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ALCOHOL ADVISORY COUNCIL OF NEW ZEALAND
Kaunihera Whakatupato Waipiro o Aotearoa

Features

From 0.08 to 0.05

Let's Ease Up on the Drink New Zealand

The ADA Act Explained

ALAC's Policy Positions

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The Alcohol Advisory Council of New Zealand was established by a 1976 Act of Parliament, under the name the Alcoholic Liquor Advisory Council (ALAC), following a report by the Royal Commission of Inquiry into the Sale of Liquor.

The Commission recommended establishing a permanent council whose aim was to encourage responsible alcohol use and minimise misuse.

ALAC's aims are pursued through policy liaison and advocacy, information and communication, research, intersectoral and community initiatives, and treatment development. ALAC is funded by a levy on all liquor imported into, or manufactured in, New Zealand for sale and employs 32 staff. The Council currently has seven members and reports to the Associate Minister of Health.

Kia ora, Kia orana, Ni sa bula, Namaste, Taloha ni,
Malo e lelei, Fakaalofa atu, Halo olaketa,
Talofa lava, Greetings...

Gerard Vaughan
Chief Executive Officer

MESSAGE FROM THE CEO

So how would you react if someone invited you to a BBQ but told you not to bring your mates along? This is exactly what we have done in our new EASE UP ON THE DRINK campaign launched this month. However the twist is that the mates are the people you become when you drink too much.

These ads, although very different from the hard hitting ones we launched two years ago, are just as powerful. They show someone helping a mate or loved one by having the important conversation about how their drinking is impacting on those around them. These ads show an alternative to the more common situation in New Zealand of no one saying anything. They give 'permission' to those who are ready and want to talk to someone they care about regarding the need to sort their drinking out.

The call to action in these ads is consistent with the increasing number of people we are seeing who want to participate in solutions to alcohol problems. Large numbers of New Zealanders have met with and made submissions to the Law Commission during its review of our out of date liquor laws. This includes people working at the community level to prevent and reduce the harm from alcohol misuse. Some of these were profiled at our Working Together Conference earlier this month.

In this edition we also introduce you to our three new Council members. Our new Chair Rea Wikaira has continued the Council's work programme of meetings and briefings on ALAC's advice on law changes. During these briefings we have emphasised the need for an integrated response to the complex problem of alcohol abuse - that is a total rewrite of the Sale of Liquor Act. Along with a new primary objective of the Act to reduce alcohol-related harm, we also outlined the complementary package required that includes proactive enforcement of the laws, nationwide trading hours, community say in licensing, minimum purchase age of 20, brief interventions for hazardous drinkers, a whole-of-Government process similar to "Smokefree" to deal with the issue of alcohol promotion and lowering the blood alcohol limit for adult drivers from .08 to .05.

We look forward to the ongoing debate and action throughout this year as we work together to reduce alcohol-related harm.

We are also looking to change our approach to producing this magazine in the future and will keep you informed as plans progress.

Gerard Vaughan
CEO

May 2010

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Message from the Minister

Hon Peter Dunne – Associate Minister of Health

We are already into our fifth month of 2010 and what a busy year it has been so far.

Late last year three ALAC Council members completed their terms. I wish to personally thank and acknowledge the significant contributions made by the former Chair, Peter Glensor, and Council members, Robyn Northey and Alick Shaw. In speaking with CEO Gerard Vaughan, I know he and his team are grateful for the commitment shown by each of these individuals in working to assist all New Zealanders to understand the harmful effect of alcohol, and I too endorse their gratitude.

With the changing of the guard in 2009 I wish to welcome the new Chair of ALAC, Rea Wikaira and Council members Dr Ian Miller and Barbara Docherty. In viewing their credentials, I am confident that each member will bring particular skills and experience that will further assist ALAC in promoting a safe drinking culture for all New Zealanders.

I have now met with Rea on a number of occasions and am impressed with his knowledge of the business of ALAC and his commitment to work with the team in these challenging times. I am also aware that this magazine provides an overview of each of the Council members so look out for those.

Recently, I visited the Wellington Hospital Emergency Department and downtown area during the early hours of a typical Sunday morning. During the visit I was able to spend time talking with Emergency Department and Police staff about the significant pressure alcohol misuse is putting on health services and Police resources.

Because of the often uncooperative and intoxicated state of many people at that time of night Police and emergency services end up having to play a babysitting role on top of trying to do their actual jobs. As well as being annoying and a hindrance, this behaviour means the overall capacity to respond to other events and emergencies is also somewhat compromised.

The role that our emergency services play is crucial and most-often taken for granted, so their call for a legal framework that prevents many of the problems they have to deal with is not only understandable but also desirable.

I also recently attended the ALAC Working Together Conference - *Time for Action* in Auckland. I was impressed with the diversity of attendees which included local councils, Police, the industry and other health sector professionals, which resulted in constructive dialogue and forming a collaborative approach towards promoting a safe drinking culture to all New Zealanders.

Much of the discussion throughout the duration of this conference focused on the recent release of the Law Commission report, *Alcohol in Our Lives; Curbing the Harm*, a report on the review of the regulatory framework for the sale and supply of liquor.

As you are probably aware the Government is currently considering the Law Commission's recommendations, however let me set the context around what I believe any reform of liquor laws should be based upon.

There is an essential truth about alcohol's place in our society that cannot be overlooked - it is here to stay.

Alcohol is an ingrained reality in our society, which poses little problem for the majority of drinkers, and we should not be afraid to acknowledge that. However, as a compassionate society, we do have responsibilities to honour.

There will always be those for whom the experience with alcohol will never be a positive one. It is the circumstances by which these people suffer from the misuse of alcohol that we must focus our attention. The challenge is to curb the economic and social consequences of its misuse on those individuals and families through policies that are both credible and publicly acceptable.

The Government's aim is therefore to get the balance right and come up with law that the average New Zealander knows to be just, fair and effective.

Let’s ease up
ON THE DRINK NEW ZEALAND

The latest phase of ALAC’s national marketing campaign is aimed at encouraging New Zealanders to look after themselves and the people they care about around alcohol.

The campaign focuses on giving people the confidence and tools to do things to reduce the chances of people drinking too much and experiencing harm – from the way they set up and ‘host’ social occasions through to how they might talk to someone close to them if they’re concerned about their drinking.

The campaign launched on 7 April with the first of three new television commercials going to air. The commercials focus on the conversations people might have if they are worried about the drinking of someone they care about. The first ad shows two mates having a conversation at sports practice following a recent BBQ where one of them had too much to drink and started causing problems for himself and his friends.

A second commercial went to air in early May, showing two friends at work talking during a coffee break about the last work drinks. A final commercial goes to air in early June showing the conversation between a husband and wife in a home setting.

In support of the television commercials, there will also be print advertising and radio ads aimed at encouraging people to call the Alcohol Drug Helpline (0800 787 797) to talk about their own drinking or the drinking of someone they care about.

