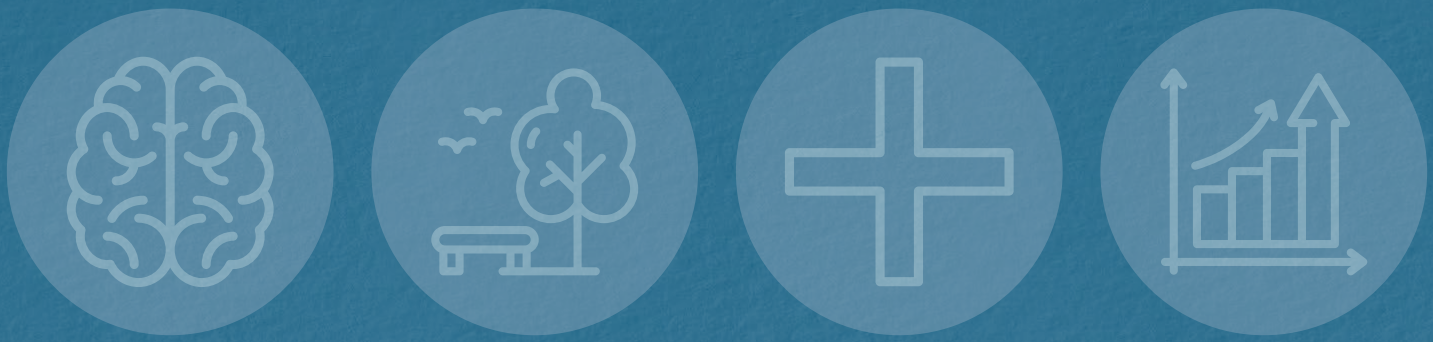
Canterbury Health System

Alcohol-related Harm Reduction Strategy

2018-2023



Canterbury District Health Board
Te Poari Hauora ō Waitaha

Canterbury Clinical Network
Transforming Health Care. Whanau Ora ki Waitaha.

Contents

Acknowledgements

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This document has been collated by the Health in All Policies Team at Community and Public Health and reflects careful consideration of all feedback received throughout the development process.

Foreword

The Canterbury Clinical Network is pleased to bring you an unprecedented display of unified action against alcohol-related harm via the Canterbury Health System Alcohol-related Harm Reduction Strategy.

This Strategy shines the spotlight on an issue which impacts all of us, whether you are part of the health workforce or use our health services here in Canterbury.

It is important for us as a health system to recognise how alcohol-harm impacts the health of our people. Alcohol is the most widely used, widely available drug in New Zealand. While alcohol consumption costs our health system considerably in money, time and resources, we are equally concerned about the mounting evidence of the harm it causes to individuals, whānau, communities; and our more vulnerable communities when misused. This is not just because of acute injuries, motor vehicle accidents, addiction and intoxication, but also long-term chronic disease, fetal alcohol spectrum disorder, family violence, financial hardship, crime and other social harms. Despite all of this, the normalisation of alcohol in New Zealand society makes it a difficult topic to address.

Change is possible. More New Zealanders are choosing to drink less, and our teenagers are increasingly choosing to delay their drinking. Drinking less for the sake of your health and the health of your whānau is becoming a more attractive and achievable option.

We as a health system want to work together to raise awareness of the health impacts associated with alcohol use, improve how we measure harm, better coordinate services and support everyone to make better informed choices about how they and their loved ones are drinking.

Through this Strategy the wider health system supports Canterbury District Health Board's mission to improve, promote and protect the health and wellbeing of our people whilst reducing disparities. Additionally, it contributes to the vision of the Christchurch Alcohol Action Plan, of a safe, vibrant, healthy Christchurch, free from alcohol-related harm.

He waka eke noa
We're all in this together

Nō reira,
Tēnā koutou katoa,

Dr Ramon Pink
Medical Officer of Health for Canterbury
Member of the CCN Alliance Leadership Team

Overview

Background

Alcohol is a major public health issue because of the harm it causes to individuals and communities. Despite wide acceptance that drinking alcohol can lead to a number of health and social problems, it remains the most commonly used recreational drug in New Zealand.[1]

Alcohol-related harm is the term used to explain the wide range of negative effects from alcohol use. It includes **acute harm** such as intoxication or injury; **chronic harm** through over 200 diseases that have been associated with alcohol use; and **indirect harm** via alcohol-related social issues such as family violence, crime, financial hardship and lost productivity.

In New Zealand, alcohol is estimated to contribute to 800 deaths a year, of which nearly half are injuries, almost one third are from cancer and over a quarter are from other diseases.[2]

Alcohol is a leading preventable cause of early death, disability and social harm
(WHO, 2014)[9]

Our health system absorbs significant costs due to alcohol-related harm. In 2011 the wider cost of alcohol-related harm to the Canterbury health system was estimated at $62.8 million.[3]

Alcohol contributes to **800 deaths** in New Zealand each year[2]

43% of deaths are due to injuries, **30%** from cancers and **27%** from other chronic diseases[2]

600-3,000 babies are born with Fetal Alcohol Spectrum Disorder in New Zealand each year[4]

20.8% (1 in 5) adults in Canterbury drink at **hazardous levels**[5]

6.9% of presentations to Christchurch Hospital ED are related to alcohol[6]

Alcohol use is the leading cause of health loss in adults in NZ[7]

Alcohol costs the Canterbury Health System **$62.8 million per year**[3]

Alcohol is known to be a factor in **at least 30%** of family violence incidents[8]

Rationale for Strategy Development

In July 2012, the Canterbury District Health Board (Canterbury DHB), as part of the South Island Alliance, committed within their alcohol position statement[4] to developing an alcohol harm reduction strategy. The Canterbury Health System Alcohol-related Harm Reduction Strategy (the Strategy) is the realisation of this commitment (see Appendix).

A number of activities to reduce alcohol-related harm already occur within the Canterbury health system such as; health promotion, community and GP-based assessment and treatment services, specialist services, alcohol licensing and compliance and inter-agency action groups (see Figure 1). Strategy development has identified opportunities to improve integration of these activities across the health system.

The Canterbury DHB remains a strong advocate for further national alcohol law reform in line with the 5+ Solution to reduce availability and accessibility, as detailed in the Law Commissions' Report[5]. International evidence tells us this is the key driver in reducing alcohol-related harm to our population. Whilst opportunities to continue to engage in this national debate are key components of the strategy, the intention goes beyond this to identify a number of local opportunities to develop a health system that is collectively engaged in reducing alcohol-related harm in Canterbury. The Strategy intends to ensure the Canterbury health system's local approach to alcohol-related harm is streamlined, effective and patient-centred.

