



Child and Youth Mortality Review Committee

Te Rōpū Arotake Auau Mate o te Hunga Tamariki, Taiohi

Special Report: The involvement of alcohol consumption in the deaths of children and young people in New Zealand during the years 2005–2007

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Citation Child and Youth Mortality Review Committee, Te Rōpū Arotake Auau Mate o te Hunga Tamariki, Taiohi. 2009. *Special Report: The involvement of alcohol consumption in the deaths of children and young people in New Zealand during the years 2005–2007*. Wellington: Child and Youth Mortality Review Committee.

Published in September 2011 by the Child and Youth Mortality Review Committee
PO Box 25496, Wellington, New Zealand

ISBN 978-0-478-38507-6 (Print) ISBN 987-0-478-38506-9 (Online)

This document is available on the Committee's website at: <http://www.cymrc.health.govt.nz>

Acknowledgements

The CYMRC wishes to thank the following individuals who provided input into this special report:

- Natasha McMillan Consultancy, for completing the preliminary analysis of this data and preparing the CYMRC's submission to the Law Commission's consultation paper, 'Alcohol in Our Lives'
- the CYMRC local mortality review groups, who reviewed these deaths and provided the detailed data that is reported in this report
- the New Zealand Mortality Review Data Group, who house the CYMRC data
- CYMRC advisors, especially those from the Ministry of Health, Ministry of Justice, Ministry of Transport, and New Zealand Police
- Dr Geoff Robinson, the Chief Medical Officer of the Capital & Coast DHB.

Chair's Introduction

Alcohol behaves like a toxic tide impinging on all children and young people born and growing up in New Zealand. Harm from alcohol can begin before birth, affecting the developing brain and body of the fetus when the mother drinks. In infancy, alcohol impacts on the quality of parenting, contributes to family violence, and leads to under-supervision of vulnerable infants and children.

We see a dramatic increase in death rates for injury from age 15 years onwards. Much of this relates to adolescent risk-taking behaviour for which alcohol is a precipitating factor. This report focuses on a small subset of alcohol-related harm and unintentional injury; specifically, motor vehicle-related injury. The effects of alcohol are so pervasive that a more complete review of harm over a longer period would be an enormous undertaking.

This report highlights that too many young people are victims of their own drinking or victims of the drinking of others. These issues represent different parts of the same problem but require different strategies for prevention. Victims of their own drinking typically drive while intoxicated, carry out risky behaviours (eg, being an intoxicated pedestrian) or drink to the point of poisoning and death. Most victims of others' drinking get into cars with, or are injured by, an intoxicated driver or are assaulted by people who are drunk.

Alcohol causes or contributes to a significant number of deaths each year that have not been considered in this special report. For example, alcohol impairs awareness, and some overseas studies have shown that up to one in four cases of sudden unexpected infant death is related to alcohol use in parents and caregivers (Blair et al 2009). Alcohol alters mental state, increases impulsivity and aggression, and impairs judgement, contributing to a proportion of suicides (Ministry of Health 2008).

We hope this report can be used as an indicator of the extent of the problem. It must, however, be remembered that death only represents the very tip of an iceberg of harm related to alcohol in our society.

Nick Baker, Chair

Child and Youth Mortality Review Committee (CYMRC)

Introduction

'Alcohol is the most commonly used recreational drug in New Zealand. While most New Zealanders enjoy alcohol moderately and socially, alcohol misuse results in increased mortality and morbidity, as well as considerable harm to society' (Ministry of Health 2009: 1).

While it is commonly accepted that alcohol misuse is harmful, very little is known about the effects of alcohol on the lives of children in New Zealand, particularly those under the age of 16.¹ This special report was commissioned to investigate the role that alcohol consumption plays in the deaths of children and young people in New Zealand.²

Background

The minimum legal age for purchasing alcohol in New Zealand is currently 18 years³ but there is no legal drinking age in this country. Therefore, although it is illegal for people under the age of 18 years to buy alcohol, minors are allowed to be supplied with alcohol in certain circumstances (Ministry of Health 2009: 152).

Existing data suggests that a lot of young people in New Zealand are consuming alcohol. Results from the *2007/08 New Zealand Alcohol and Drug Use Survey (NZADUS)* demonstrated that eight out of 10 people aged 16–17 years had consumed alcohol in the past year (Ministry of Health 2009: 152). Among people aged 16–17 years, there was no difference between males (79.8%, 68.1–91.4) and females (79.4%, 69.9–89.0) in regards to who had consumed alcohol in the past year, but males were significantly more likely to have consumed alcohol three to six times a week (14.3%, 5.8–27.8) than females (2.9%, 0.5–9.0) (p -value < 0.05) (Ministry of Health 2009: 152 and 154).

Similarly, a large national survey of New Zealand secondary school students in 2007 found the 'amount of alcohol drunk by many students [to be] substantial with about one-third (34%) of students reporting that they had engaged in binge drinking (5 or more drinks within 4 hours) in the last 4 weeks'. The same survey found that 'almost one-third (30%) drink weekly or more often' (Adolescent Health Research Group 2008: 26).

Analysis of Data from the CYMRC Data Collection

Data and sources

Data for this special report was collected from the Child and Youth Mortality Review Committee (CYMRC) database, with additional information from Coronial Services in a small number of cases.

The CYMRC database contains a range of information on each child or young person who

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- 1 The *New Zealand Alcohol and Drug Use Survey (NZADUS)* provides data on the use of alcohol and drugs by the New Zealand population aged 16–64 years.
 - 2 The CYMRC wished to contribute to the 2009 Review of the Sale of Liquor Act being led by the New Zealand Law Commission so the preliminary analysis undertaken for this special report was included in a submission to the Commission's consultation paper 'Alcohol in Our Lives.' The CYMRC wishes to thank Natasha McMillan Consultancy for preparing that submission, parts of which are included in this special report.
 - 3 This minimum legal purchasing age was lowered from 20 in 1999. The Alcohol Reform Bill, which is currently before Parliament, proposes raising the age from 18.

died in New Zealand since 2002. The depth and range of information contained varies on a case by case basis. By 2005 the CYMRC database was fully established, thus allowing the CYMRC to collect more comprehensive information on each death. As such, information about alcohol use by the child or young person who died and their caregivers is more readily available from this time.

Information from Coronial Services is included in the CYMRC database and, because a coronial report of a death occurs following any court proceedings and involves assimilation of a number of sources of information (including pathology and Police reports), there is often a considerable time lag between the death and the publishing of the coronial report. Therefore, this report focuses on deaths occurring before 2008 to allow time for the coronial process to be complete. Requests were made to view Coronial Services files for a small number of cases where coronial reports were still not housed in the CYMRC database.

The combination of the reasons outlined above influenced the focus of this report on deaths in the years 2005, 2006 and 2007, as this time period was considered likely to have the most complete data.

The total number of cases investigated is small (n=357) so this report cites data from the *2007/08 New Zealand Alcohol and Drug Use Survey (NZADUS)* to provide more information on occasions when the CYMRC numbers are too small to allow for significant conclusions.

Subset of deaths investigated

This report aims to examine data likely to produce the most comprehensive picture of the role of alcohol consumption in the deaths of children and young people in New Zealand, without including data already addressed in other CYMRC reports.⁴ Therefore, CYMRC chose to focus on:

- motor vehicle deaths during 2007
- deaths other than motor vehicle (specifically drowning, assault, suffocation, poisoning and falls) from 2005 to 2007.

Focus on motor vehicle deaths (2007)

We limited our investigation of alcohol involvement in motor vehicle accidents to 2007 and to those accidents which occurred on New Zealand roads (not in off-road settings such as driveways, farms, or motocross events), because one year would provide a reasonable picture of the factors involved with alcohol consumption and motor vehicle deaths.

Focus on deaths other than motor vehicle deaths (2005–2007)

The analysis of alcohol involvement in deaths other than motor vehicle deaths focused on the categories:

- drowning
- assault
- suffocation
- poisoning
- falls.

