Policy Briefing Paper

Women and Alcohol in Aotearoa/New Zealand

Te waipiro me ngā wāhine i Aotearoa

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Alcohol Healthwatch
Whakatūpato Waipiro

WOMEN'S HEALTH Action

Introduction

The harmful use of alcohol has a serious effect on public health and is a major risk factor for poor health globally, as well as nationally. The concept of the harmful use of alcohol is broad and 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.

The New Zealand Law Commission provides a comprehensive summary of alcohol use in New Zealand today in their review of our alcohol laws - *Alcohol in Our Lives – Curbing the Harm*[1]. The report provides a clear 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. Despite this, 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 appropriateness of efforts to reduce alcohol harm for women.

Women have traditionally consumed less alcohol than men but experience damage at lower levels of consumption. Recently, media attention has focused on what they have described as the 'problem' of women's alcohol consumption, with a suggestion that women are drinking more, at a younger age, and that women's use and abuse of alcohol is converging with men's. While evidence is emerging that there has been a significant shift in women's drinking toward heavier use, 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 and debate.

This briefing paper summarises research, funded by the Ministry of Health and commissioned by Alcohol Healthwatch and Women's Health Action, that addresses this knowledge gap. We have undertaken a review of 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?

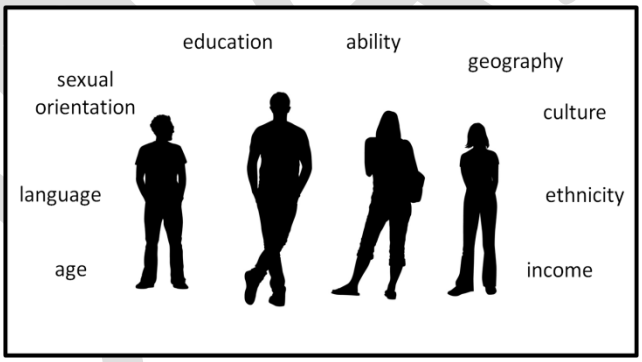
This briefing paper provides a context for research on alcohol and women. It then highlights key findings from the research on the following topic areas: the prevalence of women's drinking; the

harmful effects of alcohol on women; risk 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 recommendations to help ensure that actions taken to reduce alcohol harm are sensitive to gender, and thus more likely to have a positive impact on the lives of women.

Why focus on women?

The lived experience, as well as the biology of women is different to men. This means that effective health responses need to be sensitive to gender. The World Health Organization (WHO) has recognised that sex – the biological differences between women and men, and gender – the cultural norms that determine femininity and masculinity – have an important impact on health and wellbeing[2].

As gender influences health, the use of a gender lens for the study of health issues, and the inclusion of a gender-based perspective in the development of health policies and programmes, are essential for improving health for both men and women. Gender-based analysis is a method for examining the intersection of sex and gender, with other identity factors including but not limited to ethnicity, indigeneity, socio-economic status, and ability (see the box below) in influencing health and social outcomes[3]. Attention to difference, and how differences affect health status, and access to and interaction with the health care system, is essential to ensure effective public policy, with intended and equitable outcomes.



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[4]. CEDAW is an international treaty and rights-based framework which was adopted in 1979 as one of the six primary international documents for the protection and promotion of human rights. The convention sets out an agenda for addressing discrimination and achieving equity for women. New Zealand ratified it in 1985. 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 Organisation hold that good public health practice that aims to achieve health equity requires the integration of gender considerations in 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 measures to ensure that gender considerations are mainstreamed into all national plans and government institutions[5]. Incorporating a gender-based perspective into alcohol policy and programme development is therefore timely and should be prioritised.

Why focus on alcohol?

Global

The harmful use of alcohol is the third leading risk factor for premature deaths and disabilities in the world[6]. Leading alcohol researchers have labelled alcohol as "no ordinary commodity"[7]. 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 and various 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 several infectious diseases like HIV/AIDS, tuberculosis and pneumonia. A significant proportion of the disease burden attributable to harmful drinking arises from unintentional and intentional injuries, including those due to road traffic crashes, violence and suicides. Fatal injuries attributable to alcohol consumption tend to occur in relatively young people.

