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ALCOHOL ADVISORY COUNCIL OF NEW ZEALAND
Kaunihera Whakatupato Waipiro o Aotearoa



FEATURE: A nation of binge drinkers
EARLY INTERVENTION: What is a standard drink?
MĀORI MATTERS: Hui Whakakotahi 2004



ARE YOU A BINGE DRINKER?





The Alcohol Advisory Council of New Zealand was established by a 1976 Act of Parliament, under the name the Alcoholic Liquor Advisory Council (ALAC), following a report by the Royal Commission of Inquiry into the Sale of Liquor.

The Commission recommended establishing a permanent council whose aim was to encourage responsible alcohol use and minimise misuse.

ALAC's aims are pursued through policy liaison and advocacy, information and communication, research, intersectoral and community initiatives, and treatment development. ALAC is funded by a levy on all liquor imported into, or manufactured in, New Zealand for sale and employs 30 staff. The Council currently has eight members and reports to the Minister of Health.

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Kia ora, Kia orana, Ni sa bula, Namaste, Taloha ni,
Malo e lelei, Fakaalofa atu, Halo olaketa,
Talofa lava, Greetings...



Dr Mike MacAvoy
Chief Executive Officer.

WORDS FROM THE CEO

We recently released a commissioned study by BRC entitled “*The Way We Drink; A Profile of Drinking Culture in New Zealand.*” While the report is very revealing in exposing segments of the population, which showed up as being risky drinkers, the report did not bring with it any great surprises. Why then did we undertake the study? Firstly, it provides us with some base line data on which we can evaluate a range of strategies we plan, in conjunction with others, to introduce. Secondly, and perhaps more importantly, the survey revealed the toleration and acceptance of intoxication or getting drunk by close to half the adult drinking population. The latter is a key point, as if we intend to change the incidence and frequency of intoxication, then changing the acceptance and tolerance of drunkenness is obviously a key strategy.

When the report was released we used the words ‘binge’ to describe a pattern of drinking in which the intended aim of a drinking occasion, is an occasion to become intoxicated. There exists some confusion in the public’s mind as to whether a binge is the same as a “bender” or, as it has been used by us, as a description of a drinking occasion where the amount of alcohol consumed was likely to cause the person to be intoxicated and therefore at risk of harm to themselves or others. Such a notion generated considerable media discussion and comment as to whether the measures we had used were realistic in terms of the average drinkers consumption. Indeed, for many the cut off point of five glasses for teenagers and seven for adults was considered light on in terms of their usual consumption pattern. A glass in this case represented was self-reported and not necessarily a standard drink.

The timing of the release of this report coincided with the release of the Alcohol Harm Reduction Strategy for England by the British Prime Minister. It is not surprising that the main focus of that strategy relates to binge drinking, particularly among males under 25 years.

Interestingly, the costs attributed to this pattern of drinking are around £UK20 billion per year. A staggering figure and, if it follows Australian trends, the social costs of alcohol will exceed the health costs four-fold. Details of the British strategy can be found at www.number10.gov.uk/output/Page3669.asp

Mike MacAvoy

March 2004

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A nation of binge

Some 1.5 million New Zealand adults are binge drinkers according to new research commissioned by ALAC.

And the research shows that 50 percent of all New Zealanders (adults and youth) accept drunkenness as socially acceptable with 1.2 million believing that it's okay to get drunk, 350,000 binge drinking on their last drinking occasion and 275,000 setting out to get drunk on their last drinking occasion.

ALAC Chief Executive Dr Mike MacAvoy says BRC Marketing and Social Research's *The Way We Drink: A Profile Of Drinking Culture In New Zealand* shows that drinking in a risky way is not just the behaviour of the very young or the dependent drinker.

"New Zealanders in all walks of life, all ethnicities, urban and rural, men and women, believe that getting drunk is okay, with the majority reporting they drink in a risky way.

"We commissioned research into drinking behaviours because we suspected that risky drinking is more widespread than we like to admit. What this research shows us is that drunken behaviour is a part of mainstream New Zealand culture. It's not just the behaviour of young people or dependent drinkers," Dr MacAvoy says.

"New Zealanders are concerned about young people's risky drinking behaviours, and rightly so.

"Fifty thousand 12 to 17 year olds are 'uncontrolled binge drinkers' with a further 75,000 binge drinking at social events. But youth drinking culture mirrors an adult drinking culture. New Zealanders accept risky drinking and being drunk as a social norm, with significant numbers of adults actively setting out to get drunk," Dr MacAvoy says.

"The culture of New Zealand drinking is our problem and we all have to change our patterns of drinking and tolerance of binge drinking and intoxication. New Zealanders must confront the reality of their drinking habits. I challenge New Zealanders to change their drinking behaviours. It is never okay to get drunk," Dr MacAvoy says.

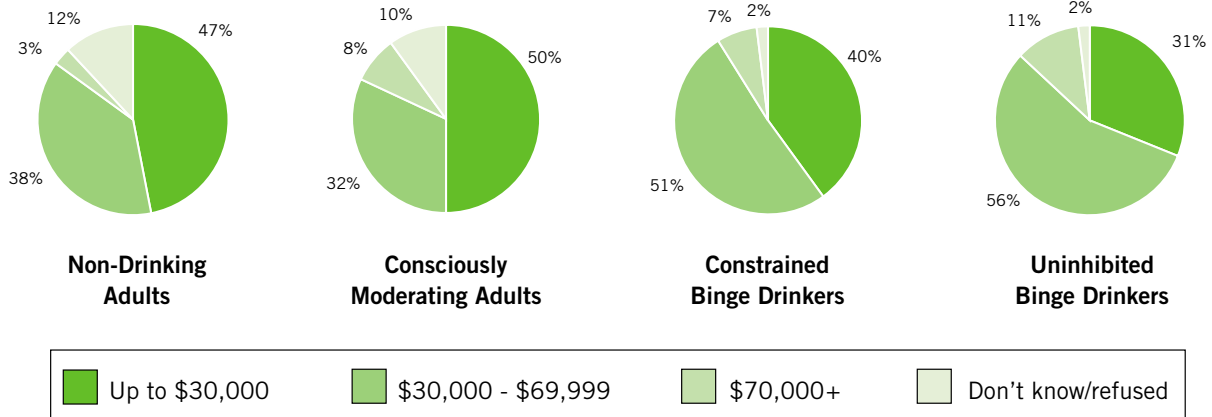
The research segments all New Zealand adults (18+ years) into people who:

- don't drink at all – "non-drinkers" (19 percent of the population)
- consciously limit their intake – "conscious moderators" (29 percent of the population)
- are unable to drink as much as they would like to, for a range of reasons – "constrained binge drinkers" (23 percent of the population)
- have no restrictions on their drinking – "uninhibited binge drinkers" (29 percent of the population).

