More Effective Social Services

Submission to: Productivity Commission

2 December 2014

Alcohol Healthwatch is a non-government organisation and operates as a charitable trust. We deliver a range of health promotion services to reduce alcohol-related harm under contract to the Ministry of Health. We have over 20 years of experience operating within the health system and across a wide range of other services and systems, including justice and education.

Unfortunately, as a small organisation we do not have the time or capacity to respond to the full scope of questions included in the Issues Paper. However, we do believe we can offer a valuable perspective to this discussion. In this submission we provide some real world examples of how commissioning and purchase affects the delivery and effectiveness of services, and offer some ideas for improving how government agencies commission and purchase social services.

We are happy to speak with the Commission should this opportunity arise.

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Alcohol as a social issue:

- Health and disability

Alcohol is the world's third leading risk factor for premature deaths and disabilities (after high blood pressure and smoking), and the single leading risk factor for death and disability in young people worldwide. In New Zealand, alcohol is responsible for 5.4% of deaths and 6.5% of disability-adjusted life years lost under 80 years of age. It is causally linked to over 60 diseases and negative health outcomes, and a significant risk factor in over 200 more. It is recognised as one of the four leading risk factors for non-communicable diseases.

Around 20% of New Zealand drinkers are classified as hazardous drinkers, and 25% as harmful drinkers, equating to approximately 700,000 New Zealanders. Inequities abound for Māori and other groups within the population in relation to alcohol harm. Alcohol causes the premature death of between 800-1000 New Zealanders every year, with breast cancer the leading cause of alcohol-related death for both Māori and non-Māori women. Around half of these deaths are associated with injuries such as those resulting from traffic crashes and violence, the remainder are from chronic health conditions such as cancer and liver disease. The health and social cost has been estimated at around $5 billion a year.

Drinking during pregnancy can result in Fetal Alcohol Spectrum Disorder, a range of adverse effects largely associated with brain damage including developmental delays, learning and behavioural disorders and intellectual disability. These effects are life-long and problems are exacerbated by lack of or inappropriate responses.

Injuries are the leading cause of death among young men, with alcohol-related violence and traffic crashes being the greatest risk factors.

The impact on health services are significant and span all aspects of health, including emergency services, acute and chronic health hospital services, mental health and addictions, primary care, sexual health and family planning, health promotion and health protection.

- Police, Justice and Corrections

Alcohol's impact on the Justice and Corrections systems are also significant. Entries into these systems come from multiple directions, such as through the perpetration of violence, vandalism, theft and other criminal offending, drink-driving, liquor ban breaches, liquor licensing breaches.

There are around 30,000 drink-driving convictions each year. Only a small proportion of these are referred for an alcohol use assessment and/or intervention.

Alcohol is implicated in a third of all violence, a third of all family violence and half of all sexual assaults and homicides. Those affected by Fetal Alcohol Spectrum Disorder are over represented in the Justice system.

- Education

A survey among high school students (Youth 2000) shows that while binge-drinking in this population has reduced since 2000, in 2012, 23% reported binge-drinking in the last four weeks. Early drinking by young people increases their risk of failing school, criminal offending, depression and mental illness, experiencing problems with alcohol during their life course including addiction.

Tertiary students are the heaviest drinking group in the population, and numerous harms are attributed to this consumption including poor or failed academic performance.

- Local Government

Local Government are involved in alcohol-related through various legal requirements such as liquor licensing, monitoring and enforcement of alcohol control bylaws, but also through necessity such as security, community safety, cleaning and damage repair of public properties.

More recently they have also been involved in developing Local Alcohol Policies, as enabled by the Sale and Supply of Alcohol Act 2012. This in turn has brought them, and other public service agents into direct conflict with vested interest groups, and the threat or reality of costly legal proceedings to defend their Policies.

Responding to alcohol-related harm

Alcohol-related harms are wide-ranging and present a significant burden on society and social services. The risk factors creating these harms are complex yet simple. Addressing alcohol-related

harm requires multiple agencies and services to work together, towards common goals with common understandings and in a co-ordinated fashion.

There is a substantial evidence-base to guide effective policies and intervention. However, we are working in a planning vacuum as there has been no National Alcohol Strategy or Plan since 2003, and the National Drug Policy expired in 2012.

These planning frameworks have been fiscally neutral in the past and have been largely ineffective at engaging the full range of services impacted upon by alcohol harm.

