

## Submission Form for the Draft National Alcohol Action Plan

The questions in this form are designed to help you to focus your response and make it easier for us to analyse submissions. However, you don't have to answer every question and may add additional comments.

The form is also available from the National Drug Policy website (<http://www.ndp.govt.nz>).

If you answer any of the questions below, please give detailed reasons and explanations whenever you can. If there is insufficient space, attach extra pages.

Please note that you do not have to provide personal information if you would prefer not to.

Submissions close 5 pm, Friday 7 November 2008.

Send one copy of your submission to: [NDP@moh.govt.nz](mailto:NDP@moh.govt.nz)

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You are making this submission:

- as an individual  
 on behalf of a group or organisation  
 other (please specify).....

Please indicate which sector or sectors your submission represents:

- |  |  |
|--|--|
| <input type="radio"/> Individual                   | <input type="radio"/> Family/whānau                    |
| <input type="radio"/> Academic/research            | <input type="radio"/> Māori                            |
| <input type="radio"/> Pacific                      | <input type="radio"/> Industry                         |
| <input type="radio"/> Education                    | <input type="radio"/> Local government                 |
| <input type="radio"/> Provider                     | <input type="radio"/> Funder                           |
| <input type="radio"/> Non-government organisation  | <input type="radio"/> Prevention/promotion             |
| <input type="radio"/> Professional association     | <input checked="" type="radio"/> District Health Board |
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Please note that your submission and all correspondence you have with the Ministry of Health may be the subject of requests under the Official Information Act 1982. If there is any part of your submission or correspondence that you consider could properly be withheld under the Act, please include a comment to this effect along with the reasons why you want the information withheld. If you are writing this submission as an individual (rather than on behalf of an organisation), the Ministry of Health will omit your personal details from the submission if you include the following statement at the front of your submission and sign it:

- I do not give my permission for my personal details to be released to persons requesting my submission under the Official information Act 1982.

07 November 2008

National Drug Policy Team  
National Alcohol Action Plan Consultation Feedback  
Ministry of Health  
PO Box 5013  
**WELLINGTON**

Dear Sir/Madam

**Submission on the Inter-agency Commission on Drug's Draft National  
Alcohol Plan: Consultation Document**

Thank-you for the opportunity to provide a written submission on the National Alcohol Plan: Consultation Document.

This submission is from Capital and Coast District Health Board (C&C DHB), which plans, funds, and provides health services to a population of 270,000 people living in Wellington City and its suburbs, the Porirua Basin, and the Kapiti Coast including Waikanae.

The contact point for this submission is:

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Yours sincerely



Ken Whelan  
**Chief Executive Officer**

## 1. Capital and Coast DHB

### 1.1. Who we are and what we do

Capital and Coast District Health Board (C&C DHB) is one of 21 District Health Boards (DHBs) in New Zealand. The organisation serves about 270,000 people living in Wellington City and its suburbs, the Porirua Basin, and the Kapiti Coast including Waikanae. It also provides some specialist services for a regional population of about 900,000 people. This makes us one of the largest DHB in the country.

Capital & Coast District Health Board has two distinct roles. Firstly, its Directorate of Planning and Funding Service (P&F) is responsible for assessing the health needs of the people of the district, and then arranging the most appropriate services to meet those needs. We deliver community, primary, secondary and tertiary health services. C&C DHB has 7 Primary Health Organisations providing a range of primary health care services. Secondly, the DHB's Hospital and Health Services (HHS) is responsible for providing secondary services via the hospital and community out reach programmes. Specialist tertiary-level care is also provided to patients from the lower North Island and upper South Island. Multi-disciplinary services are provided in the community from a number of community bases. These include general and specialist district nursing, specialist multi-disciplinary rehabilitation services, occupational therapy, speech language therapy, physiotherapy, dietetics, social work and home support services. Mental health, alcohol and drug services are also provided in the community.

### 1.2. Our strategic priorities

One of the main objectives of the DHB is to improve, promote, maintain and protect the health and independence of our communities. Our District Strategic Plan describes our vision, mission, health goals and strategies for achieving these goals (C&C DHB 2006).

Our Vision is *Better health and independence for people, families, and communities* and Our Mission is *Together, improve the health and independence of the people of the district*. Our two main health goals are:

- Reducing disparity (reducing differences in peoples' health)
- Reducing the incidence and impact of chronic disease (reducing the amount of ongoing illness and it's impact on peoples' lives)

We have six major strategies to achieve our health goals. These are:

- 1 Developing our workforce.
- 2 Supporting and promoting healthy lifestyle.
- 3 Working with communities.
- 4 Focusing on people through integrated care.
- 5 Managing our money effectively.
- 6 Updating our hospitals.

