



UNDER THE INFLUENCE

RESHAPING NEW ZEALAND'S DRINKING CULTURE



Te Ope Whakāora

SOCIAL POLICY AND
PARLIAMENTARY UNIT

Working for the eradication of poverty in NZ

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UNDER THE INFLUENCE

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Public Policy & Research Ltd

The Salvation Army Social Policy and Parliamentary Unit

April 2010



FROM THE FOCUS GROUPS



You're revered for how much you can drink, get kudos for it, rather than being ostracised ...

It's the way we've been brought up ... Brought up to drink to get drunk ... I learned to drink off my father ... To be in with your family, you've got to drink ...

Sports clubs are supposedly there to keep you healthy but there's drinking after the game ... Growing up, playing the game and having a few beers.

When I was drinking, you could drop me anywhere in the city and I would know where the nearest place to buy booze was ...

You pay more for Coke than for beer ...

What slows teenagers down from drinking is they don't like the taste, all they want is the effect and that's what they get with alcopops ...

Look at the smoking, smoking isn't cool. Show what you look like when you're pissed.

Get the outlets to be more vigilant. There should be much stricter fines for contravention of liquor licenses ...

You're in crisis, then you have to wait [for treatment]. There's three options, death, jail, or hang in there and wait. It's Russian Roulette ...

Depression and emotional issues are triggers for drinking ... it's hard to find the right support, and to know it's OK to ask for help ...

There are stereotyped views about who is an alcoholic, we need to challenge those ... Nobody is spared ...

The number one thing that's got to change is the culture; it's normal [to drink], it's intergenerational ...



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EXECUTIVE SUMMARY

This report presents a summary of findings from 20 focus groups with people who have attended or who are attending Salvation Army addiction treatment programmes. The purpose of the focus groups was to learn more about people's experiences with alcohol and their ideas for limiting the harm that alcohol causes in our society.

The report also places the findings from the focus groups in the wider context of research on environmental influences on drinking behaviours.

What the literature says about influences on drinking behaviours

A selected overview of literature concerned with environmental influences on drinking behaviours identifies the wide range of influences that affect when, where, how and with whom we drink, as well as the links between influences, behaviour and alcohol-related harm. This literature also provides insights into how changes in those environmental factors—through legislation, policy or practice—can change drinking behaviours and impact on alcohol-related harm.

International and New Zealand evidence is that the following environmental factors influence drinking behaviours and contribute to alcohol-related harms:

- the broad cultural context of institutions, practices, attitudes and values
- social factors, particularly the family and peer group

- market factors, particularly alcohol advertising (including promotions), pricing and products
- legislative and regulatory factors, particularly availability, the legal purchase age and enforcement

In brief, research shows that culture, family and peers are all major influences on drinking behaviours:

- In New Zealand, there is a widespread cultural acceptance of drinking and it is an intrinsic part of much of our social life, for both genders. Young adults are the heaviest drinkers and most likely to engage in risky drinking such as binge drinking and becoming intoxicated.
- There has been extensive international research on the role of families, particularly parents, in influencing drinking behaviours. Key influences have been identified as: parenting practices, parents' own drinking behaviour, family conflict, and parental supply of alcohol. Often, these factors work together as influences.
- Friends and social networks are significant influences on drinking attitudes and behaviours. Drinking with friends and workmates, associations with playing and watching sports, and the presence of alcohol in social situations is fundamental to how New Zealanders relax, feel at ease with others and express a sense of belonging. International research confirms that one major reason why young people use alcohol is because their peers use it.

Key aspects of the market influence drinking behaviours:

- An extensive body of research across many countries shows that price influences alcohol consumption, with higher prices lowering consumption and price reductions increasing consumption. Price increases have also been found to reduce vehicle crash fatalities, adverse health effects, child abuse and other violence.
- Evidence about the link between exposure to alcohol advertising and alcohol consumption is mixed, although on balance there is growing evidence that alcohol advertising does influence drinking behaviour, including the amount of alcohol consumed, and the age at which young people start drinking.
- The type of alcohol product has an influence on the drinking patterns of different segments of the population. Since the early 1990s, an increasing range of alcohol products have emerged on the market. New products such as ready-to-drink beverages (RTDs) tend to be the drinks of choice of young people. A growing body of research argues that RTDs are specifically marketed to appeal to young people, and have been a major contributor to youth initiation into drinking, increases in the amount and frequency of youth drinking, youth binge drinking, and higher levels of youth intoxication.

With regard to the way the legislative and regulatory environment influences drinking behaviour:

- Both overseas and New Zealand studies have shown that consumption increases when the number and density of liquor outlets increase. There appears to be a particular relationship with high outlet density and underage drinking. Studies have also found that a higher density of licensed premises is associated with alcohol-related harm such as increased rates of homicides and assault, greater prevalence of drinking and driving, alcohol-related hospital admissions, child abuse and neglect, pedestrian injuries, and property damage.
- International studies have shown longer trading hours are associated with higher levels of drinking and intoxication and resulting problems with public disorder, violent assaults, increased alcohol-related hospital admissions and increased traffic casualties.
- A wide range of studies overseas and in New Zealand concludes that the purchase age does influence young people's drinking patterns. In particular there is a 'trickle down' effect with those close to the legal purchase age also gaining access to alcohol. Lowering the purchase age has been found to contribute to increased alcohol consumption levels and heavy drinking, traffic crashes and disorder offences among young people.

- Studies have shown that enforcement is a critical influence on drinking behaviours. Inadequate enforcement of purchase age laws has been found to contribute to early exposure of minors to alcohol and underage drinking, as well as increases in intoxicated drinkers. Effective enforcement has been found to reduce risky drinking behaviours and alcohol-related harm.

What the focus groups said about drinking influences

The focus groups broadly agreed that alcohol is embedded in the New Zealand way of life. Alcohol consumption is widely accepted as part of social gatherings, celebrations, recreation, relaxation and reward.

Within a culture that has normalised the consumption of liquor, there are some strong influences that lead people to drink. The focus groups identified those major influences as:

- family environment
- social and peer group
- availability of alcohol
- alcohol advertising and packaging
- the association of sports with alcohol
- the price of alcohol

Within these broad range of influences, many people experience specific triggers that prompt the desire to drink. Focus group participants identified the main triggers as:

- emotional issues and personal state of mind

- social situations
- availability and proximity of alcohol
- alcohol advertising
- the price of alcohol

Across all the focus groups, the three most important influences and triggers were considered to be: personal issues, social and peer group influences, and the availability of alcohol.

Focus group ideas for limiting alcohol-related harm

Focus group participants emphasised that multiple responses are needed to engage a wide range of people. In particular, the focus groups made clear distinctions between moderate drinkers and those for whom alcohol is a big problem in their lives. They also distinguished between young people starting to drink, and adults with well established drinking habits.

Focus group participants made the following suggestions for limiting alcohol-related harm:

- public education about the impacts of alcohol, with a particular emphasis on children and young people
- increase the range and types of treatment
- increase the purchase age
- restrict alcohol advertising and promotions and introduce health warnings on product labelling
- restrict the availability of alcohol

- tightening of liquor licensing and stricter enforcement
- raise the price of alcohol
- use alcohol excise tax for public education and treatment
- lower legal blood alcohol levels, establish tougher penalties and increase assessment and treatment for drink drivers
- training, guidelines and voluntary codes of practice for the liquor industry, justice sector, general practitioners, agencies providing financial assistance, employers and sports clubs

The focus groups considered the most effective responses to be: public education campaigns, particularly targeted to children and young people, and treatment.

Although there was widespread support for public education, some focus group participants expressed scepticism about the effectiveness of social marketing campaigns for adults. In contrast, all considered that it is necessary to focus on educating children on safe drinking behaviours and the effects of alcohol. Participants considered that schools and sports/recreation organisations catering to children and young people need to be actively involved in such education.

There was almost universal support for public education to:

- reduce stigma through raising public understanding about alcohol dependence

- encourage people to seek help for their alcohol problems

There was a very clear message that the only effective response for those dependent on alcohol is treatment. Those who are alcohol dependent will not significantly alter their behaviour in response to legislative changes or many non-legislative interventions.

There was strong support across all focus groups for increasing the range and opportunities for assessment, treatment programmes, pre- and post- treatment support, and also support for families.

There was some support for other changes. Most focus groups considered that the number of liquor outlets should be reduced and that the availability of RTDs should be more tightly controlled. There was also general agreement that legislation and enforcement need to be strengthened around licensing and drink driving. There was general support for increasing controls on liquor advertising.

The widest divergence of opinion was around changing the purchase age. While there was strong support for raising the age, there was also a view that such a change would have little or no effect on underage drinking. There was more support for raising prices or introducing a minimum price as a means of reducing consumption, particularly amongst young people. However, some saw negative consequences for families if income was used for alcohol instead of essentials.

Some thoughts on policy responses

The concluding section of this report reflects on options focus group participants suggested for changing the way New Zealand manages alcohol. It also puts those suggestions in the context of the findings from the literature review on the environmental influences on drinking behaviours.

Many focus group suggestions have strong resonance with findings from studies concerned with the environmental influences on drinking behaviours. For example, in the focus groups there was support for:

- raising prices or introducing a minimum price as a means of reducing consumption, particularly amongst young people
- increasing controls on liquor advertising
- increasing controls on or banning of RTDs
- limiting the availability of alcohol, including reduction in the number of outlets and controls on the hours of sale
- strengthening enforcement, especially around liquor licensing and drink driving

International research has found that all of these measures impact on drinking behaviours.

The main policy implications from the focus group findings are:

- an effective response must be multi-faceted, with consideration given to tailoring responses to different groups and local communities

- most people who are alcohol dependent will be relatively unaffected by most interventions; the most effective policy responses for them are the provision of support and treatment.
- inter-sectoral responses are likely to be most effective, with central government agencies, local government and non-government organisations working together.
- the co-existence of mental health issues and alcohol dependence is common; programmes need to address both issues to assist people's recovery.
- consideration should be given to developing a campaign aimed at raising awareness of alcohol dependency, showing that recovery is achievable and provision of information about the availability of treatment
- regardless of the legal purchase age, there will be underage drinkers; specific policy responses need to be targeted to underage drinkers.
- the establishment of voluntary codes of conduct around alcohol are likely to engage the community more widely than a narrow focus on law enforcement





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1. INTRODUCTION

Currently, a review of liquor laws is being undertaken in New Zealand. To contribute to that review, The Salvation Army commissioned 20 focus groups with people who have attended or who are attending Salvation Army addiction treatment programmes, known collectively as The Salvation Army Bridge Programme.¹

The purpose of the focus groups was to learn more about people's experiences with alcohol and their ideas about what can be done to limit the harm alcohol causes in our society. The focus groups explored two broad questions:

- what are the influences on and triggers for drinking behaviours?
- what could be changed to reduce the negative impacts of alcohol on people's lives?

The large majority of focus group participants were alcohol dependent or problem drinkers. They have had specific experiences with alcohol, and hold strong views shaped by those experiences. Consequently, they were able to contribute valuable insights into what influences people to drink, and to drink in risky ways. They were also able to suggest what needs to happen to engage with and effect changes in the most challenging drinking behaviours. The focus groups provided useful insights into the range of policy responses that may be effective in raising public awareness about the dangers of drinking and in controlling drinking behaviours that may develop into problem drinking.

This report presents a summary of findings from the focus groups. To set the focus groups' views and experiences in a wider context, this report also presents a selected overview of literature on the range of environmental influences on drinking behaviours.

The structure of this report is:

- Section 2 describes the focus groups, explains why the focus group method was chosen, and how the focus groups were conducted.
- Section 3 provides a selected overview of literature on the range of environmental influences on drinking behaviours. This gives a wider context to the focus group findings. Research evidence shows that a wide range of environmental factors influence drinking behaviours, including cultural practices and values, the family and peer group, market factors and legislative and regulatory factors.
- Section 4 presents the views of focus group participants on the influences on drinking behaviours and specific triggers that have affected them. The focus groups identified the following as major influences on drinking behaviours: family, socialising and peer groups, the availability of alcohol, alcohol advertising and packaging, the association of sports with alcohol and the price of alcohol.
- Section 5 outlines the range of responses that participants consider would reduce the negative impacts of alcohol on

people's lives. These responses cover public education, the age at which alcohol should be purchased, alcohol advertising, promotions and product labelling, the availability of alcohol, licensing and enforcement, alcohol pricing, alcohol excise tax, drink driving controls and institutional responses.

- **Section 6** comments on the options for treatment discussed by the focus groups. This discussion is separated out from the other responses considered in section 5, as participants identified treatment as a key response in addressing the harm that alcohol causes.
- **Section 7** summarises participants' views on the most effective responses for limiting alcohol-related harm.
- **Section 8** concludes with some reflections on the issues and policy responses raised in the focus groups.



2. THE FOCUS GROUPS

Twenty focus groups were held in eight centres throughout New Zealand during September and October 2009. The focus groups were arranged through The Salvation Army Bridge Programme as a way of finding out from people who are alcohol dependent, their views on how to limit alcohol-related harm. Accessing participants through the programmes was chosen as a way to find out ideas for limiting the harm that alcohol causes from those for whom alcohol is a significant challenge. Appendix 1 describes the Bridge Programme and other alcohol-related support services provided by The Salvation Army.

The focus group method is a qualitative method useful for illuminating and exploring issues and experiences that are not able to be done using other methods such as surveys, observation or one-to-one interviews. Focus groups are not designed to generalise findings to a whole population; however, they do provide a richness of detail and the opportunity for group reflection that other methods do not offer.

The group dynamics and interaction shape the direction of focus group conversations and in this way can provide insights and information on the various perspectives and experiences of the group. The focus group may identify differences, disagreements or the degree of consensus on a topic. Drawing out diverse views is a useful way of gaining further insights into the issue being examined.

2.1 THE FOCUS GROUP PROCESS

The first step in setting up and running the focus groups was to send out information about the project to Salvation Army centres with Bridge Programmes to inform them about the project and its objectives and to provide information to be given to prospective focus group participants. The project aimed to include both those currently in a Bridge Programme, as well as some who had attended in the past. After the centres had been informed about the project, the researcher then contacted the centres to arrange times to run the focus groups.

In all, 138 people participated in the 20 focus groups, which were held in the following areas:

- Whangarei (1 focus group)
- Auckland (3 focus groups)
- Waitakere (2 focus groups)
- Manukau (3 focus groups)
- Hamilton (2 focus groups)
- Wellington (3 focus groups)
- Christchurch (3 focus groups)
- Dunedin (3 focus groups).

Focus group discussions lasted between 60 and 90 minutes. They ranged in size from four to 14 participants, with most focus groups having 6-8 members.

At the start of each focus group, the purpose of the project was explained. Individuals were assured that they would be treated with respect and that confidentiality would be maintained, with no names or personal details used in any report.

It was also explained that it was not the purpose of the focus groups to discuss personal histories; nor was the purpose to evaluate any treatment programmes they had participated in.

Individuals had the opportunity to ask questions about the project and to opt out of the focus group before it started or at any time in the focus group process. Almost all of those who were given information about the focus groups on the day they were held (over 95 percent) chose to participate. It was made clear to individuals that their participation was voluntary and that they could leave the focus group at any time if they felt uncomfortable with the process. Across all the focus groups, only three people left part way through the discussion.

A set of questions was used to guide discussions (see Appendix 2). The focus groups were conducted like conversations. The researcher aimed to establish a relaxed, comfortable environment. Participants were encouraged to raise topics, expand the discussion along different lines and to return to earlier questions or issues as needed.

Focus group questions were framed at a general level, for example: “What influences your drinking habits and behaviours?” Prompts were rarely used. Consequently, most comments were unsolicited. Although the views about the influences and triggers on drinking behaviour reiterated many of the influences and triggers identified in literature, these views were not prompted by the researcher.

As a consequence of their engagement in therapeutic programmes, many focus group participants had thought carefully about the individual, institutional, legal, cultural and societal responses needed to address alcohol-related harm in society and were therefore able to articulate their views clearly. Again, they were not prompted to focus on any particular response or intervention.

Detailed notes were taken of all focus group sessions. A summary of each focus group was prepared. Then the range of themes was identified across all focus groups. Analysis included the identification of similarities and differences in views, and the degree of disagreement and agreement on particular issues, both within and across the focus groups.

This report draws extensively on the focus group conversations. Where comments from the focus groups are presented in this report, most are paraphrased rather than verbatim. Where specific comments are quoted, they are indicated in speech marks (“/”). Where several comments are from a conversation in a focus group, they are presented with different speakers on successive lines. This shows how the conversation among participants often built on ideas and developed different points.

2.2 FOCUS GROUP PARTICIPANTS

While it is common for focus group participants not to know one another, in this project the participants were known to one another because of their involvement in The Salvation Army Bridge Programme. Most were currently

in a programme, while all but two of the remainder had been through a programme in the past. It was common for focus group participants to have been involved in more than one programme (not always a Salvation Army programme). As well as those who were current or former programme participants, one person was in the pre-programme phase, waiting to enter a programme. Another person was a volunteer worker with the programme and not a programme participant.

