CAAP

CHRISTCHURCH ALCOHOL ACTION PLAN

2017–2021

New Zealand Police
Nga Pirihimana O Aotearoa

Canterbury District Health Board
Te Poari Hauora ō Waitaha

Christchurch City Council

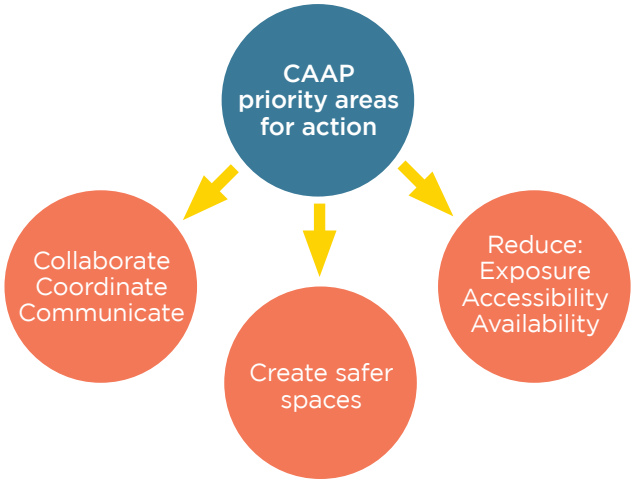
A SAFE, VIBRANT, HEALTHY CHRISTCHURCH FREE FROM ALCOHOL-RELATED HARM

FOREWORD

The Christchurch City Council, Canterbury District Health Board and NZ Police are pleased to present the Christchurch Alcohol Action Plan (CAAP).

The CAAP outlines a vision for Christchurch without alcohol-related harm. In preparing this programme of actions, the CAAP working group has met with a wide range of stakeholders, undertaken a stocktake of current activity, and completed a gap analysis to inform its direction. The CAAP acknowledges and builds on the extensive proactive and collaborative work already undertaken to reduce alcohol-related harms in Christchurch. Three clear priority areas have been identified. The CAAP seeks to:

1. Develop a strong, united and evidence-informed voice to drive alcohol harm reduction in Christchurch.
2. Set a bold new direction with a focus on non-regulated drinking environments. This focus will attempt to reduce the significant harms emanating from these settings and complement current successes within regulated drinking environments.
3. Advocate for a reduction in availability and accessibility of alcohol and exposure to alcohol marketing at a local and national level.



The CAAP alcohol harm reduction approach sits alongside and is not a substitute for the statutory alcohol licensing regime. Each partner has legislative functions associated with its alcohol licensing functions. The Police, Christchurch City Council (CCC) and Medical Officer of Health continue to independently exercise their statutory functions, duties and powers under the licensing regime prescribed in the Sale and Supply of Alcohol Act 2012.

We want the CAAP to be a resource which involves and supports all individuals, groups and organisations committed to improving public health and safety in Christchurch through the reduction of alcohol-related harm. We look forward to working with you on this exciting project.

Councillor Anne Galloway
Chair Safer Christchurch

Glossary of terms

AOD	Alcohol and other drugs
CAAP	Christchurch Alcohol Action Plan
CCC	Christchurch City Council
CDHB	Canterbury District Health Board
CPH	Community and Public Health
CPTED	Crime prevention through environmental design
DLC	District Licensing Committee
FASD	Fetal Alcohol Spectrum Disorder
HPA	Health Promotion Agency
Night Time Economy	Describes economic activity taking place in the evening after many people finish daytime employment or formal education, such as eating and drinking, entertainment, and nightlife
5+ Solution	The 5+ Solution is a set of evidence-based policy directives to reduce alcohol-related harm. They include: 1. Raise alcohol prices 2. Raise the purchase age 3. Reduce alcohol accessibility 4. Reduce marketing and advertising 5. Increase drink-driving counter-measures

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INTRODUCTION

The Christchurch Alcohol Action Plan (CAAP) has been developed in response to community concern about alcohol-related harm. It provides a collective vision, strategies and actions aimed at achieving a sustained reduction in alcohol-related harm across Christchurch.

The CAAP outlines a programme of actions to build upon and complement existing activity. It is not intended to take the place of individual organisational plans, rather to reflect the areas where agencies can gain efficiencies and effectiveness through collaborative planning and service delivery.

The CAAP is informed by New Zealand and international evidence; local data; and what our stakeholders and communities are saying about alcohol-related harm and how best to reduce it. It has been shaped by a shared vision, values and desired outcomes developed in consultation with the community.

The CAAP has been developed by a working group of three partner agencies. These agencies recognise alcohol harm as an important issue for the communities they serve and are committed to working together. This plan does not commit any agency or its resources in any way other than a good faith commitment to the successful implementation of the plan.

The CAAP offers Christchurch:

- A strong, unified and coherent voice in alcohol harm reduction
- A sustained coordinated approach to the effective reduction of alcohol-related harm
- An increased profile for alcohol-related issues in the community
- A process for monitoring and measuring progress.

Who is the CAAP for?

