A New National Drug Policy for New Zealand

Ministry of Health

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Women's Health Action (WHA)

Women's Health Action is a women's health promotion, information and consumer advisory service. We are a non-government organisation that works with health professionals, policy makers and other not for profit organisations to influence and inform government policy and service delivery for women. Women's Health Action is in its 30th year of operation and remains on the forefront of women's health in Aotearoa New Zealand. We are highly regarded as leaders in the provision of quality, evidence-based consumer-focused information and advice.

We provide evidence-based analysis and advice to health providers, NGOs and DHBs, the Ministry of Health, and other public agencies on women's health (including screening), public health, and gender and consumer issues with a focus on reducing inequalities. We have a special focus on breastfeeding promotion and support, maternal and child health, women's sexual and reproductive health and rights, and the promotion of positive body image.

Please visit our website for more information: www.womens-health.org.nz

Thank you for the opportunity to provide a submission in support of the development of a new National Drug Policy for New Zealand. Women's Health Action Trust, in partnership with Alcohol Healthwatch, has recently completed a Ministry of Health funded research project on women and alcohol in New Zealand and we are very pleased to have the opportunity to provide you with a summary of our findings and recommendations to help inform the development of a new National Drug Policy for New Zealand.

1. Introduction

The focus of this submission is to provide a summary of the key findings and recommendations of the 'Women and Alcohol in Aotearoa/New Zealand' research project recently completed by Women's Health Action in partnership with Alcohol Healthwatch and in consultation with Hapai Te Hauora Tapui Maori Public Health. While the research focused specifically on alcohol, some of the findings may be translatable to the harmful effects on women of other drugs including cannabis, methamphetamine, new psychoactive substances, and tobacco. The research was funded by the Ministry of Health and was conducted with the aim of addressing the knowledge gap in New Zealand about the patterns of women's drinking, if and how these are changing, the harmful impacts of alcohol on women's lives, including the effects of both their own drinking and the drinking of others, and the effectiveness of efforts to reduce alcohol harm for women.

The research included an extensive review of the literature on alcohol and women, with particular reference to women in New Zealand. We also undertook focus groups and individual interviews with 41 key informants working in a range of health and social services. These informants were selected for their experience with, and insights about, the effects of alcohol on the lives of women and included a Maori focus group organised and independently analysed by Hapai Te Hauora Tapui and a fono talanoa for Pacific participants.

2. Recommendations for the new National Drug Policy

Our goal in presenting the findings of our research is to provide a strong evidence-based rationale for the new National Drug Policy to include **a specific focus on women and to incorporate gender-based analysis, alongside attention to other intersecting population group differences including ethnicity, socio-economic status, age, ability, sexuality and gender identity.** This will help ensure the policy is responsive to sex and gender differences in the use and harmful effects of alcohol, helping to ensure the success of alcohol harm minimisation strategies and the best outcomes for both men and women in Aotearoa New Zealand, along with intersex and gender diverse populations.

In addition, alongside a specific focus on women and the use of gender-based analysis, the research identified multiple opportunities for reducing alcohol-related harm on which a new National Drug Policy should take a lead.

Our recommendations for a new National Drug Policy are that it should:

- Include a specific focus on women and the use of gender-based analysis.
- Recognise the health and social cost of alcohol-related harm, and enable the necessary commitment and investment to achieve measurable and sustained reductions in alcohol-related harm within the next 5 years.
- Commit to evidence-based policy implementation, and support the development of a sector-led national alcohol harm reduction strategy and accompanying action plan.
- Recognise the link between alcohol harm and social inequities, and enable actions that measurably reduce inequities and mitigate the risks of contributing to further inequities.

- Explicitly provide for workforce development and planning to meet the needs and expectations of wahine Maori.
- Include wide consultation with Maori to identify how to meet their aspirations for whanau ora.
- Include wide consultation with Pacific peoples to identify how policies and services can better meet their needs and expectations, and address inequities.

3. Why including gender-based analysis in a new National Drug Policy will help improve outcomes for women?

The World Health Organisation (WHO) have recognised that sex (the biological differences between women and men) and gender (the social and cultural norms that determine femininity and masculinity) have an important impact on health and wellbeing[1]. Sex differences are the biological characteristics such as anatomy and physiology that distinguish female and male bodies[2]. To improve health status, sex differences such as hormones and metabolic processes and their link to biological or genetic differences in susceptibility to disease or responsiveness to treatment need to be understood. For example female bodies process the same amount of alcohol more slowly than male bodies of the same body weight, meaning that alcohol can harm women sooner and more seriously, including the more rapid development of chronic alcohol-related diseases[3]. Therefore, interventions such as low risk alcohol drinking guidelines will need to take into account sex differences.

