

# AlcoholNZ

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**THIS ISSUE**

## Women and alcohol





## Message from the **Minister**

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**Hon Dr Jonathan Coleman**  
Minister of Health

Women's drinking has become a hot topic in recent years, despite the fact that it is men rather than women who are drinking at higher levels and experiencing more alcohol-related harm. There are, however, concerns that women's drinking has been increasing and that a stronger intervention focus is needed on issues specific to women's drinking.

This issue's theme of 'women and alcohol' is, therefore, timely in that it coincides with the Health Promotion Agency's new alcohol and pregnancy communications campaign and related primary health care and other activities to support women who need help.

Not drinking during pregnancy is a crucial means of preventing potential harm to the unborn child.

Activities that provide advice and support to women to stop drinking alcohol if they could be pregnant, are pregnant or are trying to get pregnant are important in helping to ensure that children have the best possible start in life.

Ensuring that appropriate addiction treatment services are available for women who need help with their drinking is also crucial. The right mix is needed of primary health care, community-based and residential addiction treatment services and a workforce trained on how best to meet the needs of women with problematic alcohol use. The right help at the right time can make all the difference.

This issue of *AlcoholNZ* provides interesting articles and new research findings about women's alcohol consumption and their attitudes towards drinking alcohol. It is useful information for developing intervention strategies and for expanding understanding of many aspects of women's drinking and its impacts on them and others.

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Welcome to

# AlcoholNZ

Welcome to the Health Promotion Agency's (HPA's) *AlcoholNZ* magazine. *AlcoholNZ* provides evidence-based articles, topical commentaries and summaries of new alcohol-related research and guidelines to update readers' knowledge of, and inform debate about, alcohol issues in New Zealand. The theme of this issue is 'women and alcohol'.

*AlcoholNZ* contributes to HPA's statutory alcohol-related functions to:

- give advice on the sale, supply, consumption, misuse and harm of alcohol
- undertake, or work with others, to research alcohol use and public attitudes towards alcohol in New Zealand, and problems associated with, or consequent on, the misuse of alcohol.

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This issue of *AlcoholNZ* provides articles about women and alcohol. Highlights include articles about drinking alcohol during pregnancy, women and treatment, and refugee and migrant women's experiences of alcohol in New Zealand.

It also features an analysis of new data about women's drinking, in particular when compared with men's drinking.

The named articles prepared for *AlcoholNZ* are the express views of the authors of the articles.



# Women and alcohol

## An introduction

*Most New Zealand women drink alcohol. Why and what they drink, how much and how frequently they drink, and if they drink at all, often differ with age, life stage, religion and circumstances.*

They may drink alcohol because they enjoy the pleasure, taste and effects that it can provide. They may drink to excess and at harmful levels for multiple reasons, such as fitting in with their peers or to help block out the stresses in their lives. They may choose not to drink for cultural, religious or health reasons, or because they could be pregnant, are pregnant or are trying to get pregnant.

Women often drink less alcohol than men, but the effects of alcohol can be different for women. Women have higher blood alcohol levels after drinking the same amount of alcohol as men, so can get drunk faster and can suffer the toxic and lethal effects of alcohol poisoning at lower doses. This is because women on average:

- are smaller than men so have less fluid in their bodies to contribute to distributing alcohol around (having a higher fat-to-water ratio)
- probably have less of the enzyme needed to break down alcohol in the liver (Health Promotion Agency, 2014).

Some alcohol effects are specific to women. Women who drink alcohol are at increased risk of developing breast cancer. The more alcohol that is consumed on average, the higher the risk of breast cancer (Babor et al., 2010). Women who drink alcohol during pregnancy increase the risk of harm to the unborn child.

Women are less likely than men to die as a result of their alcohol consumption. Research on the alcohol-attributable burden of disease and injury in New Zealand between 2004 and 2007 found that the number of male

deaths (537) was double the number of deaths in women (265) in 2007. The estimated number of years of life lost was two and a half times higher in men than in women. Most of this gap between men and women for alcohol-attributed deaths is due to differences in injury deaths. Injuries made up 73% of all years of life lost from drinking in men and 42% in women (Connor, Kydd, Shield & Rehm, 2013).

Women are more likely than men to report experiencing harmful effects from other people's drinking, including on friendships and social life, home life and financial life (Ministry of Health, 2015).

Gaining a fuller understanding of how alcohol affects women, including on unborn children if they are pregnant, is important especially when designing effective approaches to preventing alcohol-related harms, providing screening and brief interventions and treating those with problematic alcohol use.

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# Drinking alcohol during pregnancy

## An overview and new research

*As most people know, drinking alcohol during pregnancy can affect the developing baby. When a pregnant woman drinks alcohol, the alcohol in her blood passes freely through the placenta and reaches concentrations in the baby that are as high as those in the mother. Unlike the mother, the baby has only a limited ability to metabolise alcohol (Heller & Burd, 2014).*

The consequences of drinking alcohol during pregnancy can include miscarriage, stillbirth or premature birth or a child being born with life-long physical, mental, behavioural and learning disabilities. Fetal alcohol spectrum disorders (FASD) is the term used to describe the range of effects that can occur to a child. It includes diagnostic disorders such as fetal alcohol syndrome (Ministry of Health, 2010). The prevalence of FASD is conservatively estimated at 600 or more New Zealand children born with FASD each year (Connor & Casswell, 2012). However, the number of New Zealand pregnancies harmed by alcohol exposure and the exact number of people affected by FASD are unknown.

What is also not known is how much alcohol is safe for a developing fetus. The level of harm is related to the amount of alcohol consumed, the frequency and timing of consumption, and other factors such as the mother's health and genetic factors. There is strong evidence that drinking excessive amounts of alcohol during pregnancy can damage a developing fetus, but the minimum level at which alcohol begins to affect a baby is not known. A 'no-effect' level has not been established (National Health and Medical Research Council, 2009).

What is known is that FASD is preventable. The New Zealand Ministry of Health and the Health Promotion Agency (HPA) both advise that women should not drink alcohol while pregnant or when planning a pregnancy as there is no known safe level of alcohol consumption at any stage of pregnancy (Ministry of Health, 2010; Health Promotion Agency, 2014). Similar positions are held by The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (2014) and the New Zealand College of Midwives (2009).

Despite advice, many New Zealand women drink alcohol at some time in their pregnancy, although most do stop drinking or reduce their drinking when they know they are pregnant (Ministry of Health, 2015). Unplanned pregnancies are at higher risk of exposure to alcohol because women have not reduced their alcohol consumption in anticipation of getting pregnant, and recognition of an unplanned pregnancy tends to happen later than a planned pregnancy (Mallard, Connor & Houghton, 2013).

