



**Report to the Ministry of Health**

***Review of the National Alcohol Strategy  
2000-2003***

**Final Report**

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## Executive summary

Alcohol is the most commonly used drug in New Zealand, and is one of the leading causes of drug-related harm. The Government's response to addressing alcohol-related harm has been previously guided by the joint Ministry of Health and the Alcohol Advisory Council's (ALAC) publication, the *National Alcohol Strategy (2000-2003)* (the NAS). The Government adopted a new National Drug Policy in March 2007, signalling the development of action plans based on the principles set out in the National Drug Policy. It is therefore timely to review the NAS to identify the extent to which it provides an effective and collaborative framework to minimise alcohol-related harm in New Zealand and to inform the development of a new Alcohol Action Plan.

This report is the product of a review of the NAS. It results from a qualitative, and where possible quantitative, review of the NAS, with information drawn from three sources:

- A document review identifying relevant national alcohol policies.
- Interviews with key stakeholders.
- Written material provided from other key stakeholders.

## Methodology

The project was overseen by the NAS Working Group, a working group consisting of Inter-Agency Committee on Drugs-member agencies (IACD) with an interest in alcohol policy. A Project Team from *Allen and Clarke* undertook a document search and review to identify evidence to support best practice approaches to the development of strategic alcohol policy in jurisdictions comparable to New Zealand, the scope of jurisdictions' national alcohol policies, and to source any published literature on New Zealand's NAS, particularly any evaluative studies.

A small number of key stakeholders were identified by the NAS Working Group and *Allen and Clarke*, and contacted to be a part of the review. This was a targeted approach designed to provide information relevant to the Terms of Reference for the review (appendix B). Stakeholders were asked a series of questions on specific elements of the NAS, such as its approach, specified outcomes, priorities, and target groups. Stakeholders were also asked about the impact of the NAS, communication and collaboration with stakeholders, the effectiveness of governance mechanisms, and future directions for alcohol policy. A questionnaire was also sent to a small number of other key stakeholders with whom the Project Team could not meet.

The Project Team received responses from a wide range of stakeholders, including 12 key government agencies, three local government organisations, interest groups, industry groups, research organisations, liquor licensing enforcement agencies, a treatment provider and a district health board. This provided a generally representative snapshot of sectors and agencies involved in alcohol policy.

## **Document review**

A document review was undertaken with a view to identifying approaches to alcohol policy in other comparable jurisdictions including the underpinning philosophy, identified areas for actions and interventions, scope, and governance structures.

Five national alcohol strategies from Australia, Canada, Ireland, Scotland and the United Kingdom were reviewed alongside a variety of literature. A very wide range of activities, initiatives and interventions were found to be undertaken through national alcohol strategies. The structure and focus of the national strategies differed between all jurisdictions, although the actual interventions being undertaken were common to all. Generally, the five national alcohol strategies reviewed have an overall focus on supply control, demand reduction and problem limitation, as is used in New Zealand.

Supply control strategies were utilised in some way to restrict the availability of alcohol in all of the jurisdictions reviewed, though approaches differed between jurisdictions. Strategies included enforcement of supply control legislation, minimum legal ages of purchase and consumption of alcohol, local authority involvement, and specific strategies for indigenous people in Australia, New Zealand and Canada.

One of the objectives associated with demand reduction strategies in New Zealand and other countries is to increase knowledge about risk factors associated with alcohol. This involves providing clear and accurate information about alcohol and its effects. Several of the national strategies, including New Zealand's, refer to the need to debate or reassess the role that alcohol plays within society and the culture that exists around it. Specific demand reduction strategies in the jurisdictions reviewed included guidelines and labelling, health promotion, alcohol advertising and promotion, and price and taxation.

Most national alcohol strategies provide much focus on problem limitation strategies that seek to manage and reduce the harm related to alcohol consumption. A number of these strategies group interventions under settings. Common settings identified were licensed premises, driving, and the workplace. Treatment, workforce development, monitoring and research were also identified as key components in strategies to reduce alcohol-related harm in the jurisdictions under review.

## **Findings from key informant interviews**

The responses from stakeholders demonstrated a high level of consistency on most questions and areas of concern. Stakeholders provided the Project Team with frank, qualitative comment on the effectiveness of the NAS as a strategic document, and on the implementation of this strategy.

Generally, stakeholders felt that although the NAS was relatively high level, it was a well written and clear strategy with enduring high level goals and outcomes. The document and its desired outcomes were praised but as a strategy it was considered to be ineffective in informing the development of alcohol policy and actions.

Key findings include:

- Leadership needs to be stronger, and specific responsibilities given with agencies accountable for the delivery of specified outcomes.
- There is a need for a robust monitoring framework with requirements for reporting, which needs to be specifically resourced.
- The profile and the messages contained within the document need to be more visible, particularly for non-government sectors.
- An evidence-based approach needs to form the basis of a new Alcohol Action Plan.
- A new Alcohol Action Plan will need to ensure buy-in from those organisations to be involved in its development and implementation.

Most concerns were raised in relation to the effectiveness of the implementation of the NAS and the lack of monitoring and accountability to ensure that the NAS was implemented. A strong need for better leadership, clear responsibilities, and accountability was identified, as well as better and more extensive communication. A variety of limitations of the NAS have been identified in this review, a number of which at a basic level stem from a lack of collaboration and communication.

While the governance structures and mechanisms for collaboration were considered to be theoretically sound, the perception from stakeholders is that the NAS has not been as effective as it could have been. It was not widely communicated, has been under-utilised and under-resourced, and for many agencies was considered out of date.

A number of considerations are put forward to assist in the development of a new Alcohol Action Plan.



## Recommendations

The following recommendations are put forward to assist in the development of a new Alcohol Action Plan under the revised National Drug Policy 2007 - 2012. These recommendations arise from the findings of the review of the NAS and have been informed by stakeholder interviews, written information received from stakeholders, and a review of other national alcohol policies.

### Leadership and governance

- the Ministry of Health needs to take an active leadership role in the development of the new Alcohol Action Plan but also ensure that the goals and objectives adopted for that Action Plan have a focus wider than just health to ensure ownership by all agencies and relevant stakeholders
- provision of clarity is needed around the roles of the Ministry of Health and ALAC regarding alcohol policy and leadership of the implementation of a new Alcohol Action Plan. One means of achieving this could be the development of a Memorandum of Understanding between the two agencies
- the new Alcohol Action Plan should be a whole-of-government strategy that takes into account relevant existing strategies and clearly outlines the role that the range of government and non-government agencies working in alcohol policy and programme areas should play in its implementation
- it is recommended that the IACD continue to comprise the principal governance mechanism for the new Alcohol Action Plan but improvements should be considered in relation to oversight of alcohol policy and programme development, implementation and review. A variety of mechanisms could be considered including any or all of the following:
  - a regular, standing item on the agenda of the IACD to monitor progress towards achievement of the outcomes listed in the Action Plan
  - the establishment of an alcohol subcommittee or working group
  - greater communication with NGO stakeholders
  - a sector-wide National Government Organisation (NGO) forum parallel to the IACD which could feed into IACD processes
- improvements should be made in the dissemination of information from the IACD to non-government stakeholders and in general liaison and consultation between the IACD and NGOs

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### Accountability and monitoring

- clear lines of accountability should be detailed in relation to the achievement of the Plan's goals and objectives. Responsibility for achievement of the various desired outcomes of the new Alcohol Action Plan should be placed on individual agencies and organisations

- a strategy needs to be developed to ensure consideration of the new Alcohol Action Plan in the planning and decision-making processes of the organisations to be involved in its implementation, and to ensure the desired outcomes of the Action Plan are explicitly built into project and programme delivery. Organisations should be required to show how their actions contribute to the identified outcomes under the Action Plan
- consideration should be given to the establishment of a mechanism for ensuring completion of work agreed to be undertaken by IACD members or the committee as a whole. This mechanism could comprise an IACD sub-committee or working group, a lead agency within the IACD taking responsibility or funding an external organisation to monitor progress. There could also be consideration given to a Cabinet mandate similar to the New Zealand Disability Strategy, which requires accountability from Chief Executives of government agencies
- consideration could be given to a review of the performance contracts between government agencies and the Government, with the New Zealand Disability Strategy used to illustrate a possible way of achieving greater accountability at the operational rather than legislative level
- a clear monitoring framework for implementation of the Alcohol Action Plan should be developed. This should set out specific responsibilities and requirements for reporting and updates, the datasets that must be used, and means of benchmarking the data
- there is a need for a central monitoring point where information is collected from the monitoring framework, analysed and disseminated

## **Collaboration and communication**

- in developing and implementing a new Alcohol Action Plan, genuine collaboration and communication needs to be promoted within and between government agencies, and with NGOs, councils and community groups
- when a new Action Plan is released, and on an ongoing basis, the strategic objectives and details of that Action Plan need to be effectively and comprehensively communicated to stakeholders and the wider community
- any communications about the Alcohol Action Plan should explicitly profile the goal to reduce alcohol-related harm and also raise the awareness of the public in relation to the harms caused by alcohol
- strategic engagement with stakeholders is necessary to ensure that the Alcohol Action Plan is seen as a whole-of-government plan and to promote ownership of the Action Plan at a community and/or implementation level
- collaboration needs to be ensured at an implementation level, and barriers to this addressed, such as competition for resources, lack of communication and direction from a national level, and overlap and lack of coordination of services
- consideration should be given to the establishment of a sector stakeholders group to support implementation of the Alcohol Action Plan and promote collaboration between government and non-government agencies

## Priority setting and strategic considerations

- it is recommended that the National Drug Policy (2007-2012) sets the framework for a future alcohol action plan and the three pillar approach continue to provide the basis to guide action, but that consideration is given to the priority weighting of the three pillars
- a framework to prioritise actions under the three pillars needs to be developed and an evidence-based rationale provided to target actions and resources to the most effect
- any new Action Plan that is developed under the National Drug Policy should be *evidence based* and a strong emphasis on the principle of evidence-based approaches be included in a new Action Plan, with a prominent role for monitoring and evaluation to ensure that emergent research and data are able to guide action and priority setting over time
- consideration needs to be given to whether focussing on the current target groups in the NAS are the most effective means of bringing about positive change
- existing alcohol strategies and actions plans developed by government agencies, organisations, local authorities and the World Health Organisation's WPRO Regional Strategy to Reduce Alcohol Related Harm should be considered in the development of a new Action Plan: to both reduce duplication and increase the effectiveness of New Zealand's approach
- analysis is needed to clarify the links between the Sale of Liquor Act, the Local Government Act and associated Long Term Council Community Plans, and the Resource Management Act at an implementation level, in light of councils developing local alcohol strategies

## Implementation and resourcing

- the development of a new Alcohol Action Plan needs to be informed by an appropriate level of consultation to ensure that parties with an interest in alcohol policy and programme development have a suitable opportunity to comment before the Action Plan is finalised to ensure ownership and engagement with it
- sufficient resources need to be allocated to the development and implementation of a monitoring framework for the Alcohol Action Plan, and responsibility allocated for this with clear timeframes and reporting requirements
- careful consideration needs to be given to the resources necessary to ensure effective implementation of alcohol-related policy and programme work at both a central and local level as initiatives are developed and proposed for inclusion in the Alcohol Action Plan.



# 1 Introduction

The Government's response to addressing alcohol-related harm has been previously guided by the joint Ministry of Health and the Alcohol Advisory Council of New Zealand's (ALAC) publication, the *National Alcohol Strategy (2000-2003)* (the NAS).

The NAS identified key alcohol issues, priorities for action, and strategies to address these issues. Professional education and workforce development are also highlighted for action. The strategies to achieve outcomes involve the control of alcohol supply (through education, regulation and enforcement), reduction in demand, and problem limitation (including strategies to reduce road fatalities and other harm). The NAS stressed the importance of partnerships and strategies being adopted in conjunction with one another rather than in isolation. Finally, it outlined a framework for monitoring and measuring progress towards key alcohol-related outcomes. The content of the NAS is summarised in *Appendix A*.

The Government adopted a new National Drug Policy (NDP) in March 2007 (Ministry of Health 2007b), signalling the development of action plans based on the principles set out in the NDP. It is therefore timely to review the NAS to identify the extent to which it provides an effective and collaborative framework to minimise alcohol-related harm in New Zealand and to inform the development of a new Alcohol Action Plan. The Ministry of Health, on behalf of the IACD, engaged *Allen and Clarke* to undertake a review of the NAS to:

- review how the NAS monitoring framework has contributed to the achievement of strategic objectives related to alcohol policy
- review how the coordination and collaboration mechanisms such as the Inter-Agency Committee on Drugs has operated in relation to alcohol policy, and how these have operated inter-sectorally to produce successful outcomes
- identify new or emerging approaches to strategic and operational alcohol policy used other jurisdictions comparable to New Zealand
- identify future issues that are likely to arise for alcohol policy in New Zealand, and
- inform the development of a new Alcohol Action Plan.

The full Terms of Reference is included in *Appendix B* of this report.

## **1.1 Report structure**

This report is organised in the following manner:

- *Part 1* – Introduction: introduces the project, its structure, and methodology.
- *Part 2* – Background: summarises the development and implementation of the NAS, summarises alcohol issues in New Zealand, and identifies the governance and constitutional framework in which the NAS sits.
- *Part 3* – Document review of national alcohol policies: outlines the findings of the document review on national alcohol policies in other jurisdictions.
- *Part 4* – Findings: discusses the information collected through interviews with stakeholders.
- *Part 5* – Analysis: analyses the findings of the key informant interviews.
- *Part 6* – Future directions: sets out recommendations to inform the development of a new Alcohol Action Plan.

Further material about the methodology is provided in the *Appendices B - E*.

## **1.2 Methodology**

The report is the product of a preliminary scoping exercise. It results from a qualitative review of the NAS, with information drawn from three largely qualitative sources:

- A document review identifying national alcohol policies;
- Interviews with key stakeholders; and
- Written material provided from other key stakeholders.

Quantitative information was sought through the document review and the interviews with key stakeholders, however, a paucity of data was found. The interview process clearly identified a lack of reporting on the outcomes of the NAS and the lack of available quantitative data that could be attributed to the NAS (see comments in *section 1.3* on limitations).

The project was overseen by the NAS Working Group, a working group consisting of IACD-member agencies with an interest in alcohol policy. The NAS Working Group approved the following methodology.

### **1.2.1 Document review**

*Allen and Clarke* undertook a document search and review to identify evidence to support best practice approaches to the development of strategic alcohol policy in jurisdictions comparable to New Zealand, the scope of jurisdictions' national alcohol policies, and to source any published literature on the NAS, particularly any evaluative studies. The review involved the following key steps:

- Development of a tightly defined terms of reference for the document search;
- A search against the terms of reference (undertaken by the Ministry of Health's library staff); and
- Review of all returned abstracts and selection of material meeting the inclusion criteria (including a full critical appraisal of literature where appropriate).

Further information about the Terms of Reference for the document review and a detailed methodology is included in *Appendix C* of this report.

### **1.2.2 Interviews with key stakeholders**

The Project Team met with a variety of stakeholders. This was a targeted approach designed to answer or provide information on the questions raised in the Terms of Reference. In total, the Project Team interviewed or received responses from:

- 12 government agencies
- Three local government agencies or organisations
- Two interest groups
- Two industry groups
- Two research organisations
- Two liquor licensing enforcement agencies
- One treatment provider, and
- One district health board.

A full list of interviewees is included in *Appendix D* of this report.

The interviews were semi-structured and followed the questions included in *Appendix E*. Information received through interviews was coded and analysed to identify key trends and future directions. The findings of this report are supported by a number of comments attributed directly to stakeholders. These comments were provided during free and frank discussion. In respect of this, a small number of comments have no attribution.

The Project Team invited a further seven government agency stakeholders (with whom it could not meet) to submit written responses to the same questions covered in the interviews. Four responded. Their responses were analysed and are included in this report.

## **1.3 Limitations**

A large number of stakeholders have an interest in New Zealand's alcohol policy to prevent and reduce harm relating to the use or misuse of alcohol. Not all potential stakeholders were consulted given the project's tight timeframe. While a sample representing the diversity in stakeholders was sought, the Project Team acknowledges that this report is largely based on the opinions of 25 organisational informants. These opinions are supported by key documents (when these were

available); however, it is possible that there are issues for other stakeholders that are not identified in this report. The Project Team notes that as there was general consensus in the comments made by different informants, there is likely to be an acceptable level of validity in the scope of the information received.

Turnover of staff within the roles and organisations interviewed as part of this project means that there were few people holding the same position now as they did when the NAS was in operation. This means that, in terms of evaluation, stakeholders' institutional knowledge and knowledge of the NAS varied considerably. A number of stakeholders noted that they could not comment on some historical matters.

It was anticipated that the document review would source evaluative studies on national alcohol policies, especially on the NAS and its outcomes; however, the document search returned only one such study. Quantitative data on the monitoring framework and outcomes of the NAS was also sought in all of the interviews with stakeholders. However, no quantitative material arising from the NAS monitoring framework was provided to the Project Team. The interview process identified a lack of reporting on the outcomes of the NAS and the lack of available quantitative data that could be attributed to the NAS. No reports based on the monitoring framework or the NAS were identified or provided by any government department. Interviews also produced a clear view from stakeholders that the NAS had not had a noticeable impact on alcohol consumption and alcohol related harm, although as noted in the report, the lack of monitoring of activities makes any cause and effect relationship(s) difficult to verify either way. There is a considerable body of research on the impact of alcohol consumption, behavioural patterns, and alcohol-related harm; however, no evidence of causation was found between the NAS and alcohol consumption or alcohol-related harm. Overall, these limitations mean that the evaluation contained in this report is predominantly limited to qualitative material rather than a more formal outcome or impact-focused evaluation.

## 2 Background

*Part 2* of this report summarises current trends in alcohol use and misuse in New Zealand. It also identifies other contextual information relating specifically to the framework and content of the NAS, and of the current mechanisms that provide for the governance and accountability for achieving the goals and objectives of the NAS.

### **2.1 Alcohol use and misuse in New Zealand**

Alcohol is the most commonly used drug in New Zealand, and is one of the leading causes of drug-related harm (along with tobacco).

Data from the 2004 New Zealand Health Behaviours Survey: Alcohol Use found that most New Zealanders had consumed some alcohol within the previous twelve months with significant variations in consumption patterns across different age groups (Ministry of Health 2007a). For example:

- Prevalence of alcohol consumption is high: 81.2 percent of New Zealanders aged 12-65 consumed alcohol in the last 12 months; 14.7 percent consumed a large amount of alcohol each week; and 9.5 percent got drunk once a week.
- There are differences in the prevalence of alcohol consumption by gender:
  - Men are more likely to consume alcohol than women and are more likely to consume larger amounts at least once a week.
- There are differences in the prevalence of alcohol consumption by ethnicity:
  - Non-Māori are more likely to consume alcohol than Māori.
  - Māori are more likely to consume large amounts of alcohol at least one time per week.
- Approximately 55 percent of young people (aged 12 to 17 years) had consumed alcohol in the past year, and approximately 12.4 percent consumed a large amount each week.

Available statistical information about the harms caused by alcohol use and misuse focuses on health and crime-related issues. ALAC (2005) found that an estimated 3.9 percent of all deaths in New Zealand can be attributed to alcohol consumption (2000 figures), resulting in a net loss of 60 lives when the beneficial effects of alcohol are considered. This study also found that alcohol is a key contributing factor in injury, that consumption behaviour is important in determining the health effects associated with drinking, that a large burden of disability due to alcohol consumption is not recorded, and that the health burden unequally falls on Māori.

While recent research indicates that moderate use of alcohol may provide limited health benefits in some circumstances, certain patterns and levels of consumption (such as binge drinking) cause a significant level of harm in New Zealand. Research by ALAC (2004) shows that one in ten people drink with the express purpose of getting drunk and that one in six New Zealanders consumes alcohol in a risky manner. In recent times, the prevalence and frequency of alcohol consumption of

young New Zealanders (aged 14 to 17 years) has decreased from 79 percent in 2001 to 66 percent in 2003 (ALAC 2003).