"Uninhibited binge drinkers tend to drink two or three times a week, with 14 percent drinking between seven and 10 drinks the last time they drank and a staggering 11 percent drinking more than 11 drinks. Uninhibited binge drinkers are most likely to be able to afford as much alcohol as they want. They are the group less likely to identify any reasons to modify their drinking behaviour or attitudes," Dr MacAvoy says.

drinkers

Who are they (household income)?



“Constrained binge drinkers” tend to drink five or more cans of beer once a week, at home or at a friend’s place. Despite identifying reasons why they would constrain their drinking, they are still drinking heavily. In fact constrained binge drinkers are more likely to have had nine or more average glasses of alcohol (20 percent) than “uninhibited binge drinkers” (15 percent).

“There is evidence that constrained binge drinkers would join the uninhibited binge drinkers if they could afford more alcohol and had fewer responsibilities,” Dr MacAvoy says.

Pakeha, urban, male

The research showed the New Zealand binge drinker is most likely to be a Pakeha urban male of 30 years or older, with a household income over \$70,000.

The research shows that the wealthier we are, the more we drink and that those who can’t afford to drink as much, would if they could,” says Dr MacAvoy.

“We can no longer pretend that binge drinking is solely a teenage problem, nor is it just a male problem. Over half of New Zealand adults demonstrate risky drinking behaviour and women match men in the binge drinking stakes.”



A nation of binge



Māori

Adult Māori drink less regularly but more heavily than most New Zealand drinkers.

Māori are:

- less likely to be regular drinkers – 39 percent of Māori drank at least once a week compared with 56 percent of all New Zealand adults
- more likely to have drunk more than 10 glasses on the last drinking occasion – 22 percent of Māori compared with 8 percent of all New Zealand adults.

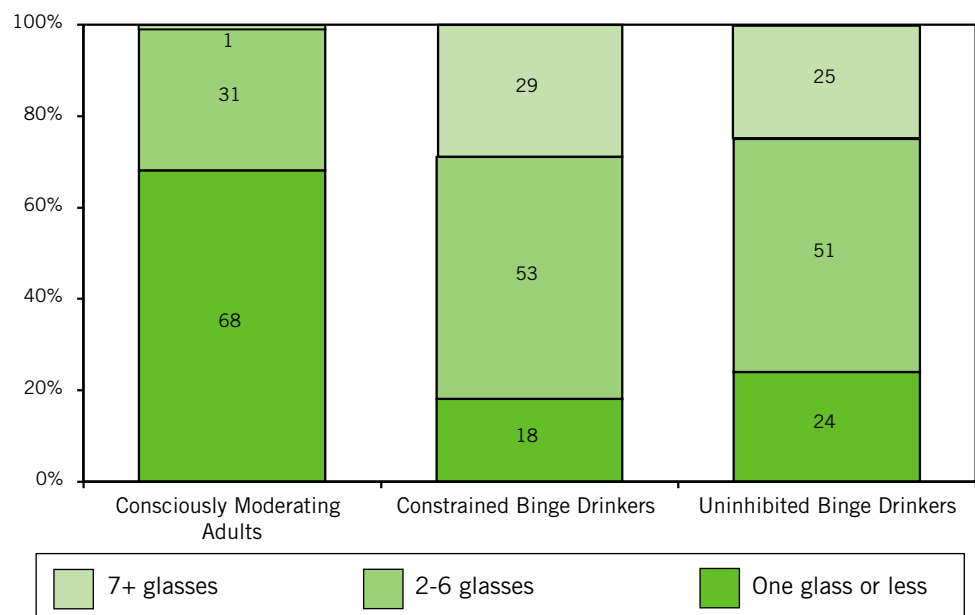
New Zealand's adult Māori population (18+ years) can be divided into people who:

- don't drink at all – “non-drinkers” (18 percent of Māori adults compared with 19 percent of all New Zealand adults)
- are aware of how much they are drinking – “conscious moderators” (19 percent of Māori adults compared with 29 percent of all New Zealand adults)
- are unable to drink as much as they would like to for a variety of reasons – “constrained binge drinkers” (38 percent of Māori adults compared with 23 percent of New Zealand adults)
- have no restrictions on their drinking – “uninhibited binge drinkers” (25 percent of Māori adults compared with 29 percent of New Zealand adults).

Dr MacAvoy says Māori adults share similar attitudes and behaviours towards alcohol consumption to the rest of the New Zealand population with many Māori demonstrating uninhibited binge drinking characteristics. However, lower income levels appear to have an impact on access to alcohol for Māori adults.

“ALAC is working with Māori communities to support them in identifying and responding to alcohol-related issues facing Māori whānau. A national hui held by ALAC last month set up a taumata (national leadership group) for the Māori drug and alcohol sector to provide leadership and guidance to reduce harm from alcohol for Māori,” Dr MacAvoy says.

Segments by risky drinking (Adults)



drinkers

Pacific people

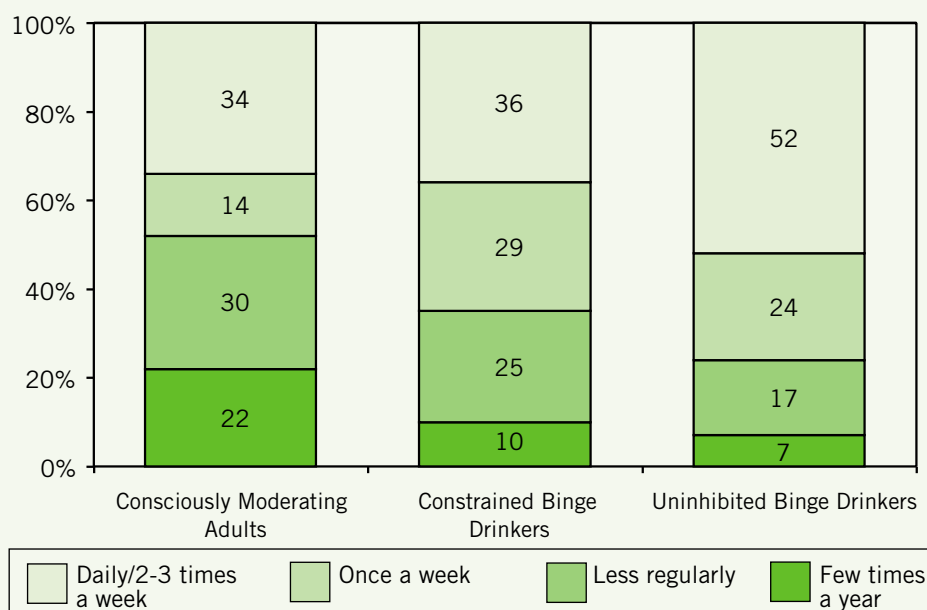
Pacific people are less likely to drink at all but when they do drink, they drink heavily. Pacific people are:

- more likely to be non-drinkers – 46 percent of Pacific people compared with 19 percent of all New Zealand adults
- less likely to have been early starters – 32 percent of Pacific people did not start drinking more than the occasional sip until they were 20 years old, compared with 28 percent of all adult New Zealanders
- less likely to be regular drinkers – 33 percent of Pacific people drink at least once a week compared with 56 percent of all adult New Zealanders
- more likely to have drunk more than 10 glasses on the last drinking occasion – 22 percent of Pacific people compared with 8 percent of all adult New Zealanders.

