

Report

*Women and Alcohol
in Aotearoa/New Zealand
Te waipiro me ngā wāhine
i Aotearoa*

Jenny Rankine

with Amanda Gregory, Anna Tonks and Te Pora Thompson-Evans

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Whakatūpato Waipiro



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2. Summary

This précis brings together the summaries at the end of each section in the report.

The Women and alcohol/Te waipiro me ngā wāhine project included a literature review of women's alcohol consumption, influencing factors, alcohol problems and interventions. It also included focus groups and key informant interviews with 41 health and welfare providers from organisations working with women affected by alcohol.

LITERATURE REVIEW

Women's drinking

While the total volume of alcohol that women drink is still around a third that of men, between 1995 and 2000 the amount women and men aged 20 to 39 drank in a typical session and their rates of drunkenness were converging. The proportion of young women aged 16 to 17 having eight or more drinks in a session tripled between 1995 and 2011, and was greater than the proportion of young men in 2011. However, there is no general recent analysis of convergence between men and women's drinking.

The proportion of abstainers has increased significantly over the last decade among female secondary school students, and in the last 18 years among women up to age 65. However, those who drink did so more times on average in a year, and increased the typical amount they drank. Between 1995 and 2000 young women aged 16 to 24 increased the amount they drank in a typical session from four to six drinks. Between 1995 and 2011, the proportion having five or more drinks at least once a week increased by 50%.

Among female secondary school drinkers, the proportion who binge drink has also increased. Ten percent of female students usually drank 10 or more drinks per session in 2012. In 2006, 36% of female tertiary students got drunk once a week and 39% drank six to 10 drinks a session. In 2006, 44% of women aged 55 to 70 drank hazardously. Most female secondary students drink RTDs.

Māori and Pacific women are more likely than Pākehā to be non-drinkers, to drink less often, and to have more drinks on a typical occasion, although these factors vary by ethnicity among Pacific women. The proportion of drinkers among Māori women aged 16–24 has increased significantly in the last decade. The proportion of Māori women drinking hazardously declined from 31 to 28.5% between 1996 and 2006.

Pacific women increased the average number of times they drank in a year over the last decade; the proportion drinking hazardously rose from 21 to 26% between 1996 and 2006.

Pākehā women are more likely to be drinkers and to drink regularly, but less likely to be binge drinkers. The proportion of European/other women drinking hazardously increased from 12 to 14.5% between 1996 and 2006.

'Asian' women have high rates of non-drinking, tend to drink less often and to have low quantities per session, although these vary by ethnicity. The proportion drinking hazardously declined from 5 to 4% between 1996 and 2006.

Women in more affluent areas are more likely to drink daily. Those in more deprived areas are more likely to drink hazardously.

Lesbian and queer women are more likely to be drinkers than their heterosexual peers, and in 2004 were more likely to drink at least weekly; binge drinking rates are higher among bisexual secondary school students than those attracted to the same or the opposite gender. However, information is scant. This review found no data about transgender women's drinking in New Zealand.

In 2006, around 80% of women were drinking alcohol around the time they became pregnant. Most stopped, but up to 36% continued to drink during pregnancy.

Sportswomen had an average drinking score above hazardous level in 2006. Those receiving alcohol sponsorship had higher hazardous drinking scores than those with none, and those sponsored at individual, team and club level had the highest score.

Half of a sample of female prison inmates in 1999 drank at hazardous levels before they were convicted.

Sex-based differences

Women process and absorb the same amount of alcohol slower than men of the same weight, so that alcohol damages women sooner and more seriously. Girls and women who drink similar amounts to their male peers are likely to develop chronic alcohol-related diseases more quickly.

Influences on drinking

Alcohol has never been more heavily marketed; it is now embedded in young people's online socialising. This marketing is a major social determinant of people's drinking. It is linked to increased drinking in 10- to 29-year-olds, and encourages drunkenness, particularly around young women's social networking, music and sport.

Alcohol advertising to men reinforces sexualised and trivialising images of women that impede the prevention of sexual and domestic violence.

In contrast to the tobacco industry, the alcohol industry is represented in alcohol policy-making bodies in New Zealand and internationally. The industry consistently lobbies for ineffective strategies about alcohol harm as well as self-regulation of marketing, and against the most effective policies that restrict alcohol availability and accessibility and regulate price.

Alcohol policies have been steadily relaxed over the last two decades, gradually transforming alcohol from a potentially lethal product requiring social intervention to prevent a range of problems, into an ordinary consumer item. Alcohol has never been more readily available.

A high density of alcohol outlets is linked with increased binge drinking, and increased adolescent and tertiary student drinking. Outlets are clustered in poor neighbourhoods and may have a stronger influence than peer norms.

Public disapproval is higher for female than male drunkenness. However, heavy drinking has become a social norm for many young women and male drinking patterns set the standard. Young women perceive drinking as a sign and result of gender equality, as well as a way of resisting traditional constructions of femininity.

Women's experience of child abuse and adult sexual and domestic violence, as well as racism, poverty and discrimination, is linked with increased drinking. Heavier drinking is also linked with depression, body dissatisfaction, anxiety and post-traumatic stress disorder.

Questions about alcohol benefits

Claims in the early 1980s about cardiovascular benefits from moderate drinking have been overstated, and some of the apparent benefits may be due to other unmeasured lifestyle factors. As a result, estimates of health benefits to women from alcohol in Aotearoa have trended downwards over the last 26 years. Benefits are probably slight, and apply only to older people who drink less than half a standard drink a day. They apply more to Pākehā than Māori, and to men than women. For women they are outweighed by health dangers from moderate drinking, such as an increased risk of breast cancer.

Health problems from alcohol

Alcohol-related problems affect Māori women much more than tauwiwi; Māori women's rate of years of life lost to alcohol is 2.7 times that of tauwiwi women.

Alcohol-related Injuries caused 30% of years of life lost to Māori women and 15% for tauwiwi women in 2007. Binge drinking is most risky – it doubles women's immediate risk of unintentional and traffic injuries.

Alcohol was involved in one in three traffic crash injuries to Māori and one in four for tauwiwi women, although this is likely to be an undercount. In 2009 women made up almost one in three alcohol-affected drivers in traffic crashes, although this is increasing.

Alcohol use by violent partners was linked to more frequent and severe violence and injury for women, and more than half of women killed by their partners.

After the minimum purchase age dropped from 20 to 18 in 1999, alcohol-related hospitalisations, emergency

department presentations and alcohol-related traffic accidents increased among 15 to 19-year-old young women. Most of those aged 12 to 14 admitted to hospital for alcohol poisoning in 2002 were girls. This is a continuing concern.

Five in every 100 babies were estimated to be affected by Fetal Alcohol Spectrum Disorder (FASD). New Zealand has no standardised routine screening, systematic intervention or support programmes, and the lifetime consequences are serious.

Previous national FASD prevention campaigns have portrayed the pregnant woman as under surveillance and solely responsible for any risks to the fetus. This is similar to overseas campaigns which blame the pregnant woman and ignore the contribution of their partners, families, and the wider environment, including alcohol marketing and policy.

Alcohol is carcinogenic. Each 10g of alcohol a day on average increases a woman's breast cancer risk by 10%. Alcohol was estimated to cause one in seven cases of breast cancer in 2004, to have killed 72 women in 2007, and hospitalised more than 400 in 2009. Alcohol also contributes to a range of other cancers.

Women who drink heavily have a higher risk of fire injury or death, and of alcohol-related self-harm and suicide attempts. Women are 13 times more likely to injure themselves in a fall after three drinks than non-drinking women.

At least 3% of women are addicted to (dependent on) alcohol and 7% abuse alcohol at some time in their lives. Illness, disability or early death from these alcohol disorders caused half of all the healthy years of life that all women lose due to alcohol. In women aged 15 to 29, depression was the fourth-highest cause of years of disability due to alcohol in 2004.

Rates of alcohol disorders are higher among Māori, Pacific and young women, and women with low incomes or living in poor neighbourhoods. Multi-drug use is common among dependent women; they are twice as likely to die as alcohol-dependent men of the same age. Many alcohol-dependent women are also depressed. Alcohol disorders are likely to increase significantly among older women in the next decade. Women's hospitalisations for two alcohol-caused conditions, alcoholic psychosis and gastritis, significantly increased between 1996 and 2011.

After drinking, up to 11% of female tertiary students had had unprotected sex in the last three months, and 16% of secondary school students in the previous year. This increases their risk of sexually-transmitted infections and unplanned pregnancies.

Heavy drinking also contributes to a range of heart and circulation problems.

Social problems from alcohol

Alcohol is increasing health and social inequities in Aotearoa, including between Māori and tauīwi women, for Pacific women and those living in poor communities.

The full picture of the damage done to non-drinkers by drinkers is still being developed and is currently likely to be under-estimated. Women disproportionately bear more of the consequences of men's heavier drinking. Women are more likely to have a heavy drinker in their lives than men, and heavy drinkers significantly lower the wellbeing of those around them. Women in 2009 were also more likely than men to report problems from someone else's drinking in the last year; 19% had been left without enough money and 6% without food. Growing up in a heavy drinking household may prevent children from developing fully, resulting in a need for long-term support at school and later in life.

One in five women under 20 had been sexually harassed by someone who had been drinking in the last year, and one in three female university students in the last three months. Seven percent of female university students had had alcohol-related unwanted sex. Alcohol is the most common drug used to enable sexual assault.

Alcohol-related violence to women usually happens at home and has a major impact on their wellbeing. More than one in three women experience alcohol-related violence from a partner; this was more likely for Māori women. Binge drinking by both parties increases women's risk, and heavy drinking by a violent partner makes serious injury for the woman more likely.

Women's own aggression towards others is also related to how much they had drunk.

The denser the alcohol outlets in an area, the higher the rates of family violence, drink driving and traffic crashes. Women made up nearly one in five offenders who drank before committing a crime in 2008. The number of women caught drink driving increased by 1,700% between 1986 and 2006, compared with 185% for men. In 2008, 9% of women had worked in a paid job under the influence of alcohol in the previous 12 months. Twelve percent were less productive at work or had to take time off because of someone else's drinking.

More than 100 female secondary students are suspended each year for alcohol problems. Six percent of female secondary students in 2012 said their drinking had affected their schoolwork during the previous year, and one in five female university students had missed at least three classes in three months from their drinking.

Among secondary school students, alcohol-related problems decreased between 2007 and 2012, including drink driving and things like stealing that could have got them into trouble.

One estimate of the costs of harmful drinking in New Zealand totalled almost 3% of GDP; in other countries it has been estimated at about 1%. These estimates do not include some major costs to women, such as the intangible costs of sexual abuse and physical violence, costs to sexual and domestic violence services from alcohol-related incidents. They also do not include non-healthy system costs incurred by children and adults with FASD, or lost production by family members from their care.

Protective factors, resiliency and wellbeing

There is little research on these issues in Aotearoa outside of treatment. Resilience and health tend to be discussed as individual traits, which downplays broader environmental influences on alcohol use.

The most effective population protective factors are government controls on alcohol sellers and marketers. Social inequities drive drinking, but there has been no research on the impact of attempts to reduce these disparities on people's drinking.

Community level protective factors may include a range of positive traditional and non-traditional connections for young Māori women. The high proportion of non-drinkers among Pacific women, and taboos against mixed-gender drinking are protective and could be reinforced. The brother-sister covenant may be protective in some Pacific communities, as may more alcohol-free social spaces for lesbian and queer women.

Families that use alcohol and other drugs responsibly, and resolve conflict without violence, contribute to young women's wellbeing. Egalitarian relationships protect heterosexual women against harmful drinking. Close relationships with mothers may also protect young women against frequent drinking. Preventing sexual abuse of girls and their experience of family violence would help reduce their use of alcohol in later life. Delaying teenagers' first drinking reduces later problems.

Some Australian abstainers or occasional drinkers successfully resisted heavy drinking environments, but this review found no similar New Zealand research.

Interventions

The Alcohol Reform Bill was described as a once-in-a-generation opportunity to reduce damage from alcohol. However, this opportunity was squandered because the the resulting Sale and Supply of Alcohol Act 2012 omits the most effective measures for reducing hazardous drinking and related problems for women.

These interventions are government alcohol policies that restrict the marketing, availability and accessibility of alcohol, rather than initiatives focused on individual drinkers.

Policies restricting alcohol marketing, availability and accessibility

- A higher purchase price delays the start of drinking by teenagers and reduces heavy drinking; it may be even more effective for women. It also decreases rates of violence against women.
- Restricting alcohol marketing reduces alcohol-related harm for women, particularly drinkers under 18. Regulation is most efficient when it is independent; industry self-regulation is ineffective.
- Reducing the number and density of alcohol outlets reduces binge drinking and total consumption among women, as well as violence against women, drink driving, traffic crashes and other problems.
- Reducing alcohol retail trading hours reduces alcohol harm, including alcohol-related violence against women.

- Raising the purchase age reduces drinking among underage young women, and alcohol-related problems.
- Bars may commonly serve drunken patrons. Licensing enforcement is under-funded; sustained enforcement helps reduce women's heavy drinking.
- Women's convictions for drink driving are increasing more than twice as fast as men's. The planned lowering of the legal limit to 0.05, combined with compulsory breath testing, will reduce women's injuries from alcohol-related traffic crashes.

Health system interventions

Fetal Alcohol Spectrum Disorder (FASD)

- New Zealand's health response to FASD lags behind that of comparable countries. A FASD register, standardised systematic screening, and FASD primary or secondary intervention programmes need to be established.
- Partner violence is the most common predictor of pregnant women's drinking. Anti-violence campaigns targeting partners of pregnant women and screening of pregnant women for partner violence are primary prevention strategies for FASD.
- Primary prevention initiatives led by indigenous people are effective in reducing their rates of FASD.
- Early intervention with FASD children results in similar outcomes to their non-affected peers.
- Warning labels on alcohol containers do not change drinking behaviour, but do raise awareness of the teratogenic effects of alcohol as long as they are prominent, consistent and compulsory, and part of a wider strategy.

Brief interventions

- Brief alcohol interventions in general practice and hospital departments effectively reduce drinking and alcohol-related problems among women. However, these interventions are being implemented only slowly.

Social inequalities

- Countries with greater social inequality have higher rates of alcohol and other drug addiction. In 2011, Aotearoa had the fastest growth in income inequality among OECD countries. Racism, poverty and other systemic inequities are drivers of women's drinking, and policies to reduce them would therefore be a primary prevention strategy to reduce alcohol consumption. However, such structural policies have not been evaluated for their impact on the amount women drink.
- Reducing rates of sexual abuse and maltreatment of children, sexual assault of adult women and partner violence would be a primary prevention strategy to reduce women's drinking. However, anti-violence campaigns are inadequately funded and vulnerable to policy changes, and evaluations have not measured their impact on women's drinking.
- Egalitarian relationships protect against harmful drinking by heterosexual women. Support for female victims of incestuous abuse as children is also protective.

Social and justice services

- Specialist refuge services for women experiencing domestic violence who also have AOD and mental health problems are effective. Existing services for women experiencing these issues are often poorly co-ordinated.
- Brief interventions are also effective in justice system contexts, including for female drink-drivers. However, they are being implemented only slowly.

Community action

- Community projects on alcohol have had wide positive impact, although evaluation has rarely included a gender analysis.
- Kaupapa Māori campaigns have been effective in urban and rural Māori communities.
- Pacific community campaigns have raised awareness of alcohol impacts and led participants to question their drinking behaviour.
- Regional alcohol accords are a useful way to augment other interventions.
- Programmes to reduce alcohol-related harm in sports clubs have reduced women's drinking, improved team performance and created a safer environment for whānau and spectators. However, evaluation has rarely included a gender analysis.
- Programmes aimed at reducing social supply to underage drinkers can reduce binge drinking, but are unsustainable unless commercial availability is also targeted.
- Tertiary institutions are sites of heavy drinking, but approaches have been ad hoc and unco-ordinated.

Education

- Social marketing and classroom education campaigns that advocate sensible drinking are overwhelmed by industry advertising and the disinhibiting effects of alcohol. There is no evidence that social marketing campaigns or school-based education advocating sensible drinking have any long-term impact on consumption.
- Campaigns aimed at pregnant women's drinking need to involve partners, whānau and friends, and also tackle the alcogenic environment, rather than presenting the pregnant woman as an adversary of her fetus, and solely responsible for any risks to it.
- There is no evidence that low-risk drinking guidelines affect drinking rates or alcohol problems.

Relationship and family interventions

- Initiatives to reduce family social supply to underage drinkers are also unsustainable without wider restrictions on alcohol accessibility.

Individual interventions

- Compulsory or coerced addiction treatment for beneficiaries is ineffective and expensive. It has a significant negative impact on women, particularly indigenous and ethnic minority women, and overloads treatment programmes with recreational substance users.
- AOD services are under-funded, resulting in a major overall unmet need for AOD treatment, and for kaupapa Māori services.
- Gender-specific addiction treatment for women is effective, particularly for women who have experienced prior or ongoing abuse by men.
- Strengthening cultural connections, involving whānau and using a decolonisation focus are important in making alcohol treatment programmes effective for Māori.
- Most women presenting for alcohol treatment have other mental health conditions and have experienced violence. Addiction, mental health and domestic violence services that act independently, and do not collaborate, do not result in best outcomes for women. AOD services that work holistically, cross-screening for these factors and taking into account housing, poverty and other healthcare needs, are more effective.
- Alcohol treatment agencies usually work in a heterosexist way and lack knowledge about lesbian and queer women's lives and experiences of discrimination that may drive their drinking.
- AOD treatment for violent men may also be effective primary prevention against domestic violence.

Intervention gaps

There have been few interventions targeting particular populations of women, systemic social inequities that affect women, and few primary prevention interventions created for Māori and Pacific female drinkers, female tertiary students or sportswomen.

Data limitations

The most consistent finding in this review was the lack of gender analysis in research and evaluation; as a result many studies were left out of this review. This review found no research about AOD treatment for pregnant women in Aotearoa.

FOCUS GROUPS AND INTERVIEWS

This study organised six focus groups of health system and community health and social service providers and three individual interviews, with a total of 41 participants. They represented:

- DHB mental health and emergency services
- Groups working against sexual and domestic violence and providing support and counselling
- Community organisations for lesbians and queer youth, those working against eating difficulties, and family support
- A group of alternative education workers
- Two non-government AOD treatment managers and a nurse manager.

One group was Māori and one Pacific. Most of the rest included Māori, Pacific and tauwiwi members.

Māori focus group

The major influences were alcohol advertising, especially for young women, and easy accessibility in low-income neighbourhoods due to the high number of alcohol outlets.

Other influences were using alcohol to cope with poverty, poor health and racism, and a community norm of heavy binge drinking.

The major damage was to women's parenting, including children missing school and the threat of having children taken away, as well as violence against women. Participants also mentioned fights, the financial cost of drinking and FASD.

Participants said that interventions needed to be kaupapa Māori-oriented, presented in familiar and culturally appropriate settings, and supporting women's agency to escape poverty. Examples included marae-based whanaungatanga programmes, alcohol-free events and patrols by Māori wardens on benefit days. Access to higher education had also reduced women's drinking.

Participants said that dominant-culture GP and health services were often racist, and overlooked the issues underlying Māori women's drinking.

Kaupapa Māori services were seen as poorly and inequitably funded.

Other focus groups

Pacific

Pacific participants agreed that alcohol consumption among women had increased markedly in a generation, and were concerned at what they saw as high rates of drunkenness among young and older women.

Alcohol marketing and the density of liquor outlets in Pacific neighbourhoods were seen as strong influences, as well as the low price of alcohol, social inequities and trauma.

Participants struggled as parents to maintain cultural values of respect, spirituality and traditional boundaries in the face of what they described as this overwhelming pressure.

A major alcohol problem was the erosion of cultural wellbeing and family cohesion. Others included sexual abuse, unplanned pregnancies, fighting by young women, expulsions from tertiary education, and suspicion of government.

Suggestions for community health promotion included using cultural performances, online social media, hip hop songs, video and radio clips, and Pacific-language radio shows.

Mixed groups and interviews

Participants noted a younger starting age for female drinkers, consuming larger amounts per session, drinking more frequently, and drinking to harmful levels.

Influences included heavy alcohol advertising, permissive alcohol policies, easier access because of the number of outlets, a lower purchasing age, and a low price.

Colonisation, racism, poverty, social exclusion and heterosexism were all described as contributing to harmful drinking among women. Other factors were child sexual abuse, adult sexual assault, domestic violence, gender discrimination, difficulty juggling paid work and family duties, and unrealistic norms about women's bodies.

The dominant Kiwi drinking culture also encouraged and promoted harmful drinking.

Participants in all groups discussed the difficulties of parenting in a permissive alcohol climate. Some thought parents needed to be stricter about not giving alcohol to underage children, while others described this as a losing battle to influence young people to drink responsibly in a pro-alcohol culture.

Participants discussed a wide range of problems; the most frequent were alcohol-related sexual and domestic assaults. The involvement of alcohol reduced men's responsibility and increased women's in the court system, and diminished victims' chances of justice. They noted that adults cause most alcohol problems, despite a social focus on problems caused by young people.

Other problems included suicide attempts, sexually transmitted infections, unplanned pregnancies, fighting, traffic and other injuries, alcohol poisoning, family breakdown, impaired parenting, FASD, reduced educational performance, cancer and brain damage.

Suggestions included:

- Banning alcohol advertising
- Stronger government policies that reduced accessibility of alcohol through higher prices, reduced outlets and a raised purchase age
- Reducing social inequities
- Changing Kiwi drinking norms
- More funding to prevent sexual and family violence.
- AOD and mental health treatment services, including for domestic violence, were seen as separate, with poor collaboration. Services were overloaded and under-funded, and did not cater well for women with children or lesbian and queer women.

RECOMMENDATIONS

Gaps identified in this review include:

Consumption

- National survey data which enable comparisons over time, while allowing for changes in methodology and survey design that takes new research into account, and which analyse gender by age, ethnicity, deprivation, and area type
- Kaupapa Māori and mana wāhine research about alcohol
- Longitudinal data about the alcohol consumption of female adolescent heavy drinkers as they move into their 20s and 30s
- Qualitative data about why more women remain non-drinkers than men, how women sustain non- or occasional drinking, and how non-drinking can be supported
- Representative or large-scale data on lesbian and queer women's AOD use
- Data about alcohol consumption by women with intellectual and other disabilities and their access to AOD services.

Influences

- Research exploring any links between experience of systemic racism and discrimination, and AOD use.
- Health and social problems
- The impact of other people's drinking on women and children
- The prevalence of FASD
- The impact of women's drinking on children and whānau
- The health and social impacts of older women's drinking
- The impact of alcohol on women's economic independence
- The rate of women arrested for being drunk and disorderly over time
- The rate of alcohol-related crime by women over time.

Interventions

- Prevention of FASD
- Evaluation of major alcohol policy changes
- Evaluations of Pacific interventions, including pan-Pacific and ethnic-specific
- Evaluations of interventions using kaupapa Māori approaches
- Evaluations of the impact of policies against racism and discrimination on AOD use
- Evaluations of the impact of campaigns against violence on women's AOD use.
- Lack of analysis by gender

A major gap was a persistent failure to analyse research by gender. Many studies on a range of topics failed to do this, making the research of limited value to women.

3. Terminology and glossary

This section includes definitions and discussion of different meanings of some common terms.

AAF: Alcohol-attributable fraction – the proportion of a condition estimated to be caused by alcohol.

ACC: Accident Compensation Corporation.

Aiga: Family (Samoan).

ALAC: Alcohol Advisory Council, now part of the Health Promotion Authority.

AOD: Alcohol and other drugs. Alcohol is a psycho-active drug. This report uses the phrase 'alcohol and other drugs' or AOD to avoid an inaccurate distinction between alcohol and other psycho-active drugs. However, it also quotes researchers' own phrasing, which includes 'alcohol and drugs'.

Aotearoa: New Zealand (Māori).

'Asian': An umbrella term for a range of diverse nationalities and ethnicities. The quotation marks acknowledge that it is not a single ethnic category.

AUDIT: Alcohol Use Disorders Identification Test – a score of eight or more on the 10-item AUDIT is the threshold for 'potentially hazardous drinking'. On the abbreviated AUDIT-C, a score of four indicates hazardous drinking (see below).

Awhi: Support (Māori).

BAC: Blood alcohol concentration.

BAL: Blood alcohol limit.

Binge drinking: Definitions of this term have varied, and only sometimes take gender into account. For example, the ALAC Alcohol Monitor of 2009–10 defines an adult binge drinker as someone 18 or older who drank seven or more standard drinks in their last drinking session. Previously their definition referred to seven or more drinks in the last two weeks (Research NZ, 2011, 2007). The Youth 2012 report on alcohol defines binge drinking as having five or more standard drinks within four hours (Clark et al., 2013b).

Black: When capitalised, this refers to ethnicity.

DALYs: Disability-adjusted life years. A measure of overall disease burden – the number of healthy years of life lost due to illness, disability or early death due to alcohol.

DHB: District Health Board, providers of public health services.

Drinking: Refers to alcohol, rather than any other liquid.

Drink driving: Refers to people who have driven after drinking, as well as to those who were apprehended or convicted of driving over the legal blood alcohol limit.

FASD: Fetal Alcohol Spectrum Disorders. An umbrella term for the range of effects that can occur in an individual whose mother drank alcohol during pregnancy. This may include physical, mental, behavioural and learning disabilities with possible lifelong implications. FASD is not a clinical diagnosis.

Fono: Meeting (Pacific languages).

Fono talanoa: Talking meeting (Pacific languages).

Hapū: Sub-tribe (Māori).

Harakeke: Flax weaving (Māori).

Hazardous/heavy drinking: Definitions vary. The Ministry of Social Development 2010 Social Report, Te Rau Hinengaro: NZ Mental Health Survey and the Ministry of Health NZ Health Survey use an AUDIT score of eight or more as the threshold for hazardous or 'potentially hazardous drinking' (MOH, 2013; MSD, 2010; Oakley Browne et al., 2006). The Ministry of Health 2007–8 and 2004 NZ Alcohol and Drug Use Surveys defined 'drinking a large amount of alcohol' for women as more than four standard drinks on a single occasion (MOH, 2009a, 2007). A comparison of national surveys in 1995 and 2000 defined a heavier drinking occasion for women as six or more drinks (Habgood et al., 2001).

Hiko: Walk, often in protest (Māori).

Hinengaro: Mind (Māori).

Hui: Meeting (Māori).

Iwi: Tribe (Māori).

Kai: Food (Māori).

Kaimahi: Health worker (Māori).

Kaiwhakahaere: Director, manager (Māori).

Kaupapa Māori: A Māori-controlled concept of Māori knowledge, which assumes the validity and legitimacy of Māori language and culture. It uses and supports te reo Māori, challenges inequities and seeks transformation (Pihama, undated).

Kava: A sedative drink used for medicinal, religious, political, cultural and social purposes throughout the Pacific and in Pacific communities in Aotearoa.

Kōrero: Discussion, talk (Māori).

Kuia: Female elder (Māori).

LGBTT: Lesbian, gay, bisexual, takatāpui and transgender (see Queer).

Mahi: Work (Māori).

Mana wāhine: 'Recognising the dignity and authority of [Māori] women' and 'engaging in political work to ensure that that same dignity is recognised by others' (Waitere & Johnston, 2009, p. 18).

Manāki: Caring, protection (Māori).

Marae: Māori meeting house.

Matauranga wāhine: Women's knowledge (Māori).

Mau rākau: Māori weaponry (Māori).

Mokopuna: Grandchild/children (Māori).

Moana: Sea, ocean, large lake (Māori).

NGO: Non-government organisation.

Non-drinkers: Definitions vary. This may refer to those who have not drunk alcohol in the last 12 months (MOH, 2009a; Peck, 2011) or those who do not drink at all (Research NZ, 2011), or those who have never drunk alcohol.

On-licences and off-licenses: Restaurants, bars, nightclubs and hotels are on-licensed premises, as alcohol can be drunk there. Liquor stores and supermarkets are off-licenses, as liquor can only be drunk off-site.

Pacific: An umbrella term for a range of different ethnicities; this report uses the term Pacific peoples to reflect this.

Pākehā: This report uses the term Pākehā rather than New Zealand European for the dominant ethnic group in Aotearoa, because 'European' locates Pākehā New Zealanders elsewhere, implying that they are visitors rather than permanent residents (Black, 2004). The term Pākehā also acknowledges that people of European descent living in Aotearoa have a different culture from those living in Europe and other former English colonies.

Pālagi: People of European descent (Pacific languages).

Preloading: Drinking at home before going out to drink.

PTSD: Post-traumatic stress disorder.

Queer: This umbrella term refers to women who have relationships with other women who do not identify as lesbian, or may describe themselves as genderqueer rather than as women. Otherwise the report uses authors' acronyms, including LGBTT (q.v.).

Rangatahi: Young people (Māori).

SES: Socio-economic status.

Social supply: Supply of alcohol by family and friends to teenagers under the legal purchasing age.

STI: Sexually-transmitted infection.

Tabu: Sacred, restricted (Fiji).

Takatāpui: Close friend of the same gender. Inclusive Māori term for lesbian, gay, transgender and queer.

Talanoa: Tell stories, discuss (Pacific languages).

Tamariki: Children, young people (Māori).

Tane/tāne: Man/men (Māori).

Tangata whenua: People of the land, indigenous people (Māori).

Tapu: Sacred, restricted, forbidden (Māori).

Tauīwi: Non-Māori, foreigners; in this report it refers to Pākehā and all other immigrant populations.

Te reo: The Māori language.

Tikanga: Correct procedures, Māori customs.

Tinana: (Human) body (Māori).

Ua: Wine (Māori).

Wahine/wāhine: Woman/women (Māori).

Wairua: Spirit, soul, spirituality (Māori).

Whakapapa: Genealogy, descent (Māori).

Whakawhanaungatanga: Process of establishing relationships, relating well to others (Māori).

Whānau: Extended family/families, family group/s (Māori).

Whānau ora: Healthy families (Māori).

Whanaungatanga: Kinship, family connection (Māori).

Whenua: Land, country (Māori).

White: When capitalised, this refers to ethnicity.

YLL: In calculations of economic cost, years of life lost due to alcohol.

4. Introduction to the project

This project was funded by the Ministry of Health and commissioned in August 2011 by Alcohol Healthwatch and Women's Health Action to explore five questions:

1. What are the patterns of drinking among women, have these changed over time and if so how?
2. What harms result for women from their own or others' drinking?
3. Is the impact of alcohol on women's health, either through their own drinking or that of others, a growing problem?
4. If so, what are the major influences on women's drinking or the harm to women from others' drinking?
5. What is currently working for preventing or reducing harm to women from their own or other people's alcohol consumption?

The project included a literature review of women's alcohol consumption, influencing factors, alcohol problems for women and interventions. It also included focus groups and key informant interviews with 41 providers of services in organisations working with women affected by alcohol. It resulted in this report and a briefing paper.

4.1 Framework for the literature review

This review uses a public health approach that includes the social determinants of health. This is informed by a gender-based analysis, and takes note of kaupapa Māori and Samoan frameworks.

A public health approach views problems from alcohol as an issue for the whole population, rather than as a personal choice: 'The primary determinants of disease are mainly economic and social, and therefore its remedies must also be economic and social' (Rose, 1992, p. 129). Alcohol is an economic product and drinking is very much a social behaviour.

Public health approaches consider the interaction of the drinker, the drug and the environment, which includes the wider socio-economic context (Abel et al., 1992). This report uses an ecological public health model to analyse influences on women's drinking and interventions at the level of individuals, their families, their communities and the wider society (Lang & Rayner, 2005; Lang et al., 2001).

A country's drinking culture is shaped by social, economic and environmental factors that can be changed by public health policies aiming to reduce alcohol-related harm. The value of a population focus is in identifying health risks and suggesting interventions likely to benefit the greatest number of people (Babor et al., 2010).

4.1.1 Models of wellbeing

Although this project outlines alcohol-related problems, a focus on risk and harm is not enough. It also considered the issue in the light of different models of wellbeing.

The importance of wellbeing as a positive goal is seen when one asks: What quality of life does alcohol provide that nothing else does? There are evidence-based tools to improve personal and social wellbeing (Aked et al., 2008). Improving the social context means strengthening local connections, support networks and the sense of belonging that provides the social fabric of communities. It also means tackling health and social inequities and creating social change. An example would be to address the role of alcohol in violence against women.

Te Pae Mahutonga (Durie, 1999) is a Māori model of wellbeing, using the symbolism of the Southern Cross constellation. The four stars represent mauri ora (cultural identity), waiora (environmental protection), toiora (healthy lifestyles) and te ōranga (social participation). The pointer stars represent the context needed to achieve these results: ngā manukura (effective leadership) and mana whakahaere (autonomy).

4.1.2 Gender-based analysis

Women's roles and opportunities have changed profoundly since the days of the six o'clock swill when bars closed soon after work. Most women are in paid work and engaging in other aspects of the public sphere, no longer relegated to the private life of the family (MWA, 2010). However, there has not been an equal movement of men into caring work, resulting in a double burden of domestic and paid work that produces ongoing conflicts for women (Else, 1996; Statistics NZ, 2011b). Although women's educational qualifications have increased on average, they are still concentrated in a narrow range of lower-paid occupations, their median incomes are much lower than men's, and they are under-represented among leaders (MWA, 2010, 2002).

A gender-based analysis identifies differences and inequities that come from the unequal gender norms and power relationships between men and women, and the effects of this on men's and women's wellbeing and health (Statistics NZ, 2011b; MSD, 2010; NZFVC, 2007; WHO, 2002; Fleming et al., 1997).

Gender is relational – masculinity and femininity are created in opposition to each other. For example, characteristics such as physical strength and authority mark men's superiority over women, and create difficulties for gender definitions when women have them. Women who show these 'masculine' characteristics threaten male dominance and are stigmatised (Lyons, 2009).

Health behaviours are gendered (Saltonstall, 1993). Dominant forms of masculinity portray male bodies as invulnerable, risk-taking and resistant to help-seeking from health professionals. Female bodies are portrayed as vulnerable, so women are more likely to engage in healthy behaviours. The female gender role carries an expectation that women will take responsibility for the health of male partners and family members (Mahalik et al., 2007).

Drinking is also gendered social behaviour (Obot & Room, 2005; Lyons, 2009), marked by how much is drunk, types of drinks and drinking locations. In the dominant culture, men are expected to drink excessively, mainly beer, and in public. Heavy drinking by women is much less socially acceptable (Abel et al., 1992) and alcohol problems are unfeminine, whereas being unable to handle heavy drinking is unmasculine (Jakobsson et al., 2008).

Several factors have resulted in a lack of attention to women's increased drinking and the resulting damage, as well as problems from 'moderate' levels of drinking. One factor is that young men drink a high proportion of the alcohol consumed and make up a high proportion of heavy drinkers (MOH, 2009a; Research NZ, 2011; MSD, 2010). Masculinity and male sport are a major part of alcohol marketing, particularly of beer (Hill, 1999). The alcohol industry encourages policymakers to define the alcohol 'problem' as unhealthy overuse by individual young men, rather than as a harmful product that needs to be regulated for population health (for example, Stimson et al., 2007).

A gender-based analysis recognises that society's unequal gender relations affect women differently from men. For example, most of those who are raped, sexually abused as children, or live in fear of their partner's violence are female (See section 11.3 Violence against women). Women are also more likely to live in poverty and to head sole parent families (Statistics NZ, 2005).

A gender-based analysis also acknowledges that unequal gender relations affect different groups of women in different ways, and that some are more privileged (MWA, 1996). For example, the average hourly wage in 2008 was \$18.12 for Pākehā women, and \$15.15 and \$14.75 for Māori and Pacific women respectively (MWA, 2008). Different cultures, classes and communities also have different norms for masculine and feminine behaviour.

A gender-based analysis attempts to explore the experiences, priorities, and the impact of alcohol interventions on different groups of women, as well as gender differences in the social meanings of alcohol use (Broom & Stevens, 1990).

However, alcohol researchers and policy makers did not begin to take gender into account until the 1990s. New Zealand researchers said then that most alcohol research studied only men or did not mention gender (Roman-Clarkson et al., 1992), and that 'much of the information about alcoholism is about men and male rodents' (Hill, 1996, p. 29).

4.1.3 Kaupapa Māori analysis

Kaupapa Māori methodologies are used in research and service provision and are based on a Māori world view. These methodologies ensure, among other factors, that research provides data of equal explanatory power to identify health and social disparities, contribute to Māori development, and assess the performance of the Crown under te Tiriti o Waitangi (for example, Robson & Harris, 2007; Robson & Reid, 2001; Bramley et al., 2006).

Mana wāhine analyses use Kaupapa Māori methodologies to put Māori women at the centre rather than as 'other' to Pākehā women or Māori men, and to develop theory from Māori women's experiences (Mikaere, 2003; Pihama, 2001; Smith, 1999).

This document reports Māori and indigenous data separately where it is available. The Māori focus group in this project was organised and analysed by Māori women using kaupapa Māori methodology.

4.1.4 A Samoan framework

A Samoan approach to gender arrangements included principles of belonging, liberation, sacredness and the inter-connectiveness of relationships, as expressed in the lifelong covenant relationship (feagaiga) between Samoan brother and sister (White, 2000; Percival et al., 2010). In this covenant, expressed in different ways in different Pacific cultures, the sister's life is sacrosanct to the brother. Samoa's gender arrangements between males and females are based on this covenant.

Pacific women in the Pacific focus group organised as part of this project brought their ethnic-specific understandings of the brother-sister covenant to the discussion. Where data about Pacific women is available, it is reported separately from Māori and Pākehā women and by ethnicity where possible.

4.1.5 Colonisation

The history of Aotearoa as a sovereign indigenous country that was colonised by an overseas power has shaped inequalities in health between tangata whenua and tauwi women ever since.

Māori were one of the few indigenous populations that did not have a tradition of making alcohol before the arrival of Europeans (Huriwai et al., 2000), so that its introduction was fundamentally linked to the colonisation process (Stuart, 2009). This experience resulted in a range of responses. One is illustrated by a literal translation of the Māori word for alcohol, *waipiro* – stinking water.

Pākehā land purchasers provided alcohol and other goods to many Māori women and men during long visits to townships for Native Land Court hearings in the 1800s (Rei, 1993; Ebbett & Clarke, 2010). This created debt, and purchasers then seized the debtors' land to pay the debts. This in turn created a harmful cycle for some Māori, with land and cultural loss leading them to drink more heavily (TPK, 1995).

Colonisation, land loss and migration to cities have undermined *whānau*, *hapū* and *iwi* structures, and hugely disrupted *tikanga*, *wairua* and identity among many Māori (Huriwai et al., 2000; Robson & Harris, 2007; Ebbett & Clarke, 2010). The colonisation of *tikanga* undermined the former balance in the relationship between Māori women and men, and the change from communal living to nuclear family households has restricted the community participation of Māori women (Mikaere, 2011; Pihama, 2001).

Colonial trauma

A range of terms describe the impact of colonisation on indigenous communities and individuals down through the generations – historical trauma (Wesley-Esquimaux & Smolewski, 2004; Evans-Campbell, 2008; Brave Heart, 2003), multigenerational stress disorder (Fenrich & Contesse, 2009) and colonial trauma (Lloyd, 2000; Turia, 2000).

Individual responses to this trauma can include post-traumatic stress disorder, grief, anxiety, depression and substance abuse (Evans-Campbell, 2008). Saggars and Gray (1998, p. 4) argue that 'the history of alcohol and other drug problems among indigenous peoples ... is inextricably linked to their respective colonial histories'.

Community effects of this trauma are illustrated in rates of sexual abuse and family violence, internalised racism, and significant health disparities between indigenous peoples and descendants of settlers (Evans-Campbell, 2008; Durie, 2003; Second Māori Taskforce on Whānau Violence, 2004; Wesley-Esquimaux & Smolewski, 2004).

The need to respond to this historical trauma has led to the development of kaupapa Māori theory and services in alcohol and other drug treatment, mental health, family violence and criminal justice sectors (Adamson et al., 2010a; Second Māori Taskforce on Whānau Violence, 2004; Evans, 2010). These usually include decolonisation strategies as a core component (Cunningham, 2011; Smith, 1999).

The New Zealand government has also had a colonising relationship with some Pacific countries. For example, New Zealand police enforced colonisation in Samoa, killing independence leader Tupua Tamasese Lealofi III and others during a peaceful march in 1929, on a day that became known in the country as Black Saturday (NZHO, 2011).

Privilege

The flipside of indigenous colonial trauma and marginalisation is settler colonial privilege, gained from a social order based on settler cultural beliefs, institutions and processes (Durie, 2005; Mikaere, 2011; Borell et al., 2009; Black & Stone, 2005). This benefits Pākehā, who monopolise positive health statistics.

In liberal societies such as New Zealand, which have official ideologies of ethnic equality, government agencies and public discussion often strongly deny the existence and influence of racism, colonisation and privilege (Cunningham, 2011; Mikaere, 2011; Hodgetts et al., 2004; Tait, 2007).

Colonisation also led to decades of government policy framed by deficit theory, which blames indigenous peoples and individuals for their ill-health (Pihama & Pehehira, 2005; Borell et al., 2009; Robson & Harris, 2007). These same concepts make the privilege of being a member of the dominant culture invisible, and so present Pākehā as individually responsible for their more positive health outcomes.

Racism

The multiple losses from colonisation have been reinforced by the ongoing effects of systemic racism against Māori in housing, employment, justice and welfare (MSD, 2010; DOC, 2007; Rankine, 2005; Jones, 1999; WARAG, 1985).

Pacific peoples were used as scapegoats by the Muldoon government for the economic recession in the 1970s (Anae, 1997). Samoan and Tongan families asleep at home were raided at dawn by immigration officials seeking overstayers, although the bulk of overstayers at the time were from Australia and the UK (Anae, 2011). Pacific and Māori people were also routinely stopped on the streets on suspicion of being overstayers. Anae (1997) describes these campaigns as traumatising a generation of Pacific peoples.

4.1.6 Other systemic inequities

Gender, socio-economic status, disability in an able-bodied world, and sexual identity are other factors in health inequities. Heterosexism – the assumption that heterosexuality is the only or the normal sexual identity – ignores, marginalises or condemns non-heterosexual relationships and identities (CSAT, 2009a). Institutional and individual responses to lesbianism can result in career loss, social rejection, harassment and hate crime (MacEwan & Kinder, 1991; Swiebel & van der Veur, 2009). Transgender women also face extensive social prejudice, which restricts their work opportunities (for example, King et al., 2009; HRC, 2008; Swiebel & van der Veur, 2009).

4.2 Alcohol industry structure

The alcohol industry in Aotearoa is dominated by overseas-owned multinational corporations. These companies often control the manufacturing, distribution and sale of particular alcohol products, and there are growing links between the spirits, wine and beer sectors (NZ Law Commission, 2009).

The two dominant beer companies are both overseas-owned. In 2009 Lion Nathan was owned by Japanese beer producer Kirin, and Dominion Breweries by Heineken and a Singapore company (Ibid, p. 26). The bulk of the lucrative pre-mixed spirit drinks (RTDs) market was owned by Pacific Equity Partners and a Hong Kong company. Kiwi wine brands such as Corbans, Montana and others are owned by a range of Australian, US, European and Japanese corporations (Saunders, 2011). About half the New Zealand wine industry is currently owned by French company Pernod Ricard (Babor et al., 2010).

Most off-licences are supermarkets owned by Australian company Progressive Enterprises and rival New Zealand co-operative Foodstuffs. Their intense competition stimulates persistent weekend alcohol discounts that increase total supermarket sales and have led to accusations of below-cost selling (NZ Law Commission, 2009). This competition has driven down the prices of wine and beer in supermarkets and liquor stores compared to bars and restaurants (McEwan et al., 2010).

The corporate imperative to increase alcohol sales, and thus profits, directly conflicts with the social need to reduce the human and economic costs of damage from alcohol (Babor et al., 2010).

Majnoni d'Intignano (1998) has described the damage from alcohol as an 'industrial epidemic', driven by globalised producer corporations aiming to increase their profits. Savings from mergers and acquisitions are fed into increased brand marketing, and lobbying to influence government alcohol policies (Babor et al., 2010).

Like other high-income countries, the New Zealand market is regarded as 'mature' with little room for growth. The global alcohol industry views low and middle-income countries, where total consumption is increasing, as providing greater opportunities for expansion (Room et al., 2002).

4.3 Alcohol policy and legislation review process

In 2007, the government asked the NZ Law Commission, an independent advisory organisation, to review evidence and New Zealand alcohol laws in the face of growing concern about alcohol-related social harm. The review was the most thorough since 1986.

The commission presented its final report, *Alcohol in our lives: Curbing the harm*, to government in 2010 with 153 recommendations about alcohol pricing, marketing, licensing, purchase age, sale and supply.

The Alcohol Reform Bill introduced in the same year included 126 of the Law Commission's recommendations, at least in part. This report assesses the commission's recommendations and the final Sale and Supply of Alcohol Act 2012 in the light of the evidence about alcohol-related harm to women.

5. Review methodology

This review used the two Law Commission reports and the public health policy book *Alcohol: No ordinary commodity* as benchmarks, and gave priority to recent systematic and meta-analyses. Studies that did not analyse by gender are only mentioned if this review found no other evidence. Searches were largely restricted to the last 10 years, although some earlier material was cited to indicate the pace of change in this area over a generation.

Each search included a gender-specific word, some word for alcohol, and particular topic terms. Searches were also done for specific populations of women. The review sourced peer-reviewed papers from health and social science databases, including Scopus, Web of Knowledge, PsychInfo, PubMed, Google Scholar, Index NZ, APAIS and the Cochrane Library.

Websites were searched for research reports and grey literature from international, government and NGO agencies. In Aotearoa this included Te Puni Kokiri, the Ministries of Health, Justice, Social Development, Pacific Island Affairs, and Women's Affairs, CYFS, NZ Police, the Family Violence Clearing House, ALAC, the NZ Drug Foundation, Alcohol Healthwatch, National Drug Policy NZ and the Accident Compensation Corporation.

Searches were largely carried out between October 2011 and mid-2012; only a few studies were included from 2013. The review assessed over 1,000 items including articles from journals, magazines and newspapers as well as reports, books, conference papers, theses and websites, and consulted experts in the field where evidence was lacking.

Many kaupapa Māori studies examine differences between Māori and tauwiwi. However, among women, this elides differences that this review aims to explore, so it attempted where possible to analyse tauwiwi by ethnicity and other factors.

5.1 Limitations

The brief for this review was very broad and the time available was very limited, which meant that international research on many aspects of the topic could be sampled only thinly, and could not be critiqued in detail for rigour. The research on the predictors and problems from women's drinking is vast. This review is long, but far from definitive.

The review did not analyse research on population interventions that was canvassed exhaustively in the Law Commission's review. It also did not search for damage to children from alcohol, or for gambling, which may have left some gaps in these areas.

6. Women's drinking

6.1 Patterns of drinking among women

Different drinking patterns – for example, frequent moderate drinking, frequent heavy drinking, and sporadic heavy or binge drinking – have different impacts on health and injuries, which are discussed in section 10: Alcohol-related health problems (Connor et al., 2005a). An important point to keep in mind is that drinkers commonly understate their intake of standard drinks (10g or 12 ml of alcohol). In 2004 and 2007, drinking amounts reported in two national surveys equated to one litre of pure alcohol per person per year less than the amount per person available for consumption, taken from sales and import statistics (Connor et al., 2013). This is partly because survey respondents want to give socially desirable answers, surveys are likely to under-represent heavy drinkers, and drinkers are likely to underestimate standard drinks.

To account for this under-reporting, Fryer and colleagues (2004) calculated a conversion rate from drinkers' number of reported drinks or glasses to standard drinks (330mls for beer with 4% alcohol, 100mls of wine, and 30mls of spirits) of 1.25 per drink for beer drinkers, 1.95 for wine drinkers, 2 for spirit drinkers, and 1.6 for binge drinkers.

6.1.1 The whole population of women

Drinkers commonly understate their intake of standard drinks.

Until the 1960s, alcohol was mostly drunk by men in hotels, which either excluded or were generally avoided by women (McEwan et al., 2010). Dominant social attitudes and women's drinking behaviour have both changed substantially since that time.

Everyday language now indicates the pervasiveness of alcohol in Aotearoa; it is usually what is referred to by the verb 'to drink'. When someone says 'She drinks a lot', listeners understand that the person is talking about alcohol rather than water (Heath, 1995).

Statistics about women as a whole have limited value in explaining drinking among particular groups of women. However, there are some patterns in women's drinking that hold true for most female populations in Aotearoa: women drinkers are tending to drink more, some of their drinking patterns are converging with men's, and young women drink more than older women.

However, the total amount of alcohol women drink remains around one-third of that drunk by men. In 2011 women drank 33% of all alcohol consumed compared to 30% in 1995, although this change was not statistically significant (Huckle et al., 2013).

Women make up a majority of non-drinkers – 65% in 2009 (Research NZ, 2011). A comparison of the National NZ Alcohol Surveys found that the proportion of women aged 16-65 who had not drunk alcohol in the last 12 months significantly increased from 15% in 1995 to 17% in 2011, a result of a significant increase in abstaining among women aged 35-54 (Huckle et al., 2013). The NZ Health Survey also found that the proportion of women who had not drunk alcohol in the previous year increased from 20% in 2006-7 to 26% in 2011-12 (MOH, 2013). There has been no consistent pattern in the proportion of female non-drinkers in other national surveys. This variability is partly due to the definition of non-drinking (see Terminology and glossary).

The proportion of drinkers who were women appears to be stable in the ALAC Alcohol Monitor (52% in 2005-6, 50% in 2009-10). In the latest survey women made up 53% of moderate drinkers (those having fewer than seven drinks in their last session) and 42% of binge drinkers. It was not possible to compare the latest and earlier surveys on these two measures because of changes in definitions (Research NZ, 2011, 2007).

However, women drinkers of all ages tend to have increased their alcohol intake over the last 15 years, and this has been most marked in younger women (Fergusson & Boden, 2011; Fryer et al., 2011). The National NZ Alcohol Surveys found that between 1995 and 2011 drinking women aged 16-65 significantly increased the number of times a year that they drank on average, and the amount they drank on a typical occasion (Huckle et al., 2013).

In 1995, 4% of all women aged from 16 to 64 were drinking enough to get drunk at least once a week. This rose to 8% in 2008 (McEwan et al., 2010). This is consistent with the National NZ Alcohol Surveys, which found a significant increase between 1995 and 2011 in the proportion of women aged 16-65 who had drunk five or more 15ml drinks (six or more standard drinks) at least once a week. This was driven by an increase among women aged 16-44, as there was no change among older women (Huckle et al., 2013).

However, the NZ Health Survey found no change in the proportion of all women who drank hazardously (an AUDIT score of 8+) between 1996-97 and 2006-07 (Huckle et al., 2013).

This review found little data comparing rural and urban women's drinking. Some national surveys reported on rural and urban drinking patterns but did not analyse this by gender (eg, Research NZ, 2011).

Young people routinely start drinking years before they can legally buy alcohol. In 2009–10, the average age at which young female drinkers said they 'really started drinking' was 15 (Research NZ, 2011).

Many drinkers also use other drugs; surveys did not enable a comparison with non-drinkers' use of other drugs. Thirty-four percent of women who drank in 2008 also smoked tobacco; 11% also used cannabis; 13% also used pain-killers, sedatives or anti-depressants; 6% also used BZP party pills; and 3% also used ecstasy, amphetamine, heroin or cocaine (MOH, 2009a).

6.1.2 Gender convergence

McPherson and colleagues (2003) define gender convergence as an increasing resemblance between women's and men's drinking patterns, rather than exactly equal levels. In 1978, 14- and 15-year-olds were the only females drinking the same amounts as their male classmates (Warren et al., 1989).

Huckle and colleagues (2013) in a comparison of surveys from 1995 to 2011 said that the volume of alcohol that women drink 'was not even close to catching up to that of males', but did not analyse convergence in patterns of drinking.

A comparison of 1995 and 2000 national surveys found converging rates between men and women aged 20 to 39 on the amount of alcohol drunk in a typical occasion, total amount and intoxication. In people over 40, women's frequency of drinking was increasing and converging with men's (McPherson et al., 2003). The proportion of women aged 16 to 17 having eight or more drinks in a session (28%) converged and exceeded that of their male age peers (25%) between 1995 and 2011 (Casswell, 2012).

However, there has been no recent analysis of convergence across the whole population.

Internationally

The gap between Canadian men's and women's drinking prevalence has been closing since the 1990s (Poole & Dell, 2005). Gender gaps in heavy binge drinking rates have decreased or vanished in Ireland, Norway, Australia and the UK (Obot & Room, 2005), especially among youth and adults aged up to 34 (Wilsnack et al., 2009; Keyes et al., 2007).

6.1.3 Indigenous women

Māori women

Kaupapa Māori and other studies consistently reported a higher likelihood of non-drinking among Māori women (ranging from 15 to 23%), drinking less often and a larger number of drinks on a typical occasion than tauwiwi (MOH, 2013; MSD, 2010; Bramley et al., 2006). This is a similar pattern to indigenous women in Australia, Canada and the USA. However, Māori women's drinking patterns are in flux.

The proportion of non-drinking Māori women was 40% in an early 1980s survey (Murchie, 1984). In MOH surveys over the decade to 2008, the proportion decreased from 30 to 16.5% (MOH, 2009a); and increased to 23% in 2011-12 (MOH, 2013). A comparison of the National NZ Alcohol Surveys found no change between 2000 and 2011 in the proportion of Māori women aged 16-65 who were drinkers. However, the prevalence of drinking increased significantly among those aged 16-24 over this period. In 2011, drinking prevalence among Māori women was more strongly related to age than among all women – 92.5% of those aged 16-24 were drinkers, compared to 65% of those aged 55-65 (Huckle et al., 2013).

The proportion of Māori secondary students who had tried drinking alcohol significantly declined between 2000 and 2007, although the drop was greater among male students (Clark et al., 2008). Māori women were significantly more likely to say they started drinking at 14 or younger, first drank four or more drinks in a session and first got drunk at that age than other New Zealand women (MOH, 2009a).

Between 1997 and 2007 the proportion of all Māori women aged 16 to 64 who were drinking hazardously declined slightly from 31% to 28.5%, although this was not significant (MSD, 2010). Māori women were 1.5 times more likely to have drunk four or more drinks weekly during the previous 12 months and to have drunk enough to feel drunk, than all New Zealand women.

The National NZ Alcohol Surveys found no change between 2000 and 2011 in how many times Māori women aged 16-65 drank in a year, how much they drank in a typical session, or the proportion having five or more drinks at least once in the last week (Huckle et al., 2013). However, there was a significant increase over this period in the proportion of Māori women aged 45-54 who drank five or more drinks in the last week, from 7 to 16%.

Women in the Pacific

Alcohol was not made in most Pacific islands before it was introduced by sealers and traders, and has been produced commercially in the Pacific only since the 1950s (MOH, 1997).

Most women in Pacific countries are non-drinkers; however, the longstanding gap between men and women's use of alcohol seems to be narrowing, and women's drinking patterns are changing (WHO, 2011c).

In surveys between 2003 and 2008, the proportion of female non-drinkers was highest in Tonga (96%), followed by Fiji (92%), Samoa (90%) and the Cook Islands (53%) (WHO, 2011c). Alcohol statistics were unavailable for Niue, Tokelau and Tuvalu.

Most women in Pacific countries are non-drinkers.

Rural rates of non-drinking were often higher than urban (Barnes et al., 2010), and rates among young women lower (WHO, 2011c). For example, among 15 to 24-year-old Tongan women, only 53% had never drunk alcohol and 43% in Tokelau; and 56% among American Samoan secondary students (Howard et al., 2011).

In 2005, female drinkers in the Cook Islands had the lowest per capita consumption alcohol in litres (2.3), followed by Fiji (4.7), Samoa (7.2) and Tonga (13.7).

In 2002, Samoa recorded the lowest proportion of female binge drinkers (six or more drinks per session – 7%), followed by Fiji (13%), the Cook Islands (38%) and Tonga (41%) (WHO, 2011c). Binge drinking was also more common among young women. Sixteen percent of Samoan women aged 15 to 24 and 53% of young Tokelau women had more than five drinks per session (Howard et al., 2011); in Fiji, 65% of young women were binge drinkers (WHO, 2011a). However, these reports did not explore how frequently these women binge drank.

Australia

The 2004-5 NATSI Health Survey found that 14% of Aboriginal and Torres Strait Islands women had never drunk alcohol (Trewin, 2006); 29% of indigenous women aged 15 to 34 in a far north Queensland survey were abstainers (McDermott et al., 2009). Indigenous women consistently had similar or higher rates of non-drinking to non-indigenous women across all age groups (Trewin, 2006).

Twenty-eight percent of Aboriginal and Torres Strait Islands women reported drinking alcohol in the previous week. Twenty-seven percent of indigenous women drinkers were described as low risk (less than two drinks per day or four in a session), 8% as risky drinkers (between two and four a day), and 6% as high risk drinkers (more than four drinks a day).

Seven percent of indigenous women aged 18 and 34 were described as high-risk drinkers, more than double the proportion of non-indigenous women (3%), although the margin of error for indigenous estimates was large (Ibid). The north Queensland study found that 56% of Aboriginal and 65% of Torres Strait Island women drank more than two drinks a day or more than four in a single session (McDermott et al., 2009).

Canada

A much higher proportion (45%) of First Nations women than all Canadian women (26%) had not drunk alcohol in the past year. More First Nations women (43%) had had five or more drinks in one session than all Canadian women (24%) (MacMillan et al., 2008). Inuit people did not drink often, but when they did they tended to binge drink – 62% of Inuit women drinkers had five or more drinks in a session (Jette, 1994, cited in Muckle et al., 2011).

Canadian indigenous adolescent girls had higher rates of drinking than their non-indigenous peers (Elton-Marshall et al., 2011), and had their first alcoholic drink at a younger age. Indigenous and non-indigenous girls reported similar rates of binge drinking (five or more per occasion).

USA

No single survey has measured drinking across all indigenous peoples in the USA. Consumption differs significantly with time, tribe, region and reservation (Walter et al., 2002).

The National Health Behaviours Survey 2008-10 found that 18% of indigenous women were lifetime abstainers, a higher proportion than White women (Schoenborn et al., 2013).

Indigenous teenage girls were more likely to drink early regularly, although they had similar levels of alcohol use to boys (Cheadle & Whitbeck, 2011).

Another survey found that on average, females in four Native American tribes began drinking at 18, drank two days a month, had three drinks in a session, and drank heavily just over one day a month. Eleven percent drank more than 10 drinks a day (May & Gossage, 2001).

Eight percent of indigenous women binge drank – in this case five or more drinks in a single occasion in one month. Rates of heavy drinking – more than one a day – were lower among indigenous (3%) than White women (5.3%) (Steele et al., 2008).

6.1.4 Women from dominant ethnic groups

Pākehā women

Few surveys have measured the drinking of Pākehā women as a distinct group. They are usually grouped with other non-Māori, non-Pacific women (eg, Research NZ, 2007; MOH, 2013). There is little data about drinking by Pākehā women of different age groups. Pākehā consistently reported a higher prevalence of drinking, and of drinking more often, than other women (eg, MOH, 1999b).

Eighty-one percent of European/other women surveyed in 2011 had drunk alcohol in the last 12 months (MOH, 2013), a drop of 9% since a 2007 survey (MOH, 2009a). Pākehā secondary students (70%) were the most likely of all ethnicities to report that their parents drank (Ameratunga et al., 2011).

European/other women were significantly more likely than all other women to have started drinking aged 14 or younger, and to have first got drunk then. They were also significantly more likely to drink alcohol every day than all other women (MOH, 2009a).

Binge drinkers were less likely to be Pākehā (Research NZ, 2007); 27% of Pākehā females aged 12 to 24 were binge drinkers (seven or more drinks in a session) and 36% had fewer than seven drinks (Research NZ, 2011). However, response rates were low in this survey. The proportion of Pākehā drinkers who drank dangerously increased slightly between 1997 (12%) and 2007 (14.5%) (MSD, 2010).

Australia

Of those girls and women who spoke English at home (a proxy for White ethnicity), 72% of 14 to 19-year-olds had drunk a full glass of alcohol in the past year, and 95% of 20 to 29-year-olds. Across the age groups, the rate only dropped to 83% from age 60 (AIHW, 2010).

USA

Sixty-five percent of White women reported ever drinking alcohol (Falk et al., 2006). Five percent drank more than one drink a day (Steele et al., 2008). Fifty-three percent of adolescent White females said they drank, and 31% reported binge drinking – very similar to male rates (Wahl & Eitle, 2010). In the 2008-10 National Health Survey, White women had the highest proportion of heavy drinking (more than seven drinks a week on average) of all single ethnicity groups (6%) (Schoenborn et al., 2013).

White female university students reported higher rates of alcohol use in the past month and of binge drinking in the last fortnight than ethnic minority women – also very similar to their male peers (Randolph et al., 2009).

UK

Across the UK, White women consistently reported lower rates of abstaining, drinking more often and having more drinks in one sitting than all women. Eleven percent of Irish and White British women said they did not drink alcohol compared to 14% of the whole female population (Becker et al., 2006; Goddard, 2006). Among adolescent females, 89% of White English and 95% of White Irish women had ever consumed a whole drink, higher than their Black peers (Stillwell et al., 2004).

White Irish women had higher rates of drinking in all frequency categories compared to ethnic minorities, with 30% drinking three or more days a week, and 11% almost every day (Becker et al., 2006). Fourteen percent of White British women drank five or more days a week (Alcohol Concern, 2008; Goddard, 2006).

Twenty-three percent of White female British drinkers drank three or more units, and 10% drank six or more on a typical day in the previous week, higher proportions than ethnic minority women (Goddard, 2006). Thirty-seven percent of White women reported hazardous drinking levels (Borrill et al., 2003). The proportion of adult females who were binge drinkers peaked in 2003 and declined slightly in 2004 and 2005 surveys (IAS, 2008).

Sixty-seven percent of White English 14- to 16-year-old girls reported being drunk in the last three months, and 16% one or more times a week – a slightly higher rate than their male peers (Stillwell et al., 2004).

6.1.5 Pacific women in Aotearoa

A pattern of high rates of abstaining, not drinking often, and drinking high amounts per session has been found consistently among Pacific populations (Research NZ, 2011), although rates of non-drinking differ markedly in surveys.

Forty-seven percent of all Pacific women in 2011 (MOH, 2013) and 56% of those aged 12 to 24 said they did not drink in 2010 – higher than their Māori and non-Māori peers (Research NZ, 2011).

However, studies which analyse only pan-Pacific alcohol patterns conceal significant ethnic differences (Huakau, 2007). Of women aged 35 and older surveyed in 2002–3, Samoan women were most likely to say they did not drink (92%), followed by Tongan (78%), Cook Islands (75%), and Niue women (65%) (Sundborn et al., 2009). However, the numbers in each of these groups were small. When younger women were included (13–65-year-olds), Huakau and colleagues (2005) found much lower proportions of abstainers – 71% of Tongan women, 52% of Samoan, 34% of Cook Islands and 33% of Niue women.

The proportion of Pacific women abstainers has dropped over the last decade (Huckle et al., 2013; MOH, 2009a), due to young Pacific women's higher rates of drinking. Tautolo and colleagues (2005) found that 84% of female Cook Island secondary students and 79% of female Niue students were drinkers.

The National NZ Alcohol Survey Series found that Pacific women significantly increased the number of times they drank in a year on average between 2003 and 2011, a change driven by women aged 45–54 (Huckle et al., 2013). Huakau (2007) found that among drinkers, most Samoan, Tongan and Niue women drank less than once a week, while most Cook Islands women drank weekly.

Pacific women averaged five drinks per session in 2003 (Huakau et al., 2005). Huckle and colleagues (2013) found no change between 2003 and 2011 in the amount Pacific women drank on a typical occasion or the proportion who drank five or more drinks at least once a week. In 2007, the proportion of binge-drinking Pacific female secondary students (33%) matched their male counterparts (32%) (Teevale et al., 2012). Pacific students from relatively well-off neighbourhoods binge-drank more often.

Binge drinking also varied by ethnicity. Cook Islands women drank an average of nine drinks in a typical session, Tongan women eight, and Samoan and Niue women five (Huakau, 2007). Schaaf (2004) found that Niue female students had higher rates of binge drinking than other Pacific students.

Pacific women in Aotearoa aged 13 to 65 drank an average of 14 litres of pure alcohol a year (Huakau et al., 2005), similar to the highest average in the Pacific, while those over 35 drank much less (3.3L) (Sundborn et al., 2009).

The proportion of Pacific women drinkers who drank hazardously increased between 1996–7 and 2006–7 from 21% to 26% (MSD, 2010).

6.1.6 'Asian' women in Aotearoa

Women in the umbrella category 'Asian' (which includes Chinese, Indian, Korean, Filipina, Japanese, Sri Lankan, Cambodian and other ethnicities) were significantly less likely to drink alcohol than the whole population in 2007–8 (MOH, 2009a); only 55% had had alcohol in the last year.

'Asian' drinkers were significantly less likely to have started drinking before 14, or to have drunk more than four drinks in one session then. They were also significantly less likely ever to have drunk enough to feel drunk, or to have drunk more than four drinks in one drinking session (Ibid).

The proportion of 'Asian' women drinking hazardously declined from 5 to 4% between 1997 and 2007 (MSD, 2010).

There was no gender separation in the Youth 2007 analysis of Chinese, Indian and 'Asian' secondary school students (Parackal et al., 2011). However, their drinking rates were consistent with these figures. Between 64 and 66% were non-drinkers; 14 to 17% said they had drunk five or more drinks in a session in the last month – half the proportion of Pākehā students.

Women with higher socio-economic status increased how often they drank between 1995 and 2004.

6.1.7 Women with different socio-economic status

Aotearoa

Women living in more affluent neighbourhoods (NZDep2006 quintile 1), and those with higher educational qualifications and income, tended to drink alcohol more often than those in poorer areas or with fewer qualifications and less

income (Huckle et al., 2010). Women in richer suburbs were significantly more likely ever to have drunk in the previous year and to drink every day, than those in deprived neighbourhoods (NZDep2006 quintile 5) (MOH, 2009a). Women with higher socio-economic status (SES) increased how often they drank between 1995 and 2004.

Higher proportions of secondary students from affluent areas were also current drinkers, and more likely to report that their parents drank (Ameratunga et al., 2011). Weekend teenage parties supplied with large amounts of alcohol were more common in affluent communities (NZ Law Commission, 2010). However, these results were not analysed by gender.