There are also significant gaps in knowledge and understanding so sector and agencies rarely understand the impact alcohol is having on their service, or what they can be doing to most effectively deal with it.

The worst scenario occurs when they do learn what impact is having on their service and clients but do not have the resources, systems or mandate to respond effectively.

A couple of illustrative examples:

- ***Alcohol and Violence***

In 2002 we commissioned an analysis of Police incidents of family violence and the reporting of alcohol involvement. It's fair to say that this was significant (even acknowledging poor and under-reporting).

We attempted to take this information to the community via the agencies involved with family violence and were pushed back. We got the distinct impression that the sector was not ready for this, and respectfully retreated.

In 2012 and 2013 we undertook comprehensive literature reviews of alcohol's role in injuries and violence, and another on alcohol and women. In short, alcohol is a MAJOR contributor to poor health and social outcomes, and that this is grossly under-reported and responses are under resourced.

We are learning more about the impact on those other than the drinker, such as children who are exposed to such risks as drink-driving and violence in the home. Exposure to violence is particularly high for women, for example it is estimated that more than 10,000 sexual assaults occur in New Zealand each year which involve a perpetrator who has been drinking.

Since undertaking this work and publishing Policy Briefing Papers on these matters, we have become more committed to supporting the implementation of effective alcohol harm prevention policies and strategies.

Below are the recommendations from our Women and Alcohol in Aotearoa/New Zealand Policy Briefing Paper. These are very similar to recommendations made in our our Policy Briefing Paper on Alcohol, Injuries and Violence. We believe these might provide some guidance as to what can be done to more effectively address a significant social issue.

The Paper can be found on our website www.ahw.org.nz.

The recommendations are cross-sectoral, relating to health, justice and social development in New Zealand.

1) Making gender matter

Strategies, polices and programmes intending to reduce alcohol-related harm use gender-based analytical tools to ensure sex differences and gender influences, and any related inequalities, are identified and addressed.

2) Prioritising alcohol

A whole-of-government and cross-sectoral approach is adopted to address alcohol-related harm, and alcohol is given a greater priority in national policy and planning.

3) Ensuring the effectiveness of alcohol policy interventions

Evidenced-based alcohol policy interventions are implemented in accordance with the Global Strategy to Reduce Alcohol-Related Harm, and as recommended by the New Zealand Law Commission.

4) A strategic approach to research

A strategic and co-ordinated approach to alcohol research is implemented in order to enhance knowledge about the role of alcohol in diverse populations of women; and inform the development, and measure the impact of interventions in terms of their effectiveness for diverse populations of women.

5) Co-ordinating efforts addressing alcohol harm and violence against women

Strategies and interventions to reduce alcohol-related harm are co-ordinated with activities to address violence against women, including sexual and family violence.

6) Focusing on social determinants

A whole-of-government approach addresses social and ethnic inequalities, including poverty and institutional racism. Increase the use of Health Impact Assessments to ensure proposed policy, plans and programmes achieve desired outcomes.

7) Reducing alcohol-related harm for Māori women

Wāhine Māori rangatiratanga over alcohol harm is developed and supported through sector-wide capacity and capability building.

8) Enhancing service delivery to Māori

Service for Māori is delivered within a kaupapa Māori values framework that reflects the aspirations of whānau ora.

9) Enhancing services for Pacific peoples

Increased funding and support is made available for alcohol-related research, programmes and services that address the needs of Pacific communities.

10) Enhancing services for Asian, New Migrant communities and other groups experiencing alcohol-related harms.

Increased funding and support is made available for alcohol-related research, programmes and services that address the needs of Asian, New Migrant and other groups who experience alcohol-related harms.

11) Enhancing screening and brief intervention

Routine and standardised screening for harmful alcohol use is integrated within and across sectors, and routinely linked to best-practice brief interventions or referrals to treatment services. Relevant agencies coordinate more closely, to build on current pilot screening and brief intervention programmes, extend coverage, build best practice and ensure sustainability.

12) Enhancing treatment services
AOD treatment services are assessed for their responsiveness to women, and a plan is developed and implemented to address the gaps and issues.
13) Empowering communities
Communities are better resourced and supported to lead interventions that reduce alcohol-related harm.

A number of other reports contain recommendations on addressing alcohol, including the recently published report from the Glenn Inquiry into family violence and a health select committee report on addressing the needs of vulnerable children.