On the basis of their beliefs, attitudes and behaviours towards alcohol, New Zealand's adult Pacific population (18+ years) can be divided into people who:

- don't drink at all – “non-drinkers” (46 percent of Pacific adults compared with 19 percent of all New Zealand adults)
- are aware of how much they are drinking – “conscious moderators” (14 percent of Pacific adults compared with 29 percent of all New Zealand adults)
- are unable to drink as much as they would like to for a variety of reasons – “constrained binge drinkers” (10 percent of Pacific adults compared with 23 percent of New Zealand adults)
- have no restrictions on their drinking – “uninhibited binge drinkers” (31 percent of Pacific adults compared with 29 percent of New Zealand adults).

Segments by frequency of drinking (Adults)





A nation of binge drinkers

“Pacific people tend to have extreme drinking patterns and ALAC is committed to working with Pacific communities to support them to work with their families to reduce harm,” says Dr MacAvoy.

Pacific people report that they limit the amount of alcohol they drink because of religious beliefs or commitments. This confirms previous ALAC research into Pacific people’s drinking habits.

A fifth of the women over the age of 18 who drink, binge drink

Dr MacAvoy says adult women binge drinkers match men in the amount they drink and also in their attitudes to accepting drunken behaviour.

“Where women differ is that they are more likely to be concerned about their drinking habits than men but it’s not stopping them from binge drinking,” Dr MacAvoy says.

The research shows 650,000 women accept drunkenness as socially acceptable with 17 percent of adult women saying they drank more than seven average drinks on their last drinking occasion.

Adult women who binge drink tend to be Pakeha, in full-time employment and have a personal or household income between \$30,000 and \$70,000. They are usually 25 years of age and over, have children between the ages of five and 15 years and live in a large town or city. They usually drink at home between one and three times a week, and over a third have more than five drinks at any one time.

“This is a significant concern for New Zealand women. Medical evidence is clear, women who drink like men experience much greater harm as a result,” Dr MacAvoy says.

“Although women’s drinking habits are matching those of men, women are concerned about the long-term effects of alcohol on their physical well-being and worry that they forget what they were doing when they are drunk. What concerns ALAC is that these inhibitors are not having a significant impact on women’s drinking behaviours,” Dr MacAvoy says.

The research involved interviewing 1783 people by telephone last year. For a copy of the research go to www.alcohol.org.nz

Second-hand effects of alcohol

We've all heard about the second-hand effects of smoking, and a major publicity campaign is underway to address the issue. But what about the second-hand effects of alcohol? Are you affected by someone else's drinking? Does your drinking have an adverse effect on someone? The answer may be yes.

Second-hand effects are the negative experiences that result from someone else's drinking. On a personal level this might mean street disorder, a broken letterbox, someone urinating in your garden, the broken night sleep from the neighbour's party next door, unwanted advances from an intoxicated person, or people being afraid to venture into the central city at night. There can be media focus on this, and certainly when people are protesting about the number of licensed premises in an area, these are prime concerns. However, there has been little supporting research until recently.

As part of the ongoing study of hazardous drinking, by the Injury

Prevention Research Unit (IPRU) of Otago University, researchers John Langley, Kyp Kypri and Shaun Stephenson estimated the incidence of second-hand effects of alcohol consumption among tertiary students.

The survey invited 1910 students aged 16 to 24 to complete an Internet-based questionnaire. Eighty-two percent responded. The results were published in the *British Medical Journal* in November last year.

They found that second-hand effects due to alcohol were more common than had been expected, with 84 percent of the survey respondents reporting one or more of the effects. Women were slightly more likely to report an effect (85 percent) than were men (81 percent). The most commonly reported effects were disrupted sleep or study; having to take care of a drunk person; and being insulted or humiliated.

ALAC's Group Manager Population Programmes, Sandra Kirby, welcomed the study and says, "This has defined what many people already discuss anecdotally – drinking to intoxication

causes problems not just for the person but for those around them. Although the survey group were all tertiary students, it is highly likely that these effects would be the same in the general population."

ALAC has been a part funder of the hazardous drinking project along with the Health Research Council.

Dr Kypros Kypri, the lead researcher for the project has recently moved to New South Wales to take up a position as Senior Lecturer in Population Health at the University of Newcastle. As part of this role, Kyp will be project managing the Enhanced Alcohol Intelligence Project for the New Zealand Police and continuing his links with IPRU.

Sandra says, "ALAC congratulates Kyp on his appointment to the University of Newcastle. This appointment acknowledges the significant contribution Kyp has made in the field of population health research. We are really delighted that this appointment maintains some strong ties to the New Zealand alcohol field so his skills can continue to be used."

Second-hand effects survey

Second-hand effects due to alcohol among university students experienced at least once in the four weeks before being asked. Values are numbers (incidence; 95% confidence interval)