Most intoxicated patients in a study of Wellington Hospital's emergency department came from medium to affluent suburbs (Quigley, cited in NZ Law Commission, 2009, p. 77).

Women in poorer areas tend to drink more per drinking session. The proportion of female drinkers with a potentially hazardous drinking pattern in the poorest areas was significantly higher than in the richest areas (MSD, 2010). More women in poor areas drank four or more drinks in a session than in the richest areas (MOH, 2009a). Women in poor areas were twice as likely to drink this amount in a session weekly as those in the richest areas. In the Survey of Family, Income and Employment in 2004-5, the frequency of women's binge drinking increased as their educational level decreased (Jatrana et al., 2011).

Women from the poorest areas were significantly more likely to have drunk four or more drinks in a session when they were 14, and to have felt drunk in the past year. They were more than twice as likely to have felt drunk weekly than women in the richest areas.

Women with lower SES were most at risk of drinking heavily in drinking sessions. They increased the amount they drank between 1995 and 2004, while women with higher status did not (Huckle et al., 2010).

UK

Weekly drinking, frequency, and binge drinking were highest for high SES and lowest for low SES women aged over 16 (Measham & Ostergaard, 2009). However, while women with higher educational qualifications were more likely to binge-drink in their 20s, they were less likely to do so in their early 40s (Jefferis et al., 2007).

US

Women living at four times the poverty level were heavier drinkers (6%) than women on lower or below poverty level incomes (4%).

6.1.8 Young women

Aotearoa

The proportion of female secondary students who were current drinkers dropped significantly from 68.5% in the first Youth 2000 survey to 45.5% in 2012 (Ameratunga et al., 2011; Clark et al., 2013a). This is consistent with results from the NZ Health Survey, where the proportion of 16 to 17-year-old young women drinkers dropped significantly from 79% in 2006-7 to 59% in 2011-12 (MOH, 2013, 2009a).

However, of those secondary students who did drink, 28% had five to nine drinks in an average session in 2001, 33% in 2007 and 30% in 2012 (Clark et al., 2013b; Ameratunga et al., 2011; AHRG, 2004). About 10% usually had 10 or more drinks a session in 2012. This is consistent with a quarter of 14 to 15-year-old girls visiting Auckland GPs in 2003 drinking at a 'risky' level (Goodyear-Smith et al., 2004).

More female than male secondary students under the age of 13 drank at least once a week in the Youth 2007 survey (Ameratunga et al., 2011) and the proportion of girls who had drunk once in the previous month was the same as for boys.

Three-quarters of all drinking by people aged 12 to 19 happens in heavier drinking occasions – six or more drinks for young women. This compares to half of all alcohol drunk by people aged 14 to 65 (Huckle et al., 2011).

Almost half (48%) of girls aged 12 to 17 who drank were binge drinkers in 2009, and 44% of 18 to 24-year-old women. This compares to 42% of all women over 18 (Research NZ, 2011). The proportion of women aged 18-24 in the Alcohol and Drug Use Survey who drank hazardously (an AUDIT score of 8+) did not change between 1996-97 and 2006-07 (Huckle et al., 2013). However, a comparison of National NZ Alcohol Surveys found that the proportion of female drinkers aged 16-24 having five or more drinks at least once a week increased significantly from 19% to 28% between 1995 and 2011; most of the increase happened between 1995 and 2000 (Ibid.).

The proportion of 16-19-year-old young women in these surveys who drank eight or more drinks in a typical session also significantly increased between 1995 and 2011, while the proportion of young men of the same age drinking this amount

dropped between 2004 and 2011 (Casswell, 2012). A higher proportion of young women aged 16 to 17 (28%) than young men (25%) drank this amount in the 2011 survey.

Alternative education students tended to drink more than other secondary students in an average session – 90% of drinkers in alternative education had had five or more drinks in a session in the previous month (Clark et al., 2010), with no significant gender difference.

Eighty-nine percent of the female students at Teen Parent units reported regular drinking before their pregnancy. After they gave birth, when they did drink, almost half drank five or more drinks in one session (AHRG, 2008).

In 2005, 52% of female tertiary students at eight university campuses said they had more than four drinks in a session during their last year in high school at least once a month (Kypri et al., 2009b).

Getting drunk at least once a week is most common among 18- to 24-year-old women (16%), and half as likely among 25- to 34-year-olds (9%) and 16- to 17-year-olds (8%) (McEwan et al., 2010).

Between 1995 and 2000 women aged 16 to 24 increased the amount they drank on a typical occasion from four to six drinks (McPherson et al., 2003).

In a 2004 survey of people under 25 leaving bars and clubs around the Auckland region, 31% of young women had breath test readings over 400mcg/l, the legal driving limit for people over 20. Six percent were over 600 (SHORE & Whariki, 2005). Thirty-nine percent of young women said they would usually drink more than they had when they were tested; 46% were on their way to another club.

Six out of seven New Zealand communities rated youth drinking as their biggest alcohol-related problem in 2007 (MacLennan et al., 2012).

There was little data available about whether or how young women's binge drinking patterns change as they become parents, or enter their 30s.

Australia

Twenty-one percent of 11-year-old Victorian secondary students had drunk alcohol in 2002, and 7% of 15-year-olds were frequent binge drinkers (Toumbourou et al., 2009). In a 2010 national survey, 5% of 12 to 17-year-old girls and 30% of 18 to 19-year-olds drank at least once a week (AIHW, 2011). Twenty percent of 18 to 19-year olds were described as risky drinkers (more than two standard drinks a day) and 22% had more than four standard drinks in one session at least once a week.

Canada

Thirty-five percent of 15-year-old girls said they had their first alcoholic drink by 13 (Currie et al., 2008). A 2003 survey of Ontario secondary students and a 2002 national student survey found that reported rates of feeling drunk were not significantly different between boys and girls (Poole & Dell, 2005).

USA

Five percent of 11-year-old girls had drunk alcohol in the past year. By age 15, 2% were binge drinking frequently (Toumbourou et al., 2009) – similar rates to their male peers.

Europe

Forty-eight percent of 15-year-old English girls said they drank their first alcohol at age 13 or younger (Currie et al., 2008). Women aged 16 to 24 had the highest rate of weekly drinking among women (IAS, 2008).

However, one study reported that between 1998 and 2006, weekly drinking, frequent drinking, heavy drinking and binge drinking decreased among women aged 16 and 24 (Measham & Ostergaard, 2009). In 2006, 55% of this age group drank weekly, 3% drank five or more times a week, and 21% had had more than six drinks in one session in the previous week (Ibid).

Between 1988 and 2003, the percentage of 16- to 24-year-old women in the UK exceeding a 'sensible weekly limit' more than doubled from 15 to 33% (IAS, 2008).

An average of 9% of 13-year-old and 21% of 15-year-old girls in 41 European countries drank alcohol at least once a week (Currie et al., 2008). Thirteen percent of 15-year-old girls said they first got drunk aged 13 or younger. Girls in northern European countries were as likely as boys to do so.

6.1.9 Tertiary students

Aotearoa

Tertiary students are more likely to drink hazardously than their non-student peers (Kypri et al., 2005a).

Forty-three percent of female student drinkers at the University of Otago said they got drunk at least once in the preceding week, and 49 had an average of six drinks a session (Kypri et al., 2005b). These figures matched those of male students. In 2006, 36% of female student drinkers at Waikato University halls of residence said they got drunk once a week and 33% drank an average of seven to nine drinks a session (McEwan, 2009). Twenty-three percent of women from six university campuses had had more than four drinks in one session in the last week and 14% reported two of these binges (Kypri et al., 2009b). Women had an average AUDIT-C (abbreviated) score of 5.3; a score of four indicates hazardous drinking.

Sixty percent of all students said that they usually knew beforehand if they were going to get drunk. These students were likely to drink more on a typical occasion (McEwan et al., 2011). There was no difference by gender.

The proportions of male and female students in Dunedin student halls of residence having six to 10 drinks a session were similar (39%) in 2000 (Kypri et al., 2002). Rates of binge drinking once (37%) or at least twice in the last week (14%) were similar among female and male students at eight university campuses in 2005 (Kypri et al., 2009b).

Australia

Fifty-three percent of female students aged 18 to 24 drank four or fewer drinks per occasion, and 47% drank seven or more (O'Hara et al., 2008).

Canada

In 2000, a higher proportion of female students than male were drinkers (Poole & Dell, 2005). Forty-one percent of female students reported harmful drinking in the past 12 months and 29% reported dependent drinking.

UK

One qualitative study of female tertiary student binge drinkers found that they associated drinking with freedom and regulated it through group norms. The group stigmatised drinking to excess as an abuse of freedom, but their threshold for excess was very high. They enjoyed feeling drunk and trivialised problems from drinking (MacNeela & Bredin, 2011).

6.1.10 Older women

The 2011 National NZ Alcohol Survey found that older women drank more often in a year than younger ones on average, except among Pacific drinkers, where the opposite was true (Huckle et al., 2013). Across the population, women aged 55-65 almost doubled the average number of times they drank in a year between 1995 and 2011, from 56 to 110 occasions. Women aged 35-44 increased their average number of drinking occasions from 53 in 1995 to 82 in 2011, and drinking frequency among those aged 25-34 also increased significantly. Older women also significantly increased their average amount they drank on a typical occasion over this period.

Older people are more physiologically sensitive to alcohol than middle-aged adults, and alcohol also produces harmful effects in combination with medications commonly prescribed to older women. A 2006 postal survey found that 44% of women in Aotearoa aged 55 to 70 drank at or above an age-adjusted hazardous drinking threshold (Towers et al., 2011). High-earning Pākehā aged under 65 with good living standards were more likely to drink hazardously than other older drinkers.

Five percent of older women in this survey had six or more drinks in one session at least once a month, and 3% binged at least weekly. There was no analysis of gender patterns by ethnicity or socio-economic status. However, older Māori were likely to drink less often than non-Māori, but tended to drink more in an average session. People with a high income were also more likely to binge drink.

An earlier postal survey of 141 older Christchurch people, with a similar response rate but using a different measure, found a much lower rate of hazardous drinking among women (1% in the previous 12 months), with 14% having been alcohol dependent at some point during their lifetime (Khan et al., 2002a).

In Australia, women aged 70 or older (12%) were the age group most likely to drink every day (AIHW, 2011).

Female university students had an average AUDIT score of 5.3, when 4 indicates hazardous drinking.

6.1.11 Lesbian, queer and transwomen

Aotearoa

High levels of social stigma around lesbian and queer identities make it difficult to obtain reliable samples of same-sex attracted women (Pega & MacEwan, 2010). Data from representative surveys may under-represent them, while results from snowball and convenience samples cannot be generalised.

Given these constraints, some consistent patterns have emerged. Lesbians and bisexual women tend to have a lower rate of non-drinking than their heterosexual peers (Pega & Coupe, 2007; Welch et al., 1998), and are more likely to have drunk at least weekly (Pega & Coupe, 2007).

There was no gender analysis in the Youth 2007 results for lesbian, gay or bisexual (LGB) secondary students (Rossen et al., 2009). However, LGB students were more likely than heterosexual students to drink alcohol weekly, and to have five or more drinks in a session in the last month. Binge drinking was higher among students attracted to more than one gender (51%) than among those attracted to only the same or only the opposite sex (35%) (Pega et al., 2012). This review found no research from Aotearoa about the substance use of transwomen.

Australia

Surveys have found significantly lower proportions of non-drinkers among lesbian and queer women than all women (Leonard et al., 2012; Tonkin et al., 2010; Hyde et al., 2009).

However, national and state-wide studies found different rates of daily and binge drinking. A recent national survey found that the same proportion of lesbians as all women (4.9%) drank daily, while a smaller proportion of bisexual women (3.7%) did so (Leonard et al., 2012). State-wide studies of same-sex attracted women have found a higher likelihood of risky alcohol use and binge drinking in Queensland (QAHC, 2010), New South Wales (ACON, 2009) and Victoria (Hillier et al., 2005). Western Australian lesbian and bisexual women drank more often and in greater amounts than the general population (Hyde et al., 2009); 26% drank more than four standard drinks at least weekly. Lesbians and queer women in Victoria were more likely than women nationally to exceed the recommended maximum daily amount of alcohol at least once a week (Murnane et al., 2000). Just over half of these women said alcohol and other drug use among their peers was a major problem.

USA

Adolescent lesbian and bisexual (LB) women had significantly higher rates of drinking in the last month, binge drinking and a higher usual number of drinks than their heterosexual peers (Ziyadeh et al., 2007; Burgard et al., 2005). More LB girls had their first drink before age 12 than heterosexual girls.

Bisexual women reported the highest number of drinks per year (466) compared to lesbian women (366), heterosexual women with experience of same-sex partners (322) and heterosexual women with only male partners (146). This ranking was the same for having five or more drinks in one session, being drunk, and alcohol dependence (Drabble & Trocki, 2005; Wilsnack et al., 2008).

Two studies found that lesbian and bisexual women's drinking rates persisted rather than declined with age (Roberts, 2001). However, among Southern lesbians the average number of drinks per day decreased with age (Austin & Irwin, 2010).

There is little research on transgender women. What there is indicates that they may have high rates of substance abuse, including of alcohol, cocaine and methamphetamine (CSAT, 2009a).

UK

One study in Scotland found a higher likelihood of risky alcohol use and binge drinking among lesbian and queer women than all other women (Inclusion Project, 2003).

6.1.12 Pregnant women

Aotearoa

About half of pregnancies are unplanned; most women do not realise they are pregnant until several weeks after conception and one in ten may not realise for three months (Salmon, 2007). Women drinkers whose pregnancies are unplanned therefore have a higher risk of having a child with FAS (Stuart, 2009).

About 80% of New Zealand women were drinking alcohol around the time they conceived, a high rate compared with other first-world countries (AHW, 2010b). Eighty-nine percent of teen parents reported drinking regularly before their pregnancy. Almost half said they had five or more drinks in an average session (Johnson & Denny, 2007). Two out of three Taranaki women who had just given birth said they had four or more drinks in a session before they knew they were pregnant (Ho & Jacquemard, 2009).

Most pregnant women reduced or stopped their drinking after they realised they were pregnant, but between 25 and 36% of pregnant women in eight studies continued to drink (AHW, 2010b). One study estimated that 29% of pregnant drinkers represented 73,000 women in the three years to 2007 (MOH, 2009a).

One study of methamphetamine (P) use by pregnant women found that 51% of the sampled women were drinking, compared to 13% of a similar US sample (Wouldes, 2012). Ten percent of the New Zealand women had at least one standard drink a day, and slightly more of these women also used P at least three times a week.

European/other women were significantly more likely to say they drank while pregnant, and Pacific and 'Asian' women significantly less likely, compared with all pregnant women (MOH, 2009a; Watson & McDonald, 1999). Fewer Māori (19%) than tauiwi women (26%) drank during pregnancy in 1999 (McLeod et al., 2002).

Borrows and colleagues (2011) categorised mothers from the Pacific Islands Families Study into four groups based on their acculturation – separators (low New Zealand, high Pacific acculturation); integrators (high NZ–high Pacific); assimilators (high NZ–low Pacific); and marginalisers (low NZ–low Pacific).

Compared to separators, the babies of integrator mothers were 2.6 times more likely to be exposed to alcohol during pregnancy; seven times for the babies of marginalisers and 14.6 times for the babies of assimilator mothers. They concluded that 'having strong and numerous bonds to identify with may have a protective influence' (Ibid, p. 715).

A much smaller proportion (2%) of teen parents said they continued to drink during pregnancy (Johnson & Denny, 2007). However, midwives in one national survey indicated that 80% of teenage pregnancies were alcohol-exposed (Mathew et al., 2001).

More than half of a sample of breast-feeding women had drunk alcohol in the last seven days (McLeod et al., 2002).

Australia

Eighty percent of non-indigenous pregnant women drank in the three months before their pregnancy; 53% had planned to get pregnant (Colvin et al., 2007). Ninety percent of all women thought alcohol should be avoided in pregnancy and 87% believed it should also be avoided while breastfeeding. However, rates of drinking during pregnancy ranged from 30 (AER, 2010) to 59% (Colvin et al., 2007).

Nineteen percent reported drinking two or more drinks in a session at some stage of their pregnancy. The number of women drinking one to two drinks on a typical occasion did not differ across the pregnancy, but the frequency of occasions declined. Four percent of women drank five or more drinks in a session during their first trimester (Ibid).

Knowing the negative impacts of alcohol on the fetus did not correlate with lower expectations of drinking during pregnancy among women with higher education who had drunk during previous pregnancies (Peadon et al., 2011). Women may associate risk only with binge drinking.

6.1.13 Sportswomen

Three studies found high levels of drinking among sportswomen in New Zealand (O'Brien et al., 2008; 2007; Quarrie et al., 1996), although another report suggested that the evidence of higher levels of hazardous drinking among sportspeople was not conclusive (PS...Services, 2010). Two studies reported AUDIT scores of 8.7 among sportswomen, when eight or higher

Most women reduced or stopped drinking after they found they were pregnant, but 25-36% continued to drink.

indicates hazardous drinking (O'Brien et al., 2007; Quarrie et al., 1996). A 2008 study among university sportspeople found no significant gender difference in AUDIT scores (O'Brien & Kypri, 2008); women averaged 10.7.

Thirty percent of university sportswomen reported frequent binge drinking, with 40% drinking seven or more standard drinks in an average session (O'Brien et al., 2008). Among female rugby players, 38% drank six or more drinks per session at least weekly (Quarrie et al., 1996). Team players had significantly higher AUDIT scores than individual sportswomen (O'Brien et al., 2008; 2007).

For Pacific secondary students, playing for a sports team or club outside school was linked with an increased risk of binge drinking (Teevale et al., 2012).

Sportspeople with alcohol sponsorship, whether as an individual, team or club member, had average AUDIT scores 2.4 points higher than those without (O'Brien & Kypri, 2008). Those sponsored at all three levels had the highest AUDIT scores. Receiving cheap or free alcohol and drinking at the sponsor's pub were also linked with higher scores.

However, a survey of sports clubs from a range of codes found that half had observed 'excessive' drinking less than monthly in their club rooms, and 40% had never observed 'excessive' drinking or intoxication (PS...Services, 2010).

6.1.14 Sex workers

Sex workers have reported a high prevalence of drinking and other drug use (Saphira, 2008; Jordan, 2005). Those who started commercial sex work before 18 tended to start drinking and using other drugs earlier and to drink or take more (Saphira & Glover, 2004).

6.1.15 Prison inmates

Aotearoa

Forty percent New Zealand female prisoners reported drinking two to three times weekly in the six months before conviction (Abbott & McKenna, 2005). Thirty-eight percent said they drank more than 10 drinks per session, and nearly half had AUDIT scores indicating hazardous drinking. There were no significant differences by ethnicity.

The Christchurch Prisons Epidemiology Study found a high lifetime and current prevalence of AOD abuse and dependence among male and female prisoners, as well as higher rates of most major psychiatric diagnoses. Four percent of female inmates in a similar national study were diagnosed with alcohol abuse and 2.5% with alcohol dependence for the last month, described as 'grossly elevated' compared to rates for non-inmates (Brinded et al., 2001).

Substance misuse in Australasian inmates is typically estimated at 60 to 80%, making AOD one of the major identified criminogenic needs (Huriwai, 2002).

Australia

Multi-drug use was common among Australian female prisoners (Johnson, 2006b). Among teenage offenders, 19% of urban and 48% of rural females drank 15 or more drinks per week (Kenny & Schreiner, 2009).

6.1.16 Women with disabilities

This review found no research about the alcohol use of women with disabilities in Aotearoa. One study in Washington State found that secondary school students with disabilities were more likely to binge drink than their able-bodied peers (WSDOH, 2009).

6.2 Types of alcohol that women drink

6.2.1 Aotearoa

The research reviewed focused strongly on ready-to-drink pre-mixed spirit drinks (RTDs or alcopops), which were introduced to New Zealand in 1995. By 2005 43 million litres were available, making it the fastest growing alcoholic beverage during that decade (Huckle et al., 2008b; NZ Law Commission, 2010). Alcohol Action NZ (2011) argued that the alcohol industry added sugar to these drinks to make them palatable for women and young people. The alcohol content of some RTDs was later increased to 12% (ALAC, 2008a).

Young New Zealand drinkers perceive RTDs as mostly drunk by 'learner' or female drinkers because their sweetness masks the taste of alcohol (Fountain & Fish, 2010; NZ Law Commission, 2009; McCreanor et al., 2008). Young people – women and men from 14 to 24 – are the most common drinkers of RTDs (Huckle et al., 2008b).

Young people who drank them were more likely to be heavier drinkers than those who did not. RTDs made up 70% of the alcohol intake of 14- to 17-year-old girls. Drinkers who had RTDs typically drank more in a session, and more often in a year than those who drank other spirits, beer or wine (Huckle et al., 2008b).

In 2012, most female secondary students (71%) drank RTDs (Clark et al., 2013a). Māori and Pacific students more commonly preferred RTDs, while Pākehā and 'Asian' students preferred beer (Ameratunga et al., 2011). Queer secondary students preferred spirits, with fewer drinking beer than their heterosexual peers. Fifty-one percent of female students in alternative education drank RTDs (Clark et al., 2010).

Among women aged 35 to 74, Pākehā most commonly drank wine (69%), while Pacific women drank spirits (34%), beer (28%) and wine (27%) in more equal proportions (Sundborn et al., 2009).

In New Zealand, young people described sparkling wines as an initiation drink for new female drinkers; among middle-aged women it meant sophistication. Women saw sparkling wine as a happy drink and associated it with feeling giggly and light (Fountain & Fish, 2010).

Young people who drank RTDs were more likely to be heavier drinkers than those who did not.

6.2.2 International

A preference for RTDs and wine is also common in other similar countries, except in the Pacific; for example, almost all alcohol consumed in Samoa is beer (WHO, 2011b).

Australia

In 2007, women were most likely to consume bottled wine, except for 14- to 19-year-old low-risk drinkers who preferred RTDs, and 14- to 29-year-old risky drinkers who preferred bottled spirits and liqueurs (AIHW, 2008).

RTDs have become increasingly popular among 12- to 17-year-old women, and their consumption of other spirits has decreased (Chikritzhs et al., 2009; Strivastava & Zhao, 2010). RTDs, wine and spirits are more popular among women than men.

Canada

Eight percent of 15-year-old Canadian girls drank RTDs weekly, and 7% each drank beer or other spirits weekly (Currie et al., 2008).

USA

Eight percent of young women mixed energy drinks with alcohol (O'Brien et al., 2008); 7% of 15-year-old girls drank RTDs weekly and 5% drank other spirits (Currie et al., 2008).

UK

RTDs were the most popular drink among 15-year-old English girls; 25% drank them weekly. The next most popular were other spirits (16%), beer (14%) and wine (12%) (Currie et al., 2008).

6.3 Locations of women's drinking

Home-based drinking accounts for about 70% of alcohol drunk in New Zealand (Collie, 2011). Fifty-eight percent of women surveyed outside two Auckland bars in 2008 had drunk alcohol with their friends at home before going out to the bars (Kirkwood, 2009a). This preloading is a common youth drinking pattern, which the NZ Law Commission was told had intensified in the last two years because of discounting by large retailers (2010, p. 43).

Younger female secondary students in 2007 were more likely to drink with friends (73%) than their male peers, and this increased with age for teenagers (Ameratunga et al., 2011). Ninety-five percent of female 17-year-olds drank with friends. Queer students were less likely to drink with family (36%) and more likely than their heterosexual peers to drink by themselves (19%). There was no analysis by gender.

6.4 Sources of women's alcohol

Hager (2011b) says that some women are forced by controlling partners to use alcohol or other drugs to make them drunk and compliant. Otherwise, the source of alcohol is an issue mainly for young women under 18. Goodyear-Smith (2004)

suggested that these girls possibly had easier access to alcohol than boys.

This is supported by results from the Youth 2012 study, which found that female secondary students (47%) were more likely than males (39%) to have friends give them alcohol or to get someone else to buy it for them (35% vs 23.5%) (Clark et al., 2013a). A majority of female students in alternative education (57%) said they got their alcohol from their parents (Clark et al., 2010).

Nine percent of female students bought their own alcohol in 2012, a drop from 14% in 2007 (Ameratunga et al., 2011, p. 23; Clark et al., 2013a) Bottle stores were the most common source in 2012 (71%). Girls (23%) were asked for ID slightly less often than boys (27%) in commercial outlets.

6.5 Data limitations

Most research in Aotearoa that gave consumption data for both genders did not analyse gender by ethnicity or age. Overall trends by gender obscure the diversity of women's drinking patterns.

National surveys of drinking patterns have changed the questions they ask and the age range of people surveyed over time, making it very difficult to assess long term trends (for example, Research NZ, 2011, 2007). A more strategic approach is needed to ensure comparability and continuity, while managing changes in methodology and survey design to take new research into account.

Measures of proportions of drinkers are affected by sampling method and the response level achieved with each survey. Surveys with low response rates tend to underestimate heavy drinkers and abstainers, and these biases may differ between men and women. Prevalence estimates and trends over time in surveys with low response rates may be unreliable.

Some analyses controlled for gender as a fixed covariate – for example, Fergusson and Horwood's (2000) study of alcohol abuse and crime. This obscured data about women and treated gender as if it was fixed rather than a social construction that has changed over time.

Data on total population consumption, by beverage and by quantity of pure alcohol, comes from the total amount of alcohol available for consumption, which is reported by manufacturers for excise tax. Almost all other data comes from self-reports in general surveys. These are subject to bias from respondents who want to appear socially responsible, as well as from problems with remembering one's intake of a drug that affects memory (Sundborn et al., 2009).

Such surveys exclude very heavy and dependent drinkers, who are often functionally homeless, transient or without telephones (Jones et al., 1995).

The Youth 2000, 2007 and 2012 surveys of secondary students do not include young people who are not in school that day, who have left, been suspended or are in alternative education. They are likely to represent a more stable and healthy population of young people than those who are homeless, transient, truant or suspended from school, although more of these are boys (Clark et al., 2013b).

Another source of under-estimation is drinkers' tallies of their intake of standard drinks (10g of alcohol) in a typical drinking session, which can be half the true number (Fryer et al., 2004).

Drinkers also considered a drinking session to be around five hours, rather than the 24 hours more commonly assumed by researchers. Thirty percent of this sample reported that they had drunk in the 24 hours before the finish time of their last drinking session (Ibid).

SUMMARY – WOMEN'S DRINKING

While the total volume of alcohol that women drink is still around a third that of men, between 1995 and 2000 the amount women and men aged 20 to 39 drank in a typical session and their rates of drunkenness were converging. The proportion of young women aged 16 to 17 having eight or more drinks in a session tripled between 1995 and 2011, and was greater than the proportion of young men in 2011. However, there is no general recent analysis of convergence between men and women's drinking.

The proportion of abstainers has increased significantly over the last decade among female secondary school students, and in the last 18 years among women up to age 65. However, those who drink did so more times on

average in a year, and increased the typical amount they drank. Between 1995 and 2000 young women aged 16 to 24 increased the amount they drank in a typical session from four to six drinks. Between 1995 and 2011, the proportion having five or more drinks at least once a week increased by 50%.

Among female secondary school drinkers, the proportion who binge drink has also increased. Ten percent of female students usually drank 10 or more drinks per session in 2012. In 2006, 36% of female tertiary students got drunk once a week and 39% drank six to 10 drinks a session. In 2006, 44% of women aged 55 to 70 drank hazardously. Most female secondary students drink RTDs.

Māori and Pacific women are more likely than Pākehā to be non-drinkers, to drink less often, and to have more drinks on a typical occasion, although these factors vary by ethnicity among Pacific women. The proportion of drinkers among Māori women aged 16-24 has increased significantly in the last decade. The proportion of Māori women drinking hazardously declined from 31 to 28.5% between 1996 and 2006.

Pacific women increased the average number of times they drank in a year over the last decade; the proportion drinking hazardously rose from 21 to 26% between 1996 and 2006.

Pākehā women are more likely to be drinkers and to drink regularly, but less likely to be binge drinkers. The proportion of European/other women drinking hazardously increased from 12 to 14.5% between 1996 and 2006.

'Asian' women have high rates of non-drinking, tend to drink less often and to have low quantities per session, although these vary by ethnicity. The proportion drinking hazardously declined from 5 to 4% between 1996 and 2006.

Women in more affluent areas are more likely to drink daily. Those in more deprived areas are more likely to drink hazardously.

Lesbian and queer women are more likely to be drinkers than their heterosexual peers, and in 2004 were more likely to drink at least weekly; binge drinking rates are higher among bisexual secondary school students than those attracted to the same or the opposite gender. However, information is scant. This review found no data about transgender women's drinking in New Zealand.

In 2006, around 80% of women were drinking alcohol around the time they became pregnant. Most stopped, but up to 36% continued to drink during pregnancy.

Sportswomen had an average drinking score above hazardous level in 2006. Those receiving alcohol sponsorship had higher hazardous drinking scores than those with none, and those sponsored at individual, team and club level had the highest score.

Half of a sample of female prison inmates in 1999 drank at hazardous levels before they were convicted.

Summaries of each section are compiled in the précis at the beginning of the report.

7. Sex-based biological differences

7.1 Physiology and body function

On average, women weigh less than men, have a smaller volume of water in their bodies to dilute alcohol, a higher proportion of fat, and more alcohol sensitivity. They produce smaller amounts of an alcohol-metabolising enzyme, so alcohol is processed more slowly. This results in higher blood alcohol concentrations (Schulte et al., 2009; Schuckit et al., 1998) when they drink the same amount of alcohol per body weight (Holmila & Raitasalo, 2005; Nolen-Hoeksema, 2004).

For this reason, the health problems of women who drink heavily become severe more quickly than for men (ALAC, 2004).

7.2 Effects on the brain and thinking

Between puberty and adulthood, our brains undergo a second major period of development in the areas responsible for self-control, judgement, emotions and organisation, which is probably not complete in women until around the age of 23. Adolescents are therefore more vulnerable than adults to the effects of alcohol on learning and memory. They are also affected differently by repeated heavy drinking, particularly binge drinking (BTA, 2010). This has impacts on young women's ability to drive safely.

Women do not need to reach equal levels of consumption with men to reach equal levels of intoxication and risk.
McPherson et al.,
2003, p. 748

Teenage girls in the USA who had at least four drinks in one session had significantly less activity in brain areas used in spatial memory and attention tasks. Young binge-drinking women may be more vulnerable to the neurotoxic effects of heavy drinking in adolescence than binge-drinking boys of the same age (Squeglia et al., 2011).

Certain brain areas and types of thinking have been found to be more affected by alcohol in adult women than men (Mumenthaler et al., 1999; Oscar-Berman & Shagrin, 1997). Women were consistently more impaired by alcohol than males with similar blood-alcohol concentrations on a range of tasks involving motor co-ordination and the speed and capacity of information processing (Miller et al., 2009). Alcohol may do more damage to thinking and problem-solving in women (Nolen-Hoeksema, 2004).

Alcoholic women have been found to have smaller volumes of grey and white brain matter than non-alcoholic women, and comparisons with men indicated that women may be more sensitive to alcohol neurotoxicity (Ibid).

Women alcoholics experienced damage to a critical brain neurotransmitter three times faster than male alcoholics. Compared to a control group, the action of serotonin, which regulates impulse control, sleep, and is critical in treating depression and anxiety, was reduced by half in the alcoholic group (Fahlke et al., 2012). These women had been drinking the equivalent of 12 bottles of wine a week for four years and had the same serotonin damage as the men, who had been drinking the same amount for 12 years.

Memory function and attention are also more impaired in women than men (Mumenthaler et al., 1999; Niaura et al., 1987). Female binge drinkers had less activation in parts of the brain during spatial working memory tasks than female controls and men (Squeglia et al., 2011). Alcoholic women also performed worse than male alcoholics, and female and male controls, on a range of cognitive tasks, including cognitive flexibility and visuo-spatial processing (Flannery et al., 2007).

7.3 Hormones and the menstrual cycle

Alcohol increases the levels of oestrogen circulating in the blood, and therefore increases the risk of hormone-dependent breast cancer (Chen et al., 2011). Evidence is mixed on the interaction of women's menstrual cycles, hormones and alcohol effects. Some earlier studies reported that blood alcohol concentration and other measures were influenced by different times in the menstrual cycle, but some later studies disputed this claim (Mumenthaler et al., 1999; Haddad et al., 1998). However, menstrual cycles affect levels of craving for alcohol and other substances (ALAC, 2004). Higher levels of the female hormone progesterone have been linked with faster alcohol elimination from the body (Dettling et al., 2008).

7.4 Drug interactions

Women use more minor tranquillisers, other prescription and over-the-counter medications than men, and their use increases with age (Chan, 1984). Over-the-counter medications such as aspirin and the antacids Apo-Cimetidine and Zantac interact with alcohol metabolism, leading to a higher blood alcohol concentration (Chen & Maier, 2011).

Alcohol increases the sedating effect of sleeping tablets, and increases the likelihood of aspirin irritating the stomach and paracetamol damaging the liver. Alcohol interacts with prescription drugs such as opiates, paracetamol, anti-depressants, antibiotics, anti-histamines, anti-inflammatory drugs, hypoglycaemic agents, warfarin, barbiturates and some heart medicines (ALAC, 2011a).

Minor tranquillisers such as benzodiazepines interact with alcohol to increase the risk of overdose and death (Lee, 2003). When women drink alcohol and smoke marijuana, their ability to drive is impaired more than when they drink alcohol on its own (Ashton, 2001).

SUMMARY – SEX-BASED DIFFERENCES

Women process and absorb the same amount of alcohol slower than men of the same weight, so that alcohol damages women sooner and more seriously. Girls and women who drink similar amounts to their male peers are likely to develop chronic alcohol-related diseases more quickly.

8. Influences on women's drinking

We have used the ecological public health model (Lang & Rayner, 2005; Lang et al., 2001) to discuss the influences on women's drinking at the level of populations, communities, families and relationships, and individuals.

8.1 Societal and population level

8.1.1 Industry marketing and advertising

Advertising generally promotes consumption as the answer to common discontents in industrialised countries, such as loneliness, meaninglessness and sexual dissatisfaction (Lasch, 1978). Consumer culture fosters the desire for self-realisation, where consumers supposedly have free choice to be and consume what they want (Rose, 1999). Marketing encourages a constant recreation of personal identity and image (McCreanor et al., 2005).

Alcohol marketing is 'a key social determinant' that shapes population health behaviours (McCreanor et al., 2008, p. 945). Marketing aims to ensure that alcohol is treated as an ordinary consumer commodity, rather than as a dangerous drug requiring particular treatment to ensure public health (Casswell & Zhang, 1997).

According to the Foundation for Advertising Research (FAR, 2006a), spending on alcohol advertising declined between 1992 and 2006. Inflation-adjusted expenditure decreased 46%, while total advertising expenditure on all goods and services increased 88%. This may reflect a move away from advertising in expensive commercial media to cheaper online marketing. In the UK from 2003-8, advertising spending declined in all media except for the internet, where it increased by 48% over that period (Fuchs, 2011).

Impacts

Aotearoa

Sellman and Connor (2009, p. 7) argue that the rise in women's drinking

... has not been an accident of history. It has been driven by a highly successful marketing campaign of the alcohol industry which spends in the region of \$200,000 a day targeting sub-populations where there is potential for growth in consumption, including women.

A review by Weir (2007) found support for a link between increased exposure to alcohol advertising and increased drinking. Liking TV beer ads increased current and expected future drinking among 10- to 17-year-olds (Wyllie et al., 1998b), and contributed to the amount drunk by 18 to 29-year-olds. Thirty-nine percent of girls and 28% of young women said they learnt about drinking from watching the ads.

Thirty percent of the young women said that alcohol ads were among their favourite television advertising. One-quarter thought the ads showed real-life scenes, and young women agreed that the ads showed people getting drunk, although this is against the voluntary alcohol advertising code (Wyllie et al., 1998a).

Liking alcohol ads and brands was also a stronger predictor of the amount participants in the Dunedin Multidisciplinary Health and Development Study drank at 21 than how much they had drunk at 18 (Casswell & Zhang, 1998). However, this effect was not as strong in young women.

Young people at a national hui identified marketing of alcohol price, access, promotions and competitions as a major contribution to youth drinking culture (Robertson, 2008).

International

Underage youth in the US were exposed to more magazine alcohol advertising per capita than other age groups (CAMY, 2002). A content analysis of alcohol advertising in US youth magazines between 2003 and 2007 concluded that young people are also more likely than adults to see ads which depict addicted behaviour and breach voluntary advertising codes (Rhoades & Jernigan, 2013). The study defined 'addiction content', as depicting drinking at inappropriate times of day; referring to excuses for drinking; or implying prolonged consumption or dependence on the product. It found that this content and ads violating voluntary guidelines increased in publications with greater youth readership. Eight percent of the ads also depicted sexism or objectification, all of women; these ads were more likely to appear in magazines with greater adult readership.

Up to one-third of teenage drinking may be attributable to alcohol advertising.

Alcohol advertising and promotion 'increases the likelihood that adolescents will start to use alcohol and to drink more if they are already using alcohol' (Anderson et al., 2009b, p. 1; Smith & Foxcroft, 2009). Up to one-third of teenage drinking may be attributable to alcohol advertising (Denny, 2011). Since most studies have only surveyed measured media, this is likely to be an underestimate, especially as the alcohol industry spends only one-quarter of its promotion budget on broadcasting, magazines and movies.

Alcohol was the most prominent substance in young people's media in the UK (Atkinson et al., 2011). The age when individuals started drinking was significantly correlated with how often they recalled TV alcohol ads, although individual drinking was not predicted by how often they saw an ad.

Marketing to men

Aotearoa

Much alcohol advertising and sponsorship uses masculine imagery and male sport to encourage the biggest market – men's drinking (Hardy, 2007; Hill, 1999), and in the process create problems for women.

Corporations advertise their products to men as 'the remedy that allows men to relax and socialize, uninhibited by the burdens of life' (Smith, 2005, para. 33). These ads represent women as peripheral – either 'hotties' or 'bitches' – and masculinity as emotionally illiterate and contemptuous of women's concerns (Messner & de Oca, 2005).

In beer ads for Tui, Lion Red and Speights, Hardy (2007) found that women were positioned as 'bimbos' whose role was to serve the male protagonists. Male responses to the women in the advertising were sexualised. Women found this positioning 'sickening' and described the pressure these ads created to have the perfect body.

Speights beer ads tied dominant masculinity to drinking with one's mates in pubs or other male-dominated environments, and positioned the brand as defending men from the encroachment of domestic life, changing gender relations, and Māori and other non-Pākehā masculinities (Jackson et al., 2009, p. 183). These authors describe the Speights 'Great Beer Delivery' campaign as 'sexist and misogynist'.

Beer advertisements depict male bonding without intimacy. Beer acts as a substitute for demonstrations of affection, since 'concern about intimate relationships is women's work' (Smith, 2005, para. 54; Wenner, 2009). More recent 'retro sexist' ads (Sarkeesian, 2010) and those targeting young men, use irony and humour to undermine readings of them as offensive (Jones & Reid, 2010; McKay et al., 2009).

Under the NZ Code for Advertising Liquor, alcohol advertisements 'shall not be sexually provocative or suggestive or suggest any link between liquor and sexual attraction' (ASA, 2003). Women's Health Action (2009, p. 8) found many advertisements that it considered breached this part of the code, and viewed industry responses to complaints about sexist advertising as 'highly cynical'.

Parker and Towns (2011, p. 12) concluded that Advertising Standards Authority judgements about two popular and ironically humorous alcohol advertisements that demeaned women failed to recognise their potential for harm, and ruled against the intent of the code. They concluded that advertising standards 'are not working with alcohol advertising', are 'highly unlikely to work' (p. 12) and that alcohol advertisements undermine efforts to stop violence against women.

Beer in Aotearoa has been portrayed as a masculine drink, and RTDs are trivialised as feminine. Women who drink beer have been presented as unusual, with some ads making them seem 'hyper-masculine'. They become 'one of the boys' – part of the masculine culture (Hardy, 2007, p. 76).

International

Internal marketing company documents showed an explicit intention to appeal to femininity and masculinity (Hastings, 2009). The strategy for each brand and type of drink aimed to promote a certain type of gendered image and sexualised stereotype, creating certain types of drinkers.

The advertising industry has a history of sexualising women, incorporating stereotypes, sexual appeals and sexualised clothing, which women commonly dislike more than men. Researchers said there was a need for an 'independent and enforceable regulatory framework' because advertisers continue to use messages that offend a proportion of the public (Jones, 2010 #336, p. 33). The authors said this tendency to stereotype and sexualise women seems to be increasing and the alcohol industry has drawn particular criticism.

For example, marketing students liked three Australian TV alcohol ads for their humour, but women were much more liable to dislike all three than men. More female students disliked an ad using the more recent stereotype of an active, powerful and promiscuous woman more than one using the older stereotype of a passive female sex object.

A US coalition argued that sexist advertising of alcohol had a cumulative effect that reinforced trivialisation of women, and granted men permission for abusive behaviour when they are drinking (Woodruff, 1996). While men remain distrustful of women, seeing them as nagging 'bitches' or 'whores', they 'remain more open to the marketing strategies of the industry' (Messner & de Oca, 2005, p. 1892). These authors point to 'revenge-against-women themes' evident in recent US alcohol ads as potentially dangerous for women (Ibid., p. 1906).

Marketing to women

Aotearoa

Since the 1960s alcohol has been marketed to women as a symbol of sophistication (Warren et al., 1989). Young, professional, Pākehā women were targeted in the 1980s as a market that was 'not yet drinking to capacity' (Huygens & Menzies, 1986, p. 25). After brand advertising was allowed on broadcast media in 1992, the television advertising spend quadrupled (Casswell & Zhang, 1998).

Certain drinks have been aimed at women. For example, the marketing for the RTD Archers Aqua depicts young women having fun socially. The packaging for beer hoppers – flavoured beer aimed at women – uses more refined graphics than the hard-edged or distressed fonts of male-oriented beers (McCreanor et al., 2005). Marketing events have been aimed at women, such as a Glamour party in Auckland sponsored by Bacardi, with tequila shots and Britney Spears perfume as door prizes (WHA, 2009).

International

In Europe, 2% of alcohol is aimed specifically at women, and 1% at men (EUCAM, 2008). Products such as beer that have traditionally been marketed to men are now also marketed to women. Some companies have created emotional appeal by linking with women's causes such as breast cancer, a proportion of which is caused by alcohol – see Health problems (Ibid).

Marketing links certain drinks with being feminine (for example, peach liqueur and RTDs) and masculine (pints) (Dempster, 2011). RTDs are associated with young women, being cool, sociable, self-assured and confident (WHA, 2009). They are marketed as a 'starter' drink, tasting of sweetness rather than alcohol.

Other new types of drink have also been developed specifically for women (EUCAM, 2008). Fruit-flavoured beers come in smaller packs to make them appear exclusive, as opposed to manly bulk beer drinking. Drinks aimed at older professional women are marketed as sophisticated, while light beer is for dieting and health-conscious women. The 'Skinnygirl cocktail' suggests weight loss and exploits social expectations about women's bodies (EUCAM, 2011).

Marketing created particular images for each brand. Lambrini ads focused on working class women, featuring friends having fun and socialising, without responsibilities (Szmigin et al., 2011). Pinka girls were shown as cool and exotic (Hastings, 2009). Women incorporate these images into their own beliefs – Australian university students associated certain personality traits with certain drinks (Jones & Reid, 2010).

Marketing online

Alcohol companies invest heavily in marketing to young people through online social networking and other youth culture websites, with cumulative effects (McCreanor et al., 2008).

Alcohol websites use online 'ambient marketing' strategies, which blur the line between product advertising and the drinkers' social lives by encouraging drinkers to upload photos and videos of themselves with the product (McEwan et al., 2010; Lyons, 2009). When people 'like' a photo of themselves at a branded event, the photo can be sent automatically to the social networking pages of all their friends.

Alcohol marketing has increased on electronic media, including brand websites, sponsored news sites, social networking sites, product placement in films, and mobile phones (Lyons, 2009; SHORE, 2006).

8.1.2 Hospitality industry and other marketing

Pub promotions often use women and female sexuality to attract male punters, offering free drinks to women and wet T-shirt competitions or 'strip shows to draw everyone in at lunchtime' (Hill, 1996, p. 29; The Buffalo Club, 2012; Mangawhai Tavern, 2012).

In 2011, some bars and pubs aimed to attract female customers and couples with young children by providing fresh flowers, hand cream in toilets, champagne specials, children's play areas and discos, and mum and baby mornings (Harvey, 2011).

Also in 2011, coloured hip flasks with the words 'It Girl' on the front were marketed by clothing company factorie, a subsidiary of Cotton On, to their mainly teenage clientele. The flasks fitted into a jeans pocket (Squires, 2011).

8.1.3 Industry sponsorship

Sponsorship of music, sports and cultural events regularly places alcohol brands into leisure activities and promotes drinking (Jette et al., 2009; Babor et al., 2010). These non-media forms of promotion have been estimated at 60% of marketing expenditure in the USA (SHORE, 2006). In 2003 alcohol was one of three products dominating internet sites for the top eight sports of New Zealand five- to 17-year-olds (Maher et al., 2006). In 2005, researchers found many examples of alcohol sponsorship at music and sports events aimed at teenagers (McCreanor et al., 2005). Alcohol companies also sponsor the NZ Music Awards, the Big Day Out and other summer rock music events (SHORE, 2006).

A 2006 report, commissioned by the Association of NZ Advertisers, calculated that alcohol sponsorship was worth \$20 million in 2006, and largely went to sport (72%), arts and culture (22%) (FAR, 2006a). The report was written by the Foundation for Advertising Research, which lobbies against state regulation of advertising, and for industry self-regulation (FAR, 2006b).

It found that sponsorship contributed to specific events and was paid in annual amounts to organisations. Sponsored arts and culture events included the Eilerslie Flower Show, Montana World of Wearable Arts, Montana Book Awards, Arts Foundation of NZ and NZ Fashion Week, which appeal to a largely female, older and wine-drinking audience (Ibid).

Sporting codes use elite teams to attract sponsorship, and sponsored funds to develop grassroots clubs, including women's rugby. The report argued that without alcohol sponsorship, some events would be cancelled or much reduced, sports codes would cut back on services to grassroots clubs and long-term development, and many local sports clubs would not survive. The report did not mention the Health Sponsorship Council, set up to replace tobacco sponsorship after this was banned.

The authors found that alcohol sponsorship had small or ambiguous effects on drinking, with often contradictory research findings.

While alcohol sponsorship has been prominent for male codes and events – such as the All Blacks, the Rugby World Cup and the Warriors – the Silver Ferns have no alcohol sponsors. Of the five New Zealand netball franchises in the ANZ Championship, only two listed minor sponsorship from a winery and a licensing trust on their websites in late 2011. Netball NZ has an in-kind wine sponsor for its own hospitality, but otherwise has not contacted or been approached by any alcohol companies. Jenifer Hunt, Business Development Manager, says the organisation is 'very conscious of the [Silver Ferns] role as role models' (Hunt, 2012).

8.1.4 Alcohol industry lobbying

Unlike the tobacco industry, the alcohol industry and its sponsored social lobby organisations are represented in alcohol policy-making bodies and events around the world (Anderson, 2003). These lobby organisations aim 'to benefit their funding body, the beverage alcohol industry, rather than to benefit public health or the public good' (Ibid., p. 1). Eurocare called for more vigilance and monitoring of this industry activity.

The alcohol industry's main lobbying message is that damage comes not from the product but from the drinker. According to this argument, most harm is caused by a small group of drinkers who cannot handle their alcohol and who must be dealt with individually. Collective measures would penalise the majority of responsible drinkers (DSANZ, 2012; EUCAM, 2011; Casswell & Maxwell, 2005b; Anderson, 2003).

For example, the Distilled Spirits Association argued that the Health Promotion Agency (HPA) should promote 'responsible alcohol consumption as part of a healthy, balanced lifestyle' and recommended industry membership on the HPA board (DSANZ, 2012 #867, p. 3).

Since about half of all alcohol is drunk during risky or binge drinking sessions in the USA, the UK, Canada and Australia, a large part of the industry's profit depends on the heavy drinkers that it stigmatises (Baumberg, 2009).

The industry lobbies strongly against price and marketing restrictions (Casswell & Maxwell, 2005a), usually in favour of self-regulation, which is ineffective (NZDF, 2006a). Self-regulated marketing oversight systems usually focus on content and ignore the exposure to this marketing, and are slower than advertising cycles. They also do not control unmeasured new media such as e-mail, texting, pxting or many aspects of product placement (Casswell & Maxwell, 2005a).

The industry-funded International Center for Alcohol Policies... repeats a tobacco industry tactic of casting doubt on effective strategies that reduce profits, or presenting them as the subject of debate.

In August 2012 the alcohol industry lobbied successfully for the removal of a restriction on RTDs with more than 5% alcohol in off-licenses and its replacement with industry self-regulation (Jones, 2012a).

The industry also lobbies to restrict health promotion about alcohol to 'public education on responsible drinking', and to stop government funding of any public health groups that advocate changes in policy (DSANZ, 2012, p. 8).

The European Centre for Monitoring Alcohol Marketing (EUCAM, 2011) says the alcohol industry ignores the addictive, psycho-active, carcinogenic, teratogenic, and poisonous nature of its product, and lists other key industry lobbying messages; evidence that contradicts them is in square brackets:

- Non-drinkers do not matter and are not part of contemporary culture. [Globally 55% of women and 35% of men have never drunk alcohol (WHO, 2012).]
- Alcohol problems can only be solved by the industry and all other stakeholders working together. [There is 'a fundamental conflict of interest' between alcohol corporations and public health policymakers (EUCAM, 2011, p. 9; COIC, 2012; Casswell & Maxwell, 2005a; SHORE, 2006)]
- Alcohol marketing simply helps the consumer select a brand. Industry self-regulation restricts offensive advertisements. [See research reviewed in section 8.1.1: Industry marketing and advertising and section 13: Interventions.]
- The best way to protect society from alcohol harm is education about responsible drinking. [See evidence reviewed in section 13: Interventions.]

The International Center for Alcohol Policies (ICAP) is a major alcohol industry-funded policy and lobby organisation based in Washington DC; alcohol corporation Philip Morris was one of its founding companies. An analysis of its publications found that the industry depicts itself as representing public health while ignoring the public health strategies that evidence shows are most effective in preventing and reducing alcohol harm (Jernigan, 2012).

It functions 'like a WHO unit on alcohol, with certain key omissions' (Ibid, p. 82), collaborating regularly with industry representatives to 'conclude the opposite of what WHO publications were concluding' (Ibid, p. 83). Its guide for policy development omits three of the most effective policies – taxation, restrictions on advertising and marketing, and limits on physical availability.

ICAP repeats a tobacco industry tactic of casting doubt on effective strategies that reduce profits, or presenting them as the subject of debate; examples include increasing alcohol excise taxes and reducing outlet density, which are supported by a consensus of public health researchers. ICAP's advocacy of a greater role for the industry in policy development 'led to the delay and near-failure in 2007 and 2008 of efforts to create the WHO *Global strategy to reduce the harmful use of alcohol*' (Ibid, p. 85).

ICAP's advocacy led to the US Center for Substance Abuse Prevention changing its editorial guidelines from 'alcohol and other drugs' to 'substance abuse'. ICAP has promoted weak national alcohol policies in developing regions with under-resourced public health sectors (Ibid, p. 86); in Lesotho and Malawi, alcohol policies were written by industry employees (Bakke & Endal, 2010).

Opposition to alcohol industry involvement in public health policy making is building. The health ministers of the European Union stated in 2001 that '[p]ublic health policies concerning alcohol need to be formulated by public health interests, without interference from commercial interests' (WHO European Ministerial Conference on Young People and Alcohol, 2001). They repeated this in 2011 in the European Alcohol Action Plan (WHO Regional Committee for Europe, 2011).

The Conflict of Interest Coalition (COIC), including 161 public health organisations from around the world, formed in 2011 to campaign against conflicts of interest in public health policy-making, including about alcohol. Its statement of concern called on the World Health Organization to 'identify conflicts [and] eliminate those that are not permissible' (COIC, 2012, p. 2). The coalition is developing guidelines distinguishing BINGOs (business interest NGOs) from PINGOs (public interest NGOs), both of which are included under the UN civil society umbrella. COIC is also developing an ethical framework and code of conduct to prevent and manage conflicts of interest in the development of public health policy.

Alcohol corporations are strong supporters of international free trade agreements (FTAs), which treat alcohol like any other commodity. FTAs require governments to lessen and ultimately remove tariff and non-tariff trade restrictions, and restrict governments' ability to introduce certain alcohol policies once they have signed (Babor et al., 2010).

FTAs threaten the most effective strategies for reducing damage across populations, such as using alcohol taxes to raise the price of alcohol, and restricting availability (Ibid), as well as awareness strategies such as warning labels on alcohol containers (PHA, 2013). The World Health Organization (2007b, p. 40) says that:

Time after time, countries in one or another part of the world have been forced under such agreements to weaken or abandon important aspects of their alcohol policies ...

Multinational alcohol corporations also use the penalties built into these agreements to challenge restrictions on particular products. This threat was made by lobbyists for Australian-owned companies during submissions on the Alcohol Reform Bill,

which proposed to regulate the strength of RTDs (Green Party, 2011). Under the Closer Economic Relations Trade Agreement with Australia, the government would not have been able to stop Australian RTDs, with their higher legal alcohol limit, from being sold in New Zealand. According to lobby group It's our future (2012) 'under the TPPA [Trans-Pacific Partnership Agreement] we risk the same thing, but with all 10 negotiating countries. This would have the same effect as watering down our regulations to the country with the lowest standards.'

8.1.5 Government policies, taxes and regulations

Policies that focus on the seller rather than the drinker, by restricting alcohol availability and marketing, are the most effective way to prevent hazardous drinking and alcohol damage across populations (Babor et al., 2010). These policies are the responsibility of governments and include:

- Legal restrictions on marketing
- Higher alcohol taxes
- Limits on the number and density of alcohol outlets in communities
- Restrictions on the hours and days of sale
- Strict enforcement of liquor laws regarding sales to underage and intoxicated people.

Also effective are:

- A legal purchase age of 20 years or higher
- Lower blood-alcohol driving limits.

Permissive policies on these issues 'play an important role in the development of alcohol use and misuse' in adolescents (Fergusson & Boden, 2011, p. 239). These issues are explored in section 13: Interventions.

8.1.6 Alcohol availability and price

In 1990, there were 18 alcohol licences for every 10,000 New Zealanders. By 2006 this had almost doubled to 35 per 10,000 (Huckle et al., 2008b). These researchers did not find any link between the willingness of alcohol outlets to sell to people under the minimum purchase age without ID, and young people's drinking quantities.

Access to alcohol from licensed premises had a greater impact on drinking and alcohol-related problems for young people aged 15 and 18 in the Dunedin Multi-disciplinary Health and Development Study than peer or parental influence (Casswell & Zhang, 1997), although there was less parental approval of young women's drinking.

Almost all those who attended the NZ Law Commission consultation meetings about its alcohol review believed that 24-hour trading had contributed to alcohol problems (NZ Law Commission, 2010).

Women remain a large majority – around 85% – of supermarket customers (Hill, 1996; Mhurchu et al., 2007), where about 70% of alcohol is sold (Alcohol Action, 2011), although this differs by beverage. More than half of total wine sold in 2008 was from supermarkets, but only 33% of beer (NZRA, 2009).

The sale of wine in supermarkets from 1990 was particularly important in increasing the amount of wine that women drank (Zhang & Casswell, 1999). Women found supermarkets a safer and more comfortable place to buy wine, and the grocery bill an easier way of disguising alcohol purchases (Wyllie et al., 1993). The change led to a 17% increase in table wine sales (Wagenaar & Langlely, 1995).

Supermarkets heavily discount alcohol, sometimes to below its wholesale price for other outlets, leading to accusations of loss leading – selling at a loss to attract customers (NZRA, 2012). The price of wine and standard draft and lager beers has decreased relative to inflation over the last 20 years (NZ Law Commission, 2010).

An analysis of alcohol prices in Aotearoa from 1988 to 2011 found that drinking beer, wine and spirits was more strongly related to alcohol affordability relative to earnings than its price relative to other goods (Wall & Casswell, 2012). The affordability of alcohol has increased over the last decade, with cask wine being cheapest; by 2009 it cost \$2.78 for enough cask wine to make an average working adult legally unfit to drive (Gunasekara & Wilson, 2010).

This study found that a glass of bottled water cost more than a glass of wine or a bottle of beer, and alcohol was only slightly more expensive than milk. Another study found that at the lowest discounted prices (53c per standard drink), smaller women could exceed the legal blood alcohol driving limit after drinking just over a dollar's worth of an RTD (Sloane et al., 2011).

At discounted prices, small women could exceed the legal blood alcohol driving limit after just over a dollar's worth of an RTD.

One mother at an Otago consultation meeting said, 'I am sick of food pamphlets showing us how cheap alcohol is in our supermarkets' (NZ Law Commission, 2010, p. 48).

8.1.7 Dominant social norms about alcohol and gender

Aotearoa

Before six o'clock closing ended in 1967, public bars were restricted to men, and women were allowed to drink only in lounge bars. Women's drinking was expected to be more restrained (NZ Law Commission, 2010). Public disapproval of female drunkenness has a long history, matched by female resistance to these unequal standards (for example, Grimshaw, 1972; Laurie, 2003; Rei, 1993; Coney, 1993; Abel et al., 1992; Broom & Stevens, 1990).

McEwan and colleagues documented the changes in drinking culture over 40 years, to the current situation where large numbers of New Zealanders use alcohol, cannabis and other drugs to 'get out of it', and 'an altered state of consciousness is viewed as a desirable and normative goal' (2010, p. 25). This evolution coincided with a profound change in the public participation of women, and in women's social roles.

International

Alcoholic Australian women have been seen as doubly deviant because they have failed to be 'good women' as well as flouting common social conventions (Broom & Stevens, 1990). Their drinking implies maternal incompetence and promiscuity. Alcoholism among men is seen as 'masculine excess', while in women it becomes a social threat. Concern about women's drinking tends to focus on the danger it creates for their children, rather than on the welfare of the women themselves.

In the USA, women's drinking has historically been ridiculed and stigmatised, a position that was reinforced by law (Nicolaidis, 1996).

Changes in young women's drinking in the UK, and its convergence with patterns of men's drinking, have been attributed to women's greater economic independence, making their work and leisure patterns becoming more similar to men's (Measham & Ostergaard, 2009).

Young women's group norms

Aotearoa

Young women now regularly binge drink, prefer beer and drink in public, all traditional signs of masculine drinking (Lyons, 2009). Although they also feminise this behaviour by drinking wine and cocktails, this suggests a disruption in gender relations. Young women see heavy drinking as part of New Zealand identity (Lyons & Willott, 2008; Braun, 2008). Groups of young women friends described drinking as much as men, and the importance of heavy drinking as a female group norm (Lyons & Willott, 2008).

This was illustrated when they tried to estimate the drinking of their peers. Eighty percent of female university students over-estimated the rate of other women's drinking, and 40% over-estimated the actual rates of vomiting by other women after drinking (Kypri & Langley, 2003). They consistently thought that their drinking was more moderate than their peers.

Those women who said they drank the same amount as their peers had AUDIT scores 2.6 points higher than other surveyed women, indicating more hazardous drinking. Women who drank four or more drinks in a session were more likely to over-estimate the incidence of other people's drinking (Ibid).

Friendship groups saw women's increased drinking as a sign and a result of gender equality. These women and men viewed women who drink as 'empowered, independent, pleasure-seeking social beings, which is linked to their changing positions in society' (Lyons, 2009, p. 402).

However, an unequal gender power structure persisted. Most participants 'tended to define women's drinking in male terms and used men and male drinking behaviour as the standard with which to compare and contrast other drinking...' (Lyons & Willott, 2008, p. 13).

This was also consistent with Guyatt's (2005) study of Fat Freddie's student pub in Christchurch, an environment set up in opposition to the private domestic world of women, in which women participated on male terms.

The serving staff were divided by gender, with bar work defined as women's work because it required them to flirt with male customers. They were employed for their looks, required to wear tight tops, and had a reputation for being 'hot'. Security work was defined as male because it required strength and aggression.

Lyons, Dalton and Hoy (2006) found that women's magazines gave women more choice of alcohol types than men's magazines gave men. Women's drinks were portrayed as glamorous and sparkling. Drinking women were shown as classy, busy professionals, whose drinking was an everyday social activity. The beverages are portrayed as feminine, but 'women's drinking is constructed in traditionally masculine ways' (Ibid, p. 227).

Traditional standards of femininity continue to influence drinking. Women who breach these norms are seen as 'lower class, or a waste of space' (Pedersen, 2010). Women are still condemned for being drunk in public (Lyons & Willott, 2008). They are expected to be in control of their drinking and to look after each other. Young women perceived specific groups of women, such as older female drinkers, to be particularly immoral or deviant (Ibid).

Our neo-liberal society encourages young people to form identities from the pursuit of pleasure, calculated hedonism and 'controlled intoxication' (Szmigin et al., 2008). They are encouraged to be whoever they want through buying things, and to glamorise themselves, a crucial part of which involves alcohol and drinking (MacNeela & Bredin, 2011; Rolfe et al., 2009). Young people 'make meanings from alcohol marketing that create and maintain social environments where drinking to intoxication is the norm and the expectation' (McCreanor et al., 2008, p. 944).

Young women's online norms

The pursuit of pleasure involves more than the actual drinking session. It includes planning the session, frequently on Facebook or other social media, uploading photos online, and tagging and commenting afterwards. Licensed venues and alcohol companies use social media to make themselves part of the online contexts in which these drinking sessions happen.

Women within friendship groups are often given the responsibility, sometimes negotiated in the group, of taking the photos of drinking nights and uploading them onto Facebook. 'It's like the young women are doing the 'friendship group' housekeeping, while the men carry on with the task of drinking [which resonates with] functionality/activity being aligned with masculinity, while [appearance] and passivity is aligned with femininity' (Lyons, 2011).

Young Bebo users actively marketed alcohol brand names, creating 'intoxicogenic social identities' that present binge drinking as normal (Griffiths & Casswell, 2010, p. 525). They did this by commenting in forums, posting photographs of themselves in heavy drinking occasions, answering quizzes about their drinking and circulating videos of alcohol ads. Young women had created 28% of the Bebo personal pages.

Another study of students talking about their drinking, Facebook and alcohol advertising found that student alcohol culture and industry marketing on social networking sites were synonymous for both genders (Hebden, 2011). The study tentatively concluded that the student drinking culture encouraged by Facebook worsens alcohol problems.

The boundaries between student alcohol culture and industry marketing on social networking sites have blurred, so that the two are synonymous.

International

Young women's norms in Australia

Three-quarters of 14 to 22-year-old Australian women believed regular drinking was acceptable (AIHW, 2002), and associated being drunk with socialisation, fun and excitement (Fryer et al., 2011). Drinking was seen as part of a big night, and drinking at home before going out (preloading) was common (Fry & Dann, 2003).

Drunkenness was important to friendships for young Australian women (Waitt et al., 2011), who were non-judgemental about friends' drinking. Some enjoyed alcohol-induced drama.

The more favourable Australian female university students perceived 'important others' to be about drinking, the more likely the students were to drink more (O'Hara et al., 2008).

Young women's norms in the USA

US female college students described their own consumption as 'drinking like a guy' (Young et al., 2005). This was seen as being equal to their male peers, but the phrase was more about expressing their own sexuality, rather than being gender-equal. They reported pressure to drink heavily to impress male peers.

Female college students tended to over-estimate how much they thought their male peers wanted their female dates, partners and friends to drink, and this over-estimation was linked with the woman's own drinking (LaBrie et al., 2009).

Young women's norms in the UK

Young women saw heavy or binge drinking and drinking alongside their male peers as part of female youth and student culture (Griffin et al., 2006). They saw alcohol a source of pleasure, and viewed drunkenness positively (Szmigin et al., 2008). Young women planned their level of intoxication before a night out, planning safety in a 'controlled loss of control' (Measham, 2002 cited in Rudolfsdottir & Morgan, 2009). Drinking was seen as a way to express femininity, through choices like the type of drink and glass.

These women regarded others, but not themselves, as taking part in out-of-control and unacceptable forms of drinking, which they said made women emotional and men violent (Rudolfsdottir & Morgan, 2009). They did not see themselves as binge drinkers – they were 'just drinking' (Szmigin et al., 2011, p. 773). These women thought their drinking behaviour was linked closely with their age, and that with a family and a few more years their drinking would reduce and become more 'sensible'. They often used alcohol as an excuse for lapses in judgement and sexual behaviour (Rudolfsdottir & Morgan, 2009).

Binge drinking has been represented in British newspapers as unnatural, violating ideals of femininity in which women's behaviour is restrained and they are restricted to a domestic world. Some female heavy drinkers, particularly working-class women, emphasised toughness in their discussions of drinking in ways that countered passive and respectable norms of femininity (Day, 2010). For them, entry into the masculine world of drinking involved 'becoming one of the boys' (Day, 2003) and tolerating sexist abuse.

The term 'ladettes' is used to describe some young female drinkers in the UK (Jackson, 2006). It is associated with young women drinking and behaving in stereotyped masculine ways, but also with sex, breaching acceptable feminine behaviour, and female celebrities being able to drink more than men (Ibid; EUCAM, 2008). The term has evolved from negative meanings in the mid-90s, and includes young working-class and middle-class women (Jackson & Tinkler, 2007). Media representations tend towards moral panic (Day, 2010), and report ladettes as the result of women's financial and social freedom – hedonistic, driven by fun, unfeminine, upsetting the social order and no longer caring for men. As well as sexual promiscuity, drinking is central to a ladette's social identity (Griffin et al., 2009; Jackson & Tinkler, 2007).

Researchers point to historical amnesia in media descriptions of ladette culture. It has been presented as a new phenomenon, but the 'modern girls' of the 1920s were very similar. The mainly negative descriptions of the phenomenon in 1920s and contemporary UK media are also similar – an example of persistent social construction of women's behaviour (Jackson & Tinkler, 2007).

The meaning of drinking for young women varied across different social classes, although the undesirability of extremely drunk women was consistent (Griffin et al., 2009). White middle-class young women tended to distance themselves from their own loss of control and the risky situations resulting from their drinking. They associated their drinking with traditional gender roles and moral worthiness, opting out of the intoxication culture. In contrast, working-class women tended to place themselves within the intoxication culture (Ibid).

