



ALCOHOL USE AND HARMS IN HALDIMAND AND NORFOLK COUNTIES

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Purpose of the Report

The aim is to use this report as a basis for discussing alcohol use and alcohol-related harms in Haldimand and Norfolk counties. The goal is to highlight that these harms are not just personal issues for those who drink, but rather an issue that affects the entire community.

This report blends local data on alcohol consumption and alcohol-related harms, with personal stories from the 2016 online “Alcohol Use in our Community” survey interspersed throughout the report, in order to provide a picture of how alcohol affects our community. When local data are not available, findings from research studies and provincial or national data are used to fill in the gaps. Additionally, the Haldimand-Norfolk Health Unit (HNHU) consulted with key community stakeholders to gather local perspectives about the impact of alcohol and to brainstorm opportunities for collaborative action to address this issue. The summary of the meeting can be found in Appendix A.

“We now know too much. It is now unethical for us not to act.”
Dr. Robert Strang, Provincial Medical Officer of Health, Province of Nova Scotia

Introduction

Alcohol is a socially accepted part of everyday life for most Canadians and is the most widely consumed psychoactive drug in Canada. In 2013, almost 80% of Canadians, an estimated 22 million people, reported drinking alcohol in the previous year.¹ Many Canadians associate drinking with pleasurable social events such as music festivals, watching sports, parties, and vacations. Celebrations and milestones like weddings, anniversaries, and awards are often “toasted” with alcohol. Although alcohol is widely consumed, it is not harmless.

Alcohol consumption has been identified as a component cause for more than 200 diseases, injuries and other health conditions, and the second leading risk factor for death, disease and disability with only tobacco causing more harm in high-income nations like Canada.^{2,3,4,5,6} This places the burden from alcohol higher than that from other health risks, such as overweight and obesity, physical inactivity, illicit drug use, unhealthy diet and others.^{2,4}

Our understanding of the dose-dependent health effects of alcohol continues to evolve.⁷ Average long-term consumption levels as low as one or two drinks per day have been causally linked with significant increases in the risk of at least eight types of cancer and numerous other serious medical conditions.⁸ Harms from drinking alcohol go beyond interpersonal or health-related harms for individuals. Harmful use of alcohol may also impose significant social and economic costs on society.⁶

This report aims to clarify why it is important for us to talk about alcohol and why it matters as well as to provide strategies and interventions known to be effective in addressing alcohol-related harms. This will provide direction for community and stakeholders to work collectively toward a coordinated approach to improve and preserve the health and wellbeing of Haldimand and Norfolk residents.



“Offering a drink to a guest is considered appropriate social behaviour. In the past I have declined alcohol at a family social function and was told to “Loosen up!” I did not appreciate being scolded because I turned down a “bevvie”. Alcohol use runs in families and a person might not fit in because he/she said, “No.” to the offer of a drink. If this is what happens in a family situation, what occurs in bars and restaurants? A drink order is usually the first one taken at a licensed establishment and that order arrives at the table promptly. We live in an alcohol culture.” – Community member (Alcohol Use in our Community survey)



Why Talk About Alcohol?

“Alcohol is one of our most potent “hidden hazards”. Hidden hazards are events or conditions in society whose seriousness tends to be significantly underestimated by the public.¹⁰”

(Thomas & Davis, 2006)

Changes to Provincial Alcohol Controls

There is a variety of evidence supporting the role that control systems play in influencing alcohol consumption and health outcomes.¹¹ Government run monopolies play a key role in regulating access to alcohol by maintaining effective alcohol control strategies such as legal drinking age and enforcement, the regulation of alcohol pricing, hours and days of sale and upholding a socially responsible mandate.¹²

There has been a recent shift towards loosening of alcohol controls and gradual privatization of the liquor market in several provinces.

Highlights of changes in Ontario:

- 2011 - Amendment to the Liquor Licence Act (LLA) of Ontario - premises such as spas, hair salons, art galleries, bookstores, etc. are allowed to apply for a liquor licence;
- 2014 - Vintner's Quality Alliance (VQA) wines sold at farmers' markets;
- 2015 - Expansion of beer, wine, and cider sales to grocery stores - ultimately, beer, wine and cider will be available in up to 450 grocery stores in Ontario. This is in addition to more than 450 Beer Stores and more than 660 LCBO (Liquor Control Board of Ontario) stores across Ontario.

In Ontario, these changes came about despite the fact that results from the Ontario Adult Survey indicate that just over 75 per cent of Ontarians live within a ten minute commute from an alcohol retail outlet.¹³ Evidence links alcohol availability, consumption and harm: increased availability leads to increased rates of drinking, resulting in increased harm.^{2,11,12, 14}

DID YOU KNOW?

The 2002 partial privatization of the liquor market in British Columbia that resulted in an increase in the number of liquor stores per capita has led to increases in rates of alcohol consumption and of alcohol-related deaths.^{15,16}

(Stockwell et al., 2009; Stockwell et al., 2011)

The Business and Cost of Alcohol

Alcohol is a multi-billion dollar industry. The industry ensures that regulated alcoholic beverages are available to Canadians and sales of alcohol contribute to the Canadian economy. Alcohol production and sales provide employment while taxes and pricing provide revenue for provincial and federal governments.¹⁷ At the local level, rise of local wineries, breweries, and restaurants is often seen as a positive boost to local economy because they encourage tourism and entrepreneurship.

Sales of alcohol continue to increase in Canada. From April 2015 to March 2016, Canadians spent \$22.1 billion on alcohol, 3.5 per cent more than the previous year.¹⁸ Sales of alcoholic beverages show how much Canadians are spending on alcohol and indirectly, reflect how much Canadians are drinking.

Alcohol presents a paradox in terms of its benefits and costs to Canadians. Governments earn substantial revenue from the sale of alcohol and use these funds to provide goods and services to the population. On the other hand, alcohol consumption is associated with substantial health and social harm that cost those same governments billions of dollars each year in health care and enforcement.¹⁷

It is estimated that the total direct and indirect costs of alcohol in Canada in 2002, were \$14.6 billion, with over \$7.1 billion in indirect costs due to productivity losses (disability or premature death), 3.3 billion dollars in direct costs to healthcare, and \$3.1 billion in direct costs to law enforcement.¹⁹ New research is needed to determine the cost of alcohol in more recent years.

It is important to recognize that the negative impacts associated with alcohol use far outweigh the benefits. Both the revenue and costs associated with alcohol are substantial and that in most jurisdictions direct alcohol-related costs exceed direct revenue.¹⁷ In Ontario in 2002, the costs of alcohol-related harm exceeded revenue by an estimated \$456 million.²⁰

Alcohol is unique among psychoactive substances used in Canada because its associated enforcement and health costs are nearly equivalent, indicating that alcohol is as much a concern to public safety as it is to public health.²¹

(Thomas & Davis, 2006)

Alcohol Outlet Density in Haldimand and Norfolk

There is strong evidence that increasing the density of alcohol outlets results in higher alcohol consumption and greater alcohol-related harms.²² Ontario does not currently have a provincial policy limiting the density of alcohol outlets.

Haldimand and Norfolk counties have a higher density of alcohol outlets compared to the provincial average. In 2014, the overall density of alcohol outlets in Ontario was 17.4 for every 10,000 people aged 15 and older and was 20 for every 10,000 people aged 15 and older in Haldimand and Norfolk counties.²²

The alcohol outlets include on- premise and off-premise outlets. On-premise outlets may include bars, clubs and restaurants, while off-premise outlets may include liquor stores, beer stores, grocery stores, breweries and wineries. Some findings indicate that off-premise outlet density may have a greater impact on levels of alcohol consumption.²²

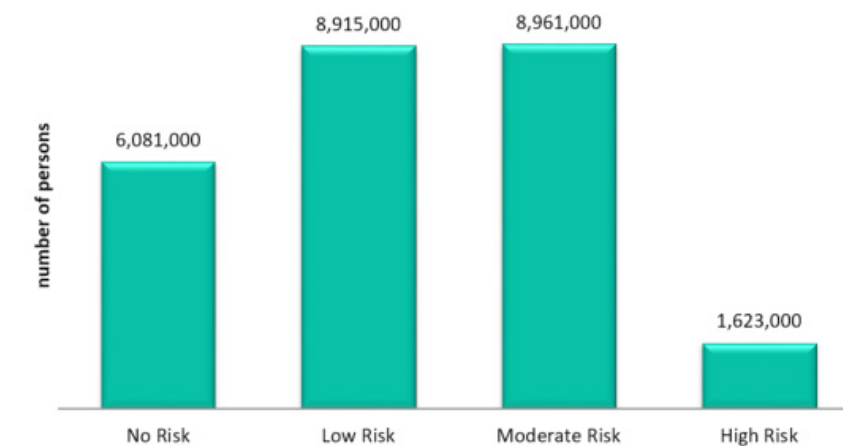
There are currently 59 licensed establishments in Haldimand County and 114 in Norfolk County, including wineries, breweries and distilleries. These numbers do not capture alcohol retail outlets such as The Beer Store and The LCBO in Haldimand and Norfolk counties.

To capture the alcohol outlet density in Haldimand and Norfolk, the HNHU is working with Geographic Information System (GIS) specialists to create GIS maps reflecting the current landscape. Maps can be found in Appendix B.

Canadian's and Alcohol Consumption

There is a misperception that alcohol issues and related harm are mainly limited to those with alcohol dependence or alcoholism. The 2009 Canadian Alcohol and Drug Use Monitoring Survey (CADUMS) shows that in comparison to the 20 million “current drinkers” in Canada, alcohol dependant drinkers make up a very small percentage of the population, 2.5% or 750,000 people.²³ While alcohol dependency is an issue for some people, for the majority of the population it is their pattern of drinking that can increase their risk of harm.^{23, 24}

Distribution to Alcohol-Related Risk in Canada, 2009²⁴



Source: Canadian alcohol and drug use monitoring survey. (CADUMS, 2009)

A significant proportion of alcohol-related harm and costs are associated with the large number of moderate-risk drinkers who occasionally drink above the recommended levels. This is the “prevention paradox,” which states that a large number of people exposed to moderate risk can create more cases of harm than a small number exposed to higher risk.¹⁷

(Thomas & Davis, 2006)



As a first responder, I see the effects of alcohol use on drivers and passengers, those unharmed, injured, and very recently deceased. I have organized and attended many fundraisers that “wouldn’t make any money” if alcohol was not served to excess. I have watched pleasant people become irritating, pushy, over-bearing, and even violent over the course of an evening social function as more alcohol is consumed. None of these people - even the “happy drunks” - are aware of how their personality has changed or how those around them are required to react to them.”

– Community member



Alcohol consumption in Canada increased by 13% between 1996 and 2010 and concurrently, national and provincial surveys indicate that approximately 20% of drinkers drink above the *Canada's Low Risk Alcohol Drinking Guidelines* (the guidelines can be found on page 8) ^{2,25} Several factors may be driving these developments, including a gradual shift towards privatization, increased access to alcohol, extensive marketing and increased acceptability of alcohol use in Canadian society.¹¹ As a legal commodity, alcohol is heavily promoted via advertising and, as a result, the public is reminded daily of its positive aspects while its negative aspects are relatively under-exposed.²¹

While a majority of the population consumes alcohol in low-risk patterns, a substantial proportion of Canadians drink above the recommended levels at least occasionally, i.e. monthly or more often.²⁴ It is the larger proportion of the population who drink heavily at single events that produce far more common and wide-reaching negative impacts on the health, safety and well-being of individuals and communities. Impaired driving, alcohol poisoning, mental health issues, unwanted or high-risk sexual encounters, violence, injuries, and chronic disease all have direct links to this occasional heavy use of alcohol.²⁶

Under-Reporting of Alcohol Consumption

Self-reported alcohol consumption is significantly lower when compared to per capita alcohol sales.¹⁷ After correction of the under-reporting in the daily and weekly amount consumed to Canadian data, it was revealed that young people and low volume drinkers tend to under-report to a greater extent than older and high volume drinkers.²⁷ Men and women were similar in terms of the extent to which they under-report their consumption of alcohol.²⁸

Local Findings for Self-Reported Patterns of Drinking in Haldimand & Norfolk

Table 1: 2013/2014 Self-Reported Type of Drinker, Adults (19+ Years of Age), Haldimand and Norfolk and Ontario

Type of Drinker	Haldimand-Norfolk (%,95%, CI)	Ontario (%,95%, CI)
Regular - at least one drink a month	66 (61.3-70.7)	60.5 (59.5-61.4)
Occasional - drinks less than once per month	17.7 (14.0-21.4)	17.4 (16.7-18.1)
No Drink in the Last 12 Months	16.3 (12.5-20.1)	22.2 (21.3-23.0)

Data Source: Canadian Community Health Survey 2013-2014. Statistics Canada, Share File, Knowledge Management and Reporting Branch, Ontario MOHLTC

Table 2: 2013/2014 Self-Reported Regular Drinker, Adult (19+ Years of Age) Haldimand and Norfolk and Ontario, by Sex

	Males (%,95%, CI)	Females (%,95%, CI)
Haldimand-Norfolk	70 (62.0-78.0)	62.1 (55.4-68.9)
Ontario	69 (68-70.6)	52.1 (50.8-53.5)

Data Source: : Canadian Community Health Survey 2013-2014. Statistics Canada, Share File, Knowledge Management and Reporting Branch, Ontario MOHLTC

In 2013/14, 66% of Haldimand and Norfolk residents, aged 19 years and older, were regular drinkers. This rate is slightly higher than Ontario (60.5%) but not significantly different.

Canada's Low Risk Alcohol Drinking Guidelines

Canada's *Low Risk Alcohol Drinking Guidelines* were developed in 2011 to encourage a culture of moderation and aim for consistency and clarity of alcohol-related health and safety messages.⁸

The guidelines identify three distinct types of risk from drinking:

- Situations and individual circumstances that are particularly hazardous (e.g. women who are pregnant or planning to become pregnant, teenagers, persons on medication, driving a vehicle or using machinery and tools, doing any kind of dangerous physical activity, etc.);
- Increased long-term risk of serious diseases caused by the consumption of alcohol over a number of years (e.g. liver disease, some cancers, etc.);
- Increased short-term risk of injury or acute illness due to the overconsumption of alcohol on a single occasion (e.g. alcohol poisoning, falls, injuries, etc.).

The *Low Risk Alcohol Drinking Guidelines* (LRADG) set limits to reduce short and long term effects alcohol consumption has on health.

It is important to remember that these are:

- low-risk, not no-risk guidelines;
- the guidelines set limits, not targets;
- the guidelines are for adults aged 25–65 who choose to drink;

Guideline #1 - If choosing to drink, reduce your risk of chronic disease by drinking no more than:

- 10 standard drinks a week for **women**, with no more than 2 drinks a day, most days
- 15 standard drinks a week for **men**, with no more than 3 drinks a day, most days.
- Plan non-drinking days during the week to avoid developing a habit.

Guideline #2 – If choosing to drink, reduce your risk of immediate injury and harm by drinking no more than:

- 3 standard drinks for **women** on any single occasion and stay within the weekly limits
- 4 drinks for **men** on any single occasion and stay within the weekly limits
- Drink slowly. Have no more than 2 drinks in any 3 hours. For every drink of alcohol, have one non-alcoholic drink. Eat before and while you are drinking. Set limits for yourself and stick to them.

Do not drink when you are: driving a vehicle or using machinery and tools, taking medicine or other drugs that interact with alcohol, doing any kind of dangerous physical activity, living with mental or physical health problems, living with alcohol dependence, pregnant or planning to be pregnant, responsible for the safety of others, or making important decisions.

REDUCE YOUR RISK: Follow Canada's Low-Risk Alcohol Drinking Guidelines ¹¹

Reduce your short term risk of injury

2

3

No more than **2 drinks a day** most days for women.
No more than **3 drinks a day** most days for men.

Reduce your long term risk of disease

10

15

No more than **10 drinks a week** for women.
No more than **15 drinks a week** for men.

WHEN ZERO IS THE LIMIT

WHAT IS A STANDARD DRINK?

Don't drink if you are:

- **Under the legal** drinking age
- **Driving a vehicle or** using machinery/tools
- **Taking medicine or** other drugs that interact with alcohol
- **Responsible for the** safety of others
- **Living with mental** or physical health problems

- **Making important** decisions
- **Doing any kind of** dangerous physical activity
- **Living with alcohol** dependence
- **Pregnant** or planning to become pregnant

Beer

341 ml (12 oz.) 5% alcohol content

Wine

142 ml (5 oz.) 12% alcohol content

Distilled Alcohol

(1.5 oz.) (rye, gin, rum, etc.) 40% alcohol content

=

=

Local Findings for Self-Reported Alcohol Consumption in Haldimand & Norfolk

Figure 1: Self-Reported Crude Rate of Exceeding the Low-Risk Alcohol Drinking Guideline for Chronic Disease, Haldimand and Norfolk and Ontario, 2003, 2005, 2007/08, 2009/2010, 2011/12, 2013/14

	2003	2005	2007/2008	2009/2010	2011/2012	2013/2014
H-N	25	30.1	31.4	25.2	20.6	24.2
ON	23.2	24.2	23.4	22.3	23	20.6

Data Source: Public Health Ontario. Snapshots: Ontario and Haldimand and Norfolk Public Health Unit: Self-reported rate of exceeding the low-risk alcohol drinking guideline for chronic disease (both sexes, males, females) (2003, 2005, 2007/08, 2009/10, 2011/12, 2012/14). Toronto ON: Ontario Agency for Health Protection and Promotion; 2017 Jan 4. Available from: <https://www.publichealthontario.ca/en/DataAndAnalytics/Snapshots/Pages/Health-Behaviours---Alcohol-Use.aspx>

In 2013/14, 24.2% of Haldimand and Norfolk residents, aged 19 years and older, reported exceeding the LRADG for chronic disease. This rate is slightly higher than Ontario (20.6%) but not significantly different.

