

NEW ZEALAND HEALTH STRATEGY

DHB TOOLKIT

# Minimising Alcohol and Other Drug Related Harm

*To minimise the harm  
caused by alcohol, illicit and other drug use  
to both individuals and the community*

**2001**



Edition 1: October 2001

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# Executive summary

## **Objective: To minimise harm caused by alcohol and illicit and other drug use to both individuals and the community**

This toolkit is designed to assist District Health Boards (DHBs) to implement the New Zealand Health Strategy (NZHS) priority population health objective:

*‘(to) minimise harm caused by alcohol and illicit and other drug use to both individuals and the community.’*

The Public Health Directorate of the Ministry of Health has led the toolkit development, with expert drug and alcohol input in primary care, secondary/tertiary care and public health. This toolkit also has links to toolkits in several other NZHS priority areas.

A substantial range of existing work forms the policy context in the alcohol and drug area. The *National Drug Policy* [www.ndp.govt.nz](http://www.ndp.govt.nz) and National Mental Health Strategy form the alcohol and drug policy framework. Sitting under these are the *National Alcohol Strategy* <http://www.alcohol.org.nz> and *Strategic Framework for Alcohol and Drug Services*, among other documents.

Substance abuse causes significant harm to the health of New Zealanders. The most widely used drugs, alcohol and tobacco (tobacco is covered in a separate toolkit), account for the majority of that harm. As the NZHS identifies, at some time in their life nearly one in five New Zealanders will suffer an alcohol use disorder. Much of the harm from alcohol use in New Zealand is a consequence of heavier drinking occasions. This harm includes deaths and injuries resulting from drunk driving, drownings, and violence both within and outside the home. Alcohol abuse also contributes to some types of cancer, stroke, heart disease, mental health conditions, suicide, and is associated with offenders.

Daily or near daily use of cannabis over years, puts users at greatest risk of adverse health consequences such as: respiratory diseases including the possibility of cancers, subtle cognitive impairment, psychotic symptoms among vulnerable individuals, and dependency. By age 21, 9 percent of the population are expected to be dependent on cannabis. Injecting drug use produces serious risks to individuals and society including overdose, blood-borne disease, and crime to support dependence. About 45 percent of all identified injecting drug users are infected with hepatitis C.

The NZHS emphasises the need for health policy to reduce inequalities between those population groups with the poorest health status, and particularly Maori and Pacific peoples. Priorities should be set according to need, with benefits to be gained when services are targeted or adapted to specific population groups. Further information is available on the Ministry’s work on [reducing inequalities in health](#).

A comprehensive, intersectoral approach to reducing drug and alcohol-related harm is advocated. This involves a co-operative approach from DHBs, with all relevant government agencies and non-governmental organisations. DHBs should instigate interventions across the full framework of primary care, secondary/tertiary care and public health. People have diverse health needs, using various services from different providers in different settings, sometimes at the same time. Thus for people to achieve the best package of care and to avoid service duplication, co-ordination within and between services is necessary.

Key recommended interventions for reducing alcohol and drug-related harm, for DHBs to implement and support are categorised in this toolkit under primary, secondary/tertiary, and public health. Supporting information relating to each intervention is also provided.

# Introduction

The New Zealand Health Strategy (NZHS) has identified 13 priority areas as a focus for improving population health. District Health Boards (DHBs) will be required to report annually on progress towards each of these priority areas. The Minister of Health will then report to Parliament on overall progress in these areas (New Zealand Public Health and Disability Act 2000 s 8(4)).

This toolkit specifically addresses the priority area:

*‘minimise harm caused by alcohol and illicit and other drug use to both individuals and the community.’*

**Drugs**, as discussed in this toolkit, cover alcohol, all illicit recreational substances, prescription drugs that may be abused and other drugs such as solvents. [Tobacco](#) is covered by a separate toolkit.

This toolkit provides:

- evidence-based guidelines on the best way to achieve health gain by minimising alcohol and other drug related harm
- information on the policy context, current governmental strategies/plans and key reference documents on minimising alcohol and other drug related harm.

This toolkit is designed to assist DHB personnel, particularly those in the purchasing arms of DHBs, to implement the objectives of the National Health Strategy. It should help development of service specifications but should not be considered a service specification itself.

## Development of the toolkit

The lead agency for developing this toolkit was the Public Health Directorate of the Ministry of Health. It was developed in conjunction with the Mental Health and Personal and Family Health directorates of the Ministry, with input from an external advisory group comprising alcohol and drug related expertise in primary health, secondary/tertiary health and public health.

## Linkages

This toolkit overlaps with a number of other NZHS priority areas, in particular:

- to reduce smoking
- to reduce the rate of suicides and suicide attempts
- to reduce the incidence and impact of cancer
- to reduce the incidence and impact of cardiovascular disease
- to reduce violence in interpersonal relationships, families, schools and communities
- to improve the health status of people with severe mental illness
- to reduce obesity.

# Background

## Existing work

Various strategy documents and plans forming current Government policy (referenced at Appendix 2), which are completed or in draft, relate to minimising alcohol and other drug related harm. Several refer to or are directed at specific population groups. They include:

- the *National Drug Policy* <http://www.ndp.govt.nz/moh.nsf/indexcm/ndp-policyactionplans-home>
- *Looking Forward: Strategic Directions for the Mental Health Services*
- *Moving Forward: The National Mental Health Plan for More and Better Services*
- the *National Alcohol Strategy* <http://www.alcohol.org.nz>
- *A National Strategic Framework for Alcohol and Drug Services*
- the *Blueprint for Mental Health Services in New Zealand*
- the *National Mental Health Funding Plan 1998–2002*
- *He Nuka mo nga Taitamariki*, a national workplan for child and youth mental health services
- *Tuutahitia te wero: Meeting the challenges*, Mental Health Workforce Development Plan 2000–2005
- the Maori Mental Health Strategy, *Towards a National Maori Mental Health Strategy*, draft discussion document.
- the Mental Health Promotion Strategy, *Building on Strengths, a Springboard for Action: a new approach to promoting mental health in New Zealand/Aotearoa*, Consultation Document.
- the *New Zealand Strategic and Action Plan for Public Health*
- the [Maori Health Strategy](#)
- the [Pacific Health Action Plan](#)
- the Youth Health Strategy
- the [Health of Older Peoples Strategy](#)
- the Primary Health Care Strategy

## Policy context

The policy framework for action to address alcohol and drug related harm in New Zealand is set by:

- the [National Drug Policy](#) (NDP), released by the Ministry of Health in 1998
- the National Mental Health Strategy (NMHS), as expressed in the documents *Looking Forward: strategic directions for the mental health services* (Ministry of Health 1994) and *Moving Forward: the national mental health plan for more and better services* (Ministry of Health 1997).

Both the NDP and NMHS are covered in further detail below. Developing and implementing the NDP was a key strategic direction arising from *Moving Forward*. These strategies link to the Mental Health Commission's (1998) *Blueprint for Mental Health Services*, which quantifies the developments required to implement the National Mental Health Strategy.

The other government strategies and plans listed above ('Existing work') also form the policy context. Two particularly important strategies sitting respectively under the NDP and NMHS are

the *National Alcohol Strategy* and the *National Strategic Framework for Alcohol and Drug Services*, both outlined further below. Figure 1 provides an overview of the policy context.

### *National Drug Policy*

[www.ndp.govt.nz](http://www.ndp.govt.nz)

The NDP, co-ordinated by the Ministry of Health, is a comprehensive, intersectoral strategy to reduce all drug-related harm. It uses a three-pronged approach of:

- supply control (limiting the availability of drugs) eg, through law enforcement
- demand reduction (reducing the desire to use drugs) eg, through education programmes
- problem limitation (mitigating the harm already occurring from drugs) eg, through treatment services.

The NDP's overall policy goal:

*'... as far as possible within available resources, is to minimise harm caused by tobacco, alcohol, illicit and other drug use to both individuals and the community.'*

Intersectoral collaboration is modelled and achieved under the NDP by means of the Inter-Agency Committee on Drugs (IACD), comprising relevant social policy and law enforcement agencies, and the Ministerial Committee on Drug Policy (MCDP), comprising relevant Ministers. The IACD ensures policies and programmes are consistent and mutually supportive across government agencies. It develops policy and makes recommendations to the MCDP. The MCDP reviews progress on implementing the NDP and recommends new policy initiatives to Government.

The NDP is based on a 'harm minimisation' approach. It aims to reduce the overall impact of any adverse health, social and economic consequences of drug use to the individual or society, without necessarily attempting to totally eliminate drug use.

The NDP is not an 'A to Z' action plan of how New Zealand will act to reduce drug-related harm. Rather it provides a framework under which action can be taken to:

- improve co-ordination and collaboration among agencies to reduce drug-related harm
- identify and quantify drug-related problems
- raise the profile of actions to reduce drug-related harm
- identify areas where services or activities are lacking
- set priorities for action
- implement measures to reduce drug-related harm.

### *National Alcohol Strategy*

<http://www.alcohol.org.nz>

The National Alcohol Strategy (NAS) forms an important subset of the NDP. It provides a set of strategies to achieve the alcohol-related targets listed under the NDP. In the words of the NAS:

*'The New Zealand Health Strategy sets the focus, the National Drug Policy tells us where we want to get to, while the National Alcohol Strategy is a more detailed 'road map' of how to get there for alcohol.'*

The six parts of the NAS cover the following:

- introduction to the strategy

- a discussion and overview of key alcohol issues, including patterns of consumption, types of alcohol-related harm, and groups at risk of harm, as well as high-risk environments and events
- the alcohol-related priorities for action and the desired outcomes for each priority, as specified by the *National Drug Policy*
- a range of strategies for addressing alcohol-related harm, grouped into three broad categories – supply control, demand reduction and problem limitation
- the importance of professional education in effectively addressing alcohol-related harm, and a range of strategies for workforce development
- a framework for monitoring and measuring progress towards the *National Drug Policy*'s alcohol-related outcomes, and a number of possibilities for future research.

### *National Mental Health Strategy*

The National Mental Health Strategy sets the strategic direction for New Zealand's mental health treatment services, including alcohol and drug related services. The NMHS positions alcohol and drug treatment within the mental health structure and highlights the NDP as the key related strategy.

The NMHS has two key goals:

to decrease the prevalence of mental illness and mental health problems within the community  
to increase the health status of, and reduce the impact of mental disorders on, consumers, their families, caregivers and the general community.

The NMHS has seven strategic directions:

1. more mental health services
2. more and better services for Maori
3. better mental health services
4. balancing personal rights with protection of the public
5. developing and implementing the *National Drug Policy*
6. developing the mental health services infrastructure
7. strengthening promotion and prevention.

