 23% in 2016 to 12% in 2017 (Figure 1).

Unlike Australia where the national average percentage of methamphetamine-related presentations (Figure 2) remained similar in 2018 and 2019 (3.0% and 2.8% of total ED presentations, respectively), New Zealand data shows that these presentations have more than doubled over the two-year period, both as a percentage of total ED presentations (0.7% in 2018 compared to 1.9% in 2019) and case numbers (three patients in 2018 compared to eight patients in 2019).

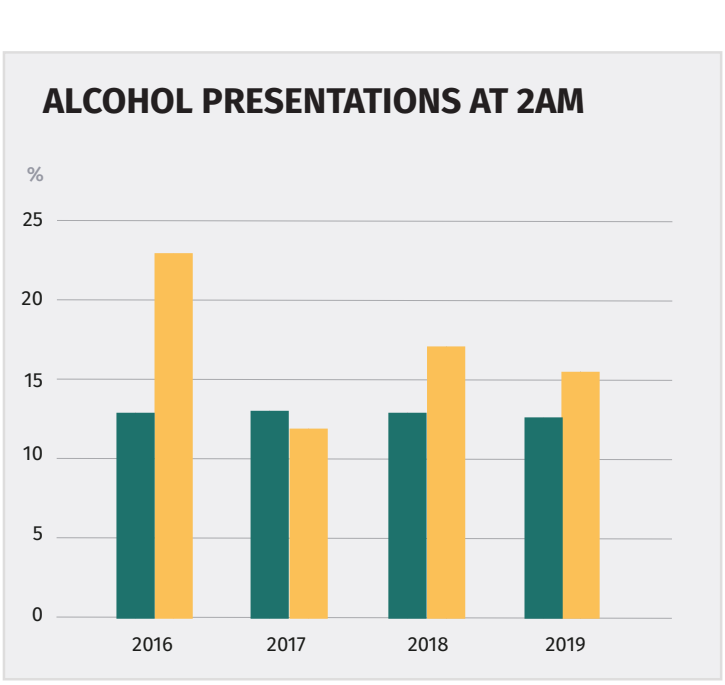

Figure 1 *Percentage of total presentations that were alcohol related at 2.00am in Australian and Aotearoa New Zealand EDs*

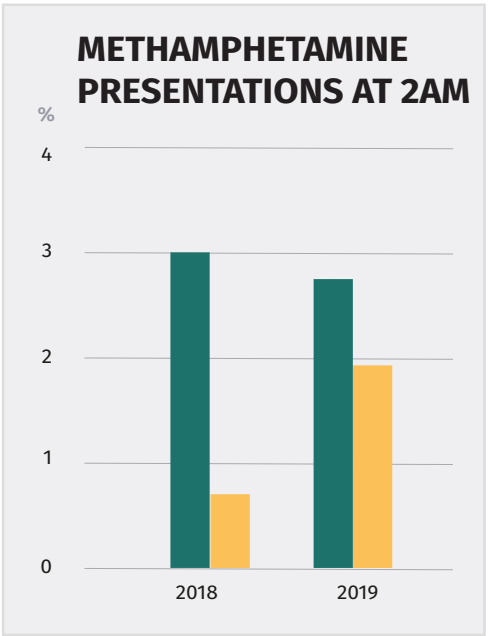

Figure 2 *Percentage of total presentations that were methamphetamine related at 2.00am in Australian and Aotearoa New Zealand EDs*

[IV] Percentages denote the proportions of participating EDs of all EDs in each jurisdiction/jurisdictional grouping.

Presentations in the Australian jurisdictions

The percentage of alcohol-related ED presentations since 2016 are presented by jurisdiction in Figure 3.

In Australia, WA had the highest percentage of alcohol presentations in 2019, with more than one in five (22%) ED patients attending due to alcohol-related reasons. This is consistent with previous snapshot years where WA has consistently reported the highest percentage of alcohol-related presentations. In contrast, VIC reported the lowest percentage of alcohol-related presentations (8%) in 2019 and has remained below the national average across all snapshot years.

