Tackling alcohol harm in Hawke's Bay

Hawke's Bay District Health Board
Alcohol Harm Reduction Strategy

2017-2022

Prepared by Jessica O'Sullivan for Hawke's Bay District Health Board
Peer Reviewed by Dr Rachel Eyre, Hawke's Bay District Health Board

1. Executive Summary

In Hawke's Bay, one in every four adults is a "hazardous drinker"[1]. Hawke's Bay also has higher rates of hazardous drinking than the rest of the country and our hazardous drinking rates are increasing over time.

There is no doubt that we are at the beginning of a long journey to change our national drinking culture and, ultimately, reduce alcohol related harm and inequity in our community. We know that the levers which hold the greatest promise (and evidence base) for effecting change (such as price control, drinking age, accessibility and sponsorship/advertising) are largely outside of Hawke's Bay DHB's control.

We also know that the harm caused by alcohol is significant, and, over time, will place an increasing burden on the health system through injury, violence, foetal alcohol spectrum disorder, cancer and chronic conditions, to name a few. So regardless of progress at a national level, we need to identify what can be done locally, and make a start.

In 2016, Hawke's Bay DHB adopted a Position Statement around alcohol, with the vision of *"Healthy communities, family and whānau living free from alcohol-related harm and inequity".* In adopting this Position, Hawke's Bay DHB drew an important line in the sand, acknowledging that alcohol is a priority health and equity issue for Hawke's Bay.

This Alcohol Harm Reduction Strategy has been developed for, and by, the DHB and health sector in Hawke's Bay, but the strategies and actions identified reach far beyond the control of the health sector. Partnerships across sectors and throughout our community to reduce alcohol harm are essential.

Given the sheer size, scale and complexity of the task at hand, it is simply not possible to do everything that needs to be done at once and it is critical that the DHB prioritises carefully, particularly where additional resources are required. There is a significant amount of work which is already part of "business as usual" (such as licensing work) and this should continue. In terms of new investment, the following three areas of focus have been identified as priorities for the next five years:

- **Health services**
- **Young people**
- **Unborn babies**

Each of these focus areas require further engagement and planning. For young people and unborn babies, broader inter-sectoral approaches will be necessary and strategies will need to consider the contexts of, and influences on, the target populations. In the case of unborn babies (to prevent foetal alcohol spectrum disorder), this might include the role of whānau and community in supporting pregnant women not to drink and in the case of young people, the influence of parent/whānau role modelling and the school environment.

Planning in each of these areas must achieve the right balance of universal (i.e, whole of population) and targeted approaches to ensure that we achieve the vision of reducing alcohol-related harm and inequity in our community. DHB and health sector leadership, together with Māori and Pasifika leadership, will be integral to achieving this.

[1] This means they are likely to be harming their own health or causing harm to others through their behaviour.

2. Background

2.1 The journey this far

Work to elevate alcohol harm as a health sector priority has been underway for a number of years now, and the development of this Strategy signals an important milestone in this journey. A timeline of activity leading up to this point is set out in Appendix 1 and the most recent activity is discussed below.

In November 2016, Hawke's Bay DHB adopted a Position Statement around alcohol, with the vision of *"Healthy communities, family and whānau living free from alcohol-related harm and inequity".*

In May and June of 2017, a number of key health sector stakeholders were engaged in discussions around potential areas of focus and service gaps. On 5th July, a workshop was held with health sector stakeholders at which there was strong support for the strategic framework set out in this Strategy (Appendix 2), and some useful discussions around the proposed priority focus areas.

2.2 Why do we need to take alcohol-related harm seriously?

Despite its wide social acceptability and "normalisation" in New Zealand society, alcohol is no ordinary commodity. Alcohol is a toxin, an intoxicant, and an addictive pyschotropic drug. It has been classifed as a Group 1 carcinogen (carcinogenic to humans) by the World Health Organisation, alongside substances such as asbestos and formaldehyde.

It is also the drug that causes most harm to the most people in New Zealand.

Every year around 600-800 New Zealanders die from alcohol-related causes and the harm caused by alcohol is estimated to cost an overall $6.5 billion per year.

In Hawke's Bay, based on hospital bed days alone, alcohol-related harm is conservatively estimated to cost $3 million per year (2014-15).

2.3 What does alcohol-related harm look like in Hawke's Bay?

One in every four adults in Hawke's Bay is a "hazardous drinker". This means they are likely to be harming their own health or causing harm to others through their behaviour.

The Hawke's Bay population as a whole is drinking more hazardously than New Zealand with hazardous drinking rates in this region 60% higher than nationally. Moreover, hazardous drinking rates appear to be increasing over time.