The rest of this article outlines recently released research findings about alcohol use and pregnancy, including from the Ministry of Health's 2012/13 New Zealand Health Survey (NZHS) and from a qualitative research project and a literature review that HPA commissioned to inform its programme of work to reduce alcohol consumption during pregnancy.

## **Alcohol and pregnancy – what new data shows**

National data about alcohol use and attitudes towards alcohol, including drinking during pregnancy, provides a useful national picture and helps to monitor trends. In the Ministry of Health's 2012/13 NZHS, 565 women who were pregnant in the previous 12 months answered questions about alcohol use during pregnancy (Ministry of Health, 2015). Key findings are summarised below:

### ***Rates of alcohol consumption during pregnancy***

- About one in five women (19%) who were pregnant in the last 12 months drank alcohol at some point in their most recent pregnancy.
- Younger women were more likely than older women to drink alcohol during pregnancy (28% of women aged 15 to 24 years compared with 17% of women aged 25 to 34 years and 13% of women aged 35 to 54 years).
- The highest rates for drinking during pregnancy were for Māori women (34% compared with 20% for European/Other women, 10% for Pacific women and 4.3% for Asian women).

### ***Changes to drinking behaviour leading up to and during pregnancy***

- Most women who were pregnant in the last 12 months altered their drinking behaviour leading up to and during pregnancy.
- One in three women (31%) stopped drinking before pregnancy, and one in two (55%) stopped drinking when they became aware of their pregnancy.
- One in six women (about 15%) continued to drink during most of their recent pregnancy. Of this group, the majority (8.5%) reduced their drinking while pregnant.

### ***Drinking behaviour before pregnancy***

- Most women (78%) who were pregnant in the last 12 months and who drank during their pregnancy reported risky drinking at some point in the past year (defined as drinking more than four standard drinks on one occasion).
- Of these women who reported drinking during their most recent pregnancy, 89% of those aged 15 to 24 years and 73% of those aged 25 to 34 years reported risky drinking in the past year.

## Advice not to drink during pregnancy

- More than two-thirds (68%) of women who were pregnant in the last 12 months and who had ever drunk alcohol received advice not to drink during pregnancy.
- About half (49%) of those advised not to drink while pregnant were advised by general practitioners (GPs). Of those who were advised not to drink by someone other than a GP, this advice was received from another health professional (eg, nurse, midwife or obstetrician), a spouse or partner, a relative or a friend (Ministry of Health, 2015).

A fuller analysis of this NZHS data can be found in the Ministry of Health publication *Alcohol Use 2012/13: New Zealand Health Survey* available to download at [health.govt.nz](http://health.govt.nz).

## Understanding factors that influence alcohol use during pregnancy

Having an understanding of the factors that influence alcohol use during pregnancy is helpful when developing prevention strategies. The qualitative research project *Insights from women about drinking alcohol during pregnancy* (Research New Zealand, 2014b) was commissioned by HPA to inform its alcohol and pregnancy work programme and to help fill a gap in New Zealand research identified in the companion literature review (Research New Zealand, 2014a). The overall objective of this research was to identify and understand the factors that influence alcohol drinking practices during pregnancy among different groups of New Zealand women.

Face-to-face interviews were conducted during July 2014 with 24 women from the greater Wellington region. These women were either pregnant at the time or were recent mothers and held the attitude that either it's not OK to drink at all or it's OK to drink a little, occasionally.

The following factors were found to have influenced these women's attitudes and behaviours towards drinking alcohol during pregnancy:

- *A woman's desire to drink alcohol during pregnancy.* This was largely determined by pre-pregnancy drinking behaviour. Women who hardly drank pre-pregnancy found it easy to stop drinking when pregnant; those who enjoyed drinking before they became pregnant were less inclined to give up alcohol completely during pregnancy.
- *A woman's level of anxiety about baby's health and wellbeing.* Women who were more anxious were more risk averse, so not drinking alcohol was an easy choice. This tended to include women whose pregnancy was planned, those for whom it was their first pregnancy and those who were older or very young.
- *A woman's knowledge and understanding or misunderstanding of the risks and immediate/short-term effects of alcohol for the developing baby and the potential longer-term/permanent impacts.* All women understood that drinking excessive amounts of alcohol could have detrimental effects on their babies, but women were less knowledgeable about the effects of moderate or less frequent drinking. Women who believed there could be long-term effects of low to moderate alcohol consumption imagined these effects to be relatively minor. Those who had researched the topic found the evidence inconclusive and, in the absence of information to the contrary, concluded that it was OK to drink a little, occasionally, during pregnancy. A few assumed that their babies were protected by the placental barrier.
- *Advice from a lead maternity carer, especially a midwife.* The stronger a woman's relationship with her midwife, the more likely she was to ask for and follow his or her advice. Most women recalled receiving advice not to drink alcohol from their midwife and/or doctor, but few recalled this being backed up with any information or discussion about the topic.

## What other literature shows

The literature review *Drinking alcohol during pregnancy* (Research New Zealand, 2014a) reviewed recent New Zealand and international published literature related to alcohol and pregnancy. Highlights include the following:

- Predictors of drinking during pregnancy that are consistently identified in the literature are: frequent and/or high alcohol consumption prior to pregnancy; alcohol problems; being abused or exposed to violence; social or psychological factors such as anxiety and depression; older age; higher socio-economic status; and smoking.
- Women drinking at high-risk levels after the first trimester are more likely than other pregnant women to be younger, have lower levels of education, be single parents and smoke cigarettes or use recreational drugs.
- The majority of women know that stopping alcohol use is an important behaviour associated with increasing the chances of having a healthy baby, although many women have limited knowledge about the specific effects of alcohol on the unborn child.
- Health care providers are seen as a key source of information for pregnant women and can act as endorsers or spokespersons for prevention messages.

Further research findings about alcohol and pregnancy can be found in the literature review and the qualitative research report that are published on HPA's websites – [alcohol.org.nz](http://alcohol.org.nz) and [hpa.org.nz](http://hpa.org.nz).

## Prevention strategies

The challenge then is what can and should be done to prevent and reduce alcohol use during pregnancy. Making a difference requires a range of strategies by many players at many levels.

