

Presenting the Ministry of Health's public health focus

New Discussion Paper Seeks Comment on Proposals for the Public Health Bill

*Louise Delany, Public Health Legislation Review,
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A new discussion paper, *Public Health Legislation: Promoting Public Health, Preventing Ill Health and Managing Communicable Disease*, was recently released by the Minister of Health.

The paper follows up the Government's decision to replace the Health Act 1956 and the Tuberculosis Act 1948 with a new Public Health Bill. The paper provides details and seeks comments on selected topics proposed for inclusion in the new Public Health Bill. The broad legislative framework for the Bill was proposed in a 1998 discussion document.

Topics in the discussion paper include:

- **Notifiable conditions.** It is suggested that the term 'disease' be replaced with the wider concept of 'condition'.
- **Notification to health authorities of specified information.** What criteria should help decide which conditions should be notifiable?
- **Promotion of public health in a positive sense.** Current patterns of disease and mortality show that non-communicable diseases (such as cancer and heart disease) are now the greatest areas of concern at the population level. Proposed regulation-making powers could influence factors relevant to ill health (eg, access to products, services and facilities, constituents of products and their promotion).
- **Immunisation, screening, registers and issues relating to child health.** Regulation-making powers for immunisation could allow a number of options in relation to certification of a child's immunisation status. Provisions for registers could provide a framework for the National Immunisation Register.

continues on page 6

Contents

Progress on Meningococcal Disease Campaign Plans	2
Thumbs up for BreastScreen Aotearoa	3
New Appointments for Screening Programmes	4
Notifiable Diseases and Conditions Schedules Upgrade	5
Establishment of Scholarship Scheme and New Public Health Intelligence Applications Laboratory	6
Campaign Encourages Women to Have Regular Mammograms	7
Dr Barry Borman Newly Appointed Chair of ICBDMS	8
Environmental Health Action Plan ..	9
Māori to Retain Control of Cervical Screening Data	10
Leaky Buildings and Potential Health Effects	11
Kaipara Eradication Programme Kicks Off	12
'Desolate Mooncape' Contract Won by NRL	12
Methamphetamine – Reclassification and Action Plan ..	13
Suicide Prevention Programmes in Schools	14
Ministry of Health v James McNee 1,4 Butanediol Prosecution	15
Achieving Health for All People	16
The Youth Health Action Plan	16



Ministry of Health management and staff
wish you a healthy and happy holiday season
and best wishes for 2003

Editorial

Don Matheson

Deputy Director-General, Public Health Directorate



December is the time for celebrity advice on reading material for the summer holiday. The directorate has three discussion pieces to while away the long summer days.

My recommended summer reading involves a Whodunnit?, a Sci Fi classic, and a contemplative piece for the meaningful discussions with friends and family when it is too wet to go to the beach and the credit card opposes more shopping.

Firstly, the 'Whodunnit?' – or, more importantly, having done it – how much power should public health workers have to curb the spread of communicable diseases? Who said public health legislation is boring? Certainly not anyone who reads the draft document on the proposed public health legislation. It tackles the big issues of the day, extending the scope of public health legislation beyond communicable disease and environmental health into the contemporary issues of non-communicable disease control and the legislative requirements of screening programmes and registers. Even in the traditional areas, it is important that there is wide discussion on what powers public health workers should have to control communicable diseases, especially when there is a tension between public health objectives and individual rights. The discussion document

invites comment on the role of public health law in curbing the diabetes and obesity epidemic. To what extent would legislation play a role in public health campaigns around these issues?

The Sci Fi Classic refers to another discussion document, this time on radiation protection legislation. The current law, although addressing the issues raised by Madam Curie, needs to be modernised to take into account the huge technological and organisational developments in both ionised and non-ionised radiation. The existing legislation did not conceive of the complexity and uses and potential abuses (such as dirty bombs) of radiation in the current era.

Now for the 'Contemplative Piece'. It is the collective thoughts of the public health sector in response to the New Zealand Health Strategy: Achieving Health for All People. The document explores where public health should focus its efforts if it is to make an impact on improving the health of the population and addressing health inequalities. Well worth mulling over, as it will be the document that guides the sector for many summers to come.

Enjoy the summer break.



Progress on Meningococcal Disease Campaign Plans

Planning for an immunisation campaign against group B meningococcal disease is gathering pace at the Ministry of Health.

Clinical trials are well under way in south Auckland, meanwhile work on planning the pilot vaccination campaign, also in the south Auckland area, means the programme is starting to take shape.

Phase II of the clinical trials, involving around 300 8–12-year-olds from the south Auckland

suburbs of Papakura and Manurewa, started in October. These follow the completion of Phase I clinical trials in which 75 healthy adult volunteers participated. Formal evaluation of the adult clinical trials, which are being managed by Auckland University, will be completed early next year. Each clinical trial participant receives three injections, six weeks apart.

Pending further approvals, a pilot vaccination campaign is planned in the second half of next year. Counties Manukau District Health Board has

Thumbs up for BreastScreen Aotearoa

An independent report on BreastScreen Aotearoa (BSA), released in October, commends the quality systems in place to ensure the national breast screening programme provides the maximum benefit to New Zealand women.

