The Health Impacts of Alcohol in the Buller District and the West Coast

A report to the Buller District Council From the Medical Officer of Health

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Community & Public Health West Coast
a division of Canterbury District Health Board

Index

Executive Summary

This report has been prepared by the Medical Officer of Health and other staff of Community and Public Health as part of the development of a Draft Local Alcohol Policy (LAP) by the Buller District Council under the Sale and Supply of Alcohol Act 2012. LAPs are a tool for Territorial Local Authorities and their regulatory partners to reduce alcohol-related harm through the control of alcohol licensing in their districts. Additionally Local Alcohol Policies give local communities more input into licensing decisions.

The West Coast population

The West Coast is home to a population of 32,148 people in 2013. The Buller District has the second largest population of the three West Coast districts, with 10,473 residents in 2013, a 7.9% increase since 2006. The West Coast population is relatively socio-economically deprived which contributes to higher levels of health need and increased vulnerability to alcohol-related harm.

The licensing environment

Overall, the West Coast has a disproportionately high number of alcohol outlets per head of population relative to the rest of New Zealand with just over 60% as many on and off licenses and approximately 50% more club licences. The proportion of alcohol outlets by head of population also differs by district with the highest proportion being in the Westland District and the lowest in the Grey District. The Buller District's proportion is still just over two and half times the New Zealand average.

The health impacts of alcohol in the Buller District and the West Coast

This report summarises the evidence for the health impacts of alcohol on the West Coast and in the Buller District and places them in the context of what is known about the health impacts of alcohol in New Zealand as a whole.

All three districts of the West Coast have higher rates of alcohol-related deaths than the national rate with the Buller District's rate being the lowest for the Coast but still 40% higher than the national rate. The West Coast also has higher rates of alcohol-related hospitalisation than the national rate and the Buller District's rates are the highest of the three West Coast districts. West Coast young people aged 15-24 have almost two and half times the rate of alcohol-related hospitalisation of New Zealand as a whole and Canterbury. The West Coast overall has higher than the New Zealand average rate of alcohol-involved road traffic crashes (11.6 vs 7.8/10,000 population). The rates vary between the districts with the Grey District having the highest rate (13/10,000), followed by Westland and Buller.

Ambulance data on alcohol-related harm on the West Coast have only recently become available but the trends observed so far are broadly consistent with national data, including: higher numbers of males than females, highest numbers of cases in age 15-19 and 20-24 age groups. However, despite the above, there are high levels of alcohol involvement across a

wider range of age groups (15-19, 20-24, 25-29, 30-34, 35-39 and 49-44) and high levels of alcohol involvement by location in houses, on the road and in public places.

West Coast health professionals report that they deal frequently with a wide range of health impacts from alcohol ranging from acute intoxication and its effects on behaviour to its chronic effects on mental and physical health across the age range. Several observe that these effects are widespread and pervasive and create a significant burden on local health services, families and whānau and the wider community.

Drinking behaviours

West Coasters have higher rates of hazardous drinking than the national rate. The West Coast Community Alcohol survey found that, in common with New Zealand as a whole, the majority of West Coasters (85%) drink alcohol. Significant proportions also reported risky drinking behaviours like binge drinking, heavy drinking and frequent drinking. All these behaviours increase the risk of adverse health impacts significantly.

At least one in five West Coasters exceeded the safe limits for drinking in the last year and met the criteria for binge drinking. Males were significantly more likely to report drinking 13 or more alcoholic drinks on one occasion compared to females (18% vs 7%, $p<0.01$). Males were also significantly more likely than females to drink four or more times a week (21% vs 9%, $p<0.01$). Those aged over 65 were significantly more likely to drink four or more times a week than respondents in younger age groups ($p=0.01$). Women were less likely than men to report having six or more drinks on one occasion (36% vs 68%, $p<0.01$). People 65 and over were also less likely to report having drunk 6 or more drinks on a single occasion than those aged 18-24 (13% vs 76%, $p<0.01$).

Community views on alcohol and alcohol licensing

The West Coast Alcohol Survey asked a sample of 1204 residents from all three districts of the Coast (Buller 413, Grey 420 and Westland 371) a range of questions about their opinions on alcohol use, the numbers, location and trading hours for licensed premises, potential restrictions on the operation of alcohol outlets such as one way door policies, and liquor bans. There were few differences between the views of respondents across the three districts.

The majority of respondents agreed that alcohol was a problem on the West Coast. The problems most identified as related to alcohol included: anti-social behaviour, people being unable to carry out everyday tasks like going to work, intimidating behaviour, assaults and violence, noisy parties, unruly behaviour, vandalism and litter, pre-loading and feeling unsafe in public places when there are people around who have been drinking. About three quarters of respondents agreed that drinking at parks, cars, beaches and BBQ areas caused negative impacts of drinking, while around half thought this was the case for drinking at and after public events, or drinking at pubs or bars. Over a third agreed that drinking at private houses or sports clubs caused negative impacts, while smaller proportions agreed that drinking at community clubs or cafes did.

Three quarters of respondents agreed that pubs and bars are a great place to socialise and just under two thirds agreed that pubs and bars play a role in bringing the community together. However, less than a third agreed that drinking is part of the West Coast being a fun place to live.

Only 19% of respondents agreed that people should be able to buy alcohol readily throughout the whole of the West Coast and men and those aged under 25 were more likely to hold these views. Respondents from the Grey District were more likely to disagree that people should able to buy alcohol readily at most hours than those from other districts.

Most respondents supported maintaining (68%) or reducing (26%) the current trading hours of alcohol outlets and just over 30% supported shorter or much shorter trading hours for pubs/bars, bottle stores and supermarkets. About three quarters of respondents thought that there was the right number of supermarkets and bottle stores selling alcohol on the West Coast, while about a quarter thought there were either too many or far too many supermarkets and bottle stores selling alcohol. Almost no-one thought there should be more alcohol outlets.

Around three quarters of respondents agreed that bottle stores, pubs and bars should not be allowed to operate near early childhood centres, primary or secondary schools or community facilities. Just over half of respondents agreed or strongly agreed that bottle stores, pubs and bars should not be able to operate near places of worship.

There were equally high levels of support for one way doors and alcohol bans in all three districts. Just under three quarters of respondents agreed that one way door restrictions should be required for pubs and bars and 90% of respondents agreed that local alcohol bans are a good way to curb alcohol-related problems in specific areas.

Conclusions and recommendations

The West Coast and the Buller District are experiencing high levels of adverse health impacts from alcohol and there are high levels of risky drinking behaviours. The community also recognises that there is a range of problems associated with alcohol. There is community support for actions related to licensing that would help to reduce alcohol related harm, such as controls on trading hours, outlet numbers and locations, as well as one way doors and liquor bans. Development of a LAP for the Buller District will not solve all of the district's problems with alcohol but it is an opportunity to take action to help reduce alcohol-related harm and move closer to achieving the aims of the new legislation.

The Medical Officer of Health recommends:

Trading Hours

Trading hours in the draft LAP should be more restrictive than the default hours in the legislation and different hours are appropriate for different types of licences.

- For on-licences, hours should be a maximum of 8.00 am to 1.00 am
- For off-licences, hours should be a maximum of 9.00am to 9.00 pm

Discretionary conditions such as one way doors should be considered for hotel and tavern licences in main centres such as Westport.

Location and density of licences

Consideration needs to be given to the number of licences already in an area, local community views and the amenity of the area, along with proximity of sensitive sites.

There should be a cap on the number of off-licence outlets at current numbers.

Special Licences

Discretionary conditions should be applied dependent on such factors as location, numbers attending, type of event, time of event, number of times it occurs.

Discretionary conditions

Appropriate use of discretionary conditions is recommended as an important consideration in new licence applications and in renewals. A range of issues may be addressed through such conditions.

Other issues that may have a place in discretionary conditions are security, supervision, the premise environment, both indoor and outdoor, and the need to consider impacts from large seasonal variation in patronage.

It may also be appropriate to consider if the amount of advertising on an off-licence, especially regarding cheap alcohol, should be subject to discretionary conditions.

1. Introduction

This report has been prepared by the Medical Officer of Health and other staff of Community and Public Health as part of the development of a Draft Alcohol Policy by the Buller District Council under the Sale and Supply of Alcohol Act 2012.

1.1 Overview of the Act and the purpose of a Local Alcohol Policy (LAP)

The Object (section 4) of the Sale and Supply of Alcohol 2012 are as follows:-

(1) The object of this Act is that—

(a) the sale, supply, and consumption of alcohol should be undertaken safely and responsibly; and

(b) the harm caused by the excessive or inappropriate consumption of alcohol should be minimised

(2) For the purposes of subsection (1), the harm caused by the excessive or inappropriate consumption of alcohol includes—

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

(b) any harm to society generally or the community, directly or indirectly caused, or directly or indirectly contributed to, by any crime, damage, death, disease, disorderly behaviour, illness, or injury of a kind described in paragraph (a).