The degree of risk for harmful use of alcohol 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 vulnerable groups and individuals are more susceptible to the toxic, psycho-active and dependence-producing properties of ethanol. At the same time, it is generally accepted that drinking small amounts of alcohol may not increase the probability of negative health and social consequences in the otherwise healthy adult population. However, the evidence of protective effects of low levels of drinking on heart disease have been greatly overstated, and such effects have no bearing on the public health response to alcohol-related harm.

Despite the need and this sound evidence for more effective action on alcohol, political barriers prevent or slow progress. The influences of the global alcohol industry and international trade agreements are obvious. In 2010 the WHO published the *Global Strategy to Reduce the Harmful Use of Alcohol*, providing a guide to member states for introducing more effective measures to address the alcohol-related harm burden. This document draws on the substantial scientific knowledge base of cost-effective strategies and interventions to prevent and reduce alcohol-related harm. As a WHO signatory,

the New Zealand Government has an obligation to work effectively to reduce the burden of harm from alcohol.

National

The comprehensive review of our alcohol laws completed by the Law Commission in 2010 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"[8]. 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"[9].

In economic terms this alcohol-related harm is estimated to cost us $5.3 billion dollars annually in health and social costs[10]. Alcohol causes at least 1,000 premature deaths in New Zealand each year, and many thousands more experience physical, emotional, social and economic harm from their alcohol use. More recent research explaining and measuring the impact of alcohol on those other than the drinker, argues this is substantial, and potentially greater than the harm to drinkers from their own drinking[11]. 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 this harm. And despite having been presented with strong evidence and public support for substantive reform, the New Zealand Government has rejected the most effective options available. Instead, the Alcohol Reform Bill presented only limited potential for reducing the burden of harm resulting from alcohol use.

(NB) The Alcohol Reform Bill was progressing through its third and final reading in Parliament as this document went to print. It is expected to pass into law by the end of 2012.

The research

The research consisted of a review of the literature on women and alcohol with particular reference to women in New Zealand. These findings were supplemented with focus groups and individual interviews with key informants working across the health and social services. These informants were experienced with, and able to offer insights about, the effects of alcohol in 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 key informant interviews were held with a total of 41 participants. A Māori focus group was organised and analysed independently by Hapai Te Hauora Tapui 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[12] with supervision from the facilitator. Mixed focus groups had a semi-structured format. Interviews were transcribed verbatim and coded for thematic analysis[13].

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

- **Research limitations**

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

There were no focus group representatives who worked directly with female prisoners, sex workers or immigrant communities. The inclusion of 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, including disaggregation by gender, age and ethnicity, have been collected inconsistently over time. Most data rely on respondent self-reports, which is well-recognised as under-reported. Under-representation of high risk drinkers in population surveys is also well recognised. The ability to make 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, the following discussion presents overall research trends and key informant perspectives, which help to give a picture on the current status of women's drinking.

Patterns of alcohol consumption vary between different groups of women. For women overall the literature suggests that there has been little change in the prevalence of drinking in recent times. However, there are indications that for some groups of women their alcohol consumption is converging with men's and that women are now more likely to drink beverages with higher alcohol content. There are also indications in the literature that risky drinking patterns, such as heavy per occasion drinking or "binge-drinking", frequent drinking and earlier onset of drinking have become more prevalent among some women drinkers.

Convergence between men and women

Some evidence suggests convergence between men and women's drinking and an increase in the volume drunk 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. However, there are no more recent analyses of convergence. During the same period, young women aged 16 to 24 increased the amount they drank on a typical occasion from four to six drinks. Ten percent of female secondary school students usually drank 10 or more drinks per session. In 2006, one in three female tertiary students got drunk once a week and drank seven to nine drinks an average session[14]. During the same period, 44 percent of women aged 55 to 70 drank hazardously[15], and around 80 percent of women were drinking alcohol around the time they became pregnant[16]. Most stopped on confirmation of pregnancy but up to 36 percent continued to drink some alcohol during pregnancy.

> *... 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 latest New Zealand Alcohol and Drug Use data[17], conducted in 2007-08, 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.

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, there had been no significant changes to the proportion of drinkers between 1996 and 2008.

Drinking amounts

In 2007-08 women aged 18-24 years were more likely 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. More than three quarters of women aged 16-17 years, seven out of ten of those aged 25 – 34 years, and one in three women aged 55 to 64 had done so.