The report follows a review carried out by British cancer screening expert Professor Jocelyn Chamberlain of the South West Wales Cancer Institute to assess any implications for the programme following last year's release of the Report of the Ministerial Inquiry into Cervical Screening Abnormalities in Gisborne.

In the report's summary Professor Chamberlain says, 'The quality of the [programme's] screening process is high and it is provided in a consistent way across all lead providers that is likely to maximise the benefit and minimise the harm.'

'The systems in place to safeguard against poor performance are comprehensive, and, although it is never possible to guarantee 100 percent "safety", the danger of an incident comparable to earlier screening failures in New Zealand is remote,' Professor Chamberlain says.

Professor Chamberlain also notes 'most of the recommendations of the Gisborne Inquiry Report, which apply in modified form to BSA, have already been implemented.'

National Screening Unit (NSU) Group Manager Karen Mitchell welcomed the report. 'Professor Chamberlain has provided a comprehensive assessment of the programme that followed a very thorough process of meetings with many of the key people involved in breast screening in New Zealand.'

Most of the report's 22 recommendations provide advice on operational aspects of the programme while others suggest further policy development.

'We will be working with the programme providers on addressing the issues raised. This work has already begun,' Ms Mitchell says.

The report finds that the principal constraint for the programme is the lack of a national population-based register. The Ministry of Health's New Zealand Health Information Service (NZHIS) is leading the Population Register Project and it is anticipated that the first stage of its development will be completed by mid-2003.

The report also recommends that consideration be given to the establishment of a seventh lead provider to relieve the very large workload in the BreastScreen Auckland and North (BSAN) region.

'The NSU is working with BSAN, DHBs and other local service providers to review the provision of

continues on page 14

presented the Ministry with a draft scoping report for the pilot, which the Ministry is now considering.

Director of the Meningococcal Vaccine Strategy, Dr Jane O'Hallahan, said the project was progressing well.

'Key areas the Ministry team is focusing on at the moment include the pilot project, exploring payment options for primary health care providers delivering the vaccine, talking with health professional groups and the school sector about their involvement in the project, and selecting a tenderer for the storage and transport of the vaccine.

'We are developing plans to ensure that those groups most at risk of meningococcal disease, and those groups and individuals least likely to access the vaccination, are immunised first. We have

developed a Māori Strategic Operational Plan, aligned with He Korowai Oranga and Whakatātaka, to ensure high coverage rates for Māori. We are also determining the workforce available to vaccinate under-20-year-olds,' Dr O'Hallahan said.

'Every month that goes by we hear about more deaths and people left with serious disabilities from this disease. This ensures the Ministry's MVS team stays focused and pushes ahead to plan the vaccination campaign as quickly as it is possible to do,' she said.

For further information visit www.moh.govt.nz/meningococcal or phone (04) 496 2000. If you are wanting information on the clinical trials, phone Auckland University on 0800 116 160.

New Appointments for Screening Programmes

Three new public health and clinical experts have been appointed to the National Screening Unit (NSU).

Dr Ashley Bloomfield has been appointed to the position of Public Health Leader for Screening Programmes, Dr Hazel Lewis has been appointed to the position of Clinical Leader for the National Cervical Screening Programme and Dr Madeleine Wall has been appointed Clinical Leader for BreastScreen Aotearoa. All three roles are newly established positions.

Within his new role Dr Bloomfield is responsible for delivering public health medicine leadership for both current and future screening programmes and for maintaining links overseas in order to identify international developments in screening.

Dr Bloomfield, who was previously Manager of the National Health Committee, brings strong public health leadership experience to the role, which will enable him to lead the strategic development of screening both within the Ministry and across the health sector. He will also be providing health screening advice to the Government and those in the wider sector.

NSU Group Manager Karen Mitchell welcomed the appointments as an important step forward in the development of screening in New Zealand.

Dr Ashley Bloomfield is a public health physician with hospital and general practice clinical experience and was previously Manager of the National Health Committee from March 2000 until October this year. He has also worked in academic, public health provider and health care funding organisations. Between 1999 and 2000 he was Executive Director of the New Zealand Guidelines Group, which is responsible for the development of evidence-based practice guidelines for the health sector.



'The two clinical leadership roles are responsible for providing clinical oversight and leadership for the programme teams within the NSU. The roles will lead the development of broad national policy and quality improvement processes for the respective programmes. They will also lead the development and maintenance of competency and expertise in screening across the sector and will liaise with programme service providers and professional groups.

'The establishment of the three roles effectively completes the design of the National Screening Unit. The unit was established at the beginning of last year and now has a team of 33 people responsible for the management and co-ordination of the two national screening programmes,' she said.

'The two clinical leaders have a more "hands-on" focus, working alongside the managers of the two programmes. In developing the two positions we took into account the advice of Dr Euphemia McGoogan, Scottish cytopathologist and advisor to the Minister of Health, who supported their establishment,' Ms Mitchell said.

The NSU is an autonomous unit within the Ministry of Health and is responsible for the management and co-ordination of the two national cancer screening programmes – the National Cervical Screening Programme (NCSP) and BreastScreen Aotearoa (BSA).

Dr Madeleine Wall is of Te Rarawa, Te Aupouri and Ngati Maru descent. She was previously Clinical Director for BreastScreen Central from the start of the programme in December 1998. She graduated in medicine from the University of Otago and is a trained radiologist.