4 See, for example, the CYMRC's *Fifth Report to the Minister of Health* (2009) which covers a number of different types of deaths including suicide.

A decision was made to exclude other types of deaths because, while alcohol causes or contributes to deaths of every type, the relationships are complex and data collection is often incomplete, especially in relation to alcohol involvement. As an example, blood alcohol estimations are not routinely done in cases where the victim is not driving a vehicle. At times the presence of a causal relationship between alcohol and death can be very difficult to ascertain, as in cases of suicide. Furthermore, while alcohol may play a role in many different categories of death, sometimes it is not possible to determine consistent themes due to small numbers of cases. Therefore, the following types of deaths were excluded from the analysis of alcohol involvement in deaths other than motor vehicle deaths:

- deaths primarily caused by medical reasons (719 deaths)
- suicides (343 deaths)
- sudden unexpected death of an infant (200 deaths; because data on a caregiver's drinking and blood alcohol levels is not systematically captured)
- categories with very small numbers of deaths and cases where we did not have complete data (129 deaths).⁵

Definition of death with alcohol involvement

To identify the extent to which alcohol consumption was involved at the time of death, all information contained in the CYMRC database for the above subsets of cases was reviewed to consider whether:

- the child or young person was affected by alcohol at the time of death and, if so, to what extent
- another person, who was responsible for the death of the child or young person, was affected by alcohol at the time of death and, if so, to what extent
- there were patterns in alcohol consumption related to the deaths of children and young people in New Zealand.

We sought to identify whether conclusive information on alcohol involvement was available for each case. For some cases, blood alcohol concentration (BAC) and evidential breath test data was available in toxicology or post-mortem documentation. If such data was not available, we reviewed the descriptive details looking for any evidence of alcohol involvement that may have been overlooked.

After examining the available data, the cases were then categorised into six fields:

- death clearly 'attributable' to alcohol
- alcohol as 'contributing' to the death but along with other factors that also contributed
- alcohol 'possibly' as a factor but only in trace amounts
- no alcohol consumption at all (ie 'zero')
- alcohol possibly consumed but 'not a factor' in causing the death
- alcohol involvement 'unknown'.

5 Some categories of death were not included due to the small sample sizes – as in cut/pierce, fire/burn/smoke, and struck by or against (not due to assault). Other cases were excluded because the data was not yet available – as in awaiting coroner.

Once the cases were categorised, 'attributable' and 'contributing' categories were combined into 'alcohol involved' while the others were combined into 'alcohol not involved' or 'insufficient information'.

Intoxication was established according to the legal limits for operating a motor vehicle in New Zealand. If a child or young person had a blood or breath alcohol concentration above the legal limit for their age,⁶ then that person was identified as intoxicated and the death was generally classified as attributed to alcohol.

Alcohol-related deaths for all causes of death investigated in this research

The proportion of deaths that had alcohol involvement varied by cause of death (chi-square=11.36, df=5, p=0.045). Alcohol involvement was highest in motor vehicle, assault and fall categories (Table 1).

Table 1 Alcohol relatedness, by nature of death, for deaths of children and young people investigated in this research who died during the years 2005 to 2007 in New Zealand, aged between 4 weeks and 24 years and 364 days (n=357)

Nature of death	Overall number	Number with alcohol involved	Percentage with alcohol involved, by nature of death
Motor vehicle (2007 only)	158	49	31.0%
Drowning (2005–2007)	70	11	15.7%
Assaults (2005–2007)	54	16	29.6%
Poisoning (2005–2007)	34	7	20.6%
Suffocation (2005–2007)	31	3	9.7%
Fall (2005–2007)	20	6	30.0%
Less assaults falling under causes above*	(-10)	(-5)	-
TOTAL	357	87	24.4%

Note: Alcohol involved means that the death was completely attributable to alcohol or alcohol clearly contributed to the death. Once again, it is important to note that this analysis excludes those cases where: (1) the relationship between alcohol and death would be difficult to ascertain, (2) categories of death where the numbers are too small for analysis or (3) data is not yet complete.

* Ten of the assaults also fell into one of the cause categories investigated (ie, the assault was through drowning, submersion, suffocation or through use of a motor vehicle in 2007). The remaining 44 assaults were caused by a child or young person being struck by or against something or somebody, being cut or pierced, in a fire, or via the use of a motor vehicle (in 2005 and 2006) or other causes (such as an intentional fire or use of firearm).

Of the deaths investigated in this research, motor vehicle deaths account for 80.3 percent of all alcohol related deaths occurring each year (Table 2).

6 At the time of these deaths, the breath alcohol limit (measured in terms of micrograms of alcohol per litre of breath) was 150 for those aged under 20 years and 400 for those aged over 20 years. Meanwhile, the blood alcohol concentration or BAC (measured in terms of milligrams of alcohol per 100 ml of blood) was 30 for those aged under 20 years and 80 for those aged over 20 years (New Zealand Transport Agency 2009).

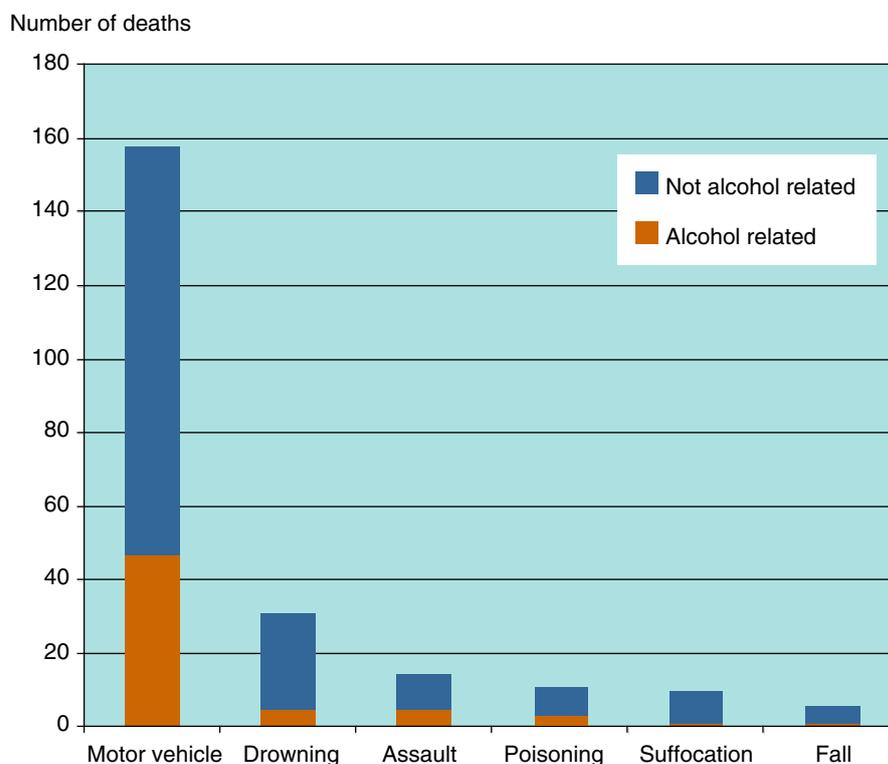
Table 2 Yearly average of alcohol relatedness, by nature of death, for all children and young people investigated in this research who died during the years 2005 to 2007 in New Zealand, aged between 4 weeks and 24 years and 364 days

Nature of death	Average yearly number of deaths	Average yearly number of deaths with alcohol involvement	Percentage of alcohol related deaths investigated in this research
Motor vehicle	158	49	80.3%
Drowning	23	4	6.0%
Assaults	18	5	8.7%
Poisoning	11	2	3.8%
Suffocation	10	1	1.6%
Fall	7	2	3.3%
Less assaults falling under causes above*	(-3)	(-2)	
TOTAL	224	61	

Note: Alcohol involved means that the death was completely attributable to alcohol or alcohol clearly contributed to the death. Once again, it is important to note that this analysis excludes those cases where: (1) the relationship between alcohol and death would be difficult to ascertain, (2) categories of death where the numbers are too small for analysis or (3) data is not yet complete.