### *A National Strategic Framework for Alcohol and Drug Services*

The recently released *National Strategic Framework for Alcohol and Drug Services* (Ministry of Health 2001) outlines priorities for the development of alcohol and drug treatment services in New Zealand, as well as specifying strategies for implementation. It prioritises the following special populations, plus the alcohol and drug treatment workforce, for future service consolidation and development:

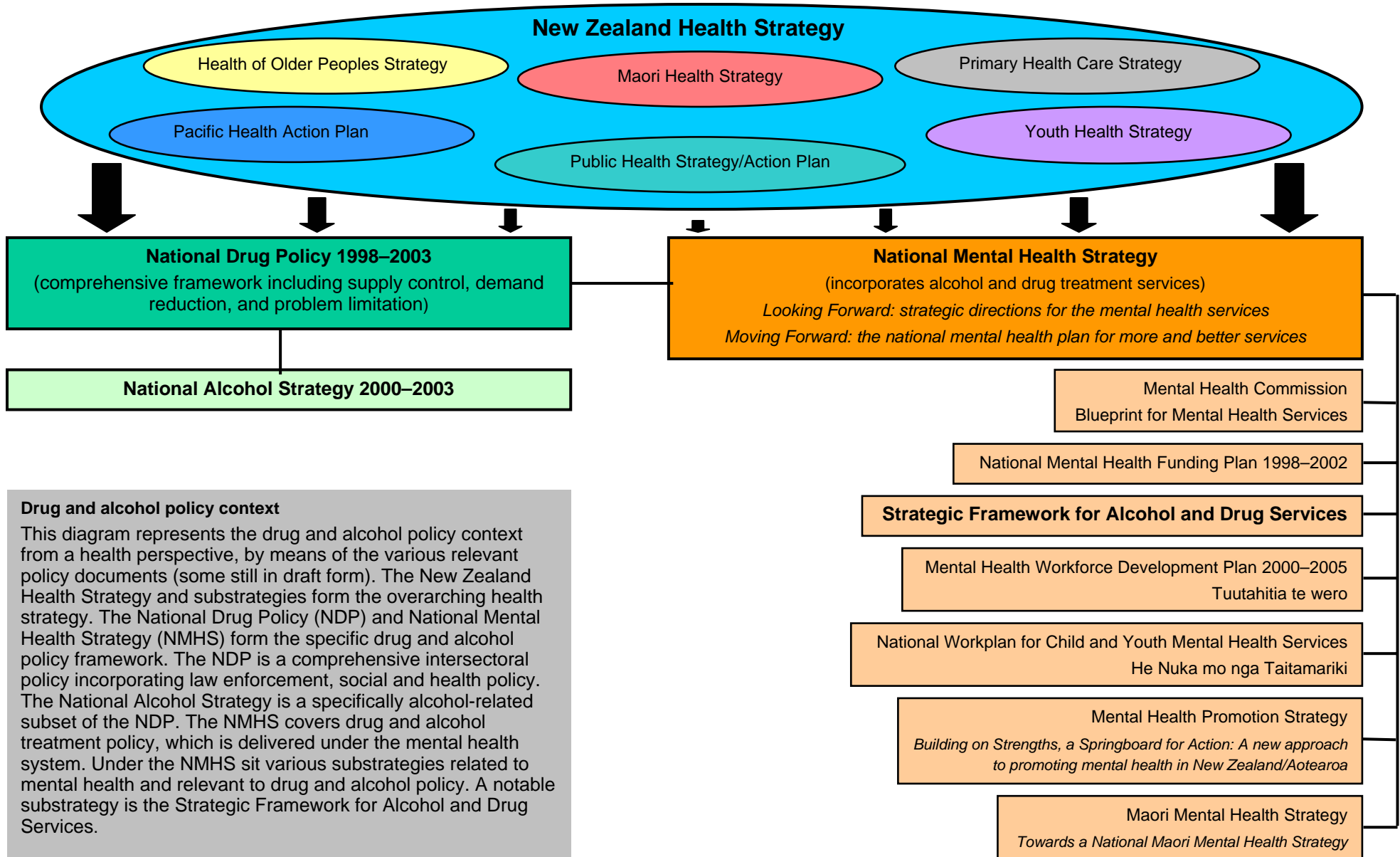
- **Priority one:** develop alcohol and drug treatment services, particularly kaupapa Maori services, responsive to Maori
- **Priority two:** develop alcohol and drug treatment services for Pacific peoples
- **Priority three:** develop specialist alcohol and drug services for children and youth
- **Priority four:** develop specialist alcohol and drug treatment services for consumers/tAngata whaiora with complex and or severe needs (eg, coexisting disorders)
- **Priority five:** develop the alcohol and drug treatment workforce.

The order of priority reflects an emphasis that funders need to consider when developing services for particular at-risk or vulnerable groups in the community. However, any such targeted

developments need to be considered while consolidating the gains and developments made in other parts of core alcohol and drug services.

In addressing these priorities, DHBs need to consider what services are already available in their region and what appropriately requires development in relation to regional and national needs. Regional and national planning also needs to ensure equity in resource allocation (particularly in relation to the needs and the degree of harm to and within local communities), while taking account of the benefits of different services for certain groups.

**Figure 1: Drug and Alcohol Policy Context**



**Drug and alcohol policy context**

This diagram represents the drug and alcohol policy context from a health perspective, by means of the various relevant policy documents (some still in draft form). The New Zealand Health Strategy and substrategies form the overarching health strategy. The National Drug Policy (NDP) and National Mental Health Strategy (NMHS) form the specific drug and alcohol policy framework. The NDP is a comprehensive intersectoral policy incorporating law enforcement, social and health policy. The National Alcohol Strategy is a specifically alcohol-related subset of the NDP. The NMHS covers drug and alcohol treatment policy, which is delivered under the mental health system. Under the NMHS sit various substrategies related to mental health and relevant to drug and alcohol policy. A notable substrategy is the Strategic Framework for Alcohol and Drug Services.

# Nature of the problem

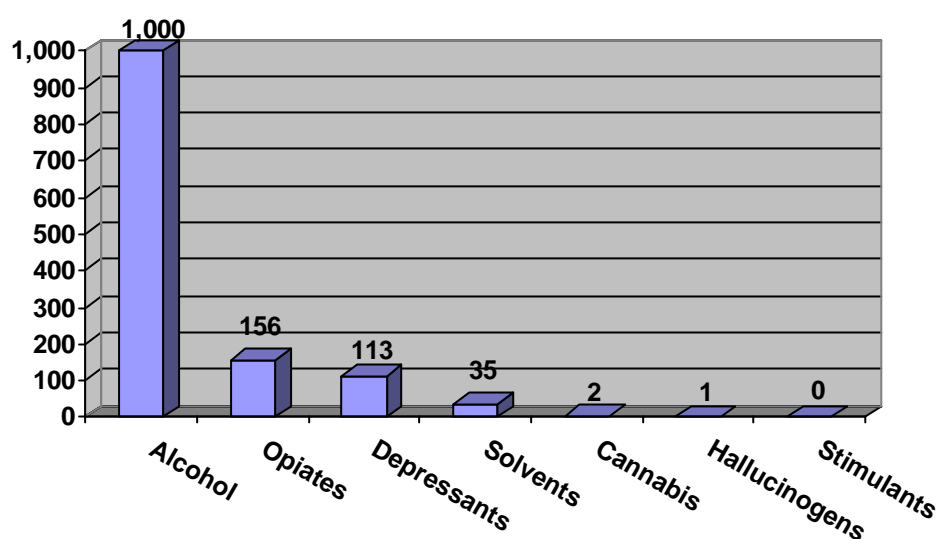
Substance abuse causes significant harm to the health of New Zealanders. The most widely used drugs, alcohol and tobacco, account for the majority of that harm. [Tobacco](#) is covered in a separate toolkit.

The New Zealand Health Strategy states:

*‘Over 80 percent of adult New Zealanders consume alcohol. At some time in their life, nearly one in five New Zealanders will suffer an alcohol use disorder. Alcohol abuse is a risk factor for some types of cancer, stroke, and heart disease. Alcohol abuse also significantly contributes to death and injury on the roads, drowning, suicide, assaults and domestic violence. The abuse of illicit drugs also harms New Zealanders. Of particular concern is the risk to public health from the transmission of blood-borne viruses through the sharing of needles and syringes, and cognitive impairment. People who experience both drug and mental health problems have particularly poor health outcomes ...’*

Figures 2 and 3 provide drug-related mortality and morbidity data respectively. They give some indication of the relative extent of harm to health from different substances in New Zealand. Alcohol clearly causes the most harm in relation to these figures, associated with 1,000 deaths from 1990 to 1996 and 22,800 hospitalisations from 1996 to 1998.

**Figure 2: Total number of deaths<sup>1</sup> from drug-related conditions<sup>2</sup> over 1990–1996**

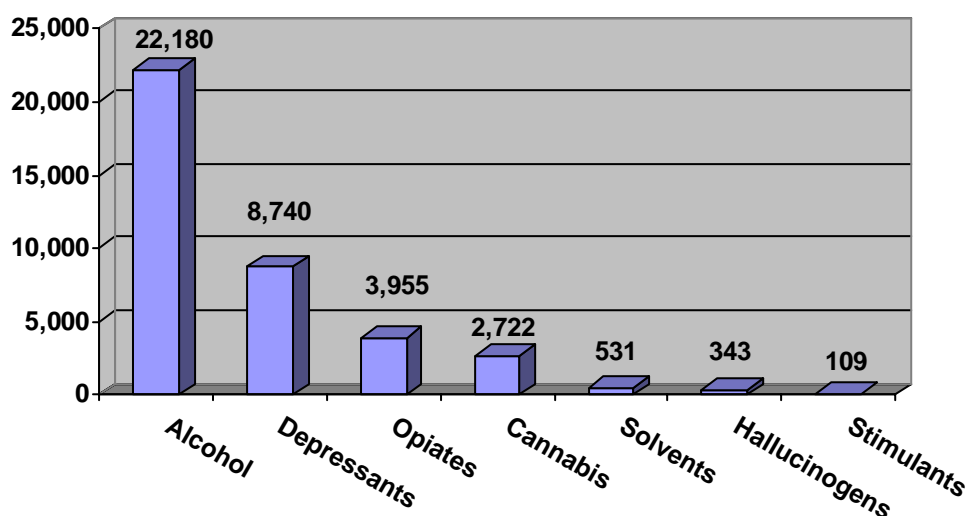


**Notes:**

1. Excludes deaths from external factors, eg, car crashes, falls, drowning.
2. Includes drug-related illness and disease, eg, dependence, non-dependent abuse, psychoses, poisoning.

**Source:** New Zealand Health Information Service

**Figure 3: Total number of hospitalisations<sup>1</sup> where drug-related conditions<sup>2</sup> were diagnosed over 1996–1998**



**Notes:**

1. Includes publicly funded hospitalisations for inpatients and day patients only. These data should therefore be treated as merely indicative as most drug treatment is community-based.

2. Includes hospitalisations for drug-related illness/disease, eg, dependence, non-dependent abuse, psychoses, poisoning, as the reason for admission or as a principal or secondary diagnosis.

**Source:** New Zealand Health Information Service

### *Alcohol*

Total alcohol consumption in New Zealand has declined considerably over the past 15–20 years (ALAC and Ministry of Health 2001); although rose between 1997 and 1999. (Statistics New Zealand 1999; 2000). It is uncertain yet whether this marks the start of a new upward trend, or is just a short-term ‘blip’ in the downward trend.

Despite a decrease in aggregate alcohol consumption, there is evidence of variation in drinking trends among New Zealanders. During the past ten years survey data collected annually in Auckland have shown an increase in heavier drinking occasions, particularly among younger groups. Among those aged 14–19 years, there was an increase in those drinking larger quantities (6 or more drinks) on a drinking occasion, from 12 percent to 25 percent over the 1990s (Casswell and Bhatta 2001).

A national survey undertaken in 1995 revealed that the heaviest five percent of drinkers are responsible for drinking one third of all alcohol consumed. These heavier drinkers are mostly men, particularly young men. (Wyllie et al 1996).

Much of the harm associated with alcohol use in New Zealand is a consequence of heavier drinking occasions. This harm includes deaths and injuries resulting from drunk driving, drownings, and violence both within and outside the home. Reduced productivity in the workplace due to alcohol misuse also represents a significant cost to industry, and the consumption of alcohol during pregnancy carries the risk of the child being born with Fetal Alcohol Syndrome (FAS). The annual social costs of alcohol misuse in New Zealand have been estimated as being between \$1.5 billion and \$2.4 billion. Alcohol-related conditions are estimated to cost New Zealand \$74 million each year in hospitalisations alone (Devlin et al 1996).

A number of studies indicate that alcohol-related harm is greater amongst some groups than others. A 1997 study of youth aged 14 to 18 found that a third had hurt themselves after drinking, one in eight got themselves into a sexual situation they were not happy with, and one in eleven had got into trouble with the law (Alcohol Advisory Council 1997). Not surprisingly given their

typically high levels of consumption, young men (aged 18 to 24) report problems associated with their drinking. Over half of young men in this age group report alcohol-related problems such as memory loss, getting in to fights, having arguments, being absent from work and driving drunk (Wyllie et al 1996). There is also evidence of an increase in excessive drinking amongst young women. Nearly a quarter of those young women aged between 18 and 19 years who drink, consume sufficient to feel drunk at least once a week. (Field and Casswell 1999).