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. Frequent heavy drinking (more than four standard drinks at least weekly) was most common among 18 -24-year-old women (19%), followed by 16-17-year-olds (16%).

Ethnic differences

There are ethnic differences in the proportion of drinkers, frequency and volume of drinking amongst women. Māori and Pacific women were more likely than Pākehā women 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 Māori women drinking hazardously declined from 31 to 28.5 percent between 1996 and 2006. For Pacific women it rose from 21 to 26 percent[18]. 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 percent 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 percent between 1996 and 2006[19].

Other differences

Socio-economic status and sexual identity also influenced 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[20]. Women active in sports had an average drinking score above hazardous level in 2006[21]. Half of a sample of female prison inmates in 1999 drank at hazardous levels before they were convicted[22].

No research was identified about the use of alcohol by women with disabilities in New Zealand.

What women are drinking

Women drink a mix of 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-drink pre-mixed spirit drinks (RTDs) to young people, particularly to young women. Young people, both female and male, are the most common drinkers 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 percent of the alcohol intake of 14-17-year-old girls[23]. Drinkers who drank RTDs typically consumed 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 in many RTD brands has risen since they were introduced in the 1990s.

> *… the younger they are with their alcohol, by the time they are 16 it is already embedded in their lives … (Hospital focus group)*

Harmful effects of alcohol on women

The consumption of alcohol is associated with a range of negative health impacts. Heavy per occasion drinking or "binge drinking", frequent drinking, the early onset of drinking, and drinking when other risks are present, are the common forms of drinking that increase the risk of experiencing alcohol-related harm. This can be immediate (which is often associated with binge drinking), or chronic, resulting from longer term use of alcohol.

Other alcohol-related harms for women include social and cultural disintegration and economic vulnerability. 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 them from the drinking of others[24].

The research was clear that the harmful effects of alcohol on women are increasing, and there were almost no areas where alcohol-related harm was reducing. This was widely supported by key informants, who said that alcohol consumption was implicated for women either directly or indirectly in:

- Sexual and domestic violence
- Drinking to unconsciousness and alcohol poisoning
- Unplanned pregnancies
- Sexually transmitted infections
- Self-harm and suicide attempts
- Injuries from traffic crashes, assaults and fighting
- Compromised parenting and the involvement of child protection agencies
- Fetal Alcohol Spectrum Disorder
- Financial problems
- Increased pressure on others, having to look after others or pick up extra responsibilities due to others' drinking. Breakdown of families, whānau and aiga
- The erosion of cultural wellbeing and values
- Reduced educational achievement
- Increased social inequalities
- Long term effects such as addiction, brain damage and cancer, particularly breast cancer

Some of these are discussed below:

Increasing inequalities

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

Violence against women

Key informants agreed with the research finding that alcohol was prominent in sexual and domestic violence against women, and that alcohol-related violence was worsening. Increasing evidence is demonstrating that violence is the major alcohol-related harm experienced by women and children as a consequence of the drinking of others, overwhelmingly men[25]. There is currently debate about the extent of the association between alcohol and violence against women. Given the highly gendered

nature of such violence, alcohol is best understood as significantly implicated in the dynamics, for example by increasing the prevalence and severity of attacks.

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[26].

If women in abusive relationships are consuming alcohol themselves, this can prevent them from seeking help[27]. If the woman was drinking at the time of the assault it can lead to guilt or self-blame, 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.

Around one in 10 New Zealand women experience an alcohol-related sexual assault in their lives, but this is also likely to be undercounted as police systems do not allow drug and alcohol-assisted sexual violence to be identified[28]. Alcohol is linked to half of all reported sexual assaults[29]. 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, while men's drinking makes them less responsible. Female victims who had been drinking were 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[30]

About one in 16 female secondary and tertiary students has 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[31], 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 women has had injuries, she's going to end up dead ...
(Violence against Women participant)

Cancer

In 2000 it was estimated that cancers made up 14% of all alcohol attributable deaths among women (Connor et al 2005a). Breast cancer is the second most common cancer affecting women and alcohol consumption increases the risk of breast cancer among women[32]. There is a 10 percent increase in the risk of cancer for each extra standard drink consumed per day, and there is no known safe threshold[33]. It was estimated in 1991 that 18% of women's hospital admissions for breast cancer were alcohol-related[34]. Based on this, of the 2,458 cases of breast cancer registered in 2005, 442 women's hospitalisations were alcohol-related.

