Wrestling with the hydra: Health and welfare workers' perspectives on women and alcohol in Aotearoa/New Zealand

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Abstract

This article briefly describes the context of women's drinking and alcohol policy in Aotearoa/New Zealand and the methodology of interviewing service providers about the impacts of women's alcohol consumption. It then analyses the views of 40 health and social welfare professionals about their perceptions of alcohol-related harms to women. It describes three spiralling factors that these workers perceived as both causing and resulting from women's drinking and the impacts on their staff and sectors of women's alcohol-related trauma. The study concludes that gender analysis is essential in addiction research and that qualitative research with experienced service providers may be a useful element in evaluating changes in social policy.

Keywords

Alcohol, women, violence against women, service providers, Māori, Pacific

Introduction

Alcohol policy is made in the context of a Kiwi culture of intoxication resulting from a combination of liberalised alcohol licensing laws and marketing regulations, the growth of consumer culture and online social networking, and the development of new alcohol products (McEwan, Campbell, & Swain, 2010). Drunk women are more socially tolerated than 50 years ago, but remain more stigmatised than drunk men (McEwan et al., 2010).

Qualitative research with health and social service workers is an effective way of exploring social problems affecting particular populations (e.g. Campbell, Rondon, Galway, & Leavey, 2013), scoping potential alcohol interventions (e.g. Horsfield, Sheridan, & Anderson, 2011; Pega & MacEwan, 2010), and identifying difficulties with interventions in particular contexts (e.g. Moriarty, Stubbe, & Bradford, 2009). Treatment workers provide valuable qualitative evidence about problems in alcohol treatment (e.g. Resnick & Griffiths, 2012) and evaluations of pilot programmes (e.g. Henry & Stephens, 2012; Ward, 2009). Service worker informants also raise practice issues relevant to policy; however, the only explorations of service worker experiences about alcohol in Aotearoa/New Zealand have focused on single environments such as hospital emergency departments (e.g. Gunasekara et al., 2011).

This paper aims to fill a gap in qualitative information about alcohol harms for women that would be useful for policy makers, drawn from the repeated experiences of service workers over time. The research incorporated feminist expansion of the concept of trauma (Muzak, 2009) to include women's everyday experiences and the trauma of colonisation (Brave Heart, 2003; Second Māori Taskforce on Whānau Violence, 2004). The study took a feminist standpoint approach (Harding, 1993), acknowledging the intersections of gender with other social power relations, basing the research agenda in the experiences of the most marginalised women.

The paper introduces changes in women's alcohol consumption and describes the study methodology. It then focuses on cause and effect spirals that participants identified and the effects of alcohol harm on their sectors.

Context of women's alcohol consumption in Aotearoa/New Zealand

Between 1995 and 2000, women aged 20 to 39 years were converging with men in the amount of alcohol they drank in a typical occasion, the total amount they drank, and drunkenness; the frequency of drinking among women aged over 40 years was also increasing and converging with that of men (McPherson, Casswell, & Pledger, 2003). Between 1995 and 2011, the proportion of women aged 16 to 17 years having eight or more drinks in a session (28%) converged and exceeded that of young men (25%) (Casswell, 2012). Tertiary students (Huckle, Yeh, Lin, & Jensen, 2013), sportswomen (O'Brien, Hunter, Kypri, & Ali, 2008), indigenous women (MOH, 2013; MSD, 2010), and lesbian and bisexual women (Pega & Coupe, 2007) have higher risks of hazardous drinking.

Māori were one of the few indigenous populations in the world without an alcohol-making tradition (Huriwai, Sellman, Sullivan, & Potiki, 2000), and alcohol became linked to colonisation and land loss (Stuart, 2009). Alcohol was also unknown in most Pacific countries before it was introduced by sealers and traders (MOH, 1997). Until the mid-1900s, tauiwi women, Māori, and young people were seen as needing state regulation to restrict their drinking and protect them from alcohol; women were largely excluded from public bars until the 1960s (McEwan et al., 2010). Despite a profound change in women's paid work since then (MWA, 2010), a 1992 study concluded that 'there does not appear to be a convergence in women's alcohol use and related problems relative to men's' (Abel, Wyllie, & Casswell, 1992, p. 31).

Alcohol and social inequities

Alcohol dependence has a close link with social and economic disadvantage (Wilkinson & Marmot, 2003) and in 2010 was thought to be 'actively *driving* inequalities' in Aotearoa/New Zealand (NZ Law Commission, 2010, p. 148), as Māori were four times more likely than tauiwi to die of conditions attributable to alcohol (ALAC, 2009; Kypri, 2003). There are also persistent disparities between the health of the dominant Pākehā population and Pacific peoples (Statistics NZ & MPIA, 2010, 2011). The higher density of bars and off-licences in poor communities in Aotearoa/New Zealand may increase deprivation and widen social inequities (Hay, Whigham, Kypri, & Langley, 2009).