The introductory section on Local Alcohol Policies (LAPs) states:

75 Territorial authorities may have local alcohol policies

(1) Any territorial authority may have a policy relating to the sale, supply, or consumption of alcohol within its district

Local Alcohol Policies (LAPs) are a tool for Territorial Local Authorities and their regulatory partners, the Police, the Medical Officer of Health and Licensing Inspectors to reduce alcohol-related harm through the control of alcohol licensing in their districts. Additionally the Act aims, through Local Alcohol Policies, to give local communities more input into licensing decisions.

In producing their draft LAP, section 78 (2) of the Act specifies a number of matters that **ter**ritorial authorities must have regard to, including

(f) the overall health indicators of the district's residents; and
(g) the nature and severity of the alcohol-related problems arising in the district.

In addition, section 78(4) specifies that the authority must not produce a draft policy without having consulted the Police, inspectors, and Medical Officers of Health, each of whom must, if asked by the authority to do so, make reasonable efforts to give the authority any information they hold relating to any of the matters stated in subsection (2)(c) to (g).

This report presents the data available on the overall health indicators of the West Coast population and the health impacts of alcohol in the Buller District and the wider West Coast. The most recent data available are included. Data on crime and disorder related to alcohol are presented separately in a report from the West Coast Police.

Section 295 of the Act imposes a duty on the Police, licensing inspectors, and the Medical Officer of Health within each district to collaborate to

> (a) establish and maintain arrangements with each other to ensure the ongoing monitoring of licences and the enforcement of this Act; and
> (b) work together to develop and implement strategies for the reduction of alcohol-related harm.

There is already a very good working relationship between the three agencies in the Buller District and a shared commitment to positive actions to reduce alcohol-related harm, including supporting the development of a LAP by the Buller District Council.

The West Coast District Health Board is also strongly supportive of actions to reduce alcohol-related harm on the West Coast and identified working with Territorial Local Authorities to develop Local Alcohol Policies as a strategy in their Alcohol Position Statement (adopted in 2012).

2. The West Coast and Buller District Populations

The West Coast is home to a population of 32,148 people in 2013, an increase of 2.6% from 2006. By 2026, the West Coast's population is predicted to grow to over 33,300 people. The Buller District has the second largest population of the three West Coast districts, with 10,473 residents in 2013, a 7.9% increase since 2006.

2.1 Population characteristics and health needs

As might be expected from its slower population growth, the West Coast population has an older age structure compared with New Zealand as a whole, with a higher proportion of people aged over 65 compared with the national average. By 2026, the proportion of people aged over 65 will have increased by over 10%, one in every four people on the Coast will be over 65, and the number of people aged over 80 will have doubled. As the population ages, its health needs become more complicated with multiple health conditions. There are a number of long-term conditions that become more common with age, including heart disease, stroke, cancer and dementia.

Ethnicity is a strong indicator of health need. While just over 1% of the West Coast population identified as Asian and less than 1% as Pacific, one in ten West Coasters identified as Māori (10%) in the 2006 census. The Māori population on the West Coast has a different age structure and growth pattern, with 75% of the West Coast Māori population being under 45 years of age. Deprivation is also a strong indicator of health need. Analysis of socio-demographic data shows that compared with New Zealand as a whole, the West Coast population has a lower mean personal income (in the 2006 Census, $20,400 per year compared to $24,400 nationally). Higher proportions of the West Coast population are also receiving unemployment or invalid benefits, have no educational qualifications and lack access to a mobile phone or motor vehicle.

2.2 Population health profile

West Coasters have a higher overall morbidity and mortality rates and lower life expectancy when compared with the New Zealand average. The overall rate of hospitalisation is also high. While gains have been made, West Coast Māori continue to have a poorer overall health status than others in the region. This is demonstrated by a range of indicators, including rates of cardiovascular disease, cancer, diabetes and respiratory disease. Māori are also under-represented among primary care utilisation data and have higher rates of smoking. A much higher proportion of West Coast Māori (55%) die before the age of 65 compared with other West Coasters (20%). West Coast children and young people have poorer health outcomes than their counterparts in other parts of the country. The leading causes of mortality, morbidity, and hospitalisations for young people on the West Coast are preventable. West Coast residents have higher smoking rates compared with other areas in New Zealand. The 2006/07 New Zealand Health Survey showed that 28.2% of West Coast residents were current daily smokers, compared to 19.1% of New Zealand as a whole. Amongst West Coast Māori, 43.3% of women and 39.6% of men smoke. The negative health outcomes associated with risk factors such as tobacco smoking place considerable pressure on our health system.

3. The Health Impacts of Alcohol in New Zealand – An Overview

Alcohol has been consumed in New Zealand since the very earliest days of European contact. The explorer James Cook is thought to have brewed the first beer at Dusky Sound in 1773 using rimu leaves and bark. By 1835, New Zealand had its first commercial brewery and by 1879, there was one hotel for every 287 Europeans. Early colonial drinking behaviours became notorious amongst travellers to this country like Anthony Trollope, who commented that New Zealanders seemed "very fond of getting drunk". George Chamier, a resident of the Bay of Islands, the site of New Zealand's first capital at Kororareka (which earnt the soubriquet of the "hell hole of the Pacific" for the drunken and disorderly behaviours of its residents), commented that "it was considered a mean thing to drink alone; it was considered meaner still not to drink at all".

Today, the majority of New Zealanders drink alcohol and it is enjoyed by responsible drinkers for its positive effects, including the part it plays in social occasions. However, just as in our early colonial past, there is a downside to alcohol consumption. Some of our attitudes to drinking may have changed since colonial times, but in many ways modern New Zealanders' drinking behaviours mirror those of their colonial forebears , with binge drinking and heavy drinking being common (see 3.4 below). This chapter provides an overview of part of that downside – the health impacts of alcohol.

3.1 Alcohol has a variety of serious health impacts

The Law Commission's 2009 Issues paper Alcohol in Our Lives summarises the health impacts of alcohol in New Zealand very well:

"Alcohol is the most commonly used recreational drug in New Zealand. It is a psychoactive substance with the potential to harm in three ways: toxicity, intoxication and dependence. Immediate harms, like alcohol poisoning and accidental injury or assaults, occur at the time of consumption and typically are the result of intoxication. Longer term or chronic health harms are associated with the cumulative toxic effects of alcohol consumed over many years and include a range of cancers, cardiovascular disease, liver disease, high blood pressure, depression, anxiety disorders and alcohol dependence.

How individuals drink – the frequency and quantity consumed – are key determinants in their risk of harm. Those who consume large quantities when they drink, including those who drink to intoxication, face an increased risk of suffering or causing an immediate or acute harm, such as an accident or injury. Alcohol poisoning and acute tissue damage are also possible outcomes of high-volume drinking. The risk of suffering longer term or chronic harms, including a range of alcohol-related cancers, relates to the toxicity of alcohol on human organs and is determined by the cumulative effects of alcohol over months or years. The frequency and quantity of alcohol consumed determines the level of risk. Similarly, at a population level, the drinking patterns of New Zealanders determine the types and levels of alcohol-related harm experienced as a nation."

3.2 Some groups are more vulnerable to alcohol-related harm

Some groups in the community experience more serious alcohol-related harm than others. Young people (aged between 15 and 29) along with Maori and Pacific people experience a greater burden of this harm compared to other New Zealanders. People living in areas of higher socio-economic deprivation, such as the West Coast, also face greater impacts from alcohol-related harm (NZLC 2010)). This association may be due in part to a link to liquor outlet numbers and density as New Zealand research shows the density of liquor outlets is higher in the most deprived areas (NZLC 2010). People living in areas with a higher density of liquor outlet are also more likely to consume more and suffer from alcohol-related harm (Connor et al 2011).

3.3 Alcohol-related harm affects everyone, not just drinkers

Alcohol-related harm is not just confined to those who drink alcohol. The Law Commission's report also went on to say that:

"the misuse of alcohol does not relate in one single problem, but a whole set of problems, some of which affect the health and wellbeing of the individual drinker, some of which impact on those with whom the drinker comes in contact, and some of which impact on the community at large"

A New Zealand study (Connor et al, 2012) found that *"one in six adults aged 16-64 years (18.1%,) reported that they had experienced harmful effects on their friendships or social life, home life or financial position in the past year due to someone else's alcohol use"*. This was a larger proportion of people than reported harm from their own drinking (12.2%). The same paper reported that women suffered more alcohol-related harm, particularly young women with 35% of women aged 18 to 24 years reporting harm.

Social harms from alcohol misuse are well recognised, for example, Babor and others (2010) found that in both individual and population studies there is a clear link between alcohol and violence and that this risk of violence increases with increasing intake of alcohol. Evidence also exists for links with issues as child abuse, family problems and work related problems such as absenteeism, lateness and poor workplace relationships.

3.4 New Zealand has a drinking problem

The 2007/08 New Zealand Alcohol and Drug Use Survey measured alcohol and drug use behaviours among over 6500 New Zealanders aged 16–64 years. It found, as have many other studies, that alcohol is a pervasive part of the lives of New Zealanders from an early age and that a high proportion of New Zealanders have risky patterns of drinking

Eight in ten (85.2%) adults had had an alcoholic drink in the past year. A small proportion of past-year drinkers (6.8%) drank alcohol every day, with European/Other people more likely to have consumed alcohol daily. The median age of having a first alcoholic drink was 16 years. One in three (31.9%) people who had ever tried alcohol had their first drink when aged 14 years or younger.

