Medical Officer of Health Report
for
Nelson City Council
Regarding
Local Alcohol Policies

20 June 2013

Prepared by the Public Health Service of

Nelson Marlborough District Health Board.

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Introduction

This report has been prepared by the Medical Officer of Health (MOH) and other staff at the Public Health Service (PHS) of the Nelson Marlborough District Health Board (NMDHB) as part of the process in the development of Draft Local Alcohol Policies (LAPS) by Territorial Authorities under the Sale and Supply of Alcohol Act 2012.

The Medical Officer of Health and NMDHB are strongly supportive of the development of LAPs as an opportunity to decrease alcohol related harm in our community and a way of enabling greater community input into alcohol licensing issues. The opportunity to contribute is appreciated. In the Act there is a specific requirement to consult the MOH in LAP development and also a section around agencies "duty to collaborate" in working together to reduce alcohol related harm (sn 295). Locally there is already a long history of collaborative work among the PHS, Council Licensing Inspectors and the Police on alcohol issues. Also there are several collaborative initiatives involving other agencies and the hospitality sector such as the Nelson Tasman Alcohol Accord and the Marlborough Alcohol Advisory Committee.

Both Nelson/ Tasman and Marlborough are involved in cross sector projects around healthy communities ("Safe at the Top" and "Safe and Sound at the Top"). Action on alcohol related problems is an aspect of these projects.

The population covered by NMDHB is outlined in the table below

Marlborough - Nelson - Tasman Statistics NZ 2011 Population Projections			
	European	**Maori**	**Total**
Marlborough District Council	42300	5100	47400
Nelson City Council	42100	4500	46600
Tasman District Council	45700	3600	49300
Total	130100	13200	143300

About eight percent of the population are Maori which is less than the national average of 15%. The Maori population is a younger population than non-Maori.

NMDHB adopted a position statement on alcohol in 2012 (Appendix One) and will be developing an alcohol harm reduction strategy as a follow on to this. Working with Territorial Authorities in developing Local Alcohol Policies was identified as an action in that position statement and will make up a component of the DHBs Alcohol Harm Reduction Strategy.

Some Relevant Parts of the Act

The object of the Act is outlined in Section 4 and identifies health impacts as potential areas of alcohol related harm that should be minimised.

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).*

Local alcohol policies are covered in subpart 2 of the Act and section 77 outlines what can make up the content of policies. LAPs are primarily around licensing issues.

77 Contents of policies

1. *A local alcohol policy may include policies on any or all of the following matters relating to licensing (and no others):*

    a. *location of licensed premises by reference to broad areas:*

    b. *location of licensed premises by reference to proximity to premises of a particular kind or kinds:*

    c. *location of licensed premises by reference to proximity to facilities of a particular kind or kinds:*

    d. *whether further licences (or licences of a particular kind or kinds) should be issued for premises in the district concerned, or any stated part of the district:*

    e. *maximum trading hours:*

    f. *the issue of licences, or licences of a particular kind or kinds, subject to discretionary conditions:*

g. one-way door restrictions.

Alcohol and Harm – General Effects

It is well recognised that drinking alcohol to a state of intoxication, binge drinking and sustained heavy drinking, leads to a number of adverse effects on health. These harms include; acute alcohol intoxication, a range of injury types, chronic diseases, mental health conditions and addiction (1, 2, 3). In addition, other related health conditions such as sexually-transmitted infections and unintended pregnancies may result from drinking (4, 5). There are a range of social harms arising from the misuse of alcohol. Alcohol-related harm can occur in the individuals who drink as well as others who are directly or indirectly affected.

Some groups in the community are more seriously impacted by 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 (pg 83)

People living in areas of higher socio-economic deprivation also face greater impacts from alcohol related harm (6: pg 94). Part of this may be linked to outlet numbers and density with New Zealand research showing outlet density is higher in such areas. (People living in areas with more outlets are more likely to consume more and suffer from alcohol related harm (6: pg 95). Density is an issue and alcohol can actually make inequalities worse. (Note that density in this context refers to number of outlets in a given geographic area not to the number of licences per 10,000 population).

An analysis reported in the New Zealand Medical Journal in 2012 (7) reported that for 2007 "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 more people than reported harm from their own drinking (12.2%). The same paper reported that women suffered more, particularly young women with 35% of women aged 18 to 24 years reporting harm.

Data from the community surveys carried out by the Tasman District Council (TDC), Nelson City Council (NCC) and Marlborough District Council (MDC) as part of preparation for the draft LAPs showed 18%, 21% and 19% respectively of respondents reported that in the last 5 years they, or someone close to them, had experienced significant harm from someone else drinking. (8, 9, 10)

In it's 2009 Issues Paper the Law Commission stated; "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 (1: pg7).

Essentially there are two broad classes of alcohol related harm, those contributing to illness, injury and poor health and those contributing to social problems. The final Law Commission report has a good summary of the health related harms and the following extract outlines these. (6: pg 70)

"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."

As expressed above, alcohol is linked to a wide range of diseases from effects on the unborn child (foetal alcohol syndrome) through to cancer, with a strong association with cancers of the head and neck and links with cancer of the breast, digestive tract and respiratory system. Other diseases and illnesses where alcohol is a major contributory factor are liver disease, pancreatitis, cardiovascular disease and high blood pressure and there is a contribution to infectious diseases such as pneumonia and sexually transmitted infections, other gastro-intestinal diseases, gout, psoriasis and of course injuries including burns. In

addition it can cause a range of mental health problems including dependence, depression, anxiety, and sleep disorders.

The existence of overall health-related benefits of alcohol is contentious, since it is debatable whether potential health benefits for individuals such as reduced coronary heart disease risk, ever outweigh co-existent harms at any level of drinking or age [11,12]. The most recent alcohol guidelines encourage consumption at low-moderate levels, avoidance of binge drinking, and non-promotion of alcohol for purported therapeutic health "benefits" [12].

Social harms from alcohol misuse are well recognised, for example Babor[3] and others reported in both individual and population studies there is a clear link between alcohol and violence and 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. Babor comments on the need for social policy around alcohol to help reduce these harms even though alcohol may be only one contributory factor.

Local Health information on Alcohol Related Harm

SUMMARY OF ALCOHOL-RELATED HARM (HEALTH-RELATED): INFORMATION FOR LOCAL ALCOHOL POLICY DEVELOPMENT.