## **2.2 Legislative and strategic framework**

*Section 2.1* discusses the strategic context for the NAS at the time of its inception, and the framework that is now in place.

### **2.2.1 Legal framework**

New Zealand's legal framework for alcohol consists of statutes and regulations to:

- control the importation, manufacture, sale and use of alcohol (eg, the Sale of Liquor Act 1989 administered by the Ministry of Justice)
- protect people from the harms associated with the use of certain substances under certain conditions (eg, the Alcoholism and Drug Addiction Act 1966 administered by the Ministry of Health), and
- set out the mandates of certain statutory bodies (eg, the Alcohol Advisory Council Act 1976 administered by the Ministry of Health).

These statutes and the regulations made under them provide the principles necessary to support the direction and development of strategic alcohol policy.

### **2.2.2 Strategic framework: 2000**

The New Zealand Health Strategy (Minister of Health 2000) sets out the Government's framework for addressing health-related issues. One of the Strategy's 13 priority population health objectives relates to supporting healthy lifestyles by minimising the harm caused by alcohol to both individuals and the community. This objective recognises that alcohol causes a significant amount of harm, including its role as a risk factor for a range of conditions, diseases, and mental issues, and as a contributing factor to injury and death arising from injury (eg, associated with drowning, suicide, road crashes, assault, and domestic violence).

The NDP (1998-2003) (update released in 2007) was the Government's initial response to provide for a coordinated, inter-sectoral, coherent, outcome-focused strategic national policy to address the harms caused by alcohol, tobacco, and illicit drugs.

Two of the NDP priority areas focused on alcohol:

- To enable New Zealanders to increase control over and improve their health by limiting the harms and hazards of alcohol use.

- To reduce the hazardous and excessive consumption of alcohol and the associated injury, violence, and other harms associated with roads, workplaces, and other drinking environments.

The NDP also identified a range of anticipated outcomes associated with these two priority areas (eg, outcomes related to community involvement, acceptance of the harm minimisation approach among government agencies and collaboration between these agencies, effective education policies, alcohol in the workplace, treatment, the workforce, and specific outcomes relating directly to key areas related to alcohol harm such as the drinking culture, consumption of alcohol during pregnancy, injury, and crime).

The NAS was developed to both complement and extend the NDP framework and the identified priority areas by providing a framework specifically for alcohol-related issues. It applied the same three-pillared approach to addressing harm (eg, strategies to control supply, reduce demand, and limit problems). It used the same priorities and outcomes. The NAS then provided greater detail on the objectives, strategies, and monitoring and evaluation framework for achieving the stated objectives. Further detail about the structure and content of the NAS is included in *Appendix A*.

### **2.2.3 Strategic framework: 2007**

The National Drug Policy 2007 - 2012 was released in March 2007 (Ministry of Health 2007b). This Policy builds on the first NDP and establishes the goals, objectives and principles that will guide drug policy and inter-sectoral decision-making for the next five years. The NDP provides a stronger focus on the role of central and local government and NGOs in supporting the development of programmes to address the three pillars of drug policy: supply control, demand reduction, and problem limitation (as the last NDP did). Its overarching goal is to prevent and reduce the health, social and economic harms that are linked to tobacco, alcohol, illegal and other drug use. The objectives relating to alcohol are similar to that presented in the first NDP. The updated NDP clearly envisions a role for action-oriented plans for substances like alcohol, and that any such plans would specify the types of activities to be undertaken, specific outcome indicators and targets, resourcing, and identification of a lead government agency for each activity.

Since the expiry of the NAS in 2003, a number of agencies contacted as part of this project indicated that they have subsequently developed organisational-level work programmes or plans of action related to alcohol. These are discussed more fully in *section 4.6.4* of this report.



### 3 Document review of selected materials

A targeted document review was undertaken to identify approaches to alcohol policy used in other jurisdictions. *Part 3* of this report outlines the findings of the document review. It focuses on the underpinning philosophy of strategic documents used to guide alcohol policy, key action areas and interventions, scope, and governance structures. The methodology for the document review is described in *Part 2* of this report and in *Appendix C*.

The documents chosen primarily fall into the following categories:

- National alcohol strategies and plans;
- A comparative review on alcohol policy undertaken by the World Health Organization (WHO); and
- Evidence-based reviews of alcohol policy.

Five national alcohol strategies in addition to the NAS were analysed. These were:

- Australia's *National Alcohol Strategy 2006 - 2009*
- Canada's *Reducing alcohol-related harm in Canada: Toward a culture of moderation*
- Ireland's *Reducing alcohol-related harm*
- Scotland's *Plan for action on alcohol problems*, and
- The United Kingdom's *Safe. Sensible. Social. The next steps in the National Alcohol Strategy*

Beginning with an assessment of the underpinning philosophy of these national policies and the way in which action plans or strategies were grouped, it was found that the structure or focus of the national strategies differed between all jurisdictions although the actual interventions being pursued were common to all jurisdictions. These included strategies to control supply, control demand, and limit problems. Therefore, within this report, the structure of the NAS of supply control, demand control and problem limitation has been used to consider these other jurisdictions' alcohol policies.

The analysis introduces consideration of the intervention area by examining the results of current research reviews on effectiveness. This is followed by a consideration of the WHO's overview (where this applies) to consider where New Zealand's use of the intervention sits when compared to other countries. Finally, the detail of the intervention within the NAS is recorded as a background to considering the position adopted by overseas jurisdictions.

Although it was anticipated that evaluative studies on national alcohol policies, particularly those on the NAS, would be returned, few such studies were returned; however, some of the evidence-based reviews did comment on national alcohol policies, including one on the NAS (eg, Casswell and Maxwell 2005).

### 3.1 Overview of the national alcohol strategies

This document review compares New Zealand's strategies for dealing with alcohol issues with those of similar jurisdictions overseas (Australia, Canada, Ireland, Scotland, and the United Kingdom). Before analysing and comparing the specific actions taken in respect of alcohol policy in these countries, it is useful to assess the underpinning philosophies and the way in which the programmes are structured.

#### 3.1.1 Goals and/or objectives

An analysis of the goals and/or objectives of the national strategies provides insight into the underpinning philosophies associated with the national strategies selected. The terminology used (eg, goals, objectives, and/or priorities) varies between countries. In some cases there are several tiers. In *Table A*, the highest level of guidance describing a national strategy has been identified to provide an easily understood indication of philosophy. In addition, several national strategies have underpinning principles or essential characteristics which inform the way that strategies are developed and guide the way in which action points or interventions should be pursued. These are also explored.

**Table A. Goals and objectives of national alcohol strategies**

Country	Goal/Objective/Priority	Principles/Essential characteristics
<b>New Zealand</b>	<ul style="list-style-type: none"> <li>To enable New Zealanders to increase control over and improve their health by limiting the harms and hazards of alcohol use</li> <li>To reduce the hazardous and excessive consumption of alcohol and the associated injury, violence and other harm, particularly on the roads, in the workplace, in and around drinking environments, and at home</li> </ul>	<ul style="list-style-type: none"> <li>Treaty of Waitangi</li> <li>Appropriateness</li> <li>Effectiveness</li> <li>Efficiency</li> <li>Empowerment</li> <li>Equity</li> <li>Innovation</li> <li>Working together</li> </ul>
<b>Australia</b>	<ul style="list-style-type: none"> <li>To prevent and minimise alcohol-related harm to individuals, families and communities in the context of developing safer and healthy drinking cultures in Australia</li> </ul>	Essential characteristics: <ul style="list-style-type: none"> <li>Evidence-based with capacity for process, impact, and outcome evaluations</li> <li>Achievable within Strategy timeframe</li> <li>Balance of whole-of-population and targeted strategies</li> <li>Link to or build upon existing responses</li> <li>Clearly relate to a longer-term vision to reduce harm</li> </ul>

**Table A. Goals and objectives of national alcohol strategies (continued)**

Country	Goal/Objective/Priority	Principles/Essential characteristics
<b>Canada</b>	<ul style="list-style-type: none"> <li>• To reduce the harm associated with alcohol use to individuals, families and communities across Canada</li> <li>• To increase common understanding of the impact and scope of alcohol-related harm to Canadian society, and to prevent and minimise negative health outcomes for those affected by alcohol consumption</li> <li>• To develop a comprehensive, coordinated, and effective approach that builds on past and present efforts to prevent, reduce and address alcohol-related issues, and identifies realistic responses</li> <li>• To multiply and strengthen collaborative partnerships among governments, nongovernmental organisations, industry, addictions agencies, law enforcement and communities that are affected by alcohol-related harm</li> </ul>	<p>Principles:</p> <ul style="list-style-type: none"> <li>• Alcohol misuse is a public health issue</li> <li>• Alcohol misuse is shaped by social and other factors</li> <li>• Successful responses to reduce the harm associated with alcohol reflect the full range of health promotion, prevention, treatment, enforcement and harm reduction approaches</li> <li>• Action is knowledge-based, evidence-informed and evaluated for results</li> <li>• Human rights are respected.</li> <li>• Strong partnerships are the foundation for success</li> <li>• Responsibility, ownership and accountability are understood and agreed on by all</li> <li>• Those most affected are meaningfully involved.</li> <li>• Reducing the harm associated with alcohol creates healthier, safer communities</li> </ul>
<b>Ireland</b>	<ul style="list-style-type: none"> <li>• To encourage the responsible use of alcohol through health promotion and education programmes, which will have particular emphasis for those groups identified as being most at risk</li> <li>• To promote and improve treatment and support services, ensuring that they are effective, adequate to the real level of need in the community, and fairly available</li> <li>• To protect individuals, families and communities from the anti-social and often criminal consequences of alcohol misuse</li> </ul>	N/A
<b>Scotland</b>	<ul style="list-style-type: none"> <li>• To reduce alcohol-related harm in Scotland</li> <li>• To raise awareness of alcohol problems in Scotland</li> <li>• To promote a social environment, policy context and legislative framework (acknowledging the role of the review of licensing law) which will support the overall purpose of the Plan</li> <li>• To recognise the links to other areas of work and encourage initiatives which will tackle the causes and effects of alcohol problems</li> </ul>	N/A
<b>United Kingdom</b>	<ul style="list-style-type: none"> <li>• To minimise the health harms, violence and antisocial behaviour associated with alcohol, while ensuring that people are able to enjoy alcohol safely and responsibly</li> </ul>	N/A

### 3.1.2 Specific strategic areas

Sitting below the goals and objectives are the strategic or priority areas under which interventions are grouped. The strategy areas, the way they are named or grouped, and the aims expressed for each strategic area, also reflect the underpinning philosophy towards alcohol issues. These provide the practical base under which programmes, policies, and interventions are grouped. *Table B* sets out the strategic areas and their aims for those countries where they are expressed.

**Table B. Strategic areas for grouping interventions**

Country	Priority area/strategic area	Aims for each area
<b>New Zealand</b>	Strategic areas: <ul style="list-style-type: none"> <li>• Supply control</li> <li>• Demand reduction</li> <li>• Problem limitation</li> </ul>	<ul style="list-style-type: none"> <li>• Strategies that control the availability of alcohol (eg, regulation and enforcement)</li> <li>• Strategies that encourage reduced and responsible use of alcohol (eg, education and information campaigns)</li> <li>• Strategies that are aimed at reducing the problems stemming from the use of alcohol (eg, provision of treatment services, and initiatives designed to reduce alcohol-related road crashes and fatalities)</li> </ul>
<b>Australia</b>	Priority areas: <ul style="list-style-type: none"> <li>• Intoxication</li> <li>• Public safety and amenity</li> <li>• Health impacts</li> <li>• Cultural place and availability</li> </ul>	<ul style="list-style-type: none"> <li>• Reduce the incidence of intoxication among drinkers</li> <li>• Enhance public safety and amenity at times and in places where alcohol is consumed</li> <li>• Improve health outcomes among all individuals and communities affected by alcohol consumption</li> <li>• Facilitate safer and healthier drinking cultures by developing community understanding about the properties of alcohol and through regulation of its availability</li> </ul>
<b>Canada</b>	Strategic areas: <ul style="list-style-type: none"> <li>• Health promotion, prevention and education</li> <li>• Health impacts and treatment</li> <li>• Availability of alcohol</li> <li>• Safer communities.</li> </ul>	<ul style="list-style-type: none"> <li>• Raise public awareness about responsible alcohol use, and enhance the resilience of individuals and communities and their capacity to participate in a culture of moderation</li> <li>• Reduce the negative health impacts of alcohol consumption and address its contribution to injury and chronic disease</li> <li>• Implement and enforce effective measures that control alcohol availability</li> <li>• Create safer communities and minimise harms related to intoxication</li> </ul>
<b>Ireland</b>	Action areas: <ul style="list-style-type: none"> <li>• Encouraging sensible drinking</li> <li>• Providing and improving treatment services</li> <li>• Protecting the community</li> <li>• Developing an information and research programme</li> <li>• Implementing and managing the Strategy</li> </ul>	<ul style="list-style-type: none"> <li>• To encourage a responsible and moderate approach to drinking, by informing individuals of the risks involved and allowing them to make informed choices, one of which may be the decision not to drink</li> <li>• To promote [treatment] services of proven effectiveness, to help people to overcome their alcohol misuse problems.</li> <li>• To protect the community from the anti-social and criminal behaviour connected with excessive or illegal alcohol consumption</li> <li>• To develop an information and research programme that will give us detailed and up-to-date knowledge of local drinking patterns and behaviours</li> <li>• To ensure the effectiveness of this Strategy, we will put in place a management structure responsible for implementing, monitoring and reporting on the Strategy and for developing it, on a rolling basis, through a regular and systematic review process</li> </ul>

**Table B. Strategic areas for grouping interventions (continued)**

Country	Priority area/strategic area	Aims for each area
<b>Scotland</b>	Action areas: <ul style="list-style-type: none"> <li>• Culture change;</li> <li>• Prevention and education;</li> <li>• Providing support and treatment services;</li> <li>• Protection and controls for individuals and the wider community;</li> <li>• Delivery.</li> </ul>	<ul style="list-style-type: none"> <li>• Culture change to introduce a national communications strategy</li> <li>• Prevent and educate               <ul style="list-style-type: none"> <li>Shorter term:                   <ul style="list-style-type: none"> <li>- To start to change unhelpful perceptions of, and attitudes to, alcohol in Scotland, offering realistic options and alternatives.</li> <li>- To promote clear and consistent messages relating to alcohol problems</li> </ul> </li> <li>Longer term:                   <ul style="list-style-type: none"> <li>- To reduce the level of consumption of alcohol by some groups within the population</li> <li>- To reduce harmful patterns of alcohol consumption</li> <li>- To reduce specific risks relating to alcohol consumption, such as hazards through work or sports</li> </ul> </li> </ul> </li> <li>• Provide support and treatment services               <ul style="list-style-type: none"> <li>- To provide equitable, accessible and inclusive services to address the needs of those who experience problems with alcohol and those affected by others' alcohol problems</li> <li>- To improve awareness of sources of help and support with alcohol problems</li> </ul> </li> <li>• Protect and control for individuals and the wider community               <ul style="list-style-type: none"> <li>Longer term:                   <ul style="list-style-type: none"> <li>- Reduce crime, nuisance and fear of crime relating to alcohol.</li> </ul> </li> </ul> </li> <li>• Delivery               <ul style="list-style-type: none"> <li>- To develop an appropriate structure to deliver the Plan locally</li> <li>- To foster accountability for delivering results</li> <li>- To improve knowledge and information about alcohol problems</li> <li>- To develop training and support for those involved in implementing the Plan</li> </ul> </li> </ul>

Examination of these strategic areas reveals a different structural approach between each country depending on national priorities for interventions; however, the various strategies to achieve these outcomes are essentially of the same type. Variation, where it exists, is only reflected in the detail or emphasis of the intervention.

## **3.2 Supply control strategies**

Supply control strategies seek to control the availability of alcohol through legislative-backed interventions. The most prominent forms of supply control interventions are restrictions on the hours, days, and places of sale, and on the density and location of retail outlets.

### **3.2.1 Supply control legislation**

The WHO has confirmed that, in most countries, there is some form of legislation that deals with the production and sale of alcoholic beverages (WHO 2004).

Regulatory arrangements around the world range from state monopolies especially on the off-premise retail sale of alcoholic beverages (which affects 15 percent of countries) to situations where there are no alcohol restrictions (almost 12 percent of countries). The remaining countries, including New Zealand, operate some form of licensing system.

Research reviewed identified a strong association between the density of outlets and alcohol-related harm (for example, Ritter and Cameron 2006). The breadth of evidence on the effectiveness of restricted trading hours or outlet density on lessening alcohol consumption is good. Evidence also indicates that these restrictions are low cost to implement (Casswell and Maxwell 2005; Babor and Caetano 2005; Room et al 2003; Babor et al 2003); however, no research was available on whether lessening the density of alcohol outlets reduces alcohol-related harm (Ritter and Cameron 2006).

In New Zealand, there are restrictions on the hours of sale (but not generally on the days of sale) and the places of sale. This accords with 44.6 -47.3 percent of other countries (depending on whether the alcoholic beverage involved is beer, wine, or spirits). New Zealand's restrictions on the places of sale accords with 55.5 - 60.9 percent of other countries that have similar restrictions (WHO 2004).

Arguably, of greater importance is the enforcement of restrictions. In response to a WHO questionnaire on alcohol policy, New Zealand indicated that it has a partial enforcement policy (as did 41 percent of other countries).<sup>1</sup> This is compared with 25.6 percent of the 78 countries that returned information who recorded having a full enforcement of supply control regulations. Countries with full enforcement include Australia and Canada. Ireland and the United Kingdom share a partial enforcement rating with New Zealand (WHO 2004).

Commentators have noted that in New Zealand over time there has been a liberalisation of restrictions on both trading hours and density of outlets with little opportunity for community control in the process. As such, the marked increase in the availability of alcohol is likely to have contributed to an increase in drinking especially among younger people (Casswell and Maxwell 2005; Babor et al 2003).

In New Zealand, all of the supply restrictions noted above are achieved primarily through legislation (eg, the Sale of Liquor Act 1989). A key objective, therefore, as noted in the NAS is to ensure that the provisions of the Sale of Liquor Act are well understood by members of the public, alcohol retailers, the hospitality industry, and the agencies responsible for administering it. It is also important to improve monitoring of compliance with the Act by licensees and their employees as well as ensuring the Act's provisions are effectively and consistently enforced. This includes actively enforcing the minimum legal age for the purchase, sale, and consumption of alcohol; ensuring identification is sought; discouraging promotions on licensed

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<sup>1</sup> Partial enforcement refers to the perceived level of enforcement of restrictions on off-premise retail sales of alcoholic beverages: hours of sale, days of sale, places of sale, and density of outlets where these restrictions apply.

premises that encourage excessive or otherwise irresponsible drinking; the restrictions of sale and supply of alcohol to intoxicated persons, and the provisions relating to purchase on behalf of, or supply to, underage drinkers.

Most other national strategies considered for this review deal in some way with restrictions on the availability of alcohol. The Australian Strategy identifies the need to increase community understanding of liquor licensing laws and requirements for the responsible service of alcohol. There is also a need to improve enforcement of liquor licensing regulations by increasing the capacity of police, local government, and liquor licensing authorities to enhance enforcement of liquor licensing laws. Under the Australian Strategy, the adequacy and appropriateness of current penalties is considered. One innovation refers to improving the reliability of information to facilitate an early warning system of possible trouble spots so as to provide opportunities for proactive policing.

The Australian Strategy also proposes a general assessment to determine if stated objectives in liquor licensing legislation are realised in each state or territory. This includes a review of the mechanisms developed and implemented and whether the outcomes of harm reduction, which has been included in liquor control legislation in each jurisdiction, are being achieved. Other legal aspects of alcohol availability specifically to be examined include the use of alcohol consumption as a legal defence for diminished responsibility and the legal issues surrounding the supply of alcohol to minors. The Strategy also identifies the need to develop a nationally consistent approach and legislation on the secondary supply of alcohol to minors.