Three in five (61.6%) past-year drinkers had consumed a large amount of alcohol (i.e. more than 4 standard drinks for women and 6 for men) on at least one occasion in the past year, with men more likely than women to have done so. One in eight (12.6%) past-year drinkers had consumed a large amount of alcohol on one drinking occasion at least weekly in the past year. The prevalence was highest among male past-year drinkers aged 18–24 years, with one in three (33.8%) having consumed a large amount of alcohol at least weekly.

The most common harmful effects experienced by adults in the past year *due to their own alcohol use* were:

- harmful effects on friendships or social life (6.9% of adults aged 16–64 years)
- having days off work or school (5.6%)
- harmful effects on home life (5.4%)
- harmful effects on financial position (5.4%)
- having injuries (4.7%)

The most common harmful effects experienced by adults in the past year *due to someone else's alcohol use* were harmful effects on friendships or social life (16.0% of adults aged 16–64 years), on home life (8.5%) and on financial position (3.6%). One in twenty-five (4.1%) adults reported having been assaulted (physically and/or sexually) as a result of actual force or violence by someone who was under the influence of alcohol or drugs, in the past year.

The survey results also showed that some population groups – in particular, younger people, Māori, Pacific men and people living in more deprived neighbourhoods – are more likely to have higher than recommended consumption levels, to engage in risky drinking behaviours and to experience disproportionate amounts of harm due to alcohol use.

Given that the effects of alcohol use and risky drinking include health problems (including injuries), social harms and financial harms, it is important to address alcohol-related harm in New Zealand by whatever means we have available.

The direct relationship between increased alcohol availability, increased alcohol consumption and phenomena such as pre-loading, and the alcohol-related harm they cause is clear. Evidence of this harm is widely available and was compiled by the Law Commission as part of a review that led to the passing of the Sale and Supply of Alcohol Act 2012.

4. The West Coast Alcohol Licensing Environment

The West Coast has a mix of alcohol outlets, ranging from small rural pubs to larger hotels and franchised off-licence outlets, such as supermarkets which belong to national chains, in its main centres.

Overall, the West Coast has a disproportionately high number of alcohol outlets per head of population relative to the rest of New Zealand with just over 60% as many on and off licenses and approximately 50% more club licences (see Table 4.1 below). Only a small part of this picture is attributable to the rural characteristics of the Coast.

Table 4.1 Number and type of alcohol outlets per head of population – West Coast

Type of licence	Number	Number if same proportion per 10,000 population as NZ average	Difference
On	138	59	79
Off	80	31	49
Club	31	17	14
Total	249	107	142

As at May 2013

Numbers of alcohol outlets vary between the three West Coast Districts with the Westland District having the highest number overall and the Grey District the lowest (see Table 4.2 below).

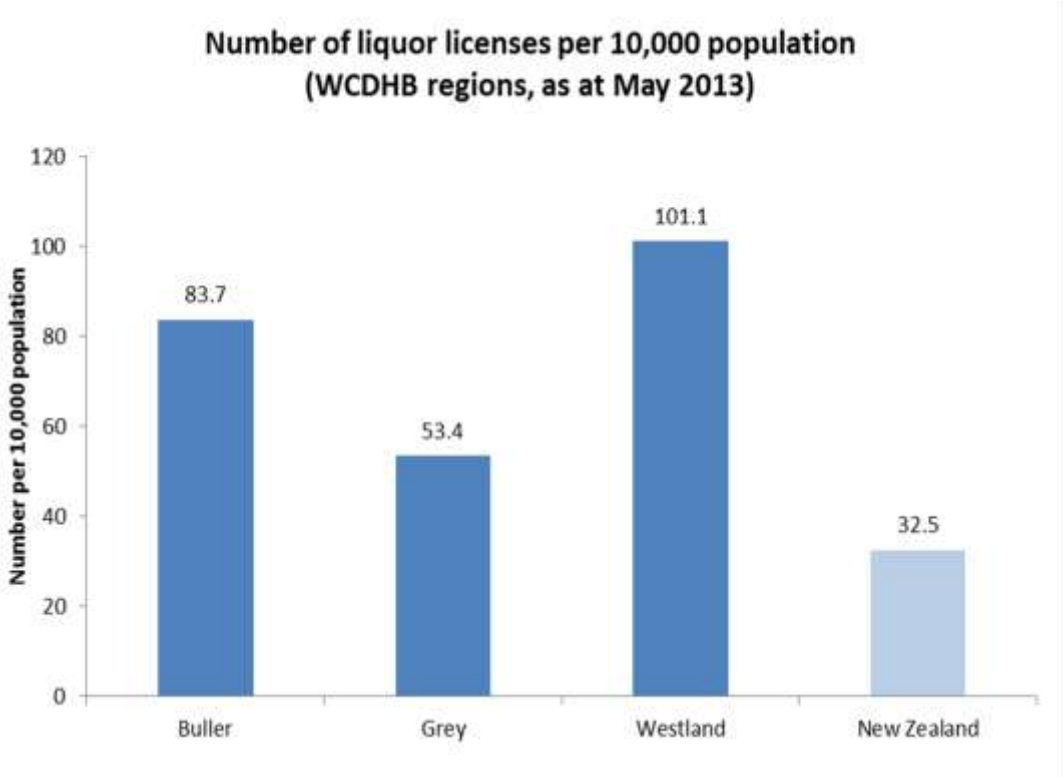
Table 4.2 Number and type of alcohol outlets in West Coast districts

	On Licence	Off Licence	Club Licence	Total
Buller	45	28	12	85
Grey	37	20	17	74
Westland	56	32	2	90
	138	80	31	249

As at May 2013

The proportion of alcohol outlets by head of population also differs by district with the highest proportion being in the Westland District and the lowest in the Grey District (see Figure 4.1 below). The Buller District's proportion is still just over two and half times the New Zealand average.

Figure 4.1 Number of alcohol outlets per head of population West Coast districts



The numbers of alcohol outlets in all three West Coast districts have declined only slightly over recent years and the current numbers represent a significant oversupply, even allowing for their geographic distribution.

One of the ways in which compliance of licensed premises with their legislative requirement not to sell alcohol to persons under the legal purchase age is checked is through controlled purchase operations. These are carried out jointly by Police and public health staff using trained volunteers who are under 18 years of age. Despite sales to persons under the legal purchase age being against the law, compliance of West Coast on and off licensed premises is less than 100% (see Table 4.3 below).

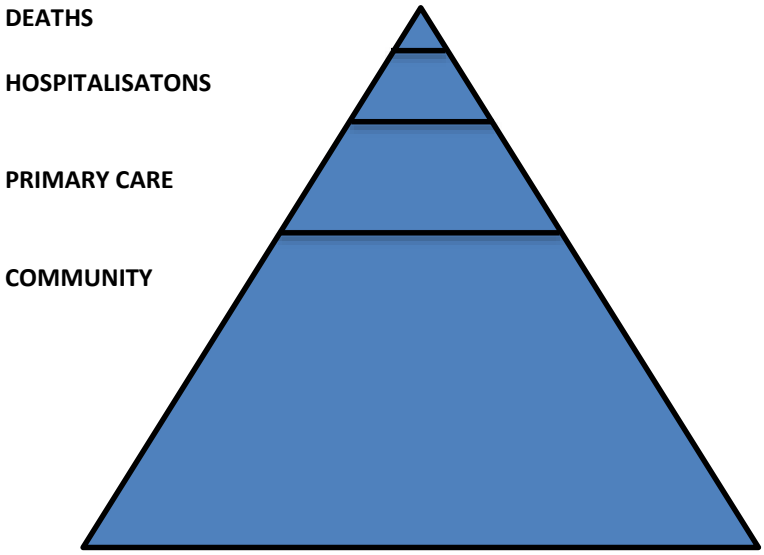
Table 4.3 Controlled Purchase Operation Compliance West Coast

	2010-2011	2011-2012	2012-2013
Outlets visited	10	17	25
Sale to under 18	1	8	3
% Compliance	90%	53%	88%

5. The Health Impacts of Alcohol on the West Coast and Buller District

The health impacts of alcohol can present to the health system at many levels from emergency departments and hospitals to ambulance services and primary care. In addition, not all of those whose health is harmed by alcohol will necessarily present to the health system, nor will the link between alcohol and the presenting illness or injury necessarily be made or documented. It is useful to think of alcohol-related health impacts as a kind of pyramid with a visible but small tip and a much larger base which is harder to see and to quantify. Paradoxically, the best data on alcohol health impacts comes from the smallest part of the harm pyramid.