Maori also report a higher incidence of alcohol-related problems, with one in five Maori men indicating that alcohol is causing problems to their health. (Wyllie et al 1996). For Pacific men, alcohol (and drug) abuse, or dependence, were the most common reasons for them to be admitted to hospital (Bathgate et al 1994). Offenders also exhibit high lifetime rates of alcohol abuse or dependence (Simpson et al 1999; Brinded et al 1996). Whilst there has been little research on the relationship between their use of alcohol and their offending, a comparatively recent Christchurch study found that young people who misused alcohol had high rates of both violent offences and property offences. (Fergusson et al 1996).

Although there is evidence that light to moderate alcohol consumption provides protection against coronary heart disease for some population groups (Public Health Commission 1994), long-term heavy alcohol use also contributes to a wide range of organ damage. In all it is estimated that alcohol-related “health” conditions account for 3.1 percent of all male deaths and 1.4 percent of all female deaths in New Zealand (ALAC and Ministry of Health 2001).

Alcohol is a causative factor in a number of mental health conditions, and alcohol dependence is a diagnosable mental disorder in its own right. (Stewart 1998). A major psychiatric epidemiology study undertaken in Christchurch in the mid 1980’s found that almost one in five people will fit the criteria for alcohol abuse or dependence at some stage in their lives (Wells et al 1989). Problematic alcohol use also frequently co-exists with other mental health problems such as depression, anxiety disorders, anti-social personality disorders and schizophrenia (Wells et al 1992; Bushnell et al 1994; Schuckit and Hesselbroack 1994). A recent study undertaken in New Zealand identified alcohol (and/or drug) abuse as one of the factors that predispose young people to suicide (Beautrais et al 1996), and another found that amongst those gamblers that were identified as pathological, 48 percent drank in a harmful or hazardous manner (Abbott and Volberg 1996).

More information about alcohol availability, management of drinking premises, marketing, and drink-driving legislation is provided in Appendix 3.

### *Cannabis*

Cannabis is the most widely used illegal drug in New Zealand. Fifty percent of the New Zealand population aged between 15 and 45 years can be expected to have tried cannabis (in the form of marijuana) but the majority do not use it regularly. Only 3 percent of a national sample had used marijuana more than 10 times in the last month, and only 1 percent were daily users (Field and Casswell 1999).

Those presenting at treatment services tend to use cannabis more frequently. An Auckland Regional Alcohol and Drug Service survey showed 27.4 percent of those presenting at the service use cannabis daily (Paton-Simpson and MacKinnon 2000).

Through daily or near daily use over years, users are at greatest risk of adverse health consequences such as: respiratory diseases including the possibility of cancers, subtle cognitive impairment, psychotic symptoms among vulnerable individuals, and dependency (Hall and Solowij 1998).

As for alcohol, young people aged 18–24 years consume the highest levels of cannabis (Field and Casswell 1999) and are thus most at risk of adverse consequences. The Christchurch Health and

Development Study of a cohort to age 21 years, found that 9 percent of the cohort were dependent on cannabis at 21 years (Fergusson and Horwood 2000).

### *Injecting drug use*

Injecting drug use produces serious risks to individuals and society including overdose, blood-borne disease, and crime to support opiate dependence.

Due to the illegal nature of this activity, it is difficult to accurately assess the number of injecting drug users (IDUs). Current estimates suggest that there are around 15 000 regular IDUs in New Zealand (Nesdale et al 2000).

In 1996, based on World Health Organization (WHO) methodology that uses the numbers of people receiving treatment for opioid dependence, it was estimated that there were 13,500 to 26,600 people with opioid dependence in New Zealand (Sellman et al 1996). Increasing numbers are presenting for treatment or coming to the attention of the authorities for injecting other substances, particularly amphetamines.

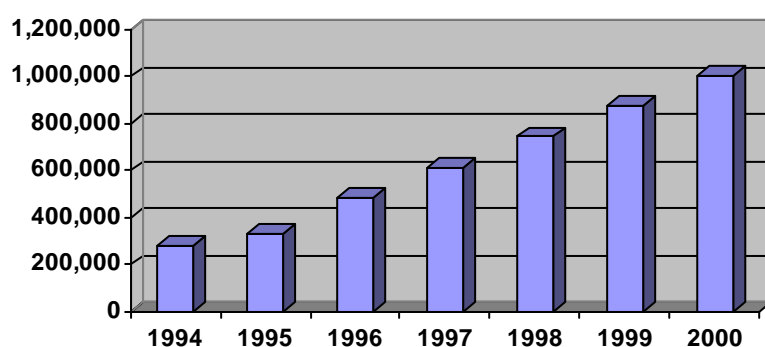
About 45 percent of all identified IDUs are infected with hepatitis C (HCV). Injecting drug use is the most commonly reported risk factor for notified cases of acute HCV infection. Less than one percent of IDUs are infected with HIV (Kemp and MacDonald 1999), but there is potential for rapid spread within the IDU population.

Predictions are that the number of people in New Zealand with HCV antibodies (currently estimated by ESR at 25,200) will increase by 50 percent over the next 10 years (Nesdale et al 2000). This projection is based on a continuation of current injecting drug use and HCV incidence in IDUs.

Some evidence suggests, however, that the rate of HCV in the IDU population is reducing. In his 1997 study Kemp found that 53 percent of participants in the Needle Syringe Exchange Programme (NSEP) were HCV positive, while in his 1998 study (same methodology) he found 45 percent of participants to be HCV positive.

The greater uptake of new, and hence clean, needles and syringes through the NSEP may be one reason for the reduction in the HCV prevalence rate. The Drug Use in New Zealand Comparison Surveys, undertaken in 1990 and 1998, indicate that the number of people using intravenous drugs in the last year has remained static at 0.1 percent. The number of needles and syringes distributed through the NSEP has increased steadily, however, over 1994 to 2000 (Figure 4).

**Figure 4: Numbers of needles and syringes distributed through the NSEP during 1994–2000**



Source: New Zealand Needle Syringe Exchange Program

Despite the apparently low numbers of injecting users in the community, the costs and harm to individuals and the wider community are such they warrant particular attention. A recommended

intervention focussed on supporting needle/syringe exchange programmes can be found in the Key Interventions Template of this toolkit, in the Public Health section (final intervention).

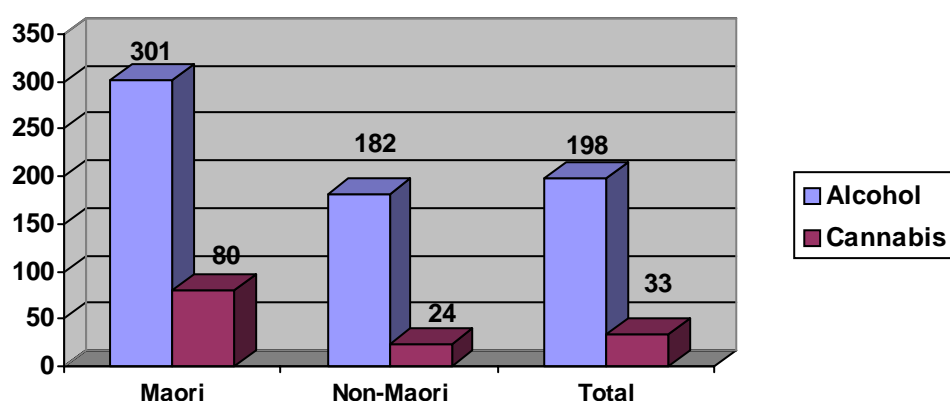
The Ministry of Health is consulting on a Hepatitis C Action Plan and harm prevention programmes for IDUs during 2001. In 2002/3 treatment issues regarding IDUs will be reviewed.

## Reducing inequalities – priority populations

The New Zealand Health Strategy emphasises the need for health policy to reduce inequalities for those population groups with the poorest health status, and particularly Maori and Pacific peoples.

There is evidence of disproportionate harm from alcohol and cannabis use among Maori compared to non-Maori. As Figure 5 indicates, in 1998 the Maori hospitalisation rate for alcohol-related conditions was about 1.5 times the non-Maori rate, and for cannabis-related conditions it was over three times the non-Maori rate.

**Figure 5: Hospitalisation<sup>1</sup> rates<sup>2</sup> for alcohol<sup>3</sup> and cannabis<sup>4</sup> related conditions amongst Maori and non-Maori, 1998**



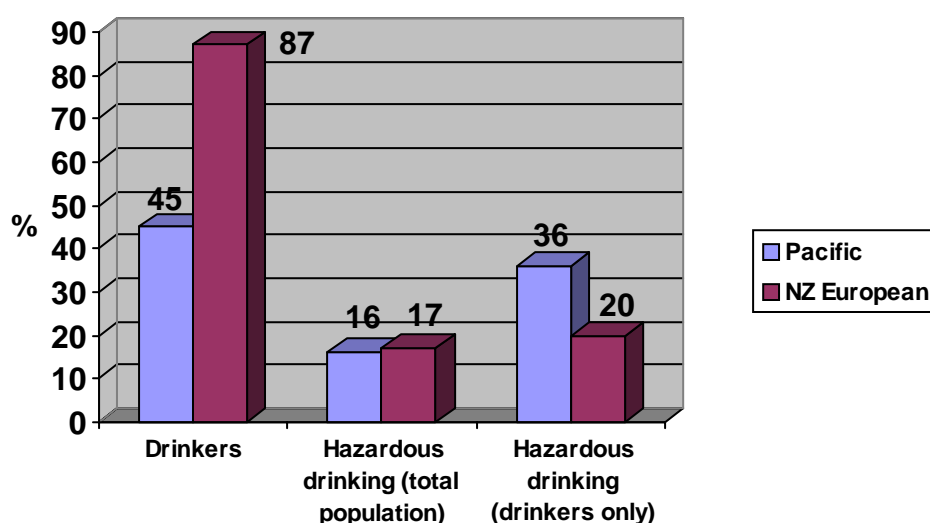
**Notes:**

1. Publicly funded hospitalisations for inpatients and day patients only.
2. Rates per 100,000 population, age-standardised to Segi's world population.
3. Alcohol-related conditions include psychoses, dependence syndrome, abuse, non-dependent use disorder, alcoholic cardiomyopathy, organ damage, and poisoning.
4. Cannabis-related conditions include psychoses, dependence, non-dependent abuse and poisoning.

**Source:** New Zealand Health Information Service

While only about half of the proportion of the Pacific population drink alcohol compared to the New Zealand European population, those among the Pacific population who do drink appear to exhibit a higher prevalence of risky drinking patterns. Figure 6 indicates that the proportion of Pacific drinkers engaging in hazardous drinking patterns in 1996/97 was approaching twice the proportion of New Zealand European drinkers engaging in hazardous drinking patterns.

**Figure 6: Proportions of Pacific peoples and New Zealand Europeans reporting drinking and hazardous<sup>1</sup> drinking, 1996/97**



**Note:**

1. An Alcohol Use Disorders Identification Test (AUDIT) score of over eight.

**Source:** Ministry of Health. 1999. *Taking the Pulse: the 1996/97 New Zealand Health Survey*.

Prioritisation is required to ensure that groups with the highest level of need (especially in relation to minimising harm) receive proportionally more resources than those with less need. Prioritisation does not mean neglect of other areas. Rather, priority areas receive added attention when funding decisions are made.

Alcohol and drug related priority populations have been variously identified in relevant policy documents including the *National Drug Policy*, the *National Mental Health Funding Plan 1998–2002*, the *National Strategic Framework for Alcohol and Drug Services* and the *Public Health Services Handbook*. These populations have particular demographic characteristics such as age, gender or ethnicity, or share unique functional characteristics such as legal features or clinical features (eg, coexisting disorder).

These characteristics have implications for achieving positive health outcomes, thus a need for interventions matched to population groups. Population-specific strategies and services oriented towards public health and primary health care appear to improve access and relevance, plus access and retention within secondary and tertiary services, for special populations. To date, however, there has been limited systematic research on their effectiveness.

Continual development of separate strategies and services for distinct groups may not be sustainable within available resources. An alternative is to develop services and a workforce that are capable of customising interventions, and flexible enough to account for the complex relationship of drug and alcohol related problems to population health. Services must also adapt to the growing knowledge about best practice in working with people with problems related to substance use.