* On average, three assaults per year also fall into one of the cause categories investigated (ie, the assault was through drowning, submersion, suffocation or through use of a motor vehicle). The remaining assaults were caused by a child or young person being struck by or against something or somebody, being cut or pierced, in a fire, or other causes (such as an intentional fire or use of firearm).

Figure 1 Alcohol relatedness, by nature of death, for all children and young people investigated in this research who died in New Zealand during 2007, aged between 4 weeks and 24 years and 364 days (n=229)



Alcohol-related deaths by motor vehicle (2007)

In 2007, alcohol-related deaths due to motor vehicles were larger than alcohol-related deaths due to drowning, assault, poisoning, suffocation or falls (Figure 1).

Overall, 158 children and young people died as a result of a motor vehicle injury in 2007 in New Zealand (Figure 1). In 49 (31%) of these deaths, alcohol was involved with the death. Two of the 49 were under 15 years of age, while 47 of the young people were older than 15 years of age, and:

- 16 died as drivers (3 aged 15–19 years, 13 aged 20–24 years)
- 17 died as passengers (13 aged 15–19 years, 4 aged 20–24 years)
- 14 died as pedestrians (7 aged 15–19 years, 7 aged 20–24 years).

There was information on levels of intoxication for 29 (59%) of the 49 young people. In 27 of the 29 cases, the young person who died was intoxicated regardless of whether the deceased was a driver, passenger, or pedestrian.

This information suggests that young people are placing themselves (and others) at risk by:

- driving while intoxicated
- getting into cars with an intoxicated driver
- putting themselves in at-risk situations as an intoxicated pedestrian or passenger.

This risk-taking behaviour in young people begins at ages where they are legally able to drive but not legally able to purchase alcohol, with the *2007/08 NZADUS* report confirming that approximately 10 percent of young people aged 16–17 years report to have driven while feeling under the influence of alcohol in the past 12 months (Ministry of Health 2009: 159).

Alcohol-related deaths by causes other than motor vehicle (2005-2007)

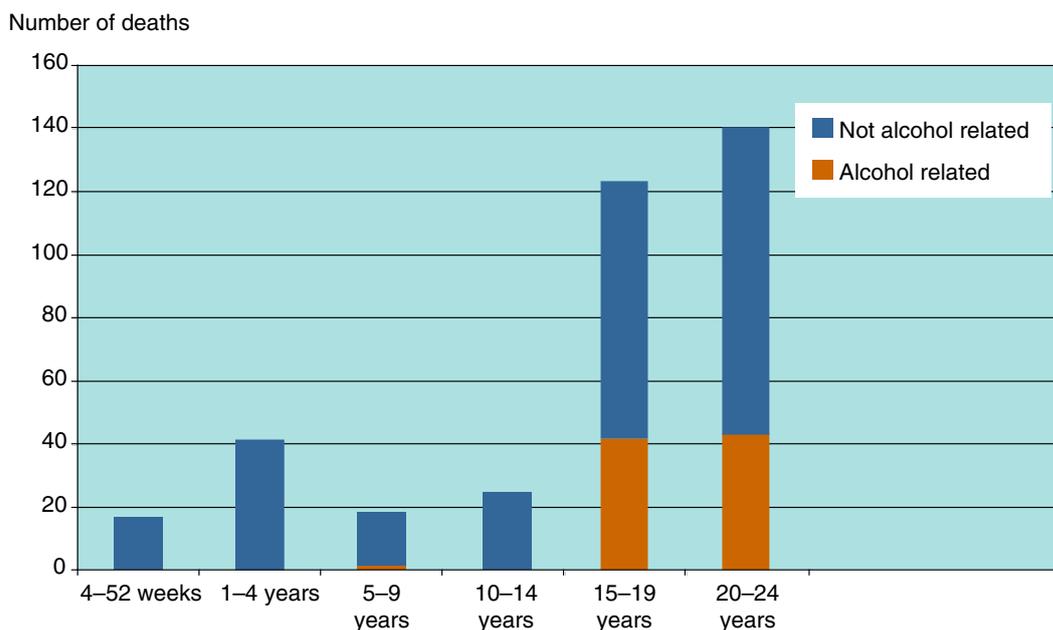
199 children and young people died as a result of a drowning, assault, poisoning, suffocation or fall between 2005 and 2007 in New Zealand. In 38 (19.1%) of these deaths alcohol was involved with the death. Alcohol was more likely to be involved in deaths due to assault and falls than due to suffocation, drowning or poisoning (chi-square=7.06, df=4, p=0.133).

Involvement of alcohol consumption in all deaths by age, gender and ethnicity

In order to assess for trends in death by age, gender and ethnicity for alcohol-related deaths in children and young people in New Zealand, we looked at all deaths (motor vehicle and non motor vehicle) investigated in this research. There were 87 (24.4%) alcohol-related deaths in 357 children and young people investigated in this research (Table 1).

Only 2 (2.2%) of the 92 deaths investigated in those aged under 15 years were related to alcohol, while 85 (32.1%) of the 265 deaths investigated in those aged between 15 and 24 years were related to alcohol (Figure 2).

Figure 2 Profile of all child and youth deaths, by age group and alcohol-relatedness, for all deaths investigated in this research, in New Zealand, aged between 4 weeks and 24 years and 364 days, from 2005 to 2007 (n=357)



Males were over-represented in all of the deaths; 250 of the 357 (70%) deaths investigated were of males. Overall, 67 of the 87 (77%) alcohol-related deaths identified occurred in males. However, rates of alcohol-related deaths for males were only slightly higher than the rates of alcohol-related deaths for females; 67 of the 250 (26.8%) deaths in males were related to alcohol, while 20 of the 107 (18.7%) deaths in females were related to alcohol.

The *2007/08 NZADUS* found no significant differences in the prevalence of drinking alcohol in the past 12 months between Māori (85.5%, 83.7–87.4) and non-Māori (85.2%, 83.8–86.6) when adjusted for age. But Māori men were significantly more likely to have consumed alcohol in the past year than Māori women (p-value < 0.05) (Ministry of Health 2009: 163). The *2007/08 NZADUS* also found that Māori (aged between 16 and 64) were significantly more likely than non-Māori to have been assaulted in the past year by someone under the influence of alcohol or drugs (p-values < 0.05). Māori women were almost four times more likely than non-Māori women to have been assaulted in the past year by someone under the influence of alcohol or drugs, adjusted for age (Ministry of Health 2009: 190).

On the other hand, the *2007/08 NZADUS* suggests that Pacific peoples were significantly less likely to have consumed alcohol in the past year (61.2%, 57.1–65.2) than non-Pacific peoples (87%, 85.7–88.3), but Pacific men were still significantly more likely to have consumed alcohol in the past year (71.8%, 66.1–77.5) than Pacific women (51.4%, 45.3–57.5), adjusting for age (Ministry of Health 2009: 191). There were no differences between Pacific peoples and non-Pacific peoples in the likelihood of being assaulted in the past year by someone under the influence of alcohol or drugs but, for both Pacific and non-Pacific peoples, men were more likely than women to have been assaulted in the past year by someone under the influence of alcohol or drugs, adjusted for age (Ministry of Health 2009: 219).

The *2007/08 NZADUS* also found that European/Other and Māori men and women were significantly more likely to have started drinking when aged 14 years or younger compared with men and women in the total population, adjusted for age, but Pacific and Asian men and women were significantly less likely to have first consumed alcohol when they were 14 years or younger (Ministry of Health 2009: 26).

Person who consumed the alcohol

In order to assess whose alcohol use was responsible for the death of the children and young people who died in these alcohol-related deaths, we looked at all 87 alcohol-related deaths identified in this research.

