National Alcohol Action Plan: Consultation Document

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Part 1: Actions

1 Introduction

It is clear from the way New Zealanders consume alcohol and the harms that result, that we need to make real and enduring changes. Much is being done to prevent and reduce alcohol-related harm, but problems persist. Tackling these problems requires a shared sense of purpose and united effort across sectors at a national, regional and local level.

Part 1 of this consultation document presents a proposed plan of action to prevent and reduce alcohol-related harm in New Zealand. It articulates a strategic direction to draw together existing plans, policies, activities and interventions across many different settings in New Zealand, and to inform future work. Most importantly, it outlines the actions proposed to reduce alcohol-related harm and identifies who is responsible for leading and contributing to their implementation.

Consultation

In forming our views about where we are going, we consulted a range of topic experts and stakeholders (including researchers and young people) to identify the main alcohol-related harms and the actions we should be undertaking to address these harms. The result of this work is this draft National Alcohol Action Plan. The next step in the consultation process is to seek feedback from the broader community about the draft plan.

As you read this part of the Action Plan, we would like you to particularly think about:

- where efforts should be focused in the next five years to make the biggest difference in reducing alcohol-related harm
- whether the actions currently identified should have the highest priority
- what gaps you see in what is currently proposed and your ideas for addressing these gaps.

A separate submission form is provided to help you give your feedback on these and other issues covered in part 2 of the document, which provides background information and rationale relevant to the National Alcohol Action Plan.

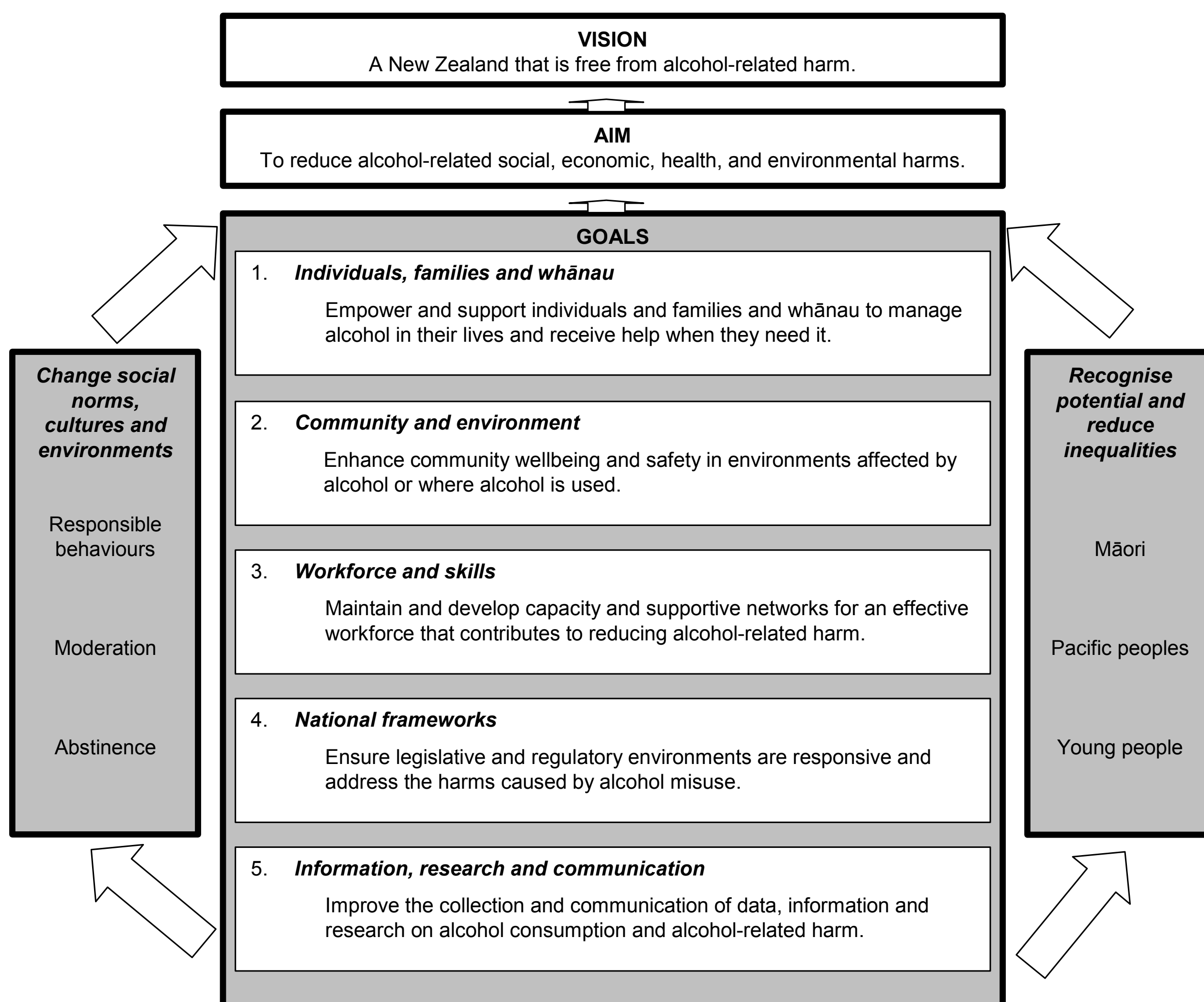
Following consultation on the draft National Alcohol Action Plan, an independent analysis of submissions will be undertaken to carefully examine and collate the feedback received. A report on the views expressed in the consultation will be produced. The National Alcohol Action Plan will then be finalised and a process for implementation will be put in place.

2 Framework for actions

The following figure captures the framework for actions to reduce alcohol-related harm. The framework's components are:

- An overarching vision and aim to connect actions to a common purpose. The proposed aim has been adopted from the overarching aim of the National Drug Policy as it relates to alcohol.
- Five goals (supported by sub-goals) which underpin the vision and aim and provide the broad areas of focus for actions to reduce alcohol-related harm. The areas are:
  - Individuals, families and whānau
  - Community and environment
  - Workforce and skills
  - National frameworks
  - Information, research and communication.
- Two themes which are reflected in the actions identified and which will be integral to their implementation and evaluation.
  - The first theme '***Change social norms, cultures, and environments***' recognises that actions to minimise alcohol-related harm need to consider the context of people's drinking and how individual, socio-cultural and environmental factors can be influenced to support responsible behaviours around alcohol.
  - The second theme '***Recognise potential and reduce inequalities***' reflects the need to develop specific strategies for different population groups (Māori, Pacific peoples and young people) that experience disproportionate levels of alcohol-related harm.

Figure 1: Framework for action



3 Actions

The proposed actions on which we are seeking your feedback are grouped under the goals of the National Alcohol Action Plan. A number of them contribute to more than one goal but have only been included once to avoid repetition. They are provided with summary information about the problems they are collectively seeking to address, and the outcomes they are seeking to achieve.

These actions have been built on:

- evidence of effectiveness in terms of reducing alcohol-related harm
- engagement with topic experts and stakeholders represented on the advisory groups.

They are also intended to reflect and respond to public concern regarding alcohol-related harm, as well as build on and link to existing initiatives at both a national and a local level.

Each goal outlines new actions on which we are seeking feedback and some existing commitments for action by agencies. Together the actions form a comprehensive

approach to achieve the goal, in order to make progress towards the overarching aim and vision of a New Zealand that is free from alcohol-related harm. The new key actions have been highlighted in the table to focus your response; a summary of these is also attached as Appendix 1.

Goal 1 (Individuals and families and whānau)

Empower and support individuals and families and whānau to manage alcohol in their lives and receive help when they need it by:

1.1 Increasing awareness and understanding about the harms associated with alcohol misuse; and

1.2 Implementing strategies to reduce harms associated with alcohol misuse.

He aha te mea nui? He tangata, he tangata, he tangata.
What is the greatest thing? It is people, it is people, it is people.

Alcohol consumption causes a wide range of self-reported problems and harms for drinkers. People also experience problems as a result of someone else's drinking (Ministry of Health 2007).

There are markedly different drinking patterns for different age groups, in terms of both the frequency and amount of alcohol consumed. Further information regarding alcohol consumption patterns and behaviours in New Zealand is outlined in Part 2 of the National Alcohol Action Plan.

Desired outcomes

Actions under this goal focus on driving change at the individual and family levels. They are intended to affect and/or influence individual and family attitudes and behaviours around alcohol. Positive outcomes include when someone chooses to address their or someone else's drinking problem or when families and whānau put in place appropriate strategies to stop young people from drinking, or supervise young people who choose to drink. These actions cover the spectrum of responses to drinking problems, but emphasise prevention.

Actions

The actions relate specifically to affecting individuals, families and whanau and do not include other responses that may positively influence behaviours and attitudes around alcohol, many of which are outlined under different goals in the National Alcohol Action Plan.

1.1 Increase awareness and understanding about the harms associated with alcohol misuse

Action		Timeframe	Lead agency/agencies	Other interested agencies
1.1.1[1]	Introduce initiatives to address the social and parental supply of alcohol to minors that will complement legislative change, including consideration of a national campaign.	By 2009	Alcohol Advisory Council of New Zealand (ALAC) Ministry of Health	New Zealand Police Ministry of Youth Development Ministry of Justice
1.1.2	Develop a calendar of significant public events, and events that are Pacific and Māori specific, where drinking culture change messages can be delivered.	By 2009	ALAC	Community groups Non-government organisations (NGOs) New Zealand Police Accident Compensation Corporation (ACC) Territorial Local Authorities (TLAs)
1.1.3	Support the proposal to Food Standards Australia New Zealand to introduce mandatory pregnancy health advisory labels on alcoholic beverage containers.	By 2010	ALAC Ministry of Health	Ministry of Justice
1.1.4	Develop and implement a project to promote host responsibility in private settings.	By 2010	ALAC	ACC Ministry of Health Ministry of Justice
1.1.5	Develop and implement a project to link national social marketing and local community actions.	By 2011	ALAC	Ministry of Social Development Ministry of Health Local Government New Zealand TLAs NGOs Community groups
1.1.6	Design Māori specific social marketing programmes to complement community initiatives.	By 2011	ALAC	Ministry of Health NGOs Community groups
1.1.7	Review the low-risk drinking guidelines.	By 2012	ALAC	Ministry of Health Interagency Committee on Drugs (IACD)
1.1.8	Implement a marketing campaign to change the drinking culture.	Ongoing	ALAC	IACD
1.1.9	Implement a drink-driving marketing campaign.	Ongoing	Land Transport New Zealand	IACD
1.1.10	Promote the host-responsibility guidelines for licensed premises.	Ongoing	ALAC	

1 Highlighted sections are new key actions.

Action	Timeframe	Lead agency/agencies	Other interested agencies
1.1.11 Increase public awareness and understanding about the standard drinks concept.	Ongoing	ALAC	
1.1.12 Provide and improve school-based education about alcohol as: • a component of the health and physical education curriculum, or • supplementary education by external providers.	Ongoing	Ministry of Education	Ministry of Health ALAC
1.1.13 Increase knowledge of the risks of alcohol consumption (including cancer).	Ongoing	Ministry of Health	ALAC

1.2 Implement strategies to reduce harms associated with alcohol misuse

Action	Timeframe	Lead agency/agencies	Other interested agencies
1.2.1 Develop and implement an action plan to address fetal alcohol spectrum disorder (FASD) and prenatal exposure to illegal and other drugs.	By 2009	Ministry of Health	IACD
1.2.2 Explore options to better address the alcohol and other drug problems of people coming into contact with the courts and criminal justice system.	By 2009	Department of Corrections Ministry of Justice Ministry of Health	Effective Interventions working group Te Puni Kokiri
1.2.3 Develop a strategy to reduce drug and alcohol use by offenders for the period 2009–2014.	By 2009	Department of Corrections	Ministry of Health Ministry of Justice Te Puni Kokiri
1.2.4 Explore options to address the care of intoxicated people.	By 2009	Ministry of Health	New Zealand Police
1.2.5 Examine ways to further improve young people's access to primary health care services. This could include health assessments, school-based services, and one-stop shops.	By 2010	Ministry of Health Ministry of Youth Development	IACD
1.2.6 Support the development, implementation and evaluation of the Wellington Wet House Project[2].	By 2010	Ministry of Health	ALAC ACC Wellington City Council Capital & Coast District Health Board
1.2.7 Review the effectiveness of a mainstream, traditional treatment intervention approach with a particular population group (to be determined).	By 2010	Ministry of Health	National Committee on Addiction Treatment Treatment sector Māori Pacific people Young people Drug and Alcohol Practitioners' Association of Aotearoa–New Zealand ALAC Te Puni Kokiri
1.2.8 Develop and implement a project to address alcohol consumption by tertiary education students and consider parallel actions for apprentices and people during other life-course transitions.	By 2012	Ministry of Health ALAC	NGOs Tertiary institutions Students associations, researchers Tertiary Education Commission Ministry of Youth Development

2 A house for chronic alcoholics that does not require them to stop drinking but works towards harm reduction e.g. addressing other health needs while the person is living in the house and seeking to reduce alcohol consumption.