Second-hand effect	Sex of victim			Victim's tendency to drink heavily*		Total (n=1524)
	Women (n=881)	Men (n=643)	Never (n=253)	Monthly or less (n=602)	Weekly or more (n=669)	
Insulted or humiliated	294 (33; 30 to 37)	221 (34; 31 to 38)	70 (28; 22 to 34)	175 (29; 25 to 33)	270 (40; 37 to 44)	515 (34; 31 to 36)
Serious argument or quarrel	148 (17; 14 to 19)	136 (21; 18 to 25)	14 (6; 3 to 9)	81 (13; 11 to 16)	189 (28; 25 to 32)	284 (19; 17 to 21)
Pushed, hit, or otherwise assaulted	118 (13; 11 to 16)	114 (18; 15 to 21)	21 (8; 5 to 12)	63 (10; 8 to 13)	148 (22; 19 to 25)	232 (15; 13 to 17)
Property damaged	174 (20; 17 to 23)	130 (20; 17 to 24)	43 (17; 13 to 22)	110 (18; 15 to 22)	151 (23; 19 to 26)	304 (20; 18 to 22)
Had to take care of a drunk student	370 (42; 39 to 45)	239 (37; 33 to 41)	45 (18; 13 to 23)	227 (38; 34 to 42)	337 (50; 47 to 54)	609 (40; 37 to 42)
Found vomit in the halls or bathroom	201 (23; 20 to 26)	173 (27; 24 to 31)	41 (16; 12 to 21)	107 (18; 15 to 21)	226 (34; 30 to 38)	374 (25; 22 to 27)
Studying or sleep interrupted	571 (65; 62 to 68)	347 (54; 50 to 58)	135 (53; 47 to 60)	323 (54; 50 to 58)	460 (69; 65 to 72)	918 (60; 58 to 63)
Unwanted sexual advance	279 (32; 29 to 35)	151 (23; 20 to 27)	24 (9; 6 to 14)	146 (24; 21 to 28)	260 (39; 35 to 43)	430 (28; 26 to 31)
Sexual assault or date rape	8 (1; 0 to 2)	3 (0; 0 to 1)	0 (0; 0 to 1)	3 (0; 0 to 1)	8 (1; 1 to 2)	11 (1; 0 to 1)
Different crime on campus	11 (1; 1 to 2)	13 (2; 1 to 3)	4 (2; 0 to 4)	5 (1; 0 to 2)	15 (2; 1 to 4)	24 (2; 1 to 2)
Different crime off campus	26 (3; 2 to 4)	25 (4; 3 to 6)	5 (2; 1 to 5)	20 (3; 2 to 5)	26 (4; 3 to 6)	51 (3; 3 to 4)
Any	752 (85; 83 to 88)	524 (81; 78 to 84)	182 (72; 66 to 77)	476 (79; 76 to 82)	618 (92; 90 to 94)	1276 (84; 82 to 86)

*Six or more drinks (60 grams ethanol) on any one occasion

Second-hand effects of alcohol use among university students: computerised survey

John D Langley, professor, Kypros Kypri, research fellow, Shaun CR Stephenson, biostatistician

1 Injury Prevention Research Unit, Department of Preventive and Social Medicine, Dunedin School of Medicine, University of Otago, Dunedin 9000, New Zealand

What is a standard drink?

Confusion over what constitutes a standard alcoholic drink is behind an education programme developed by the Alcohol Advisory Council (ALAC) and representatives of the liquor, hospitality and retail sectors.

This programme has flowed from the December 2002 introduction of compulsory standard drinks labelling of all alcohol products sold in New Zealand.

ALAC has recognised the value of standard drinks as a tool that will enable people to make informed decisions about exactly how much they are drinking – in reality and without kidding themselves. But it has also recognised that the concept is little understood by New Zealanders.

A standard drink contains 10 grams of alcohol. Standard drinks are a simple and effective way of keeping track of how much alcohol you are drinking. The easy way to know is to look at the label of the container and it will tell you how many standard drinks are in it.

Where in the past people have tried to teach the concept of standard drinks by showing different size glasses, this is more difficult these days as glasses vary so much in size and so do the products themselves in their alcohol content. For example, a bottle of wine can contain from approximately 7.3 standard drinks to 8.3, depending on the strength of the wine. Beers can vary quite a lot too.

Soon after the introduction of the compulsory labelling, ALAC approached representatives of the liquor, hospitality and retail sectors to discuss how this concept could be introduced to New Zealanders. They decided that the more messengers the better and that those who were best placed to deliver the message were probably those who had the relationship with the drinker – the liquor industry retailer or bar person – at the point of purchase or consumption.

This led to the development of a joint information programme that is to be launched this month involving television and radio advertising and a range of promotions and materials.

Included in the programme is the creation of an icon so people can tell at a glance how many standard drinks are in the bottle or can they are consuming.

Standard Drinks™

10 grams of alcohol

The image shows a graphic representation of a standard drink. On the left is a red icon of a glass with the text 'APPROX. 1.0' inside. Below this is the text 'Standard Drinks™'. In the center is an equals sign. To the right is a diagram of a glass with a red liquid level. The glass has markings for 10g, 20g, and 30g. The red liquid level is at the 10g mark. Below the glass diagram is the text '10 grams of alcohol'.

drink?

While all labels must contain the information now, the icon will be clearer and consistent. The icon, a tumbler showing the number of standard drinks inside, should start appearing on bottles in coming months, but may nevertheless take some time as companies roll it out in line with label redesign or redevelopment. Its use will be up to the individual companies.

In the meantime, one of the most useful tips is certainly that New Zealanders can start to educate themselves right now – they can quite simply look at the label on the bottle or can of alcohol they are consuming. All alcohol labels are required to carry the approximate number of standard drinks.

And next time you sit down to dinner with your friends or family, it would be interesting to see whether they can pour the seven/eight standard drinks in a bottle of wine into seven/eight glasses or look at the can of beer and note whether it's 1.3 or 1.5 or more. You might find this quite entertaining and a bit of a conversation starter as you see the looks of horror when the bucket-sized wine glass looks quite empty!

Look here to see how many Standard Drinks are in what you are drinking. The Standard Drinks content here is a guide only. It's important that you check each label, because the Standard Drinks content can be different each time.



Hui Whakakotahi

Last month's Māori summit was an overwhelming success, says ALAC's Group Manager Community Strategies Te Atarangi Whiu.

More than 150 Māori alcohol and drug practitioners and those working to improve alcohol and drug outcomes for Māori attended the three-day hui organised by ALAC and held at Te Papa-i-ouru and Tunohopu Marae in Rotorua from February 16 to 18.

"We went to the hui hoping to get agreement on the establishment of a new taumata, a national leadership group for the Māori sector tackling drug and alcohol abuse.

"ALAC was also looking for signoff on the cultural concepts framework."

Both objectives were achieved, she says. The hui agreed to the establishment of the taumata and signed off in principle on the cultural concepts framework.

"What people have committed to is to take the framework back to their places of work and use it and apply it and bring feedback to a taumata kaumatua hui to be held in Auckland in June."

Once the cultural concepts framework has been implemented, this will eventually lead to the development of cultural competences for Māori alcohol and drug workers, says Te Atarangi.

"This will lead to higher and more consistent standards and better service delivery and in the long term better outcomes for Māori."

Te Atarangi says the taumata's structure and way it functions will be clarified at the June hui.

"The good thing about the taumata is that membership of the group isn't gender, age or status based. All you need to be on this taumata is to be committed to reducing alcohol-related harm amongst Māori."

While the final shape of the taumata will be decided at the hui, Te Atarangi believes there will be a large group of people acting like a "think tank".

What may evolve from that group would be a core group that would be the public face but will have the support of the wider group, she says.

The taumata will provide vision and leadership.

"I don't think this has been done before from a bottom-up perspective.



Te Orohi Paul (Ngai Tuhoe, Ngati Awa, Te Arawa), Manager of the Rotorua-based Te Kupenga a Kahu.



Dr Paparangi Reid (Te Aupouri), Director of the Eru Pomare Māori Research Centre of the Wellington School of Medicine.