The focus group method enabled the project to build on the familiarity and common knowledge of participants. Those currently in programmes had a high level of daily interaction and were used to discussing issues with one another. This familiarity with one another enabled them to quickly concentrate on the focus group questions and engage in discussion.

The focus groups covered a wide range of ages, from just under 20 to over 60. Most were aged 30-60 years. More men (88) than women (50) were involved, although two focus groups consisted of all women as they were drawn from women-only programmes. While most participants appeared to be NZ European/Pakeha, Maori and Pacific people were also involved. There were a few who identified with Indian, Middle Eastern, British, European and Australian backgrounds.²

The large majority of participants were alcohol dependent, while some were substance addicts. Some had multiple addictions.

2.3 SURVEY QUESTIONNAIRE

At the conclusion of the focus group discussions, participants were asked whether they would complete a short (13-question) confidential survey about various aspects of their drinking history and behaviours. They were assured that their involvement in the survey was voluntary. Of the 138 focus group participants, 106 completed the questionnaire. Their responses are included with discussion of the focus group findings in Section 4 relating to the influences and triggers on drinking behaviours.

As they were drawn from the same focus groups, the profile of the survey respondents was similar to the profile of focus group participants. More survey respondents were men (65 percent) than women (35 percent). Three-quarters of respondents were aged 30-60 years.

Survey respondents gave information about their alcohol dependence, providing information about past drinking behaviour.³ Over half (55 percent) reported that when they were drinking, they drank alcohol every day. Over three-quarters indicated that when they were drinking, they had drunk seven or more drinks in a session.⁴ The majority had been concerned about their drinking, with 40 percent thinking 'all the time' that they should drink less and 23 percent 'often' thinking they should drink less. Furthermore, 38 percent reported 'often' getting into trouble because of their drinking, and 17 percent reported getting into trouble 'all the time' because of their drinking.

3. INFLUENCES ON DRINKING BEHAVIOUR

This section provides a selected overview of literature concerned with the range of environmental influences on drinking behaviours. Environmental factors influence the whole gamut of drinking behaviours, affecting both the frequency and quantity of alcohol use. These factors influence the age at which individuals start drinking, with whom they drink, what they drink, and where they drink. Environmental factors also impact on what people do when drinking; for example, whether they drink before driving. Environmental factors not only affect actions; they also shape individuals' expectations, attitudes and values towards alcohol, as well as their knowledge of alcohol. In turn, those ideas about alcohol impact on decisions about drinking and drinking practices.

This is a selected review of a considerable and growing body of evidence. The main studies focused on include the United Kingdom, United States, Canada, Australia and the European Union. Although those countries differ in their liquor laws, jurisdictions and local and central government arrangements that manage access to liquor, they include western developed countries that New Zealand is consistently benchmarked against in terms of wellbeing performance. Furthermore, New Zealand shares historical traditions, values and practices relating to alcohol use with Australia, United Kingdom, Canada and the United States in particular. For example, New Zealand and Australia share very similar per capita alcohol consumption and patterns of drinking.⁵

Consequently, environmental factors that have been found to influence drinking behaviours in those countries have considerable relevance for understanding the context, influences on and practices of alcohol use in New Zealand.

The literature on drinking behaviours shows a huge range of influences, and multiple factors operating in conjunction with one another. While genetic factors play a role, environmental factors have a significant influence. This report considers the following environmental influences on drinking behaviours that are well traversed in literature:

- the broad cultural context of institutions, practices, attitudes and values that define drinking in New Zealand
- social factors, particularly the family and peer group
- market factors, particularly advertising (including promotions), pricing and products
- legislative and regulatory factors, particularly availability, the legal purchase age and enforcement

Where influences on children and young people appear to differ from influences on adults, these aspects are also considered. For example, age-related differences have been studied in relation to alcohol advertising, the density of liquor outlets, the price of alcohol, and the appeal of different alcohol products.

Also considered are the links between particular behaviours and alcohol-related harm. In analysing the influences on alcohol

consumption, much of the literature considers both drinking behaviours and the potential of those behaviours to result in alcohol-related harm. Drinking behaviours such as excessive drinking, binge drinking and intoxication have the potential to result in harm to the individual drinker and to others.

A NOTE ABOUT TERMS USED IN THE LITERATURE

Alcohol has been called ‘no ordinary commodity’.⁶ In part, this is because it is a psychoactive and toxic substance that can result in dependence. In the literature a continuum of substance use is acknowledged: from no use, to safe use, to hazardous use, to problem use, to dependence.⁷

The literature uses a range of terms to describe and define different drinking behaviours and situations, including hazardous drinking, problem drinking, alcohol dependence and alcohol-related harm. While those terms may be used in slightly different ways, generally a standard terminology is used in the addictions sector.

Hazardous drinking is drinking that is above safe limits⁸ and, while it may not cause problems at present, is likely to cause harm in the future.⁹ Hazardous

drinking patterns can include intoxication, heavy drinking and binge drinking.

The term problem drinking refers to use of alcohol that causes problems in people’s lives, but does not meet DSM-IV criteria for a diagnosis of dependence.¹⁰

Alcohol dependence happens when drinking takes a high priority in a person’s life and he or she has great difficulty controlling consumption. Use is continued even though the person is aware of associated health or psychological problems. Generally the individual experiences unpleasant withdrawal symptoms when not drinking.¹¹

Alcohol-related harm is a widely used term that refers to health and social problems that can happen to the drinker and others (at the individual or collective levels) in which alcohol plays a causal role.¹²

3.1 NEW ZEALAND'S DRINKING CULTURE

Culture, as a way of life, is a primary and fundamental influence that shapes how we learn to drink, our drinking behaviours, and our attitudes towards alcohol.

Compared to most other countries, New Zealand has a very high proportion of alcohol users. The large majority of New Zealanders drink alcohol, at least occasionally—in the 2007/08 New Zealand Alcohol and Drug Use Survey, around 85 percent of 16–64 year olds had had a drink in the past year, and 61 percent drank at least once a week.¹³

Internationally, the highest proportions of drinkers are found in Europe, Australia and New Zealand, where between 80 and 90 percent of all adults consume alcohol. This is considerably higher than the United States (around two-thirds of adults) and Canada (around three-quarters of adults).¹⁴

In New Zealand the historical association of alcohol with male culture, mateship and work has been very strong. Drinking has been described by one historian as “the most important and defining ritual of the male community”.¹⁵ Now, drinking is an intrinsic part of much of our social life, for both genders. Alcohol is a fundamental part of recreation and leisure, celebrations and events.

The widespread cultural acceptance of drinking is reflected in the young age of using alcohol. The New Zealand Alcohol and Drug Use Survey found that about eight-in-ten 16 and 17 year

olds had had a drink in the past year. One-in-three people who had ever tried alcohol had their first drink when aged 14 years or younger.¹⁶ The Youth '07 survey of Years 9 to 13 students found that 71.6 percent of over 8,000 respondents had ever drunk alcohol, and 60.6 percent defined themselves as currently alcohol drinkers. Over one-third of the respondents aged 13 years or less reported that they were currently alcohol drinkers, and the proportion rose to around three quarters of those aged 16 and over.¹⁷ The earlier Youth 2000 survey of over 9,000 secondary students found that most had their first drink between the ages of 10 and 15, with nearly half having their first drink before the age of 13.¹⁸

Not only is alcohol widely accepted and used in our society, there also appears to be a high level of tolerance of risky drinking behaviours such as drinking to excess and binge drinking. A national survey of individuals aged 12 years and over found that one-third disagreed with the statement ‘it’s never OK to get drunk’, and one-quarter agreed with the statement ‘it’s OK to get drunk as long as it’s not every day’.¹⁹

Young drinkers seem to be especially tolerant of risky drinking behaviours. Although around two-thirds of men and women in the New Zealand Alcohol and Drug Use Survey reported consuming a large amount of alcohol, at least once in a year, the heaviest drinkers were aged 18–24 years. Eight-in-ten of those had consumed a large amount of alcohol on at least one occasion in the past year. The 18–24 age group was also the group most likely to drink

enough alcohol to feel drunk on at least one occasion in the past year.²⁰

The 2007-08 ALAC monitor report classed 24 percent of New Zealand's young people aged 12–17 as binge drinkers.²¹ This research also found that almost two-thirds of the respondents who had got drunk on their last drinking occasion stated that they had planned to get drunk.²² That is, they were 'drinking to get drunk'. Various researchers have commented on a culture of intoxication and a 'determined drunkenness' typical of young people's drinking behaviours that is part of a global youth consumption and pleasure seeking lifestyle, in which risk taking behaviour (not only related to alcohol use) is usual and expected.²³

3.2 FAMILY INFLUENCES ON DRINKING

For many people, the introduction to alcohol takes place in the family, as it is often associated with family events such as birthdays, marriages and Christmas.

While there are familial genetic factors involved in determining drinking behaviours, there are also important familial environmental factors, and the effects of genetic factors can be enhanced or reduced by different family influences.²⁴ There has been extensive research on the role of parents in influencing drinking behaviours. Key influences have been identified as parenting practices, parents' own drinking behaviour and family conflict. Often these factors work together as influences.

Parenting practices

A range of positive parenting practices—such as strong family values, standards and rules, monitoring children's behaviour, supporting children and giving rewards for good behaviour—have all been shown to reduce alcohol use in adolescence and delay alcohol use. Some research has linked the early age of starting to drink with risk of harm from alcohol when they are older. This research suggests that the later a young person starts to drink, the less chance they will have of becoming regular users of alcohol and drinking at higher levels.²⁵

Parental monitoring appears to be one of the most directly influential factors on children and young people's drinking behaviour. Children whose parents monitor their activities and set limits while supporting their independence are less likely to use alcohol, less likely to start using alcohol at an early age, and less likely to develop alcohol abuse and alcohol dependence. Several studies have provided strong evidence that effective parental monitoring of pre-teens can delay initiation into alcohol use.²⁶

Good parent-child communication is also important in controlling adolescent drinking. A number of studies have identified that parents typically have little awareness of the amount their offspring consume, however, their awareness increases with increased communication.²⁷

In contrast, numerous international studies link lack of parental support and poor parental

monitoring of their children's activities with early debut into drinking and adolescent alcohol and other substance abuse.²⁸ There is evidence that both excessively authoritarian and permissive parenting styles are associated with substance misuse.²⁹

Family conflict

Stressful and high conflict family environments have been shown to be associated with adolescent misuse of alcohol.³⁰ Longitudinal studies have found that high levels of parent-child conflict and low levels of parental monitoring are associated with a greater likelihood of adolescent substance abuse, including multiple substance abuse.³¹

In contrast, quality relationships between parents and their teenagers have been found to be associated with less drinking among teens.³² Having a secure, caring relationship and good communication with parents are protective factors against risky drinking.³³ Higher levels of attachment between parents and children have also been found to buffer the child from the effects of negative drinking behaviours of adolescent peers.³⁴

Parents' drinking behaviour

Children learn their drinking behaviour and attitudes from parents, who are significant early role models. Several studies show that children whose parents drink and hold favourable views about drinking are more likely to drink. In part, this is due to the availability of alcohol in the home, which provides opportunities for children to try alcohol. Some studies have shown that heavier drinking

parents are more likely than other parents to have teens that are heavy drinkers.³⁵ Other studies have identified that where parents are permissive about alcohol use, adolescents are more likely to binge drink.³⁶

Research has also found that children with parents who are alcohol dependent are more likely to start drinking early (by age 14), to experience drunkenness by age 17 and to develop alcohol problems themselves. However, the association of drinking problems with early age of starting to drink also exists for people without a family history of alcohol dependence.³⁷

Parental supply of alcohol

One of the factors influencing young people's drinking behaviours is whether their parents supply them with alcohol. Often, parents supply their adolescents with alcohol in the home, or allow them to take it to social events as a means of supervising and controlling the amount consumed and to encourage responsible use by young people.³⁸

Research findings into the influence of parental supply of alcohol are somewhat mixed, showing both positive and negative outcomes. Some research in Australia and the United Kingdom has indicated that young people are less likely to drink large amounts of alcohol if they get alcohol from their parents, and that young people are likely to drink less at home than at a friend's house.³⁹ However, in other research, parental supply of alcohol has been linked to teenagers' risky drinking behaviour. For example, one longitudinal study of parents'

supply of alcohol to minors in the United States indicated that early teens with parents who supplied them with alcohol were more likely to increase their alcohol use.⁴⁰

Under the current law in New Zealand, a parent or guardian is allowed to supply liquor to their child who is under 18 or to another minor if it is at a private social gathering.⁴¹ One New Zealand study of the attitudes of parents of 13–17 year olds about the supply of alcohol to minors found that parents generally opposed supply to minors, or they favoured responsible conditions of supply, such as only supplying small quantities of alcohol, with food and at home. Most did not approve of giving teenagers drinks to take to an unsupervised party. Those who had supplied alcohol to a minor said they would only do so if there was suitable adult supervision where the alcohol was used.⁴²

Even though many New Zealand parents may express cautious attitudes about supplying alcohol to minors, nevertheless, parents are important alcohol suppliers for all youth, except Pacific youth. The Youth 2000 research found that about 60 percent of students have easy access to alcohol at home. More than half of those who drink (54 percent) get alcohol from parents.⁴³ Similarly, in the Youth '07 survey, 54 percent reported that they got alcohol from parents.⁴⁴

Influence of siblings

Research has also shown that drinking by siblings, especially older siblings, is important in influencing alcohol use of teens and young

adults. The drinking behaviour and attitudes of older siblings towards alcohol act as a role model for younger family members. Some research has found that teens who start drinking when they are younger than 14 are more likely to have older siblings.⁴⁵

3.3 PEER GROUP INFLUENCES

For all age groups, friends and social networks are significant influences on drinking attitudes and behaviours. Drinking with friends, with workmates and in social situations is part of how New Zealanders relax, feel at ease with others and express a sense of belonging. In a national survey of individuals aged 12 years and over almost one half of current drinkers agreed that 'alcohol helps me wind down and relax'. One-fifth of current drinkers agreed that 'having a drink with friends and family gives me a sense of belonging'.⁴⁶

Adolescent peer group

Although parents are a very important influence on their offspring's drinking behaviours, as young people grow up they spend less time with their families, and much more time with their peers. In our society and similar societies such as Australia, drinking has been historically associated with the transition from being an adolescent to adult status and acceptance into adult society. Now, drinking still remains central to youth forging an adult identity through rites of passage such as night clubbing, drinking games and experimental use of alcohol.⁴⁷ Drinking enhances social experience and is a way of being part of and accepted into a social group.⁴⁸

A major reason why young people use alcohol is because their peers use it, and in some instances that peer influence becomes peer pressure to consume alcohol. The drinking attitudes and behaviours of friends is one of the strongest predictors of young people's alcohol use, particularly their initiation into drinking, frequency of drinking and amount consumed.⁴⁹ It appears that young people's drinking behaviours can be driven by their perceptions of what is normal drinking behaviour among their peers.⁵⁰ Having friends who drink not only simplifies the access to alcohol but also provides an environment where drinking is normal and expected behaviour. In contrast, adolescents in peer groups that have negative attitudes towards alcohol report lower alcohol use and fewer alcohol problems.⁵¹

Australian research shows that young people are most commonly supplied their first drink by a friend or acquaintance (43 percent), followed by their parents (35 percent).⁵² Similarly, New Zealand research shows that along with parents, friends are an important source of alcohol. School peers play a large part in introducing adolescents to alcohol use. Some young people's drinking patterns are well established by the time they leave school.⁵³ Among the secondary school students who took part in the Youth '07 survey, 53.3 percent obtained alcohol from friends, about the same proportion who got alcohol from parents (54 percent).⁵⁴ Friends were the most common source of alcohol for secondary school students in 2000, with 62 percent getting

their alcohol from friends.⁵⁵ Another New Zealand survey of 1,179 young drinkers aged 12–17 identified friends as the most common source of alcohol for that age group.⁵⁶ Some of those friends will be 18 and thus legally able to purchase alcohol. Others will be under 18, but nevertheless purchasing alcohol for themselves (see the discussion in Section 3.5 concerning underage purchase of alcohol in New Zealand).

Sports

For many New Zealanders, participation in sport and watching sport are important settings for recreation, socialising and friendship. There is New Zealand and overseas evidence that sport can affect alcohol use, both positively and negatively. However, the influence of sport on drinking behaviour appears to vary depending on the type of sport, the level of competition, and the cultural drinking practices of the country concerned. This section reviews some of that research.

Internationally, involvement in sports has been shown to have considerable health and wellbeing benefits. With regard to drinking behaviours, one study in Norway found that participation in sport delayed teens starting to drink, and attributed this to the strict rules for use of alcohol in most Norwegian sports clubs.⁵⁷ But other research has indicated that hazardous drinking is associated with sport. French and Swiss research has reported some evidence for lower alcohol use among elite sportspeople, but found alcohol use and risky drinking is related to the kind of sport played.