The 5+ Solution is a set of evidence-based policy directives to reduce alcohol-related harm. They are:

1. Raise alcohol prices

2. Raise the purchase age

3. Reduce alcohol accessibility

4. Reduce marketing and advertising

5. Increase drink-driving counter-measures

PLUS: Increase treatment opportunities for heavy drinkers

(Barbor et al, 2010)[12]

PREVENTION

- **Health Promotion**: Community & Public Health (CPH), Ashburton CADS, PHOs
- **Licensing and Regulation**: CPH, Ashburton
- **Data Collection**: CPH, Christchurch Hospital
- **Policy/partnerships**: CPH
- **Campaigns and Research**: Health Promotion Agency
- Community Action on Youth and Drugs Ōtautahi (CAYAD) – Waipuna SJOG
- **Workplace education and support**: (MHERC)
- Students Against Dangerous Driving
- Fetal Alcohol Community Trust
- Addiction Advocacy Service at MHAPS
- Drug Arm Christchurch
- Waimakariri Alcohol Action Group

EARLY INTERVENTION AND ASSESSMENT

Community Education and Support

- Alcohol & Drug Helpline
- Christchurch Central Service: AOD Coordination
- Peer Support (Odyssey)
- Online Resources
- MHERC
- Familial Trust
- Family Service at Salvation Army
- BIC (Primary Mental Health Service)
- PHOs: motivating conversations
- Christchurch Hospital ED "Drinking Packs"
- Workplace support services (Canterbury DHB)

Screening, Assessment and Referral Services

- Christchurch Central Service: AOD Coordination
- Alcohol & Other Drug Assessment and Treatment Service – ADAS (Odyssey)
- Christchurch City Mission
- Salvation Army
- He Waka Tapu
- Care NZ
- Hospital clinical staff – assessment and screening questions (Medical and Social Work)
- After Hours Clinics
- PHOs: motivating conversations
- PHOs: data collection
- Ashburton CADS
- Waipuna St John of God

TREATMENT AND SUPPORT

Detox Services

- Kennedy Unit (Canterbury DHB)
- Thorpe House (City Mission)
- Home detox Service (City Mission)

Residential Services

- Salvation Army Bridge Programme
- Odyssey House
- Nova Lodge
- Elm Tree Lodge (City Mission)
- He Waka Tapu

Day/Evening Programmes and Groups

- Wahine Whai Ora (City Mission)
- Alcoholics Anonymous
- ADAS
- Driving Change Programme (ADAS)
- Motivational Education Group (ADAS)
- Salvation Army Bridge Programme
- He Waka Tapu
- Care NZ
- Women and Wellbeing (Odyssey)
- Recovery 24/7 (Odyssey)
- Nga Kakano Women's Day Programme (Salvation Army)
- North Canterbury Adult AOD Outpatient Service – Rangiora (City Mission/ Wellbeing North Cant)

BI/Counselling/Harm minimisation/ Support

- Christchurch Central Service: AOD Coordination (CCS)
- Community Brief Intervention Team (CCS)
- BIC (Primary Mental Health Service)
- Adult Alcohol and Other Drug Service (City Mission)
- Youth Drug and Alcohol Service (City Mission)
- Waipuna (St John of God)
- Wellbeing North Canterbury
- Kaiapoi Community Services
- Kaikōura Health Te Ha o Te Ora
- Ashburton CADS

ONGOING CARE AND MANAGEMENT

- Comcare AOD Housing Services
- Nova Lodge
- Lifelinks (Needs Assessment Service Coordination)
- Te Awhina (Salvation Army)
- The Friday Group (City Mission & Odyssey)
- Alcoholics Anonymous
- Recovery 24/7 (Odyssey)
- Relapse prevention group (ADAS)
- General Practice

Figure 1. Representation of Alcohol-related Harm Reduction Activities and Services across the Canterbury Health System

Please note that the information in this list is intended to illustrate the wide-scope of activity related to alcohol already occurring in the Canterbury health system and although every effort was made to be accurate at the time of writing it may contain errors and omissions.

Vision

Reduced Harm from Alcohol: A Canterbury Health System working together to prevent and reduce the impact of alcohol-related harm in our community

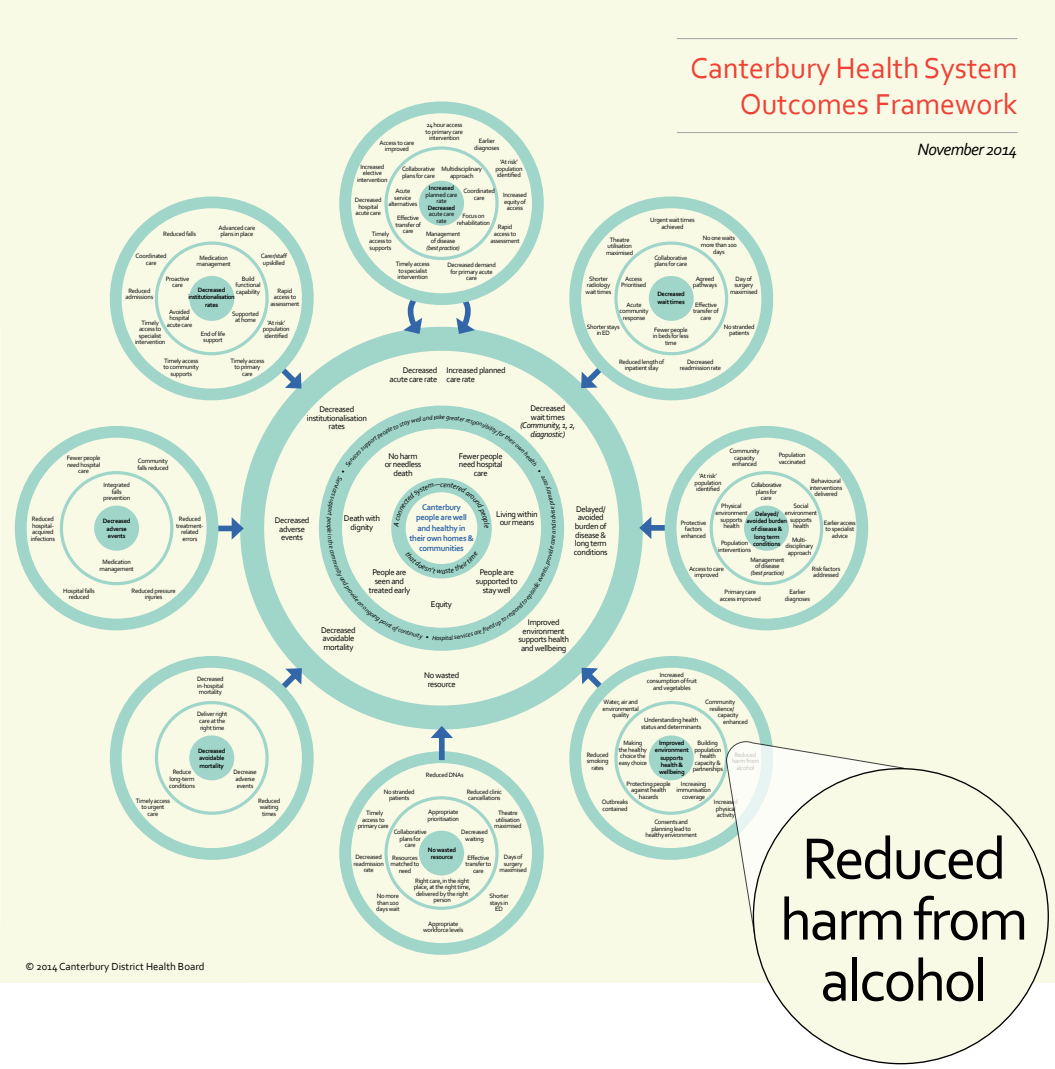

Figure 2. Reduced harm from alcohol is recognised as a population level outcome within the Canterbury Health System Outcomes Framework

Scope and Alignment with the Christchurch Alcohol Action Plan

The Canterbury health system incorporates a number of Canterbury DHB services, primary care, and local health and social services that provide education and treatment under contract. Geographically, the Canterbury health system incorporates not only Christchurch City but the surrounding regions of: Ashburton, Banks Peninsula, Selwyn, Hurunui, Waimakariri and Kaikoura. This Strategy covers all these regions.