Figure 2: Self-Reported Crude Rate of Exceeding the Low-Risk Alcohol Drinking Guideline for Chronic Disease, Haldimand and Norfolk and Ontario, Males, 2003, 2005, 2007/08, 2009/2010, 2011/12, 2013/14

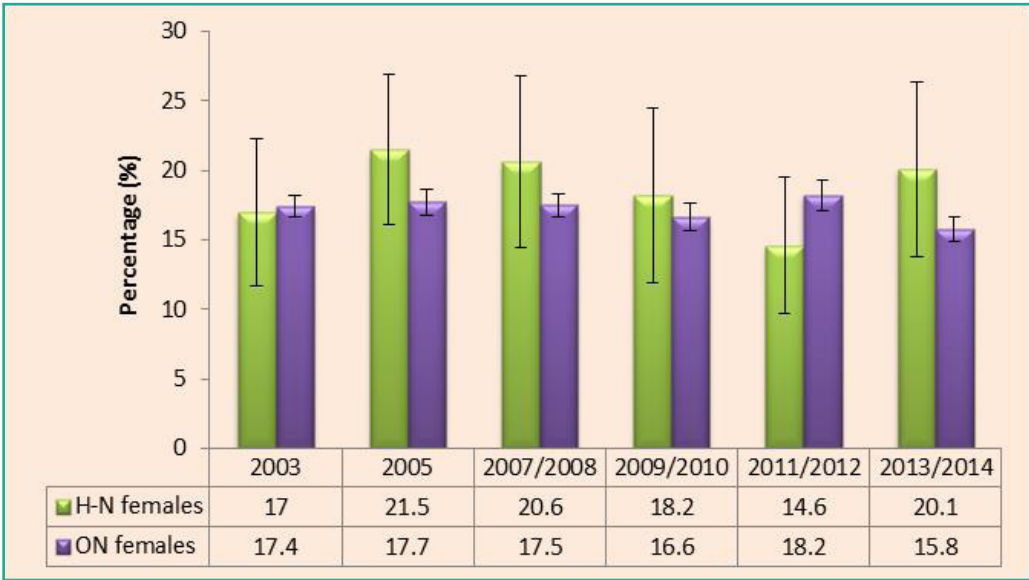
	2003	2005	2007/2008	2009/2010	2011/2012	2013/2014
H-N males	32.9	38.6	41.9	32	26.2	28.3
ON males	29.1	30.8	29.4	28.2	27.8	25.6

Data Source: Public Health Ontario. Snapshots: Ontario and Haldimand and Norfolk Public Health Unit: Self-reported rate of exceeding the low-risk alcohol drinking guideline for chronic disease (males) (2003, 2005, 2007/08, 2009/10, 2011/12, 2012/14). Toronto ON: Ontario Agency for Health Protection and Promotion; 2017 Jan 4. Available from: <https://www.publichealthontario.ca/en/DataAndAnalytics/Snapshots/Pages/Health-Behaviours---Alcohol-Use.aspx>

9 Alcohol use and Harms in Haldimand and Norfolk Counties

Alcohol use and Harms in Haldimand and Norfolk Counties 10

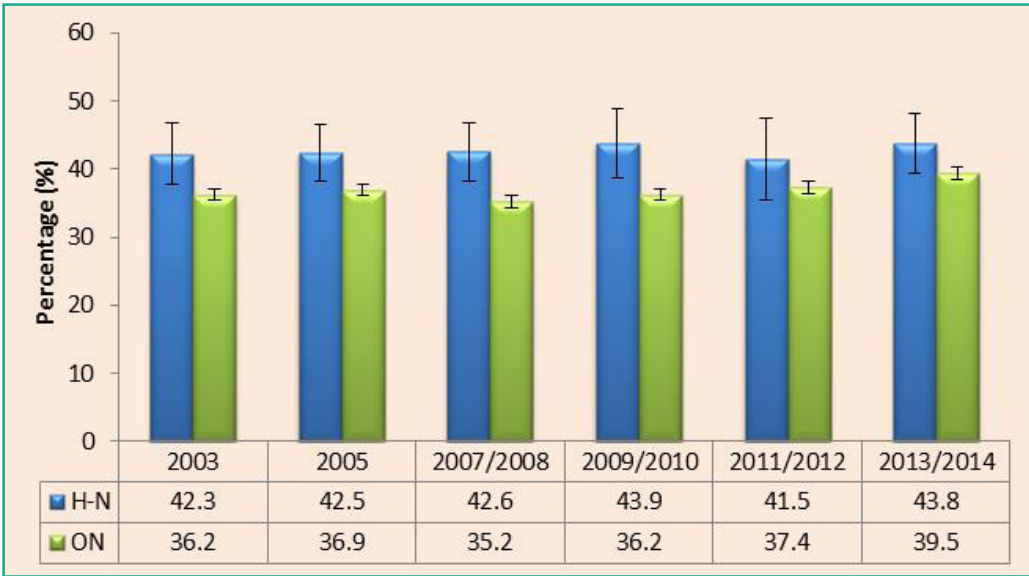
Figure 3: Self-Reported Crude Rate of Exceeding the Low-Risk Alcohol Drinking Guideline for Chronic Disease, Haldimand and Norfolk and Ontario, Females, 2003, 2005, 2007/08, 2009/2010, 2011/12, 2013/14



Data Source: Public Health Ontario. Snapshots: Ontario and Haldimand and Norfolk Public Health Unit: Self-reported rate of exceeding the low-risk alcohol drinking guideline for chronic disease (females) (2003, 2005, 2007/08, 2009/10, 2011/12, 2012/14). Toronto ON: Ontario Agency for Health Protection and Promotion; 2017 Jan 4. Available from: <https://www.publichealthontario.ca/en/DataAndAnalytics/Snapshots/Pages/Health-Behaviours---Alcohol-Use.aspx>

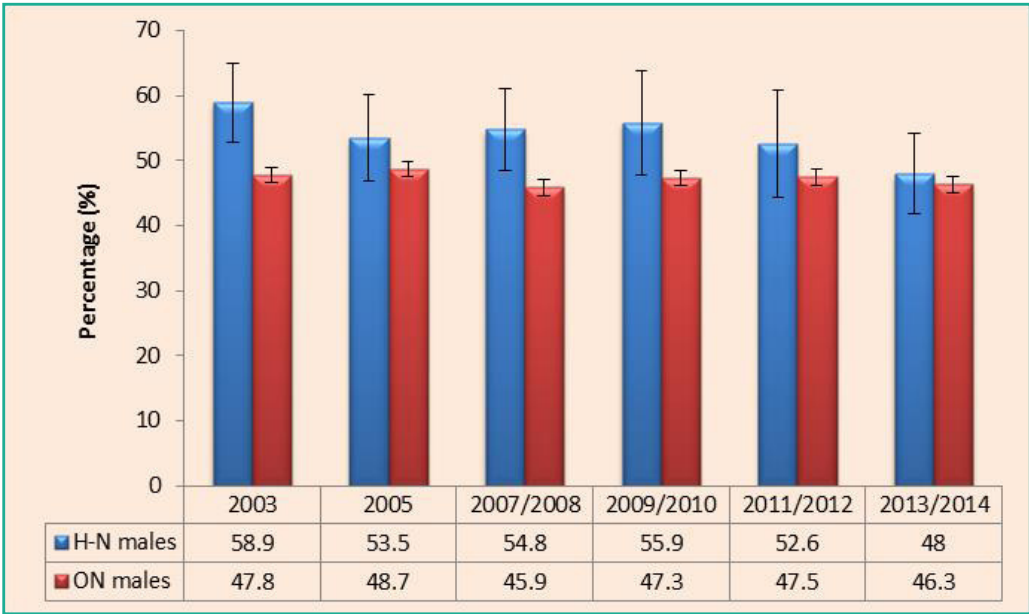
In 2013/2014, 28.3% of males reported exceeding the LRADG for chronic disease compared to 20.1% of females in Haldimand and Norfolk. However, this difference was not significantly different.

Figure 4: Self-Reported Crude Rate of Exceeding the Low-Risk Alcohol Drinking Guideline for Injury, Haldimand and Norfolk and Ontario, 2003, 2005, 2007/08, 2009/2010, 2011/12, 2013/14



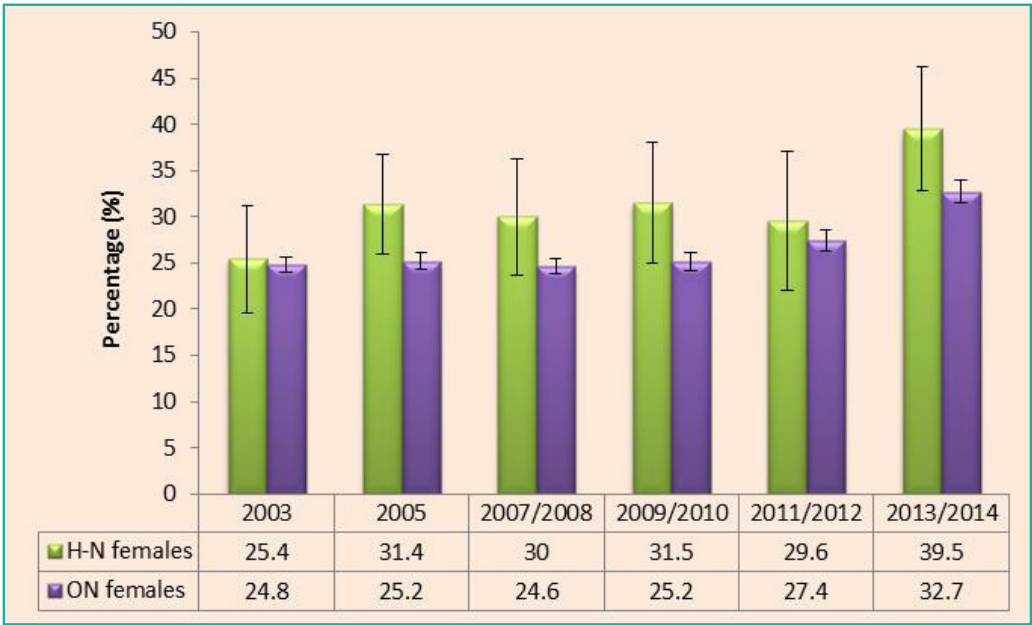
Data Source: Canadian Community Health Survey 2003-2014. Statistics Canada, Share File, Knowledge Management and Reporting Branch, Ontario MOHLTC.

Figure 5: Self-Reported Crude Rate of Exceeding the Low-Risk Alcohol Drinking Guideline for Injury, Haldimand and Norfolk and Ontario, Males, 2003, 2005, 2007/08, 2009/2010, 2011/12, 2013/14



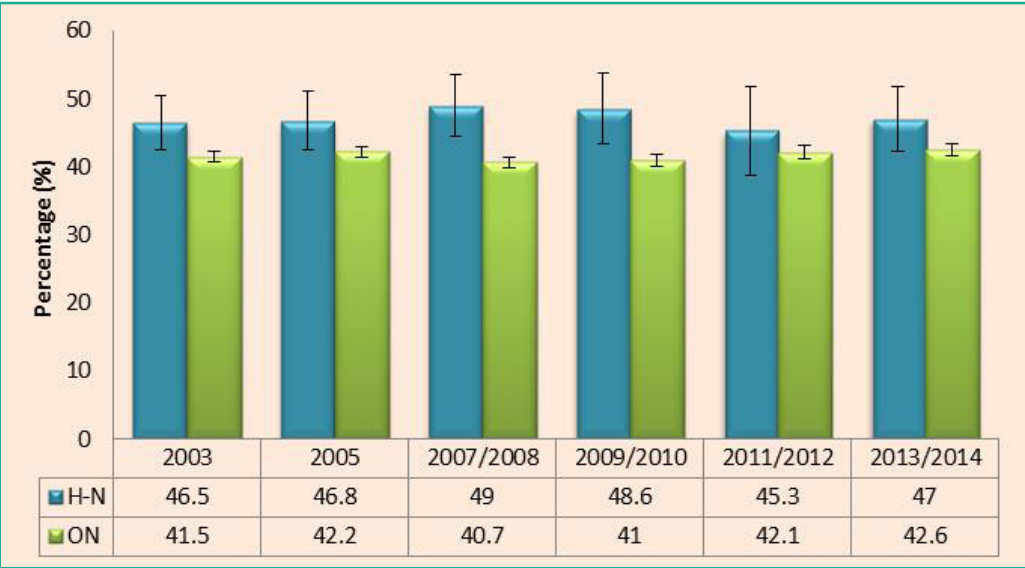
Data Source: Canadian Community Health Survey 2003-2014. Statistics Canada, Share File, Knowledge Management and Reporting Branch, Ontario MOHLTC.

Figure 6: Self-Reported Crude Rate of Exceeding the Low-Risk Alcohol Drinking Guideline for Injury, Haldimand and Norfolk and Ontario, Females, 2003, 2005, 2007/08, 2009/2010, 2011/12, 2013/14



Data Source: Canadian Community Health Survey 2003-2014. Statistics Canada, Share File, Knowledge Management and Reporting Branch, Ontario MOHLTC.

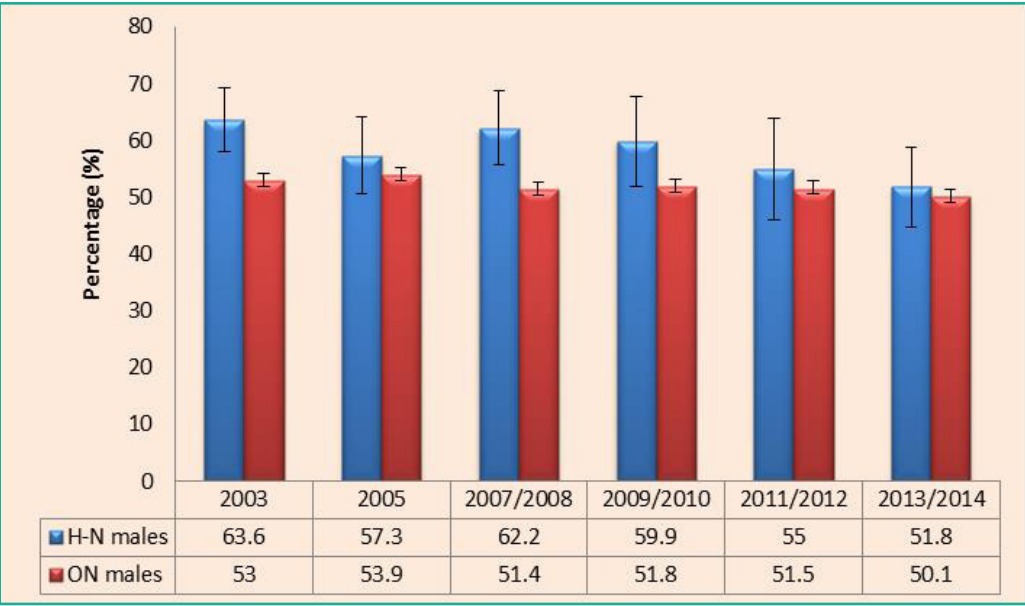
Figure 7: Self-Reported Rate of Exceeding Either Low-Risk Alcohol Drinking Guideline, Haldimand and Norfolk and Ontario, 2003, 2005, 2007/08, 2009/2010, 2011/12, 2013/14



Data Source: Public Health Ontario. Snapshots: Ontario and Haldimand and Norfolk Public Health Unit: Self-reported rate of exceeding either low-risk alcohol drinking guideline (both sexes, males, females) (2003, 2005, 2007/08, 2009/10, 2011/12, 2012/14). Toronto ON: Ontario Agency for Health Protection and Promotion; 2017 Jan 4. Available from: <https://www.publichealthontario.ca/en/DataAndAnalytics/Snapshots/Pages/Health-Behaviours---Alcohol-Use.aspx>

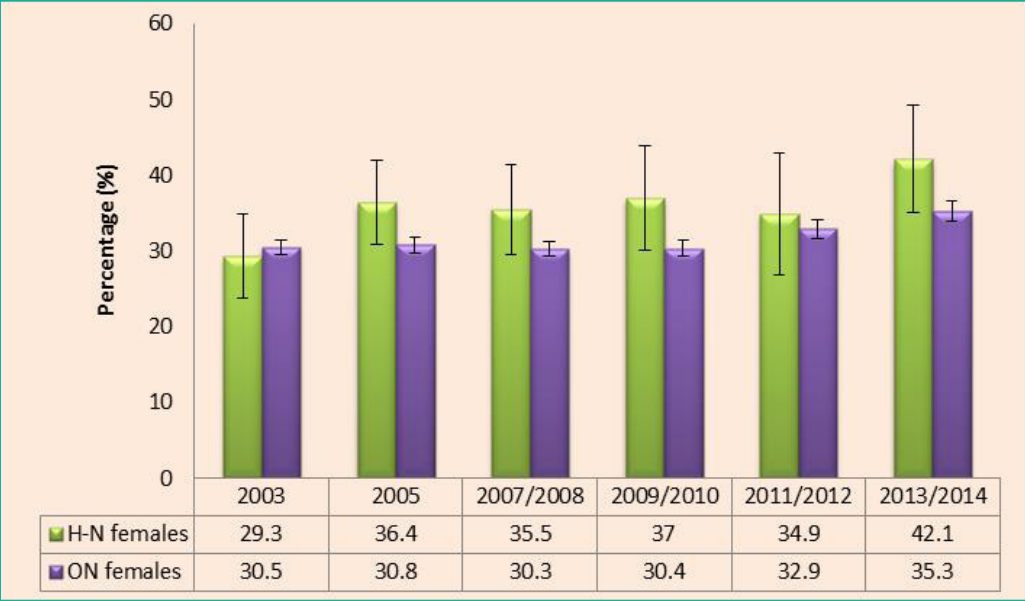
In 2013/14, almost half (47%) of Haldimand and Norfolk residents reported exceeding either of the LRADGs (#1 and/or #2). This is not significantly different than the Ontario (42.6%)

Figure 8: Self-Reported Rate of Exceeding Either Low-Risk Alcohol Drinking Guideline, Haldimand and Norfolk and Ontario, Males, 2003, 2005, 2007/08, 2009/2010, 2011/12, 2013/14



Data Source: Public Health Ontario. Snapshots: Ontario and Haldimand and Norfolk Public Health Unit: Self-reported rate of exceeding either low-risk alcohol drinking guideline (males) (2003, 2005, 2007/08, 2009/10, 2011/12, 2012/14). Toronto ON: Ontario Agency for Health Protection and Promotion; 2017 Jan 4. Available from:<https://www.publichealthontario.ca/en/DataAndAnalytics/Snapshots/Pages/Health-Behaviours---Alcohol-Use.aspx>

Figure 9: Self-Reported Rate of Exceeding Either Low-Risk Alcohol Drinking Guideline, Haldimand and Norfolk and Ontario, Females, 2003, 2005, 2007/08, 2009/2010, 2011/12, 2013/14



Data Source: Public Health Ontario. Snapshots: Ontario and Haldimand and Norfolk Public Health Unit: Self-reported rate of exceeding either low-risk alcohol drinking guideline (females) (2003, 2005, 2007/08, 2009/10, 2011/12, 2012/14). Toronto ON: Ontario Agency for Health Protection and Promotion; 2017 Jan 4. Available from: <https://www.publichealthontario.ca/en/DataAndAnalytics/Snapshots/Pages/Health-Behaviours---Alcohol-Use.aspx>

In 2013/14, 51.8% of males reported exceeding either of the LRADGs compared to 42.1% of females in Haldimand and Norfolk. However, this difference was not significantly different.

Since 2007/08, rates of exceeding either of the LRADGs have declined for men in Haldimand and Norfolk. This is not the case for women in Haldimand and Norfolk.

Heavy Drinking

Binge drinking is defined in Canada as five or more drinks for men and four or more drinks for women, on one occasion.²⁴ Heavy drinking is defined as binge drinking 12 or more times over the past year. Binge drinking is associated with risk taking behaviour. Risks and consequences associated with binge drinking include death, injury, violence, alcohol poisoning, unplanned and unwanted sexual experiences including sexual assault and sexually transmitted infections.³⁰ Prolonged heavy drinking may result in brain damage, liver disease, cancer or heart disease.⁷

Heavy Drinking:

- For males 5 or more drinks per occasion, at least once a month during the past year
- For females 4 or more drinks per occasion, at least once a month during the past year.