In 1996/97 she served on the Breast Cancer Screening Policy Advisory Group, which advised the Government on policy and quality standards for BreastScreen Aotearoa.



Notifiable Diseases and Conditions Schedules Upgrade

The notifiable diseases and conditions schedules of the Health Act 1956 were last reviewed in 1996. The Ministry of Health has contracted Allen & Clarke, Policy and Regulatory Specialists to update the schedules and, in addition, to examine the systems around notification of diseases and conditions.

The project began in late November, and is due to be completed by the end of June 2003.

As part of the project, Allen & Clarke has established a project team and is in the process of establishing an expert reference group and subgroup to advise on data collection and management. Membership of these groups is yet to be confirmed, but will include Ministry of Health and public health service staff, local authority representation, Crown Research Institute staff, laboratory staff, general practitioners, data collection agency staff, researchers and New Zealand Health Information Service staff.

Extensive consultation will take place as part of the project, both in terms of any proposed changes to the existing schedules and in terms of notification systems. All Medical Officers of Health, Health Protection Officers and allied

staff will have the opportunity to comment on a discussion document, which is due out in March 2003. However, you are welcome to provide comment or contact Allen & Clarke with any questions regarding the project at any time.

The project team includes:

Matthew Allen	Project Leader
Brigid Borlase	Lead Analyst
David Clarke	Solicitor
Dr Nigel Dickson	Technical Advisor
Mike Copeland	Economist

Medical Officer of Health and Health Protection Officer representation is currently being arranged.

For any more information on the project, please contact:

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Dr Hazel Lewis is a public health physician with over 20 years' experience. She has a special interest in women's health, in particular sexual and reproductive health, and has worked in both the provider and policy areas. She also holds the position of National Advisor, Public Health for the New Zealand Family Planning Association and continues to hold regular family planning clinics.

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Establishment of Scholarship Scheme and New Public Health Intelligence Applications Laboratory

Recently, Public Health Intelligence and Victoria University of Wellington launched the Public Health Intelligence Applications Laboratory (PHIAL) and the 'Scholarship Opportunities in Statistics' scheme.

The laboratory will combine the analytical strengths of Public Health Intelligence and the university in health geoinformatics to enhance the capacity for assessing and monitoring regional populations in a public health context. It will provide the opportunity for postgraduate students to participate in collaborative analysis for Public Health Intelligence and will also provide the opportunity for PHI staff to work with their peers at Victoria University.

The postgraduate and undergraduate scholarships in statistics are being offered as part of our development of the workforce and to encourage the applied analysis of public health topics (eg, the data from the health survey programme).

New Discussion Paper Seeks Comment Continued from front page

- **People with communicable conditions who pose risk to others.** Powers under the present Health Act in relation to people with communicable conditions and who pose significant risk to others will be continued but with increased safeguards. As a last resort, orders could be made by a court for detention or isolation.
- **Contact tracing.** Should the Public Health Bill include provisions for contact tracing – if so, what should they include and to which conditions should they apply?
- **Border health protection.** Key questions include the scope of the Bill, and whether to de-emphasise the current distinction between quarantinable and non-quarantinable diseases.

Some common themes and questions underlie many of the proposals in the paper. They include:

- How can we implement values for the good of the community and for

protecting public health while recognising and enhancing values relating to privacy and personal freedom?

- How can we provide clear guidance for public health action today while also allowing for needs, health concerns, health solutions and technologies that do not yet exist?
- How can we continue to enable action on communicable disease management and environmental health while also establishing a framework for addressing the causes of non-communicable conditions?

The closing date for submissions is Friday 28 March 2003. Submissions from all in the public health community and other sectors are most welcome and indeed essential!

Copies of the paper can be downloaded from the Ministry of Health website: www@moh.govt.nz; otherwise email phb@moh.govt.nz or ring Gabrielle Baker for a copy (04) 495 4377.

Campaign Encourages Women to Have Regular Mammograms

A series of new television advertisements, which address some commonly held concerns preventing women from having regular mammograms, are part of a campaign aimed at encouraging women aged 50–64 to enrol with BreastScreen Aotearoa.

The campaign, which began in September, uses television, radio and magazine advertising to remind eligible women that early detection through regular mammograms offers the best chance of successful treatment.

National Screening Unit spokesperson Sally Hughes says there are a number of factors that are commonly cited as reasons that some women do not have screening. These include a fear that mammograms are painful, shyness about the procedure and the time it takes to have a mammogram.

'The campaign will seek to address these fears by presenting a range of women from different backgrounds who have had mammograms and who talk about both their anxieties and then the realities of their experience,' Ms Hughes says.

The advertising also aims to encourage family and friends to support eligible women to access regular mammograms.

'For many women in the eligible age range, thinking of the health of family and friends comes before thoughts of their own wellbeing. One of the aims of this campaign will be to remind people for whom women in the 50–64 age range are their mothers, sisters, friends and grandmothers that their encouragement can be an important factor in their loved ones choosing to have a mammogram.

'New Zealand women have shown strong support for BreastScreen Aotearoa since it began in December 1998. In the two years to July 2002 more than 58 percent of eligible women have had mammograms through BreastScreen Aotearoa. During the same period 1184 cancers were detected through the programme.