Figure 5.1 The alcohol-related harm pyramid



5.1 Potential sources of data on the health impacts of alcohol

The potential sources of data on the health impacts of alcohol include:

- Deaths*
- Hospitalisations*
- Road traffic crash and injury data*
- Emergency departments
- Ambulance*
- Primary Care
- Healthcare workers*
- Community (including drinking behaviours)*

There are at least some West Coast data available for all those sources with an asterisk in the list above. As yet, routine Emergency Department (ED) data on alcohol involvement in

presentations to ED at Grey Base Hospital are not available, although this may change in the near future. Similarly, there are no routinely collected data on alcohol-related disease or injury seen in primary care (and this is not just the case on the West Coast). Ambulance data by West Coast ambulance station have only been collected since December 2012 and so it is not possible as yet to comment on trends and data quality and consistency is still improving.

Because of the relatively small numbers involved in some alcohol health impacts, and the small population of the West Coast, it is not always possible to provide reliable or stable estimates of rates for districts within the Coast, so some of the following data is presented for the West Coast overall. Similarly, the data on alcohol-related hospitalisations is not broken down by specific causes because of small numbers.

5.2 Alcohol-related deaths

All three districts on the West Coast have higher rates of alcohol-related deaths than New Zealand as a whole, with the highest rate in Westland, followed by Grey and Buller (see Table 5.1 below). The rates of wholly attributable alcohol-related deaths are more than twice the New Zealand average (note that there is no rate calculated for this category for Grey District because of the very small numbers of deaths involved in that year).

Table 5.1 Alcohol-related deaths on the West Coast by district

District	Alcohol -related deaths (wholly attributable) per 10,000 population	Alcohol-related deaths per 10,000 population
Buller	1.0	2.6
Grey	-	3.4
Westland	1.1	3.8
New Zealand	0.4	2.2

Data from Ministry of Health 2011
Alcohol attributable fractions calculated as per Connor and James

Note that deaths are classified as "wholly attributable" to alcohol are deaths in which death was caused directly by alcohol consumption e.g. alcoholic liver failure. "Alcohol-related" deaths are those in which alcohol was involved, though not necessarily the direct cause of death, e.g. road traffic crash injuries sustained while intoxicated. The alcohol-related death rate will always be larger than the wholly alcohol-attributable rate.

5.3 Alcohol-related hospitalisations

The West Coast has higher than the New Zealand average rate of alcohol-related hospitalisations although the rates vary between districts with the lowest rates in Westland and the highest in Buller (see Table 5.2 below). The Buller District's rates are approximately

29% higher than the national rate for wholly attributable hospitalisations and 30% higher for alcohol-related hospitalisations. As for the deaths data, hospitalisations classified as "wholly attributable" to alcohol are those where hospitalisation was the direct result of alcohol e.g. alcoholic pancreatitis whereas "alcohol-related" hospitalisations include those where alcohol was involved e.g. cancers.

Table 5.2 Alcohol-related hospitalisations on the West Coast by district

District	Alcohol-related hospital discharges (wholly attributable) per 10,000 population	Alcohol-related hospital discharges per 10,000 population
Buller	36.9	122.4
Grey	22.4	114.8
Westland	18.0	71.3
New Zealand	28.5	93.8

Data from Ministry of Health 2011
Alcohol attributable fractions calculated as per Connor and James

West Coast young people aged 15-24 have almost two and half times the rate of alcohol-related hospitalisation of New Zealand as a whole and Canterbury.

Table 5.3 Alcohol-related hospitalisations in young people aged 15-24 Canterbury and West Coast

DHB	Number: Total 2007–2011	Number: Annual Average	Rate per 100,000	Rate Ratio	95% CI
Young People Aged 15–24 Years					
Alcohol-Related Hospital Admissions					
Canterbury	766	153.2	212.8	1.07	0.99–1.15
West Coast	93	18.6	492.1	2.47	2.01–3.03
New Zealand	6,210	1,242.0	199.5	1.00	

Data from the NZ Child and Youth Epidemiology Service

5.4 Alcohol-related injuries

All West Coast districts have lower than the New Zealand average rates of alcohol-related injury. This may seem surprising, but it may relate at least in part to the high alcohol-related death rates as injury deaths account for a high proportion of these, i.e. alcohol-related injury is more likely to be lethal. Again, because of small numbers, only the Grey District has a figure for wholly attributable alcohol-related injury hospitalisation and this is almost twice the national rate. This comparison should be treated with caution.

Table 5.4 Alcohol-related injuries on the West Coast by district

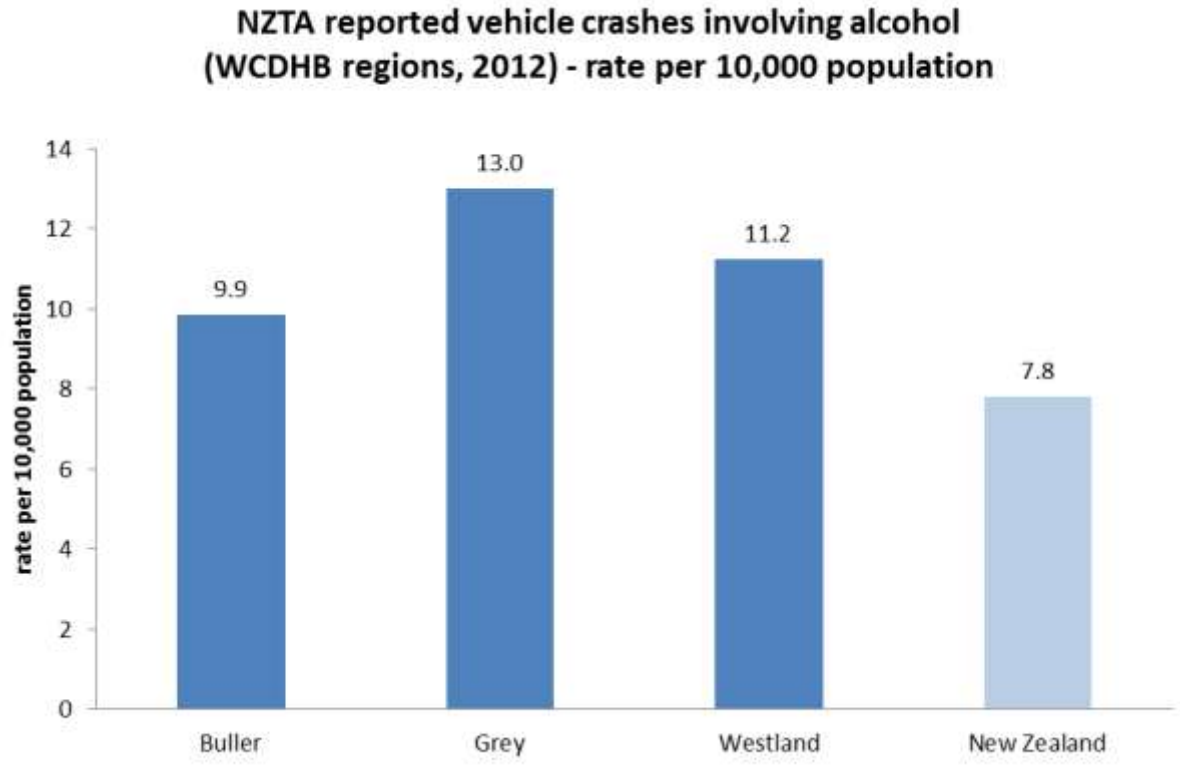
District	Alcohol-related injury hospital discharges (wholly attributable) per 10,000 population	Alcohol-related injury hospital discharges per 10,000 population	Injuries per 10,000
Buller	-	46.3	1,774.0
Grey	1.4	47.4	1,257.0
Westland	-	39.1	1,708.3
New Zealand	0.8	50.8	2,537.5

Data from Ministry of Health and ACC 2011

5.5 Alcohol and road traffic crashes

The West Coast overall has higher than the New Zealand average rate of alcohol-involved road traffic crashes (11.6 vs 7.8/10,000 population). The rates vary between the districts with the Grey District having the highest rate (13/10,000), followed by Westland and Buller (see Figure 5.2 below).