Local Findings for Heavy Drinking Patterns in Haldimand & Norfolk Counties

Table 3: 2013/2014 Self-Reported Heavy Drinking Rate, Haldimand and Norfolk and Ontario

	Non-Heavy Drinking Rate (%,95%, CI)	Heavy Drinking Rate (%,95%, CI)
Haldimand-Norfolk	58.0 (52.3-63.6)	19.8 (15.5-24.1)
Ontario	56.6 (55.6-57.5)	16.6 (16.0-17.3)

Data Source: Canadian Community Health Survey 2013-2014. Statistics Canada, Share File, Knowledge Management and Reporting Branch, Ontario MOHLTC.
* High sampling variability, interpret with caution

Table 4: 2013/2014 Self-Reported Heavy Drinking Rate, Haldimand and Norfolk and Ontario, by Sex

	Males (%,95%, CI)	Females (%,95%, CI)
Haldimand-Norfolk	23.3 (16.4-30.1)	*16.2 (10.8-21.5)
Ontario	21.2 (20.2-22.3)	12.2 (11.5-13.0)

Data Source: Canadian Community Health Survey 2003-2014. Statistics Canada, Share File, Knowledge Management and Reporting Branch, Ontario MOHLTC .
* High sampling variability, interpret with caution

Table 5: 2013/2014 Self-Reported Heavy Drinking Rate, by Education Level, Haldimand and Norfolk

Education Level	Non-Heavy Drinking Rate (%,95%, CI)	Heavy Drinking Rate (%,95%, CI)
Highschool Education or Less	59.8 (50.5-69.0)	*9.1 (3.3-14.8)
Post-Secondary Education	58.2 (50.8-65.7)	22.6 (17.3-28.0)

Data Source: Canadian Community Health Survey 2013-2014. Statistics Canada, Share File, Knowledge Management and Reporting Branch, Ontario MOHLTC.
* High sampling variability, interpret with caution.

Table 6: 2013/2014 Self-Reported Heavy Drinking Rate by Adjusted Income Level, Haldimand and Norfolk

Income Level	Non-Heavy Drinking Rate (%,95%, CI)	Heavy Drinking Rate (%,95%, CI)
Lower	52.4 (44.9-59.9)	*15.6 (9.2-21.9)
Middle	65.0 (56.2-73.9)	*17.5 (11.3-23.6)
Upper	58.5 (47.1-69.8)	32.8 (22.5-43.2)

Data Source: Canadian Community Health Survey 2013-2014. Statistics Canada, Share File, Knowledge Management and Reporting Branch, Ontario MOHLTC.
* High sampling variability, interpret with caution.

Table 7: 2013/2014 Self-Reported Heavy Drinking Rate by Total Household Income, Haldimand and Norfolk

Total Household Income	Non-Heavy Drinking Rate (%,95%, CI)	Heavy Drinking Rate (%,95%, CI)
Less than \$40,000	54.6 (44.8-64.4)	**
\$40,000 - \$69,000	63.4 (54.7-72.1)	*16.8 (10.1-23.4)
\$70,000 or more	57.0 (47.2-66.7)	26.3 (18.8-33.7)

Data Source: Canadian Community Health Survey 2013-2014. Statistics Canada, Share File, Knowledge Management and Reporting Branch, Ontario MOHLTC.
* High sampling variability, interpret with caution. ** High sampling variability data was not releasable.

In 2013/14, heavy drinking was higher for Haldimand and Norfolk residents with higher education compared to lower levels of education (22.6 % vs. 9.1 %). This difference was statistically significant.

Similarly, in 2013/14, Haldimand and Norfolk residents with higher income reported more heavy drinking compared to those with lower income levels (adjusted income 32.8% vs. 15.6%). This difference was statistically significant.

Drug of Choice for Young People

Alcohol remains the most popular drug of choice for Ontario students. Youth are particularly vulnerable to negative impacts from drinking alcohol as the human brain is still developing until about 24 years of age. The frontal lobe is the last part of the brain to mature and is involved in planning, strategizing, organizing, impulse control, concentration and attention. Drinking alcohol while in this stage of development can have negative effects on the brain.³¹

Youth risk factors identified in the literature that influence alcohol use include youth perception of parental approval of alcohol use and low parental monitoring, alcohol-using peers, early and persistent problem behaviours, alcohol use in the family context, low perception of harm, easy access and availability, poor school achievement and low school connectedness.³²

Families, friends and all Canadians who care for or work with youth can play a positive role if they recognize their influence on youth's drinking patterns and support their healthy physical, mental and emotional development.⁷

DID YOU KNOW?

The 2015 Ontario Student Drug Use and Health Survey (OSDUHS) by the Centre for Addiction and Mental Health (CAMH) stated that:

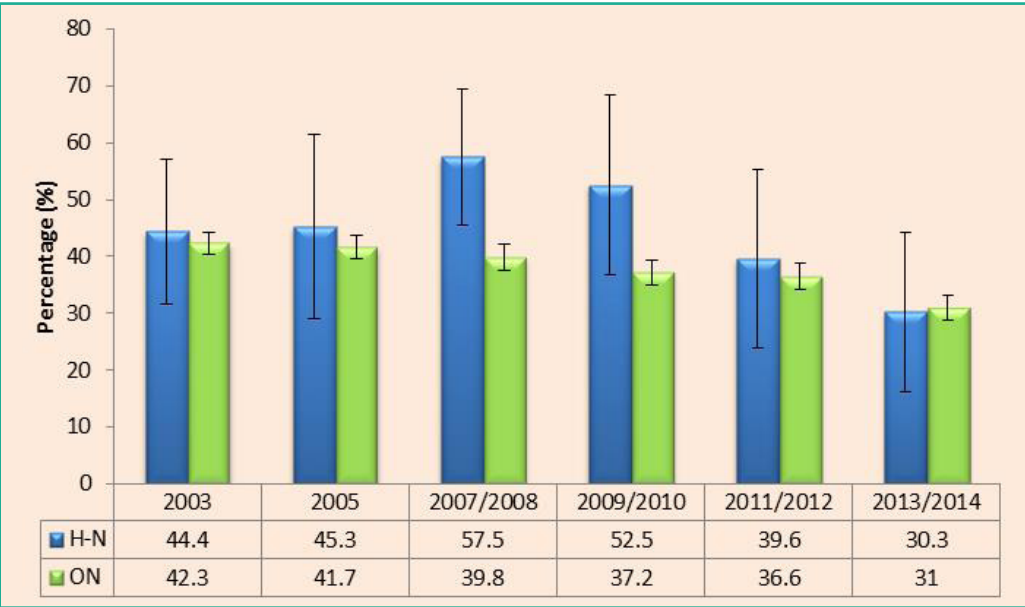
- Alcohol is perceived as the most readily available drug, with 65 per cent of all students reporting it as “fairly easy” or “very easy” to get.
- Just under half (46%) of all Ontario students reported drinking more than just a few sips of alcohol during the past year. Males (47%) and females (45%) are equally likely to drink.
- Past year drinking varies by grade (9% of 7th graders to 72% of 12th graders drank alcohol).
- While consumption of alcohol by students has decreased significantly over the last two decades, from 66 per cent in 1999 to 46 per cent in 2015, CAMH researchers remain concerned by the prevalence of alcohol consumption and hazardous drinking behaviour.
- As many as one-in five high school students reported hazardous drinking; a risky pattern of drinking that can cause current or future physical, psychological or social problems.
- An estimated 18 per cent of students reported binge drinking (having five or more drinks on one occasion) at least once in the month before taking the survey.
- About one-fifth (21.9%) of secondary students report playing a drinking game in the past month.
- Almost one-fifth (19.2%) of secondary students could not remember what had happened when they were drinking on at least one occasion during the past 12 months.
- In 2015, high school students were asked if their parents allowed them to drink at home. More than one-quarter (27%) of both males and females reported that they were allowed to drink at home with friends.

We were surprised by this number. It suggests some parents might think it's safer to supervise kids while they drink. In fact, other research shows that students who are allowed to drink at home are more likely to drink excessively.

Dr. Robert Mann | OSDUHS, 2015

Local Findings for Self-Reported Underage Drinking Rates in Haldimand & Norfolk

Figure 10: Self-Reported Underage (Age 12-18) Drinking Rate, Haldimand and Norfolk and Ontario, 2003, 2005, 2007/08, 2009/2010, 2011/12, 2013/14



Data Source: Canadian Community Health Survey 2003-2014. Statistics Canada, Share File, Knowledge Management and Reporting Branch, Ontario MOHLTC.
* High sampling variability, interpret with caution. ** High sampling variability data was not releasable.

In 2013/2014, 30% of underage residents (aged 12-18) in Haldimand and Norfolk reported drinking, compared to 31% in the province. However, this difference is not statistically significant.

Since 2007/08, the percentage of underage drinking has declined in Haldimand Norfolk (57.5% to 30% in 2013/14). Percentages have also declined in the province (2003 to 2013/14).

Why Talking About Alcohol Matters

Canadians are exposed to mixed messages regarding health benefits and risks of alcohol. Many factors influence how alcohol affects a person's health, including how much and how often a person drinks, that person's specific risk factors, and what they are doing while they are drinking.²⁹ As the research on alcohol continues to evolve, so does our understanding of alcohol and its far reaching impacts which necessitates re-evaluation of current alcohol beliefs and policies.

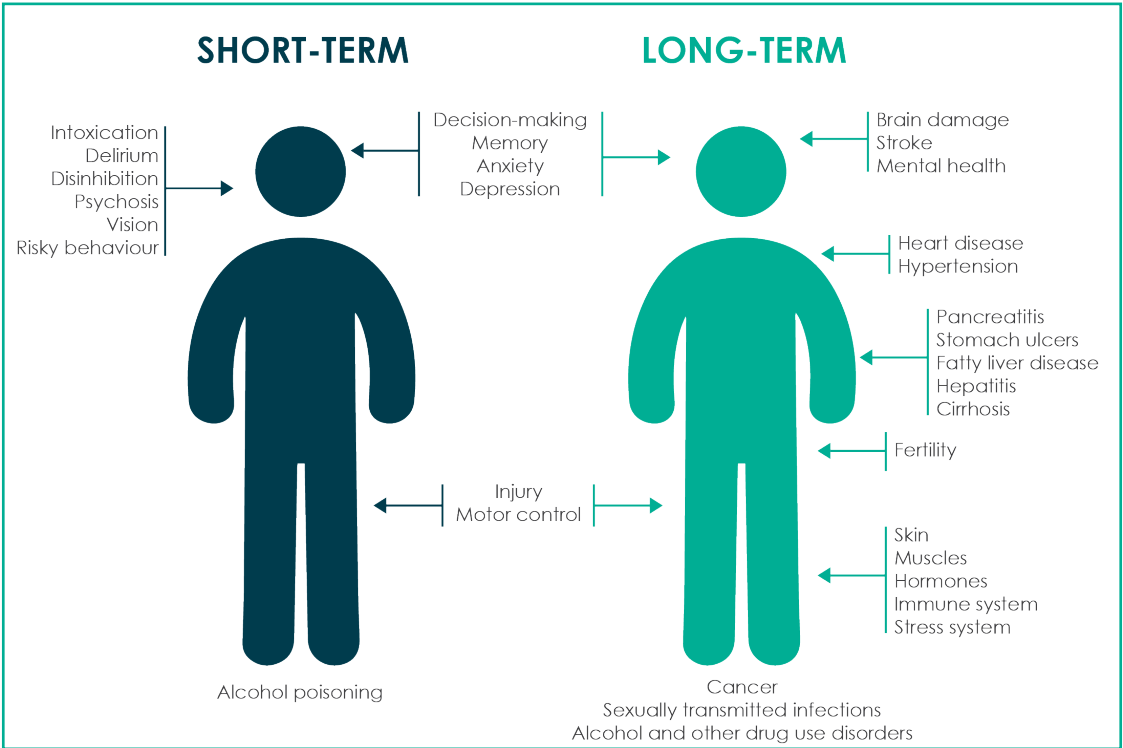
Dose Dependent Health Effects

An Overview of the Dose-Dependent Health and Behavioural Impacts of Alcohol Consumption

Direct Effects	Disease and Conditions	Functions and Systems	Behaviour
<p>Risky drinking can cause:</p> <ul style="list-style-type: none"> Alcohol use disorders Amnesia (e.g., Korsakoff's syndrome) Memory loss and blackouts Delirium due to a severe form of withdrawal Fetal Alcohol Spectrum Disorder (FASD) 	<p>Drinking alcohol is linked to:</p> <ul style="list-style-type: none"> Other drug use disorders Brain damage Liver disease Various cancers Pancreatitis Mental health disorders Suicide Stomach ulcers Hypertension Stroke Diabetes Sexually transmitted infections. 	<p>Drinking alcohol affects the following systems:</p> <ul style="list-style-type: none"> Immune Stress Memory, cognition Digestion Heart, blood, lungs Brain Hormones Muscles Fertility Skin Development 	<p>Risky drinking can lead to:</p> <ul style="list-style-type: none"> Risky behaviour Impulsivity Violence Injury Poor memory Impaired decision-making Lack of coordination Poor academic performance Impaired social and occupational functioning

Data Source: Public Health Agency of Canada. (2015). The Chief Public Health Officer's Report on the state of public health in Canada 2015. Alcohol consumption in Canada <https://www.canada.ca/content/dam/canada/health-canada/migration/healthy-canadians/publications/departement-ministere/state-public-health-alcohol-2015-etat-sante-publique-alcool/alt/state-phac-alcohol-2015-etat-aspc-alcool-eng.pdf>

Examples of Potential Health Impacts



Data Source: Public Health Agency of Canada. (2015). The Chief Public Health Officer's Report on the state of public health in Canada 2015. Alcohol consumption in Canada <https://www.canada.ca/content/dam/canada/health-canada/migration/healthy-canadians/publications/departement-ministere/state-public-health-alcohol-2015-etat-sante-publique-alcool/alt/state-phac-alcohol-2015-etat-aspc-alcool-eng.pdf>

Alcohol and Health Benefits

There is evidence that alcohol taken in small amounts benefits some adults by reducing their risk of cardiovascular disease and type 2 diabetes. Any health benefits can be achieved at one or less than one drink per day and applies only to adults age 45 or older.^{12,13} It is important to note that any instance of heavy episodic drinking reduces or erases these potential benefits.³⁵

The strength of the evidence on the health benefits of alcohol has been questioned. Unlike older studies, newer studies distinguish lifetime abstainers from those who used to drink. Newer studies now suggest that alcohol's protective effect has likely been overstated.³⁶ Furthermore, the risks and benefits of alcohol consumption can occur at the same time so it is best to adopt other less risky behaviours such as healthy diet and physical activity instead of alcohol for best health outcomes.⁷ For young people, there are no known health benefits from drinking alcohol.

Alcohol and Injuries

Alcohol is an established risk factor for self-injury, violence, impaired driving, and unintentional injury.³⁷ Nearly half of all deaths attributable to alcohol are from injuries including unintentional injuries (motor vehicle crashes, drowning, burns, poisoning and falls) and intentional injuries (deliberate acts of violence against oneself or others).³⁸ In Ontario, it has been estimated that the injuries associated with alcohol use cost the province \$440 million each year.³⁹ According to the Ontario Trauma Registry, alcohol or drugs were involved in 23% of motor vehicle collisions, 25% of homicides, 14% of suicides, and 7% of unintentional falls.⁴⁰

Alcohol and Chronic Disease

The popular perception is that damage from alcohol is primarily related to drinking and driving, Fetal Alcohol Spectrum Disorder (FASD) and alcohol dependence (alcoholism); however, there is substantial and growing evidence that alcohol contributes to over 65 chronic diseases and conditions.¹²

Drinking increases the risk of developing a number of chronic health problems, including certain cancers, cardiovascular diseases such as heart disease and stroke, liver disease, inflammation of the pancreas, alcohol dependence and mental health problems. How much and how often a person drinks can also increase the risk of developing chronic health problems.^{6,35}

Alcohol and Cancer

Cancer is linked to 30 per cent of all Canadian deaths, making it the leading cause of death in Canada.⁷ Alcohol consumption is an important known cause of cancer. Drinking as little as one drink a day on average can increase the risk for developing cancer of the breast, colon and rectum, esophagus, larynx, liver, mouth and pharynx.⁴¹ In 2016, a new study found a significant dose–response relationship between level of alcohol intake and risk of prostate cancer starting with low volume consumption. Prostate cancer is the second most common cancer in men worldwide.⁴²

There is a lack of awareness among Canadians about the full impact of alcohol on health. For example, in 2008, almost 70 per cent of Canadians were not aware that alcohol was linked to cancer, while almost half were not aware of its links to heart disease and diabetes.⁴³

In 2012, 8.8 per cent of Ontario adults aged 19 years and older (nearly 1 million people) reported drinking more alcohol than the maximum amount recommended for cancer prevention which is no more than one drink a day for women and no more than two drinks a day for men.⁴⁴

There is no “safe limit” of alcohol consumption when it comes to cancer prevention.⁴⁴

(Cancer Care Ontario, 2014)

Fetal Alcohol Spectrum Disorder (FASD)

Alcohol use by women of childbearing age is a growing concern in Canada.² Alcohol is a known teratogenic substance (toxic to the fetus). The term fetal alcohol spectrum disorders (FASD) describes the range of disorders caused by prenatal exposure to alcohol. FASD is a lifelong chronic disorder that is the leading known cause of preventable developmental disability in Canada. Babies born with FASD experience a variety of alcohol-related birth defects which can vary from mild to severe and may include a range of physical, brain and central nervous system disabilities, as well as cognitive, behavioural and emotional issues.⁴⁵

FASD cannot be cured and has lifelong implications for individuals, their families and society as a whole. It is estimated that FASD affects approximately one percent of the Canadian population.⁴⁵ The costs associated with FASD in Canada in 2013 were approximately \$1.8 billion.⁴⁶

FASD is 100% preventable. Experts recommend that the safest choice is to not drink any type of alcohol at any time during pregnancy or when planning to become pregnant.⁷ This recommendation may be difficult to follow as 50% of pregnancies are unplanned.⁴⁷

Alcohol and Suicide

There is a greater relative risk for intentional injuries, particularly self-inflicted injuries, including self-harm and suicidal behaviour, whether completed or not, when under the influence of drugs and/or alcohol.^{37,48} Approximately 25 to 30% of suicides in Canada were linked to alcohol in the early 2000s.⁴⁹ The link between alcohol and suicide is part of the broader and complex connection between alcohol and mental health.²⁹

Second Hand Effects of Alcohol

In addition to the individual harm caused by alcohol, many communities experience the second hand effects of drinking such as neighbourhood disturbances, noise, public intoxication, property damage, vandalism, physical and sexual assault, and motor vehicle crashes.⁵⁰ It is estimated that 10 per cent of all deaths in Ontario directly or indirectly result from alcohol misuse and 1 in 3 adults in Ontario report experiencing harm from someone else's drinking.^{51,52,54,60}



1 in 3

adults in Ontario report experiencing harm from someone else's drinking.