Other contemporary forms of femininity include the 'girly girl' and the 'tomboy' (Griffin et al., 2006), and have their own drinking behaviours. Some women choose 'girly' drinks. For others, drinking sensibly is boring and they reject traditional femininity. This presents some young women with a dilemma: they cannot drink like a man or like a lady (Ibid, 2008).

UK magazines presented alcohol in highly gendered ways (Atkinson et al., 2011). Women's magazines represented drinking as glamorous and associated with celebrity, while also harmful to beauty, appearance, health and motherhood. Young people saw a link between drinking, weight and appearance, especially in media comments about female celebrities' appearance and body image.

Some young women viewed public drinking by celebrities with children as inappropriate, while others argued that these images reflected unequal judgements of men's and women's drinking.

Men's magazines portrayed women drinkers as unfeminine, emotional and vulnerable. Some participants criticised the way men's magazines sexualised women who drank. The media portrayed women's drinking as more of a problem than men's. Their images of women's drinking reinforced social norms that stigmatised drunkenness among women more than among men (Ibid).

8.1.8 Institutional inequities

The government has obligations under the Convention on the Elimination of All Forms of Discrimination against Women and other UN conventions to protect women from discrimination and to reduce social inequalities. Women face persistent gender inequalities in income, caring responsibilities, leadership and other fields; however, this review found almost no research

linking sexism with alcohol use among women. The only research that mentioned this focused on violence against women by male partners, which is discussed in sections 10.3.2: Physical assault injuries and section 11.3: Violence against women and children.

The government also has obligations under te Tiriti o Waitangi (Reid et al., 2000; Anaya, 2011; MOH, 2002, p. vii) and other UN conventions (Geiringer & Palmer, 2007) to protect Māori from health disparities and to reduce social inequities generally. While there is strong recent evidence of racism against Māori, Pacific and 'Asian' peoples, there has been little research in Aotearoa about its relationship to alcohol use. One study found that Māori, Pacific and 'Asian' secondary students who experienced racial bullying or discrimination from their peers, police or health professionals were more likely to have had five or more drinks in a session in the last month and less likely to rate their health as good (Crengle et al., 2012).

Aotearoa

Asian, Māori, Pacific and secondary students of 'other' ethnicities were significantly more likely to experience ethnicity-related bullying, and discrimination from police than Pākehā students (Ibid.).

Racism against Māori

Risk factors for heavy drinking among Māori include deculturation and loss of self-determination, both a result of colonisation (Durie, 2001).

Māori respondents in 2002–3 reported the highest rate of discrimination due to ethnicity (34%) (Harris et al., 2006). They were nearly 10 times as likely to experience multiple forms of discrimination as Pākehā/others. The more forms of discrimination they reported, the poorer they rated their health, although they were not asked about alcohol use. These authors concluded that socio-economic inequities (which reflect institutional racism) and experience of racism account for much of the health disparity between Māori and Pākehā.

More than three times as many Māori respondents as Pākehā in another survey were 'very worried' about being intimidated, harassed or assaulted because of their ethnicity. More than twice as many Māori (14%) as Pākehā women (6%) were 'very worried' about intimidation, harassment or assault because of their gender (Cunningham et al., 2009).

Young Māori at a national hui said that racism and stereotypes such as 'Jake the Muss' and being 'a hard man' influenced youth drinking (ALAC, 2008b, p. 4).

Some researchers assume that the health system is neutral to Māori, and focus attention on Māori culture, behaviour and engagement with services as the reason for health disparities (Reid et al., 2000). However, there is consistent evidence that health professionals treat Māori patients differently from Pākehā, based on ethnicity (Crengle et al., 2012; Crengle et al., 2005; McCreanor & Nairn, 2002).

Racism against Pacific peoples

One in four Pacific people had experienced discrimination due to ethnicity (Harris et al., 2006); this study did not analyse by gender. Pacific peoples are also treated differently by health professionals, particularly in referrals to specialists (Davis et al., 2005; MOH & MPIA, 2004)

Racism against 'Asian' peoples

Twenty-eight percent of 'Asian' peoples had experienced some form of racial discrimination, 17% in the last 12 months (Harris et al., 2006). This was not analysed by gender.

International

Alcohol and other drug addiction rates are worse in countries with more social inequity (Wilkinson & Pickett, 2010).

Colonisation enormously undermined Aboriginal self-sufficiency in Australia, and replaced milder traditional drugs such as pitju with more harmful substances and patterns of use (Broom & Stevens, 1990). Ninety-three percent of a sample of urban Aboriginal people in Adelaide, most of whom were female, regularly experienced racism. Using alcohol and other drugs was one way they coped (Ziersch et al., 2011).

Among Native Americans aged nine to 16 living on reservations, experiencing discrimination at ages 10 to 12 was linked with drug use five years later (Cheadle & Whitbeck, 2011). Historical loss also influenced alcohol abuse by Native American women (Whitbeck et al., 2004).

One of the ways in which racism can damage health is by making people more vulnerable, and exposing them more often, to the targeted marketing of alcohol and other drugs (Krieger, 2003). Experience of racism was linked with alcohol, tobacco and other drug use in African-American adults and adolescents; this could be reduced by supportive parenting (Gibbons et al., 2010; Gibbons et al., 2004).

In a mainly male multi-ethnic sample of San Francisco transport operators, perceived racial discrimination was linked with the number of drinks per month, heavy drinking, and alcohol dependence (Yen et al., 1999). Those who reported discrimination in five or more areas of their lives drank an average of 13.4 more drinks per month than those who reported none.

Positive links between experience of racism and alcohol misuse were found in eight of 14 studies, mediated by historical loss, and with substance abuse in five of six studies. The other studies found no link (Paradies, 2006).

Poverty

Poverty increasingly has a female face. Women's median annual income in Aotearoa in 2006 was \$19,000, 39% less than men's. Women were one and a half times more likely to live on a total annual household income of \$30,000 or less (HRC, 2010). Income inequality has risen steadily since 1994 (MSD, 2010); Aotearoa had the fastest growth in income inequality among the OECD countries (NZCCSS, 2011).

Increased poverty is linked with heavier drinking and more alcohol problems (Khan et al., 2002b; Kost & Smyth, 2002; Hausstein, 2006). People who report several forms of economic or social hardship have a greater likelihood of problem drinking (Nina Mulia et al., 2008).

Heterosexism

This is the assumption that heterosexuality is the normal intimate attraction and that same-sex relationships and attraction do not exist or are deviant (Kramarae & Treichler, 1985). It is usually systemic rather than individual and embedded in organisational practices (UNHCHR, 2011).

Aotearoa

While government policies in New Zealand are more liberal about sexual and gender identity than in some other industrialised countries, discrimination on these grounds continues in social and health services (Rankine, 2008; Neville & Henrickson, 2006; HRC, 2008, 2011; Rossen et al., 2009), collection of official statistics (Statistics NZ, 2009), and same-sex adoption (O'Connor, 2013), and in the form of violence and hate crime (Pega & MacEwan, 2010).

Schools are often a hostile environment for same-sex attracted students and those whose gender identity is ambiguous (Henrickson, 2007). About three times as many lesbian, gay and bisexual students were bullied weekly at school in 2007 compared with heterosexual students (Rossen et al., 2009).

Experience of discrimination is linked with greater substance use among lesbian and queer women (Riches, 2011; Rankine, 2008; Condit, 2010; Skegg et al., 2003). A national qualitative study of young people, largely women, attracted to both men and women found that social exclusion from heterosexual communities and sexual identity stigma were risk factors for binge drinking (Pega et al., 2012).

International

The use of alcohol, tobacco and other drugs by Queensland lesbian, gay, bisexual and transgender (LGBT) people was strongly linked with discrimination; other factors included gender inequality, isolation, loneliness, normalisation of drugs and alcohol in LGBT communities and pressure to succeed (QAHC, 2010).

Lesbians and queer women living in US states that excluded sexual identity as a protected category for hate crimes and employment discrimination had more than twice the rate of alcohol disorders, and more than four times the rate of other drug disorders as their heterosexual peers in the same states, or lesbians and queer women living in states that offered protection (Hatzenbuehler et al., 2009).

The social factors influencing alcohol use for LGBT people in the USA included the availability of social support, the stigma facing sexual minorities, and perceived homophobia and discrimination (Greenwood & Gruskin, 2007).

8.2 Community level

8.2.1 Indigenous norms

Māori

This review found little research that discussed alcohol norms in Māori communities. Women in one small sample had a stronger identity as Māori than men, using a range of traditional markers. There was no link between Māori identity and the amount of alcohol they drank, but those with stronger Māori identity drank more often (Clarke & Ebbett, 2010).

8.2.2 Pacific norms

For Pacific organisations in Aotearoa, supplying plenty of food and drink, including alcohol, shows generosity. Like food, alcohol is usually drunk until a person can drink no more or it is all gone (Samu et al., 2009; Research NZ, 2009; Huakau et al., 2005). Alcohol is part of reciprocal gift-giving, so that giving bottles of spirits is now common in Samoan communities (Lima, 2000). Promoting moderate drinking or limiting the alcohol available could be perceived as stingy and mean (Samu et al., 2009).

In some Pacific cultures, gender norms restrict mixed-gender drinking (Percival et al., 2010; Samu et al., 2009). For example, Samoan and Tongan women said it was not culturally appropriate for them to drink in the presence of men. One participant said about her male cousins (Samu et al., 2009, p. 50):

... if I was sitting there and I was actually holding a bottle and I was about to drink ... they'll literally like turn their back, just so they won't see it

Another said:

If you see the girls they can never drink with the boys. You never see them together because it's quite disrespectful in that kind of context.

8.2.3 Lesbian and queer women's norms

Many lesbian and queer women's communities have evolved around drinking venues, linking identity, community and alcohol (Pega & MacEwan, 2010; Glamuzina, 1993). Auckland informants said that binge drinking and drug use was normalised in some sectors of the queer community (Rankine, 2008). A national qualitative study of young people, largely women, attracted to both men and women found that social exclusion from lesbian communities was a risk factor for binge drinking (Pega et al., 2012).

Alcohol was a big part of the lesbian social scene in the USA, and a frequent part of queer community events (Condit, 2010). Sixty-one percent of US lesbians and queer women said that alcohol was important in their coming out, and another 20% said it was involved (Boudette, 2010). Drinking was viewed as socially acceptable while women explored their sexual identity, and useful as an excuse for lapses from heterosexuality. However, other lesbians believed that this trivialised the coming out process.

8.2.4 Alcohol marketing to particular communities

O'Brien and Kypri (2008) found that 48% of a multi-region sample of New Zealand sportspeople reported alcohol industry sponsorship. Of those, 47% received free or cheap alcohol, and others received alcohol-branded uniforms and other non-alcohol products. Clubs estimated that around 9% of their income came from this sponsorship.

Lesbian and gay communities are also targets of the industry, especially for large community events. Community participants were concerned that this sponsorship was offered on condition that alcohol companies could promote their products. The lack of other funding for these stigmatised communities leaves them more dependent on these forms of sponsorship (Pega & MacEwan, 2010).

In Europe, pub and club promotions have been specifically aimed at young women to encourage binge drinking – for example, by offering free drinks (EUCAM, 2008).

8.2.5 Neighbourhood alcohol availability

Under the previous Sale of Liquor Act, decisions about liquor licensing were based only on the suitability of applicants, rather than on the impact of an outlet on a neighbourhood, the suitability of the location or the Act's aim of reducing liquor abuse (NZDF, 2011b; AHW, 2011d).

Every additional off-licence within 1km of home increases the likelihood of binge drinking by four percent.

Alcohol outlets are clustered in poor neighbourhoods, where alcohol company Lion Nathan acknowledged that low prices from discounting is common (cited in NZ Law Commission, 2010, p. 129). This clustering of bars amounts to 'a decrease in travel distance of 112m per deprivation decile' (Hay et al., 2009, p. 1089). Māori, Pacific peoples and those on low incomes are most exposed to this cheap, easily accessible alcohol (MOH, 2006a).

This density of alcohol outlets has a major influence on drinking. Teenagers aged 12 to 17 who lived within a 10-minute drive of relatively more alcohol outlets drank more in a typical session (Huckle et al., 2008a). Every additional off-licence within 1km of home increases the likelihood of binge drinking by 4% (Connor et al.,

2010). For each extra 10 off-licence outlets within a kilometre of university students' homes, they drank 1.09 times as many drinks per day on average (Kypri et al., 2008).

Alcohol outlets are also concentrated in inner city neighbourhoods that attract relatively high proportions of queer people. Lesbian and gay focus groups in 2010 were concerned about gay bars routinely serving alcohol to drunk people and allowing underage people to buy it. They perceived there to be less policing and enforcement of alcohol regulations in gay bars (Pega & MacEwan, 2010).

8.3 Relationship and family level

A national qualitative study of young people, largely women, who were attracted to both men and women, found that the negative reactions of others to their coming out increased binge-drinking. Binge drinking was also used to deal with the anxiety of meeting a new romantic partner, initiating a same-sex relationship and the pain of breaking up (Pega et al., 2012).

8.3.1 Household norms and attitudes

This review found few mentions of family norms in New Zealand research, although heavy drinking by young people was linked with parents who had alcohol problems (Russell, 2008).

Young people at a national hui said that the examples of family, friends and influential adults influenced young people's drinking culture. They identified a need 'to break the cycle of generational habits' (ALAC, 2008b, p. 4) with education, greater involvement with Mothers Against Drunk Driving and Students Against Driving Drunk and young people's individual change. In the USA, parental monitoring of their children's drinking had more influence on boys than girls (Schulte et al., 2009).

Women with alcohol problems are more likely to be partners of male problem drinkers than the other way around (Nolen-Hoeksema, 2004; Abel et al., 1992). One review found that women sometimes play the part of warden for their male partner's drinking, whereas men incite their female partners to drink (Holmila & Raitasalo, 2005).

Greenwood and Gruskin's conceptual model (2007) of factors influencing the drinking of lesbian, gay, bisexual and transgender people includes family or parental acceptance or rejection of lesbian and queer women's identities, and family or parental anti-gay prejudice.

8.3.2 Violence and sexual abuse of girls and women

Physical and sexual abuse of girls and women is a major factor in women's drinking. Violence in families is overwhelmingly gendered. Men's violence against women and children is the most significant and damaging (NZFVC, 2007).

In Aotearoa and overseas, young people who were mistreated or abused in childhood were more likely to start drinking early, drink heavily as teenagers and abuse alcohol (Fergusson & Boden, 2011; IAS, 2008; Felitti, 2004; AWCG, 1993). Women are more likely than men to experience sexual assault as children (Nolen-Hoeksema, 2004).

Adverse childhood events such as emotional, physical or sexual abuse in a California cohort were associated with 1.6 to twice the likelihood of ever drinking, and more than twice the likelihood of starting drinking at age 14 (Dube et al., 2006). These effects were a persistent influence in successive generations. The rate of alcoholism increased with each negative childhood experience. Only 3% of adults with no adverse childhood experiences were alcoholics; 6% of those with one; 10% with two, and 16% with four or more (Felitti, 2004).

Women who had been physically and sexually abused had significantly greater rates of problem drinking (La Flair et al., 2012; Hamelin et al., 2009; Stewart et al., 2009; Poole & Dell, 2005; Ullman, 2003); those who had been treated violently by an intimate partner had higher rates of alcohol dependence than those who had not (Tolman & Rosen, 2001, cited in Kay et

al., 2010; Wiechelt et al., 2011). One US study of rural women seeking refuge from partner violence found that those who had been sexually as well as physically abused were three times more likely to drink alcohol to cope (Wingood et al., 2000). One meta-analysis found that women whose partners were violent were almost six times more likely as non-abused women to misuse alcohol (Golding, 1999).

Many women can be diagnosed with post-traumatic stress disorder (PTSD) as a result of early abuse or partner violence and rape, and use alcohol to cope with these symptoms. Women with PTSD are estimated to be 1.4 times as likely to develop alcoholism (Dansky et al., 1995; Kilpatrick et al., 1992, cited in Ullman, 2003).

Young Auckland sex workers whose first experience of sex was forced were more likely to drink and use drugs, and more likely to be heavier alcohol and drug users, than those whose first experience was consensual (Saphira & Glover, 2004).

Abuse and violence in the lives of pregnant women were the most common predictors of their drinking (Skagerstrom et al., 2011).

Eight percent of New Zealand female victims of sexual offences, assaults, robbery, or threats said they had increased their use of alcohol, other drugs or prescription medication as a result (MOJ, 2010).

Estimates of the proportion of women who drink to blot out partner and other violence vary from 10% of Māori and 7% of Pākehā women (Cunningham et al., 2009) to one in three women (Hager, 2011a). Most only begin to drink heavily after the violence has started. Women in one study described the progressive loss of self caused by partner violence as 'turning into a mess/becoming an alcoholic/going crazy/cracking up' (Hand et al., 2002, p. 27).

Some women's partners force them to deal drugs or commit other crimes to gain control over the women (Hager, 2011b):

Their partner is their dealer or the provider of alcohol and addicts the woman; this is the ultimate control because he can give or withhold the substance and she is very dependent on him for her addiction.

Those who are sexually assaulted while affected by alcohol tend to blame themselves more, drink more and have more alcohol-related problems after the assault (Bedard-Gilligan et al., 2011; Testa & Livingston, 2009). Women who blame themselves for being sexually assaulted are more likely to have worse long-term results, including alcohol-related hospitalisations and arrests (Ullman & Najdowski, 2010).

8.3.3 Supply by parents and other adults

The previous Sale of Liquor Act exempted parents or legal guardians from the offence of sale or supply to those under 18. Parents could give alcohol to their under-18 children in a supervised situation, such as a private social gathering. This is referred to as 'social supply'.

Supply of alcohol by family and friends to underage drinkers was one factor predicting how much these teenagers drank in a typical session and how often they drank (Huckle et al., 2008a). Family supply was also linked with teenage drunkenness.

A postal survey of parents of teenagers concluded that parents generally acted responsibly in supplying alcohol to children (Kypri et al., 2007). Four out of five parents did not agree that it is okay for parents to give teenagers drinks for an unsupervised party, and a higher proportion of mothers (62%) agreed that no one should supply alcohol to an underage person. Many parents specified conditions for supplying alcohol to their children. However, as 36% of teenagers said their parents had given them alcohol to drink without supervision, and only 2% of parents said they had done this, it is likely that parental responses were affected by their desire to appear responsible.

8.4 Individual level

8.4.1 Motives and beliefs about alcohol

Aotearoa

Early research assumed that substance abuse was a problem of susceptible individuals, and tried to identify psychological traits of the 'addictive personality' (eg, Lang, 1983). Later research linked women's problematic substance use with high stress levels, escape from hardship or experience of life crises such as separation or divorce (Abel et al., 1992; National Council of Maori Nurses, 1988; Kupenga, 1984).

Most recent New Zealand research has used a public health approach, and mentioned individual factors or drinking motivations only occasionally. The two most common motives for drinking were 'emotional escape or relief from negative emotions' and drinking to socialise. Drinkers expected that alcohol would enhance social skills and pleasure (Clarke & Ebbett, 2010, p. 147).

New Zealand-born Niue women said that alcohol was a way of having fun and socialising with their female friends, to fit in with their peer group, and forget about their problems (Gray & Nosa, 2009). For some Cook Island women, drinking was also a sign of shaking off missionary-imposed controls on female behaviour (Banwell, 1986).

Female secondary students were more likely to drink for fun (80%), but less likely than males to drink to relax (31%) (Ameratunga et al., 2011).

Other sources state that women drink to escape 'developmental distress', conform to social norms, create identities, and 'self-manage body and spirit' (Duncan, 2011, p. 4). University sportswomen who drank to cope and for social enhancement had significantly higher AUDIT scores (O'Brien et al., 2008).

Individual factors in Greenwood and Gruskin's conceptual model (2007) about drinking by lesbian, gay, bisexual and transgender people include women's acceptance of their lesbian or queer identity; whether they are out or are hiding their identity; and whether they hate themselves for their same-sex attraction. Alcohol can also be used as a relaxant to enable women to express attraction to another woman:

Especially people in marriages, women who get drunk at a party and find themselves snogging their best friends... (Rankine, 2008, p. 27).

International

Cognitive-personality theories have focused on expectations about the effects of alcohol. Laboratory studies suggest that women may be more likely than men to avoid alcohol when coping with a stressful situation. Women may experience more conflicted thinking about their drinking than men (Nolen-Hoeksema, 2004).

A Canadian literature review (Poole & Dell, 2005, p. 7) concluded that:

Girls and women tend to use alcohol or drugs to improve mood, increase confidence, reduce tension, cope with problems, lose inhibitions, enhance sex or lose weight.

In a number of countries, expecting positive things from drinking, such as talking openly, sexual intimacy and social life, have been shown to increase women's drinking (Bergmark & Kuendig, 2008).

Young women

Among female US university students, higher positive and lower negative expectations were linked with increased disinhibition (sensation-seeking, impulsivity and novelty-seeking) and increased drinking. Expecting negative things from alcohol was linked with less drinking (Anderson et al., 2003). In adolescents, initial positive expectations have been linked with adolescent and adult drinking (Patrick et al., 2010).

Evidence about the role of self-esteem is contradictory. Some studies suggest that drinking related to low self-esteem is more common in women than men (Nolen-Hoeksema, 2004).

Poor body image may be linked with substance use. How often US tertiary students drank and smoked tobacco was significantly related to their body dissatisfaction (Granner, 2002), regardless of ethnicity. Binge drinking young Australian women were more likely to have used vomiting, fasting, laxatives or diuretics to control their weight than moderate drinkers (COSW, 2003).

Young women associated drinking with altering their mood. Some adult women thought of it as a form of self-medication and time out from poverty, unemployment and the stresses of life (Fryer et al., 2011; Rolfe et al., 2009; Stewart et al., 2009; Brown & Stewart, 2008).

Lesbian and queer women

Expecting positive things from alcohol has been linked to increased drinking in lesbian teens (Hatzenbuehler et al., 2009; Ziyadeh et al., 2007).

8.4.2 Mental health

Most of the research about alcohol and mental health discusses treatment – see Interventions.

Eating disorders commonly occur with alcohol problems in women (Stewart et al., 2009). About 25% of US college students in one small study said they restricted their eating before they went out drinking, a practice that has been called 'drunkorexia' (Osborne et al., 2011). Most did so to avoid weight gain, and one in four did so to get drunk faster. Women who fail to eat before binge drinking have a higher risk of alcohol poisoning. This behaviour is said to be on the rise in Aotearoa (Hannan, 2011).

Many researchers believe women's drinking is a sign of underlying depression (Nolen-Hoeksema, 2004), although women were more likely to have depression without an alcohol-related disorder (Schulte et al., 2009). Depression has been linked to problem drinking in US homeless and lesbian women (Austin & Irwin, 2010; Wenzel et al., 2009).

Anxiety predicted alcohol use in US pregnant and non-pregnant women (Meshberg-Cohen & Svikis, 2007).

SUMMARY – INFLUENCES ON DRINKING

Alcohol has never been more heavily marketed; it is now embedded in young people's online socialising. This marketing is a major social determinant of people's drinking. It is linked to increased drinking in 10- to 29-year-olds, and encourages drunkenness, particularly around young women's social networking, music and sport.

Alcohol advertising to men reinforces sexualised and trivialising images of women that impede the prevention of sexual and domestic violence.

In contrast to the tobacco industry, the alcohol industry is represented in alcohol policy-making bodies in New Zealand and internationally. The industry consistently lobbies for ineffective strategies about alcohol harm as well as self-regulation of marketing, and against the most effective policies that restrict alcohol availability and accessibility and regulate price.

Alcohol policies have been steadily relaxed over the last two decades, gradually transforming alcohol from a potentially lethal product requiring social intervention to prevent a range of problems, into an ordinary consumer item. Alcohol has never been more readily available.

A high density of alcohol outlets is linked with increased binge drinking, and increased adolescent and tertiary student drinking. Outlets are clustered in poor neighbourhoods and may have a stronger influence than peer norms.

Public disapproval is higher for female than male drunkenness. However, heavy drinking has become a social norm for many young women and male drinking patterns set the standard. Young women perceive drinking as a sign and result of gender equality, as well as a way of resisting traditional constructions of femininity.

Women's experience of child abuse and adult sexual and domestic violence, as well as racism, poverty and discrimination, is linked with increased drinking. Heavier drinking is also linked with depression, body dissatisfaction, anxiety and post-traumatic stress disorder.

9. Questions about alcohol health benefits

Alcohol stimulates opioid and GABA receptors in the brain, which produce feelings of wellbeing and relaxation, respectively (Bowden, 2009). Unsurprisingly, many people report that they drink to relax, get relief from anxiety and stress, for temporary escape from difficult situations and to ease social interaction (for example, Clarke & Ebbett, 2010; Robinson, 2010). These social benefits are relatively uncontroversial in the context of moderate drinking.

Whether moderate drinking is good for cardiovascular health, however, remains highly controversial. Reports of cardiovascular benefits first came to public attention in the early 1980s (Fillmore et al., 2007). Researchers found a J-shaped curve in the link between alcohol intake and cardiovascular disease (CVD) – non-drinkers had higher CVD rates than moderate drinkers, and heavy drinkers had the highest rates. This suggested there might be a protective effect from moderate drinking for those at risk of CVD – post-menopausal women and men over 45.

News about health benefits from alcohol is quickly spread by the media, where alcohol corporations are major advertisers (Roberts, 2011). Connor (2006, p. 583) describes this perception of moderate drinking as:

... the halcyon zone where alcohol is anxiolytic [anxiety-reducing] and relaxing, improves our meal, enhances our social life, and prevents our coronary disease without appearing to inflict much damage.

More recent re-analysis has identified major biases in the non-randomised, prospective studies that found these benefits (Fillmore et al., 2007; Jackson et al., 2005; Naimi et al., 2005).

One source of bias was the misclassification of occasional drinkers and 'sick quitters' – people who had reduced or stopped their drinking due to ill-health – as non-drinkers (Fillmore et al., 2007). Often, these drinkers stopped because of poor cardiovascular health, so their misclassification raised the perceived heart-related risks of non-drinkers as a group (Jackson et al., 2005). Of 54 prospective studies that had investigated the relationship, only seven were found to be free of this error (Fillmore et al., 2007).

*Damage from alcohol
far outweighed
health benefits.*

Another source of error was that moderate drinkers may have many social and lifestyle characteristics that make them less likely to have heart disease (Sellman et al., 2009). These characteristics are very hard to measure in prospective studies, which follow groups of people over time. US non-drinkers were more likely to have 27 of 30 factors linked with CVD, suggesting that 'the apparent protective effects of moderate alcohol consumption on CVD may be due to residual or unmeasured confounding' (Naimi et al., 2005, p. 369). Rehm and colleagues (2010) said that it is unclear whether moderate drinking is a protective factor for diabetes or a marker of other healthy choices.

Jackson and colleagues (2005) pointed to the non-randomised Nurses' Health Study in the USA, which reported a protective link between light to moderate alcohol intake and ischaemic heart disease (IHD). This study had previously also reported a halving of IHD risk linked with post-menopausal hormone therapy. Randomised controlled trials have since found the second link to be false, and likely to be a result of such uncontrolled factors.

Other possible confounders include underestimated drinking in self-reports, changes in individual drinking patterns and the difficulty of characterising binge drinking in epidemiological studies (Chikritzhs et al., 2009). Connor (2006, p. 583) said that 'measurement of drinking pattern has been inconsistent between studies and incomplete within them'.

Rimm and Moats (2007) restricted analysis in a large prospective study to non-smoking men who exercised and ate a good diet. They found that among these men, those who drank moderately had a lower rate of coronary heart disease (CHD) than non-drinkers. They concluded that moderate drinking reduced the risk of CHD. However, the same possible confounders may apply and there are also harmful effects from moderate drinking. For women any such benefit may be outweighed by an increased risk of breast cancer.

Recent Australasian guidelines state that cardiovascular benefits from alcohol have been overestimated (MOH, 2010a; NH&MRC, 2009a, p. 5): '... any benefits are mainly related to middle aged and older people and only occur at low levels of alcohol intake of about half a standard drink per day'. Connor and colleagues (2013) concluded that among New Zealand women generally, moderate drinking reduces deaths from ischaemic stroke, gallstones and diabetes, and from ischaemic heart disease among non-Māori women. However, this was outweighed by deaths caused by alcohol, explored in section 10: Health problems.

Research into renal-cell cancer and non-Hodgkins lymphoma has also found either no link with alcohol or a significantly lower risk in drinkers (Baan et al., 2007).

Jackson and colleagues (2005, p. 1912) concluded that 'there is no window in which the health benefits of alcohol are greater than the harms'.

9.1 New Zealand health benefit estimates

Five estimates of alcohol's contribution to disability, disease and premature death in Aotearoa reflect this evolving understanding of cardiovascular benefits. The net estimate of lives saved due to regular moderate drinking, mostly among men, has dropped in more recent calculations.

All the estimates found that damage from alcohol, expressed as disability-adjusted life years (DALYs – the number of healthy years of life lost due to illness, disability or early death from alcohol), far outweighed any health benefits. This damage is explored more fully in the next section.

The first estimate, using 1987 data, calculated that alcohol consumption resulted in a net 416 (1.5%) fewer deaths but a net loss of 9,525 person-years of life (Scragg, 1995).

Using 1996 data, the Ministry of Health (1999a) estimated that alcohol had prevented a net 59 deaths, and led to a net 3,367 years of life lost. Using the same data, Tobias (2001) calculated that women lost under a net 1% of DALYs from alcohol.

The Heart and Health Study in 2003 did not analyse information from Māori and Pacific people, and asked about usual but not binge drinking. It concluded that women would have approximately 21% fewer major coronary disease events if all female non- and occasional drinkers had the same alcohol-related coronary risk as regular moderate female drinkers (Wells et al., 2004).

A kaupapa Māori analysis concluded that the balance of alcohol benefits and damage for the cardiovascular health of Māori remains uncertain without further research into causes of cardiovascular disease among Māori (Bramley et al., 2006).

Connor and colleagues (2005a), using data from 2000 with the World Health Organization's comparative risk assessment methodology, estimated that alcohol caused 19 more deaths than it prevented among Māori women, but prevented 158 more deaths than it caused among tauiwi women.

They attributed 1,298 years of life gained (YLG) for women to the protective effects of regular moderate drinking on ischaemic heart disease, 538 YLGs for protection against stroke and 129 YLGs for protection against diabetes. They cautioned that the effect of drinking on ischaemic heart disease in Māori is not well understood, and that the protective effect may be less.

Connor and colleagues (2013), using revised WHO comparative risk assessment methods, estimated that alcohol prevented 14 deaths among Māori women and 111 among non-Māori women, predominately in older age groups, but that for both populations it caused at least double that number. They cautioned that 'the likely overestimation of the [preventive] effects due to inherent weaknesses in the research evidence needs to be kept in mind' (Ibid, p. 7).

SUMMARY – QUESTIONS ABOUT ALCOHOL BENEFITS

Claims in the early 1980s about cardiovascular benefits from moderate drinking have been overstated, and some of the apparent benefits may be due to other unmeasured lifestyle factors. As a result, estimates of health benefits to women from alcohol in Aotearoa have trended downwards over the last 26 years. Benefits are probably slight, and apply only to older people who drink less than half a standard drink a day. They apply more to Pākehā than Māori, and to men than women. For women they are outweighed by health dangers from moderate drinking, such as an increased risk of breast cancer.

10. Alcohol-related health problems

10.1 General

The World Health Organization estimated that 1.4% of women's disease and injury world-wide in 2004 was alcohol-related; the rate was three times higher (4.2%) in high-income countries (Mathers, 2009). Just over 1% of women's deaths globally were due to alcohol (WHO, 2011b), five times lower than those for men, reflecting that a majority of women world-wide are non-drinkers. In New Zealand, 5.7% of Māori women's deaths and 4% of tauwiwi women's deaths in 2007 were estimated to be due to alcohol (Connor et al., 2013). The rate of alcohol-related deaths estimated in Māori women (22 per 100,000 women) was more than double that in non-Māori women (8/100,000).

Connor (2013) listed 24 health problems partly or completely caused by alcohol; such lists are 'based on established epidemiological relationships, and so [are] inherently conservative' (Connor et al., 2005a, p. 20). Colon and rectal cancer, tuberculosis and pneumonia are newly-identified as alcohol-related conditions added since 2005. Huckle and colleagues (2013) found that alcohol-attributable hospitalisations among women aged 15 or more, and among Māori women, increased significantly between 1996 and 2011, although they found no change in overall alcohol-attributable deaths among women. There is very little research assessing trends in routinely-collected information about alcohol-related harms for women, including those requiring hospitalisation or related to drink driving. Where New Zealand information exists, all these problems are explored in more detail later in this section.

Almost 6% of Māori women's deaths in 2007 were thought to be due to alcohol.

Health problems that are completely caused by alcohol have an alcohol-attributable fraction (AAF) of 1 or 100%, and include a range of chronic conditions resulting from long-term heavy or binge drinking, or from drinking while pregnant. They include: alcohol abuse; alcoholic psychoses; alcohol dependence; alcoholic fatty liver; alcoholic hepatitis; alcoholic cirrhosis of the liver; other alcoholic liver disease; alcoholic liver failure; alcoholic polyneuropathy (multiple nerve dysfunction); alcohol cardiomyopathy (heart muscle disease); alcoholic gastritis (inflamed stomach lining); chronic alcohol-induced pancreatitis (inflammation of the gland that releases insulin); fetal alcohol syndrome (FAS); and alcohol poisoning (Connor et al., 2005a).

Binge drinking increases the risk of immediate problems to the drinker and others, such as unintentional injuries, traffic crashes, violence, crime and self-harm (Connor et al., 2005a; Connor et al., 2009).

These immediate injuries and alcohol-related problems can result from as little as one drinking session or from others' drinking, and are not necessarily the result of heavy drinking. They have an AAF less than 1 or under 100%, and include: traffic injuries; water and air transport crashes; unintended falls; fire injuries; unintended drowning; suicide and other self-inflicted injuries; assault, homicide and other deliberate injury inflicted by someone else; other injuries, including those at work; excessive cold; and poisoning by alcohol or by a non-alcoholic substance (Connor et al., 2013).

More younger people die from such injuries, resulting in more years of life lost to alcohol than the deaths of older people. In an estimate using data from 2007, the burden of this more immediate damage from alcohol fell very heavily on Māori women, who lost a net rate of 223 years of life per 100,000 to alcohol. In contrast, tauwiwi women gained a net 763 years per 100,000.

However, when the researchers combined premature death and disability from alcohol, they estimated that in 2004 women lost a net 6,544 disability-adjusted life years, a rate of 435 per 100,000 women. The impact on Māori was unable to be analysed. Alcohol use disorders caused half of women's DALYs lost, injuries 22% and breast cancer 12%. This analysis excluded social impacts and alcohol-related mental illnesses, the costs of which in other countries have been greater than direct health costs.

Female university students in two surveys reported a range of relatively common health problems from drinking: hangovers (55% in the last four weeks and 68% in the last three months); blackouts (33% and 43%) and vomiting (21% and 43%) (Kypri et al., 2009b; McGee & Kypri, 2004).

Underage young female binge drinkers in a UK qualitative study described engaging in more extreme and potentially harmful behaviour when they first started drinking, usually around age 14 in outdoor or unsupervised public spaces (Coleman & Cater, 2005). This behaviour moderated when they were able to get into pubs and bars, where their peers disapproved of arriving already drunk because they risked being barred.

Towers (2011) cited US predictions by Gfroerer and colleagues in 2003 that a large proportion of older adults are likely to develop chronic alcohol-related conditions, and that the proportion needing alcohol treatment may increase dramatically within a decade. This applied more to men than women.

10.2 Maternal and perinatal conditions

10.2.1 Fetal Alcohol Spectrum Disorder

Alcohol is a teratogen – a substance which mutates cells and can cause developmental disorders in the fetus. When a pregnant woman's blood alcohol level rises, so does that of her fetus.

Alcohol exposure at particular times early in fetal development can cause fetal alcohol syndrome (FAS). The clinical diagnosis of FAS includes:

- A pattern of facial alterations: small eye sockets, a flat mid-face, a flattened midline ridge between the nose and lip, and a thin upper lip
- Growth deficiencies in health and weight
- Permanent central nervous system damage.

While only a minority of fetuses exposed to alcohol in utero develop FAS (Woods et al., 2011), small amounts of alcohol, such as up to 70g or six units a week, can increase the risk of child behaviour problems (O'Leary & Bower, 2011), and have been significantly linked to lower IQ in children at age eight (Lewis et al., 2012).

Alcohol can also cause damage at any stage during pregnancy, which has led to further diagnostic categories – partial fetal alcohol syndrome (pFAS), alcohol-related neurodevelopmental disorders (ARND) and alcohol-related birth defects (ARBD). With FAS, these diagnoses have been grouped under the term Fetal Alcohol Spectrum Disorder (FASD) (AHW, 2010b).

Women may binge drink during pregnancy and produce apparently healthy babies. The most common alcohol injuries to the fetal nervous system cause abnormalities that may not be noted at birth (Huizink, 2009).

Babies born to mothers who used alcohol and cocaine have shown neurobehavioral deficits. When alcohol is used with other drugs, the teratogenic effects of each drug may become more harmful (Chen & Maier, 2011).

Social deprivation and having a violent or alcohol-abusing partner increased women's risk of having a child with FASD; risk is also increased in women over 30 (Stuart, 2009). Poverty worsens alcohol problems, and makes pregnant women's drinking more noticeable (Bingol et al., 1987).

Prevalence

See section 6.1.12: Pregnancy for a discussion of drinking rates during pregnancy.

Alcohol-related damage from FAS is thought to be related to a high peak blood alcohol concentration in pregnant women, making binge drinking during pregnancy a major risk factor (Stuart, 2009).

A 1995 survey of New Zealand paediatricians identified 63 children aged under 10 with FAS in 1993, less than expected given drinking rates at the time. Most paediatricians considered the diagnosis only when they identified mothers as high risk and children with facial characteristics (Leversha & Marks, 1995). An early estimate of the incidence of FAS in the developed world was 0.05 – 3 per 1,000 live births (Sampson et al., 1997). This used passive record-based systems that have since been found to underestimate prevalence.

Fatty acid ethyl esters, a result of alcohol metabolism, accumulate in meconium (a baby's first bowel motion) and indicate exposure to alcohol in the second and third trimester. In one Canadian study, 2.5% of meconium samples were positive for significant exposure. This was five times greater than the number of babies identified as high risk from surveys of mothers after birth (Gareri et al., 2008).

More recent studies using active recruitment in the USA, South Africa and Italy have found FAS in four to 12 per 1,000 live births and FASD in 2.3 to 6.3% of schoolchildren (May et al., 2011). Using these estimates, around five in 100 New Zealand children (more than 3,100 in 2009) could be born with a fetal alcohol disorder (Sellman & Connor, 2009; Statistics NZ, 2011a). This is more than the number of New Zealand children born with cystic fibrosis, Down syndrome and cerebral palsy combined (Salmon, 2008).

Effects

People born with FAS experience mental disabilities, learning difficulties, poor impulse control, problems in social perception and memory, attention, reasoning and judgement, and an inability to understand consequences (Salmon, 2011). Related

physical conditions can include heart, kidney and bone defects; immune deficiencies causing constant ear, chest and eye infections; sight, dental and feeding problems; respiratory difficulties; and constant crying as babies (Salmon, 2007; AHW, 2006). The Fetal Alcohol Network NZ (Undated) described FAS as the 'leading known preventable cause' of mental disability. People with FASD have a greater risk of secondary disabilities if they are not diagnosed at an early age and do not receive adequate care and intervention (Streissguth et al., 2004).

Later outcomes for children and adults with FASD include high rates of mental health problems (including serious depression, suicide attempts, panic attacks and attention deficit disorders), high rates of dependence for their daily needs, and a high proportion with work problems (Symes, 2004). A longitudinal study in the USA found that more than half had been expelled or dropped out of school, showed sexuality problems or inappropriate sexual behaviour, and had committed crimes, including theft, property damage, violence and arson (Streissguth et al., 1996).

Health system response

There appears to be a direct relationship between the amount of alcohol a woman drinks and the likelihood of her baby developing FASD, but no lower safe limit has been identified (AHW, 2010b). Since 2006, the Ministry of Health has advised that pregnant women should not drink alcohol.

Ho and Jacquemard (2009) found that 32% of pregnant Taranaki women in a 2006 postal survey had not been advised by a health professional to avoid alcohol completely during pregnancy. Sellman and Connor (2009) found this concerning in the face of the unequivocal MOH advice, indicating that this recommendation may not be transmitted effectively.

FASD diagnosis and assessment is a major gap.

Māori women in one study wanted 'clear messages about the effects of alcohol on fetal development' and believed that women received more messages about harm from smoking than from drinking (Stuart, 2009, p. 149). This study concluded that maternity carers needed to ask questions about women's drinking throughout their pregnancies.

New Zealand health professionals said their education about the condition was inadequate (Wouldes, 2009). While 78% said they asked pregnant women about drinking, 40% said that they did not discuss alcohol with patients if they were

from 'low-risk' ethnic or socio-economic backgrounds, and if they had not established a rapport with them. Stereotypes held by health professionals about poor, indigenous and ethnic minority people may also prevent them noting underlying biological conditions such as FASD (Woods et al., 2011).

New Zealand has no FASD register or systematic screening for FASD, and few medical professionals are trained to diagnose the condition (Stuart, 2009). Diagnosis requires a doctor's clinical assessment and neuropsychological testing (AHW, 2010b). New Zealand mothers of children with FASD said diagnosis and assessment was a major gap (Salmon, 2007).

A Canadian study found that children with FASD in an early intervention programme of nutritional, developmental and educational support had outcomes very similar to their non-exposed peers (Mutz et al., 2006).

Mother-blaming

Public attitudes to women who drink have emphasised the risks for their children and families, rather than the welfare of the women themselves. Stabile (1994, p. 172) described changes over three decades in representations of the 'maternal environment' from benevolent and nurturing to 'a hostile, infanticidal toxic waste dump, from which the autonomous [fetal] 'person' must be protected by the paternalistic arm of the government'. Pregnant women are increasingly seen as 'separate from, and in conflict with, foetuses' (Parker, 2007, p. 26) who exist in 'an environment somehow immune to racism, sexism, and economic violence' (p. 27). The health and wellbeing of the pregnant woman is of little interest, unless it can harm the 'unborn child' (p. 120).

Public health and biomedical concepts of risk have also contributed to these views, particularly findings that damage to the fetus in the first trimester can affect the health of the future adult, and even their descendants (Barker, 2002; Parker, 2009).

Parker says that public health interventions in Aotearoa about health during pregnancy have tended to focus on individual behaviours such as drinking, smoking, stress management and diet in pregnancy, as well as compliance with screening programmes and biomedical interventions. However, she says that 'socio-economic deprivation including poor educational outcomes, high unemployment, below poverty line benefits and substandard housing' pose 'much greater social structural threats to foetal *and* maternal health' (Ibid, p. 3). She says that tackling this marginalisation is not in the interests of neo-liberal governments.

'Child-centred' policies often limit the rights of mothers, rather than improving their health and ability to parent (Poole & Dell, 2005). Addicted women are defined as 'bad mothers' who are then treated in ways that undermine their competence – particularly women who drink during pregnancy or whose children are born with FASD (Broom & Stevens, 1990).

In North America, legal interventions that enabled women who drink during pregnancy to be confined and their children taken into care, indicated a shift from viewing fetal alcohol exposure as a public health problem to 'a problem of public order' (Bell et al., 2009, p. 160). The perception that pregnant women's drinking is a type of child abuse has become dominant.

However, the threat of losing children to state systems encourages women to hide their drinking and pushes them away from treatment (Daniels, 1999). North American authorities have singled out indigenous women, women from other minority ethnicities, single and poor mothers for this treatment. White middle-class women who binge drink have not been viewed in the same way (Bell et al., 2009).

Parker (2009, p. 8) concluded that women with the fewest material resources are least able to be the self-regulating 'pregnant healthy citizen' the neo-liberal state requires, and are therefore most likely to be blamed and to feel guilty.

New Zealand health posters also portray the pregnant woman who drinks as an adversary or even an abuser of her fetus, and a bad mother (Parker, 2007). Three poster images separated the two, reducing or eliminating the woman, and one gave the fetus speech. All constructed the individual pregnant woman as under surveillance and responsible for any risks to the fetus. None showed the father-to-be or mentioned his contribution to fetal risks, or involved the woman's family.

New Zealand women with children diagnosed with FASD have felt 'unjustifiably viewed as 'bad mothers' ... responsible for their offspring's criminal behaviours' (Salmon, 2007, p. 73). Parker (2007, p. 129) concluded that

... we may be witnessing the evolution of a public culture that endorses resentment toward pregnant women in favour of the foetus, and which endorses subtle (and not so subtle) forms of coercion against those who transgress the boundaries of what we deem 'acceptable behaviour for mothers'.

FASD is regularly described as 100% preventable (Salmon, 2008), but the focus on the obligation of the individual pregnant woman ignores any social and government responsibility for the alcogenic environment that surrounds her (Parker, 2007). Personal responsibility is most often stressed by those who want to reduce government and wider social responsibility for such issues (Daniels, 1999).

Daniels (1999, p. 97) says that 'most threats to fetal health are produced by environmental and occupational toxins', and corporations and government regulators, including alcohol corporations and alcohol policy-makers, have largely escaped responsibility for this damage.

Just saying no to alcohol is impossible for many women, including those who are addicted. 'It takes a community to support a woman in her efforts not to drink', according to a Canadian community FAS prevention campaign (Stuart, 2009, p. 148).

Stuart concluded that partners, whānau and friends need to understand their supporting role. Women with alcohol problems have a high risk of relapse if they give birth to children with FASD, due to the difficulties of parenting them, feelings of guilt, and their own and social judgements that they are 'bad mothers' (AHW, 2007).

Research about FASD rarely considers the contribution of fathers. Their drinking has been linked with an increased risk of birth defects and cognitive deficits in children, as well as low birth weight (Daniels, 1999). However, studies on men's workplace and environmental exposures to teratogenic toxins rarely control for men's alcohol and other drug use.

Men who abuse their female partners are more likely to abuse them when they are pregnant, and to abuse them more often and more severely (Ibid). Pregnant women may drink to numb the pain from their partner's sexual or physical abuse. Alcohol-abusing women are more likely to be in relationships with alcoholic men than the other way around, and these partners may encourage women's drinking with pressure or emotional abuse.

Poole and Dell (2005, p. 10) said that 'a colossal shift' was needed in the attitudes of health professionals and government agencies towards women who have problems with their drinking, to reduce the guilt, shame and stigma that stop women finding help.

A focus on the obligation of the individual pregnant woman ignores any social and health system responsibility for the alcogenic environment that surrounds her.

10.2.2 Other perinatal conditions

In pregnant women, having more than three drinks a week can increase the risk of miscarriage in the first three months of pregnancy, and there is some evidence that alcohol is linked with premature birth (NZDF, 2006b). Heavy alcohol use can deplete pregnant women's levels of vital nutrients such as folate (AHW, 2007) and limit the absorption of micronutrients (MOH, 2006b). Alcohol intake during the last three months of pregnancy is strongly linked to low birth weight – babies weighing less than 2.5kgs (NZDF, 2006b) – although smoking and other factors have more impact on low birth weight than alcohol (OCPLBW, 2007). Low birth weight is a risk factor for some later health problems. In 2004, Connor and colleagues (2013) estimated that alcohol caused 4.4% of the babies born with low birth weight, which in 2010 equated to 163 babies (MOH, 2010b). They calculated that in 2004 alcohol resulted in the loss of 77 disability-adjusted life years due to low birth weight. They also estimated that in 2007 alcohol caused 7.3% of the deaths of low birth weight babies among Māori and 3.7% of those among tauiwi; two Māori babies and one tauiwi baby died that year as a result.

Alcohol is also a risk factor for asphyxia, placental separation from the uterus and other pregnancy complications (Meyer-Leu et al., 2011; Aliyu et al., 2011).

Drinking alcohol during breastfeeding can reduce milk production (NZDF, 2006b). One Australian study also found that heavier drinkers were more likely to give up breastfeeding earlier (Giglia et al., 2008).

10.3 Injuries

10.3.1 General

Injury makes up a large part of the damage from alcohol, whether intentional (such as assault) or unintentional (such as traffic crashes) (Connor, 2008). One in 10 women who drink nearly every day will be hospitalised for alcohol-related injury at some point in their lives, even if they have only one or two drinks each time (NH&MRC, 2009a).

Injury rates are strongly affected by drinking patterns; binge drinkers have the highest risk (Connor et al., 2005a). Drinking four drinks in one session more than doubled the risk of an injury for women in the six hours after drinking (NH&MRC, 2009a). Women who drank heavily in the six hours before exercise were 14 times more than likely to be injured than non-drinkers (Gmel et al., 2009).

Measuring injuries in surveys

Women are less likely to report an injury from their own drinking than men. Māori women were more likely to report an injury from their own drinking than all women (MOH, 2009a).

It is difficult to compare rates of injury among different groups of women, as surveys have used different definitions, including physically hurting themselves, being injured in a non-traffic accident, or needing medical treatment. They have also asked about injuries resulting from one's own or another's drinking, as well as different time periods.

Injuries resulting from drinking among different populations have therefore ranged from –

- 1.5% of female university students injured in the preceding four weeks from their own drinking (Kypri et al., 2009b)
- 8% of female rugby players in the last 12 months (Quarrie et al., 1996)
- 15% of 16 and 17-year-olds young women nationally in the last 12 months (MOH, 2009a)
- 18% of female secondary students in 2012 (down from 23% in 2007) in the last 12 months; 3% of whom needed medical treatment (Ameratunga et al., 2011; Clark et al., 2013a)
- 50% of all alternative education students in the last 12 months (Clark et al., 2010), although this was not analysed by gender
- 57% of another university sample in the last six months, most of whom were female (McEwan et al., 2011).

Four percent of female secondary school students and 70% of all alternative education students had injured someone else in the last year when they had been drinking (Clark et al., 2013a; Clark et al., 2010). Four percent of Pacific women reported a non-vehicle crash injury from someone else's drinking in the last 12 months (Huakau et al., 2005).

Measuring injuries through the health system

Another way of measuring alcohol-related injuries is through the health system, in general practice and hospital emergency services. While more men are treated for injuries in these settings than women, the gender difference in alcohol-related injuries is much less.

Two studies found a higher proportion of women injured after drinking. More female than male patients attending Dunedin general practices for an injury in 2008 had been drinking beforehand (McLean & Connor, 2009). Half of the women had had more than four drinks. Gunasekara and colleagues (2011) said that only since the purchase age was lowered in 1999 had 12- to 14-year-olds been seen with injuries in emergency departments after drinking, and most of these were girls.

Women made up one in three of those with injuries treated at Auckland Hospital's emergency department (ED) in December 2000. There were no gender difference in the amount these patients had drunk, and alcohol-related injuries were more serious. The researchers calculated that the risk of an injury presentation to the ED was 2.8 times higher after drinking (Humphrey et al., 2003), or 1.14 for every two cans of beer. An international study in 2002 calculated that people were 7.4 times more likely to be injured and present to a hospital ED after drinking than if they were sober (WHO, 2007a). New Zealand reported the second highest proportion of alcohol-related injuries in this study, more among men than women.

Male and female presentations to Dunedin Hospital's ED between 2001 and 2011 were steadily converging (Chai et al., 2011). Admission spikes were linked with student drinking events such as the Hyde Street keg party, St Patrick's Day, Undie 500, the Toga Party and other days in Orientation Week, but spikes decreased over the decade, as did overall ED presentations.

Ten percent of Norwegian women attending an emergency department with an injury in 2008 tested positive for alcohol compared to 23% of men, but women were almost as likely as men to have a combination of alcohol and prescription drugs in their blood (Bogstrand et al., 2011).

Deaths

Between 2005 and 2007, 19% (20) of the deaths of New Zealand girls and young women aged up to 24 were related to alcohol (CYMRC, 2009); 55% died due to another person's drinking. This report did not analyse alcohol-related deaths from vehicle crashes, assault or falls by gender, or the role of women's drinking in the deaths of children. There were no female deaths due to risk-taking after drinking in public urban places such as streets, parks or sports areas.

Connor and colleagues (2013) estimated that in 2007, injuries caused one in four alcohol-attributable deaths in women, and were the leading cause of women's years of lives lost to alcohol (42%); 23 Māori women and 43 tauiwi women were estimated to have died from injuries caused by alcohol that year.

10.3.2 Physical assault injuries

This and the following section discuss injuries and deaths from violence reported through the health and justice systems. Discussion about other alcohol-related violence to women is found in section 11.3: Violence against women and children.

Assaults by partners that involved alcohol resulted in worse injuries for the woman (Testa et al., 2003; Graham et al., 2011). This is reflected in a significantly higher rate of alcohol involvement for female patients in Auckland emergency departments with assault-related injuries (21.5%) compared to those with unintentional injuries (Fanslow et al., 1998). This is likely to be an undercount, as there was no routine screening for alcohol in injury cases.

Alcohol was involved in 87% of hospital face and jaw fractures from intimate partner violence, and 72% from interpersonal violence between 1996 and 2006 (Lee & Snape, 2008; Buchanan et al., 2005). The proportion of fractures caused by assault has grown steadily as those from traffic crashes have declined.

Connor and colleagues (2013) estimated that 14 to 16% of injuries from assault in women aged 15 to 79 in 2004 were alcohol-related, resulting in the loss of 108 disability-adjusted life years.

One international review of injuries in hospital EDs found that binge drinking increased women's risk of violent injury more than it did for men, consistent with a stronger link between the victim's drinking pattern and the risk of alcohol-related victimisation for women (Wells et al., 2007b). See section 11.3 for more detail.

10.3.3 Femicide and child deaths

Femicide

Aotearoa

Femicides are killings of women by men out of contempt for women, a sense of superiority or an assumption of ownership (Russell & Harmes, 2001). Alcohol abuse by a violent male partner quadruples a woman's risk of death (Brown, 2011). However, police reports are likely to undercount the involvement of alcohol in family homicides (Martin & Pritchard, 2010).

Alcohol and drug abuse featured in about two-thirds of homicides within New Zealand families between 2002 and 2006

Alcohol abuse by a violent male partner quadruples a woman's risk of death.

(ibid.). The perpetrator's substance use featured in more than half of all couple-related homicides. Between 2002 and 2008, substance use was the most common factor in the deaths of non-partner adults by another family member (FVDR, 2011).

In 2007, alcohol was estimated to cause 31% of the deaths from assault among tauwi women aged 15 to 29 and 47% of those among Māori women of that age group. Alcohol was estimated to result in the deaths of four tauwi and three Māori women that year (Connor et al., 2013).

International

In many country studies there is no analysis by gender in the proportion of violent deaths attributable to drinking (Room & Rossow, 2001; Darke & Dufloy, 2008). Problem drinking by violent male partners in the USA was linked with eight times the amount of partner abuse and twice the risk of attempted or completed femicide.

Victims in one study drank much less than their partners (Sharps et al., 2001), although a recent review of alcohol toxicology in homicides found that 48% of female victims had been drinking (Kuhns et al., 2010). Half of female homicide victims in New South Wales had a substance in their blood; in half the victims of partner homicides it was alcohol (Darke & Dufloy, 2008).

Child deaths

Abuse of alcohol or other drugs is one factor that made adults in Aotearoa more likely to fatally maltreat a child. Other factors included poverty, little education, unemployment, being youth, poor mental health, experience of family violence as a child, and a history of offending (MSD, 2006).

10.3.4 Traffic crashes

Drink driving that does not result in crashes or injuries is discussed in section 11.5.1: Drink driving.

Aotearoa

Researchers have studied the contribution of alcohol to individual people's injuries and to individual crashes that may have involved several people.

Each additional off-licence in Manukau City in 2008–9 correlated to an increase in traffic offences and motor vehicle accidents reported to police. Additional clubs or bars were linked to increased traffic offences, and additional licensed restaurants or cafés with more traffic crashes (Cameron, 2010).

Alcohol-involved crashes increased significantly for all women drivers aged 14 or more between 1999 to 2007, but decreased significantly between 2008–2010 (Huckle et al., 2013). These trends were also true of Māori women drivers; there was no significant change in crashes for Pacific and 'Asian' women drivers between 2002 and 2010.

Traffic injuries

Estimates of alcohol involvement in crash injuries range from 21 to 37% of individual injuries and 14% of crashes. However, the role of alcohol in these injuries is likely to be considerably underestimated, as only 10% of drivers in reported non-fatal injury crashes were tested for blood or breath alcohol in 2005–7 (Connor & Casswell, 2009).

Māori were significantly more likely than other women to be in a crash due to someone else's drinking (MOH, 2009a). Alcohol was estimated to be responsible for up to 25% of road traffic injuries for tauwi women aged up to 44, and up to 37% for Māori women (Connor et al., 2005b). Using more recent figures, Connor (2013) estimated that alcohol caused 28% of road traffic injuries in women aged 15 to 29 in 2004, resulting in the loss of 989 disability-adjusted life years.

Alcohol contributed to 14% of injury crashes in 2009 (MOT, 2010a). Women made up 32% (8,342) of alcohol offenders in national crashes (MOT, 2010c) and 20% of drivers in far north crashes (Evaluation Solutions, 2010b).

Women made up 15% of those affected only by alcohol, 15% of those who had used alcohol and cannabis, and 25% of those affected by another combination of drugs (which usually included alcohol) (Poulsen, 2010).

After the lowering of the minimum purchase age in 1999, 18- to 19-year-old women were involved in 51% more alcohol-involved crashes than before the change, with 15- to 17-year-olds having 24% more such crashes. Hospitalised injuries showed a similar pattern (Kypri et al., 2006). The researchers concluded that crashes had significantly increased over what would have been expected without the law change, and that there was evidence of a trickle-down effect for 15- to 17-year-olds.

A study of fatal Friday and Saturday night crashes found that women have a death rate of 0.40 per million trips, compared to men's of 0.95 (Keall et al., 2004). Non-drinking victims made up almost half of those injured in alcohol-related traffic crashes in 1996 (Miller & Blewden, 2001). One in 70 trips driven over the legal limit was estimated to result in a crash or a drink-driving conviction, and one in 90 in a crash, often as well as a drink-driving conviction.

Judges ordered only 7% of people convicted of excess alcohol in 2006–7 to receive an AOD assessment. One percent of people with one conviction were ordered to be assessed, 6% of those with two convictions, and 31% of those with four (Rout, 2008).

Traffic deaths

At 80mg of alcohol per 100ml of blood, the current New Zealand legal adult limit, a driver over 30 is 16 times more likely to be in a fatal crash as she would be with no alcohol in her blood (MOT, 2010a).

In 2007, alcohol was estimated to cause 37% of traffic crash deaths among Māori women aged 15 to 29 and 25% of those among tauwiwi women in that age group. Alcohol was estimated to result in 15 tauwiwi and 11 Māori women's deaths from crash injuries that year (Connor et al., 2013). The role of alcohol in death from traffic crashes is also likely to be underestimated, as only 80% of drivers or riders killed in road crashes in 2009 were tested for blood alcohol (MOT, 2010c).

Alcohol contributed to 34% of fatal crashes in 2009 (MOT, 2010a), and women made up 19% of alcohol-affected drivers in these crashes (MOT, 2010c). Of all drivers involved in fatal crashes that year, women made up 17% of those affected by alcohol and other drugs. This proportion has increased in the past few years.

Almost one in four drivers (24%) killed in traffic crashes between 2004 and 2009 were female (Poulsen, 2010).

International

Men remain the primary subjects for research and drink-driving interventions. More research is needed into women's drink driving (GRSP, 2007).

The density of alcohol outlets has been linked consistently with the rate of traffic crashes and traffic injuries in an area (Gruenewald et al., 2002; Treno et al., 2007).

A US analysis of fatally injured drivers found that females with alcohol in their blood were 20% more likely than alcohol-affected male drivers to have at least one child passenger (Voas et al., 2002). In crashes where a child was killed, women drivers were about half as likely as male drivers to have alcohol in their blood.

10.3.5 Falls

People aged 25 to 60 were almost four times more likely to fall over after one or two drinks, and 13 times more likely after three or more drinks than similar-aged sober controls (Kool et al., 2008). Women made up 54% of those injured from falls, but their alcohol involvement was not stated.

Connor and colleagues (2013) estimated the AAF for injuries from falls at 7 to 8% for all women aged 15 to 59 in 2004; women lost 85 disability-adjusted life years from alcohol-related falls that year. Between 1988 and 2010, 37,851 women aged 15 to 59 were admitted to hospital with fall-related injuries (NIQS, 2012). If all women injured from falls were admitted to hospital, 7% amounted to 3,028 alcohol-related fall admissions in this period.

Four tauwiwi and one Māori woman were estimated to have died from falls in 2007 that were attributed to alcohol (Connor et al., 2013).

10.3.6 Fires

Alcohol causes fires through inattention, lack of care, incapacity or acts of omission. Alcohol also inhibits the body's choke response to smoke and suppresses the immune system, so that alcohol-affected women who were burned were three times more likely to die than burned women who had not been drinking (Heimdall Consulting, 2005).

Connor and colleagues estimated that alcohol caused between 10 and 12% of fire injuries in 2004, losing women 34 disability-adjusted life years. Between 1988 and 2009, 1,205 women were discharged from public hospitals after injuries from fire or flames. If all women injured in fires were admitted, this equated to 120 girls and women with alcohol-related fire injuries (NIQS, 2011a).

The density of alcohol outlets has been consistently linked with the rate of traffic crashes and traffic injuries in an area.

Forty-nine girls and women died in residential fires between 1997 and 2003; one in four (12) were aged under 10; another third (14) were over 75. Twenty-seven were Pākehā, 21 were Māori and one was 'Pacific'. Alcohol involvement was not identified by gender. Forty-two male and female victims had blood alcohol levels above the legal driving limit. Fourteen victims were dependent on alcohol or other drugs; alcoholics were 10 times more likely to die in a fire than other people (Heimdall Consulting, 2005).

In five fire deaths caused by careless smoking, the victim's blood alcohol level was at least twice the legal driving limit. One in three (14) of those who died in fires were non-drinking victims of fires caused by alcohol-affected people

Drinking was a factor in more than half the deaths from unattended cooking fires; however, women were 2.5 times less likely to die from these fires than men (Duncanson, 2001).

10.3.7 Occupational and machine injuries

Devlin (1997) estimated alcohol caused 13% of women's hospital admissions from machine injuries in 1991. Between 1988 and 2009, 1,788 women were discharged from public hospitals for unintentional injuries from using machinery, a crude rate of 4.2 per 100,000 women (NIQS, 2011b). If the 1991 AAF remained accurate, this equated to 232 hospital visits caused by the effects of alcohol. No later New Zealand estimate was found.

A Canadian study in 2002 found that a much lower proportion (2%) of women than men were injured at work; this affected 3.5% of weekly heavy drinkers, compared with 2.1% of those who binged up to once a month and 2.3% who did not drink that year. Women working in primary industries, trades and transport were more likely to be injured than white-collar workers (Wilkins & Mackenzie, 2007).

10.3.8 Drowning

Alcohol is a major modifiable risk factor in drowning deaths, and drinking has been described as a major gap in drowning prevention campaigns (Purnell & McNoe, 2008). Between 1980 and 2002, 219 people aged under 25 died from drowning in alcohol-related incidents. These were not categorised by gender, but 76% of all people who drowned were male (CYMRC, 2005).

When motor vehicle accidents, suicides and homicides were excluded, two of the remaining 110 people whose drowning was alcohol-related were female. The gender discrepancy is consistent with overseas results, and is linked with dares and male risk-taking (Ibid).

Connor and colleagues estimated that alcohol caused 12 to 19% of injuries from drowning incidents for women in 2004, resulting in the loss of 48 disability-adjusted life years. Alcohol was estimated to cause 43% of drowning deaths among Māori women aged 15 to 29 and 29% among tauwi women of the same age in 2007; this was estimated to result in one tauwi and one Māori woman's death that year (Connor et al., 2013). Between 2006 and 2010, 9% (7) of female deaths from drowning involved alcohol (WSNZ, 2011).

10.3.9 Other unintentional injuries

In 2004, 15% of injuries from non-alcohol poisonings in women aged 15 to 29 were estimated to be due to alcohol, as well as 10 to 13% of injuries from other unintentional causes (Connor et al., 2013). Poisonings lost women 204 disability-adjusted life years (DALYs) and other unintentional injuries lost them 340 DALYs. In 2007, four tauwi and two Māori women were estimated to have died of poisoning from a substance other than alcohol, but caused by drinking; six tauwi women and two Māori women were estimated to have died from other unintentional injuries.

10.4 Self-inflicted injuries

Aotearoa

This review found little data relating women's drinking to self-harm, due to a lack of gender analysis and small sample sizes. New Zealanders with substance use disorders had a higher likelihood of suicidal thoughts and plans than all other co-occurring disorders (Wells et al., 2007a). However, data was not reported separately by gender. Up to one in five women aged 26 in a longitudinal Dunedin cohort reported harming themselves, and 35% had used substances to get intoxicated to deal with emotional pain (Nada-Raja, 2004).

Connor and colleagues (2013) estimated that in 2004 between 3 to 5% of self-inflicted injuries by women aged 15 to 79 were caused by alcohol, resulting in the loss of 297 DALYs, and that in 2007, nine tauwi and three Māori woman died from alcohol-related self-inflicted injuries.

More same-sex attracted 26-year-olds in a longitudinal cohort had used alcohol to deal with emotional pain than both-sex and opposite-sex attracted young women (Skegg et al., 2003). A similar gradient was found for attempted suicide, suicidal thoughts, deliberate self-harm and injury from self-harm. The study did not relate alcohol use to self-harm, and the number of same-sex attracted women was very small.

In another qualitative study with young people attracted to more than one gender, three-quarters of whom were female, most believed that self-harm was not a risk factor for binge drinking (Pega et al., 2012). However, five participants believed that depression, self-harm and binge drinking were linked for young people with this attraction.

For Māori secondary students, binge drinking had only a weak link with suicide attempts; there was no separation by gender (Clark et al., 2008). There has been no analysis of any link between alcohol and suicide in the Youth 2000, 2007 and 2012 surveys (Fortune et al., 2010).

State policies that reduce alcohol availability probably reduce suicide rates.

