

SUBMISSION TO THE 2009 LAW COMMISSION'S PAPER *ALCOHOL IN OUR LIVES*



Fetal Alcohol Network New Zealand

"Everyone is part of the solution"

INTRODUCTION

Fetal Alcohol Network New Zealand (FANNZ) is a collective of people and agencies with a shared concern about Fetal Alcohol Spectrum Disorder (FASD) and with experience and expertise with regards to its prevention and intervention.

The people who make up the Fetal Alcohol Network come from families living with an FASD and also include a wide range of professionals involved with health & disability, education, justice, social services and community-based organisations. Approximately 300 individuals currently make up the network, with many of these disseminating the information on FASD prevention and support through their own networks.

Our purpose is to connect and inform people and to work collaboratively on the prevention of Fetal Alcohol Spectrum Disorder (FASD) and improve the outcomes for those born affected.

FANNZ is linked through an email information update service, face-to-face meetings, community and workforce educational activities and international affiliations with FASWORLD and other organisations. The coordination of FANNZ activities is managed by Alcohol Healthwatch. FANNZ has a contact website www.fan.org.nz which is supported by NZORD, the New Zealand Organisation for Rare Disorders and further information can be found on the Alcohol Healthwatch website www.ahw.org.nz.

It was the resolve of the network to make a submission in response to the Law Commission Review Issue Paper 'Alcohol in our Lives' and to express our collective concern about alcohol use during pregnancy and how this is influenced by the current regulated and social environment in New Zealand. This submission has been prepared by the FANNZ Coordinator and Health Promotion Advisor Christine Rogan.

In response to the call for FANNZ to make this submission, the coordinator received a lot of support and also a timely reminder that the effects of FASD are life-long for families living the experience. A couple of these responses are shared as follows:

“Yes, a great idea along with individual ones. I fully intend to do a rather personal one because family pressures at present prevent me from doing anything which requires research – yes my FASD buddy and the time required to keep him and family afloat!! Anyway the more that’s said about the cost to society socially and in financial terms the better. In our personal lives [Partner] and I have to factor in the equivalent of a full day’s work each week to support [Son with an FASD].”

“I received your emails but I don’t have time to think at the moment or its that I’m too tired to think. [Son’s] life is falling apart at present and I have no idea where that is going. I just feel so sad for him.”

The Fetal Alcohol Network makes this submission based on available evidence, our collective experiences of the impact that FASD has on children and family’s lives, as well as the responsiveness that communities are providing to protect the health of the unborn baby.

In so doing we support an integrated package of options that will work effectively to reduce all alcohol-related harm across communities. This is urgent and overdue, not just to reduce harm for this generation but for the next, an investment in the future. The measures suggested are evidence-based and supported by many health agencies in New Zealand and around the world including the World Health Organisation.

FANNZ commends the Law Commission for its comprehensive ‘First Principles’ review of alcohol and for recognising and acknowledging the extent and scope of alcohol-related harm. Protecting children from harm is a paramount ‘principle’ and sadly it is too often overlooked when economic imperatives are at stake. Our experience tells us that children are being seriously disadvantaged in our communities through alcohol exposure, prenatally and postnatally and that not enough has been done to shed light on the problem and work together on solutions. Consequently the issues balloons out to become entrenched, intractable and generational.

It is right and proper that the Law Commission focus attention on preventing the obvious trauma associated with alcohol in our lives that can be influenced by legislation – youth access, drink-driving, violence, injury, alcoholism. These are serious preventable traumas that demand action. However, as the Law Commission also recognises, these are but the visible tip of a far greater range of consequences that are currently below the radar and diffuse in society. FASD is found among these.

We note and appreciate that the Law Commission has recognised FASD as an adverse outcome from drinking that has been under-recognised and marginalised across the sectors. We strongly agree! Preventing even one child, from being born affected by alcohol, saves a lifetime of disability, social disconnection and cost burden on the individual, their family/whanau and public health system. FANNZ asks that the Law Commission support our long term call for resources to be directed toward FASD preventive interventions across all

sectors, not just in health. To do so, we believe it is important that you know a little of what we speak.