The Draft National Alcohol Plan is consistent with C&C DHBs objectives and functions, vision, mission, health goals and strategies. It is most relevant to our strategy of supporting and promoting healthy lifestyles, but it also has important potential links to our strategies of developing our workforce, working with communities, and focusing on people through integrated care. Supporting and promoting healthy lifestyles is considered fundamental to addressing the increasing incidence and impact of chronic disease. Our District Strategic Plan identifies drug and alcohol misuse as an important disease risk factor that can be reduced or mitigated to this end (C&C DHB 2004).

In addition, DHBs are required to work towards the thirteen priority areas outlined in the New Zealand Health Strategy. In particular, one of the thirteen population health priorities is “to minimise harm caused by alcohol and illicit and other drug use to both individuals and the community” (Ministry of Health 2001). Alcohol is also related to a number of the other priorities in the New Zealand Health Strategy such as those dealing with cancer, chronic liver disease, cardio-vascular disease, suicide and domestic violence, and severe mental illness. Similarly reducing alcohol-related harm is important to the DHB in fulfilling our responsibilities to national strategies for Maori and Pacific.

## **2. Introduction**

### **2.1. Impact of alcohol-related harm**

The inappropriate consumption of alcohol is a leading preventable cause of death, disease and disability globally (WHO 2006, WHO 2007).<sup>1</sup> Alcohol is the third-ranking preventable disease risk factor (WHO 2008) and third leading cause of preventable death in the United States, after tobacco use and being overweight or obese (Mokdad et al 2004).

C&C DHB recognises the wide variety of alcohol-related harm that affects our population. The use of alcohol has both direct and indirect health effects and contributes to a wide range of acute and chronic health issues in our population. These impacts range from the effects of intoxication such as risky behaviour, injury and alcohol poisoning, to long-term effects such as cancer and chronic liver disease. The social harms that also result from alcohol use in turn have further impacts on health outcomes. In addition, alcohol use is intimately connected with family violence and mental health. Nationally, alcohol contributes to 3.9% of deaths and 12000 years of life lost, excluding mental health and social outcomes (ALAC 2005).

Furthermore, the impacts of alcohol-related harm disproportionately affect young people and Maori and Pacific people (ALAC 2005, Ministry of Health 2007). Not only are these population groups more likely to experience higher levels of harmful consumption, but the impacts of these patterns of consumption are often much greater. Moreover, alcohol-related harm affects families and communities, not just individuals who consume alcohol.

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<sup>1</sup> The harms from alcohol outweigh any potential benefit from the mild to moderate consumption of alcohol in reducing the risk of heart disease for example (ALAC 2005, WHO 2007).

## **2.2. Our population's needs**

There is a limited amount of readily available information on alcohol consumption and alcohol-related harm at the DHB level. C&C DHB has similar hazardous drinking patterns to the rest of the country (Ministry of Health 2008). The prevalence of hazardous drinking in the combined Capital & Coast, Wairarapa, Hutt Valley DHB region does not differ significantly from the total New Zealand prevalence, after adjusting for age. Maori and Pacific populations are more likely than the total population of the three DHBs to experience hazardous drinking.

C&C DHB's previous health needs assessment draws on the Mental Health and General Practice Investigation (MaGPIe) to estimate mental illness. This study examined the prevalence and types of common mental disorders among patients attending New Zealand GP practices, and much of this study was conducted in the DHB district<sup>2</sup>. Substance use disorders were the third most common mental illness (11%), higher in males (17%) than females (8%). Substance use with either depression or anxiety disorder was as common as substance use alone. The estimated monthly prevalence of substance use disorder with significant disability in C&C DHB is 1.2% (C&C DHB 2005).

## **2.3. Impact on health services**

The manifestations of alcohol-related harm are encountered in a variety of health services, most notably emergency department and trauma related services, general medical services, and mental health and addiction services. For example, over 50% of medical admissions in C&C DHB have alcohol as factor in the admission. This results in significant financial costs to DHB and society.

## **2.4. C&C DHB interest in the National Alcohol Action Plan**

Overall, C&C DHB recognises the impact of alcohol on the health of our population and on the services and interventions that are consequently needed by our population. Therefore, C&C DHB welcomes and is supportive of a renewed focus on preventing and reducing alcohol-related harm in New Zealand and the development of this action plan. This action plan aligns with our responsibilities as a DHB, and supports our strategic priorities.

## **2.5. Our submission**

This submission is structured in two parts; the first section contains general comments and the second section contains specific comments on each goal. Our responses to the draft National Alcohol Action Plan have been made with consideration of the questions in the consultation document, in particular with reference to the three main consultation questions<sup>3</sup>. Our submission has also been developed with reference to the National Drug Policy's framework of supply control, demand reduction and problem limitation.

