Reducing Alcohol Related Harm:

Moving Toward a Culture of Moderation in Grey Bruce

A Call for Action

Grey Bruce
HEALTHY COMMUNITIES PARTNERSHIP
Working together to create healthy public policy

PUBLIC HEALTH

Position Paper on *Reducing Alcohol Related Harm: Moving Toward a Culture of Moderation in Grey Bruce. A Call for Action.*

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This document was prepared for the Grey Bruce Health Unit Board of Health and the Grey Bruce Healthy Communities Partnership.

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Executive Summary

Alcohol consumption is a serious public health issue that requires shared action by local community leaders, the Grey Bruce Healthy Communities Partnership and municipal, provincial and federal governments.

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.

(Thomas G. et al. 2007)

People in Grey Bruce are experiencing individual and community problems related to alcohol. The issue is not that Grey Bruce residents drink alcohol; it is how much, how often and the contexts for drinking that is the issue.

Alcohol is commonly viewed as a commodity that is important to many people's economic and social livelihood. However, it is important to recognize that the negative impacts associated with alcohol use far outweigh the benefits. Alcohol comes second only to tobacco as the substance that creates the most health, social, economic and criminal harm to individuals, families and communities. The annual economic negative impacts of alcohol use in Ontario, is estimated at $5.3 billion. Health and enforcement costs outweigh revenues from alcohol in almost all Canadian provinces and territories (CPHA, 2011).

It is a common misconception that individuals who are dependent on alcohol (i.e. alcoholics) are responsible for the majority of alcohol related harms. In fact, 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 (Lodge, Rempel & LeMar, 2008). Even levels of alcohol consumption as low as one or two drinks per day have been causally linked to significant increases in the risk of cancer and numerous other serious medical conditions (World Health Organization, 2011).

One in five drinkers in Grey and Bruce are regular heavy drinkers. This high-risk practice is a strong predictor of alcohol-related problems which are evident in our community. Drinking and driving is an issue, with 4% of Grey Bruce residents aged 18 and over reporting drinking before operating a motor vehicle, and 8% before driving a recreation vehicle at least once in the previous 12 months (RRFSS 2006). According to Grey Bruce police services, officers encounter people who are 'under the influence' of alcohol on a daily basis. They report that this alcohol use spills over into other incidents, which include domestic violence, neighbourhood disputes and assaults, including sexual assault.

Youth, children, and even unborn babies, in Grey Bruce are also affected by alcohol consumption. In a survey of Grey Bruce residents, 25% of respondents felt that it was safe for pregnant women to consume alcohol during pregnancy (RRFSS, 2003), suggesting a permissive social environment around drinking and pregnancy in Grey Bruce. Another local study revealed

that 4 babies in every 100 born in Grey Bruce were significantly exposed to alcohol while in the womb (Gareri et al., 2008). These numbers are staggering considering that no amount or type of alcohol is safe during pregnancy. Babies exposed to alcohol before birth are at risk of developing Fetal Alcohol Spectrum Disorder (FASD), which can include vision and hearing problems, as well as slow growth and brain damage that may result in lifelong problems with attention, memory, reasoning and judgment (Poole, 2008).

Drug of Choice for Grey Bruce Youth

In Grey and Bruce, alcohol is the substance used by the largest number of students.

- **55%** of students (Grade 7-12) **consume alcohol**
- **22%** of these students are **binge drinking**
- **18%** of these students are **drinking hazardously**

Youth and young adults are especially at risk of being negatively impacted by alcohol use. They are affected by their own alcohol consumption and are vulnerable to the effects of consumption by others, especially their parents and role models. Mass promotion and normalization of alcohol permeates our community and influences our youth from a very young age. Alcohol promotion to youth is careful and deliberate and is often connected to sport. It is intentionally presented so that youth closely associate concepts of self-identity, success and belonging with drinking. It embeds a pervasive "drinking to get drunk" attitude amongst a significant proportion of young people. In turn, this culturally inoculates them against well-meaning education programmes and ironic liquor industry appeals for individuals to "drink responsibly" (Brown, 2012).

Drinking alcohol has become increasingly normalized in Grey Bruce. To make matters worse, some legislative controls in Ontario have been eroded and alcohol marketing has expanded, which is expected to increase the already high burden of alcohol use on health (Report on Alcohol Use, 2011). This increasing normalization makes it challenging to profile alcohol use as a serious, high-priority health issue. There is an urgent need for Grey Bruce to move towards the concept of *drinking in moderation*, which is a new way of thinking for the large majority of the population. Drinking in moderation is a way of making choices about alcohol use based on a clearer understanding of when, when not, and how much to drink; and the appropriate motivations and settings for drinking. It also requires a better understanding of the different risks involved in drinking and learning how to minimize these risks.