Action	Timeframe	Lead agency/agencies	Other interested agencies
1.2.9 Encourage and support early intervention and assessment for alcohol problems.	Ongoing	Ministry of Health ALAC	Ministry of Justice
1.2.10 Support improvements in the assessment and treatment of harmful drinking.	Ongoing	Ministry of Health	ALAC
1.2.11 Support programmes for disadvantaged and vulnerable young people, providing improved access to treatment for alcohol misuse.	Ongoing	Ministry of Youth Development	IACD

Goal 2 (Community and environment)

Enhance community wellbeing and safety in environments affected by alcohol or where alcohol is used by:

2.1 Promoting and supporting the development of effective community-based initiatives designed to reduce alcohol-related harm, which are tailored to local conditions;

2.2 Strengthening monitoring and enforcement to promote safety in environments in which alcohol is used; and

2.3 Increasing capacity for communities to address community-specific alcohol issues and respond to concerns at a local level.

Nā tō rourou, nā taku rourou, ka ora ai te iwi.
With your food basket and my food basket, the people will thrive.

Alcohol-related harm and initiatives are inextricably linked to social, economic and structural relationships within the community system. Harms include injury, crime, public disorder and public nuisance.

Desired outcomes

Addressing alcohol-related harms in communities and environments require local knowledge and leadership and a collective approach at the community, district or regional level. The role of Government and central government agencies is to create a supportive environment by providing sustainable funding systems, research and policy forums, guidelines, and standards, and by collaborating with community-based workers in the alcohol sector.

Actions under this goal focus on supporting districts and communities to prevent or reduce alcohol-related harm at a local level. They build on district and local initiatives such as Long-Term Community Council Plans, local alcohol strategies, District Health Board annual plans, the health promotion work programmes of public health units, and school-based alcohol and other drug policies.

Actions

The actions relate specifically to enhancing public well being and safety in communities, notwithstanding that often changes are required at an individual, family or a national level to affect local environments. Other actions in these areas are outlined under different goals in the National Alcohol Action Plan.

2.1 Promote and support the development of effective community-based initiatives designed to reduce alcohol-related harm, which are tailored to local conditions

Action		Timeframe	Lead agency	Other interested agencies
2.1.1	Implement a pilot of the Party Safe Programme to reduce alcohol-related harm at private parties.	By 2009	New Zealand Police	ALAC
2.1.2	Implement guidelines for large scale public events such as after-ball parties, festivals, concerts, and sports events.	By 2009	Local Government New Zealand ALAC	Community groups Public health units (PHUs) NGOs New Zealand Police ACC TLAs
2.1.3	Facilitate communication between Territorial Local Authorities and central government on issues relating to Long-Term Community Council Plans.	By 2010	Department of Internal Affairs	Local Government New Zealand TLAs Ministry of Justice
2.1.4	Develop and implement a resource kit for Māori who want to take action at a community level.	By 2010	ALAC	
2.1.5	Promote best practice approaches to enhancing community safety, including best practice advice and information for community action on alcohol.	By 2011	Local Government New Zealand ALAC Ministry of Justice	Community groups NGOs New Zealand Police ACC Ministry of Health

2.2 Strengthen monitoring and enforcement to promote safety in environments in which alcohol is used

Action	Timeframe	Lead agency	Other interested agencies
2.2.1 Implement actions to reduce alcohol-related sexual violence.	By 2009	Ministry of Justice	New Zealand Police ACC ALAC Ministry of Health
2.2.2 Implement recommendations of the Office of the Auditor-General (2007), including protocols such as: • recording different roles and common goals, and pooling resources • review the Public Health Unit Manual • for information sharing • approaches to processing applications	By 2010	Local Government New Zealand Department of Internal Affairs	New Zealand Policy Ministry of Health PHUs TLAs ALAC Ministry of Justice
2.2.3 Implement the New Zealand Police Alcohol Action Plan (2006).	By 2010	New Zealand Police	
2.2.4 Implement the Road Policing Strategy (2008) and continue to emphasise enforcement of drink-driving laws e.g. compulsory breath-testing operations.	By 2010	New Zealand Police	Ministry of Transport
2.2.5 Explore the issues associated with recreational water activities and alcohol use.	By 2010	Ministry of Transport	ACC ALAC New Zealand Police Maritime Safety New Zealand
2.2.6 Evaluate the effectiveness and use of liquor bans and bylaws as a mechanism to reduce alcohol-related harm.	By 2011	Local Government New Zealand	New Zealand Police
2.2.7 Consider the penalty options for recidivist drink-drivers, including treatment options.	Ongoing	Ministry of Transport Ministry of Health	Ministry of Justice New Zealand Police
2.2.8 Strengthen monitoring and enforcement of the Sale of Liquor Act 1989, including controlled purchase operations with partner agencies to reduce the illegal supply of alcohol to minors from licensed premises.	Ongoing	Ministry of Justice New Zealand Police TLAs District Licensing Authorities (DLAs) PHUs	ALAC Ministry of Health
2.2.9 Emphasise the enforcement of liquor bans and public place drinking laws.	Ongoing	New Zealand Police	

2.3 Increase capacity for communities to address community-specific alcohol issues and respond to concerns at a local level

Action	Timeframe	Lead agency	Other interested agencies
2.3.1 Identify methods to increase the effectiveness, capacity and coverage of youth-specific community programmes such as Community Action on Youth and Drugs (CAYADs) and Youth Access to Alcohol (YATA).	By 2009	Ministry of Health ALAC	IACD
2.3.2 Consider incorporating alcohol and other drugs issues into Gov3 social sustainability or other relevant initiatives to establish the government as a best practice employer.	By 2009	Department of Labour	ACC ALAC Ministry of Health Ministry of Social Development
2.3.3 Research and implement actions to address the link between alcohol and sport.	By 2010	Ministry of Health ACC	ALAC Sport and Recreation New Zealand
2.3.4 Consider increasing the capacity of community crime-reduction projects, for example Project CARV (Curbing Alcohol Related Violence) and Crime Prevention through Environmental Design.	By 2010	Ministry of Justice	IACD
2.3.5 Support local authorities to use new legislative provisions to enhance community control of alcohol availability.	By 2009	ALAC Ministry of Health Ministry of Justice	New Zealand Police Local Government New Zealand PHUs TLAs Te Puni Kokiri
2.3.6 Investigate the value of and ways to effectively encourage workplaces to consider implementing alcohol policies that incorporate host responsibility principles and practices.	By 2011	ACC ALAC	Department of Labour IACD

Goal 3 (Workforce and skills)

Maintain and develop capacity and supportive networks for an effective workforce that contributes to reducing alcohol-related harm by:

3.1 Building capacity and capability of the workforce to ensure that it is appropriately skilled and resourced to address alcohol-related harms; and

3.2 Supporting and encouraging the dissemination of information, sharing best-practice and innovation across and between the workforces dealing with alcohol related harm.

Mā tini, mā mano, ka rapa te whai.
By joining together we will succeed.

Future challenges for the workforce include a wider variety of areas in which they are expected to be skilled and competent to address alcohol problems as appropriate. This is the case for workers in the alcohol and hospitality industries, health sector, research, policing and social service or justice sector. Equally, a multi-skilled professional approach to screening, assessment, and brief interventions is emerging within the primary care setting. Intersectoral and geographical networks, co-operation, collaboration, and partnerships are important to achieve change.

Addressing alcohol related harms requires a skilled workforce that has access to effective training and is connected up to share experiences and best practice. Workforce development and appropriate skills need to be supported to meet a range of needs to reduce alcohol-related harms.

Desired outcomes

Active networks can share knowledge, ideas, and strategies and help to foster a skilled, innovative workforce. To support this, a credible knowledge base needs to be built and maintained through research and evaluation, monitoring and communication. Actions under this goal are intended to foster a skilled, trained workforce, working to the highest standards and ensure that the latest best-practice techniques are disseminated and communicated to workforces in different areas[3].

Actions

Community-level actions that are applicable to goal 2 are also mechanisms for intersectoral collaboration and action to reduce alcohol-related harm (for instance, local alcohol strategies and management plans, community action programmes, and liquor liaison groups). The actions listed under this section focus on supporting and developing stronger intersectoral networks, and emphasise the importance of evaluation and review of interventions and programmes to ensure they are effective and meeting the needs of the workforce.

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[3] The Ministry of Health's *Tauawhitia te Wero – Embracing the Challenge: National Mental Health and Addiction Workforce Development Plan 2006-2009* outlines a strategic focus for changes required to achieve the workforce needed to deliver future mental health and addiction services. The Ministry-funded Workforce Programme with an Alcohol and Other Drug focus (Matua Raki) has a workforce strategy and a comprehensive overview of workforce development initiatives across AOD and other health sectors.

3.1 Build capacity and capability of the workforce to ensure that it is appropriately skilled and resourced to address alcohol-related harms

Action	Timeframe	Lead agency	Other interested agencies
3.1.1 Continue the Alcohol and Physical Health initiative • Investigate the wider applicability of the Auckland City Hospital project (an initiative with Community Alcohol and Drug Services Auckland) • Consider replicating programmes in other parts of New Zealand.	By 2010	Ministry of Health	ALAC ACC
3.1.2 Increase primary care and other community health workers' early identification of and response to alcohol-related problems, including utilisation of brief interventions. Use appropriate screening tools for early and brief intervention (including population-specific tools).	By 2012	Ministry of Health	District Health Boards Medical Colleges ALAC New Zealand Police
3.1.3 Promote and support the consistent use of effective alcohol and other drug policies and programmes in schools.	Ongoing	Ministry of Education	Ministry of Health ALAC
3.1.4 Continue Let's Get Real, a framework that addresses knowledge, skills, and attitude as well as core criteria for working with population and specialist areas in mental health and addiction services.	Ongoing	Ministry of Health	
3.1.5 Provide screening and brief intervention training to agencies who work with adults or young people and alcohol.	Ongoing	Ministry of Health	IACD
3.1.6 Fund scholarships/ bursaries, field secondments and internships to accelerate workforce development.	By 2008	Ministry of Health	
3.1.7 Pilot providing on-site alcohol and other drug training for intermediate and specialist level practitioners through mobile workforce teams.	By 2008	Ministry of Health	
3.1.8 Review the Alcohol and Other Drug Practitioner Competencies.	By 2009	Ministry of Health	

3.2 Support and encourage the dissemination of information, sharing best-practice and innovation across and between the workforces dealing with alcohol related harm

Action	Timeframe	Lead agency	Other interested agencies
3.2.1 Revise and promote drug and alcohol education guidelines.	By 2010	Ministry of Education	Ministry of Health Ministry of Youth Development ALAC
3.2.2 Connect people who work on alcohol-related harm and promote intersectoral collaboration, for example, by using: • ALAC's yearly partnerships conferences • public health unit symposiums.	Ongoing	ALAC Ministry of Health	IACD

Goal 4 (National frameworks)

Ensure legislative and regulatory environments are responsive and address the harms caused by alcohol misuse by:

4.1 Ensuring alcohol-related legislation and regulation are appropriate and effective in reducing alcohol-related harm in light of new evidence and changing public expectations; and

4.2 Communicating with the public and providing information about alcohol legislation and regulations.

Government and central government agencies are responsible for ensuring legislation, policies, and regulatory frameworks effectively reduce alcohol-related harm in New Zealand. In light of increased public awareness of alcohol-related problems and emerging evidence regarding alcohol-related harms, it is important that legislation and related initiatives are administered appropriately and regularly reviewed to ensure they are effective and align with the aim to reduce alcohol-related harm in New Zealand.