International

Women with alcohol disorders had approximately 17 times the rate of completed suicides in a UK review (Raistrick et al., 2006). Alcohol was implicated in 40% of attempted suicides by UK women (Alcohol Concern, 2008). One international review found a stronger link between alcohol use disorders and suicide in women than men (Wilcox et al., 2004).

A rise in drinking by UK women appears to be accompanied by a rise in alcohol-involved deliberate self-harm and suicidal thinking and behaviour (Haw et al., 2005). Suicide and alcohol are closely linked in countries where getting drunk is a common reason for drinking (Razvodovsky, 2009). A one-litre increase in per capita alcohol sales in Russia was estimated to result in a 2.8% increase in female suicides; the same increase in vodka sales would increase women's rate by 6%.

Significant proportions of women who committed suicide were found to be drunk in Estonia (22%), Finland (20%), Slovenia (18%) and Scotland (37%) (Värnik et al., 2006). Alcohol restrictions after 1985 and the subsequent drop in consumption were linked with an 18% fall in female suicide rates in the Slavic and Baltic regions between 1984 and 1988. In Estonia, the restrictions were linked with a 40% drop in the rate of women found with alcohol in their blood after committing suicide (Ibid). Värnik concluded that state policies that reduce alcohol availability probably reduce suicide rates, although causality could not be confirmed.

There is a close link between alcohol abuse and self-neglect among victims of elder abuse; those with AOD abuse problems in a New York sample were 70% more likely to neglect their own care (Choi & Mayer, 2000).

10.5 Alcohol poisoning

Nearly one in three (32%) in a 2006 university sample, most of whom were female, reported 'passing out' as a result of their drinking in the last six months (McEwan et al., 2011, p. 72).

In 2008, 156 women and 166 men were hospitalised for alcohol poisoning; this amounted to a rate of eight people in every 100,000 (Tisch & Slaney, 2009). Almost one in five (62) of those hospitalised was under the legal drinking age.

Two studies noted a significant increase in intoxicated young women arriving in hospitals after the legal purchase age was lowered to 18 in 1999. The number of 15 to 19-year-old young women nationally with injuries and alcohol toxicity who were admitted to public hospitals increased by 31% between 1997–99 and 2000–2 (AHW, 2002). However, these admissions among girls aged 10 to 14 increased by 260%. Girls in this age group made up 64% of these admissions in 2000–2.

The number of intoxicated 18- and 19-year-olds presenting to Auckland Hospital's emergency department with more than the legal blood alcohol limit for driving increased by 50% to 107 in the 12 months after the law change, and numbers rose to 95 for the 15- to 17-year age group (Everitt & Jones, 2002). There was no increase in the proportion of those over 19 who were intoxicated and no analysis by gender. Huckle and colleagues (2013) found no significant change in women's hospitalisations for alcohol poisoning between 1996 and 2011; however, such studies rely on staff measurement, may exclude patients who spend only a short time in the emergency department, and are likely to be underestimates.

A study of poisoning cases treated in Auckland DHB over two years to 2000 found that alcohol alone was responsible for 56% of cases, and 55% of people treated for alcohol poisoning were women (Public Health Advice, 2000). Most people with alcohol poisoning were aged 15 to 24.

In 2007, one Māori woman was estimated to have died from alcohol poisoning (Connor et al., 2013).

Underage young female binge drinkers in a UK qualitative study were more likely than young males to report collapsing from severe intoxication and uncontrollable vomiting after binge drinking. This was usually a result of drinking rapidly and mixing their drinks and 'frequently caught people unawares' (Coleman & Cater, 2005, p. 131).

10.6 Alcohol abuse, dependence and other mental illness

Data drawn from groups of women in alcohol treatment is discussed in section 13.4.5: Voluntary AOD treatment. This section discusses population studies.

Alcohol abuse and dependence are defined in the following sections; together they are termed alcohol use disorders, which are 'chronic and relapsing' (Moriarty et al., 2009, p. 4). Women with a history of alcohol dependence or abuse are more likely than men to report health problems, and death rates for women with drinking disorders are significantly higher than for men (Nolen-Hoeksema, 2004; van der Walde et al., 2002).

People with substance use disorders in Te Rau Hinengaro, the NZ Mental Health Survey, had higher rates of other chronic conditions than those without any disorder (Wells et al., 2007a). In the previous year, 57% of women with any substance abuse disorder experienced chronic pain, 28% had respiratory conditions, 16% had high blood pressure, 12% had cardiovascular disease, 6% had diabetes and 6% had cancer.

Connor and colleagues (2013) estimated that women lost 4,798 disability-adjusted life years to alcohol use disorders in 2004. They also estimated that four tauiwi and two Māori women died of alcohol use disorders in 2007, although most such deaths are coded to other specific causes, such as cirrhosis, breast cancer or road traffic crashes.

Half of all people with alcohol abuse disorders experienced them by age 19 and three out of four by 25. The lifetime prevalence for alcohol disorders in Aotearoa identified in Te Rau Hinengaro was twice as high as the aggregated prevalence from six European countries, and rates for alcohol disorders in the past 12 months were also higher. Prevalence of alcohol disorders for all New Zealanders in the past 12 months was higher among people with a lower household income and those living in more deprived neighbourhoods (Wells et al., 2007a). Seventy percent of women with any substance abuse disorder also smoked tobacco.

The lifetime prevalence of any substance abuse disorder was 22% among Māori women and 12% among Pacific women (Oakley Browne et al., 2006). Niue and Cook Island women in Auckland were more likely than women of other Pacific ethnicities to have been treated for an alcohol-related condition in 2011 (Jackson & Minster, 2012). The prevalence for Pākehā women was not stated; for all women it was 8%.

The rate for all women in Te Rau Hinengaro is higher than the lifetime rate of alcohol disorders among Christchurch women in 1986 – 6%, a total then of more than 60,000 women (AWCG, 1993).

Same-sex attracted women had higher rates of substance use disorders than heterosexual women in the USA (Hatzenbuehler et al., 2009; CSAT, 2009a).

10.6.1 Alcohol abuse

Alcohol abuse is more common than dependence or addiction to alcohol. Alcohol abuse is usually diagnosed only when a person is not dependent on alcohol. The criteria include one or more of the following:

- Repeated failure to carry out obligations at home, study or work because of drinking
- Persistent drinking in hazardous situations (for example, before driving)
- Persistent legal problems related to drinking
- Continued drinking despite repeated social or relationship problems (Wells et al., 2007a).

Two percent of all women (this included non-drinkers) had abused alcohol in the last 12 months, and 6.9% had done so over their lifetime. When non-drinkers were excluded, the proportion of the whole population who had abused alcohol increased by 0.7%. This figure was not analysed by gender (Ibid.).

Forty-five percent of all people who abused alcohol in Te Rau Hinengaro also had a drug use disorder; this was also not analysed by gender.

International

Six percent of American women fitted the criteria for alcohol abuse at some time in their lives (Nolen-Hoeksema, 2004). In the UK, poor young women and richer women aged over 64 were more likely to die of conditions directly caused by alcohol (Harrison & Gardiner, 1999).

10.6.2 Alcohol dependence

Aotearoa

The criteria for alcohol dependence syndrome, commonly referred to as alcoholism, includes at least three of the following symptoms during the previous 12 months:

- Tolerance to alcohol, shown by a need for more drinks to get drunk or less effect with the same number of drinks
- Withdrawal symptoms when sober
- Drinking more or for longer than intended
- A continuing wish or unsuccessful efforts to reduce drinking
- Significant time spent obtaining alcohol
- Stopping or reducing important social, work or leisure activities because of drinking
- Continuing to drink regardless of the negative effects on physical or emotional health (Wells et al., 2007a).

The risk of alcohol dependence rises with increased drinking for individuals and for populations (Babor et al., 2010). The heavy binge drinking pattern of young New Zealanders carries a high risk of alcohol disorders; starting drinking by 15 tripled the risk of being substance-dependent by 32 (Odgers et al., 2008). There was no analysis by gender.

New Zealand estimates of alcohol dependence varied. One percent of all women in 2004 (including non-drinkers), were dependent on alcohol in the last 12 months, and 2.6% over their lifetime (Wells et al., 2007a). In 2000, the proportion of Auckland female drinkers with symptoms of alcohol dependence ranged from 10% to 20% depending on age (Huckle et al., 2012). Women who grew up in poor families, and same-sex attracted women, had a higher risk of alcohol dependence (Wouldes et al., 2011; Fergusson et al., 2005b).

More than one in four people dependent on alcohol (28%) in Te Rau Hinengaro were also drug dependent (23%) or abused drugs (28%). Fifty percent of those dependent on drugs also reported alcohol abuse in the past year, and 43% of drug-dependent people also had alcohol dependence. This was not analysed by gender (Wells et al., 2007a).

The Ministry of Justice (2008) estimated that 83% of prisoners had a substance abuse disorder at some time in their lives, compared to 32% in the whole population. Of 470 female offenders surveyed in 2003, 13% were alcohol dependent and 14% were dependent on alcohol and other drugs.

The economic demands of an alcohol addiction may force women into prostitution or keep them involved (Jordan, 2005).

International

Women in the Cook Islands, Fiji, Solomon Islands, Tokelau, Tonga and Samoa had very low rates of alcohol use disorders – less than 0.15% (WHO, 2011b).

A random population sample in Germany found that alcohol-dependent women were nearly five times as likely to die prematurely than non-addicted women, and more than twice as likely to die early than alcohol-dependent men (John et al., 2012)

Eight percent of US women fit the criteria for alcohol dependence at some time in their lives (Nolen-Hoeksema, 2004); indigenous American women had a higher rate of alcohol use disorders in the past year (9%) than women of all other US ethnicities (Falk et al., 2006).

Same-sex attracted women had higher rates of alcohol dependence in Scotland (Inclusion Project, 2003). The risk increased from heterosexual women, to heterosexual women with experience of same-sex partners, to lesbians, with bisexual women most at risk (Drabble & Trocki, 2005; Austin & Irwin, 2010).

Among women prisoners in seven Australian states who drank regularly before they were arrested, 57% were alcohol dependent (Johnson, 2006b). The same proportion of UK women inmates had an alcohol use disorder (Newbury-Birch et al., 2009).

10.6.3 Other mental health problems

Forty percent of New Zealanders in Te Rau Hinengaro who had a substance use disorder in the last year also had an anxiety disorder, and 29% also had a mood disorder (Wells et al., 2007a). This was not analysed by gender.

Alcohol dependence causes moderate to severe depression (Samokhvalov et al., 2010). Women were more likely to have alcohol problems and depression at the same time (Lejoyeux & Leheret, 2011; Brown & Stewart, 2008; Nolen-Hoeksema, 2004), and to say they developed depression first. Among those with alcohol use disorders,

Women are more likely to have alcohol problems and depression at the same time and to develop depression first.

the link between depression and alcohol problems was stronger for women than men (Ibid). About one in five New Zealand women who drank hazardously also experienced mood, anxiety or other mental disorders (Oakley Browne et al., 2006). Connor and colleagues (2013) estimated that alcohol contributed slightly (4%) to depression in women aged 15 to 29 in 2004, resulting in 10% of disability-adjusted life years (DALYs) and 24% of years with a disability due to alcohol in this age group. Depression was the fourth-highest cause of alcohol-related DALYs for this group of women.

10.6.4 Brain damage

Alcohol is a neurotoxin – it can damage the nervous system, including the brain. This is most evident in FASD, adolescent brain damage, and the effects of chronic heavy drinking on the brain later in life.

Eventually this may include Wernicke's encephalopathy (characterised by confusion, involuntary eye movement, eye muscle paralysis, and unsteady and clumsy limb movements); Korsakoff's psychosis (severe memory loss, inability to remember new things, invented memories, apathy and lack of insight); Marchiafava-Bignami disease (progressive damage and death to the corpus collosum connecting the left and right brain hemispheres); and alcoholic dementia (O'Connor, 2008).

Women are more vulnerable to brain damage from addiction to alcohol and other drugs than men (Raistrick et al., 2006). Young people's heavy drinking does more harm to their bodies than adult heavy drinking. Evidence is increasing that heavy drinking in adolescence results in permanent brain damage (OPMSAC, 2011).

The number of women hospitalised for alcoholic psychosis increased significantly between 1996 and 2011 (Huckle et al., 2013).

10.7 Infectious disease

Heavy drinking significantly speeds the progression of liver disease and reduces the effectiveness of treatments for hepatitis C (Harris, 2010).

10.7.1 Tuberculosis

Alcohol is a cause of pulmonary and other respiratory tuberculosis (TB) and is also linked with a worsening of the condition. Heavy drinkers have about three times the risk of developing TB (Rehm et al., 2010). There were 150 notifications of TB in women in New Zealand in 2010 (Bissielo et al., 2011). Connor and colleagues (2013) estimated that in 2004, 19% of tuberculosis in women aged 15 to 29 was due to alcohol, causing the loss of 13 DALYs. In 2007 it was estimated to cause 32% of tuberculosis deaths in Māori women aged 15 to 29 and 19% of those in tauwiwi women in the same age group.

10.7.2 Pneumonia

Community-acquired pneumonia (CAP) is one result of damage to the immune system from heavy drinking. About five drinks a day increased the risk of developing CAP by 130%, and alcoholics had eight times the risk of contracting CAP (Rehm et al., 2010). Connor and colleagues (2013) estimated that in 2004, alcohol caused 9% of lower respiratory infections, resulting in the loss of 19 DALYs. In 2007 it was estimated to cause 10% of pneumonia deaths in tauwiwi women aged 15 to 29 and 14% of those in Māori women of the same age group. This was estimated to cause the deaths of two tauwiwi and one Māori woman in 2007.

10.7.3 Sexually transmitted infections (STIs)

Drinking was associated with reduced use of condoms in some studies, which increased the risk of Chlamydia and other STIs (Johnston, 2011; Fergusson & Boden, 2011; Nolen-Hoeksema, 2004), including among underage sex workers (Saphira & Glover, 2004). This was likely to be a factor in the doubling of herpes risk among 32-year-olds who first started drinking before 15 (Odgers et al., 2008); there was no analysis by gender. Alcohol was consistently raised in focus groups as a reason for the high rates of STIs in Aotearoa (Braun, 2008).

Alcohol also raises blood sugar levels, making women more likely to develop Candida infections (Warren et al., 1989).

People treated for STIs have had significantly higher rates of alcohol use, alcohol problems and alcohol abuse or dependence in case-controlled and clinical studies (Boden et al., 2011).

Australian young women who binge drank regularly were more likely than moderate drinkers ever to have had an STI (Jonas et al., 2000). Young African-American women who drank on an average of four days a month were more likely than non-drinkers to have an STI (Seth et al., 2011).

10.8 Other sexual and reproductive problems

Results about alcohol and fertility were inconsistent; some studies showed that having fewer than five drinks a week could diminish fertility (eg, Jensen et al., 1998), while others found no effect from alcohol on ovulation disorders (eg, Chavarro et al., 2009). Heavy drinking was associated with miscarriage and spontaneous abortion (McCaul & Furst, 1995). Women with alcohol use disorders were more likely to experience sexual dysfunction, disrupted menstrual cycles and early menopause (Poole & Dell, 2005; Nolen-Hoeksema, 2004).

10.8.1 Risky sexual behaviour

Aotearoa

See also section 11.3.2: *Sexual harassment, abuse and assault.*

In an early study, 20% of Dunedin women said that being 'a bit drunk at the time' was the main or one reason for first having sexual intercourse (Dickson et al., 1998, p. 31). Women for whom it was also their partner's first time were less likely to have been influenced by drinking (9%).

Drinking and other drug use was also the first reason given by participants in 15 focus groups for people having unprotected rather than safe sex (Braun, 2008).

Estimates of the prevalence of alcohol-related unprotected sex were highest in university students; they ranged from:

- 5% among female university students in the last four weeks (Connor, 2010; Kypri et al., 2009b);
 - 10-11% among female university students in the last three months (Cashell-Smith et al., 2007; McGee & Kypri, 2004);
- to
- 13% of secondary students in the last year (Clark et al., 2013a).

Three percent of female tertiary students had had sex they were unhappy about at the time after drinking during the previous four weeks (Connor, 2010; Kypri et al., 2009b), and 6% in the previous three months (Cashell-Smith et al., 2007; McGee & Kypri, 2004). One percent (Kypri et al., 2009b) and 8% (Connor, 2010) had had sex which they later regretted after drinking in the last four weeks, and around 15% in the last three months (Cashell-Smith et al., 2007; McGee & Kypri, 2004). Five percent of female secondary students had had unwanted sex after drinking (Clark et al., 2013a).

Female university students had a higher risk of alcohol-related risky sex or an unwanted approach if they agreed that drinking gave them confidence to approach people they were attracted to (30%), that drinking reduced their inhibitions (29%), and that drinking makes sex better (5%) (Cashell-Smith et al., 2007).

Women in alcohol treatment have reported previous risky sexual behaviour as payment for alcohol and other drugs they could not afford (Kiepek, 2008).

Niue women in a qualitative study reported unwanted pregnancy, unsafe sex and vulnerability to rape or sexual abuse among the negative effects of heavy drinking (Gray & Nosa, 2009). One woman in a Samoan study said that it was commonly assumed that 'as soon as you drink you're easy' (Lima, 2004, p. 322).

Young African-American women who drank on an average of four days a month were more likely than non-drinkers to have multiple male sexual partners, to have a risky male sexual partner, and never to use condoms with casual male sexual partners (Seth et al., 2011).

UK

A qualitative study found that the most commonly mentioned negative result of binge drinking by 14 to 17-year-olds was a sexual experience they later regretted; this ranged from having sex with someone embarrassing to having unprotected sex. Women were the only ones to report damage to their reputations from these experiences (Coleman & Cater, 2005).

10.8.2 Unplanned pregnancies

Policy makers usually count unplanned pregnancies as problems, but communities, whānau and the women concerned may not – unplanned may not mean unwanted.

Heavy drinking increased the likelihood of sexual risk-taking, which in turn was related to higher rates of unplanned pregnancies and abortions (Fergusson & Boden, 2011; Nolen-Hoeksema, 2004).

Girls who were drinking at 15 or younger had more than three times the likelihood of pregnancy before the age of 21 (Odgers et al., 2008). Twenty-seven percent of women in a Dunedin cohort had had at least one unwanted pregnancy by the age of

25 (Dickson et al., 2002, p. 156), and alcohol was the second most common reason. One in five said they were 'a bit drunk', 18% that their partners were drunk, 12% that both of them had been drinking and 31% that either or both had been drinking.

10.9 Cancers

In 2007, a World Health Organization working group of 26 scientists from 15 countries confirmed that alcohol is carcinogenic to humans (Baan et al., 2007). Smoking and drinking synergistically multiply women's risk of cancer (Baan et al., 2007).

10.9.1 Breast cancer

Breast cancer is the second most common cancer affecting women, and the more alcohol a woman drinks, the higher is her risk (Babor et al., 2010). Drinking about 50g of alcohol a day (5 glasses of wine or cans of beer) increases a woman's risk by 50% over that of a non-drinker (Baan et al., 2007); each additional 10g of alcohol per day (a glass of wine or can of beer) increases the risk by 10%, with no known safe threshold (Chen et al., 2011). Women's with a higher cumulative average alcohol intake between their first period and their first pregnancy had a higher risk of later breast cancer; the risk increased for women whose first pregnancy was more than 10 years after their first period (Liu et al., 2013).

The more alcohol a woman drinks, the higher is her risk of breast cancer – there is no known safe threshold.

In 2004, alcohol was estimated to cause 13 to 15% cases of breast cancer in women, leading to the loss of 1,174 disability-adjusted life years (Connor et al., 2013). In 2009, 2,759 cases of women's breast cancer were provisionally registered. If all the registered women went to hospital for treatment, an AAF of 15% would equate to 414 women hospitalised in that year for breast cancer due to alcohol.

In 2007, an estimated 1,374 years of life lost (YLL) due to cancer were attributed to alcohol – 34% of the total. Breast cancer deaths are distributed unequally among women in Aotearoa. In the same year, Connor and colleagues estimated that 19%

of breast cancer deaths in Māori women aged 15 to 29 and 14% in non-Māori women of the same age range were caused by alcohol, resulting in the deaths of 60 tauwiwi and 12 Māori women that year.

Age-standardised breast cancer death rates in 2005 were 202 per 100,000 Māori women, 158 for Pacific women, and 109 for non-Māori, non-Pacific women (MOH, 2009b). Between 1996 and 1999, death rates among non-Māori, non-Pacific women were 68% lower than Māori rates (Sarfati et al., 2006).

There is some evidence that lesbians may have a higher risk of breast cancer than heterosexual women, related to higher rates of drinking and a lower likelihood of having children (ILGA, 2011).

10.9.2 Other cancers

The Cancer Council Australia concluded that any drinking increases a person's risk of alcohol-related cancer; again, the more one drinks, the higher the risk. Both the council and the Cancer Society of NZ recommend that people limit their drinking or avoid alcohol completely to reduce their risk of cancer (Winstanley et al., 2011; Cancer Society of NZ, 2012).

Drinking five glasses of wine a day increased the risk of cancers of the pharynx, mouth and throat by up to three times, compared with non-drinkers (Baan et al., 2007). Connor and colleagues (2013) estimated that 25 to 37% of mouth and oropharyngeal cancer and 16 to 22% of oesophagus cancer in women in 2004 was caused by alcohol. This resulted in the loss of 155 disability-adjusted life years in 2004. In 2007, the deaths of five tauwiwi women in 2007 from oesophageal cancer, as well as six tauwiwi women from mouth and oropharyngeal cancer, and one tauwiwi woman from laryngeal cancer were estimated to be alcohol-related.

Connor and colleagues also estimated that 5 to 7% of colon cancer, 7 to 8% of rectal cancer and 11 to 12% of liver cancer in women was alcohol related. In 2004, this resulted in the loss of 198 disability-adjusted life years to colon cancer, 108 to rectal cancer and 45 to liver cancer. In 2007 this was estimated to have caused the deaths of 17 tauwiwi women and two Māori women from colon cancer; eight tauwiwi women from rectal cancer; four tauwiwi women and one Māori woman from liver cancer (Ibid.). Alcohol also contributes to cancer of the bile ducts (Connor et al., 2005a)

10.10 Cardiovascular disease

Alcohol contributes to a range of heart and circulation problems. In 2004, an estimated 21% of hypertensive heart disease and 19% of ischaemic heart disease in women aged 15 to 29 was caused by alcohol. This resulted in the loss of 276 disability-

adjusted life years from haemorrhagic stroke, 23 from hypertensive and 60 from ischaemic heart disease. In 2007, alcohol was estimated to have caused the deaths of 25 tauwi women and four Māori women from haemorrhagic stroke, as well as one tauwi woman each from hypertensive heart disease and cardiac arrhythmia (Connor et al., 2013).

High alcohol intake was linked to high blood pressure in a kaupapa Māori analysis (Bramley et al., 2006). The link was U-shaped for Māori and tauwi women, with light to moderate drinkers having lower blood pressure than non-drinkers and heavy drinkers. This summary of five New Zealand studies found similar links between alcohol and four heart health risk factors – blood lipid levels, diabetes, blood sugar levels and obesity – for Māori and tauwi. For tauwi, increases in the amount drunk were linked with higher blood pressure, while for Māori the pattern was variable.

Heavy binge drinking is related to ischaemic heart disease, in which fatty deposits in the walls of arteries to the heart restrict oxygen and lead to heart attacks. Connor (2013) estimated that this caused 10 deaths among Māori women in 2007, but that moderate drinking prevented 25 deaths from this condition in tauwi women.

Among younger women and those without heart disease risk factors, having more than two drinks a day was linked with a significantly increased risk of heart disease, including cardiomyopathy, dysrhythmia and hypertension (Nolen-Hoeksema, 2004).

10.11 *Gastrointestinal conditions*

10.11.1 **Liver cirrhosis**

Female drinkers were likely to get liver diseases such as cirrhosis and hepatitis quicker than male drinkers and from a smaller number of daily drinks (Raistrick et al., 2006; Poole & Dell, 2005). Alcohol had a stronger impact on death than illness from liver cirrhosis (Rehm et al., 2010).

In 2004, alcohol was estimated to cause 62 to 64% of liver cirrhosis, resulting in the loss of 412 DALYs in New Zealand women. In 2007, 22 tauwi and four Māori women were estimated to have died from alcoholic liver cirrhosis, in addition to those who went on to get liver cancer (Connor et al., 2013). The prevalence of chronic liver disease, much of which was caused by heavy drinking, was significantly higher among Tongan women than all Pacific women living in Auckland (Jackson & Minster, 2012). The number of women admitted to hospital with alcoholic liver cirrhosis significantly increased between 1996 and 2011 (Huckle et al., 2013).

10.11.2 **Other gastro-intestinal conditions**

There was a significant increase in hospital admissions for women with alcoholic gastritis (inflammation of the stomach lining) between 1996 and 2011 (Huckle et al., 2013). In 2007, one tauwi woman was estimated to have died of pancreatitis (inflammation of the gland that releases insulin) due to alcohol (Connor et al., 2013). Alcohol also contributes to diseases of the stomach and duodenum (the beginning of the small intestine) (Connor et al., 2005a).

10.12 *Other conditions*

Alcohol was estimated to cause 16 to 21% of epilepsy in women in 2004, resulting in the loss of 135 DALYs, and the deaths of three tauwi women from this condition in 2007 (Connor et al., 2013); alcohol also contributes to enlarged veins in the swallowing tube (oesophageal varices).

Alcohol has been described as a trigger for psoriasis (Rehm et al., 2010); again, the heavier the drinking, the higher the risk. Alcoholics have twice to 10 times the rate of psoriasis as the general population, although heavy drinking could also be a response to the disease.

Drinking during adolescence and early adulthood can dramatically affect the health of bones and may increase women's risk of osteoporosis (Poole & Dell, 2005).

Cognitive decline and earlier death are related to heavy drinking after 65 (Towers et al., 2011). This could affect a significant proportion of older women, particularly well-off Pākehā women.

SUMMARY – HEALTH PROBLEMS FROM ALCOHOL

Alcohol-related problems affect Māori women much more than tauwiwi; Māori women's rate of years of life lost to alcohol is 2.7 times that of tauwiwi women.

Alcohol-related Injuries caused 30% of years of life lost to Māori women and 15% for tauwiwi women in 2007. Binge drinking is most risky – it doubles women's immediate risk of unintentional and traffic injuries.

Alcohol was involved in one in three traffic crash injuries to Māori and one in four for tauwiwi women, although this is likely to be an undercount. In 2009 women made up almost one in three alcohol-affected drivers in traffic crashes, although this is increasing.

Alcohol use by violent partners was linked to more frequent and severe violence and injury for women, and more than half of women killed by their partners.

After the minimum purchase age dropped from 20 to 18 in 1999, alcohol-related hospitalisations, emergency department presentations and alcohol-related traffic accidents increased among 15 to 19-year-old young women. Most of those aged 12 to 14 admitted to hospital for alcohol poisoning in 2002 were girls. This is a continuing concern.

Five in every 100 babies were estimated to be affected by Fetal Alcohol Spectrum Disorder (FASD). New Zealand has no standardised routine screening, systematic intervention or support programmes, and the lifetime consequences are serious.

Previous national FASD prevention campaigns have portrayed the pregnant woman as under surveillance and solely responsible for any risks to the fetus. This is similar to overseas campaigns which blame the pregnant woman and ignore the contribution of their partners, families, and the wider environment, including alcohol marketing and policy.

Alcohol is carcinogenic. Each 10g of alcohol a day on average increases a woman's breast cancer risk by 10%. Alcohol was estimated to cause one in seven cases of breast cancer in 2004, to have killed 72 women in 2007, and hospitalised more than 400 in 2009. Alcohol also contributes to a range of other cancers.

Women who drink heavily have a higher risk of fire injury or death, and of alcohol-related self-harm and suicide attempts. Women are 13 times more likely to injure themselves in a fall after three drinks than non-drinking women.

At least 3% of women are addicted to (dependent on) alcohol and 7% abuse alcohol at some time in their lives. Illness, disability or early death from these alcohol disorders caused half of all the healthy years of life that all women lose due to alcohol. In women aged 15 to 29, depression was the fourth-highest cause of years of disability due to alcohol in 2004.

Rates of alcohol disorders are higher among Māori, Pacific and young women, and women with low incomes or living in poor neighbourhoods. Multi-drug use is common among dependent women; they are twice as likely to die as alcohol-dependent men of the same age. Many alcohol-dependent women are also depressed. Alcohol disorders are likely to increase significantly among older women in the next decade. Women's hospitalisations for two alcohol-caused conditions, alcoholic psychosis and gastritis, significantly increased between 1996 and 2011.

After drinking, up to 11% of female tertiary students had had unprotected sex in the last three months, and 16% of secondary school students in the previous year. This increases their risk of sexually-transmitted infections and unplanned pregnancies.

Heavy drinking also contributes to a range of heart and circulation problems.

11. Alcohol-related social problems

11.1 General

This section reports general and less serious problems. Specific and more serious damage is reported in later sections.

11.1.1 Problems from another person's drinking

Much of the research about damage from alcohol focused on drinkers' health problems, usually through the analysis of routinely-collected health system data (Room et al., 2010). Health and social harm caused by alcohol to those other than the drinker is 'often only fitfully recorded' by these and other systems (Ibid., p. 1857). Population surveys on alcohol problems tend to concentrate on less severe problems, and data by response institutions such as police on more severe problems. Both are necessary for a full picture; this is still being developed, so the problems below are likely to be a conservative list.

The World Health Organization concluded that although men in developing societies drink more, women disproportionately bear the consequences, through male violence, the impact on family finances and other factors (Room et al., 2002). Connor and Casswell (2012) found that in 2006-07 women reported more problems than men did from other people's drinking, and that the problems from others' drinking was higher than harm from women's own drinking.

In a survey of the general population in New Zealand in 2008-9, women were significantly more likely to report having a heavy drinker in their lives (31%) or problems from someone else's drinking (23%) than men, and the heavy drinkers were more likely to be in the women's household or a close relative outside the household (Casswell et al., 2011a). Māori women were almost 50% more likely to have problems from someone else's drinking (MOH, 2009a).

People with a heavy drinker in their lives had wellbeing scores about 4% lower on average. Those most exposed to heavy drinkers had average health status score about 16% lower than those who knew no heavy drinkers. This reduction in health status is similar to that found in carers of people in poor health from Parkinson's disease (Casswell et al., 2011b).

The most common problems caused by these heavy drinkers in the previous year included:

- The drinker failing to do something the woman was counting on (57%)
- Emotional hurt or neglect (51%)
- A serious argument (51%)
- The drinker showing little interest (47%)
- Having to clean up after the drinker (38%).

Five percent of children in these households had been left unsupervised or unsafe as a result of this person's drinking.

Women who had been affected by a stranger's heavy drinking reported:

- Being annoyed by vomit, urination or littering (59%)
- Being kept awake or disturbed at night (51%)
- Avoiding drunk people or places (27%)
- Feeling unsafe in a public place (21%) or while waiting for public transport (18%) (Casswell et al., 2011a).

Almost three in four of the 3,972 people who rang the Alcohol Drug Helpline about a woman's drinking from 2010 to 2012 were worried about social issues such as problems with families and relationships, legal, financial or job issues, according to Peter Cornes of ADANZ (Personal communication, 13 December, 2012).

Children brought up in families living in hardship and distress due to heavy drinking often lack the repeated positive sensory experiences that are needed to develop healthy brains. Many go on to need support at school and from the justice and health systems (BTA, 2010).

11.1.2 Problems from their own drinking

In 2007, 30% of women aged 18 and over said they had had problems from their own drinking (Meiklejohn et al., 2012). A higher density of alcohol outlets within 1km of home, particularly clubs and off-licenses, was linked with more problems from women's own drinking (Connor et al., 2010).

Those most exposed to heavy drinkers had average health status scores 16 percent lower than those who knew none.

One in four female university students reported an emotional outburst and 12% a heated argument as a result of their drinking in the last four weeks (Kypri et al., 2009b).

Two out of three of the 14,652 women who rang the Alcohol Drug Helpline about their own drinking from 2010 to 2012 were concerned about social problems; the four most common topics were job issues, family or relationship problems, financial issues and legal problems, according to Peter Cornes of ADANZ (Personal communication, 13 December, 2012).

Pacific women reported a range of problems in the last 12 months (Huakau et al., 2005):

- Unable to remember what they had done while drinking (27%)
- Been drunk when there was a reason to stay sober (16%)
- Ashamed of what they had done while drinking (24%)
- Had a physical fight because of their drinking (11%)
- Stayed drunk for several days (8%)
- Had a drink first thing in the morning (7%)
- Their hands shook a lot in the morning after drinking (6%).

Women university students said they would 'usually' stop their drinking when

- They started to feel like vomiting (76%)
- They vomited (71%)
- They knew they were very drunk or wasted (70%)
- They felt very tired and wanted to sleep (69%)
- Their head or the room started spinning (61%)
- They started to feel unable to walk (61%)
- They started to feel unable to talk properly (51%) (McEwan et al., 2011).

Two other drinking effects that students used to monitor their drunkenness were not significantly different by gender: when the night is no fun, and when friends told them to stop drinking (Ibid).

11.2 Worsening social and health inequities

11.2.1 Aotearoa

Alcohol dependence has a close link with social and economic disadvantage (Wilkinson & Marmot, 2003). The NZ Law Commission (2010, p. 148) said that alcohol-related damage may now be 'actively *driving* inequalities'.

The 1999 drop in purchasing age was expected to increase health disparities, because of the relative youth of the Māori population. The disparity between Māori and tauwiwi life expectancy attributable to alcohol was also expected to increase if alcohol policies remained unchanged (Kypri, 2003). Māori were four times more likely than tauwiwi to die of conditions attributable to alcohol (ALAC, 2009), worsening existing health inequalities.

Drinking alcohol many times before the ages of 15 was linked with failure to achieve educational qualifications, substance dependence and criminal convictions at age 32 (Odgers et al., 2008), and early abuse of AOD increased the risk. There was no analysis by gender.

Poor drinkers had less money to reduce risks from alcohol, for example by calling a taxi or going to the doctor if they were sick. One of the most harmful drinking patterns, binge drinking, is more affordable than regular drinking (Room, 2004). The higher density of bars and off-licences in poorer communities may increase deprivation and widen the social and health gap (Hay et al., 2009).

Addiction to alcohol contributes to impoverishment. Nineteen percent of women affected by a heavy drinker had been left without enough money for the things they needed, and 6% had gone without food (Casswell et al., 2011a). Four percent reported that they had been left without enough money for the needs of children in their household.

11.2.2 International

The lower a person's socio-economic status in their country, the higher was their burden of alcohol-attributable disease per litre (WHO, 2011b). Alcohol increased existing inequities in death and illness rates between richer and poorer people.

The World Health Organization concluded that attempts to prevent or deal with alcohol problems will be less effective as long as the social inequities that 'breed drug use are left unchanged' (Wilkinson & Marmot, 2003, p. 25).

In Finland, women with a basic education had more than four times the rate of alcohol-related death of those with upper tertiary education. Unskilled working women had more than twice the death rate of women in upper white-collar jobs

(Herttua et al., 2008). In all of Europe, 6% of the inequality in mortality among women of different socio-economic status was accounted for by alcohol-related deaths (Mackenbach et al., 2008, cited in WHO, 2011b).

11.3 Violence against women and children

This section largely discusses research about the relationship of alcohol to violence against women. Research about injuries and deaths from violence recorded by health and justice systems are largely discussed in section 10.3: Injuries.

11.3.1 General

Violence has a major impact on the lives of women from all population groups. Some studies described alcohol as a contributing cause of violence (Heise, 2011; Babor et al., 2010), although some (eg, Boden et al., 2012) used contested methodology (see section 11.4: Violence by women). Most studies about violence against women concluded that alcohol was not a necessary or sufficient cause of this violence, but was a factor in how often it happened and how severe it was.

New Zealand men were more than twice as likely to experience an alcohol-related physical assault as women, overwhelmingly from other men (Connor et al., 2009; MOH, 2009a). However, men were more likely to be assaulted outside their home, for example in the street or around bars, whereas women were more likely to be assaulted at home by their partners or people close to them (MOJ, 2010; Leonard et al., 2002; Langley et al., 1996).

There was a consistent link between alcohol outlet density and reported violent crime, including assault, rape and murder (Zhu et al., 2004; Gruenewald et al., 2006). Two studies found a link between outlet density and rates of domestic violence over time, which was particularly strong for off-license liquor stores (Livingston, 2011; Cunradi et al., 2011).

While there is less research on the impact of opening hours, one review found a consistent link between extended late-night opening hours of pubs, bars and nightclubs and assault, among other problems (Stockwell & Chikritzhs, 2009).

Alcohol was involved in 39% of incidents of assaults and threats reported in a national survey in 2009; in 23% both parties had been drinking beforehand, and in 16% only the offender (MOJ, 2010). This was not analysed by gender.

Rates of alcohol-related assault vary widely in different populations of women.

Young women had higher rates. Five percent of all women said they had been physically assaulted due to someone else's drinking in the last year. Māori and women living in deprived areas were significantly more likely to report this than other women (MOH, 2007, 2009a). Among Pacific women in another survey, the proportion was 10% (Huakau et al., 2005).

The odds of teenage women being assaulted in the last year increased with the amount they usually drank (Clark et al., 2009), ranging from 26% among non-drinking secondary students; 32% among moderate drinkers and 43% among those who had five or more drinks in one session.

Of those women who had been affected by a stranger's heavy drinking, 3% said they had been physically hurt in the last year, 15% had been threatened and 24% had been verbally abused (Casswell et al., 2011a).

Overseas studies have found a link between alcohol use by paid carers and abuse of their elderly clients, predominantly psychological and verbal abuse and neglect (Rabold & Gorgen, 2007; Choi & Mayer, 2000).

Violence was considered by to be a major alcohol-related problem by a random sample of residents in Dunedin, Wellington, Palmerston North and Hamilton surveyed in 2007 (Maclennan et al., 2012). More assaults and disorder were linked with pubs and bars than licensed restaurants (Hay et al., 2009).

Alcohol is not a necessary or sufficient cause of violence against women, but affects how frequent and severe it is.

11.3.2 Sexual harassment, abuse and assault

Aotearoa

See also section 10.8.1: Risky sexual behaviour.

Sexual harassment

Sexual harassment due to someone else's drinking in the last year was relatively common among young women and less common for older women. Prevalence in the previous 12 months ranged from 9% for all women, with Māori more affected than tauīwi (MOH, 2007); 10% for Pacific women in 2003 (Huakau et al., 2005); 18% for all women from a stranger who had

been drinking (Casswell et al., 2011a); to 19% for all women under 30 (Habgood et al., 2001). One in three (34%) of University of Otago students reported being sexually harassed in the previous three months (Cashell-Smith et al., 2007).

Sex which is unhappy or unwanted because of drinking was common for university students and linked with heavier drinking, earlier binge drinking at high school and starting drinking early in adolescence (Connor, 2010; Kypri et al., 2009b; Cashell-Smith et al., 2007; McGee & Kypri, 2004). In two surveys one in five and one in three university students had received unwanted sexual advances due to someone else's drinking in the previous four weeks, and this was significantly linked with their own level of drinking (Connor, 2010; Cashell-Smith et al., 2007).

Sexual abuse and assault of adult women

At least one in five women experienced sexual abuse or assault in their lives (Morris & Reilly, 2003). In 2004, women were three times more likely to be sexually assaulted by someone who had been drinking than men (Connor et al., 2009). Compared with non-drinkers, Connor's team found that victims who drank more than six drinks in a typical session and those who drank at least once a week had a higher risk of sexual assault. Those who drank that amount at least every second day had a higher risk of physical assault. These results were not analysed by gender.

Alcohol-related unwanted or forced sex also impacted more on young women. Among alternative education students, 37% reported unwanted sex after drinking in the last 12 months, although this was not analysed by gender (Clark et al., 2010). Female University of Otago students reported similar rates of alcohol-related unwanted sex during the last four weeks (6%; Cashell-Smith et al., 2007) as female secondary students did for the previous 12 months (5.4%; Clark et al., 2013a).

Two percent of women aged 12 to 80 in a representative survey had been forced into doing something sexual by the heavy drinker in their lives who most negatively affected them (Casswell et al., 2011a). These drinkers were almost all family or household members or friends. Two percent of those affected by a stranger's heavy drinking had also been forced into sex.

Half of all perpetrators and victims had been drinking before reported sexual assaults (Russell, 2008). Alcohol is the most common drug used to enable sexual assault. However, the media concept of drug and alcohol-assisted sexual violence (DASV) does not include a woman's voluntary drinking and police data systems also do not enable DASV to be identified. Thirty DASV cases were reported in four months in 2002, but the number may be far higher.

The West Auckland young men who described themselves online as 'roast busters' from 2011 to 2013 boasted in videos of gang-raping young women. When asked on ask.fm how they did this, they said: 'just got her drunk' (Gavey, 2013).

Participants from four Pacific ethnicities identified alcohol and drug use as a risk factor for sexual violence in a focus group prevention study (Percival et al., 2010).

A review of 61 rape trial sentencing notes found that in 50 cases the offender had been drinking or was suspected of drinking; 30 abused alcohol, and 37 survivors had been drinking. In seven of these cases, the victims were teenage girls and the offender had supplied the alcohol (Russell, 2008).

Women who were drunk before they were raped were perceived as less believable, more at fault and more responsible for what happened (Russell, 2008). Her alcohol or other drug use could lead to a lower likelihood of reporting the rape to the police, insufficient evidence for a trial due to the effect on her memory, early withdrawal of legal cases, and a lower chance of conviction. Male offenders who were drunk before the rape were seen as less blameworthy in contrast to a sober man, who was seen as taking advantage of a drunk woman.

Sexual abuse of children

Parental alcohol problems increased children's risk of sexual abuse (Wouldes et al., 2011; Harold, 2011).

International

Much of the international research focused on the small proportion of coerced or unwanted sex that is reported to police. Heavy drinking was likely to be a context for male sexual assault against women (Obot & Room, 2005). Twenty percent of US college students reported having had sex when they were so affected by alcohol or other drugs that they were unable to consent (Kalof, 2000). This form of sexual assault was three times more common among these women than rape or attempted rape using force (Testa & Livingston, 2009).

Between 52 to 58% of men convicted of sexual assault and rape had been drinking before the offence, and another 12% were also taking drugs (Russell, 2008; IAS, 2008). Men who drank heavily reported more assaults and being more sexually violent (Abbey et al., 2001).

Drinking by either or both parties was implicated in between 40 and 65% of reported rapes, although many of the studies were limited to US college campuses (Robertson, 2008). Reported sexual assaults involving alcohol were more likely to occur in public places, by perpetrators who were less well-known to the victim, and physical injuries were often more severe than those where no one had been drinking (Bedard-Gilligan et al., 2011; Connor et al., 2009).

The perpetrator's drinking, his beliefs about women and propensity to sexual violence were the most influential factors in alcohol-related sexual assault (Abbey et al., 2001; Ullman, 2003). Women who drank once or twice a week, or who drank six or more drinks in a session, had a much higher risk of sexual victimisation (Ullman, 2003). One US study of college women found that women who were sexually assaulted had three times the binge drinking days of those who were not (Combs-Lane & Smith, 2002).

In the USA, women whose sexual assaults involved threats to their life had a higher risk of alcohol-related hospitalisations (Ullman & Najdowski, 2010).

Victims of alcohol-involved sexual assaults had higher rates of self-blame (Testa & Livingston, 2009), and women who blamed themselves for sexual assaults had a higher likelihood of later alcohol-related hospitalisation and arrest (Ullman & Najdowski, 2010).

11.3.3 Violence by family members

Aotearoa

Against adult women

Male violence towards female partners is common in Aotearoa. Fifty-three percent of Māori women in Auckland and Waikato reported physical violence from a partner; 31% of Pacific women; 30% of Pākehā/other women and 10% of 'Asian' women (Fanslow et al., 2010). More than one in three men in an early survey said they had been physically violent to a partner in their lives, and half had been psychologically abusive in the last year (Leibrich et al., 1995).

Heavy drinking by violent male partners was linked with an escalation of their verbal and physical abuse and more serious injury to the woman (Connor et al., 2011; Brown, 2011). Additional off-licences also correlated with increases in family violence reports to police (Cameron, 2010). Men were more likely to assault a partner while drunk than women (Shine/Te Kakano Tumanako, 2011).

Women were also at higher risk of partner rape when their male partner was a heavy user of alcohol, drugs and pornography (McPhillips et al., 2002).

Those who binge drank at least monthly were twice as likely to be an aggressor to their partner and three times as likely to be a victim of partner aggression compared to non-binge drinkers (Connor et al., 2011). This was not analysed by gender.

Between 2005 and 2008, one in three alleged perpetrators had been drinking in incidents where family violence was the most serious offence recorded by police (Stevenson, 2009). In 2007–8, alcohol was a factor for 16% of the victims in these incidents. However, in 40% of incidents the involvement of alcohol was unknown. In the far north, 36% of family violence-related offences were alcohol related (Evaluation Solutions, 2010a).

The prevalence of alcohol-related violence varied by ethnicity. Māori women were 'almost four times more likely than tauwiwi women to have been assaulted in the past year by someone under the influence of alcohol or drugs' (MOH, 2009a, p. 190). In the NZ Crime and Safety Survey, in violent incidents by a partner or other well-known person, 'significantly more Māori victims said the offender was affected by alcohol (59%) or drugs (45%) than did European victims (35% and 22% respectively)' (Cunningham et al., 2009).

The Pacific Island Families Study found that being a victim and a perpetrator of intimate partner violence (IPV) was significantly linked with drinking alcohol since the birth of the child (Paterson et al., 2007). For 56% of mothers who had experienced any IPV, it was linked with problem drinking by at least one partner; for 31% with only the mother's drinking; and for 21% with only the father's drinking (Schluter et al., 2008).

There is very little research about partner violence in same-sex relationships in Aotearoa. Drinking has been linked with domestic violence between female partners (Pega & MacEwan, 2010).

Eight percent of women and 6% of children in a representative survey said they had been physically hurt by a heavy drinker in their lives (Casswell et al., 2011a); 30% of the women felt threatened or scared by the drinker. Six percent of the children had witnessed serious violence in their home and 13% had been verbally abused by the heavy drinker. Two out of three of these drinkers were partners, household members or relatives.

International

Density of alcohol outlets in the USA had an impact on partner violence – an increase of 10 outlets per 10,000 people increased male-to-female partner violence by 34% (McKinney et al., 2009).

Heavy drinking was often a household context for these attacks (Graham et al., 2011; Obot & Room, 2005); in Australia alcohol was estimated to be involved in half of all partner violence and 73% of physical assaults by partners (Laslett et al., 2010).

Drinking by abusers was associated with the frequency and severity of their attacks (Braaf, 2012). US abusers who had been drinking that day were 11 times more likely to attack their partners than if they had not (Fals-Stewart, 2003), and male college students were seven times more likely to be psychologically aggressive to female partners (Moore et al., 2011). Drunkenness, rather than moderate drinking, was important in the escalation of abuse (Wells & Graham, 2003). Alcohol-related attacks are more serious and deadly on average than those without alcohol involvement (Graham et al., 2011; Testa et al., 2003).

Meta-analyses generally found that a more moderate link between alcohol and violence than these studies. One meta-analysis found a small to moderate link between alcohol use and male-to-female partner violence overall, with a stronger link to aggression in clinical samples and those with severe alcohol problems (Foran & O'Leary, 2008, of 50 studies). Another assessing 11 studies concluded that the evidence linking men's drinking to intimate partner violence was weak; studies with the smallest samples had the biggest odds ratios (Gil-González et al., 2006). The authors concluded that there was not enough evidence to support preventive policies based on male drinking as a risk factor in partner violence, and called for more case-control and cohort studies. One 2004 meta-analysis of 94 studies found that alcohol was a moderate risk factor in intimate partner violence (IPV), less influential than illicit drug use and attitudes condoning violence (Stitha et al., 2004).

Half of abusers in US anti-violence programmes had substance abuse problems. Seventy-four percent of women asking for refuge housing in Washington State had alcohol and other drug problems (Mackness, 2008). Some women reported deliberately not drinking to retain as much control as possible in potentially dangerous domestic situations (Testa et al., 2003).

Women who were drinking heavily and being abused in a relationship were less likely to be able or to want help from police or social services (Thompson & Kingree, 2006).

Substance abuse is also estimated to be a factor in 80% of US child maltreatment cases (Mardani, 2010).

11.4 Violence by women

Some researchers using the disputed Conflict Tactics Scale (CTS) found that women were as violent as men (eg, Boden et al., 2012; Fergusson et al., 2005a). However, this scale was developed to count tactics used by couples in resolving conflict and was not designed to identify patterns of coercion and control; as such, it has been described as inappropriate as the sole measure in populations where violence and abuse occurs in relationships (Giles, 2005).

Studies which use the CTS treated violent acts by men as though they were equivalent to those by women. However, the scale measures only individual instances of violence, not its impact, severity, acts of sexual coercion or murder, or the effects of living in fear (White Ribbon, 2012; Paymar & Barnes, 2007; Taft et al., 2001; NZ Law Commission, 2001). It also does not include the use of economic deprivation, intimidation, isolation, and stalking, which are common to male perpetrators and rare among women (Tower, 2007). It is also affected by men and women's persistent tendency to minimise instances of male violence and exaggerate instances of women's (Giles, 2005).

Studies using the CTS and a questionnaire focused on assault with the Dunedin longitudinal cohort on the same day had significantly different results. The CTS-based study found similar proportions of violent acts by gender (Magdol et al., 1997), while the assault study found four times as many assaults by male partners on women than

by female partners on men (Langley et al., 1997). The CTS author said results were 'likely to be used by misogynists and apologists for male violence' (Straus, 1997).

Methodologies that take into account the context, meaning, motivations and impacts of violence have found that most of women's violence towards men was largely in self-defence or retaliatory, and did not control men or make them live in fear (Braaf & Meyering, 2013; NZFVC, 2007; Taft et al., 2001); indeed, some men found women's violence funny (Holtzworth-Munroe, 2005). This review found little research about the impact of alcohol on women's violence, in comparison to the wealth of data about its impact on men's.

The Conflict Tactics Scale study found similar proportions of violent acts by gender, while the assault study found four times as many assaults by male partners on women.

Four and 8% of female tertiary students in two samples said they had been physically aggressive to someone else as a result of their own drinking in the past month (Kypri et al., 2009b). Secondary students showed the same association between increased drinking and violence as cited previously: 21% of female non-drinking secondary students said they hit someone else in the last year, compared with 26% of moderate drinkers and 36% of binge drinkers (Clark et al., 2009).

Every additional symptom of alcohol abuse in a Christchurch sample was linked with a 1.2-fold increase in violent crime, but the link was weaker among women (Fergusson & Horwood, 2000).

The likelihood of serious child abuse by women increased up to eight times if the mother drank hazardously around the time the child was conceived or during the first three months of pregnancy (Duncanson et al., 2009).

In Australia, either the offender or the victim had been drinking in 44% of partner homicides from 2000 to 2006 (Dearden & Payne, 2009). Killings by women of their male partner were three times more likely to have been alcohol related than male killings of their female partner.

In 2006, 9% of 18- to 34-year-olds in the UK said a drunk woman had physically assaulted them, and 4.1% had seen a drunk woman assault someone else (IAS, 2008).

11.5 Other crime

General

Aotearoa

Each additional off-licence in Manukau City in 2008–9 correlated with up to 65 additional police events a year, including anti-social behaviour, alcohol and other drug offences, family violence, property abuse, property damage, traffic offences and vehicle crashes. Each additional club or bar was linked with up to 101 extra events, and each new licensed restaurant or café with up to 29 extra events (Cameron, 2010). These categories were not analysed by gender.

At least one out in three offences recorded by police has been committed by someone who had been drinking beforehand (NZ Police, 2010). Eighteen percent of the police budget is spent on alcohol-related crime, including one in three violent offences, one in two drug and antisocial offences, one in three family violence offences and one in five sexual offences. These categories were also not analysed by gender. The Ministry of Justice (2008) estimated that up to 80% of offenders in court have alcohol and other drug problems.

According to police Alco-Link data, the proportion of women among those who drank alcohol before committing a crime increased from 17% in 2005–6 to 20% in 2012 (Stevenson, 2009; Huckle et al., 2013).

People who drank by the age of 15 were more than five times as likely to have a number of criminal convictions at age 32 (Odgers et al., 2008); again there was no analysis by gender. However, women were significantly less likely to commit alcohol-related crime after drinking than men (Stevenson, 2009).

Twenty-one percent of alcohol-related offenders in the Whangarei police district in 2007–2009 were women (Shetty, 2010); 18% of offenders who drank before committing any kind of crime in 2007–8, and 12.5% of those recorded in the NZ Arrestee Drug Abuse Monitoring (ADAM) programme in 2006–2007 (Hales & Manser, 2007). Half of the latter group were Māori.

The ADAM programme measures AOD use among people apprehended in police watch houses. Most (58%) had been arrested before, and most had also used cannabis (69%). Fifteen percent had been dependent on alcohol during the last 12 months. Thirty-six percent had been drinking and 18% smoking cannabis when they were arrested.

Interestingly, these were lower proportions than a 1991 estimate of the proportion of crime by women due to alcohol (29%) (Devlin et al., 1997).

Of young people screened with the Youth Offender Risk Screening Tool, police identified the drinking of 37% of young Māori women and 19% of young Pākehā women as moderately or severely concerning (Stevenson, 2009).

A random sample of residents in seven New Zealand regions surveyed in 2007 believed that alcohol played a major or leading role in violent crime and family violence (Maclennan et al., 2012).

International

The number of UK women arrested for being drunk and disorderly rose by more than 50% between 2003 and 2007 (IAS, 2008). Assaults by women in Scotland rose 61% in five years, with a 36% rise in serious assaults and attempted murders by women.

11.5.1 Drink driving

Drink driving where injury or death was recorded through the health and justice systems is largely discussed in section 10.3: Injuries.

The number of women caught drink driving increased by 1,700% in the 20 years to 2006, compared with 185% for men.

International research concluded that alcohol impairs driving from very low levels (MOT, 2010b). The driving of the vast majority of drivers was impaired at a blood alcohol concentration (BAC) of 0.05 (50mg of alcohol per 100ml of blood), and significantly impaired at 0.08, the current New Zealand legal limit.

Fewer women than men reported or were convicted of drink driving, but women's apprehensions and convictions were increasing much faster than men's. The number of women caught drink driving increased by 1,700% in the 20 years to 2006, compared with an increase among men of about 185% over the same period (Data supplied by MOJ, 2012; NZPA, 2008).

Huckle and colleagues (2013) also found a significant increase between 1980 and 2008 in prosecutions for all women's drink driving. There was no significant change between 2009-11 except among young women aged 14-17, whose prosecutions significantly decreased. This is likely to be related to the introduction of a zero blood alcohol limit in 2011 for drivers aged under 20.

Prosecutions of Māori women also significantly increased between 2002-2007, and significantly decreased between 2009-11. Prosecutions of Pacific women drivers increased between 2002-07 but showed no change after that.

Over the past 10 years, police reported that the number of women detected drink driving had increased two-and-a-half times as fast as men (Stevenson, 2009). This was consistent with women's drink-driving conviction rates in the USA (Kelley-Baker & Romano, 2010).

In 2007-8, 12,694 females were arrested for drink driving; arrests of Māori women outnumbered those of Māori men. Māori made up 38% of arrested women, with ages spread evenly from 20 to 49, whereas a 'large percentage' of arrested Pākehā women were aged 40 to 49 (Stevenson, 2009, p. 64).

Between 2005 and 2008, 6% of drivers had been apprehended for drink driving more than once a year; and 19% of drink-driving offences were at least the third for that person in 2007-8 (Ibid). This was not analysed by gender.

Between 1990 and 2010, women's convictions for blood alcohol above the legal limit and driving under the influence of alcohol or other substances increased by 263% (from 2,456 to 6,463), while men's increased by 114%. Drug driving convictions amount to 0.01% of offences detected (Jones, 2012b).

Four percent of female university students reported drink driving in the previous four weeks (Kypri et al., 2009b). Three percent of female secondary students with access to cars in 2012 had driven after drinking in the same period (down from 9% in 2007) (Clark et al., 2013a; Ameratunga et al., 2011). Sixteen percent of women in a national survey said they driven under the influence of alcohol in the previous 12 months (MOH, 2009a). Māori women were significantly more likely to say they had done so than all women.

Six percent of female university students in 2005 (Kypri et al., 2009b) and 19% of female secondary school students in 2012 had been driven in the last month by someone who had been drinking; 1% of secondary students had had a car crash in the last year after drinking (Clark et al., 2013a). Nine percent of the university students reported both drink driving and being a passenger.

Eighteen percent of women in a representative survey had felt at risk in a car driven by a heavy drinker in their lives during the last year, and 2% had been injured (Casswell et al., 2011a); of the women affected by a stranger's heavy drinking, 1% had been injured in a car crash.

Four percent of Pacific women had been in a car crash in the previous year as a result of someone else's drinking (Huakau et al., 2005). This was four times the rate found for all women in the 2000 National Alcohol Survey.

Dangerous driving was considered by to be a major alcohol-related problem by a random sample of residents in Dunedin, Wellington, Palmerston North and Hamilton surveyed in 2007 (Maclennan et al., 2012).

Women in California were more likely to drink and drive in areas with a high density of alcohol outlets than men in those areas, and young women were more likely to do so than older women (Treno et al, 2003).

11.5.2 Vandalism

Female students were less likely than males to vandalise property because of their drinking; 2% of women from six university campuses in 2005 had done so in the past four weeks (Kypri et al., 2009b) and 3% of Otago female students had done so in the past three months in 2002 (McGee & Kypri, 2004).

Thirteen percent of women in a representative sample who had experienced harm from a heavy drinking stranger reported damage done to their house, car or property (Casswell et al., 2011a).

Vandalism was considered to be a major alcohol-related problem by a random sample of residents in Alexandra, Dunedin, Wellington, Palmerston North and Hamilton surveyed in 2007 (MacLennan et al., 2012).

11.5.3 Other crime

In 2002, 9% of University of Otago female students said they had stolen public or private property because of their drinking in the last three months (McGee & Kypri, 2004); in 2005, 5% of women from six university campuses had done so during the last month (Kypri et al., 2009b). Twelve percent of female secondary students in 2012 said they had done things, such as stealing, that could have got them into serious trouble after they had been drinking during the previous year, down from 15% in 2007 (Clark et al., 2013a; Ameratunga et al., 2011).

11.6 Family problems

Intimate relationships become fragmented and eventually disconnect completely as one partner becomes increasingly dependent on alcohol (Adams, 2010). Male and female partners who drank together had more negative interactions, particularly when the man was aggressive (Nolen-Hoeksema, 2004).

People whose frequency or amount of drinking per session is significantly different from their partner's were less satisfied with the relationship than those whose drinking pattern was similar (Meiklejohn et al., 2012).

Women's family lives (12%) and friendships (20%) were harmed more by other people's drinking than by their own (5% and 6% respectively). Women were more likely than men to report problems in these areas from other people's drinking, and less likely to report problems from their own (MOH, 2009a). Māori women were more likely than all women to report family and friendship problems.

Residents of an Auckland alcohol treatment programme (three women and nine men, all Pākehā) had experienced many family disruptions from their drinking, including losing custody of their children, jobs, relationship breakdowns, physical and psychological abuse, depression and ill health (Schäfer, 2011).

11.7 Financial problems

Women were more likely to have financial problems from other people's drinking than men, and less likely to have them from their own (MOH, 2009a). Five percent of women said their financial position was worse due to other people's drinking, and the same proportion said it was worse due to their own drinking; financial problems were more common among Māori women and those living in deprived areas, regardless of who was drinking.

11.8 Work-related problems

ACC (2008) estimated a high rate of binge drinking among full-time workers (48%), although this was not analysed by gender. Employees with alcohol and other drug problems had a higher risk of injury at work, were more likely to arrive late, take time off, or lose their jobs. Their work colleagues faced a higher risk of injuries and arguments, increased workload and having to cover for their alcohol-impaired workmate (ACC, 2008; Casswell et al., 2011a).

Women in a national survey were significantly less likely to have worked while feeling under the influence of alcohol (9%) than men (17%) (MOH, 2009a), and less than half as likely to have operated machinery under the influence in the last year.

In 2003, 9% of Pacific women had taken time off work because of their drinking during the previous year, three times the proportion of women in a 2000 national survey (Huakau et al., 2005).

Twelve percent of women in another representative survey were less able to do their paid work or had to take time off because of a heavy drinker in their lives (Casswell et al., 2011a). For 3% of women, a co-worker was the heavy drinker who most affected them. Four percent of this group experienced an accident or close call at work.

Wellington Hospital emergency department staff, at least half of whom were female, reported that abusive and aggressive behaviour from intoxicated patients was common in their workplace (Gunasekara et al., 2011). Almost half had experienced verbal abuse and 27% had been physically assaulted by drunken patients, with nurses the most likely to report these behaviours.

Most said they felt threatened by these patients, and almost half said the patients negatively affected staff mood. Staff said intoxicated patients significantly increased their workload, especially on Thursday, Friday and Saturday nights and after major sporting or music events. These patients' drunkenness made it impossible for staff to assess, treat or get consent for treatment; this and staff attitudes impaired their care. Staff also said that drunken patients frequently made other patients feel threatened, unsafe, and more stressed.

11.9 Educational difficulties

Children of alcoholics were more likely to reach a lower educational level than other children (Casswell et al., 2011a). People who were exposed to alcohol at age 13 or 15 were more than twice as likely to have no educational qualifications by age 32 (Ogders et al., 2008). This was not analysed by gender.

In 2006, 107 female students were suspended from public schools for alcohol use (Craig et al., 2008); they were not categorised by ethnicity. However, a total of 77 Māori, 76 Pākehā and 26 Pacific students were suspended.

Six percent of female secondary students in 2012 said their performance at school or work had been affected by their drinking in the last year, down from 9% in 2007 (Clark et al., 2013a; Ameratunga et al., 2011). Eighty percent of students in alternative education said their performance was affected, but there was no gender analysis (Clark et al., 2010).

Missing a class was the most common study problem from their drinking during the last three months for female University of Otago students, reported by 43% in 2002 (McGee & Kypri, 2004). Twenty-two percent had missed classes three or more times. Forty percent said they had been unable to concentrate in class due to their drinking; for 17% this happened three or more times. Twenty-four percent had been late for a class, 8% three or more times. Seven percent had failed to complete an assignment on time at least once because of their drinking.

11.10 Other social costs

Women (1%) were significantly less likely than men (3%) to report legal problems from their own drinking (MOH, 2009a). Māori women were three times more likely to report these problems than all women.

Residents in eight New Zealand cities considered alcohol and other drugs to be the second most visible criminal or anti-social activity over the past year in the Quality of Life Survey, and women (68%) were more likely to consider it a problem (Nielsen, 2011). Women (50%) were more likely than men (33%) to feel unsafe in the centre of their city after dark, and 25% of women cited alcohol and other drug problems as a reason. Forty-one percent of Whāngarei women aged 18 to 35 in a non-representative survey about a liquor licensing policy did not feel safe in the city's CBD at night, compared to 30% of men (Shetty, 2010).

Ninety percent of noise complaints received by the Far North District Council came from licensed premises (Evaluation Solutions, 2010a).

11.11 Economic costs

The estimated cost of alcohol damage varies markedly depending on methodology; it has been described as 'the economic contribution of a powerful industry ... offset by the high costs of cleaning up after it' (Hill, 1996, p. 28). Treasury (Barker, 2002, p. 17) estimated the total external costs 'to be significantly more than the revenue collected' by government.

New Zealand estimates for lost productivity among working people in the 1990s ranged from \$57 million per year (Jones et al., 1995) to \$16.1 billion (Easton, 1997). Economic models assume that consumers rationally take into account the costs of the drinks they buy, even if they expect to pay these costs in the future. 'However, it is not immediately obvious that 'rationality' applies when there is drunkenness or addiction' (Easton, 2006, para. 11). He cited estimates of the social costs of alcohol in Canada in 1992 at 1.09% of GDP, and in Australia in 1999 at 0.92%.

Alcohol and road safety researchers define external costs differently (Miller & Blewden, 2001). In alcohol research, the external costs of drunk-driver crashes are those the drinker chooses not to take into account when she decides to drink and drive (Easton, 1997). However, in road safety research, external crash costs are those imposed on one group of road users by another group involved in the crash.

Miller and Blewden (2001, p. 787) estimated that 'Half of alcohol-related crash costs are paid by people other than those at fault'. They estimated alcohol-related crash costs at \$1.2 billion in 1996 – 38% of all crash costs. Alcohol-related incidents caused 31% of crash deaths. Miller and Blewden calculated the total cost of each fatal injury in a traffic crash at \$2.163 million, largely made up of lost work and quality of life; \$914,400 of this cost was not paid by the drink-driver. They estimated that each fatal crash cost \$2,602,900.

This amounted to an estimated 75 cents per drink, \$1,100 a year for each heavy drinker, \$2.80 per kilometre driven under the legal blood alcohol limit and \$17.80 per kilometre driven at 80 mg/ml and above. Alcohol-related crashes where the blood alcohol level of the driver was below the legal limit cost an estimated \$134 million.

In 2009, the social cost of traffic crashes involving alcohol or drugs was estimated at about \$890 million – nearly a quarter of the cost of all crashes involving injury (MOT, 2010a).

Injuries to other people in traffic crashes involving alcohol-affected drivers were estimated to cost more than \$2.5 billion between 2003 and 2007, or half a billion dollars a year. This is about 0.4% of current GDP, and around 42% of the estimated yearly cost of all alcohol-related traffic injuries (Connor & Casswell, 2009). WHO (2007b, p. 21) concluded that the costs of alcohol-related police, fire and social services usually 'far outweigh the costs of health services'.

BERL (2009) estimated the total cost of harmful alcohol use in New Zealand at \$4.9 billion for the 2005–6 year, equivalent to two-fifths of the year's Vote Health, or almost 3% of GDP. They concluded that 50% of this cost was potentially avoidable. They assumed that 253,300 women used alcohol in a harmful way, and a further 47,700 used alcohol with other drugs. Female harmful drinkers were estimated to outnumber males in the 15–24, 35–39 and 45–64 age groups.

This equated to an average cost of \$16,408 per harmful female drinker. The injury cost was approximately \$1.6 billion, an average of \$3,100 per harmful drinker.