In 55 (63.2%) of the 87 alcohol-related deaths identified, the young person who died had consumed the alcohol that was responsible for the death. In 28 (32.2%) of the cases it was another person who had consumed alcohol that was responsible for the death, and in four (4.6%) of the cases it was both the young person who died and another person who had consumed the alcohol that was responsible for the death (Table 4). Males were more likely to die of their own alcohol usage ($p=0.04$). Meanwhile, while many females died because of their own alcohol usage, over half of the females who died did so due to someone else's alcohol usage (Table 4).

Table 4 Person who consumed the alcohol that was responsible for the death by gender, for all deaths investigated in this research, from 2005 to 2007 in New Zealand (n=87)

Person who consumed the alcohol that was responsible for the death	Total number (n=87)	Females (n=20)	Males (n=67)
The young person	55 63.2%	8 40.0%	47 70.1%
Another person	28 32.2%	11 55.0%	17 25.4%
Both	4 4.6%	1 5.0%	3 4.5%

In the two cases of death related to alcohol in children under 15 years of age identified in this research, the child died due to someone else's alcohol consumption. Meanwhile, in the 85 deaths of children and young people aged 15 years and older, those aged 20–24 years old were more likely to die because of their own alcohol usage, compared with those aged 15–19 years ($p=0.001$) (Table 5).

Table 5 Person who consumed the alcohol that was responsible for the deaths in age groups 15–19 and 20–24 years, for deaths investigated in this research, from 2005–2007 in New Zealand (n=85)⁷

Person who consumed the alcohol that was responsible for the death	Total number (n=85)	15–19 years (n=42)	20–24 years (n=43)
The young person	55 64.7%	19 45.2%	36 83.7%
Another person	26 30.6%	20 47.6%	6 14.0%
Both	4 4.7%	3 7.1%	1 2.3%

Main themes emerging from the CYMRC local review process

The CYMRC maintains 20 local mortality review groups throughout New Zealand that collect additional data on child and youth deaths. Such information is not gathered systematically and very small numbers are involved, so caution is required in interpreting this data. Given these limitations, we have identified the following themes regarding the sources of alcohol and the

7 The sample size is now 85 because we have excluded all cases below 15 years of age.

social, behavioural and environmental contexts of consumption from the details available for our cases.

Sources of alcohol and context of consumption

Alcohol consumption occurred in a variety of settings: at domestic addresses, at parties or in public places. While these venues were mentioned, there was little mention of how the alcohol had been provided to minors. In the very few instances where the source of alcohol was identified, this was through minors asking an older friend to purchase alcohol on their behalf or minors receiving alcohol from a parent or caregiver. When alcohol was purchased by drinkers who met the minimum purchase age, it came from a variety of sources, both off-premise and on.

Several incidents involving assault (and in some cases involving motor vehicle accidents) occurred when party-goers, who had been based at a domestic address or at a licensed premise, congregated outside and then spilled onto an adjacent setting (such as a street or car park) sometimes continuing to drink even when noticeably affected by alcohol.

Only young men were mentioned in relation to the consumption of alcohol in urban public settings, such as streets, parks, reserves and sports areas. In some instances, alcohol had been consumed at coastal or river settings or around other bodies of water. There were instances of young men and young women apparently losing their footing or accidentally falling while affected by alcohol. However, young men accounted for all the instances where a young person had engaged in risk-taking behaviour (for example, swimming or diving or jumping from a height into water) while affected by alcohol. In some cases they were doing something they had done many times before but alcohol impairment had tragic consequences.

In several instances where young people consumed alcohol and became so intoxicated (solely with alcohol or in combination with other substances)⁸ that a friend or relation had put them to bed, they subsequently died through aspiration of vomit.

In other instances, alcohol appeared to have been consumed in circumstances where a young person died in their efforts to return home, either through driving or as a passenger in a motor vehicle that crashed, or through being hit by a motor vehicle as they returned home on foot.

Aside from a few instances, most alcohol consumption occurred from late afternoon onwards, and many of the instances that resulted in death occurred in the late hours of the evening or the very early hours of the morning, generally at the end of the week or over the weekend.

These findings from the CYMRC local review process match those of the *2007/08 NZADUS*. According to the report, the majority of past-year drinkers aged 16–17 years had consumed alcohol at someone else's home (79.1%, 72.4–85.9) or their own home (74.3%, 66.6–82.0). The *2007/08 NZADUS* did not find any significant differences in the location of drinking alcohol by gender among past-year drinkers aged 16–17 years (Ministry of Health 2009: 156).

8 This report does not assess the involvement of other drugs. One recent report analysed blood samples taken from 1046 drivers of all ages who died in motor vehicle crashes in New Zealand between 2004 and 2009 to look for the presence of drugs and alcohol (Poulsen 2010). This study found 48 percent of the deceased drivers had alcohol or other drugs in their blood that may have impaired their ability to drive safely. Of those, 28 percent had combined alcohol and cannabis. Meanwhile, a further 25 percent had a combination of drugs, which sometimes included alcohol. Cannabis was the most widely used drug in combination with alcohol. Poulsen reminds the reader, however, that the presence of drugs and alcohol in the study samples does not necessarily infer significant impairment.

Intoxicated caregivers

The local reviews have identified cases where intoxicated parents or caregivers have caused or contributed to the deaths of infants and children. These deaths generally occurred when the normal alertness of adults had been reduced, leaving the infant or child at increased risk.

For example, in a few instances, deaths occurred due to a parent or caregiver consuming alcohol before or while driving children or young people or otherwise being responsible for them in hazardous circumstances (eg, water, boating activities, or fire). While this chapter has not included cases of sudden unexpected death in infancy (SUDI), there are reports of intoxicated parents suffocating infants while co-sleeping.

Types and amounts of alcohol consumed

The CYMRC local reviews report instances of both young women and young men consuming beer, wine, and spirits. The only mention of 'alco-pop' consumption (ie, pre-mixed, ready-to-drink beverages that include spirits, also known as RTDs) in the CYMRC data was by young women.

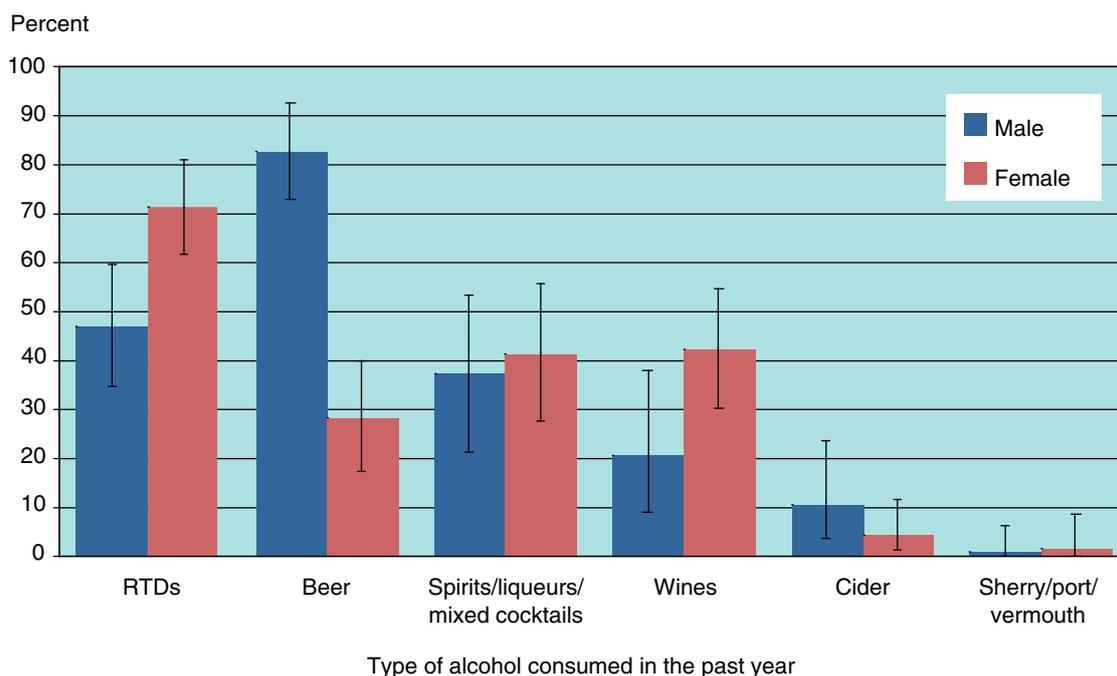
The 2007/08 NZADUS reports that people aged 16–17 years were significantly more likely to have consumed RTDs in the past year compared with all past-year drinkers aged 18–64 years. In fact, as Table 6 illustrates, 59 percent of past-year drinkers aged 16–17 years had consumed RTDs; 56 percent of past-year drinkers aged 16–17 years had consumed beer but, as Figure 3 shows, males were significantly more likely than females to have consumed beer in the past year while females were significantly more likely to have consumed RTDs.

