Submission to the Inquiry into preventing child abuse and improving children's health outcomes

4th May 2012

Alcohol Healthwatch is an independent charitable trust working to reduce alcohol-related harm. We are contracted by the Ministry of Health to provide a range of regional and national health promotion services. These include: providing evidence-based information and advice on policy and planning matters; co-ordinating networks and projects to address alcohol-related harms, such as alcohol-related injury, fetal alcohol spectrum disorder, supply to minors and tertiary student drinking; and co-ordinating or otherwise supporting community action projects.

Thank you for the opportunity to submit our thoughts on this inquiry. Our comments will mainly focus on aspects that relate to our mission to reduce alcohol-related harm in Aotearoa- New Zealand.

We would appreciate the opportunity to present an oral submission.

If you have any questions on the comments we have included in our submission, please contact:

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Introduction

New Zealand is one of the most poorly performing countries in the OECD in terms of outcomes for children (28th out of 30 countries). We also have one of the lowest rates of public investment in children in the OECD (less than half the average spend per child under the age of 6 years). The investment we do make ranks as one of the least effective.

We are frustrated that we are continually talking about these horrendous statistics and issues year in and year out. We need action. We applaud the preventative approach that this inquiry is taking as this is what is required to make a real difference to these issues.

Lievore and Mayhew (2007) define child abuse and neglect as including:

1. Children witnessing inter-parental violence
2. Physical discipline and physical abuse of children
3. Childhood sexual abuse
4. Child injury, mortality, homicide and suicide
5. Child neglect

(Accessed from Infometrics, 2010).

Alcohol abuse and dependence is one of the markers that increase the probability of child abuse and neglect. Alcohol also plays a part in a number of the other markers that have been identified such as poverty, education, mental health, past exposure of parents to interpersonal violence or abuse and social deprivation. It is useful to look at how alcohol abuse/dependence affects each of these definitions of child abuse and neglect to understand how important it is that alcohol-related harm is taken seriously by policy makers.

1. Children witnessing inter-parental violence

Intimate partner violence is a major social and economic burden in New Zealand with one in three ever-partnered women experiencing violence from their male partners (Fanslow, 2004 & Lievore, 2007). It is estimated that one in seven New Zealand families experience violence (Snively, 1994); this is further evidenced by New Zealand Police attending a family violence incident every seven minutes (NZPA, 2010).

A recent OECD report that included all OECD countries ranked New Zealand as having the highest prevalence of physical violence from intimate partners (OECD, 2010). In addition, a recent study published in the Lancet, suggests that New Zealand has the highest rates of partner physical or sexual assault of all the six countries from where the research data was collected (England, Sweden, Western Australia, Canada (Manitoba), USA and New Zealand), (Gilbert, 2011). Furthermore, in New Zealand, Police note that alcohol is a factor in a third of all reported family violence (Broad, 2010).

Violence is one of many negative outcomes associated with the consumption of alcohol (Room, 2005). The World Report on Violence describes alcohol abuse as a risk factor for more than one type of violence and an important situational factor that can precipitate violence. Alcohol is regarded as a precipitant to violent behaviour and associated with both perpetrator and victim (WHO, 2005 & Krug, 2002).

Babor et al., (2010) suggest a causal relationship between alcohol consumption and violence. These claims are also supported by a number of recent studies, both national and international, that suggest a causal relationship between alcohol and violence (Boden, 2011, Livingston, 2011, Connor, 2011, and Cunradi, 2011).

Alcohol misuse has been associated with intimate partner violence (IPV) in both experimental and empirical studies (Abramsky, 2011, McKinney, 2010, Foran, 2008, and Boden, 2011).

It should however be noted that not all alcohol consumption leads to violence, but the literature does suggest that the sustained use and abuse of alcohol does appear to increase an individual's chance of being violent (MOJ, 2009).

2 & 3. Physical Discipline, physical abuse of children and childhood sexual abuse

Of the 30 OECD countries, New Zealand ranked second to last in child health and safety rankings (OECD, 2009). New Zealand has the fifth worst child death record of 27 countries by maltreatment/abuse (UNICEF, 2003). On average 1 child is killed every 5 weeks and most of these children are under 5 years of age (Child Matters, 2011).