National Screening Unit spokesperson Sally Hughes at the launch of the campaign



Example of the magazine advertisement

'The challenge now is to ensure that those women in the eligible range who have not yet begun to have regular mammograms are aware of the programme and the facts about mammography. The campaign will also focus on increasing participation among Māori and Pacific women.

'We're also keen to ensure that those eligible women who use private screening programmes are aware that mammograms with BreastScreen Aotearoa are free.'

Women aged 50–64 (inclusive) are encouraged to ring the BreastScreen Aotearoa free phone line (0800 270 200) for further information about the programme or to enrol for a mammogram.

Dr Barry Borman

Newly Appointed Chair of ICBDMS

Dr Barry Borman, Public Health Intelligence Section Manager, was elected as Chair of the International Clearinghouse for Birth Defects Monitoring Systems (ICBDMS) at its recent Annual Meeting in Atlanta.



Preceding the annual meeting a two-day conference (attended by more than 900 people) organised by the Centers for Disease Control and Prevention (CDC) to celebrate the 10th anniversary of the US Public Health's Recommendation on Folic Acid and the opening of the new National Center on Birth Defects and Developmental Disabilities. Following the conference a collaborative scientific meeting was held between the ICBDMS and the North American Network of Birth Defect Monitoring Programmes (attended by about 250 people).

The ICBDMS, which has its headquarters in Rome, was founded in 1974 to encourage an international exchange of data and to encourage collaborative

research in birth defects. Regular reports, newsletters and an annual report are produced (see www.icbd.org).

New Zealand became a full member of the ICBDMS in 1977 and Barry has been the Programme Director since 1988.

Currently, there are 36 member programmes representing 34 countries. The programmes monitor the occurrence of birth defects in about

three million births per year. The programmes are diverse, varying with local conditions and with the availability of personnel and other resources. Some programmes are nationwide, population-based and mandated by legislation; others are organised as local, hospital-based research programmes.

ICBDMS monitors the occurrence of births with multiple malformations and possible associations between defects and drug exposure during pregnancy.

Achieving Health for all People: Whakatutuki te oranga hauora mo nga tangata katoa A Framework for Public Health Action

The public health plan was mailed to public health providers and key stakeholders in late November.

The plan will be trialled by DHBs and public health service providers over the next six months. During that time the Ministry will be seeking feedback from users of the plan about ways of making the final plan a useful resource to all those involved in public health.

The team involved in the development of the plan sincerely thank all those who have been

involved in any way with its development, those who made submissions, attended meetings or took part in the sector reference group.

Additional copies can be obtained from the Ministry of Health and can also be downloaded from the Ministry's website www.moh.govt.nz. Also available on the website are supporting documents such as the analysis of submissions.

For any enquiries about how to access the plan please contact Joanna Bourke-Vete on joanna_bourke-vete@moh.govt.nz or phone (09) 580 9107.

Environmental Health Action Plan

The Ministry of Health and the Institute of Environmental Science and Research Limited (ESR) are working on the development of an Environmental Health Action Plan, to take us into the next decade in environmental health policy and programmes. The current environmental health planning framework is primarily based on work undertaken in the early and mid-1990s.

The foundation of the current environmental health programme is the work done in the early 1990s, which identified drinking-water as the highest priority for the Ministry's environmental health programme and which led to the development and implementation of the drinking-water strategy.

From 1993–95, the Public Health Commission developed a public health strategic plan with goals and objectives and some targets. The commission also developed a Māori health strategic plan (He Matariki), which includes reference to te ao turoa.

'Te ao turoa (the physical, social and spiritual environment) has an impact on the overall wellbeing of Māori. For example, the loss of mahinga kai (traditional food gathering areas), the desecration of wai tapu, pollution of coasts, rivers and lakes and the decline in certain traditional food species through overuse, have all had an impact on the wellbeing of whānau, hapu and iwi.'

In the environmental health area, the Public Health Commission prepared policy advice papers on water quality, hazardous substances, food safety, local environments, school health, fluoride and oral health. These included policy, programmes and research/information recommendations but, because of the structural arrangements at the time, the commission did not include regulatory services in their consideration of issues.

One of the New Zealand Health Strategy's 10 goals is a healthy physical environment. The strategy includes objectives relating to housing, transport, food security, drinking-water, sanitation and environmental hazards but the 13 population health objectives (or priorities) to focus

on for action in the short to medium term are only indirectly related to environmental health. The Ministry has also published *Strengthening Public Health Action* (Ministry of Health 1997), which builds on the Public Health Commission's strategic direction and which develops the goals and objectives for environmental health that the commission prepared.

This year the Public Health Advisory Committee released its report on *The Health of People and Communities: The effect of environmental factors on the health of New Zealanders*, which includes recommendations for environmental health policy and programme development.

The Public Health Directorate of the Ministry of Health is working on *Achieving Health for All People: A Framework for Public Health Action* that is likely to include an objective 'to promote healthy communities and environments'.

Environmental health 'strategy'

Because the strategic framework and plans of the 1990s are largely implemented, it is timely to review and revise the strategic planning for environmental health. ESR has been contracted to support the Ministry in developing an Environmental Health Action Plan. ESR is running the plan development process, including conducting a workshop and discussion processes, and will prepare a draft consultation document.