The Canadian Strategy also seeks to maintain current systems of control over alcohol sales. It identifies the need to enhance staff training at alcohol-selling outlets and to implement ongoing enforcement compliance programmes to ensure that alcohol is consistently sold in accordance with the law. Recognising that the increased physical availability of alcohol can lead to increased harm, the Strategy also calls for provincial and territorial governments to re-examine and analyse the regulations existing around hours and days of alcohol sales and outlet density. The Canadian Strategy identifies the need to conduct research on the nature and extent of underage access to alcohol followed by the implementation of appropriate programmes and policies to respond to the issues revealed by research results. Associated with this, is the need to strengthen enforcement and sanctions for people producing or using fake identification.

Of the strategies examined, Canada appears to be unique in noting the need to conduct research to specify the magnitude and nature of what was named third-party supply of alcohol (i.e., the supply of alcohol outside the legal distribution system and in those jurisdictions where alcohol is banned). Another innovation is the recommendation to investigate the implications of making liability insurance mandatory for all licensed establishments in Canada (eg, options like self-insurance programmes that do not place undue economic burdens on the hospitality industry).

An important objective of Ireland's Strategy is to reduce access to alcohol by underage drinkers although details of how this might be undertaken are not noted. In general, the Strategy refers to the need to work with a range of interested

organisations to develop measures that encourage and support responsible trading practices. It also recommends building on existing good practice and initiatives to support and promote training for all serving and door staff in the hospitality industry.

The Scottish Strategy records discussion on issues without proposing specific actions. In this regard, the Strategy mentions licensing law, preventing underage sales, and proof of age schemes as well as the supply and training of door stewards.

The United Kingdom's Strategy emphasises the need for sound enforcement and notes the Government's intention to work with police and local authorities to ensure that enforcement activity is efficient and well targeted. Another area of emphasis is on underage sales, and ensuring that policing tools were being applied effectively.

### **3.2.2 Legal age**

Another area of supply control involves imposing age requirements on the purchase and consumption of alcoholic beverages. Research has shown that the age of onset of drinking alcohol is important in both short-term and long-term effects on health. There is also a relationship between the level of age requirements and alcohol-related unintentional injuries (WHO 2004). Furthermore, there is strong evidence of a correlation between raising age limits and lessening alcohol-related impacts, even with a moderate level of enforcement (Babor and Caetano 2005; WHO 2004). One review of studies identifies that there is strong evidence that a minimum age of 21 years is associated with reductions in the level of drinking and traffic crashes in people aged 18 to 20 years. There is some suggestion that a 21-year old minimum drinking age reduces suicides amongst this age group as well (Wagenaar et al 2005). Noting the importance of enforcement, one area identified as a future policy direction is around strengthening the legal requirement to sight proof of age (Casswell and Maxwell 2005; Babor et al 2003).

Using beer as an indicator sensitive to purchase by youth, a WHO study found 14.8 percent of countries have no restrictions on the age of on-premise purchase and 21.4 percent for off-premise purchases. Countries with a low age restriction of 15 or 16 years made up 13 percent for on-premise purchases and 11.6 percent for off-premise. The most common category was 17-18 years (only one country had 17), which accounted for 64.3 percent of countries with age restrictions in relation to on-premise purchase and 58 percent for off-premise purchases. New Zealand, with an age of restriction of 18 years for all alcohol is in this category. This leaves countries with restrictions set at between 19 and 21 years of age which made up 7.8 percent for on-premise sales, while for off-premise it was 8.9 percent. Of those strategies examined in this review, only Canada differs from New Zealand with an age limit of 19 years (WHO 2004).

All jurisdictions considered in the review have a minimum legal purchase age, but references to this only appeared in two strategies. The NAS recorded an objective to gather information on the impact in relation to alcohol-related harm of minimum age changes introduced in 1999, which reduced the legal purchase age to 18 years.

The Canadian Strategy notes that given the relationship between legal purchase age and alcohol-related harm, consideration should be given to increasing the legal purchase age of alcohol to 19 years in Alberta, Quebec, and Manitoba.

### **3.2.3 Local authorities**

A further objective of supply control strategies is to encourage local bodies to better address alcohol issues by effective use of legislation, bylaws, policies, and plans in relation to the development of comprehensive local alcohol policies, the better co-ordination between planners and district licensing agencies, and the appropriate location of licensed venues and retail alcohol outlets.

The Australian Strategy requires an examination of opportunities for local government to consider the costs and benefits of liquor licensing applications in their area especially when exercising their building and planning regulatory authority. The Strategy also recommends that local authorities recover the additional costs of maintaining public amenity in areas with high densities of late night liquor outlets through measures such as differential rates and the application of direct fees and charges related to licensing provisions.

To further strengthen the regulation of alcohol availability through liquor licensing controls, the Australian Strategy identifies the need to increase community involvement in liquor licensing decision-making processes and in responding to related concerns. To assist with this, the development of a 'toolkit' to assist local government and local communities to participate in liquor licensing decision-making processes has been suggested. Further community action is urged through the suggestion of the inclusion of alcohol as a priority issue in local community safety initiatives.

The Canadian Strategy considers it important to require liquor control boards to maintain a social-responsibility frame of reference for all matters pertaining to their operations and governance. This includes the management of alcohol availability in 'high risk communities' in a socially responsible manner. The Strategy also emphasises the need for information on licensing decisions to be made public. It requests that all liquor licensing authorities and liquor control boards collect and make public detailed information on both off-premise and on-premise alcohol-outlet density.

The Irish Strategy identifies a need to investigate licensing options, including variations in opening hours and on-street controls.

### **3.2.4 Indigenous peoples**

Several national strategies refer to supply control strategies for indigenous people; however, the emphasis somewhat differs. In New Zealand activities are primarily aimed at encouraging local authorities to support strategies for minimising alcohol-

related harm that have been developed by Māori community service providers and marae-based committees.

In Australia, the aim is also to increase community involvement in liquor licensing decision-making processes with emphasis on supporting Aboriginal and Torres Strait Islander communities to advocate for restrictions in the availability of bulk wine in areas affecting these communities. Furthermore, the Australian Strategy encourages and supports Aboriginal and Torres Strait Islander communities to develop local solutions to particular problems, including those who have the opportunity and decide to go 'dry' and require health and social support services to assist people to moderate drinking behaviours. Where this has already occurred, the Strategy records the need to continue to monitor the impact of arrangements by Aboriginal and Torres Strait Islander communities for restricted availability and total bans on alcohol in the context of reducing violence and enhancing public safety in and around indigenous communities.

A similar recommendation is made in the Canadian Strategy, which recommends the evaluation of the outcomes of trial alcohol control measures in remote communities (particularly in the three territories), including total bans, limitations on importing alcohol into the community, and severely restrictive selling practices. The need to work with First Nation communities is highlighted.

### **3.3 Demand reduction strategies**

One of the objectives associated with demand reduction strategies in New Zealand and other countries is to increase knowledge about risk factors associated with alcohol. This involves providing clear and accurate information about alcohol and its effects.

#### **3.3.1 Drinking culture**

Several of the strategies refer to the need to debate or reassess the role that alcohol plays within society and the culture that exists around it. For example, the NAS refers to the need to promote public discussion and debate about the place of alcohol in New Zealand society and the best ways of minimising alcohol-related harm. The Australian Strategy identifies the need to develop a shared vision for long-term culture change with the aim of reducing alcohol-related harm and developing safer and healthy drinking cultures in Australia. The need for cultural change is also a major component of the Scottish Strategy. This was to be addressed, in part, through a national communications strategy. The need to change culture within organisations and professions was also identified as important with the emphasis being on organisations and professional bodies adopting appropriate alcohol policies.

### 3.3.2 Price and taxation

The effect of price changes on alcohol consumption has been extensively investigated with a strong correlation found. If prices of alcohol products go up, consumption generally comes down (WHO 2004). Young drinkers have been found to be especially price sensitive. Additionally, while it has often been assumed that heavy drinkers or problem drinkers would not pay attention to price changes, evidence has demonstrated that these drinkers respond to prices as others do. Furthermore, while the effectiveness is high, and research support broad, the cost of implementing such a policy is low (Casswell and Maxwell 2005; Babor and Caetano 2005; Babor et al 2003). A review of research has shown that tax increases will have an effect on lessening alcohol-related harm in particular cirrhosis mortality, alcohol-related traffic fatalities, and violent crime (Babor and Caetano 2005; Wagenaar et al 2005; Chaloupka et al 2002). While price change is one of the most effective strategies to lessen alcohol consumption and alcohol-related harm, the intervention is one that is often the most difficult for a government to implement. An increase in price needs to be politically justified to voters, particularly as a price change will effect all, including moderate drinkers (Room et al 2003).

The 2002 WHO questionnaire measured tax as a percentage of retail price for different alcoholic beverages. At that time, New Zealand returned a result of 10 percent for beer, 15 percent for wine and 38 percent for spirits. For beer, New Zealand was in a middle bracket of 10 to 29 percent tax with 52.3 percent of other countries. A further 24.6 percent of countries had higher alcohol-specific tax. For wine, New Zealand was in the middle bracket with 43.3 percent of other countries, although 28.3 percent of countries had higher taxes. With spirits, New Zealand was in the middle bracket of 30 to 49 percent tax with 33.3 percent of other countries. Nevertheless, 30 percent of other countries had higher taxes (WHO 2004).

The NAS contains references to a taxation response amongst its demand reduction strategies. The main objective is to develop a comprehensive taxation policy on alcohol to discourage excessive use, and recoup some of the external costs caused by the misuse of alcohol. While such a policy is being developed, it is intended to retain an inflation-indexed excise tax on alcohol and a specific levy on alcohol to fund work by ALAC. Another identified specific aspect of investigation is in relation to the adoption of an excise tax based on alcohol content, rather than beverage type.

Most of the other strategies have some reference to pricing or taxation, although the emphasis placed on these policies varies. The Canadian Strategy particularly focuses on pricing. One objective is to adopt minimum retail social-reference prices for alcohol and index these prices, at least annually, to the Consumer Price Index. The intention is that a competent body should review alcohol pricing throughout Canada, at least annually, and publish a report recommending increases where prices were not keeping pace with inflation. Another ideal identified in the Canadian Strategy is to move towards alcohol volumetric pricing (based on the volume of ethyl alcohol in alcohol products) within each beverage class. This policy required consultation between all provincial and territorial governments in Canada and the alcohol industry. The Canadian strategy also expresses an intention to create

incentives, either through tax or price adjustments, to promote the production and marketing of lower-alcohol content beers and coolers. The objective behind the policy is to reduce overall the volume of absolute alcohol consumed per capita in Canada.

Compared with the breadth of the NAS and the specificity of the Canadian Strategy, the other strategies examined have either broad or minimal references to price or taxation. The Australian Strategy refers to a need to investigate price-related levers to reduce consumption of alcohol at harmful levels. The Scottish Strategy refers to pricing and taxation in passing as this could only be brought in at the United Kingdom level of government. The United Kingdom's Strategy records only an intention to begin to consider the matter; noting that the government would commission an independent national review of evidence on the relationship between alcohol price, promotion and harm, and, following public consultation, will consider the need for regulatory change in the future, if necessary. There is no mention of this intervention type within the Irish Strategy.

### **3.3.3 Guidelines and labelling**

One of New Zealand's demand reduction strategies is the wide dissemination of information relating to the nationally agreed upper limits for responsible drinking. To assist with this, there is an objective to provide consumers with accurate and clear information on alcoholic drink containers. The specific actions recorded under this objective include the introduction of standard drinks labelling and the increase of public awareness and understanding of the standard drinks concept. In addition, further examination is recommended on the benefits and costs associated with providing additional product information on alcoholic drink containers, health warnings being an example; however, a review of available research on labelling has revealed that health warning labels produced no change in behaviour despite the warnings being reported as having been seen (Babor and Caetano 2005).

The Australian Strategy expresses the need to increase community awareness and understanding through the development of labelling of alcohol products to introduce standard drinks information as this would improve the consistency and clarity of messages associated with the promotion of the Australian Alcohol Guidelines.

When the Canadian Strategy was released, it proposed to develop and promote national alcohol drinking guidelines to encourage a culture of moderation, and to aim for consistency and clarity of alcohol-related health and safety messages. Associated with this, the Canadian Strategy also proposes to regulate for standardised, easily visible labels that convey the number of standard drinks in each container.

The Scottish Strategy refers to the intention to participate in discussions on labelling issues at the United Kingdom government level. The United Kingdom's Strategy refers only to consultation on the need for legislation in relation to alcohol labelling to include information on sensible drinking and warnings on drinking while pregnant. It

records the need for sustained national campaigning to raise the public's knowledge of units of alcohol and to ensure that everyone has the information they need to estimate how much they really do drink.

### **3.3.4 Health promotion**

All of the national strategies emphasise the use of health promotion interventions to achieve objectives; however, research on the effectiveness of various health promotion efforts has raised questions on the worth of this approach. Recent analysis of research shows that health promotion through mass media messages has no effectiveness to cause change (Room et al 2003). For example, a recent analysis of community interventions with a range of components (including mass media messages, organisers, and events), found modest gains only; with little clarity on how long-term any changes in behaviour would be (Giesbrecht and Haydon 2006). The general approach now considers that publicity should only be used in support of those initiatives which are shown to be effective (Casswell and Maxwell 2005; Babor et al 2003).

There also has been considerable research into school-based education and its impact on modifying behaviour. This has generally shown that while the cost of these interventions is comparatively high, they have limited effectiveness in leading to long-lasting behavioural change (Casswell and Maxwell 2005; Room et al 2003; Babor et al 2003). For example, while programmes have increased knowledge and changed attitudes towards alcohol, this has not necessarily translated into a change in drinking behaviour. Even programmes aimed at teaching resistance skills only produce a modest change in drinking behaviours and only while the programme was in effect. Any gains occurring during this time disappear when the programme ends (Babor and Caetano 2005).

The use of health promotion in the NAS aims to provide clear and accurate information about alcohol and its effects. Health promotion is also proposed to stress a message of moderation, including low alcohol use, abstinence, and the importance of eating food with alcohol. An important part of identified demand reduction strategies is targeted health promotion to identified at-risk population groups so as to reduce the level and likelihood of alcohol-related harm. Groups identified in the NAS include young people, young men, young women, older people, Māori, Pacific peoples, minority groups (gay, lesbian, bisexual and transgender people), tourists, and recent migrants. The information supplied should be easily understood by these groups, relevant, and in a form that makes it effective. The NAS also records the need to consult with the target population groups in the development of the information and the use of media that are relevant to the population groups. In the case of ethnic groups, it included resourcing communities to develop programmes in accordance with their own cultural perspectives. Further, the involvement of other interested groups around the target group was noted (eg, parents for young people, family for older people). In addition to information which reflected general health promotion objectives in relation to alcohol, there were specific objectives for the various population groups.

The Australian Strategy proposes to develop and implement social marketing campaigns to reduce alcohol-related harms by:

- reducing the perceived acceptability of intoxicated behaviour
- promoting the Australian Alcohol Guidelines and standard drink labels and measures, and
- increasing awareness of the significant costs to individuals, families, communities, and the Australian economy of the harmful use of alcohol.

Social marketing campaigns must be comprehensive, targeted, well coordinated, and developed through consultation mechanisms with key community partners and audiences, including the alcohol beverage and hospitality industry, the health sector, law enforcement, school-based drug education programs, young people and local communities. The Strategy also notes a need for appropriate research and thorough consultation to inform the development of social marketing campaigns aimed at Aboriginal and Torres Strait Islander peoples.

The Canadian Strategy also notes an intention to develop a comprehensive, sustained and coordinated social marketing campaign with multi-sectoral partners to promote the national alcohol drinking guidelines. It also intends to support and fund local communities to develop and implement community-wide health promotion initiatives that emphasise the national alcohol drinking guidelines and prevent and reduce alcohol-related harm. One particular population group singled out is underage youth for which messages could promote abstinence as a valid goal as well as the avoidance of high-risk drinking for those who choose not to abstain from alcohol. The need for a programme for young adults is also identified.

The Irish Strategy also advocates for the development, through consultation with key stakeholders, of a coordinated and integrated health promotion and education programme that emphasises the potential harm to people's health and wellbeing arising from high-risk drinking patterns and levels of consumption. Associated with this are health promotion programmes tailored to the requirements of population groups including primary and secondary schoolchildren, teenagers and young adults, women and older people. Health promotion programmes to contribute to the awareness of the role of alcohol misuse in domestic violence and abuse and to reduce drinking-related anti-social and criminal behaviours were also proposed.

The Scottish Strategy refers to health promotion programmes, identifying children and young people as key target groups, and the need to investigate other groups requiring acknowledgement. Emphasis is on health promotion in primary care to address alcohol problems in the context of delivering other health advice.

The objective of the United Kingdom's Strategy national campaign is to challenge public tolerance of drunkenness and drinking that causes harm to health, raise awareness of the risks of harmful drinking, provide messages associated with alcohol and pregnancy, and prevent harm occurring in under-18 year olds. It is intended that the Government develop a range of new kinds of information and advice aimed at people who drink at harmful levels and their families and friends.

### **3.3.5 Alcohol advertising and promotion**

Alcohol marketing is rapidly increasing with new innovations being utilised. Most of the research conducted has focused on whether this advertising has any influence on drinking behaviour. Research has also examined the impact of advertising bans. In the latter case, a review of research has suggested that restrictions on advertising do not have a major effect on drinking and the evidence on the effects of interventions is often mixed (Babor and Caetano 2005; Room et al 2003). There has been little research undertaken on the effectiveness of seeking to control advertising content (Casswell and Maxwell 2005; Babor et al 2003).

Part of New Zealand's demand reduction strategy relates to controls on alcohol advertising and promotion. This includes the following specific objectives:

- Ensure that alcohol advertising sponsorship conforms to the relevant codes of practice (to be achieved by regular reviews of codes of practice and the alcohol advertising that occurs);
- Minimise the exposure of young people to alcohol marketing messages (through the continued use of broadcast time constraints and policing of packaging and merchandising guidelines);
- Minimise the use of marketing strategies that may cause or contribute to alcohol-related harm (including aggressive pricing or promotion strategies and point-of-sale alcohol promotions); and
- Ensure that any new detrimental alcohol marketing strategies are identified early and do not become established in New Zealand.

Other national alcohol strategies considered in this project allude to alcohol advertising; however, few recommendations are made in this regard. The Australian Strategy specifically refers to the implementation of monitoring and annual reporting on the advertising and promotion of alcohol. This includes maintenance of existing prohibitions on any alcohol promotion that encourages rapid and/or high levels of alcohol consumption. The Scottish Strategy mentions that issues surrounding alcohol advertising will be raised once further research is conducted.

## **3.4 Problem limitation strategies**

Most national alcohol strategies provide much focus on problem limitation strategies that seek to manage and reduce the harm related to alcohol consumption. A number of these strategies group interventions under particular settings.

### **3.4.1 Licensed premises**

A review of research on initiatives to manage the drinking environment has shown that good enforcement of legislation governing the sale of alcohol to intoxicated persons is more effective than voluntary codes, staff training, and in-house policies

(Babor and Caetano 2005; Casswell and Maxwell 2005; Babor et al 2003); however, responsible host strategies can reduce heavy consumption and high-risk drinking if they are properly implemented and consistently adhered to over time as well as supported by enforcement available under the law (Babor and Caetano 2005). Overall, there has been little evaluation of the effectiveness of staff training initiatives and work that has been carried out has produced mixed results (Wagenaar et al 2005; Room et al 2003). At best, when compared to other initiatives, aimed at modifying the drinking context, these have a good effectiveness, although the breadth of research in support is not wide. Costs associated with this approach are viewed as ranging from moderate to high. It has been suggested that an increase in licensing fees should always endeavour to cover the costs of enforcement (Casswell and Maxwell 2005; Babor et al 2003).

Problem limitation strategies have been identified in the NAS for both licensed and other social settings. Within licensed premises, this involved the promotion of initiatives, such as host responsibility and the display of this information for patrons. The importance of ensuring that training was available and actually occurred is noted; as well as ensuring that those in the hospitality industry who applied for new or renewed licences have a written host responsibility policy. A further proposal in the NAS suggested the promotion of the availability of low alcohol and non-alcoholic drinks as well as the encouragement of licensees to price such drinks in a way that reflects their lower cost to the licensees.