In New Zealand, every hour, two children are physically, sexually or emotionally abused (MSD, 2011). A recent report estimates child abuse to cost New Zealand $2 billion every year (Infometrics Ltd, 2010). Others however have estimated the figures to be higher. For example, Jülich (2004) suggests child sexual abuse alone costs New Zealand $2.4 billion a year.

The New Zealand National Survey of Crime Victims found that the lifetime prevalence of sexual interference or sexual assault and experience of sexual interference or sexual assault before the age of 17 for women and men to be 13.5% and 3.8% respectively (Morris, 2003). Lifetime prevalence was relatively high for Māori (12.2%) as compared to NZ European/European 9.2%; Pacific peoples 3.2% and Other 2.3%.

A cohort study of New Zealand children from birth to age 25 by Fergusson et al. (2000) showed that 1 in 5 people had experienced sexual abuse before the age of 18 (cited in Fanslow, 2007). Dr. Fanslow also cites another New Zealand study that found rates of child abuse at 32% before the age of 16 (Anderson et al., 1993).

Alcohol use and abuse is closely associated with child abuse, neglect, maltreatment and injuries (WHO, 2006, UN, 2006). Violence against children and child abuse as a result of parents/caregivers alcohol use and abuse is a growing concern worldwide and in New Zealand (WHO, 2006, UN, 2006, CDC 2008, Casswell 2011). One in every six cases of child abuse is alcohol related (Eurocare, 2007). Evidence suggests parent's alcohol abuse increases children's risk of physical and sexual abuse (Gluckman, 2011).

Child protection services report alcohol abuse by parent or caregiver as one of the top contributors in child protection cases (Meredith, 2011).

The positive association between parents/caregivers alcohol use and child abuse (physical/ sexual) can be approached in a number of ways. A parent or caregiver under the influence of alcohol may be unable to provide adequate child care, good quality parenting, keep the child safe (lack of supervision), meet their needs, perform tasks of parenthood, raise the child properly and teach moral and social learning's. Furthermore, alcohol abuse by parents and caregivers can lead to physical and/ or sexual child abuse, child neglect and vice versa (WHO, 2006, UN, 2006, CDC, 2008, Bromfield, 2010, Casanueva, 2005, Meredith, 2011 & Lown, 2011).

Casswell and colleagues (2011) in their research (which involved 3068 New Zealanders) found that one in four respondents said that they had at least one heavy drinker in their lives. Of these:

- 17% of respondents with children indicated that their children experienced harm because of others drinking in the previous 12 months.

- 11% of respondents living with children indicated that the child had been yelled or verbally abused, 2% were physically hurt as a result of someone's drinking.
- 7% said that children had witnessed serious violence because of someone's drinking.
- 5% children were left in unsupervised conditions or unsafe conditions.
- 5% indicated that there was not enough money left to meet children's needs.
- 30% had to take on extra responsibilities caring for children or others.

Research carried out to inform the Campaign for Action on Family Violence clearly stated the extent of harm that children experience as a result of parents or caregivers alcohol use, and the long term harmful consequences that result from the traumatic experiences that occurred during their childhood (Centre for Social Research and Evaluation, 2008 & Girling, 2006). Children who witness adult violence at home, and children who are victims of abuse and violence, carry the trauma for the rest of their lives. Recent studies have also shown that children who are exposed to domestic violence, child abuse and child maltreatment have adverse psychosocial and behavioural outcomes in present and later life (Sternberg, 2006 & McCabe, 2005). Research has also found that child abuse is associated with an increased risk of poor physical health in adulthood including respiratory, cardiovascular, gastrointestinal, neurological, musculoskeletal and metabolic disease and disorders (Wegman, 2009). Furthermore, children and young people who experience domestic violence and abuse are at heightened risk of substance abuse (alcohol, drug and tobacco), delinquency, risk taking behaviour, eating disorders, self-harming behaviour and suicide, depression and post-traumatic stress reactions, increased aggression, violence and criminal activity in later life (Bentovim, 2009, Lamont, 2010 & Carrington, 2006).

4. Child injury, mortality, homicide and suicide

Children and young people are dying directly from alcohol-related harm in New Zealand.