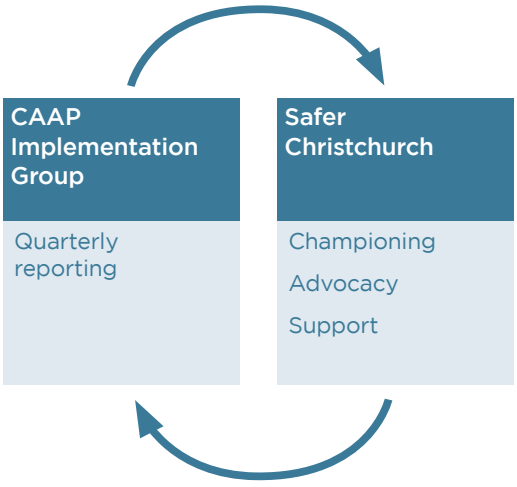
The CAAP has been developed with support from the Safer Christchurch and Healthy Christchurch inter-agency groups. The principal agencies leading the CAAP are Christchurch City Council, Canterbury District Health Board and NZ Police. These organisations will lead the programme of actions and partner with other interested and invested parties to achieve the collective vision.

It is intended that the CAAP be a dynamic resource that expands to incorporate and support all those individuals, groups, communities and organisations committed to improving public health and safety through the reduction of alcohol-related harm in Christchurch.

Who will lead the implementation of the CAAP?

Management oversite of the CAAP sits within each of the partner organisations. Safer Christchurch will champion, advocate and support the CAAP.

Proposed stewardship structure for the CAAP:



Regular implementation group meetings will assess progress, agree actions and determine responsibilities for actions. Working groups will be formed for any major initiatives, and expertise external to the implementation group may be called upon to assist.

Community and sector meetings and workshops will be hosted to ensure that all interested parties are updated on the CAAP and its progress and provide opportunities for input into its successful delivery.

The CAAP has a five-year timeframe. Milestones and a monitoring framework will be developed within the CAAP to guide implementation and to measure effectiveness.

BACKGROUND

A short history

Starting with the 1989 Sale of Liquor Act, successive governments have liberalised alcohol policy in New Zealand leading to a significant rise in the number of alcohol outlets and aggressive competition resulting in increased marketing and discounting of alcohol (Law Commission 2009). Further law changes have allowed for broadcast advertising of alcohol, increased trading hours, Sunday trading, and a reduction in the minimum purchase age from 20 to 18 years. The increase in availability and promotion of alcohol has been associated with an increase in harm (Kypri et al 2006).

Community concern over growing harms motivated a comprehensive review of alcohol laws by the Law Commission in 2009. In response to this review, the government passed the Sale and Supply of Alcohol Act 2012, with the object of minimising the harm caused by the excessive consumption of alcohol.

Significant community concern has been expressed in Christchurch about the wider alcohol-related harms that fall outside of the regulatory environments specified in the Act. The CAAP has emerged as a tool to address these wider concerns.

Overview of current activity

A 2017 stock-take of alcohol activity in Christchurch shows a range of alcohol harm reduction initiatives are currently in place. The actions identified are in addition to the regulatory functions associated with alcohol licensing. These include but are not limited to: information and messaging as part of national social marketing campaigns; web-based support and school-based education and information for young people; advocacy for evidence-based policy; and services for the treatment of acute and chronic alcohol-related harms.

Principal partner roles in alcohol harm reduction

NZ Police	Data collection specific to alcohol offending
	High visibility policing
	Alcohol licensing and enforcement
CDHB	Health promotion
	Advocacy and policy
	Data collection specific to alcohol
	Treatment and support services
	Alcohol licensing and enforcement
CCC	Community development
	Advocacy and policy
	Alcohol licensing and enforcement

Defining alcohol-related harm

Alcohol-related harm caused by the excessive or inappropriate consumption of alcohol is broadly defined by the Sale and Supply of Alcohol Act 2012 as including —

(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).

Alcohol-related harm also includes chronic harm, such as mental illness and the over 200 diseases associated with alcohol use, as well as the indirect social harms.

The cost of alcohol-related harm

Alcohol harm affects the whole community. There are direct economic costs associated with alcohol harm such as health and social care, the police and criminal justice system and the unemployment and welfare systems. Indirect economic costs include lost productivity due to absenteeism, decreased output and unemployment. The intangible costs of pain and suffering, and poor quality of life, and the opportunity costs of money spent on alcohol rather than education, for example, are harder to measure but perhaps more important.

Globally, it is recognised that alcohol is a major contributor to health inequalities (Di Cesare M et al 2013). In New Zealand, we see more alcohol outlets (Law Commission 2010) and more alcohol-related harm (Ministry of Health 2015) in socially deprived communities.

Despite there being more non-drinkers in the most socioeconomically deprived areas, those who do drink are likely to drink excessively and experience more harm compared to those living in more affluent neighbourhoods (Ministry of Health 2015).

