Auckland Regional Public Health Service

Rātonga Hauora ā Iwi o Tamaki Makaurau

Working with the people of Auckland, Waitemata and Counties Manukau

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Submission on *Taking Action on Fetal Alcohol Spectrum Disorder (FASD)*

Thank you for the opportunity for Auckland Regional Public Health Service (ARPHS) to provide a submission on the Taking Action on Fetal Alcohol Spectrum Disorder (FASD) discussion document.

The following submission represents the views of the Auckland Regional Public Health Service and does not necessarily reflect the views of the three District Health Boards it serves. Please refer to Appendix 1 for more information on ARPHS.

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Summary and Key Recommendations

1. Taking Action on Fetal Alcohol Spectrum Disorder (FASD) is a valuable step forward for the New Zealand Government to take in reducing alcohol-related harm.

2. Effective prevention, reduction and management of FASD requires a shared responsibility with committed cross-government and cross-sector policy and service delivery working together to achieve a well-coordinated, funded and effective strategic direction.

3. To improve outcomes for the prevention and reduction of FASD in New Zealand, the wider determinants of health must also be considered.

4. A life-course approach would assist to ensure good outcomes. The action plan needs to include pre-conception and breastfeeding periods.

5. Action taken by the Ministry of Health around pregnancy and alcohol consumption will empower women to make healthier choices for the unborn child.

6. Education is necessary but insufficient on its own to address New Zealand's drinking culture or FASD.

7. Some of the most effective interventions for reducing alcohol-related harm which can be further implemented in New Zealand are:
    - The implementation of a minimum price for alcohol
    - An increase in tax on alcohol
    - Restrictions on marketing and advertising, and
    - Reducing the availability/accessibility of alcohol.

8. Actions specific to FASD include:
    - Broad, effective access to pregnancy testing
    - Clear, consistent and precautionary messaging around alcohol during all stages of pregnancy, including prior to conception and breastfeeding stages. This should be at a population level and targeting of specific high risk populations may be beneficial
    - Adequate funding and support for antenatal support services, including patient navigator services (particularly for vulnerable patients) could assist to improve the social determinants of health
    - Mandating a prominent health advisory message on all products and at point of sale
    - Clear and resourced referral pathways for those suffering from alcohol addictions
    - The inclusion of a better public service target related to reducing the incidence of FASD, so that a wide range of actions can be taken across

the public service in order to effectively address the wide array of causal factors associated with FASD.[1]

- Effective monitoring of progress with the Action Plan.

Research Overview

9. The discussion document rightly identifies FASD as an umbrella term used to describe the wide range of effects associated with alcohol exposure in pregnancy. A recent comprehensive systemic review and meta-analysis identified 428 comorbid conditions co-occurring in individuals with FASD.[2] In addition there is some indication of alcohol consumption prior to conception being associated with FASD associated conditions such as gastroschisis.[3] Both female and male alcohol intake at the time of conception is also associated with spontaneous abortion.[4]

10. Alcohol adversely affects lactation, infant behaviour (e.g. feeding, arousal) and psychomotor development of the breastfed baby.[5]

11. We would like to emphasise the importance of clear and consistent messaging around alcohol consumption prior to, and during pregnancy. Clear messaging on the known impacts of alcohol in pregnancy is known to be important for pregnant women.[6]

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[1] Better Public Services: Supporting vulnerable children (2015). Retrieved from URL: http://www.ssc.govt.nz/bps-supporting-vulnerable-children

[2] Popova, S., Lange, S., Shield, K., Mihic, A., Chudley, A.E., Mukherjee, R. A. S., Bekmuradov, D., Rehm, J. (2016). Comorbidity of fetal alcohol spectrum disorder: a systematic review and meta-analysis. *The Lancet*. Retrieved from URL: http://dx.doi.org/10.1016/S0140-6736(15)01345-8 http://dx.doi.org/10.1016/S0140-6736(15)01345-8