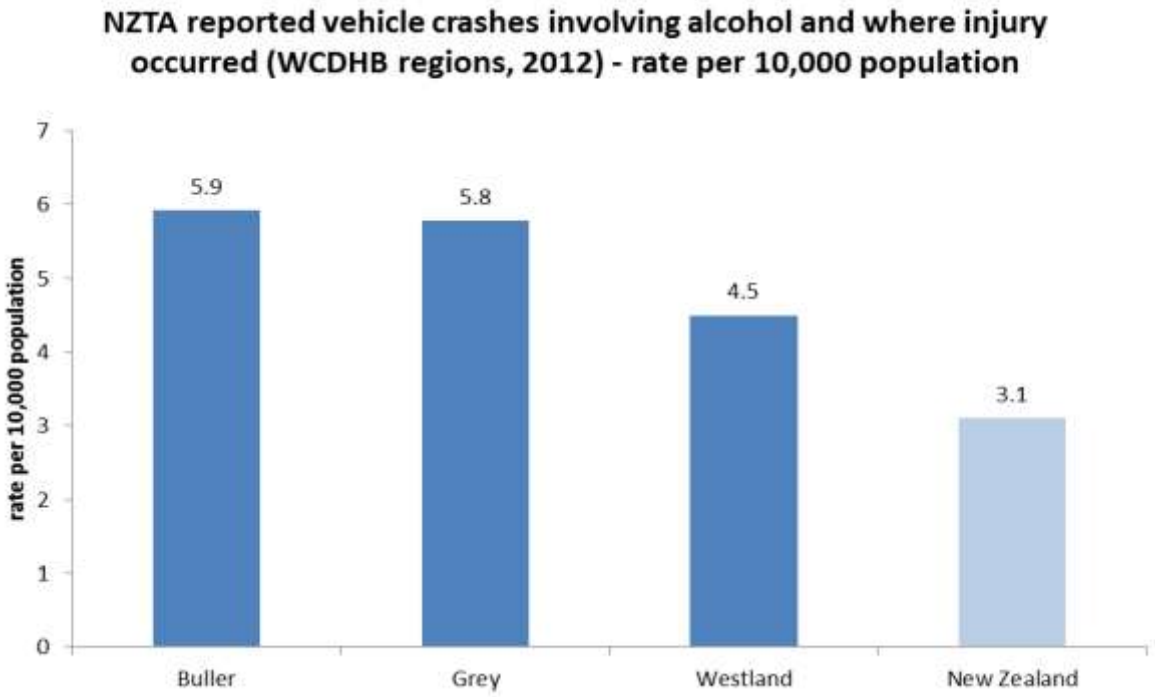
Figure 5.2



Data from NZTA

Road traffic crashes involving alcohol on the West Coast were also more likely to involve injury than in New Zealand as a whole. Again, the rates vary between the districts but all are higher than New Zealand as a whole, with Buller and Grey District rates almost twice the national rate and the rate in the Westland District one and a half times the national rate (see Figure 5.3 below).

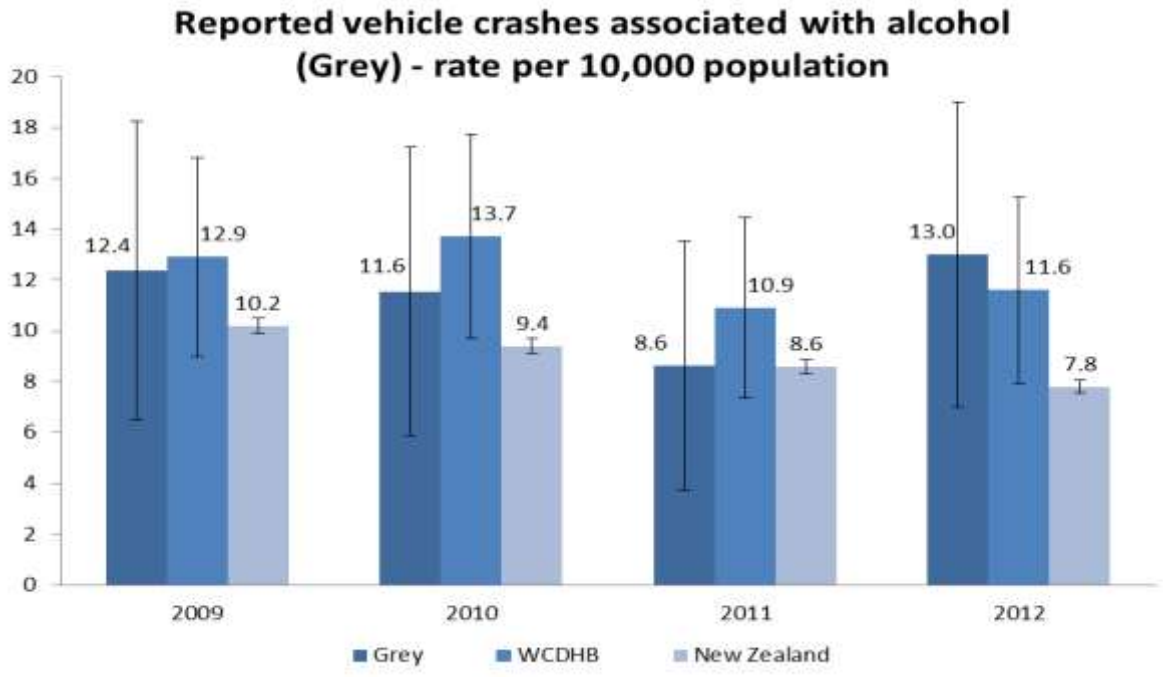
Figure 5.3



Data from NZTA

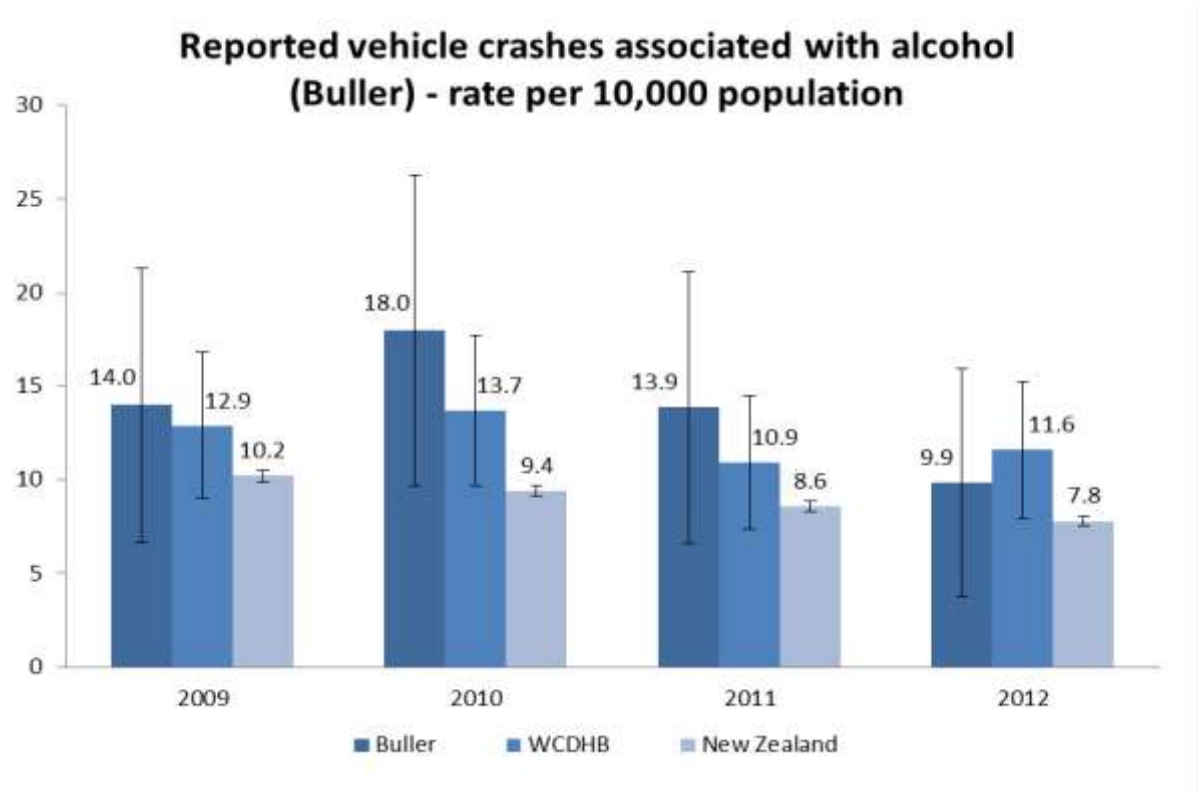
The rates of alcohol-related road traffic crashes across all three districts fluctuate from year to year though they are declining nationally. The rates by district from 2009-2012 are shown in Figures 5.4- 5.6 below. Note that the scales on the vertical axes of each of these graphs differ.