The teratogenic drink

Alcohol is a drug that is marketed and regulated as a beverage, a food. However, this 'food' depletes vital nutrients needed for healthy growth and development such as folate, is devoid of nutrients itself, and is teratogenic in that it alters the course of normal cell development. What's more, as pointed out by Warrant and Hewitt (2009), "*Because of its common availability and usage, alcohol is more than just a teratogen; it is the most prominent behavioural teratogen in the world.*"¹

The effects of alcohol on the developing fetus are well documented in the medical literature and evidence is mounting. Prenatal alcohol exposure is linked to a range of diseases and disorders that extend beyond those most directly associated with a fetal alcohol spectrum disorder.

Science is investigating the link between the prenatal environment and adult diseases and some of that work internationally is turning its attention to alcohol's pervasive effects on the wider burden of disease. Preliminary data from a few scientific studies show a cause for concern. There are indications that prenatal alcohol exposure alters DNA and gene expressions (epigenetic) that may predispose individuals to previously unrelated diseases including cancer². Perhaps that is not a surprising finding, given that alcohol is also carcinogenic.

We are not wishing to overstate or sensationalise the issue here, but merely pointing out that prenatal alcohol exposure is very likely linked to a range of disorders and diseases in more ways than we currently recognise, strengthening the argument for greater prevention efforts.

Yet this 'food' sits on market shelves, is promoted and festooned with seductive, colourful imagery and clever words to attract consumers, without a hint of its capacity to destroy lives. How is it possible to reconcile food handling regulations as being anywhere near adequate and appropriate for alcohol? Alcohol is a toxin - a primary source of harm. Neither the Food Standards Australia New Zealand (FSANZ); the Food Safety Authority; the Food Act 1981 nor its intended replacement Bill; nor the Wine Act 2003 for example are therefore adequate or appropriate vehicles for addressing the directly harmful effects attributable to alcohol. How, does one reconcile the teratogenic or carcinogenic effects of alcohol with the intention behind the Wine Act 2003 for example, which is there to set standards for the '*identity, truthfulness and safety*' in wine as well as the '*minimising of risk*

¹ Warren K and Hewitt B (2009). *Fetal Alcohol Spectrum Disorders: When Science, Medicine, Public Policy and Laws Collide*. Developmental Disabilities Research Reviews, 15: 170-175.

² Infante-Rivard C, Krajcinovic M, Labuda D and Sinnett D (2002). *Acute Lymphoblastic Leukemia Associated with Parental Alcohol Consumption and Polymorphisms of Carcinogen-Metabolizing Genes*. Epidemiology. Vol, 13:3. 277-281.

to human health arising from the making of the wine.'? Truthfulness is not achieved when there is silence on a product's inherently harmful properties. If alcohol is to continue being treated as a 'food', it is in an absurd league of its own.

In a 2006 nationwide survey³, over 50 per cent of New Zealand women believed some alcohol during pregnancy was safe to consume - and who could blame them? So little has been done to ensure there is adequate information available on which to make a well informed decision about the consumption of this beverage/food/drug.

The most recent national drinking survey shows that 28 percent of women who had been pregnant in the past three years drank alcohol during pregnancy. Only 68 percent of those surveyed were advised not to drink. This is indicative of a strong social pressure to drink and a lack of information about the harmful effects⁴.

The longer this situation continues the greater the likelihood that FASD - and possibly a host of other diseases - will be the outcome, with much of it remaining invisible, having never being associated with the alcohol consumption in the first place.

As a direct cause of birth defects and multiple other diseases, alcohol warrants special attention and stringent regulation that is currently lacking.

Recognising & Responding to FASD

Recent epidemiological studies carried out in schools (general population) in three countries, have found the rate of FASD to be 2-5 out of every 100 children (2-5%)⁵. As New Zealand has never carried out specific research to ascertain prevalence to date, the previous international prevalence estimate of 1:100 live births is most often quoted.