[3] Richardson. S., Browne, M., Rasmussen. S.A., Druschel, C.M., Sun, L., Jabs, E,W., Romitti, P.A., (2011). Associations between periconceptional alcohol consumption and craniosynostosis, omphalocele, and gastroschisis. *Birth Defects Research Part A. Clinical and Molecular Teratology*. Retrieved from URL: http://onlinelibrary.wiley.com/doi/10.1002/bdra.20823/full

[4] Henriksen, T., B., Hjollund, N., H., Jensen, T. K., Bonde, J., P., Andersson, A., Kolstad, H., Ernst, E., Giwercman, A., Skakkebæk, N., E., Olsen, J., (2002). Alcohol Consumption at the Time of Conception and Spontaneous Abortion. *American Journal of Epidemiology*. Retrieved from URL: https://aje.oxfordjournals.org/content/160/7/661.short

[5] Giglia RC & Binns CW (2006) Alcohol and lactation: a systematic review. Nutrition & Dietetics 63: 103–16.

[6] Anderson, A., Hure, A., J., Kay-Lambkin, F., J., Loxton, D.J. (2014). Women's perceptions of information about alcohol use during pregnancy: a qualitative study. *BMC Public Health*. Retrieved from URL: http://bmcpublichealth.biomedcentral.com/articles/10.1186/1471-2458-14-1048

Responses to Discussion Document Questions

Q1: Matters to consider in developing the Action Plan

12. Alcohol (ethanol) is a psychoactive, neurotoxin and teratogen that has a causal link to over 60 negative health outcomes, and increases the risk of over 200 others.

13. Alcohol use is normalised in our culture, and heavy and harmful drinking is prevalent among New Zealand drinkers, including females. Alcohol is aggressively promoted by commercial interests, and is widely accepted by society. Global alcohol producers such as Diageo have prioritised women as a specific area of growth in the coming years for their brands.[7]

14. FASD cannot be effectively treated in isolation of the wider alcohol misuse problem that is occurring in New Zealand. As with any public health issue there is benefit to approaching this issue at a population level and focusing on reducing inequities. An effective strategy also requires a comprehensive, multi-faceted approach using various leverage points to achieve outcomes.

15. There are a number of best practice interventions that could be implemented as part of a comprehensive approach to tackling FASD in New Zealand. These encompass areas such as:
    - FASD prevention policy and practice,
    - Screening, assessment and diagnostic training and practice,
    - Intervention policy, training and practice, and research.

16. FASD would benefit from strong leadership from the Ministry of Health and District Health Boards, and shared responsibility with committed cross-government and cross-sector policy and service delivery. Such leadership and collaboration is vital in sending clear and consistent messages to the public regarding the adverse health impacts of alcohol and assists in the de-branding of alcohol as an ordinary commodity.

17. A well-coordinated, funded and effective strategic direction would be beneficial with FASD, including action on the wider determinants of health and the 'best buy' (in terms of the most cost effective and most effective at reducing alcohol-related harm) policy interventions. These include increasing the price of alcohol through setting a minimum price and an increase in excise tax, restricting the marketing and advertising of alcohol and reducing accessibility and availability of alcohol. [8] Given the current regulatory environment, the latter may best be

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[7] See http://www.diageo.com/en-row/ourbrands/infocus/Pages/inn.aspx

[8] For useful research and resources from overseas, please see 'Reducing alcohol exposed pregnancies' cited as: Barry KL, Caetano R, Chang G, DeJoseph MC, Miller LA, O'Connor MJ, Olson HC, Floyd RL, Weber MK, DeStefano F, Dolina S, Leeks K, National Task Force on Fetal Alcohol Syndrome and Fetal Alcohol Effect. Reducing alcohol exposed pregnancies: A report of the National Task Force on Fetal Alcohol Syndrome and Fetal Alcohol Effect. Atlanta, GA: Centers for Disease Control and Prevention; March 2009.

achieved through strengthening the public health voice in Local Alcohol Policies and in implementing the objectives of the Sale and Supply of Alcohol Act 2012.