While advertising is an important part of the campaign, it is just one part of a broader marketing approach which aims to communicate with New Zealanders at times and in places where they are making decisions about the way they or the people around them drink. This will include developing information and resources aimed at people hosting drinking occasions at home and to encourage them to think about the range of practical things they can do to manage alcohol, such as providing low-alcohol and interesting non-alcohol drinks, providing substantial food, planning to do more than just drink and setting their expectations about drinking.

The new campaign builds on the success of ALAC’s previous advertising, which saw approximately 20 percent of New Zealand drinkers aged over 18 who were aware of the advertising reporting they had started to drink less.

Visit www.alac.org.nz and click on the ‘Ease up on the drink’ button to find out more and view the advertisements.

Ease up on the drink.

ADA Act Explained

What is the Alcoholism and Drug Addiction (ADA) Act 1966? What does it say and how does it work? This article aims to answer these and a number of other questions about the Act.

What is the purpose of the ADA Act?

The ADA Act provides for people who are diagnosed as 'alcoholics' and 'drug addicts' to undergo compulsory treatment under a court order at specially certified institutions.

Who provides compulsory treatment under the ADA Act?

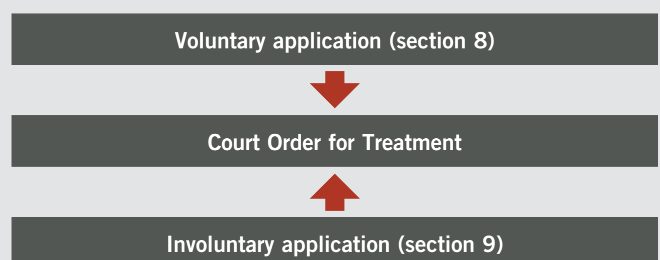
The following organisations are certified treatment institutions:

- Nova Trust: 43 Newtons Road, Christchurch
  Ph: (03) 349 2053.
- Salvation Army Bridge Programme Christchurch: 35 Collins Street, Addington, Christchurch
  Ph: (03) 338 4436.
- Salvation Army Bridge Programme Wellington: 26 Riddiford Street, Newtown 6021, Wellington
  Ph: (04) 389 6566.
- Salvation Army Bridge Programme Auckland: 7-15 Ewington Avenue, Mt Eden, Auckland
  Ph: (09) 630 1491.

How can compulsory treatment be initiated under the ADA Act?

The ADA Act procedures for compulsory treatment are usually initiated via a voluntary application for committal (Section 8) or an involuntary application for committal (Section 9).

Figure: Two ways the ADA Act can be initiated



Both voluntary and involuntary applications are made through the District Court or Family Court and proceedings are conducted in private. The person being considered for committal has the right to challenge an application and give evidence including calling witnesses and being represented by a solicitor or counsel.

The Court generally takes into consideration that the person's alcohol or other drug use is a serious threat to their health, causes harm, suffering or serious annoyance to others, or stops the person looking after themselves.

Applications cannot proceed without consulting the institution where the person will receive treatment, i.e. a place at the institution must be arranged **before** an application can proceed and no Court fees are payable for any application (Section 35).

Definitions: alcoholic and drug addict

*Section 2 of the ADA Act defines an '**alcoholic**' as: "any person whose persistent and excessive indulgence in alcoholic liquor is causing or is likely to cause serious injury to his health or is a source of harm, suffering, or serious annoyance to others or renders him incapable of properly managing himself or his affairs."*

*Section 3 of the Act defines a '**drug addict**' as: "any person whose addiction to intoxicating, stimulating, narcotic, or sedative drugs is causing or is likely to cause serious injury to his health or is a source of harm, suffering, or serious annoyance to others or renders him incapable of properly managing himself or his affairs."*

xplained

Important notes

- Treatment institutions are not secure units, i.e. people are not locked up when in treatment.
- The process of committal is not quick; there are a number of steps to work through and this can take time. When treatment facilities are full the waiting time can vary.
- Availability of treatment places depends on where in New Zealand the person is living. Community Alcohol and Drug Services (CADS) or other Alcohol and Other Drug (AOD) agencies can provide information and support.
  For information about CADS and other agencies in your area see www.addictionshelp.org.nz.
- CADS and other agencies can also assist with exploring other treatment options (i.e. options that do not require committal). CADS provide services free of charge.
- The ADA Act is considered by many to be outdated and is currently under review.

A voluntary application is made by a person who themselves wishes to undergo compulsory treatment. Sometimes a person recognises that their circumstances have become unmanageable or have reached a crisis point and that voluntary committal will help them to get into and/or stay in treatment. In some instances, voluntary applications are made in response to family pressure or when the person is faced with a choice between seeking treatment or being sent to prison.

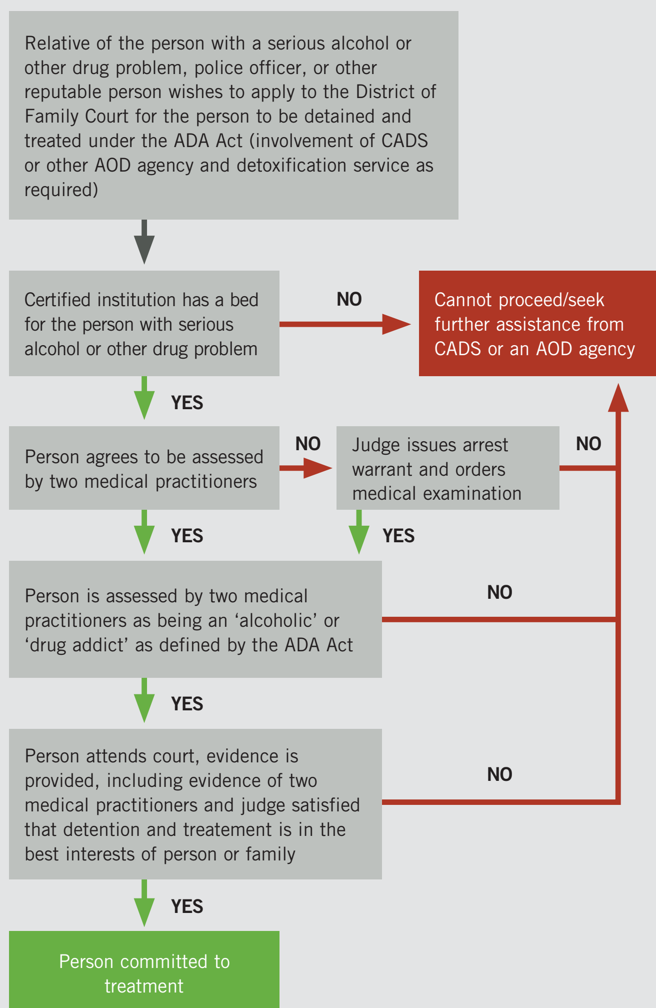
The judge must be satisfied from the information provided that the person is an 'alcoholic' or 'drug addict' and that he or she fully understands the nature and effect of the application (e.g. that it will result in the person being placed under a compulsory treatment order over a two-year period).