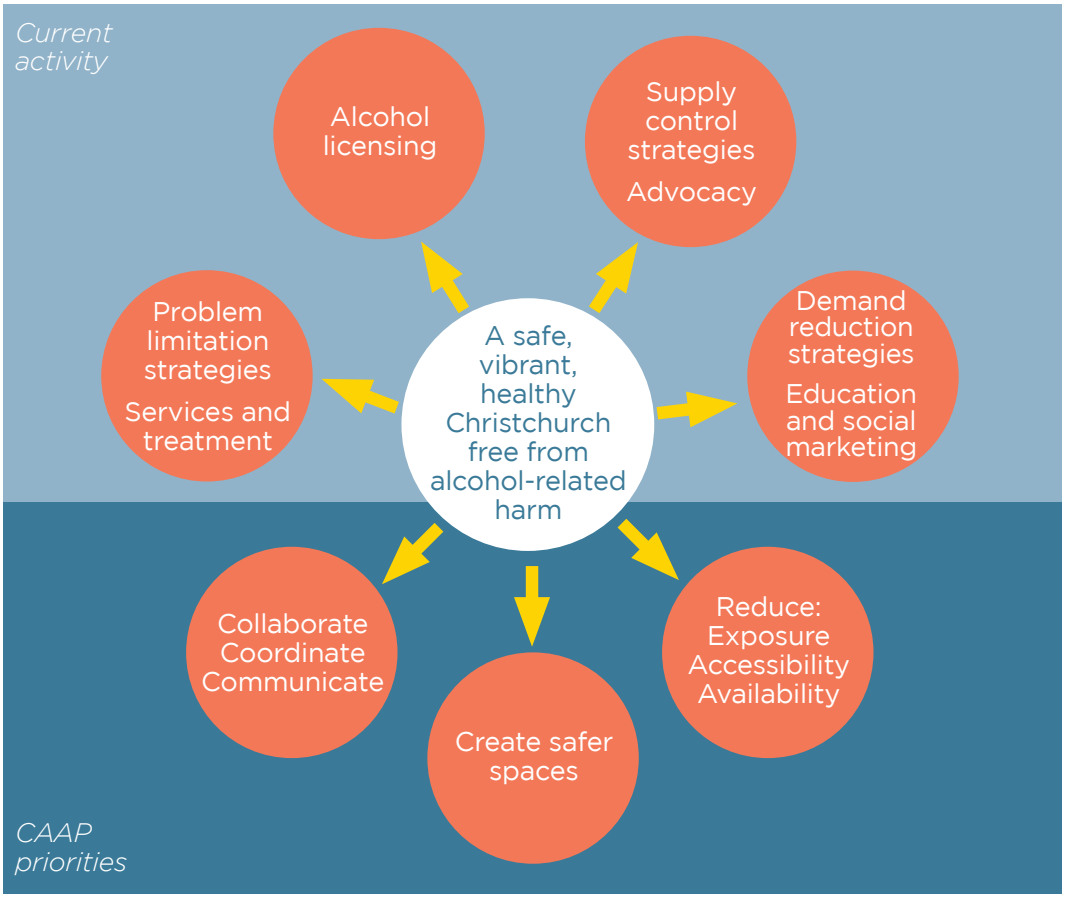
The direct costs of alcohol misuse are typically borne by government, whereas indirect costs tend to be borne by society at large and intangible costs by drinkers, their families and their communities.

Studies attempting to quantify the social costs of alcohol-related harm vary significantly. A World Health Organization-endorsed study estimated that harmful alcohol use cost New Zealand $4.9 billion (Berl 2009). The Law Commission (2010) estimates the annual cost to be as much as $5.3 billion.

OUR APPROACH

We intend to continue with and build on the successes of existing alcohol harm reduction activity — high profile social marketing campaigns that seek to address the binge-drinking culture, licensed establishments demonstrating responsible service of alcohol, resiliency-based messaging for young people, and advocacy for further evidence-based policy development.

We feel it is time to be bold and target the significant alcohol-related harms emanating from non-regulated drinking environments, domains not typically targeted by existing efforts. Our harm minimisation approach will encompass the prevention and reduction of health, social and economic harms experienced by individuals, their families, friends, communities and society due to alcohol misuse.



While youth have been identified as a group central to the CAAP, it is also acknowledged that alcohol harm impacts across all life-stages. For example, trauma experienced by young children with alcohol dependent parents, FASD in babies caused by drinking during pregnancy, chronic illness in middle-age, and the risk of harm to older people who drink to excess. Actions must consider the impact of alcohol on all ages and life-stages in order to comprehensively address alcohol-related harm.

Our approach encompasses supply control, demand reduction and problem limitation strategies.

Our vision and values

Vision

A safe, vibrant, healthy Christchurch free from alcohol-related harm.

Core values

We are guided by the following values:

- **Partnership with Māori** — We are committed to working with Māori and honouring the principles of the Treaty of Waitangi. We will work with Ngāi Tahu and mana whenua and their representatives, including the Māori health provider alliance — Te Rūnanga o Ngā Maata Waka to reduce harms associated with alcohol misuse in our communities.
- **Equity** — All members of our community need a fair and just opportunity to live lives free of alcohol-related harm. All people should have appropriate support to address alcohol-related harm, in acknowledgement that harm impacts disproportionately across our community. People should have an awareness of personal choices for improving health, and opportunities to help improve the health of our communities.
- **Respectful relationships** — We work together in collaboration, treating our partners with dignity and respect. We will ensure the voices of Māori, Pacific, young people and lower-socio-economic communities are heard and their issues addressed.
- **Evidence-based approaches** — We use evidence and data to inform our work. We are committed to making sustainable change through the implementation of evidence-based approaches and recognise the need to take a broad view to the causes of, and solutions to alcohol-related harm.
- **Strengths-based approach** — Our communities are resourceful and resilient. We seek to empower communities and build upon their strengths, with a focus on wellbeing.