Q2: Our agency's role

18. Public Health Units have a role in reducing the accessibility and availability of alcohol through their legislative role under the Sale and Supply of Alcohol Act 2012. This requires that Medical Officers of Health look into all alcohol licence applications in the region and oppose those that do not fit with the objectives of the Act in minimising alcohol-related harm, and ensuring the safe and responsible supply of alcohol.

19. The Auckland Medical Officer of Health (MOH) recently opposed the provision of an alcohol licence to an Auckland maternity hospital seeking that pregnant or breastfeeding women were not supplied alcohol.[9] This opposition was based on strong evidence of alcohol harm during pregnancy and lactation. The opposition was unsuccessful, allowing alcohol to remain available to patients receiving care at the Auckland maternity hospital.

Q2 (b) Ways to support Action Plan

20. Evidence shows that reduced availability of alcohol is associated with reduced alcohol-related harm.[10] Alcohol-free environments will be key in reducing the availability/accessibility of alcohol, as has already been shown with the introduction of smokefree environments in New Zealand.[11] Alcohol-free environments are particularly important for protecting the most vulnerable groups in our society, such as the unborn/ breastfeeding child and school children. In accordance with collaboration across the social sector, alcohol-free environments could most usefully include those sites providing social services for the good of vulnerable members of the population e.g. hospitals and schools.

21. Consideration needs to be given to a sustainable funding source for workforce training and professional development to meet the constant and growing demand for knowledge transfer and FASD practice integration.

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[9] The Medical Officer of Health v Birthcare Auckland Limited [2015] NZARLA 107 (5 March 2015).

Auckland Medical Officer of Health v Birthcare Auckland Limited [2015] NZHC 2689.

[10] Babor T, Caetano R, Casswell S, et al (2010). Alcohol: no ordinary commodity. Research and public policy: second edition. Oxford University Press, 2010.

[11] Ministry of Health. After the smoke has cleared: evaluation of the impact of a new smokefree law. A report commissioned and funded by the New Zealand Ministry of Health. https://www.health.govt.nz/system/files/documents/publications/smokefree-evaluation-report-with-appendices-dec06.pdf

Q2(c) Responsiveness to Maori

22. Māori are disproportionately harmed by alcohol in general. Māori tamariki, whānau and hapū are also disproportionately harmed by FASD.

23. A supportive environment that reduces alcohol availability, stops cheap alcohol from being promoted and provides services that are consistent with a Whanau Ora approach is needed to protect tamariki and mokopuna and preserve whakapapa.

24. The action plan would benefit from greater focus on inequities and inequalities, with the inclusion of equity specific action points and indicators.

Q3: Principles in the Action Plan

25. The principles proposed for the action plan are strengths-based and in particular we commend the focus on empowering family/whānau, collaboration, sustained systemic change and a strengths-based approach. These are all evidence-based approaches that are effective in improving population health. These principles also reflect the scope and complexity of FASD and what is involved.

26. Prevention is key. Effective and appropriate early intervention can lead to significant health gain across the population. Therefore we recommend strengthening the prevention focussed principle to reflect the importance and effectiveness of this approach. For example, this principle is strengthened by changing the wording to 'Prevention first and foremost'.

27. The objective "Strive for sustained, systemic change" could also be strengthened to 'Invest in sustained and effective systemic change'. This would make the principle more action oriented and reflect the importance of investment in the sustainability of this work.

28. Additionally an equity principle such as 'Achieving Equity' could be included as a principle. To ensure that inequities are actively addressed throughout the action plan, there needs to be a strong focus on this throughout the planning process.

Q5: Outcomes

29. We strongly support proposed outcome 1 as the evidence is clear that there is no safe level of alcohol consumption during pre-conception, pregnancy and breastfeeding.

30. Supporting women to abstain from alcohol during pregnancy can be seen as a whole of society responsibility which can best be achieved by creating

supportive environments. The evidence-based policy measures mentioned earlier are key to achieving this.

31. Although we agree that a solid evidence-base is required to underpin effective public health interventions, understanding and improvements can also be achieved through practice-based evidence such as evaluation.

Q6. What changes would you make to these outcomes? Why?