Sexual Assault and Violence

Alcohol is the most commonly used substance to impair judgement and is often used in predatory behaviour like drug-facilitated sexual assault.⁵³ Injuries from assaults or fights are significantly more likely to involve alcohol. Alcohol consumption has been determined to play a role in approximately 40 to 56 per cent of assaults.⁴⁸ Alcohol consumption was also linked to a higher risk of sexual assault, robbery and physical assault.⁵⁴

Domestic Violence

Strong links have been found between alcohol use and the occurrence of domestic violence in many countries. Evidence suggests that alcohol use increases the occurrence and severity of domestic violence.⁵⁵ In Ontario, in 2008, 47 per cent of domestic homicides involved excessive alcohol or drug use by the perpetrator.⁵⁶ It is important to note that alcohol use alone cannot be blamed for occurrence of violent behaviour however alcohol use directly affects cognitive and physical function, reducing self-control and leaving individuals less capable of negotiating a non-violent resolution to conflicts within relationships.⁵⁷

When liquor stores were privatized in Alberta in 1993, rates of violence involving alcohol rose dramatically, increasing from 40 per cent to 60 per cent in the year after privatization. Rates of spousal and non-spousal homicides involving alcohol also increased, and Alberta's rates of alcohol-related spousal and non-spousal homicide and general crime were higher than the national average.

(Government of Alberta, 2007)

Impaired Driving

Impaired driving rates have been declining over the past 30 years. However impaired driving still remains one of the most frequent criminal offences and is among the leading criminal causes of death in Canada.⁵⁸ Alcohol misuse is involved in about 40 per cent of all traffic collisions and according to the Ontario Ministry of Transportation, drinking and driving accounts for almost 25 per cent of all of the traffic fatalities in Ontario.⁵⁹

Local Haldimand and Norfolk Ontario Provincial Police data can be found in Appendix C



40% of car crashes involve alcohol.

“My top concern with alcohol use in our community is drinking and driving. Because of the lack of available cabs and the expensive price, it's difficult to find a sober driver. Also because of how spaced out the towns are in the county, people may think a 15 minute drive won't be detrimental if they're under the influence because it's a route they have taken numerous times, but that could make driving impaired even more dangerous.”

– Community member

Alcohol and Health Inequities

Health inequities refer to the differences in health status among population groups that are deemed to be unfair, unjust, or preventable, as well as socially produced and systematic in their distribution across the population.⁶⁰ In order to address chronic diseases and injuries and their risk factors, public health must consider health equity and the socio-ecological context.

Drinking has been called a personal choice however personal choices are often influenced by variety of factors such as living conditions, social context and available opportunities. Alcohol consumption (i.e., patterns and amount consumed) as well as the potential health consequences are complex and vary by biology, genes, age, sex, mental health status, adverse life experiences and social determinants such as income, education, working conditions or personal health and coping skills.^{61,62}

“Yes I see a lot of poverty and alcohol misuse in this community. My concern is people start to see it and they think it is normal. They are raised with it, and they do not see the dangers. You come home from work and drink a beer, it becomes normal. There are AA meetings every day but Saturday...in town. There is help if they want help and come and listen.”

– Community member

The Social Determinants of Health⁶³

- Aboriginal Status
- Health Services
- Disability Status
- Housing
- Early Life
- Income and Income Distribution
- Education
- Race
- Employment and Working Conditions
- Social Exclusion
- Food Security
- Social Safety Net
- Gender
- Unemployment and Employment Security

The negative impacts of high-risk drinking cross all sectors of the population, yet they exert an even greater burden on certain populations such as youth, First Nations, Inuit and Métis people of Canada, and people who are homeless or otherwise living in poverty.^{2,7}

At the population level, alcohol consumption tends to be related to accessibility, so that those with higher disposable income or socio-economic status are likely to drink more.⁶⁴ Socio-economic status (SES) is a factor that is based largely on income, education and employment.⁶⁵ In Canada, men and women with high SES are more likely to drink and undertake risky drinking than those with low SES.⁷ However, people with lower SES appear to be more vulnerable to tangible problems and consequences of alcohol consumption.⁶⁶



Those of lower income drink less but are at increased risk of harm from alcohol.

Theories explaining why people with lower SES face disproportionate harm from alcohol use:

- **Materialist:** Those with fewer resources (be it social, economic or environmental) are less protected to cope with adverse effects of alcohol.
- **Inaccurate consumption reporting:** Self-reports and omission of some high prevalence groups, e.g. people experiencing homelessness. (Studies are often criticised for not being accurate in this area).
- **Other unhealthy behaviours:** When adding alcohol into the mix of other harmful behaviours, alcohol acts as a catalyst, accelerating and multiplying negative effects rather than just accumulating.
- **Drinking patterns:** binge drinking in lower Socio-Economic Status (SES) groups vs. more regular drinking among higher SES groups (not been substantiated by research).

(Gallinat, 2016)⁶⁷

Alcohol interacts with other risk factors and conditions, including, for example, tobacco use, unhealthy diet, and physical inactivity resulting in elevated health risks. For certain types of cancer, a combination of drinking and tobacco smoking will lead to risk levels that are considerably higher than those found among drinkers who do not smoke, or smokers who do not drink.⁶⁸

There is increasing consensus that the key path towards health equity is creating public policy that strengthens and makes more equitable the distribution of the social determinants of health.⁶⁹ The World Health Organization suggests that health equity can be promoted by improving living conditions by considering health equity in all policies, systems, and programmes. Policies that improve access to social determinants such as education, employment and housing, for example, also improve health outcomes.¹²

Local Findings for Haldimand and Norfolk Counties

Emergency Department Visit Rates for Alcohol-Related Chronic Conditions

The following data highlights chronic diseases that are 100 per cent attributable to alcohol consumption and result in emergency department visits. These include alcoholic psychosis, alcohol abuse, alcohol dependence syndrome, alcohol polyneuropathy, degeneration of nervous system due to alcohol, alcoholic myopathy, alcoholic cardiomyopathy, alcoholic gastritis, alcoholic liver disease, fetal alcohol syndrome, fetus and newborn affected by maternal use of alcohol, and alcohol-induced chronic pancreatitis.

These conditions are 100 per cent preventable.

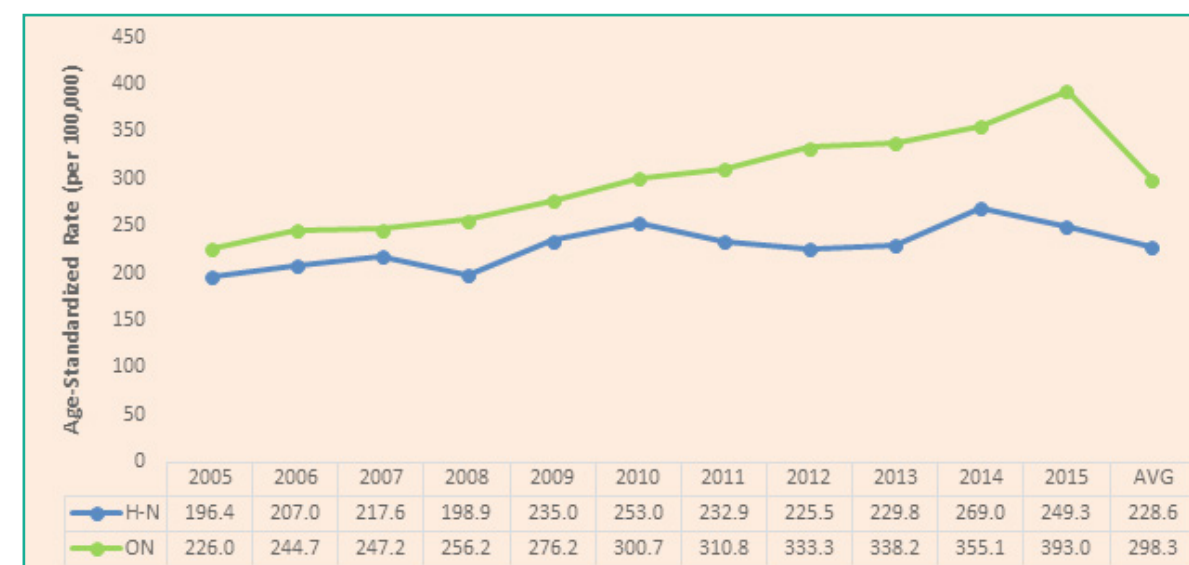
Data exclude other alcohol-related chronic conditions such as cancer, cardiovascular disease and over 60 other medical conditions in which alcohol consumption plays a critical role but are not 100 per cent attributable to alcohol.



“I’m concerned that alcohol consumption has become so commonplace that it isn’t considered a drug in the collective consciousness of the community. Alcohol is treated very differently than all other drugs, yet its effects on the user and those around the user can be equally devastating.” - Community member



Figure 11: Age-Standardized Emergency Department Visit Rates for Alcohol-Related Chronic Conditions (Both Sexes Combined)



Data Source: Emergency Department Visits and Ontario Population Estimates 2005-2015, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO.

Table 8: Total Number of Emergency Department Visits for Alcohol-related Chronic Conditions

	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	AVG.	Total
HN Total#	230	235	249	220	261	285	265	259	249	295	264	263.4	2,812

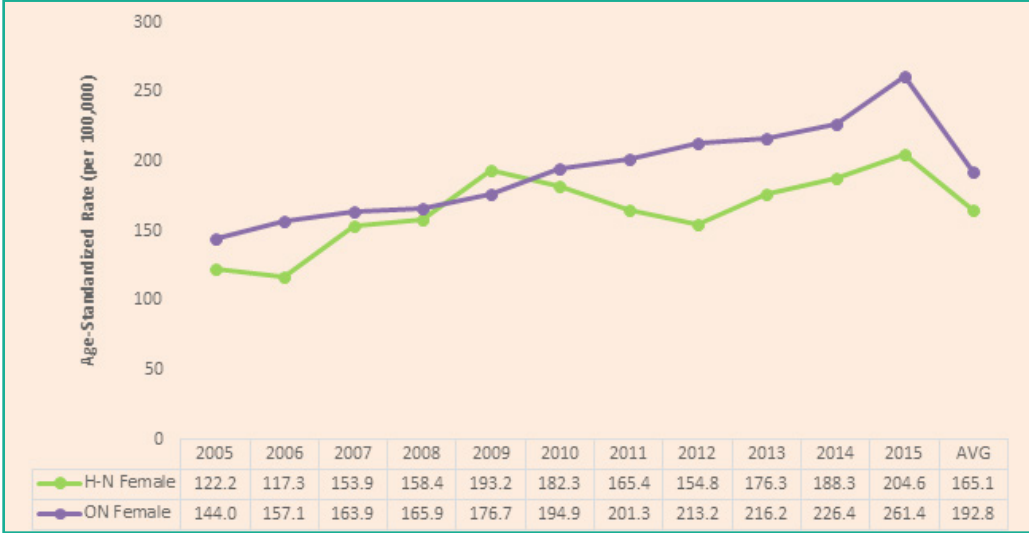
Data Source: Emergency Department Visits and Ontario Population Estimates 2005-2015, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO.

From 2005 to 2015, the average age-standardized rate for emergency department visits for alcohol-related chronic conditions was 228.6/100,000. These rates for Haldimand and Norfolk have consistently been lower than the province.

Since 2005, there were 2,812 emergency department visits due to alcohol-related chronic conditions, of which all were 100% preventable.

Overall since 2005, age-standardized rates for emergency department visits for alcohol-related chronic conditions have increased. This is consistent with the province.

Figure 12: Age-Standardized Emergency Department Visit Rates for Alcohol-Related Chronic Conditions, per 100,000 (females)



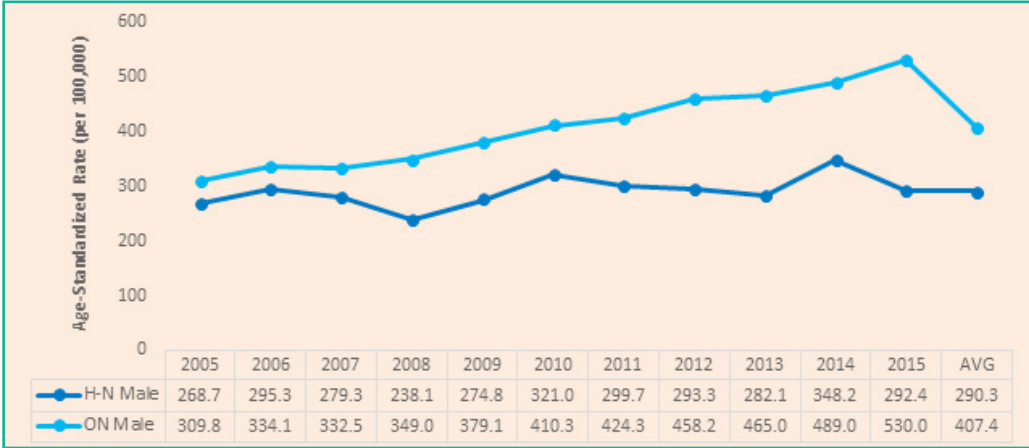
Data Source: Emergency Department Visits and Ontario Population Estimates 2005-2015, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO

Table 9: Total Number of Emergency Department Visits for Alcohol-related Chronic Conditions (females)

	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	AVG.	Total
HN Total#	70	66	82	85	98	103	94	81	93	101	103	179.0	976

Data Source: Emergency Department Visits and Ontario Population Estimates 2005-2015, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO.

Figure 13: Age-Standardized Emergency Department Visit Rates for Alcohol-Related Chronic Conditions, per 100,000 (males)



Data Source: Emergency Department Visits and Ontario Population Estimates 2005-2015, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO

Table 10: Total Number of Emergency Department Visits for Alcohol-related Chronic Conditions (males)

	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	AVG.	Total
HN Total#	160	169	167	135	163	182	171	178	156	194	161	166.9	1836

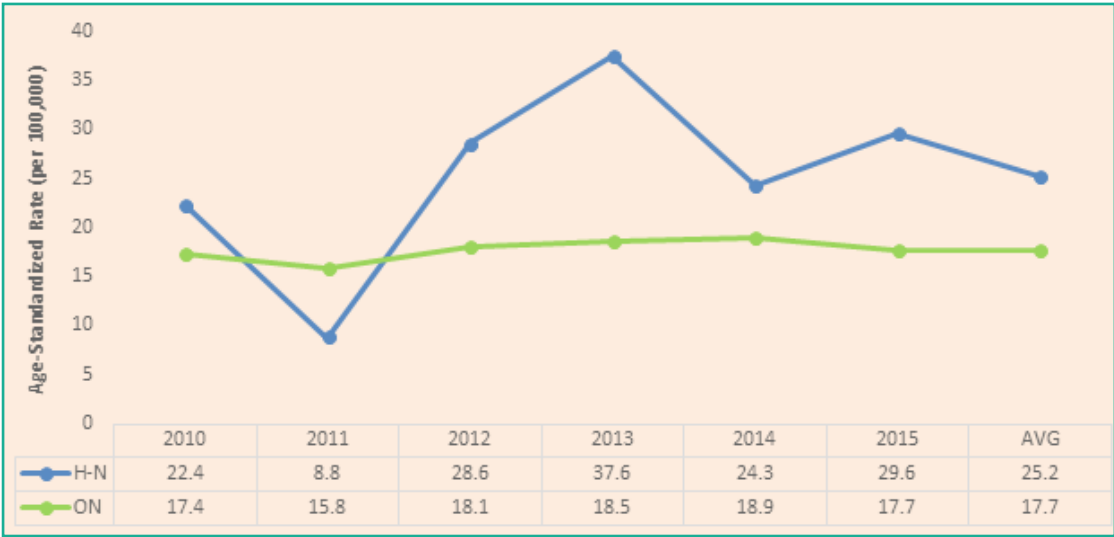
Data Source: Emergency Department Visits and Ontario Population Estimates 2005-2015, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO.

Haldimand and Norfolk males were twice as likely compared to females to visit the emergency department for alcohol-related chronic conditions.

Emergency Department Visit Rates for Alcohol-Related Acute Causes

The following data highlights acute conditions that are 100 per cent attributable to alcohol consumption and result in emergency department visits. These include alcohol poisoning, suicide by and exposure to alcohol and excessive blood level of alcohol. Data exclude alcohol-related acute causes such as motor vehicle crash injuries and other acute causes of injuries such as fall injuries, drowning injuries, burns, and countless other conditions that are not 100 per cent attributed to alcohol consumption but are a result of person's alcohol consumption or a result of someone else's alcohol consumption e.g. victims of impaired driving.

Figure 14: Age-Standardized Emergency Department Visit Rates for Alcohol-Related Acute Causes, per 100, 000 (both sexes combined)



Data Source: Emergency Department Visits and Ontario Population Estimates 2010-2015, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO

Table 11: Total Number of Emergency Department Visits for Alcohol-related Acute Causes (both sexes)

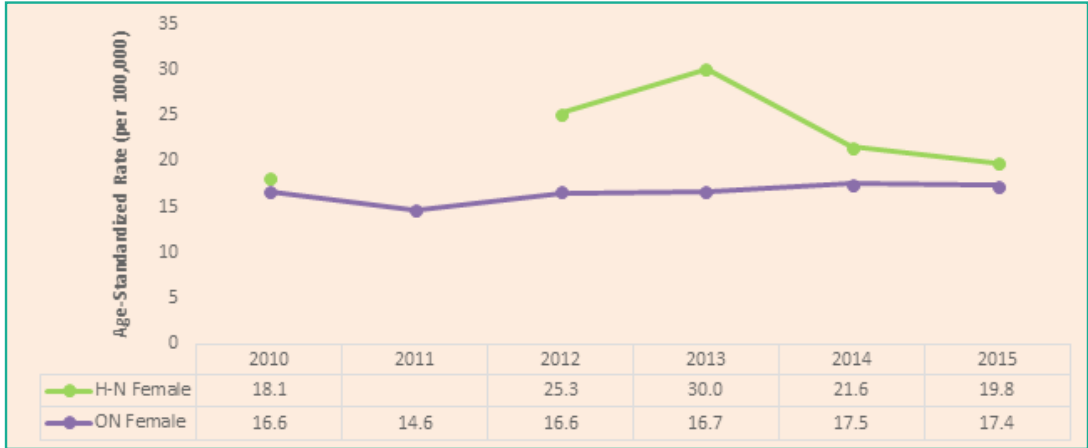
	2010	2011	2012	2013	2014	2015	AVG.	Total
HN Total #	22	8	30	36	24	27	24.5	147

Data Source: Emergency Department Visits and Ontario Population Estimates 2010-2015, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO

Since 2010, there were 147 emergency department visits for alcohol-related acute causes in Haldimand and Norfolk, all of which could have been prevented.

Haldimand and Norfolk typically had higher age-standardized emergency department visit rates for alcohol-related acute causes compared to the province. (Average: 25.2 vs. 17.7/100,000).

