Submission to the Green Paper for Vulnerable Children

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Alcohol Healthwatch is an independent charitable trust which works to reduce alcohol-related harm. We are contracted by the Ministry of Health to provide a range of services regionally and nationally, including provision of research-based information on policy and practice, as well as coordination and public health expertise for inter-agency and community group's who work on alcohol issues.

Thank you for the opportunity to submit our thoughts on the Green Paper for Vulnerable Children.

Our comments will mainly focus on aspects that relate to our mission to reduce alcohol-related harm in Aotearoa- New Zealand. In our submission, we will briefly outline the broader issues of alcohol-related harm and then focus on more recent research highlighting the harm to others caused by alcohol, and the relationships between alcohol and poverty and alcohol and non-communicable diseases. We will also discuss the impact of fetal alcohol spectrum disorder on this issue. In conclusion, we provide a table with some suggestions for future action that address the questions put forward by the Green Paper.

We would appreciate the opportunity to present an oral submission in due course.

If you have any questions on the comments we have included in our submission, please contact:

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Introduction

Alcohol consumption is one of the most significant risks to health. Globally, alcohol is responsible for 3.8% of all deaths and 4.5% of the burden of injury and disease as measured in disability-adjusted life years (DALY) lost. It is the third largest contributing factor to injury and disease worldwide (World Health Organisation, 2011).

Alcohol abuse contributes to a wide range of social and health problems, including depression, injuries, cancer, cirrhosis, dependence, family disruption and loss of work productivity. Health and social problems from drinking affect not only the drinkers but those around them too.

The cost of alcohol-related harm in New Zealand has been conservatively estimated to be $5.3billion a year or $14.5million a day. The true cost is immeasurable.

Heavy alcohol use takes a particular toll on children and young people, and has been linked to high rates of youthful criminal behaviour, injury and impaired ability to achieve educational qualifications.

Children and young people are dying directly from alcohol-related harm in New Zealand. The recently published Child Youth and Mortality Review Committee's (2009, published in 2011) special report on the involvement of alcohol consumption in the deaths of children and young people from 2005-2007 suggests that an average of 61 children and young adults aged between 4 weeks and 24 years and 364 days died because of their or someone else's drinking. In 32% of the deaths, the death occurred due to someone else's drinking. The proportion of alcohol involvement in deaths was highest for Motor Vehicle Accident's (31%), closely followed by falls (30%), assaults (29.6%), poisoning (20.6%), drowning (15.7%), and suffocation (9.7%) respectively.

We know what is required to reduce the burden of alcohol-related harm. We already have the evidence. We are also learning more about the harm that alcohol causes to others (that is, other than the drinker), and the relationship between poverty and alcohol, and alcohol as a risk factor for non-communicable diseases.

Public health and the rights of the child must be prioritised in decision-making if we are to effectively protect and promote health for children. Not lip service, but courage and leadership.

Harm to others caused by alcohol

The negative impact of alcohol consumption goes far beyond the consumer, it also affects those who are directly or indirectly associated with the drinker. Researchers have traditionally focused on the impacts experienced by the drinkers themselves and have also looked at the social impacts of alcohol use and misuse. However, Babor (2011) argues that the social effects or consequences that mostly reflect "*spoiled social occasions, emotional wounds, arguments, physical violence, workplace problems, failed expectations, care demands, embarrassment and exposure to physical risk*" fail to include the broad spectrum of consequences such as "*chronic stress, failed marriages, maladaptive family dynamics, unwanted noise, broken bottles and trash to clean up, childhood psychological trauma, fetal alcohol spectrum disorders, neighborhood crime, family members' increased health care needs, and environmental degradation connected with the production of alcoholic beverages (e.g. water pollution)*". Babor refers to them as "*the more subtle, chronic and unseen"* consequences.

A recent New Zealand study that investigated the harm that alcohol caused to others found that a large proportion of New Zealanders report that they experience physical, social, economic and psychological harms because of the drinking of others (Casswell, Harding, You, & Huckle, 2011). Eighty-four percent of these respondents indicated that they experienced adverse impacts from the drinking of the person who most affected them. Among younger respondents (12-29 years) over 95% of those who reported one person who most negatively affected their life reported at least one specific harm because of this person's drinking (Casswell et al, 2011). Seventeen percent of respondents with children in the household reported that their children experienced harm because of the drinking of someone else (Casswell et al, 2011). The considerable impacts on children found in this study fit with previous research that indicates that heavy alcohol use in the family is a risk factor for child abuse (Walsh, MacMillan & Jamieson, 2003).