Sources of information on specific areas of alcohol-related harm

Emergency Department (ED) visits

This data is useful for identifying most types of acute harm including demographic and time trends, and presentation characteristics (eg diagnosis, day/time). Information about the involvement of alcohol in presentations is collected by triage nurses at NMDHB hospital EDs. An audit of weekend ED presentations during 2011 identified those which were alcohol-related based on information from the clinical records, and this data is presented in this report. The audit found that the routine collection of information about alcohol at triage was incomplete and inconsistent. Subsequently, a new 3-step system of data collection is currently being trialled.

Hospital admissions

This data can capture information about the burden due to chronic conditions such as alcohol-related liver diseases and cancers (using attributable risk concepts), as well as more severe acute presentations. In this report data was only available for admissions where the condition is wholly attributable to alcohol. This will lead to a significant under-estimation of the size of the problem since it does not include a number of important conditions such as some types of cancer which are partially attributable to alcohol, or more serious alcohol-related injuries which require hospital admission.

Alcohol-related vehicle crashes

This can identify injury and non-injury crashes where alcohol has been identified as a factor, as reported to the NZ Transport Agency. Useful for comparing trends over time, or between geographic areas (TLA areas).

Compliance with Controlled Purchase Operations (CPOs)

This is a measure of how well local licensees comply with license provisions, namely age-restrictions on sale of alcohol, using data collected by the Public Health Unit and the New Zealand Police.

Density of alcoholic liquor licences

The density of licences issued per 1,000 population has been associated with levels of alcohol-related harm in NZ (13) and can be measured for on-licences, off-licences and club-licences, using data from the Ministry of Justice.

Health provider perceptions of local alcohol harm and licensing issues

A survey (administered on-line and postal) was conducted during April and May 2103 to seek the opinion of health providers concerning local patterns of alcohol-related harm in Nelson-Marlborough, and possible interventions that could be used to address these through local licensing arrangements. Respondents included general practitioners, community and hospital-based practitioners working in the drug and alcohol/mental health/youth health fields, as well as clinical directors of the NMDHB, Emergency Department staff, Ambulance Services, Gambling Services, Maori Health Providers, Pacific Reference Group, and school counsellors.

Outpatient attendances for alcohol problems

Currently data is not routinely available that identifies trends in alcohol-specific referrals to the NMDHB Drug and Alcohol services.

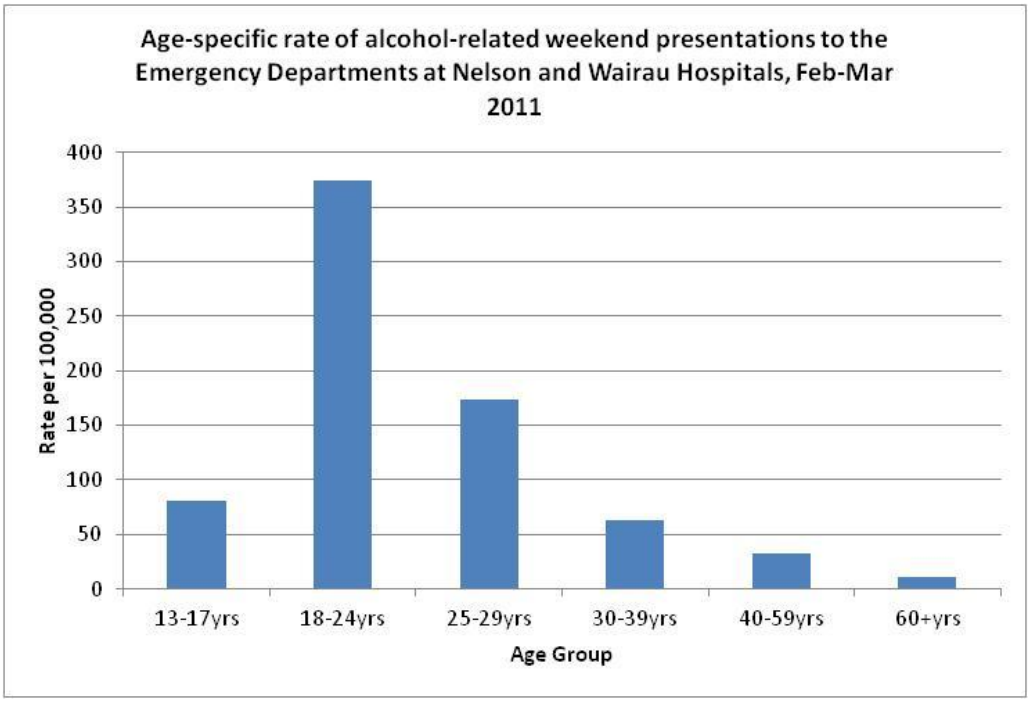
Nelson and Wairau Hospital Emergency Departments

Overall impact:

Estimated 1,215 alcohol-related ED visits per year (based upon data from the 2011 audit). Overall, 10% of weekend ED presentations were alcohol-related, and this was similar at Nelson Hospital (9%) and Wairau Hospital (11%).

Age:

Peak 18-29 years but also affects significant numbers in the other age groups. This emphasises the need to focus on younger age groups, but not to forget the impact across the whole age range.



Gender:

Males have greater numbers than females, but there is only a small difference in terms of the proportion of ED visits (12% of male presentations and 9% of female presentations were alcohol-related).