If used as a proxy for New Zealand, a prevalence rate of 1:100 would mean approximately 600 babies born affected each year. Using Canadian econometric figures to estimate the health, educational and social service costs of FASD, the added cost in financial terms would be in the vicinity of \$31,000 for every baby born – each year for the rest of their lives.⁶

³ Parackal S, Parackal M, Ferguson E & Harraway J (2006). *Report on Awareness of the Effects of Alcohol Use During Pregnancy Among New Zealand Women of Childbearing Age. Submitted to the Alcohol Advisory Council & Ministry of Health.*

⁴ *Alcohol Use in New Zealand: Key results of the 2007/08 New Zealand Alcohol and Drug Use Survey.* (2009). Ministry of Health.

⁵ May P, Gossage J, Kalberg W, Robinson L, Buckley D, Manning M, Hoyme H (2009). *Prevalence and Epidemiologic Characteristics of FASD from Various Methods with an Emphasis on Recent In-School Studies.* Developmental Disabilities Research Review 15: 176-192.

⁶ Stade B, Ali A, Bennett DI, Campbell D, Johnston M, Lens C, Tran S & Koren G (2009). *The Burden of Prenatal Exposure to Alcohol: Revised Measurement of Cost.* Canadian Journal of Clinical Pharmacology, Vol 16 (1) e91-e102.

Ultimately the goal is to prevent an individual being born affected. However, in a society where drinking is a normalised behaviour, that outcome is unlikely, so we need to ensure those affected are better supported.

We know from international evidence over the past 30 years that FASD is linked to a range of ongoing adverse health, disability and social outcomes, and that failing to address these early and appropriately leads to a second wave of disabilities – mental health problems, school failure, trouble with the law and alcohol & drug problems⁷.

A recent Swedish study found that prenatal alcohol exposure was predictive of substantially reduced educational attainment, lower earnings and higher welfare dependency rates.⁸ Prenatal alcohol exposure for instance is shown to be predictive of alcoholism in adolescents and adults⁹. Studies also indicate that individual with FASD are sadly, over-represented in the criminal justice system and prisons. A Canadian study of 287 Youth remanded for a forensic psychiatric/psychological assessment found 67 of the young offenders (23.3%) had an alcohol-related diagnosis¹⁰. Children and youth with an FASD are at increased risk for maladaptive behaviour because of the constellation of brain based disabilities such as poor impulse control, poor reasoning and judgement, abstraction, adaptation, socialisation and their inability to alter behaviour.

However these consequential outcomes are failing to be recognised as disabilities in the wider society. A further email communication from a member of the public received this week, illustrates well this situation. With their permission I share their correspondence thus,

“I have just read your Fetal Alcohol Spectrum Disorder Briefing paper 2007 and was wondering if you can help me at all?? I am an adoptive parent of a child now 2 years 10 months old whose birth mother drank and sniffed glue. We have had our fair share of 'problems' but managed to get through these - temper tantrums, self harm etc. We have now taken on a second child (with potentially the same problems) and we are having problems getting financial support from WINZ.

⁷ Streissguth A, Barr H, Kogan J and Bookstein F (1996). *Understanding the Occurrence of Secondary Disabilities in Clients with Fetal Alcohol Syndrome (FAS) and Fetal Alcohol Effects (FAE)*. Final Report. University of Washington School of Medicine Department of Psychiatry and Behavioural Sciences.

⁸ Nilsson J P (2008). *Does a Pint a Day affect your Child's Pay? The Effect of Prenatal Alcohol Exposure on Adult Outcomes*. Institute for Labour Market Policy Evaluation. Swedish Ministry of Employment. www.ifau.se

⁹ Baer J, Barr H, Bookstein F, Sampson P and STreissguth A (1998). *Prenatal Alcohol Exposure and Family History of Alcoholism in the Etiology of Adolescent Alcohol Problems*. Journal of Studies on Alcohol. Vol 59: 5, 533-543.

¹⁰ Fast D, Conry J and Loock C (1999). Identifying Fetal Alcohol Syndrome Among Youth in the Criminal Justice System. *Developmental and Behavioural Pediatrics*. Vol 20, No. 5.

We send the 2 year old to Creche. This was to help her with social, behavioural and developmental reasons. BUT WINZ will not subsidise her creche because I have to be sick or my 2 year old has to be sick in order to get the maximum subsidy. They are saying that if we can prove that she has a disability we could get the disability allowance, but Fetal Alcohol Syndrome is not recognised as a disability, but learning problems are! She has been referred to Child development services and we see a psychologist, occupational therapist, Paediatrician, and up to approx one month ago a speech therapist. This is not enough to say that she has a disability - or that they should subsidise creche?