The study counted costs from premature mortality, excess unemployment, absenteeism due to sickness or injury, and reduced productivity. It did not count the intangible costs of domestic and sexual violence to women as a result of someone else's drinking. While it counted the police and justice system costs of these crimes, it did not count the costs to community anti-violence services such as Women's Refuge. It counted the health system costs of people with FASD, but not the lost production of family members for their care.

The BERL analysis was critiqued for its methodology by Crampton and Burgess (2009), who called the final BERL figure 'grossly exaggerated' (Crampton, 2009). Crampton and Burgess estimated external alcohol costs at \$662 million, which they said was almost matched by the \$516 million received in alcohol taxes.

Crampton and Burgess cited literature indicating that drinkers earned at least 10% more than equivalent non-drinkers, that moderate drinking increased benefits from experience and education, that moderate drinkers lived longer, and that alcohol saved more lives than it cost. They also questioned BERL's estimate that 50% of costs were avoidable. Crampton and Burgess's conclusions were unsupported by other research reviewed above, including studies cited in section 9.1: New Zealand health benefit estimates, and section 10: Alcohol-related health problems.

Later, related research by Crampton, Burgess and Taylor critiquing alcohol cost studies was commissioned by the Australian National Alcohol Beverage Industries Council (NABIC). Crampton presented it to the national conference of the Australian Liquor Stores Association, and at NABIC's request spent a day in Canberra discussing the research with media and ministry officials (Crampton, 2012).

Alcohol contributed to up to 22% of all claims to ACC, which cost around \$650 million a year (Houlahan, 2009). Fourteen of the 18 members of the Capital & Coast and Hutt Valley District Health Boards described the impact of alcohol on the health budget as 'completely intolerable' in an open letter to the *Dominion Post* in 2011 (Newton, 2011).

Assuming a conservative prevalence (1% of live births), at least 625 babies would be born with FASD each year, with a combined lifetime cost in health and social services of more than \$1 billion a year (AHW, 2010b).

Injuries to other people from traffic crashes by drink drivers were estimated to cost more than half a billion dollars a year in 2007.

SUMMARY – SOCIAL PROBLEMS FROM ALCOHOL

Alcohol is increasing health and social inequities in Aotearoa, including between Māori and tauīwi women, for Pacific women and those living in poor communities.

The full picture of the damage done to non-drinkers by drinkers is still being developed and is currently likely to be under-estimated. Women disproportionately bear more of the consequences of men's heavier drinking. Women are more likely to have a heavy drinker in their lives than men, and heavy drinkers significantly lower the wellbeing of those around them. Women in 2009 were also more likely than men to report problems from someone else's drinking in the last year; 19% had been left without enough money and 6% without food. Growing up in a heavy drinking household may prevent children from developing fully, resulting in a need for long-term support at school and later in life.

One in five women under 20 had been sexually harassed by someone who had been drinking in the last year, and one in three female university students in the last three months. Seven percent of female university students had had alcohol-related unwanted sex. Alcohol is the most common drug used to enable sexual assault.

Alcohol-related violence to women usually happens at home and has a major impact on their wellbeing. More than one in three women experience alcohol-related violence from a partner; this was more likely for Māori women. Binge drinking by both parties increases women's risk, and heavy drinking by a violent partner makes serious injury for the woman more likely.

Women's own aggression towards others is also related to how much they had drunk.

The denser the alcohol outlets in an area, the higher the rates of family violence, drink driving and traffic crashes. Women made up nearly one in five offenders who drank before committing a crime in 2008. The number of women caught drink driving increased by 1,700% between 1986 and 2006, compared with 185% for men. In 2008, 9% of women had worked in a paid job under the influence of alcohol in the previous 12 months. Twelve percent were less productive at work or had to take time off because of someone else's drinking.

More than 100 female secondary students are suspended each year for alcohol problems. Six percent of female secondary students in 2012 said their drinking had affected their schoolwork during the previous year, and one in five female university students had missed at least three classes in three months from their drinking.

Among secondary school students, an encouraging sign is a decrease in alcohol-related problems between 2007 and 2012, including drink driving and things like stealing that could have got them into trouble.

One estimate of the costs of harmful drinking in New Zealand totalled almost 3% of GDP; in other countries it has been estimated at about 1%. These estimates do not include some major costs to women, such as the intangible costs of sexual abuse and physical violence, costs to sexual and domestic violence services from alcohol-related incidents. They also do not include non-healthy system costs incurred by children and adults with FASD, or lost production by family members from their care.

12. Protective factors, resilience and wellbeing

This discussion also uses the ecological model to consider individual, family, community and population levels of wellbeing. This review found little literature about resilience or wellbeing related to alcohol.

The context for this discussion is a neo-liberal society, where health has become defined as the personal responsibility of individuals (Hodgetts et al., 2004) and a moral obligation (Conrad, 1994). This disrupts the gender order, because it values a stereotypical female concern with health and wellbeing above a supposedly masculine indifference or avoidance (Lyons, 2009). Definitions of resilience also tend to focus on how an individual adapts to adversity, and on the personal and community resources they use to do this (Moewaka Barnes, 2010). The challenges to which the individual is responding are rarely measured, which downplays the social causes of individual suffering (Kirmayer et al., 2009). Edwards (2008) suggested a strengths-based community approach, rather than the blame implicit in an individual focus.

The power relations inherent in ethnicity, class and gender social hierarchies are also often ignored in research on resilience, which does not address ways to stop modifiable social problems. Moewaka Barnes (2010, p. 26) said in a kaupapa Māori analysis: 'As a society we need to ask what types of challenges are acceptable and what happens when challenges are inequitable and ongoing.'

Different groups of women face different degrees of adversity, and have different access to support. For Māori, colonisation has meant that Pākehā-dominated social institutions continue to make decisions for Māori in which they are not involved, and many Māori women cannot access Māori cultural institutions that provide strength and wellbeing (Lawson-Te Aho, 1998; Cram, 2012).

The natural desire for personal wellbeing leads to the question: What alternatives, without alcohol's potential for damage and addiction, can provide subjective wellbeing, meaning and purpose, and the confidence to make connections with others?

12.1 Population protective factors, resilience and wellbeing

The most effective population protective factors against alcohol damage are government controls on sellers and marketers of alcoholic beverages. This is dealt with in section 13.1: Societal and population level interventions.

Delaying the start of drinking protected against alcohol problems developing among young people (Odgers et al., 2008; NH&MRC, 2009b). The later young people had their first alcoholic drink, the less likely they were to become regular drinkers (AIFS, 2004).

A WHO report says that to be effective, AOD policies must be supported by broader social and economic policies that reduce social deprivation and inequities, as they breed the use of alcohol and other drugs (Wilkinson & Marmot, 2003).

One US national longitudinal survey found that individual religiosity was a protective factor against binge drinking and abstinence for young heterosexual women.

However, it was not protective for lesbians, and among young bisexual women it increased the odds of young bisexual women drinking at all and binge drinking (Rostosky et al., 2010).

Alcohol policies need to be supported by broader social and economic policies that reduce deprivation and social inequities.

12.2 Community protective factors and resilience

12.2.1 Māori and indigenous peoples

Moewaka Barnes (2010) argued that markers of Māori identity such as fluency in te reo and familiarity with one's marae were not consistently or strongly linked with positive health outcomes, and that a range of positive connections may contribute strongly to resilience among Māori youth.

Borell (2005) found that young people from South Auckland countered negative stereotypes through a shared Southside identity, which was a source of pride, confidence and belonging. Although some may have wanted greater cultural connection, it was difficult for them to take part in traditional activities such as kapa haka.

Having stronger connections with their culture improved Native American women's resilience against problems from alcohol (Whitbeck et al., 2004).

A study with Native Alaskan participants, who had been sober for at least five years after problem drinking without treatment, found that they wanted to stop drinking so they could be mothers and grandmothers, contributing to family and community. They emphasised relationships rather than themselves in their recovery (Mohatt et al., 2007). Many recognised and wanted to stop repeating their own earlier trauma in the lives of others. Many saw themselves as recovered, in contrast to the disease model of alcoholics as always 'in recovery'.

12.2.2 Pacific peoples in Aotearoa

Samu and colleagues (2009) argued that the high proportion of non-drinkers in Pacific populations should be celebrated and reinforced. Pacific peoples were also five times more likely to stop drinking once they had started than Pākehā (Sundborn et al., 2009).

Pacific young people aged 12 to 17 were the only ones who did not get most of their alcohol from parents (Samu et al., 2009). Factors protecting Pacific secondary students against binge drinking included parents' use of a Pacific language, parents' knowledge of their children's whereabouts after school and at night, and students' own church attendance (Teevale et al., 2012). Samu and colleagues recommended greater use of Pacific parents and churches as harm-reduction resources.

Another qualitative study found four cultural factors contributing to Pacific young people's abstinence or responsible drinking (Suaalii-Sauni et al., 2012): an awareness that their actions would affect the reputation of their family and community; an appreciation of Pacific values of respect and reciprocity as well as taboos about men and women drinking together; a commitment to the abstinence teachings of their church; and peer experiences that make them consider the damage from heavy drinking.

The brother–sister contract 'prescribes language and behaviour between brother and sister, close cousins and relatives of opposite gender, as well as other children raised as part of the family' in different Pacific cultures (Percival et al., 2010, p. 12). It restricts mixed-gender drinking in many Pacific communities, so that Pacific women who want to drink tend to do so with their women friends (Gray & Nosa, 2009). This contract has been identified as protective against sexual violence (Percival et al., 2010).

12.2.3 Lesbians and queer women

A national qualitative study found that friends or community that supported young people who were attracted to more than one gender, as well as public representations and roles models of both-sex attracted people, could reduce binge drinking (Pega et al., 2012).

In Aotearoa, lesbian and mixed gay organisations regularly run events and support groups that are alcohol, drug and smoke-free. In Auckland these have included lesbian dances and dancing groups, and youth support groups (Rainbow Youth, 2009). The strongest single community need identified in an assessment for the former Auckland City Council area was for safe, non-judgemental and alcohol-free social spaces where isolated lesbians and other queer people could socialise (Rankine, 2008).

12.3 Family protective factors and resilience

Young people from families who provide good examples of alcohol and other drug use, and find non-violent ways to resolve conflict, generally do better than those from families without these protective features (Bagshaw, 2011). Tuvalu participants in a qualitative study of Pacific concepts to deal with family violence in Aotearoa identified family evening devotions as a time for the family to address any household conflicts and problems with alcohol and other drug abuse (MSD, 2012).

A qualitative study of Pacific youth found that one factor contributing to abstaining or responsible drinking was the presence of strong positive or negative role models in their family (Suaalii-Sauni et al., 2012).

In a cohort of Australian adolescent girls, having an emotionally close relationship with their mother was linked with drinking less frequently, through reducing their time with high-risk peers (Kelly et al., 2011). Parental disapproval of drinking had only a weak effect on girls' alcohol intake.

Because the emotional, sexual and physical abuse of girls and partner violence against adult women have such significant effects on early use and adult abuse of alcohol (see section 8.3.2: Violence and sexual abuse of girls and women), the prevention of this violence has been identified as a major protective factor against AOD abuse and addiction (Felitti, 2004; La Flair et al., 2012).

Workshops for families and parents, such as the Strengthening Families Program in the USA, reduced young people's drinking and drunkenness (Spoth et al., 2009; 2001).

An Australasian panel developed evidence-based guidelines for parents to prevent alcohol problems in their adolescent children (Ryan et al., 2011). Strategies included delaying their adolescent's introduction to alcohol for as long as possible, modelling responsible drinking, talking with them about alcohol before they drink and if they drink without permission, establishing family rules about alcohol, monitoring adolescents when they are unsupervised, preparing them to deal with peer pressure and unsupervised drinking sessions, and hosting adolescent parties (Parenting Strategies, 2011).

Other evidence-based strategies included encouraging alternatives to alcohol use, agreeing on consequences for breaking family rules, and contacting the hosts of adolescent parties to check the level of safety and supervision (Leung et al., 2010).

For adult heterosexual women, egalitarian relationships protected against harmful alcohol use (Adams, 2010).

12.4 Individual protective factors and resilience

This review found very few studies examining individual protective or resilience factors, apart from in addiction treatment. A qualitative study of Pacific youth found that a contributing factor to abstaining or responsible drinking was an awareness of the impact of heavy drinking on their health or career goals (Suaalii-Sauni et al., 2012).

One review concluded that protective factors change with age during adolescence, and may include challenging media stereotypes of gender roles, as well as more consistent parental and school rules and actions about teen drinking (Schulte et al., 2009).

Female prisoners who had support and non-drinking friends were less likely to relapse after release from prison (Clark et al., 2011), and women who received help after disclosing incestuous abuse as children were less likely to develop an alcohol disorder (Hurley, 1990).

Many people reduce or stop drinking as a result of health conditions that are worsened by alcohol. However, one study found that this created unresolved dilemmas for people with hepatitis C (Harris, 2010). They believed that if they reduced their drinking they would be forced to face the social stigma surrounding the condition, so some avoided social events. Those who continued to drink often felt isolated by disapproval from health workers or others with hepatitis C.

Women who drank with family, workmates or strangers, or who had something happening after drinking (for example, work the next day) were likely to drink less (Fryer et al., 2011). Young women who went out drinking planned to look out for each other, but 'it doesn't always work that way, especially if your friends are legless, too' (Lang, 2008, p. 32).

Fry (2010) identified three resistant identities among young non- or infrequent young Australian drinkers: sporty/healthy; ambitious professional; and faith-based. She described the ways in which these young people maintained this behaviour and resisted heavy drinking environments. She said that the 'preoccupation with epidemiological and economic data, coupled with overlay of media-induced moral panic surrounding youth binge drinking, has resulted in a marginalisation and ... a comparatively understudied examination of cultural and subcultural aspects of alcohol consumption' (Ibid, p. 1280). This review found no similar New Zealand qualitative research into women's resistance to heavy drinking.

Australian women used different ways to limit their drinking, including refusing unwanted drinks, counting drinks, limiting the number they drank, and quenching their thirst before drinking (AIHW, 2010). These moderators were used most often by women over 30, and least often by adolescents. Australian women most often reduced their drinking for health reasons, followed by lifestyle and social reasons (AIHW, 2008).

SUMMARY – PROTECTIVE FACTORS, RESILIENCY AND WELLBEING

There is little research on these issues in Aotearoa outside of treatment. Resilience and health tend to be discussed as individual traits, which downplays broader environmental influences on alcohol use.

The most effective population protective factors are government controls on alcohol sellers and marketers. Social inequities drive drinking, but there has been no research on the impact of attempts to reduce these disparities on people's drinking.

Community level protective factors may include a range of positive traditional and non-traditional connections for young Māori women. The high proportion of non-drinkers among Pacific women, and taboos against mixed-gender drinking are protective and could be reinforced. The brother-sister covenant may be protective in some Pacific communities, as may more alcohol-free social spaces for lesbian and queer women.

Families that use alcohol and other drugs responsibly, and resolve conflict without violence, contribute to young women's wellbeing. Egalitarian relationships protect heterosexual women against harmful drinking. Close relationships with mothers may also protect young women against frequent drinking. Preventing sexual abuse of girls and their experience of family violence would help reduce their use of alcohol in later life. Delaying teenagers' first drinking reduces later problems.

Some Australian non- or occasional drinkers successfully resisted heavy drinking environments, but this review found no similar New Zealand research.

13. Interventions

This section uses research evidence to assess the recommendations from the NZ Law Commission review of alcohol law from 2007 to 2010, and the resulting Sale and Supply of Alcohol Act 2012.

Prevention strategies can be primary, secondary or tertiary; primary prevention strategies aim to prevent early drinking, or to prevent a change from casual to regular drinking. They include regulatory and other measures, and initiatives such as mass social marketing campaigns. Secondary strategies try to prevent regular drinking from developing into heavy or hazardous drinking. Treatment for people who already have drinking problems is usually described as a tertiary strategy (Abel et al., 1992).

13.1 Societal and population level interventions

Martin and Casswell (1988, p. 273) said that women had 'generally not been targeted in preventive efforts to reduce alcohol consumption'. On the contrary, New Zealand women's increased drinking has occurred under policies that have increased the availability, affordability and marketing of alcohol, creating an increasingly alcogenic environment.

Policy between 1989 and 2008 was described as 'a shift from consumption that was demand-driven but constrained by regulation, to a saturated market where increases in consumption are being achieved by initiatives from the suppliers' (Connor, 2008, p. 12).

The National Drug Policy 2007-2012 included sections on Māori, Pacific peoples and young people, but not on women generally or in these groups, and did not mention same-sex attracted people, despite government concern about higher substance use among queer populations (Pega & MacEwan, 2010).

International public health and alcohol researchers agree on the alcohol policies that effectively reduce the effects of harmful drinking (Babor et al., 2010). This underpins the regional and global alcohol strategies adopted by the World Health Organization. Organisations such as the British Medical Association have advocated for an international framework for alcohol control, similar to the WHO Framework Convention on Tobacco Control (Connor, 2008).

'Reducing alcohol and drug abuse' is one of four priority areas in the current Ministry of Justice plan for better public services (MOJ, 2012). The plan proposes to increase AOD treatment in prisons and the community, and reduce the availability of alcohol using the licensing and social supply provisions in the Sale and Supply of Alcohol Act, with pro-active policing on licensing restrictions. However, the plan proposed no extra funding for these activities. Results will be measured every six months by their impact on crime statistics, with the aim of reducing certain types of crime by 2017.

Kypri and colleagues (2010a) argued that the impact of alcohol policy changes should be evaluated, and that if evidence is lacking, the government should require the alcohol industry to prove that increased availability would not increase alcohol-related damage.

13.1.1 Alcohol taxes and other price controls

Alcohol review and law reform

The NZ Law Commission recommended increasing the alcohol excise tax by 50% (which would have increased prices by around 10%), and removing the tax on products with up to 2.5% alcohol to encourage their development. It also recommended that the government fully investigate a minimum price regime to reduce the availability of cheap alcohol.

The government rejected any increase in alcohol excise tax, and left this measure out of the Sale and Supply of Alcohol Act (NZ Government, 2012).

Evidence

Using a tax to increase the price of alcohol is the single most effective way to lower consumption and damage from alcohol (Babor et al., 2010; OPMSAC, 2011). Price is a primary prevention strategy with a long-term effect, because higher prices delay the start of drinking in young people, slow their progress to heavier drinking, and reduce the amount drunk per session (Anderson et al., 2009a).

New Zealand uses a banded excise tax system that is not based on ethanol content, enabling manufacturers to get the best tax advantage from cheap, high-alcohol products (Casswell & Maxwell, 2005b). Tax on beer was 10% in 2005, half that in Australia.

Higher alcohol prices delay the start of drinking in young people, slow their progress to heavier drinking, and reduce the amount they drink per session.

Easton (2010) suggested a graduated increase in excise duty, reducing as the price rose. This would set a minimum retail price, with the profits from the increase going to the government rather than the alcohol industry. Minimum pricing strategies may also prevent intense discounting of alcohol (Babor et al., 2010).

Such a measure is more effective with heavy drinkers, who drink more cheap alcohol, and has little effect on moderate drinkers. Excise tax increases are usually strongly resisted by the alcohol industry. For example, in 2010 the industry intensively lobbied Scottish politicians and defeated the introduction of a minimum price (Meier et al., 2008; EUCAM, 2011).

Most research on the impact of price used sales data that cannot be analysed by gender. However, a price increase in Scotland reduced consumption by 18% across the whole population, and by 20% among women, indicating that women may be more sensitive to this measure than men (Kendell et al., 1983).

The World Health Organization recommended a minimum price policy in the Global strategy to reduce the harmful use of alcohol (2010), which was endorsed by New Zealand government representatives in a consensus vote of the World Health Assembly.

Increasing the price and reducing the availability and promotion of alcohol would help reduce the amount and severity of family violence in Aotearoa (Connor et al., 2011). Higher alcohol taxes and prices have been linked with decreases in rates of rape and assault in the USA and of violence against married women (Markowitz & Grossman, 2000; Durrance et al., 2011). A 1% increase in the price of pure alcohol in the USA was estimated to decrease the number of abused women by 53,500 using 1987 data (Markowitz, 2000).

Women showed significantly more support (more than six out of 10) than men for increasing the prices of cheap alcohol in a 2010 survey (Peck, 2011).

Summary of the evidence

The Sale and Supply of Alcohol Act excluded an increase in excise tax that would have reduced damage to female heavy drinkers, delayed the start of drinking among teenagers, and helped reduce violence against women.

13.1.2 Regulation of advertising and sponsorship

Alcohol review and law reform

Most (86%) of the submissions to the NZ Law Commission consultation supported banning or restricting alcohol advertising in all media. The commission recommended a new offence for irresponsible promotion of drinking or supply, and a five-year programme to gradually restrict alcohol promotion and sponsorship, and limit promotion to minimal product information.

The government rejected most of the commission's recommendations about alcohol marketing. The Sale and Supply of Alcohol Act contains a new offence about promoting alcohol irresponsibly. This includes promotion likely to encourage people to drink excessively, of discounts implying that the price is 25% less than usual; offering prizes, goods or services on condition that participants buy alcohol; and promotion to minors (NZ Government, 2012).

Evidence

Legal restrictions on advertising, sponsorship and marketing help reduce damage from alcohol for both genders, particularly underage drinkers. Regulation is most efficient when it is independent of the industry and co-operates across national boundaries (Babor et al., 2010). However, bans can push marketing into less regulated media such as the internet.

Research indicates that marketing restrictions which rely on voluntary codes and focus only on traditional media are inadequate (Casswell & Maxwell, 2005b; Kypri et al., 2011b). Allowing industry self-regulation of broadcast alcohol advertising resulted in more exposure, rather than less (NZDF, 2006a); and generally resulted in self-interested outcomes (SHORE, 2006, p. 32), that did 'nothing to reduce exposure to alcohol brand messages'.

Public health advocates and the alcohol and hospitality industries are strongly opposed on this issue (Casswell & Maxwell, 2005b). Kypri and colleagues (2010a) argued that the NZ Law Commission should recommend a restriction on alcohol advertising on radio and television similar to France's Loi Evin. They also recommended a ban on alcohol sponsorship of sport, and the use of alcohol tax revenue for sports sponsorship through an independent body similar to the Health Sponsorship Council as more equitable than current alcohol sponsorship (Kypri et al., 2009a).

More than 250 non-government organisations from 43 countries endorsed the Global Resolution to End Alcohol Promotion in World Cup Events, which aimed to reduce the industry's use of high-profile sports to promote its products (O'Brien & Kypri, 2008). Six major Australian sporting bodies signed a voluntary code of conduct about alcohol in 2009 (Kypri et al., 2009a).

In 2010, women were significantly more supportive than men of increased restrictions on alcohol advertising and promotions that were seen and heard by children and young people, and of banning alcohol advertising and promotion. More than half the women surveyed supported a ban, compared with just over two out of five men (Peck, 2011). People on lower incomes were significantly more supportive of a ban than those on high incomes. Those aged 15 to 17 were significantly less supportive of both interventions than those 18 and older; income and age categories were not analysed by gender.

Women were also significantly more supportive than men of banning alcohol sponsorship of sporting, music and cultural events which children and young people were likely to attend. This move also had significantly less support from those aged 15 to 17 than those 18 and older (Ibid).

Studies cited in section 8.1.1: Industry marketing and advertising concluded that much of the alcohol advertising aimed at men undermines the prevention of violence against women.

Most of a random sample of residents in seven New Zealand regions supported a local government ban on alcohol advertising on local government property (MacLennan et al., 2012). Most people in a representative survey (59%) supported restrictions on alcohol marketing (Huckle et al., 2011).

Summary of the evidence

The Sale and Supply of Alcohol Act excluded significant restrictions on alcohol advertising, marketing and sponsorship, which is a primary prevention strategy that would help delay the onset of drinking and reduce heavy drinking in young women. Restrictions would also eliminate alcohol advertisements that trivialise women and undermine attempts to reduce violence against them.

13.1.3 Regulation of alcohol availability

The number and type of outlets, hours of trading and the minimum purchase age all affect the availability of alcohol, and are discussed separately below.

Stronger control of the number of alcohol outlets, and of the total amount of available alcohol, were the two alcohol-related recommendations for creating equity in health from the WHO Commission on Social Determinants of Health (WHO, 2008).

Māori historically attempted to regulate alcohol in areas they controlled. One example was the King Country Pact in the Tainui area, under which the King Country remained dry until 1954 (Moewaka Barnes, 2000). Te Puea Herangi witnessed the devastating effects of the official policy of alcohol saturation in Taranaki after the invasion of Parihaka in 1881. In response, she banned alcohol on Waikato marae (Te Runanga o Kirikiriroa, 2011).

Trading hours in Aotearoa have lengthened gradually over the last 20 years. In the 1980s, Auckland CBD on-licences had to close by 10.30pm unless they provided food. By the mid-1990s, city bars largely closed at 3am, and by 2004 most CBD bars and clubs had 24-hour licences (Casswell & Maxwell, 2005b). Under the previous Sale of Liquor Act licences could allow trading at all hours of the day, and the law allowed minimal community input into licensing decisions.

The Alcohol Reform Bill originally included a ban on RTDs with 5% alcohol or more from off-licences. However, after intensive industry lobbying this measure was removed in August 2012 in favour of industry self-regulation and a provision to restrict RTD sales in future (Jones, 2012a).

Australia

The 2008 Northern Territory Intervention by the federal government in remote Aboriginal communities included:

- Forced prohibition in some areas
- Income management for all benefit recipients in prescribed Aboriginal communities with vouchers that could not be used to buy alcohol
- A weakening of the permit system that let communities restrict entry
- A requirement across the territory for ID and records of off-licensed alcohol purchases over \$100 (Boffa et al., 2007; Toohey, 2008).

Large signs banning alcohol and pornography were put up outside some communities (AIDA & CHETRA, 2010).

The intervention was strongly criticised as racist, paternalistic and ineffective; as undermining community autonomy with no basis in evidence (Ibid; Maddison, 2008; Boffa et al., 2007); and as a 'return to an assimilationist approach' (Douglas, 2007,

p. 32). Vouchers could be sold for cash; travelling to buy alcohol led to more drink driving; and weakening the permit system undermined communities' ability to restrict black market alcohol sales (Stringer, 2007).

Many Aboriginal communities were already voluntarily dry; alcohol was banned except at a few canteens that limited drinking or take-away purchases to six cans (Toohey, 2008). An evaluation concluded that the restrictions were unlikely to work as they undermined existing community actions, contributed to feelings of powerlessness and stigma, and 'could potentially lead to profound long-term damage' (O'Mara, 2010; AIDA & CHETRA, 2010). The income management scheme has since been extended to other Aboriginal and Torres Strait Islander communities in the Northern Territory, Western Australia and Queensland.

Liquor licensing and trading hours

Alcohol review and law reform

The NZ Law Commission made nine recommendations about types of outlets, including:

- Restricting off-licences to specialist alcohol retailers, food retailers and on-licence holders (except for restaurants, nightclubs and sports clubs)
- Retaining restrictions on service stations and takeaway food outlets
- Ensuring only specialist alcohol retailers can sell spirits
- Allowing other outlets to apply for licences in certain economic circumstances
- Requiring supermarkets to keep alcohol in one place on the premises.

The Sale and Supply of Alcohol Act included these provisions (AHW, 2012).

The commission also recommended national maximum trading hours of 9am to 10pm for off-licences and 9am to 4am for on-licences and licensed clubs, with a mandatory one-way door (no customers allowed in) from 2am, binding on licensing authorities. It suggested local authorities should have discretion to restrict hours further under Local Alcohol Policies. It said that alcohol sales from on-licences, including clubs, should be permitted on prohibited days only when supplied with a meal, and no alcohol should be sold from off-licences on prohibited days.

The Sale and Supply of Alcohol Act allowed longer hours than the commission recommended. It established national trading hours of 7am to 11pm for off-licences and 8am to 4am for on-licences, which could be reduced under a Local Alcohol Policy. The Act enabled but did not require one-way door policies.

Evidence

Reducing hours and days of sale would reduce rates of alcohol-fuelled assault.

Restricting trading hours and opening days of retail outlets is effective when it reduces alcohol availability and where problems such as late-night violence are related to hours of sale (Babor et al., 2010).

When closing times at Timaru's 12 central bars were changed to a standard 3am in 2007, the rate of violence incidents in the city's central area dropped. The effect was particularly strong on weekends between 3am and 6am. Recorded violent incidents dropped two-thirds near the five bars with previous longer hours. Crime was not displaced elsewhere, and the number of drunk people who police needed to take home also dropped by almost one-third (Police, 2009).

The availability of alcohol is related to levels of child maltreatment; reducing hours and days of sale is a primary prevention strategy for reducing rates of alcohol-related assault (Connor et al., 2009). In Newcastle, New South Wales, a restriction in pub closing times to 3.30am resulted in a 37% drop in incidents of assault compared to a similar area where opening hours remained unchanged (Kypri et al., 2011a).

The commission's recommendation for a 4am pub closing time was described as 'timid', leaving 'the bulk of the late night violence problem untouched' (Kypri et al., 2011b, p. 428). The researchers argued that stopping sales at 2pm would considerably reduce alcohol problems. Alcohol Action (2011, p. 2) describes this 'tinkering' with opening hours as 'very weak', arguing for 10am to 10pm off-licence hours and an 'end to normal supermarket sales of alcohol' (p. 3).

The commission's consultation (NZ Law Commission, 2010, p. 43) showed 'a surprisingly strong sentiment in favour of removing alcohol altogether from supermarkets and returning to the pre-1989 era when it was only sold by specialist liquor outlets', and chair Sir Geoffrey Palmer acknowledged that the commission's recommendations about supermarkets were not strong enough (Alcohol Action NZ, 2011).

More than seven out of 10 women supported reducing the hours during which alcohol could be sold in a 2010 national survey, significantly more than men (Peck, 2011). There was no significant difference in support by ethnicity.

Summary of the evidence

Although separating alcohol from other items in supermarkets would signal that it is not an ordinary product, re-introducing the ban on alcohol sales in supermarkets would reduce women's heavy drinking. Tighter restrictions on opening hours for licensed premises would also reduce alcohol-related violence to women and children as well as problems for women from their own drinking.

Minimum legal purchase age

Alcohol review and law reform

The NZ Law Commission recommended increasing the purchase age to 20 for all licensed premises; making it an offence to sell or supply alcohol on licensed premises to anyone under 20, even when accompanied by a parent; and making it an infringement for anyone under 20 to buy or drink alcohol on licensed premises.

The government partly accepted these recommendations. The Alcohol Reform Bill originally proposed a split alcohol purchase age of 18 for on-licence sale and supply and 20 for off-licence sale and supply. This is similar to the de facto situation before 1999, which police described as unworkable (Hill & Stewart, 1996).

Kypri and colleagues (2010a, p. 2) described 'the folly of this intuitively appealing compromise' as 'gambling with the health of young people' (Kypri & Langley, 2006). The researchers said it went in the face of evidence that many licensed premises were not safe for young people, and allowed high rates of drinking to drunkenness. However, this provision was voted out in August 2012, leaving the purchase age at 18.

The Act also enabled parents and guardians to continue to buy their children alcohol in licensed premises (NZ Government, 2012, sections 240 and 241).

Evidence

Increasing the minimum purchase age is one of the most effective ways to reduce alcohol-related harm, and costs little to implement (Babor et al., 2010).

After the minimum age was dropped from 20 to 18 in 1999, the promised enforcement of a 'hard 18' limit did not eventuate. It resulted in a significant increase in alcohol-related hospitalisations, A&E presentations and alcohol-related traffic accidents among 15 to 19-year-old young women (Gunasekara et al., 2011; Kypri et al., 2006; Huckle et al., 2005; Everitt & Jones, 2002); see sections 10.3.1: Injuries and 10.5: Alcohol poisoning.

Several US states dropped their minimum purchase age in the 1970s, and then raised it to 21 in 1984. The increased age was linked with reduced drinking, reduced driving violations and reduced traffic crashes among women (Hendtlass, 1988; Abel et al., 1992). Conversely, reducing the minimum purchase age in Australia was linked with an increase in traffic crashes, other emergency hospital admissions and crash deaths among women (Ibid).

An exemption in the previous Sale of Liquor Act that allowed liquor to be supplied to people under 18 for private functions such as after-ball parties caused annual problems in school ball season (AHW, 2011e).

In a 2010 national survey, women were significantly more supportive of raising the minimum purchase age to 20 – just over eight out of 10 women compared with around three out of four men (Peck, 2011). Support was strongest among those over 25 and weakest among those aged 15 to 17.

Parents or caregivers of children aged five to 16 were significantly more supportive of the move than others. However, age and parental status was not analysed by gender. A representative survey also showed very strong public support (78%) for a minimum purchase age of 20 (Huckle et al., 2011).

Summary of the evidence

The Sale and Supply of Alcohol Act's purchase age of 18 will not reduce damage from young women's and men's drinking as much as a minimum purchasing age of 20.

Outlet density

Alcohol review and law reform

The NZ Law Commission said that communities should have more say on local licensing issues, and that licensing authorities should take into account the aim of the law, the impact of an additional outlet on the neighbourhood, and existing numbers and types of outlets.

It recommended that local authorities be required to develop a Local Alcohol Policy which should include:

- A stock take of the number, type and hours of licensed premises
- Local population demographics and overall health indicators
- An assessment of alcohol-related problems
- Permitted areas for licensed premises
- Areas subject to liquor bans
- A process for managing intoxicated people in public places by police, ambulance and health services.

The Sale and Supply of Alcohol Act allowed but did not require local bodies to develop Local Alcohol Policies (NZ Government, 2012, section 75). Alcohol Action NZ (2011, p. 3) described this provision as saying 'you can take on the alcohol industry in your own local communities, don't expect us to do anything nationally'.

Evidence

Restricting the density of alcohol outlets is an effective secondary prevention strategy to reduce heavy drinking and damage from alcohol (Babor et al., 2010).

The previous Sale of Liquor Act did not allow the existing density of liquor outlets to be considered in decisions on new licences, despite clear evidence of heavier drinking and more severe problems from a higher density of outlets reported in the sections on health and social harms (Casswell & Maxwell, 2005b). Changes that supposedly enabled licences to be easily lost, as well as gained after the 1989 law change, did not eventuate.

An early study of the impact of an increase in the number and type of liquor outlets in Western Australia found that the incidence of liver cirrhosis rose 29% in Western Australian women, but only minimally in women in Queensland, where outlet numbers did not change (Smith, 1989). Hendtlass (1988) found a relationship between the density of off-licence liquor outlets and changes in women's drinking over a seven-year period, although no link between density and liver cirrhosis in women.

Two out of three people said there were too many alcohol outlets in a 2010 national survey; there was no significant difference by gender (Peck, 2011). Most people in a representative survey (66%) supported restrictions on the number of outlets (Huckle et al., 2011).

Summary of the evidence

Mandatory Local Alcohol Policies that take into account the density of liquor outlets would help reduce problems for women from their own and other people's drinking. To be effective, such policies would also need to be accompanied by evidence-based national restrictions on trading hours, purchasing age and other aspects of alcohol accessibility.

Licence monitoring and enforcement

Alcohol review and law reform

The NZ Law Commission made 22 recommendations about existing offences, monitoring and enforcement, including:

- Defining intoxication
- Giving police greater powers to close licensed premises
- Requiring potential customers to show staff age-verifying ID
- Allowing licensees, managers and licensed door staff to confiscate falsified ID documents, except for passports
- Allowing managers' certificates or licences to be cancelled automatically for five years after three convictions within a three-year period
- Making the following into infringement offences:
 1. Permitting people under 20 in a restricted or supervised area
 2. Selling spirits in anything other than a glass
 3. A manager not being present at all times
 4. Claiming a false age
 5. Serving alcohol on licensed premises while intoxicated.

The government accepted most of these recommendations. However, the Sale and Supply of Alcohol Act did not give power to licensees, managers or door staff to confiscate false IDs.

Evidence

Enhanced enforcement of licence and legal requirements in premises is effective if it becomes a sustained part of police practice (Babor et al., 2010). However, control and inspection of premises by local councils and police has been inadequately resourced (Casswell & Maxwell, 2005b).

An evaluation of the Whangarei District Council's draft liquor licensing policy concluded that hours for pubs, clubs and bars should be reduced; that the policy should emphasise enforcement, and that evidence did not support a one-way door policy to prevent patrons from leaving and re-entering venues after 1pm (Shetty, 2010). It recommended a comprehensive strategy including outlet density and location, marketing restrictions, pricing, host responsibility and community programmes.

Community action on enforcement

The Auckland Regional Community Action Project (ARCAP) led to a significant decrease in the proportion of Auckland alcohol sales to minors without ID. High media coverage and collaboration encouraged increased enforcement (Huckle et al., 2005). It demonstrated that 'community action interventions ... can be effective in redirecting resources to achieve preventive outcomes at a population level' (Cagney & Palmer, 2007).

The Hawera Alcohol and Young People project led indirectly to the amendment of legislation that allowed police to conduct controlled purchase operations around the country. In Hawera, it led to improved age-checking in licensed premises, raised awareness of alcohol damage among young people, and increased co-operation among regulators (Milne et al., 2007). However, changes were still made by individual personnel rather than by institutions.

An analysis of the Hawera and ARCAP projects concluded that purchase surveys, combined with community action and media advocacy, are effective ways of improving age-checking at licensed premises, and contribute to increased enforcement (Huckle et al., 2007).

The Auckland Regional Alcohol Project from 2002 to 2005 used purchase and exit surveys to reduce intoxication among young people in pubs and clubs, and purchases by underage people from off-licences (Conway et al., 2007). This project re-oriented the workload within the four public health organisations involved, focused more strongly on environmental strategies, and improved collaboration.

Half the premises visited for exit surveys had at least one patron showing visible drunkenness; 31% of young women had breath test results over the driving limit for people aged over 20 (SHORE & Whariki, 2005). The results suggested that half of Auckland's licensed premises may have been serving patrons showing signs of drunkenness.

Almost half those involved in the Youth Access to Alcohol project in 30 different communities believed youth had less access to alcohol from 2002 to 2005 during the project (Cagney & Palmer, 2007). Communities used a wide range of strategies, mostly targeting young people and alcohol retailers.

Three community action projects about alcohol were among those analysed for markers of effective community action in one meta-analysis (Greenaway & Witten, 2006). Fundamental to success was building transformative relationships that allowed the adoption of new ways of working. Other requirements were skilled leadership and facilitation, adequate resources, infrastructural development, strategic support from government and community organisations, effective co-ordination, vision building, forging relationships, finding mentors, effective planning and critical reflection.

Summary of the evidence

Licensed premises may be continuing to serve drunk women against the law. Police and community purchase and shoulder-tap surveys are important tools to monitor how well licensees verify the age of customers. More resources are needed for enforcement of licensing laws by police and local councils. In the absence of these resources, community action projects illustrate the effectiveness of enhanced enforcement.

13.1.4 Regulation of drinking in public places

Alcohol review and law reform

Rather than re-instating the offence of being drunk in a public place, the commission recommended a range of measures, including civil cost recovery from drunk people needing care or transport, funding nurses at police watch-houses, and a maximum fine of \$500 for breaching liquor bans. The Sale and Supply of Alcohol Act included most of the commission's recommendations, except for civil cost recovery and a maximum fine.

Purchase surveys, with community action and media advocacy, improve age-checking at licensed premises, and contribute to increased enforcement.

Evidence

Under the previous Sale of Liquor Act it was illegal for those aged under 18 to be drunk in a public place. The Local Government Act allowed councils to adopt liquor control bylaws or liquor bans for certain areas at certain times. By 2009, 93% of local councils had adopted at least one liquor ban (AHW, 2011b).

Much of the public disorder which bans aim to address could be improved by an increase in purchase age and by effective enforcement of existing laws (Casswell & Maxwell, 2005b). Bans in particular areas were recommended by the Child and Youth Mortality Review Committee to reduce alcohol-related deaths (2009), and were linked to increased public perceptions of safety (Bijoux, 2005). An alcohol ban at Piha in 1995 resulted in a decline in first-aid callouts, ambulance use and vehicle crashes, as well as anti-social behaviour, with no displacement to other West Auckland beaches (Conway, 2002). This improvement had largely been maintained.

Bans have been linked with a drop in vehicle crashes and alcohol-related injuries. However, there were few other evaluations of bans, despite their proliferation (Matheson, 2005).

Bans were most effective as part of a collaboration between police, community groups and local bodies, in a multi-pronged approach to reduce alcohol-related public disorder. Without strategies to reduce overall alcohol availability, they simply moved the problem somewhere else (AHW, 2010a; Sim et al., 2005; Matheson, 2005; Webb et al., 2004). However, providing alcohol-free activities and venues may reduce this displacement.

Summary of the evidence

Women experience problems from men's drinking in public places and from their own. Bans can reduce traffic crashes, injuries and public disorder if they do not relocate the problem. However, bans also need to be accompanied by the restrictions on alcohol availability discussed above.

13.1.5 Countermeasures against drink driving

Alcohol review and law reform

The legal blood alcohol concentration (BAC) at the time of writing is 0.08 mg/100mL. Lowering the legal BAC to 0.05 was supported by 98% percent of submissions on drink driving to the NZ Law Commission in 2009. The commission referred the issue to the Minister of Transport. In 2010, the government's *Safer Journeys* Road Safety Strategy 2020 introduced:

- A zero blood alcohol limit for drivers under 20 years
- Interlocks that prevent convicted drunk-drivers from starting their car
- Stronger sanctions for repeat and serious drink-driving offenders
- The collection of data about drivers in fatal or serious crashes with a BAC between 0.05 and 0.08.

The government decided in 2010 not to lower the legal BAC (AHW, 2011c). A cost benefit analysis estimated that lowering the limit to 0.05 would save at least three lives and prevent 64 injury-causing crashes a year, and save almost \$200 million in social costs over 10 years (Leung, 2013). In September 2013, a Labour MP's Land Transport (Safer Alcohol Limits for Driving) Amendment Bill drawn from the ballot proposed lowering the BAL to 0.05, and the adult breath alcohol limit from 400mcg of alcohol per litre of breath to 250mcg. In November 2013, the government introduced the Land Transport Amendment Bill 2013 to lower the legal limits to these amounts.

Evidence

Lowering legal BALs for drivers and increasing enforcement, especially compulsory breath testing, are effective in reducing injuries for all people from alcohol-related traffic crashes (OPMSAC, 2011; Babor et al., 2010; Connor & Casswell, 2009).

New Zealand's lower limit for drivers aged under 20, compulsory random breath testing, immediate licence suspensions and penalties for serious drink-drivers have been assessed as more effective than many other aspects of the country's alcohol policy (Casswell & Maxwell, 2005b).

A study of crash data from 1998-99 found that drivers with a BAC of 3 to 50 mg/100mL (0.03-0.05 – below the legal adult limit of 0.08) were involved in the same proportion of alcohol-related injury crashes as those with levels of 0.051 to 1.5 (Connor et al., 2004). Each year in New Zealand, 'adult drivers with a BAC between 0.05 and 0.08 are responsible for at least seven deaths, 45 serious injuries, and 102 minor injuries' (MOT, 2010b, p. 1). This study estimated that lowering the legal limit to BAC 0.05 would reduce the amount of alcohol that all drivers drink, save up to 33 lives a year, prevent up to 686 injuries and save up to \$238 million in social costs.

The legal BAL of 0.08 for adults is higher than in many comparable countries (Casswell & Maxwell, 2005b). Drivers over age 30 were 16 times more likely to be in a fatal crash at a BAC of 0.08 than if they were sober (MOT, 2010b). This risk was higher for younger drivers – those aged 15 to 19 were 86 times more likely to be in a fatal crash at this BAC.

Alcohol Action NZ (2011, p. 4) described the Alcohol Reform Bill's failure to reduce the adult drink-drive limit to 0.05 as a 'willingness to sacrifice of up to 60 lives and allow more than 1000 extra alcohol-related injuries on our roads by continuing legal drink driving for at least another two years'.

An evaluation of four levels of drink-driving interventions between 1987 and 1997 found that aggressive compulsory breath testing accompanied by zero alcohol tolerance in young drivers, media campaigns and visible booze buses for drink-driver processing were 'dramatically effective', halving serious and fatal injury crashes late at night (Miller et al., 2004). The evaluation concluded that sustained effort was critical, and that compulsory breath testing was most effective when combined with community-based initiatives to reduce drunk-driving.

Summary of the evidence

Reducing the legal BAC to 0.05 will reduce women's injuries and other social costs from traffic crashes. Evidence discussed in section 11.5.1: Drink driving shows a need for anti-drink-drive campaigns targeting Māori and middle-aged Pākehā women.

13.1.6 Reducing entrenched and systemic inequities

Māori commentators have critiqued some government actions, such as the Foreshore and Seabed Act 2004 and the Marine and Coastal Area (Takutai Moana) Act 2011 (Kaitiaki o te Takutai, 2010) and the 2007 police raids in Ruatoki (Keenan, 2008), as ongoing colonisation. Jackson (2009) said this was also illustrated by persistent difficulties for Māori in acting according to tikanga 'without constant auditing by government agencies'.

The Waitangi Tribunal report *Ko Aotearoa Tēnei* (2011, p. xxiv) suggested solutions to inequalities based on a fundamental shift in the government's approach:

Unless it is accepted that New Zealand has two founding cultures, not one; unless Māori culture and identity are valued in everything government says and does; and unless they are welcomed into the very centre of the way we do things in this country, nothing will change. Māori will continue to be perceived, and know they are perceived, as an alien and resented minority, a problem to be managed ... but never solved.

Government programmes to reduce persistent health disparities, especially for Māori and Pacific peoples, were undermined after Don Brash's 2004 speech, which said 'There can be no basis for special privileges for any race, no basis for government funding based on race' (Callister, 2007).

A government review, which Callister described as ad hoc rather than rigorous and publicly debated, led to some projects aimed at reducing disparities being phased out. Reid and colleagues (2000) said this approach ignored evidence of inequities between Māori and tauwiwi within socio-economic groups, and moved the debate out of a Tiriti o Waitangi framework.

'Lifting Māori outcomes' is a priority in the whole-of-government programme *Addressing the Drivers of Crime* (MOJ, 2009). However, the government has no official intervention programmes or social marketing to combat racism (HRC, 2012).

Evidence

Evidence in section 8.1.8: Institutional inequities shows a link between experiences of racism, poverty, heterosexism and other systemic discrimination and increased alcohol use. A review of research about hapū ora (wellbeing in the early stages of life), including the impact of alcohol on the fetus, focused on the need to address societal conditions such as policies, social norms and systemic racism, as well as support for the mother, baby and whānau, and to improve health services (Barnes et al., 2013).

Researchers have advocated for policies against racism to improve public health (Krieger, 2003; McKenzie, 2003; Jones, 2000; MACMPDSW, 2001). However, official ideology in neo-liberal former colonies resists an acknowledgement of ongoing racism as a determinant of health and government policy (Stringer, 2007; Nairn et al., 2006), instead preferring frameworks such as disadvantage, which can be more victim-blaming (Coram, 2008).

Young Māori at a national hui recommended strengthening tikanga Māori and the core structure of whānau and hapū, and 'promoting what "being Māori" is really about' as solutions to the influence of racism and 'cultural stereotypes (including violence)' on youth drinking (ALAC, 2008b, p. 4).

The most promising responses to discrimination involved multiple government departments and agencies; top-down commitment; meaningful partnerships with Māori, Pacific peoples and others affected by disparities; targeted rather than universal programmes; and evaluation (HRC, 2011).

Summary of the evidence

Ending Treaty breaches, acknowledging racism, poverty and other systemic social inequities, and developing policies to counter them, are likely to be primary prevention strategies for preventing alcohol problems.

13.1.7 Guidelines on safe drinking levels

There is no evidence that low-risk drinking guidelines have any effect on drinking rates or problems (Babor et al., 2010).

Casswell (2011, p. 1) critiqued drinking guidelines as 'a good example of the "new public health", responding to the demands of ... neo-liberal ideology' but 'deeply flawed' as public health interventions. She said they mesh with the aims of transnational alcohol corporations – to downplay the importance of the drinking environment and their role in creating it. Her description of the UK 'collision' between a focus on individual responsibility for drinking and a culture of intoxication, supported by market deregulation and permissive licensing, also applied to Aotearoa.

She described 'exhortations to drink sensibly' as overwhelmed by the psycho-active disinhibiting effects of alcohol, and the associations of fun and excitement created by industry advertising. She concluded that:

To the extent [guidelines] dominate the policy landscape and justify ignoring more effective ways of addressing what shapes people's behaviour, they will contribute to alcohol-related harm (p. 2).

Heather (2012, p. 1) said that despite this, guidelines are essential for establishing what is hazardous or risky drinking and, therefore, for brief interventions. He argued that 'guidelines must have a chance of plausibility in the public mind' to be useful (p. 2), and criticised the Australian guideline of no more than two standard drinks a day (one pint of UK 4.5% beer) as 'likely to be met with incredulity and derision'.

ALAC changed its low-risk drinking guidelines in late 2011. It was then incorporated into the Health Promotion Agency, which recommends no more than two standard drinks a day for women, no more than 10 a week, and no more than four on any single occasion, with at least two non-drinking days every week (HPA, 2013). The previous recommendation for women was no more than four standard drinks a day and no more than 14 per week.

The HPA also recommends to parents that they discourage drinking by children under 18, and particularly under 15, and that they try to delay drinking for those aged 15 to 17 for as long as possible.

One researcher critiqued Australian policy and social marketing about sensible drinking as 'constrained within [a] ... framework promoting alcohol unit warnings on alcohol vessels and standard drink guidelines' (Fry, 2010, p. 1279). The researcher called for 'a wider range of urban and night-time spaces, less predicated on the consumption of alcohol' (p. 1292).

Summary of the evidence

Guidelines have no effect on alcohol consumption or harm but are useful to inform brief interventions.

13.1.8 National social marketing campaigns

Social marketing messages to limit drinking have no long-term impact on consumption (Babor et al., 2010).

One qualitative study indicated that blanket social marketing campaigns will not influence young people from a range of different social networks equally (Abel & Plumridge, 2004). It concluded that robust health promotion initiatives need to take into account the norms and moral assumptions operating within different social networks.

It is commonly assumed that health promotion that works for men will also work for women. However, the different social roles of men and women and the power relations between them make it likely that 'effective intervention strategies also differ' (AWCG, 1993, p. 9). Public health promotion about health risks for all people particularly affect women, because of the social expectation that heterosexual women will be responsible for the health of their menfolk and children (Parker, 2007).

Evaluations of social marketing included little mention of women. The 'Ease up on the drink' social marketing campaign was delivered for less than \$5 million, at the same time as \$50 million was spent on alcohol advertising and sponsorship, together with an unknown amount on web and other electronic alcohol promotion (ALAC, 2011b). Ninety-five percent of respondents in this evaluation knew of the campaign, and 64% of those said it helped them to act on their drinking or someone else's. Of those, 24% said they were drinking less (Ibid).

An early evaluation of the NZ Community Action Programme found that a combination of media and community intervention was more successful than the use of social media alone in changing attitudes about young men's drinking, and that raising awareness about alcohol policy influenced individual attitudes to drinking (Casswell & Stewart, 1989).

The Alberta Alcohol and Drug Abuse Commission Alcohol Prevention Programme for Adolescents was not effective without

its expensive radio and television component and did not sustain long-term positive results (H&WC, 1992).

Studies of young people's print and electronic media found that health promotion messages conflicted with alcohol marketing, which was increasingly integrated into youth norms (Atkinson et al., 2011; McCreanor et al., 2008). UK young people and media workers said that health-related messages about alcohol were not seen as newsworthy or entertaining.

Summary of the evidence

Social marketing alone does not reduce alcohol consumption; however, it can support community intervention and drink-driving countermeasures.

13.1.9 Health system interventions

See also section 13.4.1: *Brief interventions.*

FASD

Alcohol is one of very few known teratogens that is freely available, widely promoted and carries no health warnings (AHW, 2007). Damaging fetal exposure to alcohol often happens before a woman is aware she is pregnant, so prevention requires population-based as well as targeted measures (Sellman & Connor, 2009).

Evidence

Primary preventions led by indigenous people have cut FASD rates by up to half in indigenous communities in Canada and the USA. One kaupapa Māori study suggested that such measures in Aotearoa should involve kuia, as they have high credibility among teenage and young urban Māori mothers who may not have access to elders (Stuart, 2009). Other primary prevention suggestions include:

- A sustained awareness programme for women of child-bearing age
- Simple screening questionnaires in primary care for pregnant patients
- Health warnings on alcohol containers and in all alcohol outlets (AHW, 2007; NZDF, 2006b; Poole & Dell, 2005).

Evidence cited in section 10.2.1: FASD indicates that prevention campaigns that simply blame women, while ignoring their partners and families and the alcogenic environment, will be ineffective. The 1980s Pregnant Pause Campaign targeting pregnant Australian women raised awareness about alcohol use during pregnancy but had minimal impact for the resources used (Coates et al., 1982). Barnes and colleagues (2013) said the evidence suggests that interventions need to consider the structural and support conditions surrounding pregnant Māori women as well as clear messages about not drinking during pregnancy. They said more research was needed into effective strategies for reducing drinking among pregnant Māori women and their whānau, and into whānau and community factors that support alcohol-free pregnancies.

Skagerstrom and colleagues (2011) recommended screening women for experience of violence and alcohol and other drug use during pregnancy, because violence was the most common predictor of their drinking.

The online Pregnancy and Alcohol Cessation Toolkit (PACT) supports health professionals to implement Ministry of Health guidelines and encourage pregnant women to reduce or stop their drinking (Rogan, 2012). It includes four modules linked to other resources, clinical scenarios, self-evaluation questionnaires and survey feedback. However, uptake has been slow (Huthwaite et al., 2012).

Other policy recommendations to reduce the damage experienced by children with FASD include:

- Clinician and neuropsychological training for multidisciplinary diagnostic teams
- Setting up a specialist FASD diagnostic, training and research organisation
- Developing New Zealand-based FASD diagnostic guidelines
- Setting up an FASD education programme for community-based services (AHW, 2010b).

Alcohol warning labels

Alcohol warning labels are compulsory in at least 18 countries (FARE, 2011). While such labels on alcohol containers do not change drinking behaviour (Babor et al., 2010), they raise awareness, although this tends to reduce over time unless they are part of a wider strategy (NZDF, 2006b; Kypri et al., 2011b).

Kypri implied that women may drink less once labels list the number of calories in alcohol. However, encouraging women to count calories and be concerned about their weight undermines their wellbeing (WHV, 2009; COSW, 2003).

In December 2002, the Health Select Committee supported pregnancy warning labels on alcohol products. In 2003 the government directed ALAC to apply to Food Standards Australia NZ, and an application for a pregnancy warning was submitted

Warning labels on alcohol containers are most effective when compulsory, highly visible, and based on evidence.

in 2006. In January 2011, the Independent Panel for the Review of Food Labelling Law and Policy recommended (Blewett, 2011, p. 10):

- Generic alcohol warning messages on alcohol labels 'but only as an element of a comprehensive multifaceted national campaign targeting the public health problems of alcohol in society'.
- That a message about the risks of consuming alcohol while pregnant be required on alcohol containers and at the point of sale.
- That alcohol labels include the energy content.

In November 2011, the Australian and New Zealand governments allowed the alcohol industry two years to adopt labels voluntarily before making them compulsory.

An audit of the Australian alcohol industry's voluntary DrinkWise warning labels found that a year after they were introduced in 2011, fewer than one in six alcohol products carried them and they were inconspicuous, taking up less than 5% of label space (IPSOS, 2012). Public health organisation FARE described this as 'the abject failure of the voluntary industry regime' (FARE, 2012).

FARE (2011, p. 4) summarised the evidence about alcohol warning labels: they need to be 'specific and unambiguous, targeted at specific types of harm, and phrased in such a way that attracts the attention of the drinker ... [as well as] consistent in the style of text, colour, clearly defined borders, placement and orientation' on alcohol products.

Summary of the evidence

Anti-violence campaigns targeting partners of pregnant women are likely to be a primary prevention strategy for FASD. Primary prevention programmes led by indigenous people have reduced pregnant women's drinking in comparable countries. Sustained awareness programmes about drinking during pregnancy need to include women's families and communities, and be supported by the evidence-based restrictions on alcohol accessibility discussed earlier. Warning labels on alcohol containers and at point of sale are most effective when compulsory, highly visible and consistent across products, and part of a sustained programme.

Early intervention programmes including nutritional, developmental and educational support have reduced secondary disabilities in people with FASD in comparable countries.

13.1.10 School-based education

School-based education programmes are costly, and have no long-term effect on student drinking or on alcohol-related problems (Babor et al., 2010; Casswell & Maxwell, 2005b). Providers have been resistant to this finding (ASB Community Trust, 2008). However, despite their expense, Connor (2008, p. 12) said 'educational initiatives and public information campaigns are always popular with politicians and with the alcohol industry'; which other researchers attribute to their individual focus and lack of impact on sales (Casswell & Maxwell, 2005b).

School-based education programmes in the 1970s used fear to discourage students from taking drugs, and were later replaced by social influence approaches. These aimed to build self-esteem, explore social pressures to use alcohol and other drugs, and provide skills to refuse even when this went against peer norms (Abel et al., 1992). An early WHO study found that peer-led, school-based education programmes helped delay onset and reduce drinking in the short term among 13- and 14-year-old girls in four countries, including Australia (Perry, 1989).

An evaluation of the DARE to Make a Choice education programme for secondary students found that most teachers rated it as successful in preventing harm from alcohol and other drugs (Cagney & Palmer, 2007). However, the programme was not seen as responsive to different cultural views, and inadequate in encouraging critical media analysis among students. There was no evaluation of its impact on student drinking behaviour or alcohol problems.

Research indicates that information about alcohol is best taught by students' regular teachers as part of the curriculum, rather than by invited private providers. Alcohol and other drugs are a topic in the health and physical education curriculum in most primary and secondary schools (Casswell & Maxwell, 2005b).

Summary of the evidence

School-based education has no long-term effect on student alcohol consumption or problems.

13.1.11 Reducing violence against women and children

Earlier sections showed a causative link between women's experience of childhood sexual abuse or maltreatment, as well as adult sexual assault and partner violence, and their increased use of alcohol.

A wide range of strategies and interventions at national and community levels aim to prevent sexual and family violence against women and children. They include national social marketing programmes, community refuges, crisis phone lines, community-based prevention projects, community action projects, and school and community education programmes. Many are inadequately funded (eg, Duff, 2013; Dallas, 2013), vulnerable to changes in government funding priorities, and contested by organised men's groups (White Ribbon, 2012).

In the domestic violence sector, these initiatives have been described by survivors of domestic violence as 'many people ... trying to solve the issue in many different ways [with] no-one particularly making any headway' (It's still not ok!, 2010, p. 41).

Hager (2007) identified a pressing unmet need for a specialised refuge service for women who need integrated substance abuse, mental health and domestic violence support. This is discussed in section 13.4.5: Voluntary AOD treatment.

Summary of the evidence

Reducing rates of sexual abuse of children and adult women, as well as rates of domestic violence, is a primary prevention strategy for reducing alcohol problems among women.

13.1.12 Testing caregivers in cases of child injury

The chair of the Child and Youth Mortality Review Committee called for police to have the discretionary right to blood-test adult caregivers for alcohol when children die of Sudden Unexpected Death in Infancy (SUDI), or in driveways and home swimming pools (Collins, 2011; CYMRC, 2011). The Law Commission report did not discuss this issue, and this review found no evaluation of such an intervention.

13.2 Community level interventions

Community action on alcohol issues has a long tradition in Aotearoa, including women's role at the forefront of the temperance movement in the 1800s, and the strong overlap between campaigns for temperance and women's suffrage. Many Māori women worked to reduce alcohol availability and harm through Pākehā-dominated organisations and in Ngā Komiti Wāhine, a national network of iwi-based women's committees affiliated to Te Kotahitanga, the Māori Parliament (Rei, 1993).

In 1949 Te Puea Herangi led about 600 representatives of the Kingitanga, Māori Womens Welfare League, community and church organisations on a hiko to Wellington to protest a government Liquor Amendment Bill, which ignored the King Country Pact that kept the Tainui area dry (Te Runanga o Kirikiriroa, 2011).

More recently, community action has used licensing and planning laws to control alcohol availability, and campaigned on issues such as drink driving (Laverack, 2006). These are explored in detail below and summarised at the end of the section.

USA

The Oglala Sioux of South Dakota sued five alcohol corporations and four nearby beer stores in 2012 for the cost of health care, social services and child rehabilitation caused by chronic alcoholism on South Dakota's Pine Ridge Reservation. The suit charged that the beer stores bootlegged alcohol on the reservation, where it is banned, and that alcohol corporations supplied the stores with 'volumes of beer far in excess of an amount that could be sold in compliance with the laws of the state of Nebraska' and tribal regulations (Associated Press, 2012).

13.2.1 Challenging alcohol advertising

Feminists campaigned against sexist alcohol advertising, and in favour of more strict regulation of such advertising, through the national feminist magazine *Broadsheet* from the 1970s (eg, "Drinking in great shape!," 1981, Jan/Feb), voluntary ad hoc organisations such as Watchwomen in Auckland in the early 1980s, as well as women's centres and women's health groups (eg, Wade, 2012; Luddite Journo, 2012).

In February 2012, Auckland group Feminist Action campaigned successfully against a series of TV ads supposedly set in the Tui brewery. They featured scantily clad female workers in sexualised poses, portrayed as more stupid than the clumsy group of men who tried to steal the beer. The group argued that the ads promote forms of masculinity that demean women and are linked with violence towards them (Harper, 2012).

These campaigns raised awareness of feminist analyses about the objectification of women (Papadaki, 2011), but have not been evaluated.

13.2.2 Community education programmes

Most of a random sample of residents in seven New Zealand regions agreed that local government should run education programmes to encourage responsible drinking (Maclennan et al., 2012). However, evidence suggests that 'reasonable and rational appeals are not effective in reducing rates of alcohol consumption or alcohol-related harms' (Fergusson & Boden, 2011, p. 241).

Pacific communities

The community-based Inu Safely Inu Smart programme used sociodrama and shared reflection to explore the impact of risky drinking among Tongans in Auckland (Research NZ, 2009). It provided training workshops for community group and youth leaders.

The Otara Project developed an intensive youth development programme that included alcohol and other drug interventions for young offenders (Ibid). No published evaluation was found for these projects.

Lesbian and queer women

There have been several small awareness campaigns about alcohol and other drugs among lesbian and queer communities, although this review found no evaluation of their effectiveness. The Party Dyketionary, (Madgeskind, undated) a six-page 1980s Auckland health promotion resource, provided non-alcoholic cocktail recipes, party games and safe drinking guidelines for lesbians.

In 1992–3, the Auckland Lesbian and Gay Centre organised regular alcohol-free dances for lesbians and queer people (ALGC, 1993). In the 1990s, a Wellington-based lesbian group produced a series of ALAC-funded posters and postcards that were distributed nationally to promote responsible AOD use by lesbians and queer women.

An AOD and same-sex domestic violence awareness campaign called Make Moments Memorable ran in national queer community publications and websites early in 2012. It aimed to remind 'us all that we are in control of many of the situations and all of the choices we make'. It involved major gay-owned bars and clubs providing stickers saying 'Out of it ... or onto it?', 'Did I ... or didn't I?' and 'Did I really do that last night?' (TMLN, 2011). No evaluation was available.

Auckland's RainbowYouth, a queer youth support organisation, runs six ongoing AOD-free support groups. It was one of four recipient youth organisations for the 2012 FebFast campaign by the NZ Drug Foundation. The initiative raises awareness of alcohol issues by asking New Zealanders to sponsor people for giving up alcohol during February. Rainbow Youth planned to use the funding to change the way alcohol and other drug use is viewed by queer youth, using the curious.org.nz and the rainbowyouth.org.nz websites (GayNZ.com, 2011).

Pregnant women

One US study found that female confidantes are actively involved in women's pregnancies and most often offer advice (Dunn, 2004). It recommended community-centred media messages that stress the importance of advice and encouragement from friends to help pregnant women stop drinking, and which challenge permissive advice that may support unhealthy behaviour.

13.2.3 Altering the drinking context

Evaluations and reviews of community action rarely mentioned gender in the organisation or results of interventions. One small exception was in pseudo-patron surveys of sales to underage people in licensed premises, which found that nightclub door staff were more likely to check young women's IDs, and hotel bar staff were more likely to check young men's (Lang et al., 1996). This was taken into account in some projects that used mixed-gender pairs of pseudo-patrons (Huckle et al., 2007).

An evaluation of the first phase of the national Community Action on Youth and Drugs (CAYAD) project found that it had influenced local and national policy about alcohol (Litmus, 2009). It also increased informed community discussion about alcohol and other drug issues; helped community organisations adopt effective alcohol and other drug policies; increased capacity to support young people in education, employment and recreation; and helped reduce alcohol supply to young people.

Other positive effects included a wider whānau engagement, fewer alcohol-related school suspensions, and a drop in youth crime in four communities. CAYAD Nelson produced a guide to best-practice alcohol and drug policy for youth organisations, and a workbook with templates for policy development (Duncan, 2011).

A community action project in Waiuku from 2003 to 2006 to reduce alcohol harm included licensee education; designated driver campaigns; school and media talks and public meetings; support for controlled purchase operations; submissions to council; website development for youth and families; T-shirts; and youth concerts. As a result, licensees, particularly sports clubs, took greater responsibility for reducing alcohol harm; police and licensing inspectors enhanced their enforcement of licensing laws; the council developed a district alcohol harm reduction strategy; and key agencies collaborated more closely (Johns, 2006).

A project in Waihi linking the national social marketing campaigns It's Not Ok! and Ease Up on the Drink raised awareness of the impact of alcohol-related family violence on Waihi children, but found that social marketing or awareness-raising campaigns alone did little to help those who were most vulnerable (Petersen, 2011).

Evaluation of the It's Not OK! campaign against family violence did not assess its impact on women's drinking (McLaren, 2010).

Most of a random sample of residents in seven New Zealand regions, surveyed in 2007, agreed that local government should play a major role in ensuring the wellbeing of the community (Maclennan et al., 2012). They strongly supported strict enforcement of alcohol laws by local government staff and police, a focus of many community action projects.

Māori communities

A kaupapa Māori evaluation found that two successful community action projects in West Auckland and rural Counties Manukau combined evidence-based objectives with Māori worldviews (Moewaka Barnes, 2000). The Whānau and Tu BADD programmes in West Auckland challenged masculine norms about drink driving, and developed alcohol policies with marae and other venues.