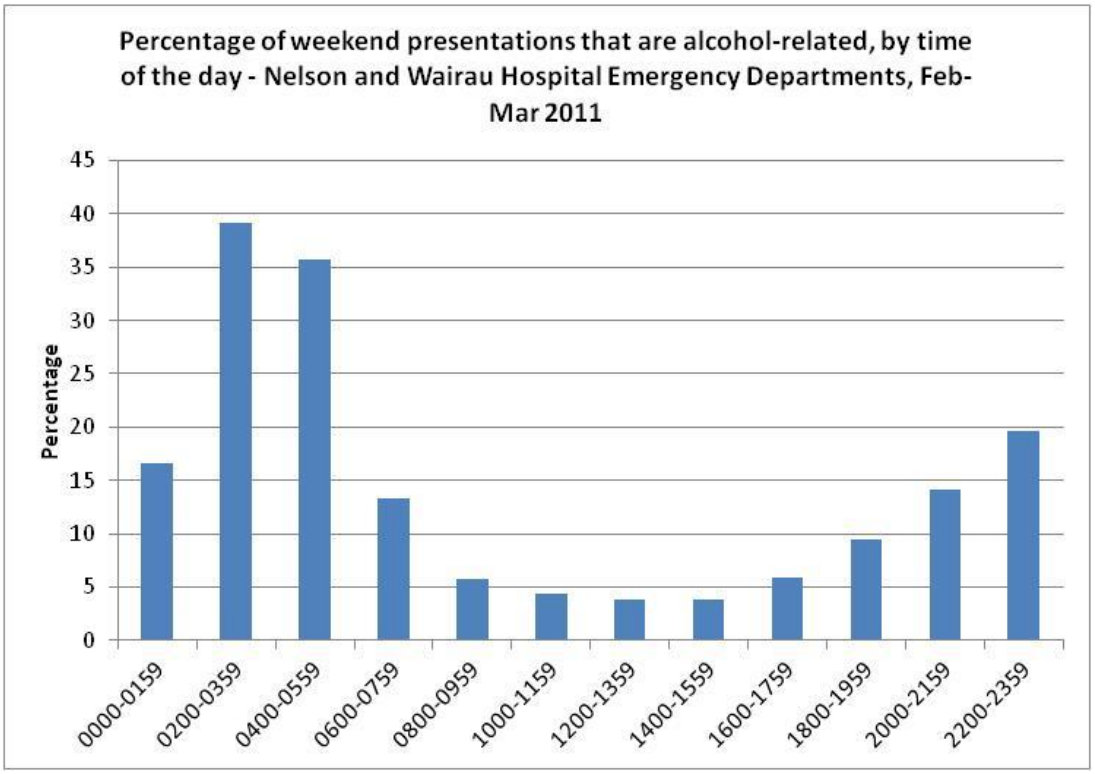
Type of weekend ED alcohol-related harm:

- Acute intoxication – 10% of alcohol-related presentations,
- Injuries – 55% (20% involved violence),
- Medical/other – 20%,
- Mental health – 15%.

Note: for alcohol-related violence injuries, 73% involved males, 73% involve 18-24 year olds, and 64% of these presented at night between 2200 and 0800.

Time/Day:

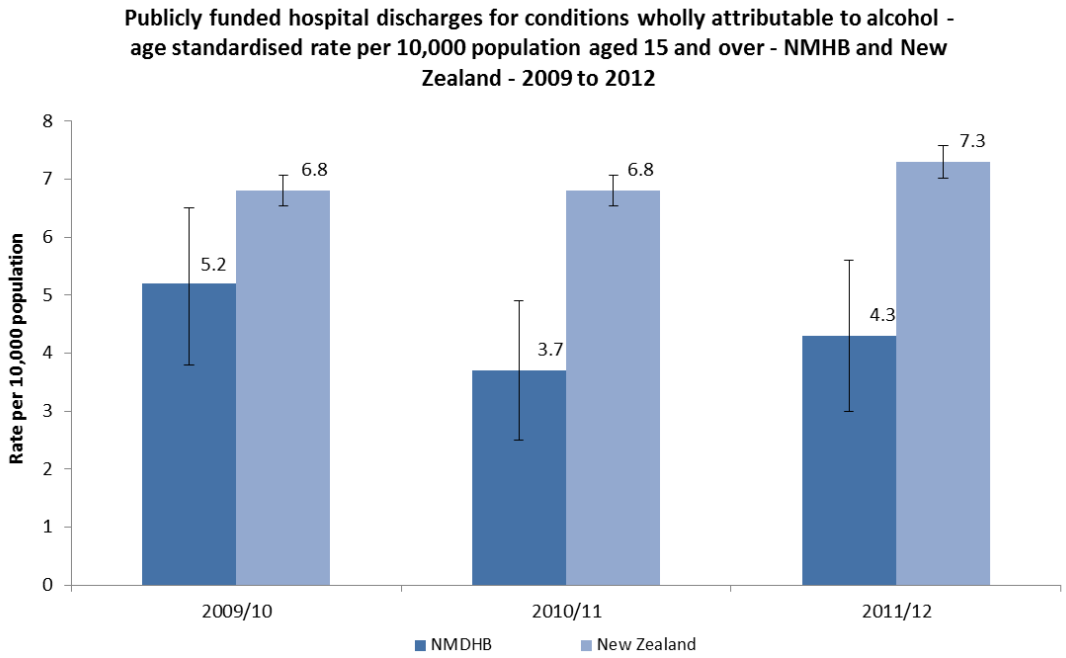
ED alcohol-related presentations: most commonly (65%) on the weekend (based upon other NZ data), and especially Friday and Saturday late nights between 2200-0400.



Nelson and Wairau Hospital admissions

Publicly funded hospital discharges for conditions wholly attributable to alcohol

The data presented below suggests that for the limited number of conditions that are wholly attributable to alcohol, the Nelson-Marlborough district has lower rates than New Zealand. However, this picture does not include admissions for other important chronic conditions including some forms of cancers which are partially attributable to alcohol, nor injuries where alcohol has played a role. Using a broader definition of alcohol-related hospitalisation, a recent review of alcohol-related hospital admissions in young people aged 15-24 years has shown that over the period 2007-2011, Nelson Marlborough had a rate of admission consistently higher than for New Zealand as a whole (14). Important causes for admission amongst this age group included injury as well as mental/behavioural disorders and acute intoxication.