A study by Laslett and colleagues (2011) investigated the adverse effects of drinkers in Australia. The study sample included 2,649 Australians and found that 30% of the respondents reported that they were negatively affected by the drinking of someone close to them. A further 70% of the participants reported that they were negatively affected by a stranger's drinking. In relation to gender, men reported that they were more affected by strangers, friends and co-workers, while women were more affected by someone they knew in the family or household.

These effects from others' drinking are often overlooked in policy development, and yet their common occurrence suggests that these harms should be considered.

Poverty and alcohol

The relationship between alcohol and poverty is complex in that it can act as both a protective and a risk factor, as can relative wealth. Alcohol use and poverty, when they occur together, each intensifies the damage done by the other (Samarasinghe, 2009). The obvious connection is the effect on health. A poor person who drinks heavily is much more likely to suffer damaging health consequences from alcohol than a wealthy person drinking equivalent amounts. The greater impact includes, for example, the loss of income from taking time off work which may mean poorer nutrition for the family, inability to access health services, and/or reduced ability to meet their children's needs such as educational requirements. More subtle effects include the effect of alcohol on such things as how we relate to each other. The vulnerability of some men, and most women and children is increased as a result. This has far greater damage in overcrowded and open living conditions (Samarasinghe, 2009).

Research conducted in Manukau showed that liquor outlets were more numerous in communities with lower socio-economic status, the opening hours of premises were longer and prices of alcohol cheaper (University of Waikato, 2012). These conditions are shown to increase harmful effects of alcohol such as the number of violent incidents and road crashes.

This clearly demonstrates firstly that the alcohol industry continues to abuse our vulnerable populations, and secondly that measures to reduce the accessibility of alcohol will benefit vulnerable members of our society. These communities must not be burdened with additional responsibilities. Controlling and regulating the alcohol industry is the job of Government.

The relationship between variables such as these reinforces the reasoning for the requirement to address the wider determinants of health which will in turn increase child wellbeing in New Zealand. Attention also needs to be paid to the contributing factors that lead to decreased wellbeing in our children; alcohol-related harm is obviously a major contributing factor in intensifying the vulnerability and poor outcomes that a large number of children face in our country.

Alcohol and Non-Communicable Diseases

Non-Communicable Diseases (NCDs) are the leading cause of death globally. Cardiovascular diseases, cancers, diabetes and chronic lung diseases make up 2/3rds of these deaths. The harmful use of alcohol is a contributing factor in all but chronic lung disease, and has been therefore named as one of the four main risk factors for these lifestyle diseases, alongside tobacco use, insufficient physical activity and unhealthy diet.

New Zealand has for some time recognised Non-Communicable Diseases as a growing challenge. Globally, the challenge has been translated into a declaration at the United Nations General Assembly in which World Health Organisation Member States, including New Zealand, committed to taking action to reduce the incidence of Non-Communicable Diseases.

The patterns of incidence are changing with NCDs - shifting from the rich to the poor, urban to rural, men to women and elder populations to younger populations (Arulrhaj, 2012). Alcohol has been identified globally as a major player in youth non-communicable disease (Arulrhaj, 2012).

NCDs strike disproportionately among people of lower social positions. NCDs and poverty create a vicious cycle whereby poverty exposes people to behavioural risk factors for NCDs and, in turn, the resulting NCDs may become and important driver to the downward spiral that lead families to poverty. NCDs have potentially serious socioeconomic consequences, through increasing individual and household impoverishment therefore impacting on children and hindering social and economic development. Once again the loss of household income from unhealthy behaviours and the high rate of disability due to NCDs is a particular burden on vulnerable families and children. The cost of the unhealthy behaviour and the resulting costs of treatment/healthcare/care for those who suffer from the negative effects of illness often cause a significant drain on the family expenditure. Additionally, the costs to health-care systems from NCDs are high and projected to increase. Economic analysis suggests that each 10% rise in NCDs is associated with 0.5% lower rates of annual economic growth (Robert Wood Johnson Foundation, 2011).

Lifestyle diseases such as these can be prevented by modifying lifestyle patterns. Legislation and service delivery which promotes and complements healthy lifestyle patterns need to be implemented. The Government needs to make a long-term and cross-party commitment to reducing all of the four major risk factors for non-communicable diseases for the collective good of our population.

