

**Policy  
Briefing  
Paper**

# ***Women and Alcohol in Aotearoa/New Zealand***

***Te waipiro me ngā wāhine i Aotearoa***

---

**2013**

---

**Women and Alcohol in Aotearoa/New Zealand - Te waipiro me ngā wāhine I Aotearoa  
Policy Briefing Paper, 2013.**

*This Policy Briefing Paper was prepared by Alcohol Healthwatch and Women's Health Action, Auckland New Zealand.  
Further copies can be downloaded from the Alcohol Healthwatch website [www.ahw.org.nz](http://www.ahw.org.nz) and the Women's  
Health Action website [www.womens-health.org.nz](http://www.womens-health.org.nz)*

ISBN: 978-0-9941021-0-2 (Printed)

ISBN: 978-0-9941021-1-9 (Electronic)

# Contents

Introduction	4
Why focus on women?	5
Why focus on alcohol?	6
Our investigation	7
How are women drinking?	8
What are women drinking?	9
Harmful effects of alcohol on women	10
Major Influences on women's harmful alcohol use	13
Protective factors against women's harmful alcohol use	14
Preventing or reducing the harmful effects of alcohol on women	15
Conclusion	18
Recommendations	19
Action Point	20
References	21
Acknowledgements	27

# Introduction

The harmful use of alcohol has a serious effect on public health. It is a major risk factor for poor health globally, as well as nationally. The concept of the harmful use of alcohol is broad. It encompasses the drinking that causes detrimental health and social consequences for the drinker, the people around the drinker and society at large. It can ruin the lives of individuals, devastate families, and damage the fabric of communities.

In their final report on the review of our alcohol laws, *Alcohol in Our Lives – Curbing the Harm*<sup>1</sup>, the New Zealand Law Commission provides a comprehensive summary of alcohol use in New Zealand today. The report gives an in-depth picture of the role of alcohol in the lives of New Zealanders, the size and scope of the alcohol industry, the harms of alcohol, and how we might best address them.

However, despite the Law Commission's review, relatively little is known about the patterns of women's drinking in New Zealand, if and how these are changing, the harmful impacts of alcohol on women's lives and the effectiveness of efforts to reduce alcohol harm for women.

While women have traditionally consumed less alcohol than men, they experience damage at lower levels of consumption. More recently, media attention has focused on the "problem" of women's alcohol consumption. There is a suggestion that women are drinking more, at a younger age, and that their use and abuse of alcohol is converging with men's. There is emerging evidence of a significant shift towards heavier alcohol use among women, however, the data are limited and very ad hoc, making it difficult to analyse trends. Given the gaps in our knowledge about women and alcohol in New Zealand, the strong media interest, and the current lack of any strategic policy framework, the conditions are set for uninformed public discussion, debate and policy response.

Funded by the Ministry of Health, Alcohol Healthwatch and Women's Health Action commissioned research with the aim of addressing this knowledge gap and to better inform policy and programme development. We reviewed research on women and alcohol, and interviewed key informants who daily encounter the impacts of alcohol in women's lives. In particular the research asked:

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

This briefing paper provides a context to the research. It then summarises the findings including those related to the prevalence of women's drinking; the harmful effects of alcohol on women; risks and protective factors that influence women's drinking; and interventions that are or may be effective at reducing alcohol-related harm for women. It concludes with a set of recommendations, to help ensure that steps to reduce alcohol harm will improve health outcomes for women.

**A copy of the full research report, on which this paper is based, is available to download from the Alcohol Healthwatch website, [www.ahw.org.nz](http://www.ahw.org.nz) and the Women's Health Action website [www.womens-health.org.nz](http://www.womens-health.org.nz).**

# Why focus on women?

The World Health Organization (WHO) has recognised that sex (the biological differences between women and men) and gender (the social and cultural norms that determine femininity and masculinity) have an important impact on health and wellbeing<sup>2</sup>.

Sex differences are the biological characteristics such as anatomy and physiology that distinguish female and male bodies. Many of these differences are related to the different reproductive systems in males and females<sup>3</sup>. Some people are born with a reproductive or sexual anatomy that doesn't fit the typical definitions of female or male. These people are referred to as intersex<sup>4</sup>. To improve health status, sex differences such as hormones and metabolic process and their link to biological or genetic differences in susceptibility to disease or responsiveness to treatment need to be understood.

Gender influences are the socially constructed roles and responsibilities, attitudes, behaviours values and relative power that society differentially ascribes to the two sexes. While gender is a fluid concept and not restricted to the two distinct categories of male and female most societies are organised 'along the "fault lines" of sex and gender such that women and men are defined as two different types of people, each with their own roles, responsibilities and opportunities'<sup>5</sup>. The past 50 years have seen significant change in women's social roles, particularly in developed countries. Women today balance the stresses of multiple roles, including family and childcare responsibilities, paid employment, and community and voluntary activities. Despite many gains, women in New Zealand continue to experience persistent inequities, including higher rates of poverty, a gender pay gap, high rates of intimate partner and sexual violence, lower representation in decision-making and disparate access to paid parental leave and early childhood education<sup>6</sup>. All of these factors intersect to have a detrimental impact on women's physical and mental health.

As sex and gender influences health, effective health research, policies and programmes must be sensitive to sex differences and gender influences. Gender-based analysis is a tool permits the identification of potential inequalities that arise from belonging to one sex or another and the gendered values ascribed to that sex, or from relations between the sexes. As the WHO has identified, 'These inequalities can create, maintain or exacerbate exposure to risk factors that endanger health'. It is also a method for examining the intersection of sex and gender with other identity factors influencing health and social outcomes including but are not limited to ethnicity, indigeneity, socioeconomic status, sexuality, gender identity and ability<sup>7</sup>.

As signatories to the United Nations Convention on the Elimination of Discrimination Against Women (CEDAW\*), the New Zealand government has a special responsibility to progress towards gender equality for women<sup>8</sup>. Article 12 of the convention requires that:

*States parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.*

Both the United Nations and the World Health Organization hold that for public health practice to achieve health equity, gender considerations must be integral to all facets of research, policy and programme development. The CEDAW Committee's recent review of New Zealand's progress in implementing the convention expressed concern that the New Zealand government has not taken sufficient steps to ensure that gender considerations are mainstreamed into all national plans and government institutions<sup>9</sup>. Incorporating gender-based analysis into alcohol policy and programme development is therefore timely, and should be a priority.

\* CEDAW is an international treaty and rights-based framework adopted in 1979 as one of the six primary international documents for the protection and promotion of human rights. The convention's agenda addresses discrimination and achieving equity for women. New Zealand ratified it in 1985.

# Why focus on alcohol?

## Global context

The harmful use of alcohol is the world's third leading risk factor for premature deaths and disabilities<sup>10</sup>. Leading alcohol researchers have described alcohol as “no ordinary commodity”<sup>11</sup>. It is estimated that 2.5 million people worldwide died of alcohol-related causes in 2004, including 320,000 young people between 15 and 29 years of age. Harmful use of alcohol was responsible for 3.8% of all deaths in the world in 2004, and 4.5% of the global burden of disease.

Harmful drinking is a major avoidable risk factor for neuropsychiatric disorders and other non-communicable diseases such as cardiovascular diseases, cirrhosis of the liver, breast and other cancers. For some diseases there is no evidence of a safe threshold of alcohol intake before the risk increases. The harmful use of alcohol is also associated with infectious diseases such as HIV/AIDS, tuberculosis and pneumonia. A significant proportion of the health burden attributable to harmful drinking arises from unintentional and intentional injuries, including those caused by road traffic crashes, violence and suicides. Fatal injuries attributable to alcohol consumption tend to occur in relatively young people<sup>12</sup>.

The degree of risk of harm from alcohol use varies with age, sex and other biological characteristics of the consumer, as well as with the drinking context. Risks also vary in relation to the patterns of drinking. Some groups and individuals are more susceptible to the toxic, psychoactive and dependence-producing properties of alcohol, making them particularly vulnerable.

The widely held view that low levels of alcohol consumption are universally safe or even beneficial to the healthy adult population has been scientifically challenged. This is particularly so in relation to the risk of cancer for which no safe alcohol threshold has been identified<sup>13</sup>. Equally important is recognising that the evidence of moderate drinking having a protective against heart disease has been shown to be greatly overstated. Such misperceptions have the potential to weaken the public health policy response to alcohol-related harm.

Despite the need and the sound evidence for more effective action on alcohol, political and commercial barriers prevent or hinder progress. The influence of the global alcohol industry and international trade agreements are obvious. In 2010, WHO published the *Global Strategy to Reduce the Harmful Use of Alcohol*. This strategy draws on the substantial scientific knowledge base of cost-effective strategies and interventions, and effectively calls on member states to introduce more effective measures to reduce the alcohol-related harm burden. As a WHO signatory, the New Zealand government has an obligation to work effectively to reduce the burden of harm from alcohol.

## New Zealand context

The Law Commission's comprehensive 2010 review of our alcohol laws concludes that “New Zealanders have been too tolerant of the risks associated with drinking to excess” and that the “unbridled commercialisation of alcohol as a commodity in the last 20 years has made the problem worse”<sup>14</sup>. Furthermore they agreed with Alcohol Healthwatch's assertion that “the law as it stands is acting counter to its object and resulting in increased harm rather than reduced harm”.