Significant inequities also exist, with higher rates of hazardous drinking by Māori compared with non-Māori, and higher hospitalisation rates for alcohol-related conditions for Māori and for women.

The age group with the highest rates of hazardous drinking is 15-24 years where, in Hawke's Bay, 41% of this age group are drinking hazardously.

In a recent community survey in Hawke's Bay, two-thirds of respondents said that alcohol has a negative impact in their community.

2.4 What works to reduce alcohol related harm?

The strongest measures for reducing alcohol-related harm are at the national policy level and involve increasing price, reducing availability (e.g. limiting exposure, hours and outlet density), increasing the drinking age and reducing advertising and sponsorship.

Locally, the opportunity exists for communities to have more say to reduce availability through the Local Alcohol Policy (LAP) process and Sale and Supply of Alcohol Act (2012) licensing decisions, but to date there has been limited success in this regard both locally and nationally.

Screening and brief intervention[2] approaches, for example in the hospital (ED), primary care, maternity and in settings which can achieve wider community reach is a proven cost-effective and effective strategy to reduce alcohol-related harm.

The next 'best buys' at a DHB level include a range of community-level interventions that aim to delay drinking in young people, reduce harm to Māori, Pasifika and pregnant women and seek to reduce availability (limiting both demand and supply). In the absence of a 'single fix', evidence suggests that clustering interventions can make a difference.

3. Strategic framework overview

The strategic framework in Appendix 2 has been developed to guide future DHB and health system action and investment around alcohol over the next five years. This framework is closely aligned to the National Drug Framework and has been endorsed by a wide range of sector stakeholders.

The overall goal is *"Healthy communities, family and whānau living free from alcohol-related harm and inequity".* To achieve this goal, four key outcomes have been identified:

- Delayed uptake of drinking by young people;
- Reduced hazardous drinking across the whole Hawke's Bay population;
- Reduced hazardous drinking within priority populations (Māori, Pasifika, young people and pregnant women); and
- Reduced illness, injuries and deaths from alcohol.

The key objectives required to achieve these outcomes can be divided into three areas:

- Reducing **demand** for alcohol by addressing the underlying drivers of alcohol use, and influencing societal attitudes towards alcohol (i.e. our drinking culture);
- Influencing the **supply** of alcohol, by addressing the availability of alcohol and the exposure to alcohol in our everyday lives;
- Providing appropriate, accessible and timely **services** for those who need help with their drinking.

The strategic framework then identifies a range of strategies and approaches required to achieve these objectives, including raising community awareness and de-normalising drinking, strengthening our impact on licensing decisions, incorporating alcohol screening and brief intervention into normal clinical routine by health professionals in general (i.e. not limited to the addiction sector), and addressing service gaps and barriers to ensure timely and appropriate treatment services.

Given the sheer size, scale and complexity of the task at hand, it is simply not possible to do everything that needs to be done at once and it is critical that the DHB prioritises carefully, particularly where additional resources may be needed. The strategic framework therefore

[2] Brief intervention is a short, purposeful, non confrontational, personalised conversation with a person about an issue related to alcohol, tobacco, other drug use and/or gambling (i.e. any or all of these) (Matua Raki, 2012)

identifies three priority focus areas where stakeholders believe the greatest gains can be made over the next five years:

- Health services;
- Young people; and
- Unborn babies.

In the case of young people and unborn babies, strategies need to take into account the broader context of the target group. For example, the role of whānau and community in supporting pregnant women not to drink, and the role of parents/whānau and the school environment in young people's decisions around drinking.

Planning in each of these areas must achieve the right balance of universal (i.e. whole of population) and targeted approaches to ensure that we achieve the vision of reducing alcohol-related harm and inequity in our community. Leadership (in its many forms, discussed in section 4.2 below) will be integral to achieving this, and with the exception of work to develop health services, success in all areas will require inter-sectoral partnerships.

4. Building blocks

There is no doubt that we are at the beginning of a very long journey to reduce alcohol related harm and inequity in our community. Therefore, the initial focus must be on constructing the "building blocks" needed to support the long term, transformational change which lies ahead.

4.1 Governance and delivery structures

A system-wide approach will be necessary to tackle alcohol harm and as such, this Strategy will require a high level of 'ownership' and accountability. At this stage, it is envisaged that the DHB's Clinical Council would be well placed for this role with a possible second "tier" of governance in the form of an alcohol harm reduction steering group with representation across the health system.