Alcohol and Fetal Alcohol Spectrum Disorder

According to recent research, pregnant women in New Zealand are drinking and using other drugs during pregnancy at a rate that is at least four times that of the United States (Wouldes, 2012 unpublished). The estimated rate of FASD in the USA is one percent of all birth making the potential

rate of FASD at least four times higher. Unlike the USA however, New Zealand has no comprehensive plan to prevent FASD or to identify and assist affected children and families.

Alcohol is a teratogen, a substance that from conception onwards can mutate DNA and alter the course of normal cell development until birth. The primary insult to the brain can be compounded when combined with other drugs, but alcohol is singularly the most damaging of all recreational substances. This organic brain damage is hidden yet likely contributing to the big problems New Zealand is grappling with - poverty, violence, crime, school failure, underemployment, unplanned pregnancy and alcohol and drug abuse – which in turn is perpetuating the generational cycle of these problems.

A child whose genetic potential has been severely compromised in this way will struggle to understand and manage their learning and behaviour in a world that struggles to understand them. Without appropriate knowledge, understanding and support, these individuals become the adolescents, adults and parents who are viewed as 'failures' in our society – a negative cycle of failure that does not have to be that way.

Children with FASD are at extreme risk of developing secondary disabilities as they grow up. These are thought to occur largely because of the lack of recognition of the primary organic brain disorder and absence of inappropriate treatment to accommodate and compensate for this through childhood and adolescence.

Secondary disabilities include the significantly increased risk of mental health problems, school suspension or expulsion, alcohol and drug problems, unemployment and trouble with the law. These types of problems are what New Zealand is grappling to overcome but they are seldom tracked back to early brain development. Often by the time the child or adolescent presents with such problems, the behaviour has become entrenched; such behaviours are resistant to change. Early identification of FASD is the opportunity to put in place measures that protect the vulnerable child from the factors that increase the risk of such problems emerging in the first place. Viewed in this way, intervention is prevention.

Suggested Actions

New Zealand needs strong, evidence-based legislation to prevent alcohol-related harm in general and in particular that which impacts on those other than the drinker, especially our children. The Global Alcohol Strategy presents a framework on which to develop our response.

The table below suggests possible actions related to preventing the extra burden that alcohol-related harm is causing our children. The action points draw from the significant evidence base that is available on effectively reducing alcohol-related harm in populations. The table places the action points under the headings used in the Green Paper for ease of understanding.

SHARE RESPONSIBILITY	**Parents and Caregivers** Research shows that empowering parents to influence their children's drinking behaviour is more effective than targeting children and young people themselves.

	Support parents to be well-equipped to act with confidence and communicate effectively with their children about alcohol. Alcohol and drug education in schools and public service advertisements such as those advocating responsible drinking or avoidance of drink driving have little or no effectiveness. **Communities** Protect communities by removing the responsibility of protecting themselves from harms associated with legal drugs. National Government, local government, agencies, and the alcohol industry must all step up and take their responsibilities. This will free communities and families up to play the roles they are best at. For example, the new alcohol legislation will empower communities to object to liquor licences. Ideally communities should be protected from this over-supply in the first place rather than having to engage in endless legal wrangles against well-resourced alcohol interests. Community/family energy and resources could be much better spent – providing the care and protection of our children.
SHOW LEADERSHIP	**Vulnerable Children's Action Plan** Leadership needs to start at the top with the creation of a Minister for Children. This role can then lead the strategic direction which should include an action plan for all children. This planning should be widely consulted on with relevant agencies including those involved with alcohol-related harm prevention. **Legislation changes** Government policy has a significant impact on the health and wellbeing of children as it influences the wider determinants of health. A long-term, cross-party, whole of government approach to creating environments that support and protect children is necessary and should be prioritised. Children should be placed at the

	centre of decision making. Strengthen the new alcohol legislation to ensure that the wider environment is supportive of parents in their role to protect their children against alcohol-related harm. The three 'best buys', despite not being in the new Alcohol Reform Bill should be progressed without further deliberation. These are: raise the taxes on alcohol, restrict the access to retailed alcohol and enforce bans on alcohol advertising. Raising the purchase age to 20 years is also important in light of the evidence base concerning brain development. The recent disclosure of a public opinion survey on alcohol attitudes in New Zealand showed significant support for such measures (Peck, 2011). **Working with whanau, hapu, iwi and Maori leaders** Implementing a Whānau Ora approach to planning and service delivery should be paramount. Outreach services have proven to be effective in 'reaching' tamariki ora and providing required services and these should be extended where required.
MAKE CHILD-CENTRED POLICY CHANGES	**Review Government spending to get better results for vulnerable children** Support a multi-sectoral and preventative approach to improving the wider determinants of health and lifestyle patterns and decreasing inequalities. Recognise that there are children in our society whose brain and genetic potential has been permanently compromised by prenatal alcohol exposure and that these children are particularly vulnerable. Acknowledge that FASD is a disability and needs to be a funded policy priority across health and social services. Research shows that the first 0-3 years are the most important years of development for children. Therefore, Government investment should reprioritise spending to provide more early intervention. This should include