As part of the central emphasis on the need to reduce intoxication, the Australian Strategy identifies the need to reduce the outcomes of intoxication and associated harm in and around late night (extended hours) licensed premises and outlets. The primary response in the Strategy is to develop and ensure participation in nationally consistent 'responsible service of alcohol' training programmes. These include the provision, management and promotion of late night transport options including taxis and designated driver programmes from licensed premises. It also refers to the policing of later night liquor outlets to ensure compliance with legislation, regulations, and good practice guidelines. A further suggestion focuses on environmental design and place management to reduce alcohol-related harm on and around licensed premises.

The Canadian Strategy also refers to implementing server-training programmes as a pre-condition for receiving and/or renewing licences for serving alcohol. This includes the implementation of the use of proven violence prevention programmes in licensed establishments. These training programmes include regular recertification of servers, ongoing enforcement compliance checks, and periodic programme evaluations to sustain and improve impacts over time. Establishments that have a history of service-related problems experience more frequent compliance checks.

The Scottish Strategy refers to the need to work with the industry to improve and promote training in the responsible serving of drinks. The United Kingdom also intends to review and consult on the effectiveness of the industry's Social Responsibility Standards in contributing to a reduction in alcohol-related harm. Other recommendations focus on supporting local action to secure the replacement of glassware and bottles with safer alternatives in individual high-risk premises and

on forming an expert group to reach agreement on how high-risk premises can be best identified. The Irish Strategy does not refer to licensed premises interventions.

### 3.4.2 Driving

An important aspect of the problem limitation strategies being used is to further reduce the incidence of alcohol-impaired driving. Most countries (93 percent) have laws restricting driving while above a specified blood alcohol concentration (BAC). It is generally held that the effectiveness of any drink-driving law is primarily determined by enforcement factors such as the degree of certainty of detection and the quickness of punishment. The frequency of random testing is therefore an important indicator used to assess the effectiveness of a programme (Ritter and Cameron 2006; WHO 2004). A review of the research evidence on BAC levels as well as random breath testing indicates that these measures are very effective. Although the costs associated with these measures range from low to moderate, they are still regarded as being cost-effective strategies (Babor and Caetano 2005; Casswell and Maxwell 2005; Babor et al 2003).

Other ways to manage drink driving have also been considered; however, the use of alternative transport systems or the use of designated drivers has been shown by research available to date to not be effective and to have little impact on alcohol-related accidents (Ritter and Cameron 2006; Casswell and Maxwell 2005; Babor et al 2003). Commentators have also noted that the general evidence for mass media campaigns to change risk behaviour is either poor or not available. Similarly, evidence on the use of educational interventions for drink-drivers has produced equivocal results despite this being one of the mainstays of action to deal with drink-drivers (Ritter and Cameron 2006). On the other hand, other interventions found to be effective have included graduated licensing provisions for new drivers, with commensurate low BAC levels, as well as empowering police to administratively (i.e., immediately) suspend driving licences (Room et al 2003).

The WHO questionnaire reveals that 26 percent of countries had a high maximum legal BAC of more than 0.6 permille.<sup>2</sup> New Zealand is in this group with a 0.8 level (although there are lower levels for graduated new licence holders and other categories of drivers). New Zealand's general BAC is shared by Canada, Ireland and the United Kingdom. Stricter levels were observed elsewhere: 39 percent of countries surveyed by WHO having limits in the 0.4 to 0.6 permille range, including Australia. A further 28 percent had a lower level of 0.0 to 0.3 permille (WHO 2004).

Although there are many countries with stricter blood alcohol levels, it is also important to evaluate the likelihood of being detected. From the WHO questionnaire, a total of 23 percent of countries recorded an 'often' rating for the frequency of random breath tests. This included Australia and a number of European countries. Countries returning 'sometimes' for frequency of tests accounted for 32 percent of the sample. Both New Zealand and Canada were within this category. A further 16

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<sup>2</sup> This refers to the amount of ethanol in grammes in each litre of blood: g/1000millilitres.

percent were in the 'rarely' category. Thirty percent, including Ireland and the United Kingdom, do not use random breath tests (WHO 2004).

Due to the variation between blood alcohol levels being used and the frequency of testing, a further analysis in the WHO was required to ascertain what percentage of countries had a low allowable blood-alcohol rate and a high frequency of testing. About 45 percent of countries met both criteria. Of the countries considered in this report, only Australia was in this category (WHO 2004).

In the NAS, several specific aspects have been identified in relation to drink driving:

- Increase the frequency of compulsory breath testing;
- Actively promote initiatives designed to reduce alcohol impaired driving (eg, designated drivers, the availability of public transport options);
- Increase the emphasis on addressing drinking and driving in known areas of high risk, such as rural roads;
- Develop targeted strategies to reduce alcohol-related road crashes amongst Māori;
- Improve strategies for dealing with repeat drinking drivers and those with very high breath and/or BAC; and
- Continue to monitor international evidence on different legal limits for breath/blood alcohol levels when driving vehicles, and assess the relevance of such evidence for New Zealand.

All other strategies refer to drink driving but in various degrees of specificity. Most refer to the continuance of strategies or programmes already in progress. In the Australian Strategy, an additional proposal is to conduct trial demonstration projects in partnership with key stakeholders that aimed to reduce drink driving in regional and rural areas.

The Canadian Strategy refers to the ongoing need to support the *Strategy to Reduce Impaired Driving 2010*, and re-invigorating law enforcement around drinking and driving. In relation to high-risk or alcohol-dependent drivers (i.e., people registering BACs of 0.15 or higher), more specific and better deterrents and rehabilitation of repeat offenders is sought. Specific suggestions included:

- Technology-based solutions (eg, ignition interlock systems);
- Education and public awareness initiatives;
- Improved assessment protocols; and
- Improved treatment and rehabilitation, drawing on harm reduction and medical models to better address the concurrent issues of chronic alcohol misuse and possible cognitive impairments.

In addition, schemes for short term suspensions and other proposed actions to address drinking drivers with lower BACs are included in the strategy. For graduated driver licensing programmes, there is a need to adopt a zero-tolerance alcohol (0.00 percent BAC) provisions for all drivers until the age of 21 years.

The Irish Strategy includes only a general reference to the expectation that the strategy would contribute to further reductions in the number of alcohol-related casualties among road users. To evaluate this, it is recommended that an annual review occur to assess the contribution that the Strategy made.

The Scottish Strategy identifies the *Scottish Road Safety Campaign* as the five-year strategy for drink-drive publicity. The United Kingdom's Strategy primarily refers in passing to the need for concerted local action to enforce the law on drink driving. Further drink-drive legislation is under consideration by the United Kingdom Government. This may deal with issues like the drink-drive limit, proposed changes to penalties for road traffic offences, and the introduction of targeted breath testing and roadside testing to provide admissible evidence in court.

### **3.4.3 Workplace**

Another environment identified in the NAS is the workplace. To reduce alcohol-related harm in the workplace, it is important to develop and promote workplace alcohol policies that incorporate host responsibility principles and practices and are available to deal with any alcohol-related problems in the workplace. Education of employers and employees about the effects of alcohol on work performance and safety is noted as another initiative. Research initiatives on the extent of alcohol-related problems in New Zealand workplaces, the desirability of using alcohol testing in workplaces, and introducing reduced Accident Compensation Corporation or insurance levies for industries and organisations with approved alcohol policies in place are also recommended.

In the Australian Strategy, the recorded objective is to introduce basic strategies in the workplace to prevent and reduce alcohol-related harm. This includes the development of evidence-informed workplace policies, alcohol and drug awareness initiatives in the workplace, and employee assistance programmes.

The Canadian Strategy identifies the need to develop and adopt comprehensive policies for alcohol within every sector of the Canadian workforce, with a special emphasis being placed on safety-sensitive professions. Similarly, the Irish Strategy calls for employers to develop and implement workplace policies on alcohol misuse, which treat alcohol problems as a health issue and which support treatment options.

The Scottish Strategy also alludes to the need to work with employers to develop better workplace alcohol policies within occupational health strategies and plans. The aim is to cover 40 percent of the Scottish workforce by 2006. The United Kingdom Strategy does not have specific reference to workplace requirements.

### **3.4.4 Other settings and other issues**

Outside of licensed premises, the NAS is almost unique in advocating an increase of awareness for host responsibility in other settings such as homes or other social settings where private functions might be held (although the Australian Strategy also

identifies the need for guidelines on private host responsibility, particularly for parents). Other strategies considered in this review do not mention private settings.

Public places are identified in the NAS as an important environment for problem limitation strategies. This partly relates to reducing alcohol-related harm at organised public events by educating event organisers on how to manage the availability and use of alcohol, by implementing available guidelines, by developing host responsibility guidelines and by supporting alcohol-free events. For informal or unplanned public events, it is thought that alcohol-related harm could be reduced by raising the awareness of local authorities' power to set conditions around the possession and use of alcohol in public places and providing guidance on how to manage alcohol-related problems that may occur at unplanned events. The Australian Strategy also refers to the need to revise, develop where necessary, and disseminate best practice guidelines on management of alcohol-related issues at public events. Harm minimisation and health promotion in community sports club settings where alcohol-related harm occurs is noted. The need for guidelines on ensuring the safety of people who are intoxicated in public settings and on responding to drinking in public places among communities of concern, in both urban and regional locations is identified. None of the other national alcohol strategies considered for this review refer to public places, although the Scottish Strategy records a brief mention of alcohol at sporting events.

Another public environment to reduce alcohol-related harm especially identified within the NAS, is in relation to the dangers of combining alcohol with water-based recreational activities for which education of the public is the primary intervention. No other strategy refers to this.

Within the Scottish and the United Kingdom's strategies, the emphasis is less on settings but on dealing generally with the link between alcohol and crime, especially violence and domestic abuse. The emphasis is on public safety and the way that the criminal justice system in particular could deal with alcohol-related crime. There are local and national actions to target alcohol-related offenders, using a combination of penalties and health and education interventions to drive home messages about alcohol and risks and to promote behaviour change. One direction in the United Kingdom's Strategy is on greater support to encourage more and stronger local partnerships and industry participation. It also seeks to improve the way alcohol-related offenders are dealt with including publication of an alcohol information pack for offenders under probation supervision and a prisoner befriending scheme.

The Australian Strategy also has a broader focus than settings in considering the prevention and management of alcohol-related injuries other than road traffic injuries. It seeks to explore opportunities to engage with the insurance industry to develop strategies to minimise the risk associated with alcohol use.

### **3.4.5 Treatment**

A review of research on the effect of specialised treatment programmes for problem drinkers indicated that participation in almost any kind of treatment is associated with significant reductions in alcohol use. Although reductions occur regardless of the

intervention, the weight of evidence suggests that behavioural treatments teaching relapse prevention skills are more effective than therapies exploring the underlying causes of excessive drinking. Consideration of pharmacological treatments has identified certain compounds which are effective in the prevention of relapse but these are viewed as an adjunct to outpatient therapy (Babor and Caetano 2005). There is fairly consistent evidence that assessments and brief interventions by primary care workers during the course of their regular practice impacts on drinking levels. While the cost of this intervention is low, the difficulty lies in gaining support from health workers to become involved (Room et al 2003).

As part of New Zealand's problem limitation strategies, the NAS includes a series of objectives were identified in relation to treatment by:

- increasing understanding of the range, the causes, and the treatment of drinking problems through the provision of information and the continuing support of the National Centre for Treatment Development
- increasing primary care workers' early identification of and response to alcohol-related problems through education and training but also possibly through contractual levers or incentives as far as screening as a brief intervention is concerned
- ensuring the provision of a coherent and comprehensive approach to alcohol treatment through well-resourced, publicly funded, and nationally co-ordinated treatment services and a comprehensive range of treatment options including effective pharmacotherapies
- ensuring treatments are accessible by publicising the full range of alcohol treatment and support services, addressing specific barriers to treatment (such as location and cultural appropriateness), and exploring options for delivering treatment for which access is not dependent upon location
- ensuring treatments are effective by developing treatment manuals and protocols, promoting research into treatment effectiveness, and supporting increased training opportunities for treatment workers, and
- ensuring that treatment services are responsive to unmet and emerging needs especially to several population groups such as adolescents, Māori, Pacific peoples, people with both alcohol use problems and mental health problems, and people in the criminal justice system.

In the Australian Strategy, there are similarly detailed recommendations in relation to treatment services:

- Initiate a national effort to enhance the capacity and legitimacy of the nursing profession in addressing alcohol-related health problems by; including alcohol and drug education in all undergraduate curricula; implementing mandatory policy to ensure that, in all health care settings nurses and midwives automatically assess all patients for levels of consumption; provide nursing and midwifery staff with resources to support alcohol-related screening and early interventions in primary care settings; and support further development of the Nurse Practitioner role in relation to alcohol and drugs.

- Promote primary care settings as an accessible and non-stigmatising opportunity for health promotion, prevention and treatment of alcohol use problems, including increasing the uptake of pharmacotherapy treatment for alcohol dependence; and providing a full range of approaches to Aboriginal and Torres Strait Islander peoples.
- Improve capacity and encourage a system-wide health response to people at risk of short-term and longer-term alcohol-related health problems including the development of an assessment; establishing linkages between hospital accident and emergency departments and specialist alcohol and other drug services and to general practitioners; identification of programmes in consultation with Aboriginal and Torres Strait Islander communities.
- Support whole-of-community initiatives to reduce alcohol-related health problems, especially for key population sub-groups (pregnant women, young people, Aboriginal and Torres Strait Islander peoples, older people, and people who have experienced alcohol dependence); recognise the importance of thiamine fortification in preventing serious alcohol-related disease; supporting local communities in developing and implementing such initiatives; addressing the co-occurrence of depression and alcohol use; data collection on foetal alcohol spectrum disorders in the general population and in high risk groups.

There are also numerous treatment proposals within the Canadian Strategy:

- Develop integrated and culturally sensitive screening, brief intervention and referral tools and strategies.
- Ensure adequate ongoing funding, quality training and accreditation for specialised addiction services.
- Improve access to addiction services in isolated, rural and remote regions of Canada and for vulnerable populations.
- Evaluate treatment programs to determine promising practices and disseminate the findings.
- Coordinate the transfer of knowledge relating to the evaluation and research of prevention, treatment and population health policies and programs addressing alcohol.
- Strengthen drug and alcohol curriculum in undergraduate, post-graduate and continuing professional development programmes.
- Disseminate screening and diagnostic tools to, and promote their use by, family physicians, paediatricians, and other health professionals.
- Prepare periodic reports on the impact of alcohol on chronic disease and coordinate these with the ongoing Costs of Substance Abuse reports.

Within the Irish Strategy, the treatment objectives are to:

- review treatment service provision to ensure that the provision of treatment services (this includes services being adequate to the population's assessed needs, and delivered in ways that are effective, flexible, accessible, equitable and accountable)
- ensure effective service provision by agreeing on standard method(s) for measuring the effectiveness of treatment and support services and developing a

system that will enable meaningful and relevant comparisons to be made between all existing treatment and support services

- provide service continuity by ensuring that alcohol treatment services are comprehensive, coherent and complete
- ensure that, where and when it is known to be a useful and effective approach, brief treatment interventions can be applied by personnel trained and authorised to do so
- assess the potential for using innovative approaches, such as 24-hour crisis-response services or specialised accommodation, and
- contribute to the development of treatment opportunities for sentenced offenders.

The Scottish Strategy identifies the need to develop a framework for support and treatment services. This framework would take into account the needs of children and young people, people living in rural communities, people with mental health and alcohol problems, people with alcohol-related brain damage, homeless people, and people in prisons. The potential of including thiamine in beer is also a feature. The United Kingdom's Strategy focuses on earlier identification, intervention and treatment of drinking that could cause harm.

### **3.5 Workforce development**

The NAS identifies a comprehensive number of objectives and actions related to workforce development. A selection of key action points include:

- promoting and supporting the integration of alcohol education and training into the vocational training programmes of groups likely to encounter people with drinking problems
- supporting the provision of short courses to assist generalist workers update and extend their alcohol knowledge and skill base
- supporting the provision of alcohol training for volunteers working in health and social services
- supporting the provision of comprehensive, multidisciplinary undergraduate and postgraduate vocational training programmes
- supporting the development of kaupapa Māori education and training programmes, and programmes and training from a Pacific perspective
- addressing other barriers to training for treatment personnel, especially geographical and financial barriers
- increasing the number of practitioners employed in community-based assessment and treatment services, to recommended benchmark levels
- promoting and supporting the integration of alcohol education and training into training programmes for health promoters
- supporting the provision of appropriate training for people working in the hospitality industry, including managers, bar staff and security staff
- supporting the development of relevant training for licensing inspectors employed by local authorities and police
- supporting the production of high quality research on alcohol issues, and

- promoting and support the evaluation of existing alcohol education and training programmes and approaches.

Other strategy documents refer to the importance of and need to develop a workforce to meet all requirements of implementing the strategies, but did not identify a comprehensive list as included in the NAS.

### **3.6 Monitoring and research**

In the NAS, a monitoring framework is set out. The monitoring framework is a list of indicators matched against alcohol objectives identified as part of the NDP. Few targets are identified other than for responsible drinking levels, drinking and young people, alcohol and road crashes, alcohol-related crimes, and alcohol-related drownings. The NAS identifies that other targets cannot be set due to the need to full information and research requirements. The document search and stakeholder interviews identified a lack of quantitative information on the outcomes of the monitoring framework that would enable an evaluation of its success or otherwise (see comments in *section 1.3* on limitations).

Most other strategies referred to the need for monitoring occurring at central and local levels. For example, the Australian Strategy envisages the development of an annual national alcohol action audit with an accompanying forum to promote implementation and to ensure accountability of all parties to the Strategy. The Irish Strategy identifies the need for a central structure for managing and monitoring the development and implementation of the Strategy, but also for local structures involving the setting up of local community groups to implement the strategy.

The NAS had a number of research aims included as part of the required interventions associated with supply control, demand reduction and problem limitation. Other strategies also refer to the need for research and information. For example, the Canadian Strategy recommends the development of a national, coordinated, ongoing data-collection and reporting system of common indicators relevant to acute and chronic alcohol-related harm across all jurisdictions. It also identifies the need to develop a strategic national alcohol research programme that is informed by a determinants of health approach and is directed at gaining a better understanding of the risk and protective factors surrounding alcohol use. The Irish Strategy envisages the development of a baseline research report to provide an analysis of drinking patterns, attitudes and behaviours, designed to support the Strategy's objectives, and which identifies areas where information is currently unavailable. Based on this, an on-going information and research programme to effectively support the Strategy would be designed.

## 4 Findings of the key informant interviews

*Part 4* of this report outlines the findings of the key informant interviews undertaken to inform the review of the NAS and its implementation. It sets out the findings from interviews and questionnaires from stakeholders from the following sectors:

- Government agencies (including Crown entities and local government);
- Non-government organisations;
- Treatment providers;
- Researchers; and
- The alcohol retail and hospitality industries.

Further detail on the methodology used to conduct the key informant interviews is included in *Part 1* of this report, and in *Appendices B, D* and *E*. An analysis and synopsis of future directions are included in *Part 5* and *Part 6* of this report.

### **4.1 Knowledge and relevance of the National Alcohol Strategy**

*Section 4.1* records observations of stakeholders' knowledge of the NAS, and comments made regarding its relevance to the organisation and individual concerned.

Seven organisations and individuals demonstrated a good working knowledge of the NAS and commented that they had previously used the document in their operational work. The remaining 17 stakeholders, particularly service providers, local government, and industry, but also some government agencies, demonstrated a very limited knowledge of either the existence or content of the NAS. For example, a number of stakeholders, including several from government agencies, had not previously read the document prior to being contacted as part of this review. It appeared that there was very low awareness of the existence of the strategy at a regional and local level.