This alcohol-related harm is estimated to cost us \$5.3 billion dollars annually in health and social problems<sup>16</sup>. Each year alcohol causes at least 800 New Zealanders to die prematurely, and many thousands more experience physical, emotional, social and economic harm from their alcohol use. More recent research explains and measures the impact of alcohol on those other than the drinker, arguing that this is substantial, and potentially greater than the harm to drinkers from their own drinking<sup>17</sup>. Children, young people, Māori, Pacific peoples and those living in more deprived areas are among those who experience disproportionate problems. Despite the significant burden of harm, New Zealand currently has no agreed national plan to address it. Furthermore, the once-in-a-generation opportunity for substantive reform, presented by the New Zealand Law Commission's review, was missed when the New Zealand Parliament passed new alcohol legislation on 11 December 2012\*.

\* The Sale and Supply of Alcohol Act 2012 passed into law on Tuesday 11 December 2012 and gained Royal Assent on 18th December 2012.

The new law includes some positive measures, such as allowing greater community involvement in liquor licensing, clarifying who and how alcohol can be supplied to minors, and limiting where alcohol can be sold in supermarkets. However, it does not include mechanisms to respond to the Law Commission's recommendations for raising the minimum legal purchase age to 20 years, increasing alcohol excise tax, and prohibiting all alcohol advertising and sponsorship in all media (other than objective product information).

## **Our investigation**

We commenced the research with a review of the literature on alcohol and women, with particular reference to women in New Zealand. We also undertook focus groups and individual interviews with key informants working in a range of health and social services. These informants were selected for their experience with, and insights about, the effects of alcohol on the lives of women.

- **Literature review**

The review gave priority to more recent systematic reviews and meta-analyses and to studies in the last decade. Studies that did not analyse by gender were included only if there was no other evidence on a particular topic. The review included peer-reviewed articles from research databases and research reports from a range of agencies.

- **Focus groups and individual interviews**

Six focus groups and two individual interviews were held, and 41 key informants participated in the research. Hapai Te Hauora Tapui organised and independently analysed a Māori focus group, using a kaupapa Māori, semi-structured interview technique. A fono talanoa was held for Pacific participants facilitated by a Pacific facilitator, with interviews transcribed verbatim and coded for thematic analysis<sup>18</sup>, with supervision from the facilitator. Mixed focus groups had a semi-structured format. Interviews were transcribed verbatim and coded for thematic analysis<sup>19</sup>.

Over 40 organisations were approached to participate and 20 were represented in the focus groups, spanning a range of organisations, sectors, communities and ethnicities.

- **Research limitations**

Resource constraints meant that certain aspects of the topic were sampled only thinly, and the review should not be considered definitive. The scope did not include children and should not be considered representative of the literature on the harmful effects of alcohol on children.

No focus group representatives worked directly with migrant and refugee communities, female prisoners or sex workers. Representation by key informants working with these additional groups would have enriched the information.

# How are women drinking?

Gaining an accurate and meaningful picture of trends in women's alcohol consumption over time is difficult, and understanding how alcohol impacts on different groups of women even more so. Methodological differences have meant that data has been collected inconsistently, and not always in a way that allows for disaggregation by gender, age and ethnicity. Most data also relies on respondent self-reports, with under-reporting a well-recognised phenomenon. Under-representation of high-risk drinkers in population surveys is also well recognised. The ability to draw definitive conclusions about how many women are consuming harmful levels of alcohol, how frequently they drink, how much they are drinking, and how this is changing over time, is therefore limited. However, there are some patterns in women's drinking that hold true for most female populations in Aotearoa: women are drinking more, their drinking patterns are converging with men's and young women drink more than older women. The following discussion presents overall research trends and key informant perspectives relating to these changing patterns, which help to give a picture of the current status of women's drinking in New Zealand.

*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...*

(VIOLENCE AGAINST WOMEN PARTICIPANT)

## Proportion of drinkers

The New Zealand Alcohol and Drug Use data (2007–08)<sup>20</sup> shows that 83% of women had drunk alcohol in the past year, compared to 88% of men. A lower proportion of Pacific and Asian women were drinkers, although this varied by ethnicity. Women living in more deprived neighbourhoods were also less likely to be drinkers<sup>21</sup>.

Māori and Pacific adults were significantly more likely to be drinkers in 2007–08 than in 1996–97, but across the whole population aged 16 to 64, between 1996 and 2008 there were no significant changes in the proportion of drinkers<sup>22</sup>. A recent analysis indicates that the prevalence of drinking among 35–54 year old women decreased between 1995 and 2011<sup>23</sup>.

Some evidence suggests convergence between men's and women's drinking, and an increase in the volume consumed by young women. Between 1995 and

2000, women and men aged 20 to 39 were converging in the amount they drank in a typical session, the total volume drunk and their rates of intoxication<sup>24</sup>. However, there are no more recent analyses of convergence.

## Age-related hazardous drinking among women

One recent survey reported that between 1996 and 2012 the rate of hazardous drinking among women remained relatively stable at around 12% of drinkers<sup>25</sup>. However, other surveys indicate that women of all ages have increased their alcohol intake in the last two decades, and this has been most marked in younger women<sup>26 27 28</sup>.

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<sup>29 30</sup>. This is consistent with results from the New Zealand Health Survey, where the proportion of 16 to 17-year-old young women drinkers significantly reduced from 79% in 2006/7 to 59% in 2011/12<sup>31 32</sup>. However, of those secondary students who did drink, 28% had five to nine drinks in an average session in 2001, and 30% in 2012<sup>33 34</sup>. About 10% usually had 10 or more drinks a session in 2012.

In 2007–08 women aged 18–24 were more likely than other women to have more than four standard drinks on at least one drinking occasion in the last 12 months, with four out of five doing so<sup>35</sup>. More than three quarters of women aged 16–17 years, seven out of 10 of those aged 25–34, and one in three women aged 55 to 64 had done so. Between 1995 and 2000, the amount young women aged 16 to 24 drank on a typical occasion increased from four to six drinks<sup>36</sup>.

In 2006, one in three female tertiary students got drunk once a week and drank seven to nine drinks an average session<sup>37</sup>.



During the same period, 44% of women aged 55 to 70 drank hazardously<sup>38</sup>. Around 80% of women of childbearing age were drinking alcohol around the time they became pregnant. Most stopped on confirmation of pregnancy, but up to 36% continued to drink some alcohol during pregnancy<sup>39</sup>.

Women living in more deprived neighbourhoods were more likely than those in affluent neighbourhoods to drink more than four standard drinks in a drinking session. Asian women (and men) were significantly less likely to binge drink.

## Ethnic differences

There are ethnic differences in the proportion of drinkers, and the frequency and volume of drinking among women. Māori and Pacific women were more likely than Pākehā

women to be non-drinkers and to drink less often, but more likely to have more drinks on a typical occasion, although these factors vary by ethnicity among Pacific women. The proportion of Māori women drinking hazardously declined from 31% to 28.5% between 1996 and 2006. For Pacific women it rose from 21% to 26%<sup>40</sup>. Pākehā women were more likely to be drinkers and to drink regularly, but less likely to binge drink. The proportion of Pākehā women drinking hazardously increased from 12% to 14.5% between 1996 and 2006. Asian women had high rates of non-drinking, tended to drink less often and drank low quantities per session, although drinking patterns varied by ethnicity. The proportion drinking hazardously declined from 5% to 4% between 1996 and 2006<sup>41</sup>.

## Other differences

Socio-economic status and sexual identity also influence drinking patterns. Women in more affluent areas were much more likely to drink daily than those in deprived areas. Women who identified as lesbian, bisexual or queer were more likely to be drinkers and to drink weekly than heterosexual women, although evidence is sparse<sup>42</sup>. Women active in sports had an average drinking score above hazardous level in 2006<sup>43</sup>. Half of a sample of female prison inmates in 1999 drank at hazardous levels before they were convicted<sup>44</sup>. No research was identified about the use of alcohol by women with disabilities in New Zealand.

## What are women drinking?

Women drink a range of beverage types including wine, beer and spirits, although there are patterns of alcohol choice by ethnicity and age. Among women aged 35 to 74, Pākehā women most commonly drank wine (69%), while Pacific women drank spirits, beer and wine in more equal proportions.

There is strong evidence about the appeal of ready-to-drinks (RTDs) for young people, particularly young women. Young people, both female and male, are the most common consumers of RTDs, and those who drink them are more likely to be heavier drinkers than those who do not. In one study RTDs made up 70% of the alcohol intake of 14–17-year-old girls<sup>45</sup>. RTD consumers typically drank more in a session, and more often in a year than those who drank other spirits, beer or wine. Key informants strongly associated RTDs with harms. The alcohol content of many RTD brands has risen since they were introduced in the 1990s.

*...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... It's not our culture... Where did that come from?... that is an impact of colonisation...*

(MIXED FOCUS GROUP PARTICIPANT)

*...RTDs seem to be the problem...  
...With RTDs and spirits in particular, young people need to drink a lot less to get drunk quicker...*

(MIXED FOCUS GROUP PARTICIPANTS)

# Harmful effects of alcohol on women

Heavy per-occasion drinking (often referred to as binge drinking), frequent drinking, the early onset of drinking, and drinking when other risks are present, are the common forms of alcohol consumption that increase the risk of alcohol-related harm. This can be immediate (often associated with binge drinking), or chronic (from longer-term use).

