Position statement on reducing alcohol related harm

The District Health Boards of Wairarapa, Hutt Valley and Capital and Coast and Regional Public Health are committed to reducing the alcohol-related harm. Our efforts to do so will be based on the best available evidence and we will undertake the following actions within our available resources.

1. We support the adoption of the most effective population-based strategies to reduce harmful use of alcohol, as identified by the World Health Organisation, including; reducing the availability of alcohol, increasing the purchase age, reducing the legal blood alcohol concentration for driving, increasing the price, and reducing alcohol advertising and marketing.

2. We support government policy to:
   i) Reduce excessive drinking by adults and young people;
   ii) Reduce the harm caused by alcohol use including crime, disorder, public nuisance and negative public health outcomes;
   iii) Support the safe and responsible sale, supply and consumption of alcohol;
   iv) Improve community input into local alcohol licensing decisions;
   v) Improve the operation of the alcohol licensing system.

3. We will actively work towards reducing alcohol and other drug-related harm inequalities in identified high-risk populations.

4. We will promote harm reduction strategies for alcohol and other drugs through the provision of information to health care professionals and the public.

5. We will work to increase access to treatment options for alcohol and other drugs across the region, particularly for high-risk populations.

6. We will work to increase opportunities for screening and brief interventions in appropriate health settings such as emergency departments and primary care.

7. We will actively work to increase our capacity to monitor the impact of alcohol and drug-related harm on health services.

8. We will link with Primary Health Organisations, Non-Government Organisations, Justice and Education sectors and other parts of the Health sector and communities to ensure that we have a full understanding of the alcohol and other drug issues as experienced by our population and can then determine the best interventions to address any emergent issues.

9. We will support our public health and clinical staff in their work to; plan for, promote, support and deliver alcohol and other drug harm reduction and treatment strategies appropriate for our regions' communities.

10. We will engage with local government and communities to identify alcohol issues and support the implementation of local solutions.

11. We will actively work to increase our capacity to assess the impact of our interventions.

Background and rationale

The impact of harmful use of alcohol on health and health services

Hospital services face daily the outcomes of harmful consumption of alcohol across the lifespan. Emergency departments, trauma wards, operating theatres and intensive care units bear the brunt of providing care for injury, violence and acute conditions. Other services carry the burden of care for patients with mental illness or chronic disease and cancer brought about by harmful alcohol consumption over the longer term. Others deal with the developmental problems arising from alcohol use in pregnancy such as foetal alcohol spectrum disorders.

New Zealanders' pattern of drinking is of concern. We live in a society that supports harmful drinking and where consuming alcohol is seen as a normal accompaniment to our everyday activities. While there are many people who drink at low risk levels or do not drink alcohol at all, drinking at harmful levels and getting drunk is accepted. Such behaviour is frequently celebrated and glamorised. Our young people drink the way they do because they see this behaviour as "the norm". What they see and hear from adults and the community promotes this message.

It is vital then, that more people adopt the recommended guidelines for low risk drinking (see appendix 1). Following these guidelines can be difficult due to alcohol consumption being used and accepted as a means of dealing with stress, Further the social pressure to drink, the vast range of alcohol products, the way it is promoted, its availability during most hours of the day and days of the week, and the number of settings for drinking and purchase make it easy to drink large amounts.

The increasing scientific evidence regarding the health outcomes influenced by alcohol indicates the importance of tackling societal attitudes and behaviours towards alcohol. In particular historical liberalisation of policy has been accompanied by increases in the quantity of alcohol consumed[1].

- In 2007 in New Zealand alcohol is estimated to have been responsible for 802 deaths (5.4% of all deaths) and 13,769 years of life lost (YLLs) under 80 years of age. Much of the harm (43%) was due to injury (unintentional, violence and self-harm), but alcohol also contributed to a range of chronic non-communicable diseases, including cancers, liver disease and cardiovascular diseases[2].

- Alcohol related admissions to hospital transition from injury as the primary cause to increasing presentations of chronic conditions such as cancer, cardiovascular disease and digestive disorders[3] as age increases.

- Men have roughly twice the rate of death and hospital admissions attributable to alcohol. Deaths from injury were more common in men, contributing to 73% of all years of life lost from drinking in men and 42% in women[4].

- 82% of New Zealand women report consuming alcohol prior to conception and 34% report drinking during pregnancy[5].

---

[1] Huckle, T., R. Q. You, et al. (2011). "Increases in quantities consumed in drinking occasions in New Zealand 1995â€“2004." *Drug and Alcohol Review* 30(4): 366-371.

[2] Connor J, Kydd R, Shield K, Rehm J. (2012) *Alcohol-attributable burden of disease and injury in New Zealand:* 2004 and 2007. Wellington: Alcohol Advisory Council of New Zealand

[3] Connor, J., Kydd,R.,Rehm, J.,Shield,K. (2013). *Alcohol-attributable burden of disease and injury in New Zealand:* 2004 and 2007. Research report commissioned by the Health Promotion Agency. Wellington, Health Promotion Agency.

[4] Connor, J., Kydd,R.,Rehm, J.,Shield,K. (2013). Alcohol-attributable burden of disease and injury in New Zealand: 2004 and 2007. Research report commissioned by the Health Promotion Agency. Wellington, Health Promotion Agency.