Once the voluntary application has been made then the voluntary aspect of the process ceases and the person's treatment becomes compulsory until they are formally discharged from the institution. This can:

- Help to keep a person in treatment (i.e. they have made a *decision to stay in treatment and there are consequences for* breaking this decision).
- Avoid the person being sent to prison.

An involuntary application may be made to a district court judge by a relative of the person with a severe alcohol or other drug problem, a police officer, or "any other reputable person". It is often helpful for those applying for a committal order to have the support of a CADS or other treatment agency during this process (NB for committal to Nova Trust a referral must be made by a CADS or other AOD agency).

Figure: Key steps in an Involuntary Application under the Section 9 of ADA Act



ADA Act Explained continued

Usually the judge will make an order summoning the person who is the alleged alcoholic or drug addict to show why an order should not be made requiring them to be detained for treatment. The judge may also issue a warrant for the arrest of the alleged alcoholic or drug addict, if this is shown to be necessary to compel the person to attend court or assessment.

The ADA Act stipulates that two doctors are required to assess the person prior to committal for treatment and must give either oral or written evidence that they believe the involuntary patient to be an alcoholic or drug addict within the meaning of the ADA Act.

If the person refuses to have a medical examination as required by the Act, the judge may issue a warrant for the person's arrest and at the same time order that the alleged alcoholic or drug addict undergo medical examination.

As with voluntary applications, a certified institution has to agree to take the person before an application will proceed.

On hearing the application and evidence provided, the judge needs to be satisfied that the application is appropriate, i.e. that the person's detention and treatment is in the person's own interest or in the interest of the person's relatives (Section 9(6)).

What is the nature of compulsory treatment?

The nature of compulsory treatment usually involves a residential programme that the person must attend.

It is an offence to attempt to leave treatment, and it is an offence to assist someone to leave (Section 25). It is also an offence under the Act if anyone who knows that the person has been committed under the Act supplies (or attempts to supply) the person with any alcohol or other drugs (either within the institution or while the person is on leave).

A committal order is in place for a maximum of two years. In practice, most people are not detained in treatment for more than six months and sometimes the treatment period is much shorter than this. The Nova Trust Programme is six months long and the Salvation Army Bridge Programmes are eight weeks long.

If the person needs to undergo detoxification treatment, then a short stay in a detoxification facility is usually required prior to the person being transferred to the certified institution. This can be coordinated by either the certified institution (where feasible and practical) or by a CADS or other AOD agency.

Can a person complain or appeal about being detained under the ADA Act?

The ADA Act provides the right to appeal against a committal within three weeks after the date that the court order is signed. There are no other complaint mechanisms built into this Act and complaints are rarely made to the Health and Disability Commissioner.

Who can transfer, discharge or grant leave of compulsory treatment under the ADA Act?

Section 18 of the ADA Act allows the Minister of Health, the certified institution's supervisory committee or the manager of the institution to transfer the person to another institution, release the person on leave from the institution (usually with specified conditions), or discharge the person from compulsory treatment at any time, but only by written order. In practice, once the treatment programme is completed, people are granted leave but remain under the committal order for the remainder of the two-year period. This means that the Act can be invoked if needed.

The person under committal can apply for discharge after six months. If the application is refused, the person can apply to the High Court to have the application granted.

Why seek treatment for yourself or others under the ADA Act?

Some people seek treatment under the ADA Act (i.e. voluntary application) as they are facing the possibility of a prison sentence and compulsory treatment is considered a more acceptable path. Also, because the treatment is compulsory, the person may be more likely to stay in treatment longer, increasing the likelihood of recovery. In either case, the person making the voluntary application may have tried other avenues to seek assistance and failed, thus supporting the choice of compulsory treatment to attempt recovery. A voluntary application indicates an initial commitment by the person to choose recovery.

Family members or others may seek treatment for a person with a serious alcohol or other drug problem because they are concerned for the welfare of the person and believe the person is unwilling or unable to seek treatment of their own accord. Often the person is in a crisis and no other treatment options are available or less coercive options have already been tried.

What are the limitations of seeking treatment under the ADA Act?

It may be difficult to get a certified institution to accept the person for treatment and therefore prevent an application being made.

While the treatment is compulsory and it is an offence to leave, in practice the person is not held in a secure environment. Treatment relies on a level of cooperation by the person and does not necessarily confine the person or prevent them from harming themselves or others.

Other considerations

Once a committal order has been made, the treatment is compulsory regardless of the type of application and the person has limited mechanisms to opt out of treatment until discharged from the provisions of the Act. The person can also be charged with offences under the Act, e.g. for "violent, unruly, insubordinate, destructive, indecent, or insulting conduct" or leaving (or attempting to leave) treatment.

A person who is subject to an involuntary application may feel that their freedom is being denied and may respond negatively to those making the application.

Once the person has been committed to compulsory treatment family members and others need to support the treatment process and remain involved. It is vital that family and friends do not provide the person with alcohol or other drugs, or attempt to assist the person to leave treatment without formal discharge (both offences under the ADA Act).

More information

For information about CADS and other treatment agencies in your area see www.addictionshelp.org.nz.

District health board (DHB) community alcohol and other drug services (CADS) will provide free support for people with serious alcohol or other drug problems and/or their family members to seek compulsory treatment under the ADA Act or other treatment options where appropriate. Local contacts can be found under the 'Hospitals and other health services providers' section in the White Pages.

The ADA Act can be viewed or downloaded at www.legislation.govt.nz/act/public/1966/0097/latest/DLM380085.html

Alcohol Drug Helpline 0800 787 797
http://www.adanz.org.nz/Services/Home

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from 0.08 to 0.05?

Early in March 2010 Minister of Transport Steven Joyce launched the Government's Road Safety Strategy 2010-2020.

The top priorities for action in the strategy are:

- **Young drivers**
- **Alcohol and drug impaired drivers**
- **Motorcycling**
- **Roads and roadsides**
- **Safer speeds.**

Mr Joyce says these were chosen as priorities because they are problem areas where real gains can be made.

The strategy identifies alcohol and drug impaired driving as one of the largest causes of serious road crashes. In 2008, alcohol and drugs contributed to 31% of fatal crashes and 21% of serious injury crashes. These crashes resulted in 119 deaths, 582 serious injuries and 1,726 minor injuries. It is estimated that in 2008 the social cost of crashes where alcohol and drugs were a factor was $841 million.

The strategy identifies a number of probable first steps to address drink-driving:

- Either lower the adult drink-drive limit to a Blood Alcohol Content (BAC) of 0.05 and introduce infringement penalties for offences for a BAC between 0.05 and 0.08, or
- Conduct research on the level of risk posed by drivers with a BAC between 0.05 and 0.08
- Address repeat offending and high level offending through compulsory alcohol interlocks
- Address repeat offending and high level offending through a zero drink-drive limit
- Review the traffic offences and penalties for causing death or injury

To increase the safety of young drivers, the probable first steps include lowering the youth drink-drive limit to zero.