STRATEGIC ALIGNMENTS

Policy	Relevant priorities
National Drug Policy 2015–2020 (Ministry of Health)	Sets the platform for change and identifies key priority areas and strategies including a harm minimisation approach. Relevant priorities: • Objective 1: Delaying the uptake of AOD by young people • Objective 2: Reducing illness and injury from AOD • Objective 3: Reducing hazardous drinking of alcohol • Objective 4: Shifting our attitudes towards AOD
Healthy Christchurch Charter Alcohol statement of intent 2014	Sets a platform for signatory organisations to voice their collective concern about alcohol misuse and harm. Relevant priorities: • Support for the '5+' solution (Raise alcohol prices; Raise the age of purchase; Reduce alcohol accessibility; Reduce marketing and advertising; Increase drink driving counter-measures) • Improved surveillance data recording and dissemination • Advocacy for central government policy to support local government initiatives • Encouragement for the development of a Canterbury-wide alcohol harm minimisation strategy
Safer Christchurch Strategy 2016–2021	Sets a platform for the creation of a safer city with the goal of making Christchurch the safest city in New Zealand. The reduction of harm caused by the misuse of alcohol is a cross-cutting theme of the strategy. Relevant priorities: • Priority area 1: Proactive partnerships that have a shared commitment to a safe city • Priority area 2: Reducing and preventing injuries • Priority area 3: Reducing and preventing the incidence and effects of crime • Priority area 5: Building in safety

Policy	Relevant priorities
Police Draft National Alcohol Harm Reduction Strategy –2021	Sets national priorities for alcohol harm reduction. • Develop and implement district plans to address alcohol-related offending. These plans are to specifically address causation of offending in order to ensure long term sustainability • Undertake quality licensed premises checks in at-risk locations using the Graduated Response Model and focus on licensee responsibility and sales of alcohol to minors • Apply tactics to target public place drinking, including employing high visibility patrols at high-risk times and locations
Canterbury Health System Alcohol-related Harm Reduction Strategy 2017–2021	Sets the strategic direction for alcohol across Canterbury's entire health sector. All four strategic focus areas are relevant to the CAAP: 1. Influence behaviour change and social norms 2. Coordinate prevention, identification, treatment and support 3. Promote healthy environments 4. Measure harm and monitor performance
Health Promotion Agency Alcohol Strategy 2017–2021	Outlines the strategic direction for HPA's alcohol work. CAAP priorities align with the following HPA priority areas: • Priority 1: Build social permission for people to drink at low-risk levels or not drink • Priority 3: Influence policies, practices and the management of environments to support people to drink at low-risk levels or not drink • Priority 4: Contribute to strengthening protective factors that support low-risk drinking or not drinking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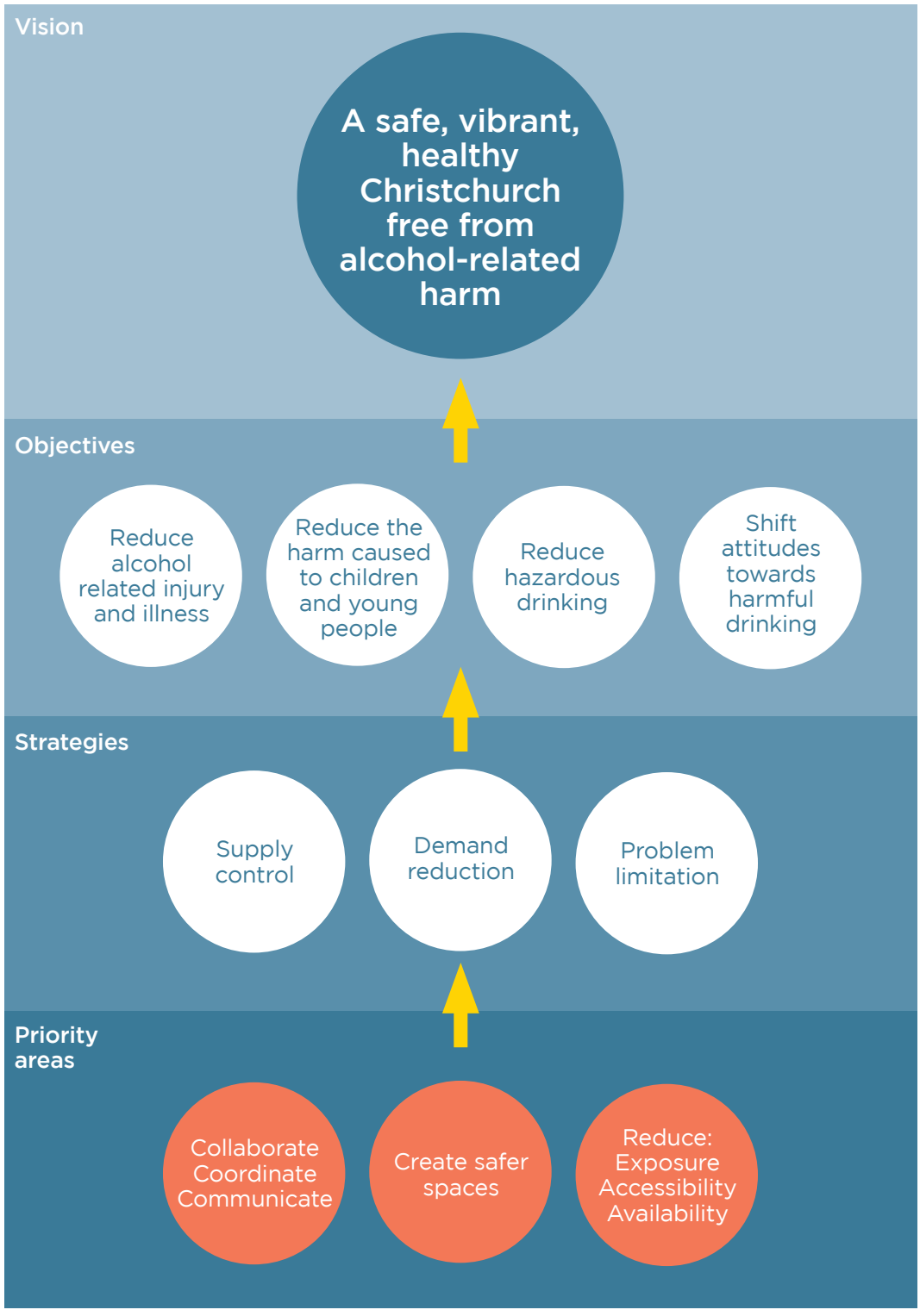
STRATEGIC FRAMEWORK