Creating a culture of drinking in moderation begins within our community. It is up to us to present as positive role models and to influence the attitudes and practices of the younger generation. This takes time. What we know from our experience with both tobacco and impaired driving is that it requires at least a generation of education, enforcement and advocacy to transition from the status quo to a newly established culture of *drinking* in moderation (National Alcohol Strategy, 2007). It is therefore critical that we immediately begin

to address alcohol use in Grey Bruce with strategic and concentrated action. To delay action would be detrimental to the health and wellbeing of both current and future generations.

In order to effectively change behaviour and reduce the harms associated with alcohol use in Grey Bruce, a comprehensive health promotion strategy is required. The strategy must include education, awareness and skill building, but more importantly, it must focus on advocating for, and creating healthy public policy to move Ontario and Grey Bruce towards a culture of drinking in moderation.

We know what works.

Grey Bruce has a history of taking successful action to prevent or reduce the harm from health issues. Healthy public policies and interventions are essential in reducing the harms associated with alcohol consumption (Babor et al., 2012). These include policies that:

- Regulate the physical and legal availability (drinking age, government monopoly, hours/days of sale, outlet density)
- Affect pricing and taxation (to limit purchase power)
- Regulate alcohol advertising and marketing
- Modify the drinking environment (staff training, i.e. *Safer Bars*, enhanced enforcement of the Liquor Licence Act)
- Include education (to challenge the norms of alcohol use and misuse)
- Strengthen and promote early intervention and access to treatment, and
- Enhance drinking-driving countermeasures (lowered blood alcohol concentration limits, educate public on legislation, penalties on fines, sobriety checkpoints)

These policy approaches balance the interests of health protection, harm prevention, and the health benefits of drinking in moderation.

About this Report

This report identifies some of the issues as they relate to levels of alcohol consumption and alcohol-related harm in Grey Bruce. In addition, it outlines strategies and interventions known to be effective in addressing alcohol-related harm. The report provides direction for key community stakeholders to collectively work toward a coordinated approach to improve the health and well being of Grey Bruce residents.

Evidence for Reducing Alcohol Consumption

Alcohol consumption is a serious public health issue. There is no shortage of alarming evidence to highlight alcohol as an important health issue within our community. Even more distressing, is the abounding evidence that demonstrates alcohol use is on the rise and that the associated alcohol related harms and social costs are also increasing. These increases are clearly linked to a visible increase in alcohol availability and accessibility in recent years.

1. *Extensive integration of drinking into many social contexts and settings and societal tolerance of high-risk drinking especially among young adults*

It is a toxic reciprocal relationship. As societal tolerance of high-risk drinking increases, so too does the integration of drinking into many social contexts and settings; as drinking becomes more extensively integrated into our social contexts and settings, our societal tolerance of high-risk drinking, especially among young adults, also increases.

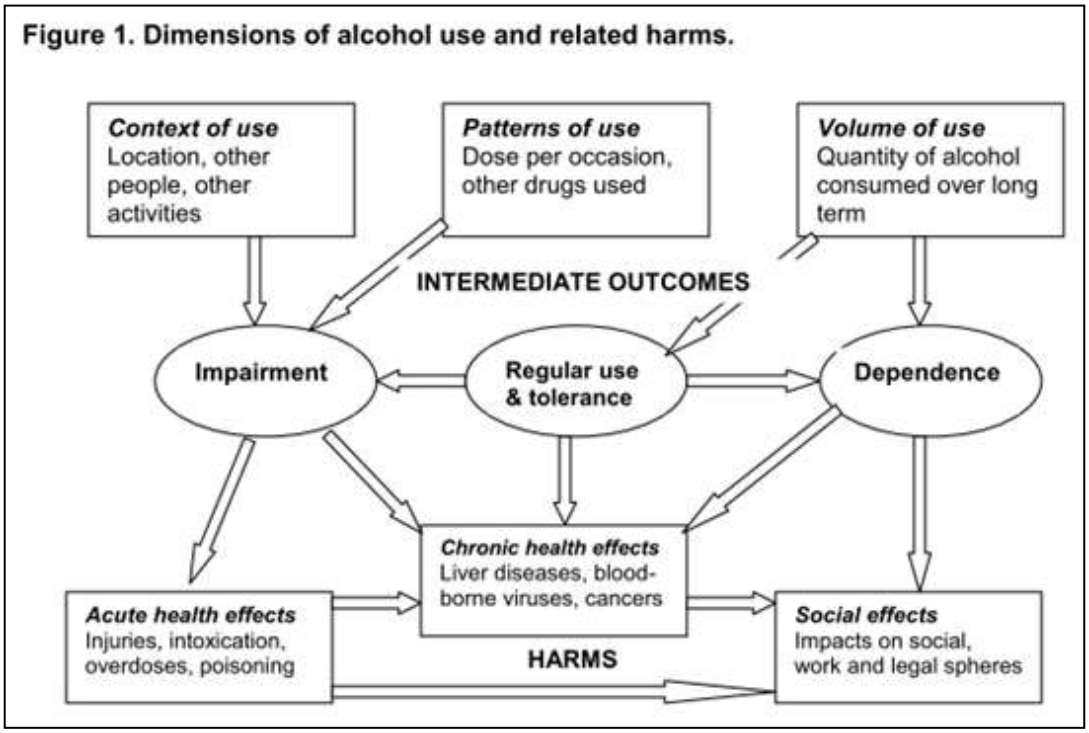
In 2011, per capita sales of alcohol totalled 8.0 litres of pure alcohol per person aged 15 years and over in Canada, and 7.5 litres of pure alcohol per person aged 15 years and over in Ontario. The low for Canadian per capita consumption (purchase) in the previous 22 years was 7.2 litres of pure alcohol per person in 1997, while the low for Ontario per capita consumption (purchase) in the previous 22 years was 7.1 litres of pure alcohol per person in 1997 and 1998. The current Canadian figure is 11% higher than the 1997 low, and the Ontarian figure is 6% higher than its 1997–'98 low. (Statistics Canada, 2011)