The Sale of Liquor Act 1989 provides the principal legislative framework for alcohol policy in New Zealand. The Act's primary objective is 'to establish a reasonable system of control over the sale and supply of liquor to the public with the aim of contributing to the reduction of liquor abuse, so far as that can be achieved by legislative means'.

There is increasing concern regarding the extent of alcohol-related harm, and communities are frustrated by their inability to manage that harm. There is a need to improve local control over where, to whom, when, and how alcohol can be sold in communities, to ensure that social impact is taken into account in licensing conditions.

The Government has recently introduced the Sale and Supply of Liquor Enforcement Bill that aims to:

- support a more moderate drinking environment and culture to reduce the normalisation of youth drinking

- support a more moderate drinking environment and culture to reduce the normalisation of youth drinking
- enhance the responsibility of friends and adults who supply alcohol to minors
- increase youth responsibility and accountability
- improve compliance and responsibility of industry
- increase community input into licensing decisions
- clarify the types of premises that may hold off-licences
- ensure that alcohol advertising is not inconsistent with the promotion of responsibility and moderation in liquor consumption
- minimise overall exposure to alcohol advertising to children and young people under the minimum legal purchasing age
- ensure that alcohol advertising does not hold strong appeal to minors.

Other relevant legislation includes the:

- Alcoholism and Drug Addiction Act 1966, which provides for the compulsory detention and treatment of alcoholics and drug addicts at certified institutions
- Resource Management Act 1991, which sets out a framework for making decisions about land use activities
- Summary Offences Act 1981, which sets out offences for drinking in a public place
- Local Government Act 2002, which provides for local authorities to play a broad role in planning for the social, economic, environmental, and cultural wellbeing of their communities
- Alcohol Advisory Council Act 1976, which sets out ALAC's mandate
- Commerce Act 1986, which promotes competition in markets in New Zealand.

There are also national self-regulation standards for some market activities – for example, the Code for Advertising Liquor.

Desired outcomes

Actions under this goal are intended to ensure that legislative and regulatory frameworks promote and support the minimisation of alcohol-related harm in New Zealand. Laws and policies relating to the sale, supply and consumption of liquor also should have regard to present and future social conditions and needs. Areas to be considered include, for example, alcohol labelling, packaging and advisory labels, access to alcohol (the minimum legal purchase age or drinking age), alcohol availability, alcohol advertising, sponsorship and promotion, price policies, alcohol excise, district planning, and blood alcohol content levels. Surveillance, research, analysis, and consultation should be undertaken to inform policy.

Actions

It is Parliament's role to enact legislation. The National Alcohol Action Plan identifies possible legislative changes that are well supported by existing evidence.

Projects involving legislation usually also involve supportive and complementary non-statutory measures, such as communications, operational policies, systems and training. Some of these are outlined under the other goals in the National Alcohol Action Plan.

4.1 Ensure alcohol-related legislation and regulation are appropriate and effective in reducing alcohol-related harm in light of new evidence and changing public expectations

Action	Timeframe	Lead agency	Other interested agencies
4.1.1 Enact the Sale and Supply of Liquor and Liquor Enforcement Bill, including proposals from the Review of the Sale and Supply of Liquor to Minors and the Review of the Regulation of Alcohol Advertising.	Bill to be introduced in 2008	Ministry of Justice Local Government New Zealand Ministry of Health	New Zealand Police ALAC TLAs Te Puni Kokiri
4.1.2 Evaluate the effect of lowering the blood alcohol content levels at which it is legal to drive, particularly for young drivers and commercial drivers using the international literature and lead a public discussion on the approach that should be adopted in New Zealand utilising this evidence.	By 2011 and subject to Parliamentary timetable	Ministry of Transport	New Zealand Police Ministry of Health
4.1.3 Conduct a comprehensive review of the regulatory framework for the sale and supply of liquor.	Final report in 2011	Law Commission	IACD Other departments as necessary
4.1.4 Review the Alcoholism and Drug Addiction Act 1966 to make better provision for the care and treatment of alcoholics and drug addicts.	By 2012 and subject to parliamentary timetable	Ministry of Health	IACD
4.1.7 Review the alcohol excise regime to ensure it aligns with the goal of reducing alcohol-related harm.	By 2011 and subject to parliamentary timetable	Ministry of Health New Zealand Customs	IACD

4.2 Communicate with the public and provide information about alcohol legislation and regulations

Action	Timeframe	Lead agency	Other interested agencies
4.2.1 Ensure young people are involved in decision-making about alcohol issues.	Ongoing	Ministry of Youth Development	Ministry of Health ALAC TLAs

Goal 5 (Information, research and communication)

Improve the collection and communication of data, information and research on alcohol consumption and alcohol-related harm by:

5.1 Collecting and analysing data on alcohol consumption, trends and harms;

5.2 Supporting and undertaking research on alcohol consumption and alcohol-related harm; and

5.3 Disseminating and communicating information on alcohol consumption and alcohol-related harm.

Information, research, and communication are vital in order to ensure that policies and programmes implemented under the National Alcohol Action Plan are informed by evidence of effectiveness. While the evidence base for the development of alcohol policy and interventions is growing in New Zealand, improvements can be made in some areas. For example, there is currently a wide range of data sources and information available but it is not as readily accessible as it could be to inform action on alcohol.

Desired outcomes

Good information to inform policy and measure the impacts of policy interventions is vital to monitoring and reviewing any strategies and interventions that are intended to effect change under the National Alcohol Action Plan. The evidence base for alcohol use, related harm, and effective interventions needs to be continually built, and where there is no robust information about the extent of the harm or where evidence is lacking about effective interventions, further research or evaluation programmes need to be undertaken.

Actions

5.1 Collect and analyse data on alcohol consumption, trends and harms

Action	Timeframe	Lead agency	Other interested agencies
5.1.1 Analyse and make readily accessible the results from the 2007 New Zealand Health Behaviours Survey: Alcohol Use.	By 2010	Ministry of Health	
5.1.2 Analyse and make readily accessible the alcohol-related results from the Youth 2007 survey	By 2010	ALAC	Ministry of Youth Development Ministry of Health
5.1.3 Develop and implement actions to improve area-level information on alcohol. For example: • District Health Board-level alcohol indicators. • Accident and emergency department data.	By 2012	Ministry of Health	ACC IACD
5.1.4 Further analyse New Zealand Police data – Alcolink and New Zealand Arrestee Drug Abuse Monitoring project.	By 2012	New Zealand Police	Department of Corrections IACD

5.2 Support and undertake research on alcohol consumption and alcohol-related harm

Action	Timeframe	Lead agency	Other interested agencies
5.2.1 Review the effectiveness, including the cost-effectiveness, of preventing, diagnosing, and managing fetal alcohol spectrum disorder (FASD) (as part of the action plan to address FASD).	By 2009	Ministry of Health	IACD
5.2.2 Research the cost of alcohol and other drug-related harm.	By 2009	Ministry of Health	ACC
5.2.3 Research the costs and benefits for the treatment of alcohol dependence.	By 2009	ACC	Ministry of Health
5.2.4 Conduct New Zealand-based research on the impact of alcohol availability, including outlet density and type of outlets selling alcohol.	By 2010	ALAC	Ministry of Justice New Zealand Police Local Government New Zealand PHUs TLAs
5.2.5 Research alcohol advertising and sponsorship.	By 2010	Ministry of Health	
5.2.6 Research attributable fractions of alcohol in diseases.	By 2011	ALAC	Ministry of Health
5.2.7 Develop and implement a national programme and funding approach for alcohol research and evaluation, including setting up a National Research Advisory Committee.	By 2012	ALAC	IACD Researchers in alcohol sector
5.2.8 Increase the capacity of alcohol projects funded by the National Drug Policy Discretionary Grant Fund.	Ongoing	Ministry of Health IACD	

5.3 Disseminate and communicate information on alcohol consumption and alcohol-related harm

Action	Timeframe	Lead agency	Other interested agencies
5.3.1 Develop and launch an online evidence base for alcohol (ie, a clearinghouse of evidence at national and district levels).	By 2010	Ministry of Health	IACD Researchers and evaluators

4 Monitoring and review

This section sets out the framework for monitoring and reviewing the actions planned under the National Alcohol Action Plan.

Data to be collected and monitored under the National Alcohol Action Plan

Changes to population-based drinking patterns, behaviours and harms provide an indication of how New Zealand is progressing towards the aim of becoming free of alcohol-related harms. Analysis of relevant data can highlight areas of increasing or reducing inequalities, progress and emerging issues.

Future trends will be influenced by many factors, but several changes in alcohol consumption and alcohol-related harm are core indicators to determine the impact of actions on the issue being addressed. The information that will be collected and monitored under the National Alcohol Action Plan includes:

- population-based alcohol statistics, including alcohol consumption, alcohol-related vehicle crashes and alcohol-related offences
- population drinking patterns and behaviour data
- the progress of projects identified under the National Alcohol Action Plan
- process outcomes and performance measures for the National Alcohol Action Plan.

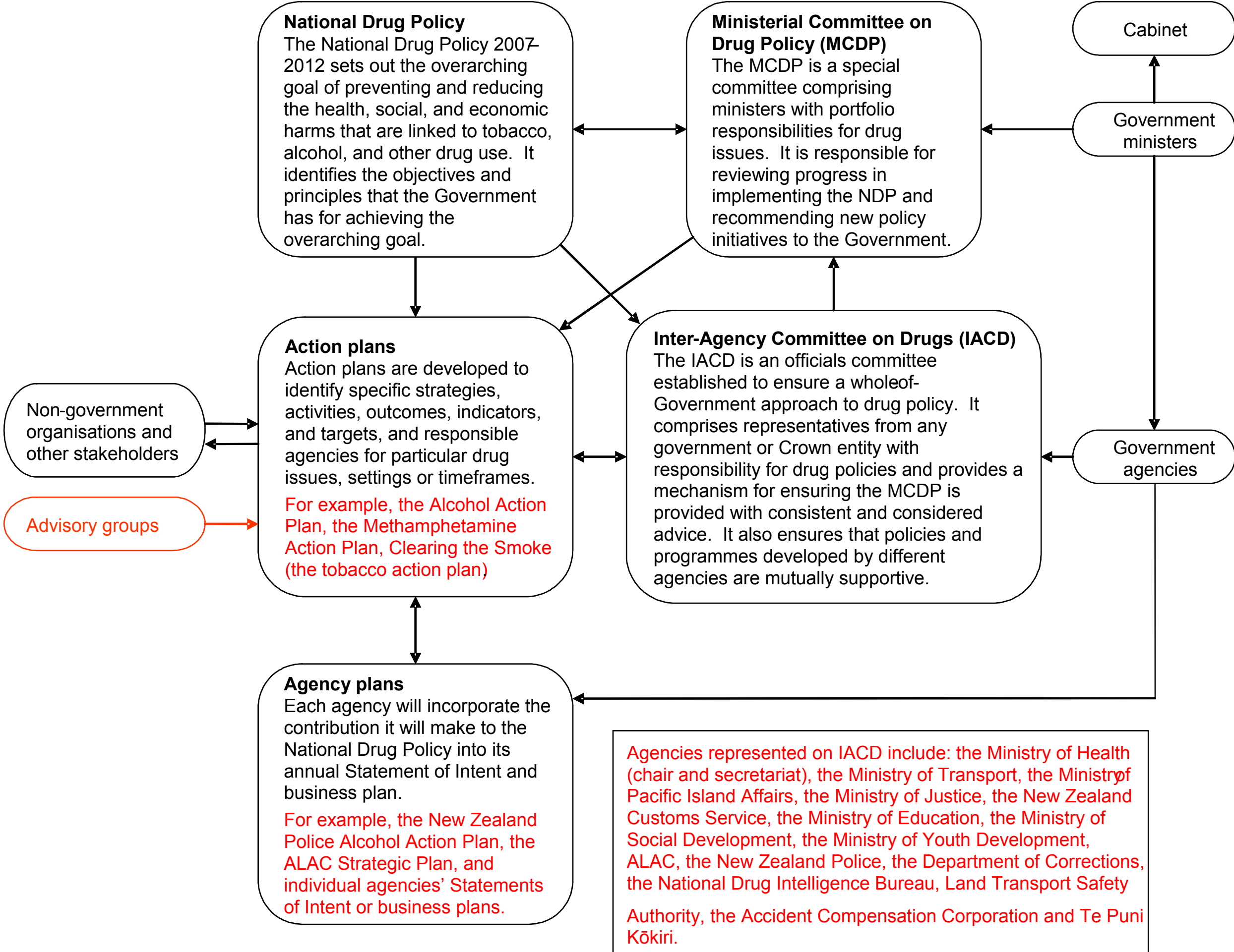
It is intended that the monitoring and review framework for the National Alcohol Action Plan will be finalised following the consultation process and endorsement of the vision, aim, goals and actions to be implemented under the National Alcohol Action Plan. Requirements for monitoring, review and communication will be a core part of the National Alcohol Action Plan to ensure that it is making progress towards achieving its goals. In particular, the detail of outcomes, indicators and targets are necessary to provide certainty around responsibilities and reporting requirements.