Figure 5.4



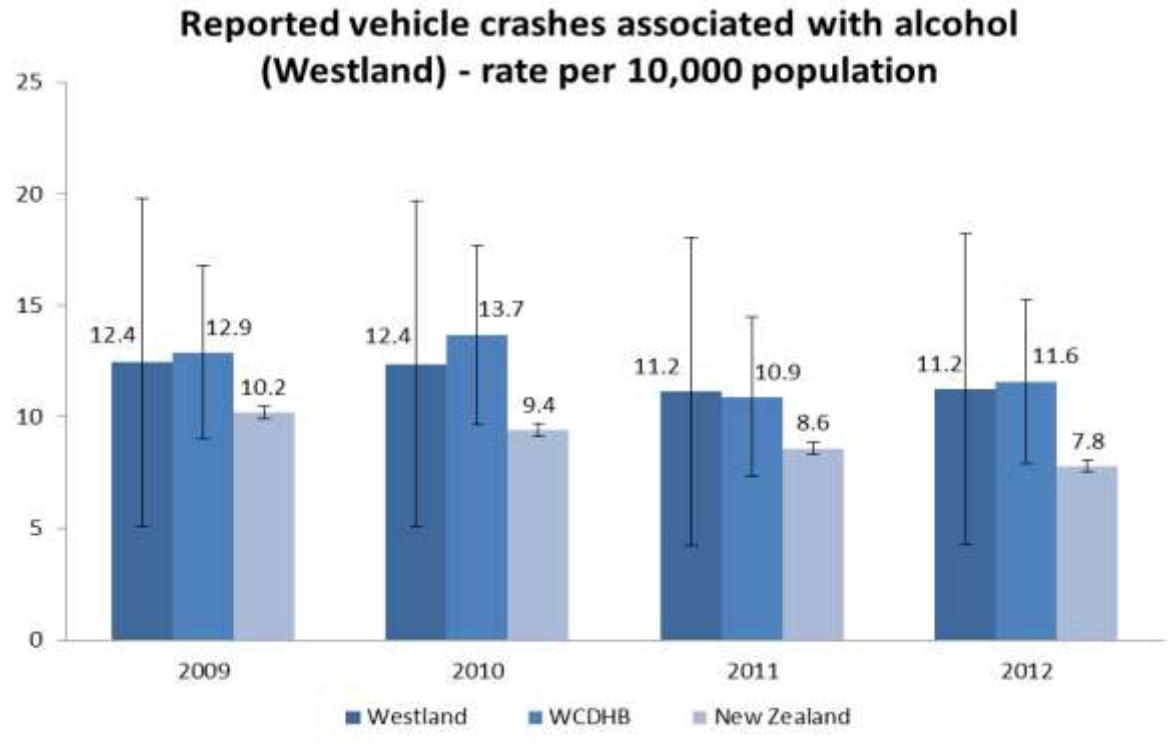
Data fromNZTA

Figure 5.5



Data from NZTA

Figure 5.6



Data from NZTA

5.6 Ambulance data

Ambulance data on alcohol involvement in cases attended by an ambulance have only recently become available. These data have been collected systematically only since December 2012. They are recorded by ambulance station. There are five West Coast ambulance stations: two in the Buller (in Reefton and Westport), one in the Grey District (in Greymouth), and two in Westland (Hokitika and Hari Hari). Data are collated by month.

Case data include age, sex, amount of alcohol consumed (classified as low, medium, high or unknown). There are also data on location of the incident (licensed premises, house, public place, road and other).

While it is not possible to draw too many conclusions from these data at this stage, including the extent of variation between districts, the trends observed so far include:

- Higher numbers of males than females
- The highest numbers of cases is in age 15-19 and 20-24 age groups
- However, despite the above, there are high levels of alcohol involvement across a wider range of age groups (15-19, 20-24, 25-29, 30-34, 35-39 and 49-44)
- There are high levels of alcohol involvement by location in houses, on the road and in public places.

These data are broadly consistent with what is seen nationally.

5.7 Drinking behaviours

As already mentioned in 3.4 above New Zealand data on alcohol consumption and drinking behaviours have been collected nationally as part of the Ministry of Health's Alcohol and Drug Use Survey 2007/2008. Data on hazardous drinking from the same survey are available at District Health Board Level and both are shown below in Table 5.4. Hazardous drinking has a specific definition: it is a pattern of drinking that causes a high risk of harming physical or mental health or having harmful social effects on the drinker or others. It corresponds to a score of 8 or more out of 10 on the AUDIT questionnaire. The West Coast has a higher rate of hazardous drinking than New Zealand as a whole.

Table 5.5 Prevalence of drinking, risky or hazardous drinking and drinking by minors

District	Drinking Prevalence (%)	Risky drinking (%)	Hazardous drinking (%)	Drinking by minors (%)
West Coast	-	-	21.8	-
New Zealand	85.0	61.6	19.6	79.6

As part of the West Coast Community Alcohol Survey commissioned by Community and Public Health (the survey sample and methods are described in more detail in the next chapter) earlier this year, survey respondents were asked about their drinking behaviours and the results are presented in Tables 5.5- 5.8 below. It should be noted that younger people (aged 18-24) were under-represented amongst the survey respondents, so that the reported patterns of drinking are a more accurate reflection of drinking behaviours in older age groups.

Table 5.6 Prevalence of drinking alcohol

	Yes (%)	No (%)
Had a drink containing alcohol in the last year	85	15

The proportion of survey respondents reporting having a drink containing alcohol in the last year is the same as for the national data above in Table 5.4. There was no difference between the three districts in the proportion of respondents having drunk alcohol in the last year.

Table 5.7 Frequency of alcohol consumption

	Monthly or less often (%)	Up to 4x a month (%)	Up to 3x a week (%)	4x or more a week (%)
Drank alcohol	40	24	22	14

There was no difference in the frequency of drinking alcohol between the three districts. Males were significantly more likely than females to drink four or more times a week (21% vs 9%, $p<0.01$). Those aged over 65 were significantly more likely to drink four or more times a week than respondents in younger age groups ($p=0.01$).

An increased frequency of drinking increases the lifetime risk of hospitalisation or death from alcohol-related injuries. For example, research suggests that when drinking occasions are frequent (nearly every day), the lifetime risk of hospitalisation for alcohol-related injury for both men and women is approximately 1 in 10, even if the number of drinks consumed on each occasion is two or less (National Health and Medical Research Council 2009). The Health Promotion Agency recommends that every week people have two or more days when they do not drink any alcohol.

Table 5.8 Intensity of alcohol consumption

	1-2 (%)	3-4 (%)	5-6 (%)	7-9 (%)	10-12 (%)	13+ (%)
Largest no. of drinks on 1 occasion	28	29	14	8	10	11

There was no difference in the reported intensity of alcohol consumption between the three districts. Drinking more than six drinks on one occasion (figures in red above) exceeds the recommended safe limit for males (for females it is drinking greater than four drinks). ALAC uses a threshold equivalent to seven standard drinks consumed in one drinking session as an indication of a binge drinking occasion for an adult. For young people (18-24) it is five or more standard drinks. As such, at least 21% of all respondents exceeded the safe limits for drinking in the last year and met the criteria for binge drinking. Males were significantly more likely to report drinking 13 or more alcoholic drinks on one occasion compared to females (18% vs 7%, p<0.01). Although the frequency of drinking is higher in those aged 65 and over than in young people, those aged 18-24 were more likely to report drinking 13 or more drinks on one occasion than those aged 65 and over (42% vs 3%, p<0.01).

Table 5.9 Frequency of heavy drinking

	Never (%)	Less than monthly (%)	1-2/month (%)	1-2/week (%)	Daily/almost daily (%)
6 or more drinks on 1 occasion	55	25	13	6	1

There were no differences in the frequency of heavy drinking between the three districts. Over half the respondents had not drunk six or more drinks on one occasion in the last year. Women were less likely than men to report having six or more drinks on one occasion (36% vs 68%, p<0.01). People 65 and over were also less likely to report having drunk 6 or more drinks on a single occasion than those aged 18-24 (13% vs 76%, p<0.01).

The risk of alcohol-related injury increases with the amount of alcohol consumed on a drinking occasion. Evidence suggests that drinking four drinks on one drinking occasion more than doubles the relative risk of an injury in the six-hour time period after drinking, for both men and women (National Health and Medical Research Council 2009).

ALAC recommends that, on any one drinking occasion, men should drink no more than six standard drinks and women should drink no more than four standard drinks (Alcohol Advisory Council of New Zealand 2008). This is supported by current World Health Organization (WHO) recommendations, through the Alcohol Use Disorders Identification Test (AUDIT). Drinking above this amount increases the risk of alcohol-related harm. However, due to variability between individuals, it should be remembered that there is no specific safe amount of alcohol for everyone, all of the time (Alcohol Advisory Council of New Zealand 2008).

5.8 Health professionals' perspectives

In preparing this report an email invitation was sent to health professionals on the West Coast to provide their comments on the health impacts of alcohol on the West Coast. The following is a selection of their comments (all those quoted have given permission for their

names/practice locations to be used). They provide an insight into the health impacts of alcohol from those at the "coal face" of the health service who have to deal with them.

"*The cost to the community and the health system of alcohol misuse on the Coast is absolutely staggering and far exceeds that I have seen in other parts of NZ. The intergenerational effects of this abuse mean babies and children are affected as well! The only benefits are to the purveyors of alcohol. As you well know education is singularly ineffective in reducing alcohol abuse but limiting availability and increasing price are known to work*"

Dr Paul Corwin, GP, Grey District

"We see more after hours patients because of alcohol. Kids are getting drunk and having sex with people they did not want to - they are worried and feel guilty. We have elderly who have been chronic drinkers - brain damage and dementia. Social isolation. Parents drinking is impacting on kids - we have seen some kids with this problem. Patients who cannot recall accidents because they have been drinking"

Practice Staff, Westland Medical Centre

"Acute alcohol intoxication has most of the attention - but it's chronic alcohol use that causes us more concern and longer term damage - especially amongst the elderly - this is probably a guess, but the numbers damaged by chronic alcohol abuse appear higher than binge drinking.