A comprehensive approach is needed to reduce alcohol-exposed pregnancies. This should include population-based strategies as well as targeted, individual-level interventions. It should also address the diverse needs of all women of childbearing age, including those who are pregnant, those who are trying to become pregnant and those who might become pregnant (National Task Force on Fetal Alcohol Syndrome and Fetal Alcohol Effect, 2009).

HPA's alcohol and pregnancy work, which is focused on reducing alcohol drinking during pregnancy, includes all of these components. A comprehensive approach has been developed that includes marketing and communication strategies to raise population awareness of the risks of drinking in pregnancy, and activities to support health professionals to provide brief advice routinely to women at risk of alcohol-exposed pregnancies. HPA is also supporting efforts to ensure effective support and treatment for those women at greatest risk of having alcohol-exposed pregnancies.

The first phase of HPA's alcohol and pregnancy communications begins in mid-June 2015. The campaign will use digital channels, such as social networking sites and online advertising, to target young women who drink with a message that if there is any chance you could be pregnant, don't drink alcohol.



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# Women and treatment Transformations – we do recover

*The following article has been prepared by Suzy Morrison, Matua Raki.*

“She could never go back and make some of the details pretty. All she could do was move forward and make the whole beautiful” (Brown, 2010, p. 63).

I was invited to write an article on women and treatment with a focus on alcohol. A huge topic and one that is close to my heart. I am a woman in long-term recovery from dependency on alcohol and other drugs (AODs). I have worked as a social worker and am an AOD clinician. I currently work at Matua Raki – National Addiction Workforce Development Agency as the consumer project lead.

Statistics relating to alcohol use reveal that alcohol is the most commonly used recreational drug in Aotearoa New Zealand (Ministry of Health, 2009).

Historically men have been more likely than women to drink heavily (and use other drugs). It appears that a younger generation of women is emerging and beginning to get closer to matching their male counterparts. There is evidence, however, that women and men differ in the causes and progression of their problematic substance use (Nelson, 2012).

Although most women can enjoy alcohol without negative consequences, for some women using alcohol is a problem with negative impacts on them, their families, their friends and their communities. This is backed up by a growing body of evidence.



I want to acknowledge that problematic alcohol use affects many women regardless of age, race, ethnicity, sexual identity or religion. Dependency does not discriminate. It affects young women, middle-aged women, older women, Pākehā women, Māori women, Pasifika women and Asian women. It also affects their families.

### **A brief history**

Throughout my adult years I attempted to manage my use of alcohol. I tried everything to drink alcohol in a way that was 'socially acceptable'. I really wanted to be that woman, the woman in the advertisements having fun who could enjoy a glass of wine, maybe two, and leave it there. That is not how it was for me. I was unable to stop once I had started. Consequently I believed I was deeply flawed. I experienced blackouts and never told anyone. It was a secret. I didn't want others to know how out of control I was and felt. I was full of shame and alone.

For many years I was involved with outpatient AOD services that did their best to support me and my family. I was afraid to tell them my full story for fear my daughters would be taken from my care. In the end, my life became so unmanageable and so full of fear and guilt and shame that I reached out for help and agreed to go to a residential treatment centre.

Access to residential treatment out of my area saved my life. During my time in treatment my family members were able to participate. As a result of a week spent in treatment with me, my partner realised he needed to address his dependency issues and went on to do so. My 15-year-old daughter also came for 'family week'. She later went back and did treatment for six weeks as a family member. Three years later she realised she had her own dependency issues and made a decision to recover. I attribute my daughter's early identification of her own issues to the opportunity she had to participate in my and her own treatment.

### **Barriers to accessing treatment and consequences**

It seems there are barriers unique to women that can prevent easy access to treatment.

Stigma is one. Although stigma (self and societal) affects everyone, women with problematic substance use are thought to be more severely stigmatised due to attributed stereotypical characteristics, such as being caring and nurturing, especially if they are mothers (Nelson, 2012). Nelson goes on to say, "Women are traditionally seen as carers and nurturers and when faced with the reality of their problematic substance use they can feel very

shamed, and are very often ostracised by society. It is thought that the stigma attached to men's problematic substance use is not as extreme as that experienced by women, primarily due to these traditional stereotypes that are attributed to women and their roles" (p. 60).

These experiences are borne out by the practice-based evidence of a woman who has been assessing people seeking residential treatment for more than 20 years. I asked Kathy Mildon, social worker at the Higher Ground Drug Rehabilitation Trust (Higher Ground) in Auckland, what her observations were of the women who presented for assessment. Kathy responded, "By the time women get to us they tend to be more physically and mentally unwell than the men. They have been out there longer, often because of child care responsibilities."

I spoke with her about Higher Ground's weekly pre-admission women's group. Kathy said the focus of the group inevitably led back to children and perceived stigmas, internal and external. Common concerns were: the guilt and the shame of AOD use and associated behaviours; how it affected their children; and the fear of having the children removed if services were to hear their full stories.

Higher Ground has 52 residents at any one time, with usually a 50-50 split between females and males. Recent research identified some of the differences related to gender. Women had fewer legal problems than men and were more likely to indicate that alcohol was their drug of choice. They reported more health problems, both physical and psychological (Raymont, 2013).

## One size doesn't fit all

So we are aware that there is a problem for many women in our community. And we are aware that one size does not fit all. How then do women access treatment that fits? I spoke with a woman who had been alcohol dependent for many years and she stated that she hadn't known where to turn despite regular involvement with mental health services since 16 years of age.

Lisa<sup>1</sup> is in her mid-30s and has been in recovery from alcohol dependency for five years. I asked her how she had found her way to treatment and what had happened for her when she got there.

Lisa told me she had got to a crisis point, despite doing her best to manage. In her words, "I was more and more out of control. I thought I can't do this one more time." Lisa called the 0800 Alcohol and Drug Helpline (run by Alcohol and Drug Association New Zealand). She had seen its number several months prior and had taken note. Lisa recalled her experience of that first anonymous call to the Helpline warmly, stating "they listened and did not judge". Lisa was given the number for the Community Alcohol and Drug Service in her area. She rang and made an appointment and was assessed and allocated for weekly one-to-one counselling. This was followed with a referral to a women's group in Intensive Outpatient Treatment (IOP) – a setting that Lisa described as "a perfect fit for me". The Women's IOP was followed up with the option of two years participating in a continuing care group that enabled Lisa to connect with the peer and community supports in her area.

However, one size does not fit all. For Lisa, outpatient treatment followed by gender-specific IOP was "a perfect fit". For me, residential treatment out of my area saved my life and gave me the time and space in a supportive environment to 'come to'. For other women, the right fit may be counselling, mutual aid groups in the community such as Alcoholics Anonymous and Narcotics Anonymous, support from a church or other community group, or online support such as the [livingsober.org.nz](http://livingsober.org.nz) website.