Table 6 Type of alcohol consumed in last 12 months, among past-year drinkers (unadjusted prevalence)

Type of alcohol	Prevalence (%) for past-year drinkers (95% CI)	
	Aged 16–17 years	Aged 18–64 years
Ready-to-drink beverages (RTDs)	59.0 (51.3–66.7)	20.5 (18.9–22.0)
Beer	56.1 (49.2–62.9)	60.8 (59.4–62.2)
Spirits/liqueurs/mixed cocktails	39.4 (29.6–49.3)	46.9 (45.2–48.5)
Wine	31.5 (21.6–41.4)	63.7 (61.8–65.5)
Cider	7.7 (3.5–14.4)	5.3 (4.4–6.2)
Sherry/port/vermouth	1.3 (0.1–4.7)	7.0 (5.8–8.2)

Source: 2007/08 New Zealand Alcohol and Drug Use Survey, Ministry of Health, 2009, page 155.

Figure 3 Type of alcohol consumed in last 12 months, among past-year drinkers aged 16–17 years, by gender (unadjusted prevalence)



Source: 2007/08 New Zealand Alcohol and Drug Use Survey, Ministry of Health, 2009, page 155.

Issues and Recommendations

Observations by the CYMRC on reduction in alcohol-related harm

From the cases selected for this CYMRC review, more than 30 percent of the children and young people aged over 15 years died of an alcohol-related death, although it is likely that our analysis underestimates the involvement of alcohol, especially in the deaths of those under 15.

For deaths due to someone else's consumption of alcohol, the majority died because they (1) were passengers in a vehicle with an intoxicated driver, (2) found themselves in a position where they did not receive adequate supervision due to an intoxicated parent or caregiver, or (3) were victims of assault by an intoxicated person.

For those who died due to their own consumption of alcohol, some of the key behaviours associated with their deaths included:

- driving while intoxicated
- finding themselves in situations where they were at risk of assault
- walking in dangerous places with poor visibility while intoxicated (such as on or by busy roadways, or in rough or steep terrain)
- jumping, diving or swimming after consuming alcohol
- ingesting other substances in combination with alcohol.

Other behaviours associated with alcohol-related deaths included:

- young people driving in breach of their licence conditions, including carrying passengers and having consumed alcohol and driving outside stipulated hours
- impulsive use of a vehicle, often when upset or angry
- driving too fast for conditions.

Options for intervention

1. Preventing young people from driving while intoxicated

Motor vehicle accidents accounted for the greatest proportion of all deaths and all alcohol-related deaths. Reducing the number of alcohol-related motor vehicle deaths would have the greatest impact on reducing the total number of alcohol-related deaths. A single intoxicated driver can lead to multiple deaths.

The CYMRC believes the act of learning to drive must be completely separated from the act of learning to drink alcohol. It is unreasonable and unsafe to expect young people to develop these two complex skills simultaneously. Babor et al concur in their book, *Alcohol: no ordinary commodity*. 'Young drivers (adolescents between 16 and 20 years) are at elevated risk for traffic crashes, especially alcohol-involved crashes, as a result of their limited driving experience and their tendency to experiment with heavy or binge drinking' (2010: 177).

In its *Fifth Annual Report to the Minister of Health* (2009), the CYMRC reviewed key facts relating to transport deaths in young people, the findings of recent surveys of young people, and research which compared fatality in jurisdictions with and without a zero BAC. From this review, the CYMRC concluded that a zero BAC for young people is justified.

Babor et al write 'the evidence for the deterrent impact of establishing or lowering the legal BAC limit is strong' (2010: 170). In fact, United States studies comparing states that passed zero tolerance laws with states that did not pass such laws find a 20 percent relative reduction in fatal crashes among drivers below 21 years of age in the states that passed the zero tolerance laws (177). Studies in Australia and Canada find roughly similar rates. Babor et al caution, however, that 'without consistent and visible enforcement the effects may be attenuated and may diminish over time' (page 170 and 178).⁹

Recommendation 1: CYMRC supports the enforcement of the zero BAC for young and novice drivers.

2. Preventing young drivers from breaching their licence conditions or riding in a car with a driver in breach of their licence conditions

New Zealand has a Graduated Driver Licence System, and Babor et al contend that such graduated licence systems are generally effective. 'Policies to delay youth access to a full licence and other driving restrictions can be effective strategies for reducing drink-driving problems among this population' (Babor et al: 183).

The CYMRC local death reviews revealed, however, a surprisingly high number of motor

9 The recent Land Transport (Road Safety and Other Matters) Amendment Act 2011 established a zero BAC for all drivers under 20 years of age as well as other measures that will raise penalties for dangerous driving behaviours and make it easier for Police to charge drivers in breach of their licensing conditions.

vehicle deaths (alcohol and non-alcohol related) involving a driver in breach of licence conditions. The case reviews suggested that:

- some were not aware of the licensing rules
- some young people regularly breached the conditions
- others, who should be in position of responsibility, may have supported the breach by allowing use of vehicles.

The Land Transport (Enforcement Powers) Amendment Act of 2009 strengthens penalties for drivers who are in breach of licensing conditions. For instance, demerit points for breaches in licensing conditions have increased from 25 to 35, and Police have greater powers to deal with graduated licensing breaches. It will take a few years to see whether this results in any statistically significant reductions in child and youth alcohol-related mortality.

Recommendation 2: CYMRC supports the enforcement of legislation designed to prevent young people from breaching the conditions imposed by their type of driving licence, including: legal alcohol limit, transporting passengers and driving outside curfew hours.

3. Raising the cost, limiting the availability of alcohol, or making it less attractive

Another interesting finding from the reviews appears to be that young people are much more likely to drink ready-to-drink spirits¹⁰ than older people; young females are even more likely to drink them than young males. Babor et al state there has been a growing concern about such drinks in recent years, particularly because there is some evidence that these sweet-tasting drinks might be more attractive to young people (116, citing Copeland et al 2007); their marketing targets young drinkers (116, citing Jackson et al 2000), and the sweet flavour makes it hard to assess how much alcohol is actually being consumed.

Raising the cost of alcohol

It would seem plausible that raising the price of alcohol would make it less available to youth, but there is debate about whether price increases should affect all alcohol or just specific types of alcohol. Some argue that price increases directed towards specific types of drinks could lead to drink substitution (see Babor et al, chapter 8). As Babor et al write, 'the issue of beverage substitution has been a key concern in debates over specific alcopop taxes, with suggestions that consumers will simply switch to mixing their own spirits-based drinks' (117). While there is some evidence that caution must be used when increasing alcohol prices as it could lead to substitution of other types of alcohol and a rise in illegal markets, there are a number of international studies that find alcohol taxes reduce youth alcohol consumption (Babor et al:121) and road traffic fatalities (123).

The Australian government implemented a tax on ready-to-drink spirits in 2008, despite strong opposition from the alcohol industry and other critics. Australian Bureau of Statistics data from 2004 to 2009 for those aged 15 and under confirm 'that the alcopops tax reduced consumption of alcopops' (Hall and Chikritzhs 2011). While 'consumption of spirits did increase, [it was] not by enough to offset the reduction in alcopops drinking' (ibid). Overall there 'was a 2% reduction in alcohol per head' in the 15 and under age group (ibid).