Sexual health

Excessive drinking is a common reason for unprotected sex[35]. Women bear a disproportionate disease burden of sexually transmitted infections from unprotected sex. Impacts include sexually transmitted infections (STIs), unplanned pregnancies, infertility and cervical cancer.

One in five women attributed their first sexual intercourse about 20 years earlier, to drinking[36]. Among tertiary students, sex that is unsafe, unhappy or unwanted is linked with heavier drinking. Women who used alcohol to increase confidence and improve sex experienced higher rates of unsafe sex and sexual harassment[37]. Alcohol was often raised in focus groups as a reason for unprotected sex and the high rates of STIs[38].

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 are no prevalence data on FASD in New Zealand. Recent studies in the USA, South Africa and Italy have found FAS rates of between four to 12 per 1,000 live births and FASD in 2.3 to 6.3 percent of school children[39]. 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 2000, 52 percent of estimated years of life lost to women due to alcohol were from injuries[40]. 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[41]. Some studies of hospital emergency departments found that more women than men are injured after drinking. Alcohol-related injury rates vary across different groups of women; younger women are at higher risk.

Alcohol was 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[42]. 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, and the proportion of alcohol-affected women drivers in traffic crashes is also rising[43].

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 health problems, and death rates for women with these disorders are significantly higher than for men[44].

Two percent of all women (including non-drinkers) had abused alcohol in the last 12 months, and 6.9% had done so over their lifetime; the proportion of drinkers was not analysed by gender[45]. 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.

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[46]. This is lower than the 9 percent of 18-year-old women found in 1994[47].

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%). 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.

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 %)[48].

Depression

Alcohol dependence causes moderate to severe depression[49] . Women are more likely to have alcohol problems and depression at the same time, and to say they developed depression first[50]. 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[51].

Economic impacts

Existing estimates of the costs of alcohol are weighted towards areas, such as crime, dominated by men's drinking problems, and 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 production by family members from the care of people with FASD[52].

Major influences on women's harmful alcohol use

The harmful use of alcohol is not simply the result of individual choice. Women's lived experiences and material realities, including exposure to violence and social inequalities, influence the harmful use of alcohol. To understand women's harmful alcohol use a combination of environmental, social, cultural and economic factors that act as influences need to be considered. These influences may be gender specific - for example, violence against women - or have a particular impact on women because of their role in families whānau.

Key informants agreed on a range of influences on women's harmful use of alcohol, which were supported by the research. Some of these are discussed below:

- The increase in alcohol advertising, marketing and sponsorship, including products such as RTDs aimed at young women
- The relatively low price of alcohol, particularly compared to milk and bottled water
- Alcohol industry strategies of deep discounting to increase sales and consumption
- A higher density of alcohol outlets and a greater variety of outlets, including supermarkets
- Extended opening hours for bars and clubs
- A drop in the purchase age in 1999
- High rates of sexual assault, domestic violence and child abuse affecting women
- Historic and current social inequalities
- Less strict parental guidance and control of alcohol supply to under-age children
- The normalisation of New Zealand's binge-drinking culture.

Violence against women

As demonstrated in the previous section, violence against women is a harmful effect of alcohol, because for example, alcohol has been shown to increase the prevalence and severity of attacks. However, violence against women also drives women's harmful alcohol use.

> *… 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.*
> *(Hospital focus group)*

Partner violence

Women who have been physically and sexually abused have significantly greater rates of problem drinking[53], and those who had been treated violently by an intimate partner had higher rates of alcohol dependence than those who had not[54]. Estimates of the proportion of women who drink to cope with partner and other violence vary from 10 percent of Māori and 7 percent of Pākehā women[55] to one in three women in abusive relationships[56]. 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 had increased their use of alcohol, drugs or medication as a result[57].

Sexual violence

Young people who were mistreated or abused in childhood were more likely to start drinking early, drink heavily as teenagers and abuse alcohol[58]. Women are more likely to experience sexual assault as children and use alcohol to cope with post-traumatic stress disorder (PTSD)[59]. Women with PTSD are estimated to be 1.4 times as likely to develop alcoholism[60]. 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[61]. Women who blame themselves are more likely to have worse long-term results, including alcohol-related hospitalisations and arrests[62].