The draft purpose of the plan is:

To provide the strategic and operational direction for Environmental Health activities in New Zealand for 10 years.

The aim is to set and achieve health outcomes within a 10-year timeframe. The plan will fit under the New Zealand Health Strategy and will address environmental health-related goals. It also draws on the other strategic documents discussed above, as well as on international examples (eg, EnHealth Council).

The plan will allow agencies such as the Ministry of Health, public health services, District Health

continues on page 10

Boards, ESR and local government to plan resources and capabilities and to provide a sense of purpose to show how activities are contributing to improved health status. The plan will be operationalised largely through the Ministry's work plan, ESR work plans and public health services. The plan will also provide a framework for the broader sector and will identify where agencies fit into the environmental health picture.

The process for development of the plan must include health agencies and other agencies to ensure first that environmental health issues are identified and, second to identify opportunities to respond to issues.

In summary, the process will focus on the following themes:

- gaining support and commitment through inclusiveness
- learning from past experience
- understanding environmental health issues now and in the future
- identifying opportunities to respond to issues.

There will be a number of workshops, focus group meetings and interviews conducted between now and June 2003. The timetable for interviews and workshops will evolve as interviews progress. If interviews indicate a considerable range of views and opinions about the plan by the key stakeholders then it is possible that both the interview and workshop timetable will need to be extended to ensure we have an understanding of most of the Environmental Health Plan picture. Again, if the interviews indicate considerable diversity, then the workshop format will need to be adjusted to suit. The consultation will culminate in the release of a draft plan for formal consultation after 1 July 2003.

Following receipt and analysis of comments and submissions on the draft plan it will be amended and finalised.

Māori to Retain Control of Cervical Screening Data

The National Kaitiaki Group, established under health regulations in 1995, will continue to consider all applications for access, use and publication of aggregate Māori women's data on the National Cervical Screening Programme register.

In addition, improved processes will be put in place so that the National Screening Unit (NSU) can more easily access the data for the purposes of auditing. The decision followed a review of the 1995 Kaitiaki Regulations. The review was one of the recommendations of the Gisborne inquiry into the under-reporting of cervical smear abnormalities.

Women's Affairs Minister Ruth Dyson said it is important to Māori women that their data held on the register is treated appropriately and used in a way that benefits tangata whenua.

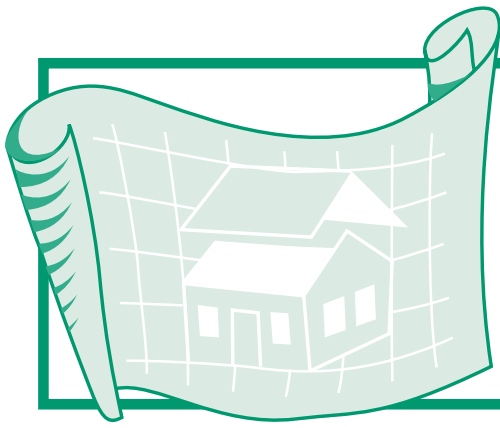
'This decision balances protection of that data with the need to use it to monitor and evaluate the National Cervical Screening Programme to ensure it is safe and effective for Māori women.'

Ms Dyson said the decision followed nationwide consultation with Māori women and the release of a discussion document that sought comment on four options ranging from retaining the existing system to repealing the regulations and dissolving the National Kaitiaki Group.

'In making its decision, the Government has listened to Māori women and their whānau. Most submissions supported the status quo, along with improved processes, so that the National Cervical Screening Programme can better access the data.' The Government also noted that the programme would benefit from the establishment of an advisory group of Māori women to provide advice on screening issues.'

Ms Dyson announced the decision at the Māori Women's Welfare League's September annual conference in Gisborne.





Leaky Buildings and Potential Health Effects

Background

On 31 August 2002 the Building Industry Authority (BIA) released the *Report of the Overview Group on the Weathertightness of Buildings to the Building Industry Authority*. One of its recommendations was that the BIA work with the Public Health Directorate of the Ministry of Health to resolve how potential health risks associated with fungal decay can be identified and to provide information on precautions that need to be taken when removing cladding. The Ministry has provided information to the BIA and to public health services so they can respond to public concerns among their local communities. The Occupational Safety and Health Service (OSH) has also developed a comprehensive information bulletin on health effects and precautions for builders and contractors in consultation with health officials.

Moulds and human illness

Moulds and other fungal spores are ubiquitous. They can be isolated from both indoor and outdoor air as well as from soils and water bodies. Mould spores are carried by the wind and will grow in any suitable conditions. Some of the moulds in houses cause wood rotting; others merely grow on damp surfaces.

Any conditions that lead to dampness in buildings can give rise to elevated levels of moulds. Common causes are condensation due to unflued gas heaters and cookers, tumble driers, poor ventilation and cold spots due to poor insulation, which is why moulds are often found on the inside of outside walls. Leaky buildings are obviously another potential source of dampness.

Leaky buildings reflect a number of problems with building detailing, specification or construction. While most moulds are harmless to healthy individuals – and some are an essential component of foodstuffs, such as blue cheese – dampness and mould growth in buildings have been traditionally associated with poor health.