The operational steering and delivery structure remains a "work in progress" with responsibility for internally focused DHB work allocated to the Executive Director Provider Services (also to the Executive Director Primary Care once they start) and responsibility for externally focussed work (i.e. with communities and other sectors) allocated to the Executive Director for Strategic Health Improvement.

Given the wider, inter-sectoral nature of the priority focus areas around young people and unborn babies, there is likely to be an important role for a governance structure outside of the DHB (for example, the Intersector Forum).

Next steps:

- Confirm Clinical Council as governance body for DHB work to reduce alcohol harm;
- Executive Director Provider Services, Executive Director Primary Care and Executive Director Strategic Health Improvement to agree coordinated steering and delivery structure of internally and externally focussed work.

4.2 Leadership

Leadership is an essential building block for change and, in the case of alcohol, will come in a number of different forms, including:

- DHB Board and Executive Management leadership;
- Clinical and health service leadership;
- Māori and Pasifika leadership;
- Inter-sectoral leadership; and
- Community leadership - community leaders and champions, schools, workplaces etc.

Examples of leadership include Ngāti Kahungunu Iwi Inc's alcohol free policy for all whānau events, and the recent example of the MAC rugby club in Flaxmere becoming alcohol-free.

Next steps:

- Review Hawke's Bay DHB's Alcohol Policy (including the provision of alcohol at the Health Awards);
- Identify ways to communicate health sector leadership to the community;
- Advocate at a national level for stronger policy levers to reduce alcohol related harm.

4.3 Inter-sectoral action

The provision of health services is the only area within the proposed programme of action which lies entirely within the control of the DHB and health sector. Success in all other areas will require partnerships with non-health sector stakeholders. Influencing youth drinking, in particular, will require broad engagement across our community including with schools, training institutions, social sector partners, NGOs and many more.

Next steps:

- Advocate in inter-sector forums to establish alcohol harm reduction as a priority for joint action and for role modelling by agencies, Councils and the DHB through, for example, alcohol policies and alcohol-free events;
- Work with the education sector to advance a whole of school approach to alcohol, including alcohol-free fundraising events (with a target of zero alcohol special license applications being received from schools for fundraising where minors are present).

4.4 Performance and measurement framework

Over the first 12 months of this Strategy, the four key outcomes set out in the strategic framework will need to be "unpacked" into a comprehensive system-wide outcomes framework which includes short, medium and long term measures and targets, including in each of the priority focus areas, to enable progress to be tracked and reported.

The outcomes framework will draw on the set of alcohol harm reduction indicators being prepared for DHBs by Massey University and will include the new mandatory Emergency Department data (commencing from July 2017) which will help Hawke's Bay DHB to monitor the extent of alcohol related harm, the burden on the health system and the effectiveness of any interventions.

Next steps:

- Identify and assign responsibility for the development of a performance and measurement framework for alcohol harm;
- Performance framework to include system level measures as well as population level health outcomes.

5. Priority focus area – Health services

The strongest lever this DHB holds to reduce alcohol related harm lies in the health workforce itself. Not only are people working in health in a position to advise and influence the patients and clients they work with, they are also the largest single workforce in Hawke's Bay – in itself, a captive audience for building community awareness around hazardous drinking.

With clear evidence now available around the harms caused by hazardous drinking and the benefits of screening and brief intervention, a conversation about alcohol can – and should – become part of routine clinical practice.

There are a number of barriers that need to be overcome in order for screening and brief intervention to become part of the normal clinical routine, perhaps the most important of which is that health professionals need to have the skills (and therefore the confidence) to have an effective conversation about alcohol.

Opportunities also exist to build alcohol into the wider "healthy lifestyle" context and associated programmes.

Next steps:

- Convene a steering group and project planning group to develop an action plan focussed on building the systems and workforce capacity and capability required to implement alcohol screening and brief intervention.

6. Priority focus area – Young people

Remaining alcohol free throughout childhood and into adolescence is important to ensure a healthy start to life. There is now clear evidence that early uptake of alcohol is a strong predictor for ongoing problems in adult life, including alcohol and substance dependence. It is encouraging that (according to national survey data) more young people are choosing not to drink alcohol and when they do drink, they are drinking at less harmful levels.

Strategies to reduce and delay youth drinking include:

- Reducing the exposure of young people to alcohol promotion and sponsored events;
- Addressing the drivers of youth drinking;
- Delivering clear, consistent and positive messaging;
- De-normalising alcohol and providing opportunities for "fun" without alcohol;
- Whole of school approaches;
- A health workforce skilled in "youth friendly" approaches to identify alcohol issues and intervene early;
- Appropriate counselling and treatment services.