## Support from peers

What both Lisa and I benefited from, though, was the support of unpaid peers along the way.

The question arises, what is a peer? A peer is a person who has had a similar experience to another person, such as, in this context, a lived experience of addiction and recovery. Peer credentials may be legitimised in terms of recovery status rather than acquired education credentials. Peer workers can provide assertive linkages in the community to sustain recovery.

Peer support work (PSW) is emerging as a discipline in the AOD sector. There is a visible return of people in recovery into the addiction milieu. It has experienced growth in recent years. Much of this growth is in Auckland. PSWs are generally placed within established AOD treatment settings.

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1 Name has been changed.



Pregnancy and Parental Services (PPS), a mobile outreach service based in Auckland, is an example of an integrated service that uses paid PSWs as part of its service delivery. PPS works with pregnant women and parents of children under three years of age who use AODs, regardless of custody issues, and who are poorly connected to health and/or social services. The PSW model enhances clients' self-efficacy and self-esteem and supports clients to engage with the wider community.

### Bringing the strands together

My story and Lisa's story have many similarities to the stories I have heard women speak as they transform their lives. Since I began my recovery journey, I have heard hundreds of stories in anonymous rooms and in the context of being a social worker and an AOD clinician. We may look different on the outside but the secrets, shame, guilt, loneliness and fear are universal. It's not what we take; it's where it takes us.

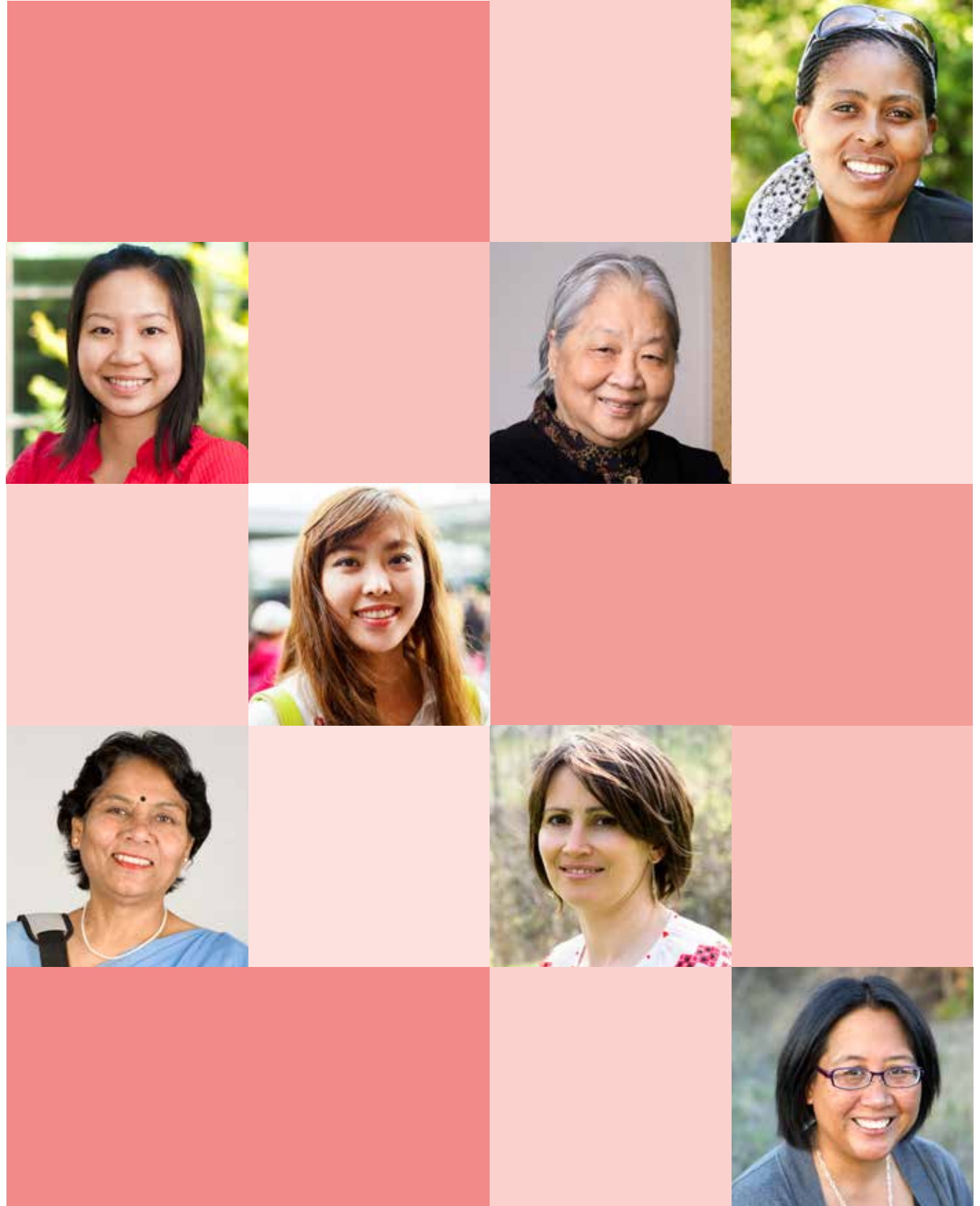
When I was going through the very painful, lonely and drawn-out process of letting go of the idea that I could or should fix myself, I thought I was the only one. The shameful secret that I could not stop once I started kept me very sick. Blessedly, I was wrong. I am not the only one.

In the words of David Best et al. (2010), "Recovery is most effective when service users' needs and aspirations are placed at the centre of their care and treatment" (p. 24). Easy access to treatment services is paramount to support the women and their families in our communities affected by problematic AOD use.

I will be forever grateful for the wise, empathic and patient counsel that I received. The transformation continues. Services were there to support me, before, during and after I was able to see and face the changes. They were there as my daughter came to terms with her alcohol dependency. The only thing I would change with the service I received would be the addition of a PSW – someone who has their own story, their lived experience of dependency and recovery alongside me to navigate the slings and arrows of outrageous fortune.