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> *… in effect a RTD can be cheaper than a bottle of water… 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*

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 causes heavier drinking and more alcohol problems[63]. Poverty is gendered in New Zealand. Women's median annual income in 2006 was $19 000, 39 percent less than men's. Women were one and a half times more likely to live on a total annual income of $30,000 or less[64]. People who report several forms of economic or social hardship have a greater likelihood of problem drinking[65].

There is a relationship between racism and harmful drinking. Students who identified themselves as Māori, Pacific and Asian in the Youth 2007 survey 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[66]. However, there has been little other research about racism and harmful drinking.

Liberal policy environment

Changes in women's harmful use of alcohol have occurred in an environment of liberalised alcohol policy. Increasing the number of 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[67]. A high density of alcohol outlets is linked with increased binge drinking, increased secondary and tertiary student drinking, violence, road crashes and police call-outs[68]. Evidence supports alcohol regulation as the most effective way to prevent harmful alcohol use.

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 the harmful use of alcohol. As well as promoting drinking generally, evidence suggests that young people's exposure to alcohol marketing speeds up the onset of drinking[69] and increases the amounts consumed by those already drinking[70]. It 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 of marketing, alcohol has gained a variety of symbolic meanings for women. They include fun and freedom, hospitality and social connection.

Biological differences

Women process 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.

Changing gender roles

Public disapproval of drunkenness is higher for women than for men. However, heavy drinking has become a social norm for many young women, with traditionally male drinking patterns setting the yardstick. 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.

> *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…*
> *(Alternative education participants)*

Family influences

Key informants were particularly concerned about the social supply of alcohol by parents to underage children. Parents often did this so that their children drank at home where parents saw it as safer and where they could supervise and influence the amount their teenagers drink. There is no evidence that this has a protective effect on subsequent hazardous drinking or alcohol-related harm.

Protective factors for women's harmful alcohol use

While there is little research on factors that protect women from harmful alcohol use, research has shown that the conditions for resiliency 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 resiliency are produced at a micro and macro level.

Social inequalities are a driver of harmful alcohol use, but there has been no research on the impact of harmful alcohol use on attempts to reduce these disparities. 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 alcohol access and availability[71].

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[72], as may the promotion of alcohol-free social spaces for young lesbian, bisexual and queer women[73].

Delaying teenagers' first drinking reduces the risk of them experiencing problems with alcohol later in life[74]. Families who use alcohol responsibly, and resolve conflict without violence, contribute to young women's wellbeing in particular[75]. Egalitarian and respectful relationships protect women against harmful drinking[76]. Close relationships with mothers may also protect young women against frequent drinking[77]. Preventing sexual abuse, and exposure to family violence would help reduce the likelihood of harmful use of alcohol later in life.

Key informants also discussed other important factors including promoting girls and women's self esteem, positive body image, encouraging critical analysis of alcohol advertising and beliefs, supporting strong families and whānau, promoting cultural connectedness and pride, strengthening communities, and support for alcohol-free community events.

Preventing or reducing the harmful effects of alcohol on women

As we have demonstrated, the harmful effects of alcohol on women are a result of combinations of environmental, social, economic and individual factors which intersect in complex ways. This means single prevention or harm reduction strategies may be inadequate and ineffective. The evidence and key informant experience demonstrates that preventing or reducing the harms to women from their own or others' harmful use of alcohol requires a sustained combination of evidence-based policy and community measures.

Population-level interventions

- **Alcohol-specific**

Many of the drivers for the harmful effects of alcohol on women lie at the population level. This means, that 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:

> *Any intervention is the same really, though, unless you change their lives and the opportunities that they have …*
> *(Māori focus group)*

- 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 most 50mg/100ml.

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

- **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[78]. 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 to reduce alcohol-related harm. Women are often struggling with violence and alcohol at the same time, but interventions about these issues remain poorly co-ordinated.

Community and family interventions

Key informants suggested a wealth of community and health promotion interventions to increase womens' wellbeing and resilience and challenge heavy drinking norms. Community projects on alcohol have had wide positive impact[79].