Compared to 2016, there were minimal changes in the percentage of total ED presentations related to alcohol in 2019 for NSW (12% cf. 13%), VIC (9% cf. 8%), QLD (13% cf. 12%) and WA (21% cf. 22%). The largest change was in SA where alcohol-related ED presentations reduced by 5% over the four-year period, from 15% in 2016 to 10% in 2019. The combined data for the ACT, NT and TAS reduced by 2.5% over the same time period, however this should be interpreted with caution due to the inability to assume the data is representative of one specific jurisdiction.

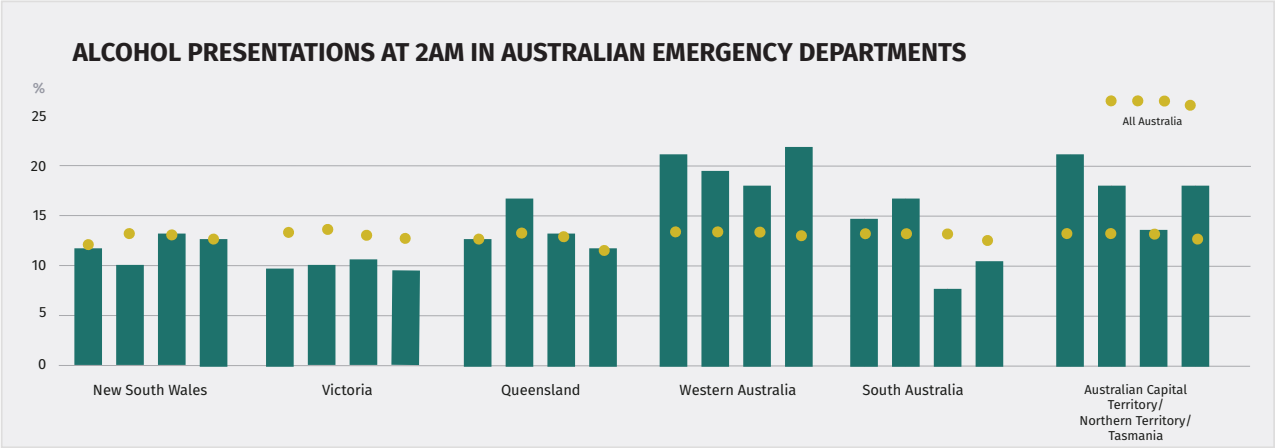

Figure 3 *Percentage of total ED presentations that were alcohol related at 2.00am in Australian jurisdictions, 2016-2019*

A comparison of the percentage of methamphetamine-related presentations recorded in 2018 and 2019 are presented by Australian jurisdiction in Figure 4.

In 2019 all jurisdictions had similar percentages of methamphetamine presentations, ranging between 2.0% and 3.8%, with an average of 2.8%. This is consistent with the 2018 average. However, changes in reported percentages varied for individual jurisdictions. SA had the highest percentage of methamphetamine presentations compared with the other states and territories, almost one in 25 presentations – approximately 3.8%, increasing from 2.4% in 2018. Compared to the 2018 AHSS, the percentage of methamphetamine related ED presentations increased for NSW (2.3% cf. 3.3%) and the combined data for the ACT, NT and TAS (1.0% cf. 2.2%).

WA reported the largest difference in methamphetamine-related presentations in 2019 compared to 2018, reducing from 5.9% to 3.3%. VIC also reported a reduction in methamphetamine-related presentations from 2018 to 2019 (3.3% cf. 2.0%). There was a less than 1% reduction in methamphetamine-related presentations in QLD.