Whakakotahi 2004

“This is important because it then comes from the community, from the people who know the issues so it is not policy or a vision set at a political level and then imposed from the top; rather it’s a view that has come from the grass roots.”

Te Atarangi says the sector has been talking about the need for such a leadership group for some time. It was discussed at the first summit four years ago.

“I am pleased with the progress which is the result of a lot of hard work.

“What Hui Whakakotahi has demonstrated for me is that the field has matured. We have matured in terms of size that is, grown in terms of numbers, but I think we have also matured in terms of realising that this is our issue; this is about our own Tino Rangatiratanga and we are the ones to provide the leadership.

“This is about Māori having the ability to carve the direction in which we want to proceed. Part of that is about capacity; we now have the capacity. There is the resource and the intelligence now to provide the leadership whereas five to 10 years ago there wasn’t because we were still establishing services.”

Te Atarangi says another achievement to come out of the hui was the information sharing.

“Having so many people involved in the sector together in one place meant people were able to exchange ideas and challenge each other’s thinking.”

The keynote speakers complemented each other well and really engaged people, getting them to focus on the issues.

They were:

- Moe Milne (Ngati Hine, Nga Puhī nui tonu), an independent contractor in the Māori Health field with a wealth of knowledge and experience in the Hauora Māori field, especially in the Mental Health and Disability fields
- Te Orohi Paul (Ngai Tuhoe, Ngati Awa, Te Arawa), who has been involved in the Māori Alcohol and Drug field for the past two decades and is currently manager in a new Rotorua-based Māori PHO – Te Kupenga a Kahu
- Director of the Eru Pomare Māori Research Centre of the Wellington School of Medicine Dr Paparangi Reid (Te Aupouri)

- Takarangi Metekingi (Tainui, Te Ati Haunui a Paparangi, Ngati Hauti), the Deputy Director of the Moana House residential programme in Dunedin

- Amster Reedy (Ngati Porou) who has been involved in Māori education at all levels, from Te Kohanga Reo to being both a teacher and principal of Ngata Memorial College

Te Atarangi praised the hospitality of the local people who “looked after us well, fed us well and opened their thermal bathhouses for us”.



Hui Whakakotahi 2004

New manager for New manage

When the Alcohol Helpline opened for the first time in November 1995 Cate Kearney was there in the first intake of volunteers.

At the time she was completing a distance course through the Central Institute of Technology (CIT) as an alcohol and drugs counsellor. Seven years later she has returned, this time as its new manager.



**Cate Kearney,
Alcohol Helpline manager.**

Initially the Helpline was concerned solely with alcohol. It was a localised service, restricted to Christchurch and was open for four hours a day seven days a week.

Today the service has expanded. Still Christchurch based, it is now a national 0800 telephone information service open from 10am to 10pm seven days a week.

Its brief has widened. In December 2002 the Drugline was set up so the Helpline now caters for not only those seeking help for alcohol-related problems but also those seeking help with problems with other drugs.

The service is provided by the Alcohol Drug Association New Zealand (ADA) under contract to the Alcohol Advisory Council of New Zealand and the Ministry of Health.

Cate was appointed manager in November last year and brings to the job a wealth of both practical and academic experience.

She has postgraduate qualifications in Child and Adolescent Mental Health (Cert), Health Sciences (Dip) and is currently completing a Masters in Health Sciences. She is a member of NZAC and DAPAANZ.

Her last role was as women's co-ordinator with the Community Alcohol and Drug Service (CADS) in Christchurch where she initiated a new co-ordinated service for women with children.

"I strongly believe in the work the Helpline (and ADA) does and see a great deal of potential for further growth especially with the inclusion of the Drugline.

"While the Helpline has always received calls relating to drug use, the Helpline paid and unpaid staff were primarily trained and confident in responding to calls concerning alcohol.

"When Drugline was added to the service there was an intensive programme of education and upskilling for the volunteers to ensure they were equipped for the new challenge."

Cate says her strong clinical background and training in health promotion are skills she can utilise to ensure that the Helpline

Helpline

Director for Helpline

staff continue to be developed in relation to training and supervision and access to up-to-date and accurate information.

She also has a history of innovation around service development which she brings to the Helpline to support further growth in this national service.

“Callers can access brief intervention counselling through our Brief Intervention Counsellors. Callers requiring on going counselling and other interventions are referred to specialist agencies.

“The Helpline aims to increase access to services and to intervene in the cycle of use at an earlier stage than might happen if people were to wait e.g. for a doctor’s referral. We are an early intervention and referral service and latterly, thanks to the great ALAC resources, we seem to be supporting more callers at the “maintenance” stage of change.

“The Helpline is also a service to come back to if seeking other referral options in New Zealand. The Helpliners tell anecdotal stories about New Zealanders and travellers regularly calling the Helpline to find out about support meetings such as AA/NA.”

Cate says alcohol-related calls to the Helpline increased by 10 percent in the last financial year with the service fielding 12,529 valid calls compared with 11,019 in the previous year. Seventy percent of these calls related to alcohol.

“There are periods of dramatic call increases,” she says. “Television promotions that highlight problematic alcohol use such as the ‘Had Enough’ ALAC campaign that ran from March to June 2003 resulted in increased calls to the Helpline. For example, we had almost 900 calls in January, and February went up to more than a thousand, peaking in May with 1678 calls.”

Cate says the majority of the calls to the Helpline are about alcohol but many calls are difficult to categorise as they concern both alcohol and other drugs.

“More women than men call the Helpline, reflecting the role the service plays in supporting women who are concerned about a family member or friend’s drinking. There is a change in the gender statistics when the person with the problem is identified (approx 50 percent are male).”

Cate says the newly established Drugline is showing good growth. Looking at the call statistics for this financial year, it appears that just under half of the calls to the Helpline are about other drugs but the actual number of alcohol calls has not decreased. Overall there are more calls to the Helpline. Most calls are about cannabis followed by methamphetamine, followed by opiates, nicotine, benzodiazepines and inhalants.

Cate says there has been a noticeable increase in the numbers seeking information and advice concerning methamphetamine. “At this stage most calls come from the North Island and are from concerned others rather than the person with a problem. We notice an increase in calls when there are television documentaries or high profile cases in the media. We have increased our resources to respond to this and now have a pamphlet ‘Concerned about Someone’s Methamphetamine Use’.”

The social costs of alcohol

The social costs of alcohol

Last year economist Brian Easton travelled to Switzerland to attend a conference on the social costs of alcohol abuse in that country. Attendance at the conference was made possible by grants from the Alcohol Advisory Council and Economics Department of the University de Neuchâtel. Brian Easton reports.

The conference was centred on the launching of a study commissioned by the Swiss Federal Office of Public Health to assess the costs in Switzerland of alcohol misuse, prepared by a team from the Economics Department of the Université de Neuchâtel, led by Professor Claude Jeanrenaud.