We should get rid of all advertising for all alcohol – get it banned (Community focus group participant).

Kaupapa Māori campaigns have been effective in urban and rural Māori communities[80], and Pacific community campaigns have raised awareness of alcohol impacts and led participants to question their drinking behaviour[81].

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[82].

Programmes aimed at reducing social supply to underage drinkers have reduced binge drinking in the short term[83]. However, change is unlikely to be sustained unless commercial availability is also targeted[84].

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[85]. 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 affect alcohol consumption or problems, these can be useful adjuncts to support other interventions and more effective public policy measures[86].

Liquor outlets surrounding tertiary institutions are sites of heavy drinking, but harm reduction approaches seem to be largely ad hoc and un-coordinated. Restrictions on alcohol marketing, outlets and drinking sites have been effective in reducing consumption and problems overseas[87].

Individual-level interventions

Evidence supports that the health sector interventions has a key role in reducing alcohol harm. The key informants identified some important gaps in current health service provision. They included:

> *…the services aren't … coming together in that wrap around … way and providing for that person; it's very frustrating, isn't it? (Hospital workers)*

- **Screening and brief interventions**

Screening for harmful drinking has been little used in New Zealand health and justice settings until recently[88], and therefore there is limited capacity to provide early brief interventions.

Brief interventions in tertiary education have shown positive effects and reduced harmful drinking among women students[89]. 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[90]. However, these interventions are only slowly being implemented. Key informants reported little experience with brief interventions, 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[91]. Brief interventions are also effective in justice system contexts, including for female drink-drivers. 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. Specialist refuge services overseas for women experiencing domestic violence who also have AOD addiction and mental health problems are effective[92], but they do not exist in New Zealand.

- **Identifying and preventing FASD**

Warning labels on alcohol containers do not reduce consumption, but raise awareness of the teratogenic effects of alcohol and are a useful component of a wider strategy[93]. 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[94].

Early intervention with children affected by FASD results in improved learning and behaviour outcomes[95]. Identifying children with FASD also provides 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[96].

- **Treatment**

Key informants argued New Zealand's AOD treatment services are under-funded, resulting in a major overall 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[97], but provision is ad hoc. Kaupapa Māori alcohol treatment programmes are more effective for Māori than mainstream programmes[98]. There is recent evidence that alcohol treatment agencies are not always culturally sensitive to differences on the basis of sexual orientation and gender identity and need to improve their response to lesbian, trans and intersex clients[99] [100].

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[101]. 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[102].

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 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. There have been few interventions that specifically address the needs of women or the systemic inequalities that affect women. 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, have tended to lack assessment of the appropriateness of these interventions for women[103].

Conclusion

This paper has summarised the findings of a research project intended to help fill the gaps in current knowledge about women and alcohol in New Zealand. Its aim is to ensure informed public discussion and effective policy responses.

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. Changes in women's harmful use of alcohol are being driven by a combination 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. Successful alcohol interventions will be co-ordinated across sectors and will require investment.

While we 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 within diverse populations of women; to track patterns of consumption and harm over time and identify trends; and understand the impacts and effectiveness of alcohol-related policies and interventions for women's well-being.

Recommendations

We recommend that:

1: Gender matters

Strategies, polices and programmes intended to address alcohol-related harm use gender-based analysis.

2: Alcohol matters

A whole-of-government approach to addressing alcohol-related harm is adopted and that alcohol is given a greater priority in national policy and planning.

3: Effective policy interventions

Evidenced-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: Data collection

A more strategic and co-ordinated approach to alcohol research is achieved, ensuring that research questions allow for the disaggregation by gender, age and ethnicity; enhance our knowledge about the role of alcohol within diverse populations of women; and inform the development and measure the impact of interventions.

5: Alcohol 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: Social determinants

A whole-of-government approach is adopted to address social and ethnic inequalities, including poverty and institutional racism.

7: Reducing alcohol-related harm for Māori women

Wāhine Māori rangatiratanga over alcohol harm is developed through sector-wide engagement and health literacy.

8: Kaupapa Māori services

Service for Māori to be delivered within a Kaupapa Māori values framework that reflect the aspirations of Whanau Ora.

9: 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.

10: Enhancing treatment services

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

11: Community action

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

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