32. It is important that supporting alcohol-free pregnancies at least encompasses the time from pre-conception until after breastfeeding has ended. Alcohol is a teratogen that interferes with normal cell growth and function during development. Alcohol still affects the baby's rapidly developing brain through breast milk if the mother drinks alcohol while breastfeeding.

33. It is also important that FASD is recognised as a lifelong disability and the proposed outcomes are required across the lifespan. The discussion does not account for adolescents and adults requiring timely assessment and intervention.

34. Outcome Three relates to the importance of FASD being diagnosed as a disability as discussed elsewhere in this document. FASD is permanent, pervasive and can include severe brain damage and as such should be treated as a disability.

35. We would also like to see the outcome of alcohol-free health premises and services throughout NZ.

Q7: Building Blocks for Outcome 1

36. Alcohol use is prevalent in New Zealand society, making FASD prevention particularly challenging. Reducing the influence that alcohol has in our society is integral to achieving these outcomes. These include restrictions on the availability and accessibility of alcohol, increasing price and restricting marketing of alcohol. Restricting the marketing of alcohol is becoming increasingly important in our environment, particularly due to an increased targeting of female consumers by alcohol producers. These interventions are required to shift our entrenched drinking culture.

37. Strengthening the consistency and effectiveness of non-stigmatising messages to not drink alcohol pre-conception, during pregnancy or when breastfeeding is an important part of the package. [12 13 14] Additionally, ensuring this messaging

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[12] Ontario Agency for Health Protection and Promotion (Public Health Ontario). Effectiveness of approaches to communicate alcohol-related health messaging: review and implications for Ontario's public health practitioners. 2014 revision. Toronto, ON: Queen's Printer for Ontario; 2015

is appropriate and reaches women of childbearing age and those who experience greater harm from alcohol is essential. It is also important that other audiences in society are targeted to ensure a more supportive environment for women, and also to raise awareness of the impact that male drinking can have during conception.

38. A large proportion of pregnancies in New Zealand are unplanned. Empowering women to make active, planned choices about their pregnancy is key. The high proportion of our population in New Zealand who consume alcohol and the changing patterns of consumption for women make this empowerment an important outcome to achieve to reduce FASD incidence.

39. Supporting a consistent primary health care response will provide a good platform for the response to FASD. FASD has complex lifelong implications that no one sector or service provider can address. It will take the concerted effort of the social sector and different service providers to respond to this issue in an effective and sustained manner. Primary care provides a crucial starting point due to their role in individual health outcomes. Research and experience also shows that screening and brief intervention with women of childbearing age by primary health and addiction services is effective.

40. Funding of pregnancy counselling and brief intervention is required to support the aim of women having alcohol free pregnancies.

41. Increasing access to support and specialist services for women at high risk of having an alcohol-exposed pregnancy is also an important part of a comprehensive approach.

42. Further investment is also required to support FASD training in integrated diagnosis and care planning with child health, mental health and other services across the lifespan.

Q8 and 9: Changes to Building Blocks

43. In addition to the actions mentioned above, we also suggest the following:
    - Include men in FASD education concerning the preconception period. We note that animal studies show that paternal alcohol consumption prior to conception causes abnormal brain and organ development, i.e. fetal agenesis,exencephaly and altered organ size, in postnatal offspring. It is therefore possible that alcohol pre-conception is also an important public health issue for men, which reinforces the need to shift NZ's drinking culture 'across the board' in our efforts to prevent FASD. The Foundation of Alcohol Research and Education in Australia are currently running a

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[13] See http://www.cdc.gov/ncbddd/fasd/features/key-finding-understanding-health-messages.html

[14] See http://www.cdc.gov/ncbddd/fasd/alcohol-use.html

'Pregnant Pause' campaign which encourages men to support their partner's pregnancy and take a zero alcohol stance.