In addition, a number of international experts were invited to give papers on broader issues. The report *International Guidelines for Estimating the Costs of Substance Abuse (2ed)*, written by some of these experts and just published by the World Health Organisation, was also launched. This report highlights and reflects upon some of the papers presented at the conference.

Leaving aside a large amount of interesting institutional material about Switzerland (including that criminal activity is very low – its taxation framework will be mentioned below), the Swiss study is particularly valuable because it has paid more attention to the issues of measurement of the intangibles than most, and progressed the measurement of intangibles. Particularly valuable have been attempts to measure reductions in the quality of life by surveying individuals' (contingent) valuations.

This belongs to the willingness-to-pay approach which I and the Guidelines favour, but advances the method. There is no doubt that the third edition of the Guidelines (the revision is likely to begin in 2005) will pay considerable attention to this work.

(Other papers from the Neuchâtel team collected other useful data for social costs studies, such as on employment, although the precise magnitudes may not be internationally

transferable.) I do not propose to report upon the overall study estimates. Claude Jeanrenaud attempted to compare them with other studies in other countries. It is evident that there is still considerable variation in the application of the Guidelines, which continue to make international comparisons difficult. My impression is the costs of alcohol misuse in Switzerland are in the middle of other Western countries for which data is available. The study has to be seen in a context of the Swiss turning their attention to the misuse, as they are at an earlier stage of developing a strategy than New Zealand.

Two groups of papers (there were 18 altogether) grabbed my attention

Developments in Australia are particularly important to New Zealand. Helen Lapsley and David Collins reported on their work estimating the costs of attributable crime to alcohol misuse. This represents a major development over the last decade, for earlier the task was though impracticable. Even now criminology does not have the sophisticated "attributable fractions" that epidemiology currently provides, and Lapsley and Collins were involved in a tedious process of working with criminologists to derive workable estimates.

It turns out that while there is some ambiguity (as when there is co-dependence between alcohol and illicit drugs), it is clear that the social costs of alcohol attributable crime are significant – amounting to about .2 percent of Australian GDP. Applying that to New Zealand we should add perhaps a further \$200m to my annual costs of alcohol misuse in New Zealand.

The other Collins and Lapsley paper drew attention to their low – almost zero – estimates of net costs to the health system of alcohol use, and a correspondingly low reduction in human capital in Australia. These differ significantly from my estimates for New Zealand, arising from different counterfactual assumptions. My counterfactual assumed that there was no alcohol misuse, whereas the Australian study assumes there is no alcohol consumption at all. Since modest levels of alcohol consumption have been found to be beneficial to health and longevity, their zero consumption assumption eliminates these benefits. The low net costs to health and human capital are not the consequence of any economics, but of the epidemiological research, with the economics highlighting its finding. The conclusion emphasises the tension which alcohol policy has faced for some decades, when it was recognised that all alcohol consumption need not be detrimental (although in the past it had been

abuse workshop

abuse workshop

assumed that modest consumption was generally neutral to health, whereas more recently epidemiologists have identified a mild net benefit). What constitutes “modest” consumption depends on circumstances. In the case of pregnant women modest consumption levels are thought to be zero.

A telling paper by Ric Harwood evaluated the costs of a case of Fetal Alcohol Syndrome (FAS) – arguably the most common (known) non-genetic cause of mental retardation. Harwood, one of the most cautious in the team which developed the Guidelines, estimated the lifetime costs of a child suffering FAS as around US\$750,000 in the United States. The figure would not be as high for New Zealand, but it suggests that, say, a \$250,000 prevention programme which stopped but one case of Fetal Alcohol Syndrome would be economically justified.

(Rates for FAS are usually thought to be about one per 1000 live births, but the figure is subject to a large margin of error. This might suggest there are about 50 cases of FAS a year in New Zealand, plus further children who suffer some other (milder) fetal alcohol effects.)

A second paper by Donald Kenkel and Tsui-Fang Lin also examined FAS and looked at the impact of pregnancy and taxes on women's alcohol use. It found that pregnant women reduced their alcohol consumption (on average by half), an effect reinforced by higher excise duties. Since it is not practical to raise duties only on pregnant women, the research's policy conclusion might be that pregnant women are receptive to the notion they can improve their babies' health by lowering – and eliminating altogether – their alcohol consumption during pregnancy.

My presented paper, “The Economic Regulation of Alcohol Consumption in New Zealand”, ended the conference, nicely balancing the opening paper which was a plea from the Swiss Federal Office for Public Health, for more assistance to the development of public policy to reduce alcohol misuse and its consequences. Alas, Swiss constitutional arrangements preclude the use of excise duty in a manner similar to that in New Zealand. (I can also report that there was some amazement – even envy – that the policy recommendations in a scholarly work like my report *Taxing Harm* could be implemented within six months. I explained that treasuries with the constitutional power like to deal with tax loopholes quickly.) At the dinner for the international experts after the conference, considerable interest and support was expressed for the principle of using excise duties on alcohol primarily for the purpose of minimising harm.

This has been stated as a policy position in New Zealand cabinet papers (with the caveat there is also a revenue-raising role to cover the social costs of alcohol misuse) although, as my paper argues, it is yet to be integrated into officials' policy thinking. In the general discussion which followed, the experts urged that this approach be pursued and bedded in, and at least one remarked that New Zealand led the world. They hoped our leadership would enable their countries to adopt a similar policy framework.

Conclusions and directions

- (1) The growing evidence of mild health benefits from modest levels of alcohol consumption supports the New Zealand policy

approach of focusing on minimising harm (including drinking which causes harm) rather than attempting to reduce aggregate alcohol consumption.

- (2) There was a general agreement with the New Zealand approach of using excise duties on alcohol primarily for the purpose of minimising harm together with a revenue-raising role to cover the social costs of alcohol misuse.
- (3) Priority areas in the development of estimation of the social costs of substance abuse appear to be improved application of common principles for international comparisons; better estimates of the willingness to pay for valuing intangible costs; more work on, and the incorporation into aggregates of, the costs of alcohol attributable crime; and, of course, more data.
- (4) Preventing cases of Fetal Alcohol Syndrome (and the other, albeit lesser damaging, fetal alcohol effects) would appear to give a very high return on social investment.

Attendance at the conference was made possible by grants from the Economics Department of the Université de Neuchâtel and the Alcohol Advisory Council of New Zealand/te Kaunihera Whakatupato Waipiro o Aotearoa. I am most grateful to both institutions and to the host Claude Jeanrenaud and his support team. It is planned to publish the proceedings of the conference.

A national addictions workforce development programme

A new contract has been signed between the Ministry of Health (MOH) and the National Addiction Centre (NAC) regarding a workforce development programme for the addiction treatment field in New Zealand.