Several government agency and service provision stakeholders considered that the current NAS was now obsolete, given that it officially expired in 2003 and that no clear monitoring of the NAS had occurred. Stakeholders considered that the NAS has expired (and not been updated) and that this considerably reduced its validity, use, and relevance. Many organisations noted that they now based their alcohol-related work on the latest available research rather than any national strategic document. Two stakeholders considered that the NAS has now been superseded by the National Drug Policy 2007 - 2012.

A small number of stakeholders, particularly those from government agencies, considered that the strategic objectives and specific details were communicated to stakeholders at the time of development and release of the NAS; however, there was general consensus from almost all other stakeholders that the NAS was not

effectively communicated to the wider community, and that it had slipped in too quietly (possibly due to its late publication).

There was a general consensus among stakeholders that a lack of adequate communication and active leadership has resulted in the NAS not being effectively used in or by the sector. Five organisations and professionals, both government and non-government, said that although the NAS had been a useful reference document, it was not used effectively in planning or decision making processes. Reasons included that it is considered to be out of date, it was poorly communicated, is no longer visible, and there is no requirement to use it. This was of concern to a large number of stakeholders as they considered that the NAS should, theoretically, be a core guiding document.

More than half of the stakeholders, including a number of government agencies and almost all service providers, stated that while many organisations were working towards the same goals and outcomes, this was not being linked back to the NAS (eg, that there is limited national cohesion in alcohol policy). Some service delivery organisations explained that they were undertaking actions working towards the same outcomes as the NAS but did not directly link this work back to the NAS or its drivers.

A small number of stakeholders were better informed of the work of the Alcohol Advisory Council (ALAC) than that undertaken by other stakeholders under the NAS. These different work programmes got confused in some cases, while other stakeholders were more familiar with the NDP and placed greater importance on their engagement with this. A few stakeholders did not see the need for a new strategic document, and considered that the sector could rely on the current legislation and enforcement powers to reduce alcohol-related harm. Others felt that the continued work of organisations would be primarily based on best practice research and that this would occur with or without a national strategic document.

## **4.2 Impact of the National Alcohol Strategy**

*Section 4.2* records comments made by stakeholders about the impact of the NAS on alcohol-related issues in New Zealand. Specifically, it covers:

- how the NAS monitoring framework contributed to the achievement of strategic objectives related to alcohol policy
- whether the NAS has contributed to improved social outcomes for the identified target groups, and
- the effectiveness of the implementation of the NAS.

### **4.2.1 Successes of the National Alcohol Strategy**

Most stakeholders agreed that the NAS was well written; however, views differed on the impact it has had. There were a number of areas in which stakeholders

considered that the NAS had been successful. For example, it was seen by some government stakeholders to represent a coordinated and comprehensive strategy that fitted with international best practice and that attempted to represent the alcohol-related work undertaken by government agencies in one place.

The Ministry of Health, ALAC, Department of Corrections, Ministry of Youth Development, Ministry of Education, Wellington City Council, and Alcohol HealthWatch commented that they had actively used the NAS in developing policies, programmes, and complementary strategies to prevent or reduce the harms associated with alcohol use. The Ministry of Health in particular used the NAS to develop a guide to public health purchasing of services. Six stakeholders also considered that the release of the NAS gave focus and impetus to the issues around alcohol and had a significant impact on getting interested parties together to share information and work towards common goals. Additionally, four stakeholders considered that the NAS resulted in multiple agencies placing a priority on targeting alcohol consumption and a move towards addressing the patterns of consumption rather than total consumption.

Stakeholders identified a number of other reasons why they supported the NAS and positive work that had come out of it, including that the NAS:

- recognised the Crown's obligations arising from the Treaty of Waitangi as part of its approach to minimising alcohol-related harm
- was based on the three pillar approach and that this was/is a useful tool and simple framework for stakeholders to identify where their work fits with overall strategic directions
- guided alcohol work and policy of other agencies such as the work of various central and local government agencies, and
- was attributed with having some impact on the fact that licensed premises are better managed with enforcement having resulted in licensed premises being more responsible with regard to intoxication and minors.

Additionally, eight stakeholders commented that the NAS had gone some way to meeting the two alcohol priorities of the NDP in that it provided:

- a specific framework, guidelines, and an agreed position for a range of agencies to undertake work to reduce alcohol-related harm
- the goal of harm reduction and a process that includes supply control, demand reduction and problem limitation
- a forum for the government sector to work together in conjunction with NGOs and other providers with an interest in alcohol, particularly with ALAC as the NAS is considered to be Ministry-led but sector driven
- clarity to the Government on what alcohol work was taking place, where money had been allocated, and what services were being provided
- a gap-analysis mechanism, and
- a first step which has helped develop thinking about alcohol-related harm.

## 4.2.2 Limitations of the National Alcohol Strategy

While most stakeholders agreed that the NAS was an informative document, with appropriate outcomes and goals, there was a strong feeling that it had not been effectively implemented. While a lot of actions were consistent with the NAS, respondents were uncertain of causation pathways and questioned how much the NAS was a driver behind developments to reduce harm. The majority of stakeholders considered that ALAC was the driving force behind recent changes and that the existing work programme would have been the same even in the absence of NAS. The work of ALAC was seen as raising the profile of harmful behaviour, such as binge drinking, but there was a belief amongst stakeholders that there was still a lack of awareness about the extent of the problem of alcohol in New Zealand.

Stakeholders almost unanimously agreed that NAS had been ineffective in reaching its target audiences. Eleven stakeholders noted that consumption was actually increasing in the risk groups identified in the NAS. The NAS had, for example, identified young women as a target group, with consumption rates for this group now catching up with young men. Stakeholders identified a number of other factors which limited the effectiveness of the NAS, including:

- A lack of marketing and communication about the purpose and existence of the document
- A lack of strong leadership to push forward implementation of the NAS
- A lack of knowledge of the NAS among key agencies and a lack of key champions within those agencies pushing the NAS forward
- The lack of sustained impetus on reducing alcohol consumption
- The service delivery workforce were comfortable with the demand reduction approaches used at the time and not prepared to push harder issues of supply control
- There was no mechanism requiring the NAS to be implemented, it relied upon organisations or individuals to pick it up and implement it of their own accord
- A lack of monitoring of the strategy, by the IACD and across the sector, in part due to a lack of resources and the difficulty in putting the monitoring framework together
- Fiscal neutrality inhibited implementation of actions
- A strong industry lobby group
- The NAS did not place responsibility for outcomes with individual agencies
- The timeframe of the NAS was too short for high level goals, and
- The NAS may have become an invisible document with everyone working towards its outcomes but not referring back to it
- That the NAS has been undermined by other factors such as the reduction in the drinking age and the increasing number of outlets and liquor licenses, a reduction in the price of alcohol, and targeted marketing by industry at youth and low income consumers.

### **4.2.3 Impact of the National Alcohol Strategy**

Fourteen stakeholders agreed that the NAS has not had an impact on overall alcohol consumption in New Zealand (although the lack of monitoring of these activities makes this somewhat difficult to verify, as discussed in *section 1.3* on limitations). One of the stakeholders involved in research is currently preparing a paper for presentation to the Ministry of Health and this is anticipated to confirm that alcohol-related harms are a significant problem in New Zealand, despite the work of the NAS and other work that has occurred since the term of the NAS ended).

Specifically, the Project Team asked stakeholders to identify whether the NAS had raised the profile of goal to reduce alcohol-related harm. Most stakeholders responded that it did not, although five stakeholders considered that it had for the time that the NAS was operational. Eight stakeholders did not consider that the NAS had a profile itself (see comments in *section 4.2.1* on communications). A number of stakeholders attributed raising the profile of the goal to reduce alcohol-related harm to ALAC rather than the NAS. One stakeholder commented that raising the profile required marketing and this was a strategy that was never marketed. For example, one service provider considered that the priorities and outcomes may have flowed into Ministry of Health contracts with sector service providers and district health boards, but that the NAS was never communicated to the wider public of New Zealand. Research stakeholders, service providers, and a small number of government agencies stated that alcohol is persistently under recognised by the public for the harm that it does and there is a lot of resistance to recognising the harm caused by alcohol.

Fourteen stakeholders considered that it was questionable whether the NAS had increased the implementation of actions to reduce alcohol-related harm. Many thought that most actions had been in spite of or occurred alongside the NAS rather than as a result of it. Some stakeholders in the public health sector felt that there was dysfunction between the policy level and operation level and the NAS did not flow on from the policy level. The NAS was not considered to have been a driver for innovation by most stakeholders, other than that it was the first of its kind and was innovative because there was nothing before it. One stakeholder noted that the approach to long term culture change started under the NAS, while a number of others stated that work being done on alcohol is based on evidence on alcohol not driven by the NAS.

Accountability for achieving the NAS outcomes and objectives is discussed in *section 4.3.3* of this report.

## **4.3 Leadership, governance, and accountability**

A two-tiered governance approach was established to implement, monitor and review the NDP (and through this, the NAS). Ministerial oversight of the NAS is provided by the Ministerial Committee on Drug Policy (MCDP). The MCDP provides the overall political leadership and makes decisions on the direction of the NDP

(under which the NAS sits). The MCDP is supported by the Inter-Agency Committee on Drugs (the IACD). The IACD is an officials-level committee charged with collaborating and coordinating different drug and alcohol-related activities undertaken by each government agency. It also makes recommendations to the MCDP on new policy initiatives. The work of the IACD includes consideration of activities related to drinking (both through oversight of the NDP and the NAS, and of other alcohol-related activities that sit outside of the NAS).

The NAS was jointly published by the Ministry of Health and ALAC. Each of these organisations has a different but complementary role in leading alcohol-related work at a national level. The Ministry of Health is the lead policy agency for health issues in New Zealand. Its key roles include providing policy advice on improving health outcomes, reducing inequalities, and increasing participation, and the facilitation of collaboration and coordination within and across sectors with regard to health issues. ALAC is a Crown entity established through the Alcohol Advisory Council Act 1976 to promote the moderate use of alcoholic liquor and to reduce the personal, social, and economic evils resulting from the misuse of alcoholic liquor. It is funded by means of a levy on alcoholic liquor imported into or manufactured in New Zealand. Both the Ministry of Health and ALAC are members of the IACD.<sup>3</sup>

#### **4.3.1 Leadership: the role of the Inter-Agency Committee on Drugs and the Ministerial Committee on Drug Policy**

Key informants were asked about the governance arrangements that oversaw the implementation of the NAS. Several questions focused on the role of the IACD in:

- supporting collaboration and coordination in alcohol policy at a government level, and its effectiveness in this role, and
- facilitating collaboration between government agencies and sector stakeholders and opportunities for non-agency stakeholders to input into policy decisions.

Generally, stakeholders were supportive of the structure provided by the MCDP and the IACD, and considered that alternative or additional mechanisms were not required. Issues associated with the governance mechanisms tended to focus more on operation of the Committees rather than the Committees' roles in leading collaboration and coordination of national alcohol policy. A number of non-government organisations, including within local government were not aware of the existence of the IACD or MCDP and therefore did not answer the questions relating to these structures.

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<sup>3</sup> Other members of the IACD include Child, Youth and Family, the Department of Corrections, the Land Transport Safety Authority, the Ministry of Education, Ministry of Justice, the Ministry of Pacific Island Affairs, the Ministry of Social Development, the Ministry of Transport, the Ministry for Youth Development, the New Zealand Customs Service, the New Zealand Police, and Te Puni Kōkiri.

### ***Alcohol policy-related comments***

Nine stakeholders queried the range of agencies and organisations involved in the IACD. Most of these comments related to the ability for non-government agencies and community-based organisations to have input into the issues considered by the IACD and, through this, Ministerial decision-making. Reasons for proposing that a wider range of agencies be involved included that:

- collaboration and decision-making happens at a distance from the work that is happening on the ground
- the community and NGOs needs a clearer avenue for being involved in policy decisions made about alcohol
- collaboration in alcohol policy needs to also include those organisations that are actively involved in alcohol but which sit outside of government agencies
- the alcohol 'industry' needs to be more involved (although most other non-industry stakeholders did not support this potential addition), and/or
- it can be difficult to get some existing members of IACD to engage where drug and alcohol may not be an obvious component of the agency's core business.

Proposals for consideration included that the IACD include a representative from an NGO, or that the IACD make better and more frequent use of its powers to invite non-member participants to attend its meetings when alcohol-related issues are on the agenda. Another suggestion was to use a sub-committee model (eg, similar to that provided through the NAS Working Group), or an intentional effort by the IACD to inform non-government stakeholders of alcohol-related work, monitoring and decisions made by the IACD.

Non-government stakeholders viewed the limited communication with the alcohol sector taken by the IACD as an issue, and that the Committee could provide better two-way communications about its activities. Monitoring of the implementation of the NAS is discussed in *section 4.3.4*.

### ***General comments about the Inter-Agency Committee on Drugs***

Stakeholders generally supported the governance framework provided by the IACD and the MCDP. Advantages raised by stakeholders included that the IACD has:

- provided a mechanism for agencies to get expert advice to Ministers, and for Ministers to receive critical relevant information about alcohol use from the perspective of portfolios that they may not normally work closely with
- contributed to better relationships and greater collaboration between agencies, resulting in more opportunities for shared work and common approaches across agencies, for example, Corrections commented that it has enabled them to become involved in work on mental health
- added value to the work of agencies through the incorporation of multiple portfolio perspectives, resulting in well-rounded and fully analysed arguments, and
- provided a common language about alcohol and drug issues.

Stakeholders also identified a number of limitations specifically associated with the IACD's leadership and governance of alcohol and drug issues. These included that:

- there is a lack of clarity about which agency is responsible for leading the IACD
- sometimes advice about alcohol and drugs goes direct to Ministers rather than through the IACD, indicating some officials' lack of understanding about the roles of the IACD and the MCDP and undermining the IACD process
- some agencies do not see the value of the IACD (although this may be an issue associated with inter-agency committees rather than being limited only to the IACD)
- there is considerable variation in the level of seniority of IACD participants (eg, from entry-level policy analysts to policy managers), and
- operational issues associated with the frequency of meetings, the timeliness of minutes, attendance, etc.).

Several stakeholders, both government and non-government, commented that their concerns were the same or similar to those identified in the review of the NDP conducted in 2004 and referred the Project Team to their previous comments.

#### **4.3.2 Leadership: the roles of the Ministry of Health and ALAC**

While not specifically asked about the joint leadership of the NAS by the Ministry of Health and ALAC, six stakeholders commented on the quality of leadership provided to date. Of specific concern was the low visibility that the NAS has had under the leadership of the Ministry of Health, and the perceived lack of leadership taken in the area of alcohol policy by the Ministry of Health (government agencies in particular considered the Ministry to be the 'owner' of the NAS, while a number of non-government organisations perceived ALAC to be the owner of the NAS). There was a general call for a greater level of, and clarity in, the leadership of the NAS (and alcohol policy in general). This was supported by calls for the Ministry of Health to demonstrate its commitment to reducing the harms caused by alcohol by providing a more adequate level of resourcing to alcohol policy work at both a central level, and at the regional and local level (eg, through contracts with the district health boards). The level of potential adequacy was not explored.

Three stakeholders noted that the leadership of national-level alcohol policy appears to have fallen to ALAC in the absence of leadership from the Ministry of Health. While one stakeholder held a neutral position about this, the other two considered that the leadership might be better provided by ALAC, particularly as it has a greater capacity to work in this area.

#### **4.3.3 Accountability for monitoring the implementation of the National Alcohol Strategy**

One of the key issues raised by stakeholders was the lack of accountability for implementing the NAS.

While most stakeholders were supportive of the stated outcomes in the NAS, they considered that there were difficulties in measuring these, and no responsibility allocated for doing so (*section 1.3* discusses the lack of quantitative information available). Non-government agencies in particular felt that government agencies should be bound by the NAS and accountable for achieving its stated objectives. Some stakeholders were also unaware of their organisation's responsibilities under the NAS. A small number of non-government agencies also commented that at an implementation level organisations should be required to show how their actions contribute to the outcomes identified in the NAS.

Agencies such as ALAC, and the Ministries of Health and Education pointed to a number of their responsibilities in the monitoring framework that they had completed although there was no central monitoring point where this information has been collated. Others, such as Police and the Liquor Licensing Authority, considered that the monitoring requirements of the framework were not the most appropriate indicators of alcohol-related harms and in some cases did not relate to information currently being collected.

The accountability issues that arise from these have two components. Firstly, several stakeholders considered that because 'everyone' owns the objectives, no one agency is held accountable for achieving the objectives. Some stakeholders also noted that because no one had taken ownership of the NAS, no decisions had been made in determining what the priorities should be. This has led to little progress toward achievement. Without clear ownership there is unlikely to be clear guidance for action by any particular agency. No one had a mandate under the NAS to determine what could or couldn't be done under it. Specific responsibilities were set out in the monitoring framework of the NAS, but any agency could carry out any action they deemed to relate to one of the outcomes of the NAS. Secondly, some stakeholders consider that the NAS is a Ministry of Health/ALAC strategy rather than a whole-of-government strategy, and therefore not their responsibility (or the responsibility of community or industry organisations).

Eighteen stakeholders questioned the effectiveness of the NAS' implementation, with some noting that it would have been easier to keep the objectives alive if clear actions had followed from its introduction. There was clear comment from stakeholders that the lack of obligations on organisations taking responsibility for the strategy resulted in few clear actions (eg, accountability is limited). Some stakeholders further commented that this has meant responsibility has fallen through the cracks. Organisations outside of government, particularly industry organisations, did not see themselves as accountable for delivery of the strategies goals, but were keen to be involved in the development of any new action plan that would impact on their activities.

To ensure a greater level of accountability for alcohol and drug policy work more generally, two government agency stakeholders and two non-government stakeholders suggested that a clearer Cabinet-based mandate be provided to the NAS. This could also include a report-back requirement for the IACD. Restructuring the document was also suggested as a way of clarifying which agencies have responsibility for delivering certain activities under the NAS. One stakeholder

considered that including this information at the front of the document (rather than only in the monitoring framework) would make it easier to see who owns the strategies. Review of the performance contracts between government agencies and the Government was also proposed, with the New Zealand Disability Strategy used to illustrate a possible way of achieving greater accountability at the operational rather than legislative level.<sup>4</sup> Another option suggested by three stakeholders was to include responsibility in the performance agreements between the Chief Executive of each agency and the government.

Other options to improve accountability included enabling greater strategic engagement with other stakeholders to ensure that the NAS is seen as both a whole-of-government strategy, and to ensure that ownership extends to community organisations where these organisations exercise current responsibilities to reduce alcohol-related harm, in practical ways as well as at the policy level. This could include ensuring that the new Alcohol Action Plan feeds into the work of community agencies and organisations (eg, more practical).

#### **4.3.4 Monitoring framework**

Stakeholders identified a number of issues associated with the monitoring framework. These issues arose from the initial difficulties of developing the framework and indicators of alcohol-related harm, which has resulted in ongoing inconsistency of data, and lack of accountability. Two stakeholders had ceased to monitor areas of responsibility and, in more than one case, considered that the NAS' monitoring framework indicators for their organisation were inappropriate, for example, the Liquor Licensing Authority considered it inappropriate that they report on crime statistics and the New Zealand Police thought a number of the indicators to be inappropriate and not related to data collected.

The role of the IACD in monitoring the NAS was a critical issue. Nine stakeholders perceived that the IACD had not performed its monitoring and oversight role effectively in relation to the NAS. Of particular concern was the fact that the IACD did not/does not have a mechanism to ensure that agencies complete work for which they were responsible. Examples of evidence to support this view was the lack of accountability or follow-up by the IACD in relation to agencies' obligations to report on the NAS' monitoring framework, that there have been no recent agenda items in the IACD minutes of any form of monitoring of the NAS, and the length of time between the expiry of the NAS and its review. Improving leadership by strengthening the accountability mechanism was seen as critical to inspiring a stronger focus on alcohol-related policy work at the national level. Six stakeholders felt that there should be a sub-group monitoring the implementation of any activities made under a new Alcohol Action Plan. Some considered this should be the IACD

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<sup>4</sup> CEOs of government agencies were made accountable in an initiative tabled at Parliament. Objectives are identified and reported against in a developmental sense to bring about improvements over time. Such a process could be considered for a new Alcohol Action Plan.

while others felt that a cross-agency NAS working group which reports back to the IACD would be appropriate. Proposed options included that a standing agenda item be added to the IACD agenda. Other proposed mechanisms included appointing a lead agency in the IACD or alternatively to fund someone outside of IACD to carry out the monitoring. Accountability is further discussed in *section 4.3.3* of this report.