The Whānau Ora Health Impact Assessment Tool is one of a number of tools to be considered in implementing the actions, particularly those relating to improving Māori health and reducing inequalities. Two other tools that could be considered in finalising the monitoring and review framework include the Health Equity Assessment Tool and the Intervention Framework.

Roles and process

Progress on the implementation of the National Alcohol Action Plan will be monitored and reviewed as per the National Drug Policy reporting structure, outlined in the figure below.

Figure 2: National Alcohol Action Plan in the context of the National Drug Policy (NDP) reporting structure



Appendix 1: Key actions

1. Introduce initiatives to address the social and parental supply of alcohol to minors that will complement legislative change, including consideration of a national campaign.

2. Develop and implement an action plan to address fetal alcohol spectrum disorder (FASD) and prenatal exposure to illegal and other drugs.

3. Develop a strategy to reduce drug and alcohol use by offenders for the period 2009–2014.

4. Implement recommendations of the Office of the Auditor-General (2007), including protocols such as:
   - recording different roles and common goals, and pooling resources
   - review the Public Health Unit Manual
   - for information sharing
   - approaches to processing applications.

5. Research and implement actions to address the link between alcohol and sport.

6. Increase primary care and other community health workers' early identification of and response to alcohol-related problems, including utilisation of brief interventions. Use appropriate screening tools for early and brief intervention (including population-specific tools).

7. Enact the Sale and Supply of Liquor and Liquor Enforcement Bill, including proposals from the Review of the Sale and Supply of Liquor to Minors and the Review of the Regulation of Alcohol Advertising.

8. Evaluate the effect of lowering the blood alcohol content levels at which it is legal to drive, particularly for young drivers and commercial drivers using the international literature and lead a public discussion on the approach that should be adopted in New Zealand utilising this evidence.

9. Conduct a comprehensive review of the regulatory framework for the sale and supply of liquor.

10. Review the alcohol excise regime to ensure it aligns with the goal of reducing alcohol-related harm.

11. Develop and implement actions to improve area-level information on alcohol. For example:
    - District Health Board-level alcohol indicators.
    - Accident and emergency department data.

12. Research the cost of alcohol and other drug-related harm.

13. Develop and launch an online evidence base for alcohol (ie, a clearinghouse of evidence at national and district levels).

Part 2: Background and Rationale

Part 2 of the National Alcohol Action Plan provides the background and rationale to the actions that are recommended in Part 1. This document:

1. outlines the context for developing the National Alcohol Action Plan
2. provides background information on alcohol use and misuse in New Zealand and the international context
3. outlines the rationale for the two key themes that have been suggested for the National Alcohol Action Plan
4. provides some possible frameworks for intervention
5. outlines government strategies that refer to alcohol or that have contributed to the development of the draft National Alcohol Action Plan
6. summarises the feedback received from advisory groups in developing the draft National Alcohol Action Plan.

The attached submission form focuses on Part 1 of the National Alcohol Action Plan. However, you are welcome to provide comments relevant to any aspect of this National Alcohol Action Plan, including the information provided in this part of the document.

1 Context

Alcohol in New Zealand

Alcohol is part of New Zealand society. It is a legal, regulated, and widely available product. Alcohol is the most commonly used recreational drug in New Zealand, with the majority of adults consuming alcohol at least occasionally. When alcohol is misused, or used in risky situations, there is great potential for harm to individual drinkers, their families, and the wider community.

Any benefits that alcohol provides will be taken into account when considering the context in which alcohol is produced, marketed, distributed, and used, but these are not the focus of this plan.

Relationship of National Alcohol Action Plan with other policies and strategies

The Government's response to addressing alcohol-related harm was previously guided by the National Alcohol Strategy 2000–2003 (Minister of Health 2001). The National Drug Policy 2007–2012 (Ministerial Committee on Drug Policy 2007) signalled that action plans would be developed to achieve the objectives set out in the National Drug Policy.

Purpose of the National Alcohol Action Plan

The Interagency Committee on Drugs (IACD) has developed this draft plan to consult with stakeholders in the alcohol sector, and topic experts to inform the development of the National Alcohol Action Plan.

The National Alcohol Action Plan will be a whole-of-government plan, and will:

- be owned at a policy level by the Government
- take an interagency approach, in line with the National Drug Policy and similar to other whole-of-government strategies (for example, Healthy Eating Healthy Action (Minister of Health 2003))
- recognise the importance of and support local, regional, and community actions
- incorporate other existing strategies
- inform and guide the work programmes of government agencies, particularly IACD agencies.

Advisory groups

The IACD has taken a partnership approach to developing the National Alcohol Action Plan. Therefore, this draft plan was prepared with the help of topic experts and stakeholders, in line with the principles set out in the National Drug Policy. The eight advisory groups comprised topic experts and stakeholders in the areas of:

- supply control and law enforcement
- public health and social issues
- research
- clinical interventions and treatment services
- alcohol beverage, retail and hospitality
- Māori
- Pacific peoples
- youth.

Supporting information

Reviews of evidence regarding alcohol were also considered when this draft plan was drafted (for example, Babor et al 2003).

The National Alcohol Strategy 2000–2003 was also reviewed to supplement this work and to obtain qualitative information about the effectiveness of the National Alcohol Strategy and its implementation.

Other government strategies that focus on alcohol, refer to alcohol, or have contributed to the development of the draft National Alcohol Action Plan are listed in Part 5.

Main principles

The National Alcohol Action Plan is intended to inform the direction of future alcohol policies and interventions in New Zealand. It addresses the National Drug Policy's goal of preventing and reducing the health, social, and economic harms that are linked to alcohol use. This draft plan develops the objectives outlined in the National Drug Policy to achieve that policy's alcohol-specific goal. The objectives are to:

- prevent or delay the uptake of alcohol use, particularly in Māori, Pacific peoples, and young people
- reduce harm to individuals and their families and communities from individuals' risky consumption of alcohol
- prevent or reduce harmful alcohol use
- make families and communities safer by reducing individuals' irresponsible and unlawful use of alcohol
- reduce the cost of alcohol misuse to individuals, society, and government.

Government's strategic themes

The National Alcohol Action Plan will be implemented within the context of the three strategic themes the Government has identified: economic transformation; families – young and old; and national identity. The determinants, behaviours, and outcomes of alcohol-related harm are linked to these themes, as alcohol affects many aspects of New Zealand life. The National Drug Policy identifies that an integrated and co-ordinated approach to strategic issues is vital to reducing alcohol-related harm in New Zealand.

International commitments

The Government participates in World Health Organization activities that provide a useful guide for alcohol policy development and implementation in a national context. In particular, New Zealand has taken an active role in the development and implementation of the World Health Organization's Regional Office for the Western Pacific's Regional Strategy to Reduce Alcohol-Related Harm (WHO Regional Office for the Western Pacific 2006).

The Executive Board of the World Health Organization, of which New Zealand is a member, proposed in January 2008 that a global strategy be developed to reduce harmful use of alcohol and requested that the Director-General of Health 'collaborate and consult with member states as well as with intergovernmental organisations, health professionals, non-governmental organisations and economic operators on ways they could contribute to reducing harmful use of alcohol' (WHO 2008, p 2).

No international conventions are specific to alcohol control, although there have been international resolutions on the topic. However, the objectives outlined by the Ottawa Charter for Health Promotion are a useful basis for a comprehensive public health approach (WHO et al 1986).

Work addressing the rise in alcohol consumption by adolescents and increasing the availability and accessibility of counselling and support services, particularly for Māori children, is recommended by the United Nations Committee as part of the United Nations Convention on the Rights of the Child.

Harm minimisation framework

The National Alcohol Action Plan reflects the approach outlined in the National Drug Policy, which is based on the principle of harm minimisation.

The aim of harm minimisation is to improve social, economic and health outcomes for the individual, the community, and the population at large. Strategies that support harm minimisation can be divided into three groups (called the 'three pillars' in the National Drug Policy).

- *Supply control* strategies that regulate the availability of alcohol (for example, limiting the circumstances in which alcohol can be sold, supplied, or consumed)
- *Demand reduction* strategies that encourage reduced or responsible use of alcohol (for example, encouraging abstinence or moderation, creating awareness of the risks involved with alcohol misuse and abuse, and raising the price of alcohol)
- *Problem limitation* strategies that aim to reduce harms from alcohol misuse and abuse (for example, emergency services for acute harm from alcohol, clinical interventions, and treatment for risky or problematic alcohol use and dependence).

Supply control, demand reduction, and problem limitation strategies use tools across the intervention spectrum, from legislation (including regulation) and enforcement, to non-regulatory incentives and disincentives, education and persuasion, and clinical interventions. These strategies and tools can be used in various combinations to reduce alcohol-related harm.

2 Background

Alcohol consumption patterns and trends

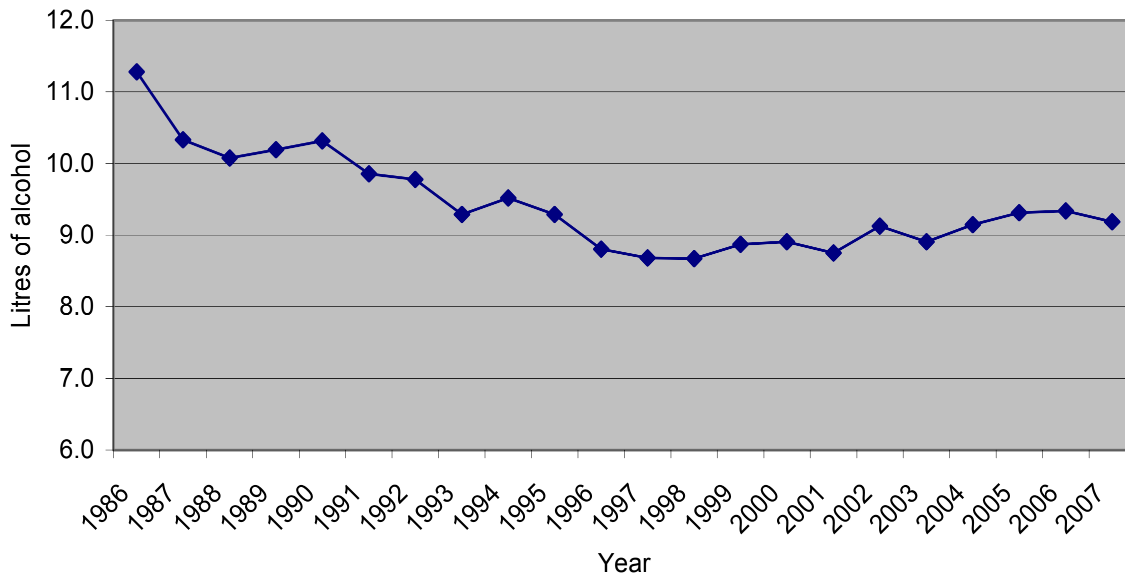
Alcohol available for consumption

Total per capita alcohol consumption has risen gradually since 1998 after hitting a 15-year low in 1997. Alcohol consumption in New Zealand is comparable to the average consumption among countries in the Organisation for Economic Co-operation and Development (OECD 2007).

The amount of alcohol available for consumption each year (that is, the quantity of alcoholic beverages released to the market each year and therefore available for consumption) is used as a proxy measure for alcohol consumption. The statistics do not necessarily imply actual consumption.

The total volume of alcoholic beverages available for consumption reached a high of 470.3 million litres in 2007, but the total volume of pure alcohol (a measure of the alcohol content contained within the various alcoholic beverages) fell slightly. The increased volume of alcoholic beverages available for consumption was due to the increased volume of spirit-based drinks available for consumption, and the decreased volume of pure alcohol available for consumption was driven by a decrease in the volume of spirits available for consumption (Statistics New Zealand 2008).