So my questions are; How can a child be diagnosed with FAS? Or more importantly can they be diagnosed at such a young age? Do you know what research if any has been done on the effects of glue sniffing - or perhaps point me in the right direction?

I feel ever so strongly that these children who have FAS are 'lost children' the government do not want to do anything about the problem until the children become a problem. This isn't fair on the child or the caregiver (in our case). And more importantly I do not understand why there is not more support out there. Perhaps you know something that I do not??"

There are several levels at which a situation like this can be viewed as unacceptable. The evidence is clear that a stable home environment is a protective factor for children affected by a developmental disability such as FASD and for preventing secondary disabilities developing. Yet here is a family, that has stepped up to provide two children who have had a terrible start in life, with the care and attention they obviously need and deserve, and the system fails to support them in that endeavour.

It is good to see current health and social development policy is moving toward the provision of early intervention services for at risk children and families, but the reality is that this is likely to be inadequate to meet the needs associated with FASD. Without robust efforts to transfer knowledge of this alcohol-related developmental disability – beginning with recognising it is a disability - as well as the ability to put policy into practice, children with FASD will remain on the outside or 'lost' as the caregiver suggests, thereby compounding existing problems and increasing the cost burden.

A recent survey of approximately 250 primary healthcare professionals in New Zealand, found there was insufficient knowledge about alcohol and other drug use during

pregnancy¹¹. Only 32% of the participants thought that health professionals were sufficiently aware of FASD and many were unfamiliar with the basic information regarding the effects of alcohol and other drug use during pregnancy. For example, despite the criteria for a diagnosis of Fetal Alcohol Syndrome (FAS) being unchanged since the 1970s, only 25 percent of the primary healthcare professionals interviewed was able to correctly identify all 4 criteria for an FAS diagnosis – abnormalities with growth, facial features, central nervous system and evidence of maternal exposure. The majority thought that an early intervention programme would be beneficial for an affected child, but nearly two-thirds (64%) were of the opinion that a diagnosis of FASD may lead to a child or family being stigmatised.

It is perhaps unsurprising that FASD is largely invisible in New Zealand. Despite a decade or more of studies pointing to concerning levels of drinking during pregnancy, none of the children born have been followed up to ascertain what effect this may have had. One reason is that there is no investment in systematic training in the recognition and diagnosis of alcohol or other drug exposed children. Without an idea of prevalence, no public funds have yet been allocated to address the problem, resulting in a classic ‘catch 22’ and a terrible waste of human potential.

When acute and chronic needs go unmet, a ‘revolving door’ situation emerges whereby people present seeking help multiple times to multiple agencies. These agencies try to do their best but ultimately fail because the services they can offer don’t fit the need or they are turned away because the need does not qualify under their criteria.

Recent evaluative evidence of innovative interventions for children with a FASD, indicate they are effective at improving behaviour and skill levels.¹² Without investment in such programmes, the status quo is costly and ineffective. To redress this will require resources, not to create more and more services but rather to reorient those services that are already there and being utilised, so they work more effectively for people with high and complex needs like FASD. We look forward to the Law commission taking up that challenge with us!

What follows is our response to specific and relevant questions asked by the Law Commission in relation to the wider alcohol environment. As stated, our responses are in line with national and international public health evidence.

¹¹ Wouldes T (2009). *Health Professionals’ Knowledge, Opinions & Practice In Relation To Alcohol, Tobacco and Other Drug Use by Women Who Are Pregnant or Women of Childbearing Age*. A Report to Alcohol Healthwatch, Auckland (In Press).

¹² Bertrand J (2009). *Interventions for children with fetal alcohol spectrum disorders (FASDs): Overview of findings for five innovative research projects*. Research in Developmental Disabilities, doi:10.1016/j.ridd.2009.02.03.

RESPONSE TO PART A: QUESTIONS

THE HARM

1. Does the level of alcohol-related harm we are experiencing justify a new approach to the law?

Yes most definitely. We are greatly concerned about the level of alcohol-related harm across New Zealand communities and believe it is at a level that warrants a new approach, one that offers greater protection and promotion of public health and community safety and a greater level of Government responsiveness when issues come to public attention.