Alcohol abuse is associated with lack of supervision of child, increasing the risk of injuries and child neglect (Casanueva, 2005). Casanueva (2005) found that maternal alcohol abuse was positively associated with child's lack of supervision and lack of supervision of the children were positively associated with children's injuries presenting to the Emergency Department.

The recently published Child Youth and Mortality Review Committee's (2009, published in 2011) special report on the involvement of alcohol consumption in the deaths of children and young people from 2005-2007 suggests that an average of 61 children and young adults aged between 4 weeks and 24 years and 364 days died because of their or someone else's drinking. In 32% of the deaths, the death occurred due to someone else's drinking. The proportion of alcohol involvement in deaths was highest for motor vehicle accident's (31%), closely followed by falls (30%), assaults (29.6%), poisoning (20.6%), drowning (15.7%), and suffocation (9.7%) respectively.

The report 'Learning from Tragedy: Homicide within families in New Zealand 2002-06' (2010), looked at the homicide deaths investigated by police during the 5 year period. Of the 291 homicide deaths during this period, 38 were child homicides. Alcohol abuse was a ubiquitous feature in the report. For couple-related homicides, alcohol and/or drug abuse featured at the time of the incidents in about two-thirds of the cases and based on the findings from this study and international research, a woman is at higher risk of being killed by her male partner if he abuses alcohol and/or drugs. One of the three most common factors associated with child homicide events was alcohol and drug abuse and the report summarised that children are at highest risk of death from maltreatment in their first year of life and when they live with young unemployed parents or caregivers who abuse alcohol and drugs. The review concluded with four key areas with potential for action to reduce within family homicides; Alcohol and drug use was one of these factors.

New Zealand has the highest rates of suicide in the OECD for youth aged 15-19 years old (OECD, 2009). Suicide rates, particularly among females aged 15-24 years are highest for New Zealand in comparison to other OECD countries (MOH, 2010a). Alcohol use is a strong indicator of increased suicide risk.

5. Child neglect

As mentioned above, alcohol abuse is often associated with a lack of supervision of the child, increasing the risk of injuries and child neglect (Casanueva, 2005). Casanueva also found that maternal alcohol abuse was positively associated with a lack of supervision for their child. Additionally, lack of supervision was positively associated with child injury presentations to the Emergency Department.

Parental alcohol abuse/dependence can also have a negative economic impact on families which can cause poor health outcomes for children. For example, if a substantial proportion of the household income is being spent on alcohol rather than on such essentials as electricity, education, nutritious food and medical care, children can have poorer health and educational outcomes.

Terms of Reference

1. *To update knowledge of what factors influence best childhood outcomes from before conception to 3 years, and what are significant barriers.*

Alcohol affects childhood outcomes in a number of ways, both directly and indirectly. Some of these have been outlined in the introduction above.

We already have the knowledge and evidence around what works best to decrease alcohol-related harm; this is articulated in numerous reports and forums. We also have strong public support as evidenced by the recent disclosure of a public opinion survey on alcohol attitudes that was carried out by the Health Sponsorship Council. This report showed significant support for a number of key policies including the three 'best buys' to reduce alcohol-related harm; raising taxes on alcohol, restricting the access to retailed alcohol and enforcing bans on alcohol advertising (Peck, 2011). However, thus far there has been little progress towards implementing best practice policies and plans and we currently have a strategy vacuum. We believe that this poses a significant barrier for our children's ability to experience the best possible health outcomes.

We have the evidence, we know what works, we now just need to act.

The Centre of Social Research and Evaluation (2008) describe the incidence of child maltreatment as the interaction of *predisposing, perpetuating* and *precipitating* risk factors (cited in Infometrics, 2010).

Predisposition appears to be influenced by genetics and lifetime experiences. In particular it appears that adults who have been abused as children are more likely to abuse their children than adults without this history. However, it is important to note here that the majority of parents who were maltreated actually do not abuse their own children.

Perpetuating factors are defined as those that affect the family in a continuing or ongoing way. These can be:

- External social or community influences such as; poor living standards, social norms that promote violence, access to alcohol and drugs and social isolation.
- Family situation influences such as; unintended pregnancy, financial deprivation, stress, unemployment, partner conflict or violence and lack of support from extended family.