Figure 3: Alcohol available for consumption, per head of population aged 15 and over, 1986–2007



Note: Statistics about alcohol available for consumption measure the quantity of alcoholic beverages (beer, wine, and spirits) *released to the market* each year, not the amount of alcohol consumed. New Zealand Customs gathers the data from documentation of tax paid on alcohol, and trade data.

Source: Statistics New Zealand (2007).

Alcohol consumption

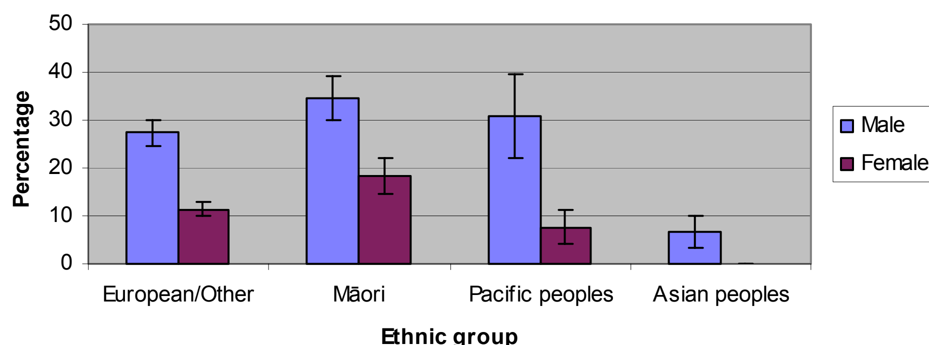
Around 81 percent of New Zealanders aged 12–65 years consume alcohol, and this figure is relatively stable for all age groups from 18 years. In each age group, males are more likely to be drinkers than are females and non-Māori are more likely to be drinkers than are Māori (Ministry of Health 2007). These patterns of gender and indigenous consumption are common in other jurisdictions (Babor et al. 2003).

Overall, around 25 percent of New Zealand drinkers aged 12–65 years consume large amounts of alcohol on a typical drinking occasion (Ministry of Health 2007); that is, they usually drink at a level that is potentially hazardous and harmful and associated with increased risk of alcohol-related harm (WHO 2001).

Māori

Māori are less likely to have consumed alcohol in the last 12 months than are other New Zealanders (Ministry of Health 2007). However, among those who do drink, Māori are more likely to consume a large amount of alcohol on a typical drinking occasion (Ministry of Health 2007) and to meet the criteria for substance abuse or dependence in the past 12 months (Ministry of Health 2006). Figure 4 shows that the prevalence of hazardous drinking is significantly higher among Māori males and females than among their European/Other counterparts.

Figure 4: Prevalence of hazardous drinking habits, by sex and ethnicity, 15+ years, percent, 2002/03[1, 2]



Note:
1 Age-standardised to WHO standard population
2 Rates have not been calculated if counts are less than 5.

Source: Ministry of Health (2004).

Pacific people

A study of drinking among Pacific people released in 2004 showed that 58 percent of Pacific people living in New Zealand drink compared with 85 percent of the total population. However, of those 58 percent, males consumed an average of nine to 10 drinks and females consumed an average of six drinks on a typical occasion. The same survey showed that 41 percent of Pacific males and 25 percent of Pacific females had consumed enough alcohol to feel drunk in the last week. This pattern of consumption leads to a high risk of acute harm.

Pacific people prefer to drink in groups rather than on their own. Group drinking patterns were evident in research by McDonald and colleagues (1997), who looked at alcohol consumption in the Cook Islands, Fiji, Kiribati, Samoa, the Solomon Islands, and Tonga in the mid-1990s. Studies by Graves (1982) and the Alcohol Advisory Council of New Zealand (ALAC) (1997) support the suggestion that Pacific people drink in groups and drink until they are intoxicated. This type of drinking behaviour may have been integrated into the lifestyle of New Zealand–based Pacific people.

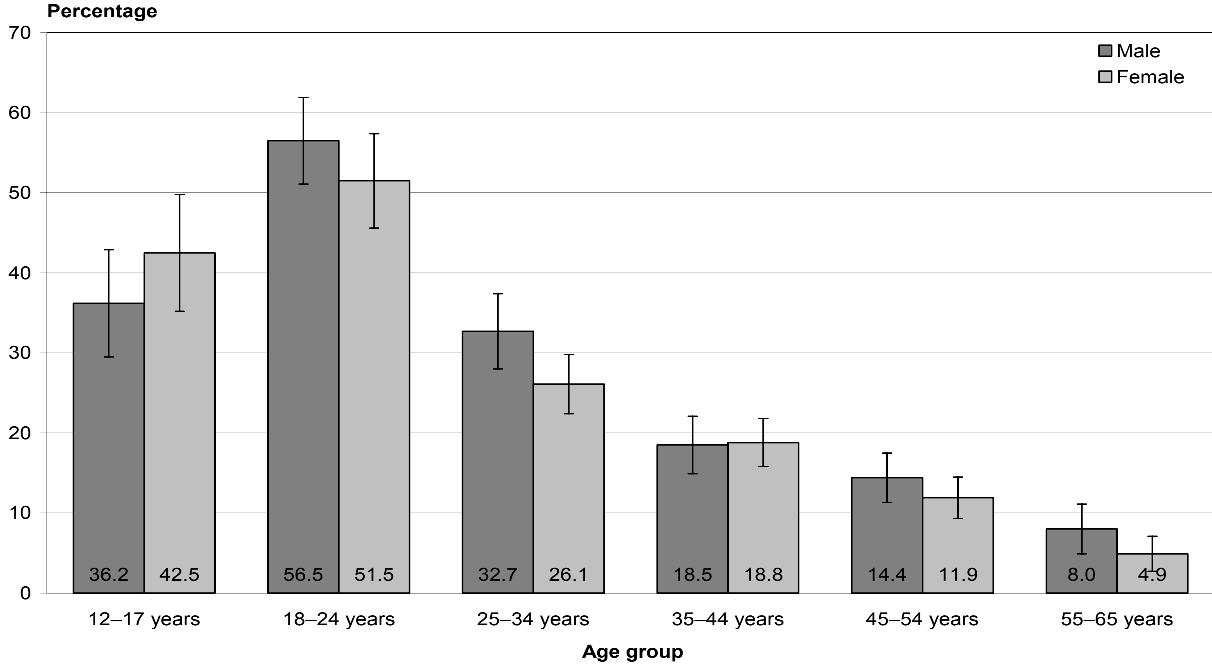
A study of the drinking behaviours of Pacific people living in Dunedin explored the views of younger Pacific people (Siataga et al 2000). The study's focus was how Pacific people understand alcohol use, alcohol-related harm, and the concept of host responsibility. Most of the participants first tasted alcohol while at secondary school. Participants preferred to drink with their peers rather than within broader Pacific communities or family members. Participants saw binge drinking as the 'normal' way of consuming alcohol within the New Zealand drinking culture.

Young people

Young people (that is, people aged 12–24) make up 19 percent of New Zealand's population (Statistics New Zealand 2006). Most young people are not problem drinkers, and half of all young people aged 12–17 identify as non-drinkers. However, a minority of young people misuse alcohol. Among all people who drink, a higher proportion of

people aged 12–17 and 18–24 drink large amounts of alcohol on a typical drinking occasion than do people in other age groups (see Figure 5). Many other countries have similar patterns of higher rates of intoxication and heavy drinking episodes among adolescents and young adults (Babor et al. 2003).

Figure 5: Prevalence of drinking large amounts of alcohol on a typical drinking occasion among drinkers, by sex and age group, 2004

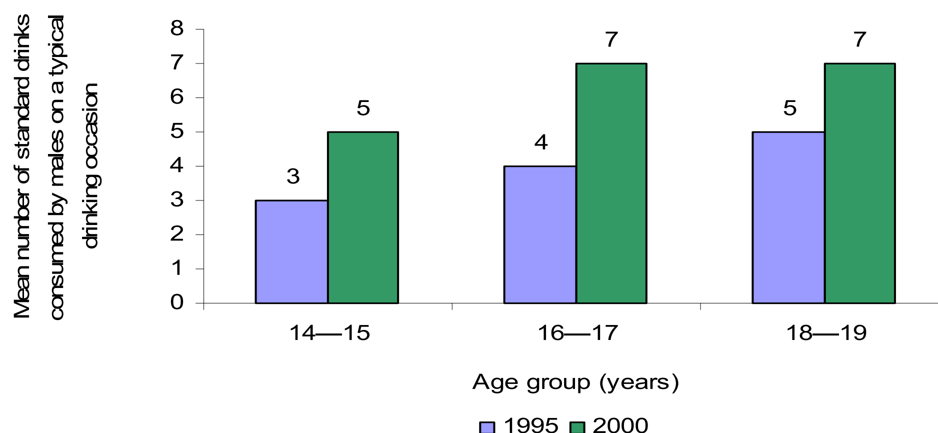


Source: Ministry of Health (2007).

One in five female drinkers and two in five male drinkers aged 15–24 drink 'enough to feel drunk' at least weekly (ALAC 2005).

The amount young men drink on each occasion increased from 1995 to 2000 (see Figure 6). Other countries also experienced an increase in the frequency of drinking and the frequency of drinking to intoxication among youth (15-16 years) over this period (Babor et al. 2003).

Figure 6: Mean number of standard drinks consumed by males on a typical drinking occasion, 1995 and 2000



Note: One standard drink equals one 330 ml can of 4 percent beer, which is equal to about 15 ml of pure alcohol.

Source: Created using data from Habgood et al (2001).

Of those young people who drink, young men drink more and more often than young women, although as more young women adopt typically 'male' drinking patterns, the gap between them is closing (Habgood et al 2001).

Māori aged under 17 tend to drink more on a typical occasion than do people aged under 17 from other ethnic groups, but this difference does not exist for those aged 17–24.

Alcohol-related trauma is a leading cause of death for New Zealanders aged under 25. ALAC estimated that 212 young people aged 15–29 died as a result of alcohol-related harm in 2000, more than in any other age group (ALAC 2005). To put this figure in context, 609 people aged 15–29 died in 2000 from all causes. Alcohol contributed to more than a third of all deaths in this age group.

Alcohol use is also correlated with youth offending – one study found that a fifth of low-risk offenders who came into contact with New Zealand Police youth aid officers were abusing alcohol and other drugs (Maxwell et al 2002). A later study found that among the 'hard core' of youth offenders who re-offend and/or offend seriously, 70–80 percent had a diagnosable alcohol and/or other drug problem (Maxwell et al 2004).

Location of consumption

Since the passing of the Sale of Liquor Act 1989, the number of licensed premises increased significantly from about 2,000 in 1990 to 15,000 in 2007. The greatest increase has been in the number of on-licences, especially restaurants, but the number of off-licences also increased significantly over this period. The increase in licences occurred during a period of legislative change, with the introduction of wine then beer trading in supermarkets, longer opening hours, Sunday trading, beer and wine sales by grocery stores, and a reduction in the minimum legal age for purchasing alcohol.

New Zealanders most often drink alcohol in their homes, followed by other people's homes. Of those who consume large amounts of alcohol, there are some differences by age and sex, with people aged 12–17 and 18–24 more likely to consume large amounts of alcohol in someone else's home than in their home, and older drinkers more likely to consume large amounts of alcohol in their own home than in someone else's. Males are more likely than females to consume large amounts of alcohol in pubs, hotels, and taverns, and sports clubs.

Alcohol-related harms

Alcohol can cause harm through intoxication, toxicity, and dependence (Babor et al 2003). The main cause of alcohol-related harm is through intoxication that contributes to accidents, injuries, and violence. Drinking patterns characteristic of heavy or frequent consumption are associated with chronic health problems such as liver cirrhosis, cardiovascular disease, and depression. Sustained heavy use can lead to dependence and an inability to control the frequency and amount of drinking.

Through intoxication, toxicity, and dependence, alcohol results in considerable health, social, and economic costs. The World Health Organization estimates that alcohol contributes around 9.2 percent of the burden of disease in developed countries, making it the third-ranked risk factor for disease. Most of the burden is a result of injuries. The cost to New Zealand of alcohol-related harm has been estimated at $1 billion to $4 billion per year (Easton 2002).