The way the current law is drafted, it is clearly more supportive of the sale of liquor than measures to meet its objective which is harm reduction. Children and Young people are exposed to alcohol every day through its normalisation in society, the high levels of advertising and sponsorship of sport and music, and easy accessibility by them and their peers. The changes to the Sale of Liquor Act have helped to encourage young people to start drinking younger than ever before and it is facilitating them into drinking at harmful levels as adolescent and adults.

2. Do you agree that getting drunk is considered acceptable drinking behaviour in New Zealand?

Yes.

New Zealand's society was founded on alcohol abuse and so it is little wonder that drunkenness is an expected outcome and a national pastime in many town centres and homes. Young people are often blamed for poor behaviour but they are surrounded by, 'adults behaving badly' and an environment that facilitates and condones heavy drinking. Such is the social pressure to drink that the non-drinking option is often viewed as weak and socially lacking or subject to derision – with the exception of 'designated driver' status.

We believe that more can be done to promote and encourage the non-drinking option for the general population, which in turn makes the choice to not drink during pregnancy much easier for women. The World Health Organisation has a sound principle to guide this approach in their 2009, Working Document for Developing a Draft Global Strategy to Reduce Harmful Use of Alcohol, which states, "*Children, young people and people who choose not to drink alcohol should be supported in their non-drinking behaviour and not experience pressure to drink alcohol.*" Currently it is virtually impossible to take a break from

that starring role of alcohol in sponsored events, arts and entertainment. Rather than being an adjunct to socialising, alcohol has become the central pillar of social events.

3. Do you think the risks associated with heavy drinking are well known? If not, what more could be done to make people aware of them?

No.

There is much misunderstanding and mixed messages regarding drinking, not least of which is the myth, that drinking alcohol protects against heart disease and this has been a persuasive argument and popular but weak 'excuse' for drinking. In the current climate where drinking alcohol is normalised, the acute effects of heavy drinking are often brushed off as temporary, injury seen as bad luck or part of the 'legend', health issues unrelated and alcoholism denied. The act of drinking over-rides common sense and better judgement and places the drinker and others at risk. This is a drug effect. In addition, the current easy accessibility of alcohol reinforces the message that alcohol is unproblematic and therefore any problem experienced is the fault and responsibility of the individual.

We support introducing a comprehensive national programme of early and brief intervention to address this awareness imbalance. This needs to be integrated across sectors so that opportunities to pick up problem drinking earlier are available and taken. It must include appropriate and culturally responsive intervention programmes for all women of child-bearing age to assess their knowledge of the risk of drinking during pregnancy and be encouraging and supportive of them making a positive change.

We also strongly support requiring clear and graphic warning labels about the risk of drinking during pregnancy be prominently displayed on all alcohol containers, at point of sale and any permitted advertising.

We note that the Law Commission has deferred to the Food Standards Australia New Zealand (FSANZ) in regards to this matter. FSANZ have declined previous attempts to require health warnings for alcohol over the last decade. The current application for a pregnancy warning label from the Alcohol Advisory Council on behalf of the former Government has been before FSANZ for over 3 years and that is to ascertain whether they will accept or reject the application. Members of this network took a public submission to Parliament 10 years ago asking for Government action. The FSANZ application is the result of that process. However, over 600,000 babies have been born in New Zealand since that petition was tabled in Parliament and none of the parents of these children had the opportunity to see a health warning on the bottle of alcohol they may have consumed.

The Law Commission must do what it can to redress this and require health warnings for alcohol as a fundamental underpinning of a comprehensive approach to harm reduction.

4. Do you think the cumulative lifetime risks associated with drinking are well known? If not, what more could be done to make more people aware of them?

As above.

The lifetime risks associated with even moderate alcohol are poorly understood and we know that health professionals are not generally well trained, confident or in a position to raise the subject with their patients.

Requiring large, graphic warning labels on all alcohol beverage containers and at point of sale would be a helpful starting point. Not only does it draw attention to the fact there are proven risks associated with consumption but it would provide health professionals and families with a pointer if concerns are raised about drinking. Health warning would also help to counter to the proliferation of positive alcohol marketing messages.