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# Navigating two worlds

## Refugee and migrant women's experiences of alcohol in New Zealand

*Every year a large number of people arrive from other countries to take up residence in New Zealand on a temporary or permanent basis. The majority stay only temporarily (less than 12 months), while approximately 45,000 to 50,000 migrants are able to stay permanently. Approval for permanent residence includes a formal annual quota for the resettlement of refugees of 750 places, plus or minus 10% (Ministry of Business, Innovation and Employment, 2014).*

Around half of all refugees and new migrants taking up residency are women (Ministry of Business, Innovation and Employment, 2014). These women come from a diverse range of countries, ethnic groups and cultures and with a diverse range of religions, backgrounds, languages and experiences. They come with their families, to be reunited with their families or on their own. They also come for a range of reasons, such as to work, to attend university or on humanitarian grounds such as to escape persecution within their countries of origin. According to the March 2015 refugee quota arrival statistics, just over 11% of all refugees approved for resettlement from 2004 were granted permanent residence under the 'women at risk'

category (Immigration New Zealand, 2015). Therefore, while arriving in a new country typically brings with it joy and excitement for many people, for most refugee women and some new migrant women it can be a daunting and challenging time.

Dr Arif and Fahima Saeid, who work for Refugees as Survivors New Zealand, explain that:

*Most refugees have experienced persecution, torture and/or imprisonment in their own countries. When refugees leave their home countries they face uncertainty and fear for their future... Once refugees arrive at any resettlement country, they face... challenges such as socio-cultural changes, language barriers... [and] limited understanding of socio-cultural norms and laws... [These challenges] can cause difficulties for refugees and their families.*

While migrants make a choice to take up new lives in New Zealand, Mariska Mannes, a former coordinator for Ethnic Voice New Zealand, comments that:

*For some, the cultural differences they encounter are almost in conflict with their own values and beliefs, and this turns what should be a happy time into one of isolation, doubt and identity crisis.*

Significant cultural differences can place refugee and migrant women in situations where they find themselves navigating between the customs that they have always known and accepted and the cultural norms and pressures of their new home countries. Alcohol use is a case in point.

This article focuses on refugee and migrant women's experiences of alcohol in New Zealand. It draws primarily from *Our Stories*<sup>2</sup> – a compilation of personal stories about alcohol use and harm from the perspectives of diverse communities in the Auckland area, and provides some snapshots from four refugee and new migrant women's stories.

## Alcohol use among refugee and migrant women

There is a dearth of information on alcohol use and harm among refugee and new migrant women, and while there is some limited ethnic-specific data, most is not disaggregated by refugee or migrant status. These data limitations, as well as diverse cultural differences among migrants, make it difficult to draw any robust conclusions on alcohol use and harm among these population groups.

Despite this, the limited data we do have and the various accounts in *Our Stories* suggest that women whose cultural and religious beliefs and values forbid the consumption of harmful substances such as alcohol are more likely than other women to be non-drinkers. They are also less likely to consume large amounts of alcohol on a typical drinking occasion than their male counterparts and New Zealand-born women (McLeod & Reeve, 2005; Community Insight Group, 2014).

In addition, the perceived lower drinking rates among refugee and migrant women can be a reflection of how men's and women's alcohol use is viewed within their communities. Jenny Wang, founder of the Chinese New Settlers Services Trust, points out that:

*In China... it is cool for a boy to have a high alcohol tolerance and it is essential to be a big drinker. However, it is very silly for a girl to drink, or to be drunk.*

Taruna, a practising Hindu woman from Delhi, India, also states:

*Traditionally as Hindus we do not drink – especially females – but the culture is changing... Hindu men are allowed to drink, but it is frowned upon for women to drink.*

Despite what appear to be low drinking rates, there is a concern that this is beginning to change, particularly among young refugee and new migrant women. Young women can feel torn between their desire to conform with the values, beliefs and expectations of their families, cultures and religions (eg, strict abstention from alcohol) and the pressure to conform with New Zealand peer expectations (eg, you don't say 'no' to alcohol).

## Peer pressure and the New Zealand drinking culture

A number of the refugee and migrant women interviewed as part of *Our Stories* spoke about both the benefits and the challenges of adjusting to a different culture and lifestyle in New Zealand. In particular, they spoke about the freedom that being in this country offered them as well as the pressures that some felt were attached to this, such as the pressure to drink and the perceived cultural norms of this country as they relate to alcohol use.

Mariska Mannes, who has worked with a number of international students, comments that:

*Peers can negatively influence an individual when the perceived group norm encourages them to engage in harmful behaviours such as substance and alcohol use... For international students, the freedom of being away from home, the pressure to fit in to the student culture and the easy availability of alcohol have consequences. These could range from being expelled from school to even having their visas revoked but, more concerning, is when a student feels their sense of identity is being compromised, especially when they do not know how to say 'no' or when faced with peer pressure.*

2 *Our Stories* was developed by the Health Promotion Agency's (HPA's) Community Insight Group in 2014 and can be read online or downloaded at [alcohol.org.nz](http://alcohol.org.nz) by entering 'Our Stories' in the keyword search engine. The Community Insight Group was established in 2011 to inform HPA policy and practice. Using their own personal experiences and/or work in these communities, members provide glimpses of what it is like to live in New Zealand as migrants, refugees, persons with disabilities, gay, lesbian, bisexual and transgender people and persons with former alcohol or other drug addictions.

This is well demonstrated through comments made by Shanti, a young new immigrant university student:

*He was pressured and I was pressured. They were making fun of him and I thought maybe I should taste it because everyone is laughing at him. So I drank a glass of beer... I didn't like it but I did drink it, so I was kind of forced to drink... Here it is different – you can't just say no to a beer.*

Shanti also describes her impressions of the New Zealand drinking culture when she first arrived here.

*On my first day in New Zealand, my brother took a friend and me to have a look at the city. It was a Saturday night and people were puking and yelling. I was like, does this happen all the time or is something going on? My brother said, 'No, this happens all the time.' I was, like, seriously? I have gone to the city a couple of times since. I don't have a car so I don't go much, but whenever I go there that is the same scene. Eighty percent of the reason you go clubbing is for drinking; that is what I have heard from my dorm, from the guys and the girls.*

## Conflict between two worlds

Some of the refugee and migrant women interviewed highlighted that the combination of a cultural norm of excessive drinking, the easy availability of alcohol and the challenges they typically faced in adapting to New Zealand life can be lethal. These factors can contribute to refugee and migrant women turning to alcohol despite strong cultural and religious beliefs to the contrary. This conflict can have a significant impact on the wellbeing of refugee and migrant women, particularly young women who may find the pressure to fit in with their peers overwhelming.

The conflict between cultures, its impact and the strategies used to navigate between two opposing worldviews are highlighted in the following comments by Fahima Saeid, who works closely with young refugee women.