The Regional Office for the Western Pacific of the World Health Organization (2007) notes that alcohol-related harm includes:

- more than 60 types of diseases and other health conditions, including:
  - mental disorders and suicide
  - several types of cancer
  - other non-communicable diseases such as cancer
  - intentional and unintentional injuries, particularly as a result of driving while intoxicated
- high-risk behaviours, including:
  - unsafe sex
  - psychoactive substance use
- effects on others, including:
  - effects on family members
  - effects on victims of violence and accidents associated with alcohol use
  - effects on the community
  - lost productivity
  - costs to the health and welfare, transportation, and criminal justice systems.

International context

Concern is growing internationally about the increasing levels of alcohol consumption and related harm. The World Health Organization estimates that around 2 billion people worldwide consume alcohol and 76.3 million have diagnosable alcohol use disorders (WHO 2004).

New Zealand has taken a leading role in international alcohol policy, both as a leader in the development of the Western Pacific Regional Strategy to Reduce Alcohol-Related Harm and as an active contributor to international resolutions in the area.

Emerging research has provided a basis for generating public discussion on alcohol issues generally, as well as an impetus for the application of interventions to change attitudes and behaviour. International experience in reducing alcohol-related harm was summarised in the landmark publication *Alcohol: No ordinary commodity* (Babor et al 2003).

In response to growing concern about alcohol-related harm, international jurisdictions comparable to New Zealand have developed national strategies to reduce alcohol-related harm. While the structures and philosophies of the national strategies differ between jurisdictions, the interventions, activities, and initiatives undertaken have a similar overall focus on supply control, demand reduction, and problem limitation, as are used in New Zealand.

Supply control strategies to restrict the availability of alcohol include the enforcement of legislation, minimum legal ages for purchasing and consuming alcohol, local authority involvement, and specific strategies for indigenous people. Demand reduction strategies include guidelines and labelling, health promotion, alcohol advertising and promotion, and pricing and taxation. Many national alcohol strategies have an inherent focus on problem limitation strategies that seek to manage and reduce the harm related to alcohol consumption. Key components in this area include treatment, workforce development, monitoring, and research.

International health agencies are growing concerned over the potential impact of trade agreements on alcohol consumption and related harm. Measures that affect the supply and demand for alcoholic beverages, such as import duties, are affected by multilateral and bilateral trade agreements. These agreements, in accordance with global trade pacts, aim to facilitate the free flow of goods and services between countries, so tend to abolish restrictions.

3 Rationale

This section presents the rationale for the two key themes that have been suggested for the National Alcohol Action Plan: Change social norms, cultures, and environments and Recognise potential and reduce inequalities.

Change social norms, cultures, and environments

Since 2004, increasing attention has been paid to the role of drinking culture as a factor in alcohol consumption. Drinking culture is broadly defined as the customs and attitudes shared by groups of people involved in drinking alcoholic beverages (Research New Zealand 2006). A study of drinking in various countries found that culture is 'a substantial determinant of alcohol consumption among Western nations' (Peele 1997, p 60). Other countries have similarly responded to the issue of drinking culture through government strategies, either explicitly such as in Australia's *National Alcohol Strategy 2006-2009: Towards Safer Drinking Cultures* or through particular policies such as France's bans on television alcohol advertising and sponsorship of youth events.

New Zealand's drinking culture is characterised by an acceptance or a tolerance of drunkenness. Efforts to change New Zealand's drinking culture, therefore, focus on gradually changing this culture towards one where moderation is the norm and drunkenness is unacceptable. Ultimately, changing attitudes is expected to result in changing the behaviours and drinking patterns of individuals and groups in various settings and situations. The process of this change may take decades, rather than years, as illustrated by the time it has taken to change attitudes to drink-driving and smoking (Measham 2006).

'Drinking culture change' is, therefore, both an objective and a process. The strategies to change the drinking culture include demand reduction strategies (for instance, moderation messages using social marketing), supply control strategies (particularly in relation to on-licences) and problem limitation strategies (for instance, assessment and brief interventions targeting risky drinking). Strategies can be targeted at individuals, families and whānau, organisations, or communities. To design effective interventions to change the drinking culture we need to understand the context of people's drinking and how individual, sociocultural and environmental factors can be influenced to support moderation.

Recognise potential and reduce inequalities

The concept of reducing inequalities is one of the principles outlined in the National Drug Policy. This concept means reducing disadvantage and promoting equality of opportunity in order to achieve a similar distribution of outcomes across different groups, and a more equitable distribution of overall outcomes within society. The objectives and actions identified in the National Alcohol Action Plan take account of the influences on health and wellbeing and how they can be addressed in order to improve socioeconomic, ethnic, gender, and geographic inequalities.

Several groups experience a greater burden of alcohol-related harm either by causing such harm or being victims of such harm. The previous National Alcohol Strategy identified young men and women, offenders, older people, Māori, Pacific people,

polydrug users, and people with co-existing disorders as groups at risk of alcohol-related harm or facing particular challenges in relation to alcohol. Children are also an important population who need to be protected from the risky consumption of alcohol.

Māori, Pacific people, and young people are a key focus because these groups experience a disproportionate amount of alcohol-related harm compared with other population groups. Activities and services need to incorporate strategies that will lead to reductions in the inequalities of health outcomes for these groups. As noted in He Korowai Oranga: Māori Health Strategy, the range of approaches and interventions that are undertaken need to be accessible, effective, and culturally appropriate to reduce disparities among groups at greater risk (Minister of Health and Associate Minister of Health 2002).

Strengths-based approaches

Besides interventions targeting alcohol-related harm, strengths-based or community resilience approaches can indirectly reduce alcohol-related harm and reduce inequalities. Strengths-based approaches build the strengths, or assets, of a community or population group to improve the balance of risk and protective factors. For instance, major protective factors for young people include the quality of their relationships with parents and whānau and their connectedness with schools and communities.

Examples of strengths-based approaches can be found in the Youth Development Strategy Aotearoa (Minister of Youth Affairs 2002) and He Korowai Oranga: Māori Health Strategy (Minister of Health and Associate Minister of Health 2002), which aims to build whānau ora (healthy families). Te Puni Kōkiri and the Ministry of Pacific Island Affairs take strengths-based approaches to realise the potential of Māori and Pacific peoples.

Priority populations

Māori

Before contact with Pākehā, Māori lived in one of the few parts of the world that had not developed alcohol. However, by the time of the signing of the Treaty of Waitangi on 6 February 1840, traders had introduced alcohol widely. Although Pākehā settlers drank most of the alcohol, temperance propaganda presented Māori as the victims of alcohol and reliant on the paternalistic Pākehā for laws and treatment (Hutt 1999).

As Hutt (1999) states, the two important historical points are that:

- Pākehā expected Māori to 'quail before the vices of Europeans' (p 12)
- drunkenness was a major social characteristic of the young British colony.

Before 1870, drunkenness comprised more than half of all causes of convictions. However, in the 264 cases of drunkenness brought before the police and Magistrate's Court at Wellington in 1844–48, only one person was Māori. Māori drinking levels did not reach the levels of the settlers until the 1890s. Until 1948, legislation discriminated against Māori to a degree that reflected stereotypes of a perceived Māori inability to cope with alcohol, while at the same time dismissing Māori attempts to control alcohol use in their communities (Hutt 1999).[4] In the 21st century, Māori suffer disproportionate levels of alcohol-related harm (Jackson et al 2005).

For several years, Te Puni Kōkiri has developed its Māori Potential Approach to achieve its strategic outcome of Māori succeeding as Māori. The Māori Potential Framework is an outcomes-based tool for identifying where and how to support the realisation of Māori potential (Te Puni Kōkiri 2005).

The Māori Potential Framework identifies three key poutokomanawa that are fundamental to achieving improved quality of life for Māori.

- Mātauranga (knowledge) acknowledges that building knowledge and skills is a key to maximising Māori wellbeing.
- Whakamana (influence) recognises that to maximise Māori quality of life, Māori need to lead, influence, and make positive choices for themselves and others.
- Rawa (resources) acknowledges that to maximise Māori quality of life, Māori must have the necessary resources such as physical assets, human capital, and financial assets to make the most of opportunities.

The Māori Potential Framework provides a useful framework in which to develop actions relevant for Māori.

Pacific peoples

The Pacific population is diverse, comprising at least 13 distinct language and cultural groups, and people born in the Pacific Islands and born in New Zealand. The Pacific population includes people from many Pacific ethnic groups, primarily Samoan, Cook Islands, Tongan, Niuean, Fijian, and Tokelauan, with smaller numbers from Tuvalu, Kiribati, Papua New Guinea, Vanuatu, the Solomon Islands, and the small island states of Micronesia.

Demographically, Pacific peoples in New Zealand are characterised by high fertility rates, rapid diversification of the gene pool, a high population growth rate, and a youthful population, all of which are generally characteristic of developing nations. Despite inevitable population ageing and a likely drop in fertility rates, the age structure of the Pacific population over the next 50 years will be more youthful than the current New Zealand population structure, and this will have direct implications for New Zealand's labour market and New Zealand society as a whole.

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4 For example, the dismissal of the King Country sacred pact dismantled in the 1940s and 1950s.

In 2006, 265,974 Pacific people lived in New Zealand (up from 231,801 in 2001), making up 6.9 percent of the population and the majority of whom were New Zealand-born. The Pacific population is youthful and expected to continue to grow rapidly for some time. This population's median age is 21 years compared with 35 years for the total population.

Pacific people are located throughout New Zealand, but are concentrated within the urban areas of Auckland, Wellington, and Christchurch. Migration to provincial areas has also occurred in line with work opportunities (Ministry of Pacific Island Affairs 2005).

The current policy frameworks for addressing the needs of the Pacific population are focused on shifting attention away from social disparity towards self-reliance and economic prosperity. This approach should be reflected in any actions undertaken to reduce alcohol-related harm incurred by Pacific people. In particular, planned actions should reflect factors such as the values and cultural preferences that influence how Pacific people view alcohol use and the harm that might result from that use.

When planning actions relevant for Pacific peoples, we need to consider:

- health promotion and preventive programmes that are community driven and focus on reducing the high incidence of alcohol-related harm among Pacific peoples
- services to meet the needs of a growing Pacific youth population
- the move towards 'by Pacific for Pacific' specialist service provision, which is becoming common in health delivery
- the continued development of the Pacific workforce to improve the capabilities and capacity of Pacific providers to enable the delivery of 'by Pacific for Pacific' services
- increasing the participation of Pacific communities all aspects of New Zealand life.

Young people

Context for young people's drinking

New Zealanders aged 12–24 face a common decision: how to use or not use alcohol and other drugs. Their drinking decisions are influenced by many factors in many contexts. Young people witness drinking, including binge drinking, by older people, sportspeople, musicians, parents, and older siblings. They are also subject to intense alcohol marketing campaigns involving multimillion dollar advertising, price pointing, 'freebies', product placements, and new products that are designed to encourage young people to drink.

In this context, young people who drink report that they drink for many of the same reasons as adults do: to socialise, have fun, and alter their mood. But the cost of alcohol-related harm is far higher for young people, their friends, and families than it is for older drinkers. These harms including violence, drownings, car crashes, unwanted pregnancies, other drug misuse, date rape, sexually transmitted infections, poor relationships, neurological damage, and poor performance at school or work.

Multifaceted approach to address young people's use and misuse of alcohol

Initiatives to reduce alcohol-related harm work best when the many different parts of a young person's life support the initiatives, including their peers, their families, their schools, their communities, the media, and the alcohol industry. In addition to these groups, a modern, workable legislative and regulatory environment must underpin every approach to reducing alcohol-related harm.

The following examples illustrate some parts of a 'multifaceted' approach to reducing alcohol-related harm among young people.

A young person's family has an important role to play in reducing alcohol-related harm. Research has established that for most young people, families and whānau are critical to role modelling, informing, and providing support and boundaries for young people (Ministry of Youth Development 2004). Given the role many families play in supplying alcohol to young people and with research proving that delaying the onset of a young person's regular drinking is critical to their good health (Grant and Dawson 1997), young people's families and whānau must be an important focus for any initiatives to reduce alcohol-related harm.

We know that young people who engage in risky behaviour with respect to alcohol often do not seek treatment or advice from health services. They do this for many reasons, including cost, inaccessibility of services, a lack of awareness about services, and fears about confidentiality (Ministry of Health 2007). The location of health services and the type of services a young person receives are important.