Such findings suggest that mechanisms to raise the cost of alcohol ought to be considered in New Zealand as well. The recently released report from the Office of the Prime Minister's

¹⁰ RTDs, also known as alcopops, premixed spirits, or designer drinks.

Science Advisory Committee concurs. They write, 'There is consistent evidence from around the world that increasing the taxation of alcohol (and thence the price of alcohol) is one of the most effective methods for reducing alcohol consumption and related harms. This approach has been found to be more effective in reducing heavy drinking and is likely to be effective in reducing alcohol consumption amongst younger drinkers' (2011: 239).

Raising the purchasing age and establishing a minimum drinking age

There is a considerable amount of research suggesting that the lowering of the purchasing age from 20 to 18 years in 1999 has had a deleterious effect. Kypri et al (2006) examined incidence rates for young men and women injured in alcohol-involved traffic crashes before and after the reduction in New Zealand's minimum purchasing age. They found that the ratio of the alcohol-involved crash rate relative to 20–24-year-olds was 12 percent larger for 18–19-year-old males and 14 percent larger for 15–17-year-old males after the reduction. Similarly, it was 51 percent larger for 18–19-year-old females and 24 percent larger for 15–17-year-old females after the reduction (128). This suggests that increasing the minimum purchasing age would lead to fewer alcohol-involved crashes as well as an overall reduction in alcohol-related harms.

Meanwhile, Wagenaar has conducted a considerable amount of research on the implementation of minimum drinking ages. The United States is arguably the most well known for having a uniform legal drinking age of 21. In a review of this policy, Wagenaar and Toomey argue that 'increasing the legal age for purchase and consumption of alcohol to 21 appears to have been the most successful effort to date [to reduce youth drinking in the U.S.]. The magnitude of effects of the age-21 policy may appear small ... however, even modest effects applied to the entire population of youth result in very large societal benefits' (2002: 219).

Babor et al contend that minimum drinking age policies have been effective in other countries as well, but caution us to remember that such laws are only useful if enforced.¹¹

Controls on sources of alcohol

The CYMRC case reviews suggest that young people acquire alcohol from a number of sources in New Zealand. They might purchase alcohol at off-premise establishments (ie, stores or markets), on-premise establishments (ie, pubs, bars, etc), or from family and friends. Limiting the availability of alcohol needs to involve all of these actors.

It is important to discourage friends or family members from providing alcohol to young people. There are a number of ways this could be done, ranging from media initiatives, school and health-based programmes, or more serious penalties because the provision of alcohol to minors could be viewed by some as a criminal act.¹²

The CYMRC case reviews indicate that most fatalities occurred late at night or in the very early hours of the morning. This suggests that reduced trading hours late at night could

11 Many European countries are often cited as the counter example – ie, a conglomeration of model communities that have no minimum drinking ages and no related problems. Wagenaar and Toomey argue, however, that 'the idea that Europeans do not have alcohol-related problems is a myth. European youth may be at less risk of traffic crashes because youth drive less frequently in Europe than in the United States. Compared with the United States, Europeans have higher legal driving ages, more expensive automobiles and greater access to public transportation. Looking beyond traffic crashes, however, European countries have similar or higher rates of other alcohol-related problems compared with the United States. For example, in 1990, France and Italy had higher per capita alcohol consumption and higher rates of cirrhosis deaths than did the United States ... Europeans are initiating the debate on the most appropriate age for legal access to alcohol' (2002: 220).

12 The Alcohol Reform Bill currently before Parliament has provisions that would require the explicit or implied consent of parents or guardians before a minor can be supplied with alcohol by another adult.

possibly prevent alcohol-related harm. Examples from abroad suggest that 'increasing the hours and days of sale is typically related to increased consumption and alcohol-related harm (usually acute harm) and studies of reduced hours of sale or bans on days of sale are associated with reduced problems' (Babor et al: 136).

Reduced trading hours for on-licensed premises: a success story

Timaru has experienced a measurable reduction in levels of recorded violence in its central business district (CBD) after implementing reduced trading hours in on-licensed premises.

Timaru has a population of approximately 30,000 people (NZ Police 2009). Its CBD is home to 12 bars, all located within one central city block (ibid). Since 2002, the CBD has been covered by a liquor ban by-law, which prohibits the possession or consumption of alcohol in public places. In January 2007 this liquor ban was extended to cover a wider area (ibid).

In an effort to further reduce its levels of violent crime, Timaru Police focused on the well-established link between alcohol and violent crime (Bye 2007 as cited in NZ Police 2009). While the liquor ban by-law prohibited possession or consumption of alcohol in public places, the Timaru Police recognised that on-licensed premises (eg, bars or nightclubs) represent another setting for drinking that can lead to violence, especially in the late evening or early morning when premises close and patrons disperse on to the street (NZ Police 2009).

Therefore, in October 2007, the Timaru Police and local government liquor licensing inspectors successfully advocated to change the closing times of all bars in Timaru's CBD. Where there had been a range of closing hours before (with at least 4 bars open until 5:00am and 1 with a 24-hour licence), a standard closing time of 3:00 am was implemented in October 2007 (ibid).

'The impact from the change in licensing hours was assessed using a variety of crime and incident statistics collected by Police ... The level of recorded violence in the CBD reduced considerably after bar closing times were adjusted to 3:00 am. The most profound reduction appeared to occur at weekends between 3:00 am and 6:00 am; with the level of recorded violence dropping by two-thirds in the vicinity of the five bars [that had originally been open until 5:00 am or later] ... Importantly, the evidence suggests violent crime was not simply displaced to an earlier time, or elsewhere within Timaru; rather, the total number of violent incidents reported by Police reduced by 8% (dropping from 402 incidents to 369 incidents) in the 12 months immediately following the trading hour change' (ibid).

In sum, 'despite problems associated with interpreting the data statistically [because the numbers are very small], there has been a noticeable drop in violent offending. Timaru Police also feel strongly that the change made from 5:00 am to 3:00 am bar closing times has made a real difference in helping reduce alcohol-related problems in the CBD. It follows that, although Timaru's population size, overall pattern of offending, and compact CBD mean that what works in Timaru might not be automatically applicable elsewhere, Timaru's results offer a promising case-example of the impact of adjusting liquor licence conditions to require later-trading bars to close earlier' (ibid).

There have also been a number of studies that cite the success of responsible beverage service (RBS) training programmes. Babor et al suggest that the proven benefits of such RBS programmes include:

- retailers better understanding why it is important to prevent alcohol intoxication, particularly in youth
- retailers better understanding the laws and regulations related to serving alcohol and their own legal liability
- retailers having improved skills to recognise intoxication and deal with intoxicated patrons (150).

New Zealand Red Cross save-a-mate (SAM) programme

Save-a-mate is a programme designed to teach (1) alcohol and other drug knowledge and (2) first aid in relation to alcohol and other drug emergencies. While it is primarily directed towards young people as a peer education programme, it is also proving a useful RBS programme, particularly when young people are working as servers in bars and restaurants.

According to the NZ Red Cross website, 'it is designed to teach people how to respond to any adverse alcohol and other drugs incidents that they experience.'

The save-a-mate (SAM) programme is a four-hour workshop involving presentations, activities and group work. The first part of the workshop looks at how alcohol and other drugs affect the body. The second part of the workshop looks at harm minimisation when using alcohol and other drugs, and teaches how to provide first aid when things go wrong. It is delivered through existing organisations (such as community groups, youth groups, residential facilities or treatment and support programmes).

The purpose of SAM is to strengthen the health and wellbeing of young people by providing education on current and emerging health issues related to alcohol and other drug use. It develops the capacity of young people to provide support to peers on issues to do with alcohol and other drugs by building resilience, increasing support networks and preventing uptake of harmful behaviour.