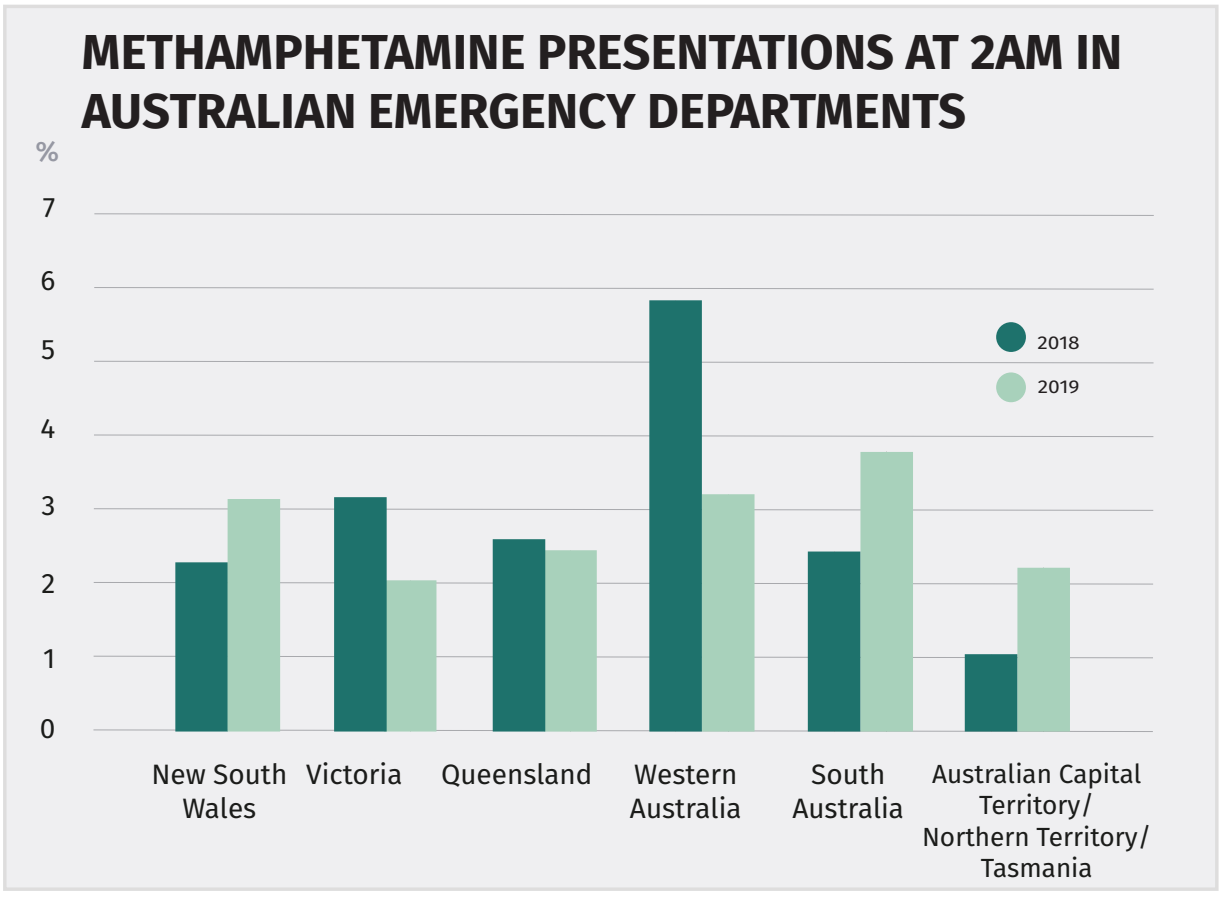

Figure 4 *Percentage of total ED presentations that were methamphetamine related at 2.00am in Australian jurisdictions, 2018-2019*

Discussion

Alcohol has never been cheaper, more heavily promoted, or more readily available, and alcohol harm is the biggest preventable public health issue facing EDs.[1] ED presentations relating to AOD harm represent significant challenges for the acute health system, particularly in the context of rising patient demand pressures, hospital access block[v], overcrowding, and limitations to ED capacity and resourcing. Inconsistent collection of routine AOD-related ED data means the impacts of alcohol and methamphetamine harm are underestimated in EDs, and the acute health system is under-resourced to properly care for affected populations. Demand for community-based generalist and specialist AOD treatment services also outstrips supply.[6]