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<sup>2</sup> Seventy GPs in Wellington, Kapiti and Manawatu were randomly selected. 3,414 patients answered a general health questionnaire, and a further 908 were selected for more detailed psychological assessment. The results presented are based on the detailed assessment.

<sup>3</sup> Where should efforts be focused in the next five years to make the biggest difference in reducing alcohol related harm? Are there actions currently identified that should have the highest priority? What gaps are there in what is currently proposed and how should these be addressed?

### **3. General comments on Draft National Alcohol Action Plan**

#### **3.1. Action plan themes**

- **C&C DHB agrees with and supports the emphasis on changing social norms, culture, and environments. This is particularly important for young people. Patterns of alcohol consumption and the drinking context are just as important as absolute volumes consumed for producing harm, if not more important when one considers that it is the pattern and context that contributes towards harmful long term overall consumption. Hazardous patterns of drinking cause more harm for any given volume of alcohol consumed (WHO 2007). New Zealand has been described as having a ‘binge’ drinking culture (Research New Zealand) with hazardous or binge drinking common (Ministry of Health 2007). The determinants of individual alcohol consumption are wide-ranging and include availability, access, price, socialisation processes, law enforcement, information, cultural norms, marketing, purchasing power or disposable income, and overall population consumption, as well as age, gender and life stressors (WHO 2007, Research New Zealand 2006).**
- **The socialisation of alcohol is the basis of what we are concerned with here in this theme. So long as we legitimise its availability and usage in certain circumstances we are vulnerable as a society. Any other action we take is amelioration and not prevention. The question is how we move to socialise and protect the vulnerable, perhaps using a percentage of the liquor company profits to work with those who are most affected.**
- **Reducing inequalities is a core objective of the DHB. C&C DHB agrees with and supports the theme of ‘recognising potential and reducing inequalities’. We also support the use of tools such whānau ora health impact assessment and the health equity assessment as a means of translating the intention of this theme into how these actions will actually be designed and implemented and work for Maori and Pacific.**
- **We recommend adding women of reproductive age as an important priority population alongside Maori, Pacific, and young people. This is in light of the evidence showing that 13% of mothers continuing drinking during pregnancy (Ministry of Health 2007) and concern is growing over the increasing levels of alcohol consumption in young women. There is no known safe level of alcohol consumption to prevent harm to the un-born child.**

#### **3.2. Overall approach**

- **C&C DHB supports the use of “evidence of effectiveness in terms of reducing alcohol-related harm” to generate actions.**
- **We support and encourage the inter-sectoral approach being taken. Action to reduce alcohol-related harm needs to involve collaborative efforts within the health sector, as well as across multiple sectors, and this action needs to be coordinated.**

- **C&C DHB supports actions being taken at multiple levels (individual, family, local, regional and national) to complement and support one another, with actions relating to all three ‘pillars’ of supply control, demand reduction, and problem limitation. Certainly, the evidence shows that awareness raising and education are not effective prevention measures by themselves (WHO 2007, ARPHS 2005).**
- **We recommend that actions in this plan be linked into wider health and other sector strategies and programmes of work. For example, the plan should link to wider health workforce development not just mental health workforce, to wider health information strategies, to the range of health issues addressed in schools, to wider youth development and so on.**
- **The current action plan does not include actions to be taken at an international level. We note that New Zealand is already involved in alcohol-related harm reduction at an international level (p25). The supply of alcohol and the social norms and culture that influence drinking behaviour are increasingly affected by what is happening globally and therefore there is a need for ongoing action at an international level that contributes to and supports action at the national, regional, and local level (WHO 2007, WHO 2008). Thus, we recommend that the action plan include actions for New Zealand to take at an international level.**

### **3.3. Priority areas in the next five years**

- **C&C DHB has two main areas we think are priorities for attention.**
- **Firstly, C&C DHB recommends that efforts should be focused on reducing the supply (availability and access) of alcohol, particularly to our young people. We note the evidence that demonstrates the increased availability and access to alcohol that has occurred over the last 10-15 years (pp 26-31). Specifically, this means focusing efforts on the development of goal 4, as supply control strategies are mostly achieved through legislation and strengthened enforcement measures. These actions are needed to achieve a full range of actions across supply control, demand reduction and problem limitation. National frameworks are also needed for supporting goal 2, around the community and environment.**
- **We note that in the background information provided, the observation is made that “the research evidence in terms of what works in reducing alcohol-related harm supports the introduction of population-wide primary prevention interventions that control the access to, availability of, and affordability of alcohol products” (pg 38). These types of interventions are also some of the most cost-effective actions that can be taken.**
- **However, work on control of supply needs to take account of the fact that the most common venue for alcohol consumption in New Zealand, including for consuming large amounts of alcohol, is private homes (Ministry of Health 2007). Furthermore, it is friends**

and family that supply the majority of under-age drinkers with alcohol (Ministry of Health 2007). Lastly, concerns from our emergency and acute care staff indicate that acute presentations are related to supply from off-licences and the low price of spirits.