Risky drinking appears to be more prevalent in team sports.⁵⁸ Other research in the United States and Europe has shown that excessive alcohol consumption is common for both sportspeople and their fans.⁵⁹

In New Zealand⁶⁰ and Australia,⁶¹ sports players and sports clubs have a long history of association with drinking, including risky drinking behaviours. Generally, sports environments can influence drinking behaviours including underage alcohol consumption, levels of consumption and drink driving. The ways that sports clubs provide and manage alcohol, and alcohol sponsoring of sports events and teams constitute an environment where many young people are exposed to alcohol. Also, since elite sportspeople are important role models for young people, media reports of their drinking behaviours may influence young people's drinking behaviours and attitudes.

Consistent with overseas studies of drinking and sportspeople that show risky drinking behaviours, one New Zealand study that surveyed 1,214 sportspeople found high levels of alcohol consumption. This research also showed that sportspeople's hazardous drinking is associated with driving while intoxicated and antisocial behaviour. Overall, the study found that 68 percent of elite-provincial sportspeople, 53 percent of club/social sportspeople and 50 percent of international level sportspeople could be classified as hazardous drinkers. These rates of hazardous drinking are considerably higher

than for the population as a whole (17 percent) and even for the 15–24 age group, which tend to be high alcohol consumers (33 percent)⁶² These rates appear to be considerably higher than more recent measures of high alcohol use. For example, 25 percent of New Zealanders 18 years and over can be described as binge drinkers (consuming seven or more drinks on one occasion).⁶³

A more useful comparison may be with younger age groups that are closer to the ages of most elite sports people. Studies show heavy alcohol consumption is more usual in younger age groups. Binge drinkers are more likely to be in the 18–39 year age group,⁶⁴ and particularly in the 18–24 age group,⁶⁵ the peak age of heavy alcohol consumption where the Ministry of Health reports that eight in ten drunk heavily on at least one occasion in the last year. For the 18–24 age group, the Ministry of Health also reports that one in three men and one in five women consumed a large amount of alcohol at least weekly in the last year.⁶⁶

Work

The workplace is also an important site where social attitudes, expectations and behaviours around drinking can influence individuals. Australian research has found that exposure to a heavy drinking work culture can increase the likelihood of individuals developing risky drinking behaviour. Women employees seem to be particularly vulnerable to workplace influences. This study found that the largest percentages of workers who frequently drank

at high risk levels were in the hospitality industry. Those in the mining industry were most likely to be involved in infrequent short-term risky drinking.⁶⁷

3.4 MARKET FACTORS

A range of market factors have been found to influence drinking behaviours. Key factors are:

- price
- advertising
- new products

Price

Alcohol in New Zealand has become more affordable over the past 20 years. Price has been particularly affected by the widespread availability of discount drinks and specials.⁶⁸

An extensive body of research across many countries and using many different methods shows that price does influence alcohol consumption.⁶⁹ A meta-analysis of 112 studies of alcohol tax or price effects on alcohol consumption concluded that there is “statistically overwhelming” evidence that there is an inverse relationship between price and drinking; i.e. a higher price reduces consumption.⁷⁰ Price has been found to be one of the top three reasons, along with strength and taste, for the purchasing of a particular brand of alcohol.⁷¹ A rise in price has also been found to result in some consumers shifting to cheaper alcoholic beverages.⁷² This may be to retain their consumption level.

As well as leading to overall reductions in

the frequency and quantity of drinking, price reductions have also been found to reduce vehicle crash fatalities, adverse health effects, child abuse and other violence.⁷³

Research on price includes analysis of the effects of changes in alcohol excise taxes on consumption. Reductions in alcohol taxes and prices have been found to increase sales and consumption rates in Finland, Norway and Switzerland. Increases in alcohol taxes were followed by reductions in consumption in Australia’s Northern Territory, Malaysia and Philippines.⁷⁴ Several countries, including Australia, Germany, Switzerland, the United Kingdom and Ireland, have introduced a tax on RTDs and have reported a subsequent decrease in consumption of RTDs. Some of those countries have also reported a substitution effect, with consumers switching to cheaper alcoholic beverages.⁷⁵ Minimum alcohol pricing is soon to be recommended in the United Kingdom to address the health impacts of alcohol misuse.⁷⁶

Some studies have looked at varying effects of price across population groups and for different beverages. One meta-analysis of 112 studies concluded that price affects consumption of all types of alcoholic beverages, and across the whole population of drinkers, from light drinkers to heavy drinkers.⁷⁷ Other studies have shown that price can affect drinking to intoxication.⁷⁸ But another meta-analysis of 132 studies of alcohol demand across 24 countries found differences in price elasticities across types of alcoholic beverages, across different age

groups and between women and men. Demand for beer was found to be less responsive to price changes than demand for wine and spirits. Women tended to be more price sensitive than men.⁷⁹

Because alcohol has addictive qualities, some price inelasticity is expected. One study found that the only group that price does not appear to have an impact on is the top 5 percent of drinkers.⁸⁰ Higher prices have been found to influence the amounts consumed by frequent and heavy drinkers.⁸¹ Some studies even show that price increases have a greater effect on the behaviour of frequent and heavy drinkers, than on those who drink moderately.⁸²

Most studies have shown that price has a major impact on young people's alcohol consumption, with it dropping significantly in response to a rise in the price of alcohol.⁸³ Research has shown a reduction in the frequency of young people's drinking, heavy drinking, binge drinking and underage drinking. Higher prices also appear to delay the age at which young people start to drink.⁸⁴ Some studies show that cheap drinks promotions, give-aways associated with alcohol and price specials appear to be associated with young peoples' increased alcohol consumption, binge drinking and drinking and driving.⁸⁵

Despite the weight of findings indicating young people's sensitivity to the price of alcohol, there have been a few studies that show only statistically insignificant effects of price rises

on teens' drinking.⁸⁶ One meta-analysis of 132 studies of alcohol demand found that under 18 year olds were least responsive to price. The author noted that this finding was "counter-intuitive" and suggested that it may relate to over 18s consuming a greater share of wine and spirits, which are more price-sensitive beverages than beer.⁸⁷ Another study using regression modelling found that beer taxes do not reduce young people's prevalence of drinking or binge drinking and suggested that this may relate to the price level, rather than to the price rise itself.⁸⁸

Advertising

In New Zealand, advertising of alcohol is self-regulated through the Code for Advertising Liquor that requires advertising to adhere to certain principles. Those principles include responsibility and moderation in consumption, a high standard of social responsibility, and hours in which alcohol advertising cannot be shown on television. The Code also states that advertising should not be directed to minors or have strong appeal to minors.⁸⁹

Evidence about the link between exposure to alcohol advertising and alcohol consumption is mixed, although on balance there is growing evidence that alcohol advertising does influence drinking behaviour. A large body of research suggests that alcohol advertising that portrays drinking in its cultural context, as an integrated part of a lifestyle, is particularly influential because it resonates with widespread beliefs and social norms.⁹⁰

Many studies clearly show a positive link between exposure to alcohol advertising and increased consumption. One study of alcohol control policies and adolescent alcohol use in 26 countries concluded that policies controlling the marketing of alcohol are associated with lower prevalence and frequency of adolescent drinking, and a higher age of first alcohol use.⁹¹ Some cross-national research showed that countries with partial restrictions on alcohol advertising had 16 percent lower alcohol consumption rates and 10 percent lower vehicle fatality rates compared to countries with no restrictions. Countries with complete bans on alcohol advertising had even greater reductions, with 11 percent lower alcohol consumption rates and 23 percent lower vehicle fatality rates compared to countries with partial restrictions on alcohol advertising.⁹²

However, other studies have shown more limited impacts of alcohol advertising; for example, that advertising affects brand choice but not consumption.⁹³ One study found that the demand for spirits is more responsive to advertising than the demand for beer.⁹⁴

The impact of advertising on children and young people's drinking expectations and behaviours is of particular interest in the literature. Many studies argue that because of the presence of alcohol advertising everywhere, including in promotions and product placement, this does influence children and youth, even though alcohol advertising may not deliberately set out to

target minors. There is also evidence of some deliberate targeting of 'entry level drinkers', such as in United States research, which shows that alcohol companies have placed their advertising, particularly for beer and spirits, where youth are more likely to be exposed to it than adults.⁹⁵

Several studies have concluded that alcohol advertising contributes to young people's positive attitudes and expectations about alcohol use, as well as their decisions and intentions to drink.⁹⁶ Some research suggests that alcohol advertising that portrays youth lifestyles and identities contributes to increasing youth alcohol consumption.⁹⁷ Youth-oriented social networking internet sites, viral marketing and mobile phone technology have all extended the reach of alcohol marketing into youth lifestyles, and expanded the environmental influence of advertising.⁹⁸

There is evidence that exposure to various types of alcohol marketing increases the likelihood of underage drinking.⁹⁹ Research in the United States has documented the large amounts of youth exposure to alcohol advertising through television, radio, magazines and the internet.¹⁰⁰ One study that notes the growing body of evidence for a positive association between alcohol advertising and alcohol consumption among young people looked at alcohol advertising on television. It found that certain elements in alcohol advertising such as animals, humour, music and celebrities appeal to children and

adolescents. The study found that young people who drank alcohol more frequently rated alcohol advertisements as more likeable and influential than those who drank alcohol less often or did not drink. However, the authors cautioned that young people who are predisposed to drinking may have more favourable attitudes towards alcohol advertising.¹⁰¹ Other research in the United States has shown that sixth graders' (aged 11–12 years) exposure to beer advertisements on television, radio, magazines, in-store displays and promotional items is strongly predictive of grade seven (aged 12–13 years) intentions to drink as well as drinking behaviour.¹⁰² A similar study showed a link between exposure of seventh graders to several forms of beer advertising and alcohol use at grade nine (aged 14–15 years).¹⁰³

The strongest evidence for the influence of alcohol advertising on consumption has come from several longitudinal studies that look at exposure to alcohol marketing in the traditional media, as well as promotion in films and branded merchandise. Those studies have found that advertising has small but significant effects on whether young people drink and whether they drink heavily. There is also evidence to suggest that exposure to alcohol advertising has more impact on drinking behaviours when it is cumulative.¹⁰⁴ New Zealand longitudinal research has also shown that young people's recall and positive responses to beer advertising predicts later heavier drinking.¹⁰⁵

New products

Since the early 1990s, an increasing range of alcohol products that “blur the distinctions between traditional alcohol beverage categories” have emerged on the market. This proliferation of new style alcohol products has contributed to a change in the profile of the alcohol consumer, away from the traditionally male, to much more diversified drinking segments based on age, gender and drinking styles (such as the weekend drinker).¹⁰⁶ A significant new product is the ready-to-drink beverage (RTD), a mix of alcohol (spirits or wine) and non-alcoholic beverage (such as soft drink or fruit juice).

New alcohol products tend to be the drinks of choice of young people.¹⁰⁷ The popularity of RTDs among youth is well established in several countries, including the United States, Australia and Scotland. A key concern expressed by health professionals has been whether RTDs act as a bridge to stronger alcohol products and lower the age at which young people start to drink alcohol.¹⁰⁸

A growing body of research argues that RTDs are specifically marketed to appeal to young people's tastes and especially “to embed alcohol products and consumption into the lifestyles of young people.”¹⁰⁹ Alcohol has an acquired taste that is usually unpalatable to the young and deters them from drinking. However, RTDs are distinguished by a sweet taste that appeals to the young palate and masks the alcohol.¹¹⁰ A range of research argues that RTD marketing has been a major

contributor to youth initiation into drinking, increases in amount and frequency of youth drinking, youth binge drinking and higher levels of youth intoxication.¹¹¹

One Californian study found that underage drinkers consumed 47 percent of alcopops in 2007.¹¹² In Australia, where the popularity of RTDs steadily declines after age 18, research has been conducted on the palatability (taste preference) of a range of alcoholic and non-alcoholic beverages with 350 12–30 year olds. This study found that a large proportion of young teens in the study (12–15 year olds) believed that RTDs are packaged to directly appeal to them. Among the youngest age groups, RTDs was commonly the first alcohol used, and the most preferred. This research also found that the palatability of the alcohol taste in the pre-mixed drinks increased with age—the 12–17 year olds preferred RTDs that tasted of soft drinks.¹¹³

This overseas research is supported by several New Zealand studies. The Youth '07 study (Years 9–13 students) found that the most common type of alcohol consumed by school students is beer (consumed by 35.2 percent of those current alcohol drinkers), closely followed by ready-made alcoholic drink (34 percent). RTDs were by far the favoured drink of girls in the study (47.5 percent of current alcohol drinkers) compared to boys (22.3 percent of current alcohol drinkers). Similar proportions were found in the ALAC 2007–08 Alcohol Monitor, which reported that RTDs were the second most consumed alcohol

by young drinkers aged 12–17 years, at 35 percent.¹¹⁴ The New Zealand Alcohol and Drug Use Survey found that RTDs were the most popular drink among 16–17 year olds.¹¹⁵

3.5 LEGISLATIVE AND REGULATORY FACTORS

The legislative and regulatory environment controls people's access to alcohol and how they use it. There is evidence from several countries and different jurisdictions that population-based measures that affect the supply and demand of alcohol do affect consumption. These controls, which reflect societal norms and values around drinking, also influence people's attitudes to alcohol. For example, the legal purchase age establishes social expectations about the age at which drinking is regarded as acceptable, and can deter some minors from drinking.¹¹⁶ The hours of opening and management of licensed premises set the conditions to shape drinking behaviours such as excessive consumption and tolerance of intoxication.¹¹⁷ Success or failure to enforce regulations send messages about the acceptability of underage drinking, intoxication and drink driving.¹¹⁸

This section discusses three important areas of the legislative and regulatory environment that influence drinking behaviours:

- controls on the availability of alcohol
- the legal purchase age
- enforcement

Availability

Availability relates to the policies and regulations that determine and control the physical presence of alcohol, such as where it is able to be purchased and at what times. Two aspects of availability are considered for their influences on drinking behaviours in the following discussion: density of outlets; and hours and days of sale.

Density of outlets

Changes in the law have increased the number of places where alcohol can be sold in New Zealand, and increased the density of outlets where people can purchase and consume alcohol. Especially significant in New Zealand has been the expansion of alcohol into a wider range of retail outlets, particularly supermarkets and neighbourhood liquor stores. One illustration of the proliferation in outlets is that in 1989 New Zealand had 6,000 liquor outlets, while after law changes, there were 14,800 liquor outlets in 2004. In comparison, Australia, with five times New Zealand's population had fewer liquor outlets, at 12,000.¹¹⁹

A clear New Zealand pattern is that the highest densities of off-license alcohol outlets are located in the poorest urban areas. Consequently, those most exposed to alcohol are low-income families, Maori and Pacific peoples.¹²⁰

Internationally, the density of licensed premises has been found to be a critical factor influencing the frequency of drinking and

quantity of drinking. Simply, consumption increases when the number of outlets increases. Overseas studies argue that a proliferation of outlets increases public perception of alcohol as an ordinary, everyday commodity with no particular risks attached to it. On the other hand, restrictions in availability of alcohol raise the transaction costs associated with acquiring alcohol, such as the costs of travel, time and inconvenience. These transaction costs may reduce demand for alcohol.¹²¹

It seems that there is a particular relationship between high outlet density and underage drinking.¹²² Where there is a proliferation of alcohol outlets, children and young people have high levels of exposure to alcohol as an easily accessible product.¹²³

A New Zealand study of the influence of outlet density in Auckland on 1,179 young drinkers aged 12–17 years showed not only that almost one fifth of underage drinkers were purchasing alcohol, but also that those in higher density outlet areas were consuming larger quantities of alcohol.¹²⁴ This study also emphasised the importance of enforcement of the minimum purchase age for controlling alcohol-related harm among young people.

Studies in the United States, Australia and Europe have found that a higher density of licensed premises is not only associated with greater levels of alcohol consumption, but also with alcohol-related harm such as increased rates of homicides and assault, greater prevalence of drinking and driving, alcohol

related hospital admissions, child abuse and neglect, pedestrian injuries and property damage.¹²⁵ These effects are particularly noticeable when there has been a major shift in availability from tight restrictions to widespread availability, rather than when there are minor changes in an environment where there is already considerable availability of alcohol.¹²⁶

There is evidence that limiting the density of liquor outlets is effective in reducing drinking and alcohol-related problems.¹²⁷ However, one United States study of three different age groups based on the National Survey on Drug Use and Health found different effects for different age groups. For young adults (18–25 years) and adults (26 years and older) lower alcohol outlet densities reduce the prevalence of drinking. But for those aged 12–17, outlet density did not appear to affect prevalence of drinking or binge drinking. The author suggested that for the youngest age group, non-commercial sources of alcohol are more important than liquor outlets.¹²⁸

Trading hours

Over time, there has been a gradual lifting of restrictions in trading hours in New Zealand; now liquor can be sold at any time. Internationally, long trading hours have been linked to higher levels of drinking and intoxication and resulting problems with public disorder.¹²⁹

A systematic review of 49 studies covering Australia, the United Kingdom, Canada and the United States found that where trading

hours have increased, they are associated with increased consumption, as well as alcohol-related harm such as violent assaults and increased traffic casualties.¹³⁰

Another systematic review involving 15 studies from the United States, Canada, Australia, United Kingdom, Sweden and Brazil on hours and days of sale found that these had impacts on consumption, drinking patterns and damage from alcohol. This review found that the impacts on consumption included higher volumes of high alcohol content beer, wine and spirits purchased in licensed hotels during late trading hours. Younger people frequented premises with extended opening hours. Impacts of longer trading days and hours on alcohol-related harm included higher rates of alcohol-related vehicle injuries, assaults, homicides and alcohol-related hospital admissions.¹³¹

These studies also provide evidence that restricting trading hours is effective in reducing drinking and alcohol related problems.¹³² For example, one United States study of three different age groups based on the National Survey on Drug Use and Health found that a ban on Sunday off-premises sales reduced drinking prevalence and binge drinking among those over the purchase age and also among minors.¹³³

Purchase age

In 1999, New Zealand reduced the age at which people can legally purchase alcohol from 20 to 18 years.