A number of Scottish and Welsh studies concluded that in houses with elevated levels of moulds adults demonstrated increased symptoms of nausea, vomiting, blocked nose, breathlessness, wheezing, backache, fainting and bad nerves and emotional reactions. Children suffered more than usually from aches, pains, diarrhoea, headache, vomiting, sore throats, coughing, fever and respiratory symptoms.

Fungi are ubiquitous throughout the environment and there are many moulds/fungi that cause health effects, although few cause severe systemic disease. For example, fungi may cause superficial skin infection such as ringworm or athlete's foot, mucous membrane infections such as candidiasis (thrush), lung infections such as aspergillosis and serious infections such as endocarditis (an infection surrounding a heart valve) or brain abscess. Systemic fungal infections are more likely to occur in people whose immune systems are suppressed (due to infections such as the human immunodeficiency virus) or who have chronic illnesses such as diabetes. A fungus may also produce a toxin that is harmful, such as the mould *Stachybotris chartarum*.

Stachybotris sp, found in buildings with damp and mould, has been suggested to be a cause of sick building syndrome and is linked to the building inhabitants/workers complaining of eye and nasal irritation, fatigue and other symptoms. However, many different moulds grow in damp buildings and do not cause illness. Investigation following an outbreak of severe illness with pulmonary haemorrhage in young children in Cleveland, Ohio, suggested *Stachybotris sp* may be implicated, but this has not been proven. Research and information about fungi as pathogens will continue to emerge.

The national reference mycology laboratory at Auckland Hospital has confirmed that they are unaware of confirmed human cases of illness from exposure to *Stachybotris* in New Zealand. There is, however, no formal surveillance system as this is not a notifiable disease.

Kaipara Eradication Programme Kicks Off



Survey team member searching SSM habitat for larval samples

On 24 October 2002, Hon Marian Hobbs, Associate Minister for Biosecurity, signed the exemption to the Resource Management Act, which permitted the southern saltmarsh mosquito (SSM) eradication programme to commence in the Kaipara Harbour.

Eradication operations started almost as soon as the ink dried, with helicopters, quad bikes and groups of 'foot sloggers' flying, driving or trudging over the SSM habitat areas to deliver the treatment product, a benign insect growth regulator, s-methoprene. This campaign of treatment is scheduled to continue for two full summers by which time it is anticipated that if all goes to plan, the mosquito will be eradicated in the Kaipara Harbour.

A massive effort has been put into the preparation of the eradication programme. Over the past 12 months the Ministry's contractors, New Zealand Biosecure, have been heavily engaged in preparatory work, which has included:

- extensive surveillance to locate, identify and map saltmarsh mosquito-infested sites
- continued control of the species with a larvicide (*Bti*) to keep the biomass suppressed below nuisance level in the Kaipara Harbour
- recruitment and training of additional staff to work on the eradication programme
- extensive public education of stakeholders to inform them of the programme and its impact.

Operationally, the project is very challenging. A major impediment has been the poor land communications in the region. The use of light helicopters to move survey staff rapidly around the location has overcome this obstacle. The programme will be using a range of 'tools' to eradicate the mosquitoes in a framework of 'Integrated Mosquito Management'. Larvicide will be used to supplement the growth regulator s-methoprene.

'Desolate Moonscape' Contract Won by NRL

It's hard to find a good reason to make a trip to Mauritania according to The Lonely Planet guide on the internet, which describes the West African country as, among other things, 'one of the least trodden spots in the world' – but that hasn't stopped the National Radiation Laboratory (NRL) in Christchurch.

It's been awarded the contract by the Comprehensive Test Ban Treaty Organisation (CTBTO) to survey the country for the best location to place one of the 80 radionuclide stations being set up around the world to monitor the treaty.

The Comprehensive Test-Ban Treaty (CTBT), to which many countries including New Zealand are signatories, is seen as a major step towards

the curtailment of nuclear weapons production, and eventual disarmament. The treaty can only be effectively implemented, however, if there is a monitoring system in place to verify that weapons testing is in place, and if it does occur, to identify the violator.



Martin Gledhill and Nanette Schleich

Because of this need, the CTBTO is setting up 321 stations in an International Monitoring System (IMS) to track any violations. It uses four

Methamphetamine – Reclassification and Action Plan

In the past two to three years the prevalence of methamphetamine in New Zealand society has increased dramatically.

Police and Customs officers have been seizing more methamphetamine than ever before and the police have encountered increasing numbers of clandestine methamphetamine production labs in the past three years.

The rate of arrests and incarcerations on methamphetamine-related offences has also increased dramatically in this time. All these indicators point to the rise of methamphetamine as a drug of serious concern in New Zealand.

In response to these developments two courses of action have been followed: reclassification of methamphetamine as a Class A drug and the development of an action plan on methamphetamine by interested agencies.

In June this year the police wrote and presented a paper to the Expert Advisory Committee on Drugs (EACD) proposing an increase in the

classification of methamphetamine to give powers to the police to search and seize without a warrant. The EACD made a recommendation to the Minister to reclassify methamphetamine as a Class A drug. The Government is expected to consider this matter in the near future and this may lead to further consideration by the Health Select Committee.