Findings from our 2019 AHSS and time-course data collected since 2016 show that in EDs overall, presentations due to alcohol harm represent a greater proportional burden than those due to methamphetamine harm. Overall, prevalence in the snapshot did not appear dissimilar to annual patterns of risky drinking[vi] and methamphetamine use[vii] in the general population, although there are varying consumption patterns and harms between genders, among age groups and by geography.[7] As an example, prevalence of recent methamphetamine use has increased in recent years among young rural Australians and is now higher than in their city and regional counterparts.[8]

Even though alcohol use is endemic in Australia and New Zealand, media in both countries have reported methamphetamine 'epidemics' for years, particularly the use of 'ice' and 'P'[viii].[9-11] Recent methamphetamine use in the Australian and New Zealand general populations is low at around one per cent (1.4% and 0.8% respectively) – with research suggesting a similarly low rate of presentation to major tertiary hospital EDs where AOD presentations are common.[7, 12-14] However, despite the low reported figures methamphetamine presentations have become a serious issue for ED staff.[13-15] In addition, it is possible that AOD presentations are under reported due to insufficient data.

In the ED methamphetamine presentations are of high acuity. Among other factors, frequent and heavy methamphetamine use is associated with psychosis, major depression, higher levels of health service utilisation and repeated ED presentations.[16-20] Patients attending EDs due to methamphetamine have complex needs and require active care, greater clinical resources, and longer ED lengths of stay for stabilisation.[13, 20] A 2017 study of presentations to an inner city Australian ED related to methamphetamine use over one month found that patients were predominantly male, acutely intoxicated, had used methamphetamine in the past 28 days, presented voluntarily, needed physical and mechanical restraint and were aggressive to other patients and staff.[21] Taken together, this presentation group is highly resource intensive and needing complex care.

In the past decade methamphetamine has become more potent, cheaper and easier to obtain, possibly explaining some of the increases in harm such as those observed in ED settings.[22,23] For instance, among patients seeking help from EDs for mental health crises, almost a third have substance use recorded as a feature of their presentation, and long ED stays are widespread.[24,25] A sizeable proportion of toxicology presentations also involve methamphetamine intoxication. This has prompted jurisdictions such as WA to establish specialised urgent care centres where ED patients who are behaviourally unwell, particularly those who are agitated and aggressive, can be cared for safely.[14,26]

State governments and hospitals have started to invest in reorienting EDs to include models of care that integrate specialist expertise in mental health, emergency medicine, and alcohol and drug. Some examples include the Psychiatric and Non-prescription Drug Assessment (PANDA) Unit at St Vincent's Hospital Sydney in NSW, the Mental Health Observation and Assessment (MHOA) Units and Urgent Care Centres (Toxicology) in WA, and the Alfred Mental Health Service at the Alfred Hospital in Victoria. These models are multidisciplinary in their staffing mix, targeted to manage the health effects of drug and alcohol use and minimise the risks related to aggression and violence in the ED.

[v] Admitted patients who wait more than 8 hours in the ED before being admitted into hospital
[vi] Lifetime risk from alcohol consumption equates to on average more than two standard drinks per day. In 2016, lifetime risk was 17%.
[vii] In the past 12 months. Note that use is underestimated in general population surveys.
[viii] In Australia, potent crystalline methamphetamine is colloquially known as 'ice'; in New Zealand, the drug is known as 'P'.

Implications

Findings from ACEM's AHSS have consistently shown that about one in seven presentations to EDs are alcohol related. While methamphetamine presentations are of lower prevalence than alcohol presentations, the significant harms associated with both drugs warrant action in both areas.