Alcohol-related harms for women include financial vulnerability, diminished physical and mental health, an increase in the severity and prevalence of violence directed at them, unplanned pregnancies and compromised parenting, family breakdown and erosion of cultural values and wellbeing. At its worst, alcohol can result in injury, illness and death for women. Women experience these harms from their own drinking, and are more likely than men to experience harm from the drinking of others<sup>46</sup>.

The research found that the harmful effects of alcohol on women are increasing, and that in almost no areas is alcohol-related harm reducing. Some of the major harmful effects of alcohol on women as identified in both the review of the literature and by key informants are profiled below. See the full research report for a comprehensive record of alcohol-related harms for women.

## Violence against women

Both the review of the literature and information gathered from key informants confirmed the prominence of alcohol in sexual and domestic violence against women, and that alcohol-related violence is worsening. Increasing evidence shows that violence is the major alcohol-related harm experienced by women and children as a consequence of the drinking of others, overwhelmingly men<sup>47 48</sup>.

There is strong evidence that in the context of domestic or sexual violence, alcohol is a key factor in the prevalence and severity of attacks. At least one in three New Zealand women experience violence from male partners in their lives, and at least one in three cases of reported domestic violence is alcohol-affected, although the actual number is considered likely to be much higher<sup>49</sup>.

If women in abusive relationships are consuming alcohol themselves, this can prevent them from seeking help<sup>50</sup>. If the woman was drinking at the time of the assault it can lead to guilt or self-blame, inhibit access to justice and increase her potential for alcohol abuse. Key informants said that the woman's drinking often shifts culpability from perpetrators to victims, sometimes leading to family violence charges being downgraded.

It is estimated that more than 10,000 sexual assaults occur in New Zealand each year which involve a perpetrator who has been drinking<sup>51</sup>. While issues of under-reporting and under-recording of alcohol and drug assisted sexual violence are acknowledged, alcohol is linked to half of all reported sexual assaults<sup>52</sup>. However, 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, and men who drink as less responsible<sup>53</sup>. Female victims who had been drinking are more likely to blame themselves for their rape. In cases of sexual violence that go to court, the victim's alcohol or other drug use can lead to police not believing her, insufficient evidence due to the effect on her memory, the victim withdrawing legal cases early, and a lower chance of conviction<sup>54</sup>.

About one in 16 female secondary and tertiary students have had unwanted (as distinct from forced) sex in the past year after drinking. While men and women reported roughly similar rates of unwanted sex and sex they were unhappy about<sup>55</sup>, given the gendered nature of sexual coercion, for many women the impact is likely to have been greater.

*....Alcohol just escalates the violence to a stage where the woman has had injuries, she's going to end up dead ...*

(VIOLENCE AGAINST WOMEN FOCUS GROUP PARTICIPANT)

## Increasing inequalities

Alcohol-related harm does not affect all women in the same way. Those who experience higher deprivation, Māori and Pacific women, and other marginalised women experience these impacts disproportionately, which exacerbates existing inequalities. The density of alcohol outlets in areas of higher deprivation, and with high proportions of Māori and Pacific peoples, aggravates a wide range of alcohol-related problems, increasing the inequalities and transferring money from these communities to the owners and shareholders of alcohol retailers and producers. The unequal distribution of alcohol damage amongst women concerned many key informants. They were disturbed about the way alcohol is eroding cultural resilience and wellbeing, family cohesion and community connectedness, creating a world that is often unsafe or uncaring, particularly for women.

## Cancer

In 2007 it was estimated that cancers made 44.1% of all alcohol-attributable deaths among women<sup>56</sup>. Breast cancer is the second most common cancer affecting women and alcohol consumption increases the risk of breast cancer among women<sup>57</sup>. There is a 10% increase in the risk of breast cancer for each extra standard drink consumed per day, and there is no known safe threshold<sup>58</sup>. It was estimated in 2004 that 13-15% of women's breast cancer cases were alcohol-related<sup>59</sup>. Based on this, of the 2,759 cases of breast cancer registered in 2009, 414 were alcohol-related.

## Sexual health

Excessive drinking is a common reason for unprotected sex<sup>60</sup>, with impacts including sexually transmitted infections, unplanned pregnancies, infertility and cervical cancer. Women bear a disproportionate disease burden of sexually transmitted infections (STIs) from unprotected sex.

In one study, one in five women attributed their first sexual intercourse about 20 years earlier, to drinking<sup>61</sup>. Among tertiary students, sex that is unsafe, unhappy or unwanted is linked with heavier drinking<sup>62 63 64 65</sup>. Women who used alcohol to increase confidence and improve sex experienced higher rates of unsafe sex and sexual harassment<sup>66</sup>. Alcohol was often cited in focus groups as a reason for unprotected sex and the high rates of STIs<sup>67</sup>.

## Fetal alcohol spectrum disorder

Alcohol exposure during pregnancy can result in fetal alcohol spectrum disorder (FASD) which includes fetal alcohol syndrome (FAS), along with other alcohol-related birth defects and disorders. There is no prevalence data on FASD in New Zealand. Recent studies in the USA, South Africa and Italy have found FAS rates of between four and 12 per 1,000 live births, and FASD in 2.3–6.3 per 100 of school children<sup>68</sup>. Using these estimates, around five in 100 New Zealand children could be born with FASD. 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.

## Injuries

In 2007, 42% of estimated years of life lost to women due to alcohol were from injuries<sup>69</sup>. Alcohol consumption increases the risk of injury from traffic crashes, falls, poisoning, drowning, burns and fire, as well as those from assault and other violence, suicide and self-harm, and those at work. Rates of injury are strongly associated with drinking patterns, with binge-drinking women having the highest risk. Drinking four drinks in one session more than doubled the risk of injury for women in the six hours after drinking<sup>70</sup>. Alcohol-related injury rates vary across different groups of women; younger women are at higher risk<sup>71</sup>.

Alcohol is estimated to be responsible for up to 25% of road traffic injuries for non-Māori women aged up to 44, and up to 37% for Māori women<sup>72</sup>. While men make up most drink drivers, the number of women caught drink driving increased by 1,700% between 1986 and 2006, compared with 185% for men<sup>73</sup>. The proportion of alcohol-affected women drivers in traffic crashes is also rising<sup>74</sup>.

## Alcohol abuse, dependence and other mental illness

Alcohol disorders include alcohol abuse and alcohol dependence (addiction). Alcohol abuse means continued drinking despite repeated social or relationship problems, and is more common than addiction. Women with a history of alcohol dependence or abuse are more likely than men to report physical and mental health problems and death rates for women with these disorders are significantly higher than for men<sup>75</sup>.

In one representative study, 2% of all women (including non-drinkers) abused alcohol in the last 12 months, and 6.9% have done so over their lifetime; the proportion of drinkers was not analysed by gender<sup>76</sup>. Half of all people with alcohol abuse disorders experience them by age 19, and three out of four by 25. Forty-five percent of all people who abused alcohol also had a drug use disorder; this was also not analysed by gender<sup>77</sup>.

Estimates of alcohol dependence are inconsistent and depend on survey details. One percent of all women in 2004 (including non-drinkers) were dependent on alcohol in the last 12 months, and 2.6 percent over their lifetime<sup>78</sup>. This is lower than the 9% of 18-year-old women found in 1994<sup>79</sup>.

### Use with other drugs

Use of other drugs with alcohol is common: more than one in four people (28%) dependent on alcohol in a national survey were also drug dependent (23%) or abused drugs (28%)<sup>80</sup>. Fifty percent of those dependent on drugs also reported alcohol abuse in the past year, and 43% were alcohol dependent. This was not analysed by gender. Seventy percent of women with any substance abuse disorder also smoked tobacco<sup>81</sup>.

People with substance use disorders had higher rates of other chronic health problems than those without any disorder. For women, these included chronic pain (57%), respiratory conditions (28%), high blood pressure (16%), cardiovascular disease (12%), diabetes (6 %) and cancer (6 %) <sup>82</sup>.

### Depression

Alcohol dependence causes moderate to severe depression<sup>83</sup>. Women are more likely to have alcohol problems and depression at the same time, and to say they developed depression first<sup>84</sup>. Among people with alcohol disorders, the link between depression and alcohol problems is stronger for women than men. About one in five New Zealand women who drank hazardously also experienced mood, anxiety or other mental disorders<sup>85</sup>.

## Economic impact

Existing estimates of the costs of alcohol-related harm exclude much of the alcohol harm that women experience. For example they leave out the intangible costs of sexual abuse and other violence to women and children related to other people's drinking, or the costs to community anti-violence services. They also exclude lost productivity by family members from the care of people with FASD<sup>86</sup>.

# Major influences on women's harmful alcohol use

The harmful use of alcohol is not simply the result of individual choice. Understanding women's harmful alcohol use requires attention to a range of environmental, social, cultural and economic influences. These include the availability and affordability of alcohol, drinking culture, social and economic inequalities, and the experience of violence and abuse.

Some of the major influences on women's harmful alcohol use as identified in both the review of the literature and by key informants are profiled below. See the full research report for a comprehensive record of influences on women's harmful alcohol use.

## Violence against women

As shown in the previous section alcohol has been shown to increase the prevalence and severity of violence against women and is therefore a harmful effect of alcohol. In turn, violence against women is also a key influence in women's own harmful drinking.