- Parental or caregiver behaviour or characteristics such as; lack of bonding with the baby, depression, physical or mental health problems, alcohol or drug abuse, inadequate parenting skills (and lack of support), involvement in criminal activity and lack of impulse control.
- Child characteristics such as; unwanted child or disability or other high need characteristics.

Precipitating factors are those events that directly trigger an abusive episode such as incessant crying or a crisis event for the parent.

All of these factors make a strong case for applying a prevention strategy to improve the outcomes for children.

Equity from the start

Early childhood development – including the physical, social/emotional, and language/cognitive domains – has a determining influence on subsequent life chances and health through skills development, education and occupational opportunities. Through these mechanisms, and directly, early childhood influences the subsequent risk of obesity, malnutrition, mental health problems, heart disease, and criminality. This has huge implications for the individual's health and society at large (WHO, 2008).

Evidence for action

Investment in the early years provides one of the greatest opportunities to reduce health inequities within a generation. Experiences in early childhood (defined as prenatal to 8 years old), and in early and later education, lay critical foundation for the entire life-course. The science of early childhood development shows that brain development is highly sensitive to external influences in early childhood, with lifelong effects.

Studies in child development emphasise that different stages of the life cycle are critical to the formation of different abilities. When the opportunities for formation of these abilities are missed, remediation is costly, and full remediation is often prohibitively costly. In terms of reversing the negative effects, the earlier the detection and intervention, the more positive the outcomes are likely to be. More recently, developments in neurosciences and epigenetics have generated other plausible explanations for why path dependence seems to matter so much in child development (Infometrics, 2010).

Skill development has important implications for both the later financial welfare of individuals, and potentially also generates further spillover benefits for others as well. There is a broad base of evidence that higher skills (at least as proxied by educational achievement) are related to higher earning prospects at the individual level, and that these individual returns to education have risen over the last half century. The evidence is less clear cut between higher educational attainment and economic growth, but a number of studies find that a positive relationship between education outcomes and economic growth, as suggested by theory, does exist (WHO, 2008).

The case for prevention

Brain development is continuous over many years. Neuroscience provides a compelling argument for beginning intervention programmes at birth, if not prenatally. Developmental research shows that children master different skills at different ages, which suggest that opportunities for a variety of effective interventions are present throughout early childhood (Infometrics, 2010).

Currently there appears to be a natural bias against investment in preventative activities. Some prevention measures may appear to have large upfront costs and results may not be delivered short

term, however the case is strong for the positive impacts that preventative investment can have both economically and developmentally.

A number of international studies have found that national commitment and investment in public health strategies (that is, preventative health strategies rather than reactive health services) that are evidence-based can result in significant health care cost savings and overall economic cost savings (Robert Wood Johnson Foundation, 2011). For instance, in one particular study published in July 2011, researchers found that for each 10% increase in local public health spending, there were significant decreases in infant deaths (6.9% drop), deaths from cardiovascular disease (3.2% drop), deaths from diabetes (1.4% drop), and deaths from cancer (1.1% drop), (Robert Wood Johnson Foundation, 2011).

Economists now assert on the basis of the available evidence that investment in early childhood is the most powerful investment a country can make, with returns over the life course many times the amount of the original investment. Governments can make major and sustained improvements in society by implementing policies that take note of this powerful body of research while, at the same time, fulfilling their obligations under the UN Convention on the Rights of the Child (WHO, 2008).

Additionally, other potential benefits include:

- Gains in altruistic utility – knowing that we have done the right thing and knowing that children's wellbeing will improve with this investment.
- Fiscal/economic savings will increase the ability for greater future support for the elderly. If less is required to be spent on justice, social welfare for the working aged, and if economic growth and the tax based broadens, then more can be spent on health and income support for other things such as support for the elderly.
- Fiscal savings in this area will also mean that these savings can be fed into other areas of need such as education, job creation and health.
- Prospects of lower crime in the future will increase people's feelings of security and wellbeing as well as decreasing the cost burden that crime causes.

On the other hand, remedial actions are costly and ineffective. A lack of preventative action consigns whole segments of society to outcomes well below their potential. It also imposes costs on the rest of their peers who have to put up with supporting them and dealing with the consequences of the later anti-social activities of many child victims of abuse, neglect and poor health.