The Canterbury Clinical Network is a collective alliance of healthcare leaders which provides a partnership framework, enabling components of the health system to come together, agree priorities and collaboratively achieve outcomes.

"Reduced Harm from Alcohol" is recognised as a key population level outcome within the Canterbury Health System Outcomes Framework.[13] This Strategy aligns directly to this outcome.

Concurrently, the Christchurch Alcohol Action Plan (CAAP) has been developed by Christchurch City Council, NZ Police and the Canterbury DHB and has been endorsed by Safer Christchurch.[14] It identifies cross-sector opportunities to achieve a safe, vibrant, healthy Christchurch free from alcohol-related harm.

This Strategy demonstrates the health system's contribution to achieving the objectives of the CAAP and ensures that the link to activities occurring outside of the health system is strong.

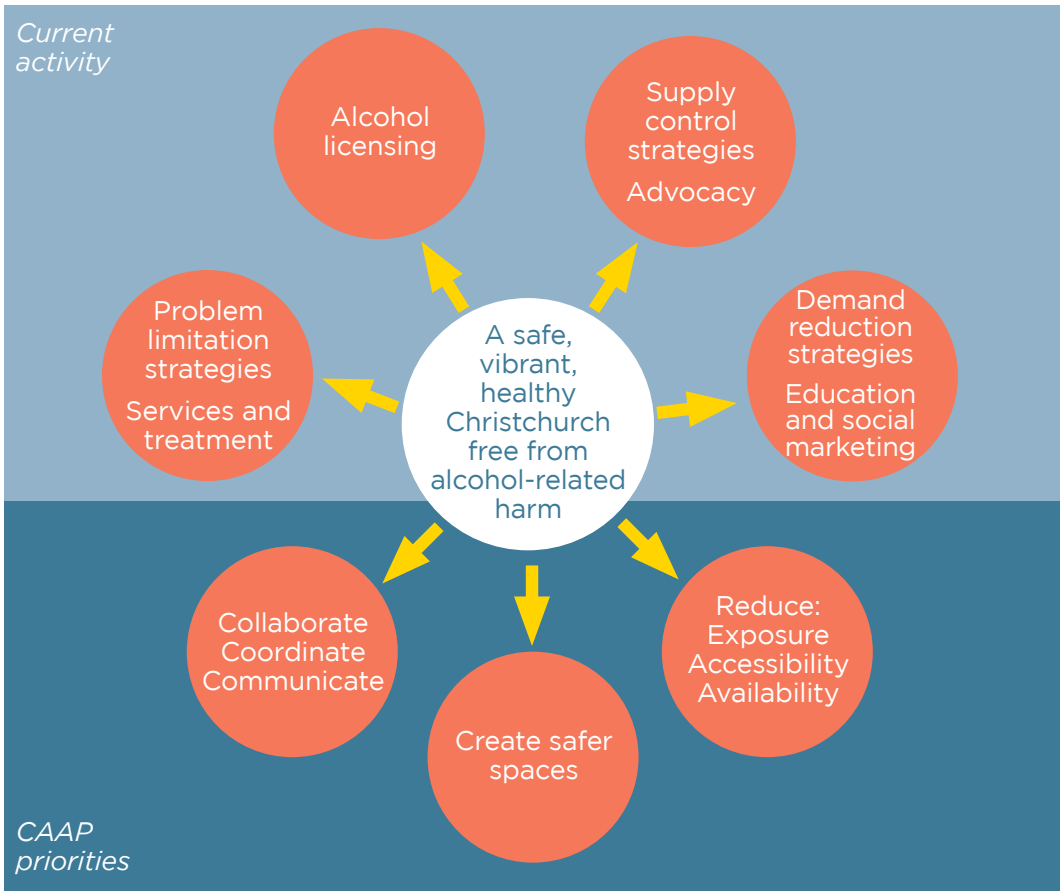

Figure 3. Vision and priorities of the Christchurch Alcohol Action Plan

Strategy Development

The Strategy was originally a collaborative vision between Canterbury DHB Planning and Funding and Community & Public Health, however, the consultation process made apparent that a whole of health system approach is necessary to effectively reduce the impact of alcohol-related harm.

Initial consultation included a series of local stakeholder events. Attendees communicated a clear collective aspiration to reduce alcohol-related harm and change societal attitudes towards alcohol.

A background review of national and international alcohol strategy, evidence-based measures to reduce harm and local data to inform how alcohol impacts the population of Canterbury was completed in late 2016.

The review process also encompassed a stocktake of alcohol-related harm reduction activities already occurring across the Canterbury health system (see Figure 1).