Of course, health warnings would be far more effective without liquor marketing and sponsorship as is the case with tobacco. We recommend that alcohol advertising and sponsorship be banned in all media. In particular we wish to see the end of “life style” advertising which portrays alcohol consumption always in a positive and alluring light and makes it difficult if not impossible to counter with health messages.

Alcohol advertising encouraged the uptake of alcohol by children and makes it more difficult for parents to set boundaries. The level of advertising liquor to young people through social networking sites is of particular concern. Protection systems like those to eliminate exposure to pornography seem a useful proposition to apply.

5. Is the management of intoxicated people an acceptable use of a large part of the New Zealand Police resources? If not, what are the alternatives?

No.

It is unfortunate that so much of police time is used dealing with the result of alcohol intoxication. It is not only a waste of police resources it is a waste of health resources, given the degree of injury, violence and poisoning-related hospitalisation. It is ironic that alcohol health promotion is not given a greater priority by district health boards wishing to cut costs given that alcohol creates a large and preventable drain on their in-patient resources.

Police need resources directed toward better licensing controls and monitoring of host responsibility practices within licensed premises, instead of spending their time cleaning up their mess. Often in the media, licensees are heard to complain that they are not to blame for intoxication as it is youth drinking large amounts before they head into town – known as ‘pre-loading’. While there is no doubt this occurs, the responsibility for who is let into a licensed premise in the first place is the responsibility of that license holder. If the patrons are already intoxicated and then served alcohol, the licensee is breaking the law pure and simple. They cannot welcome the dollars spent by intoxicated patrons and then claim no fault.

Penalties need to increase to encourage greater compliance with host responsibility practice and greater resources and powers given to the police, the medical officer of health and the licensing agency for monitoring and enforcement of drinking environment so there is less drunkenness, injury and violence for the police and other agencies to have to clean up and patch up.

OBJECT OF THE LAW

6. Is the balance in the current law between individual responsibility and providing an environment that is conducive to moderate drinking the correct one? If not, what changes could be made?

No.

We support the Law Commission's proposal for a completely new Act. We agree with the Commission's objectives for such an Act, as they are given in "Alcohol in Our Lives". We also believe the Act need a specific object to reduce alcohol-related harm. Given the level of preventable harm from alcohol that is experienced day in and day out across all communities, the health and safety of the community must be the primary consideration ahead of any individual drinker's rights and ahead of any commercial imperatives.

If the base of the Act is broadened the other alcohol-related matters that require a regulatory framework could then be brought under such an Act such as those area pertaining to the control of alcohol advertising, sponsorship and merchandising of alcohol products, labelling, point of sale health warnings, drink driving regulation – all of which currently sit outside of the current Sale of Liquor Act. This would ensure a more positive and inclusive common purpose more akin to the Smokefree Environments Act, for what essentially is the control of a harmful substance.

Essentially any proposed legislation needs to avoid falling into the trap of promoting moderate drinking. Moderation is a very misleading term when it comes to alcohol and there is plenty of evidence that moderate drinking contributes significantly to harm. Many people believing themselves to be moderate drinkers drink significant and misjudged quantities of alcohol. The emphasis of new legislation needs to stay firmly focussed on harm reduction as its objective.

RESPONSE TO PART B: RANGE OF OPTIONS

SUPPLY CONTROLS

Purchase/drinking age options

We support increasing the minimum purchase age from 18 years to 20 years from any licensed premises, and mandatory age verifications for the sale of alcohol.

We note that the Law Commission is favouring a 'split age' of 18 years for on licensed purchase and 20 for off-license. While this can be seen as a step in the right direction it will be less effective at curbing access to alcohol by minors than if the legal age was returned to 20 year for all.

Supply to minors

We are very concerned about the level of regular heavy drinking by young people and the early age at which this now begins. Adolescents are still growing and maturing and their brain is not yet fully developed and can be damaged by binge drinking. We are also concerned about the link between alcohol and unprotected sex which can result in unwanted sex, sexually transmitted infections and unplanned pregnancy which may also be alcohol exposed. All of this brings to bear a society of failed partner relationships and single parent trajectories. It is fair to say that relationships - and any children that are born from them - do not fare well when the only connecting feature is alcohol and sex. Midwives surveyed nationwide in 2001, reported that 80 percent of their pregnant teenage client drink during pregnancy¹³.