- **Fetal Alcohol Spectrum Disorder**

Fetal Alcohol Spectrum Disorder (FASD) is a range of physical, cognitive and behavioural impairments caused by alcohol exposure during fetal development. Alcohol is a teratogen that interferes with normal cell growth and function during development. Impairments may include facial and organ malformations but primarily FASD is about multiple brain deficits that substantially impair day-to-day functioning and communication across the lifespan. These pose major challenges for individuals with FASD, their families and the broad range of service providers they encounter, that are amenable to appropriately directed support.

Alcohol, being almost universally available is pervasive in New Zealand society, making FASD prevention particularly challenging. In the developed world FASD is recognised as the leading preventable cause of developmental disabilities, yet in New Zealand, no reliable data has so far been gathered, no comprehensive government plan of action has yet been established and babies continue to be born adversely affected by alcohol.

Based on overseas studies and drinking patterns, New Zealand could have 3,000 babies a year or more born with FASD. Better information is vital to develop effective policy and health and other sector responses to reduce the prevalence and societal impact of FASD. Babies born with FASD don't outgrow the problems. On the contrary their difficulties grow as they grow. Individuals with FASD are more likely to experience adverse outcomes than the general population particularly in adolescence and adulthood. Referred to as secondary disabilities, these adverse outcomes include mental health problems, addictions, education failure, trouble with the law and becoming victims of crime.

Māori are disproportionately harmed by alcohol. The damage alcohol (waipiro) causes to unborn babies was recognised by Māori when it was first introduced in the 1800s. Recognising FASD and re-orienting existing services toward improved outcomes for the FASD-affected population will reduce the cost burden of secondary disabilities and increase prevention. The earlier in life that FASD is recognised and responded to appropriately, the greater the chance of successful living and protection of the next generation. Neglecting this has dire long term consequences, especially for our most vulnerable children.

Currently many individuals with FASD are behaving inappropriately in the community without appropriate support structure and are over-represented in the justice sector. This is a cost to society

as well as an ineffective way to manage FASD disability. Caregivers are crumbling under the strain of preventing further harm from occurring by building the child's strengths and are doing so in isolation of effective supports or recognition. Many parents are simply blamed for the problem – as indeed often are their disabled children - when it is the teratogenic effects of alcohol and misunderstanding to blame. That must change.

FASD has complex lifelong implications that no one agency or family can address alone. FASD prevention and intervention is a societal responsibility requiring Government and cross-sector 4 commitment and collaboration that has the backing of Government funding. The cost of neglecting FASD is far too great.

We include a ***Call To Action*** on FASD below. This is based on information shared at the Fetal Alcohol Spectrum Disorder (FASD) Symposium and the FASD Policy and Research Roundtable hosted by the University of Auckland's Centre for Addiction Research and Alcohol Healthwatch on 5th and 9th September 2014.

It identifies areas of priority to prevent FASD and to address the gaps in service delivery to those affected by FASD. It is underpinned by a commitment to the Treaty of Waitangi. It recognises New Zealand's obligations under a range of United Nations charters.

FASD Prevention Policy and Practice

• Reduce the environmental influence of alcohol known to increase harm including reduction in availability, increase in price and restriction of promotional marketing.

• Strengthen consistency and effectiveness of non-stigmatising messages to not drink preconception, during pregnancy or when breastfeeding, including on the product and point of sale.

• Require screening and brief intervention with women of childbearing age by primary health and addiction services, and referral to specialist services for those at increased risk.

• Ensure FASD prevention is taught across the education curriculum and in specialist courses.

FASD Screening, Assessment and Diagnostic Training and Practice

• Direct health funding to support FASD training in integrated diagnosis and care planning with child health, mental health and other services across the lifespan.

• Provide for the establishment of a Centre of Excellence where expertise can guide and maintain consistency of evidence-based practice and continuing education across services.

• Together with FASD experts, develop guidelines and referral pathways for children and youth with FASD similar to that for Autism Spectrum Disorder.

• Screen children for FASD at point of entry into Children's Teams, Gateway or other child health programmes.

• Ensure children in care who are at very high risk of having FASD are screened and if positive, receive timely diagnosis, care and education adapted to their special needs.

• Provide for Specialist FASD Advisor in schools.

• Screen for FASD in youth justice, care and protection residences and alcohol and drug services and provide appropriate intervention pathways to reduce the risk of recidivism.