Timeline of events

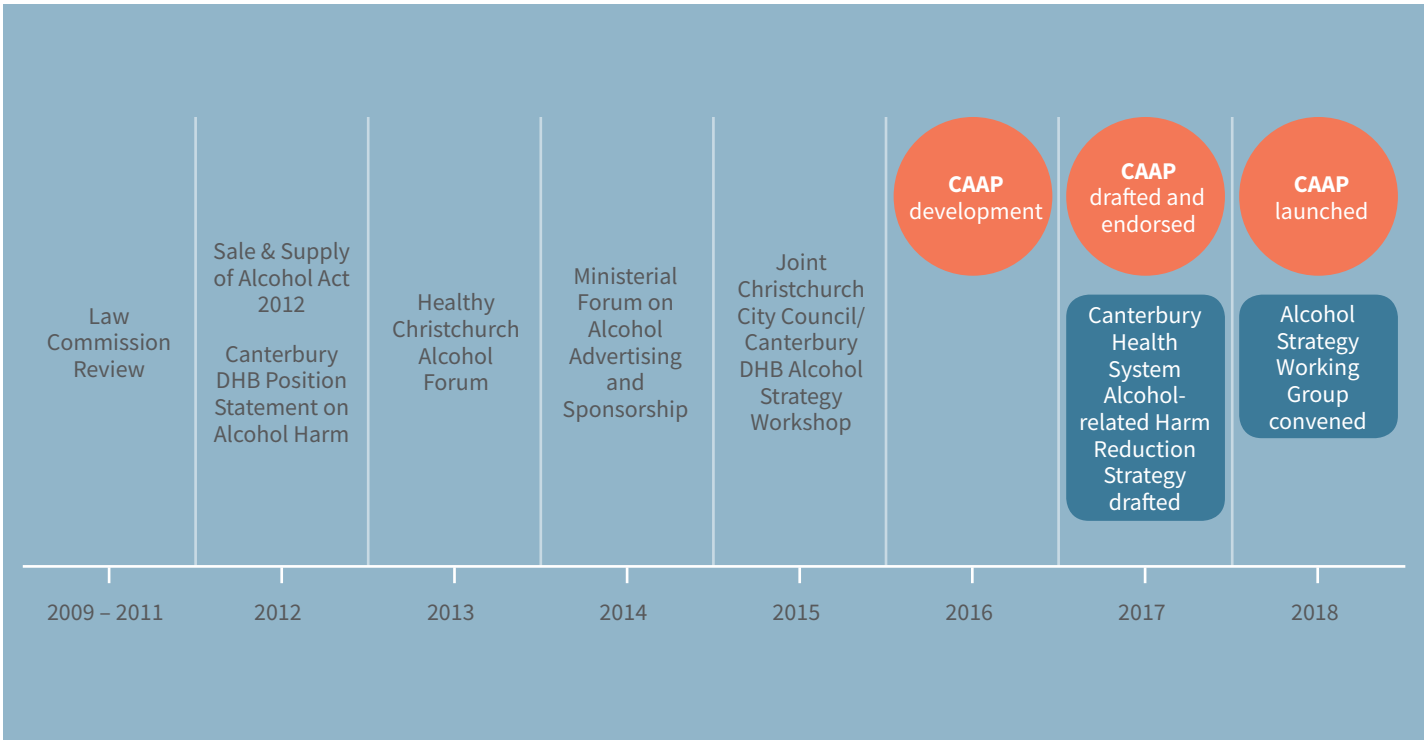

Figure 4. Events leading to the development of the Canterbury Health System Alcohol-related Harm Reduction Strategy

Engagement meetings with partners across the health system were held in late 2016 and early 2017, from which a strategy development Working Group was established, with membership from:

- Planning & Funding
- Community & Public Health
- Mental Health
- Allied Health (specifically Social Work Services)
- Emergency Medicine
- Primary Health Organisations
- Christchurch Central Service – AOD Coordination
- Māori Health Provider

The Working Group agreed a vision, focus areas and objectives for the strategy through a series of scoping activities and discussions. The outcome of this work is a concise strategic framework which defines four focus areas with a number of underlying objectives and recommendations.

Strategic Framework

Strategy Diagram

The Strategy builds on the Canterbury Health System Outcomes Framework model which already includes the outcome "Reduced Harm from Alcohol".

This Strategy is an expansion of this system-wide objective and has been visually depicted to reflect the relationship to a system-wide approach.

The Strategy framework (Figure 2) reflects the Strategy vision within a central circle, mirroring the Canterbury Health Systems Outcomes Framework objective described above. The vision is surrounded by an inner circle of fundamental ways of working, which are then surrounded by the four focus areas from which the Strategy objectives are built upon.

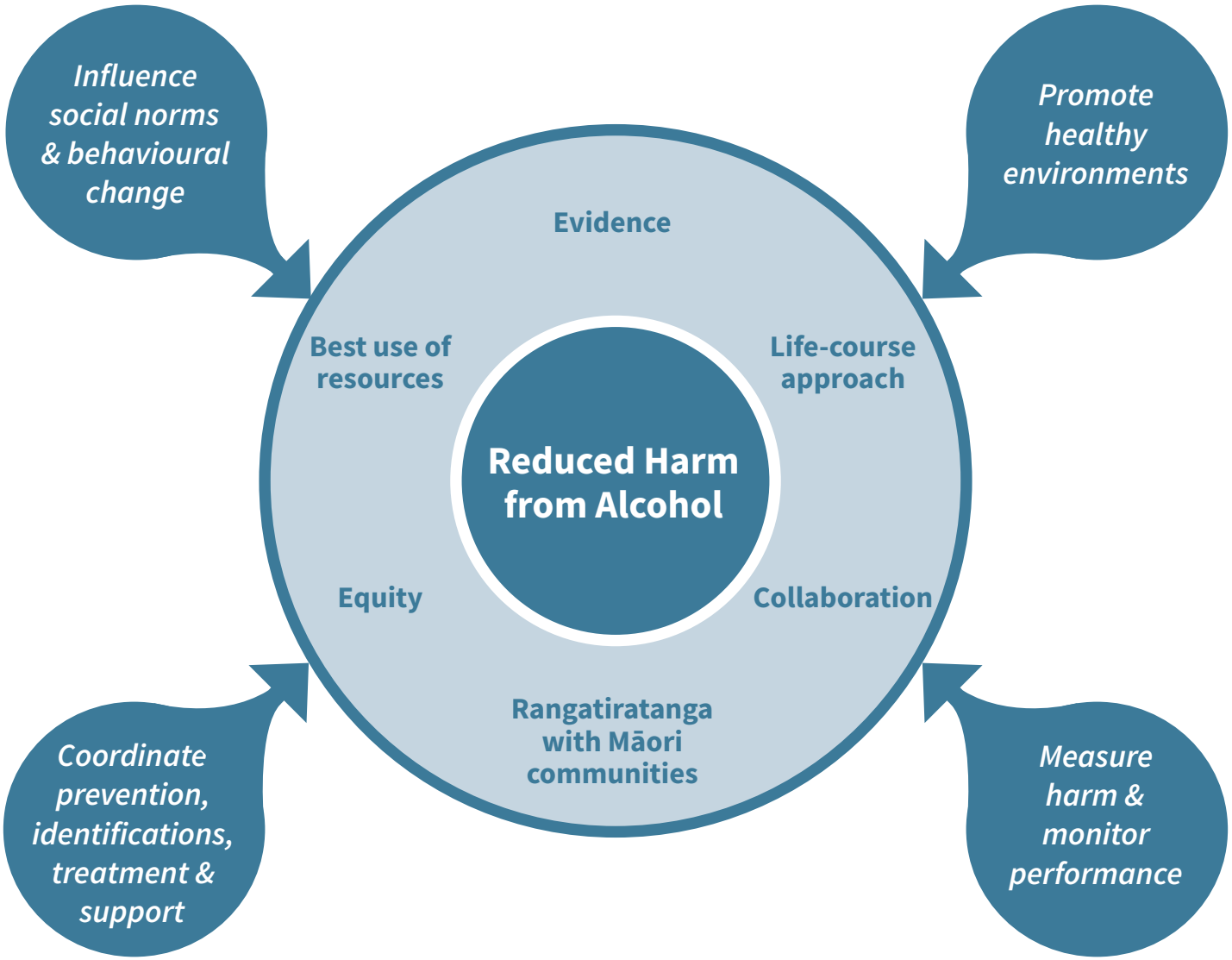

Figure 5. Framework for the Canterbury Health System Alcohol-Related Harm Reduction Strategy

Values and Ways of Working

The values of this Strategy align with Canterbury DHB strategic goals, with respect to alcohol use:

- that people take greater responsibility for their own health;
- people stay well in their own homes and communities; and
- that people receive timely and appropriately complex care.