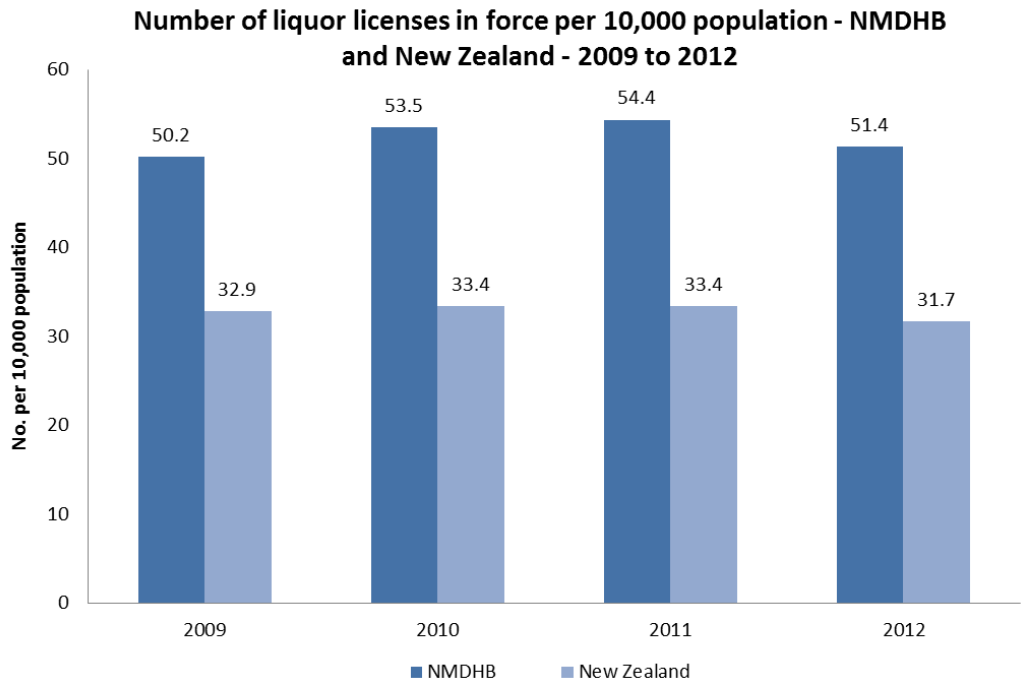
Source: Ministry of Health (numerator), Statistics New Zealand (denominator)

Note:

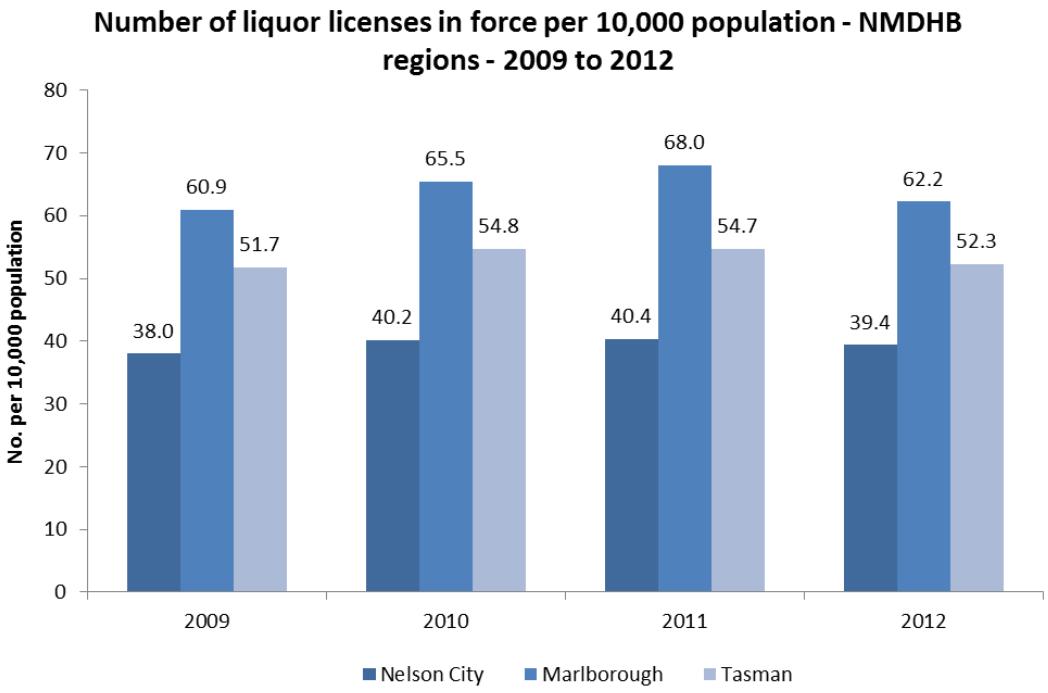
- Data from hospital admission records in the National Minimum Data Set provided by the Ministry of Health. Admission records are coded by the treatment a patient received and the diagnosis of disease or injury. Cases are coded using the International Classification of Diseases (ICD) as published by the World Health Organisation.
- Data includes all publicly funded hospital discharges for conditions that by definition are wholly attributable to alcohol by ICD code and included by Jones *et al.* *(15)*.
    - E24.4 - Alcohol-induced pseudo-Cushing's syndrome,
    - F10 - Mental and behavioural disorders due to use of alcohol
    - G31.2 - Degeneration of nervous system due to alcohol
    - G62.1 - Alcoholic polyneuropathy
    - G72.1 - Alcoholic myopathy
    - I42.6 - Alcoholic cardiomyopathy
    - K29.2 - Alcoholic gastritis
    - K70 - Alcoholic liver disease
    - K86.0 - Chronic pancreatitis (alcohol induced)
    - T51.0 - Ethanol poisoning
    - T51.1 - Methanol poisoning
    - T51.9 - Toxic effect of alcohol, unspecified
    - X45 - Accidental poisoning by and exposure to alcohol
- Short stay Emergency Department visits have been excluded from these data due to the differing reporting methods between District Health Boards. A number of District Health Boards report all short stay Emergency events, yet others do not. To allow a valid comparison to be made between the Nelson Marlborough District Health Board (NMDHB) and New Zealand, Emergency Department events have been excluded.
- Data only includes those events that were publicly funded. Events may have also occurred within the private sector and subsequently not be captured in the above data. The private sector is not required to report hospital admissions unless the event is publicly funded within the private sector.
- ICD coding criteria and hospital/DHB reporting procedures can change from year to year. As such, it is advisable to exercise caution when making assumptions on trends or comparing rates across years.
- A number of factors play a role in the decision to admit a patient presenting with some of the above conditions, for example local management practice and the availability of inpatient beds may influence the likelihood of admission.

Density of alcohol liquor licences per 10,000 population

These data indicate that NMDHB has a higher density of licensed premises than New Zealand, and densities are particularly high in Marlborough. The number of vineyard licences is likely to be a factor in this measure. It is also important to note that the Top of the South has high numbers of visitors many of whom will be visiting licensed premises and the density of licences per 10,000 population refers to resident population.