Figure 15: Age-Standardized Emergency Department Visit Rates for Alcohol-Related Acute Causes, per 100,000 (females)



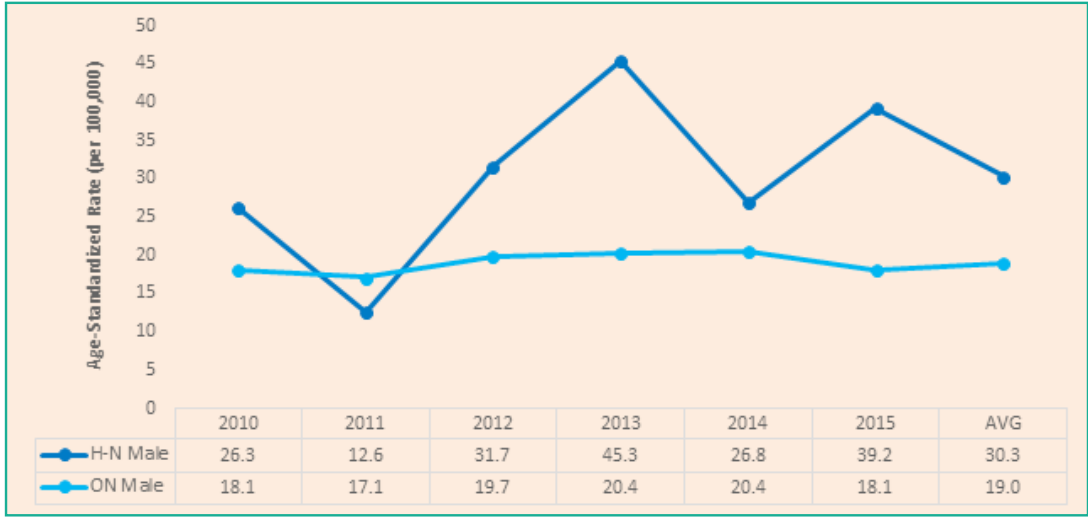
Data Source: Emergency Department Visits and Ontario Population Estimates 2010-2015, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO

Table 12: Total Number of Emergency Department Visits for Alcohol-related Acute Causes (females)

	2010	2011	2012	2013	2014	2015	AVG.	Total
HN Female #	9	**	14	14	11	9	9.5	57

Data Source: Emergency Department Visits and Ontario Population Estimates 2010-2015, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO.
** High sampling variability data was not releasable.

Figure 16: Age-Standardized Emergency Department Visit Rates for Alcohol-Related Acute Causes, per 100,000 (males)



Data Source: Emergency Department Visits and Ontario Population Estimates 2010-2015, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO.

Table 13:Total Number of Emergency Department Visits for Alcohol-related Acute Causes (males)

	2010	2011	2012	2013	2014	2015	AVG.	Total
HN Male #	13	6	16	22	13	18	14.7	88

Data Source: Emergency Department Visits and Ontario Population Estimates 2010-2015, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO.

Since, 2010, there were more emergency department visits for males than females in Haldimand and Norfolk for alcohol-related acute cases.

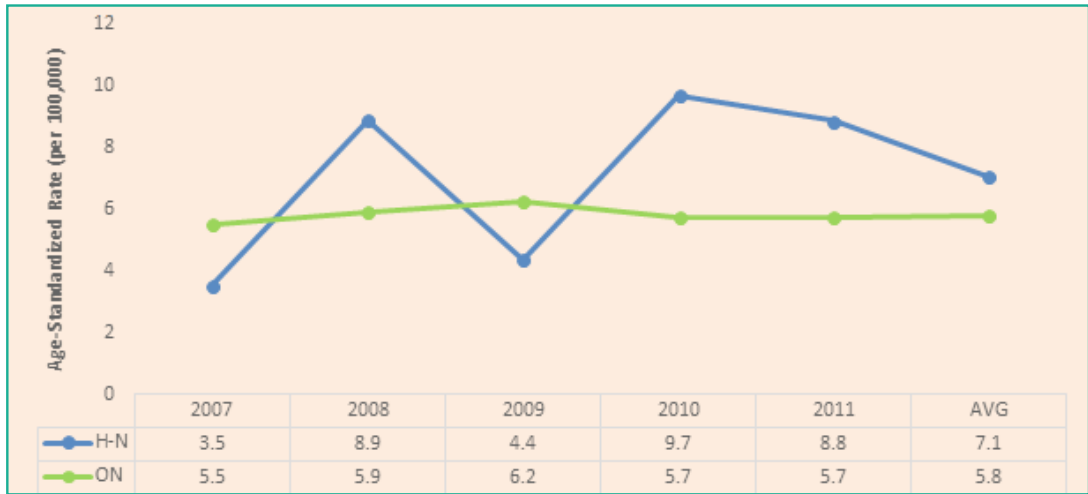
In 2015, males had higher age-standardized rates for emergency department visits for alcohol-related acute causes than females in Haldimand and Norfolk (average: 39.2 vs. 19.8/100,000).

Alcohol-Related Mortality Rates

The following data highlights mortality rates for chronic diseases and acute causes that are 100 per cent attributable to alcohol consumption as listed in the emergency department visits section.

The following data exclude deaths that are not 100 per cent alcohol attributed causes such as cancers, stroke or cardiovascular deaths, deaths as a result of impaired driving, falls, or drownings in which alcohol consumption was a contributing factor but not the primary cause of death.

Figure 17: Age-Standardized Alcohol-related Mortality Rates, per 100, 000 (Both Sexes Combined)



Data Source: Ontario Mortality Data and Ontario Population Estimates 2007-2011, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO.
Date Note: Mortality data included 100% alcohol attributed causes (chronic causes and acute causes). The primary cause of death code was used. Includes Ontario residents only.

Table 14: Total Number of Alcohol-Related Deaths (both sexes)

	2007	2008	2009	2010	2011	AVG.	Total
HN Total #	6	14	7	16	13	7.1	56

Data Source: Ontario Mortality Data and Ontario Population Estimates 2007-2011, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO.
Date Note: Mortality data included 100% alcohol attributed causes (chronic causes and acute causes). The primary cause of death code was used. Includes Ontario residents only.

Between 2007 and 2011, 56 deaths have been caused by alcohol in Haldimand and Norfolk, all of which were preventable.

The average age-standardized rate for alcohol mortality was 7.1/100,000. These rates have not been stable in Haldimand and Norfolk but overall are higher than the province (average: 7.1 vs. 5.8/100,000).

What Do We Do Now?

Healthy public policy and community-wide programs facilitating healthier individual choices are more effective in reducing the prevalence of modifiable risk factors at a population level than trying to change behaviours one person at a time.¹⁸

(Dr. Linda Rabeneck, Cancer Care Ontario)

Strategic Action Needed

An effective response to alcohol-related problems is beyond the scope of a single government department, organization, agency, community or individual. A comprehensive approach to reducing alcohol-related harm which focuses on population interventions combined with targeted interventions is required.¹² A two-tiered approach is recommended to counteract the negative impacts of alcohol use.

Population-based prevention efforts are needed to focus on shifting the community alcohol norms and to lower the large number of moderate risk drinkers and the smaller number of high-risk alcohol drinkers to effectively reduce alcohol-related harm and costs to community.⁷⁰ Promoting *Canada's Low-Risk Alcohol Drinking Guidelines* can help reduce risky alcohol consumption among the population; however education and persuasion approaches alone will not be enough to create a culture of moderation in Canada.¹²

Below is a list of evidence based recommendations from the Locally Driven Collaborative Project (LDCP) workgroup in the 2014 report “*Addressing Alcohol Consumption and Alcohol-Related Harms at the Local Level*”. The Haldimand-Norfolk Health Unit aims to work on implementing some of these evidence-based actions as well as establishing a local stakeholder group to address this issue.

“Alcohol consumption is a major contributor to public health and safety harms – not only to drinkers but also to non-drinkers and other innocent victims. Is associated with traffic crashes, violence, property damage, family breakdown, work place injuries and incidents, cancer and other chronic diseases, to mention a few. Stronger precautionary pricing policies, controls on the number of alcohol outlets, effective server training, and easy access to treatment and counselling are components of a comprehensive community-based response.”

- Dr. Norman Giesbrecht CAMH

Recommendations for Local Level Actions

Pricing and Taxation	1. Work with community partners to support the creation and advancement of a local stakeholder group to educate the public and policy makers. 2. Work with local municipalities to identify and implement local pricing strategies.
Physical Availability	3. Work with community stakeholders to continue to prevent further expansion of alcohol sales. 4. Continue to influence policy development around outlet density and hours of alcohol sale at the provincial and/or local level
Marketing and Advertising	5. Implement youth engagement strategies to empower youth to advocate against alcohol marketing and advertising. 6. Continue to explore effective counter-marketing approaches to alcohol advertising and marketing.
Modifying the Drinking Environment	7. Create an alcohol report about your community to show alcohol consumption, availability and alcohol related harms at the local level. 8. Work with local businesses and stakeholders to modify the drinking environment.
Drinking and Driving Countermeasures	9. Work with law enforcement and community stakeholders to incorporate local surveillance data on alcohol related harms into a community report, including local drinking and driving statistics. 10. Support municipalities and law enforcement to continue to enforce existing laws and regulations around drinking and driving.
Education and Awareness-Raising	11. Implement education and awareness-raising strategies as a part of a balanced and comprehensive approach.
Treatment and Early Intervention	12. Build the capacity of health care professionals to implement early intervention and screening into their practice. 13. Implement early intervention strategies as a part of an overall strategy to reduce alcohol-related harms.

Source: Locally Driven Collaborative: Addressing Alcohol Consumption and Alcohol-Related Harms at the Local Level

Implementation Strategies for Local Level Action

The following are just a few examples of local level actions and advocacy opportunities to affect change in our communities. Haldimand and Norfolk residents and agencies are welcome to investigate other strategies and are encouraged to mobilize to spearhead initiatives to decrease alcohol-related harms.

For Municipalities

- Create or update Municipal Alcohol Policies (MAPs) in Haldimand and Norfolk Counties
- Advocate for the creation of a provincial alcohol strategy - Ontario does not have a provincial alcohol strategy. A coalition of leading health organizations have been calling on the Ontario government to develop a comprehensive alcohol strategy to address the health harms of alcohol for a long time and issued a formal request in 2015 especially concerned with the announcement of the planned introduction of beer sales to grocery stores across the province (please see appendix D). The Ministry of Health and Long Term Care, Strategic Initiatives Branch in the Population and Public Health Division conducted a consultation in February of 2016 and was supposed to consult with their colleagues from other parts of government, public health, and industry leaders and report back to Cabinet with a draft Alcohol Policy in the spring of 2016, to be followed by the policy's implementation. However at the time of this report in 2017, this has yet to happen.
- Strengthen local zoning regulations to avoid congestion of alcohol outlets.
- Offer alcohol-free entertainment, recreation and community events.
- Apply alcohol industry sponsorship restrictions to community events.
- Strengthen local restrictions on alcohol advertising such as imposing constraints on number, location, size, and content of ads - Exposing young people to alcohol marketing increases the likelihood of adolescents starting to drink alcohol and increases the amount consumed by those already drinking.^{72,73}

For community stakeholder groups and others

- Advocate for more liquor inspectors - there are currently only two liquor inspectors covering not only the vast geographic region of Haldimand and Norfolk counties but also multiple neighbouring counties and municipalities. Inspectors are responsible for liquor enforcement at licensed establishments, special events, "stag and does", summer festivals and more. In addition, these inspectors also inspect OLG lottery retail locations, beer and wine in grocery stores, charitable gaming events, just to name a few.
- File advertising concerns and complaints to Advertising Standards Canada and advocate for new standards.
- Advocate for introduction of standard drink labeling in addition to mandated alcohol per volume content on alcoholic beverage packaging and labels. Local wineries, breweries and distilleries can champion this change and elevate commitment to social responsibility - Communicating standard drink information helps in monitoring personal alcohol consumption. Lack of knowledge about standard drinks can preclude people from engaging in responsible drinking practices, even if they are aware of drinking

- guidelines and motivated to monitor and regulate their alcohol consumption.^{74,75,76}
- Incorporate health warnings on labels - this grassroots initiative that can be championed by local businesses to mirror changes is already implemented in other countries around the world.
- Develop a comprehensive and sustainable epidemiological surveillance system to capture effects of changes to alcohol availability, consumption patterns, alcohol-related harms and direct and indirect costs.
- Increase capacity for screening and brief interventions by advocating for the creation of an OHIP billing code for alcohol screening and early intervention strategies.

DID YOU KNOW?

Saskatchewan is an example of how well alcohol pricing policies can work to reduce alcohol consumption and related harm, while still generating economic gains. In 2010-2011, through mandated tax increases on beer and minimum pricing policies, the province of Saskatchewan decreased its consumption of alcohol by 135,000 liters of pure ethanol. Furthermore, these policy changes generated more than nine million dollars in revenue (Thomas, 2012b). The policy changes introduced by the province of Saskatchewan therefore led to a decrease in consumption (presumably in part due to the higher cost of alcohol), while still increasing government revenue due to the increased cost of alcohol.⁷¹

LDCP report, page 63.

Conclusion

Alcohol is a socially accepted part of everyday life for most Canadians and the most widely consumed psychoactive drug in Canada. Haldimand and Norfolk counties' alcohol outlet density and residents' drinking patterns and rates are higher than the provincial average. Alcohol is commonly consumed but it is not harmless, though it is often considered so.

Reducing alcohol related harms requires a collaborative approach with strong leadership and support at all levels. There is a need for more research to get a more accurate picture of harms related to alcohol at the local level as well as a need to evaluate current alcohol policies in our counties. There is an opportunity to challenge the status quo of alcohol culture and become more mindful of the exposure to alcohol advertising. At an individual level, there is an opportunity to empower Haldimand and Norfolk county residents to make informed decisions with regards to alcohol consumption.

The hope is that this report serves as a starting point of reflection, knowledge, and discussion among members of the community, local service providers, and decision makers and mobilizes collective action to reduce the harms associated with drinking alcohol in Haldimand and Norfolk communities.

Methodology

The Canadian Community Health Survey, IntelliHealth Ontario, and Public Health Ontario Snapshot data sources were used to extract data on alcohol related indicators.

Canadian Community Health Survey (CCHS)

The CCHS is a national population household survey conducted by Statistics Canada that provides timely, regular, cross-sectional estimates of health status, health determinants and health system utilization across Canada. The CCHS data is always collected from persons aged 12 and over living in private dwellings in over 100 health regions covering all provinces and territories. The CCHS excludes populations on Indian Reserves, youth aged 12 to 17 living in foster homes, Canadian Forces Bases and residents of certain remote regions. The CCHS covers approximately 98% of the Canadian population aged 12 and over.

Bootstrap weights were used to estimate precision. Bootstrap is a method used to create a mean value for a point estimate, calculate the point estimate using 500 different weights and calculate the variance and 95% confidence interval for that estimate.

A confidence interval is an interval within the true value of the variable in which the proportion, rate and mean are contained. In this report, this is calculated as a 95% probability. If the confidence bounds between point estimates do not overlap, then the difference between the estimates being compared are most likely statistically significant.

The bootstrapping method also produces the coefficient of variation (CV), which is used to determine if the point estimate is releasable. Data with a CV between 16.6% and 33.3% should be interpreted with caution due to high sampling variability. Data with a CV greater than 33.3% are not reportable due to extreme sampling variability and are therefore suppressed. Survey respondents who refused to answer the survey question or had a response coded as “don’tknow” or “not stated” or “refusal” were excluded from the indicators.

Public Health (PHO) Snapshots

PHO Snapshots was used to provide statistical data on adult levels and patterns of alcohol use in Haldimand-Norfolk and Ontario. The PHO Snapshots reports referenced in this document were based on data from the Canadian Community Health Survey.

IntelliHealth

IntelliHealth is a knowledge repository that contains clinical and administrative data collected from various sectors of the Ontario health care system. Some of the kinds of data that can be accessed through IntelliHealth include data related to hospital services, community care, medical services, vital statistics and population data. The following data were used in this research:

- Emergency Department Visit
- Ontario Mortality Data

Alcohol-Related ICD Codes- Chronic Disease – 100% Attributed Methodology

Cause	ICD-10
Alcoholic psychosis	F10.3-F10.9
Alcohol abuse	F10.0, F10.1
Alcohol dependence syndrome	F10.0, F10.1
Alcohol dependence syndrome	G62.1
Degeneration of nervous system due to alcohol	G31.2
Alcoholic myopathy	G31.2
Alcoholic cardiomyopathy	I42.6
Alcoholic gastritis	K29.2
Alcoholic liver disease	K70-K70.4, K70.9
Fetal alcohol syndrome	Q86.0
Fetus and newborn affected by maternal use of alcohol	P04.3, O35.4
Alcohol-induced chronic pancreatitis	K86.0
Acute Cause	ICD-10
Alcohol poisoning	X45, Y15, T51.0, T51.1, T51.9 (T codes not included for mortality data)
Suicide by and exposure to alcohol	X65
Excessive blood level of alcohol	R78.0

Reference: CDC Alcohol and Public Health: Alcohol-Related Disease Impact (ARDI)

References:

¹Health Canada. (2015). Canadian tobacco, alcohol and drugs survey 2013. Retrieved from <https://www.canada.ca/en/health-canada/services/canadian-tobacco-alcohol-drugs-survey/2013-summary.html>

²Canadian Public Health Association. (2011). Too high a cost: A public health approach to alcohol policy in Canada. Retrieved from http://www.cpha.ca/uploads/positions/position-paper-alcohol_e.pdf

³World Health Organization. (2009a). Global health risks: Mortality and burden of disease attributable to selected risk factors. Retrieved from http://www.who.int/healthinfo/global_burden_disease/GlobalHealthRisks_report_full.pdf

⁴World Health Organization. (2011). Global status report on alcohol and health. Retrieved from http://www.who.int/substance_abuse/publications/global_alcohol_report/msbgsruprofiles.pdf?ua=1

⁵Rehm, J., Mather, C., Popova, S., Thavorncharoensap, M., Teerawattananon, Y., & Patra, J. (2009). Global burden of disease and injury and economic cost attributable to alcohol use and alcohol-use disorders. *Lancet*, 373, 2223-2233. doi: 10.1016/S0140-6736(09)60746-7

⁶World Health Organization. (2014). Global status report on alcohol and health. Retrieved from http://apps.who.int/iris/bitstream/10665/112736/1/9789240692763_eng.pdf?ua=1

⁷Public Health Agency of Canada (2015). The Chief Public Health Officer's Report on the State of Public Health in Canada 2015: Alcohol Consumption in Canada. Retrieved from <https://www.canada.ca/content/dam/canada/health-canada/migration/healthy-canadians/publications/department-ministere/state-public-health-alcohol-2015-etat-sante-publique-alcool/alt/state-phac-alcohol-2015-etat-aspc-alcool-eng.pdf>.