Soon after the launch of Safer Journeys, Minister Joyce was reported as saying he was confident Cabinet would approve a reduction from a 30mg alcohol limit to zero for drivers under 20.

ALAC Chief Executive Officer Gerard Vaughan said ALAC had been pushing for some time for a zero limit for young drivers and he applauded the move. However, ALAC would also like to see the current Blood Alcohol Content limit of 80 mg/100ml for adult drivers reduced to 50mg/100ml. New Zealand's legal BAC limits were high by international standards.

"The World Health Organization (WHO) recommends a legal BAC limit of 50mg/100ml for adults and a zero BAC for young people. The amount you can drink under the current regime is ridiculously high. Our current BAC of 0.08 allows people to become significantly impaired and still legally drive. The Ministry of Transport says it allows a man of average height and weight to consume six standard drinks within 90 minutes (about three quarters of a bottle of wine). For a woman it allows four standard drinks to be consumed (about half a bottle of wine)."

Mr Vaughan said the current BAC of 0.08 for adult drivers was set in 1978. Since then New Zealand and international research had consistently demonstrated the benefits associated with BAC levels of 0.05, or lower, in saving lives and preventing serious injuries.

Mr Vaughan said other countries that dropped the BAC from 0.08 to 0.05 saw reductions in crashes. In Australia New South Wales achieved an eight percent reduction in fatal crashes and a seven percent reduction in serious injury crashes; Queensland achieved an 18 percent reduction in fatal crashes and a 14 percent reduction in serious crashes. Belgium achieved a 10 percent reduction in all alcohol-related fatalities and France achieved a 30 percent reduction in alcohol-related fatal crashes.

ALAC's Policy Positions

However Government responds to the recommendations made in the Law Commission Report Alcohol in Our Lives – Curbing the Harm, it is likely that there will be some legislative change. ALAC made a substantial written submission to the review, and here we summarise the positions ALAC has taken in regard to some potential legislation changes.

To see a copy of ALAC's full submission to the Law Commission on the Alcohol in Our Lives discussion document go to our website www.alac.org.nz.

BLOOD ALCOHOL CONTENT (BAC)

- Lower the legal Blood Alcohol Content (BAC) limit for driving in New Zealand from 80mg/100ml for adult drivers down to 50mg/100ml, and the under 20 year old BAC to zero for all under 20 year olds, regardless of licence status.
- Introduce infringement notices for offences between the old BAC levels and the proposed new ones.
- Introduce mandatory alcohol interlocks for drink-driving offenders, as these offenders clearly need treatment and support to overcome their drinking issues.
- Introduce a legal BAC for those in charge of pleasure craft such as yachts.

AVAILABILITY AND ACCESS

- Introduce a nationwide set of trading hours, restricting off-licence hours from 8am to 10pm, and on-licences until 2am but also allowing for community say and local variation (extensions or shortening) of the nationwide on-licence trading hours via a well-consulted local alcohol policy and if a licensee can satisfy the LLA that it has a plan to manage the risk of harm.
- Make local alcohol policies mandatory.
- Give the LLA and DLA wider powers to refuse licences and the ability to impose conditions on licences.
- Restructure licensing fees.
- Remove all existing exemptions (police, armed forces, fire fighters, Parliament) from obtaining a licence to sell alcohol.
- Introduce new legal provisions for the type of premises able to apply for off-licences.
- Retain restrictions on the types of premises able to apply for off-licences.

PRICE AND PROMOTION OF ALCOHOL

Price

- Increase the retail price of alcohol to reduce the incidence of heavy sessional drinking.
- Review the excise structure to ensure the tax burden is spread so that the more alcohol purchased, the more tax payable.

ALAC's Policy Positions continued

- Remove the excise tax on low-alcohol products.
- To enable further work, the lack of access to sales data (price and volume) for the purposes of policy analysis needs to be addressed.
- There may be a case to increase excise tax, but any decision about this should follow policy work to compare it with the minimum price option.

Promotions

- Off-licence alcohol marketing and retailing practices should be governed by a similar law that is in place for on-licences.
- Immediate measures should be taken to reduce the exposure to alcohol promotion of those under the minimum purchase age such as a 9.30pm watershed for broadcast advertising material, restrictions on advertising on public transport (including bus shelters) and cinemas, restrictions on price promotions and limiting areas of supermarkets where alcohol is displayed.
- Principles and codes for the promotion of alcohol should be enshrined in law, rather than being voluntary and a breach of these should be considered a breach of licensing conditions.
- A whole-of-Government process, similar to 'Smokefree', should be initiated to deal with the issue of alcohol promotion.

SUPPLY TO MINORS, INCLUDING PURCHASE AGE AND DRINKING AGE

- Raise the minimum purchase age to 20 years.
- Make it an offence for all persons to supply alcohol to a young person under 18 without the consent of a parent or guardian of the young person.
- Make it a legal requirement for any person supplying alcohol to a young person under 18 to supervise the consumption of the alcohol.
- Make age verification for the sale of alcohol mandatory. A nationally recognised and tamper proof system of age identification would greatly assist this measure.
- ALAC does not support the introduction of a minimum legal drinking age.
- ALAC does not support a split purchase age.

DRUNKENESS IN A PUBLIC PLACE

- Do not create an offence of drinking in a public place.
- Do not reintroduce the offence of being drunk in a public place.

TYPES OF PRODUCT AVAILABLE, CONTENT, SIZE AND PACKAGING

- No change to the types of products available at off-licences.
- Provide a regulatory power to prohibit the sale of undesirable liquor products based on expert recommendations to the Minister.
- Introduce measures to limit the alcohol content of ready-to-drinks and the size of single serve containers.
- There should be mandatory labelling providing advice recommending that pregnant women should not consume any alcohol.

TREATMENT

- There needs to be effective, accessible treatment across the spectrum of care (primary health, to specialist intensive alcohol and drug services). There are clear gaps in the delivery of brief interventions in primary health settings and integrating alcohol treatments into general practice. Therefore:
  - ALAC is keen to play a more active role in monitoring and providing advice on alcohol and other drug service provision and funding
  - ALAC supports the development of a comprehensive plan for alcohol treatment, to be led by the Mental Health Commission and supported by ALAC, that will be based on a number of high priority and best practice principles including:
  - Brief early interventions and alcohol treatments should be provided in primary health settings
  - Family inclusive practice and well validated age and culturally appropriate services need to be increased
  - Alcohol and other drug assessment and treatment should be taken into account during sentencing in cases where alcohol and other drugs may have contributed to the offending.

The ALAC Working Together Conference

TIME FOR ACTION

"The best ALAC conference ever." is the feedback ALAC has been receiving from participants of its Working Together Conference – Time for Action, held at the TelstraClear Pacific Events Centre in Manukau.

There were many high quality speakers and presentations over the two-day conference held on 6-7 May 2010.

Hon Peter Dunne, Associate Minister of Health was the opening Keynote speaker, setting the scene for the conference.