'Brief interventions', often as part of a general health assessment, are a quick, non-threatening and often informal way to give information and show support to a young person. They have shown to be effective in encouraging people with low-level or emerging problems with alcohol use to make positive changes in their behaviour (Moyer et al 2002). This type of service is used in New Zealand in many primary care locations, in school health services such as AIMHI (Achievement in Multicultural High Schools), on university campuses, at youth 'one-stop shops' such as Vibe, online, and by accident and emergency services.

Some young people need more support than primary care services can offer. It is important young people have good access to specialist services for young people, such as those provided by Child and Adolescent Mental Health Services or Community Alcohol and Drug Services (Ministry of Health 2007), or in partnership with NGOs such as Odyssey House. It is also important to ensure that young people have the choice of alcohol and other drug services that reflect their culture and sense of self, such as Te Waireka in Hawke's Bay.

New Zealand is pioneering community-wide approaches to alcohol-related harm reduction. Services such as Community Action Youth and Drugs and Youth Action to Alcohol fund community-wide initiatives for alcohol and other drug harm reduction. They seek to bring together various community organisations and aim to support successful local initiatives and develop new initiatives. Evaluations of some of these services have been positive and are attracting international attention (Centre for Social and Health Outcomes Research and Evaluations 2006).

4 Frameworks for intervention

This section presents some frameworks for intervention as a context for considering the recommended framework and actions in Part 1 of the National Alcohol Action Plan.

Alcohol as a regulated product

A whole-of-government approach is needed for regulation affecting the alcohol and hospitality industry sectors. Alcohol is not an ordinary economic product, for two reasons.

- Alcohol is an addictive drug, so there is a group of dependent consumers for whom the economic concept of rational consumer choice does not apply.
- Alcohol is associated with negative consequences, such as health problems, high-risk behaviours and effects on others.

When designing policy options for regulating the alcohol market, all government agencies should use similar criteria under which to show that all impacts have been considered, whether the aim of the regulation is to reduce harms or reduce business compliance costs. General criteria include:

- effectiveness
- proportionality
- fairness
- administrative simplicity and efficiency
- a precautionary approach (Nuffield Council on Bioethics 2007, p xviii).

Evidence based and/or evidence-informed policy and interventions

Evidence-based and/or evidence-informed policy-making is being encouraged in all areas of the public service, and the alcohol-related policy and programmes are no exception. The research evidence in terms of what works in reducing alcohol-related harm supports the introduction of population-wide primary prevention interventions that control the access to, availability of, and affordability of alcohol products. For example, the minimum legal purchase age, alcohol taxes, outlet density restrictions, restrictions on hours and days of sale, lowered blood alcohol content limits, and restrictions on alcohol advertising.

Social, cultural, and economic factors also affect final decisions on what, when, where, and how a government can intervene to reduce alcohol-related harm. The intervention ladder and the spectrum of responses are two holistic approaches to assessing intervention – the former relates to policy development and the latter relates to addressing alcohol-related problems.

Intervention ladder

Because alcohol is a legal, regulated drug, it is open to a wider range of interventions than are illegal drugs. Table 1 suggests an 'intervention ladder' for alcohol, showing types of actions ranging from coercive to non-intrusive actions, from 'big' policies to small ones. It is useful for brainstorming a range of options for responding to alcohol issues. A planned strategic response or programme may use a mixture of actions from each rung of the ladder.

Table 1: Intervention ladder for designing actions and policies to limit alcohol-related harm

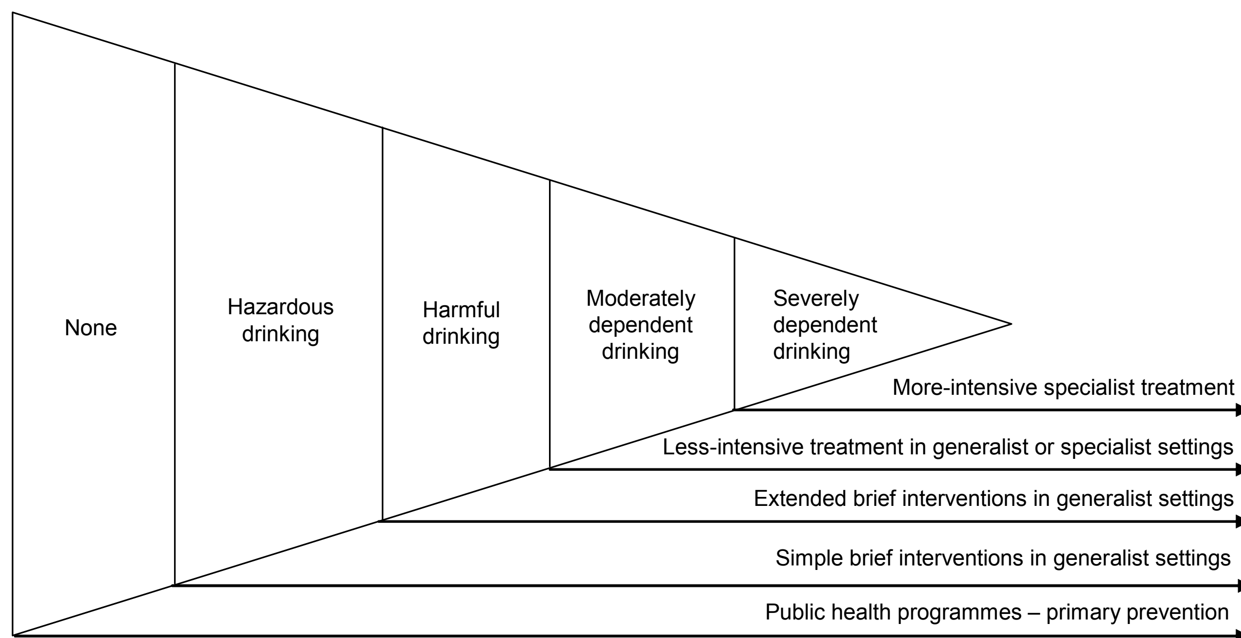
Action	Example
Eliminate choice	Regulate alcohol in such a way as to eliminate choice, for example, have a minimum legal purchase age.
Restrict choice	Regulate alcohol in such a way as to restrict the options available to people with the aim of protecting them or their communities, for example, restrict where licensed premises can set up.
Guide choice by using disincentives	Put in place financial and other disincentives to influence people not to pursue certain activities, for example, taxes on alcohol and the voluntary Code for Advertising Liquor, which relies on disincentives to achieve compliance.
Guide choice by using incentives	Implement regulations and strategies that guide people's choices using financial and other incentives, for example, offer payment for glass bottle returns near areas where students live.
Guide choices by changing the default policy	For example, design environments to minimise alcohol-related harm, such as using lighting and following Crime Prevention through Environmental Design principles.
Enable choice	Enable individuals to change their behaviours, for example, ensure licensed outlets offer no-alcohol and low-alcohol beverages, arrange for safe transportation options, and ensure bars and nightclubs offer a range of activities so people do not focus on drinking. Social marketing to change people's behaviours also comes under this category.
Provide information	Inform and educate the public, for example, publish low-risk drinking guidelines and information packs for parents.
Do nothing or only monitor the situation	

Source: Adapted from Nuffield Council on Bioethics (2007, p xix).

Spectrum of responses

Figure 7 shows a spectrum of health sector responses for addressing alcohol problems. The figure shows that many responses are possible in generalist settings, not just in specialist addiction settings. We suggest that this approach could be useful when considering not only the type of intervention required but also the intensity of the response or intervention required.

Figure 7: Spectrum of health sector responses to alcohol problems



Source: Raistrick et al (2006).

5 Government strategies

Beyond the specific strategic framework for addressing drug and alcohol-related harm, the overarching strategies for health and disability services in New Zealand are the New Zealand Health Strategy (Minister of Health 2000) and New Zealand Disability Strategy (Minister for Disability Issues 2000). Other strategies that contain an alcohol focus from various sectors include:

- *Alcohol Action Plan* (New Zealand Police 2006), which aims to improve the New Zealand Police's ability to prevent and reduce alcohol-related harm
- *Health and Physical Education in the New Zealand Curriculum* (Ministry of Education 1999)
- *Our Strategic Direction 2008–2013* (ALAC 2007).

Other relevant strategies relate to the development of specific diseases or the burden of harm experienced by different population groups are included in, for example:

- *He Korowai Oranga: The Māori Health Strategy* (Minister of Health and Associate Minister of Health 2002)
- *Whakatātaka: Māori Health Action Plan* (Minister of Health and Associate Minister of Health 2002)
- *Te Tāhuhu – Improving Mental Health 2005–2015: The Second New Zealand Mental Health and Addiction Plan* (Minister of Health 2005)
- *Te Kōkiri – The Mental Health and Addiction Action Plan 2006–2015* (Minister of Health, 2006) (which implements Te Tahuhu)
- *Youth Health: A guide to action* (Ministry of Health and Ministry of Youth Affairs 2002) identifies tobacco, alcohol and other drugs as specific health risks for young people

- *Strategy to Reduce Drug and Alcohol Use by Offenders 2005–2008* (Department of Corrections 2004) (which has a specific strategy to minimise harm related to drug use by offenders)
- *New Zealand Injury Prevention Strategy: Rautaki Ārai Whara o Aotearoa* (Minister for ACC 2003).

Regional and local strategies and management plans address alcohol-related harm in specific areas. Alcohol-related problems vary across communities, so a range of strategies is intended to support communities in addressing alcohol issues at a local level. An up-to-date list of local government alcohol strategies and management plans is available on the Alcohol Advisory Council of New Zealand's website (http://www.alac.org.nz/LiquorLicenseInfo.aspx?PostingID=7986).

6 Advisory group feedback

Eight key advisory groups

The draft National Alcohol Action Plan was developed after consultation with advisory groups comprising topic experts and stakeholders in the areas of:

- supply control and law enforcement
- public health and social issues
- research
- clinical interventions and treatment services
- alcohol beverage, retail and hospitality
- Māori
- Pacific peoples
- youth.

The key themes, actions and key issues from the advisory group meetings are outlined below.

Key themes

The eight advisory groups identified seven key themes.

1. Prioritise alcohol at government level to recognise the impact alcohol-related harm has on many aspects of New Zealand society.
2. Change social norms associated with alcohol use, including the environment in which people make their drinking decisions.
3. Improve collaboration, integration, and partnership to address alcohol-related harm:
   1. across central and local government
   2. between agencies
   3. between agencies and communities
   4. within communities.

4 Encourage and empower local authorities and communities to address local alcohol-related issues by developing and implementing local responses. (Emphasis was placed on the importance of national policy and a legislative framework to regulate the use of alcohol and to enable rather than prevent local responses to local issues.)

5 Increase resources for and more effectively resource:

    1. services to address individual and collective needs, particularly early intervention services that address secondary alcohol-related harms for example, harm to whānau
    2. the alcohol research workforce, alcohol research, and the dissemination of that research.

6 Improve the availability and accessibility of robust baseline data on alcohol-related harm and trends, and complement this data with an effective monitoring and evaluation framework that people implementing local initiatives can use when developing programme or intervention evaluations at a local level.

7 Ensure leadership and accountability are clear to reduce alcohol-related harm.

Differences in the way themes were addressed or emphasised

While the advisory groups generally agreed about the key themes, they differed in how they expressed the themes and emphasised different aspects of each theme. These differences are detailed in tables 2-9.

Advisory groups differed substantially in the emphasis they felt should be placed on individual responsibility and the level of government intervention at a population level. Most groups appeared to favour more and more restrictive government regulation of the alcohol market. However, these same groups also identified community control of alcohol policy and intervention as being important for addressing local issues. It may be that groups wanted more restrictive government regulation to enable local communities to better address local issues.

Māori and Pacific advisory groups

The Māori and Pacific advisory groups emphasised collectivity and the importance of focusing on the concept of overall community and whānau wellbeing as opposed to using individual frames of reference. This is relevant across the spectrum of research, community action, and treatment services and interventions.

Youth advisory group

The Youth Advisory Group noted that young people tended to be seen as a homogenous group with a ‘problem’ that needed ‘fixing’. Their view was that the current approach to youth alcohol consumption excluded rather included young people and that young people needed to be part of the solution. In fact, young people felt abandoned by current alcohol policy, particularly the social marketing approaches aimed at older drinkers.