The following ways of working have been identified during strategy development as an important foundation for all alcohol-related harm reduction efforts in Canterbury:

1. Equity

Alcohol-related harm impacts on certain groups disproportionally. Actions should be a mix of universal and targeted measures to ensure that inequities around who experiences alcohol-related harm are reduced and not increased.

2. Collaboration

Reducing the harm caused by alcohol requires coherent, collaborative working across the health sector and beyond. This strategy provides an opportunity to demonstrate the potential of primary, secondary and tertiary care, and non-governmental organisations (NGOs) to work together to collectively reduce alcohol-related harm. This strategy also provides an opportunity for others to adopt the Canterbury DHB position statement on alcohol.

3. Life-course approach

Alcohol-related harm impacts differently across a lifespan. While youth have traditionally been singled out as the target group for alcohol harm reduction activities and still form an important part of this strategy, the impact of alcohol across life-stages is emphasised; for example acute harm experienced by young adults, chronic illnesses which become apparent during middle-age and the vulnerability of older people who drink. Opportunities to influence different life-stages include targeting pregnant women to reduce rates of Foetal Alcohol Spectrum Disorder or parents who model harmful drinking behaviour to their children.

4. Rangatiratanga within our Māori Communities

This strategy acknowledges the success of local providers who use Māori and bicultural models of health to engage those who identify as Māori in reducing harmful alcohol use. This strategy also acknowledges the important role mana whenua and tangata whenua have in supporting the health and wellbeing of their communities and the Canterbury DHB's commitment to working in partnership with Te Rūnanga o Ngāi Tahu and Papatipu Rūnanga. The strategy should enable iwi, hapū, whānau and local marae to identify and lead their own activities to reduce alcohol-related harm, and support initiatives across various focus areas.

5. Evidence-based

This strategy is built on a strong evidence-base, incorporating both the local impact of alcohol-related harm and effective measures to reduce this harm. This strategy acknowledges that the most effective way to reduce harm caused by alcohol at a population level is through national law change which reflects the 5+ Solution. There is a significant evidence-base to show that legislative change is a very effective method to alter the environment where choices about drinking are made.[15] At the local level, a number of other evidence-based activities can also be carried out.

6. Best use of resources

This strategy includes a stocktake of current activities and services in the alcohol sector to improve visibility of services, and raise awareness for professionals and the public as to what is available. It is important that the health sector works together to ensure a system where the right care is provided, in the right place, at the right time, by the right person.[16] A strategic, coordinated approach to alcohol-related harm reduction will prevent duplication, and reduce the demand on specialist services in the long-term through investment in innovative, preventative approaches.

Focus Areas

Four focus areas with specific objectives provide direction and measurable outcomes for the Strategy. These focus areas cover prevention, treatment and evidence gathering activities.

1. Influence behaviour change and social norms

The way in which individuals drink alcohol is in part influenced by the way alcohol is portrayed in wider society. Many people do not appreciate the health risks associated with their own drinking behaviour. This focus area of the strategy aims to increase understanding of the risk from alcohol to health. Alcohol is not an ordinary commodity.[12] Action needs to be taken to counter normative drinking attitudes and behaviour at both a national and local level. Social norms around drinking alcohol can be changed; as illustrated by the shift in attitudes to drink driving.

2. Promote healthy environments

Health is influenced by a wide range of factors beyond the health sector. Examples include how alcohol is regulated and how built environments impact upon drinking behaviour. This focus area links strongly with the Christchurch Alcohol Action Plan's objective "Create Safer Spaces" which also promotes strong relationships with decision makers outside of health to consider how the rebuild of Canterbury will impact upon drinking behaviour.

The Strategy also strongly supports work undertaken by Canterbury DHB in assisting its partners, the Police and Christchurch City Council to effectively regulate and enforce the Sale and Supply of Alcohol Act 2012 and Local Alcohol Policies.

3. Coordinate prevention, identification, treatment and support

Many activities occur across the Canterbury health system to identify and intervene around harmful alcohol use; for example, specialist addiction services, treatment of alcohol-related injuries and health promotion work on and around tertiary campuses. Any level of drinking may carry some risk. Coordination of activities to reduce harm is important for ensuring that alcohol-related harm is identified early, and that the right type of support is accessible in a timely manner for individuals, families and communities experiencing alcohol-related harm.

4. Measure harm and monitor performance

Collection of alcohol-related data will help inform and evaluate strategy actions and effectiveness. Understanding the evidence behind alcohol-related harm in Canterbury will help focus activities in the most effective areas. The Strategy aims to expand upon current data collection methods and identify additional data sources to help build a better understanding of how alcohol-related harm impacts our community. This data will be shared across the health system and beyond.

Objectives

The following objectives aim to achieve the overarching outcomes of each related focus area. The objectives under focus areas 1 and 2 aim to achieve change at a population level, consequently reducing the load on the health system from preventable alcohol-related admissions. Focus area 3 objectives aim to ensure that treatment services are as efficient and patient-centred as possible. Focus area 4 objectives link to development of a solid evidence base and provides direction for monitoring the implementation and impact of the Strategy.

Strategy development has identified where activities are already occurring, but also areas for which future opportunities exist. The table below includes examples of what is currently meeting the specific objective, and an example of the types of activities identified as future opportunities. Each would require assessment as to their feasibility via a proposed selection criteria prior to any form of implementation.

FOCUS AREA 1	OBJECTIVE	
Influence Social Norms and Behaviour Change 	1. Strong partnerships to support alcohol-related harm reduction initiatives.	**Health services have an important role in actively working with each other and external organisations to ensure there is a collaborative approach to reducing alcohol-related harm in Canterbury.** E.g. Currently Canterbury DHB is collaborating with partners in the implementation of the Christchurch Alcohol Action Plan. **Future opportunities** could be developed between Te Rūnanga o Ngāi Tahu and Papatipu Rūnanga and the health system to support priorities and approaches for reducing alcohol-related harm within Māori communities.
	2. Increased awareness of the health risks associated with alcohol.	**Health services have a responsibility to consistently communicate the evidence-based health risks associated with alcohol. Such messages should be aligned with the Health Promotion Agency, the governmental lead for health messaging.** E.g. Currently Community & Public Health are piloting the "Game On" programme with sports clubs to raise awareness of the health risks associated with alcohol within the sports sector.