The main areas the Minister addressed were the progress of the Global Alcohol Strategy, ALAC's new marketing campaign, the Law Commission's review of alcohol legislation, the new Road Safety Strategy and the Government's Drivers of Crime alcohol workstream.

In regard to the review of alcohol legislation the Minister said, "You can rest assured that the Government's focus will be on workable, rather than feel-good, solutions, and will uphold the balance I spoke of last year between the rights of the overwhelming majority of New Zealanders who enjoy a drink without any prospect of personal or social harm, and dealing with the specific problems associated with problem drinking by a minority."

Paul Quigley, Emergency Medicine Specialist at Wellington Hospital talked about the frustration felt by emergency services at having to divert resources to drunk patients.

"Many patients come in unconcerned at the fact they are in ED with sometimes quite serious injuries," said Paul. "ED doctors have had enough. We are frustrated. This shouldn't happen."

Dr Quigley said that up to seventy percent of presentations were totally preventable. "Once the patients have sobered up, staff make a brief intervention - you have just spent the night in my ED and that was entirely preventable."

Rt Hon Sir Geoffrey Palmer made his final public address regarding the Law Commission's Report *Alcohol in our Lives: Curbing the Harm*.

Sir Geoffrey told the conference that he hoped to address "some of the more pernicious and self-serving arguments mounted against the report."

"It is always the case in a public debate that there is a formidable list of clichés, half truths and sound bites designed to obfuscate, divert and disassociate," he said. "Some of the arguments are simply bizarre."

He hit out at criticism that the report represented a "nanny-state approach", saying an excise tax on alcohol would be consistent with the Government's recent decisions to increase tax on tobacco and cigarettes, and to restrict access to cold and flu medicines containing methamphetamine ingredients.

He also dismissed criticism that nothing could make a difference, saying research had shown the measures would work.

"Price, availability, age, the number of liquor licences and the level of enforcement would all make a difference," Sir Geoffrey said. "People may not like the measures. That is a different thing."

Presentations from the conference can be found on www.alac.org.nz.

Alcohol in our Lives
Curbing the Harm

Sir Geoffrey Palmer making a keynote presentation at the ALAC Working Together Conference – *Time for Action.*

"The subject of our report is a social battleground replete with both passions and prejudices. We have tried to steer a reasonable course around these policy whirlpools and fashion a report that will address the needs of the society as a whole"

Sir Geoffrey Palmer

The Law Commission Report *'Alcohol in our Lives – Curbing the Harm'* was published at the end of April. The Law Commission held meetings and consultations all over New Zealand and received 2,939 submissions, more than any other project in the 24 year history of the Law Commission.

Launching the final report, Sir Geoffrey Palmer said "Those who enjoy alcohol socially and drink in a low risk manner will be little affected by the Law Commission's recommendations. Our reforms are firmly targeted at reducing the harms associated with heavy drinking and drinking to intoxication. To do this we need to ensure that alcohol is promoted, sold and supplied in a manner which better reflects the risks and responsibilities associated with its consumption".

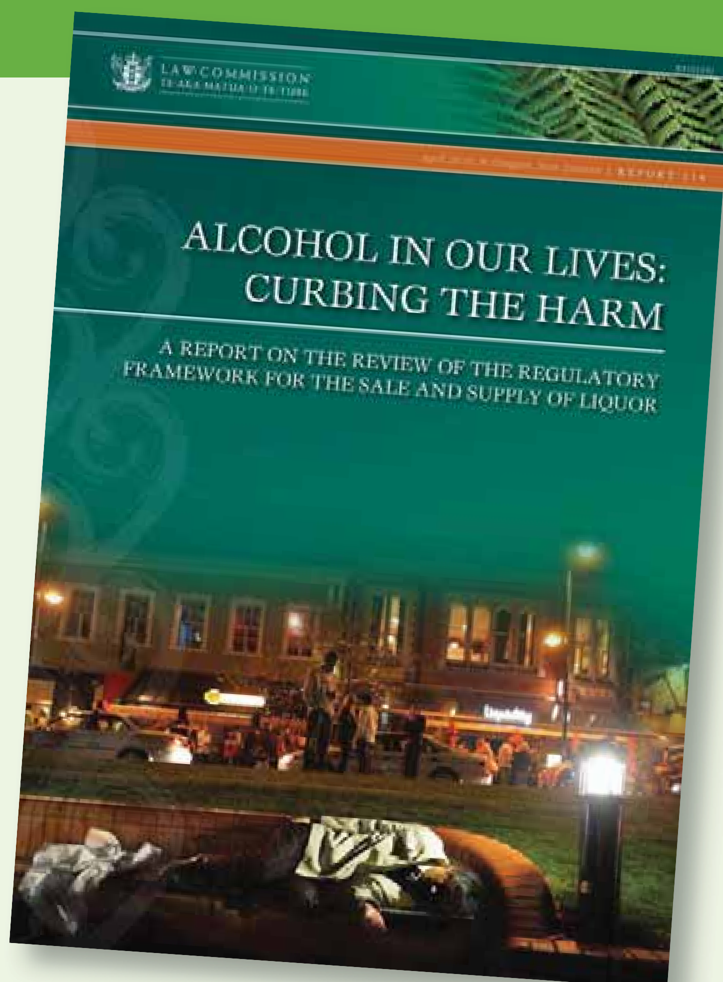
"While the law cannot directly control how people drink, it can ensure the law governing how alcohol is promoted, sold and supplied, better recognises the risks associated with alcohol and discourages abuse. The international evidence was clear that the most effective policies to reduce alcohol-related harm were those which targeted the availability, price and promotion of alcohol. Policies which targeted cheap alcohol were particularly important because research shows low cost alcohol is favoured by young and heavy drinkers".

The report contains 153 recommendations to Government, intended to work together to reduce alcohol related harm.

The key elements of the recommendations are:

- a new Alcohol Harm Reduction Act to replace the Sale of Liquor Act 1989;
- increasing the price of alcohol through excise tax increases in order to reduce consumption;
- regulating promotions that encourage increased consumption or purchase of alcohol;
- moving, over time, to regulate alcohol advertising and sponsorship;
- increasing the purchase age for alcohol to 20 years;
- strengthening the responsibility of parents supplying alcohol to minors;
- increasing personal responsibility for unacceptable or harmful behaviours induced by alcohol;
- cutting back the hours licensed premises are open;
- introducing new grounds upon which licences to sell alcohol can be declined;
- allowing more local input into licensing decisions through local alcohol policies and District Licensing Committees (the bodies we are recommending replace District Licensing Agencies);
- streamlining the enforcement of alcohol laws and placing the overall decision-making in a new Alcohol Regulatory Authority (building on the existing Liquor Licensing Authority) presided over by District Court judges especially selected for the task; and
- a substantially improved and reorganised system for the treatment of people with alcohol problems.

The report is available at www.lawcom.govt.nz



TLGB Community
more likely to suffer harm

Recently, ALAC released the Takatāpui, Lesbian, Gay and Bisexual Scoping Exercise, a scoping report about the burden of alcohol-related harm on the takatāpui, gay, bisexual and lesbian (TLGB) population, and the gaps in support for this group.