- Secondly, C&C DHB recommends that another priority area is the improvement of data collection, which should involve consistency and common understandings across the multiple sectors involved in this plan.

#### **4. Specific comments on the Draft National Alcohol Action Plan**

##### **4.1. Goal One - Individuals, families and whānau: empower and support individuals and families and whānau to manage alcohol in their lives and receive help when they need it.**

- C&C DHB would welcome central government support for action 1.2.6, our Wet Hostel initiative.
- C&C DHB supports action 1.1.1 to help address the supply of alcohol to minors by parents and others.
- Early Intervention and treatment service developments need to be designed to address the other social, economic and health issues, including both physical and mental, that often accompany alcohol misuse and dependence.
- Intervention and treatment services need to support children as well as youth. Local evidence suggests that our hospital services see very young children in states of intoxication.

##### **4.2. Goal 2 - Community and environment: Enhance community well-being and safety in environments affected by alcohol and where alcohol is used.**

- C&C DHB supports sub-goal 2.3 of “increasing capacity for communities to address community-specific alcohol issues and respond to concern at a local level”. DHB conversations with our communities suggest that our communities are concerned about alcohol-related issues but need appropriate support from health planners, funders and providers.
- We are concerned about the markedly increased alcohol outlet density in lower socio-economic, highly populated Maori and Pacific areas such as Porirua East.
- One also needs to consider balancing the effect of a legitimised drug such as alcohol against other ‘drugs’ that are not, and the consequent tension and pressure that creates on the maintenance of community action.

##### **4.3. Goal 3 - Workforce and skills: Maintain and develop capacity and supportive networks for an effective workforce that contributes to reducing alcohol-related harm**

- Workforce in many parts of the health sector come into contact with people at risk of or experiencing alcohol-related problems. There is good evidence to support screening, assessment and brief interventions by health professionals (WHO 2007, ARPHS 2005). Therefore C&C DHB supports actions in this area, particularly in increasing and shifting resources to intervene earlier, using a wider range of the health workforce. This is also consistent with the aims of our DHB Mental Health and Addiction Service Development Plan 2005-2010 *'The Journey Forward'*.
- However, as noted previously, this work needs to be incorporated into broader workforce development, especially primary care development as a whole, the broader work of integrating mental health and primary care, along with a consideration of capacity issues.
- The workforce needs to reflect the wide diversity of community groups, with targeted programmes to meet those diverse needs whether they be related to ethnicity, age, gender, or income.

**4.4. Goal 4 – National frameworks: Ensure legislative and regulatory environments are responsive and address the harms caused by alcohol misuse.**

- C&C DHB views the implementation of this goal as a priority area. These actions are important for enabling increased control of supply and demand reduction, as well as for supporting local and community action. There is good evidence of the effectiveness for all the actions listed under this goal (WHO 2007, Babor et al cited in ARPHS 2005).
- Suggested measures include increasing the price of alcohol and placing further restrictions on alcohol promotions and advertising.

**4.5. Goal 5 - Information, research and communication: improve the collection and communication of data, information and research on alcohol consumption and alcohol-related harm.**

- One of the desired outcomes of this goal is to build the evidence-base for effective interventions and undertake evaluations where necessary. C&C DHB supports this intention, but would point out that the wording of the goal and its related sub-goals does not adequately reflect this intention, being limited to the words 'alcohol consumption' and 'alcohol-related harm'.
- C&C DHB would like to see actions 5.2.3 and 5.2.4 in relation to research on alcohol availability and alcohol advertising prioritised. Along with action 5.2.7 for supporting work on evaluation.
- C&C DHB in particular supports action 5.1.3 to improve area level information, particularly about children and young people. We recommend that DHBs are listed as interested agencies. Area-level information is helpful to support community or local area level action.

- **We believe there is a gap in range of research proposed. In addition to the impact of the availability and marketing of alcohol, it is important to expand our understanding of the other societal structures and processes that generate our attitudes and cultural norms to alcohol i.e. the determinants of alcohol consumption and creation of demand. Such research would be consistent with the theme of changing social norms, culture, and environments.**

#### **4.6. Monitoring and review**

- **C&C DHB note that there was no advisory group advising on monitoring and evaluation.**
- **We think monitoring and evaluation is an important aspect of a large multi focussed intersectoral approach such as this plan. The final plan needs to include a clear monitoring and evaluation framework, with mechanisms for overseeing and reporting on progress, allocated responsibilities and should demonstrate how evaluation will be incorporated.**

## 5. References

ALAC 2005. *The burden of death, disease and disability due to alcohol in New Zealand*. ALAC Occasional Bulletin Publication No. 23. Alcohol Advisory Council of New Zealand: Wellington

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