*Islam's holistic approach to health and wellbeing means that anything that is harmful or mostly harmful is forbidden. Therefore, Islam takes an uncompromising stand towards alcohol and forbids its consumption in either small or large quantities. God tells us in the Quran that intoxication and gambling are acts from Satan and orders us to avoid them (Qur'an 5:90)... Religious beliefs and cultural identity among Muslim youth and adolescents may affect the way they address issues of alcohol use, immigration and the need for peer affiliation. They can feel torn between their parents' cultures and mainstream Kiwi culture.*

*Youth, faced with such conflict, may seek to resolve their conflict by developing double identities. They may maintain a religious or cultural identity among family and community members, while maintaining a separate and distinct 'Kiwi' identity among peers and in their educational environment to increase their level of acceptance and feelings of belonging. The two identities are often incongruent with one another and can challenge the individuals' abilities to cope with difficult situations. It can also affect their self-esteem and confidence.*

Farah, a Somalian and Muslim woman, provides an example of young migrant women adopting double identities to navigate cultures:

*Before when we used to hang out, it was just us girls... the only social contact where they think they can catch boys is to go out partying and drinking... They wanted to venture out, so by day they will dress fully covered and scarved, and by night it would be transitioning into short skirts, scarf off, and change their name as well. It's like a new identity, a visible transformation. Exactly how their behaviour is as well, it's the same transition.*

Priscilla, a Burmese and Buddhist woman, also adds a word of caution:

*The shift between two cultures – with alcohol frowned upon within their eastern culture yet accepted in the west – can lead to domestic problems where drinking is concerned.*

## A need for more understanding and appropriate intervention

The data limitations and diverse nature of refugee and migrant women prevent us drawing any robust conclusions about alcohol use and harm among these groups. While *Our Stories* provides some insights into refugee and migrant women's experiences of alcohol in New Zealand, more in-depth work is required to better inform and target appropriate interventions for these population groups.

The normalisation of excessive alcohol use in this country, the temptation of having alcohol so freely available, and the many challenges that these new migrant and refugee women typically face in adapting to new lives (including peer pressure to drink and adhere to New Zealand cultural norms) can contribute to their turning to alcohol despite strong cultural and religious beliefs of abstinence. Those women who do indulge (even in a small amount) face the risk of bringing great shame on their families. This, in turn, can lead to further adverse outcomes for those individuals and their families and can stop them seeking the help that they need. To navigate cultural differences, some young refugee and migrant women have adopted double identities, which can also leave them feeling vulnerable in both worlds.

In light of this, there is a need to explore how some of these difficult and often not talked about issues (such as alcohol use) can be raised safely, respectfully and guilt-free so that solutions can be found within refugee and migrant communities to prevent the escalation of alcohol use and harm among their population groups. This will mean working alongside multiple communities, given the diverse ethnic and cultural backgrounds of the refugee and migrant populations in New Zealand.

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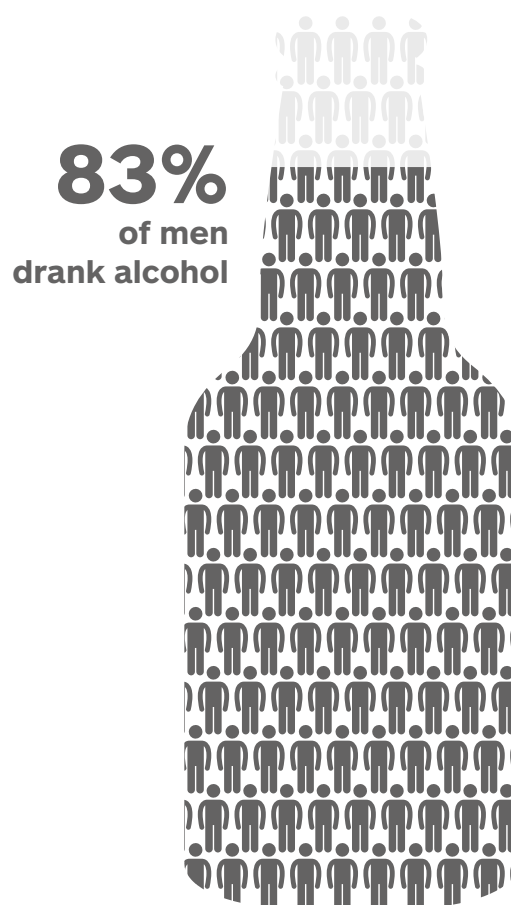
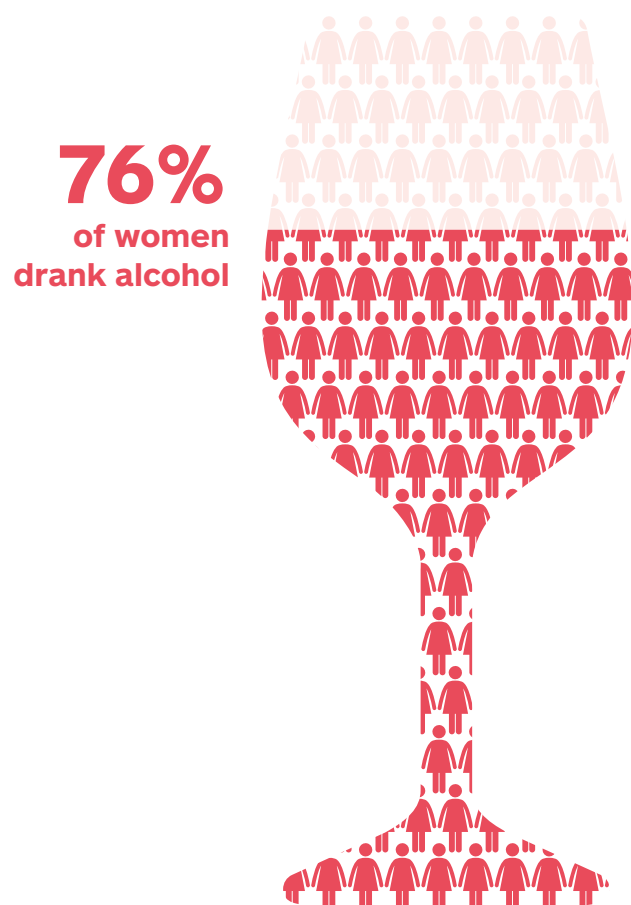
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# Women's alcohol use and harms compared with men's

## What new national alcohol data shows

*This article provides an overview of findings from recently released data from the Ministry of Health's New Zealand Health Survey (NZHS) and the Health Promotion Agency's (HPA's) Attitudes and Behaviour towards Alcohol Survey (ABAS) about women's self-reported alcohol use, patterns of drinking and harms from drinking alcohol, in particular in comparison with men.*

### In the last 12 months...



Data from large national surveys such as the NZHS and the ABAS can provide a very useful picture about New Zealanders' alcohol use, attitudes and behaviours. The analysis of the data from these surveys is also used to inform policy and practice and to identify and examine trends and differences, including between men and women and for different age groups.