Profile of Alcohol Consumption in Grey Bruce
82% of Grey Bruce residents aged 18 and over are current drinkers (RRFSS 2009).
13% of Grey Bruce residents aged 18 and over who are current drinkers drink every day (RRFSS, 2009), and
19% of the Grey Bruce population are regular heavy drinkers. This rate has not significantly changed since 2000/01 (CCHS, 2009/10).
The number of current drinkers remains similar over the past six years.
Levels of regular heavy drinking in Grey and Bruce may be declining as levels in Ontario and Canada have been declining since 2001. However, about 1 in 5 drinkers in Grey and Bruce continue to be regular heavy drinkers. This high risk drinking practice is a strong predictor of alcohol-related problems.

2. Alcohol related harms and social costs

Many people put themselves at increased risk of health and safety problems due to the volume and pattern of their alcohol consumption. Over and above the amount of alcohol people consume, it is also important to take into account why, with whom and where drinking occurs (Demers et al, 2002). The relationships between different patterns and intensities of drinking and different health and social outcomes are illustrated in Figure 1.

Figure 1. Dimensions of alcohol use and related harms.



(Alcohol and Health in Canada: A Summary of Evidence and Guidelines for Low-Risk Drinking, November 2011)

The national guidelines for low-risk drinking (Appendix) 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) and for which abstinence or only occasional light intake is advised;
- Increased *long-term* risk of serious diseases caused by the consumption of alcohol over a number of years (e.g., liver disease, some cancers); and
- Increased *short-term* risk of injury or acute illness due to the overconsumption of alcohol on a single occasion. (Butt et al., 2011)

Evidence for Reducing Alcohol Consumption

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. Risk of these individual medical conditions increases with every increase in average daily alcohol consumption over the long term. In addition, there are a number of serious medical conditions caused entirely by hazardous alcohol use (Butt et al., 2011).

Alcoholic beverages are classified as "carcinogenic to humans". There is no safe level of alcohol consumption to avoid cancer risk. Meta-analyses estimate that consuming an average of two drinks per day increases risk by 75-85% for cancers of the oral cavity and pharynx, 40-50% for laryngeal and esophageal cancers, 25-30% for breast cancer, and 5-9% for colon and rectal cancer, compared to non-drinkers. Consuming more than four alcoholic drinks per day further increases risks and, for some cancer sites, escalates in individuals who also smoke.

Regular heavy alcohol consumption is also causally associated with type-2 diabetes and adverse cardiovascular outcomes, including cardiomyopathy, systemic hypertension, hemorrhagic stroke, some forms of heart failure and overall cardiovascular mortality. Occasional heavy drinking among low-to-moderate drinkers is also associated with cardiovascular disease. Low-to-moderate alcohol consumption with no heavy drinking may be related to decreases in overall cardiovascular disease mortality and lower risks of ischemic heart disease, ischemic stroke and type-2 diabetes. Consumption greater than four alcoholic drinks a day is, however, associated with a 69% increased risk of ischemic stroke and more than twice the risk of haemorrhagic stroke compared to those that do not drink alcohol. Moderate drinkers reporting occasional heavy drinking have an approximately 45% increased risk of ischemic heart disease, compared to those reporting regular moderate consumption.

(Taking Action to Prevent Chronic Disease, 2012)

Evidence for Reducing Alcohol Consumption

Youth are especially at risk of alcohol-related harm. Particularly the short-term impacts of alcohol such as falls, date rape and other assaults, and injuries and deaths caused by impaired driving (Canadian Centre on Substance Abuse, 2007). The effect of drinking on mortality and morbidity is larger for youth than adults. People 15-29 years of age experience 33.6% of alcohol-attributable disability-adjusted life years (DALYs), compared to 22.0% in the 45-59 age group (Rehm et al., 2009a). Youth who dwell in small towns or rural regions are more likely to identify themselves as current heavy drinkers and have higher rates of driving and riding with a drunk driver (Degano et al., 2007).