Parents and whānau have an important role to play in reducing youth drinking, through role modelling and having the skills to guide their young person through the risk taking years. A focus on youth also provides a less confrontational way of encouraging the adult population to think about their own drinking.

The need to engage young people in education, training and employment has been identified as a key goal of the Hawke's Bay Social Inclusion Strategy and addressing youth drinking has an important role to play in achieving this goal.

Next steps:

- Identify appropriate governance body (Executive Director, Strategic Health Improvement);
- Convene a project planning group to develop an action plan around youth drinking with broad cross-sector representation and strong youth leadership and participation.

7. Priority focus area - Unborn babies

Hawke's Bay DHB has made good progress over recent years in recognising Foetal Alcohol Spectrum Disorder (FASD) and taking action to address FASD within its clinical services. There is strong leadership and mobilisation around FASD and the next step is to focus on prevention and early intervention.

There are still myths and misconceptions about drinking during pregnancy (both at a community level and within the health workforce itself) which need to be addressed as a matter of urgency through the development of consistent messages, supported by:

- Environments and communities which support women to abstain from drinking during pregnancy;
- Whānau and community support mechanisms;
- Primary prevention approaches within schools;
- Screening and brief interventions (midwifery and general practice);
- Clear referral pathways for women in need of support.

The message that there is no safe amount of alcohol which can be consumed in pregnancy must take into account that, most often, women don't drink alone and are influenced by those around them. Strategies to prevent FASD must avoid making drinking during pregnancy the sole responsibility of the pregnant woman, but rather employ community development approaches to create an environment and support system in which pregnant women are supported not to drink.

Next steps:

- Identify appropriate governance body (Executive Director, Strategic Health Improvement);
- Convene a project planning group to develop a FASD prevention plan;
- DHB Population Health Team to lead this work.

8. Treatment services

As community awareness grows, and as the clinical workforce begins to build screening and brief intervention into its normal clinical routine, we can expect an increased demand for treatment services. Some gaps are already known, for example services for young people, pregnant women, and adults with moderate levels of hazardous drinking and more may emerge over time.

Without appropriate treatment services in place, strategies to implement screening and brief intervention, to reduce youth drinking and to support pregnant women to abstain during pregnancy will fail. This is because health professionals need to be confident that when they identify problem drinking beyond their ability to manage that they can refer. It is therefore critical that an assessment of treatment services is incorporated into the planning for all priority focus areas.

Next steps:

- Governance body to ensure appropriate input from treatment services across all priority focus areas.

9. Communications and messaging

Communications and messaging have a critical role to play in implementing this Strategy. Across all three priority focus areas, key messages need to be agreed and communicated consistently across the whole community. An overarching communications and media plan will need to be developed to support each of the priority focus areas, to create more visibility around the role of licensing in addressing alcohol harm and to elevate "alcohol" into the consciousness of our community.

Next steps:

- Ensure communications expertise is included in all action planning around priority focus areas;
- Develop overarching communications plan to support Strategy implementation;
- Work with Iwi and hauora providers to ensure culturally appropriate messaging that is strengths based and encompasses a broad hauora approach.

10. Business as usual

There is a lot of work around alcohol which forms part of the DHB's "business as usual" and this should continue, such as licensing and regulatory work and health promotion activity around key events and host responsibility. Some new work is planned, including a project to help mobilise communities to get involved in licensing policy and decision making processes.