- Ensure health professional training in Alcohol Screening and Brief Intervention and Referral to Treatment (SBIRT) includes the risk of alcohol to the unborn child and assistance with achieving abstinence. This opportunity needs to be extended to those supporting youth and those answering helpline services such as Plunket, Alcohol and Drug Helpline, Youthline and Lifeline.
- Integrate alcohol and pregnancy brief intervention into contracts that deliver sexual and contraceptive healthcare and existing quit programmes for smokers.
- Ensure any exposure during pregnancy is recorded and transferred to the child's notes for future reference should problems emerge during development.
- Develop care services that enable mothers at risk to remain connected to their families and children and ensure this continues after the birth of the child. This will ensure that consistent and well informed care can be established and maintained in recovery from alcohol addiction and beyond. It will also improve maternal health, bonding and go some way to reduce the risk of further high risk pregnancies. A model with proven effectiveness from women with addictions is the Parent and Child Assistance Programme from the University of Washington, Seattle.

44. ARPHS recommends starting with 'supporting a consistent primary health care response' simultaneously with 'increasing access to support and specialist services for women at high risk of having an alcohol-exposed pregnancy'. These two combined are consistent with current SBIRT efforts and will provide the outreach for those known to be at higher risk while giving health professionals a clear referral pathway for high risk women they encounter through screening.

Q 10: Assessing effectiveness

45. ARPHS supports surveillance of the following measures:
    a. Percentage of women within childbearing age range who are asked about their alcohol use.
    b. Percentage of women who are planning to get pregnant, are pregnant or are breastfeeding are asked about their alcohol use.
    c. Percentage of women of childbearing age are screened and if required provided a brief intervention/referred for treatment.
    d. Percentage of women who are planning to get pregnant, are pregnant or are breastfeeding who are screened and, if required, provided a brief intervention/referred for treatment.
    e. The numbers and type of healthcare professionals undertaking alcohol and pregnancy SBIRT education/training.
    f. Numbers of PHOs integrating and implementing active alcohol and pregnancy SBIRT initiatives.

g. Incidence and impact of FASD in NZ population and how these change over time mapped against the objectives of the action plan.

h. Awareness levels of women within childbearing age re: alcohol and pregnancy messages (e.g. include questions in Healthy Lifestyles Survey or something similar).

i. Awareness levels of men regarding the role of alcohol use and its impact on FASD.

46. As a short term indicator, ARPHS would support using an increase in referrals and admissions to supportive addiction services that have developed expertise in catering to alcohol and pregnancy related matters. An apposite example is the Pregnancy and Parental Service available through Auckland's Community Alcohol and Drug Service (CADS) Auckland.[15]

47. As a long term indicator, ARPHS would support using increased knowledge of risk among women of childbearing age and fewer women reporting drinking at any time during their pregnancy. To provide meaningful data, the research should be consistent with previous national alcohol survey methods and questions. Ethically, there must be ready access to treatment services for those at risk and for their children.

Q 11 and 12: Building Blocks for Outcome 2

48. We consider that the building blocks listed are pivotal to achieving Outcome 2 and are consistent with the evidence of effectiveness and clinical experience.

49. Currently general awareness and understanding of FASD in New Zealand is very limited.[16] This can be evidenced anecdotally and also by the large percentage (up to 80%) of New Zealand women who consume alcohol during pregnancy.[17]There appears to be far more public awareness of the impacts of smoking on pregnancy than of the impacts of alcohol on pregnancy. This represents a major challenge.

50. It is important that we ensure this increased capacity for understanding follows a non-discriminatory approach, both for those who are affected by the disorder and also their caregivers and families. FASD is a lifelong disability with significant unmet need. FASD needs to be diagnosed and recognised as a clinical disorder and not dismissed wrongly for example, by poor parenting practice or other circumstances.

51. Building evidence-based awareness and understanding among professionals is integral and would benefit from a cross-social sector approach.

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[15] See http://www.cads.org.nz/Pregnancy.asp

[16] Petersen, I.; McCrea,R.L.; Lupattelli, A.; Nordeng, H. (2015). Women's perception of risks of adverse fetal pregnancy outcomes: a large scale multinational survey. British Medical Journal Open Access. Accessed from bmjopen.bmj.com/content/5/6/e007390.abstract?sid=37ad2b71-da52-4f53-9fdd-70cc1ea03931.

[17] Ibid.