A few stakeholders considered that the indicators require better targeting and benchmarking, and should make use of existing data collections. The work being done by ALAC on indicators was mentioned by several stakeholders and suggested as a means of updating the indicators in the NAS.

Research-oriented stakeholders stated that monitoring is the key to the effectiveness of any strategy, and the majority of stakeholders raised concerns that monitoring of the NAS was inadequate. Monitoring is considered to be expensive and no new resources have been put into it. Service providers in particular raised concerns regarding resourcing and that no money is provided to monitor and evaluate.

The literature states that there has been a liberalisation of restrictions on both trading hours and density of outlets selling alcohol in New Zealand, and the marked increase in availability of alcohol is likely to have contributed to an increase in drinking especially among younger people (Casswell and Maxwell 2005; Babor et al 2003). In the last 10 years there has been a 56 percent increase in the number of on-licensed premises, and a 33 percent increase in the number of off-licensed premises (New Zealand Police 2006).

## **4.4 Collaboration and communication**

Stakeholders were asked about communication and collaboration in the development of the NAS and in the development of initiatives under the NAS, as well as questions regarding possible mechanisms to increase collaboration.

*Section 4.3* discusses the NAS governance mechanisms, some of which have a specific function to support collaboration and coordination across government agencies in relation to alcohol policy; however, collaboration and communication were critical issues for stakeholders, and these are discussed in further detail in this section.

### **4.4.1 Collaboration**

Most stakeholders appeared to agree that there has been sufficient collaboration at a national level between stakeholders with an interest in alcohol policy. The occurrence of collaboration at a high level was seen by three non-government stakeholders to exclude non-government stakeholders. Non-government stakeholders pointed out that many of the issues around alcohol are complex and require collaboration by agencies to address root problems at a community level. Collaboration is required to ensure that all agencies in communities are working

together to ensure these outcomes and this needs to start with the heads of departments. Some stakeholders pointed out that collaboration to date has been on the easy issues and not those which cause tension such as taxation, pricing of alcohol, and alcohol manufacture. To implement any new Alcohol Action Plan, there are contentious issues that need to be on the agenda to discuss and this will take leadership and collaboration to get an outcome rather than shelving contentious issues.

Specific issues relating to relationships were identified between the Ministry of Health and ALAC, and ALAC and industry groups as well as lack of engagement by specific government agencies. While stakeholders stated that collaboration and communication should not be dependent on personalities, there was comment from a small number of stakeholders that some limitations in the past may have been affected by this. Many of the comments regarding relationships were similar to those made in the review of the NDP and four respondents referred the Project Team to the review of the NDP to see comments that they had made previously.<sup>5</sup>

Non-government stakeholders expressed concerns at the lack of engagement by government agencies in processes at a regional and local level and identified relationship issues between the Ministry of Health and the Police as problematic at a local level. Sharing information was an issue picked up on as important by Police, particularly at a local level to inform practice. For example, they identified issues with accessing information on emergency admissions from district health boards and maintaining a balance between complying with the Privacy Act and getting good sound information to inform research and initiatives. A number of stakeholders stated that collaboration needs to start at a Ministerial level and be made a requirement for Ministries – particularly between the Ministry of Health and Police to collaborate at a local level.

A number of stakeholders commented that collaboration needs to be a requirement of CEO performance and that requirement fed down to an implementation level in communities. It cannot be something that agencies could do but a requirement in recognition that alcohol is a major contributor to harm. Stakeholders advocated making connections in both a strategic and practical sense. It was suggested that a national strategy should fit with community desires and the suggestion made to consider local authority alcohol strategies as well as existing national alcohol strategies of various departments.

One of the limitations raised regarding collaboration by non-government stakeholders was that there is no body where all of the stakeholders sit around the table (eg, the IACD provides this function at the agency level, but there is no inter-sectoral body itself). While the IACD may provide a mechanism for collaboration at an agency level, non-government stakeholders appeared to be concerned that there was poor communication between the IACD and non-government stakeholders and few formal channels for them to provide input. A number of non-government stakeholders expressed the view that government agencies get better buy-in and

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<sup>5</sup> ALAC, ADANZ, Alcohol HealthWatch, and the NZ Drug Foundation

better outcomes when all of the stakeholders are part of the partnership and the implementation. Industry representatives and some NGOs stated that they had to initiate most of the collaboration with government themselves.

At an implementation or local level, a lack of resources is seen by stakeholders involved in service provision, local government, and research, to create an environment of competition that acts as a barrier to collaboration. Also, at a local level there is a variety of engagement by different groups. Eight stakeholders noted that communication and collaboration did not appear to be coordinated but carried out between different groups on different issues, and this work appeared to be driven by individuals and particular organisations. For example, there has been little collaboration in terms of district health board priorities and the development of local council alcohol strategies. Buy-in to a new Alcohol Action Plan will require government agencies to interface with local processes in developing initiatives. This will require considerable collaboration and communication with these stakeholders at a local level. This would also better support the implementation of any new Alcohol Action Plan.

Three stakeholders in the government and industry sectors identified that when the NAS was developed, the attitude to industry was hostile. Attitudes of some stakeholders have now changed and the importance of obtaining buy-in from all sectors was emphasised – with the caveat that there is a danger that input from industry could water down any action plan and a public health approach to alcohol is still appropriate.

#### **4.4.2 Communications**

There were divergent views on communications. When asked whether the strategic objectives and details of the NAS were effectively communicated to stakeholders, Ministry of Health representatives considered that effective communication was made with the public health sector, non-government organisations, and others who work in alcohol area. Sector representatives held converse opinions. For example, non-government stakeholders considered that the objectives and details of the NAS were not effectively communicated to stakeholders and wider public. Most stakeholders agreed that communication was relatively nonexistent to the wider community. For example, after initial communications when the NAS was developed and released, stakeholders considered it to be a “silent” document and non-interactive. Stakeholders felt that the Ministry of Health had taken a “hands-off” approach to the document and any communications regarding it. The impact of the limited nature of communications was possibly evidenced by the lack of awareness of the NAS identified in the sector. There was a general consensus among stakeholders that a lack of adequate communication and active leadership has resulted in the NAS not being effectively used in or by the sector.

## **4.5 Priority setting**

The National Drug Policy 2007 - 2012 sets out the framework for action plans to be developed under the Policy (including a new Alcohol Action Plan). Stakeholders were asked a number of questions regarding the appropriateness of the approaches used in the NAS, the identified outcomes, target groups, and means of setting priorities related to alcohol. Their comments are recorded in this section.

### **4.5.1 Three pillar approach**

All stakeholders held the view that the three pillar approach (supply control, demand reduction, and problem limitation) provided an appropriate base to guide the actions of agencies and any future Alcohol Action Plan (as is consistent with the NDP). This approach was recognised as international best practice, conceptually appropriate, and conducive to action. Non-government stakeholders noted that the pillars remain an easy way for a range of stakeholders to see where their work fits. While the three pillars were considered to provide an appropriate base for action, some stakeholders commented that it did not provide a framework for prioritising actions under the NAS. Research stakeholders stated that one of the key difficulties in implementing the NAS was that it did not give any direction as to the emphasis needed or the most effective place to target limited resources for the most effect. The NAS as a strategy did not provide a rationale for where resources should be targeted.

Eight stakeholders raised concerns regarding the relative weighting given to the three pillars. Stakeholders involved in service provision, research, and interest groups, as well as three government agencies expressed a view that greater weighting should be given to prevention rather than treatment with a lesser weighting to be given to problem limitation – although it was recognised that currently there is a need for treatment because of existing problems. Service providers as well as researchers, in particular, felt that greater emphasis should be placed on supply control with a number of comments regarding the role and constraints on those who make and market alcohol. Supply control was seen by stakeholders involved at a local level as well as interest groups as the hard option while under the NAS the primary focus has been on the easy option of problem limitation. Stakeholders involved in research stated that evidence suggests supply control is the most important and effective area of intervention in alcohol-related harm and considered that there was not enough emphasis on supply control in New Zealand.

### **4.5.2 Other principles**

While there was a high level of satisfaction with the existing pillars, stakeholders made a small number of suggestions about other approaches, principles, or underpinning factors that could be considered in the development of the new Alcohol Action Plan.

These include possible pillars, principles, and priorities:

- Evidence base  
Two stakeholders suggested that an evidence-based approach / research could form a fourth pillar. A number of other stakeholders also noted the importance of the application of evidence, although from a more principles focus. Components of this approach could include using current research to inform the development of a new Alcohol Action Plan, enabling emergent research to guide action and priority setting over time, and a priority needs to be put on better benchmarking so that trends in alcohol-related harm can be measured over time.
- Holistic approach  
Alcohol abuse is considered to be the end result of a variety of other problems and a number of service providers suggested that a priority be placed on a holistic approach to strategy and implementation. Stakeholders stated that reducing alcohol-related harm needs to be looked at holistically but some sectors still look at it only in terms of health impacts, or crime reduction, or as an injury reduction issue rather than as an integrated issue.
- Price strategy  
Price was identified by stakeholders such as the New Zealand Drug Foundation, ALAC, Alcohol HealthWatch, SHORE, and CAYAD, as the primary factor affecting alcohol consumption. There was a clear perception that price is the key factor that will discourage youth drinking, discourage moderate drinkers becoming heavy drinkers, and reduce the amount that heavy drinkers consume. While acknowledging the political difficulties in doing so, price was suggested as a key priority area for action to reduce alcohol-related harm. The document review also identified price changes as one of the most effective strategies to lessen alcohol consumption.
- Private settings  
As 70 percent of consumption occurs in private settings, priority should be placed on reducing the harms caused by consumption in these settings (vis-a-vis consumption in licensed premises as these are a safer, more controlled environment).
- Spectrum of Prevention  
Only one stakeholder suggested a possible alternative to the three pillar approach: Alcohol HealthWatch put forward the Spectrum of Prevention (*Appendix F*) as an alternative that could be used in day to day planning as well as strategic planning. The Spectrum of Prevention outlines a continuum of strategies which when used in combination are considered to affect social change. The continuum includes: influencing policy and legislation; changing organisational practices; educating providers; promoting community education; strengthening individual knowledge and skills; and fostering coalitions and networks, all underpinned by building a solid base of information.
- Drink driving, particularly with regard to youth.

Stakeholders also identified priorities of the NAS that have been superseded and could be removed. For example, workforce development is now part of the Workforce Advisory Council's work programme; however, some stakeholders,

including the Mental Health Commission and some working in the public health sector, considered that workforce development and coordination were still lacking in the sector working to reduce alcohol-related harm.

### **4.5.3 Outcomes of the National Alcohol Strategy as a guide for action**

The majority of stakeholders agreed with the outcomes set out in the NAS and considered that these provided a clear direction for the sector and continue to do so. Of those not familiar with the NAS, four stakeholders considered that these outcomes were aligned with their work programmes and goals. Sentiment was expressed that the fact these areas were still a problem pointed to ineffectiveness on the part of the NAS in addressing these issues, while others were concerned that they were good outcomes but difficult to measure and no responsibilities allocated for this. Five stakeholders stated that there were too many outcomes and restated concerns regarding the lack of ownership of the outcomes (see comments in *section 4.3.3* on accountability). It was noted that if there had been better monitoring, more useful comment could be made as to the appropriateness and effectiveness of the outcomes.

### **4.5.4 Target groups**

Comments about target groups related to the refinement of the existing approach or a structural reform relating to the use of target groups.

#### ***Refinement of the existing target groups***

The majority of stakeholders felt that the target groups identified in the NAS remain appropriate. Most of the identified groups continue to be target groups for action by individual organisations: they continue to be enduring target groups. Some argued that this was a sign of the ineffectiveness of the NAS at reaching these groups while others attributed prioritisation of these groups to current research such as ALAC's alcohol consumption surveys. There was a strong view among stakeholders that the target groups in any future Alcohol Action Plan need to be evidence-based. A number of additional target groups were suggested:

- Youth in general but in particular young women and pre-drinkers (eg, children aged 10-14 years as drinking is considered to be a learned behaviour)
- Middle-aged, middle class and/or parents (as role models for youth)
- At-risk communities
- Crime-related target groups (eg, Māori and Pacific males aged 14-25 years, other offenders, and those in the criminal justice system), and
- Target groups based on socioeconomic status rather than ethnicity.

A small number of stakeholders commented that there were too many target groups, to the point where very few people in New Zealand were not a target group. As with

the three pillars, there was no mechanism for agencies to prioritise action to affect any particular target group over another.

### ***Structural considerations***

Six stakeholders, particularly non-government and researchers, considered that too high a priority had been placed on the target group approach, and that this is not the most effective way of changing behaviours. There was a strong view among stakeholders that a new Alcohol Action Plan should target initiatives based on the evidence demonstrating the most effective ways of targeting. Suggested alternative approaches proposed included:

- A settings-based approach: changing the environment in which people operate rather than telling them what they should or should not do
- A focus on risky behaviours, using target groups as a means to implement actions to reduce these, with an increased focus on the environment around particular groups, and/or
- Focusing on the population as a whole owing to recognition that the problem is cultural rather than confined to certain sectors of the population.

## **4.6 Other strategic issues**

In the course of the interviews, stakeholders raised a number of issues, which are useful strategic considerations in moving the national strategic policy for addressing alcohol-related harm forward. These included: socio-cultural and political considerations, the structure, presentation, and language used in the NAS, and other strategic linkages.

### **4.6.1 Socio-cultural and political considerations**

A small number of respondents, both government and non-government, stated that the Ministry of Health allocates significantly more capacity and resources to other drugs rather than alcohol. The IACD was also seen as prioritising other drugs above alcohol. The majority of stakeholders commented that the public as a whole were misinformed on the level of harm caused by alcohol relative to other drugs. This was in spite of the fact that alcohol is the drug that causes the most harm in New Zealand society. Most non-government organisations highlighted concern that alcohol has been treated like any other commodity, when the misuse of alcohol is harmful and significant in New Zealand. Several stakeholders commented on the cultural aspect of binge drinking as part of New Zealand society and the need to address this.

Most stakeholders supported ALAC's recent cultural change campaign. One stakeholder compared the New Zealand drinking culture with other countries and the particular characteristic of binge drinking that is prevalent here. These political, budgetary, and socio-cultural factors impact negatively on the ability to develop successful actions to reduce alcohol-related harm.

Some service providers suggested that the real problem relates to the free availability of alcohol, which is specifically targeted at young people and low income households. Several stakeholders expressed the view that alcohol should not be treated as any other commodity and that the amount of harm that it causes needs to be more widely recognised at a strategic level. Several philosophical issues around social responsibility were raised, particularly by industry representatives who felt that social responsibility needs to be exercised by individuals and families and is not the ambit of legislation and regulation, or of industry. A small number of stakeholders, from interest groups and two from government agencies, stated that part of the rationale behind the harm minimisation approach to alcohol is that the problems associated with alcohol are too hard to deal with. Government stakeholders identified the two biggest difficulties that any national alcohol strategy or action plan faces are New Zealand society's attitude towards alcohol, and the enormous amount of money put into the industry and alcohol advertising by industry.

Six stakeholders commented that if there was to be a real effort to make a difference in reducing alcohol-related harm, it must go beyond a strategy or agencies with an interest, to effect societal change. It was emphasised that sports clubs, workplaces and churches, need to be involved, and MPs and leaders in sports clubs and communities need to set an example. Industry must also be involved.

#### **4.6.2 Structure and presentation of the National Alcohol Strategy**

Two non-government stakeholders made extensive comment on the nature of the document which correlated to comments that other stakeholders made in passing regarding the nature of a new document. It was stated that any future Alcohol Action Plan:

- be a strategic framework with action plans which are not set but rather a work-in-progress (eg, that it is not a static document)
- be modest
- be evidence-based but flexible to allow for innovation
- include clear milestones
- be used as a monitoring and planning tool for agencies, and
- clearly explain the links between the objectives, outcomes, activities, and milestones.

In developing a new Alcohol Action Plan, careful consideration will need to be given to who the document is aimed at and how it will be implemented, as the form of the document or Action Plan will be driven by the functions that it is required to carry out. Stakeholders raised a small number of queries in relation to who the NAS was targeted at, and suggestions that to implement an action plan, the document must be accessible to those implementing actions at a local level. Some stakeholders considered that the new Alcohol Action Plan must be more of a planning and monitoring process which is guided by a strategic framework. It needs to provide a useful tool for each of the organisations using it in their planning processes, and there needs to be engagement with it.

A need was seen to consider the presentation format and use of a new Alcohol Action Plan as a tool. For example by using web based technologies, and a process of activity, feedback, monitoring, and coordination between groups. The Waitakere City Council indicated that its Alcohol Strategy provides a clearer structure for linking the components of their strategy (*Appendix G*), and this could be used in a new Alcohol Action Plan.

There was clear emphasis by a number of stakeholders, both government and non-government, on the importance of process, particularly relating to obtaining buy-in from all stakeholders, including the industry. Several NGOs commented on the extent to which industry should be involved in developing strategies. Concern was raised by several stakeholders that industry should not be involved in developing strategies, while two government agencies stated that their comments be accounted for but weighted in light of the harm caused by alcohol or else any future Action Plan aimed at reducing alcohol-related harm will be ineffective.

### **4.6.3 Language**

Stakeholders were asked how well the concept of problem limitation was understood. This produced a wide range of responses. A small number of stakeholders thought the term was inherently problematic. The majority of stakeholders considered that it was well understood within government agencies or at a national level, but poorly understood at an implementation level. All stakeholders thought that it was poorly understood by the public or could not comment. A number of stakeholders noted that their organisation did not use the term problem limitation, and some noted that they had also criticised the NDP for this and that New Zealand was the only country using this terminology. Half of the respondents suggested that the term be replaced with either:

- Harm reduction;
- Harm minimisation; or
- Treatment.

Emphasis was placed by three stakeholders on the need for consistency in language across the sector. Others placed emphasis on the need for different terminology in presenting the NAS or its successor the new Alcohol Action Plan in a way that communicated outcomes or behaviour to the public rather than using supply control or demand reduction. NGO stakeholders suggested that strategy discussions should be framed in terminology showing desired outcomes – for example, “discouraging use” instead of “demand reduction” as people better understand behaviours. This stakeholder added a caveat that for ease of grouping actions the three pillars were fine. They were useful as a tool for developing a new Alcohol Action Plan but questioned whether they should be presented in the final plan.

The language used in any subsequent plan should be targeted at the audience the strategy or plan is designed to reach and the audience should be made explicit before language concerns are brought into discussion as mentioned in *section 4.6.2*.

#### **4.6.4 Other alcohol strategies**

It is worth considering the existence of a number of other alcohol strategies or action plans that have been developed in the absence of the NAS being updated. One government agency commented that alcohol work was stated in agencies' Statements of Intent and creating a new Alcohol Action Plan simply required pulling it all together. In developing a new Alcohol Action Plan existing strategies will need to be closely examined and incorporated or else the situation will arise where the new action plan will not belong to the whole of government but each agency again carrying out their own actions. A very different view was given by other stakeholders who considered that the ineffectiveness of the NAS required a new approach rather than just putting what everyone was doing separately into one document. It requires agencies and implementers to collaborate.

Existing alcohol strategies include:

- Department of Corrections, *Strategy to Reduce Drug and Alcohol Use by Offenders 2005 – 2008*.  
The Department of Corrections is required by law to issue a drug and alcohol strategy every three years. The strategy is consistent with the NDP, and is based on the three pillar approach. The goal of the strategy is to reduce re-offending by reducing offender drug use in prison and post-release. It contains three key objectives and lists the specific initiatives to be carried out under each:
- *The Police Alcohol Action Plan*  
This Action Plan was released in 2006, and is specifically tailored to the work of the New Zealand Police. It states that overseas studies estimate that 50-70 percent of police work is associated with alcohol. This strategy does not mention the NAS though it mentions what it sees as the key organising strategies on alcohol. The goal of the strategy is to improve the Police's ability to prevent and reduce alcohol-related harm. It contains four linked objectives to assist in working towards this goal.