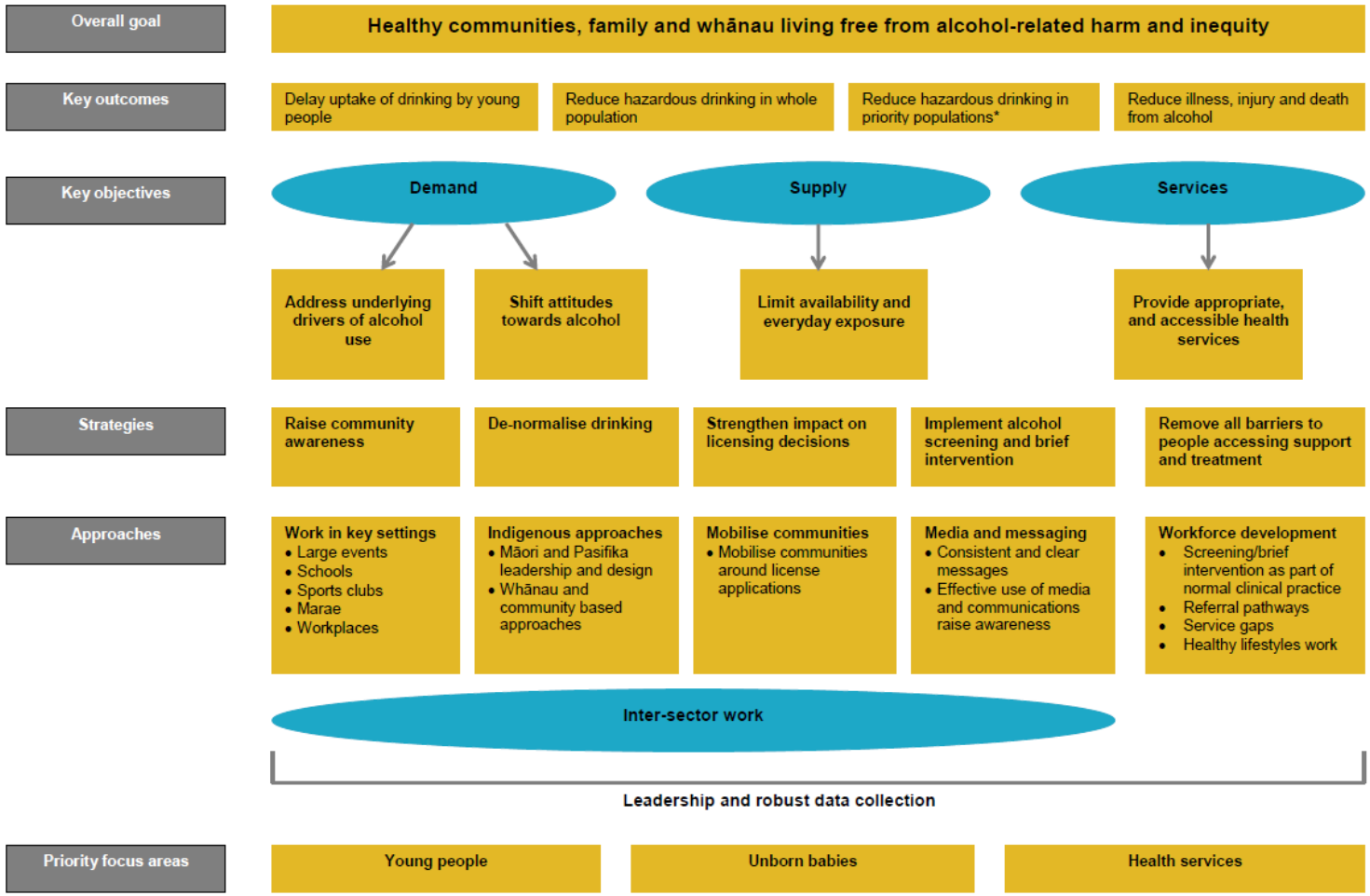
Next steps:

- Undertake project to increase community participation in licensing decisions;
- Continue to work proactively with large event organisers to denormalise drinking and reduce harm;
- Participate in the development of Wairoa's Local Alcohol Policy to ensure it is responsive to community needs;
- Support community initiatives around alcohol (including for example Safer Communities projects and the social supply project in Wairoa).

Appendix 1: Timeline of activity leading into the development of this Strategy

Activity	Date
"First" DHB alcohol strategy planning workshop with key DHB alcohol stakeholders (subsequently referred to as 'Alcohol Advisory Group')	4 Feb 2016
Second meeting of Alcohol Advisory Group	21 March 2016
Production of video clip to support Position Statement https://vimeo.com/174437689	April-June 2016
Dr Paul Quigley presents to DHB Grand Round about screening and brief intervention in the Wellington Emergency Department	May 2016
Prof Jennie Connor & Doug Selman visit to Hawke's Bay around causal relationship between Alcohol and Cancer	Aug 2016
Presentations to DHB Committees (two rounds) including Issues/Discussion paper followed by Draft Position Paper	June-Sept 2016
Foetal Alcohol Awareness day awareness raising by HBDHB	Sept 2016
DHB Board adopts Position Statement	Nov 2016
Alcohol Advisory Group re-convened to oversee stakeholder engagement process and strategy development	2 May 2017
Stakeholder engagement process	May/June 2017
Alcohol Advisory Group meeting to review results of stakeholder engagement process	7 June 2017
Stakeholder workshop – stakeholder engagement results and draft strategic framework presented	5 July 2017
Strategy to DHB Committees and Board for approval	July/Sept-2017

Appendix 2: Strategic Framework



* Priority populations: Young people, Māori, Pasifika, Pregnant women