Gender influences are the socially constructed roles and responsibilities, attitudes, behaviours, values and relative power that society differentially ascribes to males and females. While gender is a fluid concept and is not restricted to the two distinct categories of male and female most societies are organised 'along the "fault lines" of sex and gender such that women and men are defined as two different types of people, each with their own roles, responsibilities and opportunities'[4]. The past 50 years have seen significant change in women's social roles, particularly in developed countries. Women today balance the stresses of multiple roles, including family and childcare responsibilities, paid employment, and community and voluntary activities. Despite many gains, women in New Zealand continue to experience persistent inequalities, including higher rates of poverty, a gender pay gap, high rates of intimate partner and sexual violence, lower representation in decision-making and disparate access to paid parental leave and early childhood education.

The harmful use of alcohol, both women's own drinking and the drinking of others interact with many of these factors to have specific harmful effects on women. For example, there is strong evidence that in the context of intimate partner or sexual violence against women, alcohol consumption by the

[1] World Health Organisation. 2002. Integrating gender perspectives in the work of WHO. http:/www.who.int/gender/documents/gender/a78322/en/index.html
[2] Women's Health Action recognizes that some people are born with a reproductive or sexual anatomy that doesn't fit the typical definitions
[3] Schulte M.A., Ramo, D., & Brown, S.A. (2009). Gender differences in factors influencing alcohol use and drinking progression among adolescents. Clinical Psychology Review, 29(6). 535-547.
[4] BC Women's Hospital and Health Centre and British Columbia Centre of Excellence for Women's Health. 2004. P.19.

perpetrator is a key factor in the prevalence and severity of attacks[5]. **Recognising the gender differences in alcohol related harm, and in particular that many of the harmful effects of alcohol on women are caused by others drinking, provides a strong rationale for the new National Drug Policy to expand its definition of harm to place a greater emphasis on the harm that alcohol and other drugs cause to people other than those who use them (p.5 A New National Drug Policy for New Zealand: Discussion document). A successful National Drug Policy will be attentive to the gender differences in the dynamics of alcohol (and drug) -related harm.**

As both sex and gender influences the health and social outcomes related to the harmful consumption of alcohol, effective research, policies and programmes intending to reduce alcohol-related harm must be sensitive to sex differences and gender influences. Gender-based analysis is a tool that permits the identification of differences and potential inequalities that arise from belonging to one sex or another, and the gendered values ascribed to that sex, or from relationships between the sexes. As the WHO has identified, 'These inequalities can create, maintain or exacerbate exposure to risk factors that endanger health'. It is also a method for examining the intersection of sex and gender with other identity factors influencing health and social outcomes related to the harmful consumption of alcohol including ethnicity, indigeneity, socioeconomic status, sexuality, gender identity and ability[6].

Both the United Nations and the World Health Organisation hold that for public health practice to achieve health equity, gender considerations must be integral to all facets of research, policy and programme development. The CEDAW Committee's recent review of New Zealand's progress in implementing the convention expressed concern that the New Zealand government has not taken sufficient steps to ensure that gender considerations are mainstreamed into all national plans and government institutions. **Incorporating gender-based analysis into the development of a new National Drug Policy should therefore be prioritised.**

4. Including a specific focus on women and alcohol

In addition to demonstrating the importance of attention to sex and gender differences in all aspects of the new National Drug Policy, our research provides a rationale for including a specific focus on women as a population group in the strategy. Our research indentified differences in how women are drinking, what they are drinking, the major influences on women's harmful use of alcohol, in the harmful effects of alcohol on women, and in the strategies that will best reduce the harmful effects of alcohol on women. A more substantial description of these is included in our policy briefing paper 'Women and alcohol in Aotearoa New Zealand' which summarises the research, and which we have included as an appendix to this submission. However, we provide some examples below:

[5] Stevenson, R. (2009). National alcohol assessment. Wellington: NZ Police.
[6] Health Canada. 2003. What is gender-based analysis? http://www.hc-sc.gc.ca/hl-vs/pubs/women-femmes/gender-sexes-eng.php

4.1 How and what women are drinking?

One recent survey reported that between 1996 and 2012 the rate of hazardous drinking among women remained relatively stable at around 12% of drinkers[7]. However, other surveys indicate that women of all ages have increased their alcohol intake in the last two decades, and this has been most marked in younger women[8 9 10]. There are ethnic differences in the proportion of drinkers, and in the frequency and volume of drinking among women. Maori and Pacific women were more likely than Pakeha women to be non-drinkers and to drink less often, but more likely to have more drinks on a typical occasion, although these factors vary by ethnicity among Pacific women[11]. Pakeha women were more likely to be drinkers and to drink regularly, but less likely to binge. There is strong evidence about the appeal of ready-to-drinks (RTDs) for young people, especially young women. Young people, both female and male, are the most common consumers of RTDs, and those who drink them are more likely to be heavier drinkers than those who do not. In one study RTDs made up 70% of the alcohol intake of 14-17 girls[12].