Source: Ministry of Justice (numerator), Statistics New Zealand (denominator)



Source: Ministry of Justice (numerator), Statistics New Zealand (denominator)

Note:

- Number of licences is correct as at May for each given year.
- There are four classes of licence: on-licences, off-licences, club licences and special licences. The figure above includes only on-, off- and club licences.
- Overall, NMDHB has a greater number of in-force liquor licences per 10,000 population than New Zealand overall, although the statistical significance of this difference has not been determined.

Licence Condition Compliance (CPOs)

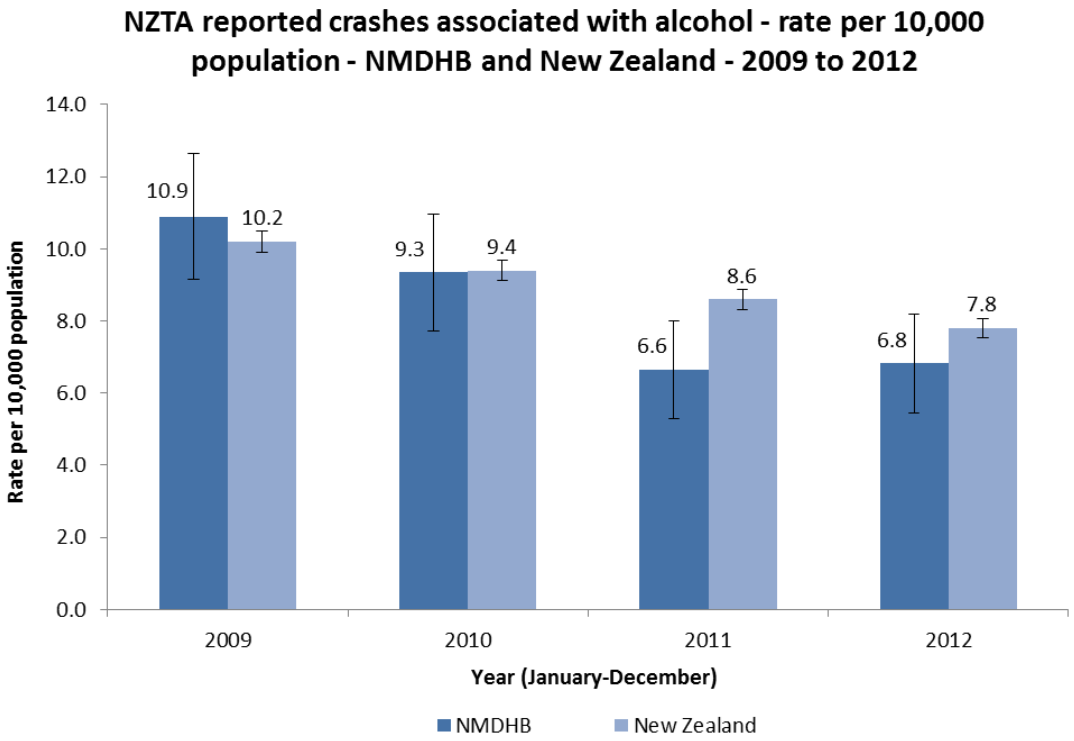
Controlled Purchase Operations of on- and off-licensed premises send supervised volunteers aged under 18 years to buy alcohol from licensed premises. Retailers are said to have complied with the Sale of Liquor Act if they refuse to sell alcohol to the under-age volunteer. CPOs involving club licensed premises check for sale of liquor to non-club members or the general public.

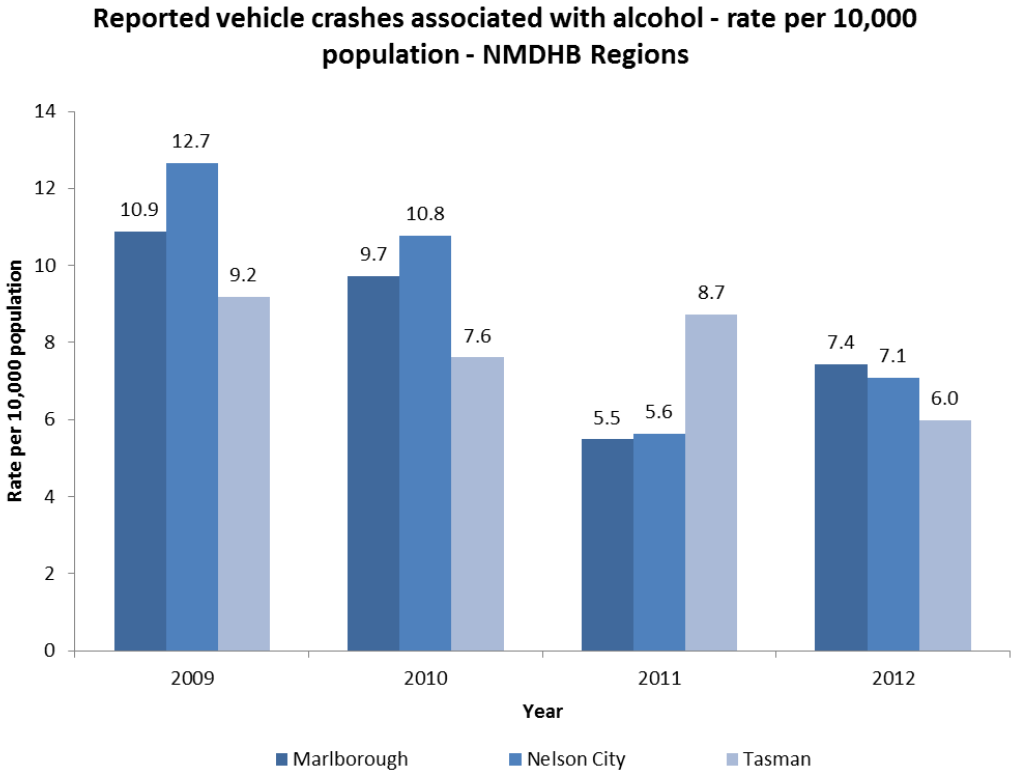
The annual data for Nelson-Tasman and Marlborough areas is summarised in the table below. (source NMDHB PHS and NZ Police)