This programme is being funded through the Mental Health Directorate of the MOH and is similar to two others in the Mental Health area: at the Werry Centre, University of Auckland, directed by Dr Sally Merry, focused on Child and Youth Mental Health; and the Te Rau Matatini programme centred at Massey University, Palmerston North under the overall direction of Professor Mason Durie, focused on Māori Mental Health. There are clearly many opportunities for collaboration among the three programmes.

This new addictions workforce development programme will be managed by Ian MacEwan based in Wellington, where one of two new satellites of the NAC will be established. The other will be in Hamilton with Dr Murray Hunt and Vicki Crarer being key figures, linking with Dr Joel Porter in his new role with the Centre for Gambling Studies in Auckland.

An advisory group will be established over the next month or so, which will provide guidance to the programme and develop a five-year workforce

development strategic plan. Key projects include:

- development of a national addictions workforce development strategy
- a scoping project involving a repeat of the 1998 National Telephone Survey of alcohol and other drug treatment workers, along with more extensive interviews of people exiting the addictions treatment sector early as well as those who've stayed a long time
- development of a national addictions training provider network
- a series of one-day clinical update short-courses for alcohol and other drug treatment workers
- a series of one-day addiction short-courses for mental health workers
- developing and piloting a Māori addiction treatment short-course
- developing a clinical helpline for alcohol and other drug treatment workers.

Director of the National Addiction Centre Doug Sellman says the programme is a major step in the further development of the addictions treatment field in New Zealand and represents a serious commitment by the MOH to assist the field to continue to grow in strength as a specialty area within the Mental Health sector.

“The NAC views this contract as the start of a new era,” he says. “For the past seven years the Centre has struggled to establish itself as an ongoing concern, sitting within a university and aiming to be closely aligned and responsive to real life treatment concerns.

“We remain very grateful to ALAC for those seven years of core funding, encouragement and support. This has enabled the NAC to build a strong foundation in clinical research, teaching, and, connection with the treatment field. Now we are able to extend the infrastructure of the NAC northwards, and, in collaboration with national colleagues, facilitate workforce development for the betterment of people with addiction problems in Aotearoa.”

Cutting Edge 2004

Well, Cutting Edge, the annual treatment conference, is on the horizon again; and this year it is shaping up to be a highly informative conference, because of the range of exciting content that will be presented. We are fortunate that ALAC is remaining the principal sponsor for the Conference and continues to hold this national hui in very high regard.

Cutting Edge 2004 will be held at the Palmerston North Convention Centre from September 2 to 4, 2004

You may (or may not!) remember that the keynote speaker at the first Cutting Edge Conference in Auckland in 1995 was Dr Gillian Tober from the Leeds Addiction Unit (LAU), UK. Here we are, nearly 10 years on, and Gillian has accepted our invitation to return, but this time accompanied by Dr Duncan Raistrick, Clinical Head of the LAU. Both Gillian and Duncan have been leaders in the internationally important UK MATCH trial, a follow-on from the mighty Project MATCH study conducted in the US in the mid-90's. At Cutting Edge 2004 we will have the opportunity of hearing, at first hand, several presentations of UK MATCH, which has been investigating the effectiveness of active involvement of "significant others" in outpatient treatment of alcohol dependence compared with motivational enhancement therapy. First results are due mid-year.

We are in the process of inviting an overseas expert in the treatment of methamphetamine dependence to complement New Zealand data on the extent of the national

methamphetamine problem. It is important to identify that there is a problem and what the extent of it is. However, more important in the end is to find effective means to deal with the problem. Cutting Edge 2004 will face this issue head on.

This year's "distinguished academic from a field other than the addiction treatment sector" is going to be Dr Martin Kennedy from the Christchurch School of Medicine. Martin is one of New Zealand's leading genetic researchers and he has a particular interest in the genetics of mental health disorders focused on improving pharmacotherapy treatments. He has a knack of making complex ideas understandable to non-experts and is sure to answer all our questions about some of the basics about genes as well as indicate how things are likely to develop over the next few decades regarding the use of genetic knowledge for the benefit of our patients/clients.

The overall theme of the Cutting Edge 2004 is "Integration" and submitted abstracts for papers, workshops and posters, which are related to this theme, will be given priority. There are many areas of "integration" or "non-integration" that can be considered –

integration of addiction into mental health, integration of gambling and smoking cessation into addiction, the old chestnut of co-existing disorders, the place of Māori/Pacific Island/Asian dedicated treatment services, integration of pharmacotherapy and psychotherapy in treatment, integration of family work with an individual-based approach, integration of basic sciences (e.g. genetics) with clinical practice etc etc.

There will also be the usual broad array of meetings and get-togethers of the various groups that make up our field, a dinner to remember, unsurpassed national networking, scholarships, prizes and great organisation, all for the continuing incredibly low registration fee, made possible by the generosity of ALAC.

See you there!

Doug Sellman

Director

National Addiction Centre

News

Children, the world over, mimic the behaviour of their heroes

This year ALAC continued its sponsorship of the highly distinguished Say When Halberg Awards.

ALAC welcomes

ALAC welcomes Sue Paton as ALAC's new Manager Early Intervention.



Sue has worked at the Wellington City Mission for Youth for the last four years as Senior Counsellor.

Prior to this she was responsible for development

and delivery of alcohol and drug education and small group intervention programmes for Wellington secondary schools through Cross Roads Counselling and the Salvation Army Bridge Programme.

Sue has certificates in counselling, clinical supervision, and community work and is nearing the completion of her Masters of Education.

She says she is excited about the challenges of her new role.

"I am enthused by ALAC's mission to promote moderation and reduce harms related to alcohol, the primary drug of choice for New Zealanders," she says. "I am also keen to start working at a national level as this offers me the opportunity to have a wider influence on the health and well-being of New Zealanders than experienced in my past roles."

The awards, hosted each year at a dinner organised by the Halberg Trust, recognise the outstanding sporting achievements by New Zealand sports men, women and teams over the previous 12 months. This year's dinner was held in the Christchurch Convention Centre, with more than 900 guests in attendance.

In his message to guests, ALAC Chairman Professor Andrew Hornblow said sport continued to play a pivotal and integral role in the lives of New Zealanders, providing, health, well-being, enjoyment and goals – values that ALAC shared.

"But this is also an opportunity for us to stay in touch with many leaders in the sporting world and businesses and organisations who, through their involvement and interest in sport, are in prime positions to help ALAC achieve its goal of reducing alcohol-related harm for New Zealanders.

"One of the messages ALAC delivered on the night was 'Children, the world over, mimic the behaviour of their heroes'."

Professor Hornblow told guests, "Whether you are a nationally or internationally recognised sporting star, a participant at a local level, a coach, a parent or have some other contact with younger people and children, you are probably a hero to a young person. It's easy to forget they watch so closely."