Action should focus on evidence-based approaches to harm minimisation through the multi-pronged approach of harm reduction, demand reduction and supply reduction. ACEM supports an approach to harm minimisation that centres on people-focused policies and interventions, which recognise the socioeconomic and cultural context of AOD rather than extending prohibitionist and punitive approaches.[1]

Key areas for policy reform

- Robust data collection from EDs
- Screening, brief intervention and referral for treatment programs in the ED
- Multidisciplinary interventions in the ED
- Improved integration and resourcing of AOD services
- Long-term demand and supply reduction strategies
- Harm reduction through creating safer settings
- Independent regulatory body to control alcohol advertising, sponsorship and promotions

Robust data collection

Current data collection and coding systems do not accurately capture the true burden of drug-related ED presentations, leading to systematic underreporting of this issue. Indeed, the lack of appropriate ICD-10 (International Classification of Diseases version 10) diagnostic codes for acute recreational drugs means that only one in 10 ATS-related ED presentations can be accurately captured.[27] Likewise, in NSW it has been shown that only 1% of AOD related ED presentations are identified as having a primary diagnosis related to alcohol, with identification or reporting of secondary diagnoses related to alcohol also under reported.[28] Implementation of consistent, routine AOD ED presentation data collection is required to help governments and stakeholders better understand the burden of AOD across the Australian and New Zealand acute health systems and resourcing needs.

ACEM recommends

- Implement compulsory collection of minimum AOD presentation data through addition of AOD data elements to the National Non-Admitted Patient Emergency Department Care (NAPEDC) Dataset.
- Introduce a Last Drinks surveys to ensure that sources of problematic alcohol supply can be identified.
- Further investigate to determine the optimal coding method to ensure that data collection accurately captures drug-related ED presentations.

Screening, Brief Intervention and Referral for Treatment Programs

Screening, Brief Intervention and Referral to Treatment (SBIRT) models have been developed for healthcare settings to identify, reduce and prevent problematic use and abuse of, and dependence on, alcohol and other drugs.

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).[29]

ACEM's *Statement on Alcohol Harm* and *Statement on Harm Minimisation Related to Drug Use* both acknowledge that the ED setting provides valuable opportunities to identify AOD-related problems in presenting patients.[1] While the use of brief interventions originated in the ED, evidence of the success of SBIRT models in these settings is largely observational, with limited controlled trials conducted and mixed findings depending on the severity of patients' drug use.[30]

Some EDs have reported difficulties in implementing SBIRT particularly without appropriately trained personnel and time constraints.[31] Further evidence is therefore needed to examine the feasibility and effectiveness of these interventions in the ED. 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.

Multidisciplinary interventions in the ED

State governments need to invest in reorienting EDs to include models of care appropriate to patient demand and case mix that integrate mental health, general medical and AOD/toxicological care. More flexible and integrated care across mental health, substance use and primary care services is essential, together with a prioritisation of early intervention for methamphetamine-related psychotic symptoms. Changes are needed to the design and resourcing of EDs to better prevent, minimise and manage violent behaviours that often accompany alcohol and drug presentations, including methamphetamine-related psychosis.

Improved integration and resourcing of AOD services

A lack of service development and integration means that many people whose presentations primarily involve AOD use and who would be better served in the community seek help from EDs in crisis and with nowhere else to go. Presentations involving methamphetamine-related psychosis are among the most resource intensive in the ED.

ACEM recommends

- Increase resourcing for community-based AOD services that offer comprehensive medical and psychosocial care and support;
- Resource for increased specialist AOD treatment options, starting with alcohol or methamphetamine-related harm including methamphetamine-induced psychosis. Specialist services could include in-hospital withdrawal services and access to specialist psychiatric support;
- Provide integrated care pathways out of EDs and into specialist treatment programs, so that health professionals can offer assertive interventions to people whose drug and alcohol use has come to a crisis point, starting with an immediate appointment for publicly funded care and support; and
- Further investigate integrated models of care in communities where there is a higher burden of AOD use and fewer services to address this burden. The potential benefit of teleconsultation should be explored to increase both geographical reach of support services, and access to after-hours care.