# Best evidence on interventions

## Comprehensive intersectoral approach

Reducing alcohol and other drug-related harm is considered best achieved through a comprehensive, intersectoral approach (Ministry of Health 1998; WHO 1998). The nature and extent of alcohol and other drug related harm is influenced by, and in turn influences, a number of personal and societal variables. Correspondingly, a wide variety of government agencies, non-governmental organisations (NGOs) and community agencies need to be involved in minimising the harm caused by alcohol and other drugs.

Ideally, for action to be effective, DHBs will play a key role in developing intersectoral partnerships with relevant organisations. All relevant sectors, for example health, law enforcement, education and social policy, must act in a co-ordinated and co-operative fashion in implementing interventions across the population. The *National Drug Policy* is certainly designed to operate in this manner.

DHB interventions should also cover the comprehensive framework of primary care, secondary/tertiary care and public health, as set out in the key interventions template of this toolkit.

## Co-ordination

People have diverse health needs, using various services from different providers in different settings, sometimes at the same time. For people to achieve the best package of care and to avoid service duplication, co-ordination within and between services is necessary. The Primary Health Care Strategy (Ministry of Health 2001a) highlights the different levels at which co-ordination is necessary for effective service provision, as follows.

- **A broad, intersectoral approach**  
Health improves through changing the social, economic and cultural impacts on the community's health problems. DHBs need to work with other sectors to effect change in these areas.
- **A collaborative, multidisciplinary approach**  
To meet people's needs completely, a range of practitioners providing collaborative care is necessary. Working in partnership with Maori and Pacific providers is one way to reduce health inequalities in these populations.
- **Co-ordination between primary and secondary care**  
Primary care requires support from secondary services to best manage health problems.
- **Co-ordination between primary and public health services**  
Primary health care and public health services should draw on the expertise of each other, in considering how they can best contribute to broad population-based health initiatives
- **Co-ordination between primary and disability support services**  
Overcoming the social and environmental barriers to full participation faced by people with disabilities requires action on a wide range of fronts. DHBs should ensure that barriers to accessing services by people with disabilities are minimised, linkages with disability organisations are built and, through intersectoral activities, opportunities for people with disabilities to participate in the community and wider society are maximised.
- **Co-ordination between primary and mental health services**  
DHBs need to help build effective linkages between primary care providers and mental health services, so care of those with chronic and/or long-term mental health problems is effectively co-ordinated.

- **Co-ordination for specific population groups**  
Some populations have particular needs that require the involvement of several different providers. Young people, for example, often need a range of care and services from different providers simultaneously. This requires joint ‘care plan’ arrangements between providers to ensure continuity and co-ordination of care.

## Key recommended interventions

Key recommended interventions for reducing alcohol and drug-related harm for DHBs to implement and support, are presented in the following key interventions template.

In line with the New Zealand Health Strategy's fundamental aim of reducing inequalities in health among different populations, recommended interventions include those targeted at specific population groups.

Key documents, several of which assess evidence on interventions to minimise alcohol and other drug related harm, are referenced at [Appendix 2](#).

.

*Key interventions template*

<b>Action / intervention</b>	<b>Services / resources / strategies</b>	<b>Partners</b>	<b>Evidence</b>	<b>Population</b>	<b>Comments</b>
A brief description of actions to be undertaken	Examples of recommended services, resources and public health strategies	Likely stakeholders and agencies	References and summaries of support	The target population group or groups	Extra information/ comment

## Primary health care

Action / intervention	Services / resources	Partners	Evidence	Population	Comments
<p><b>Screening</b> <i>Increase screening in primary health care settings and general practice</i></p>	<p>Alcohol Use Disorders Identification Test (AUDIT) Severity of Dependence Scale (SDS) Drug Abuse Screening Test (DAST) Chemical Markers</p> <p><b>Note:</b> As some screening tests are age- and gender-sensitive, training is recommended. For some other screening tests, eg, CAGE and MAST, see <i>Guidelines for Alcohol and Drug Assessment</i> (ALAC 1996). Also see <i>Alcohol and Drug Problems: Handbook for health professionals</i> (O'Hagan et al 1993).</p>	<ul style="list-style-type: none"> <li>• General practitioners (GPs)</li> <li>• Independent Practitioner Associations (IPAs)</li> <li>• Te Ohu Rata o Aotearoa</li> <li>• Royal New Zealand College of GPs</li> <li>• Practice nurses</li> <li>• Nurse practitioners</li> <li>• College of Nurses</li> <li>• Primary Healthcare Nursing</li> <li>• Community health workers (including Maori and Pacific)</li> <li>• Nga Ngaru Hauora o Aotearoa</li> <li>• ADA Alcohol &amp; Drug Helpline</li> <li>• Problem gambling treatment services</li> <li>• Mental health services</li> <li>• Consultation and liaison with specialist alcohol and drug (A&amp;D) services</li> <li>• Ministry of Health</li> </ul>	<p>Approximately 80 percent of the New Zealand population visits their general practitioner every 12 months. However, between 65 and 82 percent of patients presenting to general practice with alcohol-related problems are not detected by their GP (National Health Committee 1999).</p> <p>Skinner (1982) Skinner et al (1986) Saunders et al (1993) Gossop et al (1995) Paton-Simpson and MacKinnon (2000)</p>	<p>All those 14 years of age and over attending their GPs should be screened at least every 3 years.</p> <p>Health workers in primary health care and other community health settings need to systematically provide opportunistic screening to their populations (at least every 3 years).</p> <p><b>Note:</b> Some evidence suggests that many Pacific peoples and Maori underutilised primary health care (Gribben 1999; Malcolm 2000).</p>	<p>Screening by GPs will require a change in the way their services are delivered. It should be included in a more general regular preventive interview / questionnaire. If this practice is to be taken up, it may need to be a requirement for funding (eg, model of immunisation, which contains funding thresholds in terms of rates achieved).</p> <p>Key to primary health care sector is <b>opportunistic</b>. The Department of Corrections is now using Responsivity AUDIT and DAST in its standard assessments. These are amended versions of AUDIT and DAST and will affect the rates of referral to A&amp;D services.</p>

Primary health care – continued

Action / intervention	Services / resources	Partners	Evidence	Population	Comments
<p><b>Brief interventions</b>  <i>Increase brief interventions, where appropriate, in primary health care settings and general practice</i></p>	<p>Alcohol Drug Association NZ (ADA) – Alcohol and Drug Helpline  ALAC resources, eg, <i>Drinking and Your Health</i> self-help booklets  Tobacco, Alcohol &amp; other Drugs – early intervention training programme (TADS), Drinkless (screening and brief intervention training)  <i>Users’ Check Up</i> (Baker 1997)  Heather (1995a)  Motivational techniques  <a href="http://www.alcohol.org.nz">www.alcohol.org.nz</a></p>	<p>As above plus:</p> <ul style="list-style-type: none"> <li>• A Alcohol and Drug Helpline</li> <li>• ALAC</li> <li>• Schools of medicine</li> <li>• Goodfellow Unit Auckland University</li> <li>• National Centre for Treatment Development (NCTD)</li> <li>• Wellington Institute of Technology (WELTEC)</li> </ul>	<p>Brief intervention has been shown to reduce alcohol consumption among heavy drinkers (National Health Committee 1999).  The recommendation for brief intervention in problem drinking is supported by evidence from randomised controlled trials (National Health Committee 1999).  Millar and Sanchez, cited in Bien et al (1993)  Heather (1986, 1995b)  Wallace et al (1988)</p>	<p>Brief interventions are appropriate for:</p> <ul style="list-style-type: none"> <li>• those with mild to moderate substance abuse problems</li> <li>• those identified through appropriate screening to be drinking or using other drugs hazardously.</li> </ul>	<p>Their ease of administration, low intensity and low cost make a strong argument that brief interventions should be available in primary health care.  GPs and other primary health care workers are encouraged to access the National Health Committee’s (1999) <i>Guidelines for Recognising, Assessing and Treating Alcohol and Cannabis Abuse in Primary Care</i>.  It is recommended that lessons from the understanding of alcohol use, abuse and dependence be applied to other substances in a common-sense way.  <b>Note:</b>  Tobacco, Alcohol &amp; other Drugs – early intervention training programme (TADS) have a national contract to provide their training. However, to make this happen, they will require collaborative relationships with local DHBs and provider groups.</p>

Primary health care – continued

Action / intervention	Services / resources	Partners	Evidence	Population	Comments
<p><b>Pregnant women</b>  <i>Increase enquiry about and discourage alcohol use amongst pregnant women, those planning pregnancy, and breast feeding mothers, by primary health care workers</i></p>	<p>ALAC Fetal Alcohol Syndrome (FAS) Resources                      Fetal Alcohol New Zealand Trust (FANZ) resources</p>	<ul style="list-style-type: none"> <li>• Midwives (and their professional association)</li> <li>• GPs</li> <li>• Practice nurses</li> <li>• Plunket nurses</li> <li>• Community (including Maori and Pacific) health workers</li> <li>• Maori Women's Welfare League</li> <li>• ALAC</li> <li>• FANZ</li> <li>• ADA Alcohol and Drug Helpline</li> </ul>	<p>Considerable evidence that maternal intake can cause both physical disability and intellectual impairment in newborns.</p> <p>One report estimates that each year up to 360 births are of children whose development has been affected by their mother's drinking during pregnancy. (ALAC and Ministry of Health 2001, pp 10–11)</p>	<p>Drinking should be discouraged for:</p> <ul style="list-style-type: none"> <li>• all pregnant women</li> <li>• women contemplating pregnancy</li> <li>• breast feeding mothers.</li> </ul>	<p>Interventions at the primary care level need to be reinforced by public education campaigns.</p> <p>Primary health care practitioners will need to be appropriately resourced.</p> <p>A New Zealand survey of pregnant women found that of those who drank, a third continued to drink at least weekly, and that a small proportion were drinking at hazardous levels.</p>
<p><i>Increase identification, appropriate referral and follow-up support for alcohol and drug dependence</i></p>	<p>AUDIT, SDS, DAST etc                      Postgraduate courses offered by the Universities of Otago, Massey and Auckland                      Undergraduate courses offered by the Wellington Institute of Technology and Massey University                      Te Wero me te Aranga (training programme operated by NgA Manga Puriri and Northland Health)                      Courses offered by Te Wananga o Raukawa</p>	<ul style="list-style-type: none"> <li>• GPs</li> <li>• Practice nurses</li> <li>• Community health workers</li> <li>• Providers</li> <li>• Universities and Wananga</li> <li>• ADA Alcohol and Drug Helpline</li> </ul>		<p>People who are substance dependent (or in remission)</p>	<p>As well as identifying people drinking in a risky manner, widespread opportunistic screening will identify those with more advanced levels of dependence for whom referral to a specialist agency is indicated.</p> <p>GPs and other primary care workers are more likely to screen/intervene if they believe appropriate support from specialist services is readily available.</p>

Primary health care – continued

Action / intervention	Services / resources	Partners	Evidence	Population	Comments
<p><b>Management of drugs of dependence</b></p> <p><i>Increase the appropriate management of drugs of dependence, including the use of pharmacological interventions, in primary care settings.</i></p>	<p>Postgraduate courses in pharmacotherapy offered by the Universities of Otago and Auckland.</p> <p>The 8-hour methadone training programme provided particularly for GPs and pharmacists by the Goodfellow Unit (University of Auckland).</p> <p>Resource: Centre for Substance Abuse Treatment 1997</p>	<ul style="list-style-type: none"> <li>• GPs</li> <li>• Practice nurses</li> <li>• Pharmacists</li> </ul>	<p>The value of opioid substitution is well established.</p> <p>Naltrexone and Acamprosate have been shown to be helpful in preventing relapse amongst people dependent on alcohol (ALAC and Ministry of Health 2001 p 39)</p>	<p>People dependent on psychoactive substances and or in remission</p>	<p>Through continued case management and support for opioid-dependent people stabilised on methadone, places in methadone programmes will be freed up.</p> <p>Close working relationships of gazetted GPs and those in authority with specialist services are an essential component in the effective and integrated management of opioid-dependent people in the primary health care system. Shared care arrangements are reported as helpful.</p> <p>Currently Naltrexone and Acamprosate are not subsidised medications.</p>