We see the effects of alcohol related dementia, family abuse, family shame and denial…. The problem with alcohol is the confabulation - which can be very convincing and it can be years before we become aware of the extent of the problem. It's harder to get families on board than with Alzheimers - not only because they've often borne the brunt of years of abuse, but also because of the shame. And then we see the teenagers/young adults with their binge drinking - injuries, unexpected sex and associated consequences. And I've now been here long enough to see the generational cycles repeating themselves - a thoroughly depressing outcome"

Dr Anna Dyzel, GP, Hokitika

The impacts for Grey ED of alcohol-related presentations are:

- inappropriate behaviour the nurses have to put up with
- increased security that needed to be put in place on Thursday, Friday and Saturday nights as we have a sole practitioner working in the department on nights.
- the increased use of resources
- the waste of taxpayers' dollars

People also feel unsafe at night walking around as there are a number of alcohol-related assaults which present at the emergency department.

(Julie Lucas, Clinical Nurse Manager Emergency Department, Grey Hospital)

'I am currently a GP at Greymouth Medical Centre but have previously worked at various practices on the coast over the past 5 years including Buller MedIcal Centre, Reefton Medical Centre, South Westland MC , High St Medical Centre & RAGP - in fact everywhere except Hokitika. I have also worked for 10 years in ChCh and done locum work in Marlborough, Otago, Fiordland and Turangi.

My experience is that alcohol causes an enormous amount of harm on the West Coast - more so than anywhere else I have worked. We are already understaffed here and do not need the extra workload, quite apart from the direct and indirect harm to Coasters. I see many patients whose mental and physical health is chronically compromised by excess alcohol consumption, and many whose lives have been blighted by alcohol related accidents or violence. Indirectly, spending on alcohol reduces funds available for other essentials such as food or medication. I do not do overnight on call in Greymouth, but my night time experiences in Westport and Reefton were frequently either caused by or at least made more unpleasant for all concerned by inebriation.

Unfortunately there appears to be a drinking culture on the West Coast which normalises unsafe levels of alcohol intake, such that people find it hard to accept advice on recommended levels. Whilst this is cultural to a certain extent and may take some time to alter, any measures which limit the easy availability of alcohol are likely to help.

I have no religious or other objection to alcohol per se, but as consumed by a large proportion of Coasters it is causing enormous harm and I would happily pay a premium or limit my own access in order to address this.

Dr Sally Widdowson, GP,Greymouth

"In comparison to overall presentations I see relatively few people due to alcohol problems. The majority are the young dudes from the tour buses (Kiwi Experience/Stray) who tend to injure themselves at Mahinapua doing dumb stuff running round being young bucks/buckesses (due to over indulgence). I don't recall seeing anything from a malicious nature. A relatively large number of emergency contraceptive pill recipients are from 'Oops - got drunk last night and forgot to use a condom'"

Megan Collie, Rural Nurse Specialist, Franz Josef

"I have been a RNS (rural nurse specialist) in Hari Hari for 3½ months and at this time EtOH issues have not impacted upon the primary health resources in a significant manner. There are a few patients that do have some elevated Liver Function tests. There is a culture of drinking and driving and alcohol. There have been cases of people driving after a session of drinking but fortunately there have been no accidents related to this during my time in the district"

Rose Fraser, Rural Nurse Specialist, Hari Hari

I am a registered nurse and Duly Authorised Officer working for the Triage Assessment and Crisis Team (TACT) on the West Coast. I have the following comments to make in my experience as a nurse dealing with crisis in and after hours with limited resources.

When someone is intoxicated the risk to themselves and others including clinicians is enhanced: - impulsivity, violence, poor (and often illegal) choices and the increased likelihood of suicidal thoughts can be evident. This means that more care, time and resources are used to maintain safety as well as placing those involved at risk.

Rightly or wrongly previous clinical practice has been to 'assess once sober' for any underlying mental health issues as when someone is cognitively impaired by use of alcohol presence of mental disorder can be blurred. Best practice now indicates that we should be utilising the Mental Health Act under the supporting clause of a person displaying 'disorder of volition' (unable to make a conscious choice or decision), thereby essentially imposing an Act which limits one's rights until assessment, transport, safety (in all spheres:- medical, psychiatric, proposed patient and community) can be ascertained. This process places a much larger strain on resources and often complicates the co-ordination of a crisis after hours - prolonging the process.

The need to 'detox' someone first to then assess for an underlying mental illness fills limited beds and prolongs admissions.

When alcohol is involved more services tend to be utilised i.e. Police, security staff (not that we have any), medical staff and mental health staff.

There are no resources on the Coast to address accommodation of at risk, chronic alcoholic users. This places a huge drain and many hours between Police and TACT staff trying to find accommodation for chronic 'at risk' (suicidal thinking and low mood) and alcohol use. Mental health inpatient units are not ideal nor are backpackers.

Lee Marshall, Registered Nurse, TACT Team

"I am the counsellor for Rata Te Awhina Trust and I cover the Coast area from Westport to Hokitika. I currently have a caseload of 24 clients their ages range from 18 to 62. Out of the 24 clients I am working with, only six appear to have no alcohol related issues. I have two clients that I have yet to meet. 13 of the people I am counselling have historical, familial physical and/or sexual abuse issues which have severely impacted on their lives. All of these report that the incidents of abuse usually happened when the perpetrators had been drinking alcohol.

I am at present working with four clients who are alcohol dependent and hoping to make positive changes in their life. Two are in early recovery. I am counselling five young mothers through the C.Y.Ps contract. Two of these admit to having had issues with alcohol and have made significant changes to their drinking habits. Four of these women have been in abusive relationships where alcohol is a key factor. I am also working with a young father who admits to becoming violent when he has consumed alcohol.

I am also the A.O.D assessor for L.T.S.A. clients and at present I have four on my client load. In all four cases the people have had over three drink driving sentences.

Counsellor, Rata Te Awhina Trust

6. West Coast Community Alcohol Survey

Community and Public Health, West Coast commissioned a telephone survey to determine West Coast community views on alcohol and liquor licensing in order to help inform the development of West Coast LAPs. The survey was carried out in May 2013.

The target population was adults aged 18 years and over who lived in the West Coast region (Buller, Grey and Westland Districts). A random sample was chosen from the Telecom White Pages for the specified sampling frame The survey sampling (stratified random sampling) was designed to provide a sufficiently large sample in each of the districts to allow for comparisons between them and also a sufficient sample size in each age group to allow for comparisons between age groups.

The questionnaire was designed by staff of Community and Public Health's information Team and was adapted for the West Coast from a survey used by the Christchurch City Council. The questionnaire sought respondents' opinions on alcohol use, the numbers, location and trading hours for licensed premises, potential restrictions on the operation of alcohol outlets such as one way door policies, and liquor bans. Respondents were also asked about their own drinking behaviours and this data is presented above in Chapter 5 of this report. Data collection was contracted out to a private research company.

A total of 1204 people completed the survey: 413 were from Buller District, 420 from Grey District and 371 from Westland District. This sample size gives sufficient statistical power for comparisons between districts and between age groups.

6.1 The survey sample

As is usually the case in telephone surveys, females were over-represented in the respondent sample (60% vs 40%). The proportion of respondents identifying as Maori was slightly lower overall and in each district than the proportion in the 2006 census (9%). Most importantly, and despite the vigorous efforts of the research company, people in the youngest age group (18-24) were under-represented (see Table 6.1 below).

Table 6.1 The respondent sample

	Buller (%)	Grey (%)	Westland (%)	Overall (%)
Male	40	39	40	40
Female	60	61	60	60
NZ European	93	96	95	95
Maori	8	5	7	6
Other	3	2	1	2
Age 18-24	4	4	5	4
25-34	8	11	11	10
35-44	18	19	18	18
45-54	31	28	25	28
55-64	22	21	25	22
65+	17	17	16	17

6.2 Problems caused by alcohol

Respondents were asked the extent to which they agreed or disagreed about a series of statements about alcohol.

The statements that respondents agreed or strongly agreed with relating to problems caused by alcohol were:

- Antisocial behaviour mostly involves people who have been drinking (90%)
- Excessive drinking leads to people being unable to carry out everyday tasks like going to work (90%)
- Intimidating behaviour, assaults and violence usually involves people who have been drinking (86%)
- Problems arising from noisy parties, unruly behaviour, vandalism and litter usually involve drinkers under 25 (83%)
- Pre-loading (e.g. drinking in a house, car or public place before going out at night) is a major cause of alcohol-related problems (79%)
- People don't feel safe in public places when there are people around who have been drinking (74%)

There were no differences between the districts in the extent to which respondents agreed or disagreed with statements about alcohol-related problems. Older people (aged 65 and over) were more likely to agree (than younger respondents) that people don't feel safe in public places when there are people around who have been drinking ($p<0.01$).

6.3 Hours and location of alcohol sales

Respondents were also asked the extent to which they agreed or disagreed with statements about the availability of alcohol, including trading hours of licensed premises.

- Only 19% of respondents agreed that people should be able to buy alcohol readily throughout the whole of the West Coast
- Men were more likely (p=0.001) than women to agree that alcohol should be available at most hours, throughout the whole of the West Coast
- Respondents under 25 were also more likely (p=0.003) to agree that alcohol should be available at most hours, throughout the West Coast
- Respondents from the Grey District (81%) were more likely (p=0.01) to disagree that people should able to buy alcohol readily at mots hours than those from Buller (73%) or Westland (71%).