FASD Intervention Policy, Training and Practice

• Ensure that the parent/caregiver voice is included and heeded in regard to FASD specific policy around health, education and justice.

• Prevent discrimination by recognising FASD is a lifelong disability with significant unmet need that is not explained by poor parenting practice or other circumstances.

• Recognise the fiscal, emotional and time-consuming demands on those caring for a child or adult with FASD by ensuring their eligibility for financial and respite care support.

• Ensure those diagnosed with FASD are eligible for disability and education supports that are not predicated on IQ alone but equally consider deficits in executive and adaptive function.
• Fund and mandate experts to deliver integrated intervention training and support programmes in mental health, justice, addictions, education, police etc. that will assist individuals with FASD to reach and maintain their potential.

FASD Research
• Build a research network to guide and conduct FASD-related research.
• Fund a World Health Organisation national prevalence study which New Zealand has been invited to participate in to ascertain the scale of FASD.
• Conduct a Youth Justice FASD prevalence and intervention study.
• Develop a national database for the collection and analysis of FASD clinical data.
• Conduct a cost benefit analysis to determine the cost of FASD in New Zealand.
• Research the outcomes of FASD and the cost-benefit of intervention strategies.

Some of the action points identified in this FASD Call to Action represent work already begun by front-line professionals and families as demonstrated at the FASD Symposium and Roundtable. Much of this work has occurred in the absence of specific funding or structure. To ensure FASD planning and practice is well informed and funding is effectively directed, existing FASD experience and expertise must be recognised and more fully engaged in the process.

These matters form the substance of this Call to Action. They are consistent with the 'FASD Call to Action' from the delegates attending the 2013 Australasian FASD Conference in Brisbane [http://www.phaa.net.au/AFASDC_2013.php], the recommendations made by the New Zealand Parliamentary Health Select Committee in their Inquiry Into Improving Child Health Outcomes and Preventing Child Abuse (2013), and subsequently agreed to by the Government and 'The International Charter on the Prevention of FASD'

In conclusion:

Alcohol is a very real and significant issue presenting in a multitude of ways to our social services. It is an issue that our social services need to be better equipped to respond to.

Through our engagement with numerous agencies involved in social services and clients of these services over the years we have heard repeatedly that the community/sector knows what needs to be done, and are frustrated by the barriers that they encounter. What they need are services with the knowledge, skills and systems that can help them deliver effective solutions.

Some common issues we observe:

- Lack of information and research to adequately define the issue/s. This results in a 'Catch 22' situation - we can't accurately define or describe the issue/s so we don't act to address it.
- Unwillingness to accept the issue/s – this can be due to ideology, but often it is because the service does not have the resources or infrastructure to respond.
- Multiple sectors - with each sector dealing only with bits of the issue, or not dealing with it at all.

- Lack of common understanding or language to engage across sectors.
- Small groups without adequate resources to do enough about the issue despite the willingness and expertise, and large service agencies putting their resources elsewhere.
- Funding of new projects/programmes, despite there being existing programmes that are struggling to survive, or have been inadequately resourced to be effective.
- Short term projects 'Pilots" – these often result in disenfranchised groups in the community and distrust of Government agencies and those associated with them.
- Inadequate resourcing of evaluation – so we don't know/can't show a programme has worked or not. This can result in significant waste of resources and reinventing wheels.
- Holistic responses seem to be the last option, despite being the most effective at dealing with complex and inter-generational social issues.
- Complicated, and ever changing structure and processes of Government agencies – it is difficult enough to deal with one sector, yet alone multiple. In the last few years we have seen the Ministry of Health restructure, ACC restructure, ALAC disestablished and Health Promotion Agency formed – just to highlight a few.

While the above recommendations and call to action may not directly respond to the Commission's inquiry questions, we believe that if taken into consideration they could help identify more effective commissioning and purchasing practices of our social services.

Putting such recommendations into practice will require greater levels of co-ordination and leadership at the national level, a public service that is willing to listen and respond to the issues as they actually present, and a willingness and commitment to support the delivery of proven strategies to address the issues.

By considering our collective response to alcohol we may learn how to be more efficient and effective across a range of other issues.

Social issues rarely present themselves in isolation or in shapes and sizes that fit the boxes of Government or agency contracts. They require a long term structured approach, with flexibility to put resource where it is needed, when it's needed.

Failing to invest in what works simply results in making the burden on individuals, children and families greater, and the cost on society increase over time.

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