Drug of Choice for Grey Bruce Youth

In Grey and Bruce, alcohol is the substance used by the largest number of students.

- **55%** of students (Grade 7-12) **consume alcohol**
- **22%** of these students are **binge drinking**
- **18%** of these students are **drinking hazardously**

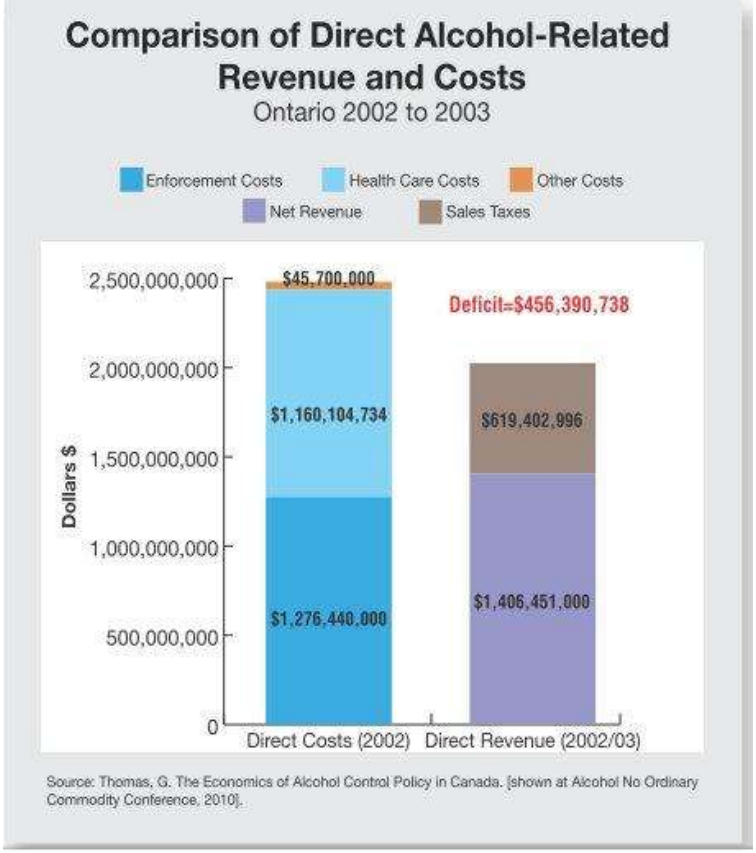
Alcohol is contra-indicated for many medications. The combination of alcohol and medication creates pharmacological interactions that may be extremely dangerous and even deadly (Ben et al., 2007). It can make medications less effective or interfere with their elimination from the body, rendering therapeutic effects uncertain or overly strong. Examples of medications that can cause potentially serious physical or psychological problems when combined with alcohol are those used for the treatment of rheumatism, arthritis, pain relief, infections, depression, epilepsy and high blood pressure.

Nearly half of all deaths attributable to alcohol are from injuries including unintentional injuries (road traffic accidents, drowning, burns, poisoning and falls) and unintentional injuries (deliberate acts of violence against oneself or others) (Cherpitel et al., 2009). In 2009 in Canada, 714 Canadians were killed in traffic crashes involving a drinking driver. In that year, 27.7% of fatal crashes involved a drinking driver. This percentage has decreased from a high of 35.2% in 1995. In spite of the lower share of fatal crashes involving alcohol, an estimated 19.2% of Canadians asked in 2011 if over the past 30 days they had driven after consuming any amount of alcohol answered yes to the question (TIRF, 2011). Further, “when asked about driving when they thought they were over the legal limit in the past 12 months, 5.4% of Canadians admitted to doing this in 2011” (TIRF, 2011). Locally, 6.3% of Grey Bruce residents aged 18 and over reported having consumed 2+ drinks in the hour before operating a motor vehicle (car, truck, van or motorcycle) at least once in the previous 12 months (Grey Bruce Health Unit, 2011).

If all Canadian drinkers were drinking alcohol within the national low-risk drinking guidelines, it is estimated that alcohol-related deaths would be reduced by approximately 4,600 per year. From a population health perspective, there are multiple compelling reasons for the public health community to respond to the health and social costs related to alcohol (CPHA, 2011). While sometimes difficult to measure, it must be remembered that the greatest costs associated with substance use are human costs – costs to individual well-being, relationships,

social cohesion, family life, housing, education, employment and chronic and acute health conditions.