2. *What practical improvements can be made to health, education, social and other services, targeted at the preconception period that will improve infant and child outcomes (including the maintenance of a healthy body weight).*

One of Alcohol Healthwatch's priority work areas is preventing and addressing Fetal Alcohol Spectrum Disorder (FASD). FASD is an umbrella term describing the range of effects that can occur in an individual whose mother drank alcohol during pregnancy. These effects may include physical, mental, behavioural, and/or learning disabilities with possible lifelong implications.

Alcohol is a teratogen, a substance that from conception onwards can mutate DNA and alter the course of normal cell development until birth. The primary insult to the brain can be compounded when combined with other drugs, but alcohol is singularly the most damaging of all recreational substances. During early development, the whole brain is susceptible to the teratogenic effects of alcohol with the result that multiple domains of the brain are adversely affected – cognition, adaptation, attention, memory and executive function to name a few. A child whose genetic

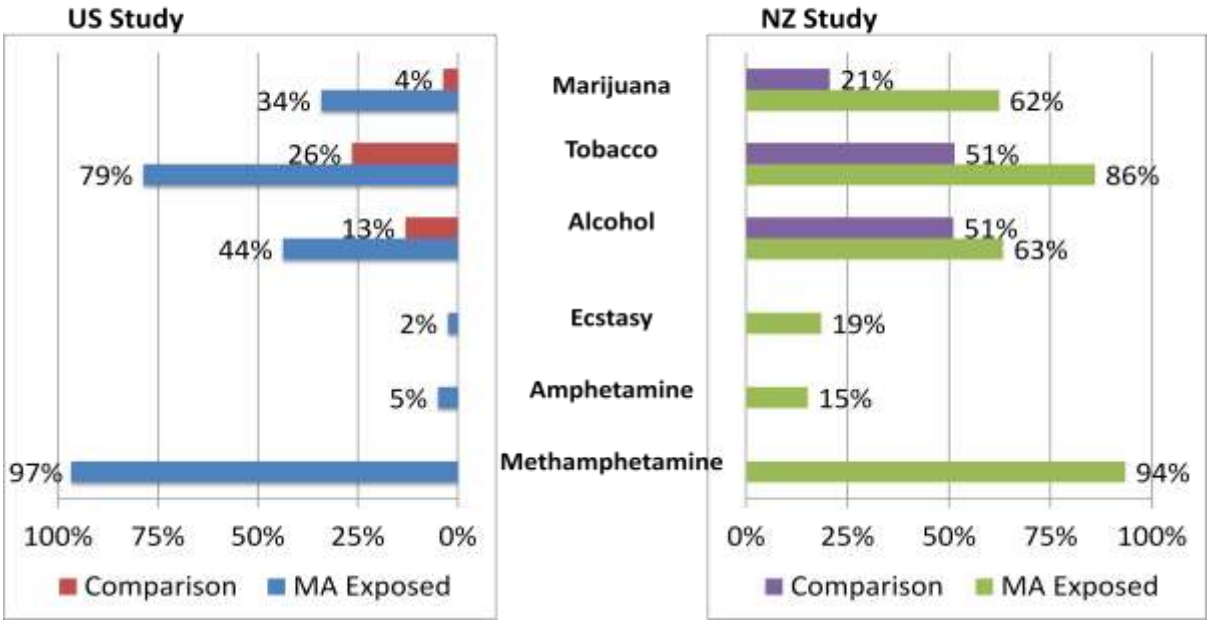
potential has been severely compromised in this way will struggle to understand and manage their learning and behaviour in a world that struggles to understand them. Without appropriate knowledge, understanding and support, these individuals become the adolescents, adults and parents who are viewed as failures in our society – a negative cycle of failure that can be slowed or stopped through appropriate intervention. The financial cost to New Zealand's economy that this and other alcohol-related disability causes is huge and the resulting human cost that is paid by the children, their families and their communities is immeasurable.

Firstly, we require the medical profession to provide consistent advice based on the best evidence available. This evidence says that **there is no safe level of alcohol for a pregnant woman**. It also says that if you are planning to become pregnant it is safest not to drink alcohol. This information needs to be given out more consistently and made more readily available to women of childbearing age; particularly those high-risk women.