Development and implementation of long-term demand and supply reduction strategies

Australian and New Zealand EDs need relief from the pressures of managing highly complex, mentally unwell, behaviourally disturbed people whose drug and alcohol use has come to a crisis. All governments need to commit to consistent and coordinated interventions to reduce alcohol and drug related harm in the community. These reforms need to draw on evidence-based supply reduction strategies that have been effective, starting with reducing the availability and affordability of alcohol. For example, significant work undertaken by the NT Government for alcohol policy reform has resulted in a decline in ED presentations by almost 25%.[32]

ACEM recommends

- Trial alcohol demand reduction measures, such as minimum unit pricing and volumetric tax on alcohol sales.
- Trial alcohol supply reduction measures, such as risk-based licensing practices, licensing policies to reduce alcohol outlet density, greater regulation and restriction on alcohol promotion and advertising, and more active enforcement of regulations on off-license and online alcohol outlets.
- Evaluate the impact of such demand and supply reduction measures to ensure positive outcomes for communities are achieved.

Harm reduction through creating safer settings

ACEM is supportive of measures which seek to create safer environments to reduce harms from drug use such as needle and syringe exchange programs, community prescribing of naloxone (opiate antidote), medically supervised safe injection rooms and drug checking services (i.e. pill testing). Evaluations of these programs consistently demonstrate a reduction of transmission of blood-borne disease, reduced dependence and addiction and reduced deaths from overdoses.[33,34] Importantly, research has shown that drug use does not increase with the presence of such programs.[35]

Independent regulatory body to control alcohol advertising, sponsorship and promotions

Alcohol is one of the most heavily promoted products in the world. Young people are regularly exposed to advertisements that normalises alcohol consumption as a necessary component of sporting events, celebrations and socialising, despite the significant harm it causes to the health and wellbeing of individuals, families and communities.

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.

Conclusion

ACEM recommends

- Establish independent regulatory bodies in Australia and New Zealand to control alcohol advertising, sponsorship and promotions, and strengthen regulation, including complaints and enforcement provisions.
- Introduce legislation to phase out alcohol sponsorship of sports teams, as well as alcohol advertising during televised sport).

Emergency physicians are at the forefront of responding to and treating the consequences of alcohol and other drug related harm. AOD harm represents significant challenges for the acute health system, affecting ED function, significantly impacting staff wellbeing, and exerting a negative impact on the care of other patients.

Our 2019 findings show that 13-16% of ED presentations are alcohol-related across Australia and New Zealand, with 1.9-2.8% methamphetamine-related. Alcohol-related ED presentations are estimated to cost $630 per patient in Australia[36] so our findings equate to at least 1.25 million presentations costing over $789 million in 2018-19 within the ED alone. Given that all these presentations would not have occurred without the influence of alcohol or drugs, there is great potential to prevent these cases and the associated cost of care provided by the ED through evidence-based harm minimisation approaches. Establishing robust data collection will be critical to achieving these aims and ensuring that actions are effective in addressing the true burden of this significant public health issue.

References

1. Australasian College for Emergency Medicine. ACEM statements on alcohol and other drug harm. Melbourne: ACEM; 2020. Available from: https://acem.org.au/Content-Sources/Advancing-Emergency-Medicine/Better-Outcomes-for-Patients/Reducing-Alcohol-and-Drug-Harm-in-the-ED/ACEM-Statements-on-Alcohol-and-Other-Drug-Harm

2. Australasian College for Emergency Medicine. Reducing alcohol and drug harm in the ED. Melbourne: ACEM; 2019. Available from: https://acem.org.au/Content-Sources/Advancing-Emergency-Medicine/Better-Outcomes-for-Patients/Reducing-Alcohol-and-Drug-Harm-in-the-ED

3. Egerton-Warburton D, Gosbell A, Wadsworth A, Fatovich D, Richardson D. Survey of alcohol-related presentations to Australasian emergency departments. Med J Aust. 2014;201(10):584-7.

4. Egerton-Warburton D, Gosbell A, Wadsworth A, Moore K, Richardson DB, Fatovich DM. Perceptions of Australasian emergency department staff of the impact of alcohol-related presentations. Med J Aust. 2016;204(4):155.