The 'moral force' of the legal purchase age clearly affects the decisions of some young New Zealanders to drink. For example, the Youth 2000 survey of secondary students found that 41 percent of non-drinkers did not drink alcohol because "it's illegal".¹³⁴ However, the reality is that in New Zealand minors can readily buy alcohol.¹³⁵ In the Youth '07 survey, 13.6 percent of the secondary students reported that they bought alcohol. Of those aged 17, one-fifth reported buying alcohol. Over two-thirds of students who bought alcohol bought it at a bottle store.¹³⁶

A wide range of studies conclude that the purchase age does influence young people's drinking patterns. In particular, there is a 'trickle down' effect with those close to the legal purchase age also gaining access to alcohol, either through buying it themselves or getting it from friends and siblings. Effects of the purchase age on alcohol consumption levels and heavy drinking among young people has been found in several studies.¹³⁷ For example, a reduction in the purchase age in the United States was found to be linked with increased alcohol consumption among young people.¹³⁸

Other research has shown a reduction in alcohol consumption and alcohol-related harm among underage drinkers with the raising of the purchase age. Primarily conducted in the United States and Canada, these studies suggest that increasing the legal purchase age from 18 or 19 to 21 reduces youth access to alcohol and alcohol-related harm experienced by them.¹³⁹

The impacts of lowering the legal purchase age on alcohol-related harm among young people has been found to include increases in traffic crashes, non-injury hospitalisations, suicide, vandalism and juvenile crime.¹⁴⁰

A large number of studies on the impacts of lowering the purchase age on traffic crashes, including meta analyses, have been conducted in the United States, Canada, Australia and New Zealand.¹⁴¹ From these studies, it is now widely recognised that the purchase age does have a significant impact on traffic crash injuries and fatalities. In particular, those young people bordering the legal purchase age (e.g 15–17 year olds) are affected. Studies across several jurisdictions show that a reduction in the purchase age results in increased alcohol consumption and increased alcohol related harm to young people. Studies also show that when the legal purchase age is raised, there are reductions in the involvement of those under the purchase age in traffic crashes and reduced heavy drinking among youth.

One New Zealand study on traffic crashes among 15–19 year olds between 1995 and 2003 concluded that significantly more alcohol-involved crashes occurred among 15–19 year olds than would have occurred if the purchase age had not been reduced to 18 years. The results of this study confirmed the findings of other New Zealand research.¹⁴²

Another New Zealand study that assessed alcohol-related harms and offences from 1990–2003, which encompassed a period

of increasing alcohol policy liberalisation, found both changes in drinking behaviour and increases in several areas of alcohol-related harm.¹⁴³ The 14–15 year age group showed a significant increase in disorder offences, which the study attributed to an increase in access to alcohol. Changes in drinking behaviours included an increase in 14–15 year old males drinking in some licensed premises, including sports clubs; and an increase in the amount consumed on a typical drinking occasion for 14–15 year old males. Increases in excess alcohol consumption were also observed, with particularly marked increases among 16–17 year olds in prosecutions for driving with excess alcohol. Increases were also found in prosecutions for driving with excess alcohol among 18–19 year olds and 20–24 year olds after 1999 (the year the purchase age was lowered to 18 years). Increases in alcohol-related harm included increases in the rates of prosecutions for disorder across all age groups. Up to 1999, the largest increases were among 18–19 year olds, followed by 16–17 year olds. All age groups had an increase in rates of alcohol-related vehicle crashes after 1999, with the largest increase in the 18–19 age group, followed by 20–24 year olds. This study concluded that alcohol policy liberalisation in New Zealand appears to have had a greater influence on the drinking behaviour of younger age groups, and their exposure to alcohol-related harm.

Enforcement

Enforcement of liquor laws can influence drinking behaviours in various ways. Inadequate enforcement can undermine the effectiveness of laws and policies. Failure to enforce can contribute to increased consumption and intoxication, as well as underage drinking, tolerance of drink driving and alcohol-related violence.

Effective enforcement is an important means of influencing perceptions that violations will be punished.¹⁴⁴ Enforcement can also shape attitudes towards drinking and standards of drinking behaviour, control excessive consumption and contribute to reducing alcohol-related harm.¹⁴⁵

Studies in the United States, United Kingdom, Europe and Australia have shown that inadequate enforcement of purchase age laws can contribute to early exposure of minors to alcohol and underage drinking, as well as increases in intoxicated drinkers.¹⁴⁶ There is also evidence that laws prohibiting sales to intoxicated customers have little deterrent effect without appropriate enforcement.¹⁴⁷

Other studies have found that proper enforcement does influence drinking behaviours. Compliance checks of licensed premises have reduced sales to minors.¹⁴⁸

It has also been demonstrated that more effective enforcement reduces risky drinking behaviours and alcohol-related harm. For example, one study in Stockholm found that the introduction of measures including

stricter enforcement contributed to savings due to fewer incidents of assaults and violence.¹⁴⁹ Other research shows that vigorous enforcement of drink driving laws reduces alcohol-related crashes.¹⁵⁰ This includes evaluations of enforcement of drink driving laws in Victoria, Australia, which show that community education campaigns and law enforcement substantially reduced drink driving deaths, although there was a subsequent reversal of the decline.¹⁵¹ There appears to be a large number of reasons for mixed success of those measures, such as the complexity of the laws pertaining to drink driving, shortcomings in drink driving education programmes, and specific challenges related to enforcement in rural and remote areas.¹⁵²

It has also been shown that effective enforcement of liquor laws not only affects drinking behaviours on its own, but is important in making other interventions effective. For example, in the United States, evaluation of responsible alcohol service training programmes in bars and liquor stores showed that the programmes had to be combined with the enforcement of liquor laws, as the training programmes alone had little impact on limiting intoxication, purchase of alcohol by minors and preventing drink driving. Enhanced policing of liquor laws in Torquay (England) and partnerships between police, licensees and community groups in Surfers Paradise and Freemantle (Australia) also showed reductions in alcohol-related violence and public disorder.¹⁵³

One New Zealand study of an Auckland regional intervention showed the key role of enforcement in community interventions. This intervention involved police, local council licensing inspectors and health promotion workers and focused on monitoring alcohol sales made without age identification, media advocacy, direct contact with alcohol retailers, and enforcement strategies to control access by minors to off-license premises. As a result of the intervention sales without age identification reduced from 60 percent of sales to 46 percent. This study suggested that improved enforcement can help reduce underage drinking and noted “the importance of the roles of local police and licensing staff in monitoring and enforcement”.¹⁵⁴



4. INFLUENCES AND TRIGGERS—FOCUS GROUPS



FOCUS GROUP F

There's a million reasons to want to drink.

FOCUS GROUP L

It was the done thing to do.



This section discusses the influences and triggers that focus group participants said affect drinking behaviours, both their own and others'.

While influences and triggers are closely connected (and terms often used interchangeably in research on drinking behaviours) they refer to different aspects of the way people relate to their surroundings. Influences are the broad environmental conditions and situations that determine whether people are able to access alcohol, when they can drink and how much they drink. Triggers are more personalised, individual cues or stimuli that induce people to drink in a particular environment. While two people may experience the same environmental factors, such as places, people, events or statutory controls, the immediate and specific cues that trigger drinking may be different for different individuals. For example, environments provide external triggers, such as the sight or smell of alcohol, others drinking, or alcohol advertisements that generate a desire to drink.¹⁵⁵ There are also internal triggers, such as feelings and emotions that generate an urge to drink. Even though triggers are personal in

their effects, they have been found to affect the range of drinkers—heavy drinkers, those who are alcohol dependent, and also social drinkers.¹⁵⁶

The focus groups broadly agreed that New Zealand culture is a drinking culture; alcohol is embedded in the New Zealand way of life. Alcohol consumption is widely accepted as part of social gatherings, celebrations, recreation, relaxation and reward. They noted that historically, alcohol has been seen as very much part of male culture, associated with mateship and boys coming of age. However, they considered that now for both genders, drinking is an accepted rite of passage to adulthood. Binge drinking and heavy drinking are widely regarded as acceptable, at least in some sectors of our society. Many of the focus group participants said that for them, the purpose of their drinking had been to get drunk and this was the accepted norm in their peer group.

Focus group participants identified many influences and triggers on their drinking. Some felt that anything and everything can be a trigger to drink. Three people said that talking about alcohol (including in a counselling situation) triggered the desire to drink. One man said that there have been different triggers at different times. Socialising was an important influence, with specific triggers such as being with friends, or at a barbeque. When he became alcohol dependent he did not need a trigger, he would drink at any time. Participants also made the point that a lot of

people who are alcohol dependent drink on their own, so the triggers are often about their state of mind, rather than being with others.

Within a culture that accepts and expects people to drink on a wide range of occasions, and has normalised the consumption of liquor, there are some strong influences and triggers that lead people to drink. Often those influences and triggers are intertwined, or are different facets of a person's experience. Consequently, the following discussion uses the terms together. The focus groups identified those major influences and triggers as:

- family environment
- social and peer group
- availability of alcohol
- alcohol advertising and packaging
- the association of sports with alcohol
- the price of alcohol
- emotional issues and personal state of mind

Across all the focus groups, by far the most important influences and triggers were identified as:

- Personal issues and problems. Often these are related to family issues, relationships, money problems or work. They can be both environmental influences, and more immediate triggers that prompt a person to drink.
- Social and peer group influences, particularly the environments in which

individuals socialise and who they spend time with.

- The widespread availability of alcohol in many types of outlets and long opening hours.

Of lesser importance, but still identified as relevant influences, were the price of alcohol, family upbringing and alcohol advertising.

The wide range of drinking influences and triggers are discussed below.

4.1 FAMILY ENVIRONMENT

Generally, the focus groups thought that the family environment was one of the strongest influences on drinking as children emulated adults. Sixty-four percent of those focus group participants who also responded to the survey identified their family as having at least some influence on their decision to start drinking. For over one fifth (22 percent), their family was "the most influence", while for 42 percent their family had "some influence". Family influences appeared to be more important for women than for men. A higher proportion of women than men reported their family having at least some influence on their decision to start drinking (72 percent compared to 60 percent). Women were also more likely to drink at home with family members than men (39 percent compared to 17 percent). A higher proportion of men than women reported that their family had "very little" or "no" influence on their decision to start drinking (34 percent compared to 25 percent).

Focus group participants considered that picking up drinking behaviours from parents was common. Families were also important in the way that they valued alcohol. In most of the families, drinking alcohol was acceptable, and in some it was desirable; it was part of the family's identity and way of life. Most participants said that in their families there was no talk about alcohol-related harm or understanding of alcoholism.



FOCUS GROUP J

Growing up, I learned to drink off my father.

To be in with your family, you've got to drink.

FOCUS GROUP G

I aspired to [drink] because grown ups were doing it.

FOCUS GROUP E

It's the way we've been brought up to drink. Brought up to drink to get drunk.



Participants' families demonstrated a range of drinking behaviours, from those with no use of alcohol (a minority), to those in which adults were moderate drinkers, through to those where family members drank heavily. Most participants were from families where adults drank at least occasionally.

Parents' drinking can either encourage or discourage use of alcohol. Many of the men

said they followed the influential role of their fathers as a drinking role model. But a few said that the alcohol-fuelled violence in their families made them not want to drink. One had turned to other drug use because of an abhorrence of alcohol. However, others said that seeing parents using alcohol legitimised it in their eyes. For many, family drinking was associated with role models of usual and unremarkable behaviour.

For many participants, drinking with family was associated with being part of and being accepted by the family. Alcohol was often an important part of family occasions such as weddings and funerals. Some were exposed to alcohol early in the family environment, and were encouraged to drink a little, or it was regarded as fun to allow children to "be barman" and pour drinks at parties. Several said they were drinking regularly at ages 12-14, often because of alcohol being acceptable and available in their family.

A few talked about the positive experiences with alcohol in their families. They said that having a few drinks with family while they were growing up was an important means of communicating with their parents. They did not recall abuse of alcohol, but rather it being part of good times with family. But for others, an abusive or dysfunctional family environment was influential in their turning to alcohol to cope with problems.

In summary, focus group participants considered that acceptance of alcohol in the family environment and the drinking

practices of older relatives were significant influences on drinking. Specific family situations that triggered drinking included family celebrations. For a few, an abusive or dysfunctional family environment triggered drinking as a way of coping.

4.2 SOCIAL AND PEER GROUP

For both men and women in the focus groups, alcohol has been associated with being with friends and having a good time. Most associated drinking with events and celebrations. Social occasions generally involved drinking. This is similar to the experiences of many in our society.

For many, alcohol became part of their image and style. As adults, it was a way of showing that they had made it in their social circle.

As a young person, drinking was a way of showing they were no longer a child. Many of the focus group participants started drinking as teenagers with their friends, who were a major influence on their drinking. To drink was to be cool, to be part of the crowd. One person said, “It started because I wanted to become a man.”

Often, part of acceptance into the group is to drink. For some, alcohol helped them to cope with shyness or awkwardness in social situations. Having a drink made them feel more comfortable. One person said: “I felt out of place not drinking,” and another commented, “I used to have a glass in my hand to communicate.”



FOCUS GROUP B

I’ve never been to a barbeque where there hasn’t been alcohol available.

There’s lots of events where alcohol is the main feature.

Spending all day at the cricket drinking in the sun.

FOCUS GROUP J

Christmas, getting together with friends and family, all happy.

Reunions, people back from overseas.

FOCUS GROUP N

You’re revered for how much you can drink, get kudos for it, rather than being ostracised.



The survey results showed the strong influence that friends have on a person’s decision to start drinking. Over 80 percent of those who completed the survey questionnaire reported that friends had at least some influence on their decision to start drinking. Friends had more influence than family on their decision to start drinking, with 41 percent indicating friends had “the most influence” (compared to 22 who indicated that family had “the most influence”). The strong influence of friends on the decision to drink was very similar for both women and men; 83 percent of men and 81 percent of women reported friends had at least some influence on their decision to start drinking. In the survey, the men indicated that drinking outside the home, or at home with friends was more common for them than for

the women. Men were most likely to drink in a bar or pub (28 percent), followed by drinking at home with friends (22 percent). Women were most likely to drink at home with family, rather than out at a bar or pub or at home with friends. Now that almost all those surveyed were not drinking, the influence of friends was much less; however, more men than women reported still being influenced by their friends (44 percent compared to 30 percent).

Drinking is not only associated with recreation and socialising. It can also be associated with work. Some of the focus group participants got into heavy drinking through drinking with workmates. The end of a working week means having a drink as a reward for working hard. A few became heavy drinkers through socialising with clients as an expected part of work. Others commented that drinking in work hours went on unchecked in some workplaces. A few found the workplace hostile or experienced bullying. This led to drinking as a way of coping. Sometimes work had been a positive influence, limiting the opportunity to drink and overcoming boredom, which was a reason why some said they had become heavy drinkers.

While social situations provide an influential environment that is conducive to drinking, focus group participants also identified specific triggers in social situations that generate or heighten the desire to drink. For some, being at events and celebrations triggered drinking. As several people observed, actually seeing alcohol at gatherings makes it hard to avoid drinking. Others used

drink because of specific feelings or emotions they had that related to socialising—they felt inadequate or shy in company and alcohol helped them to relax.

4.3 AVAILABILITY OF ALCOHOL

Many of the focus group participants commented that the widespread availability of alcohol all week and at all times of the day and night is a pervasive influence that is hard to avoid. Local liquor stores, dairies and supermarkets were seen to be particularly easy sources of alcohol because of the large number of them and their long opening hours.



FOCUS GROUP K

21 outlets in 8 kilometres.

It's so easy to go and pick up.

It's in your face.

Big billboards advertising cheap drink.

How do you go shopping? You have to walk through the alcohol display to get into the supermarket.

FOCUS GROUP R

[Supermarkets] you go in for bread and come out with wine.

24-hour dairies.

You can't go for a coffee only. Most cafés are licensed.

When I was drinking, you could drop me anywhere in the city and I would know where the nearest place to buy booze was.



The importance of off-license premises for access to alcohol was demonstrated in the survey, where respondents reported they had most often bought liquor from supermarkets (34 percent of respondents) followed by a local liquor store (29 percent of respondents).