3. *What practical improvements can be made to antenatal maternity services so that children 'at risk' of adverse health outcomes are identified early, monitored appropriately, and followed through to achieve best outcomes.*

According to recent research, pregnant women in New Zealand are drinking and using other drugs during pregnancy at a rate that is at least four times that of the United States (Wouldes, 2012 unpublished). The estimated rate of FASD in the USA is one percent of all births making the potential rate of FASD in New Zealand at least four times higher.

Figure 1. *Percent of US and NZ Mothers who used Marijuana, Tobacco and Alcohol by Exposure Status (Substance Use Inventory).*



(Wouldes et al, 2012).

Antenatal maternity services provide an opportune vehicle to ensure that relevant, up-to-date and evidence-based alcohol-related information is provided to mums, mums-to-be and other family members. As mentioned above, this information needs to be given out more clearly by medical

professionals, midwives, service providers and the like so that women can make informed choices around their alcohol use.

Antenatal maternity services would also provide an appropriate means of offering brief and early intervention for mums, mums-to-be and family members. Brief and early interventions have been proven to be very effective at changing people's drinking behaviour. They also provide an opportunity for referral to more appropriate services to meet the client's needs for example, alcohol and other drug treatment services with the desired goal of supporting no or lower alcohol use during pregnancy.

Improved information sharing systems between antenatal providers is also important to ensure that at-risk women are identified early and offered the required services or treatment to improve their own and their baby's outcomes.

4. *What practical improvements can be made to post-natal services (including the interface between lead maternity caregiver, Plunket and primary care) to ensure best outcomes for children.*

There are a number of effective alcohol-related interventions. An example of an effective, evidence-based program for high-risk mothers and their children is the Parent-Child Assistance Program (PCAP) that was developed in 1991 in the United States of America. It is an evidence-based home visitation case-management model for mothers who abuse alcohol or drugs during pregnancy. Its goals are to help mothers build health families and prevent future births of children exposed prenatally to alcohol and drugs.

The primary aims of PCAP are to assist substance-abusing pregnant and parenting mothers in obtaining alcohol and drug treatment, staying in recovery, and resolving a myriad of complex problems related to their substance abuse; to assure that the children are in safe, stable home environments and receiving appropriate health care; to link mothers to community resources that will help them build and maintain health, independent family lives and to prevent future births of alcohol and drug affected children.

PCAP is based on the tenet that effective intervention programmes for high-risk mothers take into account the complex nature of women's problems, and provide services that are multidisciplinary, comprehensive, coordinated and include the children. PCAP evaluations examine multidimensional outcomes, improved overall social functioning, and reduction of risk to the mother and target child. PCAP has been evaluated using blended evaluation designs and the outcomes have been published in three peer-reviewed papers. The evaluations show positive intervention effects between client groups and control groups and include an increase in abstinence from alcohol and drugs, an increase in stable, permanent housing, a decrease in mothers incarcerated during the interval, an increase in completed inpatient and outpatient treatment, an increase in the number of mothers that had employment as their primary source of income, a lower proportion of women having public assistance as their primary source of income and a decrease in index of children that were in the state foster care system.

For more information on this program visit http://depts.washington.edu/pcapuw/.

We believe that successful programmes, such as PCAP, align strongly with Whānau Ora approaches, particularly in relation to talking a whole person/setting approach.

Aos et al (2011) identify public policies that have been shown to improve outcomes such as child maltreatment, crime, education, public health and substance abuse and have completed an analysis of the costs and benefits and riskiness of each programme to the tax payer and others. The purpose of the research is to help policy makers in Washington identify evidence-based strategies that can deliver better outcomes per dollar of taxpayer spending. This type of research obviously is very relevant in these times of fiscal constraint; thereby making the findings interesting reading. Specifically, in terms of child welfare the programs that were analysed (for example, Triple P, Parent-Child Home Program and Healthy Families America) the overwhelming majority showed large monetary benefits both to the taxpayer and non-taxpayer, positive benefit to cost ratios and very good odds ratios that the benefits would indeed outweigh the costs.

Once again it is also important that more accurate alcohol-related information is available to mums, mums-to-be, and their families that follow international best evidence. In alcohol-specific terms, the 'Australian Guidelines to reduce health risks from drinking alcohol' provide a robust and evidence-based guideline. We also believe it is important to use the term 'low-risk' for levels of alcohol consumption rather than 'safe' as there is no 'safe' level of alcohol consumption.