Recent studies (e.g. Youth '07[1]), show that the non-heterosexual community are much more likely to binge-drink and suffer harm from drinking. The scoping report found that there is a growing body of evidence of a substantial drinking problem in the non-heterosexual population.

"We interviewed a large number of stakeholders, including sexual minority communities, providers of alcohol prevention and treatment services, and alcohol policy makers," said Frank Pega, the author of the study. "The interviewed stakeholders unanimously agreed that there is a need to reduce alcohol-related harm amongst sexual minority communities in light of the existing evidence."

"The evidence that we reviewed and gathered in the course of the scoping study made a strong argument for evidence-based work to reduce alcohol-related harm amongst sexual minority communities in Aotearoa New Zealand."

Some of the recommendations from the report include:

- Increasing knowledge by collecting sexual orientation data
- Undertaking specific alcohol-related research in the TLGB field
- Building on relationships within TLGB communities and organisations already working in this area and fostering collaboration between key stakeholders as a crucial way of stimulating action on reducing TLGB alcohol-related harm
- Delivering alcohol harm reduction messages and supporting community action in TLGB communities.

Key agencies (Rainbow Youth, CADS, CAYAD and NZ AIDS Foundation) have been discussing alcohol in the community, and have held initial meetings around a project on sober drivers to be run in gay clubs.

"These agencies are committed to working in Auckland and with queer youth groups nationally," said Sarah Helm, Youth Action Plan Manager at ALAC. "ALAC's presence and support for this and other work is important and we support their efforts."

"There are some positive opportunities in the queer community. Changes in law and human rights mean the community now have more capacity to look for better health and well-being, and raised expectations for quality of life."

The Takatāpui, Lesbian, Gay and Bisexual Scoping Exercise is available to download from www.alac.org.nz or email central@alac.org.nz to request a copy.

1 Rossen, F.V., Lucassen, M.F.G., Denny, S. & Robinson, E. (2009). Youth '07 The health and wellbeing of secondary school students in New Zealand: Results for young people attracted to the same sex or both sexes. Auckland: The University of Auckland.

Plans for Action

ALAC has three new action plans focussing on the organisation's identified priority populations Māori, Pacific peoples and young people. ALAC's Chief Executive Officer Gerard Vaughan said the plans reflected the organisation's commitment to reducing alcohol-related harm with those who are affected the most.

The implementation of the three action plans are being led by the three newly appointed Action Plan Managers: Gilbert Taurua, Māori Action Plan Manager, Metua Bates-Faasisila, Pacific Action Plan Manager, and Sarah Helm, Youth Action Plan Manager.

The Māori Action Plan

To enhance whanau ora by reducing alcohol-related harm among Māori.

Gilbert Taurua, who moved into the role of Pouarahi Māori (Māori Action Plan Manager) in December 2009 said "The Māori Action Plan is a result of a huge amount of consultation with Māori communities from across New Zealand. ALAC has appreciated the input from these communities and their feedback has directly shaped our new direction."

The Māori Action Plan provides a systematic framework for implementation over a three year timeframe and is guided by four overarching principles of Tiriti o Waitangi, Tino Rangatiratanga, Whānaungatanga and Pūawaitanga. These high-level principles guide ALAC's efforts to enhance whānau ora and reduce alcohol-related harm for Māori.

The Pacific Action Plan

To improve and enhance Pacific peoples' wellbeing by reducing alcohol-related harm.

"It is easy to be complacent that alcohol is not much of an issue for Pacific peoples because of our relatively high non-drinking status, but the actual harm that it causes in our communities is of huge concern," says Metua Bates-Faasisila, the Pacific Action Plan Manager for ALAC.

"This plan is helping us raise the awareness of these issues in our communities so we can do something about it".

"The most important thing is that our partners will be able to see themselves in this plan, the roles they can play and know where we can work together to get there sooner to reduce alcohol-related harm."

The Youth Action Plan

To help build healthy futures for young people and their families and communities by reducing alcohol-related harm among young people and supporting youth to lead a social change in the way New Zealanders drink.

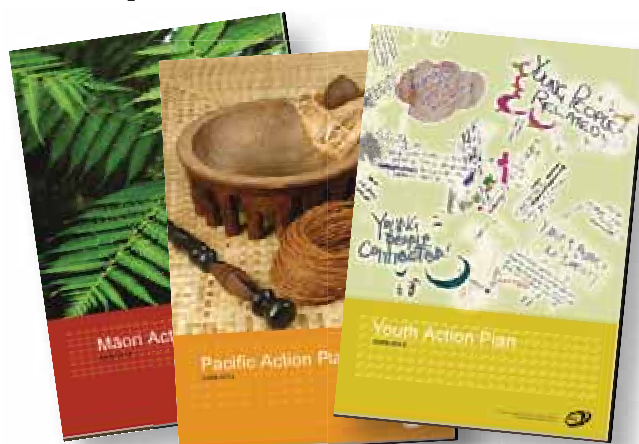
ALAC's Youth Action Plan squarely frames young people as part of the solution in reducing alcohol harm. ALAC's Youth Action Plan Manager Sarah Helm said the plan gives an inspirational platform for ALAC's work.

"Young people have great potential to create change. Most major changes in society have been at least partially driven by young people – including drink-driving. If it wasn't for the work of the Students Against Driving Drunk groups much of the major shifts in attitudes and investment in this issue might never have happened."

The Youth Action Plan is comprehensive, covering the various aspects of ALAC's work – research, collaboration, healthy environments and messages, interventions, and creating role models.

"Our plan aims to improve the health and well-being of young people, their family and communities by reducing the harm of alcohol. This year we are concentrating on research and information, forming strategic relationships, and prioritising funding for community action that focuses on youth."

All three action plans can be downloaded from ALAC's website www.alac.org.nz



Additional Liquor add to Drunken

As many communities throughout New Zealand continue to protest about the number of liquor outlets opening in their neighbourhood, researchers have for the first time come up with a model that relates the level of alcohol-related harm to the number of liquor outlets.

The research was carried out by the Population Studies Centre (PSC) at Waikato University. It was commissioned and funded by the Alcohol Advisory Council of New Zealand (ALAC), and supported by Manukau City Council.

An initial database of liquor licensees was obtained from Manukau City Council in January 2009. Data for selected indicators of social harm were obtained from the New Zealand Transport Agency (traffic crashes), Counties Manukau District Health Board (accident and emergency event data, and alcohol-related admissions to Middlemore Hospital), and New Zealand Police (police attendances) for the period 1 July 2008 to 30 June 2009.

The model used statistical methods to relate the level of liquor outlet density to a range of events such as police callouts, emergency room admissions, and motor vehicle accidents, while also taking into account the effects of population density and social deprivation. Individual models for each type of event as well as an integrated model of all events were constructed, and the results were similar between the two methods. Data on the events covered the period 1 July 2008 to 30 June 2009, while outlet density was measured based on a survey conducted in January 2009.