Public health and social issues and industry, retail and hospitality advisory groups

The Public Health and Social Issues Advisory Group preferred a focus on population-level intervention, while the Industry, Retail and Hospitality Advisory Group felt that not enough emphasis was placed on individual responsibility.

Most advisory groups identified the liberalisation of the alcohol market (that is, the promotion of alcohol as an ordinary commodity) and the normalisation of alcohol consumption in a wider number of contexts than ever before as the underlying causes of increasing alcohol-related harm.

The Industry, Retail and Hospitality Advisory Group's view was that the normalisation of alcohol consumption was acceptable, but binge drinking and the consequent drunkenness were unacceptable and in many respects were detrimental to the retail and hospitality industries. Nevertheless, this group also identified personal responsibility and behaviour change as being the keys to addressing New Zealand's binge-drinking culture.

Actions suggested by advisory groups

Tables 2–9 outline the actions the eight advisory groups suggested. The actions have been grouped according to the themes and goals of the draft National Alcohol Action Plan.

Table 2: Actions suggested by the Alcohol Beverage, Retail and Hospitality Industry Advisory Group

Theme or goal	Action
Change social norms	Share knowledge on what drives drinking behaviours with a view to reducing harm by changing individual behaviour
Individuals and families and whānau	Work with schools to improve educative material available nationally and locally
Workforce and skills	Support alcohol research
Community and environment	Continue industry-led local collaboration on programmes to reduce harm
National frameworks	Continue to enforce the Sale of Liquor Act 1989 Continue to develop and implement codes for advertising liquor and alcohol promotions
Recognise potential and reduce inequalities	

Table 3: Actions suggested by the Pacific Peoples Advisory Group

Theme or goal	Action
Change social norms	Develop and implement through the community Pacific-focused moderation messages
Individuals and families and whānau	Develop Pacific-specific resources across supply control, demand reduction, and problem limitation areas

Workforce and skills	Improve funding and monitoring approaches Ensure continuity in contracting Continue treatment workforce training programmes for Pacific people Continue early intervention training Continue early intervention resource development with a Pacific focus
Community and environment	Develop and implement Pacific-focused community action programmes
National frameworks	Ensure one government agency monitors progress on reducing alcohol-related harm Develop and implement culturally appropriate policy frameworks
Recognise potential and reduce inequalities	Develop Pacific youth as leaders Use collective rather than individual frameworks of reference when developing and implementing alcohol policy

Table 4: Actions suggested by the Clinical Interventions and Treatment Services Advisory Group

Theme or goal	Action
Change social norms	Ensure government prioritisation of alcohol-related issues, particularly the integration of alcohol issues, needs, and solutions with wider health, justice, and social needs and priorities
Individuals and families and whānau	Ensure the prioritisation framework recognises different cultural perspectives Increase services at all levels that are designed specifically for young people
Workforce and skills	Rebalance the focus and resources towards achieving the greatest good for the greatest number of people with the greatest need Develop and implement a training framework appropriate to particular interventions, client groups, and service settings Expand the range of 'treatment' modalities and locations to include early and brief interventions in non-specialised health and other agency settings
Community and environment	Implement a project focused on increasing consumer participation in the development of treatment policies, services, and interventions
National frameworks	Review the cost- and outcome-effectiveness of mainstream, traditional treatment interventions and approaches
Recognise potential and reduce inequalities	Review what constitutes 'competence', especially for interventions focused on addressing the needs of Māori and Pacific people Develop a prioritisation framework to ensure the needs of key groups experiencing disproportionate harms from alcohol are met

Table 5: Actions suggested by the Supply Control and Law Enforcement Advisory Group

Theme or goal	Action
Change social norms	Implement targeted programmes with role models
Individuals and families and whānau	Develop and implement a protocol for dealing with intoxicated people (under the Alcoholism and Drug Addiction Act 1966)
Workforce and skills	Improve the resourcing of enforcement and monitoring agencies Train police on intoxication monitoring Ensure more resources for licensed premises

Community and environment	Prohibit drinking in public places Develop and implement a host responsibility programme focused on drink-driving Develop and implement a programme on rural drink-driving Develop and implement a programme on recidivist drink-drivers Develop a project to improve and strengthen the ability to monitor licensed premises
National frameworks	Amend the Sale of Liquor Act 1989 to give local authorities greater control of outlet density and communities a greater say in the location and density of outlets Amend the Sale of Liquor Act 1989 to exempt alcohol from the Commerce Act 1986 Require security staff to be trained to New Zealand Qualifications Authority standard Develop and implement a protocol for data sharing between agencies particularly District Health Board data and crash analysis data Decrease blood alcohol content levels
Recognise potential and reduce inequalities	

Table 6: Actions suggested by the Youth Advisory Group

Theme or goal	Action
Change social norms	Involve young people in the development of national messages aimed at changing the drinking culture among young people
Individuals and families and whānau	
Workforce and skills	Introduce school-based brief and early intervention services Develop and introduce school-based referral protocols for getting young people to treatment services
Community and environment	
National frameworks	Develop and introduce robust school-based information on alcohol use and abuse to ensure a consistent approach to alcohol education in schools Review the Code for Alcohol Advertising
Recognise potential and reduce inequalities	

Table 7: Actions suggested by the Research Advisory Group

Theme or goal	Action
Change social norms	
Individuals and families and whānau	Develop and implement a youth strategy
Workforce and skills	Develop and implement a national programme and funding approach for alcohol research (eg, the National Research Committee) Develop and implement a national alcohol research forum that meets annually Improve existing data sources (eg, Alco-Link) and make data from those sources routinely available
Community and environment	Develop and implement a system that ensures research results are shared with the community in which the research was undertaken

National frameworks	Develop and implement a national clearing house for alcohol research Develop and implement an online source of alcohol-related research and data Implement a set of standard indicators of alcohol-related harm Review the excise regime
Recognise potential and reduce inequalities	Develop and disseminate alcohol research methodologies that are appropriate to priority populations Develop District Health Board-based alcohol-related harm indicators

Table 8: Actions suggested by the Public Health and Social Issues Advisory Group

Theme or goal	Action
Change social norms	Address drinking in private environments Address the link between sport and alcohol Review alcohol advertising
Individuals and families and whānau	Work with schools to improve the educative material available Develop and implement strategy to address maternal alcohol consumption
Workforce and skills	Support alcohol research Require primary health organisations to provide routine screening and offer brief and early intervention services
Community and environment	Increase the number of community-led initiatives Introduce more regulation of the number and density of liquor outlets
National frameworks	Monitor and capture data at District Health Board-level as part of a National Drug Policy online information source Update the assessment of the social costs of alcohol misuse Review the safe drinking guidelines Review the Sale of Liquor Act 1989, particularly the legal minimum purchase age Review the excise regime Decrease blood alcohol content levels
Recognise potential and reduce inequalities	Address alcohol consumption by tertiary education students

Table 9: Actions suggested by the Māori Advisory Group

Theme or goal	Action
Change social norms	Develop and implement through community Māori-focused drinking culture change messages Implement national Māori-specific social marketing programmes to complement community initiatives Develop a calendar of significant Māori-specific events where drinking culture change messages can be delivered
Individuals and families and whānau	Develop Māori-specific resources across supply control, demand reduction, and problem limitation areas
Workforce and skills	Implement treatment workforce training programmes for Māori Undertake a stocktake of Māori-specific alcohol interventions Fund primary health organisations to undertake brief and early interventions Develop appropriate screening tools for brief and early interventions

Community and environment	Develop and implement a resource kit for Māori who want to take action at the community level Work with employers in New Zealand to develop work-based alcohol policies
National frameworks	Implement legislative change that supports community action Develop and implement culturally appropriate policy frameworks Ensure messages across government agencies are consistent
Recognise potential and reduce inequalities	Improve the collection of ethnicity data on both consumption and harm

Key issues

This section summarises the key issues the advisory groups identified.

Public Health and Social Issues Advisory Group

The key issues the Public Health and Social Issues Advisory Group identified were:

- the liberalisation of the alcohol market and the normalisation of alcohol consumption in a wider number of contexts than ever before
- the lack of recognition of alcohol harm as social issue and its link to wider social issues
- the impact of alcohol-related harm on Māori development
- the need for easily accessible robust data on all harms and trends
- the need for monitoring and systematic reporting
- the need for a greater focus on population-level interventions
- the need to link alcohol strategies with other relevant strategies across the health sector and community.

Research Advisory Group

The key issues the Research Advisory Group identified were:

- the capacity and capability of the alcohol research workforce and the need for a consistent funding model
- the need for greater collaboration between researchers across government
- the need for improved access to information, greater data sharing, and an ability for information to be used at a local level, and the importance of robust baseline data
- the importance of monitoring for outcomes while ensuring the use of robust indicators
- expanding alcohol research to develop methodologies that resonate with the Māori, Pacific and youth populations
- complementing the current individual harm focus by including context and social constructs.

Clinical Interventions and Treatment Services Advisory Group

The key issues the Clinical Interventions and Treatment Services Advisory Group identified were in the areas of:

- integration – alcohol issues need to be integrated at government level and in other policy and operational contexts
- high-needs population groups – innovation needs to be encouraged and well evaluated, and practice-based evidence developed that is relevant to New Zealand populations and settings
- clinical intervention and treatment types, settings, and approaches – well-evidenced interventions need to be developed so the services provided achieve better outcomes
- workforce development – workforce development is needed
- cost–benefit analysis – analysis is needed to determine value for money, assess outcomes and ensure more people in need of help are helped
- access and availability of services for high-needs groups – earlier intervention prevents the escalation of harm
- workforce – the workforce needs to be well developed and resourced so it is equipped and competent to deliver relevant and effective services to more people.

Alcohol Beverage, Retail and Hospitality Industry Advisory Group

The key issues the Alcohol Beverage, Retail and Hospitality Advisory Group identified were:

- recognition of the role the industry can and does play in contributing to reducing alcohol-related harm
- a need for more emphasis on individual responsibility
- the importance of collaboration and partnership across the alcohol sector.

Māori Advisory Group

The key issues the Māori Advisory Group identified were:

- alcohol harms need to be framed in terms of harm to the user and harm to others
- community responsibility, involvement, and action are needed to address alcohol harms
- Māori modalities and concepts should be used, because a Māori view of what constitutes alcohol-related harm differs from mainstream views
- whole-of-government collaboration is needed to ensure messages about alcohol use are consistent and are linked to other related strategies
- Māori leaders and role models are needed to champion change
- local authorities need to be empowered to be able to address local alcohol-related harm issues

- the importance of services and rehabilitation for people in the criminal justice system, so they can be reintegrated into society
- funding for services should be based on the actual alcohol-related harm incurred – mainstream approaches fail to recognise the high levels of harm in the Māori population
- the lack of recognition of the Treaty of Waitangi in the National Drug Policy
- the lack of data about Māori drinking and related harms.

Pacific Peoples Advisory Group

The key issues the Pacific Peoples Advisory Group identified were in the areas of:

- connectedness, communication, and collaboration – agency to agency and agency to community
- monitoring and evaluation – Pacific input needed to ensure Pacific frames of reference are used
- workforce development – services need to use Pacific frames of reference
- collective rather than individual approaches – whole of family, wellbeing and strengths-based approaches are needed
- early intervention and the role of parents and family wellbeing
- young people as leaders.

Youth Advisory Group

The key issues the Youth Advisory Group identified were:

- the drinking environment in which young people operate
- societal acceptance of binge drinking and its affect on young people's decision making
- the sophistication and proliferation of advertising and marketing, which places additional pressure on young people to choose to drink alcohol
- youth having been 'abandoned ' by current policy, particularly that associated with social marketing campaigns
- young people being seen as a 'problem' that needs to be 'fixed' – exclusion from society
- inconsistent and poor school-based information about alcohol use and abuse.

Supply Control and Law Enforcement Advisory Group

The key issues of the Supply Control and Law Enforcement Advisory Group were:

- greater integration between agencies – health, education, enforcement
- improved access to information, greater data sharing and ability for information to be used at a local level – importance of robust baseline data
- empowering local authorities and others at a local level

- community control of alcohol policy
- stronger emphasis on injury prevention
- clear leadership and accountability
- measurable goals and performance measures for monitoring of NAAP's implementation.

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