New Zealand Red Cross started SAM in direct response to a clear need in New Zealand for simple, relevant and believable information about the use of alcohol and other drugs and safety for youth. For more information, go to: www.redcross.org.nz

Making alcohol less attractive

There is evidence to suggest that advertising campaigns to sell alcohol – particularly those targeted towards young people – increase alcohol use. Therefore, discussions must continue about how to prevent alcohol distributors and retailers from targeting young people in their advertisement campaigns (see Babor et al, chapter 12). One particular concern is advertising campaigns that promote an association between role models, sport and alcohol. Legislation and voluntary codes of conduct exist, but would benefit from tougher enforcement to reduce such associations.¹³

13 The Advertising Standards Authority does have a voluntary code but enforcement mechanisms are weak. The proposed Alcohol Reform Bill seeks to broaden the category of those who can be charged for the irresponsible promotion of alcohol and raise the related penalties.

Recommendation 3: Limit the availability of alcohol and make alcohol less attractive. Consider mechanisms such as:

- raising the price of alcohol
- raising the purchasing age
- initiating debate on minimum drinking ages
- limiting trading hours
- requiring responsible beverage service (RBS) training programmes
- preventing advertising of alcohol
- eliminating the links between role models, sport and alcohol.

4. Preventing a pattern of escalating alcohol-related harm

Local review groups noted that, at times, death from alcohol-related harm followed a pattern of repeated alcohol-related injury. Potential exists to support young people with better services in order to block such progressions towards worsening harm and death. When a child or young person presents to any medical professional with an alcohol-related injury, that professional should conduct a risk assessment and a brief intervention. The risk assessment should include screening for risky behaviours, especially in conjunction with alcohol use. When escalating alcohol-related harm is identified, services should work together to provide co-ordinated collaborative care and support.

These issues were explored in Chapter 3 'The Risk Taking Years – Unintentional Injury in Young People' and in Chapter 5 'Systems Improvement' within the CYMRC's *Fifth report to the Minister of Health* (2009). In that report, the CYMRC identified the lack of appropriate services available to young people, particularly those at risk of harm. In many cases risks were clustering in or around the individual prior to death but no system recognised the issues. Systems to assess risk and intervene need improvement.

Evidence suggests that brief interventions are a simple and effective way to support alcohol-positive adolescents (Babor et al: 214). Brief interventions are generally targeted to non-dependent, yet high-risk, drinkers. They are 'characterised by their low intensity and short duration, consisting of one to three sessions of counselling and education', with the aim of encouraging 'high-risk drinkers to moderate their alcohol consumption rather than promote total abstinence' (219). International evidence suggests they are very successful.

Brief interventions (also known as brief counselling and motivational interviews)

In the *Good Practice Guide to Prevention of Injuries among Young People*, AdRisk reviews a number of programmes designed to reduce injury among young people and concludes 'interventions among problem drinkers [are] effective in reducing injuries and events leading to injury (such as falls, motor vehicle crashes, and suicide attempts). Most commonly, the intervention [is] brief counselling in a clinical setting' (2008: 14). Similarly, a study by Monti et al (1999) compared alcohol-positive older adolescents who received a motivational interview (MI) during a visit to the emergency department with those who had standard care (ie, no MI) in the emergency department and found that those who had the MI were significantly less likely to report having driven after drinking, experienced alcohol-related injuries, or have received a moving violation six months after the MI (992).

According to Babor and Higgins-Biddle, such brief interventions are 'those practices that aim to identify a real or potential alcohol problem and motivate an individual to do something about it' (2001: 6).

As the study by Monti et al demonstrates, primary care is well-suited to providing brief interventions. First, brief interventions can help to identify those who are at risk of alcohol dependence so they can be referred to the appropriate specialised services. Second – and possibly most important for child and youth alcohol-related harms – brief interventions can 'identify and help hazardous and harmful drinkers who may or may not develop an alcohol dependence syndrome, but whose risk of serious alcohol-related harm can be reduced' (9).

There are numerous international, randomised clinical trials of brief interventions in a variety of health care settings showing that brief interventions are successful in reducing risk of death and injury from alcohol related harm. (See Babor and Higgins-Biddle 2001 and Dinh-Zarr et al 2009.)

Babor and Higgins-Biddle's *Brief Intervention for Hazardous and Harmful Drinking: Manual for Use in Primary Care* provides more information on how to conduct brief interventions in the primary care setting.

Recommendation 4a: Health professionals should provide opportune psychosocial screening (as in the HEADSS assessment) to all young people seen in health services.

Recommendation 4b: Health professionals should use brief interventions for non-dependent, yet high-risk adolescents.

5. Reducing environmental risks for alcohol-impaired people

A number of young people died while undertaking dangerous actions in hazardous environments. CYMRC notes two strategies to address these deaths: supervision (which is addressed in the section on host responsibility) and reducing exposure to environmental risk for alcohol-impaired people. Some of the CYMRC cases that occurred in risky environments included slipping or falling in rugged or coastal terrain especially near water, jumping or diving into water and walking on or near roads and railways.

Initiatives already exist which highlight the dangers of combining water and alcohol.¹⁴

¹⁴ See for example the very clear message on the Water Safety New Zealand website: 'Alcohol + Hot Weather + Cold Water = Death by Drowning'. <http://www.watersafety.org.nz/alcohol/>.

CYMRC fully supports initiatives like this one that have an emphasis on alcohol and risky behaviour in a potentially dangerous setting.

More extreme policies might consider actually banning drinking in certain public places. 'More than half of local governments in New Zealand have implemented permanent ongoing liquor bans in public places. There are few studies of the effects of such bans' (Babor et al: 144). Internationally, there is evidence that such bans are effective (ibid), but that is also dependent on the enforcement of such bans.

It is important to encourage young people to develop strategies for safety if they know they will be consuming alcohol in potentially hazardous settings. The Alcohol Advisory Council of New Zealand (ALAC) encourages young people to always have a sober mate and think about how everyone will get home after a night of drinking.¹⁵

Recommendation 5a: CYMRC supports the development of initiatives to broaden the public's understanding of risks of combining alcohol and hazardous environments.

Recommendation 5b: Communities ought to consider establishing liquor bans via local legislation in areas that are of high risk.¹⁶

Recommendation 5c: Every child or young person needs a sober caregiver or a sober mate at all times.

6. Increasing host responsibility

In the CYMRC case reviews there was very little mention of supervision or adult oversight of alcohol consumption by young people in either private settings or in licensed premises. Moreover, as our data indicated, there were even instances when an intoxicated parent or caregiver was the cause of the death and unable to prevent the death due to their intoxicated state.

Police in many parts of New Zealand run surveillance (Alcolink) with regard to where the last drink was taken before an offence was committed (often referred to as the Last Drink Survey). Analysis of this information allows policy to target support to alcohol merchants that are associated with higher rates of alcohol-related crime. (Such merchants are also good candidates for the RBS training programmes that are mentioned in Recommendation 3.)

Case reviews indicate that many deaths occurred when the drinker began to consume alcohol at a party or gathering held in a domestic setting, at a licensed premise, or in a park and then spilled out onto a public area such as a park or roadway. Often incidents in these settings occurred very late in the evening or early in the morning, where some people had been drinking for hours.

Many of the cases led reviewers to wonder, 'Where were the responsible adults and sober mates?' There were some instances when carers did not appear to understand the seriousness of the situation. For example, a small number of young people died from alcohol poisoning or suffocation. Several of these young people were put to bed by friends and family and died sometime later in bed. In some instances, the cause of death was the combined effect of prescription and recreational drugs in combination with alcohol.

There are already well-publicised host responsibility messages such as a media release from

15 www.alac.org.nz/GettingHome.aspx

16 The proposed Alcohol Reform Bill proposes amendments to the Local Government Act 2002 that would affect the development of liquor bans.