	Future opportunities could be developed through promoting every patient interaction within the Health System as an opportunity to positively influence attitudes around alcohol use.
3. Health professionals equipped to contribute to change.	**Health professionals should have access to training or information which enables them to confidently identify, screen and refer to address harmful drinking.** E.g. Primary Care have been developing their skill-base to provide early intervention to patients through the use of the "Motivating Conversations" training module. **Future opportunities** for the health system could be to engage Canterbury DHB People & Capability and equivalent HR resources across the health sector in sensitively supporting staff to address their own harmful drinking.
4. Local communities empowered to reduce alcohol-related harm.	**Local communities should have the ability to access health information which support their own initiatives to reduce alcohol-related harm. Enablers such as community groups, residents associations and Papatipu Rūnanga can be supported to initiate their own harm reduction measures through provision of evidence-based, local information.** E.g. Presently, Community & Public Health identify alcohol licence applications within high risk communities and ensure the community is informed. HPA has also partnered with Community Law to ensure high risk communities have access to information regarding application and objection processes. **Future opportunities** within this objective could be to produce a quarterly newsletter for local communities, providing information about latest alcohol research and examples of community-based initiatives to reduce harm.

FOCUS AREA 2	OBJECTIVE	
Promote Healthy Environments 	1. Reduced availability of alcohol for at risk groups.	**Health services should continue to participate in initiatives which monitor and reduce the availability of alcohol under the Sale and Supply of Alcohol Act 2012, particularly for communities who experience disproportionate harm.** E.g. Community and Public Health will continue routine Control Purchase Operations (CPOs) to ensure compliance of licensees. **Future opportunities** may be to expand the Good One Party register to other at risk populations.
	2. Safer and healthier drinking environments.	**Health services should continue to support partners to understand that urban design and planning processes are influential factors in shaping the drinking environment and promote collaboration with building safer, healthier spaces.** E.g. Health Organisations will continue to participate in planning processes with local government to ensure the health implications of planning decisions are considered. **Future opportunities** exist in fostering relationships with Te Rūnanga o Ngāi Tahu and Papatipu Rūnanga during development planning phases to encourage use of alcohol-harm reduction measures in the built environment.

3. Local policy which reduces alcohol-related harm.	**Health services should support evidence-based policy at both organisational and community level to reduce alcohol-related harm.** E.g. The Canterbury DHB continues to support implementation and review of Local Alcohol Policies across Canterbury. **Future opportunities** could be to support organisations across the health sector and beyond to develop and implement individual workplace alcohol policies.
4. Evidence-based national policy which reduces alcohol-related harm.	**Health services should take opportunities to advocate for national policy changes (such as the 5+ Solution) which will reduce population level harm, and are supported by strong evidence.** E.g. The Canterbury DHB and other health organisations continue to influence national alcohol policy through submissions. **Future opportunities** exist in possible advocating opportunities as a collective health system for national legislation reform which adopts the 5+ solution.

FOCUS AREA 3	OBJECTIVE	
Coordinate prevention, identification, treatment and support 	1. A coordinated health system with clear pathways to reduce alcohol-related harm.	**People should be able to access the level of assessment, treatment and support required to meet their needs to reduce alcohol-related harm.** E.g. The Christchurch Central Service – AOD Coordination provides a centralised access point to all services with processes for ongoing monitoring and review. There is also direct access to kaupapa Māori services for those who seek this approach. **Future opportunities** exist around improving access for rural communities and culturally and linguistically diverse communities.
	2. Improved access and reduced waiting times for support.	**The health system should incorporate activities to ensure opportunities for identification/screening are available in a range of settings.** E.g. Primary care, ED and other health services can access resources (online and hard copy) to provide education/information as part of motivational conversations about alcohol use. **Future opportunities** include broadening training and support to increase opportunistic screening and brief intervention and improving access for non-AOD staff to specialist advice.
	3. Reduced harm for those with complex addiction needs.	**People with complex needs may not respond to standard treatment approaches, they should be able to access a range of support to reduce the impact of alcohol-related harm.** E.g. Community Alcohol and Drug Service (CADS) is the specialist Co-existing Problems (CEP) service and provides input into all treatment planning through a centralised approach. **Future opportunities** may be to explore options that can provide long-term care and support for

	people with poor mental health and enduring alcohol use disorders who do not wish to cease alcohol use.
4. Reduced harm for at risk groups.	**There are a number of at risk groups disproportionally affected by alcohol-related harm. It is important these groups are identified and approaches for engagement tailored accordingly.** E.g. Currently a number of services provide targeted support to at risk populations, such as the Alcohol & Other Drug Assessment & Treatment Service (ADAS) for offenders, 65 Alive for older persons, and the Community Youth Mental Health Service (CYMHS). **Future opportunities** exist around working with young women who are pregnant, and establishing stronger links with Integrated Safety Response and Family Violence agencies given the strong relationship between alcohol and family violence.
5. Reduced demand for specialist treatment services.	**The health system should work together to reduce the development of severe and enduring alcohol use disorders by supporting prevention, early intervention and options for self-management.** E.g. Early intervention and self-management services are currently available through the Alcohol & Drug Helpline, Health Promotion Agency resources, upskilling primary care, MHERC training with non-health workforces, primary mental health teams undertaking Assessment and Brief Intervention (ABI), dedicated ABI in the Christchurch Central Service – AOD Coordination. **Future opportunities** exist around increasing awareness of, and access to, resources, education, training, specialist advice and support.

FOCUS AREA 4	OBJECTIVE	
Measure harm and monitor performance 	1. Develop systematic data collection mechanisms at an individual and population level.	**Accurate information on alcohol-related harm will help inform partners and identify groups which may require targeted intervention or selective prevention. Such information should provide an evidence-base which informs where future resources and efforts should be concentrated.** E.g. ED data collection on alcohol related presentations. **Future opportunities** exist around targeted screening in general practice and recording when at risk drinking patterns are identified.
	2. Improved sharing of population level alcohol data across the health system to track reduction of harm.	**Enabling the development of tools such as a "viewer" supports the desire for organisations across the health system to share information so that they better understand the overall impact of alcohol-related harm on the health system.** **Future opportunities** exist around developing platforms to share summary data such as rate of hospital admissions, primary care presentations, referrals to providers and successful treatment outcomes.
	3. Improved sharing of population level data with external partners, and the public to communicate impact of alcohol on population health.	**Population level data regarding the impact of alcohol-related harm on the health system provides an evidence-base to the health risk narrative associated with this Strategy. Such information should be shared with partners and the public to support collaborative actions to reduce harm.** **Future opportunities** exist around developing infographics which summarise alcohol health system data for dissemination via existing partnerships such as Healthy Greater Christchurch.

4. Effectiveness of alcohol-related harm reduction activities evaluated.	**A whole of system reporting framework to track indicators and report on agreed measures should be developed to monitor objectives and evaluate the impact of the Strategy as a whole.** **Future opportunities** could include seeking qualitative feedback from consumers, police and other partners.

Recommendations for Strategy Implementation

The purpose of the Strategy is to provide direction for future alcohol-related harm reduction work. Although many potential activities have been identified during development, the Strategy is not intended to specify project detail regarding implementation.

The following are recommendations for how the Strategy could be implemented in order to achieve its objectives in a collaborative, coordinated and efficient way.

1. Establish an advisory group or service level alliance

To achieve coordinated implementation of the Strategy, a group which holds a governance role in relation to achieving Strategy objectives is required. Membership of such a group requires representation from across the health system (including primary care and community services) and should include clinical experts. Use of the Canterbury Clinical Network model may be appropriate to ensure that once implementation of the Strategy is under way, individual members of the group drive agreed activities that relate to their respective services with support from the facilitator.