Year	Premises Visited	Premises Compliant	% Compliant
Nelson-Tasman			
2009 (after June)	126	120	95.2
2010	120	109	90.8
2011	111	103	92.8
2012	198	182	91.9
Marlborough			
2010 (after Dec)	25	23	92.0
2011	52	52	100.0
2012	61	57	93.4

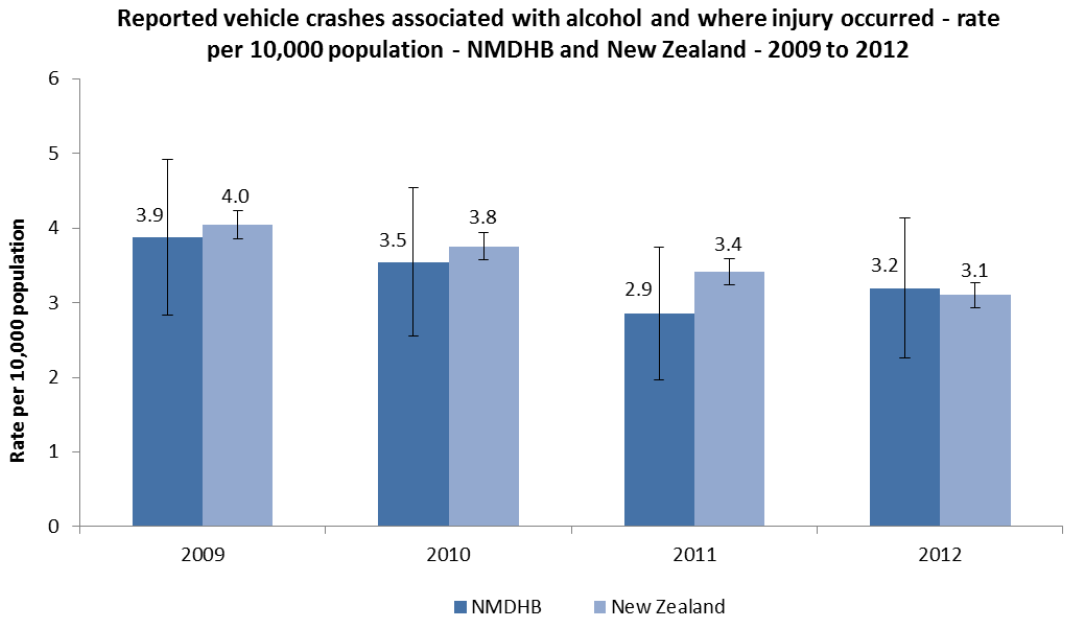
Vehicle Crashes Associated with Alcohol

There has been a downward trend in rates of vehicle crashes associated with alcohol over the period 2009- 2012. NMDHB rates are generally similar or lower compared with NZ and there were no consistent differences between the three Territorial Authorities.

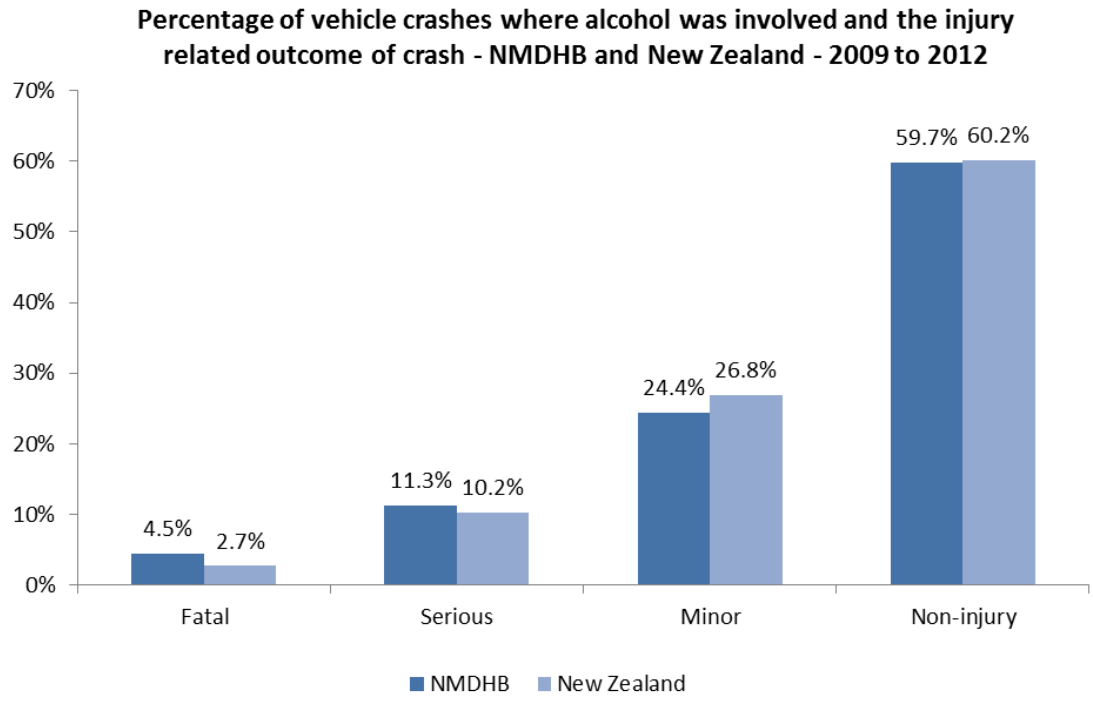




Source: New Zealand Transport Agency (numerator), Statistics New Zealand (denominator)



Source: New Zealand Transport Agency (numerator), Statistics New Zealand (denominator)



Source: New Zealand Transport Agency (numerator), Statistics New Zealand (denominator)

Note:

- Some underreporting of injury outcomes of alcohol associated vehicle crashes has been reported in the literature (16).

Within the NMDHB region between 2009 and 2012, inclusive, 40.2% of all recorded vehicle crashes where alcohol was involved resulted in an injury. This proportion is similar to that observed nationally during the same time period. The rate of alcohol involvement in vehicle crashes where injury occurred has been similar to that observed nationally since 2009.

Health Provider Perceptions of Alcohol-Related Harm and Licensing Issues (survey results)

Survey response:

Responses were received from 82 of 193 respondents (42% overall). Main responding groups included GPs (n=48) ambulance staff (8) and other (26).