5. *What, if any, improvements can be made to the 'well child' services (especially hard to reach children).*

Workforce capacity and capability development is a key issue. All types of health services need to base their knowledge of risks and interventions on the best evidence that is available. A greater ability to share information and have a higher level of transparency between agencies is important, particularly in terms of possible parental alcohol abuse. Systems need to be in place to give the ability to refer parents to alcohol treatment if required. As already mentioned, brief and early interventions to screen for harmful alcohol use are an evidence-based option to achieve this; 'well child' services could provide another vehicle for this to happen.

Accessible and accurate information on alcohol for parents should also be available via these services. This is required for parents to make informed choices about their drinking and the effects it has on their children.

6. *What practical improvements or interventions can be made to achieve optimal outcomes for children from the 6 week post-natal periods to 3 years of life, with particular reference to health services but not excluding education, social, housing, justice and other determinants of health?*

Developmental research shows that children master different ages, which suggests that opportunities for a variety of effective interventions are present throughout early childhood.

Skill development depends on both nature and nurture. Natural ability is built upon by years of schooling and training. The home environment will also influence both the duration of schooling and the level of application. Skill development builds on past skill acquisition. Skill acquisition today sets one up to acquire a higher level or different type of skill in the future.

Advances in scientific understanding of brain development have greatly enhanced understanding of how child abuse and neglect can influence brain development and thus have long lasting impacts on skill development.

Epigenetics is the interface between genes, which are fixed, and the environment, which is ever changing. Although people are born with a complement of genes that they cannot change, those genes can be switched on and off in response to environmental factors, a process that occurs from conception onwards. Alcohol is an epigenetic factor that can alter DNA methylation (Zhou et al, 2010).

Early experiences determine whether a child's developing brain architecture provides a strong or weak foundation for all future learning, behaviour and health. Genes determine when brain circuits are formed, but a child's experiences shape how that formation unfolds. Exposure before birth to alcohol, abuse and neglect fit in via the impact that traumatic events can have on brain development. For example, traumatic experiences for children lead to fear-related brain activation, which leads to adaptive changes in emotional, behavioural and cognitive functioning to promote survival. Researchers such as McGowan et al (2008) have concluded that their findings support the hypothesis that persistent elevation of stress hormones disrupts the brain's chemical balance that retards critical brain development. Toxic stress in early childhood can result in a lifetime of greater susceptibility to physical illnesses such as cardiovascular disease, hypertension, obesity and diabetes as well as mental health problems such as depression, anxiety disorders, and substance abuse.

Recommendations

These recommendations will be presented following the structure of the spectrum of prevention: Policy and Legislation, organisational practices, knowledge and skill building of professionals, strengthening individual knowledge and skills, fostering coalitions and networks and building a solid base of information.

Spectrum of prevention	Recommendations
Policy and Legislation	A long-term, cross-party, whole-of-government approach to creating environments that support and protect children is necessary and should be prioritised. Children should be placed at the centre of decision making. Guarantee a universal access to a range of early child development services: parenting and caregiver support, quality childcare, primary healthcare, nutrition, education, and social protection. Government investment should reprioritise spending to provide more early intervention. This should include appropriate intervention services for children and families affected by FASD. Please note also that we believe that 0 years should be defined as from conception, not from when a child is born.

	Foundation documents for alcohol-harm reduction need to be strengthened and updated to facilitate an evidence-based response to alcohol harm; for example, the National Drug Policy and the National Alcohol Strategy (which is now 9 years out of date). Strengthen the new alcohol legislation to ensure that the wider environment is supportive of parents in their role to protect their children against alcohol-related harm. The three 'best buys', despite not being in the new Alcohol Reform Bill should be progressed without further deliberation. These are: raise the taxes on alcohol, restrict the access to retailed alcohol and enforce bans on alcohol advertising. Raising the purchase age to 20 years is also important in light of the evidence base concerning brain development. The recent disclosure of a public opinion survey on alcohol attitudes in New Zealand showed significant support for such measures (Peck, 2011). Leadership needs to start at the top with the creation of a Minister for Children. This role can lead the strategic direction which should include an action plan for all children. This planning should be widely consulted on with relevant agencies including those involved with alcohol-related harm prevention.
Organisational Practices	We will require a multi-sectoral approach to these issues and we need to reach at-risk populations through multiple avenues. To enable this, common goals and KPIs that are measurable are required. Inter-sectoral collaboration and information sharing to improve the coordination of services is paramount. Facilitate the collaboration between services by removing barriers that preclude different services from working collaboratively to effect positive change and innovation. Strengthening investment in and further developing Whānau Ora approaches to planning and service delivery should be paramount. Universal services to all children are protective and enable early intervention within existing