Whiriwhiri te Ora built on the Tainui history of opposition to alcohol with a pledge not to drink and drive. A 'lost generations' display of people who had died from drink driving and those they had left behind was a powerful education resource. The co-ordinator also worked with Māori wardens to curtail unsafe retailers and public drinking.

Pacific communities

Le Ala, an Auckland Pacific community-based story-telling project, drew on the skills of middle-aged women in a successful community empowerment and primary prevention approach (Southwick et al., 2008). These women mediated between older men and youth, and often initiated story-telling about alcohol problems. The intervention involved up to 100 people from different ethnic communities who met in groups; pre-existing groups were more successful.

The project raised awareness of alcohol impacts on Pacific communities, and led to participants questioning their drinking behaviour. The evaluation recommended publishing Pacific stories about alcohol and strategies for reducing harm, and organising further narrative and youth-focused interventions.

Accords

A national stock take of alcohol accords – local agreements between the alcohol and hospitality industries, regulatory, enforcement and public health agencies – found that some were inactive, there was no sustainable funding for administration, and interventions depended on ALAC resources and membership support (Leach, 2010). The stock take recommended regional administration funding; media campaigns about achievements; an annual regional forum; and a national website.

An evaluation of the Far North accords found similar administrative problems and recommended funding for a paid co-ordinator and administrative re-organisation. It also recommended action plans on enforcement, and promoting food and non-alcoholic drinks in licensed premises (Evaluation Solutions, 2010b). Members identified the easy availability of cheap supermarket alcohol as a major problem. Matheson (2005) suggested that accords should be viewed as a way of augmenting other interventions.

Sports clubs and events

Aotearoa

Given the drinking rates of sportspeople discussed in section 6.1.13: Sportswomen, sports clubs have the potential to be a major site of interventions. However, initiatives have tended to be ad hoc and partial.

Evaluations of sports interventions rarely used a gender analysis. Sports clubs found that team performance improved after alcohol and other drug policies were implemented, and that they created a safer environment for whānau and spectators (Bailey & Hauraki, 2011). Policies required clear signage, restricted hours of alcohol sale, enforcement, a host responsibility

Sports clubs have the potential for major interventions but initiatives have tended to be ad hoc and partial.

approach, provision of more food, whānau involvement and responsible drinking. The study suggested that clubs attempt to move away gradually from reliance on brewery and fast-food sponsorship to sustainable, club-generated income.

The Only in the Club project aimed to stop drinking on the sidelines in two Franklin rugby union clubs, one mainly Māori, one mainly Pākehā (Kirkwood, 2009b). Evaluation found that drinking was largely confined to licensed clubrooms, spectators recognised that drinking on the sidelines was no longer acceptable, and there was an improved atmosphere at games. However, there was concern about the sustainability of the change and possible displacement of drinking. While the initiative fostered a 'more family-oriented atmosphere in the clubrooms' (p. 27), there was no mention of the impact on women.

The self-accreditation process ClubMark, introduced to New Zealand in 2006 by Sport Canterbury, focused on effective administration, with alcohol one component among many member protocols. ACC and ALAC funding for the programme ceased after one year, but some Canterbury and Nelson clubs continued to use it (Thomas, 2009).

A report on managing alcohol at large sports events suggested a comprehensive range of preventive measures to New Zealand police (Allsop et al., 2005):

- Support social interventions to reduce per-capita consumption
- Limit alcohol until the event starts and close outlets before it ends
- Allow sale of only low-alcohol beverages, or promote them actively with a clear price difference from higher alcohol drinks
- Provide cheap, high-quality food and free or very low-priced water
- Control patrons bringing alcohol into the venues
- Do not allow price discounting, alcohol prizes or other promotions
- Control supply of glass containers that could be used to cause injury
- Select non-aggressive security staff and train them in strategies to reduce violence and irresponsible service of alcohol
- Visibly enforce laws and controls on responsible alcohol service
- Consider allowing drinking only in designated areas
- Ensure that police and security staff have easy access to designated drinking areas
- Prevent access by drunk patrons and promote intolerance of aggressive behaviour
- Arrange highly visible breath testing and effective public transport, as well as safe places for drunk people to sober up and ways for them to get home.

Australia

Several interventions have been introduced to reduce harmful drinking in Australian sports codes and clubs. The Australian Drug Foundations' Good Sports programme accredits clubs at three levels as they become more responsible hosts. This includes helping a club get a liquor licence, training alcohol servers, understanding healthy attitudes towards alcohol, developing safe transport strategies, and helping clubs get non-alcohol funding (ADF, 2008).

Women drank significantly less in accredited clubs than in non-accredited clubs. Risky drinking and drink driving decreased with higher levels of accreditation, but this was not analysed by gender (Rowland, 2006a). Good Sports clubs had high levels of social capital, with survey participants reporting strong feelings of being valued and of trust and safety. There were no significant gender differences (Rowland, 2006b).

Tertiary institutions

Given the drinking rates of university students discussed in section 6.1.9, tertiary institutions also have the potential to be a major intervention site. However, until recently, initiatives tended to be ad hoc and unco-ordinated.

A survey of students, student representatives and health service staff at six tertiary campuses found a range of views about institutional alcohol policies. Most agreed that alcohol negatively impacted on students, and health services perceived it as more serious than general student associations (Cousins et al., 2008).

The Alcohol Implementation Group, chaired in 2012 by Professor Jennie Connor in the University of Otago, aimed to work strategically on alcohol issues within the university. It replaced the earlier Alcohol Taskforce Group (Connor, 2012, November 9).

The South Island Tertiary Settings Forum was initiated in 2010 to reduce alcohol-related harm in university settings across the island; it met thrice yearly (CDHB, 2012). As a result, Otago and Canterbury Universities started programmes to reduce harmful drinking in their residential halls, and they and Lincoln University held some or all of their 2012 Orientation events

off-campus. All three universities reported fewer alcohol-related problems around Orientation, such as injuries and property damage (Meates, 2012, April 19)

An evaluation was underway of the University of Otago Campus Watch programme, which aimed to reduce social disorder from alcohol, using 24-hour foot patrols of the campus and surrounding Dunedin suburbs from 2007 (Cousins et al., 2011). Patrollers reported incidents, walked students home at night and helped those who were drunk. University officials also give evidence at liquor licence hearings (Tustin, 2010).

Halls of residence at the University of Otago with moderate alcohol policies were linked with the lowest rates of drunkenness and harm (Maclennan, 2005). Other factors included gender, ethnicity, drinking patterns in high school, hall size and drinking peer group.

A 2009 harm reduction campaign aimed at Victoria University of Wellington students used two postcards headlined 'Missing' (Hutton, 2009). They reflected the observer's face and suggested they 'stick with their mates' or asked 'Do you know where your mates are?' Fifty-one percent of students thought the 'mirrors' campaign would or might affect students' drinking behaviour.

One UK qualitative study suggested that, as peer group norms regulate binge drinking among female tertiary students, peer groups must be part of interventions (MacNeela & Bredin, 2011).

Restrictions on alcohol advertising, outlets and drinking sites have been effective in reducing alcohol-related harm among tertiary students internationally (Toomey et al., 2007). Restrictions on alcohol marketing, outlets, drinking sites and other interventions on US tertiary campuses significantly decreased student drinking and alcohol problems (Weitzman et al., 2004). However, these interventions do not translate well to New Zealand, where commercial activity is already off campus and the purchase age is lower.

University Orientation events held off-campus in 2012 had fewer alcohol-related injuries and less property damage.

Summary of the evidence

Community action has led to more effective alcohol and other drug policies in community organisations; reduced alcohol supply to young people; and sustained reductions in problems from alcohol, including in some cases a lessening of alcohol-related violence. In Māori, Pacific and rural communities, it has challenged drinking and drink-driving norms, as well as reduced drinking in sports clubs. However, community action projects have often been ad hoc and dependent on outside funding. Many small interventions have not been evaluated, and evaluations of larger programmes have rarely analysed results by gender.

There are major gaps in community co-ordination and interventions aimed at female drinking norms, tertiary environments, Māori and Pacific communities, and sports clubs.

13.3 Relationship and family level interventions

Alcohol review and law reform

The Law Commission recommended that parents, guardians or any person they authorise could supply alcohol to people under 18. The Sale and Supply of Alcohol Act required parents and guardians to supply alcohol in 'a responsible manner' to under-18-year-olds (NZ Government, 2012, section 241).

Alcohol Action NZ (2011, p. 2) said this puts 'a huge burden' on parents, when the government failed to take the opportunity to make effective changes to heavy drinking environments.

Evidence

Initiatives to reduce social supply to underage drinkers are ineffective in the long term without a change in commercial alcohol availability and social norms about drinking (Cagney & Palmer, 2007; Greenaway, 2010). A range of interventions targeting parental supply to teenagers had some positive effects:

- Less parental supply (Cagney & Palmer, 2007)
- A drop in binge drinking among teenagers (Ibid.)
- Changed community norms (Greenaway, 2010)
- Reduced purchases by young people without ID
- Awareness of drink-driving prevention messages

- Improved road safety
- Better relationships between alcohol retailers and enforcement agencies (Collie, 2011).

However, there were difficulties or gaps in evaluation of these projects, and these gains often could not be sustained after the projects stopped (Ibid.).

The 2006 ALAC DVD and workbook for parents, *Bewildered – Alcohol, drugs and your children*, changed the attitudes and behaviour of many parents, with positive results for their families (Carswell, 2007). AOD services also used the resource in group and individual sessions with parents and young people, and with practitioner in-service education.

Parent Packs were produced by 25 communities, aimed at parents and caregivers managing AOD and other issues with their young people. An evaluation found them broadly acceptable to Pākehā parents and concerned organisations, but inadequate for Māori and Pacific communities (Bijoux & Collie, 2007).

In 2008, the Homeworks Trust released a video documentary and teaching resource, *He drove me mad*, about the effect of domestic violence on a victim's AOD problems and mental health, including a support website for women with this experience. The review found no evaluation of these resources.

Summary of the evidence

While parental education has changed the behaviour of some parents, supporting families to restrict their supply of alcohol to underage drinkers is likely to be ineffective in the long term without the restrictions on commercial alcohol availability described above, and enhanced enforcement of licences.

13.4 Individual level interventions

13.4.1 Brief interventions

Brief alcohol interventions can be done face-to-face, by mail or online and can involve up to three sessions of counselling or education.

Brief interventions in the health sector

The Whanganui Regional PHO integrated regional alcohol screening and brief interventions into general practices, screening more than 20,000 enrolled patients to June 2011 (CSPC, 2011). Brief interventions were delivered to 8% of these (1,726 people). Ten other PHOs are integrating these interventions into their practices.

However, many GPs may not ask their patients about drinking, and providing GPs with screening tools may not increase the rate at which they do this (Mules et al., 2012; Moriarty et al., 2009). Barriers included time constraints, patient and GP discomfort due to the stigma surrounding the topic, GP lack of confidence and knowledge, lack of funding incentives to screen for alcohol and other drug issues, and GP assumptions that patients would be dishonest about how much they drink.

Many pharmacists believed community pharmacies had a role in providing alcohol screening and brief interventions, although some were concerned about alienating customers (Horsfield et al., 2011). Other barriers included lack of experience, time, lack of privacy and financial incentives. Screening and brief interventions were more likely with appropriate screening tools, training, and public health campaigns about problem drinking.

Brief interventions for women around pregnancy

Evidence is mixed about the effectiveness of brief interventions for women around pregnancy, whether at risk of an alcohol-exposed pregnancy, pregnant, or after birth. A randomised trial of a US brief intervention which included women's partners found it was most effective at reducing the drinking of the pregnant women with the highest levels of alcohol use (Chang et al., 2005).

Individual studies of brief interventions have found them effective in reducing women's drinking:

- Before conception (Floyd et al., 2007)
- Among pregnant women when delivered by nutritionists (O'Connor & Whaley, 2007)
- When delivered in outpatient clinics (Yonkers et al., 2012); and by nurses to women who had just given birth (Fleming et al., 2008).

One South African study found a reduction in diagnoses of FAS after interventions by community health workers in two small towns; they included health talks, local media publicity, health worker training, and referrals of at-risk women (Chersich et al., 2012).

However, at least one randomised controlled trial found no evidence that brief interventions reduced drinking among UK pregnant women (Heather et al., 2006), while a US review of three earlier studies with pregnant women found no impact on average consumption in two, and only marginally significant differences in the intervention group in the third (Whitlock et al., 2004).

Screening and brief interventions for other populations

Aotearoa

Alcohol review and law reform

The Law Commission concluded that brief interventions are underused in Aotearoa, and recommended:

- The development of a national programme of screening
- Brief interventions and referral in general practice
- National use of validated brief alcohol screening tools in hospitals
- Increased use of these tools in justice, education, ACC and corrections settings.

Evidence

Brief alcohol interventions are an effective secondary prevention strategy for reducing alcohol harm (Babor et al., 2010).

These interventions led to a 22% decrease in consumption after 12 months among female university students and others admitted to emergency departments at one small and one large Dunedin hospital (Jackson, 2010). They reduced drinking, AUDIT scores and study problems among students at a university GP service (Kypri et al., 2004), although the latter results were not analysed by gender. A large trial of a 10-minute personalised web-based intervention for Māori and tauīwi university student drinkers was ongoing (Kypri et al., 2010b).

Reviews found brief interventions to be almost twice as effective as no intervention for both genders, reducing alcohol consumption up to a year later (Raistrick et al., 2006; Heather et al., 2006; Whitlock et al., 2004). Brief interventions with injured and alcohol-affected drivers in hospital emergency departments generally resulted in reduced drinking, fewer alcohol-related crashes and less injury (Dill et al., 2010). A brief motivational interview reduced risky drinking in Canadian recidivist drink drivers, largely male, for at least a year; there was no difference by gender (Brown et al., 2010). However, it did not measure the effect on drink driving.

Brief interventions were recommended as an inexpensive part of driver licensing and drink driver rehabilitation programmes in Victoria (Sheehan et al., 2005). A US study which followed convicted drink-drivers for 15 years found that initial screening categories identified groups of people with different risk profiles and rates of substance use disorders (Lapham, 2010).

However, while brief interventions in UK primary care reduced women's drinking, the effect was not as clear a year later as it was in men (Kaner et al., 2009). UK women showed significantly better results than men from three sessions of cognitive behavioural therapy, particularly for moderate drinking (Raistrick et al., 2006).

Laforge and colleagues found that four-nine page paper feedback reports posted to US college students about their drinking significantly decreased binge frequency, drinks per session and total drinks per month, with earlier and greater effects for women than men (Saunders et al., 2004). Both computer and face-to-face feedback to tertiary students about their alcohol misuse have had significant effects for up to three months (Moreira et al., 2009).

However, despite this evidence, alcohol screening and interventions have been little used in New Zealand health and justice settings until recently (Hosking et al., 2007). When used, assessments may not have been useful or accurate (Pulford et al., 2007) although health system staff in this study, 80% of whom were female, were positive about assessing patient alcohol use.

Interventions were often ad hoc. One example was an 'alcohol card' distributed in the Hutt Valley DHB Emergency Department (ED) in 2006, which invited recipients to contact the Alcohol and Drug Helpline, and to get a copy of the Had Enough? DVD. An evaluation recommended that, although the card's effectiveness could not be conclusively shown, the pilot project should continue with a poster, bigger display stands, and training for ED staff on hazardous drinking, the helpline and how to help patients link their drinking with health problems (Parsonage, 2006).

Evaluation of the police watch-house nurse initiative at Christchurch Central and Counties Manukau police stations from 2008 found it improved the health of detainees with alcohol and other drug or mental health problems, reduced their risk of harm, improved police knowledge and skills about these issues, and reduced repeat detentions of people with mental health problems (Paulin & Carswell, 2010).

National DHB data analysis of alcohol-related health problems will enable more accurate estimates of their impact on NZ women.

However, this environment of ad hoc interventions was changing. Wellington Hospital emergency department clinicians trialled an alcohol screening and brief intervention tool with all injury patients, and several other DHBs are running similar programmes (CSPC, 2011). DHBs are also implementing national data analysis of alcohol-related harm, including ED presentations. This will enable more accurate estimates of the burden of alcohol on New Zealand women (Huckle et al., 2011).

As part of the Cabinet programme to address the drivers of crime, justice sectors aim to give brief interventions to more offenders, and train police youth development officers in screening and brief interventions (CSPC, 2011; MOJ, 2009).

Brief interventions in general practice and other settings were recommended in early guidelines by the National Advisory Committee on Health and Disability

(Bushnell & Martin, 1999) and by the Child and Youth Mortality Review Committee (2009).

Interventions for people outside of health and justice environments may also be effective. The Australian campaign Hello Sunday Morning was launched in New Zealand in May 2012. It involved people stopping drinking for three months and blogging about their experience, and providers claimed it cost roughly \$160 per user. After completion, the organisation claimed that:

- Participants' average alcohol consumption dropped from hazardous to moderate levels
- The proportion who drank more than six drinks in a session weekly dropped by 28%
- It reduced the economic measure of alcohol demand over three months by \$978 per participant on average
- The proportion of women aged 22 to 25 who believed that alcohol would relieve tension also dropped from 81 to 36% (Hamley & Carah, 2011).

Summary of the evidence

Brief alcohol interventions are an effective secondary prevention strategy to reduce women's drinking and damage from alcohol. However, they are yet to be routinely implemented in all sectors likely to encounter women with alcohol problems.

13.4.2 Mutual support groups

The biggest and most well-known peer support group for people with alcohol problems who want to stay sober is Alcoholics Anonymous. Women have consistently been a minority of AA members in Aotearoa, although their proportion increased from 22% in 1976 to 40% in 2004 (AA, 2004). This equated to a maximum of 1,600 women around the country attending a meeting in a typical week.

Female AA members tended to be older, highly educated and Pākehā. The average age of female members in 2004 was 43, and 55% of women had tertiary qualifications, more than double the proportion in the whole population. Māori were under-represented at 12%, with more Māori women attending than men. Pākehā were over-represented (82%), and Pacific peoples significantly under-represented (0.7%). Women in AA were more likely than male members to have other addictions (Ibid).

There were 12 lesbian or gay AA/NA or sobriety support groups in urban areas in 1991 (MacEwan & Kinder, 1991); this review found no current information about such groups.

One review of the effectiveness of AA (Kaskutas, 2009) found that abstinence rates among members were about twice those of non-members, and that more frequent attendance was related to higher rates of non-drinking. There was no analysis by gender. A California study found that women were more likely to be abstinent over time and to maintain their AA participation than men (Witbrodt & Delucchi, 2011).

Women for Sobriety (WFS) was founded in the USA as a feminist alternative to AA for women, stressing personal control and developing an identity as a competent woman (WFS, 2011; Raistrick et al., 2006). A UK treatment review found that many group members had good outcomes, but they could not be attributed only to the effects of the group (Heather et al., 2006). Moderation Management, another US-based peer support network that did not aim for abstinence, attracted a relatively high proportion of women (49%) and young people (24%) (Ibid). Neither group seemed to have branches in Aotearoa.

13.4.3 Barriers to AOD treatment for populations of women

Historically, alcoholism was perceived as a male disorder, and diagnostic and treatment criteria were based on men's experience and characteristics (van der Walde et al., 2002). The research indicates that women faced a range of barriers to

treatment that were often different from those facing men, including stronger stigma, responsibility for children, homelessness, other mental health problems, domestic violence and lack of partner support. These are discussed separately below.

Inadequate capacity

The Alcohol Drug Association of NZ estimated that only one in five people with alcohol problems were identified and treated, often after long waiting periods (cited in NZ Law Commission, 2010, p. 420). The National Committee for Addiction Treatment said that addiction services needed to double their capacity to enable treatment for the most severely affected – specialist addiction services could treat about 0.5% of the population, and needed to be able to treat 3%. Alcohol and other drug services for children and young people were also lacking (NCAT, 2008).

A 2008 treatment paper agreed on the 'significant unmet need for treatment', particularly among young and Pacific peoples (Rout, 2008, p. 8). Only 34% of people with a substance use disorder in the NZ Arrestee Drug Abuse Monitoring survey had received treatment (Hales & Manser, 2007).

Māori, Pacific and 'Asian' peoples are under-represented among addiction and mental health workers (MOH, 2005). Māori discussing barriers to care for patients with mental health and AOD problems wanted control over the process of change in services, and the inclusion of kaupapa Māori frameworks (Todd et al., 2002).

As part of the Cabinet programme to address the drivers of crime, sectors aim to enable more offenders to access alcohol treatment and investigate barriers to expanding kaupapa Māori services (MOJ, 2009; CSPC, 2011).

Stigma

Alcohol dependence in women was more stigmatised than in men in many countries, and often provoked social outrage (Obot & Room, 2005), including in Aotearoa (for example, Lyons, 2009), Australia (Swift & Copeland, 1998), the UK (Raistrick et al., 2006; Alcohol Concern, 2004) and Sweden (Jakobsson et al., 2008). This discouraged women from talking about the problem, and undermined their attempts to get help.

Social punishments were stronger for women than for men with drinking problems. Women were also stigmatised for drinking at home, as it conflicted with the social expectation that women, particularly mothers, be unselfish and nurturing (Alcohol Concern, 2004).

Responsibility for children

Women's fear of judgement, of losing their children, or guilt about their parenting also often inhibited them from acknowledging alcohol problems (Alcohol Concern, 2004). Lack of alternative childcare also made it difficult for women to attend appointments or enter residential treatment (IAS, 2008; ALAC, 2004; Westermeyer & Boedicker, 2000). Childcare assistance was recommended as essential to enable women to enter and maintain alcohol treatment (van der Walde et al., 2002).

In the USA, state agencies have taken custody of the children of alcohol-abusing mothers, or forced pregnant drinking women to be hospitalised or incarcerated (Obot & Room, 2005).

Homelessness

Auckland women with AOD problems and no permanent safe housing, whether they had other mental illness or not, had very few places to go. Private boarding houses were often the only option, but many had a chaotic environment that worsened residents' mental health and substance abuse problems (Bukowski, 2009).

A lack of integration between housing and AOD services was clear when the Downtown Community Ministry in Wellington attempted to establish a 'wet' house for homeless people with AOD addictions – none of the relevant agencies wanted to fund it (Hutchinson & the NZ Social Entrepreneur Fellowship, 2011, p. 8).

This is an issue that is partly 'health', partly 'housing', and partly 'mental health and addiction' ... so you get into this triangulation where nobody really takes responsibility. And it is left to the least-resourced player – a small community group – to broker all these relationships.

Other mental health problems

Women with AOD and other mental health problems could be misdiagnosed when they sought help from mental health agencies that did not identify their alcohol problem. Borderline personality disorder, more commonly diagnosed in women, also often occurred with alcohol-related disorders (Stewart et al., 2009). Anxiety or post-traumatic stress disorder and alcohol-related disorders also occurred together more often in women than men.

Two of three women in the USA with alcohol disorders also had other mental illnesses, including depression, mania, phobic and panic disorders, compared to 44% of alcohol-dependent men (Alcohol Concern, 2004).

Domestic violence

Many women who were treated violently by a male partner drank to cope with the violence, but resisted treatment because this left the violent partner as the caregiver, or could lead to him or state agencies having custody of the children. Because the man's abuse remained hidden, social welfare agencies often perceived the woman as the person putting the children at risk. Or they might judge the couple 'as bad as each other', 'because when police or others go to the household the woman is always drunk and incoherent'. Women's drinking and their failure to leave to get help were often held against them by courts, police, CYFS and other services (Hager, 2011b).

Women with substance abuse problems who were escaping intimate partner violence often had chaotic lives that made it difficult for them to live in communal accommodation such as a women's refuge. They usually needed intense support; they were sometimes unable to stop using substances while in refuge, and had to stay in a refuge for a long time to make major changes in their lives. Sometimes they had already lost custody of their children (Hager, 2011c).

Refuges aimed to accommodate all women, but managing demand, safety and the complexities of a communal living environment meant that women with AOD problems were often excluded (Ibid).

More than 525 women who had mental health and substance abuse problems tried to get into a women's refuge to escape domestic violence in 2006 (Hager, 2007). A total of 447 children were with them. Refuges accepted 347 of these women; 79, with 81 children, were later moved out because they were considered a threat to other residents or because staff did not have the skills to work with them.

Most Māori women's refuges tried to accommodate every woman who was referred to them, and dealt with often serious AOD abuse problems and mental illness. For many refuges, most or all residents had substance abuse issues or other mental health problems. Pākehā-run refuges tended to screen applicants with serious substance abuse or mental health on the phone, or refer them to a specialist service.

Many women with substance abuse problems fleeing domestic violence ended up in dangerous situations if they had to leave a refuge or could not get in (Ibid).

Lack of partner support

Women with substance abuse problems who were partnered were more likely than men to have a partner who also abuses alcohol and other drugs, and who therefore might not encourage treatment (Westermeyer & Boedicker, 2000; Swift & Copeland, 1998).

13.4.4 Compulsory testing and treatment

Compulsory AOD treatment for beneficiaries has been abandoned in US jurisdictions because it was ineffective and expensive.

The New Zealand and New South Wales governments started cutting the benefits of beneficiaries who failed AOD job tests or refused alcohol treatment from mid-2013 (Levy, 2012; Goward, 2012). New South Wales women who refused AOD treatment could have their babies removed at birth (ABC News, 2012). These proposals were likely to have a significant negative impact on women, who made up 89% of New Zealand domestic purposes beneficiaries in 2009. The initiative was recommended in Aotearoa by the Welfare Working Group (WWG, 2010). Māori and Pacific women were more likely to be targeted under this approach, which was abandoned in US jurisdictions because it was ineffective and expensive (Andrew, 2011). The proposal was also likely to overload treatment agencies.

Women who drank to cope with domestic violence often found that their partner gained even more control over them if they were put under compulsory treatment orders (Hager, 2011b).

13.4.5 Voluntary AOD treatment

Alcohol review and law reform

The NZ Law Commission recommended that funds from an increase in excise tax should be used for treatment services and staff training. It also recommended integration of mental health and addiction services, co-operation across multiple

government sectors on issues like dealing with intoxicated people, and a national mental health and addictions helpline.

The Sale and Supply of Alcohol Act did not set aside money for treatment, and all treatment issues were referred to the Ministry of Health (AHW, 2011f).

Evidence

Aotearoa

Women with substance abuse disorders, both Māori and tauīwi, were more likely than men to seek help or treatment (McCormick et al., 2006; Kearney & Jamieson, 2004; Kypri, 2003; Adamson et al., 2000).

Te Rau Hinengaro estimated that 9% of people who abused alcohol sought treatment at the onset and 86% ever. The median delay in approaching a treatment service was 16 years (Oakley Browne et al., 2006). Nineteen percent of those dependent on alcohol were estimated to seek treatment at the onset and 99% ever; the median delay was seven years. There was no analysis by gender.

Just under 1% of female secondary school students in 2012 had used an alcohol and other drug service in the previous 12 months; and 2% had had difficulty getting help with stopping alcohol abuse (Clark et al., 2013a).

Numbers in treatment

Around 35,000 people with AOD problems were estimated to use DHB-contracted AOD services nationally in 2011. This excluded treatment in prison, primary care, self-help organisations, secondary and tertiary mental services. Spending on AOD services is estimated to have almost doubled between 2002 (\$65.6M) and 2010 (\$118M) (Steenhuisen, 2011).

According to data from the Ministry of Health Programme for the Integration of Mental Health Data (PRIMHD), the number of unique female clients seen by DHB AOD services increased by 72% from 2004–5 (6,820) to 2009–10 (9,468). Over the same period, the number seen by non-government AOD services increased 12-fold, from 323 to 3,896. The total number of women seen by all services almost doubled, although this figure included women who attended both types of service (Perrott, 2011).

Gender-specific treatment services

Some studies supported women-only treatment services because of prior abuse by men, or the potential of further abuse by male clients (eg, Mackness, 2008). In an early summary, Huygens & Menzies (1986, p. 25) said:

... women do best in women-only [treatment] programmes and men do best in mixed programmes. This is partly because so many alcoholic women have been sexually abused and find it extremely difficult to talk about this in front of men, and partly because women do not get the space or time to talk in mixed groups.

Hager (2011c) concluded that it is inappropriate to expect women who have experienced sexual or other abuse from men to use mixed-gender AOD services, as it can be silencing and further traumatising, especially if the men's behaviour is inappropriate or anti-social. Women in treatment have also been:

- Coerced into sex by men in inpatient units
- Taken out of substance abuse services and re-addicted by controlling men
- Treated by male staff in ways that echo the controlling behaviour of abusive partners, including the minimising of their fear and anxiety.

... all drug and alcohol and mental health inpatient services must be gender specific, and outpatient units must have women-only components. This does not mean just having separate sleeping areas for inpatient units, it means having separate services for men and women with gender appropriate staff, i.e. female staff for women's units, male staff for men's units. This also applies to the outpatient services by having, for example, separate days for each gender or services for men and women staffed by gender-appropriate staff (Hager, 2011c, p. 51).

Lesbians or queer women may also prefer to be in a women-only treatment environment, particularly if they have been abused (Birkenhead & Rands, 2012; Gray & Norton, 1998).

The ALAC guideline for treatment agencies working with female clients (2004) recommended that they provide a range of options, including women-only and kaupapa Māori services, and that they:

- State their commitment to gender equity
- Have sexual harassment policies for women
- Make female staff available as first contacts and clinicians
- Regularly evaluate their responsiveness to women
- Help overcome women's transport difficulties
- Provide information about childcare

- Collaborate closely with other services such as kaupapa Māori, domestic and sexual violence, and housing, among others
- Train staff in sexual abuse, relationship violence, sexual identity and parenting issues
- Have separate sleeping areas, bathrooms and toilets for women in residential services.

A report from PRIMHD of AOD clients seen since July 1, 2008 by DHB and non-government AOD services found only seven services that were women-only or where women overwhelmingly outnumbered men (Perrott, 2011). They were:

- The Waitemata DHB Parental AOD programme in Auckland (530 women)
- The Waikato DHB Dialectable Behaviour Therapy Team in Hamilton (180)
- An early intervention AOD service by Ngati Porou Hauora on the North Island east coast (102)
- The Salvation Army Dunedin Bridge Rural Pathways for Women (40)
- The maternal AOD service of Manaaki Oranga in New Plymouth (23)
- The Salvation Army Christchurch Serenity Haven Programme (12)
- The Salvation Army residential parent and child programme at the Wellington Bridge Centre (10).

This may omit some services, as some NGOs had yet to add their data for this period into PRIMHD.

In response to an email request on an alcohol and drug email list by one of the authors, some services gave examples of women-only treatment options in 2011. Christchurch Bridge ran women-only services, but since the earthquake was offering only one treatment programme with a women's drop-in on Monday mornings. A pilot weekly recovery group for mothers and preschool children in 2011 was so successful that it was repeated in 2012 (Hay, 2012; Fitzgerald, 2011).

Community Alcohol and Drug Services (CADS) Dunedin ran a weekly women's group for up to 12 women (Cook, 2011). The Community Mental Health and Addiction Service at Hutt Valley DHB ran a weekly group for three years for women in recovery (McCarrison, 2011). CADS in Auckland ran a 12-week women's day programme for three hours, three times a week. The Nova Trust, which ran a work-based residential programme on a farm near Christchurch, had 13 women among its 35 current residents, and ran women's sessions twice a week.

Domestic violence and AOD treatment

Brown (2000) questioned the label 'post-traumatic response disorder' when a traumatic response could be expected after persistent partner abuse. She then asked, 'if the distress were seen as the norm, rather than as a pathology or disorder, how might that shift cultural vision, social policy, and collective action?' (Ibid, p. 299).

Fundamental philosophical differences and a lack of co-ordination between mainstream domestic violence and AOD services created problems for women who experienced violence and addiction. AOD treatment services usually perceived alcohol dependency as a disease causing dysfunctional behaviour, including violence, while anti-violence programmes and refuge services perceived men's violent behaviour as deliberate (Braaf, 2012). Refuges also recognised women's alcohol abuse as a way of coping with living in constant fear.

Some women were advised to deal with their AOD issues first and come back to domestic violence agencies, or received AOD treatment in parallel with anti-violence programmes (Mackness, 2008). Anti-violence agencies sometimes saw temporary submission to a violent partner as a survival strategy, while alcohol and other drug counsellors might see it as co-dependence. Mackness concluded that 'understanding the gender and power dynamics involved in domestic violence and alcohol and drug issues should remain integral to treatment' (Ibid., p. 6).

Substance abuse agencies which failed to cross-screen routinely for sexual and domestic violence endangered women and children, and researchers suggested a combined approach to these issues (Mackness, 2008; Russell, 2008). A victim's alcohol use could make it hard for her to assess how much danger she was in, to keep to safety plans or to defend herself.

Hager (2011c) made these recommendations for collaborative AOD and domestic violence services:

- Increasing funding for refuges in Aotearoa, so that they could up-skill workers with basic therapeutic skills.
- Employing specialist AOD workers for case work, counselling, advocacy and general support for women with AOD problems in clusters of refuges.
- Offering specialist refuge services for women with complex mental and health and AOD problems related to domestic violence. These services would work intensively with women to stabilise their lives, so they could address the causes of the AOD use.

Collaborative AOD and mental health services

Researchers studying AOD treatment clients in Christchurch and Hamilton concluded that AOD clients 'should be considered part of the larger population of mental health patients, with co-existing psychiatric conditions the rule ...' (Adamson et al., 2006, p.169). Women made up almost one third of the sample; almost three-quarters (74%) of the sample had a gambling

or other non-substance disorder, with a lifetime prevalence of 90% (Adamson et al., 2006). This was not analysed by gender. The integration of mental health and addiction services was very contentious (Burns et al., 2010). The organisation of treatment services created most of the barriers to holistic care that were identified a decade ago by focus groups of clinicians, consumers and family members (Todd et al., 2002). Judgmental attitudes about substance abuse from some clinicians, especially in mental health, were another barrier. The study emphasised the importance of engaging with the needs of women and LGBT people.

A majority (54%) of a group of addiction and mental health consumers agreed that addiction was a mental health issue (Burns et al., 2010). The same proportion believed the services should be combined, while 35% disagreed. The largest proportion who agreed (47%) preferred separate buildings in close proximity; 35% preferred a model where one worker looks after both needs; and 8% a model where each area has one worker. Half were female but the results were not analysed by gender.

Pregnant women

This review found no research about pregnant women in alcohol treatment services in Aotearoa. Evidence about brief interventions for pregnant women with alcohol problems is discussed in section 13.4.1.

Māori in treatment

Māori were less likely to seek help for AOD addictions than the national average (MOJ, 2009). Alcohol dependence or abuse was the second most common reason for Māori women to be admitted to psychiatric units (Ebbett & Clarke, 2010).

The description of the male Māori residents of Moana House – ‘as mokopuna drifting both inside and outside of seriously damaged whānau, hapū and iwi constructs struggling to survive ... a colonisation process’ – might also apply to seriously addicted Māori women (Adamson et al., 2010a, p. 80).

More Māori with alcohol disorders finished kaupapa Māori alcohol programmes than mainstream programmes (McCormick et al., 2006).

Kaupapa Māori models commonly emphasised integration across personal, environmental, cultural and spiritual dimensions, with the whānau as the basic context and wellbeing a collective responsibility. The focus was whānau ora rather than just managing symptoms. Working with addicted people’s families was therefore standard practice, although this cost more and services were not always adequately funded to do this (NCAT, 2008). This differs from Western models, which tended to assume individual autonomy (Ibid).

The Kina Families and Addictions Trust (2005, p. 4) developed guidelines for Family Inclusive Practice, which assumed that services are more effective when whānau were included, and that collaboration with other agencies was needed for the broader social issues relating to substance use. This included domestic violence (Mackness, 2008).

Kaupapa Māori health frameworks, such as Te Whare Tapa Wha, Te Wheke and Poutama o te Powhiri, have been adapted to address AOD problems (Durie, 2001). However, these have had limited use and most evaluations have been of programmes with men (eg, Adamson et al., 2010a).

Huriwai (2001) discussed the importance of the complex processes of cultural connection – pride in being Māori and whanaungatanga, a sense of belonging to an iwi – in satisfaction with AOD treatment. Adamson (2010a) also discusses the importance of decolonisation as an underpinning of kaupapa Māori approaches in AOD and other settings.

One qualitative study with four Māori participants found that wairua, whakapapa and whānau were crucial to their recovery (Hughes, 2009). Discovering the history of alcohol and other drug use in their whānau was also important, and understanding the impact of their addiction on their whānau contributed strongly to detoxification and recovery. One outcome was ‘whānau healing; converting dysfunctional whānau to well functioning, strong and positive whānau’ (Ibid, p. 8).

Some researchers suggest that strengthening affiliation with Māori culture offered support and strength for Māori in treatment (Ebbett & Clarke, 2010; Durie, 2001).

Pacific peoples in treatment

This review found descriptions but no evaluations of Pacific treatment services. These programmes worked with the families of addicted people, using a mix of Pacific and Pālagi interventions (NCAT, 2008; Annandale et al., 2008). Most providers in Annandale’s stock take said many more Pacific alcohol and other drug workers were needed at all levels.

More Māori with alcohol disorders complete kaupapa Māori alcohol programmes than mainstream programmes.

A study of the Tupu AOD service for Pacific peoples run by the Waitemata DHB indicated a need for more staff, as there was an average of 12 days between receiving a referral and having a face-to-face meeting. Four out of five clients were male, few were young and most were referred from the justice system. Sixty-five percent attended less than three appointments. Home visits by clinicians made the service more accessible, but family involvement was low (CRRC, 2006).

Sexual and gender identity issues in treatment

Many lesbian, queer and transgender women experienced discrimination in AOD and mental health services, and as a result often hid their sexual or gender identities (Birkenhead & Rands, 2012).

Users of alcohol, drug and mental health services were rarely asked about their sexual or gender identity. In surveys spanning two decades, lesbian, queer and transwomen consistently preferred services to ask these questions routinely (Ibid; MacEwan & Kinder, 1991).

However, providers consistently believed in each survey that because they treated everyone the same, they offered a good service to lesbians and queer women (Ibid; Birkenhead & Rands, 2012). Many said they lacked knowledge and training about LGBT issues or needs (Ibid; Pega & MacEwan, 2010). Most AOD and mental health professionals had had no training on sexual or gender identity and wanted this training. Non-government providers reported the least experience dealing with LGBTTT communities (Birkenhead & Rands, 2012).

Issues for transwomen were very poorly understood, and they faced significant barriers to services (Ibid). Many distrusted health professionals due to previous negative experiences. One report developed by service providers said it was important that providers did not assume that the addiction problems of transgender people were caused by their gender (CSAT, 2009a). Housing and employment were major issues in their recovery.

Birkenhead and Rands produced best-practice guidelines and an audit tool for AOD and mental health services about their treatment of LGBTTT clients. This was trialled with Affinity Services, an Auckland non-government mental health provider. The requirement for this kind of audit to be part of regular audit processes was being negotiated among Auckland region DHBs (Ford, 2012).

Birkenhead and Rands recommended that AOD and mental health services implement the guidelines, provide training for staff, and support for LGBTTT clients.

Tauīwi in treatment

This review found few general treatment evaluations in New Zealand that analysed by gender.

Alcohol and other drug clinicians (59% women) reported dealing with a range of female-specific issues, including parenting (27%) and arranging childcare (9%), sexual abuse (25%) and violent partners (24%). Other treatment issues included the use of a holistic (24%) or empowerment approach (21%), women-only programmes (20%), and a clinician who is a woman (19%) or female-sensitive (14%) (Cowan et al., 2003).

Women in treatment for alcohol and other drug dependence who had witnessed violence between their parents were significantly more likely to have experienced severe childhood physical, sexual and emotional abuse, to have conduct disorder and social phobia, and to have high scores for obsessive-compulsive symptoms, depression and anxiety (Quigley, 2002).

Small but positive outcomes continued over six months for 20 female clients who attended the Seeking Safety programme at Hanmer Clinic Tauranga (Benton, 2007). These women had concurrent post-traumatic stress disorder (PTSD) and substance use disorders. They significantly improved their relationships with others, their PTSD symptoms and depression levels became less severe, and sleep disturbances and trauma scores improved.

Their feedback was consistently positive. Those with the heaviest use of alcohol and other drugs had experienced severe abuse as children and adults, had high levels of stress and little social support. However, their alcohol and cannabis use increased six months after treatment. The researcher said that this showed the difficulties of tackling the many needs of women who have experienced multiple traumas.

Twenty-two participants in a study from four Christchurch women's treatment services had poor mental and physical health, were largely poor and out of work; three out of four were parents (Kearney et al., 2005). Most were Pākehā (91%) and heterosexual (81%). Alcohol was their most common drug and most used multiple drugs. One in three had high measures of trauma.

After treatment, their dependence on primary and secondary drugs dropped significantly, they had better health and milder trauma symptoms. Qualitative responses confirmed the need to include multiple aspects in treatment and suggested building support for relationships, mental health, budgeting, sexual abuse and violence. The researchers concluded that 'targeted gender-specific alcohol and other drug treatment is effective' (Ibid, p. 31).

Fifty-nine percent of clients in three Canterbury treatment centres had major depressive disorder, 28% had an anxiety disorder and 23% another psychiatric disorder; 37% were female (Baker, 2005). Treatment reduced their alcohol and other drug use and depression symptoms; however, results were not analysed by gender or ethnicity.

International research on AOD treatment

Women tended to abuse substances at a later age than men, but became addicted more quickly. The term for this phenomenon – telescoping – indicated the ongoing use of men's experience as a treatment yardstick (Raistrick et al., 2006; Westermeyer & Boedicker, 2000). Women also developed complications such as gastro-intestinal, cardiovascular and liver diseases more quickly, and had higher rates than men of physical and mental illness when they presented for treatment (Raistrick et al., 2006; Nolen-Hoeksema, 2004).

Native American and Alaskan women

Most women in a qualitative study with Native American and Alaska Native women from nine different treatment centres had experienced abuse and neglect from childhood, been exposed to alcohol and other drugs early, and had made many attempts at recovery (Peterson et al., 2002).

Researchers concluded that treatment needed to deal with poverty, abusive relationships and negative patterns established over generations, as well as from alcohol and other drug use. It also needed to be culturally appropriate and offer multidimensional support.

Indigenous researchers agreed that enabling people to reclaim the healing mechanisms of their worldview and better understand the process which led to family and tribal losses was vital to indigenous AOD recovery (Adamson et al., 2010a).

Coyhis and White (2002) identified five movements among North American indigenous peoples that linked individual health and sobriety to tribal survival and health. Each operated on many levels, and combined spiritual rebirth, cultural revitalisation, personal healing and political advocacy.

Pregnant women

Psychosocial interventions reduced drinking or maintained abstinence in alcohol-dependent pregnant women (Heberlein et al., 2012). Stade and colleagues (2009) concluded that psychological and educational interventions may increase abstinence and reduce drinking among pregnant women; however, results were inconsistent and there were few studies in this review. Two reviews could find no randomised controlled trials of pharmacological or psychosocial interventions for pregnant women in treatment (Smith et al., 2009; Lui et al., 2008).

Lesbians and queer women

A US guide for AOD providers recommended that treatment for lesbians and queer women address their feelings about their sexual identity, and the impacts of heterosexism and trauma (CSAT, 2009a). Clients were likely to have had negative experiences with mainstream health systems and to distrust health professionals. This report by providers also said that heterosexual staff may be prejudiced about lesbian and queer clients and may believe that their sexual identity caused their abuse. The main barriers to services for Queensland lesbian and queer women were cost, heterosexism and attitudes of self-reliance. Lesbian clients were largely invisible in Queensland AOD services and faced many service gaps. Services did not systematically monitor or collect information on sexual and gender identity, and lacked awareness of LGBT cultural issues. LGBT people mainly used GPs, private psychologists or psychiatrists for mental health support. Their overall satisfaction with AOD and mental health services was poor (QAHC, 2010).

Women with intellectual disabilities

This review found no research in Aotearoa about treatment for this population. While people with intellectual disabilities in the UK had similar levels of alcohol problems to the rest of the population, one UK study concluded that there is a need for AOD training among staff supporting people with intellectual disabilities, as well as for AOD staff working with them, and a need for closer collaboration between staff in the two sectors (Clarke & Wilson, 1999).

General population

Gender-specific services

Findings about these services were conflicting. One review found gender-specific treatment to be most effective for women (van der Walde et al., 2002). Male participants and men's issues tended to dominate in mixed-gender treatment groups, and women in women-only treatment groups had higher completion rates (IAS, 2008). Another UK review found that, except for

women who had been abused, women did well in mainstream services, provided other mental health issues were dealt with (Heather et al., 2006).

Eliason (2006) suggested that residential AOD therapy communities may not be as useful for women as for men, particularly women who have been in prison, because of women's greater experience of sexual and other abuse. This trauma could be a trigger to relapse into substance abuse. She suggested that the more confronting US residential communities may be more suited to males with antisocial personality disorder, and may be potentially toxic to females with mood, anxiety or borderline personality disorders.

Childcare

A meta-analysis of treatment programmes for women with children found that women presented with 'a unique constellation of risk factors and needs', including a higher rate of mental health problems, previous physical or sexual abuse, serious health problems, poor nutrition, domestic violence and other relationship problems, and little social support (Milligan et al., 2010, p. 1). Substance abuse could affect women's parenting strongly.

The childcare and other needs of women with AOD addictions led to the development in the USA and Canada of integrated treatment programmes, including on-site pregnancy, parenting or children's services as part of addiction services. Integrated services were linked with parenting and emotional improvements, and higher rates of abstinence in one summary (CSAT, 2009b). However, a later meta-analysis found that while they were linked with significant reduction in AOD use, it was not significantly more than non-integrated programmes (Milligan et al., 2010).

Domestic violence and AOD services

Women's use of alcohol to cope with violence contributed to the co-ordination of domestic violence and alcohol and other drug treatment services in the USA and other countries (Mackness, 2008). Successful treatment for women in the USA integrated sexual abuse, domestic violence, poverty, housing and healthcare with AOD issues. For pregnant women it addressed the wider abusive environment that drove women to addiction. Clients ranked childcare as an important part of treatment success, and wanted staff to advocate for housing, child protection and welfare on their behalf (Daniels, 1999).

Treatment for alcohol dependence among a small group of US men significantly decreased male-to-female and female-to-male partner violence up to 12 months later (Stuart et al., 2003), and significantly increased women's satisfaction with the relationship. The authors suggested that AOD treatment for violent men may be an effective primary prevention strategy against domestic violence. Heise (2011), summarising research from low and middle income countries, agreed that reducing men's heavy drinking is a population-level strategy for reducing men's violence to their partners.

This remains a highly debated topic among researchers. Leonard (2005) argues that successful alcoholism treatment is likely to reduce severe and overall male partner violence, but among alcohol men it is likely to reduce violence only to the levels of non-alcoholic men. Braaf (2012) suggested that interventions dealing with the combination of alcohol misuse and men's violence-supporting attitudes and behaviour would be most effective for abused women.

AOD and mental health services

Addicted women in AOD treatment often had other mental health problems, were also functionally homeless, unemployed, estranged from their families and friends, and excluded from many aspects of life (NCAT, 2008; Bukowski, 2009).

Women in an international alcohol treatment trial were more likely than men to be depressed. Binge rather than frequent drinking was another predictor for depression (Lejoyeux & Leher, 2011). Depressed women were less motivated to start and comply with treatment, and to achieve abstinence. However, they were seven times more likely to stop being depressed if they stopped drinking. These researchers recommended that services screen women for alcohol dependence and depression, and treat the dependence first (ibid; Brown & Stewart, 2008). Interventions that address depression as well as alcohol dependence have better outcomes, as depression can increase the likelihood of alcohol relapse (Gjestad et al., 2011).

This was consistent with a qualitative study of Canadian women, which concluded that treatment for women with concurrent depression and alcohol abuse needed to deal with childhood abuse, violence in adulthood and poverty, and to help them find other ways to deal with overwhelming pain and loss (Brown & Stewart, 2008). Another study also recommended that AOD services screen for PTSD symptoms, and use interventions for trauma when necessary (Wiechelt et al., 2011).

Evaluations

Women were significantly more likely to prefer abstinence as a treatment goal in a UK randomised controlled alcohol treatment trial (Heather et al., 2010). Clients preferring abstinence were more likely to achieve it, but results were not analysed by gender (Adamson et al., 2010b).

One US study gave a choice of individual or couple therapy to women with alcohol and other drug disorders who were in heterosexual relationships (McCrary et al., 2011). They were more likely to choose and complete individual therapy, saying they wanted to deal with the problem on their own, or their partner refused to attend or was not supportive. Ethnicity was not stated.

Summary of the evidence

The Sale and Supply of Alcohol Act missed a major opportunity to use increased tax revenue to boost the capacity of under-funded AOD treatment services. This resulted in a major ongoing unmet need for AOD treatment, and for kaupapa Māori services.

Māori women are less likely to approach AOD services than tauwiwi women, but more likely to stay in kaupapa Māori services for the duration of treatment than in mainstream services. Services need to be culturally appropriate. There is a lack of primary prevention interventions in Māori and Pacific communities, and a shortage of trained Pacific AOD staff.

Gender-specific services for women are rare and seem to be ad hoc despite ALAC recommendations; few studies or contacts mentioned onsite children's or childcare services. Anti-violence campaigns targeting partners of pregnant women, and screening of pregnant women for partner violence, may be primary prevention strategies for FASD. Evidence for the effectiveness of brief interventions in pregnant women was weaker than for the rest of the population.

Specialised services for women with AOD problems who are experiencing domestic violence need to be established. Few existing services routinely ask clients about their sexual and gender identity during assessment, and most work in a heterosexist way.

Collaboration between AOD and mental health services remains poor. Cross-screening does not seem to be routine for commonly co-occurring conditions, such as depression, domestic violence and sexual abuse, and post-traumatic stress disorder. Treatment services need to work closely with organisations supporting client communities, such as intellectual and physical disability and housing services. They also need to work holistically with clients' families and support them to deal with poverty and intergenerational substance abuse.

SUMMARY – INTERVENTIONS

The Alcohol Reform Bill was described as a once-in-a-generation opportunity to reduce damage from alcohol. However, this opportunity was squandered because the the resulting Sale and Supply of Alcohol Act 2012 omits the most effective measures for reducing hazardous drinking and related problems for women.

These interventions are government alcohol policies that restrict the marketing, availability and accessibility of alcohol, rather than initiatives focused on individual drinkers.

Policies restricting alcohol marketing, availability and accessibility

- A higher purchase price delays the start of drinking by teenagers and reduces heavy drinking; it may be even more effective for women. It also decreases rates of violence against women.
- Restricting alcohol marketing reduces alcohol-related harm for women, particularly drinkers under 18. Regulation is most efficient when it is independent; industry self-regulation is ineffective.
- Reducing the number and density of alcohol outlets reduces binge drinking and total consumption among women, as well as violence against women, drink driving, traffic crashes and other problems.
- Reducing trading hours of alcohol retailers reduces alcohol damage, including alcohol-related violence against women.
- Raising the purchase age reduces drinking among underage young women, and alcohol-related problems.
- Bars may commonly serve drunken patrons. Licensing enforcement is under-funded; sustained enforcement helps reduce women's heavy drinking.
- Women's convictions for drink driving are increasing more than twice as fast as men's. The planned lowering of the legal limit to 0.05, combined with compulsory breath testing, will reduce women's injuries from alcohol-related traffic crashes.

Health system interventions

Fetal Alcohol Spectrum Disorder (FASD)

- New Zealand's health response to FASD lags behind that of comparable countries. A FASD register, standardised systematic screening, and FASD primary or secondary intervention programmes need to be established.
- Partner violence is the most common predictor of pregnant women's drinking. Anti-violence campaigns targeting partners of pregnant women and screening of pregnant women for partner violence are primary prevention strategies for FASD.
- Primary prevention initiatives led by indigenous people are effective in reducing their rates of FASD.
- Early intervention with FASD children results in similar outcomes to their non-affected peers.
- Warning labels on alcohol containers do not change drinking behaviour, but do raise awareness of the teratogenic effects of alcohol as long as they are prominent, consistent and compulsory, and part of a wider strategy.

Brief interventions

- Brief alcohol interventions in general practice and hospital departments effectively reduce drinking and alcohol-related problems among women. However, these interventions are being implemented only slowly.

Social inequalities

- Countries with greater social inequality have higher rates of alcohol and other drug addiction. In 2011, Aotearoa had the fastest growth in income inequality among OECD countries. Racism, poverty and other systemic inequities are drivers of women's drinking, and policies to reduce them would therefore be a primary prevention strategy to reduce alcohol consumption. However, such structural policies have not been evaluated for their impact on the amount women drink.
- Reducing rates of sexual abuse and maltreatment of children, sexual assault of adult women and partner violence would be a primary prevention strategy to reduce women's drinking. However, anti-violence campaigns are inadequately funded and vulnerable to policy changes, and evaluations have not measured their impact on women's drinking.
- Egalitarian relationships protect against harmful drinking by heterosexual women. Support for female victims of incestuous abuse as children is also protective.

Social and justice services

- Specialist refuge services for women experiencing domestic violence who also have AOD and mental health problems are effective. Existing services for women experiencing these issues are often poorly co-ordinated.
- Brief interventions are also effective in justice system contexts, including for female drink-drivers. However, they are being implemented only slowly.

Community action

- Community projects on alcohol have had wide positive impact, although evaluation has rarely included a gender analysis.
- Kaupapa Māori campaigns have been effective in urban and rural Māori communities.
- Pacific community campaigns have raised awareness of alcohol impacts and led participants to question their drinking behaviour.
- Regional alcohol accords are a useful way to augment other interventions.
- Programmes to reduce alcohol-related harm in sports clubs have reduced women's drinking, improved team performance and created a safer environment for whānau and spectators. However, evaluation has rarely included a gender analysis.
- Programmes aimed at reducing social supply to underage drinkers can reduce binge drinking, but are unsustainable unless commercial availability is also targeted.
- Tertiary institutions are sites of heavy drinking, but approaches have been ad hoc and unco-ordinated.

Education

- Social marketing and classroom education campaigns that advocate sensible drinking are overwhelmed by industry advertising and the disinhibiting effects of alcohol. There is no evidence that social marketing campaigns or school-based education advocating sensible drinking have any long-term impact on consumption.
- Campaigns aimed at pregnant women's drinking need to involve partners, whānau and friends, and also tackle the alcogenic environment, rather than presenting the pregnant woman as an adversary of her fetus, and solely responsible for any risks to it.
- There is no evidence that low-risk drinking guidelines affect drinking rates or alcohol problems.

Relationship and family interventions

- Initiatives to reduce family social supply to underage drinkers are also unsustainable without wider restrictions on alcohol accessibility.

Individual interventions

- Compulsory or coerced addiction treatment for beneficiaries is ineffective and expensive. It has a significant negative impact on women, particularly indigenous and ethnic minority women, and overloads treatment programmes with recreational substance users.
- AOD services are under-funded, resulting in a major overall unmet need for AOD treatment, and for kaupapa Māori services.
- Gender-specific addiction treatment for women is effective, particularly for women who have experienced prior or ongoing abuse by men.
- Strengthening cultural connections, involving whānau and using a decolonisation focus are important in making alcohol treatment programmes effective for Māori.
- Most women presenting for alcohol treatment have other mental health conditions and have experienced violence. Addiction, mental health and domestic violence services that act independently, and do not collaborate, do not result in best outcomes for women. AOD services that work holistically, cross-screening for these factors and taking into account housing, poverty and other healthcare needs, are more effective.
- Alcohol treatment agencies usually work in a heterosexist way and lack knowledge about lesbian and queer women's lives and experiences of discrimination that may drive their drinking.
- AOD treatment for violent men may also be effective primary prevention against domestic violence.

Intervention gaps

There have been few interventions targeting particular populations of women, systemic social inequities that affect women, and few primary prevention interventions created for Māori and Pacific female drinkers, female tertiary students or sportswomen.

Data limitations

The most consistent finding in this review was the lack of gender analysis in research and evaluation, as a result many studies were left out of this review. This review found no research about AOD treatment for pregnant women in Aotearoa.

14. Literature review discussion

Historical practices and constructions of gender, rather than any characteristic of alcohol or of women's biology, have shaped women's use of alcohol at a lower level than men's in Aotearoa. The use and impact of alcohol continues to be highly gendered – distinctly different for men and women as groups.

Heavy drinking among men is often accepted as a social expression of masculine risk-taking and excess. Among women, however, it has a very different social meaning. In qualitative research, drunk women were commonly referred to as disgusting, sluttish, irresponsible and a threat to the gendered social order.

This stigma about drunk women is entrenched. It was reported in research about influences, drinking rates and treatment, and has persisted since the time before women's drinking became common and public.

14.1.1 What are the patterns of drinking among women; have these changed over time and if so, how?

The age at which young women first drink alcohol has dropped over the last 50 years. A small sample of Christchurch people aged over 65, over half of whom were women, had their first drink at a mean age of 19 in the 1950s (Khan et al., 2002a), compared to a mean of just under 15 for young women surveyed in 2009 (Research NZ, 2011).

The proportion of abstainers has increased significantly over the last decade among female secondary school students, and in the last 18 years among women up to age 65.

Among drinkers, drinking has increased over time across most age groups (NZ Law Commission, 2009). The patterns of women's drinking were converging with men's in 2000, although total consumption was still a lot less. No later analyses have yet been published, although a higher proportion of 16 and 17-year-old girls than boys were having eight or more drinks in a session in 2011, and rates for this heavy binge drinking were converging for 18 to 19-year-olds.

The only survey series using the same methodology over time and with a high response rate found significant increases in three out of four measures of women's drinking between 1995 and 2011 – the number of times they drank in a year; the amount they drank on a typical occasion; and the proportion who had five or more drinks at least once a week (Huckle et al., 2013).

Differences in patterns of drinking and non-drinking among women have remained consistent by ethnicity and income. There has been no analysis of relative changes in potentially hazardous drinking among ethnic groups since the NZ Health Survey in 2007 (MSD, 2010).

Drinking prevalence remains highest among young women, and particularly high among female tertiary students and sportswomen. Young women had increased their average number of drinks in a session to six by 2000, but this review found no more recent data.

Recent research has identified that adolescent women's brains are still developing up to their early 20s, making them vulnerable to permanent damage from alcohol, especially from binge drinking. Research also raises concern about increasing rates of heavy drinking among older women. As biological changes after 65 increase the health hazards of alcohol, researchers predicted a significant increase in alcohol disorders among older women.

There is little research on how gender is negotiated in relation to the major changes in women's drinking over the last 20 years (Lyons, 2009). This review found no research about how New Zealand women maintain non-drinking or occasional drinking in heavy drinking environments.

14.1.2 If drinking patterns have changed, what are the major influences on women's drinking?

Alcohol advertising and marketing

Marketing of a harmful psycho-active drug as an ordinary and essential grocery item has become a major influence on women's drinking. Alcohol has never been more heavily promoted – advertising, marketing and sponsorship now reach deeply into the online and offline social lives of young people in ways that are often invisible to older caregivers and policymakers. As a result, many young women have adopted alcohol brands as part of their identity and alcohol is embedded in youth music, culture and sport. The Silver Ferns are a rare exception.

Alcohol marketing increases the likelihood that women will start drinking as teenagers, and will drink more if they have already started. This influence is likely to be an underestimate as it is based on measured media, where only a minority of the industry's marketing budget is spent.

Alcohol industry advertising aimed at men in Aotearoa also promotes limited representations of masculinity and harmful attitudes about women, which undermine prevention of domestic violence (Parker & Towns, 2011; Jackson et al., 2009; Hardy, 2007).

Permissive alcohol policies

Relaxed alcohol policies have been another major influence on women's drinking, allowing alcohol licences per capita almost to double between 1990 and 2006. These licences are mostly held by supermarkets, which now sell most of the alcohol consumed, largely to female customers and often below cost.

This policy indifference has exposed women in low-income neighbourhoods to the highest concentration of outlets selling cheap alcohol. This clustering increases binge drinking and total consumption among underage and older women. It also increases rates of violence against women, drink driving, car crashes and other alcohol problems. This particularly affects Māori and Pacific women and women on low incomes, increasing health and social inequities.

Liquor licences are relatively easy to get, hard to lose and inadequately enforced. This lack of enforcement undermines the efforts of parents and caregivers to limit the drinking of their underage girls, as it is easy for them or their older friends to buy alcohol. Community concern about this issue remains high.

Norms among some female groups

For many thousands of young female drinkers, drinking until they are drunk has become a group norm and a sign of gender equality. However, emulating men's drinking quantities can result in alcohol poisoning and other health problems among women.

Alcohol has become embedded in Pacific norms of hospitality, which encourage drinking until the alcohol is finished. Lesbian and queer women's communities have grown around alcohol venues, and alcohol often plays a role in coming out.

Violence against women

Women face high rates of maltreatment and sexual abuse as children, as well as sexual assault and partner violence as adults in Aotearoa. The research consistently showed that this violence is a major driver of drinking among women. Depression, anxiety and post-traumatic stress disorder among women may also be related to increased drinking.

Structural inequities

The double burden of paid and domestic work and other gender demands impact daily on many women. Government actions have been critiqued as continuing the colonisation of Māori and confiscation of Māori taonga. Māori, Pacific and 'Asian' women experience high levels of racism in Aotearoa. Women are more likely than men to live in poverty; lesbian, queer and transwomen experience high levels of discrimination. These inequities also drive women's drinking.

14.1.3 What harms result for women from their own or others' alcohol consumption?

Increasing inequities

Problems from alcohol affect poor women more than affluent women, Māori women more than tauiwī, Pacific women more than Pālagi, and queer women more than heterosexual women. They are worsening existing inequities between these groups.

The density of alcohol outlets in poor communities concentrates a wide range of alcohol-related problems in these areas and increases inequities. It also transfers relatively more money from these communities to the owners and shareholders of alcohol retailing and production companies.

Privileged groups of women, such as middle-class and affluent heterosexual Pākehā, have higher rates of moderate drinking than other women. Their wellbeing is protected by belonging to the dominant ethnic group, and experiencing much less non-gender discrimination.

Older, moderate-drinking Pākehā women overwhelmingly benefit from the small and controversial cardiovascular benefits currently thought to be due to alcohol.

Violence

Violence to women and children is the major alcohol-related problem from the drinking of others, overwhelmingly men. Between one in 10 and almost one in five women were sexually harassed during the previous year by another person who had been drinking.

One in ten women experience an alcohol-related sexual assault in their lives, but this is likely to be undercounted as police data systems do not allow alcohol-assisted sexual violence to be identified. About one in 16 female secondary and tertiary students had had unwanted (as distinct from forced) sex in the past year after drinking. While men and women report roughly similar rates of unwanted sex and sex they were unhappy about, the impact on the genders is likely to be very different.

Social attitudes assign blame very differently in cases of rape involving alcohol. Women who drink are seen as less believable and more responsible for the assault, while men's drinking makes them less responsible. Female victims who had been drinking were more likely to blame themselves for their rape.

At least one in three women experience violence from male partners in their lives; if the partner is drinking the woman is in much greater danger than if he were sober. At least one in three cases of reported domestic violence is alcohol-affected, but this is also likely to be a serious undercount.

Impacts on health

Fetal Alcohol Spectrum Disorder

In Aotearoa more than 30,000 children are likely to be born with Fetal Alcohol Spectrum Disorder (FASD) between 2009 and 2018 due to women's drinking around the time of conception and early pregnancy. However, screening, diagnosis and support programmes barely exist compared with similar countries and it is likely that only the most serious cases are identified.

Many children with FASD have multiple problems and may be unable to live independently as adults. As childcare is gendered, women are largely responsible for their care.

Campaigns against FASD in New Zealand have contributed to mother-blaming by excluding the pregnant woman's partner, wider family, community and environment (Parker, 2007). The role of partner violence in particular seems to have been ignored. Mother-blaming has led to punitive state interventions in North America against indigenous, ethnic minority and poor women who drink during pregnancy. Cuts to benefits for people who fail or refuse drug tests or AOD treatment indicates a policy environment that supports such punitive interventions in Aotearoa.

A focus on preventing FASD should not ignore deprivation, racism and inadequate housing, which may in themselves increase women's drinking, and which pose major threats to fetal health (Parker, 2007).

Breast cancer

The fact that alcohol is a carcinogen seems not to be widely known. One of the most significant threats to women's health from alcohol is a 10% increase in the risk of breast cancer for each extra standard drink a day on average, with no known safe threshold. Alcohol was estimated to cause one in seven cases of breast cancer.

Alcohol poisoning

The last law change lowering the purchase age resulted in more than double the hospital admissions of 10 to 14-year-old girls for alcohol poisoning; the Sale and Supply of Alcohol Act 2012 missed an opportunity to reduce this risk for young women.

Sexual and reproductive health

Drinking is a common reason for unprotected heterosexual sex. Women bear most of the consequences, including sexually transmitted infections, unplanned pregnancies, infertility and cervical cancer.

Drink driving

While men make up the majority of drink-drivers, women's convictions are increasing more than twice as fast, and the proportion of alcohol-affected women drivers in traffic crashes is also rising. In 2007–8, 12,694 females were arrested for drink driving. Arrests of Māori women outnumbered those of Māori men in 2008, and Māori women made up more than one in three women arrested, yet this review found few interventions targeting Māori women or Māori communities. Drink driving among Pākehā women seems most common in those in their 40s.

Testing for blood alcohol is uncommon in non-fatal crashes, so data are likely to be undercounts. Only a small proportion of repeat drunk-drivers are required to have AOD assessments due to poor co-ordination between justice and health sectors.

Economic costs

Existing estimates of the social and economic costs of alcohol exclude major costs to women and children, including sexual abuse and physical violence services and much of the cost incurred by children with FASD (BERL, 2009; Crampton & Burgess, 2009).

Problems from other people's drinking besides violence

Estimates of problems from other people's drinking are likely to be undercounts, as data sources are under-developed. Women are more affected by other people's drinking than men; one in five women had been left without enough money, had had friendships damaged and felt unsafe in public. At least one in 10 had had to take time off work or were less able to do their jobs, and had had their family lives affected.

14.1.4 Is the impact of alcohol on women's health, either through women's own drinking or the drinking of others, a growing problem?

Almost all the alcohol-related health and social problems are reported to be increasing. Decreases included some alcohol-related problems among secondary students between 2007 and 2012, such as injuries, drink driving, performance at school and stealing. Prosecutions for drink driving among Māori women and girls aged 14-17 dropped between 2009 and 2011, and alcohol-related traffic crashes by women drivers dropped between 2008 and 12. Facial fractures from vehicle crashes also decreased.