He called on those present to work with ALAC. "By modelling appropriate drinking behaviour personally and becoming less tolerant of intoxication in all environments, we can start to challenge the worrying drinking culture New Zealand seems prepared to accept."

ALAC congratulates the Silver Ferns in capturing this country's ultimate sporting prize – the Halberg Award.

As well as winning the Say When "Team of the Year", star goal shoot Irene van Dyk won the Say When "Sportswoman of the Year". The third category winner in contention for the supreme Halberg Award was canoeist Ben Fouhy, winner of the Say When "Sportsman of the Year".

Fetal Alcohol Syndrome

Two experts on fetal alcohol syndrome from the world renowned Asante Centre in Canada are visiting New Zealand next month. Dr Kwadwo Ohene Asante and Dr Julianne Conry will be holding workshops throughout the country. The visit is being sponsored by ALAC in collaboration with Fetal Alcohol Support Trust and Alcohol Healthwatch.

The Asante Centre is located in British Columbia Canada, Governed by the Greater Vancouver Fetal Alcohol Society, the centre offers diagnostic, assessment and family support services, based on a multidisciplinary team approach, for children, youth and adults affected by FAS.

Dr Asante is recognised as an expert in the area of Fetal Alcohol Syndrome and was one of the first paediatricians to study and publish on Fetal Alcohol Syndrome in BC and Canada. Dr Asante has recently been awarded the Meritorious Service Medal in recognition of his efforts in founding the Asante Centre for Fetal Alcohol Syndrome.

Julianne Conry received her PhD from the University of Wisconsin, and is an Assistant Professor Emeritus at the University of British Columbia. Dr Conry has been active in research and the clinical assessment of children, youth and adults with FAS/FAE for the past 20 years and has appeared as expert witness on FAS in the Provincial and Supreme Courts of British Columbia and the Yukon. Recent research studies include “Youth in the Criminal Justice System: Identifying FAS and other Alcohol-Related Neurodevelopmental Disabilities” (with Fast & Loock).

Workshops are planned for Auckland, Wellington, Hamilton and Christchurch. For further details contact ALAC Central Region Manager, Philip Parkinson on 04 917 0060.

Sale of Liquor Act First

A Lower Hutt bar manager, licensee and manager have been fined after a prosecution believed to be a first under the Sale of Liquor Act.

The Ministry of Health took the successful prosecution against the Grumpy Mole Saloon in Lower Hutt. The prosecution followed the sale of five-litre kegs of pre-mixed bourbon and coke.

The Alcohol Advisory Council (ALAC) welcomed the prosecution saying it has been concerned about such promotions for some time.

While the Sale of Liquor Act clearly states that it is an offence to hold promotions designed to encourage persons in excessive alcohol

consumption, and there are guidelines around such promotions, this prosecution is the first clear indication as to what is unacceptable under the Act, said ALAC deputy chief executive Paula Snowden.

Common sense would indicate that supplying a five-litre keg for a table – this is about 20 standard drinks or three bottles of wine or an almost full bottle of spirits – would seem to be promoting intoxication.

But in the case clearly the publican required convincing, she said.

“The case also clarifies that other enforcement agencies do not have to wait for the police to take an action.”

Paula Snowden said enforcement of the law was critical to reduce intoxication and alcohol-related harm and to send the message that binge drinking and intoxication are not acceptable to New Zealanders.



A multi-agency group is to be set up in Whangarei to deal with a range of alcohol-related issues in Northland.

The agreement to set up the group followed a workshop held earlier this month where more than 50 people from a wide range of organisations met to discuss ways of working more closely together to find ways to reduce alcohol-related harm in the region.

The meeting was opened by Mr Craig Brown, Mayor of Whangarei, who said alcohol problems in Northland were not just a Police, Health or Council problem, nor just the fault of parents, or schools, but a community problem.

“Local government, central government, community groups and individuals all have a responsibility to make changes in the way they currently act and this workshop is a good first step towards building effective partnerships to reach a common goal,” Mr Brown said.

Speakers from the Northland District Health Board, Northland Police and Nga Manga Puriri gave an overview of some of the alcohol-related issues as they saw them in Northland and ALAC’s Group Manager Population Programmes Sandra Kirby then gave participants an update on the recently released BRC research on people’s drinking.

The rest of the day was given over to people discussing strategies and actions that they can take to deal with some of these problems.

“The original impetus for this meeting came from several of the key agencies approaching ALAC to facilitate this workshop,” said ALAC’s Manager for the Northern Region, Ron Tustin.

“Several groups had been working on their own alcohol strategies and they wanted to get together to find some common actions that they could work on. At the same time they wanted to discuss these with the wider community. The workshop seems to have achieved its outcome.”

The following day a separate meeting was held for the enforcement agencies to look at the sorts of programmes they could develop, focusing particularly on the issues of supply of alcohol to minors and to intoxicated persons.



ALAC publications on our website



The Way We Drink: The current attitudes & behaviours of New Zealanders (aged 12 plus) towards drinking alcohol.

The executive summary of this report is available to download. The report presents the results of a survey of

New Zealanders 12 years of age and more. It was specifically undertaken in order to identify and segment the current attitudes (motivators and inhibitors) and behaviours of New Zealanders towards the consumption of alcohol.

<http://www.alac.org.nz/resources/publications/index.html>



ALAC Resources



Skeleton poster and postcard

Choose either the poster or postcard version of the immediate and long-term effects of alcohol on the body. Includes information on the effects alcohol has on the main organs e.g. brain, liver, sexual organs. They are available from ALAC’s regional offices.

Electronic mailing lists for the alcohol and drug field

Two electronic mailing lists have been set up to enable individuals to communicate via email with other alcohol and drug professionals in New Zealand.

You can either subscribe to a general mailing list or register to connect to a network of Māori alcohol and drug workers.

SUBSCRIBE NOW

Contact other alcohol and drug professionals:

1. If you have access to the web, subscribe by going to <http://lists.iconz.co.nz/mailman/listinfo/aandd>

You will find a form to fill out. You will need to choose a password.

2. If you don't have access to the web, send an email message to aandd-request@lists.iconz.co.nz leaving the subject line blank.

In the body of the message type:

Subscribe ***** (where ***** is an alphanumeric password of your choice between 4 and 8 characters).

If you have any problems with the above, or for further information, please contact Kristine Keir.

Email: k.keir@alac.org.nz

Phone: 04 917 0703

Join a network of Māori alcohol and drug workers:

1. If you have access to the web, subscribe by going to http://lists.iconz.co.nz/mailman/listinfo/te_kupenga_hauora

You will find a form to fill out. You will need to choose a password.

2. If you don't have access to the web, send an email message to p.poata@alac.org.nz

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