A number of local authorities have also developed their own alcohol strategies which will need to be considered in order to ensure the new Alcohol Action Plan is implementable and ties in with what is already being done at a local level. ALAC and the NZ Drug Foundation have also developed their own strategies. Stakeholders commented that a new Alcohol Action Plan should aim to reduce duplication and overlap at both a national and local level to be more efficient, and attempt to be more effective.

Research stakeholders pointed to the Regional Strategy to Reduce Alcohol Related Harm developed by the World Health Organisation Regional Office for the Western Pacific (WHO/WPRO) which was released in Auckland last year as an excellent

starting point for any new strategy or action plan relating to alcohol for New Zealand, as it is evidence-based, up-to-date and specific.

#### **4.6.5 Strategic linkages**

Four stakeholders, particularly industry, noted that there are currently a number of reviews that have been and are being carried out regarding the Sale of Liquor Act 1989, sale and supply of liquor to minors and alcohol advertising. Stakeholders queried how the review of the NAS tied in with these other reviews and questions were raised regarding whether these reviews will inform the development of the new Alcohol Action Plan or whether the goals and outcomes set for a new Alcohol Action Plan will also feed into legislative change. A small number of stakeholders, both government and non-government, commented that there should be a link with legislative change in any new strategy in order to rectify some of the limitations of the NAS.

Policy work is required to clarify links between the Sale of Liquor Act, the Local Government Act and associated Long Term Council Community Plans, and the Resource Management Act at an implementation level, particularly in light of councils developing local alcohol strategies. Liquor Licensing inspectors and council stakeholders noted discrepancies between these in trying to reduce alcohol-related harm.

#### **4.7 Implementation**

Stakeholders made a range of comments on the interface between strategic alcohol policy and implementation of this policy. Most stakeholders agreed that the NAS was not well implemented. Clear emphasis was made that in developing a new Alcohol Action Plan the process of implementing it needs to be considered. Key points to consider include:

- ensuring buy-in to the new policy from a Ministerial level down and from local communities up
- requiring process of activity, feedback, monitoring, and coordination between groups
- ensuring the Action Plan is realistic, affordable, and culturally appropriate, and engage with the sector better than the existing NAS did
- binding stakeholders to the process and the outcomes: implementation is a requirement
- requiring front-line organisations to demonstrate how their operational activities contribute to the identified outcomes
- ensuring appropriate structure and coordination, and
- requiring local authorities to have a local alcohol policy in line with a new Alcohol Action Plan to ensure that it feeds down to a local level.

## **4.8 Resourcing**

Stakeholders were asked to identify whether the fiscally neutral approach of the NAS was appropriate. In addition, a number of stakeholders also volunteered a range of other comments relating to the resourcing of alcohol policy and service delivery.

### **4.8.1 Fiscally neutral approach**

While the NAS could help agencies to get funding for projects, nine government agency and community stakeholders considered that the fiscally neutral approach taken in the NAS was not appropriate compared to seven who supported it (although there were strong arguments for both opinions). Reasons for the removal of the fiscally neutral approach included that this approach:

- creates a situation in which it is not feasible for most agencies to achieve the number of tasks identified in the NAS without additional resourcing
- relies on agencies to prioritise the activities within their existing budgets (rather than prioritising those in the NAS)
- limits the activities and actions undertaken by community agencies and local government because there is no resourcing available
- creates an environment of competition that inhibits collaboration at an implementation level because there is no additional funding, and
- does not meet community expectations about what could be achieved by the NAS because there is no extra resourcing.

Two of these agencies indicated that the next version of the NAS will need to provide some level of priority within the included activities and dedicated resourcing available to achieve in these areas.

Six government agencies and one industry body supported the retention of the fiscally neutral approach. Reasons for supporting this included that the alcohol-related projects often fall within specific agencies' jurisdictions, and therefore should be funded from the existing budgets (as is the current operational model used in New Zealand's public service). One of these stakeholders considered that it was the agency's responsibility for prioritising funding for activities. Another noted that the NAS should be used to guide these activities rather than to fund them. One industry organisation noted that the purpose of the NAS was not to resource projects.

### **4.8.2 Other resourcing issues**

Other resourcing related issues raised by stakeholders included that:

- more funding is required for innovative programmes to prevent or reduce the harms caused by alcohol use or misuse because of the high costs associated with this use (eg, funding for preventive approaches)

- resourcing limitations for alcohol policy generally are more problematic than the fiscally neutral approach taken by the NAS
- there has been too little resourcing for the size of the problem
- alcohol and tobacco cause a similar level of harm but the infrastructure, organisation and resourcing going to reduce tobacco-related harm is far greater than that being directed toward alcohol-related harm
- there is a need to review the competitive and silo model currently used to fund alcohol and drug services to ensure that allocation is driven by the community
- there is a need to adequately resource the regular monitoring of the new Alcohol Action Plan, and to monitor the services and programmes delivered underneath the NAS
- the NAS did not address issues around how the work might get done such as resourcing and contracting.



## 5 Analysis

Stakeholders provided comments on a variety of aspects of the NAS, its priority areas, governance mechanisms and collaboration, and its implementation and communication. Analysis is provided in *Part 5* of this report including implications for the development of a new Alcohol Action Plan.

### 5.1 *The National Alcohol Strategy as a guide to policy*

Most stakeholders considered the NAS to be a well written document containing appropriate objectives, outcomes, and target groups; however, the implementation of the NAS has been ineffective resulting in an under-utilised national policy. The NAS was seen by some stakeholders as a coordinated and comprehensive strategy that fits in with international best practice and attempted to represent the work that government undertakes in one place. It has been actively used to develop policies, programmes and complementary strategies.

The release of the NAS appeared to give focus and impetus to issues around alcohol; however this does not appear to have been maintained after the NAS reached the end of its term. Over the intervening years to this review, the NAS has ceased to be a key guiding document. When a strategy like the NAS has a set end date, there needs to be scheduled planning by the agencies involved for updating this. The NAS is considered to be expired and although it is a key reference document for some it is no longer stated in policy or plan development as it is considered to be so out of date.

There is a need for such an overarching strategy as the NAS to ensure common goals, coordinated actions, and collaboration between interested parties; however, it needs to be updated regularly, and communicated to all stakeholders (not just those in government agencies). There must also be collaboration at all levels to undertake activities, clear allocation of responsibility for outcomes, and regular monitoring in order to ensure its implementation and assess its effectiveness over time. It needs to provide a useful tool for each of the organisations using it in their planning processes. There needs to be engagement with it, and a framework for implementing it – who is working on what, by when, how, reporting requirements and identified key milestones.

Particular limitations of the NAS related to communication and collaboration, as well as leadership and accountability. These are important considerations in developing a new Alcohol Action Plan to ensure it is effective in reducing alcohol-related harm.

Stakeholders demonstrated a lack of knowledge of the NAS which may be attributed to some extent to staff changeover within organisations in the intervening period between the expiration of the NAS and this review, but it also seems to demonstrate the lack of importance attributed to the NAS by these organisations. Additionally, a number of organisations, such as Police and Corrections, have developed their own

alcohol strategies which do not mention the NAS, and which provide a negative reflection on the relevance of the NAS to these organisations.

The NAS was intended to be a national strategy document and while it is mentioned in a number of key government agency documents, it has not been mentioned as much as one would assume a document that guides policy direction and action should be. It is not an obvious document in government policy, or well utilised in the planning processes of most stakeholders.

The NAS faced a number of limitations, including those outside of its control such as the lowering of the drinking age, increase in number of licensed premises, a buoyant economy, cheaper alcohol and targeted marketing by the alcohol industry; however, feedback from stakeholders clearly indicates that the NAS was not effectively utilised and a number of factors seemed to contribute to the lack of engagement by many organisations with the NAS, including a:

- lack of adequate communication with all stakeholders about the existence and purpose of the strategy;
- lack of active leadership driving the strategies implementation;
- fiscal neutrality and short timeframe;
- lack of accountability for undertaking actions and achieving the outcomes identified in the NAS; and
- lack of active monitoring and evaluation by the IACD and across the sector.

While some agencies had carried out responsibilities under the NAS monitoring framework, no one was given accountability for the overall outcomes. A lot of actions have been carried out at a national and local level that are consistent with the NAS; however, it is questionable how much has been driven by the NAS. Stakeholders almost unanimously agreed that the NAS had not achieved its identified outcomes and was ineffective at reaching its target groups.

## **5.2 Leadership, governance, and accountability**

The issues raised by stakeholders regarding governance mechanisms focused more on the workings of the IACD rather than specific comments about the role that the IACD has played in leading collaboration and coordination of national alcohol policy. Many of the concerns raised were similar or the same as those raised in the review of the NDP. For example:

- the engagement of key IACD stakeholders through attendance at IACD meetings and the level of seniority present at IACD meetings.
- the IACD work programme and the secretariat services that support this, including the transparency of processes in which papers are put up to the IACD and to the Ministerial Committee on Drug Policy.
- a lack of clarity in the IACD work programme and the work undertaken by IACD members, particularly the focus of IACD meetings and accountability for work to be undertaken through the IACD.

- lack of opportunity for involvement from non-government agencies, treatment providers, and other pools of expertise.
- lack of overall leadership and cohesion both of the IACD and specifically on alcohol issues.

Generally, stakeholders were supportive of the structure provided by the MCDP and the IACD, and that alternative or additional mechanisms are not required to address the implementation issues identified. In particular, it was thought that the IACD provides a platform for intersectoral collaboration, and provides a forum for agencies to discuss current projects and to remain in touch with what is occurring in other departments. A number of non-government organisations, including within local government were not aware of the existence of the IACD or MCDP. The satisfaction levels of these agencies with regard to the IACD and MCDP may therefore differ.

The Terms of Reference of the IACD include that it has the role of supporting collaboration and coordination in alcohol policy at a government level. Given the concerns raised by stakeholders about the priority given to alcohol issues within the IACD, this indicates that further consideration of the IACD's role may be required, particularly regarding facilitating collaboration between government agencies and sector stakeholders, and opportunities for non-government stakeholders to provide input into policy decisions. Improvements may be possible through the use of an alcohol working group or taskforce, or a sector-wide forum of the organisations that work around liquor separate from the IACD that could feed into its processes. Broader engagement may support a greater level of ownership.

Non-government stakeholders expressed dissatisfaction with the dissemination of information from the IACD. It appears that information currently flows informally to some non-government stakeholders but there may be a need to develop a more formalised feedback structure. For example, a new Alcohol Action Plan could set out who the key contacts were and who the IACD should disseminate information to. It may also be appropriate to add a regular item on the agenda of the IACD relating to measuring outcomes of the new Alcohol Action Plan.

A large number of stakeholders raised concerns regarding the leadership of the NAS. The Ministry of Health has a role in this as it has a role to lead policy on alcohol and public health. ALAC, who a number of stakeholders, particularly non-government, saw as leading the work on the NAS, has a different statutory role. It may be necessary to clarify the differences in the roles, and how leadership differs. To do this, the Ministry may need to take a stronger leadership role, and convince its stakeholders that it is up to the task (eg, adequate resourcing at a senior level).

An important consideration related to leadership is ownership. While the Ministry of Health may lead the NAS, it needs to be seen as a whole-of-government strategy with outcomes that are not just health-orientated but also relate to the work and concerns of other agencies to ensure buy-in and action in all sectors to address alcohol-related harm.

Accountability was a key concern raised by a number of stakeholders, and is considered to be a key factor in the apparent inability of the NAS to achieve its

identified outcomes. Accountability will need to be addressed in moving forward with a new Alcohol Action Plan. For example, a new Action Plan it will need to identify the agencies involved and the actions that they will assist in implementing, or the outcomes they will be responsible for achieving. Resources will need to be specifically allocated to monitoring and the current monitoring framework of the NAS will need to be updated to incorporate current responsibilities and data sets. Requirements for monitoring should be developmental and create improvements rather than be aimed at compliance.

The monitoring framework of the NAS was not adequately utilised and requires updating using current data sets and benchmarking. There needs to be requirements for regular updates, and allocation of clear responsibilities. It is advisable to develop evidence-based measurable indicators that can be benchmarked by current data collection and provide measurements of progress over time. A new Alcohol Action Plan should include requirements for updating regularly as well as monitoring over time, and it would be advisable to establish a central point for collating data generated by the monitoring framework.

### **5.3 Collaboration and communication**

Communication and collaboration were key issues raised by stakeholders as limitations on the effectiveness of the NAS. At a national level the structures appear to be in place if the effort was made to utilise them, while at an implementation level barriers to collaboration were identified, such as competition for resources, lack of communication and direction from a national level, and instances of overlap were pointed out.

In developing and implementing a new Alcohol Action Plan, genuine collaboration and communication with NGOs, councils and community groups will be important in order to ensure buy-in to the Action Plan and a sense of ownership by those at an implementation level. A clear view was expressed by stakeholders that collaboration needs to be driven downwards from a Ministerial and CEO level. Stakeholders raised concerns that collaboration in relation to the NAS was not sufficient and a future Alcohol Action Plan will need to take this into account.

Knowledge of the NAS within agencies appears to have diminished to the point where some stakeholders were not aware of the NAS until this review. The NAS quickly lost relevance to many organisations and had no mandatory requirements for monitoring or action, and a new Action Plan will need a framework that ensures ongoing communication with, and between, stakeholders.

While the NAS is mentioned in a number of key government agency documents, it has not been mentioned as much as one would assume a document that guides policy direction and action should be. It is not an obvious document in government policy. The Ministry of Health includes minimising the harm caused by alcohol and illicit and other drug use as one of the 13 population health objectives under the New Zealand Health Strategy (Minister of Health 2000); however, in its annual report on

progress on implementing the New Zealand Health Strategy, the NAS is mentioned only once between 2003 and 2006 (in 2005). It is also telling that no mention of the NAS is made in the recent Police Alcohol Action Plan, despite mentioning what they see as the key organising strategies for alcohol. They mention Road Safety to 2010, Opportunity for all New Zealanders, and the Safer Communities Action Plan to Reduce Community Violence and Sexual Violence, but not the NAS.

#### **5.4 Priority setting**

The NDP set the strategic priorities for the NAS and the National Drug Policy 2007-2012 sets the framework for a new Alcohol Action Plan. Stakeholders were supportive of the three pillar approach and, as such, no change is anticipated in this; however, further consideration may need to be given to the weighting placed on actions under the three pillars and a means of prioritising actions be developed.

Stakeholders suggested the addition of *evidence based* as another key approach. It may be appropriate for a new Alcohol Action Plan to use this as an approach, as the three pillars guide and group actions, and all actions under each of the three pillars should be based on the best available evidence, to enable the Action Plan and initiatives to be as effective as possible. Another important consideration is a holistic approach to alcohol-related harm at a strategic level. This approach may be appropriate in considering strategic links, implementation at a local level and service delivery, as well as approaching actions relating to target groups and risky behaviours.

The outcomes of the NAS were generally agreed to be appropriate guides for action and are considered to be still applicable. The key limitation identified was a lack of responsibility for achieving the outcomes identified in the NAS. To move forward, outcomes identified by a new Alcohol Action Plan should be evidence based with clear allocation of responsibility for achieving them.

Target groups were similarly agreed to be appropriate by stakeholders and still applicable. Again, these need to be based on evidence in moving forward and a rationale provided for targeting resources and action. Stakeholders also made a number of suggestions for additional groups, the applicability of which should be determined by current evidence and additional research where necessary.

Consideration also may need to be given to alternative approaches in developing a new Action Plan. Some stakeholders, particularly non-government and researchers, felt that the target group approach is not the most effective way of changing behaviours and reducing alcohol-related harm. Consideration may need to be given to available evidence in deciding which approach to use as a new Action Plan is developed to ensure that it is as effective as possible.

## **5.5 Other strategic issues**

Concerns were raised regarding the priority that alcohol is given at a national level and the resources allocated to address the problem. It is considered that effort may be required to ensure recognition of the level of harm that alcohol causes, in order for the problem to be addressed appropriately. Consideration should also be given to some of the attitudes of New Zealand society to alcohol and the involvement of industry.

In developing a new Alcohol Action Plan, careful consideration needs to be given to who the document is aimed at and how it will be implemented, as the form of the document or Action Plan and the language used in it will be driven by the functions that it is required to carry out. The audience is an important consideration - who is the new Action Plan aimed at and who will implement it – as the process of development was considered by many stakeholders to be as important as the outcome and a key determinant of future success.

There are a number of existing alcohol strategies and actions plans developed by government agencies, organisations, local authorities and the WHO/WPRO's Regional Strategy to Reduce Alcohol Related Harm, and these are appropriate to consider in developing a new Alcohol Action Plan to reduce duplication and increase effectiveness.

One of the objectives of supply control strategies in the NAS was to encourage local bodies to better address alcohol issues by effective use of legislation, bylaws, policies and plans. In order for this to be carried out, clarity is required at a national level, and it may be appropriate to carry out policy work to clarify links between the Sale of Liquor Act, the Local Government Act and associated Long Term Council Community Plans, and the Resource Management Act, in light of councils developing local alcohol strategies.

## **5.6 Implementation and resourcing**

Stakeholders made a range of comments on the interface between strategic alcohol policy and implementation. Most stakeholders agreed that the NAS was not well implemented for a variety of reasons as outlined above. In developing a new Alcohol Action Plan the process of implementation will need to be explicitly considered in the development process and intentional effort made to ensure buy-in to the Action Plan, as implementation appears to be a key area where the effectiveness of the NAS fell short. Stakeholders, particularly those involved in service delivery, as well as a number of government agencies commented that the fiscal neutrality of the NAS was a key limitation, and the process of funding and resourcing a new Alcohol Action Plan and the initiatives under it may require careful consideration.

## **5.7 Conclusions**

The responses from stakeholders demonstrated a high level of consistency on most questions and areas of concern. Stakeholders provided the interviewers with frank, qualitative comment on the NAS as a strategic document, and on the implementation of this strategy. Generally, stakeholders felt that although the NAS was relatively high level, it was a well written and clear strategy with enduring high level goals and outcomes. The document and its desired outcomes were praised but as a strategy it is considered ineffective. Most concerns were raised regarding the effectiveness of its implementation and the lack of monitoring and accountability to ensure that the NAS was carried out. A strong focus was identified on the need for better leadership and accountability, as well as communication, with a number of stakeholders unaware of the NAS until they were approached regarding this review. A variety of limitations of the NAS have been identified in this review, a number of which at a basic level stem from a lack of collaboration and communication. While the governance structures and mechanisms for collaboration were considered to be theoretically sound, the perception from stakeholders is that the NAS has not been as effective as it could have been. It was not widely communicated, has been under-utilised and under-resourced, and for many agencies was considered out of date and no longer relevant.

The need for clear responsibilities relating to alcohol with a robust monitoring framework and requirements for reporting on this were clearly demonstrated by stakeholder's responses, in order to be able to quantitatively measure the impact that the NAS has had. Any new Alcohol Action Plan will need decisive leadership by the Ministry of Health, but to be a multi-agency initiative with ownership by the organisations to be involved in its development and implementation.



## 6 Future directions

A large number of comments were made by stakeholders regarding emerging issues that could be explored in a new Alcohol Action Plan and considerations they suggested need to be made in developing and implementing such a plan. These are outlined in *Part 4* and a brief synopsis of possible future directions provided here. The overall recommendations from this review can be found at the beginning of this document.

The NAS was written using a public health approach and most stakeholders considered this to be still appropriate now, although stakeholders from some other government agencies commented that the objectives, outcomes and strategies for action need to be wider than just health-focused to ensure that it incorporates the work of other agencies related to reducing alcohol-related harm. Most stakeholders expressed unprompted interest in being involved with the development of any new Alcohol Action Plan.