To complement the reclassification the National Drug Policy team is leading a working group, consisting of the police, the Ministries of Social Development and Justice, the New Zealand Customs Service, Te Puni Kōkiri and the National Drug Intelligence Bureau to develop an action plan to deal with methamphetamine issues with a whole-of-government approach. The Methamphetamine Action Plan is expected to be in operation at about the same time as the reclassification comes into force.

technologies; radionuclide, seismological, hydroacoustic and infrasound. The NRL has been playing a significant role in setting up the IMS.

‘Our laboratory carried out the first survey for a radionuclide station in 1998 in the Chatham Islands, and since then the methods and protocols have been adopted by the CTBTO as standard,’ said Jim Turnbull, Group Manager for the National Radiation Laboratory.

As well as in Kaitaia, surveys for radionuclide stations have since been carried out by the NRL in Rarotonga, Fiji and Kiribati, as well as a survey for an infrasound station on the Chathams. The latest contract is the first outside of the Pacific, in a key location for the IMS.

‘While Mauritania is rather an “exotic” location for a monitoring site, it’s also strategically very important, being both on the edge of the Atlantic Ocean and the Sahara Desert. The Sahara has of course already been used by the French for weapons testing in the past,’ said Mr Turnbull.

The \$70,000 contract to carry out the work was contested internationally, and was awarded to the NRL. Two senior scientists from the laboratory, Martin Gledhill and Nanette Schleich will travel to Mauritania in January next year.

‘Given the logistical necessities, such as access to electricity, line of sight to satellites, security, and ease of access, we have identified the airport as the most likely site. Both scientists will work there for a week or so under the jurisdiction and supervision of the local army, although we are advised there are no safety issues at present.’

The local army will likely also arrange the collection of scientific equipment in order to avoid customs and border problems. Samples from the site will be brought back to New Zealand for analysis of background radiation in the soil and atmosphere, in order to determine if the site meets criteria for selection for a CTBTO monitoring station.



Suicide Prevention Programmes in Schools

All school principals and boards of trustees have been advised by the Ministries of Youth Affairs, Education and Health to be cautious when inviting youth suicide prevention programmes into their schools.

This action has arisen out of concerns expressed by a range of individuals (including mental health promoters, mental health clinicians, researchers and schools) about the lack of demonstrated safety and effectiveness of some youth suicide prevention programmes being delivered in schools.

The Ministries' joint letter to schools provided information about recommended approaches to suicide prevention in schools, how to select safe programmes and where to get further information.

The information has been provided to ensure student safety is being assured. It emphasises that any programme that aims to promote good mental health and help-seeking or to prevent suicide must be able to demonstrate it is safe, evidence-based and effective. For example, research has shown that programmes that raise awareness about suicide can actually increase the risk of suicidal behaviour amongst some people.

Schools are also being reminded about key resources such as the school guidelines *Young People at Risk of Suicide: A Guide for Schools*, *Mental Health Matters* resources and information provided by SPINZ (Suicide Prevention Information New Zealand).

This advice has also been copied to public health units, child and youth mental health services and others who work closely with schools to provide mental health promotion programmes or services for young people at risk of suicide.

An independent report is also being commissioned by the Ministries of Youth Affairs, Education and Health to review the evidence relating to school-based suicide prevention programmes to outline criteria around safety and effectiveness and then to assess some prominent community-based programmes against these criteria. This report will be forwarded to schools in 2003.

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www.spinz.org.nz

Thumbs up for BreastScreen Aotearoa

continues from page 3

services in this region and identify options to address issues related to the screening workload. The unit has also been working closely with local providers to address recruitment issues in the region to further increase the number of women accessing this free service.'

BreastScreen Aotearoa was established in December 1998 and is now in its fourth year. In the last 24 months to June 2002, 176,165 women were screened in the programme, which is 58.4

percent of the eligible population. During the same period BreastScreen Aotearoa detected 1184 cancers.

'The commitment and dedication of all the people who work in BreastScreen Aotearoa is the key factor in the programme's success to date,' Ms Mitchell says.

The review of BreastScreen Aotearoa took place in February and March 2002 and followed a recommendation by Professor David Skegg of the University of Otago that called for BreastScreen Aotearoa to be evaluated against the Ministerial inquiry recommendations.

Ministry of Health v James McNee

1,4 Butanediol Prosecution

by Geoff Owen, Senior Advisor (Enforcement)

The arrest of James McNee in June 2001 was the culmination of a six-month investigation by Ministry of Health enforcement officers (assisted by Timaru Police) into the distribution of 1,4 Butanediol (a precursor to GHB or 'Fantasy') by Mr McNee and an Auckland associate.

The catalyst for the investigation was the admission of three men to Auckland Hospital over the weekend 26–28 January 2001 – suspected of having overdosed on 1,4 Butanediol while attending an Auckland nightclub.

Since mid-1999, specialists in the Department of Emergency Medicine and the Department of Critical Care Medicine at Auckland Hospital have treated increasing numbers of patients who present with toxic effects, known to be due to the ingestion of 1,4 Butanediol and the active compound to which it is metabolised within the body, Gamma Hydroxybutyrate (GHB or GBH), commonly referred to as Fantasy, Liquid Ecstasy and a large number of other street names.