Overall harm:

Overall, almost all respondents (99%) reported that alcohol problems were evident in their districts.

Demographic groups and harm:

The age group of most concern was 18-24 year olds for whom 92% of respondents rated alcohol as a "major" or "severe" problem. The other age groups of most concern were the under-18 year group (74%) and 25-34 year group (74%), but only 24% of respondents rated alcohol problems as "major" or "severe" amongst the 60+ year age group. Eighty seven percent of respondents rated alcohol as a "major problem" for males and 71% for females.

Alcohol-related conditions:

Conditions that were reported by respondents as having alcohol play a "major" or "leading" role included; violent crime (94% of respondents), domestic violence (93%), injuries/accidents (89%), STIs (79%), unwanted pregnancies (77%), illness/disability (73%), self harm (66%) and absenteeism (53%).

Impact of licensed premises on alcohol:

- Overall, 87% of respondents reported that the current availability of alcohol from licensed premises contributed to alcohol problems in their district.

- Over 90% of respondents "agreed" or "strongly agreed" that alcohol from pubs/clubs or off-licensed sales played a role in alcohol-related harm. Most concern was about

off-licensed premises (70% “strongly agreed” that they played a role). However, relatively few (20%) believed that this was the case for licensed restaurants/cafes.

Interventions for controlling alcohol harm:

- The majority of respondents “agreed” or “strongly agreed” that alcohol availability should be restricted by means of trading hour limitations (78% of respondents), location (76%) or number of licensed premises (79%), and there was little difference in preference between these three options.

- 83% of respondents thought that alcohol advertising or promotion from off-licensed premises played a role in alcohol harm, but these were less important for on-licensed pubs/clubs (69%) or licensed restaurants/cafes (19%).

72% of respondents “agreed” or “strongly agreed” that councils should address alcohol-related problems by means of urban planning processes or regulating alcohol advertising/marketing in council-owned venues/events (76%).

Comments from Health Professionals

Dr Mark Reeves: Senior Medical Officer, Nelson Hospital Emergency Department

“Harmful drinking contributes greatly to our workload in the Emergency Department. Drunk patients are often abusive and uncooperative and take up a disproportionate amount of our time and resources, sometimes compromising our ability to care for our other patients, and impacting markedly on the functionality of our department as a whole. As well as intoxication (obviously), harmful drinking has a role in a proportion of the trauma, self-harm, mental illness, depression, attempted suicide, sexual assault, sexually transmitted disease, unwanted pregnancy, non-accidental injury of children, family violence and general morbidity that we have to deal with.”

“The Nelson region undeniably has a problem with alcohol-related violence. The facts, figures, and every day and night experience of those working at the ‘front line’ make this statement undeniable. Of particular concern is the violence associated with the pre- and side-loading of alcohol by young people. Immature brains with under-developed pre-frontal cortices (the bit of the brain that predicts and weighs up the likely outcomes and consequences of one's actions), still developing personalities, fragile egos, raging hormones and muscle cars. Add alcohol and it seems like the perfect storm for something bad to happen. It does; we see the results.”

“The reasons why alcohol makes some people violent are not straightforward. Studies, mostly on men, show alcohol consumption makes people aggressive and belligerent. Alcohol also disinhibits people and impairs the ability of people to think rationally and speak clearly. This volatile mixture of altered and unstable perceptions, together with impaired ability to reason and respond calmly with language leads to misunderstandings, perceived slights, resentment and, sure enough, aggression and physical violence. In not so many

words, alcohol makes some people violent dicks. Being drunk also makes you more likely to be an assault victim. If you're drunk, there's a good chance the people around you are drunk with their similarly compromised, labile, lairy minds just waiting for you to say the wrong thing, which you may well do because ... well, you're drunk!"

"As a practising Emergency Department doctor I encourage every Council member to do everything they can to minimise the societal damage from harmful drinking behaviour, and to promote the responsible enjoyment of alcohol."

Policy options and evidence of effectiveness

Local alcohol policies are around licensing matters. The Society for the Study of Addiction to Alcohol and Other Drugs reviewed work by Babor and others on alcohol policy options in reducing alcohol related harm and ten which stood out as best practice. (17) These were:

- Minimum legal purchase age
- Government monopoly on retail sales
- Restrictions on hours or days of sale
- Outlet density restrictions,
- Alcohol taxes
- Sobriety checkpoints
- Lowered blood alcohol limits
- Administrative licence suspension
- Graduated licensing for novice drivers
- Brief interventions for hazardous drinkers

In another paper Anderson and others reviewed the evidence for effectiveness of harm reduction programmes around a range of approaches eg education, pricing, marketing and, community action. They found that increasing the price, decreasing availability and banning alcohol advertising were effective (plus highly cost effective) and that enforcing drink driving legislation and focussed individual intervention for at risk drinkers were also effective. (18)

New Zealand has some of the above policies in place and with LAP there is an opportunity to further policy intervention around hours on and off licences are open to sell alcohol and around outlet density or the number of licences in a specific geographic area. In addition one way door policies enable further controls on hours on licences are operating.

Regarding the number of alcohol outlets in an area there is international and New Zealand evidence that geographic density is associated with alcohol related harm. Examples are neighbourhood complaints of drunkenness and property damage (19), alcohol related

problems in NZ university students [20], binge drinking and the number of off licences [13] increased violent offending and greater geographic access to alcohol outlets [21].

The paper by Connor [13] stated that "more than 50 research papers have been published since the early 1980s finding associations between the spatial density of alcohol outlets and levels of harm".

However it is noted that clustering of outlets in an "entertainment precinct" of a town or city can have some benefits such as city vitality, tourism and economic benefits and in addition grouping of outlets aids policing.

Regarding trading hours the Sale and Supply of Alcohol Act 2012 has set " default" hours in legislation. These are 8am - 4am for on licences and 7 am - 11 pm for off licences. These can be varied in an LAP. Studies have looked at violence and assaults in relation to closing hours and found increases in these problems with extending hours and decreases with limiting hours. One example is a study in Newcastle Australia [22] where reducing trading hours of licensed premises from 5 am to 3 am gave an estimated 37% decrease in late night violence. Reducing trading hours will have an impact on police, ambulance and hospital resources and a positive benefit for not only the patrons of premises but the community generally. If reducing trading hours is used as a policy approach to decreasing alcohol related harm then consideration needs to also be given to possible migration of patrons to other premises that are still open. Use of one way door policies helps address this issue.