## Alcohol consumption and drinking patterns

The findings from the 2013/14 NZHS show that most adults aged 15+ years (80%) had consumed alcohol in the last 12 months. Women (76%) were less likely than men (83%) to have drunk alcohol in the last year (Ministry of Health, 2014b).

Women are less likely than men to drink frequently. In the 2012/13 NZHS, after adjusting for age differences, men were 1.2 times more likely than women to drink with medium frequency (once or twice a week) and 1.4 times more likely to drink with high frequency (at least three to four times a week). The prevalence of drinkers who drink to high frequency increased with age for both sexes (Ministry of Health, 2015).

Women are less likely than men to drink to intoxication (defined as drinking enough to feel drunk). Men were 1.2 times more likely to drink to intoxication at least once in the past year and 2.0 times more likely to drink to intoxication with high frequency (defined as at least once a week). Overall, 5.5% of women reported drinking to intoxication with high frequency. After 24 years of age, drinking with high frequency decreased with increasing age for all adults (Ministry of Health, 2015).

The 2013 ABAS examined drinking patterns and self-reported experiences after drinking alcohol over the last month. The findings about frequency of drinking and drinking to intoxication were similar to those from the 2012/13 NZHS. Women (18%) were less likely than men (27%) to report drinking alcohol within the last month or to drink at a high frequency (defined as consuming alcohol on 13 or more days within the last month). Women (15%) were also less likely to report having been drunk or intoxicated over the last month than men (20%) (Gordon & Holland, 2015).

## Age of initiation

Of the adults who had ever drunk alcohol, women (23%) were less likely than men (32%) to report drinking before the age of 15 years (Ministry of Health, 2015).

## Types of alcohol consumed

### *On a typical occasion*

Men and women typically drink different types of alcohol. Women were more likely to drink wine, ready-to-drinks (RTDs) and spirits, and less likely to drink beer. Only 30% of women typically consumed beer or cider compared with 80% of men. However, 71% of women reported typically consuming wine or sherry compared with 38% of men. The types of alcohol women typically consume vary with age and also by ethnic group (Ministry of Health, 2015).

### *On last drinking occasion*

Findings from the 2013 ABAS showed that on the last drinking occasion, the three most common types of alcohol that females aged 15 to 17 years had consumed were RTDs (73%), spirits (57%) and beer (34%) (Holland, 2015). Patterns of the types of alcohol consumed changed with age, in particular a marked increase in wine consumption with age as illustrated in Figure 1 (note multiple responses of drink types can be reported for the last drinking occasion).

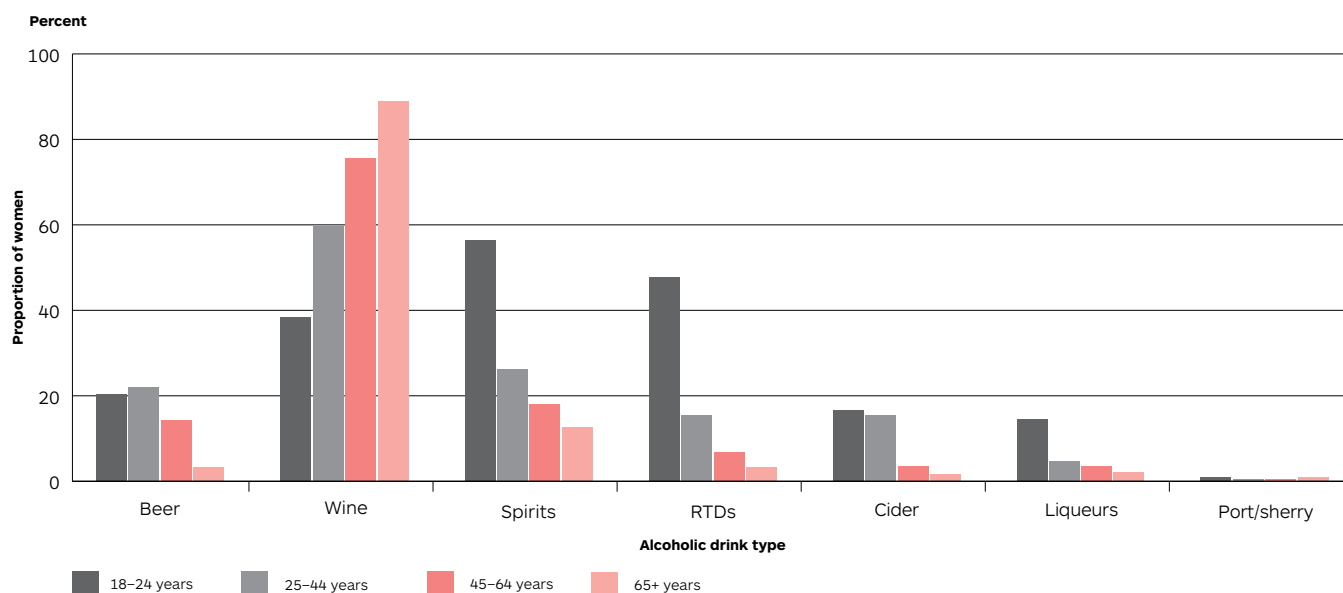
## Hazardous drinking of alcohol

Hazardous drinking refers to an established drinking pattern that carries a risk of harming the drinker's physical or mental health, or having harmful social effects on the drinker or others. It is defined in the NZHS as behaviour that results in a score of eight points or more on the Alcohol Use Disorders Identification Test (AUDIT) (Ministry of Health, 2015).

The Ministry of Health reported in its 2013/14 NZHS annual update that one in six adults (16%) had a hazardous drinking pattern, down from 18% in 2006/07. The age group with the highest proportion of hazardous drinkers were 18- to 24-year-olds (37% for men and 29% for women). Overall hazardous drinking patterns were more common among men (22%) than women (11%). The rate of hazardous drinking declined for men from 26% in 2006/07 to 22% in 2013/14. In comparison, although women were less likely to have hazardous drinking patterns, there has been no change in their hazardous drinking rates since 2006/07 (Ministry of Health, 2014a). Differences in hazardous drinking prevalence in the adult population for women and men by age are graphically shown in Figure 2 (Ministry of Health, 2014b).