4.2 Major influences on women's harmful alcohol use

The harmful use of alcohol by women is not simply a matter of individual choice but is influenced by a range of environmental, social, cultural and economic influences including the availability and affordability of alcohol, drinking culture, social and economic inequalities, and the experience of violence and abuse.

Women who have been physical and sexually abused have significantly greater rates of problem drinking[13], and those who have been treated violently by an intimate partner have higher rates of alcohol dependence than those who have not[14]. Estimates of the proportion of women who drink to

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[7] Ministry of Health (2013). *Hazardous drinking in 2011/12: Findings from the New Zealand Health Survey*. Ministry of Health, Wellington.

[8] Fergusson, D.M., Boden, J. (2011) Alcohol use in adolescence. In OPMSAC (Ed.), *Improving the transition – Reducing social and psychological morbidity during adolescence* (Vol. 235-256). Wellington: Office of Prime Minister's Science Advisory Committee.

[9] Fryer, M., Jones, O., & Kalafatelis , E., (2011) Adults and Youth 2009-10 Drinking Behaviours Report. *ALAC Alcohol Monitor.* Wellington: ALAC.

[10] Huckle, T., Pledger, M., & Casswell, S., (2012) Increases in typical quantities and alcohol-related problems during a decade of liberalizing alcohol policy. *Journal of Studies on Alcohol and Drugs, 73 (1), 53-62.*

[11 11] MSD. (2010). *The Social Report/ Te Purongo Oranga Tangata 2010*. Wellington: Ministry of Social Development.

[12] Huckle, T., Sweetsur, P., Moyes, S., & Casswell, S. (2008). Ready to drinks are associated with heavier drinking patterns among young females. *Drug & Alcohol Review, 27*, 398-403.

[13] Stewart, S.H., Gavric, D., & Collins, P. (2009). Women, girls and alcohol. In K. Brady, S. E. Back & S. F. Greenfield (Eds.), *Women and addiction: A comprehensive handbook* (pp. 341-359). New York, USA: Guilford Press

[14] Kay, A., Taylor, T.E., Barthwell, A.G., Wichelecki, J., & Leopold, V. (2010). Substance use and women's health. *Journal of Addictive Diseases, 29*(2), 139-163.

cope with partner and other violence vary from 10% of Maori and 7% of Pakeha women to one in three women[15]. Most only begin to drink heavily after the violence has started. Eight percent of female victims of sexual offences, assaults, robbery or threats said they have increased their use of alcohol, drugs or medication as a result[16].

Young people who are mistreated or abused in childhood are more likely to start drinking early, drink heavily as teenagers and abuse alcohol[17]. Women are more likely to experience sexual assault as children and use alcohol to cope with post-traumatic stress disorder (PTSD)[18]. Women with PTSD are estimated to be 1.4 times as likely to develop alcoholism[19]. Those who are sexually assaulted while affected by alcohol tend to blame themselves more, drink more and have more alcohol-related problems after the assault[20]. Women who blame themselves are more likely to have worse long-term results, including alcohol-related hospitalisations and arrests[21].

4.3 Harmful effects of alcohol on women

Our research found that the harmful effects of alcohol on women are increasing, and that in almost no areas is alcohol-related harm reducing. Alcohol-related harms for women include financial vulnerability, diminished physical and mental health, an increase in the severity and prevalence of violence directed at them, unplanned pregnancies and compromised parenting, family breakdown and erosion of cultural values and wellbeing. At its worst, alcohol can result in injury, illness and death for women. Women experience these harms from their own drinking, and are more likely than men to experience harm from the drinking of others.

Alcohol plays a prominent role in sexual and domestic violence against women, and alcohol-related violence is worsening. **Increasing evidence shows that violence is the major alcohol-related harm**

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[15] Cunningham, C., Triggs, S., & Faisandier, S. (2009). *Analysis of the Māori experience: Findings from The New Zealand Crime and Safety Survey 2006*. Wellington: Ministry of Justice.

[16] Hager, D. (2011). *Why women require specialised refuge services when they are suffering from mental health or drug and alcohol problems – and domestic violence*. Auckland: Homeworks Trust.