## Secondary and tertiary interventions

### *Key definitions and principles for secondary and tertiary interventions framework*

- **Primary interventions**, applied in primary and community health care settings, emphasise early intervention and brief therapies. **Tertiary interventions** involve specialised symptom relief and behaviour change, in settings where intensive intervention is practised. In between these two levels of activity are **secondary interventions**, providing interventions less intensive than at the tertiary level, such as supportive counselling, welfare and basic medical care (MacEwan 1997, cited in MacEwan 1999).
- **Specialist alcohol and drug services** are listed as an essential service component in the Mental Health Commission's *Blueprint for Mental Health Services* (Mental Health Commission 1998). Specific service requirements are also detailed in the *Blueprint*.
- The **efficiency** of a treatment programme (as perhaps measured by compliance with sector standards) is not necessarily the same as the **efficacy** of treatment or particular modalities.
- For working with coexisting disorders, Todd et al (1999) promote the principles of **safety** (eg, physical, mental, cultural), **stabilisation** (eg, physical, social, mental and spiritual), **assessment, treatment planning, clinical case management** and **integrated treatment**. These principles apply to the wider treatment system regardless of setting, duration of care, modality or provider involved. Continuity of care within a particular treatment programme or between providers (including intersectoral) will be more likely if elements of these principles are clearly identified and present.
- **Generalists** are those workers or agencies who make formal or informal responses to alcohol and other drug related harm and are not considered specialist treatment services. Although DHBs may not directly interact with all these generalist agencies and services, their activities will impact on the number and nature of referrals to specialist alcohol and drug services. Thus many alcohol and drug service providers will have memoranda of understanding, heads of agreement, if not contracts for service with these generalist agencies.
- To increase the capacity of specialist alcohol and drug services, there must be an **available and sufficiently trained workforce** to deliver appropriate treatment interventions in a variety of settings. The workforce must be flexible enough to work in a responsive manner for a variety of groups and populations (Ministry of Health 2001). A clinically and culturally (in its widest sense) competent workforce should more closely match an appropriately qualified alcohol and drug workforce.

## Secondary and tertiary interventions

Action / intervention	Services / resources	Partners	Evidence	Population	Comments
<p><b>Provide specialist, brief and comprehensive alcohol and drug assessment</b></p>	<p><i>Guidelines for Alcohol and Drug Assessment</i> (Alcohol Advisory Council of New Zealand (ALAC) 1996)</p> <p><i>Alcohol and Drug Problems: Handbook for health professionals</i> (O'Hagan et al 1993)</p> <p><b>Note:</b> As some standardised assessments are age-, gender- and even ethnoculturally sensitive, appropriate training must be undertaken before use.</p>	<p>As above under 'Primary interventions' plus:</p> <p>NCTD</p> <p>WELTEC</p> <p>Alcohol and drug service providers</p>		<ul style="list-style-type: none"> <li>Those referred by primary health care workers and other generalist workers, who have been screened as requiring such (ie, moderate to severe dependence)</li> <li>Those with coexisting disorders</li> <li>Those requiring access to residential services or specialist care must have a comprehensive assessment to justify the referral as required by referrers to assist case management.</li> </ul>	<p><b>Brief assessments</b> are individualised, with a brief history of past substance use, treatment and current risk factors to support a 'diagnosis' (standard and recognised system used) and a treatment plan. They should include some statement about motivation.</p> <p><b>Comprehensive assessments</b> contain the above plus more psychosocial and cultural information (giving predisposing, precipitating, perpetuating and protective factors), mental health information, a diagnosis, a recommended treatment plan and involvement of a significant other(s).</p> <p>An appropriate assessment gives a baseline for measuring change and reviewing case plans.</p> <p>The components of an assessment for use within a service should be clearly set out in service documentation.</p>

Secondary and tertiary interventions – continued

Action / intervention	Services / resources	Partners	Evidence	Population	Comments
<b>Consultation and liaison with other providers on alcohol and drug assessment and treatment</b>	Consultation and liaison service for other providers, including GPs, primary care health workers and other generalist workers	<ul style="list-style-type: none"> <li>• Specialist A&amp;D services</li> <li>• GPs</li> <li>• Primary care health workers</li> <li>• Other generalist workers</li> </ul>		Those affected by harm related to substance use	<p>Although not strictly core specialist A&amp;D service business, a consultation and liaison role is appropriate. As well as giving advice, the role may involve providing basic training for alcohol and/or drug screenings and brief intervention.</p> <p>Specialist services for specific population groups might provide specialised advice and training.</p>
<b>Provide specialist alcohol and drug treatment and maintenance services</b>	<p>1. Detoxification and withdrawal management</p> <p>Medical</p> <p>Social</p> <p>Home</p> <p>See: Abbot et al (1996) Saunders et al (1996)</p>	<ul style="list-style-type: none"> <li>• NGOs</li> <li>• A&amp;D services</li> <li>• GPs</li> <li>• Practice nurses</li> <li>• Primary care providers</li> <li>• DHB mental health hospital services</li> <li>• Consumer groups</li> </ul>	Heather and Trebutt (1988) (eds.)	<ul style="list-style-type: none"> <li>• Those with moderate to severe substance dependence</li> <li>• Those needing immediate resolution of an acute physical, social or psychological emergency resulting from A&amp;D use</li> </ul>	<p>The availability of and access to medical services to ensure safe and stable detoxification are crucial.</p> <p>With the support of specialist A&amp;D or medical services, some are able to wait for access to inpatient services. For those needing acute treatment it could be literally a matter of life or death.</p> <p>Detoxification services require concurrent counselling and care services.</p>

Secondary and tertiary interventions – continued

Action / intervention	Services / resources	Partners	Evidence	Population	Comments
<i>Provide specialist alcohol and drug treatment and maintenance services – continued</i>	<p>2. Active 'treatment' and maintenance</p> <p>Including but not exclusive to:</p> <ul style="list-style-type: none"> <li>• psycho/social/cultural interventions</li> <li>• cognitive-behavioural approaches</li> <li>• motivation interviewing and enhancement approaches e.g: MET – Motivational Enhancement Therapy - Sellman et al (2001)</li> <li>• DEARS - Develop discrepancy, express empathy, avoid argument, roll with resistance, and support efficacy</li> <li>• 12-step</li> <li>• community reinforcement</li> <li>• relapse prevention etc</li> <li>• systemic/ family approaches.</li> </ul>	<ul style="list-style-type: none"> <li>• A&amp;D services</li> <li>• Other mental health services</li> <li>• Hospital services</li> <li>• Consumer groups</li> <li>• Training and research establishments</li> </ul>		<ul style="list-style-type: none"> <li>• Those with moderate to severe mental health problems, including substance-related problems</li> <li>• Those wishing to abstain from all substance use or those wishing to reduce and manage their substance use</li> <li>• Significant others including partners, whanau and family</li> </ul>	<p>Interventions are time-limited.</p> <p>Involvement of family, whanau and other significant others should be promoted as essential to improved outcomes.</p> <p>A qualified, competent and experienced multidisciplinary team approach is encouraged.</p> <p>Services must be responsive to the needs of special populations and at-risk groups, ie, Maori, Pacific peoples, women (including pregnant women), children and youth, the elderly and those with coexisting mental health disorders.</p>
	<p><b>3. Pharmacological interventions</b></p> <p>Resources:</p> <p>Robinson and Sellman (1997)</p> <p>(Kranzler et al 1999)</p>	<ul style="list-style-type: none"> <li>• A&amp;D services</li> <li>• Other mental health services</li> <li>• Hospital services</li> <li>• GPs</li> </ul>			<p>Intensive case-management models often involve intersectoral / interagency collaborative working and linkages with consumer groups.</p> <p>Pharmacological intervention also requires concurrent counselling and care service.</p>

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*Secondary and tertiary interventions – continued*

<b>Action / Intervention</b>	<b>Services/Resources</b>	<b>Partners</b>	<b>Evidence</b>	<b>Population</b>	<b>Comments</b>
<i>Provide specialist alcohol and drug treatment and maintenance services – continued</i>	<p><b>4. Residential treatment</b></p> <p>Short term ((less than 30 days) including detoxification and respite care)</p> <p>Medium term (more than 30 days and less than 12 months)</p> <p>Therapeutic community (usually longer term)</p> <p>Supported accommodation/ transition houses</p>	<p>NGOs</p> <p>National Treatment Forum</p>	<p>For some groups, residential care is the most appropriate. Examples are those needing acute detoxification or respite, those with coexisting disorders, those with various mental health complications and those with the most severe dependence.</p> <p>Hall (1997) indicate that the evidence for residential treatment being more effective than non-residential treatment is limited.</p> <p>Hubbard et al, 1989</p>	<ul style="list-style-type: none"> <li>• Those assessed with moderate to severe dependence and or coexisting disorders</li> <li>• Those who have had failed previous attempts at non-residential treatment</li> <li>• Those who have completed residential treatment and are transitioning back into the community</li> </ul>	<p>Although nationally there appears to be an excess of residential beds, this excess may not translate to the local level.</p> <p>The capacity of residential services cannot decrease without a development of non-residential services to cater for this difference.</p> <p>Residential services for youth tend to be respite care and must be linked to community resources.</p> <p>Those referred to a residential service need an assessment from a qualified assessor matching the client to that particular intervention modality.</p>

Secondary and tertiary interventions – continued

Action / intervention	Services / resources	Partners	Evidence	Population	Comments
<p><b>Methadone</b> <i>Improve access to methadone treatment for people who are opioid dependent.</i></p>	<p>Opioid Substitution/ Methadone Treatment Resources: Mattick and Hall (1993) WHO (1993) Kemp (1999) National Methadone Protocols</p>	<p>As above ('Provide specialist alcohol and drug treatment and maintenance services') plus:</p> <ul style="list-style-type: none"> <li>• Consumers</li> <li>• Specialist A&amp;D methadone treatment services</li> </ul>	<p>Methadone maintenance has been identified as one of the safest and most effective treatments for opiate dependence. It has been found to have a cost-effectiveness ratio lower than that of many common medical treatments (Barnett 1999).</p> <p>Mattick and Hall (1993) It has been found that combining psychosocial interventions with appropriate dose produces better outcomes (Rounsaville and Kosten 2000).</p>	<p>Opioid-dependent (or in remission) youth and adults who often present with a raft of other medical, social, financial and mental health related issues</p> <ul style="list-style-type: none"> <li>• Opioid-dependent women who are pregnant and or who have given birth.</li> </ul>	<p>Assessments for the programme must be timely.</p> <p>If it is not possible to offer a position on the methadone programme to someone who is eligible for it, that person must be offered alternatives including non-pharmacological interventions.</p> <p>Due to the complexities for many who present, a comprehensive case management plan should be evident on file.</p> <p>It is expected that significant links will be made with other care workers and sectors.</p> <p>The intervention should emphasise involving significant others/whanau, such as providing education/support services (including assessment) for them, and ensuring specific intervention needs of women and children are met.</p> <p>Initiatives for GPs and others in the primary care workforce need to be maintained and developed especially as concurrent counselling and care services are necessary.</p> <p>Access to a range of other psychopharmacology services needs to be pursued.</p>