The estimated economic burden of the cost of substance abuse in Canada was approximately $40 billion in 2002 or $1,267 for every Canadian. Alcohol accounted for about $14.6 billion in costs representing 36.6% of the total costs of substance abuse with an economic burden of alcohol abuse costing each Canadian $463 per year. This includes $7.1 billion for lost productivity due to illness and premature death, $3.3 billion in direct health care costs, and $3.1 billion in direct law enforcement costs (CAMH, 2002). In 2002, the most recent data available, the total cost of alcohol-related harm in Ontario was $5.3 billion due to direct costs (healthcare and enforcement) and indirect costs (reduced productivity, etc.) (Rehm et al.,2006).



Currently, the public ownership (government) of LCBOs results in significant revenue from the sale and taxation of alcohol. Perhaps less well known is that the costs of alcohol-related harm exceed revenue by an estimated $456 million in Ontario (Thomas G. 2010).

3. Availability and Price of Alcohol

There has been increasing access to alcohol. Statistics Canada indicated that between 1993 and 2003, the number of off-premise outlets for alcohol run by the provincial/territorial monopolies increased by nearly 44% with much of this growth accounted for by the agency stores. In Ontario there are over 190 agency stores and 600 traditional LCBO outlets. This does not include the proliferation of non-monopoly outlets as well.

There is positive association between alcohol outlet density and rates of community-based violence. Emergency Department studies found that alcohol-related violence accounted for more injuries than any other causes (e.g., vehicle crashes, falls, poisoning, or burns) (Alcohol Policy Network, 2010).

The increase in the number of liquor stores in British Columbia per head of population following the 2002 partial privatisation has led to both increases in rates of alcohol consumption and of alcohol- related deaths (Stockwell et al., 2011). Privatisation of public retail monopolies in Canada would increase consumption by 10-20%. This 10% increase in consumption would result in about 704 more deaths from alcohol-related causes (Popova et al., 2012).

Increased sales through alcohol outlets are correlated with higher rates of violence. In an Ontario study, the risk of hospitalization due to violent assault was found to be 13% higher with each doubling of usual daily alcohol sales of the closest Liquor Control Board of Ontario (LCBO) outlet.

The price of alcohol is another determinant of related risk. High alcohol price reduces alcohol consumption while low alcohol price is correlated with high regional violence-related injury.

High Alcohol Price Hike Helps

"Saskatchewan is the only province in Canada to employ a policy that links price to a formula accounting for the amount of pure alcohol in each product. The idea is to make high-alcohol products, which are more harmful, too expensive to binge on want only.

In the first full year of the new pricing structure, sales of high-alcohol beer products such as Colt 45 or Big Bear dropped 62 percent, targeted ciders and coolers dropped six percent, and wine and sherry products dropped 25 percent. Overall, Saskatchewan drinkers consumed 500,000 fewer litres of high-alcohol products in the first year of the price hike, a drop of 19.4 per cent. The 2012 numbers show a further one percent decrease, the SLGA said."

(Dr. Hutton, The Star Phoenix, July 5, 2012)

4. Exposure to Marketing and Promotion of Alcohol

There is evidence that exposing young people to alcohol marketing encourages some to start drinking sooner and increases consumption amongst those already drinking (Babor et al., 2003). Mass promotion and normalization of alcohol permeates our community and influences our youth from a very young age. Alcohol promotion to youth is careful and deliberate and is often connected to sport. It is intentionally presented so that youth closely associate concepts of self-identity, success and belonging with drinking. This embeds a pervasive attitude among a significant proportion of young people of "drinking to get drunk". In turn, this culturally inoculates them against well-meaning education programmes and ironic liquor industry appeals for individuals to "drink responsibly" (Brown, T. 2012).

In the past decade, the volume, frequency and channels for marketing of alcoholic beverages has increased (Gordon et al., 2010). This is partially due to an erosion of controls on alcohol advertising in Canada, which has been ongoing since 1996 (Ogborne et al., 2006). For example, the Canadian Radio-Television Telecommunications Commission (CRTC) no longer controls day-to-day control of electronic alcohol advertising. In 2006, screening of proposed electronic alcohol advertising became voluntary. Previously, the industry was required to submit proposed alcohol advertising for review by the CRTC. What this means, is that alcohol advertising now often violates the AGCO's Liquor Advertising Guidelines, which require, for example, that an alcohol ad "does not imply that consumption of liquor is required in obtaining or enhancing...enjoyment of any activity; social, professional or personal success; or sexual prowess, opportunity or appeal..." (AGCO, 2011). Alcohol marketing utilizing these concepts reinforces pro-social attitudes about the consumption of alcohol while disregarding the potential harmful consequences (Morgenstern et al., 2011). Based on the international evidence, this high level of alcohol marketing, combined with easier access is contributing to an increase in alcohol consumption (Jernigan et al., 2012).