OUR OBJECTIVES

This section looks at our four CAAP objectives and outlines why we focus our collective energies on reducing harm in each of these areas. Together these objectives will enable us to move towards achieving our vision. An Indicators Framework will be developed to measure success against these objectives.

1. Reduce alcohol-related injury and illness

In New Zealand, around 800 deaths per year are attributable to alcohol. Injuries are the main cause of alcohol attributable deaths for people under 45 years, with alcohol-induced cancers becoming increasingly dominant from the age of 45 (Connor et al 2013).

- Alcohol attributable injuries are estimated to account for 11 per cent of all ACC claims, at a cost of $350 million per year (ACC 2012).
- More than 62,000 physical assaults and 10,000 sexual assaults occur in NZ every year which involve a perpetrator who has been drinking. Of these, 10,500 incidents require medical attention and 17,000 involve police (Connor J et al 2009).
- Between 18 and 35 per cent of injury-based emergency department presentations are estimated to be alcohol-related, rising to between 60 and 70 per cent during the weekend (Jones et al 2009; Humphrey et al 2003).
- In 2008, an estimated 378,843 (or 10%) of New Zealanders made at least one call to the police, and 257,613 (or 6.8%) required a health-related service because of someone else's drinking (Huckle et at 2017).
- More than half of alcohol-related deaths are due to injuries, one-quarter to cancer and one-quarter to other chronic diseases (Connor J et al 2005).
- The total annual public hospital discharge rate for conditions wholly and partially attributable to alcohol for persons 20 years and over has increased significantly over time in the CDHB region. However, the hospital discharge rates of acute conditions wholly or partially attributable to alcohol have remained stable over time (South Island Public Health Partnership 2015).

2. Reduce the harm caused to children and young people

Babies exposed to alcohol before birth can develop lifelong problems, including behavioural and learning difficulties, intellectual disability and heart defects. This can lead to poor life outcomes and increased risk of involvement with the criminal justice and welfare systems. There is no cure for Fetal Alcohol Spectrum Disorders (FASD), but they are preventable.

There is also evidence that parental alcohol use can harm children. Children with parents or caregivers who drink heavily are likely to suffer from a greater number of hospital admissions for physical injuries (Families Commission 2006). Children raised by caregivers who are alcohol dependent can have higher levels of anxiety, behavioural problems and other mental health issues than children who do not have alcohol-dependent parents (Maynard 1997). Research also suggests that children of alcohol dependent parents are more likely to become alcohol dependent themselves, creating generational impacts (Jennison and Johnson 1998).

Early use of alcohol raises very serious issues for our young people and society. The brain does not fully mature until the third decade of life, and the evidence suggests that exposure to alcohol during adolescence and young adulthood may interrupt important neurological processes and natural brain maturation (Inter-Agency Committee on Drugs 2015). Early onset alcohol consumption tends to increase the likelihood of regular and heavy use and has been associated with increased rates of violence and injury, unprotected sex, mental health problems, suicide, poorer educational outcomes and problem drinking later in life (Inter-Agency Committee on Drugs 2015).

- Alcohol and drug misuse is a factor in 25 per cent of families with children in Child, Youth and Family care (Office of the Chief Social Worker 2014).
- Alcohol is a contributing factor in 34 per cent of all family violence incidents (Ministry of Justice 2010).
- Of adults aged 15 years and over who reported drinking hazardously in the past 12 months 48 per cent had first used alcohol before age 15 (Ministry of Health 2015b).
- Estimates of the number of babies born each year in New Zealand with FASD range from 173 to 3000 (Health Select Committee).

3. Reduce hazardous drinking

Despite recent positive trends in alcohol consumption, the rates of hazardous drinking continue to be high. Hazardous drinking can contribute to a number of social harms — not just to individuals, but also to those around them. The most common harmful effects reported by adults due to someone else's drinking are damage to friendships and social life, and damage to home life and financial position (Ministry of Health 2010).

The links between drinking and health in older age are complex, with much still to be learned about what constitutes safe alcohol use for older adults. The picture is complicated by the impact of the ageing process itself, as well as the presence of chronic health problems, disabilities and use of prescription medicines.

There is clear and consistent evidence of an association between alcohol consumption and domestic violence (Wilson et al 2014). When the perpetrator has consumed alcohol, domestic violence is more severe and more likely to result in physical injury (WHO 2006).