Secondary and tertiary interventions – continued

Action / intervention	Services / resources	Partners	Evidence	Population	Comments
<p><b>Workforce development</b>  <i>Develop and consolidate a competent, responsive specialist alcohol and drug workforce</i></p>		<p>University of Otago</p> <ul style="list-style-type: none"> <li>• WELTEC</li> <li>• Te Runanga o Raukawa</li> <li>• Massey University</li> <li>• University of Auckland</li> <li>• Te Ngaru Learning Systems</li> <li>• Te Manga Puriri</li> <li>• Pacific Islands Drug &amp; Alcohol Services (PIDAS), Auckland</li> </ul>	<p>A comprehensive review of A&amp;D professional education and training identified that 'Those who specialise in working with alcohol and drug issues need to be, on the whole, better skilled and educated than is currently the norm' (Hannifin and Gruys 1996).</p> <p>A 1999 workforce survey revealed that less than 4% of the A&amp;D treatment workforce have a relevant postgraduate qualification (Sellman, Futterman-Collier et al 1999).</p>	<p>A&amp;D workforce with some emphasis on Maori, Pacific and Asian personnel and those working with youth</p>	<p>Success relies on a responsive workforce that is able to screen, assess and provide treatment appropriate to the severity and complexity of A&amp;D presentation.</p> <p>The Mental Health Commission's (1998) <i>Blueprint for Mental Health Services</i> identifies a need to significantly increase the number of community assessment and treatment FTEs (from 259 to 585).</p> <p>There is a need for training that involves working in a systemic way with families/whanau.</p>

Secondary and tertiary interventions – continued

Action / intervention	Services / resources	Partners	Evidence	Population	Comments
<p><b>Maori</b>  <i>Improve service provision for Maori with severe alcohol and drug related problems/disorders</i></p>	<p>Improved responsiveness of mainstream services to Maori</p> <p>Greater and improved provision of kaupapa Maori services</p> <p>Resources:            Metge and Kinloch (1978)            Robertson et al (in press)            Huriwai et al (2000, 2001)            Ministry of Health (2001)            Durie (1985, 1994)            Durie et al (1995)</p>	<ul style="list-style-type: none"> <li>• NGOs</li> <li>• A&amp;D services</li> <li>• Iwi and pan-tribal social services</li> <li>• Alcohol and drug sector Maori collectives and recovery whanau</li> <li>• Auckland University</li> <li>• NCTD</li> <li>• Wellington Institute of Technology</li> <li>• Te Ngaru Learning Systems</li> <li>• Te Wananga o Raukawa</li> <li>• Te Rau Puawai</li> <li>• Kaupapa Maori A&amp;D service providers</li> </ul>		<p>Those who identify as Maori</p>	<p>Some interventions designed for the general population have had limited effect in reducing harm among some Maori.</p> <p>Dedicated Maori services, as well as increasing the cultural content in existing services and increasing the cultural competence of clinicians, would reduce some barriers to access, engagement and retention in treatment due to cultural inappropriateness and irrelevance (Health Funding Authority 2000).</p> <p>Workforce development is essential to support this intervention as set out in the Mental Health Workforce Development Plan 2000–2005.</p>

Secondary and tertiary interventions – continued

Action / intervention	Services / resources	Partners	Evidence	Population	Comments
<p><b>Pacific peoples</b>  <i>Improve service provision for Pacific peoples with severe alcohol and drug related problems/disorders</i></p>	<p>Improved responsiveness of mainstream services to Pacific peoples            Greater and improved provision of specialist Pacific services in areas with large Pacific populations            Resources:            Metge and Kinloch (1978)            Ngan-Woo (1985)</p>	<ul style="list-style-type: none"> <li>• PIDAS, Auckland</li> <li>• NGOs</li> <li>• A&amp;D services</li> <li>• Training institutions</li> </ul>		<p>Those people dependent on alcohol and/ or drugs who identify as being of Pacific Islands descent</p>	<p>Some interventions designed for the general population have had limited effect in reducing harm amongst some Pacific peoples.            Dedicated Pacific services, as well as increasing the cultural content in existing services and increasing the cultural competence of clinicians, would reduce some barriers to access, engagement and retention in treatment due to cultural inappropriateness and irrelevance.            Workforce development is essential to support this intervention.</p>

Secondary and tertiary interventions – continued

Action / intervention	Services / resources	Partners	Evidence	Population	Comments
<p><b>Children and young people</b> <i>Improve service provision for children and young people</i></p>	<p>Specialist A&amp;D services for children and young people should increase.</p> <p>All child adolescent and family mental health services (CAFMHHS) staff should be trained to provide comprehensive A&amp;D assessment and treatment, including access to methadone treatment.</p> <p>Assessment and interventions should be multisystemic, encompassing the key systems in which the child/young person is involved, including family/whanau/carers and education.</p> <p>Intersectoral wrap around and case management models for those with complex problems involve primary care providers, A&amp;D and CAFMHHS, education, justice, welfare and NGOs.</p> <p>Resources:                      Spooner et al (1996)                      Addiction Services, Healthcare Hawkes Bay (1999)                      Health Funding Authority (2000)                      NZ Health Technology Assessment (1997)</p>	<ul style="list-style-type: none"> <li>• CAFMHHS</li> <li>• A&amp;D services</li> <li>• Primary care providers – GPs</li> <li>• Youth health centres</li> <li>• Paediatric departments</li> <li>• NGOs</li> </ul>	<p>Alcohol and drug problems contribute significantly to the mental illness burden of youth people</p> <p>The following references outline the complexity of issues associated with working with this group: Fergusson et al 1994, MacEwan 1998, Weinberg et al 1998.</p> <p>The evidence for residential treatment as a core treatment for adolescents is unconvincing (Spooner et al 1996).</p> <p>Residential detoxification is often necessary to ensure safety and stabilisation. However, where short-term respite care is also necessary, it may clash with the core activity of a service.</p>	<p>Children and young people with A&amp;D problems and their families/whanau.</p>	<p>Where CAFMHHS and A&amp;D services are not integrated, co-ordination between them is essential.</p> <p>Youth in treatment for alcohol and other drug problems differ qualitatively and quantitatively in their needs from adults. Being responsive requires different approaches to those taken with adults.</p> <p>Many of the intensive case-management models needed for working with this group involve intersectoral / interagency collaboration and linkages with consumer groups. Case notes and case plans should show evidence of such collaboration.</p> <p>This intervention has workforce development implications as noted for the interventions above.</p>

Secondary and tertiary interventions – continued

Action / intervention	Services / resources	Partners	Evidence	Population	Comments
<p><b>Coexisting disorders</b> <i>Improve treatment of those with coexisting disorders</i></p>	<p>More responsive alcohol and drug treatment services and general mental health services for those with coexisting disorders</p> <p>Accessible specialist services for those with coexisting disorders / dual diagnosis</p> <p>Resources: Todd et al (1999)</p>	<p>NCTD</p> <ul style="list-style-type: none"> <li>• Auckland University</li> <li>• WELTEC</li> <li>• Massey University</li> <li>• Te Ngaru Learning Systems</li> </ul>		Those with coexisting alcohol and drug and mental health disorders	<p>The Todd et al (1999) guidelines should be distributed more widely.</p> <p>More clinically oriented research is needed.</p>
<p><b>Consumer participation</b> <i>To ensure consumers are involved in service and policy development, evaluation and monitoring (as per Standard Nine, Mental Health Standards)</i></p>	<p>Consumer advisory groups / individuals, ADA, New Zealand Accreditation Board for Alcohol and Drug Standards, Te Whanau Manaaki o Manawatu</p> <p>Resources: <i>Clinical Process Self Evaluation</i> guidelines (Deering et al 1998)</p>			A&D service consumers	<p>Consumers must be involved in planning, implementing and evaluating mental health and A&amp;D services.</p>
<p><b>Family participation</b> <i>To ensure that families, including children, are included, involved and valued in the treatment process and receive assistance if required in their own right</i></p>	<p>Continuity of care needs to be inclusive of families.</p> <p>Mental health and A&amp;D staff and services need to develop pathways to involve families.</p>	<ul style="list-style-type: none"> <li>• Mental health and A&amp;D management and service delivery</li> <li>• Mental Health Commission</li> <li>• Consumer advisors and groups</li> <li>• Families, individuals</li> <li>• A&amp;D services</li> <li>• NGOs</li> <li>• ADA Helpline</li> </ul>	<p>Research has shown that there are significant clinical, social and economic advantages in providing mental health services in a family-inclusive way (World Schizophrenia Fellowship 1998).</p>	Families of A&D service consumers	<p>Detail about involving families in care, assessment and treatment is contained in <i>Involving Families Guidance Notes</i> (Royal Australian and New Zealand College of Psychiatrists 2000).</p>

Secondary and tertiary interventions – continued

Action / intervention	Services / resources	Partners	Evidence	Population	Comments
<p><b>Co-ordination</b>  <i>Address needs of local communities, individuals and ways to work across sectors</i></p>	<p>Provide links with:</p> <ul style="list-style-type: none"> <li>• A&amp;D services</li> <li>• Local government</li> <li>• Ministry of Health</li> <li>• allied professionals</li> <li>• intersectoral professionals</li> </ul>	<ul style="list-style-type: none"> <li>• National Treatment Forum</li> <li>• ADA</li> <li>• Mental Health Forum</li> <li>• A&amp;D services</li> <li>• NGOs</li> <li>• Consumers</li> </ul>		General	<p>People have diverse health needs and use a number of different services in different settings and times. Co-ordination among services is needed.</p>
<p><b>Improve consistency nationally regarding service access and entry priorities and procedures</b></p>	(Ministry of Health 2001)	<ul style="list-style-type: none"> <li>• A&amp;D services</li> <li>• NGOs</li> <li>• Consumers</li> <li>• Families</li> <li>• National Treatment Forum</li> </ul>		Maori, Pacific peoples and general population including other ethnic groupings	<p>It is important that an individual's service needs are co-ordinated.</p>
<p><b>Research</b></p>	<p>Greater integration and co-ordination of clinical based research            More research oriented towards treatment outcomes</p>	<ul style="list-style-type: none"> <li>• NCTD</li> <li>• Auckland University</li> <li>• Drug &amp; Alcohol Research Training Group (DART)</li> <li>• Treatment Research Interest Group (TRIG)</li> <li>• National Treatment Forum</li> <li>• Health Research Council (HRC)</li> </ul>			

## Public health<sup>1</sup>

Action / intervention	Strategies / services / resources	Partners	Evidence	Population
<p><b>Carry out public health regulatory activity related to alcohol and other drugs</b></p>	<p>Provide services in accordance with the Public Health Regulatory Services specification as detailed in the <i>Public Health Services Handbook</i> and Section 13 of the <i>Environmental Health Protection Manual</i>.</p> <p>Ensure that the Medical Officer of Health enquires into and files with the District Licensing Agency (DLA), reports on new applications and renewals for 'on' and 'club' licences.</p> <p>Advise sellers and servers of alcohol of their responsibilities under the Sale of Liquor Act 1989. Emphasis should be on:</p> <ul style="list-style-type: none"> <li>• age verification checks and prohibiting the sale of liquor to minors and intoxicated persons, eg, use of pseudo-patron surveys</li> <li>• availability and provision of non-alcoholic drinks, food and transport</li> <li>• control of trading hours and alcohol promotions, eg, promotion according to promotion guidelines (Hospitality Association of NZ (HANZ), ALAC.).</li> </ul> <p>Provide an advisory and follow-up service for prospective applicants under the Sale of Liquor Act 1989 in regard to public health requirements, eg, invitation of applicants to licensing meetings.</p> <p>Identify grounds for objections to liquor licences or grounds for requests for licence suspensions. Where appropriate, prepare cases and appear before the District Licensing Committee or Licensing Agency, eg, review test cases and their strategies.</p> <p>Collaborate with other statutory officers to ensure effective law enforcement.</p>	<ul style="list-style-type: none"> <li>• District licensing officers</li> <li>• Police</li> <li>• Licensed premises management and staff</li> <li>• Public health staff with statutory responsibilities such as medical officers of health and health protection officers</li> <li>• Fire brigade</li> <li>• Local government</li> <li>• Health promotion specialists</li> </ul>	<p><b>Note:</b></p> <p>All references listed in this public health evidence category are fully referenced in APHRU (1999a, 1999b) <b>Available at:</b></p> <p><a href="#">APHRU</a></p> <p>The enforcement of liquor laws and license conditions has been shown to be important as part of a multilayered approach to reducing alcohol-related harm (Hill and Stewart 1996b).</p> <p>Environmental strategies including regulation are likely to provide the most cost-effective use of resources with longer benefits over time (Wagenaar and Perry 1992).</p> <p>Staff training is not effective without commitment from managers and licensees (Gliskman et al 1993; Hill 1998; McKnight and Streff 1994).</p> <p>Younger drinkers experience disproportionate harm compared to older groups drinking the same quantities (Wyllie et al 1996).</p>	<p>General</p>

<sup>1</sup> Public health interventions are largely compatible with those in the *Public Health Services Handbook 2000–2001* (Ministry of Health 2000).