### Partner violence

Women who have been physically and sexually abused have significantly greater rates of problem drinking<sup>87</sup>, and those who have been treated violently by an intimate partner have higher rates of alcohol dependence than those who have not<sup>88</sup>. Estimates of the proportion of women who drink to cope with partner and other violence vary from 10% of Māori and 7% of Pākehā women<sup>89</sup> to one in three women<sup>90</sup>. Most only begin to drink heavily after the violence has started. Eight percent of female victims of sexual offences, assaults, robbery or threats said they have increased their use of alcohol, drugs or medication as a result<sup>91</sup>.

### Sexual violence

Young people who are mistreated or abused in childhood are more likely to start drinking early, drink heavily as teenagers and abuse alcohol<sup>92</sup>. Women are more likely to experience sexual assault as children and use alcohol to cope with post-traumatic stress disorder (PTSD)<sup>93</sup>. Women with PTSD are estimated to be 1.4 times as likely to develop alcoholism<sup>94</sup>. 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<sup>95</sup>. Women who blame themselves are more likely to have worse long-term results, including alcohol-related hospitalisations and arrests<sup>96</sup>.

## Social and other inequalities

The harmful use of alcohol compounds existing inequalities. In turn, inequalities drive women's harmful alcohol use. For example, increased poverty is related to heavier drinking and more alcohol problems<sup>97</sup>. Poverty is gendered in New Zealand. Women's median annual income in 2006 was \$19,000, 39% less than men's. Women are one and a half times more likely to live on a total annual income of \$30,000 or less<sup>98</sup>. People who report several forms of economic or social hardship have a greater likelihood of harmful drinking<sup>99</sup>.

There is a relationship between racism and harmful drinking. Students who identified themselves as Māori, Pacific and Asian in the Youth 2007 survey and who experienced racial bullying or discrimination from their peers, police or health professionals, are 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<sup>100</sup>. However, there has been little other research about racism and harmful drinking.

*.... I find with our young women, because of some traumatic experience they've been through... indirectly they don't realise what they are 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....*

(FONO TALANOA PARTICIPANT)

## Liberal policy environment

Increases in women's harmful use of alcohol have occurred in an environment of liberalised alcohol policy. The increase in alcohol outlets, which are often clustered in neighbourhoods of higher deprivation, has had a marked impact on the availability of alcohol, including the ability of underage drinkers to obtain it<sup>101</sup>. A high density of alcohol outlets is linked to increased binge drinking, increased secondary and tertiary student drinking, violence, road crashes and police call-outs<sup>102</sup>.

## Alcohol marketing

In New Zealand alcohol marketing practices are self-regulated by the advertising and alcohol industry. Alcohol marketing has become a major social determinant of harmful drinking. As well as promoting drinking generally, evidence suggests that young people's exposure to alcohol marketing speeds up the onset of drinking<sup>103</sup> and increases the amounts consumed by those already drinking<sup>104</sup>. Alcohol marketing is also linked to encouraging heavier drinking and supporting existing drinking norms.

Alcohol marketing has targeted young women's social networking, music and sport. As a result, alcohol has gained a variety of symbolic meanings for women, including fun and freedom, hospitality and social connection.

## Biological differences

Women process the same amount of alcohol more slowly 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<sup>105</sup>.

## Changing gender roles

Public disapproval of drunkenness is higher for women than for men. However, heavy drinking has become the social norm for many young women, with traditionally male drinking patterns setting the standard. Some young women perceive drinking as a sign and result of gender equality, as well as a way of resisting traditional constructions of femininity. RTDs and other products have been designed and marketed specifically to attract these female consumers<sup>106</sup>.

## Family influences

Key informants were particularly concerned about parents supplying alcohol to children and underage teenagers. Parents often did this so that their children drank at home, which was seen as safer, and where they could supervise and influence the amount their teenagers drink. There is no evidence that this has a protective effect against subsequent hazardous drinking or alcohol-related harm<sup>107</sup>.

# Protective factors against women's harmful alcohol use

Although there is little research on specific protective factors, research has shown that the conditions for resilience are produced at a population, community and family level. Protective factors and resilience to the harmful use of alcohol are not the sole responsibility of individual women and are not just a matter of choice. The conditions for resilience are produced at a micro and macro level.

The most effective population-level protective factors are government controls on the sellers and marketers of alcoholic beverages, focusing on price, marketing, outlet density and trading hours to limit access and availability of alcohol<sup>108</sup>.

Community-level protective factors may include a range of positive traditional and non-traditional connections, particularly for young Māori women. The high proportion of non-drinkers among Pacific women is protective and could be reinforced. The brother-sister contract may be protective in some Pacific communities<sup>109</sup>, as may the promotion of alcohol-free social spaces for young lesbian, bisexual and queer women<sup>110</sup>.

*...It's just everywhere, it's so easy because it's everywhere and there's no stigma attached to it...*

(MAORI FOCUS GROUP PARTICIPANT)

Delaying teenagers' first drinking reduces the risk of problems with alcohol later in life<sup>111</sup>. Families who use alcohol responsibly, and resolve conflict without violence, contribute to young women's wellbeing in particular<sup>112</sup>. Egalitarian and respectful relationships protect women against harmful drinking<sup>113</sup>. Close relationships with mothers may also protect young women against frequent drinking<sup>114</sup>. As child abuse and exposure to family violence increase alcohol abuse, preventing this violence would help reduce the likelihood of women's harmful alcohol use in adulthood<sup>115 116</sup>.

Key informants also discussed other important factors including promoting girls' and women's self-esteem and positive body image, encouraging critical analysis of alcohol advertising and beliefs, supporting strong families and whānau, promoting cultural connectedness and pride, strengthening communities and supporting alcohol-free events. These factors suggest a stronger focus on well-being would be advantageous.

## Preventing or reducing the harmful effects of alcohol on women

As we have shown, the harmful effects of alcohol on women are a result of environmental, social, economic and individual factors which intersect in complex ways. This means that single strategies to prevent or reduce harm are inadequate and ineffective. The evidence and key informant experience demonstrates the need for a sustained combination of evidence-based policy and community measures.

Addressing alcohol-related problems from a well-being perspective would seem most appropriate in New Zealand settings, and fit well with recognised models for well-being including Māori models such as Te Pae Mahutonga.

### Population-level interventions

#### Alcohol-specific

Many of the drivers for the harmful effects of alcohol on women lie at the population level. Effective national legislation and national and regional policies are essential to reduce alcohol consumption and damage. Key informants agreed with the research that regulatory changes would help to prevent or reduce alcohol-related harm to women and their families, whānau and communities. They should include:

- restricting or eventually eliminating or banning alcohol advertising, marketing and sponsorship in the same way as tobacco advertising has been phased out
- raising the price of alcohol
- raising the purchasing age to 20 years
- restricting the number and type of outlets, their hours of operation and the accessibility of alcohol in supermarkets and grocery stores
- reducing legal blood alcohol levels for drivers over 20 years to at least 50mg/100ml.

Research surveys and responses to the Law Commission's review show wide public support for these measures, with consistently stronger agreement among women.

*If we are going to see a change in harm we need a change in legislation to lead the way.....We need leadership about these issues... just like smoking for instance... it's got legislation to back it up...*

(MIXED FOCUS GROUP PARTICIPANT)

## Social inequalities

Countries with greater social inequity have higher rates of alcohol and other drug addiction. In 2011 New Zealand had the fastest growth of income inequality among OECD countries<sup>117</sup>. Many key informants believed that tackling systemic social inequalities and exclusion, and working towards a more equitable society would help reduce harmful use of alcohol. No research was found on the impact of attempts to reduce these disparities on harmful drinking.

## Violence against women

Sexual abuse and maltreatment of children, sexual assault of adult women, and partner violence against women all increase the harmful effects of alcohol on women. Reducing or preventing violence will help to reduce alcohol harm and vice versa. However, anti-violence campaigns are inadequately funded and vulnerable to policy changes, and evaluations have not measured their impact on women's drinking.

Key informants believed that prevention of sexual and domestic violence, and increased support for those experiencing it, were vital interventions. Women are often struggling with violence and alcohol at the same time, but interventions remain poorly co-ordinated.

## Community and family interventions

Key informants suggested a wealth of community and health promotion interventions to increase women's wellbeing and resilience, and challenge heavy drinking norms. Community projects on alcohol have had wide positive impact<sup>118</sup>.

Kaupapa Māori campaigns have been effective in urban and rural Māori communities<sup>119</sup>, and Pacific community campaigns have raised awareness of alcohol impacts and led participants to question their drinking behaviour<sup>120</sup>.

Programmes to reduce alcohol-related problems in sports clubs have reduced women's drinking, improved team performance and created a safer environment for whānau and spectators<sup>121</sup>.

Programmes aimed at reducing social supply to underage drinkers have reduced binge drinking in the short term<sup>122</sup>. However, change is unlikely to be sustained unless commercial availability is also targeted<sup>123</sup>.

Social marketing and community education about alcohol were popular interventions with key informants. Education is an appealing intervention for those seeing increasing alcohol problems. However, there is no evidence that social marketing and education programmes alone are effective in changing levels of alcohol consumption or in reducing alcohol-related harm<sup>124</sup>. Social marketing and classroom education campaigns that advocate sensible drinking are overwhelmed by industry advertising and the disinhibiting effects of alcohol.

While there is no evidence that low-risk drinking guidelines reduce alcohol consumption or problems, these can be useful adjuncts to support other interventions and more effective public policy measures<sup>125</sup>.