6.4 Social aspects and locations of drinking

The key findings on respondents' views on statements about social aspects of alcohol and locations of drinking were:

- 76% of respondents agreed that pubs and bars are a great place to socialise
- 63% agreed that pubs and bars play a role in bringing the community together (compared to 56% in Christchurch)
- Only 32% agreed that drinking is part of the West Coast being a fun place to live
- Respondents under 25 were more likely than older respondents to agree that pubs and bars are great places to socialise

Younger respondents (aged 18-24) were more likely than older respondents to agree that drinking is part of the West Coast being a fun place to live ($p<0.001$).

6.5 Trading hours

Respondents were asked what hours alcohol should be able to be sold compared to the current hours that alcohol can be sold on the West Coast. They could indicate: longer or much longer, the same or shorter or much shorter.

- Most respondents supported maintaining (68%) or reducing (26%) the current trading hours of alcohol outlets
- Over 80% thought there should be no change in the trading hours of restaurants/cafes and clubs
- Just over 30% supported shorter or much shorter trading hours for pubs/bars, bottle stores and supermarkets.

There were no significant differences in the views of respondents on trading hours by district.

6.6 Numbers of off-licences

Respondents were asked to rate their perception of the number of off-licence outlets using a five point scale: there should be a lot more outlets, there should be more outlets, there seems to be the right number of outlets, there are too many outlets, there are far too many outlets.

- 73% of respondents thought that there was the right number of supermarkets selling alcohol on the West Coast, while 25% thought there were either too many or far too many supermarkets selling alcohol
- 73% of respondents thought that there was the right number of bottle stores selling alcohol on the West Coast, while 23% thought there were either too many or far too many bottle stores selling alcohol
- 63% of respondents thought there was the right number of grocery stores selling alcohol on the West Coast, while 30% thought there were either too many or far too many grocery stores selling alcohol
- Almost no-one thought there should be more of any of these types of outlet.

There were no differences between the districts with regard to respondents' views about the number of off-licences.

6.7 Drinking location and negative impacts of alcohol

Survey respondents were asked to consider a list of statements about of negative impacts of drinking in particular locations and to indicate their degree of agreement/disagreement with these.

- 74% agreed or strongly agreed that drinking at parks, cars, beaches and BBQ areas is the cause of negative impacts of drinking
- 54% agreed or strongly agreed that drinking at and after public events is the cause of negative impacts of drinking
- 51% agreed or strongly agreed that drinking at pubs or bars is the cause of negative impacts of drinking
- 39% agreed or strongly agreed that drinking at private houses or sports clubs is the cause of negative impacts of drinking
- Just 16% agreed or strongly agreed that drinking at community clubs or cafes (13%) is the cause of negative impacts of drinking

Again there were no differences between the districts in response to these questions.

6.8 Restrictions on proximity of alcohol outlets

Respondents were asked to consider whether on and off-licensed alcohol outlets should be restricted from operating close to early childhood centres, primary or secondary schools, places of worship or community facilities. They could indicate their level of agreement or disagreement with proximity restrictions for each of the different types of outlet.

- Around 75% of respondents agreed or strongly agreed that bottle stores, pubs and bars should not be allowed to operate near early childhood centres, primary or secondary schools or community facilities
- Just over half of respondents agreed or strongly agreed that bottle stores, pubs and bars should not be able to operate near places of worship.

There were no differences in responses to these questions by district, except that fewer respondents from the Grey District disagreed or strongly disagreed that grocery stores selling alcohol should not be allowed to operate near early childhood centres (29% Grey vs 34% Buller and 34% Westland, p=0.03) or places of worship (Grey 35%, Buller 37%, Westland 41%, p=0.03).

6.9 One way doors and alcohol bans

Respondents were asked to consider whether or not one way door restrictions should be required for pubs and bars. They were also asked to indicate their degree of agreement/disagreement with the statement "Local alcohol bans are a good way to curb alcohol-related problems in specific areas".

- 71% of respondents agreed that one way door restrictions should be required for pubs and bars. Just one in five (20%) did not think one way doors should be required.
- 90% of respondents agreed or strongly agreed that local alcohol bans are a good way to curb alcohol-related problems in specific areas.

There were equally high levels of support for one way doors and alcohol bans in all three districts.

7. Conclusions and Recommendations

The West Coast and the Buller District are experiencing high levels of adverse health impacts from alcohol and there are high levels of risky drinking behaviours. The community also recognises that there is a range of problems associated with alcohol. There is community support for actions related to licensing that would help to reduce alcohol related harm, such as controls on trading hours, outlet numbers and locations, as well as one way doors and liquor bans. Development of a LAP for the Buller District will not solve all of the district's problems with alcohol but it is an opportunity to take action to help reduce alcohol-related harm and move closer to achieving the aims of the new legislation.

The Medical Officer of Health recommends:

Trading Hours

Trading hours in the draft LAP should be more restrictive than the default hours in the legislation and different hours are appropriate for different types of licences.

- For on-licences, hours should be a maximum of 8.00 am to 1.00 am
- For off-licences, hours should be a maximum of 9.00am to 9.00 pm

Discretionary conditions such as one way doors should be considered for hotel and tavern licences in main centres such as Westport.

Location and density of licences

Consideration needs to be given to the number of licences already in an area, local community views and the amenity of the area, along with proximity of sensitive sites.

There should be a cap on the number of off-licence outlets at current numbers.

Special Licences

Discretionary conditions should be applied dependent on such factors as location, numbers attending, type of event, time of event, number of times it occurs.

Discretionary conditions

Appropriate use of discretionary conditions is recommended as an important consideration in new licence applications and in renewals. A range of issues may be addressed through such conditions.

Other issues that may have a place in discretionary conditions are security, supervision, the premise environment, both indoor and outdoor, and the need to consider impacts from large seasonal variation in patronage.

It may also be appropriate to consider if the amount of advertising on an off-licence, especially regarding cheap alcohol, should be subject to discretionary conditions.

Bibliography

Anderson P, Chisholm D, Futr D. *Alcohol and Global Health 2: Effectiveness and case effectiveness of policies and programmes to reduce the harm caused by alcohol*. Lancet 2009, 373, 2234 -46

Babor, T et al (2010) *Alcohol: No Ordinary Commodity - Research and Public Policy,* Oxford University Press, Oxford.

Boden JM, Fergusson DM and Horwood LJ. (2011). *Alcohol and STI risk: Evidence from a New Zealand longitudinal birth cohort.* Drug and Alcohol Dependence 2011;113:200-206.

Connor, J., and Caswell, S. *Alcohol Related Harm to Others in New Zealand – Evidence of the Burden and Gap in Knowledge*. NZ Med J 2012;125:11-27

Connor J et al (2011). *Alcohol outlet density, levels of drinking and alcohol-related harm in New Zealand: a national study*. Journal of Epidemiology and Community Health 2011;65:41-84

Day P et al *(*2012). *Close proximity to alcohol outlets is associated with increased serious violent crime in New Zealand*. Aust NZ J Public Health. 2012;36:48-54

Donnelly N et al (2006) *Liquor Outlet Concentrations and Alcohol Related Neighbourhood Problems.* Alcohol Studies Bulletin Number 8. Sydney: Bureau of Crime Statistics and Research.

Jackson R, Broad J, Connor J, and Wells S (2005*). Alcohol and ischaemic heart disease: probably no free lunch*. Lancet 2005;366:1911-12

Jones L et al. (2008) *Alcohol Attributable Fractions for England. Alcohol-attributable mortality and hospital admissions*. Report commissioned by the UK Department of Health

Kypri K et al. *Alcohol outlet density and university student drinking: a national study*. Addiction 2008;103**:**1131-1138

Kypri K et al *(*2011). *Effects of restricting pub closing times on night-time assaults in an Australian city.* Addiction;*106:303-10.*

Ministry of Health (2009) *Alcohol Use in New Zealand: Key Results of the 2007/08 New Zealand Alcohol and Drug Use Survey.* Wellington: New Zealand

National Health and Medical Research Council (2009). *Australian Guidelines to Reduce Health Risks from Drinking Alcohol*. Canberra: Commonwealth of Australia.

New Zealand Heart Foundation (2013). Connor J (author). *Alcohol and Heart Health.* Evidence Paper, January 2013.

New Zealand Law Commission (2009) *Alcohol in Our Lives: An Issues Paper on the Reform of New Zealand's Liquor Laws.* NZLC IP15.

New Zealand Law Commission (2010) *Alcohol in our Lives, Curbing the Harm*. NZLC R114

Psutka R et al (2012). *Sexual health and the Rugby World Cup 2011: a cross-sectional study of sexual health clinics in New Zealand*. Sexual Health 2012; 9: 466-471

South Island Children & Young People Health Status Report (2012). *The Determinants of Health for Children and Young People in the South Island.* South Island Alliance Programme Office and the University of Otago, on behalf of the NZ Child and Youth Epidemiology Service (NZCYES) November 2012.

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