Public health – continued

Action / intervention	Strategies / services / resources	Partners	Evidence	Population
<p><b>Increase adoption of policies that support the reduction of alcohol and other drug related harm</b></p>	<p>Advise organisations and the public on the significance of alcohol and other drug related harm.</p> <p>Advocate, encourage, assist or make submissions for development or changes to policies, legislation, district plans, risk conditions and actions by those responsible in central and local government.</p> <p>Participate in the development, promotion, support and implementation of host responsibility programmes. Work co-operatively with licensed premises, clubs, private homes, workplaces and other places where alcohol is consumed and is sold or supplied, eg, host responsibility programme resources: (ALAC, HANZ), the bar book (Waikato District Council).</p>	<ul style="list-style-type: none"> <li>• Local government</li> <li>• Safer Community Councils, Healthy Cities, Injury Prevention Networks, Youth Councils</li> <li>• Sports clubs</li> <li>• Schools</li> <li>• Workplaces</li> <li>• Licensed premises</li> <li>• Homes</li> <li>• Other places where alcohol is consumed or supplied</li> <li>• Health promotion specialists</li> </ul>	<p>Excise taxes on alcohol affect the real price, helping to reduce the volume of alcohol consumed and slowing the recruitment of new drinkers (Edwards et al 1994; Zhang &amp; Casswell 1999).</p> <p>Policies on alcohol advertising, sponsorship and labelling have been shown to be important as part of a multilayered approach (Casswell 1995; Crapet 1997; Greenfeld 1997; Hill and Casswell 2001; Saffer 1998).</p> <p>Host responsibility and good management practices by licensees are important as part of a multilayered approach (Gliksman et al 1993; Holder and Wagenaar 1994; Holder et al 1993).</p>	

Public health – continued

Action / intervention	Strategies / services / resources	Partners	Evidence	Population
<p><b>Increase level of community action to reduce alcohol and drug related harm</b></p>	<p>Provide an accessible and recognisable point of public contact for concerns and issues regarding public health and improve public awareness of avenues for complaint, eg, Alcohol Healthwatch guidelines for community objections/ submissions.</p> <p>Facilitate the development of evidence-based community action projects that:</p> <ul style="list-style-type: none"> <li>• promote alcohol-free zones as appropriate, as well as safe drinking environments in the community, eg, youth access programme (ALAC), after ball party and event sponsorship by youth (Nelson)</li> <li>• change attitudes, behaviours and associated harm relating to alcohol and other drug consumption, eg, Waikato Rural Drink Drive project (APHRU), Mai FM Stay and Play (CYPFS)</li> <li>• reduce alcohol-related violence and injuries, adolescent drunkenness, eg, youth workers public events (Christchurch)</li> <li>• address the needs of pregnant women and women planning pregnancy</li> <li>• address the needs of other target groups including young people, men who are heavy drinkers, Maori, Pacific peoples, gay men and lesbians, eg, community action – Kereru and CAYAD (APHRU)</li> <li>• address links among sports clubs, alcohol marketing and sponsorship, and drinking cultures.</li> </ul>	<ul style="list-style-type: none"> <li>• Intersectoral groups such as Safer Community Councils, Liquor Liaison Groups</li> <li>• Schools</li> <li>• Universities</li> <li>• Marae</li> <li>• Youth groups, Youth Councils</li> <li>• Youth workers, road safety co-ordinators</li> <li>• TA community services</li> <li>• Consumer groups</li> <li>• Midwives</li> <li>• GPs</li> <li>• Police</li> <li>• Youth aid</li> <li>• Maori wardens</li> <li>• Kaumatua</li> <li>• Community health workers</li> <li>• Students Against Drunk Driving (SADD)</li> <li>• Health promotion specialists</li> </ul>	<p>Community strategies that utilise alliances and interagency partnerships are more likely to be effective through working across sectors, building community capacity, increasing community knowledge and skills and reaching different population groups (Bush 1997, 1998; Casswell 2000; Chavis et al 1993; Gerstein and Green 1993; Gillies 1997; Labonte 1998; Samrasinge 1997).</p> <p>Controlled community trials have demonstrated the effectiveness of a set of local preventative interventions (Holder et al 1997; Holder 2000; Wagenaar et al 2000)</p> <p>Alcohol-free zones and alcohol bans in designated public spaces reduce problems associated with public drunkenness, violence and street crime (Conway 1998; Jackson 2000; Ruiz 1993).</p> <p>The long-term aim is to address attitudes and behaviour through changing the drinking culture. In the shorter term the focus is on practical ways to shape the social and physical environments of drinking so as to reduce alcohol-related harm (Holder 1994; McKnight 1990; Mosher 1996), including attention to the physical design of drinking venues (Graham and Homel 1997; McIntyre and Homel 1996).</p>	<ul style="list-style-type: none"> <li>• Young persons</li> <li>• Men who are heavy drinkers</li> <li>• Maori</li> <li>• Pregnant women</li> <li>• Pacific peoples</li> <li>• Gay men, lesbians</li> </ul>

*Public health – continued*

Action / intervention	Strategies / services / resources	Partners	Evidence	Population
<p><i>Increase level of community action to reduce alcohol and drug related harm – continued</i></p>	<p>Support Maori initiatives to reduce alcohol and other drug related harm. Also support the Alcohol Advisory Council's Manaaki Tangata programme, which offers guidelines for safer alcohol use at homes, marae and sports clubs by:</p> <ul style="list-style-type: none"> <li>• identifying iwi/hapubased A&amp;D workers prepared to work with their own communities to develop community action strategies, eg, Manaaki Tangata Bay of Plenty, shattered dreams video (Tairawhiti)</li> <li>• encouraging the development and implementation of Manaaki Tangata policies, eg, 'Pa wars' (Northland)</li> <li>• providing support and supervision for Maori A&amp;D workers with Manaaki Tangata, eg, through programme and evaluation training (Whariki)</li> <li>• providing resources and training to assist workers in the field to promote Manaaki Tangata, eg, 'Bar roadshow' (Northland Health).</li> </ul>		<p>Programmes that are based on Maori social structures, delivery systems, cultural context, and controlled and delivered by Maori, are more likely to contribute to Maori development goals (Durie 1993; Forster and Ratima 1997; Moewaka Barnes and Tunks 1998).</p>	

Public health – continued

Action / intervention	Strategies / services / resources	Partners	Evidence	Population
<p><b>Increase the level of community awareness and knowledge about alcohol and other drug related harm</b></p>	<p>Promote public discussion and debate on alcohol and other drug related issues (eg, drinking cultures, sports clubs and marketing) and conduct education campaigns. For example, see <i>The Role of Local Government: youth policy</i> (APHRU).</p> <p>Provide high quality, research-based information and education to community groups and the public about:</p> <ul style="list-style-type: none"> <li>• reducing alcohol and other drug related harm, eg, see advice on purchasing strategies for alcohol and drugs (APHRU 1999a, 1999b)</li> <li>• enhancing life skills in relation to the use of alcohol and other drugs</li> <li>• processes for influencing controls over the sale of liquor including liquor licensing, Resource Management Act and district planning, eg, Alcohol Healthwatch community submission guidelines.</li> </ul> <p>Implement public education / media and social marketing campaigns to raise public awareness of alcohol and other drug related harm, eg, use of media training, Health Promotion Forum.</p> <p>Support alcohol and drug advocacy groups whose role is media advocacy and community education.</p>	<ul style="list-style-type: none"> <li>• Schools</li> <li>• Universities</li> <li>• Marae</li> <li>• Youth groups</li> <li>• Youth workers</li> <li>• TA community services</li> <li>• Consumer groups</li> <li>• Health professionals</li> <li>• Police</li> <li>• Youth Aid</li> <li>• Kaumatua and kuia</li> <li>• Maori wardens</li> <li>• Community health workers</li> <li>• SADD</li> <li>• Community action workers</li> <li>• Safer Community Councils</li> <li>• Media</li> <li>• Health promotion specialists</li> <li>• NZ Drug Foundation, Alcohol Healthwatch etc</li> </ul>	<p>Evidence suggests links among drinking cultures, sports clubs and marketing (Hill 1999; Munro 2000).</p> <p>Research on the effects of media campaigns on drug use and abuse indicates that media alone are much less effective than media messages as part of a broader campaign that includes the use of interpersonal channels. When combined with other community prevention strategies, needed information can be disseminated through local community-based media campaigns, films, pamphlets, resource centres, radio and television public service announcements, health fairs, advertisements, hot lines and speakers' bureaux. Such an approach can positively affect a community's social norms (Gerstein and Green 1993).</p> <p>Evidence suggests that national and local advocacy efforts are important in increasing the level of informed debate (Hill and Casswell 1999; Jernigan and Wright 1996; Wallack et al 1993).</p>	<p>General</p>

Public health – continued

Action / intervention	Strategies / services / resources	Partners	Evidence	Population
<p><b>Strengthen strategic alliances and interagency networks</b></p>	<p>Encourage providers of primary health care and social services to promote reduction in heavier drinking occasions and raise awareness of the health impacts of the use of alcohol and other drugs. Among pregnant women and women of childbearing age, promote awareness of foetal alcohol syndrome and foetal alcohol effects.</p> <p>Establish and maintain effective relationships with drug and alcohol service providers and co-operate with ALAC and other public health providers to take a co-ordinated approach to reducing alcohol and other drug related harm, eg, through regional network meetings.</p> <p>Work with stakeholders from communities and schools and other agencies and sectors to develop evidence-based initiatives to minimise harm by changing attitudes and behaviours relating to alcohol and drug use, eg, GAIN, school community and A&amp;D education for parents.</p> <p>Promote, support and participate in liquor licensing liaison groups to enhance co-operation and co-ordination of key organisations in the reduction of alcohol-related harm in respect of licensed outlets.</p> <p>Provide information to inform local authority councillors and planners about the role of the Resource Management Act in controlling the availability and use of alcohol, eg, involvement of planners in regard to outlet densities (see Holder 2000, on community trials).</p>	<ul style="list-style-type: none"> <li>• Local government</li> <li>• Safer Community Councils, Healthy Cities, injury prevention networks, road safety networks, Youth Councils</li> <li>• Health professionals</li> <li>• Corrections and justice professionals</li> <li>• Special interest groups</li> <li>• A&amp;D service providers</li> <li>• ALAC</li> <li>• Communities</li> <li>• Schools</li> <li>• Workplaces</li> <li>• Liquor licensing groups</li> <li>• DLAs</li> <li>• TAs</li> <li>• Health promotion specialists</li> </ul>	<p>See previous related references. See also Baum (1997), Hawe (1997), Hawe (2000), Israel (1998).</p> <p>From the literature it is known that school-based education by itself is of limited value. However, it can reduce alcohol-related harm substantially and sustainably when combined with other community prevention strategies impacting on young people, such as parenting skills programmes, media awareness, alternative recreational opportunities, environmental modifications, alcohol regulatory policies and law enforcement activities (Harachi et al 1996; Kumpfer 1997; Perry et al 1996; Samarasinghe 1997). An informed debate about the nature and detail of implementing a harm reduction approach to illicit drugs in schools is needed within schools and throughout the community (Midford et al).</p>	<ul style="list-style-type: none"> <li>• General</li> <li>• Pregnant women and women planning pregnancy</li> <li>• Young people</li> </ul>