52. ARPHS recommends the creation and funding of a 'Centre of Excellence' where expertise can be further developed to guide and maintain consistency of evidence based practice. Such a centre can contribute to continuing education across services, increased training and development for service providers, health and other professionals and increased support for those already working in the area. An effective example of this type of centre is the Asante Centre in Canada which provides assessment, support, information and resources for a range of complex developmental disorders.[18]

53. Clear referral pathways are an important aspect of the continuum of care. Expectations around improving the prevention and incidence of FASD in New Zealand require support from appropriate treatment services and referral pathways are not currently in place.

54. Evidence shows that multidisciplinary assessment is the most effective way to diagnose FASD in an individual and improves the long-term outcomes for the child. Increasing clinical capacity and capability plays an integral part of this.

Q 13: Actions to support building blocks for Outcome 2

55. ARPHS supports the following actions

1. Building family and community capacity to understand and identify FASD and other neurodevelopmental issues:

- Ensuring that the parent/caregiver voice is included and taken into account in regard to FASD-specific policies around health, education and justice.
- Preventing discrimination by increasing the awareness that FASD is a lifelong disability for the affected child.
- Providing support for families with regard to the fiscal, emotional and time-consuming demands on those caring for a child or adult with FASD by ensuring their eligibility for financial and respite care support.
- Additionally, support is required for those diagnosed with FASD in terms of eligibility for disability and education supports that are not predicated on IQ alone but equally consider deficits in executive and adaptive function.
- Funding experts to deliver integrated intervention training and support programmes in mental health, justice, addictions and education that will assist individuals with FASD to reach and maintain their potential.

2. Building evidence-based awareness and understanding among professionals:

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[18] See http://www.asantecentre.org/General_FASD.html

- Upskilling professionals outside the health sector e.g. education to ensure that FASD prevention is taught across the education curriculum and in specialist courses.
- Funding, training and support for professionals in multiple sectors to undertake screening and brief intervention with women of childbearing age.
- Funding, training and support for professionals and support workers to support FASD training in integrated diagnosis and care planning across the lifespan.
- Supporting the establishment of a Centre of Excellence where expertise can guide and maintain consistency of evidence-based practice and continuing education across services.

3. Ensuring clear referral pathways:

- Together with FASD experts, developing guidelines and referral pathways for children and youth with FASD similar to the guidelines and pathways for young people with Autism Spectrum Disorder.
- Ensuring that these referral pathways are well resourced and communicated.
- Supporting an integrated continuum of care from diagnosis through to treatment/care.

4. Providing multidisciplinary assessment and the creation of an individualised profile:

- Learning from international best practice models and also those that are currently operating in New Zealand, for example in the Hawkes Bay.[19]
- Providing funding and support for national FASD experts to advise on multidisciplinary assessment models.
- Ensuring children in state care who are at very high risk of having FASD are screened and if positive, receive timely diagnosis, care and education adapted to their special needs.

5. Increasing clinical capacity and capability:

- Ensuring multidisciplinary diagnostic teams are supported and funded in the areas of highest need in New Zealand.
- Ensuring these teams have the capacity to follow best practice models of practice along the care continuum.

56. ARPHS recommends giving priority to:

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19 http://alcohol.org.nz/sites/default/files/documents/HBDHB%20Development%20Assessment%20Programme%20FASD%20Assessment%20Pathway%20-%20Process%20Evaluation%20Report%20August%202015.pdf

- Support specialist training for all DHB child health and mental health assessment services according to best practice diagnostic and intervention protocols.
- Implementing efficient and effective ways to streamline the integration of an FASD assessment service into existing services.

Q 14: Assessing effectiveness

57. ARPHS recommends:

    1) A national repository of FASD clinical data to collect, analyse and report on:

    - Age of diagnosis.
    - Number, functionality and capacity of multidisciplinary teams in New Zealand.
    - Awareness levels amongst health, education and justice professionals around FASD.
    - Prevalence of FASD in New Zealand, numbers diagnosed and care plan details.
    - Prevalence of FASD amongst people in prison
    - Educational outcomes for individuals with FASD.