Buying alcohol from dairies and supermarkets was especially the choice of women in the focus groups. They said those outlets were convenient and relatively discrete, as buying could be done as part of grocery shopping. They also observed that the widespread availability of outlets makes it easy for someone to hide their drinking by spreading their purchases across outlets. Supermarkets with online ordering also make it very easy to access alcohol. In the survey, the supermarket was clearly the place most favoured by women for purchasing alcohol (58 percent reported that they had most often bought liquor from a supermarket). In contrast, men were more likely to purchase from a local liquor store.

Across all focus groups there was a strong view that RTDs increase the availability of alcohol to young people. They believed that RTDs are accessible because they are widely available in on-licenses and liquor stores and easy to drink as they do not have to be mixed. Furthermore, their sweetness appeals to youth taste.

The widespread availability of alcohol makes it easy for people to act on the impulse or desire to drink as the opportunity is there to purchase. Participants noted that the visible presence of alcohol in so many places triggers a desire to drink. For example, many

participants noted the way that supermarkets prominently display alcohol and occasionally offer free tastings. These practices increase the visibility of alcohol, and particularly appeal to the senses (sight, taste). Hence, those displays can actually trigger a desire to drink. Several participants also commented on the availability of alcohol in cafés as a trigger.

4.4 APPEALING ADVERTISING

Many focus group participants said that they were influenced to drink by attractive advertising and product packaging that promises success and popularity. Another key aspect of the advertising is that it makes alcohol look appetising. Good advertising appeals to the senses.

Masculine, macho advertising such as the beer slogans “measure of a man’s thirst” and “great southern man” appealed to men. Beer advertisements with sex appeal and humour



FOCUS GROUP P

It makes you feel that you will be good enough when you drink.

FOCUS GROUP S

Makes drinking look glamorous, fun.

FOCUS GROUP J

Masculine.

Tasty and appetising, looks good.

Better than most ads!

It’s cool to drink.



are also attractive. Women were also attracted by alcohol advertising, particularly those that showed alcohol to be a sophisticated choice and a way of achieving social acceptance.

Focus group participants were of the view that alcohol advertisements promote the idea that it is cool to drink. This imagery is taken further in television, films and music that portray drinking in a way that makes alcohol desirable and promote its identification with popular culture.

Advertisements often increase awareness of alcohol and consequently trigger the desire to drink. For some, billboards are a big trigger because they attract attention and are visible 24 hours a day. Some participants also found that attractive packaging acts as a trigger. The packaging of RTDs was cited as deliberately targeting young teens. Some participants talked about the power of visual triggers in advertisements or films when a bottle is opened or a drink poured. These images stimulate the urge to drink.

Although the focus groups identified appealing advertising as an influence that made drinking acceptable and desirable, the survey showed that overall, the way a drink is promoted had almost no influence on the type of alcoholic drink people bought. Only 2 percent identified the way a drink is promoted as most influencing what they would drink. By far the most important factors influencing the type of alcoholic drink they would buy was the taste (most influential for 44 percent of respondents) followed by the price (37 percent).

4.5 SPORTS

Many focus group participants said that they strongly associated drinking with both playing and watching sport. Drinking is part of the ritual of watching sport, as well as part of the after-match environment in clubrooms. Consequently, sports become an easy way for young people to be exposed to alcohol. In the experience of several focus group participants, often underage drinking in sporting environments is not well controlled.



FOCUS GROUP I

It's ingraining the whole drinking culture.

FOCUS GROUP S

Sports clubs are supposedly there to keep you healthy but there's drinking after the game.

FOCUS GROUP O

Growing up, playing the game and having a few beers.



The focus group participants considered that sports people are important role models in the community; consequently their drinking behaviour can be hugely influential on young people as there is an implication that drinking is associated with success. Also, when sports people are involved in violence and drink driving associated with alcohol, some in the focus groups considered that such behaviour is often seen to be acceptable. Nevertheless,

focus group participants were scathing about what they saw as harmful drinking behaviour by elite players that is not dealt with seriously by sports people, sports administration and the justice system.

4.6 PRICE

Although very few focus group participants who responded to the survey identified the way an alcoholic beverage is promoted as having the most influence on the type of drink they bought, in the focus group discussions many participants observed that cheap alcohol is promoted, as supermarket specials, discounted drinks in bars, and in competitions giving away free alcohol. They clearly identified cheap alcohol as a trigger to drink. Specials and promotions were identified as particularly attractive triggers, encouraging people to drink more. Many considered that bar promotions of cheap drinks are particularly aimed at young people.

Participants spoke about how drinking behaviour can be modified by price. The survey also showed that, after taste, price was the second-most important influence on choice of alcoholic drink.

Some participants said that price had been a big influence on the amount they drank, although being alcohol dependent they would not be deterred by price rises. They would drink no matter what the price; however, if their drink of choice was on special they would drink more of it. Several participants said that they sought out “loss leader” products because of the price. There was a general view

among focus group participants of all ages that young people are very price driven and this was confirmed by the younger people in their 20s in the focus groups.

Participants gave several examples of the influence of price on their drinking. One example was the purchase of alcohol from a wholesaler to drink at home before going to the pub or nightclub later. This practice enables people to fill up on cheap alcohol so they can spend less in expensive bars.

Young people in particular talked about choosing to drink at the bar that offered the best specials for the night, purchasing alcohol that included gifts in the offer, and buying single cans or bottles rather than larger quantities. Focus group participants observed that single cans or bottles of alcohol can be cheaper than a can of coke, energy drink or water. For example, specials of RTD cans for one dollar were regarded as highly attractive. One person said that when someone does not have much money, the single can will “top you up” until the next drink.



FOCUS GROUP L

There's a lot of youth who will club together to buy the biggest bang for their buck.

FOCUS GROUP R

You can buy singles for \$1, most supermarkets sell single bottles. Even a four pack is cheap.

You pay more for Coke than for beer.



4.7 EMOTIONAL ISSUES

Probably the most widespread trigger, for both men and women, were internal triggers relating to emotional issues and personal troubles. For some, these personal troubles stretched back to childhood. The range of both positive and negative emotions that would trigger a desire to drink was extensive, including anger, fear, worry, boredom, isolation, feeling inadequate, unhappiness, guilt, rebelliousness, euphoria, stress, and grief.

It was common to use drinking as a coping mechanism to deal with or block out problems that become overwhelming, such as relationship problems, loss of a loved one, loss of a job, or money worries. Several women and men talked about drinking as a response to childhood sexual and physical abuse. Others have used alcohol to cope with mental illness, particularly depression.

Some participants said they used alcohol to deal with boredom when they were young teenagers. Others noticed this pattern among their own teenage children.



FOCUS GROUP D

Any emotion really, grief, anger, loneliness.

FOCUS GROUP P

The first thing you turn to to seek relief from your situation.

FOCUS GROUP N

A lot of us are here because we used alcohol as a crutch.

FOCUS GROUP M

It made me feel good about myself, self esteem.



5. WHAT SHOULD BE DONE?



FOCUS GROUP G

As a society, how do we go about changing our thinking?

FOCUS GROUP B

The drinking culture is so ingrained, it's a long term thing that will take time, but like smoking, it can be changed.

FOCUS GROUP D

The number one thing that's got to change is the culture; it's normal [to drink], it's intergenerational.

FOCUS GROUP E

Come at it from every angle.

FOCUS GROUP J

People's attitudes are the hardest thing to change, the 'my choice to drink' thing. People don't like being told what to do.

It's almost a God-given right [to drink].



Very strong views were expressed across all focus groups that our society's attitudes and behaviours towards alcohol need to change. Many participants considered that changes in cultural norms, attitudes and practices around alcohol would be the hardest thing to effect, but a fundamental necessity if the harm and damage caused by abuse of alcohol is to be addressed.

Across all focus groups, the strongest support was for two types of interventions to limit alcohol-related harm: more public education

about alcohol, particularly starting with children; along with more opportunities for treatment. The focus groups identified a need for preventative interventions, with many participants citing education as the critical lever for changing societal attitudes and behaviours about alcohol. However, the focus groups also emphasised a huge need to widen the range of treatment options and increase the number of places available in programmes. Because of the number of issues raised about treatment, these are discussed separately in the following section 6.

As well as the emphasis on education and treatment, the focus groups traversed a wide range of views concerning the availability of alcohol, the marketing of alcohol and legislative changes.

This section covers the suggestions for interventions in the areas of:

- public education
- purchase age
- alcohol advertising, promotions and product labelling
- alcohol availability
- licensing and enforcement
- alcohol pricing
- alcohol excise tax
- drink driving
- the responses of different sectors to alcohol

5.1 PUBLIC EDUCATION

The focus groups identified options for public education about alcohol in relation to two main areas:

- education of children and young people
- social marketing campaigns



FOCUS GROUP S

Give them the ways to say no. Give them support to deal with alcoholism in their families.



Children and young people

All focus groups regarded the provision of information on alcohol to children at primary school and intermediate school as important, to give them choices in their lives. Focus group participants said the children need an alternative view, from what they experience in their families as many are growing up with alcohol and seeing the effects around them.

FOCUS GROUP E

We need more factual information for kids.

We can't just work at the bottom of the cliff.

Three focus groups noted that some campaigns have worked well in schools to raise awareness and provide alternative role models; for example, about smoking, using seat belts, fire safety, nutrition and "stranger danger".

FOCUS GROUP I

Education about seat belts; that has worked with kids.

When we were at school there was no alcohol education.

My kids come home from school and hide my smokes, and ask me why I'm smoking, that makes me feel guilty.

It was also suggested that, as well as schools, sports clubs should take a role in educating children and young people about the dangers of alcohol.

Several suggestions were made about how messages on harm minimisation and responsible drinking could be conveyed to children. It was generally agreed that information must be given in a way that children relate to, and that does not demonise alcohol so that the forbidden becomes desirable. Some said that education to build self esteem should be included in alcohol awareness education. One focus group commented:

FOCUS GROUP H

Teach it in schools when they are little, but do it the right way.

Learn about alcohol so they can make an informed choice.

We had to wait 'til now [in this programme] to learn about it.

Several participants said that children and young people needed to be given information about where to go for help, either for

themselves if they have alcohol problems, or to support them in coping with family members with alcohol problems.

Others suggested that people who have gone through treatment programmes should go into schools to talk to children. Suggestions were also made for combined alcohol education events for parents and children, as well as using prominent sports people in schools as role models of responsible drinking behaviour. One focus group advocated for compulsory defensive driving courses in schools that include drink-driving education.

Social marketing campaigns

Sixteen focus groups considered that more public education about the negative impacts of alcohol is needed. However, there was mixed support for advertising campaigns such as those run by the Alcohol Advisory Council and the New Zealand Land Transport Agency. Most participants agreed that those campaigns did not affect problem drinkers or those dependent on alcohol, and were more likely to impact on people who were responsible drinkers. One person summed up a common view about campaigns as “only effective for those teetering on the edge of having a problem”.

Some focus groups engaged in extended discussion about different advertisements, particularly whether they have any impact, and who they are meant to target. Two different focus group conversations are presented below to illustrate the detailed consideration the focus groups gave to the question of public education via media campaigns:

FOCUS GROUP A

Drink driving ads are too negative, ‘drink and drive and you’re a bloody idiot’, they don’t have any effect on the alcoholic.

But some are good, they give a plain picture of what might happen, the consequences. They are educative, raise awareness.

The kids think they will not crash.

Depends on who you are, what age you are, whether the ad works.

The non-flashy ones are way more effective than the gruesome stuff.

Ads with kids in it, really connect.

It’s better for ads to give positive messages.

They should show what alcohol does to your health, but that wouldn’t have stopped me.



FOCUS GROUP L

[advertisements need to be] hard hitting, straight talking and de-glamorise alcohol.

The message [must] come from the people who have been through it.



FOCUS GROUP B

Do the same as for cigarettes, show the harm alcohol can do.

Show people from all walks of life and the different kinds of drinkers.

The current ads are not effective. I don't pay attention to them.

I like the ALAC ads, but good choices must be shown, e.g. the sober driver alternative.

The guy swinging the child around is powerful.

Some participants thought that advertisements were not hard hitting enough because they did not do enough to de-glamorise alcohol, or make it appear uncool. Others considered that the shocking alcohol-related crash and violence advertisements de-sensitised people or sparked a response of denial: "That's not going to happen to me." They wanted to see positive messages that help people identify with and recognise they have a problem. Many considered that humorous advertisements would have more impact.

Some thought that more advertising that emphasises the damage that alcohol can do to one's children, family and friends is more likely to get heavy drinkers to take notice. They thought that type of message would get through much more strongly than messages about damage to oneself.

A few participants thought that some current messages are confusing. For example, the advertisement 'It's not what we're drinking, it's how we're drinking' was considered to give a mixed message that maybe drinking is OK, maybe it's not. Others commented that some of the anti-drink driving advertisements appeared to glorify reckless driving.

Most participants agreed that current advertisements did not target young people, and there needed to be much more focus on young people's drinking, particularly underage drinkers. One focus group noted that young Pacific people need to be reached. Another focus group suggested that advertisements should portray Maori situations such as the whanau to appeal to Maori. Some of the women participants commented that women needed more information about the particular impacts of alcohol on them, including health impacts.

Across all focus groups there was widespread support for a campaign to increase general public understanding about alcohol dependence and to challenge the stigma associated with addiction. Many participants considered that alcohol dependence is still seen as a "self-induced illness". One participant pointed out the irony of common attitudes: "There is admiration for the heavy drinker and stigma for the alcoholic." Participants also considered that general awareness among drinkers about their own behaviour and the health impacts of alcohol is very low. They said many people do not recognise they have a problem. Most participants said that before they entered a treatment programme they knew nothing about the harmful impacts of alcohol. Participants thought that if public awareness was raised and stigma challenged, this would encourage more people to seek help. In their view, the stigma of alcoholism makes it

harder for people to acknowledge they have got problems and to seek help. Comments included:

FOCUS GROUP M

They see an alcoholic as someone in the park drinking meths, not someone holding down a job.

FOCUS GROUP M

There's not an understanding out there about what alcohol does.

You'll find more people come out of the woodwork, there's a lot of denial out there.

FOCUS GROUP Q

There are stereotyped views about who is an alcoholic, we need to challenge those.

Nobody is spared.

Raise people's awareness of the risks and help them acknowledge they are alcoholics. Have celebrities and everyday people saying they are an alcoholic.

Change public perception and make people look at their own drinking.

Three focus groups particularly applauded the Mental Health Foundation's depression advertisements and would like to see something similar to raise people's awareness of alcohol dependence and challenge stereotypes and stigma. They would like to see a series of advertisements with both celebrities and with everyday people talking about their addiction. Participants strongly emphasised that those who are alcohol dependent need to be shown as coming from all walks of life, and as being all kinds of drinkers.

Two focus groups would like to see popular local television programmes like *Shortland Street* convey messages about reducing alcohol consumption, reducing stigma and showing that people can get help. There was a view that local television is too accepting of New Zealand's heavy drinking culture in how alcohol is portrayed in story lines.

One focus group suggested that an annual alcohol-free day be introduced, when people are encouraged to abstain for the day or give up altogether. It would be an opportunity to raise awareness and promote treatment options. They noted the "quit smoking" days and campaigns provided a model that might be usefully adapted to raise alcohol awareness.

5.2 PURCHASE AGE

Fourteen focus groups commented on raising the purchase age. The purchase age was one of the most debated issues, as these contrasting comments from three different focus groups show. The comments also show that, regardless of whether participants supported or opposed raising the purchase age, there was a widespread view that tougher enforcement of the purchase age is needed, including stronger controls over parents supplying alcohol to minors.

FOCUS GROUP D

Raise it, another barrier to the young kids.

Be stricter on parents supplying it to kids, it's no different to a shop keeper selling alcohol to a minor.

FOCUS GROUP G

Changing the age of drinking is easy to do, but hard to police and the damage has been done.

Policing the age much more rigorously at the point of sale, especially at dairies, it's not being followed.

FOCUS GROUP H

Raising it won't make any difference

Yes, it will make a slight difference, some might be delayed

[enforcement] it's stricter on age now than on intoxication.

There was majority support for raising the purchase age, mainly because it was believed that increasing the age would act as a barrier to very young teens accessing alcohol. Raising the age was also supported as it was regarded as possibly reducing alcohol-related offences among young people, such as drink driving and violence. Some also considered that raising the age would make it easier for outlets and police to enforce.

There was some support for keeping the on-license age at 18, but raising the age at off-license to 20 or 21 years. Others wanted the age to be raised for both off-license and on-license. A few also wanted to see the driving age increased as well, as a way of reducing drink driving amongst young people.

There was still a substantial minority who considered that raising the age would have a limited effect, although it may deter a few underage drinkers. Several participants made

the point that young people could vote, go to war and are able to exercise other legal rights at 18 and so should also have the right to drink. Some were of the view that, rather than raising the age limit, there should be greater emphasis on responsible drinking messages to young people and tighter enforcement of the current law.