Liquor outlets near tertiary institutions are sites of heavy drinking, but attempts to reduce harm seem to be largely ad hoc and un-co-ordinated. Restrictions on alcohol marketing, outlets and drinking sites have been effective in reducing consumption and problems overseas<sup>126</sup>.

## Individual-level interventions

The health sector has a lead role in reducing alcohol harm. The key informants identified some important gaps in current services. These included:

### Screening and brief interventions

Screening for harmful drinking has been little used in New Zealand health and

*Mana wāhine workshops – they work ... the outcomes of a lot of women ... aren't drinking any more, and if they do it is only for a wedding or social occasions...*

(ALTERNATIVE EDUCATION PARTICIPANT)



justice settings until recently<sup>127</sup>. There is currently limited capacity for early brief interventions.

Brief interventions in tertiary education have shown positive effects and reduced harmful drinking among women students<sup>128</sup>. These have been delivered through computers and can be cost-effective.

Brief interventions in general practice and hospital departments effectively reduce consumption and alcohol-related problems among women<sup>129</sup>. However, these interventions are only slowly being implemented. Key informants reported little experience with them, apart from an A&E worker who reported being too pressured to be able to use them.

Testing for blood alcohol is uncommon in traffic crashes where no one is killed.

Only a small proportion of even repeat drunk drivers are required to have AOD (alcohol and other drugs) assessments<sup>130</sup>. Brief interventions have also been shown to be effective in the justice system, including for female drink-drivers<sup>131</sup>. However, they are only slowly being implemented in New Zealand.

Opportunities exist to increase routine and standardised screening to identify women's harmful drinking, and intervene earlier. Primary care settings and other services that interact with women would seem obvious places to enhance or develop screening and appropriate interventions. Overseas, refuge services for women experiencing domestic violence who also have AOD addiction and mental health problems are effective<sup>132</sup>, but these do not exist in New Zealand.

### Identifying and preventing FASD

New Zealand's health response to FASD lags behind that of comparable countries. There are no FASD prevalence data, standardised systematic screening, primary or secondary intervention programmes for FASD. Pre-pregnancy drinking and partner violence are predictors of pregnant women's drinking<sup>133</sup>.

Early intervention with children affected by FASD results in improved learning and behaviour<sup>134</sup>. Identifying these children is also an opportunity to engage with mothers and address any alcohol-related issues, including violence. In other countries primary prevention initiatives led by indigenous people are effective in reducing their rates of FASD<sup>135</sup>.

Warning labels on alcohol containers can help to raise awareness of the teratogenic effects of alcohol and are a useful component of a wider strategy to address drinking during pregnancy<sup>136</sup>.

### Treatment

Key informants argued that New Zealand's AOD treatment services are under-funded, resulting in a major unmet need for AOD treatment in the general population, and in kaupapa Māori services. There is evidence that gender-specific addiction treatment for women is effective, particularly for women who have experienced social deprivation and prior or ongoing abuse<sup>137</sup>, but provision is ad hoc. Kaupapa Māori alcohol treatment programmes are more effective for Māori than mainstream programmes<sup>138</sup>. There is recent evidence that alcohol treatment agencies are not always sensitive to differences of sexual orientation and gender identity, and that they need to improve their response to lesbian, trans and intersex clients<sup>139 140</sup>.

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<sup>141</sup>. AOD services that work holistically, cross-screening for these factors and taking into account housing, food insecurity and other healthcare needs, are more effective. AOD treatment for violent men may also be an effective primary prevention of domestic violence<sup>142</sup>.

Key informants also 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, when many women experience

*The services aren't ... coming together in that wraparound ... way and providing for that person; it's very frustrating, isn't it?*  
(HOSPITAL WORKER)

all three issues at once; and inadequate funding for kaupapa Māori services.

Māori and Pacific focus group 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. Key informants said AOD services needed to be more gender-specific and culturally appropriate to be effective, and to co-operate much more closely with other services such as mental health services and the women's refuge network.

## Intervention gaps

Many alcohol interventions 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. Evidence has also shown that gender-specific policies and interventions are needed to address harmful alcohol use by women. Few interventions have specifically addressed the needs of women or the systemic inequalities that affect them. Primary prevention interventions, particularly for Māori and Pacific women, are rare. The evaluation of current strategies to reduce alcohol consumption or to treat problem drinking, has tended to lack assessment of the appropriateness of these interventions for women<sup>143 144</sup>.

*...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...*

(MIXED FOCUS GROUP PARTICIPANT)

## Conclusion

This paper has summarised the findings of an investigation intended to help fill the gaps in current knowledge about women and alcohol in Aotearoa New Zealand. Its aim is to ensure informed public discussion, and effective policy and programme development.

There are limitations in obtaining an accurate picture of women's use of alcohol, and there are variations in alcohol use between different groups of women. However, the available evidence and the experience of our key informants suggest that both the frequency and volume of women's alcohol consumption is increasing.

Women's harmful use of alcohol is being driven by a mix of environmental, social and economic factors including their experience of violence, social inequalities, changing gender roles, and liberal alcohol laws that have increased the availability, appeal and affordability of alcohol.

The harmful use of alcohol is implicated in a range of poor outcomes for women including reduced health; increased inequalities; increased frequency and severity of violence; reduced capacity to parent; and greater economic vulnerability. Because of these complex and inter-related factors, single prevention and intervention strategies are inadequate and ineffective.

The key to preventing or reducing the harmful effects of alcohol experienced by women is a strategic and co-ordinated approach that addresses the underlying drivers of harmful alcohol use, rather than just targeting individual behaviour change. To be successful, alcohol interventions will need to be co-ordinated across sectors and will require investment.

Although we now know more about the role and impact of alcohol in women's lives, significant knowledge gaps remain. This is largely as a result of a lack of available research, which makes it difficult to report meaningfully on alcohol use and alcohol-related harms in diverse populations of women; to track patterns of consumption and harm over time and identify trends; and to understand the impacts and effectiveness of alcohol-related policies and interventions for women's wellbeing.

# Recommendations

As a result of our investigation we make the following recommendations. If implemented, these measures will help to ensure effective policy responses and programmes contributing to the reduction of alcohol-related harm for women.

The recommendations are cross-sectoral, relating to health, justice and social development in New Zealand.

## 1) Making gender matter

Strategies, policies and programmes intending to reduce alcohol-related harm use gender-based analytical tools to ensure sex differences and gender influences, and any related inequalities, are identified and addressed.

## 2) Prioritising alcohol

A whole-of-government and cross-sectoral approach is adopted to address alcohol-related harm, and alcohol is given a greater priority in national policy and planning.

## 3) Ensuring the effectiveness of alcohol policy interventions

Evidence-based alcohol policy interventions are implemented in accordance with the Global Strategy to Reduce Alcohol-Related Harm, and as recommended by the New Zealand Law Commission.

## 4) A strategic approach to research

A strategic and co-ordinated approach to alcohol research is implemented in order to enhance knowledge about the role of alcohol in diverse populations of women; and inform the development, and measure the impact of interventions in terms of their effectiveness for diverse populations of women.

## 5) Co-ordinating efforts addressing alcohol harm and violence against women

Strategies and interventions to reduce alcohol-related harm are co-ordinated with activities to address violence against women, including sexual and family violence.

## 6) Focusing on social determinants

A whole-of-government approach addresses social and ethnic inequalities, including poverty and institutional racism. Increase the use of Health Impact Assessments to ensure proposed policy, plans and programmes achieve desired outcomes.

## 7) Reducing alcohol-related harm for Māori women

Wāhine Māori rangatiratanga over alcohol harm is developed and supported through sector-wide capacity and capability building.

## 8) Enhancing service delivery to Māori

Service for Māori is delivered within a kaupapa Māori values framework that reflects the aspirations of whānau ora.

## 9) Enhancing services for Pacific peoples

Increased funding and support is made available for alcohol-related research, programmes and services that address the needs of Pacific communities.

## 10) Enhancing services for Asian, New Migrant communities and other groups experiencing alcohol-related harms.

Increased funding and support is made available for alcohol-related research, programmes and services that address the needs of Asian, New Migrant and other groups who experience alcohol-related harms.

### **11) Enhancing screening and brief intervention**

Routine and standardised screening for harmful alcohol use is integrated within and across sectors, and routinely linked to best-practice brief interventions or referrals to treatment services. Relevant agencies coordinate more closely, to build on current pilot screening and brief intervention programmes, extend coverage, build best practice and ensure sustainability.

### **12) Enhancing treatment services**

AOD treatment services are assessed for their responsiveness to women, and a plan is developed and implemented to address the gaps and issues.

### **13) Empowering communities**

Communities are better resourced and supported to lead interventions that reduce alcohol-related harm.

## **Action Point**

The up-coming review of the National Drug Policy presents an important opportunity to translate some of the above recommendations into immediate action. A new National Drug Policy should:

- Include a specific focus on women and the use of gender-based analysis.
- Recognise the health and social cost of alcohol-related harm, and enable the necessary commitment and investment to achieve measurable and sustained reductions in alcohol-related harm within the next 5 years.
- Commit to evidence-based policy implementation, and support the development of a sector-led national alcohol harm reduction strategy and accompanying action plan.
- Recognise the link between alcohol harm and social inequities, and enable actions that measurably reduce inequities and mitigate the risks of contributing to further inequities.
- Explicitly provide for workforce development and planning to meet the needs and expectations of wāhine Māori.
- Include wide consultation with Māori to identify how to meet their aspirations for whanau ora.
- Include wide consultation with Pacific peoples to identify how policies and services can better meet their needs and expectations, and address inequities.