	appropriate intervention services for children and families affected by FASD. Please note also that we think that 0 years should be defined as from conception, not from when a child is born. Extra funding for community action and health promotion to prevent alcohol-related harm could come from an increase in tax on alcohol. The revenue from increased alcohol tax should be streamed back into prevention and treatment for alcohol-related issues. For example, the 'Sin Tax' that funds the Thai Health Fund. Increase participation and consultation with children and young people. **Vulnerable child-first policy** All children are vulnerable and this needs to be echoed in the policy environment. Marmot introduced the term 'Proportionate Marginalism' which says that "focussing solely on the most disadvantaged will not reduce health inequalities sufficiently. To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage" (Marmot, 2010). Under a public health model, priority is placed on having universal (primary prevention) supports for all families. More intensive (secondary prevention) interventions are provided to those families that need additional assistance with a focus on early intervention. For example, in relation to alcohol, brief interventions are proven to be effective in various settings. Tertiary protection services are a last resort, and the least desirable option for families and governments. Universal services to all children are protective and enable early intervention within existing relationships. All families may need support at some time and universal services with skilled workers can enable families to access appropriate services when needed.

	<u>Watching out for vulnerable children</u> Improve the information pathways and transparency between key agencies so that a wraparound approach can be taken to best assess and treat vulnerable children. The wellbeing of the child should be paramount in deciding what level of transparency there should be amongst professionals. Support the whole family towards sustainable change or continual re-entry into problems will occur. Resourcing advocates for vulnerable families is a cost effective approach. These advocates can provide a central point of contact for the family and the various agencies that might be involved in supporting them. Supporting the family to identify the issues affecting them and prioritise these for themselves is critical – working with their realities. Taking an empowering approach (as opposed to a punitive approach or "pass along the line" approach) must be central to this.
MAKE CHILD-CENTRED PRACTICE CHANGES	**<u>Improving the workforce for children</u>** Child Impact Assessments are a helpful tool when planning and implementing policy changes to ensure that policies place the child at the centre of the decision-making process. Health Impact Assessments are also useful for addressing the wider health impacts policies can have on the population. Perhaps a combination of the two above assessments could be developed to guide policy decisions. Support external agencies, such as NGOs, that work to reduce alcohol-related harm. Work collaboratively with the Fetal Alcohol Network New Zealand and other relevant sectors that have an association with FASD to develop strategic direction and guidelines for FASD prevention. Ensure that all relevant services are well informed about FASD and the type of support and intervention that is required by the affected child and their families/whānau.

	Ensure that the new Health Promotion Agency has a strong and autonomous alcohol-related function that uses evidence-based solutions to carry out their work. Improve the workforce for children by ensuring FASD knowledge, recognition and intervention education is fundamental for all social workers, teachers, Police, youth justice workers and health professionals and delivered in a consistent and sustainable basis. Build capacity across sectors and communities for a stronger evidence-based response to alcohol-related harm. **<u>Better connecting vulnerable children to services</u>** Ensure A&D services are sufficiently equipped and suitably skilled to better meet the needs of women (particularly women with children or who may be pregnant) and children. More investment into child specific alcohol and drug addiction services are needed; particularly in areas outside of the main cities. Ensure GP's are assessing risks of harmful drinking by screening and are confident in responding to this by either using early and brief interventions, or referring to appropriate services. **<u>Improving service delivery</u>** Intersectoral working and information sharing to improve coordination of services is paramount. Facilitate the collaboration between services by removing barriers that preclude different services from working collaboratively to effect positive change and innovation. Reorientation programmes aimed at behaviour modification are better able to meet the special needs of children and their family/whānau affected by FASD. Traditional methods may be ineffective. Reorient the health service to follow a Whānau-

	Ora approach. Research shows that it is cost effective to invest in public health (preventative measures).

In conclusion, we hope that the harmful role that alcohol plays in perpetuating the vulnerability of families and children will not be ignored. We cannot emphasise enough how important it is that the Government makes a long-term commitment to all of these issues and puts the collective good of the nation at the top of its agenda.

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