↑ Alcohol availability = ↑Consumption = ↑ problems (morbidity, mortality)

Even despite the overwhelming evidence that demonstrates that alcohol is a serious and important health issue in our community, there are many misconceptions associated with alcohol use that are often used by critics to obstruct public health approaches to addressing the issue. The following section lists many of the common misconceptions associated and an explanation of why these misconceptions are false.

Misconceptions

a. ***Only those who are dependent on alcohol (i.e. alcoholics) experience alcohol problems.***

Chronic diseases, trauma, traffic and crime statistics show that everyone in our society, including those who do not drink are at risk of experiencing alcohol-related problems.

a. ***Heavy drinkers cannot be influenced by broad-based control policies.***
Research has consistently found that the proportion of heavy drinkers is related to the alcohol consumption patterns of the entire population i.e. when population consumption levels are down, alcohol related problems at all levels of drinking are down (Edwards et al., 1995).

b. ***Alcohol-related problems result solely from drinking to or past the point of intoxication.***
Even low or moderate levels of alcohol use can impair workplace and traffic safety, increase the risk of certain cancers and harm the development of the fetus (Jernigan et al., 2001). Currently, no "safe limit" of alcohol consumption has been established.

c. ***If people only knew about the risks associated with alcohol they would make healthier choices.***
Education is an important part of any comprehensive prevention strategy. However, the evidence indicates that on its own education is of limited value. Personal choice is not the only factor influencing alcohol-related problems; the consumption of alcoholic beverages is related to a range of social, cultural, economic and environmental determinants (Jernigan et al., 2001).

d. ***There are health benefits from drinking alcohol*.**
A great deal of public communication about alcohol – in the media, and elsewhere – tends to emphasize or endorse the health and social benefits of alcohol consumption, giving repeated support to the erroneous view that the health benefits outweigh the risks. There is extensive research showing that small amounts of alcohol consumed on a regular basis by middle-aged adults has specific but limited health benefits, such as reduced risk of cardiovascular disease or type two diabetes (Puddy et al., 1999). Any instance of heavy episodic drinking reduces or erases any potential benefits. It should be noted that these potential benefits from alcohol do not apply to youth or young adults, and can be achieved by other means among older adults.

e. Support for alcohol control measures is synonymous with a requirement of personal abstention from alcohol in order to effectively advocate for alcohol policy.
In fact, existing recommendations call for a "culture of moderation". What is required is perspective to support evidence-based public health policies to reduce harm from alcohol (Manafo &Giesbrecht, 2011).

f. ***Evidence-based controls on alcohol is a prohibitionist stance*.**
The goal of effective policies is to give more thoughtful consideration to its availability and accessibility and to make changes that will reduce population-level risks to health and safety (Manafo & Giesbrecht, 2011).

Evidence-Based Recommendations for Action

Culture plays an important role in defining drinking patterns and attitudes, including those related to the acceptability of binge drinking. Entrenched cultural views of binge drinking are an important consideration in developing policy and prevention approaches. Where the view is widely held that binge drinking is acceptable and even normative, changing such drinking patterns is difficult. Policies and approaches need to be sensitive to these consideration and prevention strategies need to be framed within the context of the prevailing cultural norms if they are to be effective.

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 that focuses on **population interventions** combined with **targeted interventions** is required (Babor et al., 2003). A two-tiered approach is recommended.

The first tier of policies (population interventions) aims to reduce population-level damage from alcohol and reduce high-risk drinking in the future. Evidence–based approaches include limiting availability of alcohol (in terms of price and physical access) and restricting alcohol marketing. The second tier of policies (targeted interventions) is oriented to specific drinking situations, risk behaviours, contexts or sectors of the population. Without effective action on the first tier, attempts to control the damage and costs from alcohol through second-tier interventions will, at best, be modestly effective (Giesbrecht et al., 2011). This will involve a combination of population-level policies, and focused interventions. Community collaboration with population-level interventions are needed to reduce population-level damage from alcohol and reduce high-risk drinking.

Best practices in alcohol control policies have the potential to reduce consumption, modify drinking patterns to encourage lower risk drinking, and/or reduce harm associated with alcohol consumption. In order to address these two tiers of interventions, the following best practice actions are recommended.

The following recommendations align with:

- CPHA Position Paper on Alcohol 2012
- Taking Action to Prevent Chronic Disease: Recommendations for a Healthier Ontario 2012
- WHO Global Alcohol Strategy
- Alcohol, Cancer and Other Health Issues: An Action Plan for Prevention 2011
- Tools for Supporting Local Action to Reduce Alcohol Related Harms 2012

Evidence-Based Recommendations for Action

Tackling major health and social problems such as the problematic use of alcohol requires a combination of leadership, persistence, resources and broad base of support at all levels (Anderson et al, 2009b). The public health community needs to become fully engaged to raise community awareness of the problems associated with alcohol sales and distribution, advocate for provincial or territorial-level initiatives, and foster support in community coalitions for inclusion of alcohol as a risk factor for injuries, violence and chronic disease. At the same time, the public health community can mobilize chronic disease alliances and encourage disease-specific non-governmental organizations to become leaders on this topic and to increase their capacity to deal with this issue (CPHA Position Paper, 2011).