Chronic and long-term health and social problems resulting from heavy drinking are expected to increase with women's increased drinking. Specific predictions include increases in alcohol-related conditions, disorders and alcohol-related early deaths, and rates of alcohol-related brain damage and osteoporosis as a result of heavy drinking during adolescence.

14.1.5 What is currently working for the prevention or reduction of harm to women from their own or other people's alcohol consumption?

Interventions that restrict the sale, marketing, availability and accessibility of alcohol are the most effective ways to reduce harmful drinking and alcohol-related problems. There is strong public support for many of these measures, particularly increasing the purchase age to 20.

Unlike the tobacco industry, the alcohol industry is represented in alcohol policy-making bodies in New Zealand and internationally, and consistently argues for ineffective strategies about marketing and alcohol harm, and against the most effective policies. Internationally, alcohol corporations actively challenge regulation of alcohol availability and price through international free trade agreements; this is likely to increase under the Trans-Pacific Partnership Agreement which the government is currently negotiating.

Policies to restrict the sale, marketing, availability and accessibility of alcohol

Effective policies include:

- Increasing excise tax to increase the price of alcohol
- Restricting advertising, marketing and sponsorship of alcohol
- Banning alcohol sales from supermarkets
- Reducing hours of sale for retail alcohol outlets
- Raising the purchase age
- Enabling licensing decisions to take into account the density of alcohol outlets
- Adequately resourcing the inspection and control of licensed premises, including police controlled purchase operations
- Adequately resourcing community shoulder tap surveys about buying for under-age drinkers, and exit surveys at alcohol outlets, as part of community and media advocacy campaigns
- Reducing the adult legal blood alcohol driving limit
- Funding aggressive compulsory breath-testing combined with booze buses and media campaigns.

Health system interventions

New Zealand's health system response lags behind that of similar countries. Effective policies include:

- National FASD screening, support and intervention systems

- Brief alcohol interventions in general practice and hospital emergency departments
- Standardised screening for alcohol use and experience of violence, and brief interventions as a routine part of ante-natal health care.

Warning labels on all alcohol as part of a wider media and prevention campaign raise awareness of alcohol as a teratogen, but do not reduce overall consumption.

Primary prevention campaigns help reduce pregnant women's drinking when they involve whānau, families and communities, and do not make pregnant women solely responsible.

Education and justice systems

Use of brief interventions is rare in these sectors. Routine brief alcohol interventions are effective for students, drunk-drivers, and at other points in the police, justice and corrections systems where alcohol is a factor in offending.

Social services

Specialist or collaborative services for women experiencing domestic violence, who also have AOD and mental health problems, meet their needs better than separate services. However, these are undeveloped compared with similar countries.

Cutting the benefits of women who fail or refuse drug tests does not reduce AOD use, is expensive, and is likely to overload treatment agencies.

Promoting social equity

Greater social equity at the national level is linked with lower rates of alcohol and other drug addiction. However, official ideologies that reject the existence of racism and ongoing colonisation undermine policies against these inequities, and mean that evaluations are unavailable.

Effective violence prevention and support services also reduce women's drinking, and egalitarian heterosexual relationships are protective. However, many violence prevention and support services lack funding and are vulnerable to changes in government priorities. Campaigns against violence to women have not been evaluated for their impact on women's harmful drinking.

Community action

A wide range of community projects, including kaupapa Māori, Pacific and sports club interventions, have been effective in raising awareness, changing alcohol policies, reducing consumption, binge drinking and crime, and creating safer environments.

However, sustaining these gains is difficult as funding for such programmes is intermittent and uncertain. Programmes aimed at reducing social supply to underage drinkers are ineffective unless retail outlets are also targeted and policies restrict commercial alcohol availability.

Education

Social marketing and school-based education programmes alone do not reduce drinking or alcohol-related problems, as they are overwhelmed by industry marketing and the disinhibiting effects of alcohol.

Treatment

AOD treatment is under-funded and inadequate for the number of people with alcohol abuse problems. This is particularly true for kaupapa Māori and Pacific alcohol services. Beneficiaries who fail drug tests are now required to attend AOD services, which is likely to overload them with recreational users.

There are major gender-specific barriers to AOD services for women. They include the separation and lack of co-ordination between addiction, mental health and anti-violence services, a lack of gender-specific AOD services, a lack of childcare, and a lack of knowledge about issues for lesbian and queer female clients.

14.2 Research gaps

Gaps identified in this review include:

Consumption

- A lack of continuity in national surveys of drinking patterns (apart from the National NZ Alcohol Survey Series – see Huckle and colleagues (2013)), and a lack of data about differences between women, such as in different age groups or between rural and urban women. A strategic approach is needed to enable comparisons over time while allowing for changes in methodology and survey design that takes new research into account.
- A lack of kaupapa Māori research about alcohol, particularly from a mana wāhine perspective
- Longitudinal data about the alcohol consumption of female adolescent heavy drinkers as they move into their 20s and 30s
- Research about why more women remain non-drinkers than men, how women sustain non- or occasional drinking or resist heavy drinking, and how non-drinking can be supported
- Drinking by women with intellectual and other disabilities and their access to AOD services
- Drinking by older women
- Representative, large-scale data on lesbian and queer women's AOD use
- Drinking by transwomen.

Influences

- Studies assessing the relation between experience of systemic discrimination and alcohol use.

Health and social problems

- The impact of other people's drinking on women and children
- Research into the prevalence of FASD
- The impact of women's drinking on children and whānau
- The health and social impacts of older women's drinking
- The impact of alcohol on women's economic independence.

Interventions

- Research into the prevention of FASD
- Evaluation of major alcohol policy changes
- Evaluations of the impact of policies and programmes against racism and discrimination on AOD use
- Evaluations of the impact of social marketing campaigns against domestic violence on women's AOD use
- Evaluations of interventions using kaupapa Māori approaches
- Evaluations of ethnic-specific and pan-Pacific interventions.

Lack of analysis by gender

A major gap is a persistent failure to disaggregate research by gender. Many studies on a range of topics failed to do this, making the research of limited value to women. They included research on:

Consumption

- Drinking by female students in alternative education
- Drinking by same-sex attracted secondary students
- Binge drinking at work
- Young people's drinking in affluent suburbs.

Influences

- Experience of racism by Māori, Pacific and 'Asian' women in Aotearoa.

Health and social problems

- Long-term risks from early exposure to alcohol (as well as early pregnancy)
- Physical and sexual assault by a perpetrator who had been drinking
- The relationship between alcohol use and STIs in a longitudinal cohort
- The relationship between binge drinking and suicide in secondary students
- People with co-existing substance abuse disorders and suicidal thoughts
- Alcohol involvement in fatal fires and deaths from drowning
- Alcohol-related crime
- The cost of alcohol-related crime in the police budget
- Problems from alcohol at work
- Treatment seeking by people with alcohol disorders
- Alcohol-related facial fractures
- The impact of the lowered purchasing age on 18 and 19-year-olds in hospital emergency departments.

Interventions

- Support for alcohol-related policies
- Surveys about restrictions on alcohol marketing
- Surveys of parents and caregiver attitudes about a minimum purchasing age of 20
- Evaluations of community action projects
- Brief interventions in a university primary care service
- Evaluation of sports club alcohol policies
- Surveys of AOD staff and clients.

15. Māori focus group analysis

15.1 Methodology

The Māori focus group was held in December 2011, organised and analysed by Te Pora Thompson-Evans of Hapai te Hauora Tapui. It used a kaupapa Māori, semi-structured interview process. The nine participants were all of Māori descent, and were recruited because of their work involving Māori and alcohol counselling or health promotion services. All received information sheets, and gave written consent before the group began.

Ethics approval was sought before data collection from the Northern X Regional Ethics Committee. They deemed approval unnecessary as the research was considered to be an audit, because all focus groups were conducted only with service providers and did not access client records.

Participants were asked to share kōrero of problems and health impacts experienced by women as a result of their own and others' drinking. They also discussed patterns of Māori women's drinking, and current and potential interventions.

The discussion was audiotaped and transcribed verbatim for thematic analysis. The transcript was manually divided into units of analysis (distinct meaning phrases), which were categorised according to the interview schedule. Two transcripts were independently coded by two researchers to check for consistency. The coded and checked transcripts were merged into one document. The results summarise all the findings and have been organised in the same order as the literature review.

15.2 Results

15.2.1 Patterns of drinking

Current patterns of drinking contrasted considerably with participants' perceptions of drinking by previous generations of Māori women. The amount, nature, venue and reasons for drinking seem to have changed over time. For example, one kaimahi (health worker) explained how in cultural settings like some marae it is now acceptable to drink, whereas before this was not the case. Drinking sessions a generation ago were described as happier:

There wasn't any yelling and swearing and they seemed happier ... sing and laughing and carrying on ... not as many women drank back then (Health planner and advocate: Wahine).

Today participants said the patterns of drinking are very different. Generations are separated by their choice of drink, music and crowds. Younger wāhine tend to prefer RTDs and 'lolly drinks' rather than beer, and binge drink in shorter periods of time. Middle-aged and older wāhine tend to be heavier drinkers who prefer the traditional longer 'garage or kitchen table party scene'.

I've seen our young women walking around legless, lots of Māori just absolutely munted (AOD counsellor: Tane).

Kaimahi said that much of Māori wāhine drinking appeared to be associated with the longstanding acceptability of alcohol as part of the New Zealand culture. Branding was also described as a major, but less important, factor.

15.2.2 Influences

When questioned about what influences on Māori women's drinking, kaimahi kōrero fell into four major categories: accessibility and availability, advertising, coping and dealing with abuse, and perceived Māori history and customary drinking practices.

Accessibility and availability

Every participant spoke of recent increases in Māori access to alcohol. Two kaimahi explained that the traditionally low numbers of Māori women drinking were directly attributable to the fact that fewer stores sold alcohol, and that there was not a variety of places to buy alcohol from.

When we were growing up, you only had bottle stores (Health planner: Wahine).

The availability wasn't in the shop. Women couldn't get to it then (AOD counsellor: Tane).

The participants' main concern was the normalisation of alcohol within low-income, effectively Māori, communities. One spoke of writing a crime prevention plan and plotting a large placement of pokie machines in areas of social and financial poverty. They suspected that the placement of liquor outlets would show a similar geographical pattern.

According to kaimahi the density and proliferation of liquor outlets has increased the number of Māori women accepting outlets as a permanent feature in their communities. Alcohol is permeating Māori lifestyles where it can and does do the most harm.

[Women] can get to it now, it's everywhere. In the garages. In all the shops. We say to them, 'Don't do this, don't drink like that, don't drink all the time'. But now at the end of the day – how do we stop them? It's everywhere (AOD counsellor: Tane).

Kaimahi viewed this normalisation as stigmatising harmful drinking and frequent purchase of alcohol. Māori women were also viewed as being more open (even public) with their drinking than their tauwiwi counterparts, as a result of the easy access.

It's just everywhere, it's so easy because it is everywhere and there is no stigma attached to it (Health promoter: Wahine).

They certainly don't hide away ... a lot of Pākehā women, they hide away (Health planner and advocate: Wahine).

Alcohol advertising

Many felt the advertising of alcohol affected Māori rangatahi the most, especially with the many forms of media used by this age group. The appeal of drinking for adolescent Māori women also stemmed from the 'cool' contemporary advertising. Stakeholders said that rangatahi heavily subscribed to the glamorisation of drinking in a fantasised attempt to keep up with their non-Māori and more affluent counterparts.

It makes our young wāhine [feel] attractive and part of the crowd (Health promoter: Wahine).

The persona of drinking also extended to how they chose to dress themselves, and what adverts heralded as being sexy and having sex appeal. Most agreed that advertising in this manner was dangerous for rangatahi, and that the way women are portrayed has an impact on the way they drink.

There's a level of sexuality and sexual openness, the kids are much more open ... especially with social networking. I wouldn't be surprised if it covers up a lot of how women are feeling about themselves (Health planner: Wahine).

Using alcohol to cope

All participants spoke of how drinking hazardously was a coping mechanism for Māori women. Lack of support and the inability to deal with the reality of their economic and social situations was discussed at length. Kaimahi found it hard to think of interventions aimed at building wāhine agency.

Drinking a lot of alcohol ... they're not equipped to problem shoot or handle a lot of the problems that are happening (Health promoter: Tane).

Health

One kaimahi spoke of her work with Māori wāhine who are heavy drinkers, almost all recovering from treatment for a terminal illness. Many do not attend clinic appointments at all, or keep rebooking, so that medical professionals are immediately aggressive with them when they do attend. Their drinking is an escape mechanism for them to cope with the trauma of illness, as well as the trauma of dealing with practitioners and the clinical environment.

When they get that bottle ... It just all goes away.

They'll go back to the bottle instead of listening to [the doctor] telling you that you're bloody useless and that you are dying ... they dig themselves in deeper (AOD counsellor: Wahine).

Customary rites, passages and historical aspects of drinking

The main influence on wāhine drinking that was discussed in detail was the normality and acceptability of the 'Māori drinking culture'. This was strongly viewed as being different from the typical New Zealand drinking culture, as Māori values, poverty and social inequities generally formed the backdrop of the Māori drinking culture.

Binge drinking and moderation

Binge drinking for wāhine has become a norm, particularly for adolescents. Binge drinking has become more affordable and accessible through the availability of liquor outlets in Māori communities. The frequency and capacity of drinking has increased, according to kaimahi:

The notion of binge drinking ... is surfacing among our whānau, but particularly our women. They start when they are young (Health promoter: Tane).

Many explained bingeing as the norm, and moderation as a foreign concept in the communities they deal with. Moderation, one kaimahi felt, was up for interpretation:

What is moderation? How do we have a moderate kai? (AOD counsellor: Tane)

Others agreed that drinking in moderation was inconsistent, when perceived from Māori women's point of view and within a Māori context.

Exactly ... and how do you have a moderate beer? (Health promoter: Wahine)

Although they agreed that not all drinking was viewed this way, drinking starts off being sociable for wāhine, but can escalate continuously when some people go 'hardcore'.

One participant said that within the Māori drinking context, drinking moderately was viewed as socially undesirable; it displayed an inability to 'hack' drinking copious amounts. In many of these drinking situations, kegs or boxes are the norm. Young drinkers often sit with whānau drinking from kegs, and learn to drink heavily from these social settings.

Everyone starts laughing because they can't hack it. So they start wanting to drink more and get better at it (Health promoter: Wahine).

Such behaviour is socially acceptable in Māori communities. The large amount of alcohol available promotes whanaungatanga and sharing. Participants said it also allows Māori, especially those in urban settings, to be together. Also, given the socio-economic circumstances, it creates a sense of unity and almost pride that they are good at something, even if it is drinking.

Following on from whanaungatanga, other influences raised for Māori women included social obligations. One kaimahi explained that if family had come a long way to visit, it could be considered inhospitable not to offer drink. One example was a Māori university student:

Even if she has an exam in a few days she'll still say ... I have to cook a kai ... I'm not going to go study, that's rude if I don't go outside, sit down and drink with them (Health promoter: Wahine).

Wet and dry parties

One participant mentioned attending functions that were not originally alcohol-orientated events, but ended up being so.

The beer came out and drinking ... before you know it everyone is drinking and it's a party (AOD counsellor: Wahine).

On the other hand, two wāhine kaimahi spoke of events they had attended that had banned alcohol. While guests were welcome to arrange to drink elsewhere, the gatherings were alcohol-free. Surprisingly, accordingly to the kaimahi, those who attended in general complied with this alcohol-free status.

Other kaimahi expressed how getting together in the 'old days' was around kai and 'cups of tea' and spending quality time together.

15.2.3 Alcohol-related problems

All agreed that when wāhine are affected, the 'backlash of harm goes all through the whānau'. The financial cost of drinking was only mentioned once, as was the potential harm to babies from drinking during pregnancy. The two key themes that appeared to stand out for participants about problems to wāhine from their own or others' drinking were inattentive parenting and violence.

Parenting

Problems resulting from wāhine drinking were related to their inability to parent effectively. Kaimahi spoke of how they dealt with wāhine who failed to send their children to school as they were still drunk or recovering. Those who never sent their children to school were described as being more likely to drink during the weekdays.

They miss out on school and stay home and watch mum suffer throughout the day (Health planner and advocate: Tane).

The problem for wāhine is the risk of having other state agencies and other whānau intervening with the parenting and caring of their children, and the potential for their children to be removed. Kaimahi said that many wāhine they dealt with were single mothers who found parenting alone hard to cope with. They also dealt with two-parent families, where if the father was drinking then usually the mother was drinking as well.

Violence and abuse

Kaimahi said that Māori females were highly susceptible to experiencing violence while drinking with their male partners. Many had witnessed examples where drinking with partners or their partners' drinking resulted in physical and emotional abuse. Some spoke of Once Were Warriors¹ scenarios.

... The women, they were drinking too, but they're the ones who end up bleeding ... Fists can connect (AOD counsellor: Wahine).

1. New Zealand movie (1994), featuring serious domestic violence.

Some attributed the violence to the availability of alcohol in their communities:

We don't want our wāhine and tāne to drink because they bash them up, but you can buy it in the shop (Health promoter: Tane).

There was debate about who kaimahi saw as starting the fights that led to violence on wāhine. Some said that in some cases wāhine, when drinking, become argumentative and purposefully pick fights. Some kaimahi viewed Māori women as being verbally taunting, especially when heavy drinking was involved.

I ask myself... Do they get haurangi [drunk] to pick a fight...? I see them and they tell me. I don't see similar from tāne (AOD Counsellor: Tane).

Fighting and violence, though, have apparently changed considerably compared to days gone by.

Nowadays when whānau drink ... the fights are closed down very fast ... Forty years ago, the woman was beaten to a pulp and everyone carried on with the guitar. Now the men close down the fight and send the wāhine home. The party is usually over, so in many cases, yes ... drinking has changed (AOD Counsellor: Wahine).

15.2.4 Interventions

Any intervention is the same really, though, unless you change their lives and the opportunities that they have ... then why would you change? You can't effect change, if nothing changes (Kaimahi: wahine).

Participants were quick to identify interventions they saw as being effective in reducing or preventing damage from drinking. Almost all were not clinical. All were based and run by Māori providers, and had strong elements of Māori values like manāki (caring) and aroha (love). There was a relatively strong perception that to prevent and reduce alcohol-related problems for Māori women, interventions needed to be kaupapa Māori oriented, and run in familiar and culturally appropriate settings.

All felt strongly about the need to embed Māori value systems in interventions that dealt with Māori, even if they were run by mainstream organisations. There was also considerable support for media campaigns to be relevant to Māori, so that they could identify with and apply the characters and their messages to themselves. The consensus among kaimahi was that whatever the intervention, those that were most sustainable for wāhine supported alternatives to drinking, and created hope that they could attain opportunities for upward mobility.

Marae and cultural engagement

An urban marae in a high deprivation area was highlighted for an intervention that impacted on Māori women and their drinking. It brought one-parent whānau together and tried to maintain that whanaungatanga by supporting the social infrastructure of the family. This was done by helping wāhine to use social and housing services, advocating where needed but largely encouraging them to develop a sense of agency, and to confidently and competently access these services. Letting the children play with kids from another whānau also allowed mothers to take time out for a few hours.

It's a lot of women bringing up families on their own ... we look at them as a whānau and we awahi (Kaimahi: Tane).

Another intervention that looked at single women, in particular those with children, focussed on reducing problems by building social connections across the community. The group was based on tikanga and strengthening values and confidence.

The same urban marae also ran Māori warden patrols on benefit days when required, to create a sense of manāki and a culturally accepted, authoritative presence in the community. The patrols aim to counteract the violence and abuse linked with the high rate of drinking on 'pay days' in lower economic urban areas.

You see a lot of whānau spending a lot of their money on booze ... and they're getting drunk ... that's got to impact on their wāhine (Kaimahi: Tane).

Education

There was strong consensus about the efficacy of interventions based on further education. One intervention helped Māori women into nursing studies, with positive results. Certificates of unit standards completion were given to women to reinforce short-term achievement and show how it contributed to long-term goals. The final award ceremonies were held on the campus marae, where students shared their success with their wider whānau. According to kaimahi, during their studies a large proportion of wāhine significantly reduced their alcohol and other drug intake.

Almost all of them when asked why they stopped the booze and stuff they said: because it was hard work, putting kids to sleep, studying. It gave them hope and they saw that for their children (Kaimahi: Wahine).

Participants said that other methods such as the HALT (hunger, anger, lonely, tired) model (Johnson, 1990) had been used occasionally to help reduce or prevent alcohol-related problems.

Concerns for Māori wāhine seeking help

While many participants believed Māori interventions helped to reduce and prevent alcohol problems for wāhine, they considered mainstream interventions and traditional helping organisations largely unsuitable. They gave two reasons why wāhine Māori seeking help from medical professionals was problematic. First was the level of treatment they experienced from health professionals. Second was the inability of medical staff to look at the issues underlying drinking and related problems. Funding issues for interventions also had an impact on delivery of services to Māori women.

Professional treatment

Kaimahi spoke of the stigma associated with Māori woman seeking help from primary and mainstream services. There was considerable support for Māori wāhine perceptions that if they were to seek help from such services they would be stigmatised and 'stereotyped as a bad mother'.

I see it all the time when Māori women come in, the assumption of Māori women are useless anyway ... stands (AOD counsellor: Wāhine).

In general kaimahi felt that non-Māori and medical staff were ill-equipped to deal with the 'complexity of issues' attached to Māori women and drinking.

Somebody might be presenting with a problem of alcohol. There may be problems there in itself. It's not like going to the doctors with a cut finger is it? Often there are underlying issues which may be at the root of the problem ... relationship problems ... gambling problems. That in itself is a problem (Health promoter: Tane).

Prejudice and racism

At least half the kaimahi saw Māori women exposed to prejudice and racism as a consequence of seeking help. Discussion about systematic bias focused on Māori women being brave enough to use those words to doctors and medical staff. However, one kaimahi said that caution was needed when using such words, considering that Māori themselves were also openly expressing prejudice towards medical staff.

Funding

Funding was seen as an issue for effective interventions for Māori, as funders govern accessibility to everything for non-government organisations. Kaimahi spoke about how suspicious they were of funders, as they explained it was harder to work appropriately and in a culturally relevant way with Māori. Positive outcomes for Māori wāhine in preventing and reducing problems from drinking were tougher to achieve in such situations, given the inequitable access to funding and unrealistic, inappropriate frameworks.

It's like saying we have our bread with cream, but you have yours with butter (AOD counsellor: Tane).

15.3 Discussion

15.3.1 Patterns of drinking

Group participants believed that Māori women's drinking patterns have changed remarkably over time. Although participants differed in their kōrero about whether these changes have been beneficial for wāhine, they agreed that the choice of alcohol was no longer uniform, or as easy as having one main type of alcohol to drink (for example, just beer).

15.3.2 Influences

There was a strong consensus that the availability of alcohol in communities, especially lower socio-economic ones, was a major contributor to drinking levels among wāhine. The spread of stores and outlets contributed strongly to the perception that they are normal features of society. Kaimahi agreed that greatly reducing the number of liquor outlets would also reduce the rate of drinking among Māori women.

Another major influence was that alcohol was becoming accepted as a contemporary Māori custom. The frequency and amount of drinking, coupled with the affordability and accessibility for wāhine, contributes to the permanence and tolerance of alcohol in Māori lives.

Advertising was viewed as dangerous for younger wāhine as it gave them a false sense of identity and enforced their patterns of destructive drinking or likelihood of binge drinking. Participants believed that branding, trendiness, and age and gender targeting influenced the different drinking patterns of Māori women.

For many wāhine with health problems, drinking was described as a coping mechanism. This was also true of those dealing with difficult social and economic situations.

15.3.3 Problems

Participants strongly agreed that the primary problem for wāhine from alcohol, particularly those with tamariki, was the negative impact on effective parenting. Children may often be exposed to the health after-effects of drinking, and less attention. Non-attendance at school was discussed as the biggest detrimental factor for tamariki as a result of wāhine drinking. Participants spoke of how parenting on their own was often difficult for wāhine without a partner or whānau support.

Kaimahi agreed that there are strong links between violence, abuse and alcohol, particularly for wāhine. The precursor to the violence and abuse was related more to the availability of alcohol, social pressure and the ability to communicate. However, drinking tends to be a catalyst of violence and abuse for wāhine.

15.3.4 Interventions

Interventions for wāhine Māori have tended to revolve around education and building the whānau unit. Kaimahi described strengthening whānau as paramount for Māori women, both single and partnered, so they felt supported in coping with the wider social and economic struggles of living. According to kamahi, educating wāhine about how to navigate support and social systems to lessen the struggle has been of benefit.

Other beneficial interventions for wāhine, and probably those with the most long-term positive outcomes, have been supporting wāhine in participating and gaining qualifications in education. Participants saw these programmes as uplifting wāhine overall, with the biggest potential to aid their upward mobility and remove social barriers to wellbeing.

15.3.5 Help-seeking concerns

Kaimahi voiced concerns for wāhine seeking help. Kaimahi described how fears and experiences of stereotyping, stigma and racism hindered Māori from seeking help for their drinking. Participants also spoke of how clinical and non-Māori services and providers were not always culturally and professionally equipped to tend to Māori wāhine.

Māori frequently require a holistic approach and sense of comfort before they speak about underlying complex issues such as drinking. Kaimahi also alluded to the need for equitable funding, and equitable and realistic outcomes for wāhine to reduce the problems from their own and others' drinking.

16. Other focus group analyses

16.1 Fono talanoa analysis

16.1.1 Methodology

Talanoa means 'telling stories' and fono talanoa is literally a 'talking meeting' (Vaiotele, 2006), encouraging conversation within unspoken understandings to generate data (Tolich & Davidson, 2003; Morgan, 1997). Fono talanoa participants brought the cultural understandings of fakalilifu (Niue: respect) and aroa (Kuki Airani: compassion) to a discussion which is faka'apa'apa (Tonga: respectful, humble and considerate), anga lelei (Tonga: generous, kind, calm and dignified) and mateuteu (Tonga: well prepared, professional and responsive).

The approach involved the researcher's connectedness, encouraging participants' engagement within their cultural world-views. Participants were invited as a voice from their respective Pacific cultures. The six women came from Fiji, Niue, Samoa, Tokelau, Tonga and Tuvalu communities. A Cook Islands participant was unable to attend at the last minute. All the women were over 35, born and raised in the Pacific and permanent residents of Aotearoa. All were leaders of their communities and nominated by other leaders.

Their roles included tertiary institution student support worker, former family violence therapist, former mental health support worker, family violence prevention worker, Pacific language preschool leader, and Pacific language radio presenters.

The talanoa was facilitated in December 2011 by a Niue facilitator, and held in a church hall with a blessing by the Pālagi host female minister. The process for talanoa was as critical as the discussion and the resultant data (Health Research Council, 2005). The question schedule asked about trends and influence in drinking, alcohol-related problems and interventions. The talanoa ranged over a variety of topics, and the researchers encouraged participants to direct the dialogue into issues that interested them. All participants were provided with information sheets, and signed consent forms.

Interviews were transcribed verbatim and coded for deductive (Thomas, 2003) and thematic analysis (Braun & Clarke, 2006), which was supervised by the facilitator. Themes and topics have been organised in the same order as the literature review.

16.1.2 Results

Patterns of drinking

Participants were all concerned about what they perceived as a definite and disturbing increase in women's drinking across all Pacific ethnicities.

Tonga: It's a big problem in the teenagers, in the girls, yes.

...

Fiji: I know these days my young nieces at [school] are bringing the alcohol home ...

...

Tuvalu: And that's a real concern to me.

Group: Yes. Mmm.

Tuvalu: Like ... they don't just drink to enjoy but they just drink until they drop.

Tokelau: They are starting young ... I went to the colleges a couple of times and you'll find a lot of them, in their school backpacks they've got bottles, because they're so easy to get.

...

Tokelau: But some of them my age, some of them older than me, they are way out of hand.

Tonga: Abusing it, eh?

Tokelau: They turn up to the socials, they can hardly walk. It's embarrassing ... because ... I'm taking my children to this community social and I'm exposing them to this ... our community, you know?

Participants said that pre-loading contributes to drunkenness:

Niue: And what they were doing was they drink before they go to this spot.

And ... their time to go to social is about 10 o'clock. (Group giggling.)

They're already drunk by then, plastered by then. (Laughter.)

So they're half-cut before they even go anywhere.

The group discussed young women's drinking patterns:

Tonga: ... like in the weekends. Just enjoying drinking somewhere ... then, you know, after a few they start wanting a ride somewhere, going nightclubbing.

Tuvalu: Sometimes they just go disappearing ... they only appear ... like Monday, Tuesday.

Group: Yes.

Tuvalu: ... and you just don't know where the hell they are.

Some found this a difficult topic.

Niue: You can't really separate drug from alcohol because it's one thing. You know, if they go the extra mile to make it stretch. I hate talking about these things because it sounds, like, rather gloomy.

Drinking in the islands

Some islands have a home brewing tradition which continues in Aotearoa:

Tokelau ... our alcohol is already mixed so it's very, it's a lot safer. In the islands they run out of alcohol ... they make it. Home-brew. And that's more potent than the ua [wine], it's like kava.

Others: Yeah. Mmm.

Tokelau: That's more potent than anything else and plus if they have hot bottles they can mix it with cordial, you know? ... So there's no real two nips or whatever we call two.

Tonga: Yeah. Just water and lime or something.

Tokelau: They just put the whole bottle in what they call a kettle ... our Island kettles? Pour the whole bottle in and maybe cordial, about that much [indicating a small amount] ... And they just pass it around.

...

We had a shop and ... sometimes I'll say to my father at night, 'Dad, we're out of brown sugar'. He goes, 'Oh, people making home brew'.

Participants reflected on whether drinking patterns were any better or worse in the islands, concluding that the same influences were at work there as in Aotearoa.

[Niue is] a small place and a few people. But the level of alcohol consumption is really quite ...

Fiji: High?

Niue: Yeah. And I see that as trying to socialise and it's just ... normal.

...

The first thing that goes to Niue is the alcohol off the boat. If the sea is rough, the alcohol has to go out first. (Group laughter.)

...

Fiji: In Fiji the hours just continue to extend 'til 5am these days. So can you imagine the amount of alcohol drunk, unregulated drinking that goes on in a less regulated society?

Influences on drinking

One participant illustrated the common awareness of blending Pacific ethnicities, where behaviour and cultural understandings have to be negotiated about drinking and other issues:

... our generation that we have today, I speak for my own family, is that we don't have a pure [ethnic group]. My sisters have married Niue ... Cook Islanders. My nephew, my niece's married a Fijian ... My grandsons are Tongans. You know?

Advertising and marketing

Participants described advertising as relentless:

Niue: Day-to-day TV there's advertising, all these things. And just the music, you know, they soak all up the TV.

Some alcohol products were perceived as overtly and successfully marketed to women.

Fiji: But definitely alcohol is so available and it's so pretty.

Group agreement: It is pretty. Well packaged. Yeah.

Fiji: And it's part of a whole thing that just targets the young buyer, the young, young ones. Especially for our girls. The colours have been made for girl appeal. The shape of the bottle ... It's beautiful. That's what we buy our infused herbal oils in. And girls now can buy them in [that] saying, 'I'm a very posh woman'.

Others: Yes.

Availability of alcohol

The availability of alcohol had changed hugely since participants were young, both in Aotearoa and in their home islands. They saw their children or grandchildren in both places facing a very different environment.

Tokelau: They've got older friends that can go into a dairy, underage or not, they can purchase a four-pack. They're selling it in the supermarkets.

Others: Mmm. Hmm.

Tokelau: It's so easy, you know? So really you can't avoid it. The kids have easy access ... And it doesn't help that those people that are selling it are not controlling it there.

Outlet density

Talanoa fono participants were concerned about the proliferation of alcohol outlets in suburbs where Pacific people live.

Every block of shops has an alcohol stop there.

... Yeah. I'm talking about South Auckland.

... No. Not West. We didn't accept it.

... No. They don't. But they can sell it in the supermarket.

Price

Participants said alcohol had become cheaper than in the past:

Fiji: [When we were young] ... we knew that alcohol was expensive.

Others: Yes.

Fiji: There were only some people can afford the alcohol. The rest of us ... would tag along and we'll share. (Laughter)

Supply to underage drinkers

Participants saw parents as ultimately responsible for young people's drinking:

Niue: Yeah, but it's the adults who introduce all these things ... We asked [young people] 'How did you start drinking?' And they said ... usually at home, when the father asked them to go and get a beer from the fridge and they open it, it's a thick glass and they have a sip and that's how they start.

Participants discussed the dilemmas of parenting in an alcohol-drenched society:

Tokelau: When they turn 18, 19 ... they could have a drink at Christmas with us or they would have done it with their friends. I chose for them to drink with me so that they can learn how to drink. And it was a safe environment for them, you know? And I mean, hey ... I couldn't say no because at the end of the day they still would have done it but with outside [people]...

Dealing with trauma and pressure

Young people's drinking was seen as a way of escaping the pressures they were under and coping with prior trauma.

Tokelau: And the stress from home for whatever reason ... They have lots of things but they find drinking alcohol is a release for them.

... To voice what they are really going through.

Samoa: There's a lot of pressures that are on our young people.

...

Samoa: And I find with our young women, because some traumatic experience they've been through ... indirectly they don't realise what they're doing but it's numbing their feelings, it helps them not to speak about those experiences, and for them that's their only way ... out.

Changes to community norms

Participants saw the dominant Kiwi drinking culture as eroding traditional protective factors such as female non-drinking, and increasing the likelihood of drinking patterns that mirror Pālagi norms.

... the early days in coming to New Zealand there were few women that drinks.

... But today it's just like a normal drink wherever there's fundraising.

(Group agreement.) Yes. Yeah.

Another Samoan woman said:

... my parents were pretty strict and all of us children all tasted what we were never brought up with. You know? So our parents came to do their darndest for us but it comes back down to what are my values? And what will I be passing on to my children? You know and ... the influence of society doesn't help.

Later she said:

Samoa: Because our primary kids are ... looking at, 'Oh, it's beer, they're pissed again'.

... It becomes a norm.

Samoa: A norm for the young kids.

... Just numbing to the, to the standards.

Talanoa returned several times to the difficulty of supporting the next generation to drink responsibly and resist outside influences. One member and her husband had given up drinking to set a good example for her children, and another mentioned another couple who had done so.

I gave up the drinking and you know, all that sort of stuff. It didn't work with the children, of course, 'cos the competition with the outside world is just too great.

... this young generation who we already notice how freely they take [alcohol] as part of life. They just grow up and can't wait ... Used to be smoke to see that you're growing up at last, you know. But now it's drug and alcohol.

Later this woman asked:

... how do you compete with the world at large who allows these things to happen?

Social inequities

One woman's description of a discriminatory environment at secondary school that encouraged young Pacific women's drinking, found agreement with other participants:

Fiji: ... they're dealing with the, kind of alienation. Thinking with my niece, maybe it's a kind of classist school. Maybe she's struggling to fit in.

Others: Mmm. Mmm.

Fiji: Maybe she's not able to fit in and so she's found another group ... the drinking camp to fit into her school.

One participant referred to the colonising process and institutional racism:

Niue: So, and I hate to say, I think the White man has done a lot of damage to our health, to our brains, to our spirituality.

...

Niue: But even if you take it up to the system, the system do a lot more screw up of our families.

Others: Yes. Yes.

Niue: Because the system is just ... I usually call it injustice system because the justice system is to prove whether the perpetrator is right or wrong.

Problems

Participants agreed that Pacific peoples do not speak about some issues, including alcohol-related problems:

Tonga: But I think that the reality of it ... because in our culture we don't talk about it.

Others: Mmm, hmm.

Erosion of cultural wellbeing

Participants described the disruption that harmful drinking creates for cultural wellbeing:

Fiji: But definitely I find that ... a lot of struggle keeping our customary ... conventions and our rules and morés, and having to kind of break away every weekend, and you see the girls are breaking out and getting in to the ... alcohol.

Others: Mmm. Yeah.

...

Niue: ... the family systems have broken down and all I can say is ... I think the intervention from ... some key people in the island groups that that have the respect of the families...

This woman, after describing drinking in her formerly alcohol-free home by younger family members, said: 'it seems like the respect or the boundaries that once was secure are no longer existing'.

Fighting

Several participants identified alcohol-fuelled bullying, fighting and violence by young women with other youth as a problem:

Tonga: Whereas our girls here, they become violent too, eh? I find more girls on the street are fighting, scrapping at night-clubs.

... But they fight the boys.

Tokelau: It's scary actually.

Others: Yeah. It's scary.

...

Samoa: Like there's a bullying incident or there's a fight that's happened ... I get there – it's alcohol related.

Education

Expulsions from training and tertiary education were another problem:

Samoa: They're bringing alcohol onto campus [and] being expelled. So the career that they wanted to do they no longer can pursue it because of this alcohol problem, you know. And some of them have never tasted it at home.

Unwanted pregnancies and sexual abuse

One gave an example of unwanted pregnancies from drinking homebrew in the islands.

Tokelau: They go into the beach late at night while their parents are sleeping ... all these young mainly women, girls.

... end up with pregnancies, around child abuse and all the rest that comes with it ... well, they're none the wiser. They're all too drunk.

Participants discussed unplanned 'things', which meant sexually transmitted infections, damaged reputations, shame and regret:

Tuvalu: ... that's when the sleeping around and things occurs and ... getting involved with married man and ... these young people really have no idea what they're getting ... themselves into. The next thing you know they're pregnant ... to a married man ... I think because of all the drinking and things that's going on there's just ... no control over our – yeah.

...

Tuvalu: And I'm worried about the consequences. For instance, they may get raped, they may get, you know? All those things

...

(Group) Yes. Mmm. Yes. Yes.

Tuvalu: And you don't ... even know who they're going to go with after the dance ... So we get a little worried about those things.

Another transgression is incest, which this participant found hard to discuss:

Tuvalu: And I think this is where incest comes in as well.

Group: Yeah. Mmm.

Tuvalu: Some families like the cousins, the brothers, the sisters, they have parties all the time and there's where, all of a sudden, you hear really disgusting stories like...

Group: Yeah.

Tuvalu: First cousin or even the brothers and sisters you know, slept because, you know, they're so drunk.

Participants also mentioned traffic deaths from drink driving, family fights, and alcohol-related suicides by young women.

Suspicion of government and the alcohol industry

Some participants perceived the government as abdicating its public health responsibility about alcohol, leaving Pacific communities with few options and little influence.

Niue: ... the biggest ogre is the government of course, that condoned all these alcohols for getting all the money back from these, from these breweries and all that sort of thing.

... That's tax, you know? That's money, economic development.

So, you know, I felt quite helpless when I think about the bigger picture.

...

Fiji: Maybe the tobacco companies in the world are not as strong as the alcohol companies (laughs)... which are very, very, very strong. How do we think our little Pacifica communities, for example in South Auckland, how do we meet those kind of big money powers and the government?... Governments make policies to them and they give government the kind of money ... the government needs. So how do we protect ourselves and our children and our community? So we think about small sustainable little interventions that ... work.

Interventions

Social marketing

Participants agreed with the need for sober drivers but perceived current anti-drink-driving campaigns as normalising drunkenness.

Tokelau: ... so if you have a sober driver ...

They can drink.

(All talking at once.)

Tokelau: Everybody else in the car's still getting plastered, which doesn't change the fact that the alcohol is getting drunk.

It just means one of them is not drinking for that ...

For that particular day.

Samoa: So it makes it ... you're legalising it, if you like.

Community health promotion

Participants had a wealth of ideas for community health promotion around alcohol, including as part of Pacifica and Polyfest performances:

Tokelau: Get them to do little skits in between their performances [at Polyfest] or whatever in their own languages where they can relate, because I know a lot of the young kids, they're very proud of their culture.

They were enthusiastic about the idea of a community YouTube contest:

Fiji: Cos we could run a programme, a contest for the best alcohol skit and we will put it on YouTube.

... A skit or a song. But something that will catch the eyes or the attention of these young kids.

(All talking at once.)

Tonga: ... as groups they sit down and think about it and maybe they are drinkers.

... And maybe it would make them ... think ... you know?

(All talking at the same time.)

Samoa: I think it will ... It'll be an eye-catcher for them. At first they'll think, oh, whatever.

That's dry.

Yeah, that's dry.

But then they'd rise for it, yeah.

They thought snappy 'nek minnit' clips could be used in radio as well as video.

Samoa: I like that clip ... nek minnit thing.

Tuvalu: So it's not next minute but nek minnit?

Tonga: We could have that alcohol in stages with that nek minnit in between it.

Niue: We could go a alcohol ...

Tonga: Nek minnit one glass, you're drunk. Nek minnit, another glass ...

You're crashing the car.

...

Fiji: I really, I really believe that our people tune in from all over the country just to listen to the language, our local language. We should just be maybe using five-minute nek minnit things.

One participant was interested in creating a health promoting Facebook ad:

Samoa: You know that's where our young girls are. They can't wait to get on there ...

Tonga: I tried creating an ad ... So I did this flower thing and it came up and, whoa...Yeah and it was rolling in other people's pages and – wow.

Researcher: So you're going to go back in and do one for alcohol?

Tonga: I should, eh. And it's for free ... I'll get my son to try.

They wanted to use all possible media for health promotion campaigns about alcohol.

Niue: ... as a Pacific nation the platforms are already there ... But one of the most successful ways of getting the message across to many Pacific countries is the metaphoric language. Through songs, through hip hop themes and all that sort of thing. They bring it right close to the bones when you actually role-play these things. But include the young people to plan these things, because it's targeting them.

Samoa: But use all the media you have ... You've got the radio, you've got the internet, you've got ... why not? That's where they're getting our kids for alcohol and smoke. Why not use the same channels to get it out there, you know?

Church interventions

Participants said that Seventh Day Adventist and Mormon churches promoted abstinence. However, they also said that some churches were not helpful about alcohol.

It's laughable because that is the worst place where these children, the youths are actually exposed to it.

... Sorry to say. I mean, I go to church, you know? But I see it. And I feel sorry for these parents that stand up in front of us and say, 'Look, you know, we're going to do this and we're going to do this', but it's their children that are the instigators of all these things that we talk about.

Campaigning against more liquor outlets

One participant described the demands on community volunteers of campaigns against more liquor outlets:

Niue: And that's one thing I know that the community in the South Auckland have gone to the council, the local councils and said, we don't want any more liquor outlet in Papatoetoe, you know? We don't want this over in Manurewa because it's just too many. But it just means that people have to be vigilant and being involved to know when those things [come up].

Family intervention

One participant discussed passing on family values in the face of 'the current ... out there that is dragging all our children, everything out'.

Niue: ... the ... upside of that upbringing is somewhere along the line, they'll bounce back to those teachings.

One woman described trying to intervene about alcohol being bought for underage teenagers:

Fiji: I find my son is often approached, because he's already 18, to buy for his friends who are under 18 and I say, 'Well, have you really thought seriously about why you say yes? How you can't control somebody else's drinking?'

I know these days my young nieces ... are bringing the alcohol home. And I said, 'What, have you told your mother? Does she know that?' And I've had to actually say, 'Right, you tell your mum first before I do that you have brought the alcohol through someone' ...

And I have found that at fifth form, at fourth form ... and I think it's gone even younger than that.

Education

The talanoa fono discussed education in primary and early childhood, 'because the kids [are] starting younger':

Niue: ... some story books talk about ... the colourful waters that adults drinks and now children are drinking too but it's bad for your health. I mean, we get so excited about bird flus and everything and yet, the biggest bird flu that kills most of our people is the blimming alcohol!

Others: That's right.

Fiji: Avian in a different bottle. (Laughter)

However, one woman expressed discomfort with the concept:

Samoa: So maybe it's, um, I don't like the word educating but maybe it's informing them at a younger age, our young girls ...

16.1.3 Discussion

Participants agreed that women's drinking had increased markedly in a generation, and were concerned at what they saw as high rates of drunkenness among young and older women. Their home islands were not immune, dealing with similar increases in drinking.

Industry advertising and marketing were seen as a strong influence on women's drinking, as was the density of liquor outlets in Pacific neighbourhoods. Other influences on women's drinking were the low price of alcohol, social inequities and trauma. For these women, a major problem from alcohol was the erosion of cultural wellbeing and family cohesion. Participants struggled as parents to maintain cultural values of respect, spirituality and traditional boundaries in the face of what they described as an overwhelming pressure. Other problems included sexual abuse, unwanted pregnancies, fighting by young women, expulsions from education, and suspicion of government. The relentless pressure and huge damage led to feelings of helplessness.

However, the group was excited, enthusiastic and creative about community health promotion, suggesting building the issue into cultural performances, community YouTube contests, hip hop songs, 'nek minnit' video and radio clips, Pacific-language radio shows and Facebook.

While some church denominations supported abstaining, participants found attempts by some congregations to deal with the issue to be hypocritical. Some said that campaigns against more liquor outlets required sustained vigilance from already beleaguered communities.

16.2 Mixed focus group and interview analyses

16.2.1 Methodology

Focus groups were the primary method of collecting information as they yield rich data, give participants the opportunity to talk with others working in similar fields, and discuss similar and differing viewpoints (Tolich & Davidson, 2003). Over 40 organisations that deal with alcohol-related harm to women were approached to participate and 20 were represented in the groups.

All participants received information sheets about the research, and gave written consent. The question schedule asked about trends and influence in drinking, alcohol-related problems and interventions; it is included in Appendix 1. Although the groups had a semi-structured format, discussion covered a variety of topics and the researchers encouraged participants to direct the conversation into areas that interested them.

The mixed and tauwiwi focus groups were held in November and December 2011, facilitated by one or both Pākehā researchers, and included:

- A hospital group (co-facilitated by the Niue researcher) – Four North Island hospital and community health professionals; Māori, Pacific and Pākehā.
- A violence against women (VAW) group – five representatives from services dealing with sexual and domestic violence; Māori and Pākehā.
- A community group – six representatives from organisations serving lesbians and queer youth, dealing with crisis and counselling, family support, eating difficulties, and sexual violence prevention; Pākehā, Pacific and tauwiwi.
- An alternative education (AE) group – a participant-initiated group of eight Māori, Pacific and tauwiwi staff in an Auckland region alternative education setting.

Because some organisations could not get to the group meetings, two interviews were held with alcohol treatment managers in the north and south of the North Island (Northern and Southern treatment managers). One community nursing service manager who did not have time to be interviewed gave a written response to the question schedule.

While focus group participants spanned a range of organisations, sectors, communities and ethnicities, there are some whose inclusion would have enriched the information. For example, there were no representatives who worked directly with female prisoners, or immigrant communities.

Interviews were transcribed verbatim and coded for deductive (Thomas, 2003) and thematic analysis (Braun & Clarke, 2006). The researchers analysed the interviews they had facilitated separately, and together discussed themes in the data. Themes and topics are organised in the same order as the literature review.

16.2.2 Results

Women's drinking

Participants noted particular trends in women's drinking, often stating that women appeared to start drinking at a younger age, drink more at each setting, consume larger amounts, and beverages with higher alcohol content, than in previous generations.

Age

Hospital workers agreed that the age at which teenagers first came to hospitals with alcohol problems had 'gotten younger'.

Researcher: So when you first started, what was the ... youngest age which you would see girls with alcohol problems?

Māori health worker: Oh, it is a while back – 17? So now it's like 12, 13.

Others: Yeah, yeah.

Mental health worker: ... the younger they are with their alcohol, by the time they are 16 it is already embedded in their lives.

The amount women drink

Most participants thought there had been an increase in women's drinking and alcohol-related problems, and that was of great concern.

... my main concern is that the contribution of alcohol on negative effects for society and in particular women is just escalating to an alarming degree ... certainly in the last 5 to 10 years it's just become ... extremely concerning ... I see it as escalating [exponentially] rather than in a steady rise (Violence against women (VAW) participant).

... when I was a kid there was no alcohol anyway, my mother would never have me at the party, but today you see mummies with their babies ... sitting at a party having a beer, you know; it is a different culture (Alternative education (AE) participant).

There has been a big increase, you know, binge drinking, especially amongst our teens. I mean we are not too far off teenagers ourselves, but back in the day we didn't used to party like these guys party – everything is really out of control (AE participant).

While many participants commented on youth drinking and problems, one younger participant pointed out that alcohol-related problems were not only a youth issue.

...young people aren't the whole issue here. ... like, young people are only like 25 percent of the alcohol issue... it's more the adults that are causing ... problems with alcohol (Community participant).

However, one participant thought trends towards increased drinking needed closer inspection, and suggested that some communities of women had always drunk heavily and started drinking young. She gave the example of gay women in the 50s.

So I do wonder when they say women's drinking is worse – I am not sure what they are comparing it with ... But when I came out – the gays; I have never seen the consumption of alcohol so high, just amazing they were just, very high, you know, a lot of drunkenness (Community participant).

Although some participants had noticed very clear changes in women's drinking and related problems, others were wary of commenting on an overall picture, as members of their organisations disagreed about the extent of this change.

Some participants thought women's problem drinking might remain hidden more often in comparison to men's. Compounding this was a lack of discussion of women's drinking.

... there are more women with hidden drinking problems – that notion about talking about drinking is really minimal (Community participant).

Locations where women drink

Participants said that more women were drinking in public than in earlier generations because of fewer social controls, and that this may contribute to a perception of increased problematic drinking by women. However, they also commented on women drinking privately in the home, alone or with friends, relations or partners.

Types of beverage

While women drink a diverse range of alcoholic beverages, participants commented particularly on ready-to-drink premixed products (RTDs) created for and marketed to women.

... it used to be beer, and so even if you drank beer after beer after beer you were only going to get so intoxicated, but with the RTDs and spirits, in particular, young people need to drink a lot less to get drunk quicker (Community participant).

RTDs seem to be the problem. When we looked back we actually realised they had been around for probably 10 years but ... now they are very popular. So maybe five years ago girls would often have a bottle or two of wine which was at seven or eight standard drinks a bottle. But now they have gone to 18 Cody's, they have gone from, say, 12 to 15 standard drinks to 24... now they even have casks of RTDs so you can purchase three litres (Southern AOD treatment manager).

Hospital workers and the northern treatment manager identified RTDs as the type of alcohol most linked with problems:

... it's these Cody's that everyone drinks. It's a cheap form of alcohol, it's the premixes, it's eight percent (Emergency department (ED) worker).

Limitations of available research

Some participants thought that drinking by particular populations of women was under-researched, so little was known about problems for them.

... nobody has done any study ... Pretty much the trans[gender] women don't have anything ... there is no touching on the radar there and also with the drug and alcohol stuff comes the mental health stuff ... It is really prominent, it is really a common story (Community participant).

...

One of the areas that I don't know a lot about but I think ... needs more of a voice to it is around older women and alcohol as well, so looking at women and alcohol there is a lot of [emphasis around youth]... but particularly with an aging population in New Zealand I think that that is an area that I'd be interested to know more about (Community participant).

One participant said that research needed to reflect the ages, stages, and diversity of women's lives rather than be aggregated:

... as if alcohol and women are all one thing, as if they never change ... 'women'... start out as young babies and then they become young girls, then they become adolescent females and then they become women (Southern AOD treatment manager).

Influences

Advertising and marketing

Participants believed that alcohol advertising and marketing effectively encouraged drinking.

I was in Kingsland and there's like a Heineken ad, a Speights ad, up on these big billboards. All I wanted to do was have a drink when I got to Kingsland. I was like ... I could go for a beer because ... the whole way ... alcohol advertising. There's no limits to what they can show (VAW participant).

... the next thing that drives it is advertising. I don't know about you but when I watch alcohol advertising they seem to have the best brains in the business working on that particular advertising, it is brilliant ... It is very, very good advertising – it pisses me off (Southern AOD treatment manager).

Marketing is becoming more aggressive due to more competitors in the marketplace (Community nursing manager).

This participant perceived marketing as pushing a one-sided and inaccurate view of alcohol health benefits:

Media marketing of alcohol is very high including the health benefits of red wine, which imply safety in drinking alcohol daily without mentioning other risks associated (Community nursing manager).

Accessibility and availability of alcohol

Outlet density

All focus group were concerned about the proliferation of alcohol outlets in low-income communities, and connected this with the lack of restrictions around outlet density and ownership. For hospital workers, outlet density was the most obvious influence on drinking:

Māori health worker 1: ... they are opening them up all over South Auckland. But you don't see them opening them all up around ... Epsom ...

Māori health worker 2: Otara Mall, for example; they've got eight, eight alcohol outlets!

ED worker: But kids are buying it on the way to school and wagging ... and I'm hearing they were selling alcohol to kids, to 13-year-olds.

...

I work on K Rd and we just had the Rugby World Cup; I mean ... four liquor stores went up in three weeks (Community participant).

...

... on every second corner we have a liquor store (AE participant).

... what baffles me is that you can have the lowest socio-economic area with the most alcohol [shops], and cheapest ... I just wonder what people are thinking when they are setting up in our areas or who is allowing this ... I do query why it is that this area would have so many alcohol shops (AE participant).

Type of outlet

Participants thought that allowing alcohol sales in supermarkets made it more easily available.

... supermarket sales – I see them as really damaging ... I buy a bottle of wine every week in the supermarket – why? Because I go in there and I think ... that is a \$21 bottle of wine and it's not a bad bottle, it is only \$10. And we drink a bottle of wine a week now – if it wasn't there in the supermarket I wouldn't buy it (Southern AOD treatment manager).

Supermarkets may also be easier places to shoplift alcohol.

... with the supermarkets it is far, far too easy, although the supermarkets are quite good at asking your age. But our kids they steal – in fact, they tend to take the cask – the plastic bag out of the cardboard box and then they can mould it to the body and walk out – no bar codes to trigger any systems (Southern AOD treatment manager).

However, at least one participant lived in an area where alcohol was not available in supermarkets and said that it made little difference to drinking in her suburb.

You know, the drinking issues in West Auckland are no better really. They're probably worse than some other areas. So while I do think availability is an issue, I think taking it out of the supermarket doesn't ... provide the solution really (VAW participant).

Price

Some participants said that products with high alcohol content could be bought more cheaply than water or milk.

... those RTDs, you know, the mixes now ... is so cheap you can get rotten on \$10 (AE participant).

... in effect a RTD can be cheaper than a bottle of water... It annoys me that I can go into that supermarket ... where I buy my bottle of wine, where I can get it half-price but they won't reduce the vegetables. The essentials, the things we all need, they keep on bloody selling at the profit they can make ... [but] they special drink – it is immoral (Southern AOD treatment manager).

...alcohol ... is ... cheaper than milk now (AE participant).

Participants said price and alcohol content are successful parts of alcohol promotion and contribute to the rise in harmful drinking.

... and it's usually the ones that are on special are the ... 12, like eight percenters or the bigger cans that are eight percent and get you as drunk as possible (VAW participant).

Purchase age

Participants were clear that lowering the purchasing age had increased the accessibility of alcohol to a younger age group.

... when I was 20, 21 was the drinking age so 20 we were drinking, doing it regularly [at] ... 19 even at 18, but now when they have dropped the drinking age to 18 the trickle-down effect has impacted (Southern AOD treatment manager).

Supply to underage drinkers by older people

Some participants said that parents buying for their under-18 children and over 18-year-olds buying for underage drinkers – social supply – also contributing to increases in drinking.

... it's just expected that you provide alcohol to 14 and 15-year-olds and 16-year-olds having parties. Why are we doing that? Hello? (VAW participant)

Participants said that parents may provide alcohol to their children to limit the amount their teenagers have access to and encourage them to drink at home, which they saw as a comparatively safe environment.

... do it here where I can see you in front of me, eh? A lot of parents would say that (AE participant).

Participants were uncertain about whether this approach limited adolescent drinking and kept teenagers safe. One participant believed that this approach still sent a liberal message of parental and social approval of drinking.

I really don't agree with 'it is safer to drink with our kids' ... [parents] allow that because they think that if they drink [they will] drive, which is fair enough, but [parents] are opening the door for them ... to allow the kids to drink (Community participant).

Fewer parental restrictions around alcohol and more freedom were also seen as contributing to the increases in drinking.

[We] see fewer curfew restrictions than previous generations ... now we see many that seem to be able to stay the whole night so they are starting earlier, seven or eight and some of them go on to two or three or even all night (Southern AOD treatment manager).

New Zealand cultural norms

Participants saw New Zealand as a binge drinking culture where drinking to harmful levels was normalised and getting drunk was the reason for drinking. This contributed to women's consumption rates and alcohol-related damage.

... we are a drinking culture. It is what we do (Southern AOD treatment manager).

... that huge Kiwi culture around binge drinking and, you know, they are not just around socially drinking but around drinking until you get drunk and that's the aim (Community participant).

You go home and you have a bottle of wine and then you have another one and then you go out on the town and you drink some more, and it's about that, get to that place of nothing matters as fast as you possibly can (VAW participants).

I think that's the Kiwi way ... because a lot of us will have a cold beer when we finish, eh? Nine times out of 10 we will have a cold beer, when we have a barbecue we will have a cold beer; it is the Kiwi culture, it is the way of us ... it has actually become ingrained in the whole lifestyle of Kiwi (AE participant).

It is so true, that kind of ... looking after guests ... you go over to someone you take a bottle; if people come over you make sure there is bottles available, it is part of the hospitality (Community participant).

Participants said that children absorbed the integral role of alcohol in socialising and relaxing as they grew up:

... from a young age you ... grow up with this image of alcohol as being what you do to relax, what you do to socialise, and so it's kind of this innate knowledge that you grow up with ... That's the first thing you get to as you grow up, to relax, to socialise I need to drink alcohol. And ... you couldn't probably even give a reason why you needed to do that ... that's kind of inbuilt, and that's encouraged by media, by accessibility, by needing to feel accepted, all those kind of things. And it just creates this way of being really (VAW participant).

An increase in consumption among moderate and heavy drinkers was also seen as a result of more drinking opportunities:

... previously you might have gone out Friday night and got drunk and maybe stay drunk through Saturday. Now the high-end users are getting drunk two or three times a week, they are doing it in the middle of the week several times as well as Friday, Saturday ... The other trend is [that] there are a lot that seem to be getting drunk almost weekly (Southern AOD treatment manager).

... if you are celebrating you have to have alcohol (Community participant).

Alcohol and sport

The relationship between alcohol and sport in New Zealand and Australia, including sponsorship and routine drinking after matches, was also seen as contributing to consumption.

And they go round and sponsor everyone and of course we are all going to wear their t-shirts so we can have the sponsorship (AE participant).

Participants perceived that expectations about drinking were the same for sportswomen as for men.

... I don't think that is any different today with young people or old people in sport because you know even in master's ... sport competition you are expected to drink ... the swim team ... afterwards they go for a drink. I play squash once a week; afterwards you have a beer, there is that kind of connotation ... I was 16 and I was in an over-18 to 21-year-old sports team and there was a lot of pressure there. If you didn't drink and you didn't do that team-building in drinking with them, you weren't part of the team – so you couldn't have a choice not to drink and that's the bit which worries me (Community participant).

The hospital group believed the media was more forgiving of male celebrities with alcohol problems, such as All Black Zac Guildford in 2011:

ED worker: ... the whole slant is even though that guy ... sexually [harassed] women and hit a couple of people in that bar ...

Māori health worker: Yeah, it's okay to do it!

ED worker: ... the guy needs help, the guy needs help, we've gotta feel sorry for him, you know, he's not living up to the All Black image. Well, where's the accountability there, it's kind of like a double standard, eh?

They believed the response to a drunken female celebrity would have been different.

Māori health worker 1: ... for men in that All Black's situation, it has happened on many occasions – it's okay. But for women it hasn't come out as that, it's portrayed as not okay.

Māori health worker 2: ... It's worse when it is a woman ... because women are seen to be, should be seen to be as ladylike ...

... if it was a Silver Fern I think that it would be twice as, you know, 'She's having a breakdown', that kind of, yeah ...

Changes in community norms

Participants believed that the dominant drinking culture impacted negatively on other cultures by eroding traditional protective factors, such as the absence of alcohol from some events and locations. A Samoan woman discussed how alcohol has become embedded in hospitality, even when alcohol seems incongruous with the event.

... when we have celebration there has to be alcohol involved and even Sunday School stuff where alcohol shouldn't be there, you know ... I spoke to the leader of our Sunday School: 'Why do you have to? It is a Sunday school ... you shouldn't', and she said to me 'Because it is the guests out here and if there is no alcohol there ... it will be talked down, it will be like "Oh, they didn't host us properly".' (Community participant)

Changes in the roles of women

Participants believed that the gender double standard – where women were expected not to drink, or at least not to get drunk, while men's drunkenness was tolerated – had diminished. However, they believed women still attracted more stigma for problem drinking or drunkenness.

... my grandma always talks to me about how she thinks it's utterly disgusting about how women can drink and it's kind of socially acceptable these days for women to be drinking out of bottles and just the whole change in society from history ... women are drinking a lot more (VAW participant).

Social inequities and drinking

Many participants pointed to marginalisation, social exclusion and discrimination as drivers of drinking.

... poverty and hopelessness, poverty has always driven [alcohol consumption] and poverty is relative. By that I mean the greater the difference between wealth and poor in any community the bigger the problem appears to be; if we are all poor it is not so bad, or if we are all wealthy it is not so bad, but when you have got that mix (Southern AOD treatment manager).

...

Certainly the combination of not fitting in I think is a very strong driver, and whether it is because you have had some difficulty ... or you might have some disability ... if you are lesbian, gay or bi-sexual, undecided (Community participant).

... our transwomen who are Māori or Pacific Island and the drinking problem then leads to drugs, usually it is related not to their gender identity; I think it is related to poverty, lack of a home and income ... When I am talking poverty I [don't] mean historical poverty – growing up poor – but the lack of a home and the lack of money is actually related to the discrimination they probably face in getting a job and stuff like that (Community participant).

Alternative education workers also discussed the role of alienation and social exclusion:

... in terms of them being one of the highest risk groups with alcohol ... I think it is due to the alienation ... they are alienated from their own schools, their peers and they just do what everyone expects them to do ... because they are seen as naughty they will just continue to do that behaviour.

Participants viewed the gender inequality that restricted women's opportunities and control over their lives, and pressured women to juggle paid work, mothering and other duties, as contributing to women's drinking.

I think the social pressures now really affect women. Like, to work and balance children, work, husband or partner, social life as well. And money and everything, just everything. Yeah ... It's too much (VAW participant).

... there is a lot of sadness amongst my generation because I was born during the war ... we missed out on many, many things and there was not a lot of encouragement to do things and that sort of feeling that you didn't have a chance – like feeling often that the locus of the control was out there and you have no ability to climb above it ... and I think alcohol is a bit of a comfort (Community participant).

Colonisation

Some participants talked about the contribution of colonisation and continued poverty and marginalisation to Māori drinking.

... it is sad because that was never traditional, but contemporary society is telling us that it is normal for us to ... whakawhanaungatanga together but you need a bottle to do it, I mean hello? It's not our culture – where [did] that come from? ... that is an impact of colonisation (AE participant).

A lot of young women that I have worked with, if alcohol is an issue, heavy drinking is often in tandem with so many other complex social things ... we're talking about intergenerational kind of loss (ED worker).

Yeah and it is a layer upon layer thing, and I agree it is not just the alcohol, it's ... intergenerational; if you look at grandmother, aunty, mother, daughter and it just goes on and on (Hospital group).

Sexual and domestic violence

Participants talked about the complicated role that sexual and partner violence play in women's drinking. They saw alcohol as often involved in incidents of sexual and domestic violence, when either the perpetrator or victim or both had been drinking. They said it was also common for victims of sexual or domestic violence to drink to deal with the resulting trauma.

... the so-called high risk cases where there is ... care and protection concerns for unborn and babies ... it strikes me how much, how often sexual abuse in childhood comes up for these women, you know.

I have heard a lot of young women say they use alcohol because they are blotting out the pictures in their head. They wouldn't go to sleep without it, they have to drink, because it is untreated trauma ... It helps them, it's a strategy to cope with what has happened to them (Hospital participant).

Participants suggested that victims of domestic violence also drank to help them endure ongoing psychological and physical abuse, or drank with partners to keep the peace.

... they are using alcohol to medicate a domestic violent situation – that's quite common (Northern AOD treatment manager).

... a lot of women do drink because they are trying to ... keep the man happy so, you know, there is a small part of their life that is fun and sadly it turns ugly ... women that are being abused by their partners – if they are not drinking with the man because they have to, they are drinking with their girlfriends because they just want an outlet ... they try to find somewhere to escape from ... the abuse, the violence (AE participant).

The accessibility and availability of alcohol encouraged its use in dealing with trauma, abuse and difficulties.

...alcohol ... is the easiest coping mechanism ... cheapest and easiest to get hold of (AE participant).

However, they said that drinking to deal with abuse could block women from getting help.

Refuge worker: ... it's really common, it's almost expected in a sense – not that you'd put someone in an alcoholic bracket ... But you would expect them to be misusing alcohol in some way.

Second woman: Yeah, just noticed a huge increase in the use of it. I think ... there's always been people who need something to get through ... and the more props they have available round them the more they'll use them rather than going and getting help (VAW participant).

Some events in young women's lives were well-known for increasing the likelihood of risky drinking and alcohol-related problems.

... ball season and the relationship between body image and feeling confident and self-esteem, dieting and starvation and alcohol and the relationship that they then have around ball season, leading to situations of difficult sexual negotiation ... sexual violence leads to people getting really unwell, alcohol poisoning, that is the time when it becomes very topical for students and interesting is that they really like to talk about it as well, so that is one area that we see messages around that coming up a lot (Community participant).

Problems

General

Participants identified a wide range of alcohol-related problems for women, including sexually transmitted infections, unplanned pregnancies, alcohol poisoning, family breakdown, cancer, brain injuries and fetal exposure during pregnancy. An emergency department worker said:

I'm seeing a lot more alcohol-related admissions, you know – assaults, fighting, wagging school, groups of kids getting together in parks, fighting.

... I'm seeing young woman who exchange alcohol and drugs for sex and they won't even know who their sexual partners have been.

A number of young women have run away from home, been on the streets, so slept with men for a bed or just to keep drinking.

Hospital workers also described women with alcohol psychosis coming to emergency departments, hospitalisations for long-term alcohol-related kidney failure, and alcohol-fuelled incidents of self-harm:

[Suicide attempts] or overdoses, or cutting or attempted hanging – pretty much alcohol is [a factor in] 90 percent of ... girls that I see.

Like 14 to early 20s, yeah (ED worker).

The northern AOD treatment manager described families in crisis, major liver damage, indefinite driving disqualifications, and a spike in hospital admissions at the end of the week.