5. Australasian College for Emergency Medicine. Hospital data 2015 survey report of findings. Melbourne: ACEM; 2016.

6. Ritter A, Berends L, Chalmers J, Hull P, Lancaster K, Gomez M. New horizons: The review of alcohol and other drug treatment services in Australia. Sydney: Drug Policy Modelling Program, NDARC. Sydney: UNSW; 2014.

7. Australian Institute of Health and Welfare. National Drug Strategy Household Survey 2016: Detailed findings. Canberra: AIHW; 2017.

8. Roche A, McEntee A. Ice and the outback: Patterns and prevalence of methamphetamine use in rural Australia. Aust J Rural Health. 2016;25(4):200-9.

9. Lim M, Cogger S, Quinn B, Hellard M, P D. 'Ice epidemic'? Trends in methamphetamine use from three Victorian surveillance systems. Aust NZ J Publ Heal. 2015;39(2):194-5.

10. Bayer K. Meth plague at record levels, with P-related arrests nearly doubling in 5 years. New Zealand: NZME Publishing Limited; 2018 [updated 2018 Jul 09; cited 2020 Aug 20]. Available from: https://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=12085175

11. Lee N. Are we in the midst of an ice epidemic? A snapshot of meth use in Australia. Melbourne: The Conversation; 2015 [cited 2020 Aug 18]. Available from: https://theconversation.com/are-we-in-the-midst-of-an-ice-epidemic-a-snapshot-of-meth-use-in-australia-39697

12. New Zealand Drug Foundation. State of the nation 2018. Wellington: NZ Drug Foundation; 2019.

13. Gray S, Fatovich D, McCoubrie D, Daly F. Amphetamine-related presentations to an inner-city tertiary emergency department: a prospective evaluation. Med J Aust. 2007;186(7):336-9.

14. Bunting P, Fulde G, Forster S. Comparison of crystalline methamphetamine ('ice') users and other patients with toxicology-related problems presenting to a hospital emergency department. Med J Aust. 2007;187(10):564-6.

15. O'Leary C. Nearly 10,000 code blacks reported at Perth hospitals as emergency staff cop thuggery [News report]. Perth: South Western Times; 2019 [updated 2019 Feb 9; cited 2020 Aug 19]. Available from: https://www.swtimes.com.au/?news/health/nearly-10000-code-blacks-reported-at-perth-hospitals-as-emergency-staff-cop-thuggery-ng-b881097074z

16. McKetin R, McLaren J, Lubman D, Hides L. The prevalence of psychotic symptoms among methamphetamine users. Addiction. 2006;101(10):1473-8.

17. McKetin R, Lubman D, Lee N, Ross J, Slade T. Major depression among methamphetamine users entering drug treatment programs. Med J Aust. 2011;195(3):S51-5.

18. McKetin R, Degenhardt L, Shanahan M, Baker A. Health service utilisation attributable to methamphetamine use in Australia: Patterns, predictors and national impact. Drug Alcohol Rev. 2017;37(2).

19. Nambiar D, Stoove M, Dietze P. Frequent emergency department presentations among people who inject drugs: A record linkage study. Int J Drug Policy. 2017;44(115-120).

20. Fatovich D, Davis G, Bartu A. Morbidity associated with amphetamine related presentations to an emergency department: A record linkage study. Emerg Med Australas. 2012;24:553-9.

21. Unadkat A, Subasinghe S, Harvey RJ, Castle DJ. Methamphetamine use in patients presenting to emergency departments and psychiatric inpatient facilities: what are the service implications? Australas Psychiatry. 2019;27(1):14-7.

22. Scott N, Caulkins J, Ritter A, Quinn C, Dietze P. High-frequency drug purity and price series as tools for explaining drug trends and harms in Victoria, Australia. Addiction. 2015;110(1):120-8.

23. Australian Institute of Health and Welfare. Trends in methylamphetamine availability, use and treatment, 2003-04 to 2013-14. Canberra: AIHW; 2015.