- Twenty-one per cent of adults reported drinking at a level that was hazardous to their health, with over twice as many men (29%) as women (13%) reporting hazardous drinking (Ministry of Health 2016).
- Young adults (aged 18–24 years) also had the highest rate of weekly binge drinking (six or more drinks on one occasion) at 20 per cent.
- Māori adults were more likely than non-Māori adults to be hazardous drinkers.
- Relatively few Pasifika adults drank alcohol in the past year, but Pasifika adults who drink were 1.5 times more likely to be hazardous drinkers than non-Pasifika drinkers. Forty-three per cent of Pasifika past-year drinkers were hazardous drinkers.
- One in three (37%) Māori aged 15 years or more who drank alcohol in the past year has a potentially hazardous drinking pattern (Ministry of Health 2013).
- Twenty-one per cent of past year drinkers aged 15 to 17 years report hazardous levels of drinking (Ministry of Health 2013).
- Older New Zealand adults, especially older men, tend to drink more frequently than younger adults. Almost one third (32%) of adults aged 65–74 years report drinking 4 or more times per week, as do more than one quarter (27%) of adults aged 75 and over. (Hodges I, & Maskill C. 2014).
- Alcohol is implicated in approximately one third of police apprehensions, one half of serious violent crimes (NZ Police 2010), and more than half of all physical assaults and sexual assaults (Connor et al 2009).
- Alcohol is involved in around 90 per cent of tertiary campus assaults (Thorpe 2016).
- Communities with the greatest access to alcohol outlets are associated with the highest incidence of serious violent crime (Day et al 2012), property damage (Cameron et al 2016b), and domestic violence (Livingston 2008–2011).
- Studies suggest many older adults who are drinking hazardously or harmfully, including some with serious alcohol use disorders, are 'hidden' in the community, are not seeking help, and are not being adequately identified or engaged by health and social services (Hodges I, & Maskill C. 2014).

4. Shift attitudes towards harmful drinking

Our attitudes are a key predictor of our behaviour. They are shaped by our individual values and beliefs, the values and beliefs of our peers and people of influence, and by our surroundings, such as the messages we are exposed to and the rules set by the Government.

If we are to achieve our objectives, we need to shift the attitudes of individuals and communities to alcohol use and misuse, and to seeking help. We will seek to shift the culture of drinking by reducing alcohol advertising, reducing exposure to drinking, and providing positive messaging that supports responsible attitudes towards alcohol.

- Six per cent of all adult past-year drinkers planned to get drunk on their most recent drinking occasion, and 12 per cent reported having 'got drunk or had too much to drink' on their most recent drinking occasion (Research NZ 2014).
- On average, adults surveyed believed people should be 17 years old before being allowed to drink at home or in a restaurant under parental supervision, and 19 years old before being allowed to drink at licensed premises such as a bar or a pub (HPA 2017).
- Twenty-five per cent of high school-age students thought it was okay for people their age to drink alcohol (Adolescent Health Research Group 2013).
- Parents (59%) and friends/partners aged 18 years and over (32%) were the most commonly reported usual source of alcohol for young people aged 15 to 17 years (HPA 2017).
- Around 50,000 people wanted help to reduce their AOD use in the past 12 months but had, for a variety of reasons, not received it (Mental Health Commission 2011).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OUR STRATEGIES

The National Drug Policy provides clear direction for the implementation of evidence-based harm minimisation strategies of supply control, demand reduction and problem limitation.

Supply control strategies aim to reduce the availability of alcohol. This includes supporting approaches that control and manage supply of alcohol such as age restrictions, licensing conditions and permitted trading hours, server intervention and reduced social supply to minors.

Demand reduction strategies aim to reduce the desire to use alcohol. It includes activities that delay or prevent uptake. This means reducing use through education, health promotion, advertising and marketing restrictions, and influencing the conditions that make people turn to alcohol through community action, such as keeping children in school.

Problem limitation strategies aim to reduce harm that is already occurring to those who use alcohol or those affected by someone else's alcohol use. It includes activities that ensure access to quality alcohol brief intervention and treatment services and support for people in recovery.

Supply control

Access to alcohol for harmful use is minimised. Our strategies include:

- Promoting the expansion of existing strategies to reduce harm within licensed environments
- Working with communities to prevent social supply to young people
- Supporting citizen participation in licensing processes
- Promoting awareness of social host responsibilities

Demand reduction

People have the knowledge, skill and support to make good decisions about their alcohol use. Our strategies include:

- Providing clear, relevant and consistent evidence-based information using appropriate technologies
- Tailoring messages and information appropriate to our audiences
- Encouraging women to abstain from alcohol use during pregnancy
- Delaying onset of drinking for young people
- Collaborating to reduce advertising and sponsorship