5.3 ALCOHOL ADVERTISING, PROMOTIONS AND PRODUCT LABELLING

Across the focus groups there was a general view that more controls on alcohol advertising should be introduced as participants considered that advertising provides a visual trigger for drinking. Within that broad view, suggestions ranged from tighter controls on some aspects of alcohol advertising, to a complete ban.



FOCUS GROUP F

I think warnings on packaging would be most effective before people are addicted or into drinking.

FOCUS GROUP R

Look at the smoking, it isn't cool. Show what you look like when you're pissed.

FOCUS GROUP B

Ban alcohol giveaways, they should give away vouchers to rehab instead.

FOCUS GROUP D

Sports sponsorship, no definitely not, it influences the kids.



There was strong support in 11 of the 20 focus groups for a ban on all alcohol advertising. There was also widespread support across the focus groups for banning alcohol sponsorship of sports. The latter is seen as particularly inappropriate as it is highly visible to children and young people. Many in the focus groups said that controls on advertising of alcohol should be the same as those on cigarettes.

Suggestions were made for controlling the promotion of alcohol through:

- responsible portrayal of drinking on local TV programmes
- reducing the prominent displays of alcohol in supermarkets; suggestions:
 - » introduce guidelines and a voluntary code of conduct for supermarkets to persuade them to be more responsible in their alcohol displays
 - » require supermarkets to cordon off alcohol and only allow those 18 and over into that sales area
- banning alcohol advertising that appears to target or appeal to underage drinkers; many focus group participants considered that particular products such as RTDs are aimed at the youth market

Several focus groups contrasted the product labelling on alcohol with that on cigarette packaging. While alcohol is promoted in a glamorous manner, they observed that cigarette packaging includes public health warnings and graphic pictures of the damage that cigarettes can do to health. They would

like to see similar warnings on alcohol packaging, although many admitted that they smoked and were not influenced by such messages on cigarette packaging. However, some thought that graphic health warnings would affect younger drinkers. Some also suggested that an 0800 help line number should be printed on the packaging.

5.4 ALCOHOL AVAILABILITY

Most focus groups agreed that a lot could be done to reduce the availability of alcohol, although a few participants felt that it was too late to reverse the impacts of widely available alcohol. In contrast, a few people suggested that alcohol be banned outright, but this was generally seen to be unworkable and that prohibition would make the situation worse.

Many participants considered that reducing availability would help reduce the risk of impulsive drinking, enable better enforcement (because of fewer outlets and shorter hours) and help reduce public disorder from drunken behaviour. Many thought that a lot of the problems with violence now are after the pubs close, with people coming on to the streets “dead drunk”.

Suggestions for controlling the availability of alcohol included:

- Controlling the number of outlets. Key suggestions:
 - » A ban on sales in dairies and supermarkets. Across all focus groups most participants supported this option. Several participants voiced

particular concerns about young supermarket checkout staff being pressured by their (underage) mates to sell them alcohol. It was considered that stopping the sale of alcohol from supermarkets would help reduce the opportunities for sale to minors.

- » Controls on the number of outlets in an area.
- » A ban on outlets within a certain distance of schools.
- » A ban on alcohol sales in cafes and restaurants associated with public areas frequented by families, such as libraries and swimming pools.
- » Some would like to see alcohol sales controlled in all areas through a trust structure.



FOCUS GROUP G

Far too readily available.

FOCUS GROUP H

Take it out of supermarkets and dairies, it's a bad image to children. There's nowhere you can go that doesn't have alcohol.

FOCUS GROUP R

I can go for a swim at the council pool and buy alcohol.

FOCUS GROUP K

Reduce the opening hours, it would stop a bit of trouble.



- Reducing hours of sale. Suggestions were made to close off-licenses at 10 pm, to have reduced opening hours on Sundays, and to reduce the hours of sale in supermarkets and dairies.
- Reducing the alcohol content in drinks. This measure was regarded as helping to reduce availability as people look for the highest percentage of alcohol possible to get drunk in the shortest possible time. Lowering alcohol content is expected to reduce the social and health damage of drinking behaviour as it will take people longer to get drunk. Addicts are driven by alcohol content so it will impact on their consumption. Some suggested:
 - » Cap the alcohol content in beer to 3.5 per cent.
 - » Reduce the alcohol content of RTDs.

Banning of RTDs was widely supported across focus groups. Participants believed RTDs to be dangerous because people do not regard them as liquor, they are relatively inexpensive and easily obtainable. Several participants also linked RTDs to drink driving. They said that the pre-mixed format and easy to open containers made them ideal to drink in vehicles. RTDs are seen to be insidious, as “not really” being about drinking because they do not taste like alcohol, but instead taste sweet which appeals to youth. As one person said, “kids think the taste of alcohol is gross”. The comments of several participants made it clear they consider RTDs are deliberately marketed to young people:

FOCUS GROUP S

What slows teenagers down from drinking is they don't like the taste, all they want is the effect and that's what they get with alcopops.

FOCUS GROUP H

They are trendy, they are designed for young people and women.

FOCUS GROUP H

The packaging is to make them look like V and other drinks teens like.

5.5 LICENSING AND ENFORCEMENT

Most focus group participants were of the opinion that stricter conditions on obtaining a liquor license and stricter enforcement of regulations, coupled with higher penalties for offending premises are needed. Most thought that, generally, bars were well regulated and abided by the law, although some differences were observed between city centre bars and neighbourhood taverns, which were considered to be less concerned about compliance. Liquor stores and dairies were regarded as the worst offenders of selling to underage drinkers, to intoxicated people and to adults whom they know are supplying minors. Some who had worked in the industry said that underage sales are an ongoing problem, with young people devising tricks to obtain liquor.

Some considered that the processes to obtain a liquor license and bar manager's certificate are too lenient and need to be more rigorous. One person considered that it was easier to

get a liquor license than to get a bar manager's certificate, while another thought that the time spent on bar manager training was too short and the standard required to obtain the certificate inadequate.



FOCUS GROUP I

Beef up enforcement, it's not working.
It works in some areas but not others.
Police need to be more active where the pubs and liquor stores are.
Stricter license conditions are needed.
Fines should be more stringent.

FOCUS GROUP K

Get the outlets to be more vigilant.
There should be much stricter fines for contravention of liquor licenses, like instant fines.
Patrol public places, there's really big problems on the beaches and parks. If there are liquor bans, they are not being enforced, and patrolling them can push the problem into other areas.

FOCUS GROUP H

Yes, there are places that will serve intoxicated people



A few would like to see the law relating to adults supplying liquor to a minor tightened; they saw this as no different to a licensed premises supplying to a minor.¹⁵⁷ However, others, particularly women, justified their

purchase of alcohol for their underage teens to drink at home as responsible behaviour. They knew their teens would find other ways to drink and they would rather the teens be in safe supervised surroundings.

Other changes that focus group participants would like to see included:

- a ban on carrying liquor in the car; it must be confined to the boot as in some other countries
- a wider use of liquor bans in public places and enforcement of existing bans more rigorously
- police more proactively enforcing liquor laws, including focusing on premises and areas where there are problems with violence and disorder

5.6 PRICING

Thirteen focus groups commented on raising the price of alcohol or establishing a minimum price. Nine of those groups supported a minimum price or an increase in price, while support for those changes was mixed or rejected in the other groups. The range of issues raised about price is reflected in this exchange in one focus group:

FOCUS GROUP J

Don't muck around, put the price up. Maybe it would have slowed me down.

It would increase home brew, there's already a market in home brew.

It would penalise the couple celebrating their anniversary, they'd have to mortgage the house.

Several participants commented on the cheap price of alcohol in New Zealand compared to Australia. A minimum price was supported by some. They considered that it would provide a disincentive to young people's consumption as well as reducing adult consumption.

Participants considered young people to be particularly price driven and responsive to price increases. While all agreed that those who are alcohol dependent will not cease drinking simply in response to price rises, there was a widespread view that people will drink a greater quantity of alcohol if it is cheap. Although a few participants disagreed, there was a general view that increasing the price may slow the consumption of heavy drinkers. However, it was also a widespread view that those dependent on alcohol would also switch to cheaper alternatives wherever possible.

There was strong support for a ban on allowing single units to be sold. One focus group commented that the sale of single cigarettes and 10 packs has been banned and a similar regulation should be adopted for single units



FOCUS GROUP H

Alcoholics will always buy it and sacrifice the basics, food and warmth, or downshift, get something cheaper.

FOCUS GROUP O

Don't raise the price, there'll be less food on the table. Alcoholics will find the money anyway.



of beer and RTDs. A few would like to see a general ban on heavily discounted alcohol and cut price promotions such as “happy hours”.

Others suggested making non-alcoholic or low-alcohol drinks cheaper. They would like to see low-alcohol beer and soft drinks promoted as alternatives. It was also suggested that bars should be encouraged to serve free soft drinks.

Those who were less convinced about the effectiveness of price in reducing consumption said that those who are alcohol dependent will always buy alcohol, no matter what the price. They considered that an increase in price would increase the production and (black market) sale of home brew, as well as theft of alcohol. Others considered that low-income earners will just spend more of their income on alcohol and make sacrifices on food, shelter and heating. They saw families suffering if the price of alcohol rises.

Some also asked: is it fair to increase the price to attempt to control the excesses of a few? They questioned why moderate drinkers’ freedom to drink should be limited or penalised.

5.7 ALCOHOL EXCISE TAX

Discussion around the taxation of alcohol was spontaneously raised by focus group participants, rather than being specifically prompted. However, the discussions did not use terminology such as excise tax; rather participants used such terms as ‘liquor tax’, ‘industry tax’ and ‘tax take’.

Thirteen focus groups supported taxing alcohol and using those funds directly for treatment and public education about alcohol. There was also a suggestion that funding go towards compensation for victims of drunk drivers. Several participants suggested using a similar tax model to that employed in levying the gambling industry. Participants felt that using taxation for treatment and public education was justified as drinking alcohol is legal, and they have contributed through liquor taxation.



FOCUS GROUP H

[Alcohol] is legal, we get taxed, we are addicted, therefore they need to provide the treatment for us and our families.

FOCUS GROUP I

There’s a huge tax take from alcohol, there’s a huge vested interest.

FOCUS GROUP B

Get breweries to contribute money for programmes.



There was a strong view that funds derived from the liquor industry for mitigation of the damaging effects of alcohol should not be controlled in any way by industry interests, but that decisions about the use of such funds should be made by an independent body. In general, it was considered that the alcohol industry is a very strong lobby, which would be resistant to any tightening of legislation and increased taxation.

One focus group would like to see alcohol tax funding go towards the establishment of a commission that has more power than ALAC. The role of such a commission would be to oversee all alcohol legislation and policy, monitor changes and conduct research. They thought this commission could also take over all liquor licensing, thus giving it consistency throughout the country. The commission would also work closely with other sectors to raise awareness and promote responsible alcohol practices.

One focus group thought that companies would increase the price of alcohol to compensate for increased alcohol tax; however, they regarded this as a good thing because that would serve as a further disincentive to those driven by price.

5.8 DRINK DRIVING

The focus groups included several people who had multiple drink-driving charges. All except two focus groups wanted to see lowered (or zero) blood alcohol limits and harsher penalties for drink-driving offences.

Blood alcohol levels

There was a lot of support in the focus groups for a zero blood alcohol level.¹⁵⁸ In part this was because participants considered that the current regime is confusing and misleading as everyone is different in the way they react to alcohol; a person can be incapacitated on less than the legal alcohol limit. There was also a view that zero blood alcohol would be easier to enforce. Adopting a zero blood alcohol regime

would make the system much simpler and clearer than currently.

Although some participants agreed with a lowered blood alcohol limit, they did not agree with reducing the blood alcohol limit to zero. They thought this would penalise the majority who drank responsibly. Others wanted the blood alcohol limit reduced for those aged over 20 or even 25 years, but zero for younger people, and those on learners and restricted licenses.



FOCUS GROUP H

Booze buses, we need a lot more and random.

The worst offenders are over 40.

Country drivers are the worst.

FOCUS GROUP T

Laws are sensible now, but consequences are not hard enough. Lock up a repeat offender on the first repeat offence.

FOCUS GROUP K

Drink driving is a big problem and I feel that's getting worse.



Two focus groups did not agree with lowering blood alcohol limits because they considered that it would not make any difference to heavy drinkers who would still drive regardless.

FOCUS GROUP H

Waste of time tinkering around with that. [lowering blood alcohol] won't make any different to problem drinkers.

One of those focus groups considered that the only things that might have an effect was to confiscate cars, and to have devices in cars that would immobilise the car if the driver was over the limit. Several other focus groups would also like to see the widespread use of such devices in cars.

The other focus group that did not agree with lowering blood alcohol limits suggested increasing the frequency of random testing on the roads and targeting anti drink driving messages particularly to those over 40 and country dwellers, whom they thought were the worst offenders.

Penalties

There was general support for increasing penalties for drunk drivers, particularly repeat offenders. Many were scathing about a system that they considered allows recidivist drink-drivers to offend again, and cited examples of acquaintances with numerous drink-driving convictions (up to 22 in one case).

Several participants were critical of public figures who are perceived to abuse alcohol and to “get away” with alcohol-related offences that the average person would not get away with. They called for politicians and sports people to be better role models. One person said, “Why should we change our behaviour when they don’t change theirs?”

Many considered that it was too easy to get off having the license revoked. One person thought that prison sentences would be much more of a deterrent than loss of license. There

was a general call for more use of penalties such as confiscation of car and community service. Some would like to see a person getting an alcohol and drug assessment the first time they appear on a drink-driving charge and more use of court directed treatment programmes.

5.9 INSTITUTIONAL RESPONSES

The focus groups made several suggestions for increasing awareness of alcohol issues and improving alcohol-related practices in a range of sectors. They considered that institutional responses could be improved in the following areas: the liquor industry, justice sector, general practitioners, financial assistance (covering income support, taxation and accommodation assistance), employers and sports clubs.

Liquor industry

Several focus group participants had worked in the liquor industry. There was some support for more training to be given to bar managers on the impacts of alcohol and information about help available. There was a view that those at the point of sale could be much more informed about alcohol issues and given training on how to give information about help available to customers who clearly have an alcohol problem.

Three focus groups commented on the host responsibility of bars. They applauded pubs and clubs that offer free soft drinks and make courtesy vehicles available. However, they also commented on encountering negative

attitudes from bar staff when ordering soft drinks and, in some establishments, a practice of charging for water. They would like to see licensed premises with a more inclusive approach to non drinkers. It was also pointed out that one deterrent to people wishing to use a courtesy vehicle or taxi is a fear of leaving their car vulnerable to being vandalised in pub car parks. They commented that increased security in car parks could improve people's willingness to use alternative transport, rather than drink-drive.

Justice sector

There was a call for judges, lawyers, police prosecutors, probation officers and duty solicitors to be better informed about addiction treatment programmes available. Some participants favourably commented that some judges and lawyers in their areas are aware of treatment programmes and will direct offenders to them.

General practitioners

Three focus groups thought that general practitioners need more training on understanding alcohol, alcohol dependency and the help available. Some also said that doctors are too quick to expect people who are undergoing treatment for alcohol dependency to get off the sickness benefit in a few months. They suggested that there is little understanding of the recovery process, which may take an extended period of time and will vary according to the individual's situation.¹⁵⁹

Financial assistance

The focus groups identified several issues in dealing with agencies that provide income support, tax assistance and accommodation assistance. Lack of earning is a huge issue as the debts mount up when individuals are in treatment. Participants called for agencies such as Work and Income, Inland Revenue and Housing New Zealand Corporation to work together to support people during treatment and while they are in recovery.

Lack of agency coordination and lack of understanding of alcohol dependence and the processes of recovery were identified as ongoing issues facing people coming out of treatment.

Employers

There was a call for employers to be made more aware of the impacts of alcohol, and to control drinking at work as well as after work in the workplace by establishing alcohol policies. This approach reflects the fact that many problem drinkers are employed, and that workplaces are important sites for drinking.

Focus group participants made suggestions for employers to provide advice about help available, offer counselling to employees, and hold jobs open while people are in treatment. In the participants' experience, large employers are generally understanding, however it is difficult for small employers as many would not be able to afford to hold jobs open. They suggested that there should be a scheme to help small employers support their

staff in treatment and hold the job so that they have a job to return to.

Sports

Several participants would like to see sports taking a lead in raising awareness about the harmful effects of alcohol. They would like to see sports organisations providing information to children and young people about responsible drinking, promoting sports mentors with responsible drinking behaviour, and controlling alcohol consumption on sporting club premises. In particular, participants commented that some clubs appear to ignore minors drinking. It was suggested that some clubs rely heavily on income from the sale of alcohol and perhaps that contributes to lax controls on alcohol.



6. TREATMENT



FOCUS GROUP C

It takes a lot to walk into a place and say you've got a problem.



Given the composition of focus groups, it is not surprising that participants discussed options for treatment in detail, as most focus group participants had experience of at least one type of treatment or support services. Some had extensive experience spanning years.