    2) Reporting on regional FASD training and service provision policies and plans.

    3) Number of DHB teams providing multidisciplinary FASD diagnosis and follow-up care according to best practice.

58. As a short term indicator, ARPHS would support assessing the number of DHB teams incentivised and enabled to provide multidisciplinary FASD diagnosis and follow-up care according to best practice.

59. As a long term indicator, there should be a national repository for the collection and analysis of FASD clinical data to collect data as indicated above.

Q 15-17: Building Blocks for Outcome 3 - Recommendations:

60. ARPHS supports the listed building blocks for action. There are particular groups in New Zealand that experience more harm from alcohol that will benefit from specific approaches targeted to their needs.

61. Parents, families and caregivers caring for children and adults require adequate support from agencies. FASD models in Canada provide a good example.

62. Preventing alcohol use in pregnancy and supporting FASD service provision should improve outcomes.

63. Professionals working with affected children and families would benefit from additional training and support.

64. Priority should be given to ensuring there is a multidisciplinary team accessible for FASD assessment in each region including mental health and forensic teams. Best practice examples can be evidenced in Hawkes Bay, Taranaki and Northland.

65. Indicators should include assessment of:
    - Community awareness of key FASD and alcohol and pregnancy related concepts.
    - Level of awareness of options for help, care and support by professionals and parents/families/caregivers.
    - How well the services and referral pathways are meeting the needs of affected families and children.
    - Level of ease/difficulty for families and professionals to navigate care and referral pathways.

66. As short term indicators, we would support assessing the adequacy of FASD services that are in place for families/parents/caregivers.

67. For a long term indicator we would support assessing the accessibility of services by families/parents/caregivers and professionals.

Q 15-17: Building Blocks for Outcome 4:

68. In the developed world, FASD is recognised as the leading preventable cause of development disabilities, yet in New Zealand, no reliable data has so far been gathered. We are currently basing our FASD incidence on overseas estimates which have differing levels of reliability. Better information is vital to develop effective policy and other sector responses to reduce the prevalence and societal impact of FASD.

69. "Encourage research" could be strengthened to "Fund and adequately support NZ specific FASD research".

70. The following actions would support these building blocks:
    - Including the capture of alcohol-harm data for all patients presenting to hospital, brief intervention details and referral of patients at risk of harmful alcohol use within hospital information systems.
    - Building a research network to guide and conduct FASD-related research

- Funding a World Health Organisation national prevalence study (which New Zealand has been invited to participate in) to ascertain the scale of FASD
- Conducting a Youth Justice FASD prevalence and intervention study
- Developing a national repository for the collection and analysis of FASD clinical data
- Conducting a cost benefit analysis to determine the cost of FASD in New Zealand
- Ascertaining from families their needs, strengths and opportunities to improve services and support. These studies have been done in New Zealand in a small way via doctoral theses but there are international studies that could be extended to the New Zealand context to give us a better understanding.
- Researching the outcomes of FASD and the cost-benefit of intervention studies.

71. The actions listed above are in chronological order. The opportunity to fund a World Health Organisation prevalence study in New Zealand would be a timely opportunity to get some initial localised data.

72. We would support measuring the following to assess progress:
    - Numbers of women and men of childbearing age presenting to hospital with alcohol-related harm; numbers receiving alcohol brief intervention; numbers referred for further interventions.
    - Number and type of services providing screening and early/brief intervention to women and children with regard to alcohol and pregnancy and FASD.
    - Effectiveness of screening and early/brief interventions being carried out – how many and who are they capturing; level of advice/help being given; number being referred to treatment and other care options and the success of these.
    - Prevalence of FASD in New Zealand.
    - Prevalence of women drinking during the different stages of pregnancy in New Zealand.

73. We would support the establishment of a national repository for the collection and analysis of FASD clinical data in New Zealand as a short term indicator, and the prevalence of FASD and women drinking during the different stages of pregnancy in New Zealand as a long term indicator.

74. ARPHS welcomes involvement in any further discussions on the development of the action plan and would like to speak in support of its submission if the opportunity arises.