One stakeholder suggested that the key considerations developing a new Alcohol Action Plan were laid out in the report *Strengthening Public Health Action* (Ministry of Health 1997). The Project Team consider that these components are important considerations as part of the process of developing a new strategy or plan to address alcohol-related harm, in order to ensure the infrastructure is capable of addressing the problem and any actions proposed under the new Action Plan. These components are:

- Resourcing  
*This includes funding, provisions of national education resources, and access to technical advice and expertise.*
- Policy  
*Government decisions about alcohol need to be reviewed and updated as appropriate.*
- Legislation  
*Several stakeholders questioned how reviews of legislation such as the Sale of Liquor Act fitted with this review of the NAS and any future strategy.*
- Configuration of the public health sector and other sectors dealing with reducing alcohol-related harm  
*Is the sector coordinated? Are the sector and related sectors working together on alcohol?*
- Workforce  
*Raising the profile and capacity*
- Providers  
*Development of new and existing programmes - how effective are the programmes? What is being provided? Several stakeholders commented on the need for holistic, strategic and integrated service provision, and others the need to look at poly-drug use from a strategic view.*
- Information and research

*The importance of an evidence-based approach to alcohol policy and service provision was stated by the majority of stakeholders, as well as the need for better monitoring. There is a large volume of research on alcohol-related harm that has developed since the NAS was released and this needs to be reviewed in developing a new plan or strategy.*

## **6.1 Monitoring and accountability**

Monitoring and accountability are significant issues identified in this review. To ensure that a new Alcohol Action Plan can achieve its objectives, a strong emphasis on an evidence-based approach is suggested with requirements for monitoring, regular updating and reporting. Focusing on process and outcome evaluation will help to address some of the implementation issues and governance problems identified in earlier parts of this report. This review has demonstrated the need for the allocation of clear responsibilities with a robust monitoring framework and reporting requirements.

## **6.2 Improved leadership and communication**

The current leadership structures have been discussed in detail in *Part 4* of this report. This discussion will not be repeated here, other than to comment that there is a need for greater active leadership in the alcohol-related sectors in New Zealand. This includes ensuring greater buy-in from government agencies and communication with non-government stakeholders. Collaboration needs to occur from the top down as well as bottom up. Greater strategic engagement with stakeholders will help to ensure a whole-of-government approach and involve those who work in communities. Several stakeholders commented that to address alcohol-related problems a strategy will need to move beyond government agencies to New Zealand society.

In developing and implementing a new Alcohol Action Plan, genuine collaboration and communication between government agencies, with NGOs, councils and community groups will be important. A variety of limitations of the NAS have been identified in this review, a number of which at a basic level stem from a lack of collaboration and communication. A large amount of current work on alcohol is occurring at a local level in terms of local authority plans, District Licensing Agencies, treatment and service providers. If a new Alcohol Action Plan is to be successful in reducing alcohol-related harm, it will need the support of these people. An important consideration initially in developing a new Plan will be deciding who the end users and implementers will be.

# Appendix A Structure and content of the National Alcohol Strategy 2000-2003

## Priorities and outcomes

Priority 1 To enable New Zealand to increase control over and improve their health by limiting the harms and hazards of alcohol use

Outcomes:

- Acceptance by of harm minimisation as an effective approach to reducing alcohol-related harm and ongoing cooperation and collaboration among agencies
- Increased involvement of the community in reducing harm
- More effective school policies and education in schools
- Reduction in injury and loss of productivity in the workplace
- Improved range, quality, and accessibility of treatment options
- Improved expertise of health workers in the alcohol field

Priority 2 To reduce the hazardous and excessive consumption of alcohol and the associated injury, violence, and other harm particularly on the roads, in the workplace, in and around drinking environments and in the home

Outcomes:

- Increase the proportion of the population who do not exceed maximum responsible drinking levels
- Reduce the prevalence of drinking among pregnant or planning women
- Reduce the prevalence of harmful drinking practices among youth
- Reduce road crashes involving alcohol beyond prescribed limits
- Reduce Māori death and injury caused by alcohol-related crashes
- Reduce the rate of alcohol-related crimes
- Reduce the rate of alcohol-related drownings and injuries.

## Strategies

Supply control Implement the Sale of Liquor Act 1989 (eg, education, monitoring compliance with the Act, enforcement, research on the impacts of amendments, and local bylaws and policies)

Demand reduction Increase the availability of information on alcohol and risk generally, and specifically to develop information and programmes to encourage safer drinking cultures for youth, young men, young women, older people, Māori, Pacific peoples, and other minority groups  
Ensure alcohol is marketed responsibly  
Develop a comprehensive tax policy

Problem limitation    Encourage host responsibility in licensed premises and other safer drinking environments  
Develop workplace alcohol policies, employer education programmes, alcohol testing in the workplace, ACC-related issues, and support research into alcohol-related problems in the workplace  
Reduce alcohol-related harm in public places by education interventions  
Reduce alcohol-impaired driving (eg, education, testing, etc.)  
Treatment (eg, research, primary services, specialist services, education about availability of services, service supply, etc.)

These strategies are guided by the following principles: appropriateness, effectiveness, efficiency, empowerment, equity, innovation, and working together.

## **Workforce development**

The NAS identifies:

- alcohol-related education and training as a critical component in reducing the harms associated with alcohol use and misuse
- seeks to broaden the base for education and training for specialist providers, those working to prevent harm (eg, health promoters, community groups, people involved in the supply of alcohol, and the police and other enforcement bodies)
- identifies issues facing workforce development in New Zealand such as the depth and breadth of existing training courses, the content of available training programmes, and the effectiveness of education
- outlines wide workforce related issues such as the size of the workforce, workforce retention, leadership, and accreditation.

Specific strategies for these areas are also identified.

## **The monitoring framework**

The NAS identifies a range of targets and indicators to be used to determine the impact that the NAS has on the extent to which it achieves gains in its stated priority areas. This includes both quantitative and qualitative targets to be achieved by 2003 and indicators to assess achievement. Specific government agencies are also given responsibility for ensuring monitoring and reporting results.

## Appendix B Terms of Reference

The NAS has not been updated since its publication in 2001. During this time, the Government has adopted the National Drug Policy 2007 - 2012 and four years have passed since the term of the NAS finished. It is now time to update the NAS. The Ministry engaged Allen and Clarke to undertake a qualitative, and where possible, quantitative evaluation of the NAS using its own identified outcomes framework. This involved an assessment of the extent to which the NAS has achieved its stated outcomes, with a view to informing the direction of future effective alcohol policy in New Zealand.

Specifically, the Ministry of Health engaged *Allen and Clarke* to:

- review how other jurisdictions comparable to New Zealand address alcohol issues at a strategic and operational policy level
- review the mechanisms used to facilitate collaboration between government agencies and sector stakeholders with regard to national alcohol policy (eg, the Inter-Agency Committee on Drugs)
- identify how the NAS's monitoring framework contributed to the achievement of strategic objectives related to alcohol policy
- explore the interface between strategic alcohol policy and implementation
- identify emerging issues that could be explored in a new Alcohol Action Plan
- inform the development of a new Alcohol Action Plan.

The Project Team is mindful of the time lapse between the expiry of the NAS and this project, and of the need to relate this project's findings back to the NAS (i.e., this is a review of the NAS). In order to do this, the Project Team will draw heavily on information about the NAS during its term (2000-2003), specific actions under the NAS, and on agencies with obligations under the NAS. While current issues are also important, these will be considered in the context of emerging issues that could be considered in the new Alcohol Action Plan (rather than as relating to the performance of the NAS).

The key deliverables for this project are:

- Electronic progress reports at key milestones
- A draft, then finalised, report outlining the findings of the review and containing detailed advice on the effectiveness of the NAS as a framework to inform the development of alcohol policy.



## Appendix C Document search Terms of Reference

A document search will be undertaken as part of this project. This Terms of Reference:

- provides the parameters for document search by the Ministry of Health's library staff (i.e., it sets the scope of the search); and
- outlines additional information sources which will be included in the document review exercise (but that have been sourced by *Allen and Clarke*) for the benefit of the Ministry's library staff, and the NAS Working Group.

The search will identify:

- evidence to support best practice approaches to the development of strategic alcohol policy in jurisdictions comparable to New Zealand
- the scope of jurisdictions' national alcohol policies
- any published literature on the NAS, particularly any evaluative studies.

Identified literature on the following areas will be prioritised:

- articles, documents, and/or research that review or evaluate national alcohol policies, strategies, or programmes including those related to the NAS
- articles and literature reviews that compare different policy approaches
- articles on the governance structures for national alcohol policies
- copies of national alcohol strategies.

It is expected that the majority of documentation identified for possible inclusion in this study will be strategic documentation. A smaller volume of original research based in New Zealand may be available, and this would provide context also likely to be identified. This will be used primarily to inform the Project Team of any evidence of the performance/impact of the NAS in relation to meeting its identified objectives.

Sources of information used in the document search will include journals, periodical publications, and national strategy documents. Large scale studies that look at best practice approaches to alcohol policy are of particular importance. Key studies will also be identified and bibliographies searched for other relevant studies.

The Ministry's library service will undertake a thorough search of the Medline database and the Index New Zealand and Te Puna National Bibliographic Database. This search will be completed in accordance with this Terms of Reference. The Ministry of Health's library may need to access materials held in other libraries (eg, the ALAC library).

To supplement information provided in the document review, *Allen and Clarke* will also be interviewing key New Zealand stakeholders. Documents may be identified through this process.

The source from which quantitative data will be sought is included in *Appendix D* (i.e., interviews). Stakeholders involved in the key informant interviews will be invited to identify and supply copies of any published information that they are aware of. Where possible, such identified documents will be sought from the key informant who has identified it.

The NAS Working Group will be given the opportunity to comment on the final list of materials for proposed inclusion in the review to ensure that the list of sources is comprehensive and that key sources are identified before prioritisation begins.

The following key search terms will be used to inform the information search. The terms will be used both individually and combined to ensure that the greatest amount of possible information is captured for initial review.

- Alcohol and/or liquor and one or more of the following:
  - National strategy, national policy, state policy, regional policy, strategic policy
  - Action plan
  - Policy debate
  - Monitoring framework
  - Review, evaluation, status report, stocktake, summary.

*Allen and Clarke* have sourced a range of documents already. The Ministry's library will not need to include these. *Allen and Clarke* will source quantitative information on alcohol use and trends separately.

From the results of the search, returned documents will be prioritised according to the following criteria:

- Currency (2000 – 2006)
- Official documents on the NAS
- Official documents on strategies used in other jurisdictions
- Articles published in peer-reviewed journals
- Methodological rigour (original research will be reviewed according to the critical appraisal sheet)
- Publication by a reputable organisation or in a peer-reviewed journal.

Literature that does not meet these criteria will also be considered for inclusion in the review, but given lower priority. It is anticipated that approximately 20 official documents will be included.

## **Appendix D Stakeholders contributing to this review**

The Project Team interviewed representatives from these agencies and organisations:

- Alcohol Advisory Council
- Alcohol and Drug Association NZ
- Alcohol HealthWatch
- CAYAD
- Department of Corrections
- Hospitality Association of NZ
- Institute of Liquor Licensing Inspectors
- Liquor Licensing Authority
- Mental Health Commission
- Ministry of Education
- Ministry of Health
- Ministry of Justice
- Ministry of Transport
- New Zealand Drug Foundation
- NZ Police
- NZ Retailers Association
- Safe Waitakere (Waitakere City Council)
- SHORE
- Waikato District Health Board
- Wellington City Council

Stakeholders who responded to the questionnaire included:

- Customs
- Ministry of Pacific Island Affairs
- Ministry of Social Development
- Ministry of Youth Development
- National Drug Intelligence Bureau.



## Appendix E Questions asked of stakeholders

The following list of questions was discussed with each stakeholder. These questions cover a wide range of topics and as such some questions were more relevant to some stakeholders than other questions.

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- How did the NAS contribute to meeting the NDP priorities relating to alcohol:
  - To enable New Zealanders to increase control over and improve their health by limiting the harms and hazards of alcohol use.
  - To reduce the hazardous and excessive consumption of alcohol, and the associated injury, violence and other harm, particularly on the roads, in the workplace, in and around drinking environments, and at home.
- Did the NAS raise the profile of the goal to reduce alcohol-related harm? Why/why not?
- Did the NAS increase the implementation of actions to reduce alcohol-related harm? Why/why not?
- Was the NAS effective at reaching its identified target groups (youth, young men, young women, older people, Māori, Pacific peoples, minority groups)? Why/why not?
- Was the strategic/operational split appropriate? Why/why not?
- Has the NAS been a driver for innovation in the area of alcohol control? Why/why not?
- What successes did the NAS achieve? Its limitations? Are there areas that could be developed or improved on? If yes, which areas and why?
- Do you have any comment on the future direction of a new Alcohol Action Plan?

### *NAS and priority-setting*

- Did the three-pillar approach of demand reduction, supply control and problem limitation of the NAS provide an appropriate base to guide action?
- Are there other approaches and principles that could have improved the NAS?
- How well is the concept of problem limitation with regards to alcohol understood and accepted by:
  - a. health workers and providers?
  - b. agencies?
  - c. non-governmental organisations?
  - d. Ministers of the Crown?
  - e. members of the public?
- Did the outcomes set out in the NAS provide clear direction for the sector? Are there alternative outcomes that should be considered for the future?
- Are the key settings and target groups identified in the NAS appropriate? Are there alternative settings and target groups that could be identified and included?

### *Communication with, and involvement of, stakeholders in the development of the NAS and in the development of initiatives under the NAS*

- Were the national strategic objectives and specific details outlined in the NAS effectively communicated to stakeholders? To the wider community? If not, why not.
- What other involvement have you or your organisation, or sector, had in developing and/or implementing initiatives, action plans, etc. relating to alcohol?
- Has there been sufficient collaboration between the various sectors and agencies with an interest in alcohol policy? If not, what structures could assist in improving collaboration and co-operation?

#### *Governance mechanisms*

- What involvement did you or your organisation have in working with the Ministry of Health, ALAC, or the Inter-Agency Committee on Drugs (IACD) to develop initiatives under the NAS? Was this involvement sufficient? Are there any changes that you would want to make?
- Has the IACD contributed to closer relationships and greater collaboration in alcohol policy at a governmental level? If not, why not?
- Do these mechanisms provide an effective framework for bringing expert advice to Ministers and officials regarding alcohol issues?
- How has the IACD supported improvements in social outcomes?
- Has IACD monitoring of the NAS been effective?
- Are there other mechanisms that could assist in increasing the collaboration between government agencies? Between government agencies and non-government organisations? Between organisations and communities? Between government and industry?
- Is the fiscal neutrality of the NAS appropriate? If not, why not.

#### *Outcomes*

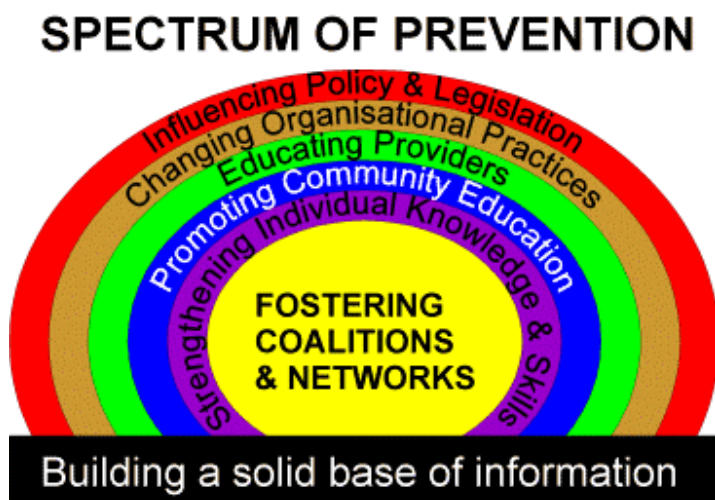
- How did your organisation contribute to the achievement of the specified targets in the NAS by 2003? And since 2003?
- Is there any published information from your organisation regarding the NAS which may be useful for the purposes of this review?

#### *Other questions*

- Do you have any other comments or issues to raise?

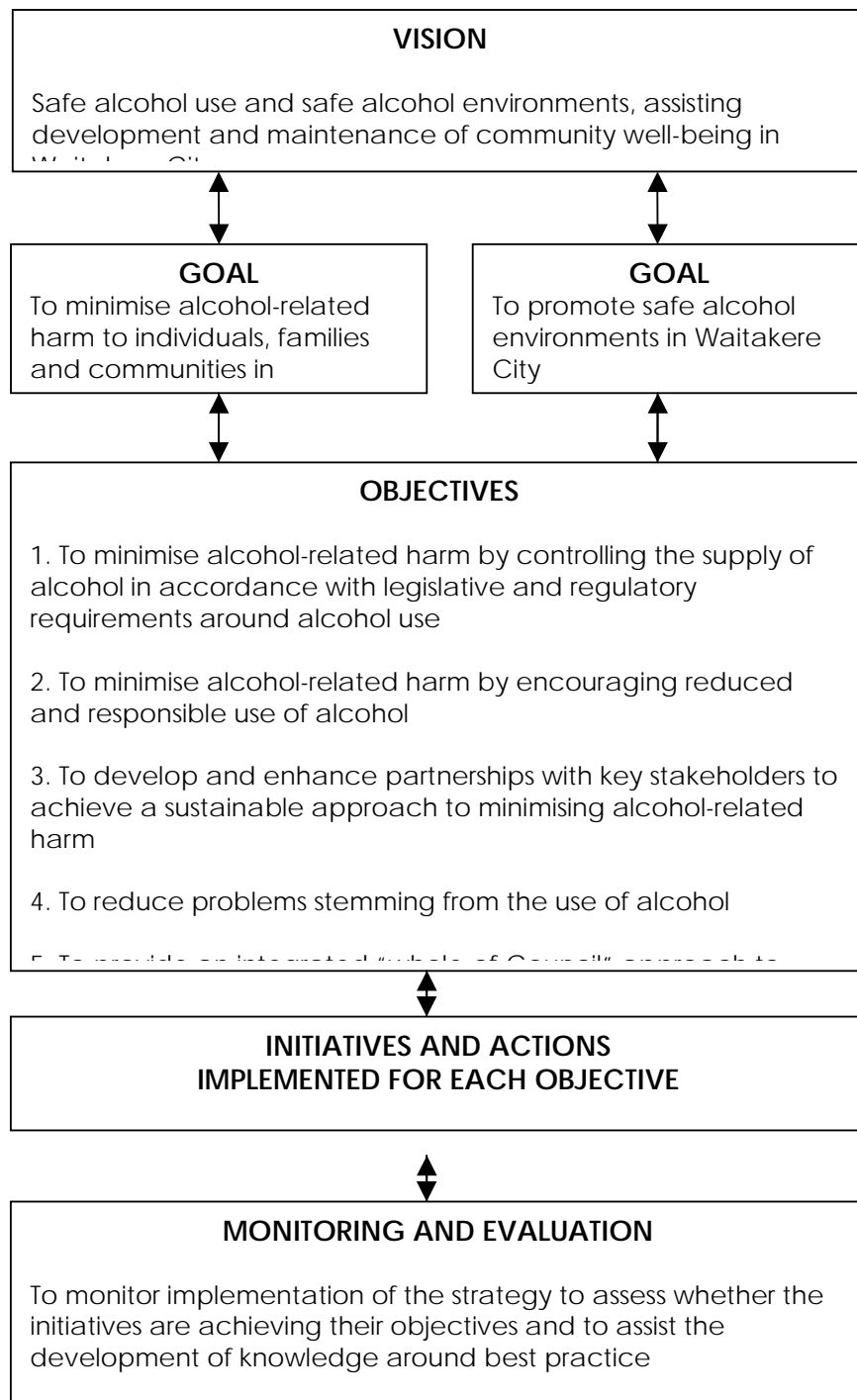
## Appendix F Spectrum of Prevention

Accessed at: <http://www.safekids.org.nz>





## Appendix G Structure of the Waitakere City Council Alcohol Strategy 2005





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