# References

1. NZ Law Commission. (2010). Alcohol in our lives: Curbing the harm. A report on the review of the regulatory framework for the sale and supply of liquor. Wellington: NZ Law Commission.
2. World Health Organisation. 2002. Integrating Gender Perspectives in the Work of WHO. <http://www.who.int/gender/documents/gender/a78322/en/index.html>
3. BC Women's Hospital & Health Centre and British Columbia Centre of Excellence for Women's Health. 2004. A Women's Health Strategy for British Columbia: Advancing the Health of Girls and Women. <http://www.bcwomens.ca/NR/rdonlyres/32FE9AE5-1952-4E54-A926-BC1116E9AA4F/32455/PWHSReport2004.pdf>
4. Intersex Society of North America. [http://www.isna.org/faq/what\\_is\\_intersex](http://www.isna.org/faq/what_is_intersex)
5. BC Women's Hospital & Health Centre and British Columbia Centre of Excellence for Women's Health. 2004. P.19
6. Human Rights Commission. 2010. Human Rights in New Zealand 2010. [http://www.hrc.co.nz/hrc\\_new/hrc/cms/files/documents/Human\\_Rights\\_Review\\_2010\\_Summary.pdf](http://www.hrc.co.nz/hrc_new/hrc/cms/files/documents/Human_Rights_Review_2010_Summary.pdf)
7. Health Canada. 2003. What is gender-based analysis? <http://www.hc-sc.gc.ca/hl-vs/pubs/women-femmes/gender-sexes-eng.php>
8. United Nations. Convention on the Elimination of All Forms of Discrimination against Women. <http://www.un.org/womenwatch/daw/cedaw/>
9. Committee on the Elimination of Discrimination against women. 2012. Concluding observations of the Committee on the Elimination of Discrimination against Women. CEDAW/C/NZL/CO/7. <http://www2.ohchr.org/english/bodies/cedaw/docs/co/CEDAW-C-NZL-CO-7.pdf>
10. WHO. Draft Global Strategy to Reduce the Harmful Use of Alcohol. Geneva, Switzerland: WHO 2010. Available at [http://www.who.int/entity/substance\\_abuse/alcstrategyaftereb.pdf](http://www.who.int/entity/substance_abuse/alcstrategyaftereb.pdf).
11. Babor, T., Caetano, R., Casswell, S., Edwards, G., Giesbrecht, N., Graham, K., Grube, J., Hill, L., Holder, H., Homel, R., Livingston, M., Osterberg, E., Rehm, J., Room, R., & Rossow, I. (2010). Alcohol - No ordinary commodity: Research and policy (Second ed.). Oxford, UK: Oxford University Press.
12. World Health Organization (2011). Global status report on alcohol and health. Geneva: World Health Organization.
13. Bagnardi V, Blangiardo C.M, La Vecchia C and Corrao G. (2001). Alcohol Consumption and the Risk of Cancer: A Meta-Analysis. Alcohol Research and Health 2001; 25(4)263-70.
14. New Zealand Law Commission, 2010, p. 5.
15. New Zealand Law Commission, 2010, p. 10.
16. Geoffrey Palmer. (2009, April 24). The Law Commission's Liquor Review, address to NZ Police's 'Alcohol Related Harm' Breakfast
17. Connor, J., & Casswell, S. (2013). Alcohol-related harm to others in New Zealand: Evidence of the burden and gaps in knowledge. New Zealand Medical Journal, 125 (1360). Retrieved from <http://journal.nzma.org.nz/journal/125-1360/5308/content.pdf>.
18. Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. Qualitative Research in Psychology, 3(2), 77-101.
19. Braun, V., & Clarke, V. (2006)
20. Ministry of Health. (2009). Alcohol use in New Zealand: Key results of the 2007/08 Alcohol and Drug Use survey. Wellington: Ministry of Health.
21. MOH, 2009.
22. MOH, 2009.
23. Huckle, T., Yeh, L.C., Lin, J., & Jensen, V. (2013). Trends in alcohol consumption and alcohol-related harms among females in New Zealand: Research report commissioned by the Health Promotion Agency. Wellington: Health Promotion Agency.
24. McPherson, M., Casswell, S., & Pledger, M. (2003). Gender convergence in alcohol consumption and related problems: issues and outcomes from comparisons of New Zealand survey data. Addiction, 99, 738-748.

25. Ministry of Health (2013). Hazardous drinking in 2011/12: Findings from the New Zealand Health Survey. Ministry of Health, Wellington.
26. Fergusson, D.M., Boden, J. (2011) Alcohol use in adolescence. In OPMSAC (Ed.), Improving the transition – Reducing social and psychological morbidity during adolescence (Vol. 235-256). Wellington: Office of Prime Minister’s Science Advisory Committee.
27. Fryer, M., Jones, O., & Kalafatelis, E., (2011) Adults and Youth 2009-10 Drinking Behaviours Report. ALAC Alcohol Monitor. Wellington: ALAC.
28. Huckle, T., et al (2013).
29. Ameratunga, S., Waayer, D., Robinson, E., Clark, T.C., Crengle, S., Denny, S., Sheridan, J., & Teevale, T. (2011). Youth '07: The health and wellbeing of secondary school students in New Zealand. Young people and alcohol. Auckland: Adolescent Health Research Group, University of Auckland.
30. Clark, T.C., Fleming, T., Bullen, P., Crengle, S., Denny, S., Dyson, B., Fortune, S., Peiris-John, R., Robinson, E., Rossen, F., Sheridan, J., Teevale, T., Utter, J., & Adolescent Health Research Group. (2013). The health and wellbeing of New Zealand secondary school students in 2012: Youth'12 Prevalence Tables. Auckland: University of Auckland.
31. MOH, 2013.
32. MOH, 2009.
33. Clarke et al, 2013.
34. AHRG. (2004). Alcohol and New Zealand youth: A snapshot of young people’s experiences with alcohol. Auckland: Adolescent Health Research Group, University of Auckland.
35. MOH, 2009.
36. McPherson et al, 2003.
37. McEwan, B. (2009). Student culture and binge drinking: An investigation of the relationship between student culture and binge drinking behaviour within the University of Waikato halls of residence student population. PhD Thesis, University of Waikato, Hamilton.
38. Towers, A., Stephens, C., Dulin, P., Kostick, M., Noone, J., & Alpass, F. (2011). Estimating older hazardous and binge drinking prevalence using AUDIT-C and AUDIT-3 thresholds specific to older adults. *Drug & Alcohol Dependence*, 117, 211–218.
39. Mathew, S., Kitson, K., & Watson, P. (2001) Assessment of Risk of Foetal Alcohol Syndrome and other Alcohol Related Effects in New Zealand: A Survey of Midwives in New Zealand. Report to the Alcohol Advisory Council of New Zealand.
40. MSD. (2010). The Social Report/ Te Purongo Oranga Tangata 2010. Wellington: Ministry of Social Development.
41. MSD, 2010.
42. Pega, F., & Coupe, N. (2007). Gay, lesbian and bisexual people’s substance use – A comparison of GLB and heterosexual participants of the Health Behaviours Surveys: 2003 Drug and 2004 Alcohol Use. Paper presented at the Te Tōrino/Re-imagining health: PHA Conference, Auckland.
43. O’Brien, K.S., Ali, A., Cotter, J.D., O’Shea, R.P., & Stannard, S. (2007). Hazardous drinking in New Zealand sportspeople: Level of sporting participation and drinking motives. *Alcohol & Alcoholism*, 42(4), 376–382.
44. Abbott, M., & McKenna, B.G. (2005). Gambling and problem gambling among recently sentenced women in New Zealand prisons. *Journal of Gambling Studies*, 21(4), 559-581.
45. Huckle, T., Sweetsur, P., Moyes, S., & Casswell, S. (2008). Ready to drinks are associated with heavier drinking patterns among young females. *Drug & Alcohol Review*, 27, 398-403.
46. MOH, 2009.
47. Connor, J., You, R., & Casswell, S. (2009). Alcohol-related harm to others: A survey of physical and sexual assault in New Zealand. *NZMJ*, 122(1303);
48. Connor, J.L., Kypri, K., Bell, M.L., & Cousins, K. (2011). Alcohol involvement in aggression between intimate partners in New Zealand: A national cross-sectional study. *British Medical Journal Open*. doi: 10.1136/bmjopen-2011-000065