2. Develop reporting arrangements that ensure wider accountability

It is recommended that the Strategy maintains lines of accountability to both the Canterbury Clinical Network, Alliance Leadership Team and the Canterbury DHB Executive Management Team (EMT). This would be via annual reporting on objectives and review of the implementation plan. The General Manager for the service under which the facilitator role would be managed, may also provide periodic updates as to progress to EMT, the Community and Public Health Advisory Committee (CPHAC), Manawhenua ki Waitaha and the Canterbury District Health Board as appropriate.

3. Establish links with the Christchurch Alcohol Action Plan

Established links between the Strategy and the Christchurch Alcohol Action Plan should be maintained via regular liaison between the project leads responsible for implementation of each plan. This would involve co-membership on the respective working groups given the number of cross-over activities. The Christchurch Alcohol Action Plan and the Strategy have been designed to complement one another rather than replicating activities to ensure that all sectors work together to achieve the shared vision of reduced alcohol-related harm for Christchurch.

4. Develop an implementation plan

It is recommended that implementation of the Strategy is managed via an accompanying implementation plan. This should detail specific activities required to achieve the objectives, set targets, timeframes and name relevant responsible leads for each activity across the health services. The implementation plan should be reviewed annually and activities formally evaluated.

5. Develop assessment criteria to select and prioritise implementation activities

From scoping already completed, there is likely to be over 60 implementation activities associated with achieving the Strategy objectives. A robust criteria for selecting and prioritising these activities is proposed and should be included in the implementation plan.

6. Develop a communications plan

It is recommended that a Communications and Engagement Plan accompanies the Strategy to ensure a coordinated release of information, consistent with the key messages of the Strategy, and to identify the communication tools to be used. Key messages should be consistent with the Canterbury DHB position statement on alcohol, the National Drug Policy 2015 to 2020[17], the Health Promotion Agency's Statement of Intent[18] and draft Alcohol Programme Strategic Plan 2017-2021, and the Christchurch Alcohol Action Plan 2017-2021.

7. Undertake evaluation and monitoring

The Work plan Portal, an online project management portal developed by Community & Public Health, is recommended as an appropriate tool to house the Strategy implementation plan and monitor implementation progress. A key strength of the Portal design is that it is internet-based and accessible to registered users from any web browser.

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Appendix

Canterbury District Health Board's Position Statement on Alcohol (July 2012)

Canterbury District Health Board
Te Poari Hauora ō Waitaha

This position statement is consistent with the position statements of Nelson Marlborough, West Coast, South Canterbury, and Southern District Health Boards and should be read in conjunction with the evidence-based background paper on alcohol.[1] Both documents have been developed collaboratively by the South Island Public Health Units and represent the South Island DHBs working together to address alcohol-related harm.

The Canterbury District Health Board acknowledges the wide range of alcohol-related harm that is experienced by people within the Canterbury district and that the burden of this harm is carried disproportionately by some population groups. It recognises that alcohol use is a major risk factor for numerous health conditions, injuries and social problems. Additionally, alcohol-related harm costs the health sector significant money, time and resources.

Canterbury DHB Position:

The Canterbury District Health Board will reduce the alcohol-related harm experienced by people within the Canterbury district by developing an Alcohol Harm Reduction Strategy. This strategy will set out the actions Canterbury District Health Board will undertake to reduce alcohol-related harm, including a communication plan. The Canterbury District Health Board will identify and record alcohol-related presentations within the Canterbury district in a consistent manner. The Canterbury District Health Board will support and assist Territorial Authorities to develop local alcohol plans that seek to reduce alcohol-related harm by providing information on alcohol-related presentations to emergency departments, and other information pertaining to the burden of alcohol. It will provide further evidence-based advice to assist with these plans.

Evidence Based Solutions:

The Canterbury District Health Board will advocate for the following evidence-based solutions to reduce the alcohol-related harm experienced by New Zealanders[2]:

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[1] A summary of evidence from the paper is attached as an appendix. Full references are in the background paper.

[2] These recommendations align with the Canterbury DHB's Submission to The Law Commission's Issues Paper on the Reform of New Zealand's Liquor Laws (2009), and with those contained in a recent Commentary from the Injury Prevention Research Unit: Kypri, K., Maclennan, B., Langley, J.D., and Connor, J.L. 2011. '*The Alcohol Reform Bill*: More tinkering than reform in response to the New Zealand public's demand for better laws'. *Drug and Alcohol Review* 30, 428-433.

Raise alcohol prices

- Increase levels of excise tax on alcohol by at least 50%
- Adjust excise tax so that alcohol products taxed directly on level of ethanol
- Use revenue from increase in excise tax to reduce harm amongst high-risk consumers
- Set minimum retail price for alcohol (per alcohol unit)

Raise the alcohol purchase age

- Restore alcohol purchase age to 20 years for both on-licences and off-licences
- Ensure enforcement of minimum purchase age
- Additionally, make it an offence for an adult other than a parent/guardian to supply alcohol to a child; and require parents/guardians who supply alcohol to their child to supervise the consumption of that alcohol

Reduce alcohol accessibility

- Restrict on-licences from selling alcohol after 2am
- Restrict off-licences to selling alcohol between 8am and 10pm
- Restrict convenience stores / dairies from selling alcohol
- Tighten law on granting of liquor licences – provide further grounds to refuse licences (e.g. detrimental social impact to community)
- Tighten restrictions on numbers of outlets in a given area

Reduce marketing and advertising of alcohol

- Ban alcohol sponsorship of sporting and cultural events
- Ban advertising of alcohol from television and cinema
- Advertising of alcohol to convey only basic information about the product
- Put health warning labels on alcohol products
- Ensure alcoholic beverages are labelled with ingredient and nutritional information
- Prohibit marketing of alcohol to youth

Reduce legal blood-alcohol limits for drivers

- Lower the legal blood alcohol (BAC) limit from 80mg/100ml blood to 50mg/100ml blood

Summary of Evidence:

Alcohol Related Harm

Alcohol use is a major risk factor for numerous health conditions, injuries and social problems, causing approximately 4% of deaths worldwide and (in 2000) 3.9% of all deaths in New Zealand. Much acute harm results from intoxication and includes: road traffic injuries and fatalities, burns, falls, drowning, poisoning, foetal alcohol spectrum disorder, assault, self-inflicted injury, suicide and homicide.

Biological effects of alcohol

Alcohol affects the brain. It alters the mood and impairs memory and psychomotor function. People who consume alcohol are less inhibited and therefore more likely to take risks and behave aggressively, leading to motor vehicle accidents and other injuries. Alcohol use is linked to a wide range of major diseases, including: heart disease, cancer, psychiatric and neurological conditions, gastrointestinal disease, and birth defects including foetal alcohol syndrome. It also contributes to diabetes, sleep disorders, and infectious diseases such as pneumonia and tuberculosis.