ALAC during Christmas 2009, which states:

*If you are the host, there are simple things you can do to help everyone enjoy the festivities without getting drunk and ruining things for everyone. Provide food, have some interesting drinks on offer other than alcohol, set the tone by talking to people in advance about what you expect and make sure there are ways for them to get home safely.*¹⁷

CYMRC believes that host responsibility messages and supporting material could be developed and extended to:

- raise awareness about the potential dangers associated with alcohol consumption, particularly in relation to binge drinking and combination of alcohol with prescription and recreational drugs
- encourage hosts to make sure guests get home safely
- encourage hosts to provide a range of low-alcohol and alcohol-free drinks as well as food when alcohol is provided
- incorporate principles of hazard management and risk minimisation specific to those hosting or holding gatherings
- ensure a greater awareness of the first aid principles that apply in instances of intoxication.¹⁸

Recommendation 6: CYMRC recommends that host responsibility and health promotion messages be extended.

7. Preventing assaults

Alcohol makes a substantial contribution to interpersonal violence. There were several instances where physical fights or other forms of altercations had erupted between intoxicated persons in such settings and resulted in a young person being fatally punched, stabbed, or deliberately assaulted or accidentally hit by a motor vehicle.

CYMRC believes a potential exists to develop stronger links between violence prevention, anger management and alcohol and drug interventions, and for a more widespread understanding of the dangers of fighting while intoxicated. These dangers include the psychological (aggressogenic) effects of alcohol and its association with violence as well as the increased risks of injury (due to a lack of protective responses).¹⁹

Babor et al found that responsible beverage service (RBS) training programmes have been effective in helping retail establishments assess and defuse potentially aggressive situations (152–153). Other points of intervention could be:

- when an altercation-related injury and an alcohol or drug-related admission is presented to primary care or an emergency facility (or possibly the point at which someone is making an ACC claim)
- in settings where patients receive specialist treatment and participate in programmes focused on alcohol treatment, drug treatment, violence intervention, or anger management.

17 ALAC. 2009. Media Release: Let's look after each other around alcohol this Christmas. 9 December 2009. www.alac.org.nz/MediaRelease_20091209.aspx

18 As an example see ALAC's First Aid fact sheet at: www.alac.org.nz/FirstAid.aspx?PostingID=613

19 For an example of a New Zealand study see: McLean R and Connor J. 2009. Alcohol and injury: a survey in primary care settings. *New Zealand Medical Journal*. 122(1303):21-28.

Recommendation 7: Health care professionals and other service providers should conduct opportune risk assessments for alcohol-related violence and seek to intervene where appropriate.

8. Informing young people, families and community about the risks of death as a consequence of others drinking alcohol

CYMRC noted the number of young women and young men under 19 years who died as a result of someone else's alcohol consumption. This is a finding that has not been discussed much to date and CYMRC believes it is an important concept for parents, family, and whānau to consider as they support their young people and try to keep them safe.

Recommendation 8: Education about the hazards of alcohol in the community should highlight the trends toward younger teenagers and females dying as a result of other people's alcohol use rather than their own.

9. Data collection

Police only have a mandate to check for alcohol-related impairment in drivers in respect to on-road events. CYMRC noted a paucity of alcohol data for many of the cases reviewed and in other categories of death including sudden unexpected infant death, off-road vehicle deaths and fires.

Recommendation 9: Police should be mandated to test for alcohol-related impairment whenever a child or young person suffers a serious injury or fatality, regardless of location.

Formal CYMRC recommendations

Legislation

1. CYMRC supports the enforcement of the zero BAC for young and novice drivers.
2. CYMRC supports the enforcement of legislation designed to prevent young people from breaching the conditions imposed by their type of driving licence, including: legal alcohol limit, transporting passengers, and driving outside curfew hours.
3. Limit the availability of alcohol and make alcohol less attractive. Consider mechanisms such as:
 - raising the price of alcohol
 - raising the purchasing age
 - initiating debate on minimum drinking ages
 - limiting trading hours
 - requiring responsible beverage service (RBS) training programmes
 - preventing advertising of alcohol
 - eliminating the links between role models, sport and alcohol.
4. Communities ought to consider establishing liquor bans via local legislation in areas that are of high risk.

5. Police should be mandated to test for alcohol-related impairment whenever a child or young person suffers a serious injury or fatality, regardless of location.

Good practice

6. Health professionals should provide opportune psychosocial screening (as in the HEADSS assessment) to all young people seen in health services.
7. Health professionals should use brief interventions for non-dependent, yet high-risk adolescents.
8. Health professionals and other service providers should conduct opportune risk assessments for alcohol-related violence and seek to intervene where appropriate.

Key messages

9. CYMRC supports the development of initiatives to broaden the public's understanding of risks of combining alcohol and hazardous environments.
10. Every child or young person needs a sober caregiver or a sober mate at all times.
11. CYMRC recommends that host responsibility and health promotion messages be extended.
12. Education about the hazards of alcohol in the community should highlight the trends toward younger teenagers and females dying as a result of other people's alcohol use rather than their own.

References

- Adolescent Health Research Group. 2008. *Youth'07: The health and wellbeing of secondary school students in New Zealand: Initial findings*. Auckland: The University of Auckland.
- AdRisk. 2008. *Good Practices Guide to Prevention of Injury among Young People*. Helsinki: National Public Health Institute.
- Babor T, Caetano R, Casswell S, Edwards G, Giesbrecht N, Graham K, Grube J, Hill L, Holder H, Homel R, Livingston M, Osterberg E, Rehm J, Room R, and Rossow I. 2010. *Alcohol: no ordinary commodity – research and public policy*. 2nd Edition. New York: Oxford University Press.
- Babor T and Higgins-Biddle JC. 2001. *Brief Intervention for Hazardous and Harmful Drinking: Manual for Use in Primary Care*. Geneva: World Health Organization's Department of Mental Health and Substance Dependence.
- Blair PS, Sidebotham P, Evason-Coombe C, Edmonds M, Heckstall-Smith EMA, and Fleming P. 2010. Hazardous cosleeping environments and risk factors amenable to change: case-control study of SIDS in south west England. *The British Medical Journal*. 399: b3666.
- Child and Youth Mortality Review Committee. 2009. *Fifth Report to the Minister of Health: Reporting Mortality 2002-2008*. Wellington: Child and Youth Mortality Review Committee.
- Dinh-Zarr TB, Goss CW, Heitman E, Roberts IG, and DiGuseppi C. 2009. Interventions for preventing injuries in problem drinkers (Review). The Cochrane Collaboration.
- Hall W and Chikritzhs T. 2 April 2011. The Australian alcopops tax revisited. *The Lancet*. 377: 1136-1137.
- Kypri K, Voas RB, Langley JD, Stephenson SCR, Begg DJ, Tippetts AS, and Davie GS. 2006. Minimum purchasing age for alcohol and traffic crash injuries among 15- to 19-year-olds in New Zealand. *American Journal of Public Health*. 96(1): 126-131.
- Ministry of Health. 2009. *Alcohol Use in New Zealand: Key results of the 2007/08 New Zealand Alcohol and Drug Use Survey*. Wellington: Ministry of Health.
- Ministry of Health. 2008. *New Zealand Suicide Prevention Action Plan 2008–2012: The Evidence for Action*. Wellington: Ministry of Health.
- Monti PM, Colby SM, Barnett NP, Spirito A, Rohsenow DJ, Myers M, Woolard R and Lewander W. 1999. Brief intervention for harm reduction with alcohol-positive older adolescents in a hospital emergency department. *Journal of Consulting and Clinical Psychology*. 67(6): 989-994.
- New Zealand Transport Agency. 2009. *The Official New Zealand Road Code: About Limits*. Wellington: New Zealand Transport Agency.
- NZ Police. 2009. *Policing Fact Sheet: Licensed premises trading hours*.
- Office of the Prime Minister's Science Advisory Committee. 2011. *Improving the Transition: Reducing Social and Psychological Morbidity During Adolescence: A report from the Prime Minister's Chief Science Advisor*. Wellington.
- Poulsen H. 2010. *Alcohol and other drug use in New Zealand drivers 2004 to 2009*. Wellington: New Zealand Police.

Wagenaar AC and Toomey TL. 2002. Effects of minimum drinking age laws: review and analyses of literature from 1960 to 2000. *Journal of Studies on Alcohol*. 63, S206-25.