49. Stevenson, R. (2009). National alcohol assessment. Wellington: NZ Police.
50. Thompson, M.P., & Kingree, J. (2006). The roles of victim and perpetrator alcohol use in intimate partner violence.
51. Connor, J. et al 2009
52. Russell, 2008.
53. Russell, 2008.
54. Russell, 2008.
55. Ameratunga, S., Waayer, D., Robinson, E., Clark, T.C., Crengle, S., Denny, S., Sheridan, J., & Teevale, T. (2011). Youth '07: The health and wellbeing of secondary school students in New Zealand. Young people and alcohol. Auckland: Adolescent Health Research Group, University of Auckland.
56. Connor, J., Kydd, R., Rehm, J., & Shield, K. (2013). Alcohol-attributable burden of disease and injury in New Zealand: 2004 and 2007. Wellington: Health Promotion Agency.
57. Babor, T., Caetano, R., Casswell, S., Edwards, G., Giesbrecht, N., Graham, K., Grube, J., Hill, L., Holder, H., Homel, R., Livingston, M., Osterberg, E., Rehm, J., Room, R., & Rossow, I. (2010). Alcohol – No ordinary commodity: Research and policy (Second ed.). Oxford, UK: Oxford University Press.
58. Chen, W., Rosner, B., Hankinson, S.E., Colditz, G.A., & Willett, W. (2011). Moderate alcohol consumption during adult life, drinking patterns, and breast cancer risk. *JAMA*, 306(17), 1884-1890.
59. Devlin, N.J., Scuffham, P.A., & Bunt, L.J. (1997). The social costs of alcohol abuse in New Zealand. *Addiction*, 92(11), 1491-1505.
60. Fergusson, D.M., & Boden, J. (2011). Alcohol use in adolescence. In OPMSAC (Ed.), *Improving the transition – Reducing social and psychological morbidity during adolescence* (Vol. 235-256). Wellington: Office of the Prime Minister's Science Advisory Committee.
61. Dickson, N., Paul, C., Herbison, P., & Silva, P. (1998). First sexual intercourse: Age, coercion, and later regrets reported by a birth cohort. *BMJ*, 316, 29–33.
62. Connor, J. (2010). Drinking history, current drinking and problematic sexual experiences among university students. *Australian & NZ Journal of Public Health*, 34, 487-494. doi: 10.1111/j.1753-6405.2010.00595.x;
63. Kypri, K., Paschall, M.J., Langley, J., Baxter, J., Cashell-Smith, M.L., & Bourdeau, B. (2009). Drinking and alcohol-related harm among New Zealand university students: Findings from a national web-based survey. *Alcoholism: Clinical & Experimental Research*, 33(2), 307–314;
64. Cashell-Smith, M.L., Connor, J.L., & Kypri, K. (2007). Harmful effects of alcohol on sexual behaviour in a New Zealand university community. *Drug & Alcohol Review*, 26, 645 – 651;
65. McGee, R., & Kypri, K. (2004). Alcohol-related problems experienced by university students in New Zealand. *Australian & NZ Journal of Public Health*, 28, 321-323.
66. Cashell-Smith, M.L., Connor, J.L., & Kypri, K. (2007). Harmful effects of alcohol on sexual behaviour in a New Zealand university community. *Drug & Alcohol Review*, 26, 645-651.
67. Braun, V. (2008). 'She'll be right'? National identity explanations for poor sexual health statistics in Aotearoa/New Zealand. *Social Science & Medicine*, 67, 1817-1825.
68. May, P.A., Fiorentino, D., Coriale, G., Kalberg, W.O., Hoyme, H.E., Aragón, A.S., Buckley, D., Stellavato, C., Gossage, J.P., Robinson, L.K., Jones, K.L., Manning, M., & Ceccanti, M. (2011). Prevalence of children with severe Fetal Alcohol Spectrum Disorders in communities near Rome, Italy: New estimated rates are higher than previous estimates. *International Journal of Environmental Research & Public Health*, 8(6), 2331-2351.
69. Connor, J. et al., 2013.
70. NH&MRC. (2009). Australian guidelines to reduce health risks from drinking alcohol. Canberra: National Health and Medical Research Council.
71. MOH. (2009a). Alcohol use in New Zealand: Key results of the 2007/08 Alcohol and Drug Use survey. Wellington: Ministry of Health.
72. Connor et al., 2005.

73. New Zealand Press Association (NZPA) (2008). Huge rise in women drink-drivers. *New Zealand Herald*.
74. Ministry of Transport (2010) Yearly report 2010 – Motor vehicle crashes in New Zealand 2009. Wellington: Ministry of Transport.
75. Nolen-Hoeksema, S. (2004). Gender differences in risk factors and consequences for alcohol use and problems. *Clinical Psychology*, 24, 981-1010. doi: 10.1016/j.cpr.2004.08.003
76. Wells, J.E., Baxter, J., & Schaaf, D. (Eds.). (2007a). Substance use disorders in Te Rau Hinengaro: The New Zealand Mental Health Survey. Wellington: Alcohol Advisory Council of NZ.
77. Wells et al, 2007.
78. Wells et al., 2007.
79. Feehan, M., McGee, R., Nada Raja, S., & Williams, S.M. (1994). DSM-III-R disorders in New Zealand 18-year-olds. *Australian & NZ Journal of Psychiatry*, 28, 87-99.
80. Wells et al., 2007.
81. Wells et al., 2007.
82. Wells et al., 2007.
83. Samokhvalov, A.V., Popova, S., Room, R., Ramonas, M., & Rehm, J. (2010). Disability associated with alcohol abuse and dependence. *Alcoholism: Clinical & Experimental Research*, 34(11), 1871-1878. doi: 10.1111/j.1530-0277.2010.01275.x.
84. Lejoyeux, M., & Leheret, P. (2011). Alcohol-use disorders and depression: Results from individual patient data meta-analysis of the acamprosate-controlled studies. *Alcohol & Alcoholism*, 46(1), 61-67; Noelen-Hoeksema, 2004.
85. Oakley Browne, M.A., Wells, J.E., & Scott, K.M. (Eds.). (2006). Te Rau Hinengaro: The New Zealand Mental Health Survey. Wellington: Ministry of Health.
86. BERL. (2009). Costs of harmful alcohol and other drug use: Final report. Wellington: Business & Economic Research Ltd.
87. Stewart, S.H., Gavric, D., & Collins, P. (2009). Women, girls and alcohol. In K. Brady, S. E. Back & S. F. Greenfield (Eds.), *Women and addiction: A comprehensive handbook* (pp. 341-359). New York, USA: Guilford Press.
88. Kay, A., Taylor, T.E., Barthwell, A.G., Wichelecki, J., & Leopold, V. (2010). Substance use and women's health. *Journal of Addictive Diseases*, 29(2), 139-163.
89. Cunningham, C., Triggs, S., & Faisandier, S. (2009). Analysis of the Māori experience: Findings from The New Zealand Crime and Safety Survey 2006. Wellington: Ministry of Justice.
90. Hager, D. (2011). Why women require specialised refuge services when they are suffering from mental health or drug and alcohol problems – and domestic violence. Auckland: Homeworks Trust.
91. MOJ. (2010). The New Zealand Crime and Safety Survey: 2009. Main findings report. Wellington: Ministry of Justice.
92. Fergusson & Boden, 2011.
93. Wiechelt, S.A., Miller, B.A., Smyth, N.J., & Maguin, E. (2011). Associations between post-traumatic stress disorder symptoms and alcohol and other drug problems: Implications for social work practice. *Practice: Social Work in Action*, 23(4), 183-199.
94. Dansky, B., Saladin, M., Brady, K., Kilpatrick, D., & Resnick, H. (1995). Prevalence of victimization and post-traumatic stress disorder among women with substance use disorders: Comparison of telephone and in-person assessment sample. *International Journal of the Addictions*, 30, 1079-1099.
95. Bedard-Gilligan, M., Kaysen, D., Desai, S., & Lee, C.M. (2011). Alcohol-involved assault: Associations with post-trauma alcohol use, consequences, and expectancies. *Addictive Behaviors*, 36, 1076-1082.
96. Ullman, S.E., & Najdowski, C.J. (2010). Alcohol-related help-seeking in problem drinking women sexual assault survivors. *Substance Use & Misuse*, 45, 341-353. doi: 10.3109/10826080903443644
97. Khan, S., Murray, R.P., & Barnes, G.E. (2002). A structural equation model of the effect of poverty and unemployment on alcohol abuse. *Addictive Behaviors*, 27(3), 405-423.
98. HRC. (2010). Human rights and women: Draft for discussion. Wellington: Human Rights Commission.
99. Nina Mulia, P.H., Yu Ye, M.A., Zemore, S.E., & Greenfield, T.K. (2008). Social disadvantage, stress and alcohol use among Black, Hispanic, and White Americans: Findings from the 2005 US National Alcohol Survey. *Journal of Studies on Alcohol & Drugs*, 69(6), 824-833.