[17] Fergusson & Boden, 2011.

[18] Wiechelt, S.A., Miller, B.A., Smyth, N.J., & Maguin, E. (2011). Associations between post-traumatic stress disorder symptoms and alcohol and other drug problems: Implications for social work practice. *Practice: Social Work in Action, 23*(4), 183-199.

[19] Dansky, B., Saladin, M., Brady, K., Kilpatrick, D., & Resnick, H. (1995). Prevalence of victimization and post-traumatic stress disorder among women with substance use disorders: Comparison of telephone and in-person assessment sample. *International Journal of the Addictions, 30*, 1079-1099.

[20] Bedard-Gilligan, M., Kaysen, D., Desai, S., & Lee, C.M. (2011). Alcohol-involved assault: Associations with post-trauma alcohol use, consequences, and expectancies. *Addictive Behaviors, 36*, 1076-1082.

[21] Ullman, S.E., & Najdowski, C.J. (2010). Alcohol-related help-seeking in problem drinking women sexual assault survivors. *Substance Use & Misuse, 45*, 341-353. doi: 10.3109/10826080903443644

experienced by women and children as a consequence of the drinking of others, overwhelmingly men[22].

There is strong evidence that in the context of domestic or sexual violence, alcohol is a key factor in the prevalence and severity of attacks. At least one in three New Zealand women experience violence from male partners in their lives, and at least one in three cases of reported domestic violence is alcohol-affected, although the actual number is considered likely to be much higher[23]. If women in abusive relationships are consuming alcohol themselves, this can prevent them from seeking help[24]. If the woman was drinking at the time of the assault it can lead to guilt or self-blame, inhibit access to justice and increase her potential for alcohol abuse.

It is estimated that more than 10,000 sexual assaults occur in New Zealand each year which involve a perpetrator who has been drinking. While issues of under-reporting and under-recording of alcohol and drug assisted sexual violence are acknowledged, alcohol is linked to half of all reported sexual assaults[25]. However, social attitudes assign blame very differently in cases of rape involving alcohol. Women who drink are seen as less believable and more responsible for the assault and men who drink as less responsible[26]. Female victims who had been drinking are more likely to blame themselves for their rape. In cases of sexual violence that go to court, the victim's alcohol or other drug use can lead to police not believing her, insufficient evidence due to the effect on her memory, the victim withdrawing legal cases early, and lower chance of conviction[27].

4.4 Preventing or reducing the harmful effects of alcohol on women

Because the harmful effects of alcohol on women are the result of environmental, social, economic and individual factors, single strategies to prevent or reduce harm are inadequate and ineffective and rather there is a need for a sustained combination of evidence-based policy and community measures. Our research concluded that effective national legislation and national and regional policies are essential to reduce women's alcohol consumption and the damage inflicted on women.

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[22] Connor, J., You, R., & Casswell, S. (2009). Alcohol-related harm to others: A survey of physical and sexual assault in New Zealand. *NZMJ, 122*(1303); Connor, J.L., Kypri, K., Bell, M.L., & Cousins, K. (2011). Alcohol involvement in aggression between intimate partners in New Zealand: A national cross-sectional study. *British Medical Journal Open*. doi: 10.1136/bmjopen-2011-000065

[23] Stevenson, R. (2009). *National alcohol assessment*. Wellington: NZ Police.

[24] Thompson, M.P., & Kingree, J. (2006). The roles of victim and perpetrator alcohol use in intimate partner violence outcomes. *Journal of Interpersonal Violence, 21*(2), 163-177.

[25] Russell, N. (2008). *A review of the associations between drugs (including alcohol) and sexual violence - Literature review report*. Wellington: Ministry of Justice.

[26] Russell, 2008.

[27] Russell, 2008.

Further regulatory changes would help to prevent or reduce alcohol consumption and damage. These include restricting or eventually eliminating alcohol advertising, marketing and sponsorship; raising the price of alcohol; and restricting the number and type of outlets, their hours of operation and the accessibility of alcohol in supermarkets and grocery stores.

Given the relationship between alcohol and domestic and sexual violence, there is a strong case to increase funding for and the coordination of efforts to addressing alcohol harm and violence against women.

Key informants suggested a wealth of community and health promotion interventions to increase women's wellbeing and resilience, and changing heavy drinking norms. Community projects on alcohol have had wide positive impacts[28]. Kaupapa Maori campaigns have been effective in urban and rural Maori communities, and Pacific community campaigns have raised awareness of alcohol impacts and led participants to question their drinking behaviour[29]. Programmes to reduce alcohol-related problems in sports clubs have reduced women's drinking, improved team performance and created a safer environment for whanau and spectators[30]. Programmes aimed at reducing social supply to underage drinkers have reduced binge drinking in the short term[31]. However, change is unlikely to be sustained unless commercial availability is also targeted[32].