⁸Butt, P., Beirness, D., Gliksman, L., Paradis, C., & Stockwell, T. (2011). Alcohol and health in Canada: A summary of evidence and guidelines for low risk drinking. Retrieved from <http://www.ccsa.ca/Resource%20Library/2011-Summary-of-Evidence-and-Guidelines-for-Low-Risk%20Drinking-en.pdf>

⁹Public Health Ontario. (2013). Alcohol policy at a glance [PowerPoint slides]. Retrieved from https://www.pub-lichealthontario.ca/en/LearningAndDevelopment/Events/Documents/AlcoholPolicyAtAGlance_2013.pdf

¹⁰Thomas, G.B., & Davis, C.G. (2006). Comparing the perceived seriousness and actual costs of substance abuse in Canada: Analysis drawn from the 2004 Canadian addiction survey. Retrieved from <http://www.ccsa.ca/Resource%20Library/ccsa-011350-2007.pdf>

¹¹Giesbrecht, N., Wettlaufer, A., April, N., Asbridge, M., Cukier, S., Mann, R., McAllister, J., Murie, A., Plamondon, L., Stockwell, T., Thomas, G., Thompson, K., & Vallance, K. (2013). Strategies to reduce alcohol-related harms and costs in Canada: a comparison of provincial policies. Retrieved from http://madd.ca/media/docs/Strategies-to-reduce-alcohol-related-harms-and-costs_ENG_FINALrevised.pdf

¹²Babor, T., Caetano, R., Casswell, S., Edwards, G., Giesbrecht, N., Graham, K., Grube, J., Hill, L., Holder, H., Homel, R., Livingston, M., Österberg, E., Rehm, J., Room, R., & Rossow, I. (2010). Alcohol: No ordinary commodity - Research and public policy second edition. New York, NY: Oxford University Press.

¹³Giesbrecht, N., & Ialomiteanu, A. (2013). Public opinion on alcohol policy, Ontario, Canada, 1996-2011: Findings, correlates and emerging issues. Presented at Alcohol Policy 16, Washington, DC, April, 2013.

¹⁴ Popova, S., Patra, J., Sarnocinska-Hart, A., Gnam, W. H., Giesbrecht, N. And REHM, J. (2012), Cost of privatisation versus government alcohol retailing systems: Canadian example. *Drug and Alcohol Review*, 31: 4–12. Doi: 10.1111/j.1465-3362.2010.00276.x

¹⁵Stockwell, T., Zhao, J., MacDonald, S., Pakula, B., Gruenewald, P., & Holder, H. (2009). Changes in per capita alcohol sales during the partial privatization of British Columbia's retail alcohol monopoly 2003–2008: a multi-level local area analysis. *Addiction* 104(11), 1827–1836. doi: 10.1111/j.1360-0443.2009.02658.x

¹⁶Stockwell, T., Zhao, J., MacDonald, S., Vallance, K., Gruenewald, P., Ponicki, W., Holder, H., & Treno, A. (2011). Impact on alcohol-related mortality on a rapid rise in the density of private liquor outlets in British Columbia: a local area multi-level analysis. *Addiction*, 106(4), 768–776. doi: 10.1111/j.1360-0443.2010.03331.x

¹⁷Thomas, G. (2012a). Analysis of beverage alcohol sales in Canada. (Alcohol Price Policy Series: Report 2) Ottawa, Ontario: Canadian Centre on Substance Abuse. Retrieved from <http://www.ccsa.ca/Resource%20Library/CCSA-Analysis-Alcohol-Sales-Policies-Canada-2012-en.pdf>

¹⁸Statistics Canada (2017). Control and sale of alcoholic beverages, for the year ending March 31, 2016. Retrieved from <http://www.statcan.gc.ca/daily-quotidien/170502/dq170502a-eng.pdf>

¹⁹Rehm J, Buliunas D, Brochu S, Fischer B. The Costs of substance Abuse in Canada 2002 Highlights. CCSA; 2006. Retrieved from <http://www.ccdus.ca/Resource%20Library/ccsa-011332-2006.pdf>

²⁰Thomas G. The Economics of alcohol Control Policy in Canada. Powerpoint Presentation at the Alcohol: No Ordinary Commodity Conference. 2010.

²¹Thomas, G.B., & Davis, C.G. (2006). Comparing the perceived seriousness and actual costs of substance abuse in Canada: Analysis drawn from the 2004 Canadian addiction survey. Retrieved from <http://www.ccsa.ca/Resource%20Library/ccsa-011350-2007.pdf>.

²²Cancer Care Ontario. (2015). Prevention system quality index: an inaugural report evaluating Ontario's efforts in cancer prevention. Toronto: Queen's Printer for Ontario. Retrieved from <https://tspace.library.utoronto.ca/bitstream/1807/74744/1/Prevention%20System%20Quality%20Index.pdf>

²³Health Canada. (2009) Canadian alcohol and drug use monitoring survey. Ottawa: Health Canada. Retrieved from http://www.hc-sc.gc.ca/hc-ps/drugs-drogues/stat/_2009/summary-sommaire-eng.php#alc

²⁴Thomas, G. (2012b). Levels and patterns of alcohol use in Canada. (Alcohol Price Policy Series: Report 1) Ottawa, Ontario: Canadian Centre on Substance Abuse. Retrieved from <http://www.ccsa.ca/Resource%20Library/CCSA-Patterns-Alcohol-Use-Policy-Canada-2012-en.pdf>

²⁵Ialomiteanu, A. R., Adlaf, E. M., Mann, R. E., & Rehm, J. (2009). CAMH Monitor eReport: Addiction & Mental Health Indicators Among Ontario Adults, 1977-2007. CAMH Research Document Series No. 25. Toronto: Centre for Addiction & Mental Health.

²⁶Lodge J., Rempel, B., & LeMar, J. (2011). Alcohol and Youth: Recommendations for research and analysis of Canadian data on alcohol and youth trends. The Alcohol Education Programs of the Ontario Public Health Association.

²⁷Zhao, J., Stockwell, T., & Thomas, G. (2015). An adaptation of the yesterday method to correct for under-reporting of alcohol consumption and estimate compliance with Canadian low-risk drinking guidelines. *Canadian Journal of Public Health* 106(4), 204-209. doi: 10.17269/CJPH.106.4753 Retrieved from http://www.cpha.ca/uploads/e-mail/cjph/v106i4/Volume_106_4_e204-e209.pdf

²⁸Stockwell, T., Zhao, J., & Macdonald, S. (2014). Who under-reports their alcohol consumption in telephone surveys and by how much? An application of the ‘yesterday method’ in a national Canadian substance use survey. *Addiction*, 109(10), 1657-1666. doi: 10.1111/add.12609

²⁹Canadian Centre on Substance Use and Addiction. (2011). Drinking Guidelines. Retrieved from <http://www.ccsa.ca/Eng/topics/alcohol/drinking-guidelines/Pages/default.aspx>

³⁰Miller, J.W., Naimi, T.S., Brewer, R.D., & Jones, S.E. (2007). Binge drinking and associated health risk behaviors among high school students. *Pediatrics*, 119(1), 76-85. doi: 10.1542/peds.2006-1517

³¹CCSA (2014). Youth AND Alcohol. Retrieved from <http://www.ccsa.ca/Resource%20Library/CCSA-Youth-and-Alcohol-Summary-2014-en.pdf>

³²Smyth, C., & Calverson, R. (2008). Alcohol, other drugs and related harms in Ontario 2008: A scan of the environment. Retrieved from http://www.camh.ca/en/hospital/Documents/www.camh.net/Public_policy/Public_policy_papers/HEP%20%20env%20scan%20January%202008.pdf

³³Centre for Addiction and Mental Health (CAMH) (2015). Drug Use among Ontario Students. Retrieved from http://www.camh.ca/en/research/news_and_publications/ontario-student-drug-use-and-health-survey/Documents/2015%20OSDUHS%20Documents/2015OSDUHS_Detailed_DrugUseReport.pdf

³⁴Manafò, E., & Giesbrecht, N. (2011). Alcohol, cancer and other health issues: An action plan for prevention. Toronto, ON: Toronto Cancer Prevention Coalition. Retrieved from <http://www.toronto.ca/legdocs/mmis/2011/hl/bgrd/backgroundfile-38346.pdf>

³⁵Rehm, J., Baliunas, D., Borges, G., Graham, K., Irving, H., Kehoe, T., Parry, C., Patra, J., Popova, S., Poznyak, V., Roerecke, M., Room, R., Samokhvalow, A. & Taylor, B. (2010). The relation between different dimensions of alcohol consumption and burden of disease: an overview. *Addiction* 105(5), 717-843. doi: 10.1111/j.1360-0443.2010.02899.x

³⁶Stockwell, T., Chikritzhs, T., Bostrom, A., Fillmore, K., Kerr, W., Rehm, J., & Taylor, B. (2007). Alcohol-caused mortality in Australia and Canada: Scenario analyses using different assumptions about cardiac benefit. *Journal of Studies on Alcohol and Drugs*, 68(3), 345–352. doi: 10.15288/jsad.2007.68.345

³⁷Ontario Injury Prevention Resource Centre (2008). Alcohol related injury - Evidence-based practice synthesis document. Retrieved from <http://www.oninjuryresources.ca/downloads/publications/AlcoholReview-D8.pdf>

³⁸herpitel, C.J., Borges, G., Giesbrecht, N., Hunderford, D., Peden, M., Poznyak, V., Room, R., & Stockwell, T. (2009). Alcohol and injuries: Emergency department studies in an international perspective. Retrieved from http://www.who.int/substance_abuse/msbalcinuries.pdf

³⁹SMARTRISK. (2006). The economic burden of injury in Ontario. Toronto, ON: SMARTRISK. Retrieved from <http://www.parachutecanada.org/downloads/research/reports/EBI2006-Ont-Final.pdf>

⁴⁰Canadian Institute for Health Information. (2007). Ontario trauma registry report: Major injury in Ontario, 2005- 2006 and 2006-2007. Toronto, ON : Canadian Institute for Health Information.

⁴¹Canadian Centre on Substance Use & Addiction. (2014). Cancer and Alcohol. Retrieved from <http://www.ccsa.ca/Resource%20Library/CCSA-Cancer-and-Alcohol-Summary-2014-en.pdf#search=alcohol%20and%20cancer>

⁴²Zhao, J., Stockwell, T., Roemer, A., & Chikritzhs., T. (2016). Is alcohol consumption a risk factor for prostate cancer? A systematic review and meta-analysis. *BMC Cancer*, 16(845), 1-13. doi: 10.1186/s12885-016-2891-z

⁴³Canadian Partnership Against Cancer. (2011). Alcohol Use and Cancer in Canada. Cancer Control Snapshot 5. Retrieved from http://www.cancerview.ca/idc/groups/public/documents/webcontent/rl_crc_snapshot_5.pdf

⁴⁴Cancer Care Ontario. (2014). Cancer risk factors in Ontario: Alcohol. Toronto: Queen’s Printer for Ontario. Retrieved from <https://www.cancercare.on.ca/ocs/curv/info/alcoholreport>

⁴⁵Public Health Agency of Canada. (2014). Fetal Alcohol Spectrum Disorder (FASD). Retrieved from <http://www.phac-aspc.gc.ca/hp-ps/dca-dea/prog-ini/fasd-etcaf/index-eng.php>

⁴⁶Popova, S., Lange, S., Burd, L., & Rehm, J. (2015). The burden and economic impact of fetal alcohol spectrum disorder in Canada. Toronto ON: Centre for Addiction and Mental Health. Retrieved from https://www.camh.ca/en/research/news_and_publications/reports_and_books/Documents/Burden%20and%20Eco%20Costs%20FASD%20Feb%202015.pdf

⁴⁷Singh, S., Sedgh, G., & Hussain, R. (2010). Unintended pregnancy: worldwide levels, trends and outcomes. *Studies in Family Planning*, 41(4), 241-250.

⁴⁸Borges, G., Cherpitel, C. J., Mondragon, L., Poznyak, V., & Gutierrez, I. (2004). Episodic alcohol use and risk of nonfatal injury. *American Journal of Epidemiology*, 159(6), 565-571.

⁴⁹Ramstedt, M. (2005). Alcohol and suicide at the population level – the Canadian experience. *Drug and Alcohol Review*, 24(3), 230-208.

⁵⁰Research and Evaluation Division of Kingston, Frontenac, Lennox & Addington Public Health. (2012). It starts here: A conversation about alcohol in the city of Kingston. Retrieved from http://www.iteuve.pt/Files/Research/KFLA_Public_Health_Safe_and_Sober_Alcohol_Report_November_2012.pdf

⁵¹Ministry of Health and Long-Term Care. (2012). Initial report on public health: Adult heavy drinking. Retrieved from http://www.health.gov.on.ca/en/public/publications/pubhealth/init_report/ahd.html#down56

⁵²Giesbrecht, N., Cukier, S., & Steeves, D. (2010). Collateral damage from alcohol: implications of ‘secondhand effects of drinking’ for population and health priorities. *Addiction*, 105(8), 1323-1325. doi: 10.1111/j.1360-0443.2009.02884.x

⁵³Ottawa Police Service. (2017). Drug facilitated sexual assault. Retrieved from <https://www.ottawapolice.ca/en/about-us/drug-facilitated-sexual-assault.asp>

⁵⁴Perreault, S. (2014). Criminal victimization in Canada. Retrieved from <http://www.statcan.gc.ca/pub/85-002-x/2015001/article/14241-eng.htm>

⁵⁵World Health Organization. (2006). Intimate partner violence and alcohol. Retrieved from http://www.who.int/violence_injury_prevention/violence/world_report/factsheets/fs_intimate.pdf

⁵⁶Office of the Chief Coroner, Ontario. (2008). Sixth annual report of domestic violence review committee. Retrieved from: http://cdhpi.ca/sites/cdhpi.ca/files/2008_Annual_Report_0_0.pdf

⁵⁷Public Health Agency of Canada. (2012). WHO facts on alcohol and violence: Intimate partner violence and alcohol. Retrieved from <http://www.phac-aspc.gc.ca/sfv-avf/sources/fem/fem-intin-alco/index-eng.php>

⁵⁸Perreault, S. (2016) Impaired driving in Canada, 2015. Retrieved on February 24, 2017 from <http://www.statcan.gc.ca/pub/85-002-x/2016001/article/14679-eng.pdf>

⁵⁹Ministry of Transportation of Ontario. (2014). Preliminary 2014 Ontario road safety annual report selected statistics Retrieved from <http://www.mto.gov.on.ca/english/publications/pdfs/preliminary-2014-orsar-selected-statistics.pdf>

⁶⁰Commission on Social Determinants of Health. (2007). Achieving health equity: From root causes to fair outcomes. Interim statement. Retrieved from http://apps.who.int/iris/bitstream/10665/69670/1/interim_statement_eng.pdf

⁶¹Ottawa Public Health. (2016). Status of alcohol in Ottawa: Let’s continue the conversation. Retrieved from http://www.ottawapublichealth.ca/en/reports-research-and-statistics/resources/Documents/state_of_alcohol_2016_en.pdf

⁶²Schmidt, L.A., Makela, P., Rehm, J., & Room, R. (2010). Alcohol: equity and social determinants. In: Blas, E. & Sivasankara Kurup, A. (Ed.). Equity, Social Determinants and Public Health Programmes (pp. 11-30). Geneva, Switzerland: World Health Organization.

⁶³Mikkonen, J., & Raphael, D. (2010). Social determinants of health: The Canadian facts. Toronto, ON: York University School of Health Policy and Management. Retrieved from: <http://thecanadianfacts.org>

⁶⁴Demers, A., & Kairouz, S. (2003). A multilevel analysis of change in alcohol consumption in Quebec, 1993-1998. *Addiction*, 98(2), 205-213. doi: 10.1046/j.1360-0443.2003.00272.x

⁶⁵Shavers, V.L. (2007). Measurement of socioeconomic status in health disparities research. *Journal of the National Medical Association*, 99(9), 1013-1023. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2575866/pdf/jnma00208-0045.pdf>

⁶⁶Grittner U., Kuntsche S., Graham, K., & Bloomfield, K. (2012). Social inequalities and gender differences in the experience of alcohol-related problems. *Alcohol and Alcoholism*, 47(5), 597–605. doi: 10.1093/alcalc/ags040

⁶⁷Gallinat, A. (2016). The alcohol harm paradox – Or why alcohol related harm affects poor people more, although they drink less. *Euro Health Net Magazine* #8. from <http://www.eurohealthnet-magazine.eu/ehn-magazine-8/the-alcohol-harm-paradox-or-why-alcohol-related-harm-affects-poor-people-more-although-they-drink-less/?platform=hootsuite>

⁶⁸Zeka, A., Gore, R. & Kriebel, D. (2003). Effects of alcohol and tobacco on aerodigestive cancer risks: a meta-regression analysis. *Cancer Causes and Control*, 14(9), 897-906.

⁶⁹World Health Organization. (2008). Closing the gap in a generation: Health equity through action on the social determinants of health. Retrieved from http://apps.who.int/iris/bitstream/10665/43943/1/9789241563703_eng.pdf

⁷⁰Giesbrecht N., Stockwell T., Kendall P., Strang R., and Thomas G.. Alcohol in Canada: reducing the toll through focused interventions and public health policies. *CAMJ*, March 8, 2011 183(4)

⁷¹Locally Driven Collaborative Project. (2014). Addressing Alcohol Consumption and Alcohol-Related Harms at the Local Level. Retrieved from http://www.oninjuryresources.ca/downloads/workgroups/ldcpalcohol/LDCP_report_FINAL.pdf

⁷²Anderson, P., de Bruijn, A., Angus, K., Gordon, R., & Hastings, G. (2009). Impact of alcohol advertising and media exposure on adolescent alcohol use: A systematic review of longitudinal studies. *Alcohol and Alcoholism*, 44(3), 229-243. doi:10.1093/alcalc/agn115

⁷³Smith, L.S., & Foxcroft, D.R. (2009). The effect of alcohol advertising, marketing and portrayal on drinking behaviour in young people: systematic review of prospective cohort studies. *BMC Public Health* 9(51). doi:10.1186/1471-2458-9-51

⁷⁴Hawks, D. (1999). Not much to ask for, really! The introduction of standard drink labelling in Australia. *Addiction*, 94(6), 801–811.

⁷⁵Dowling, N., Clark, D., & Corney, T. (2006). Responsible drinking knowledge: A comparison of Australian apprentices and university students. *Youth Studies Australia*, 25(3), 42–48.

⁷⁶De Visser, R.O., & Birch, J. (2012). My cup runneth over: Young people’s lack of knowledge of low-risk drinking guidelines. *Drug and Alcohol Review*, 31, 206–12.