100. Crengle, S., Robinson, E., Ameratunga, S., Clark, T., & Raphael, D. (2012). Ethnic discrimination prevalence and associations with health outcomes: Data from a nationally representative cross-sectional survey of secondary school students in New Zealand. *BMC Public Health*, 12(45).
101. MOH. (2006). *Decades of disparity III: Ethnic and socio-economic inequalities in mortality, New Zealand 1981–1999*. Wellington: Ministry of Health.
102. Cameron, M.P. (2010). A spatial econometric analysis of selected impacts of liquor outlet density in Manukau City. Paper presented at the Waikato Management School 2010 Seminar Series, University of Waikato.
103. Anderson, P., de Bruijn, A., Angus, K., Gordon, R., & Hastings, G. (2009b). Impact of alcohol advertising and media exposure on adolescent alcohol use: A systematic review of longitudinal studies. *Alcohol & Alcoholism*, 44, 229-243.
104. Weir, R. (2007). *Review of selected papers examining alcohol advertising*. Christchurch: New Zealand Health Technology Assessment.
105. Schulte M.A Ramo D., & Brown S.A. (2009). Gender differences in factors influencing alcohol use and drinking progression among adolescents. *Clinical Psychology Review*, 29(6). 535-547
106. MWA. (2010). *Indicators for change 2009: Tracking the progress of New Zealand women*. Wellington: Ministry of Women's Affairs.
107. Cagney P., & Palmer S. (2007). *The sale and supply of alcohol to under 18 year olds in New Zealand: A systematic overview of international and New Zealand literature (Final Report) – April 2007. Appendix C: Summary of key New Zealand non-legislative interventions*. Wellington: Ministry of Justice.
108. Babor et al., 2010.
109. Percival, T., Robati-Mani, R., Powell, E., Kingi, P., Peteru, C., Hope, L.-T., Finau, E., Selu, E., & Rankine, J. (2010). *Pacific pathways to the prevention of sexual violence: Full report*. Auckland: Pacific Health, School of Population Health, University of Auckland.
110. Rankine, J. (2008). *Lesbian gay bisexual takatāpui transgender community centre needs assessment*. Auckland: Auckland City Council.
111. Odgers, C.L., Caspi, A., Nagin, D.S., Piquero, A.R., Slutske, W.S., Milne, B.J., Dickson, N., Poulton, R., & Moffitt, T.E. (2008). Is it important to prevent early exposure to drugs and alcohol among adolescents? *Psychological Science*, 19(10), 1037-1044.
112. Bagshaw, S. (2011). Resilience. In OPMSAC (Ed.), *Improving the transition – Reducing social and psychological morbidity during adolescence* (pp. 79-86). Wellington: Office of the Prime Minister's Science Advisory Committee.
113. Adams, P. (2010). *Fragmented intimacy: Addiction in a social world*. New York: Springer.
114. Kelly, A.B., O'Flaherty, M., Toumbourou, J.W., Connor, J.P., Hemphill, S.A., & Catalano, R.F. (2011). Gender differences in the impact of families on alcohol use: A lagged longitudinal study of early adolescents. *Addiction*, 106, 1427-1436.
115. Felitti, V.J. (2004). *The origins of addiction: Evidence from the Adverse Childhood Experiences Study*. San Diego, California: Department of Preventative Medicine, Kaiser Permanente Medical Care Program;
116. La Flair, L.N., Bradshaw, C.P., Storr, C.L., Green, K.M., Alvanzo, A.A.H., & Crum, R.M. (2012). Intimate partner violence and patterns of alcohol abuse and dependence criteria among women: A latent class analysis. *Journal of Studies on Alcohol & Drugs*, 73, 351-360.
117. NZCCSS. (2011). *Vulnerability Report 10*. Wellington: NZ Council of Christian Social Services.
118. Litmus. (2009). *Process and impact evaluation of Community Action on Youth and Drugs (CAYAD)*. Wellington: Ministry of Health.
119. Moewaka Barnes, H. (2000). Collaboration in community action: A successful partnership between indigenous communities and researchers. *Health Promotion International*, 15(1), 17-25.
120. Southwick, M., Warren, H., Lima, I., & Solomona, M. (2008). *Searching for Pacific solutions: A community-based intervention project to minimise harm from alcohol use. Final Report*. Wellington: Alcohol Advisory Council of NZ.
121. ADF. (2008). *Good Sports: About us*. Australian Drug Foundation. Retrieved January 16, 2012, from <http://www.goodsports.com.au/goodsports/pages/about-us.html>

122. Cagney, P., & Palmer, S. (2007). The sale and supply of alcohol to under 18 year olds in New Zealand: A systematic overview of international and New Zealand literature (Final Report) – April 2007. Appendix C: Summary of key New Zealand non-legislative interventions. Wellington: Ministry of Justice.
123. Greenaway, S. (2010). Formative evaluation: Community action to reduce the social supply of alcohol to minors in Mangere. Auckland: Centre for Social and Health Outcomes Research and Evaluation and Te Ropu Whariki, Massey University.
124. Babor et al., 2010.
125. Babor et al., 2010.
126. Toomey, T.L., Lenk, K.M., & Wagenaar, A.C. (2007). Environmental policies to reduce college drinking: An update of research findings. *Journal of Studies on Alcohol & Drugs*, 68(2), 208-219.
127. Hosking, J., Ameratunga, S., Bullen, C., Civil, I., Ng, A., & Rodgers, A. (2007). Screening and intervention for alcohol problems among patients admitted following unintentional injury: A missed opportunity? *NZMJ*, 120(1249).
128. Jackson, B.L. (2010). Brief interventions in emergency departments. In S. Adamson & R. N. Schroder (Eds.), *NZ Addiction Treatment Research Monograph. Research Proceedings from the Cutting Edge Conference, September 2009* (pp. 17-20). Dunedin: Addiction Treatment Research Interest Group.
129. Raistrick, D., Heather, N., & Godfrey, C. (2006). *Review of the effectiveness of treatment for alcohol problems*. London: National Treatment Agency for Substance Misuse, UK.
130. Rout, P. (2008). Background resource paper – The benefits of treatment in reducing the harms associated with substance use and gambling disorders. Christchurch: Alcohol Drug Association NZ.
131. Brown, T.G., Dongier, M., Ouimet, M.C., Tremblay, J., Chanut, F., Legault, L., & Ki, N.M.K.N.Y. (2010). Brief motivational interviewing for DWI recidivists who abuse alcohol and are not participating in DWI intervention: A randomized controlled trial. *Alcoholism: Clinical & Experimental Research*, 34(2).
132. Hager, 2011.
133. Skagerstrom, J., Chang, G., & Nilsen, P. (2011). Predictors of drinking during pregnancy: A systematic review. *Journal of Women's Health*, 20(6). doi: 10.1089/jwh.2010.2216
134. Motz, M., Leslie, M., Pepler, D.J., Moore, T.E., & Freeman, P.A. (2006). Breaking the cycle: Measures of progress 1995–2005. *Journal of Fetal Alcohol Syndrome International*, 4(22), S1-S138.
135. Van Bibber, M. (1997). *It takes a community: A resource manual for community-based prevention of fetal alcohol syndrome and fetal alcohol effects*. Ottawa: Minister of Public Works and Government Services Canada, and the Aboriginal Nurses Association of Canada.
136. Babor et al., 2010.
137. Mackness, L. (2008). Improving treatment paradigms for multi-abuse domestic violence clients. *Te Awatea Review*, 6(2), 4-6.
138. McCormick, R., Kalin, C., & Huriwai, T. (2006). Alcohol and other drug treatment in New Zealand – one size doesn't fit all. *NZMJ*, 119(1244).
139. Birkenhead, A., Rands, D. (2012). Let's talk about sex ...(sexuality and gender): improving mental health and addiction services for Rainbow Communities. Auckland District Health Board, OUTline and Affinity Services.
140. Te Pou. 2012. Mental health promotion and prevention services to gay, lesbian, bisexual, transgender and intersex populations in New Zealand: needs assessment report.
141. Russell, 2008
142. Stuart, G.L., Ramsey, S.E., Moore, T.M., Kahler, C.W., Farrell, L.E., Recupero, P.R., & Brown, R.A. (2003). Reductions in marital violence following treatment for alcohol dependence. *Journal of Interpersonal Violence*, 18(10), 1113-1131.
143. McLaren, F. (2010). Campaign for action on family violence: Reach and retention of the "It's not OK" television advertisements. Auckland: Centre for Social Research and Evaluation, Massey University;
144. Bailey, K., & Hauraki, W. (2011). Alcohol and drug policies and practices – Research on sports clubs in New Zealand. Auckland: CAYAD.

# Acknowledgements

Thanks to the Ministry of Health for the funding to undertake this research and develop this policy briefing paper.

Thanks to the principal project researchers, Jenny Rankine and Amanda Gregory, and the assistance given by Anna Tonks and Te Pora Thompson-Evans.

Our thanks to focus group participants and key informants for their generous sharing of thoughts, knowledge, stories, expertise and time.

Hapai Te Hauora Tapui organised, facilitated and analysed the Māori focus group. Their contribution has been an integral part of this research and we extend our thanks to the team, in particular Nicole Coupe and Te Pora Thompson-Evans.

Pefi Kingi organised and facilitated the Talanoa Fono, co-facilitated the hospital focus group, and supervised the Pacific analysis. Many thanks for her broad cultural knowledge and research expertise.

We acknowledge and thank members of the Women and Alcohol Project Reference Group: Nicole Coupe, Zoe Hawke and Te Pora Thompson-Evans of Hapai Te Hauora Tapui; Raewyn Bhana and Asenaca Uluiviti of the South Auckland Family Violence Network; Susanna Galea and Diana Rands from Community Alcohol and Drug Services; Dale Little from the Mental Health Foundation; Kathryn McPhillips from Auckland Sexual Abuse Help; Antonia Lyons of Massey University in Wellington; Rebecca Williams and Christine Rogan of Alcohol Healthwatch; Julie Radford-Poupard and George Parker of Women's Health Action.

Thanks to Professor Jennie Connor, Head of Department, Preventive and Social Medicine, University of Otago, who peer-reviewed the full research report and this briefing paper.

We also thank the many others (too many to name individually) who have provided comment and feedback on this briefing paper in its draft form.

Also Tessa Copland of Clickety-click provided a thorough edit of the research report and George Parker led the preparation of this policy briefing paper.



**Women's Health Action**  
**PO Box 9947 Newmarket**  
**Auckland 1149**  
**New Zealand**  
[www.womens-health.org.nz](http://www.womens-health.org.nz)



**Alcohol Healthwatch**  
**PO Box 99407 Newmarket**  
**Auckland 1149**  
**New Zealand**  
[www.ahw.org.nz](http://www.ahw.org.nz)