Appendix 1 - Auckland Regional Public Health Service

Auckland Regional Public Health Service (ARPHS) provides public health services for the three district health boards (DHBs) in the Auckland region (Auckland, Counties Manukau and Waitemata District Health Boards).

ARPHS has a statutory obligation under the New Zealand Public Health and Disability Act 2000 to improve, promote and protect the health of people and communities in the Auckland region. The Medical Officer of Health has an enforcement and regulatory role under the Health Act 1956 and other legislative designations to protect the health of the community.

ARPHS' primary role is to improve population health. It actively seeks to influence any initiatives or proposals that may affect population health in the Auckland region to maximise their positive impact and minimise possible negative effects on population health.

The Auckland region faces a number of public health challenges through changing demographics, increasingly diverse communities, increasing incidence of lifestyle-related health conditions such as obesity and type 2 diabetes, infrastructure requirements, the balancing of transport needs, and the reconciliation of urban design and urban intensification issues.

Appendix 2 - Alcohol related harms and their relationship to Health Inequalities

Figure 1 below indicates the strong association between alcohol use and the social gradient, with the most deprived group at three times greater risk of alcohol dependence compared with the most affluent group.

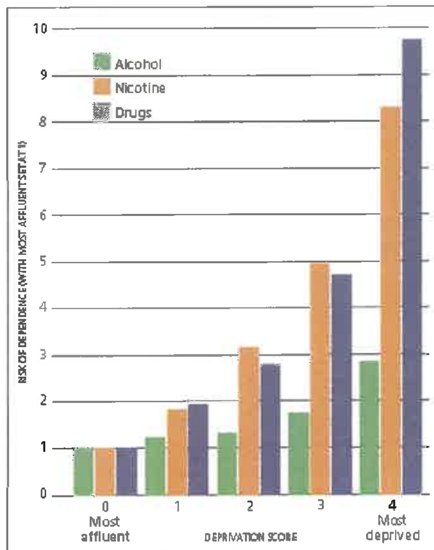

Figure 1: Socioeconomic deprivation and risk of dependence on alcohol, nicotine and other drugs[20].

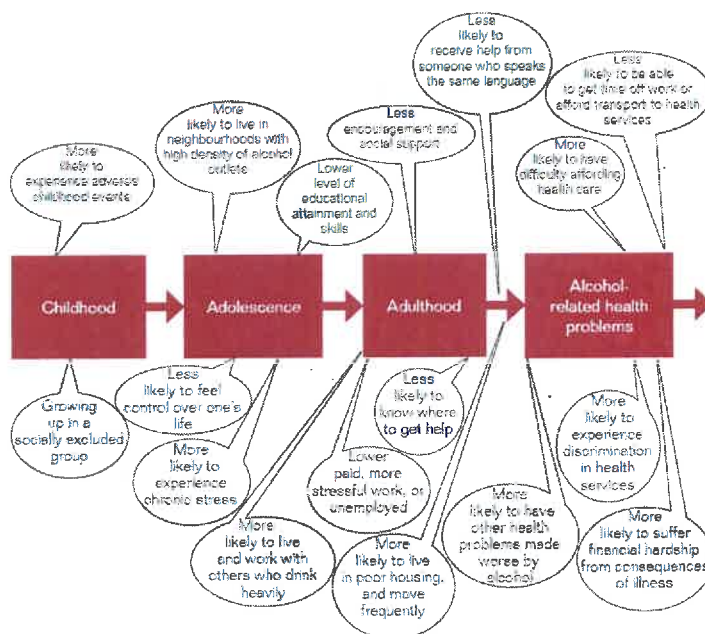

Figure 2: How inequalities in alcohol related harm compound over a life course[21].

[20] Wilkinson, R., 'The Solid Facts: Social Determinants of Health' World Health Organization. Accessed from: http://www.euro.who.int/en/publications/abstracts/social-determinants-of-health.-the-solid-facts

[21] Loring. B. (2014). Alcohol and inequities. Guidance for addressing inequities in alcohol related harm. World Health Organization (WHO). Page 11.