Several key results were found relating to the characteristics of alcohol sales in Manukau City. First, on-licence outlets (bars, clubs, restaurants and cafes) were most dense in areas with good transport links, such as town centres, and in areas with high amenity value. This is because these outlets cater to consumers who are looking for a destination at which to drink, or where drinking is incidental to some other activity such as eating a meal.

Second, off-licence outlets (alcohol retailers, supermarkets and bottle stores) tended to locate in areas of high social deprivation and high population density. Higher off-licence density was in turn associated with lower alcohol prices and longer opening hours.

The researchers found that in Manukau the addition of a single extra off-licence was associated with an extra 60 to 65 police events or incidents in the year to June 2009. Each additional club or bar was associated with an extra 98 to 101 police events or incidents, while each additional restaurant or café was associated with an extra 24 to 29 police events or incidents.

ALAC Chief Executive Officer Gerard Vaughan said in order for local body planning to effectively address ways to minimise alcohol-related harm, information about the impact of liquor outlets on local areas was needed. “We have now for the first time a New Zealand model that can be used by local authorities to show the impacts of extra liquor outlets.”

Mr Vaughan said this was supported by the recently released Law Commission recommendations to Government on reforming New Zealand’s alcohol laws. “Options include widening the grounds for refusing liquor licences to include things like outlet density.

“If the law is changed to allow density to be raised as grounds for refusing a liquor licence, evidence will still need to be produced of the harms that might result. This model provides the important evidence base for decisions on licensing at a local level.”

Waikato research associate Dr Michael Cameron said although the Manukau results were specific to that area, the model that had been developed could be used in other areas to determine what impact extra liquor outlets would have on a district.

The research showed higher liquor outlet density of both on and off-licences was associated with higher numbers of total police events.

Outlets Incidents

In particular, off-licence density was associated with higher levels of anti-social behaviour, drug and alcohol offences, family violence, property abuse, property damage, traffic offences and motor vehicle accidents.

Density of clubs and bars was associated with higher levels of anti-social behaviour, dishonesty offences, drug and alcohol offences, property abuse, property damage, sexual offences, traffic offences, and violent offences.

Density of restaurants and cafes was associated with higher levels of dishonesty offences, property abuse, traffic offences, and motor vehicle accidents.

Total police events were based on all police attendances recorded in the New Zealand Police database from 1 July 2008 to 30 June 2009. (A police attendance may not necessarily lead to anyone being charged with an offence.)

Manukau City Council Senior Policy analyst Paul Wilson said the research supported what the community had been telling the council and could be used to inform the new Auckland Council on how alcohol-related harm could be addressed.

Questions and answers about the research

Why was the research commissioned?

There has been significant recent debate over the impact of liquor outlets on communities in New Zealand. This has arisen in part because of the liberalisation of the sale of alcohol following the Sale of Liquor Act 1989, which allowed the sale of wine in supermarkets and grocery outlets and led to a substantial increase in the number of outlets supplying alcohol.

In February 2008, there were 494 active liquor licences in Manukau City – compared with just 148 in 1990. Substantial increases in the number of both on- and off-licence liquor outlets have been matched with an escalation in the level of community unease about alcohol-related harm. Of particular concern are the more vulnerable communities of Manukau City, in which the high density of liquor outlets relative to other parts of the city is a notable feature.

How was the model developed?

The model takes a snapshot of information related to liquor outlets and measures of social harm for the Manukau region for the period 1 July 2008 to 30 June 2009. The model is not concerned with comparisons with earlier time periods.

The model uses regression analysis, a technique used to understand how a variable changes (such as total police events; these are often called the outcome variables or dependent variables) when another variable changes (such as the number of liquor outlets; these are often called explanatory variables). The technique describes how the variables are associated (i.e. an increase of X liquor outlets is associated with an increase of Y total police events) but it does not necessarily imply causality.

In this study there were a number of outcome variables examined including the total number of police events, accident and emergency department admissions and hospital discharges and more specific measures relating to anti-social behaviour, dishonesty related offences, drug and alcohol related offences, family violence, property abuse, property damage, traffic offending and motor vehicle accidents, sexual offending and violent offending. Liquor outlets were the explanatory variable involved and they were divided into off-licence premises, and two categories of on-licence premises (clubs/bars and restaurants/cafes).

Regression techniques take into account the effect of other variables that could impact on the dependent variable (such as total police events) by accounting for or controlling for their effects, such as keeping the effect of other explanatory and control variables fixed. Spatial regression techniques are used when the variables of interest are spatial such as based on or affected by geography (for example all variables in this study were based on rates involving census area units) and where nearby spatial areas (in this case census area units) may influence each other and the variables of interest. Different spatial analysis techniques were used to deal with different types of spatial dependence when they were found to exist in the analyses. A number of different variants of the model were also tried to check how different model assumptions influenced the findings.

Additional Liquor Outlets add to Drunken Incidents continued

Can this model be applied to other areas?

The modeling approach employed can be used in any area where appropriate data are available.

Would it produce the same results in other areas?

The quantitative results would be different as our research has shown that the links between outlet density and alcohol-related harms are highly context-specific. However, it is likely that similar results would be obtained in some areas.

Does it produce a direct causal link?

Models of this nature are unable to definitively prove causality. This is not unusual – to determine causality we would need to conduct a controlled experiment. However, we can say that the observed associations between the variables are strong, statistically robust, and consistent with theory.

What other New Zealand literature is there on outlet density?

The New Zealand literature on the impacts of liquor outlets is limited, but has grown recently.

Kypri et al. (2008) found a significant positive relationship between outlet density and drinks per typical drinking day among tertiary students at six university campuses, as well as a measure of alcohol-related problems. No significant differences in the effects were noted between Maori and New Zealand Europeans, but the effects were larger for off-licence outlets. Huckle et al. (2008) found a significant positive effect of outlet density on how much was consumed on a typical drinking occasion among Aucklanders aged 12-17 years, but no significant effect on either the frequency of drinking or frequency of intoxication.

A copy of the research is available at www.alac.org.nz

Council Changes

Rea Wikaira (Chair)

Appointed as Chair 1 January 2010

Rea Wikaira is a Business Consultant, Advisor and Project Manager. He is the Chair of the Air Rescue/Air Ambulance Division of the Aviation Industry Association and Nga Mauri Papa Pounamu Ora Trust, and on the Board of Spectrum Healthcare. Rea has a background in Health and Disability Services, Aviation, Māori development and executive recruitment.

Dr Ian Miller

Appointed to Council 1 January 2010

Dr Ian Miller is a registered psychologist. He has previously worked in Corrections and as Manager: NZ Police Psychological Services. Since 2002 he has led a consultancy dealing with risk mitigation, trauma and crisis management, strategic organisational development, and forensic behavioural issues. He has most recently undertaken extensive research into human behaviour contributing to fire ignition and spread, and has presented internationally on this topic. Ian is also a member of the NZ Psychologists Board, and an Executive Member of the Independent Forensic Practitioner Institute.