There was a widespread view among participants that investment in treatment is money well spent, compared to the costs of alcohol-related harm to the health and justice systems, as well as to individuals, families and employers. These views are well supported by evidence of the costs of alcohol to death, disease and injury in New Zealand.¹⁶⁰

The following exchange in one focus group expressed points that were common to several focus groups:

FOCUS GROUP E

For hard core alcoholics, the main thing is treatment.

A small proportion of people are creating most of the damage, they need to be treated. They don't look at their drinking until it becomes serious.

Education won't work for them.

Save money by building more treatment centres, get people well so they can contribute to society again.

All focus groups commented extensively on what they considered to be shortcomings in the current system of provision for treatment. Often participants drew on their experiences of different types of programmes run by different agencies in forming their views. Key issues discussed were:

- gaps in the types of programmes currently available
- pre-programme support
- post-programme support
- involvement of families in programmes
- provision of assessment and programmes in the justice system
- the interface between mental health and addictions programmes
- the need for information about help to be more widely available.

These issues are discussed below.

6.1 TYPES OF PROGRAMMES

Discussion about the types of treatment programmes needed covered what participants believed to be currently available and the gaps they perceived in services, the location of services and the duration of programmes.

A wider range of programmes

The strong message from all focus groups was that there are not enough programmes to meet demand across the range of services that are needed in the community, including assessment, counselling, detoxification treatment and rehabilitation.

This perception concurs with Salvation Army data. The Salvation Army reports that for the year-ending 30 June 2009 it experienced an increase in demand with a 21 percent increase in uptake of its addictions services. A further increase in uptake of 33.5 percent was experienced for the first two quarters of the 2009/10 financial year. More people have used the service through an increase in all types of referrals, including self-referral and referrals from other addictions services, as well as social services. There has been no increase in funded bed numbers to meet the increase in demand.

With regard to assessment, several participants commented that there were waits to get assessment in their areas.¹⁶¹ Long waits was also one of the main concerns expressed about accessing counselling. Some were also concerned about the costs of counselling.



FOCUS GROUP S

People detox themselves, it's dangerous.

FOCUS GROUP L

Some think they can handle it.



With regard to the availability of “detox” programmes (detoxification treatment), participants perceived that it was hard to get support to detox, either as an in-patient, or in the community with appropriate medical support. Participants commented that if

people cannot get support to detox, or believe that no other options are available, then they detox themselves. This can be life-threatening and it is preferable to detox in supervised situations.¹⁶²

With regard to rehabilitation programmes, there was strong support for both day and residential programmes.

Residential programmes are particularly important for individuals whose living situations are not safe and/or detrimental to recovery. They are also suitable for people with extensive rehabilitation needs. In some situations intensive day programmes are linked to supervised accommodation.¹⁶³ In New Zealand, over the past twenty years there has been a shift from residential programmes as the only option, to a wider range of community-based treatment models.

In several of the focus groups there was strong condemnation of the past closure of some residential programmes. In part this



FOCUS GROUP E

You need live in treatment, you need to pull yourself right out, disconnect.

FOCUS GROUP A

Residential is 24/7 and so is the addiction.

FOCUS GROUP S

[residential] it's more intensive, it's harder than being an outpatient. The peer pressure keeps you straight.



was because those participants considered the residential aspect to be valuable for rehabilitation and recovery. There was also a view that there are insufficient community-based programmes to meet demand. Many of the focus group participants would like to see more places in residential programmes.¹⁶⁴

Although there was support for more residential programmes, some participants have found that day programmes suit them better than residential programmes as they can stay with their family. They have also responded well to the challenge of “dealing with the real world” while receiving treatment. There was also a call for flexibility and “second chances” so that people who “fall off the wagon” can re-enter programmes. Participants said it is common for people to need more than one programme of treatment.¹⁶⁵

Needs of different groups

As well as commenting on the types of programmes needed, the support and treatment needs of different groups were identified. These included programmes tailored for young people, women-only programmes, and programmes for women where they can have their children with them.

In the course of discussion, participants suggested some trends that may see current services under even more pressure. These include more young people in their 20s developing alcohol dependency and increasing alcohol problems among older people, especially older women coping

with loneliness.¹⁶⁶ One focus group, which included former programme participants now working in addictions services, suggested that both mental health and addictions services are under pressure because of young people in their 20s with drinking problems.¹⁶⁷

Programme location

Among focus group participants, there was a widely-held view that even large metropolitan centres are not well served for programmes, while many small towns and rural areas have no services at all. A number of focus group participants had travelled from provincial or rural areas to take part in a Salvation Army Bridge Programme.



FOCUS GROUP L

Country people, what do they have?



Local programmes are seen to be more accessible and personal. Several participants would like to see more community-based treatment options so that people do not have to travel long distances for treatment.

Programme duration

Several focus groups commented that programmes must be of sufficient duration and intensity. They said that one day a week courses, or once a week counselling, are not enough to challenge people, or to give them the tools they need for recovery. Some talked about short programmes that were limited

in what they provided. These were regarded as dangerous as people who go through such programmes receive some tools and then “think they are cured”. Others said that short, less intensive options do not provide a supportive and challenging community that gets them out of their daily routine and away from harmful influences. Many participants said that longer programmes are needed. In their view, an eight week residential course is too short for people who have been battling an addiction for 30 years.



FOCUS GROUP J

One day a week courses aren't enough, you've got to go every day. It needs to be intensive, like residential or all week.

FOCUS GROUP P

Programmes are great, but after 12 weeks you only start to scratch the surface.

FOCUS GROUP M

Eight weeks is nowhere near long enough, the fog is just starting to lift.

You're dealing with a lifetime issue and you can't deal with that in eight weeks.

Some programmes are very limited in what they provide, they only partly help and are inadequate. They're condensed, rushed, chuck you some tools and you are left to do the rest.

People think that once they've done the residential they are cured.



6.2 PRE-TREATMENT SUPPORT

In all the areas where focus groups were held, most participants were strongly of the view that no, or very little, pre-treatment support is available. Few participants commented that they had received any pre-treatment support. Those who did identify pre-treatment support received, said it had been counselling, or a support person dropping in to visit them at home.

A dearth of pre-treatment support becomes a particular problem if there are long waits to enter treatment. In all areas participants talked about their own and others' experiences of long waits extending to weeks and months to get into a programme after detox. They reported waiting times to enter a programme ranging from 10 days to seven months, with most waiting two to three months. Several participants reiterated that when people make contact with services they are in crisis and need help immediately. They have observed that the consequences of long waiting times include individuals resuming drinking, going to jail, or death.

Many focus group participants considered that the ideal is to go straight from detox into rehab. If this cannot be done, then a proper support programme is needed. One person in the pre-treatment stage said it is very difficult to fill in the day and sleeping is difficult. Participants suggested that support workers and programmes should be available to help individuals stay off alcohol until they enter a programme.



FOCUS GROUP H

[four months wait to get into a programme] I nearly gave up after three months ... received counselling but even talking about it was a trigger, went out and had a drink afterwards.

FOCUS GROUP N

I was waiting for a year to get into a CADS programme (Focus Group N).

FOCUS GROUP L

You're in crisis, then you have to wait. There's three options, death, jail, or hang in there and wait. It's Russian Roulette.

FOCUS GROUP G

Go to detox and then you have to wait weeks, you just fall off the wagon again. Community support is needed if you've got to wait. Someone to visit, make sure you are eating ... keep an eye on you.

I did everything myself, finding out and doing the phoning up myself. It took me two years to get it all together. I was in detox several times.



6.3 POST TREATMENT SUPPORT

Participants called for more post-treatment support to be available, as this is the time when people are at high risk and vulnerable. Many participants would like to see more long term support available. As one person said, "Recovery doesn't finish when you walk out the door; it only starts."

Some participants noted various forms of post-programme support such as counselling and support groups are available, but they are not offered in all areas. Several participants who were working commented that most support is available only during working hours, which makes it difficult for employed people to access those programmes.

Across the focus groups, there was a perception that there are few supported housing options for those leaving treatment, and the options available cannot meet demand.¹⁶⁸ Several participants said that finding suitable housing is a huge problem for most coming out of rehab, as they need a place where they are safe and can recover. Often they have lost their former accommodation and do not have a job. Some have no family or suitable support. Some participants considered that those most at risk of not finding suitable housing were young people and single people. Several participants were of the view that the relapse rate is very high and a big factor is the dearth of after care and suitable housing.



FOCUS GROUP P

Coming out, you don't know how to access support or you go to a town where there is nothing available.

FOCUS GROUP L

People literally come out of residential programmes with no place to sleep that night.

FOCUS GROUP H

[After programme support] it's a major thing, you fall over, it's the most vulnerable time.

A lot of people just got nowhere to go.

Some need somewhere to live for six months.

Rushing around trying to find a house brings on stress.



6.4 INVOLVEMENT OF FAMILIES IN PROGRAMMES

Several participants commented that they would like to see opportunities for families to be involved in some way in programmes. This would help families understand what the programmes are about, and the treatment their family member needs, as well as getting support themselves. One focus group discussed the supports needed for families and whanau:

FOCUS GROUP O

Families need support too, a support worker for them ... and making families aware of how hard it really is [to go through a programme].

Allowing people to see their families, that's a good thing and a change from 10 years ago.

Your whanau's going to be your support when you get out.

They're affected too; our drinking has scarred our families.



FOCUS GROUP L

There's very little support for families, and what there is doesn't address what people have been through in programmes.



Suggestions for involving families included: a family information night; weekend barbeques; involvement in sessions with the client at the end of the programme; and a pre-exit meeting with the family. In one area where The Salvation Army provides visitor accommodation for some families of programme participants from out of town, this was noted by one participant and much appreciated.

6.5 PROGRAMMES IN THE JUSTICE SYSTEM

A number of focus group participants had been ordered by the court to attend a treatment programme. While there was debate about court orders, participants generally supported court direction to programmes. There was also considerable support for alcohol and

drug assessment as a routine part of the court process, so that people get an opportunity to be considered for a programme early on. The following comments from two focus groups show different aspects of the discussion:

FOCUS GROUP E

We need more counselling in prisons.

Courts are referring a lot more people to rehab, it's increasing the demand.

But it's easier than going to prison.

Yeah, they are disrupting the courses.

FOCUS GROUP F

It's not just about getting out of jail, it takes balls, it's a lifestyle change.

There should be assessment in the court process.

The initial attitude is, avoid jail, but it [the programme] changes your whole way of thinking.

In several focus groups, one participant questioned whether some people attend programmes as a way of avoiding imprisonment. This generated considerable discussion. Some participants observed that court direction puts more pressure on the few programme places that are available "at the expense of someone else", as often court orders are given preference. There was a feeling of: Why should those who commit a crime get preference when those who haven't committed a crime need help too?

Some participants, both court ordered and voluntary, said that initially they had come reluctantly to a programme but it had

turned around their thinking. It was widely agreed among participants that entering a rehabilitation programme is not a soft option or an easy way to avoid a sentence. The point was made that "they [court ordered people] have a right to be here too".

In several focus groups, there was an unprompted call for more assessment and treatment programmes in prison. Several participants expressed a view that time spent in remand could be used to offer people alcohol and drug assessment, counselling and education. One focus group identified a lack of follow up support for those who have been through prison-based treatment programmes.

6.6 INTERFACE BETWEEN MENTAL HEALTH AND ADDICTIONS PROGRAMMES

Four focus groups commented on the need for better integration and cooperation between mental health and addictions services. They would like to see people who need both mental health and addictions treatment able to access both types of services from either sector. A few participants referred to their own experiences of needing help with mental health issues as well as treatment for alcohol dependence. Four participants who had graduated from a programme and were now assisting with running a programme talked about the need for coordination of mental health and addictions services.

Three focus groups argued that there has been a progressive loss of expertise from the addictions sector. They called for an increase in the numbers working in addictions, as well as specialised training for workers who can cover both addictions and mental health issues. Others considered that there are very few counsellors who are competent in both addictions and in sexual abuse counselling. Several participants perceived a need for better access to counselling for people undertaking treatment for alcohol dependence.¹⁶⁹

Those who experience addictions problems are also likely to experience mental health problems.



FOCUS GROUP P

There is not enough information about counselling and where you can get help for the underlying emotional and mental health problems that drive people to drink.

There's too much throwing pills at you.

Deal with root causes. Alcohol is the symptom not the cause.

FOCUS GROUP R

Depression and emotional issues are triggers for drinking ... it's hard to find the right support, and to know it's OK to ask for help.

Subsuming A&D under mental health was a retrograde step. There was loss of funding, closing of places and loss of expertise.



One New Zealand estimate is that 40 percent of those experiencing a substance use disorder have also experienced an anxiety disorder, and 29 percent have experienced a mood disorder.¹⁷⁰

Other research on a representative sample from Community Alcohol and Drug Service found 74 percent had a current psychiatric disorder diagnosis.¹⁷¹ Furthermore, up to 60 percent of all mental health service users experience drug and alcohol problems.¹⁷²

6.7 INFORMATION ABOUT HELP

There was strong support across the focus groups for widespread dissemination of information about where people can seek help. Most participants agreed that getting information about treatment is very difficult. Many participants said that they did not know about the help that was available before they were referred (or were court ordered) to a Bridge programme. Several people said that there is a general perception that only fee paying programmes are available, which is a deterrent to seeking help.

One focus group considered that the dearth of information on help shows that alcohol problems are not seen as worthy of attention in our society. One person in the group summed it up: "There is more information on how to get help for erectile dysfunction than for alcoholism."

Several participants suggested that information about help needs to be more visible and widely available. They believe that lack of easily available information on help deters people from seeking help. Participants in some areas said that the existing alcohol

and drug helpline is poorly advertised. Participants would like to see 0800 help numbers prominently displayed at point of sale. Others suggested that information about help should be available in shopping centres, on billboards, in doctors' waiting rooms and in newspapers. Some thought that The Salvation Army should raise the profile of the Bridge programmes so they are better known in the community.

The 2007/08 New Zealand alcohol and drug survey found that, among those people who wanted help to reduce their level of alcohol use but had not received help, the second most common reason was 'not knowing where to go for help'. Over 28 percent said they did not know where to go for help; this equates to around 18,000 of the total population aged 16-64 years.¹⁷³



FOCUS GROUP T

I thought treatment programmes were just on TV, a story line.

FOCUS GROUP J

I only found out about this [programme] when I was in prison. Heaps of people don't know they can get help.

FOCUS GROUP F

I thought rehab was just for rich folk.

I thought that too. I'm really happy my lawyer recommended I come here [to the programme].

I couldn't see any way out, I didn't know what to do. Put the help number on the bottle.



7. THE MOST EFFECTIVE RESPONSES

The large majority of focus group participants were of the view that changes are needed to the way our society deals with alcohol. Only a very small number of participants believed that nothing at all could be done to change New Zealanders' drinking behaviour. Most participants considered that there are some responses that will work. However, they emphasised that there is no one, simple solution.

Instead, the focus groups considered that multiple responses are needed that will engage different people. In particular, they made clear distinctions between moderate drinkers and those for whom alcohol is a big problem in their lives. They also distinguished between young drinkers and those who have been established in their drinking habits for years. In their view, those who are alcohol dependent will not significantly alter their behaviour in response to regulations, penalties, reducing the number of outlets, pricing signals, social marketing, or many other interventions because of their uncontrollable urge to drink. They will drink regardless and accommodate changes; as one person commented, "You make sure you organise everything around your drinking." Another said, "You'd walk across glass to get alcohol."

Most focus group participants had thought carefully about the most effective policy responses. There was a strong view that New Zealand's drinking culture will be very hard to change because it is so embedded in our social fabric. However, despite that, most also

agreed that changes in community norms and practices around drinking are desperately needed.

The two main policy responses that the focus groups considered to be potentially the most effective in changing New Zealanders' drinking practices and addressing alcohol-related harm are: public education campaigns, particularly targeted to children and young people, and treatment.

The large majority of focus group participants considered public education to raise awareness about alcohol-related harm is necessary. However, there was also a widely-held view that the attitudes of adults and parents would be the hardest to change. Some considered it is too late to change adult behaviour because they are set in their ways. There was a certain pessimism that parents are not interested in or not able to stop drinking, and are not interested in teaching their children about the dangers of alcohol.

Most of those who were sceptical about the effectiveness of social marketing campaigns for adults considered that they have a very limited effect on heavy drinkers and no effect at all on those who are alcohol dependent. They considered that it is more effective to focus on educating children, and that schools and sports/recreation organisations catering to children and young people need to be targeted.

Those who commented on the difficulties of changing public norms through education nevertheless pointed out that there has

been a huge shift in attitudes and behaviour around smoking over one generation, and similar results could be achieved with drinking behaviour. They thought that the answer was for successive governments to make a “real commitment” to address the issue.

While there was some debate about the effectiveness of campaigns to change adult drinking behaviour, there was almost universal support for public education being used to:

- Reduce stigma through raising public understanding about alcohol dependency.
- Encourage people to seek help for their alcohol problems.