Unborn children and adolescents are particularly vulnerable to the effects of alcohol. Unborn children exposed to alcohol are at high risk of problems with memory, language, attention, learning, Visio-spatial ability, fine and gross motor skills, and social and adaptive functioning. Adolescent brains are still developing and therefore vulnerable to alcohol toxicity, addictive problems and psychiatric disorders.

Alcohol-related harm

Alcohol contributes to crime in New Zealand. Nearly half of all homicides in New Zealand between 1999 and 2008 involved alcohol. A third of all offenders in the year 2007/08 had consumed alcohol. Drink driving causes substantial harm - 27% of drivers in all fatal crashes between 2007 and 2009 were reported as having consumed alcohol.

Social harm results from alcohol: reportedly 12.2% of adults experienced harmful effects on friendships, social life, home life, work/study/employment opportunities, financial position, and legal problems or difficulty learning from their own drinking in the past year.

The economic cost of alcohol-related harm in New Zealand is significant. Harmful alcohol use in 2005/06 alone cost New Zealand an estimated $4,794 million of diverted resources and lost welfare.

Alcohol-related harm and population groups

Alcohol-related harm is experienced variably throughout the population. Men have a higher rate of alcohol-related mortality than women and Māori have a higher rate than non-Māori. Evidence clearly demonstrates that Māori suffer disproportionately from a wide range of alcohol-related harms compared to non-Māori. New Zealanders with lower socioeconomic status also bear a disproportionate burden of alcohol-related harm. Children are particularly vulnerable to alcohol-related harm caused by the drinking of other people and can suffer from increased susceptibility to child abuse, neglect and witnessing family violence if caregivers have an alcohol problem.

Cost of alcohol-related harm to the health sector

Alcohol-related harm in New Zealand costs the health sector significant money, time and resources. Intoxicated patients also impact negatively on staff and other patients. An estimated 35% of injury-based emergency department presentations are alcoholrelated. From 1 November 2010 to 29 October 2011 892 patients were seen in Dunedin Hospital Emergency Department for alcohol-related presentations. The average length of stay for these patients was 4.5 hours, with an average cost to Southern District Health Board of $1,000 per person.

NZ Drinking Pattern:

Alcohol is widely available in NZ

Alcohol is easily accessible from a wide variety of outlets and to anyone over the age of 18. It can be purchased 24 hours a day, 7 days a week and on most days of the year. Alcohol can be consumed either on the premises (on-licences) in bars, restaurants, cafes, hotels, pubs and individual clubs or at special functions; or off the premises (off-licences) when purchased from liquor stores, supermarkets, grocery stores or dairies. Alcohol is more widely available now than in the past: in 2010 the number of places which held liquor licences was 14,424; this has increased from 6,295 in 1990. It is inexpensive: reportedly, in 2010, 3 litres of cask wine could be purchased (on special) for as little as $16.99.

Drinking patterns in NZ

According to recent surveys, most New Zealanders (85%) drink at least some alcohol. At least two-thirds of those surveyed in 2007/08 drank once a week. Of people surveyed, nearly two-thirds of all people drank to excess at least once a year and one in ten did so at least once a week. Harmful drinking is more common amongst Māori, Pacific and young people. New Zealanders tolerate excess drinking – less than half surveyed agreed that “It is never O.K. to get drunk” and over one quarter agreed that it is “O.K. to get drunk as long as it’s not everyday”. A third of those surveyed started drinking at around the age of 14.

How the current law impacts upon these drinking patterns

The Sale of Liquor Act (1989) has liberalised the sale of alcohol, allowing it to be sold widely, including from supermarkets and over a 24 hour period. Since 1999 (with an amendment to the Act), the purchase age has dropped to 18 (from 20 years), beer has become available in supermarkets and alcohol can be purchased on Sundays. District Licensing Authorities (DLAs) in each local area grant and renew licenses and stipulate opening times. Licensing Inspectors check that premises within their area comply with regulations (e.g. not selling to those who are already intoxicated). The Resource Management Act (1991) legislates how local communities manage the use of land, which requires that a District Plan be put into place and complied with. The Local Government Amendment Act 2001 allows local authorities to impose liquor bans, banning alcohol in public places at certain times. The Land Transport Amendment Act (2011) has lowered the blood alcohol concentration (BAC) limit for drivers under 20 years to zero. The limit for drivers over 20 years is 80mg per 100ml blood.

Evidence Based Strategies to Reduce Harm:

Raise prices

Evidence shows that when alcohol prices go up, consumption goes down. One of the best ways to influence the consumption of alcohol is through pricing. Alcohol prices are subject to excise tax, which in New Zealand is set at a particular rate depending on which band of alcohol strength the product falls into (e.g. alcoholic beverages between 9-14% alcohol are taxed at 10%). Currently excise tax rates are lower than that of other countries; they are also not adjusted for inflation. In New Zealand there is often a price differential between on and off-licences, which encourages 'preloading' (loading up on cheap alcohol before frequenting on-licences).

Raise the purchase age

Research shows that the legal purchase age affects how much youth drink. A lower purchase age has been associated with increased harm (including traffic crashes). In order for a higher purchase age to be effective, it needs to be combined with adequate enforcement. A higher purchase age acknowledges that the effect of alcohol and its harms is much greater on the adolescent brain as it is still developing.

Reduce alcohol accessibility

It is scientifically and economically effective to restrict the physical availability of alcohol in order to reduce harm. Limiting the physical availability of alcohol can be achieved through limiting the hours and days of sale, and controlling outlet density. Currently alcohol is too easily purchased and facilitates pre-loading. There are often too many alcohol outlets within an area – high densities of alcohol outlets have been shown to be associated with increased harm, including traffic crashes.

Reduce marketing and advertising

Advertising of alcohol has increased in many countries over recent decades, including New Zealand. Prior to the 1980s alcohol advertising in New Zealand was mostly non-existent, due to legislation controlling the advertising of alcohol – now alcohol advertising is left to the self-regulation of the industry. Since 1992, advertising of alcohol has been allowed on both television and radio – albeit at restricted times (9pm-6am) for television. Since 1987 alcohol companies have been allowed to sponsor sports and advertise corporately. Alcohol advertisements often sell the image that drinking is attractive, glamorous and fun; and these messages are particularly appealing to young people. Alcohol advertising not only leads to greater consumption of alcohol, but also colours people's perceptions of the drinking habits of others.

Reduce legal blood alcohol limits for drivers

With increasing levels of alcohol in the blood, driving performance declines. Currently (as of 2011), there is zero tolerance for drivers under 20 years with any alcohol at all in their blood. Drivers over 20 are legally entitled to drive after drinking with no more than 80mg per 100ml of alcohol in the blood. In 2009 in New Zealand, 138 deaths resulted from traffic accidents where alcohol (and/or drug use) was a contributing factor. Research has shown that the risk of traffic crashes

goes up proportionate to the level of alcohol in the blood: the risk doubles for those with 0.05% BAC compared to those with none; there is ten times the risk for those with 0.08% BAC; and one hundred times the risk for those with 0.15% BAC or higher.

March 2019