Barbara Docherty

Appointed to Council 1 January 2010

Barbara Docherty is a registered nurse, Clinical Lecturer at the University of Auckland and Director of the TADS (Training and Development Services) Brief Opportunistic Interventions training programme. TADS delivers national training in behavioural change interventions to health workers in primary health care and community, Māori, Pacific and youth. Barbara's background includes 23 years as a nurse in general practice and extensive research experience in prevention interventions based on early identification and intervention relating to alcohol and other harmful behaviours. She was a founding member of the New Zealand Nurses Organisation Accreditation Board, is a member of the College of Nurses (Aotearoa) and has led the formation of a number of nursing initiatives relating to harmful and risky behaviours.

Staff Updates

Dr Craig Gordon

Dr Craig Gordon is the new senior research advisor at ALAC. He is on secondment from the Ministry of Transport, where he is a senior scientist conducting research and providing advice to support policy development on a wide range of road safety issues. He has been specialising in the area of driver distraction and has recently been involved in work on drink-driving offending and crash involvement.

Craig has a psychology background and has a PhD on attitudes towards drink-driving, speeding and seatbelt wearing. Prior to his involvement in the transport sector, he worked as a researcher on a variety of topics including attitudes towards earthquakes, assessing the effectiveness of driver training, gambling behaviour in casinos, and profiling telecommunications users.

Jim Hauraki

Tahu Potiki raua ko Potatau Te Wherowhero oku Tupuna
Tapuaenuku raua ko Maunga kawa he maunga
Waiotoa raua ko Topehaehae he awa
Mangamanu raua ko Kaiatemata he marae
Ngati Kuri raua ko Ngati Haua oku hapu
Ngai Tahu raua ko Tainui-Waikato oku Iwi
Ko Huhana raua ko Haare taku matua
Ko Jim Hauraki ahau

Jim Hauraki is ALAC's new Southern Regional Manager for Te Wai Pounamu (South Island). Jim has a background in alcohol and drug prevention, intervention and treatment and brings with him extensive experience in primary, secondary and public health through various clinical and management roles he has held over last 18 years. Prior to his appointment with ALAC, Jim was a Senior Manager at He Oranga Pounamu, a Ngai Tahu mandated health and social service Māori Development Organisation based in Christchurch. Jim has also worked as Project Manager for Southlink Health Limited Management Services assisting 13 PHOs across the South Island to implement their Māori Health Plans. Prior to this he was Portfolio Manager, Māori and Pacific Health for the Nelson Marlborough District Health Board.

"I am delighted to have joined the ALAC team," says Jim. "I look forward to contributing to the team as we work collaboratively with our communities."

Sarah Helm

ALAC's new national Youth Action Plan Manager Sarah Helm (Ngai Tahu, pakeha) says she hopes that her strategic skills, community leadership and youth development background mean she can do the Youth Action Plan justice.

"ALAC's Youth Action Plan is an inspiring document that will guide the organisation's work for and with young people. The plan includes a tiered approach of information, collaboration, and leadership. It is a truly visionary platform that will help to address alcohol issues in New Zealand."

Sarah comes to ALAC after almost four years leading the association for people who work with youth, New Zealand Aotearoa Adolescent Health and Development (NZAAHD). During her time there she built up the NZAAHD's connection with its members, and the organisation's leadership, and profile. Her connection with the youth sector gives ALAC an opportunity to form strong relationships with the people who work to support and care for young people.

Her background also includes work for the NZ AIDS Foundation, where she led the national youth project for gay, lesbian, bisexual, transgender and intersex youth. She has also worked in a range of community and non-profit settings, students' associations, community centres, libraries, health promotion, and journalism.

Sarah grew up in South Auckland and Whanganui, and now lives on the Kapiti Coast. Sarah most recently worked for the Families Commission as a senior communications advisor.

Electronic mailing lists for the alcohol and drug field

Two electronic mailing lists have been set up to enable individuals to communicate via email with other alcohol and drug professionals in New Zealand.
You can either subscribe to a general mailing list or register to connect to a network of Māori alcohol and drug workers.

SUBSCRIBE NOW

SUBSCRIBE NOW

Contact other alcohol and drug professionals:

1. If you have access to the web, subscribe by going to http://lists.iconz.co.nz/mailman/listinfo/aandd

   You will find a form to fill out. You will need to choose a password.

2. If you don't have access to the web, send an email message to aandd-request@lists.iconz.co.nz leaving the subject line blank.

   In the body of the message, type:
   Subscribe ***** (where ***** is an alphanumeric password of your choice between 4 and 8 characters).

   If you have any problems with the above, or for further information, please contact:

   Email: central@alac.org.nz

   Phone: 04 917 0060

Join a network of Māori alcohol and drug workers:

1. If you have access to the web, subscribe by going to http://lists.iconz.co.nz/mailman/listinfo/te_kupenga_hauora

   You will find a form to fill out. You will need to choose a password.

2. If you don't have access to the web, send an email message to central@alac.org.nz

   Phone: 04 917 0060

COMMENTS

To comment on articles in this issue or previous issues of alcohol.org.nz please go to our blog at http://blog.alcohol.org.nz/

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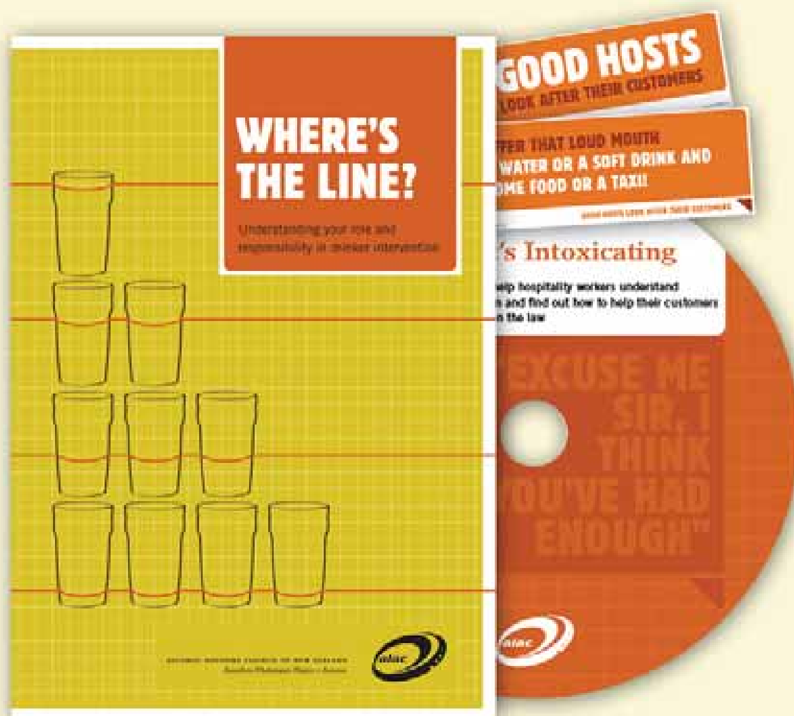

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