Alongside the call for public education was a clear message that the only response that will affect those who are alcohol dependent is treatment. Other interventions will not deter them from drinking. Consequently, there was strong support across all focus groups for increasing the range and opportunities for assessment, counselling, treatment programmes, pre- and post- treatment support, and also support for families.

There was some support for other changes. Most focus groups considered that the number of alcohol outlets should be reduced and that controls on the availability of RTDs should be introduced. There was also some support for reducing hours of sale. There was general agreement that legislation and enforcement need to be strengthened around licensing and drink driving. There was also general support for controlling liquor advertising.

The widest divergence of opinion in the focus groups was around changing the purchase age. While there was strong support, there was also a view that raising the age would have little or no effect on drinking behaviour among youth. There was more support for raising prices or introducing a minimum price as a means of reducing consumption, particularly amongst young people. However, some saw negative consequences for families if income was used for alcohol instead of essentials.



8. SUGGESTIONS FOR CHANGE

This concluding section reflects on the options that focus group participants suggested for changing the way New Zealand manages access to alcohol and addresses alcohol-related harm. It also puts those suggestions in the context of the findings from the literature review on the environmental influences on drinking behaviours.

Generally, the focus groups were of the view that New Zealand's current liquor laws and policy framework have enabled the pendulum to 'swing too far' towards easy access to alcohol. They would like to see more controls introduced to better manage the availability of alcohol in our society, and more responses that effectively deal with alcohol-related harm.

Many suggestions from the focus group discussions have strong resonance with the findings of studies concerned with the environmental influences on drinking behaviours. For example, in the focus groups:

- There was support for raising prices or introducing a minimum price as a means of reducing consumption, particularly amongst young people. The literature shows that higher prices lower consumption and price reductions increase consumption. Price increases have also been found to reduce alcohol-related harm. Young people's drinking behaviour appears to be especially influenced by price.
- There was support for controlling liquor advertising. While evidence about the link between exposure to alcohol advertising and alcohol consumption is mixed, there is growing evidence that alcohol advertising does influence drinking behaviour, including the amount of alcohol consumed, and the age at which young people start drinking.
- There was strong support for increasing controls on or banning of RTDs. A growing body of research argues that RTDs are a major contributor to youth initiation into drinking, increases in amount and frequency of youth drinking, youth binge drinking and higher levels of youth intoxication.
- There was strong support for limiting the availability of alcohol, including reduction in the number of outlets and controls on the hours of sale. Research shows that consumption of alcohol increases when the number and density of liquor outlets increase; that a higher density of licensed premises is associated with alcohol-related harm; and that longer trading hours are associated with higher levels of drinking, intoxication and alcohol-related harm.
- There was general agreement that legislation and enforcement need to be strengthened, especially around licensing and drink driving. The literature shows that enforcement is a critical influence on drinking behaviours. Inadequate enforcement of purchase age laws has been found to contribute to early exposure of minors to alcohol and underage drinking, as well as increases in intoxicated drinkers. Effective enforcement has been found

to reduce risky drinking behaviours and alcohol-related harm.

- The widest divergence of opinion in the focus groups was around changing the purchase age, although there was some support for raising it. Research shows that purchase age does influence young people's drinking patterns, and there is a "trickle down" effect with those close to the legal purchase age also gaining access to alcohol.

The main policy implications from the focus group findings are:

- An effective and strategic response to New Zealand's drinking problems must be multi-faceted, with consideration given to tailoring responses to the needs of different drinking behaviours, different groups and to local communities. Those engaging in risky drinking who are not alcohol dependent need different approaches than those who are alcohol dependent. Women and men need different approaches, while responses also need to be tailored to youth, older people, Maori, Pacific and those from cultural backgrounds where alcohol is not commonly used. New migrants from such backgrounds are often unsure how to cope with the New Zealand drinking culture. Those in the focus groups reiterated what New Zealand research has shown; that low-income neighbourhoods experience greater exposure to alcohol. This situation suggests that responses also need to be developed for local conditions.
- Treatment is a crucial part of the mix of responses if the drinking behaviours of both current and future generations are to be changed. Many responses do not work for those who are alcohol dependent, because of the compulsion for alcohol, increased tolerance and difficulty in controlling drinking. Most who are alcohol dependent cannot easily quit drinking by themselves. They are likely to be relatively unaffected by price rises, tougher penalties, social marketing campaigns or by a reduction in the number of liquor outlets or trading hours. The most effective policy responses for them are the provision of support and treatment. This report confirms issues that have been raised by other research concerning the need to increase the range of addictions services to meet growing and diverse needs, address barriers to services, and to support the ongoing development of a skilled addictions treatment workforce.¹⁷⁴
- The range of responses cannot be confined to central government agencies. Better use could be made of existing services and resources by providers working together better. Focus groups commented that often addictions services are piecemeal and do not coordinate well together, possibly because of competition for funding. Furthermore, inter-sectoral responses are likely to be most effective, with central government and local government working together. For example, local government has a key role in managing the availability of alcohol and keeping public areas safe.

- The co-existence of mental health issues and alcohol dependence is common. Programmes need to address both issues to assist people’s recovery.
- Participants pointed to a widespread lack of public awareness about, and stigma attached to, alcohol dependence. Consideration should be given to developing a campaign aimed at raising awareness of alcohol dependence, showing that recovery is achievable and providing information about the availability of treatment and support for those with alcohol dependence and their families.
- Regardless of the legal purchase age, there will continue to be underage drinkers. Specific policy responses need to be targeted to underage drinkers. Those responses identified in the focus groups include:
 - » control of alcohol promotions and advertising likely to be influential with or attractive to minors
 - » more effective enforcement of liquor sale regulations
 - » mandatory training for liquor sellers on legal requirements and responsible practice
 - » targeting adult buyers of alcohol for minors to increase responsible practice
 - » restricting or banning alcohol use at outdoor venues and community events that involve young people
 - » increasing sponsorship of alcohol-free events to reduce reliance on alcohol sponsorship or revenue from sale of alcohol
 - » information and awareness campaigns about responsible alcohol use and alcohol-related harm for children and young people
 - » support, skills development and treatment aimed at managing youth problem drinking behaviour
- Several participants made suggestions for the establishment of voluntary codes of conduct around the provision and promotion of alcohol. Such voluntary initiatives may engage the community more widely than a narrow focus on law enforcement. Participants raised the following areas for consideration:
 - guides for employers concerning the use of alcohol at work and assistance to staff with alcohol problems
 - guides for licensed premises and liquor outlets on legal requirements and responsible host ideas
 - guides for supermarkets on the responsible display and promotion of alcohol
 - guides for sports clubs in the provision of alcohol, managing drinking behaviour, managing underage drinking and host responsibility
 - voluntary codes of practice for the manufacture and responsible promotion of RTDs

POLICY RECOMMENDATIONS

Based on the outcomes and conclusions from this research the following recommendations are offered as suggestions for policy or programme responses.

1. EXCISE TAX

Increase excise tax and use the tax to secure funding for an increased number and range of treatment options and alcohol education programmes.

Rationale

The focus groups supported an increase in excise tax, but only if taxes were directly used to improve alcohol treatment and public education on alcohol.

Research shows that liquor tax increases lower alcohol consumption (because tax increases lead to a rise in the price of alcohol) while lowering of taxes increase consumption. Research also shows that young people's drinking behaviour appears to be especially influenced by price.

2. PUBLIC EDUCATION CAMPAIGNS

Run public education campaigns to:

- raise awareness and reduce stigma about alcohol dependence
- encourage people to seek help for their alcohol problems

Rationale

The focus groups were supportive of campaigns to reduce stigma and to provide information about where people could go to get help. They felt that currently, there is little

public understanding of alcohol dependency (which deters people from admitting that they have a problem), and many people do not know where to go for help, either for themselves or family members.

There is New Zealand evidence that a common reason for not seeking help is that people do not know where to go to get help (2007/08 NZ alcohol and drug survey).

3. TREATMENT AND SUPPORT

- Increase the range of alcohol assessment, treatment and support services to meet growing and diverse needs.
- Improve accessibility to alcohol assessment, treatment and support services, including increasing the provision of free services.
- Improve access to alcohol assessment, treatment and support services for those in the justice system and mental health services.
- Increase resources to support the ongoing development of a skilled addictions workforce.
- Improve services coordination, both within the addictions sector and between the addictions and other sectors.
- Increase support available to families of those who are alcohol dependent.

Rationale

All these actions were supported by the focus groups, which identified gaps in current services. Focus groups also said that there

is a general perception that only fee paying programmes are available, which is a deterrent to seeking help.

Evidence from research shows that those who are alcohol dependent are likely to be relatively unaffected by price rises, tougher penalties, social marketing campaigns or by a reduction in the number of liquor outlets or trading hours. The most effective policy responses for them are the provision of support and treatment

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ENDNOTES

- ¹ See Appendix 1 for a description of The Salvation Army Bridge Programme
- ² The comment on ethnicity and cultural background is largely based on observation and is indicative only. Participants were not asked about their ethnic background, although some commented on their own cultural or ethnic background in the course of the focus group discussions.
- ³ Almost all who completed the survey indicated they were not drinking at present, and reported on their past drinking behaviour.
- ⁴ ALAC defines binge drinking for those aged 18 and over as consuming seven or more standard drinks on one occasion. See p.20 Research New Zealand 2009 *ALAC Alcohol Monitor – Adults and Youth 2007–08 Drinking Behaviours Report*. Prepared for ALAC.
- ⁵ p.55 Brown, M., Wells, J., Scott, K. (eds) 2006 *Te Rau Hinengaro The New Zealand Mental Health*. Wellington, Ministry of Health.
- ⁶ Babor, T., Caetano, R., Casswell, S., Edwards, S., Giesbrecht, N., Graham, K., Grube, J., Gruenewald, P., Hill, L., Holder, H., Homel, R., Osterberg, E., Rehm, J., Room, R., Rossow, R. 2003 *Alcohol: No Ordinary Commodity Research and Public Policy*. Oxford University Press.
- ⁷ p.6 National Addiction Centre and Matua Raki, *Orientation to the Addiction Treatment Field Aotearoa New Zealand*. National Addiction Centre, University of Otago, Christchurch and Matua Raki, Wellington.
- ⁸ Safe limits are generally defined as: for men, no more than 21 alcohol units per week and no more than 4 alcohol units per day. For women, safe limits are no more than 14 alcohol units per week and no more than 3 alcohol units per day. Pregnant women should drink no alcohol. See <http://www.drinking-problem.sab.org.nz/>
- ⁹ p.4 National Addiction Centre and Matua Raki, *Orientation to the Addiction Treatment Field Aotearoa New Zealand*. National Addiction Centre, University of Otago, Christchurch and Matua Raki, Wellington.
- ¹⁰ p.5 National Addiction Centre and Matua Raki, *Orientation to the Addiction Treatment Field Aotearoa New Zealand*. National Addiction Centre, University of Otago, Christchurch and Matua Raki, Wellington.
- ¹¹ p.5 National Addiction Centre and Matua Raki, *Orientation to the Addiction Treatment Field Aotearoa New Zealand*. National Addiction Centre, University of Otago, Christchurch and Matua Raki, Wellington.
- ¹² p.4 World Health Organisation 2007 *WHO Expert Committee on Problems Related to Alcohol Consumption Second Report*. WHO Technical Series No. 944 Geneva, World Health Organisation.
- ¹³ p.16, 28 Ministry of Health 2009 *Alcohol Use in New Zealand: Key results of the 2007/08 New Zealand Alcohol and Drug Use Survey*. Wellington, Ministry of Health www.moh.govt.nz
- ¹⁴ National Institute of Health 2009 *International Comparisons of Adult Alcohol Consumption*. www.enotalone.com
- ¹⁵ Phillips, J. 1987 *A Man's Country? The Image of the Pakeha Male – A History*. Auckland, Penguin Books.
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APPENDIX 1: SUPPORT PROGRAMMES

SALVATION ARMY BRIDGE AND OTHER ALCOHOL-RELATED SUPPORT PROGRAMMES

Bridge Programme

The Salvation Army Bridge Programme is aimed at people moderately to severely affected by their harmful use of or dependency on alcohol and/or drugs.

The programmes involve support from initial contact through to detoxification, treatment and for a support period afterwards. The length of programmes varies, with the average period of engagement with an individual being six months. A few programmes run for up to one year.

Bridge Programmes are in 15 locations throughout New Zealand from Kaitaia to Invercargill. Those locations include wider catchment areas from where programme participants are drawn. Some locations run a range of programmes that are tailored to the needs of individuals and the community. In all areas, typically, a treatment plan is developed with the individual. Where practical, family and friends can become involved in the individual's treatment plan.

Over the 2009 calendar year, a total of 744 people from all backgrounds went through the Bridge Programme. The following provides a picture of programme participants:

- They range from under 20 years to over 60 years of age. The largest proportions are in the 40–49 (27 percent) age group and 35–39 (16 percent) age group. Almost

three quarters of programme participants are aged between 30 and 59 years old (73 percent).

- Considerably more men than women participate in the programme—64 percent are men while 36 percent are women.
- Over two-thirds of programme participants identify as NZ European (69 percent), while 23 percent identify as Maori, four percent identify as Pacific people and five percent identify with another ethnic group.

Individuals are referred to the Bridge Programme through a wide range of government and non-government agencies, including other addictions services such as CADs and social services including CAB and budget advisory services. Self referral is common. Often this reflects the actions of family and friends, as well as employers and in some cases lawyers in encouraging the individual to seek treatment.

Pre-programme support

The Salvation Army recognises that the time before treatment is very difficult for individuals. Bottlenecks into detoxification and from there into treatment mean that the process has to be carefully managed, with coordination of times to reduce waiting and to keep individuals motivated in their commitment to treatment.

Pre-programme support includes assessment, counselling and preparing individuals to enter treatment programme. The latter includes help with making arrangements regarding their family and household matters.

Contact is maintained with individuals prior to entering detoxification and treatment in a variety of ways through meetings, phone calls and text messages.

Post-programme support

The Salvation Army operates on the key principles that critical to recovery is safe accommodation and meaningful activity, such as employment, education or training that can build self-worth.

In working to those principles, The Salvation Army runs a two-year after care programme for Bridge Programme graduates. After care involves a range of activities tailored to the individual. These include group work, one-on-one counselling, Recovery Church, spiritual focus groups, and assistance with finding safe accommodation and meaningful activity.

These supports are available where Bridge Programmes are run. Those who live at a distance from programme locations may find it difficult to access support. The Salvation Army acknowledges that there are significant challenges in making support arrangements happen as this usually involves coordination of different services run by a number of agencies.

Supported Accommodation

The Salvation Army provides supported accommodation for a wide range of people. The main supported accommodation properties are in Epsom Auckland (91 beds), Addington Christchurch (75 beds), Invercargill (around 33 beds) and Palmerston North (around 15 beds).

Supported accommodation is provided to some, such as those released from prison who are waiting to enter a Bridge Programme. The accommodation is also available for those graduating from a Bridge Programme who need help with accommodation. However, most are able to arrange their own accommodation before leaving a Bridge Programme.

Working with other agencies

Salvation Army personnel work in courts and prisons providing addictions assessments and support.

The Salvation Army also refers individuals to other addictions providers, mental health providers and other specialised supports where needed.

Evaluation

The Salvation Army has recently implemented an evaluation process to gather data on post treatment outcomes. This process will include following up both those who complete a programme and those who do not.

APPENDIX 2: FOCUS GROUP QUESTIONS

- 1. What influences your drinking habits and behaviours?**
 - A. Family?
 - B. Friends?
 - C. Community? (e.g. availability, promotion, sports)
 - D. Other influences? (e.g workmates, church)
- 2. Is there something specific that triggers your drinking? (explore what that is)**
- 3. Out of all those influences and triggers, what do you think has the biggest influence on your drinking habits and behaviours?**
 - A. And why is that?
- 4. How do these influences and triggers work?**
 - A. Do they cause your behaviours? How?
 - B. Do they support or reinforce your behaviours? How?
 - C. Do they challenge your behaviours? How?
 - D. Do they change your behaviours? How?
- 5. What aspects of your environment could be changed to help reduce the impacts of alcohol on you?**
 - A. Your environment could be your family, your community, the neighbourhood, the workplace, who you have contact with.
- 6. Are there aspects of your environment that would be very difficult to change to help reduce the impacts of alcohol on you?**
 - A. What sort of things are those?
 - B. Why do you think they would be difficult to change?
- 7. In general, what aspects of our society need to be changed in order to reduce the impacts of alcohol on people's lives?**
- 8. How do you think those changes could happen?**
 - A. What should happen?
 - B. Who should be involved in making these changes?

ABOUT THE AUTHOR

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Bev James is the principal of Public Policy & Research Ltd. Bev has wide-ranging experience in policy analysis and management, social research and evaluation. Her particular interests are in housing, community development and resource management. She has worked on a range of policy and research projects for central and local government agencies, as well as for community organisations.

Bev has an academic background in sociology and has lectured at Massey University. Currently she is involved in a five-year research programme: 'Ageing in Place, repairs and maintenance of older people's housing'. Bev lives in Marlborough where she is active in the promotion of affordable housing through a local housing trust.

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