	relationships. All families may need support at some time and universal services with skilled workers can enable families to access appropriate services when needed. Improve the information pathways and transparency between key agencies so that a wraparound approach can be taken to best assess and treat vulnerable children. The wellbeing of the child should be paramount in deciding what level of transparency there should be amongst professionals. Reorient health services to follow wraparound approaches such as the Whānau Ora approach PCAP programme. Treat the whole family, not just the individual. Services at all levels need to be better coordinated and to converge at the family and local community in a way that puts the child at the centre. Ensure Alcohol and Drug treatment services are sufficiently equipped and suitably skilled to better meet the needs of women (particularly women with children or who may be pregnant) and children. Improve access of Alcohol and Drug treatment services to Māori and Pacific peoples and young people. More investment into child specific alcohol and drug addiction services is needed; particularly in areas outside of main cities. Reorientation programmes aimed at behaviour modification are better able to meet the special needs of children and their family/whānau affected by FASD. Traditional methods maybe ineffective. Outreach services have proven to be effective in 'reaching' tamariki ora and providing required services and these should be extended where required. Support a multi-sectoral and preventative approach to improving wider determinants of health and lifestyle patterns and decreasing inequalities.

	Support external agencies such as NGOs that work to reduce alcohol-related harm. More investment is needed in evidence-based interventions for alcohol such as screening and brief and early intervention.
Knowledge and skill building of professionals	Recognise that there are children in our society whose brain and genetic potential has been permanently compromised by prenatal alcohol exposure and that these children are particularly vulnerable. Ensure all health professionals are assessing risks of harmful drinking by screening and are confident in responding to this by either using early and brief interventions, or referring to appropriate services. The capacity for diagnosis and intervention for those with alcohol abuse/dependence issues needs to be improved greatly through more investment and commitment. Identify other medical professionals and service providers and develop their skills to provide brief and early intervention screening for alcohol. As a beginning point, these professionals should have high access to women, Māori and Pacific women and children and young people. Improve the workforce for children by ensuring FASD knowledge, recognition and intervention education is fundamental for all social workers, teachers, Police, youth justice workers and health professionals and delivered in a consistent and sustainable basis. Work collaboratively with the Fetal Alcohol Network NZ and other relevant sectors that have an association with FASD to develop strategic direction and guidelines for FASD prevention. The multiple avenues that are available via the different sector workforces that have contact with children and families need to be supported to provide professional alcohol-related intervention. Potential ways in which sectors such as health, education, justice and social services etc can provide value are through providing information, referrals and intervention. Regular support, training and

	workforce development can be provided for this by organisations with a focus to reduce alcohol-related harm. All types of health services should be required to base their knowledge of risks and interventions on the best evidence available such as the 'Australian Guidelines to reduce health risks from drinking alcohol'. Investment and support of evidence-based resources for health professionals should be encouraged. For example, the recent PACT resource to help health professionals discuss alcohol use with pregnant women should be supported.
Strengthening individual knowledge and skills	Alongside strengthening the knowledge and skills of the professional workforce, the capacities of individuals in the community can also be improved in relation to alcohol knowledge. Community action projects are one avenue to influence this. Enabling policies are also required to support the capacity within the community. Evidence-based ways of communicating the correct information on alcohol should be utilised. These do not include education in schools and mass media campaigns for health messages.
Fostering coalitions and networks	Build capacity across sectors and communities for a stronger evidence-based response to alcohol-related harm. More investment and commitment is required for community action projects that work in communities to decrease alcohol-related harm.
Building a solid base of information	More investment and commitment in research, monitoring/evaluation and data collection is required. Currently, we have a lack of good quality data on which we can base solid and measurable KPIs upon.

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