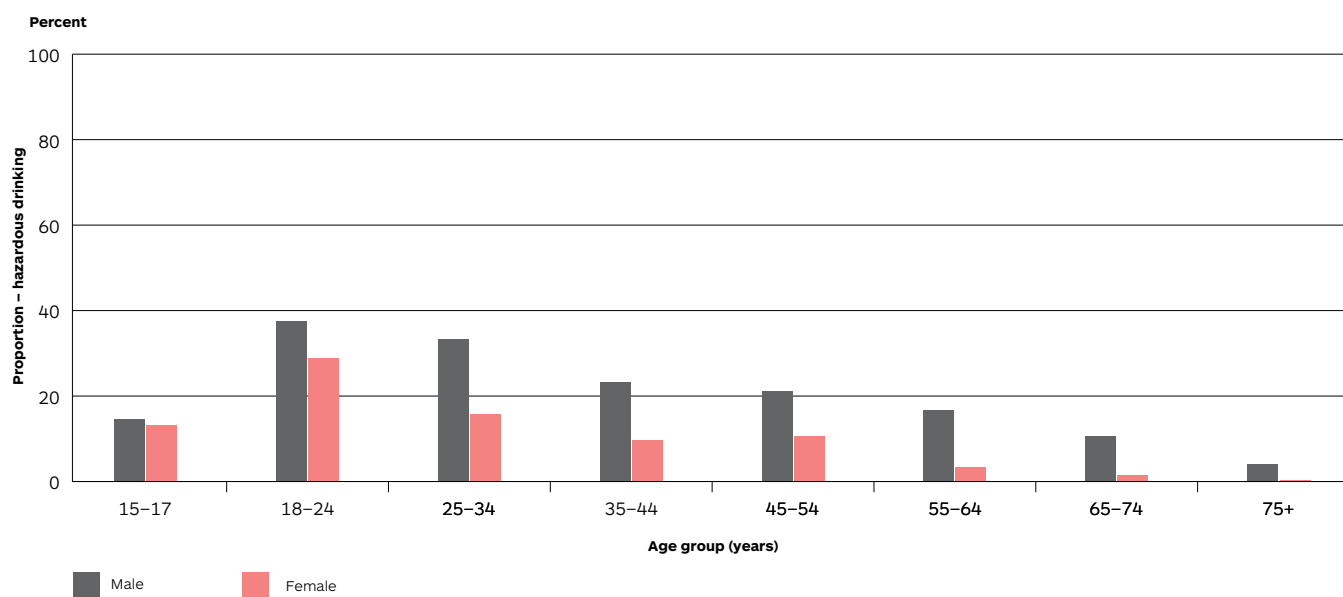


**Figure 1: Types of alcoholic drink consumed by women on last drinking occasion, by age group**



Source: 2013 ABAS data.

**Figure 2: Unadjusted prevalence of hazardous drinking in the adult population, by age and sex, 2013/14**



Source: Chart created from data in Ministry of Health (2014b).

## Harms from drinking alcohol

The 2012/13 NZHS found that women reported being less likely than men to engage in risky behaviours while under the influence of alcohol, such as driving or operating machinery. Women were also less likely than men to report a range of harmful effects from their drinking in the past 12 months. These harms included:

- harmful affects to their physical health (6.9% for women compared with 9.1% for men)
- injuries (2.7% compared with 4.2%)
- harms to friendships and social lives (4.3% compared with 6.1%)
- harms to home lives (3.5% compared with 5.9%)
- financial position affected (4.7% compared with 6.9%).

However, a greater percentage of women than men reported harmful effects from other people's drinking on friendships and social life (10% compared with 6.8%), on home life (6.7% compared with 3.9%), and on financial positions (3.0% compared with 1.6%) (Ministry of Health, 2015).

Similar findings about women experiencing less harm than men from their own drinking were reported in the 2013 ABAS. Women (11%) were less likely than men (16%) to report experiencing potential harm or negative experiences within the last four weeks associated with drinking alcohol. These experiences included: failure to meet family or work or study commitments; doing something embarrassing that they regretted; injuring themselves; getting into a fight; placing themselves into a situation where they felt unsafe or uncomfortable; driving while under the influence of alcohol; and getting into a regrettable sexual encounter (Gordon & Holland, 2015).

## Where to find further analysis and data

HPA regularly publishes findings from the ABAS, as well as analyses of alcohol-related data from its other surveys, through its factsheet series *In Fact: Research facts from the HPA*. These factsheets can be found on HPA's website – [hpa.org.nz/research-library/research-publications](http://hpa.org.nz/research-library/research-publications).

From 2011 the Ministry of Health's NZHS became a continuous survey, enabling annual updates on data about alcohol use and hazardous drinking. The most recent annual update contains 2013/14 data from people selected for the survey from July 2013 to June 2014. Additional questions about alcohol were asked in the 2012/13 NZHS. The analysis of the findings from these additional questions has recently been reported on in the Ministry of Health's 2015 publication *Alcohol use 2012/13: New Zealand Health Survey*. Reports and data tables about alcohol from the NZHS can be found on the Ministry of Health's website – [health.govt.nz](http://health.govt.nz).

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## **Health Promotion Agency**

### **Wellington Office**

Level 4, ASB House  
101 The Terrace  
Wellington Central  
Wellington 6011  
PO Box 2142  
Wellington 6140

*Phone:* (04) 917 0060

*Freephone:* 0508 258 258

*Fax:* (04) 473 0890

*Email:* [enquiries@hpa.org.nz](mailto:enquiries@hpa.org.nz)

### **Northern Regional Office**

Level 2, Ascot Central  
7 Ellerslie Racecourse Drive  
Remuera  
Auckland 1051  
PO Box 11791  
Ellerslie  
Auckland 1542

*Phone:* (09) 916 0330

*Fax:* (09) 916 0339

*Email:* [enquiries@hpa.org.nz](mailto:enquiries@hpa.org.nz)

### **Southern Regional Office**

Level 1, CBRE House  
112 Tuam Street  
Christchurch Central  
Christchurch 8011  
PO Box 2688  
Christchurch 8140

*Freephone:* 0508 258 258

*Email:* [enquiries@hpa.org.nz](mailto:enquiries@hpa.org.nz)

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