[5] Mallard S, Connor J, Houghton L. 2013 Maternal factors associated with heavy periconceptional alcohol intake and drinking following pregnancy recognition: A post-partum survey of New Zealand women. Drug and Alcohol review vol 32 issue 3

- Hazardous drinking is more common in the most deprived areas of New Zealand[6] and there is a clear association between overall alcohol outlet density and socioeconomic deprivation, with more alcohol outlets situated in deprived areas[7]

- In the Wellington Region 22% of men and 11% of women have a hazardous drinking pattern scoring 8 or more on the 10-question AUDIT test[8].

Legislative and Policy Environment

National Drug Policy
Government policy recognises that no single strategy can address the harms from drug and alcohol use and that multiple strategies are needed. The strategies are captured in a single framework of three core areas[9]:

- Supply control – control or limit the availability of drugs, including alcohol
- Demand reduction – limit the use of drugs and alcohol by individuals, including abstinence
- Problem limitation – reduce the harm from existing drug and alcohol use

The Law Commission
In 2008 The Law Commission was engaged to evaluate the existing laws and policies relating to the sale, supply and consumption of alcohol. The final report released in 2010 - *Alcohol In Our Lives, Curbing the Harm* made 153 recommendations to government for change in law.[10]

Major recommendations included: raising the purchase age to 20, sweeping reform to the self-regulation of advertising and marketing, an immediate increase in the tax on alcohol and the introduction of a minimum pricing regime, and regulations to allow restriction on the supply of alcohol. Of these major recommendations government chose to implement significant change to the supply of alcohol allowing for greater restrictions predominantly through control of hours, density and location. Communities were given some control over licensing matters with councils able to adopt Local Alcohol Policies.

The Sale and Supply of Alcohol Act 2012
In December 2012, the government introduced a new act regulating the supply of alcohol. This act has significant changes from the previous Sale of Liquor Act 1989. Particularly pertinent to health services are:

- A broader definition of alcohol related harm

  "alcohol related harm –
  (a) means the harm caused by the excessive or inappropriate consumption of alcohol; and
  (b) includes –

---

6 Connor, J. L., K. Kypri, et al. (2010). Alcohol outlet density, levels of drinking and alcohol-related harm in New Zealand: a national study. *Journal of epidemiology and community health* 65(10): 841-846

7 Connor, J. L., K. Kypri, et al. (2010). Alcohol outlet density, levels of drinking and alcohol-related harm in New Zealand: a national study. *Journal of epidemiology and community health* 65(10): 841-846

8 Ministry of Health (2013) Regional results from the 2011/12 New Zealand Health Survey http://www.health.govt.nz/publication/regional-results-2011-12-new-zealand-health-survey

9 Ministry of Health (2007) *National Drug Policy 2007-2012*, Downloaded from http://www.ndp.govt.nz

10 The NZ Law Commission (2010) NZLC R114 *Alcohol in our lives: Curbing the harm.* Downloaded from http://www.lawcom.govt.nz/project/review-regulatory-framework-sale-and-supply-liquor

(i) any crime, damage, death, disease, disorderly behaviour, illness, or injury, directly or indirectly caused, or directly or indirectly contributed to, by excessive or inappropriate consumption of alcohol: and

(ii) any harm to society generally or the community, directly or indirectly caused, or directly or indirectly contributed to, by crime, damage, death, disease, disorderly behaviour, illness, or injury of a kind described in subparagraph (i)"[11]

- An increased role for the medical officer of health

  (a) The medical officer of health is required to enquire into all licensing applications and report on those of concern
  (b) All territorial authorities must consult with the medical officer of health while drafting their local alcohol policies.

  Local alcohol policies are implemented through local council (they are voluntary, not compulsory) and guide all alcohol licensing applications in the district. They can place restrictions on the availability of alcohol by stipulating controls on the hours of operation, density of premises, the types of premises etc for given locations. The policy is both a tool for harm reduction and enables a community to have a say in licensing matters.

- A requirement to respond to territorial authorities request for alcohol related health information, particularly the health of the districts residents and the nature and severity of the alcohol-related problems arising in the district.

The district health boards of Wairarapa, Hutt Valley and Capital and Coast and Regional Public Health are committed to playing an active role in informing local alcohol policies as part of their efforts to reduce alcohol-related harm.

Evidenced based strategies

Alcohol problems are not restricted to a small proportion of heavy/dependent drinkers or to the young. Therefore action at all levels of society by all means is required to bring a societal change in attitudes to consumption. There is no single factor that contributes to the development of alcohol-related problems and a multi strand evidenced based approach addressing supply control, demand reduction and harm minimisation is required.

As a member state of the World Health Organisation, New Zealand health services are expected to demonstrate commitment to advancing alcohol harm reduction both locally and nationally. This includes advocating for more effective policy and intervention strategies suitable for the New Zealand context.

The most effective strategies for reducing the harmful use of alcohol include population based strategies such as reducing the availability of alcohol, increasing the purchase age, lowering the blood alcohol concentration for driving, increasing the price and reducing alcohol marketing and advertising[12]. At the individual level brief interventions are of assistance[13].

[11] *Sale and Supply of Alcohol Act 2012*. Public Act 2012 No. 120

[12] World Health Organization (2010). Sixty-third world health assembly. Strategies to reduce the harmful use of alcohol: draft global strategy

[13] World Health Organization (2010). Sixty-third world health assembly. Strategies to reduce the harmful use of alcohol: draft global strategy