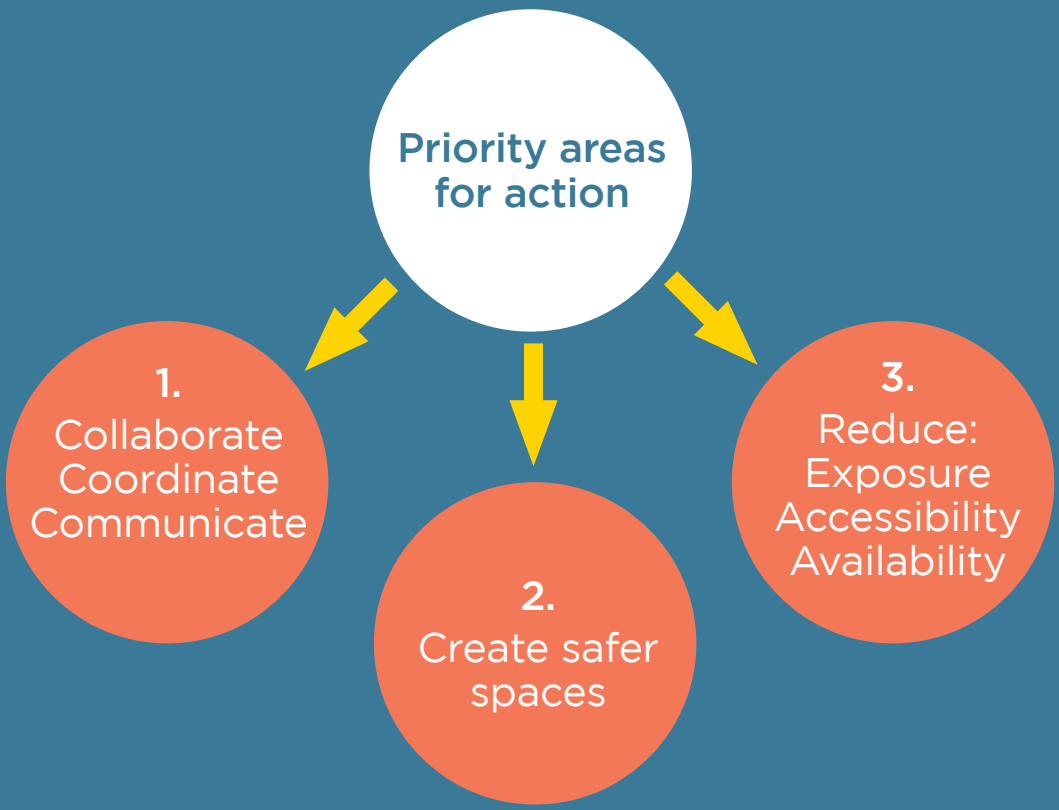
Problem limitation

Barriers are removed to people accessing and receiving support or treatment for their own or others' alcohol use. Our strategies include:

- Collaborating to reduce alcohol-related harm in the home
- Building workforce and community capacity to reduce alcohol-related harm
- Adopting the Health System Alcohol Harm Reduction Strategy to provide effective, high-quality, compassionate, timely, accessible, and age- and culture-appropriate support and treatment services

OUR PRIORITIES

Our three priorities for the next five years enable us to make meaningful progress towards meeting our objectives:



Each priority has a programme of actions outlining activities in that area.

1.
COLLABORATE COORDINATE COMMUNICATE

This priority area encompasses the development of strong leadership, the collection and distribution of data to inform practice, workforce capacity building, and the innovative and coordinated communication of key messages.

Strategic Approach		Actions
1.1	Establish and maintain a structure and process that supports leadership, collaborative planning and coordinated action	Establish a working group to oversee and drive the implementation of the CAAP
		Determine an appropriate governance structure for the CAAP
		Help establish an independent alcohol advocacy group
		Ensure CAAP goals and strategies are prominent in partner agency workplans
		Principal agencies scope the appointment of a coordinator to drive collaboration and coordination of alcohol activity
1.2	Build partnerships across sectors and the community that support collaborative approaches	Engage innovatively and collaboratively with new and existing partners
		Convene annual inter-sectoral forums to review progress, discuss issues and opportunities and develop responses
		Expand information sharing within CDHB and CCC joint work plan portal to other partners within the CAAP
		Strengthen community voices
1.3	Ensure the necessary data is available to report on progress against the plan, both alcohol-related harm and inequities outcomes	Establish Outcome Indicators to monitor progress
		Advocate for or undertake research to inform action and monitoring of indicators as required
		Support alcohol data collection in Christchurch and share trends with partners
		Investigate gaps in data and leverage relationships to encourage future collection
1.4	Provide clear and consistent evidence-based information to the community using appropriate technologies	Take a proactive stance in using digital technologies to utilise and disseminate information
		Develop a communications strategy to coordinate all activity within the CAAP
		Build relationships with media and community leaders to inform public debate on alcohol issues and reframe the public discourse towards the evidence
		Align local action with national social marketing campaigns to ensure the coordinated reach of evidence-based messages
		Identify and engage with communities and groups who are at greater risk of alcohol-related harm
		Provide information about effective community-based interventions, and build capacity at community level for their implementation
1.5	Build workforce and community capacity to reduce alcohol-related harm	Identify training needs and coordinate training opportunities for partner agencies and community stakeholders
		Ensure needs of both kaupapa Māori and mainstream services are assessed for capacity and capability for working with and responding to the needs of Māori

2.
CREATE SAFER SPACES

This priority area seeks to promote initiatives that address the harms that emanate from non-regulated drinking environments including homes, public spaces, parties and social gatherings; and also recognises the current initiatives within regulated environments.

Settings can be used to promote health and reduce harm in that they provide vehicles to reach individuals, to gain access to services, and to synergise actions. Actions often involve changes to the physical environment or to organisational structure, administration and management (WHO).

By creating environmental and social constraints we limit alcohol consumption and therefore intoxication, and reduce alcohol-related harm. Environmental constraints include factors such as increasing the risk of getting caught and punished, making it less rewarding to participate in activities that lead to harm, and increasing the amount of effort required to cause the harm (Barbor et al 2010). Social constraints include setting expectations around alcohol consumption and behaviour, and fostering positive social pressure.