Summary

General reviews of the literature and evidence from local data and opinions concerning alcohol-related harm consistently identifies the following issues and help identify priority areas for targeting action:

- People in higher deprivation areas, young people and Maori and Pacific people are impacted more by alcohol related harm.
- Binge drinking, especially during the weekend, and associations with violence and injury, involving both male and female drinkers.
- Prolonged heavy drinking across all age groups.
- Availability of alcohol, particularly from off-licensed premises, with licensed cafes and restaurants of least concern.
- "Licensing" interventions involving trading hour restrictions and density of premises are likely to be the most effective in reducing harm.

Implications for Local Alcohol Policy development:

Alcohol-related presentations for acute conditions like injury and severe intoxication has a significant impact on hospital ED services in Nelson-Tasman and Marlborough (estimated currently over 1,000 per year), and particularly involving:

- people in the 18-29 year age group,
- both male and female,
- weekend drinking, and especially late night between 0200 and 0400am,
- injuries, frequently resulting from violent incidents (fights and assaults).

LAPs should consider licensing strategies that particularly address these acute harm issues that often result from binge drinking and pre- or side-loading behaviour. They should focus on those addressing availability through on- and off-license density, location and trading hours. Having off licences close earlier than on licences may contribute to decreasing pre and side-loading behaviour. Similarly one way doors for some types of premises may decrease problems relating to acute intoxication.

Hospital admissions due to alcohol usually result from chronic conditions (more common in older people and arising as a result of consumption over longer periods of time) as well as mental and behavioural disorders and more severe injuries in all age groups over 15 years. Nelson-Marlborough may have a higher than average harm for alcohol-related hospitalisations involving younger people.

LAPs should therefore consider licensing strategies that address the acute harm issues (see ED data above) as well reduce the total consumption of alcohol over longer periods of time, particularly strategies that may reduce total off-licence sales given that the majority of alcohol is purchased from off licences.

Positive associations have been reported between the geographic density of off-licence premises and binge drinking, and density of all types of licences have been positively associated with alcohol related harm (13). Problems from geographic density are more likely to be an issue in central business districts such as central Nelson and central Blenheim although location of outlets in certain situations may be an issue and has been identified as such in local surveys . Consideration can be given to location near “sensitive “ sites such as schools and in areas of greater socio-economic deprivation.

For Nelson City the Bridge Street area has been an area with significant numbers of on-licence premises and where alcohol related problems have arisen. As well as addressing these through licensing issues other initiatives are important including current work to improve the amenity of the area and crime prevention through environmental design (CPTED). The amenity and CPTED work around licensed premises is relevant for all areas of Tasman, Nelson and Marlborough.

On a population basis Nelson-Marlborough has densities of licensed premises greater than the New Zealand average. This may be linked to the number of vineyard on- and off-licences and possibly also to other business's catering to the tourism industry. Unfortunately evidence from CPOs around sales to minors from vineyards and at the Marlborough wine and food festival indicate that this sector of the alcohol industry is not immune to problems.

LAPs should consider strategies that limit overall numbers of licences.

Although there has been a downward trend in vehicle crash rates involving alcohol, a significant proportion of these lead to an injury and this is still an important area of alcohol-related harm. Strategies that decrease acute intoxication, binge drinking and regular heavy consumption are relevant in this area.

Controlled purchase operations provide information about compliance behaviour of licensees as well as under-18 year youth access to alcohol and the potential to increase harm. Location and number of licences in an area influence ease of access and may potentially impact on underage purchasing of alcohol either by the young person themselves or by an older family member or friend. Cheap alcohol is likely to be a main driver of purchasing by young people and a focus for LAPs needs to be the sources of cheaper alcohol. These are primarily supermarkets and liquor chain outlets where scale enables price discounting.

Raising the price of alcohol is likely to have the strongest influence on access by young people but that is not in the criteria for consideration in LAPs. The amount of promotion of alcohol by a particular licensed premise, particularly for cheap alcohol may be something that could be considered under discretionary conditions that may be applied to that licence.

There may be other possible discretionary conditions worth considering for different types of licences. For example, whether special licences should be granted on school premises given the concern reflected in local surveys about location near schools. Should there be restrictions on the length of time special licences can run for and for the number of times per year a premise can have specials?

Recommendations

1 Trading Hours

- That LAPs apply more restrictive trading hours than the default hours stated in legislation.
- Different hours are appropriate for different types of licences
- For hotel, tavern on-licences and nightclubs in central urban areas 9am - 2am.
- For hotels and taverns in other areas of Nelson Tasman and Marlborough 9am - 1am
- For hotels and taverns in residential areas, 9am – 11pm.
- For all off licences, 9am to 9pm
- For all cafes and restaurants, 9am to 12 Midnight
- Discretionary conditions relating to hours such as one way doors should be considered particularly for hotel and tavern licences.

2 Location and density of licences

Consideration needs to be given to the number of licences already in an area, local community views and to the amenity of the area along with proximity to sensitive sites and location in relation to areas of high socio- economic deprivation.

3 Special licences

No special licences should be granted for school premises. Discretionary conditions should be applied dependent on such factors as location, numbers attending, type of event, time of event, number of times it occurs.

4 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 as outlined in the examples above.

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.

Appendix One

Nelson Marlborough District Health Board

POSITION STATEMENT ON ALCOHOL

The Nelson Marlborough District Health Board acknowledges the wide range of alcohol-related harm that is experienced by people within the Nelson Marlborough 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.

NELSON MARLBOROUGH DHB POSITION

The Nelson Marlborough District Health Board will reduce the alcohol-related harm experienced by people within the Nelson Marlborough district by developing an Alcohol Harm Reduction Strategy. This strategy will set out the actions Nelson Marlborough District Health Board will undertake to reduce alcohol-related harm, including a communication plan.

The Nelson Marlborough District Health Board will identify and record alcohol-related presentations within the Nelson Marlborough district in a consistent manner.

The Nelson Marlborough 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 Nelson Marlborough District Health Board will advocate for the following evidence-based solutions to reduce the alcohol-related harm experienced by New Zealanders[1]:

1 These recommendations align with the NMDHB'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, 428-43

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

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