24. Australasian College for Emergency Medicine. The long wait: An analysis of mental health presentations to Australian emergency departments. Melbourne: ACEM; 2018. Available from: https://acem.org.au/getmedia/60763b10-1bf5-4fbc-a7e2-9fd58620d2cf/ACEM_report_41018

25. Australasian College for Emergency Medicine. Waiting times in the emergency department for people with acute mental and behavioural conditions. Melbourne: ACEM; 2018. Available from: https://acem.org.au/getmedia/0857d22e-af03-40bb-8e9f-f01a2a2bf607/ACEM_Mental-Health-Access-Block.aspx

26. Government of Western Australia. Urgent care clinic opens at Royal Perth Hospital [Media release]. Perth: Government of Western Australia; 2018 [updated 2018 May 22; cited 2020 Aug 21]. Available from: https://www.mediastatements.wa.gov.au/Pages/McGowan/2018/05/Urgent-Care-Clinic-opens-at-Royal-Perth-Hospital.aspx

27. Wood DM, Conran P, Dargan PI. ICD-10 coding: poor identification of recreational drug presentations to a large emergency department. Emerg Med J. 2011;28(5):387-9.

28. NSW Ministry of Health. The hospital drug and alcohol consultation liaison: model of care. North Sydney: NSW Government; 2015. Available from: https://www.health.nsw.gov.au/aod/professionals/Publications/hosp-DA-consult-moc.pdf

29. Bogenschutz MP, Donovan DM, Mandler RN, Perl HA, Forcehimes AA, Crandall C, et al. Brief intervention for drug users in emergency departments. JAMA Intern Med. 2014;174(11):1736-1745.

30. Rodgers C. Brief interventions for alcohol and other drug use. Aust Prescr. 2018;41:117-121.

31. Egerton-Warburton D, Gosbell A, Moore K, Wadsworth A, Richardson D, Fatovich D. Alcohol-related harm in emergency departments: a prospective, multi-centre study. Addiction. 2018;113(4):623-632

32. Coomber K, Miller P, Taylor N, Livingston M, Smith J, Buykx P, et al. Investigating the introduction of the alcohol minimum unit price in the Northern Territory. Summary report. Prepared for the Northern Territory Department of Health. Geelong: Deakin University; 2020

33. Department of Health, Australian Government. Review of methadone treatment in Australia. Canberra: Department of Health; 1995. Available from: https://www1.health.gov.au/internet/publications/publishing.nsf/Content/drugtreat-pubs-methrev-toc

34. Fernandes R, Cary M, Duarte G, Jesus G, Alarcão J, Torre C, et al. Effectiveness of needle and syringe programmes in people who inject drugs – an overview of systematic reviews. BMC Public Health. 2017; 17(309):1-15.

35. Harm Reduction Australia. What is harm reduction?. Harm Reduction Australia; 2018. Available online: https://www.harmreductionaustralia.org.au/what-is-harm-reduction/

36. Lingamanaicker K, Geelhoed E, Fatovich DM. Direct cost of alcohol-related presentations to Royal Perth Hospital emergency department. Emerg Med J. 2019;31(6):1045-1052.

Further information

Acknowledgements

The College thanks the following individuals for their help preparing this report.

- Professor Drew Richardson of the Canberra Hospital ED and the Australian National University for conducting the research
- Anita Taglieri for assisting with data collection

Suggested citation

Australasian College for Emergency Medicine. Alcohol and Methamphetamine Harm in Emergency Departments: Findings from the 2019 Snapshot Survey. Melbourne: ACEM; 2020.

Contact

Emily O'Connell
Policy and Advocacy Unit, Policy and Research Division
Department of Policy and Strategic Partnerships
+61 3 9320 0444
policy@acem.org.au

Australasian College for Emergency Medicine
34 Jeffcott St
West Melbourne VIC 3003
Australia
+61 3 9320 0444
admin@acem.org.au

acem.org.au