1. Control Physical and Legal Availability of Alcohol

Strategies:
1. Limit alcohol density
2. Confine hours of service
3. Limit alcohol allowed at public events

Interventions	Municipal Governments	Local Community Leaders / Grey Bruce Healthy Communities Partnership	Appeal to Provincial/Federal Government
a. Undertake a thorough review of retail outlet numbers and density, and hours of operation for licensed establishments.	✓		
b. Moratorium on new alcohol retail outlets, and on increases in hours of operation, until reviews are completed.	✓		
c. Strengthen local zoning regulations to avoid density and congestion of alcohol outlets.	✓		
d. Evaluate license applications based on potential community impact (i.e. size of venue, number of patrons).	✓		
e. Evaluate license application process considering health and safety decisions.	✓		
f. Maintain 2 a.m. venue closures and consider earlier weekday closures.	✓		
g. Offer alcohol-free entertainment, recreation and community events.	✓		
h. Provide resolutions to the provincial government on alcohol availability concerns (i.e. maintain legal drinking age for alcohol at 19 years; maintain present government control on the sale of alcoholic beverages and not permitting expansion of the sale of alcohol in convenience stores).	✓	✓	✓
i. Implement, enforce and maintain municipal /county alcohol policies and support the process towards a county-wide alcohol policy.	✓		

2. Maintain and Reinforce Socially Responsible Pricing of Alcohol

Strategies:
1. Appeal to provincial government
2. Appeal to federal government

Interventions	Municipal Governments	Local Community Leaders / Grey Bruce Healthy Communities Partnership	Appeal to Provincial/Federal Government
a. Maintain present government control on the sale of alcoholic beverages.	✓	✓	✓
b. Appeal to impose minimum pricing laws, mark-ups, and discounting violations.	✓	✓	✓
c. Appeal to introduce incentives for lower-strength and disincentives for higher-strength alcohol.	✓	✓	✓
d. Direct revenues from alcohol to fund alcohol research and evidence-based programming.	✓	✓	✓

3. Strengthen Targeted Controls on Alcohol Marketing and Promotion

Strategies:
1. Pursue local regulations
2. Appeal for healthier alcohol advertising policies and practices

Interventions	Municipal Governments	Local Community Leaders / Grey Bruce Healthy Communities Partnership	Appeal to Provincial/Federal Government
a. Strengthen local restrictions on alcohol advertising such as imposing constraints on number, location, size, and content of ads.	✓	✓	✓
b. Apply sponsorship restrictions to community events.	✓	✓	✓
c. File advertising concerns and complaints to Advertising Standards Canada and advocate for new standards.	✓	✓	✓
d. Mobilize communities to build support for healthier alcohol advertising practices.		✓	

4. Modify the Drinking Context

Strategies:
1. Regulate special occasion events
2. Improve conditions of on-premise alcohol service

Interventions	Municipal Governments	Local Community Leaders / Grey Bruce Healthy Communities Partnership	Appeal to Provincial/Federal Government
a. Regulate, manage and evaluate public special occasion events.	✓		
b. Strengthen community support for development and implementation of house and staff alcohol policies and *Safer Bars* training, related to responsible beverage service in community licensed events/festivals and licensed establishments.		✓	
c. Provide inspectors and police with data on problem areas and assist with targeted policing and proactive policing initiatives.	✓	✓	✓

5. Continue Education, Coordination and Focus of Alcohol-Related Harm Reduction Initiatives

Strategies:
1. Drive media-based initiatives
2. Build support for comprehensive, coordinated and health-oriented strategies

Interventions	Municipal Governments	Local Community Leaders / Grey Bruce Healthy Communities Partnership	Appeal to Provincial/Federal Government
a. Educate the community on alcohol use dangers, consequences, norms, myths, offered services, and misconceptions.		✓	
b. Challenge the norms of alcohol use and misuse with media campaigns		✓	
c. Facilitate the development of comprehensive Grey Bruce Alcohol & Other Drug Strategy	✓	✓	
d. Appeal for the development of a Provincial Alcohol Strategy	✓	✓	✓

6. Strengthen & Promote Treatment and Brief Intervention Services

Strategies
1. Improve services
2. Appeal to provincial government
3. Appeal to federal government

Interventions	Municipal Governments	Local Community Leaders / Grey Bruce Healthy Communities Partnership	Appeal to Provincial/Federal Government
a. Increase capacity for screening and brief interventions.		✓	
b. Appeal for more local treatment services and treatment centres for youth.	✓	✓	✓