This approach incorporates the tenets of Crime Prevention through Environmental Design (CPTED). In addition to reducing the opportunity for alcohol-related harm to occur by the application of environmental and social constraints, CPTED ensures that places and spaces are designed and managed to positively support and enhance the safety of members of the public, and the security of property.

Strategic Approach	Actions
2.1 Reduce alcohol-related crime and violence in public spaces associated with the Night Time Economy	Investigate how best to mitigate and manage violence and disorder issues that may occur in the Night Time Economy environment
	Provide ongoing support to licensees and local business operators via Alcohol Accords to promote safe and vibrant late-night environments
	Provide high visibility policing in the Night Time Economy environment
	Recognise the use of CPTED principles as a tool for reducing alcohol-related crime and violence in public spaces
	Investigate future re-establishment of the Safe City Officer Programme to aid the Police in mitigating and managing violence and disorder issues that may occur in the Night Time Economy environment
2.2 Collaborate to reduce alcohol-related harm in the home	Collect and disseminate information on the role of alcohol consumption in family violence
	Initiate collaborative partnerships to address alcohol-related family violence
	Increase awareness, routine enquiry, brief intervention and referrals in services addressing family violence
	Evaluate and promote effective and cost-efficient prevention strategies for reducing levels of alcohol-related family violence
	Support agencies to explore the impact of alcohol-related harm on older people
	Frame alcohol awareness as a component of youth wellbeing
	Raise awareness of FASD within communities
	Support initiatives to raise awareness of the impact of drinking on whanau/family
	Support health system initiatives to raise awareness of the impact of chronic alcohol-related harm in adults
2.3 Work in educational environments to reduce alcohol-related harms	Work with the whole-of-school environment to impact policies and processes, inform parents and engage with young people to reduce alcohol-related harms
	Expand 'Good One' party register to new environments
	Work with tertiary stakeholders to reduce alcohol-related harm in and around campuses
2.4 Support community initiatives that promote safer environments	Ensure there are adequate alcohol-free venues, events and activities for young people
	Support initiatives that protect people who have consumed too much alcohol
	Support efforts to reduce the incidence of drink driving
	Support efforts to reduce the impacts of alcohol in the workplace
	Encourage safer drinking in non-licensed environments such as homes and parties
2.5 Expand upon existing strategies to reduce harm within licensed environments	Encourage all staff who sell or supply alcohol to complete the ServeWise online training
	Work together with sports clubs to reduce alcohol-related harms
	Continue to work with stakeholders in planning and managing large events

3.
REDUCE EXPOSURE ACCESSIBILITY AVAILABILITY

The CAAP strongly supports national alcohol law reform via the 5+ Solution as recommended in the Law Commission's Report (2010). International evidence shows that the 5+ Solution is the most effective way to reduce alcohol-related harm to our population. Each of the CAAP principle partners continue to engage with central government around opportunities to implement these key policy drivers nationally. The CAAP acknowledges the need for this work to continue, and identifies local collaborative opportunities to reduce exposure, availability and accessibility.

Widespread marketing which promotes alcohol as a positive and commonplace element of everyday life has an impact on social norms around alcohol (Casswell 2010) and is positively related to consumption. This has been shown in children (Barbor et al 2010), current drinkers — particularly youth (Barbor et al, 2010; Anderson et at 2009; Smith and Foxcroft 2009), and sportspeople (O'Brien and Kypri 2008). Studies have shown that reducing exposure to marketing that normalises drinking and links it to social aspirations, will slow recruitment of drinkers and reduce heavier drinking by young people (Barbor et al, 2010).

Alcohol is accessed for private consumption through two channels — off-licensed premises (bottle stores and supermarkets) and social supply. While many on-licensed alcohol outlets are heavily concentrated in central Christchurch, off-licenses are distributed throughout the wider community (CPH and CCC 2017). Social supply refers to the social networks through which minors typically access alcohol, including parents, older siblings, peers and strangers.

Strategic Approach		Actions
3.1	Work together with communities to prevent social supply of alcohol to young people	Align with national messaging to provide parents and communities with information about the risks and harms of supplying alcohol to young people
		Investigate and implement effective interventions to reduce social supply to young people
3.2	Work together with off-licensed premises to reduce alcohol-related harm	Work together with licensees to ensure managers and staff are aware of their legal obligations
		Investigate and implement effective interventions to communicate safe drinking messages to drinkers and hosts
		Undertake Controlled Purchase Operations within supermarkets and bottle stores to monitor compliance with the Act
3.3	Collaborate to further restrict alcohol advertising and sponsorship	Actively share information and collaborate in advocacy opportunities for 5+ solution policies at national and local level
		Encourage public events and activities, especially those aimed at children, young people and families to be free of alcohol marketing
		Take opportunities to reframe the alcohol debate in the media and in community settings to build public awareness of and support for reducing exposure to alcohol advertising and sponsorship
		Collaborate with sporting sector to reduce exposure to alcohol advertising and sponsorship at a club level
3.4	Enable and support citizen participation in licensing processes	Support the development of web-based Public Notification of all alcohol licensing applications and DLC Hearings
		Information and support given to local communities seeking involvement in the licensing process
		Monitor and provide communities with information about risk factors which may increase harm (e.g. outlet density)
3.5	Increase awareness of social host responsibilities	Promote community awareness of personal obligations as social hosts

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