GHB, GBL and 1,4 Butanediol are toxic, addictive and potentially lethal substances. There is no evidence to support claims of efficacy of these agents for many conditions. The only indication for their use may be in a tightly dose controlled fashion for the medical treatment of a rare medical condition, narcolepsy. They have potential for serious harm when ingested out of a medically controlled setting.

These substances are ingested because they induce a rapid onset of euphoria (15 to 60 minutes) and are not as costly as most other substances, which give the same effect. Consequently they are very popular among young people, particularly at parties, nightclubs and 'raves' and by those who cannot afford more expensive substances.

In January 2001 initial seizures of various quantities of 1,4 Butanediol, which was being sold in bottles as a CD cleaning solution and in sachets as a dietary supplement, were made at the Timaru home of James McNee.

After that time, Mr McNee made various public statements, despite the Ministry of Health's general health warning and the public reaction. TV One's 60 Minutes current affairs viewers were treated to a shot of him consuming his own product followed by inappropriate comments that his sales had increased as a result of two events; the January visit by Ministry of Health and police officers and the tragic death of Auckland man, Shawn Brenner, from what is believed to be attributable to the ingestion of 1,4 Butanediol.

Then in June 2001 an 18-year-old man was admitted to Dunedin Hospital having become comatose from ingesting 1,4 Butanediol the previous evening. Dunedin Hospital medical staff were extremely concerned for the teenager's health, given the severe and prolonged nature of his unconsciousness.

This event, combined with Mr McNee's continued media statements, led to a second search warrant being executed at his Timaru address on 21 June 2001, when more bottles of 1,4 Butanediol were seized. His police arrest followed.

The prosecution finally concluded in the Christchurch District Court on 3 September 2002, when he was sentenced to 250 hours community service and ordered to forfeit all the seized 1,4 Butanediol. In determining the sentence a number of factors were taken into account including the Court recognising that the Ministry of Health is often restricted by legislation when dealing with this type of behaviour.

What's changed now?

The substances are now Class B controlled drugs so the full weight of the Misuse of Drugs Act can now be applied. This gives police greater powers to deal with the manufacture, sale and supply of the substances. While some young people continue to abuse the substances, a number will be deterred because it is now clearly illegal to use them.

Acknowledgements

Medical information [extract] provided by Dr Gill Hood, Intensivist, Department of Critical Care Medicine, Auckland Hospital.

The running shoes were hung by the back door with care, in the hope that their owner soon would be there ...

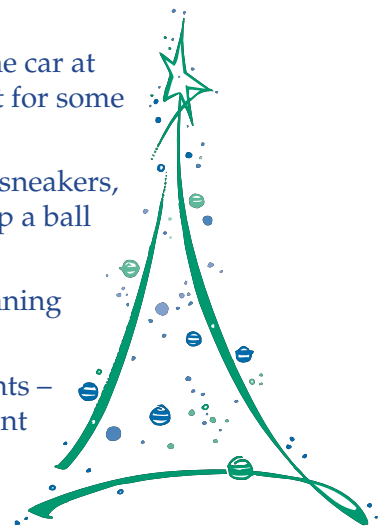
Dr Harriette Carr, Senior Analyst, Public Health Policy has some suggestions for a happy and healthy Christmas break.

We all know that we should be physically active, but at Christmas it is far too easy to come up with excuses not to be active. Christmas is a busy, often stressful period, when our usual routines are disturbed. There are Christmas parties, barbeques, Christmas shopping, school holidays and long summer days. Then there are the New Year resolutions, when we make promises to ourselves that become distant memories by mid-January.

However, it is possible to both enjoy, and indulge a little over Christmas while maintaining some form of activity. Here are a few tips (variations on past and present public health messages) so you can have your cake and eat it over Christmas ...



- ★ If you drink then drive, you are a bloody idiot – so walk instead.
- ★ Feeling stressed and down and need a lift – take the stairs instead and things will start looking up!
- ★ Food for thought? Go for a walk before dinner and think about the yummy food to follow...
- ★ 5+ a day – why not adopt this for flights of stairs as well as for fruit and vegetables.
- ★ Put some bounce in your day – jump out of bed in the morning.
- ★ Don't be a fool, obey the 10 minute rule (with apologies to LTSA and their 2 second rule) – Three lots of 10 minutes of moderate activity a day should help keep your heart pumping.
- ★ Burning the midnight oil? Try burning calories instead.
- ★ Feeling tired/tired? Leave the car at home and try walking – great for some sole/soul searching.
- ★ Slip, Slop, Slap: slip on some sneakers, slop on some clothes, and slap a ball around.
- ★ Running out of time? Try running faster.
- ★ Christmas is a time for presents – there is no time like the present for being active.



The Youth Health Action Plan

Youth Affairs Minister John Tamihere launched *Youth Health: A Guide to Action*, early in November, to a rap performed by youth at the Manukau Youth Centre.

The plan, which was produced by the Ministry of Health in consultation with the Ministry of Youth Affairs, proposes a shift in the way the health sector regards young people. It values youth as key players in achieving good levels of health and wellbeing and that means involving them in service design, policy development and enabling their views to be heard.

The plan is the first sector-specific action plan to implement the Government's youth development approach which recognises that youth wellbeing depends on healthy connections with whānau, schools, peers, work, training, culture and environment.

A copy of the plan is available from Wickliffe (see page 5 for contact details).