APPENDIX A

COMMUNITY STAKEHOLDER CONSULTATION ON ALCOHOL MISUSE
PREVENTION

OCTOBER 26, 2016

HALDIMAND-NORFOLK HEALTH UNIT

12 GILBERTSON DRIVE, SIMCOE, ON

List of Agencies that participated

Haldimand-Norfolk Health Unit
London Health Sciences
Haldimand OPP
Norfolk OPP
Haldimand EMS & Fire Services
Norfolk EMS
Norfolk Fire Services
War Memorial Hospital Dunnville
West Haldimand Hospital - Hagersville
Hamilton Health Sciences
London Health Sciences
Community Addictions and Mental Health Services of HN
Holmes House
HN Reach

Community Consultation Highlights

Some issues related to alcohol use in Haldimand-Norfolk included impaired driving, trauma, underage drinking (bush parties), assaults, domestic violence, family/laborer disputes, falls, drownings, MVC, addictions and mental health, family dysfunction, neglect, abandonment, physical/emotional abuse. One particular statistics from the OPP estimated that about 25%* of domestic violence calls were related to alcohol (*% reflects stat from the past two months and is not necessarily representative of a trend)

Stakeholders noted alcohol use as a socially acceptable behavior and therefore people do not see it as a problem. They also shared how alcohol use is glorified (e.g. Jocks seen as party animals are admired) but that there is lack of knowledge and awareness of alcohol harms. There was also discussion about specific challenges of high influx of tourists and public intoxication during certain events (Pottahawk, Friday the 13th, etc.) and also during long weekends and summer. The participants noted that most actions were reactionary and needing to be more proactive.

Stakeholders made frequent reference to existing strategies and agencies (such as CAMHS, Holmes House, RIDE, MAP in Norfolk County, Community Services Officer, OSAID, PHN in schools, OPP kids, high school liaison etc.) that are making a difference, and pointed to the need for collaboration and community engagement including bringing licensed establishments into the conversation.

Key informants pointed to regulations expanding alcohol availability as a barrier in reducing problems. In order to counteract this barrier, the group noted the need for a multi-tiered approach and community mobilization as well as a balanced approach between the promotion of alcohol industry (Wineries & Breweries) for economic growth in the region and using education and awareness such as promoting and expanded advertising of the Low Risk Drinking guidelines. There were also concerns about competing issues (drinking and driving versus distracted driving) and also a worry that legalization of marijuana may take focus off of alcohol.

Participants voiced concerns about public safety in relation to drinking, linking this to issues such as violence and impaired driving. Participants also noted the alcohol and mental health co-occurrence as another challenge. Lack of public transportation was also seen as a barrier to reducing problems related to alcohol.

Screening and brief intervention was specifically mentioned by participants as a potential solution and needing to be expanded but a barrier of no OHIP billing code for physician time for alcohol screening was also identified.

Stakeholders emphasized the benefits of and need for increased awareness and education. Education was frequently mentioned in relation to solutions to reduce alcohol related harm. Stakeholders specifically mentioned educating decision makers (Mayor, Council, BOH) in order for them to completely understand the issues related to alcohol.

Youth were one of the groups mentioned and a sense of collective responsibility around youth was evident. Participants noted the need to increase access to affordable activities (e.g. figure skating) for youth to provide alternative activities to ensure youth develop new skills and interests. Older adults (retired community) were mentioned as a priority group due to mixing medication and alcohol. Other groups or populations seen as priority included adults in general.

Lack of treatment options and stigma were seen as barriers. Stakeholders talked about the need to expand and improve treatment options. Youth were identified as a group in need of youth-focused treatment options. Stakeholders emphasized the lack of intensive residential treatment for youth as well as lack of access to services in general in rural areas. Other barriers mentioned were language and culture (as we have Mennonite and aboriginal communities in Haldimand and Norfolk Counties).

Community participants frequently framed alcohol problems as embedded within a larger social context where alcohol problems are intertwined with other problems such as unemployment, trauma, poverty and marginalization. Addressing these larger issues is important to preventing and reducing alcohol-related harm.

Small Group Discussions:

1. a. In your professional role, what are some of the issues related to alcohol use you see in H-N?
 - impaired driving :
 - legal
 - trauma
 - MVC
 - PTSD issues related to trauma
 - Bush parties/barn parties – (limited transportation)
 - Underage drinking (who’s providing alcohol)
 - Assaults
 - Crashes
 - Domestic violence
 - Family/ laborer disputes
 - Public intoxication (marina, pottahawk, Friday 13th)
 - Overconsumption of alcohol
 - Calls to bars
 - EMS primary/secondary calls
 - Falls
 - Drownings
 - MVC
 - Police OPP
 - 50% of calls alcohol related (need funding to prevent)
 - 25% of domestic violence calls related to alcohol
 - Reactive action (holidays, long weekends, seasonal summer, tourism)
 - REACH- deal with youth up to age of 18
 - Treatment- correlation b/w alcohol and suicide attempts/ideation
 - Bullying?
 - Holmes House – alcohol plays a huge role in adult addictions and mental health
 - Childhood trauma
 - Family dysfunction
 - Neglect
 - Abandonment
 - Physical abuse /emotional abuse
 - Trauma Hospitals - alcohol related cases – see presentation from London Health Sciences

b. What exists in H_N that is making it difficult to reduce problems around alcohol?

- Increased access – maybe it will lead to decrease in MVC (people not driving as much), increase in consumption
- Lack of public transportation, taxi, bus
- Large geographical area
- Influx of transient populations into the area – tourists
- Lack of resources to talk about decrease in use
- reactive vs proactive action
- socially acceptable behavior (people don't see a problem)
- promotion of alcohol industry for economic growth in the region
- family dynamics (whose job is it to talk to educate the children)
- social status – aboriginal communities
- Lack of jobs → alcohol use?
- Concurrent issues – MH / poverty/stressors/trauma
- Lack of knowledge of alcohol harms / lack of awareness
- “Wild West” – legislation not enforced or accepted
- Hometown not people visiting
- Normalized
- Rural area – lack of access to help services / isolation
- Data interpretation
- ER – busy environment / whose job is it to ask about alcohol use
- Lack of intensive residential treatment for youth
- Lack of treatment – availability and stigma
- Wineries / breweries
- Already dealing with grocery stores, convenience stores
- Event season (pottahawk, beerstock, Harvest fest, pumpkin fest, Friday 13)
- Weddings/ buck and doe

c. What groups or populations do you see as a priority with regards to alcohol related harms? Why?

- Youth up to age 18 (14-18) – REACH
 - Peers use → addiction
- Community at large – social acceptability / parents buying alcohol / behavior modification / need buy-in/ advertisement

- Target politicians – need to convince the government / start creating local policies
- Older adults /Retired community (community demographics) – mixing medication and alcohol
- Individuals with Mental Health issues
- Women H_N
- Adults (need to focus on more)
- IP – how do we know what we are doing makes a difference and changes behavior
- High tourism area
- High transient workers
- High unemployment

2a) What exists in H & N that is helping to prevent or reduce problems around alcohol?

- CAMHS:
 - addictions services
 - Holmes House
 - School Programs
- Situation Table
- Community mobilization
- CSO?
- OPP
 - high school liaison
 - VIP elementary (OPP Kids)
- AGCO – over serving (local licensed establishments /special events)
- Special occasion permits – partner with OPP
- Collaboration PHN in schools – counselling
- HU campaigns
- MADD
- OSAID – Ontario Students against impaired driving
- Annual reports which generate campaigns etc.
- Tracking of fires caused by alcohol
- AUDIT at hospitals like trauma hospital program and other professionals – dentists/pharmacists/ GP
- RIDE
- MAP (Norfolk)
- Sessions like today

b) Of the things you mentioned, are there any that should be expanded or improved?

- Mobile Crisis Rapid Response Team expand to Haldimand
- ↑ \$ penalties
- Bring licensed establishments into conversation
- Specific education campaign for mayor/council/BOH – to completely understand the issue
- Legalization of marijuana may take focus off of alcohol
- Treatment centers / # of beds / trained staff –counselling
- Awareness
- MAP (Haldimand)
- Expand SBIR at regional level / more frequent screening
- Zero tolerance for impaired driving
- Norfolk County promotes wineries and breweries (politically sensitive)
- Politicians (decision makers awareness)
- Balanced approach
- Expand LRDG advertising (LCBO LRDG ad)
- Injury prevention (nanny state – being told what to do / risk reduction instead / smart risk)
- Drinking in Europe vs Canada – mystifying alcohol
- Not reporting alcohol – not see as an issue e.g. seizures
- Increase access to affordable activities (like figure skating) for youth to give them something to do (to keep away from alcohol)
- Licensed sports lounges – bars open during hockey games, parents drinking
- Alcohol is legal – marijuana legalization might make the issue worse
- NOTE:
 - Social acceptability
 - Reactionary

c) Are there any barriers to doing work in this area within your workplace?

- Parental consent (freedom of information for disclosure)
- Staff capacity (management direction, less staff, same work)
- Funding
- Geography/transportations - Or person accessing services
- Limited resources and staff
- Language and culture
- Data codes
- Data collection
- Politics
- Provincial government – policies of ↑ available

- SBIR :
 - Whose job is it? not focused
 - comfort level / lack of training
 - Lack of time in ER to do SBIR
- Competing issues (drinking & driving VS distracted driving)
- No OHIP code for GP time for alcohol screening
- Lack of referral agencies – addictions full/wait list
- Myths of benefits of drinking / relapse
- Alcohol and mental health (co-occurrence)
- Social acceptability (jocks → party animal, looked up to / glorifying alcohol use)
- Voluntary services / self-referral (unless protection issues or immediate risk)

Questions:

- Who is responsible? Who leads?
- Does Council know about this project?

Open Discussion Segment

Q1. Do you find the data (in your own agency) captures the reality when it comes to alcohol related harms? How can we ensure that alcohol is captured in your agency (police, EMS calls, hospitals, Women's services)?

- OPP has a list of all accidents showing if alcohol was involved as well as related investigations (Liquor Licence Act charges, impaired driving, etc.)
- Hospitals record a broken arm but not how the break occurred. Did the arm break from a fall due to a person being drunk?
- After a vehicle accident does NGH track the blood alcohol of person who caused the accident and not the patient? If people from both vehicles come into hospital, would staff know which person has a high blood alcohol level?
- EMS captures the type of injury; alcohol is not the primary item captured.
- The OPP look at blood alcohol as a possibility; they look at it right away if it's considered part of an accident.

(Note: It looks like there is a need to improve the data gathered at some agencies to show the true extent of alcohol related harms).

Q2. The population is aging and alcohol use is increasing; the number of falls is increasing. How does alcohol use affect falls? How do we address this?

- The OPP talked about the aging community as well as the mixing of medications and alcohol.
- Trauma Services sees a lot of people, in their 50's and older, who have fallen from a ladder - they are not as steady and on medications. This is something they've always done; it's hard to suggest to people they shouldn't be on ladders while there are meds/alcohol in their system.
- Injury Prevention at the Health unit is looking at falls as well. What happens in the home when people are using alcohol? Equipment will not be used properly.
- Paramedics have a community program that looks at falls, meds, etc. The program is in jeopardy come March 2017.

Q3. What work is happening in regards to reaching youth? What are some of the barriers (e.g. school policies etc.)? How do we work together to come up with a solution?

- There has been a big change in the schools – they are getting stricter about providing services to students without parental consent. Has anyone seen a barrier or issue with this?

- OPP – has to be school related for an investigation, no issues so far.
- IMPACT (London Health Sciences) – have been in schools for 30+ years. All of the presentations must be approved; if they want to do a presentation at one school they need the Principal's ok, if it's broader and/or across Board, School Board approval is needed and they have to show how the presentation fits in with the curriculum.
- Hamilton Health Sciences - The Hamilton-Wentworth School Board has withdrawn a lot of presentation from outside agencies and it is now a big process to get approval to present. Presentation must be specific to the curriculum. If there is someone in the Board that can do the job (social workers etc.), you aren't allowed to bring someone in from outside.
- It is interesting to see how agencies are working around the barriers to get into schools. The Health unit is working within the comprehensive school health to get into the Norfolk and Haldimand schools.
- Addictions Counsellors aren't in the schools now. Counsellors need parental consent to see students. CAMHS is working with the school boards to get that changed.
- There is a gap - if a person has a mental health issue and an underlying issue (e.g. alcohol use); what comes first – mental health, alcohol/drug addiction, etc. We need to address where kids feel safe.
- It sounds like there is a need to have an open dialogue with school boards about what is going on and the seriousness of the issue. We need to get them on board and to start pulling others in. The school boards are the largest holder of our youth.
- School boards have a strong union; we need to be particularly sensitive to what the union won't grieve. If the union feels something is in contradiction to their agreement, it will be grieved. We don't have to be in the schools, we can take it to community events.
- It is important to find out why they are drinking - education, ease of access ...
- Students need a protective skill. Maybe schools aren't the right venue - the kids are an easy target at school. We must be sensitive to other targets too. Modelling behaviour is at the adult level - drinking and driving. We need consistent messaging.

Other Discussions

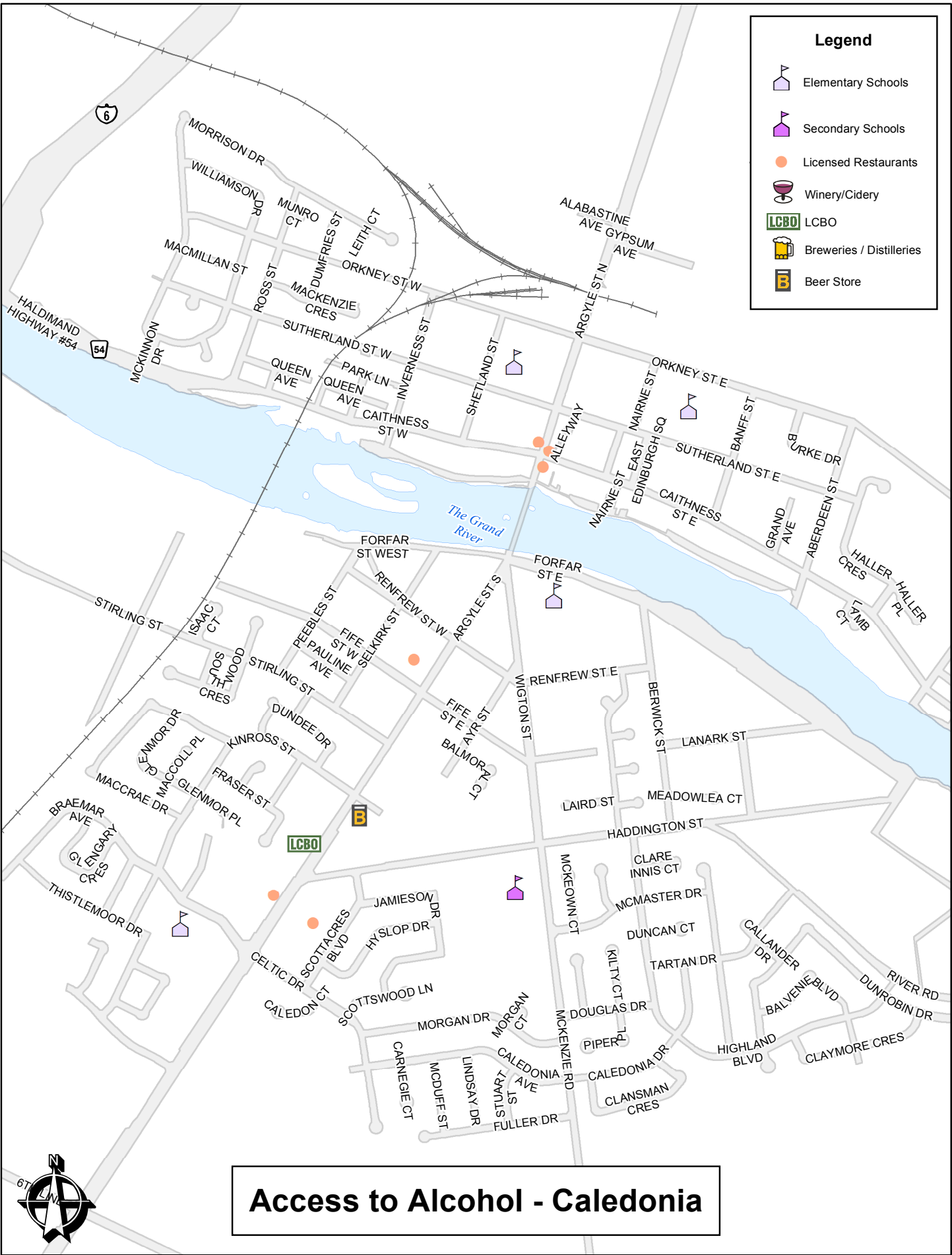
- 2015 is the first time parental provision of alcohol has been added in the Ontario Student Drug Use and Health Survey (OSDUHS) asking where students get alcohol and the results showed that 27% get alcohol from friends, family – it goes back to the social acceptability of alcohol.
- No one agency can do it all. We need to put our heads together to see what we can do. Target parents. Target students as well. It will be a long road to change, e.g. cultural norms. The first step is getting everyone in same room talking.
- It is the responsibility of parents and adults to teach kids; but if the adults don't know the low risk drinking guidelines, how do they teach the kids? We need to teach the adults too, need to change the thinking - if you're drinking at my house, forget the law of the underage drinking, it is normalized. Cultural norms are accepted. It will take time to get there.
- Hamilton Health Sciences- We need a comprehensive plan to reduce alcohol harms. Legalization of marijuana will be looked at next year. The majority of trauma hospitals in Ontario don't do drug testing; will have a challenge getting stats on drugs.
- Marijuana is a priority for the HU for substance use; we are not just working just on alcohol - it will be drugs and alcohol. Marijuana seems to be the common drugs of choice for many. Not everyone co-uses.
- One of leading causes of fire in homes is alcohol related – smoking and drinking. Cooking and drinking also put people at risk. Alcohol is a significant factor in fires and puts families at risk.
- CAMHS – People accessing alcohol related counselling shows numbers are high (no number provided).
- A submission from Haldimand EMS was also shared- "Haldimand EMS respond to calls regularly involving young users of alcohol. There is a need to educate the community about alcohol and the consequences of use".
- OPP – VIP in schools is now called OPP Kids.