Opportunities exist to increase routine and standardised screening to identify women's harmful drinking, and intervene earlier. Primary care settings and other services that interact with women would seem obvious places to enhance or develop screening and appropriate interventions. Overseas, refuge services for women experiencing domestic violence who also have AOD addiction and mental health problems are effective[33], but these do not exist in New Zealand.

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[28] Litmus. (2009). *Process and impact evaluation of Community Action on Youth and Drugs (CAYAD)*. Wellington: Ministry of Health.

[29] Moewaka Barnes, H. (2000). Collaboration in community action: A successful partnership between indigenous communities and researchers. *Health Promotion International, 15*(1), 17-25.

Southwick, M., Warren, H., Lima, I., & Solomona, M. (2008). *Searching for Pacific solutions: A community-based intervention project to minimise harm from alcohol use. Final Report*. Wellington: Alcohol Advisory Council of NZ.

[30] ADF. (2008). Good Sports: About us. Australian Drug Foundation. Retrieved January 16, 2012, from http://www.goodsports.com.au/goodsports/pages/about-us.html

[31] Cagney, P., & Palmer, S. (2007). *The sale and supply of alcohol to under 18 year olds in New Zealand: A systematic overview of international and New Zealand literature (Final Report) – April 2007. Appendix C: Summary of key New Zealand non-legislative interventions*. Wellington: Ministry of Justice.

[32] Greenaway, S. (2010). *Formative evaluation: Community action to reduce the social supply of alcohol to minors in Mangere*. Auckland: Centre for Social and Health Outcomes Research and Evaluation and Te Ropu Whariki, Massey University.

[33] Hager, 2011.

There is evidence that gender-specific addiction treatment for women is effective, particularly for women who have experienced social deprivation and prior or ongoing abuse[34], but provision is ad hoc. Kaupapa Maori alcohol treatment programmes are more effective for Maori than mainstream programmes[35]. There is recent evidence that alcohol treatment agencies are not always sensitive to differences of sexual orientation and gender identity, and that they need to improve their response to lesbian, trans and intersex clients[36] [37]. Most women presenting for alcohol treatment have other mental health conditions, and have experienced violence. AOD services that work holistically, cross-screening for these factors and taking into account housing, food insecurity and other health care needs, are more effective. AOD treatment for violence men may also be an effective primary prevention of domestic violence[38].

Our research clearly evidences the specific dynamics of women's drinking, of alcohol-related harm as experienced by women, and that the intervention and treatment needs of women may vary from those of men. We therefore recommend the inclusion of a specific focus on women as a population group in the National Drug Strategy, including a focus on the differing dynamics of alcohol-related harm between diverse groups of women.

5. The need for more research- the role of a new National Drug Policy

A solid evidence-base will be essential for ensuring the effectiveness of a new National Drug Policy into the future. Through the course of our research we concluded the need for the implementation of a more strategic approach to alcohol research in New Zealand. This would help enhance knowledge about the role of alcohol in diverse populations of women; and inform the development, and measure the impact of interventions in terms of their effectiveness for diverse populations of women. **We recommend that setting this research agenda is an additional important role for the new National Drug Policy.**

[34] Mackness, L. (2008). Improving treatment paradigms for multi-abuse domestic violence clients. *Te Awatea Review, 6*(2), 4-6.

[35] McCormick, R., Kalin, C., & Huriwai, T. (2006). Alcohol and other drug treatment in New Zealand – one size doesn't fit all. *NZMJ, 119*(1244).

[36] Birkenhead, A., Rands, D. (2012). Let's talk about sex ...(sexuality and gender): improving mental health and addiction services for Rainbow Communities. Auckland District Health Board, OUTline and Affinity Services.

[37] Te Pou. 2012. Mental health promotion and prevention services to gay, lesbian, bisexual, transgender and intersex populations in New Zealand: needs assessment report.

[38] Stuart, G.L., Ramsey, S.E., Moore, T.M., Kahler, C.W., Farrell, L.E., Recupero, P.R., & Brown, R.A. (2003). Reductions in marital violence following treatment for alcohol dependence. *Journal of Interpersonal Violence, 18*(10), 1113-1131.

6. Conclusion

Thank you for the opportunity to provide this submission with the goal of ensuring that a new National Drug Policy for New Zealand is responsive to gender differences and will ensure best outcomes for reducing alcohol (and other drug) related harm experienced by New Zealand women.