We therefore support making it an offence for any adult other than a parent or legal guardian to supply liquor to a minor.

License density & Hours

We support the establishment of national standard trading hours for both on and off-licensed premises.

These hours need to be conservatively set, particularly when close to residential areas and schools. Extension should only be granted upon application under certain condition and when public health and safety criteria can be satisfactorily met. The local community have for too long been shut out from having a say in where liquor licenses are granted. This has led to a proliferation of licenses often in local shops where children congregate before and after school. Requiring Local Councils to develop Local Alcohol Plans informed by Social Impact Assessments that communities can engage with are needed.

We support tighter restriction on the granting of licenses particularly in low-socioeconomic communities with a high demographic of young people.

DEMAND REDUCTION

Excise tax options

Alcohol is a competitively marketed product that is relatively cheap to make and sell. We support a substantial increase in the current levels of excise tax. A higher price for alcohol is well supported by evidence as a strategy to reduce consumption levels and harm. This has been recommended internationally including by the World Health Organisation as an effective measure particularly among price sensitive young people – those most vulnerable to harm. Further to this, the 1995 Alcohol Use study conducted by the University Of

¹³ Mathew S, Kitson K and Watson P (2001). *Assessment of Risk of Foetal Alcohol Syndrome and other Alcohol Related Effects in New Zealand: A survey of Midwives in New Zealand*. Report to the Alcohol Advisory Council of New Zealand.

Auckland Alcohol & Public Health Research Unit, found that Maori drinking would be mediated by pricing factors.

We also believe the Law Commission has a role to play in strongly encouraging Parliament and Government to pledge some or all of the excise tax collected from alcohol for expenses and costs associated with alcohol-related harm. For example to improve access to appropriate treatment options and to provide training and development of appropriate interventions to support individuals with FASD in the community.

Pricing options

We support investigating the introduction of a minimum price per unit of alcohol to counter the current heavy discounting and cost cutting benefits from bulk alcohol purchases.

Advertising options

We support a ban on alcohol in all media and a framework of alternative sponsorship of sport, arts and cultural events and entertainment such as happens for tobacco. To ensure there is adequate financial support for these, an alternative funding source is needed. 'Smokefree' offers a credible model.

Promotions options

We support a legal framework under the new act to regulate:

- packaging
- promotions, competition and giveaways
- point of sale placement
- display of alcohol products

PROBLEM LIMITATION

Treatment options

From a higher excise tax on liquor we support greater resourcing of the following:

- Alcohol and drug treatment services so they can specialise in service delivery areas such as addressing alcohol & drug use during pregnancy. This needs to accommodate a more integrated maternal/child healthcare approach such as that provided by the Pregnancy and Parental Services of CADS in Auckland¹⁴.

This programme is similar to services set up in Seattle, Washington, the P-Cap programme (Parent-Child Assistance Programme) ¹⁵ or the Sheway Pregnancy Outreach

¹⁴ <http://www.cads.org.nz/Pregnancy.asp>

¹⁵ <http://depts.washington.edu/fadu/>

Programme (POP) that is situated in downtown Vancouver¹⁶. This level of treatment is recognised by the Public Health Agency of Canada as part of multiple approaches to prevention¹⁷.