Sexual violence

Participants noted that alcohol played a large and increasing role in sexual assault or sexual abuse. They believed the rate of sexual assaults with alcohol as a component had increased.

... we have a whiteboard ... with our current cases on it and it's rare to have a case on the whiteboard [where] ... alcohol hasn't been a significant factor of why a patient has ended up having ... an acute sexual assault exam (VAW participant).

Participants were certain that the prevalence of alcohol-involved sexual assault was higher than the reported rate.

Most of our acute sexual assault exams ... come by the police. So they're at that level where they're being reported and you know ... that's just the tip of the iceberg (VAW participant).

Participants discussed the role of bystanders, bar staff and other people in preventing sexual assaults. They said that myths about women being partially responsible for attacks because they were drunk were still current, and impacted on victims' own sense of responsibility and self-blame.

... you get into this difficult situation when you talk about alcohol and assault where you can, you need to be so careful that you don't actually blame the person that's drinking, because, you know, most of us have been drunk and out of it and it's not okay to be ... taken advantage of (VAW participant).

Participants thought women sometimes did not classify an experience as sexual violence because of their own drunkenness at the time, although they experienced the same negative outcomes. The minimisation of their experience and emotional distress sometimes led to further drinking. Victims sometimes also reduced the culpability of the perpetrator if he had been drinking, and were less likely to press charges.

If charges were laid, the likelihood of cases of sexual violence where the woman was drunk getting to or being successfully won in court was low, due partly to these social beliefs about responsibility.

That's the perception that's out there ... Ah, it's her fault. She shouldn't have gotten herself so shitfaced. She'd be safe ... she wouldn't have got herself in that position in the first place. Or he was too drunk; he couldn't control what he was doing ... And the concern is that's a common theme in society. So that's a theme that a juror sits in a court room with and that's what runs through the head, and the defence lawyers will use that (VAW participant).

Family violence

Participants identified alcohol as contributing to family violence and the severity of the assaults, and believed the prevalence rate is also far higher than what gets reported to police.

I think, just looking back over this year, probably about 80 percent of our clients that've come into refuge it's been an alcohol-fuelled, like it's happened before but ... alcohol just escalates the violence to a stage where the women has had injuries, she's going to end up dead ... She's had to leave ...

it's ... that tip of the iceberg ... if it's being reported then it's one of those incidents that, for a variety of reasons perhaps, has come to the attention of police. But we know that there's a whole lot that don't (VAW participants).

The northern AOD treatment manager identified partner violence as the major damage to women from other people's drinking:

Husband or partner in the house that is using alcohol and/or other drugs ... extreme ongoing violence in the house. That might start off with both of them ... drinking socially together, but as they drink more and more ... one of the partners ... just gets very violent. We have got some women who are also violent as well in that situation ... But usually ... we are seeing ... desperation [about] the partner being violent, so [women] are trying to fight back or protect themselves.

Spikes in reported family violence incidents often correlated with events that combined alcohol and masculinity, such as a loss in a major men's sporting code.

... when we looked back [on the Rugby World Cup] we did have ... quite a big increase of people who stayed just one or two nights. ... So possibly it was just the one-off incident because they, their partners were so drunk ... but after the Warriors [lost a] game we had a big spike (VAW participant).

Like sexual violence, drinking sometimes confused issues of culpability, with women minimising domestic violence incidents when one or both of the parties had been drinking. This perception also impacted on the justice system.

So something that might be a MAF – male assaults female – will ... be lowered to common assault just because both of them are drunk or she was drunk. So ... it is powerful ... So they'll have all these charges, grievous bodily harm, whatever they are and if she was drunk it'll definitely become a lesser charge (VAW participant).

One participant said that drinking was such a norm in some families that women did not remember it or identify it as a contributing factor when first making a complaint.

I was actually just thinking about some of my clients who ... kind of haven't even registered that alcohol was involved. Like they've normalised it so much that like, in the first instance they don't actually relate an assault to alcohol or that it's affected any kind of judgement and then later on they're like ... you know, he'd drunk six, 8% whatever. And you're like, 'Wow! Is there ... more?' And they're like, 'Oh yeah ... And I'd had a bottle of wine'. They've normalised it so much that it's actually a non-issue to them (VAW participant).

Sometimes women attribute the violence and abuse to the alcohol rather than the abuser, which results in them staying in unsafe relationships and needing repeated help.

... the amount of women that we get that use, 'Oh, he was drunk, he would never do that when he was sober' ... the frequency in which we get those calls from the same women. 'Oh, he was drunk again' ... 'He was drunk again' ... well, you haven't actually fixed any of the problems. You haven't addressed anything because he's still getting drunk (VAW participant).

Participants were clear that alcohol was not responsible for abusers' violent behaviour – that they still chose to drink and be violent.

When you've drunk that much alcohol you aren't in control of your actions and you do make decisions that you might not have made if you were sober. But at the same time you chose to ... drink that much and put yourself in a place where you might make those decisions and you need to take responsibility for your actions (VAW participant).

Maternity, parenting and families

Participants said that alcohol compromises parenting, compounds poor parenting skills and contributes to family difficulties. The northern AOD treatment manager said:

I guess the issue of women and children ... is a really huge one. I think women who are looking after children and are abusing alcohol or have alcohol dependence, which is probably the worst of the two, that there is this compromise of the care they give their children.

A family support worker said that families where members drank to escape problems found themselves with more.

... it is one of the biggest problems that we focus on when we support families ... they think alcohol is a relief to their stress and they sort of ignore that the more they drink the more the stress is going to be there... they sort of ignore the message we say to them 'The more you drink, the more ... it is not going to go away – it will come back and it is even causing other issues if you continue to drink' (Community participant).

Several participants were concerned about women's drinking during pregnancy and the consequences for current and future generations.

... many people don't allow for the fact that mothers' use in pregnancy does expose the baby to some aspect of Fetal Alcohol Spectrum Disorder ... we see many, many more women drinking and many, many more drinking a lot and I am told that around 80% of teenagers in New Zealand continue to drink through pregnancy. Well, they are passing this on to the next generation and those kids will be more exposed, more vulnerable (Southern AOD treatment manager).

Pregnancies and sexually transmitted infections

Participants said alcohol contributed to unplanned pregnancies and STIs. For young women, unplanned pregnancy made further study difficult, and many dropped out.

I just want to see improvements in alcohol-related pregnancies, especially for our students ... because we have an awesome student get pregnant and they have to leave. Say they are 16 – what can you do?... they work hard not to separate baby and mum in the early stages, they keep them as long as they can attend, but once they have baby we know that they won't come back because you want them to be with baby – that is the best for baby at that time (AE participant).

Increasing inequality

Some participants thought that, as well as poverty driving alcohol use for some people, poverty was exacerbated by alcohol taking money out of families and communities. Others noted that profit-making companies made money while the burden of damage from their products was carried by others.

... as much as there is money being lost – particularly public money being lost because the problems around drinking – privately there is a lot of money to be made by a heavy drinking culture (Community participant).

Some participants perceived a glaring inequity between the resources of the alcohol industry and those of agencies trying to prevent or deal with harm from alcohol.

... I think in the World Cup it was like \$30m dollars was spent to advertise alcohol in New Zealand ... that's a ridiculous amount of money to be pouring into alcohol when there's NGOs who struggle to get funding (VAW participant).

Alcohol companies also have a lot of money for marketing that will counterbalance any media presence we have (Community nursing manager).

Suspicion of government vested interests

Some participants also thought that the benefits from alcohol-related taxes for local councils and government may influence them against stricter legislation or cause them to abdicate their public health responsibility. Some were very distrustful.

Less control by government on alcohol as it has an income tax revenue that is needed (Community nursing manager).

The Ministry of Health ... is not going to put money into stopping the elderly drinking because from a government point of view they actually want the older people to shuffle off ... less superannuation (Community participant).

Community fatigue in the face of liberalised policies

Many participants worked in sectors that directly dealt with damage from alcohol. They expressed a sense of exhaustion at the magnitude of the problems that they and others were dealing with.

... it's rare to not have a case where alcohol's significant to the point where we're just all burnt out with it ... We've had it ... Because that's a huge change over the last seven, eight, nine years ... Alcohol's always been a major problem but now it's just, it's to the level of stupidity ... we are really at the bottom of the cliff now (VAW participant).

... Doctors at A&E all around the country are just sick of having to deal with obstreperous young people who at the time don't even want help, in fact, fight you and hurt you and ... do damage and yet you have got to help them (Southern AOD treatment manager).

... in the rare time now we get a police officer coming in who hasn't dealt with sexual assault before ... you can feel their trauma ... it's really hard for them as well ... to deal with this stuff and we're not, we're not looking after our police force (VAW participant).

Many participants had been involved in community action about alcohol, or attempted to shape alcohol policy through civil participation or submissions. They expressed frustration over the lack of progress in alcohol policy despite huge efforts.

I think there's been advocate groups going and petitions going right around South Auckland, Counties Manukau ... from local body for years. I was part of a lobby group at council trying to get [new liquor store licences] stopped because of the effects that were occurring ...

...You ... just get this [new alcohol retail] business, and your energy is going nowhere, when next minute they're signing off another one (Hospital participant).

Some participants said their organisations were too overwhelmed and did not have easy access to government officials who could make a difference:

The problem is the people at the coalface haven't got ... the avenues and channels available to feed back to the government. We're so busy dealing with the issues and drowning in the issues that we haven't got the time and the resources or the way of getting this information to government (VAW participant).

While several participants felt exhausted, most were still passionate about their role in prevention and intervention and wanted to continue working in their fields.

I've heard a doctor say 'Look, I didn't come into medicine to do this' and you sort of feel like that, but for me I have spent my life teaching teenagers, I think they are our future, I love it, I have enjoyed them and I still enjoy them. They are the energy, they are the passion, they are what we need to save the world really, and we as adults have to help them (Southern AOD treatment manager).

Future damage

Some participants expressed concern about future harm that may result from current drinking rates. They particularly mentioned increases in breast cancer, alcohol-related brain injuries and loss of human potential through impaired academic performance.

Breast cancer risk in the future is a very worrying factor. We are likely to have a boom in the rates when younger women start getting into their 40s ... Asian cultures are not as likely to consume alcohol; however, Asian youth are being exposed and this may change (Community nursing manager).

... some scientists were predicting ... this [youth] cohort by the time they are 40 you could see about 12 percent with some permanent alcohol brain impairment (Southern AOD treatment manager).

Interventions

Protective factors

Participants discussed protective factors that could be strengthened, including promoting female self-esteem and pride, positive body image and learning to use body cues, encouraging a critical analysis of alcohol advertising and beliefs, supporting strong families and whānau, promoting cultural connectedness and pride, strengthening communities, and alcohol-free community events and environments.

Strengthening women's self-esteem and sense of wellbeing was seen as protective against harmful drinking.

... if you know your mana wāhine kaupapa, if you are taught it and educated in mana wāhine ... you would be confident in yourself ... Mana wāhine workshops they work ... the outcomes of a lot of women ... aren't drinking anymore, and if they do it is only for a wedding or social occasions ...

... sadly women ... don't feel good about themselves – their self-esteem, their confidence ... I think if our Māori women and our PI women knew their importance of who they are just by the colour of their skin and just because of their [being] women, because of the blood they carry ... [it might have an impact] (AE participants).

Valuing women for more than just appearance was also seen as protective:

... the more women can be valued for their whole identity and not just how they look, the less likely they are going to be to starve themselves or feel like they need to drink in terms of feeling confident about how they look ... I think it is dangerous to underestimate the impact that self-consciousness can have on women's choices to drink (Community participant).

Supportive families were considered to be protective:

Family, loving families ... I think the research says you have got to have a meal together at least three times a week. It is where attitudes are picked up ... attitudes and values so family is important (Southern AOD treatment manager).

Population-level interventions

Reducing inequality

Participants viewed social inclusion as an important protective factor, as well as ensuring people's basic needs were met.

... schools where kids feel welcomed are protective factors – it is the kids that feel slightly alienated that tend to be at risk of a whole lot of things (Southern AOD treatment manager).

Some hospital workers saw systemic change as necessary to halt damage from alcohol.

ED worker: If you've got a large portion of the population destroying itself with alcohol and violence, they're being subdued, their voices aren't heard and that is what it's all about ... I think people need to start organising themselves and start demanding that their basic rights be met. I think that if people's basic needs are met in terms of safe, warm housing, enough food to eat, some kind of ...

Māori health worker: Hope ...

ED worker: Hope and purpose in life – then you start getting the symptomatic effects of alcohol abating, you know ... I think that is what we need to expect our government to do; I think we should start shouting about it.

Stronger governmental policies

While many participants commented on individual treatment or community-oriented solutions, others were very clear that the government needed to pass laws to curb consumption and alcohol-related damage.

... if we are going to see a change in harm we need a change in legislation to lead the way, and that legislation should include things like not selling alcohol until 20 or even making it illegal to drink before 20 ... most people are actually in favour of increasing the age to 20, and most of them are in favour of increasing the cost ... [If] the government decided to act on behalf of our youth rather than on behalf of the liquor industry (Southern AOD treatment manager).

We need leadership about these issues ... just like smoking, for instance ... it's got legislation to back it up ... I think we've long ago proven that as individuals and as families and as social units we can't do it on our own. And I think it's time for the government to show some direction here. I believe that's the only long-term solution ... that's practically ever going to work (VAW participant).

... the government could actually recognise the statistics and they could make a statement about that ... by changing the legislation then the government are recognising the research and the comments from the engaged community ... That is a direct outcome that would change lots of women's lives, wouldn't it? (Community participant)

I just think that politicians that make these things happen should be thinking about what districts they are dealing with and what better use they could put into their community rather than more alcohol shops (AE participant).

Participants said more was needed than just education about drinking responsibly.

... it is really easy [for]... governments and the rest to kind of put out directives where they say, well, 'People just need, young people just need to drink less', you know? ... society through legislation and leadership needs to solve this ... Look where society's got with smoking and drinking and driving. We've done it ... We just need to now do it with drinking and do it the same way we did it with those things. It doesn't work to just [educate]. I mean, obviously we ... do need to do the education and everything else ... But we need to have leadership and direction (VAW participant).

Accessibility and availability

Participants discussed a range of ways of limiting alcohol accessibility and availability, including limiting outlets, restricting ownership, banning or restricting supermarket sales, increasing the price, and raising the purchase age.

...I think the price of alcohol should be increased because ... any sort of practical barriers about accessibility will limit the number of people that are harmed by alcohol (VAW participant).

... put the prices up for alcohol and drop the prices on bloody water (AE participant).

Well, raising the ... liquor price would make a huge difference; decreasing the density of liquor shops, of course, would make a big difference. The quick win is raising the price (Hospital participant).

... Why is it in the supermarkets? Why is it in every dairy? ... I just think it's absolutely appalling ... successive governments have allowed an erosion of all these things (VAW participant).

... lowering the drinking age to 18 has been problematic and it is a no-brainer that we should raise it back to 20 – if you talk to me I would say 21 (Southern AOD treatment manager).

Some participants believed that these were the only interventions that would reduce drinking and alcohol-related damage on a population level.

Alcohol industry

Some participants wanted greater accountability from the alcohol industry for alcohol-related problems, and more restrictions on providing alcohol.

... that's a section that we could easily do something about by making the alcohol industry, forcing them to be more responsible ... and it's not just the advertising and the price ... they don't get to sell alcohol unless they also do all these other things ... End of story (VAW participant).

Alcohol advertising

Many participants thought alcohol advertising needed stricter controls, if not an outright ban.

We should get rid of all advertising for all alcohol – get it banned (Community participant).

... society's drenched in alcohol advertising and ... something needs to be done about that ... but the government have already been told that in the recent [law review] processes they've been through and chosen to ignore it (VAW participant).

Drink-drive enforcement

One participant noted the police practice of issuing speeding tickets during peak holiday periods to drivers travelling at 4km an hour over signposted limits, rather than the usual 10km an hour. She suggested a parallel lower breath alcohol limit for arrests around Easter, Labour weekend and Christmas.

Regulating licensed venues

Some participants wanted stronger regulations for outlet density and management:

They need to have a lot ... stricter guidelines and a better criteria of eligibility in being able to go into liquor licensing (Community participant).

... limiting the access to shops ... making criteria where there a certain number of liquor stores around a certain area; if Remuera can do it, why can't Otara say 'You are only allowed three shops around here', because you come to Otara and it is like every corner you go to there is a liquor shop around (Community participant).

I think there needs to be a lot more regulation ... of our alcohol outlets ... in particular the bars. I mean ... to get a liquor licence you should be providing free water to everyone. And ... all your staff should have to undergo rape prevention training ... and you know ... alcohol education. Why wouldn't we ... demand that as a society? I mean, it's just a complete no-brainer ... it ... just defies belief that we're not doing it (VAW participant).

During the World Cup, venue staff resisted these interventions, indicating to participants that voluntary training may not be effective.

VAW participant 1: I'm aware that there are things that people have tried to do and there's host responsibility and all of that, but basically I'd say great, big, huge amount of cynicism coming from me. I think it's all lip service and our experience with the Rugby World Cup was a very good example of that ... Rape Prevention Education provided some host responsibility [education] during ... the World Cup ... to the bars and stuff and hardly anyone turned up ...

VAW participant 2: And even with those ... need help cards, we were distributing them while we were doing alcohol on our campaign ... and they were a very hard sell to get into bars. Most places said no to them because ... having those there would signal that stuff happens in their bars.

A few bars were noticeable, however, for taking host responsibilities seriously.

... I noticed quite a few places that did stand up ... obviously the majority of them didn't but ... places like Danny Dolan's had free fridges of water. So as you walked in they gave you a Pump bottle and you know, that's like seven bucks for a Pump bottle in town ... down at the Cloud they were quite good with distributing water and I saw it a few times where they were like, 'Hey, you look too drunk. Have a water first' (VAW group).

Changing New Zealand's drinking culture

Participants were adamant that there needed to be a shift in New Zealand's drinking culture, so that drinking until intoxication was no longer the norm. They were unsure how to make this change, saying that existing responsible-drinking messages and promotion of more moderate drinking were not successful.

I think ... [the solution is] changing the norms ... easier said than done (VAW participant).

... Having tried to pick up the Italian/French sort of culture has been a failure for New Zealand and it has been a failure in France and Italy too – their youth are going our way (Southern AOD treatment manager).

They noted that New Zealand had successfully made drink driving and smoking less acceptable, and thought strategies used in these campaigns – legislation, an advertising ban and social marketing – may help.

Health promotion and social marketing

Participants thought that health promotion and social marketing that was grounded in communities, reflected community diversity and used community skills, knowledge and talents might be effective. Some participants believed that some health promotion messages had been very successful ('ghost chips'), while others ('It's the way we're drinking') had not been.

... the ads around alcohol ... They've kind of become ... a joke ... Like, 'it's not what we're drinking it's how we're drinking', hahahaha. And get even more pissed. Or ... don't bring your friends with you next time. You know, like, oh 'Kat brought her friends with her last night'. And you know, they just become a big ... funny joke (VAW participant).

One participant thought the cost of social marketing may be prohibitive.

The cost is high for any social marketing so that is a challenge in this economic climate. The government won't be keen to risk their tax take, either, from the sale of alcohol (Community nursing manager).

Increased funding to community-based prevention programmes

Many participants were already working at least partly on prevention of damage from alcohol, and wanted to see more funding committed to prevention, intervention and collaborative models.

... that holistic approach ... that prevention stuff ... everything seems to work on trying to find ways to stop it ... can we look at projects and programs that are actually looking to prevent, not just to reduce, a statistic because we could spend years reducing statistics (Community participant).

Like I know in our ... area ... we spend \$3billion on prevention ... and six on intervention ... it'd be the same for alcohol. Like we're spending less on the prevention side than we do on the intervention. If we could reverse it ... we might make a difference (VAW participant).

Increased funding for prevention of family and sexual violence

Participants perceived sexual and domestic violence as a key driver of many women's alcohol use, so preventing this violence and taking care of and promoting the wellbeing of women and men who had been violated was seen as an important way to prevent alcohol misuse.

Community-level interventions

Some participants also thought community workshops to develop solutions to damage from alcohol might be useful.

... it would be really good to provide some intensive support into the community ... I am talking about work shopping it and getting the networks in each community, not just high-risk ones, for instance (AE participant).

Building community care

Some communities were starting conversations among members about alcohol, putting limits on drinking, particularly for minors, and expecting members to take care of each other around alcohol. One participant described the decision-making about going out drinking at a queer youth hui for underage and over-18-year-olds:

... 200 young people at a camp ... drug, alcohol and smoke-free ... it is quite a large age group and we had to negotiate with the older ones. So instead of telling them 'No, you can't do it', we...said 'Look it is unfair that you are all here and you are going to party and the younger kids can't go because they are under 18. So I want you guys to all go back together and talk about it' ... their feedback ... was actually 'No, I see your point now', because they had to talk to the young people, they had to take responsibility over their own alcohol use ... they were really cool, everybody only had two drinks except the driver, of course, who had none and then they came back at a responsible hour ... they followed all of that, it was amazing but it is because they got to engage (Community participant).

Some participants thought a culture of community care needed to be encouraged as a wider norm, so that intoxicated women would not be left to fend for themselves by the side of the road.

... one thing that that I hate seeing is, you know, 4 o'clock in town in the morning and you see the girls just by themselves stumbling along and no one does anything, they just all watch her and they laugh. And ... I always make a point to go and check on her and you know, get the friends and all that sort of stuff, but not that many people do that and that really annoys me (Community participant).

So... you see your friend who's drunk, who seems to be talking and functioning and eating and you know, saying 'I want to go here and I want to go there', but actually they're really, really vulnerable. And I don't think they have had enough education about how vulnerable that person is... That person might not be able to remember anything about that the next day, they're so pissed but they might still be standing up and functioning (Community participant).

... we've got a right as an individual in a caring society to be cared for... And alcohol allows people to abrogate their responsibility to be the carer or to think that someone deserves being cared about... And... that's shocking (VAW participant).

Another suggestion in the VAW group was to have Māori wardens look out for intoxicated people in public and safe spaces for them to be taken.

First woman: [Warden type people] who are wandering round looking out for vulnerable people and then having somewhere for them to take those people, too. Like it would make the street safer.

Second woman: Instead of them having to go back to the cells to sober up.

The *Who Are You?* campaign video produced by the Wellington Sexual Abuse Network was viewed as an excellent promotional tool that needed wider distribution:

I think we needed to put that, *Who are you?* video out nationally on TV as an ad even.

...

Wouldn't it be great if there was funding to have three or four other scenarios and including one about young men getting into trouble? (VAW group)

Alcohol-free alternatives

One participant suggested that young Māori should have more access to Māori cultural activities:

If our kids were hard core doing *mau rākau* and *harakeke* they wouldn't be drinking, because they would realise the tapu of, the sacredness of it. You know you can't do one thing and be doing something else (AE participant).

Other participants suggested other alcohol-free, community events and spaces, and affordable alternatives to drinking.

Support more community centres where they offer events and so on like... where they can have events and things that they don't have to rely on alcohol to pay for [the]... event (Community participant).

... if there was some sort of government subsidy where our DPB mothers... could go to the gym or have... morning coffee... most of our families can't even buy a coffee at McCafe... just little things like that – if they were able to do it they would be less inclined to be drinking because they have got other things to do... something that is positive... a lot of women go to church because they think 'Yay, it is free, I can go... but... then they think they are being judged because all these Christians don't drink... so then they... go home feeling belittled...

... if you take that [drinking] away from them you have got to put something in place, whether it be an after-school programme or something like that. Just a positive outlet, you know, whether it be sports or whatever it is they are in to, to keep them off the drink (AE participants).

Family-level interventions

A few participants suggested or gave examples of interventions in families; one wanted:

... families that set reasonable boundaries in life and who do monitor what their kids are doing... kids will use cell phones to check with each other; well, mothers have got to learn to use cell phones to check with each other (Southern AOD treatment manager).

Family workers used a variety of means to support pregnant women to stop drinking, including working with their families, with varying success:

... we kind of talk about the development of baby and the effects of the alcohol on babies but further than that we, there is nothing else we can do. It is really up to them to take the message on... we dealt with a few mums where we try and ask the family 'Please if you have a party have it somewhere else not here where this mum is trying to give up drinking'... we look at the people that's around them... we say it can be a plan... that, that friend of yours not visit too much or we do meetings with everyone that is involved supporting mum... very small amount of mums take the message on board unless [families] take [alcohol] away from them and then they sort stop for a while (Community participant).

One early family intervention worker said that some families resisted help until they were swamped:

... our challenge is that our programme is not compulsory, it is voluntary so we can't really enforce that to the ones that really need... support – they say 'No, I don't want to' and once they say that there is no way around to try and say 'Come, you really need this support'... because we don't have that power, but... sometimes when issues are so overwhelming they don't know where to go (Community participant).

One participant said parents needed to model moderate behaviour:

... I think it's ... about ... parents teaching and role modelling responsibility and 'Yes, you can have a glass of wine at home with dinner because, you know, you're getting older now and you know, responsible drinking can be a part of our life' (VAW participant).

Individual-level interventions

Screening and brief interventions

One participant thought there needed to be increased alcohol screening for women:

Use ... health professionals regarding risk of alcohol and breast cancer. People listen to their health professionals more ... [especially] women 30-plus. Screen all women for drinking habits. Get the Ministry of Health to set up a programme for screening women over 30 years with resources that support reduction in harm. Put it into a programme that uses women's magazines to support the initiative (Community nursing manager).

Participants spoke of the need to intervene when women used alcohol to block pain caused by sexual or domestic violence or other problems, but said the solution was not just to take away the alcohol.

... taking away the alcohol doesn't solve the problem for people who need help but ... I don't think providing them with alcohol does it either (VAW participants).

Hospital emergency departments were described as difficult environments in which to provide brief interventions:

I did some training on it myself a few years ago ... I don't feel sort of equipped to do that. It is kind of like, the limits of my role is that often I'm doing risk assessment ... Sometimes there is a therapeutic role but a lot of the time it's ... child protection, really (ED worker).

Education

Participants frequently mentioned education as an intervention, although with some ambivalence. Some noted a lack of basic information for women drinkers.

... I could name the alcohol driving limits for men but I couldn't recall what the women's ones were ... I've never actually learnt why it's different levels for women and all of that sort of stuff and I think there's just such ... a normalisation that we can do it the same as the guys and we don't understand the biology and why we are ... getting more hungover and what effects it's having on the body and there's not that knowledge of it. It's all just: 'It's all good, let's just do it' ...

I think a lot more education ... 'Cos wouldn't it be great if ... everybody knew about the harms of alcohol? You know, you can end up needing a liver transplant (VAW participants).

One participant gave an example of education interventions that worked, but also queried the effectiveness of many alcohol-related education programmes:

... there is some evidence that early interventions like we provide do help ... we work with about 550 kids a year, and about 82% are able to achieve their goal to reduce or stop their problematic [alcohol and other drug use] ...

... most research shows education in the classroom doesn't delay and reduce use so that's disappointing, but I know that – kids used to tell me, 'Hey mister, we can get the answer right here but you should see us Saturday night' ... seems like preventative education hasn't been effective up 'til now (Southern AOD treatment manager).

Some participants talked knowledgeably about the difficulty of getting into schools with specific programmes. The capacity for one programme to change behaviour and the 'one size fits all' approach were seen as problems, because programmes needed to be relevant to specific communities.

... if you want to do a programme around ... alcohol and youth the schools will go with one group and ... [does] that one course accommodate all the needs of all those 300 individuals that are in that school year? No, so it is a real problem because the government is always looking for one-stop shops ... [They don't work] in communities like the whole of Auckland, let alone the country ... Attitude isn't a one-stop shop, it is a great programme, but they don't talk about issues for queer youth and trans youth, they don't talk about those issues that are relevant to that small community (Community participant).

One participant knew of a good evidence-based programme in development in Australia that might be useful for New Zealand if it provide to be effective.

... we need to look at what's happened where they have spent a lot of money to find the programs and we need to bring them here or adapt them for here and have it done, rolled out right throughout our schools; so that to me is a big possible future (Southern AOD treatment manager).

One group was promoting critical media literacy in schools around alcohol advertising:

... we do a lot of critical media literacy in schools; students breaking down advertisements and we do a lot of alcohol advertisements because when you are buying it you don't just get the drink – you get to have the drink, look like this, have your arm wrapped around that person, and be in that setting ... you are sold a whole package (Community participant).

While most participants discussed education for youth and adults, some thought education about alcohol could begin in early childhood.

... I think that early childhood would be a really good stepping stone for getting that information to those particular whānau cause my kids come home from school and tell me 'Oh mum, this is what that cigarette is doing to you, ay?' And that's at that college level ... it would be a really nice touch to happen in there because that is the generation coming through – to change that conception of our alcohol use is what we need to be working towards (AE participant).

Participants also discussed parents' need for education and support about not supplying alcohol to their children, and encouraging boundaries around drinking.

I think we need to go back and start that educating in the home ...

... parents need a lot more educating ... around how to ... guide young people with alcohol. I think parents have lost the way as well. And that's reflected in the media and all the ... tragedies that happen with school balls, etcetera (Community participants).

Another participant thought community-based cognitive behaviour therapy (CBT) workshops with children and young people about the risks of alcohol might have a positive effect on family drinking:

... I seriously think there needs to be more CBT out there, more workshops with CBT. So that the kids and their families are making choices and better decisions ... our kids can teach their parents a lot of things (AE participant).

Educating women about being guided by their bodies was another suggestion:

... learning to eat, drink and do everything in a response to our body cues ... one of the things you have to do when you are binge drinking is ignore what your body is telling you, cause you are starting to feel sick, your vision is starting to change, your balance starting to change ... learning to intuitively respond to our bodies ... drinking alcohol to excess, you are getting a lot of cues from your body about what is needed that we are all quite well trained in our society to ignore (Community participant).

However, this participant spoke also of the complexity of expecting women to adopt healthier drinking in a society beset with problems about body image, food and self-esteem.

... we all know about getting better outcomes if you line your stomach, if you have food in you when you going out drinking – but if we are asking women to eat before going out drinking you have to recognise the issues sitting around why they are not eating and that ties into it as well (Community participant).

The northern AOD treatment manager gave an example of effective treatment education:

So we say 'Look what's happening, your liver is dying; if it dies you're going to die'... And the Pacific women really, really get that health message.

... just really pushing home what this looks like, the cost of legal fees, the cost of how much you are spending on alcohol ... and what could you save if you weren't spending \$250 a week on cigarettes and alcohol ... That makes a huge difference that a mother can say 'Well, I'm really taking care of my child in a different way now; I've got money and I've got food' and those kind of things make a big shift.

Holistic and collaborative treatment services

Many participants who dealt with treatment services wanted a more holistic approach:

I think we need to change the format and the outcomes of what we want to achieve, so I am always looking for tools that are holistic and looking for collective approaches to help with the young people that we deal with ... and the young women especially ... I find that working with young women they are going to go for a collective approach immediately, so that is an asset (Community participant).

Hospital and treatment workers spoke at length about the lack of integration between mental health and alcohol services. A treatment worker estimated that more than 80% of dependent drinkers would also have problems with trauma, depression or anxiety. When asked if mental health and AOD services meshed for a depressed, heavy-drinking woman, they said:

No, not at all. It's slightly political to say so, but traditionally in [our area] if you have got an alcohol dependent [woman] ... you have to work really hard to get [the mental health crisis team] to accept the person, they see alcohol as not in their remit.

One mental health worker said:

All of the key workers here have done like, um, not extensive [AOD] training but just ... workshops here and there, but there is no consistency and we are expected to be able to do all these things ...

Their mental health team refers clients with AOD problems to an AOD team:

... and then we felt that they haven't done anything, only to find out that they were saying, 'Well we can't do anything until they are ready'. So the client is back to how it was, so we are just doing our mental health stuff; there is no drug and alcohol input. When they are ready we will refer them again, and maybe when they get there, they will change their minds. So that's the challenge we have, just catching the opportunity ...

This worker believed that a previous system had worked better for clients:

... we don't hear of the dual diagnosis now in mental health. Because I remember way back then we would have a designated dual diagnosis specialist who had mental health and alcohol skills who sits in the team and then you refer to them. And because you are under the one roof, you work together. But now you've got another service here who comes in, so they work according to their protocols and their contracts.

Two hospital workers agreed:

Māori health worker 1: ... the services aren't ... coming together in that wrap around ... way and providing for that person; it's very frustrating, isn't it?

Māori health worker 2: So it takes a lot longer to work through.

A treatment worker said they always put alcohol-dependent women who were being abused by their partners into detox first, rather than approaching Women's Refuge immediately. One mental health worker said that women's refuges weren't available to women with mental health problems:

... for women who have mental health problems, just a tint of mental health history, they can't access the Women's Refuge because the refuge felt that they don't have the capacity to work with these women.

Participants said that some refuges could accommodate women with mental illness separately, but others did not have the funding for that, or staff lacked the resources and capacity to work with them. They gave an example of how collaboration can work:

Unless you do the work ... [for one woman] we've gone in collaboration with a kaupapa Māori immersion social work service, so we're going to be working beside them. But the domestic violence is serious and so they'll be working with that and we're working with the alcohol; and we're also working with the partner ... because she doesn't want him out of the loop. But it is chaotic at times.

One participant also wanted better collaboration between government and non-government agencies:

I've been outside picking up a young person and ... I have had the experience of putting them into cars and ... they have to go to police ... just for their own safety, but then when they experience that, you know, it is so traumatic and ... we do all this follow-up with them but I know other services don't ... I know we all have a duty of care in our service roles but sometimes ... I just find it frustrating that there is these gaps in the way that government services are set up so [us] non-government services when we try to interact with them there is no sort of through flow ... I think that is where the gap is for lots of women in our communities (Community participant).

Participants believed that projects and services providing collaborative and wraparound services needed better funding. Some participants wanted to know more about other agencies for referrals but had limited capacity to build those relationships.

Not that I really know about rehab and things like that ... I should know more, just to be really honest ... I don't have the capacity in my job ... I would have to do that when the opportunity arises ... I don't really feel there is somewhere I can put someone safely and say 'Hey, there's CADS' and then they deal with it, but I don't really know what is going to happen next, you know what I mean? And sometimes I wonder ... if ... that could be something that could be improved so that I know when I am talking to a woman [I can say] ... this is cool you need to talk to such and such [because] that is always a successful referral ... I think that would ... create better change around issues like this (Community participant).

The emergency department worker summed up the effects of unco-ordinated services on women:

I think it is so unfair to expect somebody who is a victim of domestic violence, or is self-medicating, is dealing with poverty, is a caregiver and to expect her ... to go to all these different agencies for different purposes, eh?

Others: Yeah, yeah.

Researcher: No one-stop shop?

ED worker: No, that's right and to have that level of organisation and self-care when their main job is to take care of the kids and they don't have a car and they are isolated from whānau (Hospital group).

Other barriers and inequalities in treatment for women

The northern AOD treatment manager said that some treatment services used just one model for all clients, 'and it is not specialised to women and parenting and what they need'. Instead, they stressed the importance of assessing the woman's individual needs.

... rather than overlaying templates of things ... You might have to get her to refuge as an intervention, which we sometimes need to do ... [if] the woman's hungry, you need to go and have something to eat first so she can think clearly ... and always if there are children there is solving what the issues are first. So it is multi-faceted, it is multi-dimensional and it is systemic.

The manager returned several times to the barrier that women's responsibility for childcare places on access to alcohol treatment, especially residential treatment.

... they don't want to go to rehab because they have got children at home and they would rather be at home managing their alcohol abuse or dependence than getting help.

Other participants described women as scared to approach treatment services about their drinking in case they lose custody of their children to CYFS or to abusive partners. Many women with alcohol problems and responsibility for children were described as isolated because they did not have a car or money for other transport.

Hospital workers saw a big gap between the options for affluent people with alcohol problems, who could pay for private services before they exhausted their family support, and the services available for poor people.

[Rich families] can put them into rehab centres where money is not a problem, and those that are in a low socio-economic area just cannot afford that, so they continue.

A mental health worker agreed:

I saw places only the people who can afford to pay, like private, go to that facility ... I was thinking back to the people that I worked with here in South Auckland and how they could have benefited from such interventions. Whereas in the private facility they have access to the GP who is there all the time and a psychiatrist who visits ...

A Māori hospital worker also described the lack of a gay-friendly approach that leads lesbians to avoid mainstream services:

Not just fa'afafine but I think that people who are gay or homosexual or whatever ... very rarely will they come through here, they go to ... the AIDS Foundation ... where there are people that they trust and they know there are good people there, takatāpui ... They feel safer there.

A participant in the community focus group said that training for alcohol and other drug counsellors and practitioners would be useful.

... for queer and trans youth who are women-identified when it comes to CADS ... you mentioned CADS whom we love, but in all of the country there is only one person who looks after 18 to I think it is 21 and under age group and that person is based in Auckland for same sex-attracted people, and then there is only two or three other practitioners – so practitioners need to have greater understanding. CADS practitioners need to learn about the different cultures so we need better training in diversities, diversity training to accommodate some of the issues that come up ... heteronormative approaches to rehabilitation are really common ... I can just imagine that there is thousands of young women or women who aren't getting support mainly because they can't bring up their sexuality or gender identity issues so they are not going any further into their care and ... the solution is basically training your practitioner to do that ...

The mental health worker spoke about the barriers for people with AOD problems from overloaded services:

... while you are explaining to them what the service is about, it gives them hope ... then you come back and say the waiting list is about anything up to six months. And that will deflate their hopes, so by the time there is a bed maybe they are not at that point of being ready and other problems come on top of that.

She described funding of some treatment and awareness programmes as somewhat ad hoc:

... we've got Abacus and Tupu Services for Pacific and then we have awareness programmes and ... the downside to that is that they are only, like, pilot ones. And ... another contract will come out but then they will turn it into another one, something else didn't quite fit (Hospital group).

Some participants believed that taking care of women and men who had been sexually abused was an important intervention to prevent alcohol misuse. They asked for funding for counselling of victims of sexual violence for which ACC did not require a diagnosis of mental illness:

... ACC actually continuing [funding] a child [who] has been sexually abused when they are young. When they get to adolescence that's when counselling needs to hit, to get them again because that's a really important time – that is when they run off the rails ... there is no support there and ACC doesn't recognise the horrendous [impact] ... but if you have a rugby injury, of course you get the best orthopaedic surgeon (Community participant).

Participants described some women's resistance to seeing any problem with their drinking:

... there are agencies like us but the problem is teenagers don't have a problem – nearly all of the kids we see they will tell you 'I don't have a problem – it's the mum or the police or it's the school' so that is one problem with teenagers, they are bullet-proof; and two, they don't want help (Southern AOD treatment manager).

I ... was doing an assessment with [a woman] and she has a drink-driving charge. She said 'I don't have a problem' and I said 'Why is that?' She said 'I only drink once a week'. And I said 'Well, how much did you drink on that day?' And she said 30 Codys – 30! So I said 'How did you feel – intoxicated or drunk?' 'Oh yeah, yeah, I was rough but we had a good night'. (Northern AOD treatment manager)

Gaps in treatment for women

Mental health and treatment workers described gaps in services:

...we always talk about it, the [AOD services] that we knew in the past that helped because, like the clinicians have referred people to those places before and it worked for some of these hard, difficult cases but they're still here doing the same thing. And they go, 'Oh yes, that place has closed down, so where to from here?'

The northern AOD treatment manager's service did not currently run any women-only programmes:

We ran a [weekly] women's group last year. It was just women talking about ... domestic violence and women's issues in a really safe way.

... Yes, and there is a women's centre here that runs programmes, so we can also refer people over to them.

Researcher: Do you find that they will talk about those things in a mixed group?

I think much more in a residential environment where they get to know each other ... it's less so here.

The manager said closures had led to gaps in treatment for women:

Oh gosh, there is lots of gaps. Just even things like Bethany [a Salvation Army service for young, single, pregnant women] closing is huge, because we've seen a lot of young women using alcohol and other drugs, you know, that were going there and that's closing.

Um – I don't think there is a residential treatment for women, is there? There is women and babies, I think, St Mary's Anglican Women's Trust.

Treatment clinicians who want to do their best for clients have difficulty with the combination of services that don't provide for children, don't deal holistically with domestic violence or mental health, and get closed:

Mental health worker: ... as a clinician we follow a pathway of how we are going to treat people ... 'I know this person will benefit from a ... residential place' and then you find that there's no such place ... So it also hinders the way clinicians work – sometimes the policies and contracts ... hinders what we think we should be working through (Hospital group).

Compulsory measures and tougher sentences

Some participants in the treatment sector thought having special courts and making treatment compulsory might be useful, as some women who had attended required sessions were grateful for the opportunity.

... I want to see the advent of drug courts, not just for older people but for youth. We would love to be working with the local judges with youth, then to be able to keep a consequence in place if the kid doesn't follow through fully, because we find that even kids who are coerced or forced into doing a programme quite often after a few weeks you start getting through to them. As long as there is a bit of a consequence left if they don't follow through – if it is too easy to flop out they flop out (Southern AOD treatment manager).

Two participants suggested more punitive measures for those who get into trouble with alcohol, supply alcohol to minors, or whose children are found drinking.

Tougher sentencing for misdemeanours concerning alcohol ... [like drink driving] (Community participant).

I would appreciate it if they enforced it that parents were prosecuted if their kids started drinking out in public (AE participant).

16.2.3 Discussion

Consumption

Most participants believed women's drinking rates were rising, as were associated problems. They noted a younger starting age for female drinkers, larger quantities of alcohol being drunk per drinking occasion, an increase in the frequency of women's drinking and in drinking to harmful levels, and a move to beverages with higher alcohol content.

Participants thought the diversity of women's drinking is difficult to capture and that some groups of women were being overlooked. They believed there was a high potential for hidden drinking among women.

Influences

Participants suggested that a range of influences were driving these increases. They included:

- Permissive policy and legislation, creating a much more liberal climate
- Wider accessibility and availability of alcohol due to the proliferation of licensed outlets
- A lower legal purchasing age
- A low price, particularly in relation to other drinks and activities
- Heavy alcohol advertising, including promotion of products designed for women.

The availability of cheap RTDs with high alcohol content, aimed at young women and often discounted at dozens of local outlets, summed up this combination of factors that encourage and support harmful drinking.

Participants said that the low price and lowered purchasing age has enabled young people to get alcohol easily through friends and relations. They raised the issue of social supply in all focus groups without prompting.

While many participants thought parents needed to be stricter around alcohol supply and home curfews, there were also discussions about the difficulties of parenting in a liberal climate with mixed messages about appropriate parental guidance. Some parents are trying to encourage their teenagers to drink responsibly by giving them some alcohol at home. However, some participants thought this was perhaps naïve or the wrong approach.

Colonisation, racism, marginalisation, discrimination, social exclusion, poverty and alienation contributed to harmful drinking for many women.

Participants described women drinking to blot out trauma from child sexual abuse, adult sexual assault and domestic violence; relieve stress; negotiate body image; socialise with friends, relatives and partners; and navigate contemporary female roles. These female roles included historical discrimination, stress from juggling paid work and family duties, and unrealistic social norms about women's bodies. Particular events, such as male sports events and school balls, were described as intrinsically, and often harmfully, tied to drinking.

Participants described alcohol in Aotearoa as integral to hospitality, socialising and the relief of stress. Its prevalence has led to an absence of alcohol-free spaces, places and events. Participants saw this dominant Kiwi culture as encouraging and promoting harmful drinking. The inevitability of drinking and the normalisation of drunkenness were seen as primary influences on consumption. Participants also noted the difficulty of counteracting this dominant norm in their own families.

Alcohol-related problems

Participants were concerned about the damage from women's drinking on women and their families, and the harm to women from other people's drinking. Participants described women who drank in public as being exposed to abusive and unsafe situations. They described risks of family breakdown, impaired parenting and domestic violence for women drinking at home.

The most frequently discussed problem from alcohol was sexual and domestic assault, with victims of sexual and family violence often going on to drink to manage the trauma. Participants perceived this gendered violence as affected by and causing women's drinking.

An additional problem was that the involvement of alcohol reduced men's responsibility and increased women's culpability in the minds of victims, perpetrators, jurors and others. This could lead to self-blame for victims, minimise the severity of assaults and increase the potential for misuse of alcohol to deal with the trauma. If alcohol was involved in sexual or domestic violence incidents, participants believed that the likelihood of victims being treated justly by the courts was low and the possibility of the charge being downgraded was high, due to this social myth about drinking women's culpability.

Participants described other harm experienced by women from their own or other people's drinking, including:

- Self-harm and suicide attempts
- Sexually transmitted infections
- Unplanned pregnancies
- Bullying and fighting
- Traffic crash and other injuries
- Alcohol poisoning
- Family breakdown
- Impaired parenting
- Children exposed to the risk of FASD
- Impaired educational performance
- Cancers
- Brain injuries.

Another theme was the erosion of cultural wellbeing from the dominant Kiwi normalisation of heavy drinking. This was implicit in many comments by Pākehā women – one example was the lack of care for intoxicated women – and explicit in discussion among Māori and Pacific women.

Participants were concerned about an increase in certain problems, particularly FASD, harm to children from impaired parenting, breast cancer and brain injury, if women's drinking continued to rise or did not abate.

Interventions

The lack of funding and resources for community interventions in the face of a robust and wealthy alcohol industry was a theme of the conversations. Some participants felt strongly about the inequity between what they saw as the huge resources the alcohol industry had for advertising, sponsorship and marketing, and the insecure funding and poor resources of community welfare and health sectors that had to deal with the resulting problems.

Alcohol advertising was considered highly influential in increasing drinking, and many participants called for a ban on alcohol advertising and promotion. Many participants also believed that reducing social inequities would reduce harmful drinking.

The difficulty of trying to change Kiwi drinking culture was discussed and not resolved. Some participants considered that some social marketing campaigns were effective in reducing problems among some populations (for example, the 'ghost chips' anti-drink drive advertisement). However, participants said that all the social marketing campaigns they discussed were also objects of ridicule, co-opted by drinkers to encourage drinking.

Despite the mammoth task of changing Kiwi drinking norms, many participants felt hopeful because of achievements in reducing smoking, and to a lesser extent, drink driving. They noted, however, that these social shifts had occurred as a result of legislative changes and government policies, support and action.

While participants were creative and generous about potential community solutions, they believed that the same techniques of legislation and government action would be necessary to enact real changes around the Kiwi drinking culture.

Participants perceived that existing social inequities are exacerbated by unequal access to treatment and interventions for some women, exclusion from or absence of appropriate treatment for others, and a lack of holistic and collaborative approaches. These gaps were ascribed to a lack of funding in government, AOD and community welfare sectors.

While participants were positive about treatment services, they remained concerned about the serious gaps for many women, such as childcare, and the need for more approaches that could respond to the diversity of women and their specific needs.

Young people are often the subject of discussion about alcohol in Aotearoa, and in these interviews this was certainly the case. One participant said that young people only cause 25% of alcohol-related problems, and that adult drinking needs to be acknowledged and addressed. Another participant lamented the lack of resources for solutions to harmful drinking based on youth development approaches.

Education was a popular intervention, mentioned by most participants. For several, 'more education' was their immediate response when faced with the overwhelming nature of the normative place of alcohol in Kiwi culture.

Suggestions included starting alcohol education in early childhood, effective school-based programmes, educating parents about appropriate strategies with teenagers, increasing knowledge of women's bodies, limits and body cues about alcohol, critical media literacy about alcohol advertisements, and educating licensed venue staff, which could not be left to voluntary efforts.

However, several participants expressed doubts about education as an effective way of changing drinking behaviour. Participants thought education programmes had to be specific for communities and not one-size-fits-all. Some participants with experience in delivering educational programmes had found access to schools difficult.

Other suggested potential interventions included:

- Strengthening protective factors such as supportive families
- Building mana wāhine and women's self-esteem
- Valuing women for more than how they look
- Increasing funding for family and sexual violence, and alcohol prevention programmes
- Increasing funding for holistic and collaborative approaches between treatment, mental health and anti-violence services
- ACC counselling payments for victims of sexual abuse that do not require them to have a diagnosis of mental illness.

A few participants considered punitive measures, while others believed the alcohol industry needed to be held more

accountable on a range of levels. Many participants wanted a more caring society on individual, community and societal levels. They wanted bystanders to intervene to protect intoxicated women; safe spaces; and a more inclusive and equitable society. They saw alcohol as undermining this.

Government apathy and neglect about legislation that would curb consumption and alcohol-related harm was a frequent theme. Participants reiterated the need for the most effective interventions – restricting accessibility and availability of alcohol though increasing the price, restricting alcohol outlet density, raising the legal purchasing age and banning advertising.

Several expressed cynicism or distrust about government willingness to act on alcohol, particularly if tax revenue from alcohol was at risk. Many appeared exhausted in the face of the increasing amounts of alcohol-related harm that they were expected to deal with, amid ineffective government responses. Many of those who were exhausted had been active in community attempts to influence alcohol issues, but felt unsupported because of government failure to curb damage from alcohol.

Despite this, they remained committed to their work, generous with their knowledge and creative about potential solutions. What they asked for was stronger, more effective alcohol policy led by government.

SUMMARY – FOCUS GROUPS AND INTERVIEWS

The project held six focus groups of health system and community health and social service providers and three individual interviews, with a total of 41 participants. One focus group was Māori and one Pacific. Most of the rest included Māori, Pacific and tauwiwi members.

They represented:

- DHB mental health and emergency hospital services
- Groups working against sexual and domestic violence and providing support and counselling
- Community organisations for lesbians and queer youth, those working against eating difficulties, and family support
- A group of alternative education workers
- Two non-government AOD treatment managers and a nurse manager.

Māori focus group

The major influences on women's drinking were alcohol advertising, especially for young women, and easy accessibility in low-income neighbourhoods due to the high number of alcohol outlets.

Poverty, poor health and racism also influenced women's drinking, as well as a community norm of heavy binge drinking.

The major damage from alcohol was to women's parenting, including children missing school and the threat of having children taken away, as well as violence against women. Participants also mentioned fights, the financial cost of drinking and FASD.

Participants said that interventions needed to be based on kaupapa Māori, presented in familiar and culturally appropriate settings, and supporting women's agency to escape poverty. Examples included marae-based whanaungatanga programmes, alcohol-free events and patrols by Māori wardens on benefit days. Access to higher education had also reduced women's drinking.

Participants said that dominant-culture GP and health services were often racist, and overlooked the issues underlying Māori women's drinking. Kaupapa Māori services were also seen as poorly and inequitably funded.

Other focus groups

Pacific

Pacific participants agreed that women's drinking had increased markedly in a generation, and were concerned at what they saw as high rates of drunkenness among young and older women.

Alcohol marketing and the density of liquor outlets in Pacific neighbourhoods were seen as strong influences, as well as the low price of alcohol, social inequities and trauma.

Participants struggled as parents to maintain cultural values of respect, spirituality and traditional boundaries in the face of what they described as this overwhelming pressure.

A major alcohol problem was the erosion of cultural wellbeing and family cohesion. Others included sexual abuse, unplanned pregnancies, fighting by young women, expulsions from tertiary education, and suspicion of government.

Suggestions for community health promotion included using cultural performances, online social media, hip hop songs, video and radio clips, and Pacific-language radio shows.

Mixed groups and interviews

Participants noted a younger starting age for female drinkers, consuming larger amounts per session, drinking more frequently, and drinking more often to harmful levels.

Influences included heavy alcohol advertising, permissive alcohol policies, easier access because of the number of outlets, a lower purchasing age, and low prices.

Colonisation, racism, poverty, social exclusion and heterosexism were all described as contributing to harmful drinking among women. Other factors were child sexual abuse, adult sexual assault, domestic violence, gender discrimination, difficulty juggling paid work and family duties, and unrealistic norms about women's bodies.

The dominant Kiwi drinking culture also encouraged and promoted harmful drinking.

Participants in all groups discussed the difficulties of parenting in this permissive alcohol climate. Some thought parents needed to be stricter about not giving alcohol to underage children, while others described this as a losing battle to influence young people to drink responsibly in a pro-alcohol culture.

Participants discussed a wide range of problems; the most frequent were alcohol-related sexual and domestic assaults. The involvement of alcohol reduced men's responsibility and increased women's in the court system, and diminished victims' chances of justice. They noted that adults cause most alcohol problems, despite a social focus on problems caused by young people.

Other problems included suicide attempts, sexually transmitted infections, unplanned pregnancies, fighting, traffic crash and other injuries, alcohol poisoning, family breakdown, impaired parenting, FASD, reduced educational performance, cancer and brain damage.

Suggestions included:

- Banning alcohol advertising
- Stronger government policies that reduced accessibility of alcohol through higher prices, reduced outlets and a raised purchase age
- Reducing social inequities
- Changing Kiwi drinking norms
- More funding to prevent sexual and family violence.

AOD and mental health treatment services, including for domestic violence, were seen as separate, with poor collaboration. Participants perceived services as overloaded and under-funded, and not catering well for women with children or lesbian and queer women.

17. Conclusions

17.1.1 What are the patterns of drinking among women, have these changed over time and if so how?

While increases in drinking vary between different groups of women, this project suggests that although the proportion of non-drinkers, including among secondary students, has risen over a decade, overall women who drink are starting at a younger average age, are drinking more on a typical occasion, may be more likely to drink beverages with higher alcohol content, and are drinking until they are drunk more often.

Underneath a rhetoric of equality, the stigma surrounding female drunkenness remains entrenched, inhibiting women from discussing or seeking help for problem drinking. A combination of research gaps and stigma renders our knowledge of women's drinking partial and incomplete.

While women drink a variety of alcoholic beverages, all focus groups and much of the research linked RTDs most strongly with harm.

A 1992 review of women's AOD use concluded that 'there does not appear to be a convergence in women's alcohol use and related problems relative to men's ...' (Abel et al., 1992, p. 31). The situation is now very different.

17.1.2 What are the major influences on women's drinking?

Increases in women's drinking have occurred in an environment of permissive alcohol policy. Rather than being treated as a potentially lethal product requiring social intervention to prevent a range of problems, policies have increasingly treated alcohol as an ordinary consumer commodity, an issue of personal choice and responsibility. This neo-liberal approach to alcohol consumption as an individual right underpins the increases in women's drinking.

The responsibility for regulating alcohol consumption has also steadily been shifted to the individual, who is expected to make rational choices in an alcohol-drenched environment. Women, facing gender as well as other social inequities, are expected to safely use a product that is psycho-active, addictive and heavily promoted, and which can temporarily block out trauma and anxiety.

The literature review and focus groups agreed on a range of policy and other influences on women's drinking:

- Alcohol advertising, marketing and sponsorship, including new products such as RTDs aimed at young women
- Alcohol and hospitality industry lobbying about alcohol policy
- A relatively low price for alcohol, particularly compared to milk and bottled water
- The use of low prices and discounting to increase sales and the amount people drink
- A higher density of alcohol outlets, especially in poor areas
- A greater variety of outlets, including supermarkets
- Extended opening hours for bars and clubs
- Younger adolescents being able to get alcohol through friends of legal age, especially after the purchase age was dropped to 18
- High rates of sexual assault, domestic violence and child abuse affecting women
- Historic and current social inequities, including colonisation, racism, sexism, poverty, heterosexism, marginalisation and social exclusion
- Less strict parental guidance and control of alcohol supply to under-age children
- The normalisation of New Zealand's binge-drinking culture.

Most of these factors also influence men's drinking, which adds to the harms experienced by women.

Alcohol has a variety of symbolic meanings for women, which are in part an aim and result of industry marketing. They include fun and freedom, hospitality and social connection. Many women drink for temporary relief from social inequities, stress and pain, as well as to relieve depression, anxiety, trauma and other mental health issues.

Many, particularly young, women see themselves now as equal to men and reject historical expectations of female restraint around alcohol; the alcohol industry capitalises on that perception.

Supply by parents to underage children was a concern in all focus groups. Parents often hoped to influence the amount their teenagers drink by giving them alcohol at home where it was safer.

17.1.3 What harms result for women from their own or others' alcohol consumption?

Women experience a litany of damage from their own and others' drinking; research knowledge, especially about problems for women from other people's drinking, is still evolving. The most often-mentioned problems from alcohol identified in focus groups included:

- Sexual and domestic violence – overwhelmingly identified as a major harm to women
- Injuries from traffic crashes, assaults and fighting
- Breakdown of families, whānau and aiga
- Compromised parenting, and the possibility of children being taken away from the mother
- Cancer, particularly breast cancer
- FASD
- The erosion of cultural wellbeing and values, including of respectful relationships between the genders in Pacific cultures, of caring in Māori and Pākehā cultures, and protective factors such as social connectedness and non-drinking
- Problems in education, including poor results, absences from school, expulsions and leaving early due to unplanned pregnancies
- Increased social inequities
- Drinking to unconsciousness and alcohol poisoning
- Unplanned pregnancies
- Sexually transmitted infections
- Self-harm and suicide attempts
- Brain damage
- Being unable to work
- Financial problems
- Having to look after others or pick up extra responsibilities due to others' drinking.

Some participants were also concerned about the potential for major increases in brain damage and breast cancer rates in the future, due to adolescent and young women's increased rates.

Alcohol was described as a major factor in how frequent and how severe domestic and sexual violence attacks were.

Participants were clear that alcohol and violence created a vicious circle for women, as both cause and effect. Other people's drinking increases violence against women, which increases their own drinking, which makes them more vulnerable to revictimisation and to staying in abusive situations, and prevents them from seeking help.

The woman's own drinking can lead to self-blame, which also increases her potential for alcohol abuse. The involvement of alcohol often shifts culpability from perpetrators to victims. Participants wanted ACC funding for sexual abuse survivor counselling, whether they have a mental injury or not, as this is important in reducing women's vulnerability to alcohol abuse.

The unequal distribution of alcohol problems was also a concern in most of the focus groups. Poor women, Māori, Pacific and other marginalised women bear more of the problems from alcohol, which increases social inequities between women.

Participants were also concerned about how alcohol is eroding cultural resiliency and wellbeing, family cohesion, and community connectedness, creating a world that is often unsafe or uncaring, particularly for women.

17.1.4 Is the impact of alcohol on women's health, either through women's own drinking or the drinking of others, a growing problem?

Focus groups and the literature review concurred that almost all alcohol-related problems for women are increasing, some dangerously. Participants were convinced that alcohol-related sexual and domestic violence was worsening.

They discussed the increasingly heavy, risky and traumatising workload of workers in health and policing, due to the magnitude of alcohol-related damage. Participants said this caused a strong potential for burnout, trauma and exhaustion in these sectors, and discussed community despair in the face of government indifference to this damage.

Participants expressed frustration, scepticism and distrust at the failure of successive governments and local bodies to look beyond alcohol and hospitality industry lobbying and tax income, and enact strong alcohol policies that would reduce harm.

Several participants contrasted the sparse resources of overwhelmed communities and agencies trying to prevent or deal with alcohol-related damage, and the rich corporations that profit from it. They saw the industry as evading the costs of its harmful products, and suggested that it needed to be held more accountable.

17.1.5 What is currently working for the prevention or reduction of harm to women from their own or other people's alcohol consumption?

Policy

Alcohol problems among women are caused by a complex combination of social, economic and individual factors. Prevention requires a sustained combination of synergistic evidence-based structural and community measures.

Since women experience more problems than men from others people's drinking, the harm they experience can only be reduced by population-level changes. Focus groups and the literature review concurred on the need for effective legislation and policies to reduce alcohol consumption and damage. These included:

- Restricting or banning alcohol advertising, marketing and sponsorship
- Raising the price of alcohol
- Raising the purchasing age to 20
- Restricting outlets, hours and accessibility
- Reducing legal blood alcohol levels for drivers.

Research surveys and responses to the Law Commission review showed wide public support for these measures, with consistently stronger agreement from women.

Social inequity

Many participants believed that tackling systemic social inequities and exclusion, and working towards a more equitable society would help reduce women's drinking. Many also said that preventing sexual and domestic violence and increasing support for those experiencing it would also reduce women's drinking and alcohol-related problems. Women are often struggling with violence and alcohol at the same time, but research and participants said that interventions about these issues remain separate rather than holistic.

The promotion of respectful masculinity that is needed to reduce violence against women is continually undermined by the gender relations in alcohol advertising, online marketing, and many promotions in licensed premises.

Focus groups suggested a wealth of community programmes and health promotion interventions to increase women's well-being and resilience and challenge heavy drinking norms. Social marketing and community education about alcohol were popular interventions. Education is an affordable and appealing intervention for those who see increasing alcohol problems, but have no ability to change government policy.

However, there is no evidence that social marketing and education programmes alone have any long-term effect on alcohol consumption. Some participants were ambivalent about education, and discussed the contradiction of social marketing campaigns against drink driving that normalise drunkenness.

Participants had had little experience with brief interventions, apart from an ED worker whose work was too pressured to enable her to use them.

Participants described multiple barriers to treatment for women, particularly the lack of alternative childcare; the lack of collaboration between AOD, mental health and domestic violence services.

Māori and Pacific descriptions of racism in the health and justice systems made it clear that dominant-culture health and social services need routine anti-racism training and auditing about this issue.

Participants said AOD services were under-funded, particularly kaupapa Māori services, and often ad hoc. They needed to be culturally appropriate, gender-specific, competent with lesbian, queer and transgender clients, and to co-operate much more closely with mental health services and the under-funded women's refuge network.

Many alcohol interventions also seem to be ad hoc and short term, partly because of inadequate funding. This project identified a need for systemic and holistic prevention efforts that act synergistically at the level of individuals, families, communities and the wider society. It has also shown that gender-specific policies and interventions are needed to improve the wellbeing of women.

17.1.6 Alcohol and wellbeing

In the introduction, this report asked: What quality of life does alcohol provide that nothing else does? The research review and focus groups indicate that women use alcohol for a sense of wellbeing, relief from trauma and marginalised situations for a brief time, and to relax and smooth social interactions.

However, evidence-based population health approaches promote alternative ways to increase positive wellbeing, engagement with life and a sense of purpose – simple things like time with family or friends, exercise, savouring the moment, giving to others, or learning something new (TGOS, 2008). This approach increases the proportion of flourishing and happy individuals in a population (Seligman et al., 2005). The assumption that alcohol is necessary for relaxation or to smooth social situations is a social construction in developed countries. More than half the world's population does not drink alcohol and alcohol is not necessary for wellbeing.

The Māori wellbeing model Te Pae Mahutonga (Durie, 1999) includes cultural identity, environmental protection, healthy lifestyles and social participation, which require a context of effective leadership and autonomy. Focus group participants identified alcohol as responsible for ongoing erosion of Māori, different Pacific and Pākehā cultural identities. The research has identified a range of policies that would provide environmental protection, and indicates that this lack of protection, in a context of deepening social inequities, is undermining healthy lifestyles around alcohol.

It has also illustrated widespread social participation by a range of communities in consultations, campaigns and community action about alcohol, accompanied by high levels of frustration at the resulting lack of change. The research review and focus groups indicate that the context of effective government leadership, and community autonomy, particularly for tangata whenua, is what is missing.

17.1.7 The Sale and Supply of Alcohol Act

The NZ Law Commission review and the Sale and Supply of Alcohol Act 2012 were described as a once-in-a-generation opportunity to reduce damage from alcohol (Kypri et al., 2010a). This project concludes that this opportunity was squandered because the most effective measures to reduce harm to women were left out of the Act (Huckle et al., 2012; Alcohol Action NZ, 2011; AHW, 2011a; Kypri et al., 2011b; NZDF, 2011a; CYMRC, 2009). As a result, the alcohol-related problems for women that have been explored in this report are likely to continue largely unchanged.

18. Research recommendations

Need for gender analysis

- Ensure that all commissioned AOD research analyses results by gender.

Fund research to provide:

Consumption

- National survey data with adequate response rates which enable comparisons over time while allowing for changes in methodology and survey design that takes new research into account, and which analyse gender by age, ethnicity, deprivation, and area type
- Kaupapa Māori and mana wāhine research about alcohol
- Longitudinal data about the consumption of female adolescent heavy drinkers as they move into their 20s and 30s
- Qualitative data about why more women remain non-drinkers than men, how women sustain non- or occasional drinking, and how non-drinking can be supported
- Representative or large-scale data on lesbian and queer women's AOD use
- Data about drinking by women with intellectual and other disabilities and their access to AOD services.

Influences

- Exploration of any links between experience of systemic discrimination and AOD use.

Health and social problems

- The prevalence of FASD
- The impact of women's drinking on children and whānau
- The health and social impacts of older women's drinking
- The impact of alcohol on women's economic independence
- The rate of women arrested for being drunk and disorderly over time
- The rate of alcohol-related crime by women over time.

Interventions

- Research into the prevention of FASD
- Evaluation of major alcohol policy changes
- Evaluations of Pacific interventions, including pan-Pacific and ethnic-specific interventions
- Evaluations of interventions using kaupapa Māori approaches
- Evaluations of the impact of campaigns against racism and discrimination on AOD use
- Evaluations of the impact of campaigns against violence on women's AOD use.

19. Appendix 1: Questionnaire schedule

Women and Alcohol Research Project focus group and interview questions

Kia ora, Fakalofa lahi atu, Greetings

Thank you very much for taking part in our focus group about women and alcohol in Aotearoa.

CONSUMPTION, INFLUENCES AND PROBLEMS

What are the main issues in relation to women and alcohol in New Zealand?

What do you think are the biggest contributing factors to issues around women and alcohol in NZ?

What trends (if any) have you and your colleagues noticed in women and alcohol over the last 10 years?

In your experience, what are the most common harms you are aware of from women's own drinking?

What are the most common harms to women that you are aware of from other people's drinking?

What are the trends? (Have you noticed any changes in relation to women and alcohol – what are they?)

What do you think has influenced these changes (why)?

Are there any other issues being encountered in relation to women and alcohol by your and your organisations?

INTERVENTIONS

What interventions do you know of that aim to reduce alcohol-related harm to women?

Are these interventions available, accessible and appropriate?

What interventions do you think are most effective?

Why do you think these are the most effective?

What do you think are least effective?

Why do you think these are least effective?

Are there interventions that would make a difference but do not exist? What would they look like?

Is there anything else you think is important about women and alcohol that we have not covered?

Is there anything else you think is important about reducing harm to women from alcohol that we have not covered?

Thank you for your time.

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Women's Health Action
PO Box 9947 Newmarket
Auckland 1149
New Zealand
www.womens-health.org.nz



Alcohol Healthwatch
PO Box 99407 Newmarket
Auckland 1149
New Zealand
www.ahw.org.nz

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