7. Enhance Drinking-Driving Prevention and Countermeasures

Strategies
1. Enhance enforcement
2. Shape public attitudes

Interventions	Municipal Governments	Local Community Leaders / Grey Bruce Healthy Communities Partnership	Appeal to Provincial/Federal Government
a. Educate the community on legislation, penalties, fines, etc.		✓	
b. Increase enforcement activities (i.e. patrols, sobriety checkpoints).	✓		
c. Plan and promote safe transport to and from venues.	✓	✓	
c. Promote media campaigns challenging the norms of impaired driving		✓	
d. Appeal for lower Blood Alcohol Concentration (B.A.C.) levels	✓	✓	✓

Adapted with permission from: Centre for Addiction and Mental Health and Public Health Ontario. July 2012. Draft: Tools for supporting local action to reduce alcohol-related harms. Policy options and a resource inventory to support alcohol policy in Ontario. Toronto; ON

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Glossary

absolute alcohol – ethyl alcohol containing no more than one percent water.

alcohol-related harm - any of the range of adverse effects of drinking alcohol experienced by the drinker or by other people

binge drinking/heavy drinking - drinking five or more drinks on a single occasion at least once a week during the past 12 months

current drinkers – having a drink of beer, wine, liquor, or any other alcoholic beverage during the past 12 months

high risk drinking/hazardous drinking – is a pattern of drinking that increases the likelihood of future physical and mental health problems including dependence.

low- risk drinking guidelines – national guidelines that are intended for adults aged 25 65 who choose to drink, providing information on how to reduce the risk of alcohol-related harms in both the short and long term.

morbidity – refers to non-fatal illnesses and injuries that may be caused by drinking

mortality – refers to fatal outcomes that may be caused by drinking

pure alcohol – is pure ethyl alcohol with no other additives or denaturants

regular heavy drinking – having five or more drinks on one occasion 2-3 times /month, once/week or greater than once/week within the past 12 months

responsible beverage service – an education programme that trains managers of alcohol outlets and alcohol servers or sellers how to avoid illegally selling alcohol to intoxicated or underage patrons.

screening and brief interventions – are short-term or opportunistic interventions that both introduce a patient to the notion that he or she may have issues with alcohol and suggest ways to deal with them.

Safer drinking tips

- Set limits for yourself and stick to them.
- 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.
- Always consider your age, body weight and health problems that might suggest lower limits.
- While drinking may provide health benefits for certain groups of people, do not start to drink or increase your drinking for health benefits.

Low-risk drinking helps to promote a culture of moderation.

Low-risk drinking supports healthy lifestyles.

Organizations officially supporting Canada's Low-Risk Alcohol Drinking Guidelines:

Association of Canadian Distillers
Association of Local Public Health Agencies
Brewers Association of Canada
Canadian Association of Chiefs of Police
Canadian Centre on Substance Abuse
Canadian Medical Association
Canadian Paediatric Society
Canadian Public Health Association
Canadian Vintners Association
Centre for Addiction Research of British Columbia
Centre for Addiction and Mental Health
College of Family Physicians of Canada
Council of Chief Medical Officers of Health
Educ'alcool
MADD Canada
Nova Scotia Department of Health and Wellness
Society of Obstetricians and Gynaecologists of Canada

CCSA - CCLAT
Canadian Centre on Substance Abuse
Centre canadien de lutte contre l'alcoolisme et les toxicomanies
www.ccsa.ca

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Cette publication est également disponible en français

Canada's Low-Risk Alcohol Drinking Guidelines

Drinking is a personal choice. If you choose to drink, these guidelines can help you decide **when**, **where**, **why** and **how**.

For these guidelines, "a drink" means:

Your limits

Reduce your long-term health risks by drinking no more than:

- 10 drinks a week for women, with no more than 2 drinks a day most days
- 15 drinks a week for men, with no more than 3 drinks a day most days

Plan non-drinking days every week to avoid developing a habit.

Special occasions

Reduce your risk of injury and harm by drinking no more than 3 drinks (for women) or 4 drinks (for men) on any single occasion.

Plan to drink in a safe environment. Stay within the weekly limits outlined above in ***Your limits***.

When zero's the limit

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
- making important decisions

Pregnant? Zero is safest

If you are pregnant or planning to become pregnant, or about to breastfeed, the safest choice is to drink no alcohol at all.

Delay your drinking

Alcohol can harm the way the body and brain develop. Teens should speak with their parents about drinking. If they choose to drink, they should do so under parental guidance; never more than 1–2 drinks at a time, and never more than 1–2 times per week. They should plan ahead, follow local alcohol laws and consider the ***Safer drinking tips*** listed in this brochure.

Youth in their late teens to age 24 years should never exceed the daily and weekly limits outlined in ***Your limits***.