- Recognise and respond to the disproportional level of alcohol-related harm experience by Maori whanau and its interrelatedness with health disparities of Maori. A Whanau Ora approach is very appropriate for reducing the harm from drinking during pregnancy.
- Develop the 'circle of care' concepts for FASD, where families and agencies can work together to better meet the ongoing needs of those living with FASD. In Canada, many agencies contracted to respond to FASD issues use a 'keyworker' model of community care¹⁸ whereby a skilled person coordinates the social integration needed for the affected child and family to thrive together and participate more fully in society.
- Workforce development to ensure assessment, referral and brief interventions can be delivered by appropriate professionals across sectors (for example, primary care, mental health, emergency departments, education, justice, corrections, child, youth and family, work and income, ACC).
- Fund and educate primary care providers to deliver brief interventions and referral to specialist treatment. Brief interventions in primary care settings are shown to be effective in reducing harmful drinking. It is important to ensure that such intervention is confidential and supportive so women at risk of substance abuse feel safe and confident in the knowledge that revealing any harmful behaviour will not lead to their being alienated from their child.
- Introduce electronic screening and brief interventions in a range of settings and monitor its effectiveness. These have been effective with students at the tertiary level could be introduced at secondary schools level in order to pick up problem drinking earlier and in clinical settings, where individuals concerned about health could anonymously self-assess their drinking. This also is a good way to convey information about the harm from alcohol such as that from drinking during pregnancy.
- Require the need for alcohol and other drug assessment and treatment to be taken into account during sentencing in cases where alcohol and other drugs may have contributed to the offending, and ensure appropriate referral pathways for assessment of FASD and other developmental disorders where indicated.
- Facilitate research to ascertain the prevalence of FASD in the criminal justice system, beginning with youth in residential facilities and develop programmes for rehabilitation based on evidence.

IN CONCLUSION

¹⁶ http://www.vch.ca/media/sheway_brochure.pdf

¹⁷ <http://www.phac-aspc.gc.ca/fasd-etcaf/cp-pc-eng.php>

¹⁸ <http://bluewirecs.tzo.com/canchild/kc/KC2005-1.pdf>

In a just society, the health and safety of children and the people who care for them is a paramount consideration. When it comes to the way in which we address the sale and supply of alcohol, our point of reference must be the question – what type of law do we need for our children and families to be strong and well? The Fetal Alcohol Network New Zealand, strongly support a new integrated approach to reducing alcohol-related harm that is not limited by the application of the law, but is strengthened by it.

As recognised by the Law Commission review, alcohol-related harm is extensive, pervasive and complex in its nature and New Zealand needs far greater investment in prevention to reduce the costly burden of harm. Alcohol is a drug with serious associated and proven harm at all levels of consumption. Mounting evidence tells us that it is no longer tenable to take a laissez-faire approach to liquor control. Addressing this adequately requires a national framework and a comprehensive mix of law and strategies that can take account of the often multiple aspects that are involved at any one time.

Investment in FASD understanding, recognition, treatment and prevention, can save a lifetime of harm and another generation of harm. We believe the Law Commission understands and supports this and we wish the Commission well in its endeavour to make sound harm reduction recommendations to the Government.

SUMMARY OF RECOMMENDATIONS:

- Work from the paramount principle of protecting children from harm.
- Categorise and respond to alcohol as a drug not a food.
- Recognise that the harm from drinking during pregnancy poses a significant, preventable and long-term risk to public health.
- Redirect resources toward FASD preventive measure and effective interventions across all sectors, not just in health.
- Require that clear and graphic warning labels about the risk of drinking during pregnancy be prominently displayed on all alcohol containers, at point of sale and any permitted advertising.
- Return the minimum purchase to 20 years.
- Make it an offence for any adult other than a parent or legal guardian to supply liquor to a minor.
- Establish national standard trading hours for both on and off-licensed premises.
- Place tighter restriction on the granting of licenses.
- Requiring local councils to develop Local Alcohol Plans informed by Social Impact Assessments that communities can engage with.
- Increase the current levels of excise tax on liquor.
- Investigate the introduction of a minimum price per unit of alcohol.

- Ban media promotion of liquor and establish a framework of alternative sponsorship akin to 'Smokefree'.
 - Use higher excise tax rate to increase resourcing of brief intervention and treatment services that specialise in addressing alcohol & drug use during pregnancy.
 - Develop and support a Whanau Ora approach to alcohol & drug issues in the community.
 - Develop and support a 'circle of care' approach or 'keyworker' model of care to better meet the ongoing needs of those living with FASD.
 - Workforce development for FASD across all sectors.
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CONTACT DETAILS

Name: **Fetal Alcohol Network New Zealand**

Address: C/o - Alcohol Healthwatch Trust, PO Box 99407, Newmarket Auckland 1149.

Phone: (09) 5207037

Fax: (09) 5207175

Email Contact: Christine Rogan christine@ahw.org.nz