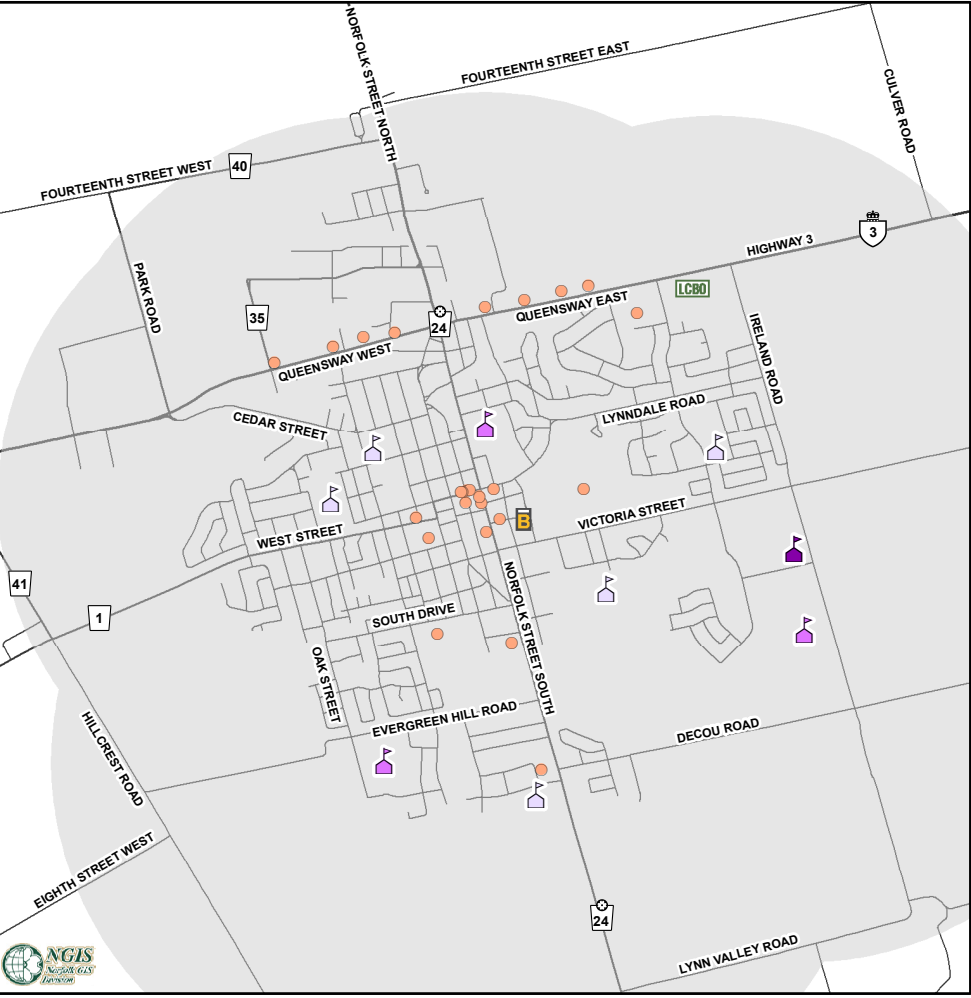
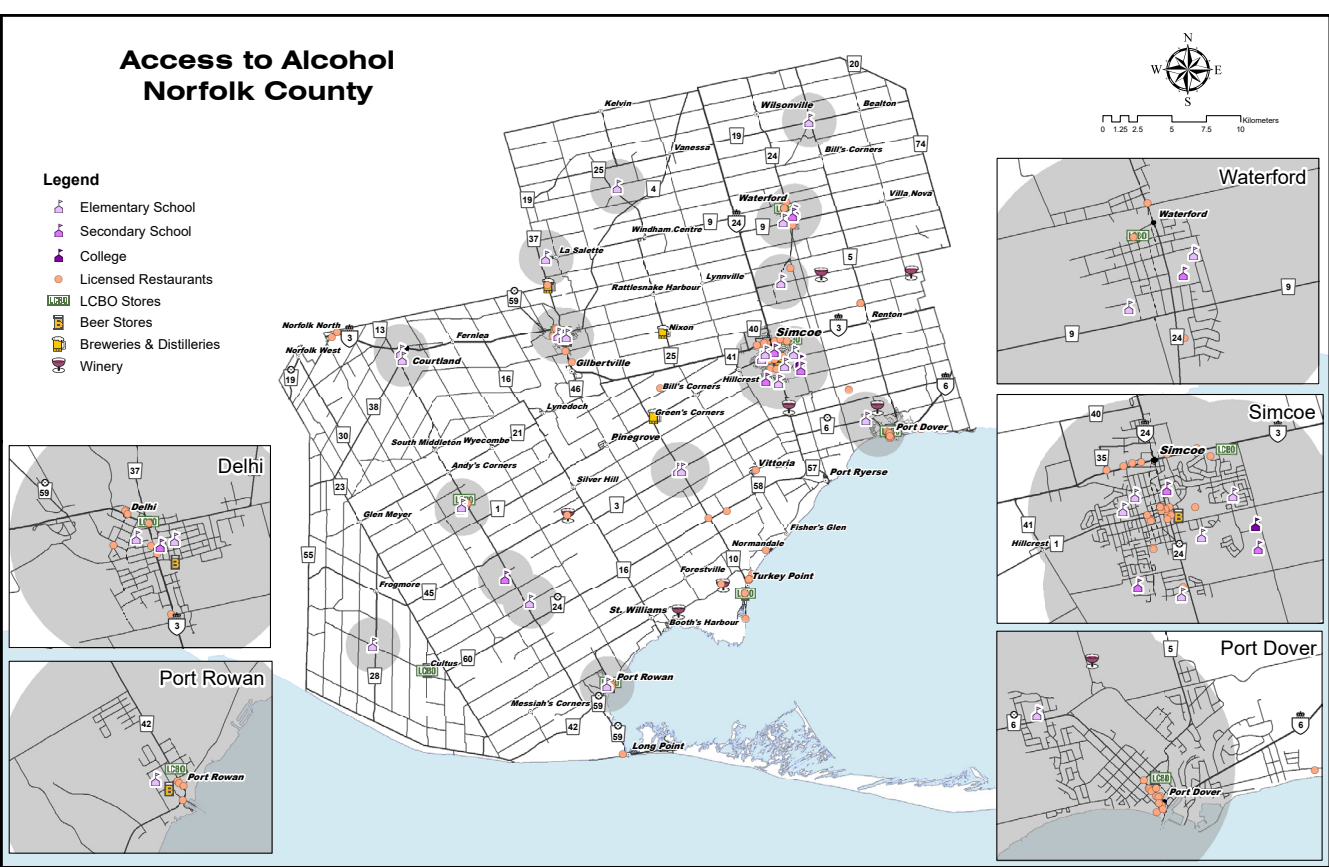
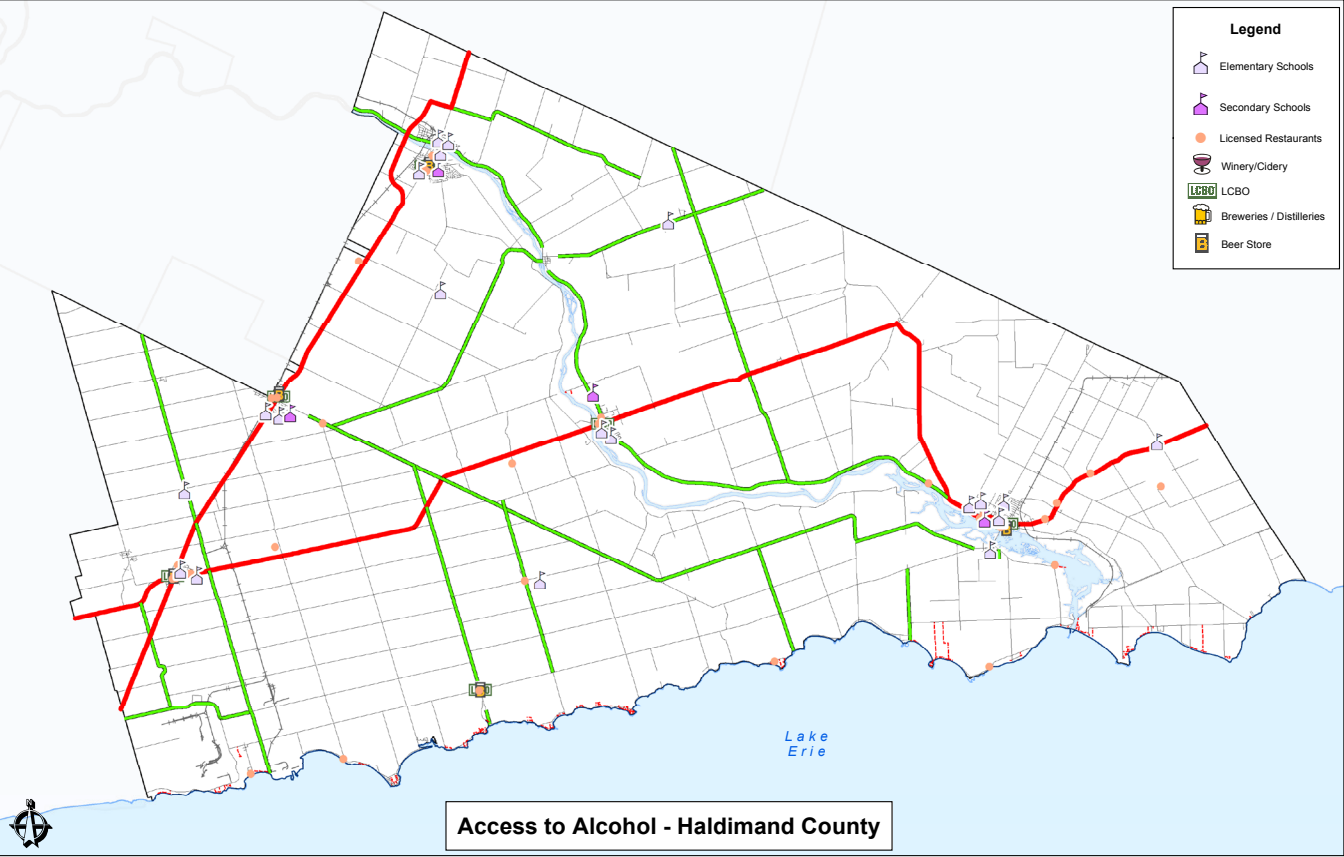
Final Note

The Health unit is planning an Alcohol Forum in 2017 so we are looking for anyone from attendees who would like to sit on a Forum Planning Workgroup or have any suggestions for speakers, etc. If you have anything else to share, please send an email or call and let us know. The Health unit will also be doing an anonymous online survey with the public. We want people to share if they are impacted by alcohol.

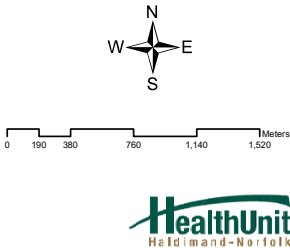
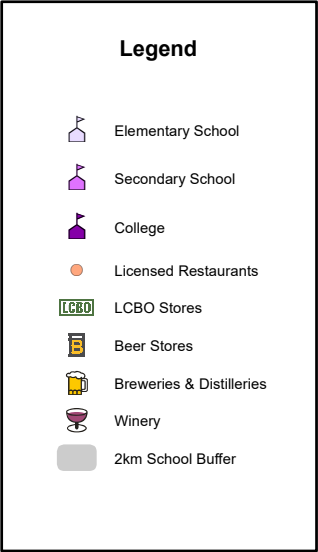
We hope to have the survey live within the next 2 weeks. Please share the survey link through your agencies. The survey will paint a picture of what's happening out there and who is being impacted.

APPENDIX B





Locations with Access to Alcohol SIMCOE



APPENDIX C



Ontario Provincial Police (PROTECTED A)
PROTECTED A

Ontario Provincial Police
West Region
Haldimand County Detachment
72 Highway 54, Cayuga, ON, ON N0A 1E0
Tel.: 905-772-3322 Fax: 905-772-5815

Occurrence: N/A Intelligence File: 2017-130-WRDAP Date: 23-Jan-17

Comprehensive Alcohol Strategy 2014 – 2016 Alcohol Related Events

The following tables represent the number of events in which alcohol was involved. Certain occurrence types (Domestics) have no tracking mechanism in place to monitor whether alcohol was involved. As a result, that data is unavailable at this time.

Collisions Involving Drugs/Alcohol	2014	2015	2016
	34	47	29
Impaired Operation of M/V (Alcohol)	2014	2015	2016
	104	134	105
ADLS Suspensions Related to Alcohol	2014	2015	2016
3 day Suspension (warn range)	33	38	18
7 day Suspension (warn range)	1	2	4
30 day Suspension (warn range)	0	0	0
24hr Suspension Novice Driver HTA (BAC < Zero)	1	2	0
24hr Suspension Driver<22yrs HTA (BAC < Zero)	0	0	0
Total ADLS Suspensions	35	42	22
Liquor Licence Act Occurrences	2014	2015	2016
	126	125	105
Liquor Licence Act Charges	2014	2015	2016
	133	139	115
Liquor Licence Act Arrests	2014	2015	2016
	75	72	63

James Robins, Provincial Constable 13436
James.robins@opp.ca



Ontario Provincial Police (PROTECTED A)
PROTECTED A

Ontario Provincial Police
West Region

Norfolk County Detachment
P.O. Box 738, 548 Queensway West, Simcoe, ON N3Y 4T2
Tel.: 519-426-3434 Fax: 519-426-2294

Occurrence: N/A Intelligence File: 6O - 16-984AN Date: 10-Jan-17
Prepared by: Paul CLARK, Provincial Constable 13713

Comprehensive Alcohol Strategy
2014 – 2016 Alcohol Related Events

The following tables represent the number of events in which alcohol was involved. Certain occurrence types (Domestics) have no tracking mechanism in place to monitor whether alcohol was involved. As a result, that data is unavailable at this time.

Collisions Involving Drugs/Alcohol	2014	2015	2016
	37	34	38

Impaired Operation of M/V (Alcohol)	2014	2015	2016
	98	91	81

ADLS Suspensions Related to Alcohol	2014	2015	2016
3 day Suspension (warn range)	43	54	30
7 day Suspension (warn range)	5	2	3
30 day Suspension (warn range)	0	1	0
24hr Suspension Novice Driver HTA (BAC < Zero)	0	0	1
24hr Suspension Driver<22yrs HTA (BAC < Zero)	0	1	2
Total ADLS Suspensions	48	58	36

Liquor Licence Act Occurrences	2014	2015	2016
	303	246	209

Liquor Licence Act Charges	2014	2015	2016
	407	357	310

Liquor Licence Act Arrests	2014	2015	2016
	130	87	91

Anyone requiring additional information is asked to contact the undersigned.

Paul CLARK, Provincial Constable #13713
Ontario Provincial Police
Norfolk County
519-426-3434

Data contained within this report is dynamic in nature and numbers will change over time as the Ontario Provincial Police continue to investigate and solve crime.

Low Sensitivity - Routine Information requiring protection. This report and the information contained therein is for the attention of any law enforcement agency and may be disseminated at the discretion of the recipient.

APPENDIX D

WHY ONTARIO NEEDS A PROVINCIAL ALCOHOL STRATEGY

Alcohol is widely consumed in Ontario. But its use is associated with a variety of harms.

Alcohol consumption is widely used and accepted in our society. The majority of us drink, and most of us do so without causing harm to ourselves or others. But alcohol consumption is responsible for a range of harms:

- It is one of the leading risk factors for death, disease and disability in Canada.¹
- Every year about a quarter of Ontario drinkers engage in high-risk drinking.²
- About a third of Ontarians experienced harm as a result of someone else’s drinking in the past year.³

Alcohol plays an important role in Ontario’s economy. But the costs far exceed the revenues.

The annual costs directly attributable to alcohol-related harms in the form of health care, law enforcement, corrections, prevention, lost productivity due to short- and long-term disability and premature mortality, and other alcohol-related problems, have been conservatively estimated at \$5.3 billion – well above the alcohol revenue accruing to the provincial government.^{4, 5} This means that the economic benefits of alcohol sales are more than offset by the costs, and that our approach to alcohol policy can be improved not only from a health perspective but also from a financial one.

Alcohol-related harms can be mitigated. But this requires a whole-of-government approach.

Research evidence clearly shows that policy tools designed to influence drinking levels and patterns can reduce the burden of death, disease, disability, and social disruption from alcohol.⁶ Among the most effective interventions are socially responsible pricing of alcoholic beverages, limits on the number of retail outlets and hours of sale, and marketing controls. These types of policies have been consistently shown to help reduce alcohol-related problems when implemented alongside more targeted interventions such as drinking and driving countermeasures, enforcement of the minimum legal drinking age, as well as screening, brief intervention and referral activities in the primary care setting.

In Ontario, as elsewhere, alcohol policy involves balancing interests – public health, government finances, economic development and consumer preferences for example – that are often at cross-purposes.⁷ As a result, alcohol policy can be fragmented and health is sometimes an afterthought. But alcohol-related harms impact all of society and the costs are borne by many government ministries and sectors, from Health and Long-Term Care to Community Safety and Correctional Services. There is a need for coordinated leadership and a comprehensive strategy.

Ontario has been an alcohol policy leader. But we are falling behind.

Historically there has been recognition in Ontario that alcohol is not an ordinary product and that a degree of control over its production and distribution is required in order to mitigate harms. Indeed, Ontario has been a national leader in a number of alcohol policy areas, with many promising practices in place.⁸ However, recent developments suggest an ongoing erosion of alcohol controls. Based on what we know from decades of research, we can expect to see an increase in alcohol-related harms as a result.

For example, in British Columbia, the introduction of private sector alcohol outlets was associated with a 3.25% increase in alcohol-related deaths for each 20% increase in private store density.⁹ Based on this finding, Ontario’s recent decision to sell beer in 450 grocery stores across the province could lead to 100+ alcohol-related deaths per year.¹⁰

Over the years, many voices from across Ontario’s health sector have called for a comprehensive alcohol strategy. A number of provinces are already moving ahead with their own provincial alcohol strategies: Nova Scotia and Alberta have strategies in place and Manitoba is currently developing one. We are falling behind.

Ontario has committed to ensuring a socially responsible approach to alcohol policy. Right now, we are falling short. It is imperative that Ontario commit to an approach to alcohol policy that prioritizes health and safety and considers the costs associated with alcohol consumption. Such an approach is critical to our health and well-being. **Our organizations believe that a provincial alcohol strategy is the best way to achieve this.**

For more information, please contact:

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¹ Lim et al. (2012). A comparative risk assessment of burden of disease and injury attributable to 67 risk factors and risk factor clusters in 21 regions, 1990-2010: A systematic analysis for the Global Burden of Disease Study 2010. *Lancet* 380, 2224-60.

² Ialomiteanu et al. (2014). *CAMH Monitor eReport 2013: Substance use, mental health and well-being among Ontario adults, 1977-2013*. CAMH Research Document Series No. 40. Toronto: Centre for Addiction and Mental Health.

³ Giesbrecht et al. (2010). Collateral damage from alcohol: implications of ‘second-hand effects of drinking’ for populations and health priorities. *Addiction* 105, 1323-25.

⁴ Rehm et al. (2006). *The costs of substance abuse in Canada 2002*. Ottawa: Canadian Centre on Substance Abuse.

⁵ Thomas (2012). *Analysis of beverage alcohol sales in Canada*. Alcohol Price Policy Series: Report 2. Ottawa: CCSA.

⁶ Babor et al. (2010). *Alcohol: No ordinary commodity – research and public policy (revised edition)*. Oxford: Oxford University Press.

⁷ World Health Organization (2010). *Global strategy to reduce the harmful use of alcohol*. Geneva: WHO.

⁸ Giesbrecht et al. (2013). *Strategies to Reduce Alcohol-Related Harms and Costs in Canada: A Comparison of Provincial Policies*. Toronto: CAMH.

⁹ Stockwell et al. (2011). Impact on alcohol-related mortality of a rapid rise in the density of private liquor outlets in British Columbia: A local area multi-level analysis. *Addiction* 106: 768-76.

¹⁰ Mann (2015). Personal communication. Calculated using data from Stockwell et al. 2011.



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