Public health – continued

Action / intervention	Strategies / services / resources	Partners	Evidence	Population
<b>Strengthen skills and knowledge of the health sector and other relevant change agents</b>	Provide workers and potential workers in health and other sectors with training programmes about alcohol and other drug related health promotion to facilitate the dissemination of appropriate information on responsible alcohol consumption and safer drug use among community groups, eg, Te Ngaru, Te Wero.	<ul style="list-style-type: none"> <li>• Education sector</li> <li>• ALAC</li> <li>• NZ Drug Foundation</li> <li>• Health Promotion Forum</li> <li>• Alcohol Healthwatch</li> <li>• Health promotion specialists</li> </ul>		A&D sector workforce
<b>Monitor and assess the effectiveness of alcohol and other drug programmes</b>	Participate in the monitoring and evaluation of host responsibility and harm reduction programmes, eg, develop inhouse evaluation capacity	<ul style="list-style-type: none"> <li>• Universities</li> <li>• Evaluation consultants</li> </ul>	Monitoring and evaluation form an important component of ensuring programme effectiveness (Hill and Casswell 1999; Waa et al).	General
<b>Maintain a database of local indicators of alcohol-related harm that includes monitoring and surveillance systems</b>	<p>Develop and maintain databases as appropriate in relation to alcohol and other drugs covering needs assessment, risk factor profiles, epidemiology and demographic profiles.</p> <p>Collect and analyse information on alcohol and other drugs.</p> <p>Work co-operatively with the licensing authorities and police on monitoring compliance with the Sale of Liquor Act and initiatives such as the Last Drink Survey (LDS) to gather data from people who exhibit evidence of having consumed alcohol which has contributed to an offence or injury. The aim is to use these data to identify the last drinking location and contribute to targeted prevention strategies for those locations/premises, eg, use of pseudo-patron surveys.</p>	<ul style="list-style-type: none"> <li>• Universities</li> <li>• Police</li> <li>• DLAs</li> <li>• LTSA</li> <li>• APHRU</li> <li>• ACC</li> <li>• Licensing inspectors</li> <li>• Local police</li> <li>• Health protection officers</li> </ul>	<p>Evidence suggests that local level data are very important in informing community strategies and policy-makers at national and local levels.</p> <p>The research literature suggests that the greatest gains will come through enforcing the existing laws and licensing system. Local partnerships among police, licensing inspectors and public health teams are critical to effective monitoring efforts (Hill and Stewart 1998; Jeffs and Saunders 1993).</p> <p>The literature shows that Last Drink Surveys are an effective way of targeting premises for host responsibility training (Arnold 1998; Hill and Stewart 1996a; Lang 1991; Stewart et al 1993; Thomas 1998; Wood et al 1995).</p>	

Public health – continued

Action / Intervention	Strategies / services / resources	Partners	Evidence	Population
<i>Maintain a database of local indicators of alcohol-related harm that includes monitoring and surveillance systems – continued</i>	<p>Monitor underage purchase through pseudo-patron operations that public health units undertake as part of their statutory monitoring duties.</p> <p>Monitor other local effects of changes to the Sale of Liquor Act such as increases in public drunkenness.</p> <p>Monitor local impacts of alcohol promotion, policy and compliance and local sponsorship and promotion practices.</p>	<ul style="list-style-type: none"> <li>• Police</li> <li>• DLAs</li> <li>• Community health groups</li> <li>• Safer Community Councils</li> <li>• Community health groups, sports associations</li> </ul>	Hill (1996), Holder et al (1997), Holder and Wallack (1986)	
<b>Reduce alcohol-related harm involving young people</b>	<p>Promote the development of youth policies and city-wide activities for and with young people.</p> <p>Provide safer socialising opportunities.</p>	<ul style="list-style-type: none"> <li>• Youth groups</li> <li>• SADD</li> <li>• City councils</li> <li>• Schools</li> <li>• Safer Community Councils</li> <li>• Health promotion specialists</li> </ul>	Conway (1999), Mosher (1996), Grube (1997) Harachi et al (1996)	

Public Health- Continued

Action / Intervention	Strategies / services / resources	Partners	Evidence	Population
<p><b>Establish / Maintain needle and syringe exchange programmes</b></p> <p>Aim: To reduce the harm associated with injecting drug use. Particularly the transmission of blood borne viruses through the sharing of injecting equipment.</p>	<p>Provide peer driven needle/syringe exchange programmes, and other outlets for needle/syringe exchange.</p> <p>Provide health education and promotion material on injecting drug use.</p> <p>Provide a collection and disposal service for used needles and syringes which are returned to needle exchange outlets.</p> <p>Resources:  <a href="http://www.needle.co.nz">http://www.needle.co.nz</a>                      Needle Exchange Programme Retailer Manual</p>	<ul style="list-style-type: none"> <li>• Needle Exchange Programme NZ  <a href="http://www.needle.co.nz">http://www.needle.co.nz</a></li> <li>• Needle Exchange New Zealand (NENZ)</li> <li>• Pharmaceutical Society</li> <li>• Pharmacy Guild</li> <li>• New Zealand Prostitutes Collective</li> <li>• Public Health Services</li> <li>• Alcohol and Drug Services</li> <li>• Sexual Health Services</li> </ul>	<p>(Chetwynd et al 1995)                      (Kemp and MacDonald 1999)                      (Nesdale et al 2000)</p>	<p>Injecting drug users</p>

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## APPENDIX 1:

### Web sites

The following are drug-related web sites to access for further information.

#### New Zealand

- National Drug Policy: [www.ndp.govt.nz](http://www.ndp.govt.nz)
- Alcohol Advisory Council: [www.alcohol.org.nz](http://www.alcohol.org.nz)
- New Zealand Drug Foundation: [www.nzdf.org.nz](http://www.nzdf.org.nz)
- Alcohol Drug Association: [www.adanz.org.nz](http://www.adanz.org.nz)
- National Centre for Treatment Development:  
<http://www.chmeds.ac.nz/departments/psychmed/treatment/index.html>
- New Zealand Health Information Service: [www.nzhis.govt.nz](http://www.nzhis.govt.nz)
- Health Education Resources: [www.healthed.govt.nz](http://www.healthed.govt.nz)
- National Society on Alcoholism and Drug Dependence [www.nsad.org.nz](http://www.nsad.org.nz)
- Alcohol and Public Health Research Unit: [www.aphru.ac.nz](http://www.aphru.ac.nz)
- Needle Exchange New Zealand: [www.needle.co.nz](http://www.needle.co.nz)
- Foundation for Alcohol and Drug Education: [www.fade.org.nz](http://www.fade.org.nz)
- Urge/Whakamanawa Youth web site: [www.urge.co.nz](http://www.urge.co.nz)  
[www.whakamanawa.co.nz](http://www.whakamanawa.co.nz)

#### Australia

- National Drug Strategy: [www.nationaldrugstrategy.gov.au](http://www.nationaldrugstrategy.gov.au)
- Australian Drug Foundation: [www.adf.org.au](http://www.adf.org.au)
- Australian Drug Information Network: [www.adin.com.au](http://www.adin.com.au)
- Reachout Youth web site: [www.reachout.asn.au](http://www.reachout.asn.au)

#### International

- Virtual Clearinghouse on Alcohol, Tobacco and Other Drugs: <http://www.atod.org>
- Drug search, United Kingdom drug information encyclopaedia (in Drugscope web site):  
<http://www.drugscope.org.uk/resources/drugsearch/drugsearch.htm>
- World Health Organization: [www.who.org](http://www.who.org)
- International Narcotics Control Board: [www.incb.org](http://www.incb.org)
- United Nations International Drug Control Programme: [www.undcp.org](http://www.undcp.org)



## APPENDIX 2:

### Key documents

- ALAC. 1999. *Overview of Specialist Alcohol and Drug Assessment, Treatment and Interventions in the New Zealand Context*. ALAC Occasional Publication: No 10. Wellington: Alcohol Advisory Council of New Zealand.
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- APHRU. 1999. *Advice for Purchasing Strategy on Public Health Issues: reducing drug related harm*. Auckland: Alcohol and Public Health Research Unit.  
<http://www.ndp.govt.nz/moh.nsf/indexcm/ndp-publications-advicepurchasingdrugphi>
- APHRU. 1999. *Advice for Purchasing Strategy on Public Health Issues: alcohol harm reduction*. Auckland: Alcohol and Public Health Research Unit.  
<http://www.ndp.govt.nz/moh.nsf/indexcm/ndp-publications-advicepurchasingstrategyphi>
- APHRU. 1998. *Trends in Drinking Patterns in Auckland 1990–1996: a brief report*. Auckland: Alcohol & Public Health Research Unit.
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- Ministry of Health. 2001. *Towards a National Maori Mental Health Strategy*. Draft discussion document prepared for the Ministry of Health, July.
- Ministry of Health. 2001. *Building on Strengths, a Springboard for Action: a new approach to promoting mental health in New Zealand/Aotearoa*. Consultation document, July.
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## **APPENDIX 3:**

# **Alcohol – further detail**

### **Availability**

The changes introduced by the Sale of Liquor Act 1989, which came into force in April 1990, have created a relatively liberal environment in relation to alcohol in New Zealand. After the Act removed any controls on the density of alcohol outlets, the number of on- and off-licensed premises in New Zealand increased markedly. Many larger traditional pubs were replaced by smaller, independently owned premises and licensed cafés and café-bars grew in number, particularly in the urban areas. New off-licences included supermarkets and superettes/grocery stores, which were allowed to sell wine from 1990.

Alcohol also became more widely available in the 1990s because restrictions were lifted on hours of trading, allowing some licensees to operate 24 hours a day. Late night trading by nightclub style-premises increased and premises were able to obtain a ‘supervised’ licence designation, allowing the sale of alcohol to those aged 18–19 years present ‘for the purposes of dining’. Alcopops or mixed ready-to-drink beverages were introduced into New Zealand in 1995 and heavily promoted. In 1995 the purchase of alcohol from premises such as pubs and taverns, whose main business was the sale of alcohol, was restricted to those aged over 20. However, a number of complex exemptions were in place, such as if an older spouse, parent or guardian was present and, in certain circumstances, related to food and entertainment, leading some to suggest that the de facto age was 18 years.

In 1999 when the Sale of Liquor Act was again amended, it removed any restraints on purchasing by those aged 18–20 years. Correspondingly the Act established appropriate age identification, but not a mandatory requirement on licensees to ask for identification. Through an additional provision, police can give infringement notices to minors found drinking on licensed premises, with fines set at \$200. The same infringement notice provisions were adopted in the Summary Offences Act for minors drinking alcohol in a public place. The 1999 Sale of Liquor Act amendments also allowed the sale of beer (but not spirits) in supermarkets and the sale of alcohol on Sundays.

### **Management of drinking premises**

Under the Sale of Liquor Act 1989 the regulatory framework was enlarged through a local level of licensing administration and monitoring, and by provisions in the Act directed at encouraging healthier drinking environments. The latter included host responsibility requirements, such as the provision of food and non-alcoholic beverages by all on-licensed premises. The 1999 Sale of Liquor Act amendments require on-licensed premises, as a condition of license, to provide information on or assistance with alternative forms of transport from their premises.

Management of the licensed drinking environment has been addressed through host responsibility training for bar staff and managers, although this training has been non-mandatory. In some parts of the country, more effective monitoring and enforcement strategies have been developed through Liquor Licensing Liaison Teams and the use of Last Drink Surveys (Stewart et al 1993).

### **Marketing**

A major change contributing to a liberal alcohol environment was the introduction of alcohol brand advertising in the broadcast media in 1992. In the first years that followed, advertising expenditure increased by 42 percent and televised alcohol advertising increased fourfold. Since then expenditure has stayed at about the same level. Liquor producers moved out of pub ownership to focus on product marketing through chains of large off-licensed outlets and brand advertising on television. Some free broadcasting time was made available for counter-

advertising as part of the policy change. This allocation has been utilised by the Alcohol Advisory Council and the Land Transport Safety Authority (LTSA). The ratio of counter-advertising to commercial advertising has been about 1:10 over the decade.

Marketing also takes place in retail outlets. The 1999 Sale of Liquor Act Amendment made it an offence to hold promotions that are intended to or are likely to encourage the excessive consumption of alcohol. Infringements can incur a fine of up to \$5,000.

### **Drink-driving legislation**

A further change during the 1990s was the introduction of Compulsory Breath Testing (CBT) in April 1993. Alongside the CBT operations, the LTSA has run advertising campaigns focusing on deterring people from drinking and driving. Graduated driver licences were introduced in 1998 with all drivers under 20 years required to have a lower blood alcohol level than adults.