Alcohol and violence

Alcohol consumption increases the odds of domestic violence against women (Connor, Kypri, Bell, & Cousins, 2011), assault (Clark et al., 2009), sexual harassment (Connor, 2010), unwanted or unhappy sex (Kypri et al., 2009; McGee & Kypri, 2004), physical aggression by young women (Clark et al., 2009), and serious child abuse (Duncanson, Smith, & Davies, 2009). Women also use alcohol to deal with pain from violence, childhood abuse, and trauma (Felitti, 2004; Muzak, 2009).

This brief review indicates reasons for concern about women's increased alcohol intake.

Methodology

This study was carried out largely in Auckland, as part of an Alcohol Healthwatch project (Rankine, 2013). Focus groups were chosen because they gave service workers the opportunity to discuss experiences with others in similar fields (Tolich & Davidson, 2003). More than 40 Auckland organisations dealing with alcohol-related problems among women were approached, and 30 organisations were represented by 40 staff in six focus groups. Two Pākehā alcohol and other drugs (AOD) treatment managers (AODTM) were unable to attend a group and were interviewed individually, one each in Wellington and Auckland. Focus groups and interviews were carried out in late 2011, and took between one and two hours.

Feminist standpoint theory led to a focus on Māori; a group of Māori health workers (MG) was facilitated by two female Māori researchers using a kaupapa Māori process (Walker, Eketone, & Gibbs, 2006). The five women and four men included AOD workers, health promoters, health planners, and community health workers.

Disparities between Pacific and Pākehā socioeconomic status also led to a focus on Pacific women. A talanoa fono (TF – talking meeting; Vaioleti, 2006) of six Pacific-born women from Fiji, Niue, Samoa, Tokelau, Tonga, and Tuvalu communities was facilitated by a female Niue researcher according to Pacific protocols (Health Research Council, 2005). They included workers in tertiary student support, mental health, family violence, Pacific language preschools, and radio programmes.

Four groups of Māori, Pacific, Pākehā, and other tauiwi participants represented their organisations, including hospitals (HG); anti-violence services (VAWG); alternative education (AEG); and community organisations providing services for lesbians and queer youth, eating difficulties, Family Start, women's refuge, and sexual violence (CG).

The Māori researchers independently analysed themes from the Māori focus group. The five other focus groups were analysed by the two Pākehā researchers; they discussed and refined themes (Braun & Clarke, 2006) together, with the Niue researcher supervising the fono analysis.

Study limitations

The focus on service workers meant that the study concentrated on problems from alcohol use and did not include women's experiences of pleasure from drinking. The study was unable to include representatives who worked directly with female prisoners, sex workers, or migrant communities from Asian countries. This was an exploratory qualitative study, and findings cannot be generalised to the population of professionals working with women and alcohol harms or the population of women who drink alcohol.

Findings

Participants' discussion about trends and influences in women's drinking, alcohol problems for women, and effective interventions is reported elsewhere (Rankine et al., 2013). This section focuses on three cause and effect spirals that participants identified in women's drinking.

1 Systemic inequities

One factor was poverty, racism, marginalisation, and other systemic inequities, which participants identified as major contributors to women's drinking:

They're dealing with the, kind of alienation. Thinking with my niece, maybe it's a kind of classist school … Maybe she's not able to fit in and so she's found another group … the drinking camp to fit into her school. (TF)

Certainly the combination of not fitting in I think is a very strong driver … you might have some disability … if you are lesbian, gay or bisexual, undecided. (CG)

Next thing driving it, poverty and hopelessness; poverty has always driven [drinking] and poverty is relative – by that I mean the greater the difference between wealth and poor in any community, the bigger the problem appears to be. (AODTM)

Members of the Māori group perceived racism in the health sector as impacting on Māori women, who could be stigmatised and 'stereotyped as a bad mother' when they went for help. Some participants, including members of the Māori group, said that interventions that left poverty and social inequities untouched would not work: 'Any intervention is the same really, though, unless you change their lives and the opportunities that they have … then why would you change [your drinking]?' (MG). Several participants talked about the vicious spiral that drinking to escape poverty and racism could cause. One said, 'they think alcohol is a relief to their stress and they sort of ignore that the more they drink the more the stress is going to be there.' (CG)

2 Violence against women

Participants commonly discussed violence against women as a major factor in women's drinking, and also in their vulnerability to further abuse:

I find with our young women, because some traumatic experience they've been through … indirectly they don't realise what they're doing but it's numbing their feelings, it helps them not to speak about those experiences, and for them that's their only way … out. (TF)

People who have experienced sexual violence and people who have sexually harmed … they have been consuming alcohol, and often the times we talk about drug-facilitated sexual violence we think the roofies – the pills – but it is actually alcohol. (VAWG)

Other people's drinking also contributes to the amount and severity of violence against women:

Just looking back over this year, probably about 80 percent of our clients that've come into refuge it's been an alcohol-fuelled; like it's happened before but … alcohol just escalates the violence to a stage where the women has had injuries, she's going to end up dead … She's had to leave. (VAWG)

These participants were clear that abusers were responsible for choosing to drink and to be violent.

One participant said that using alcohol to blot out abuse can stop women from getting help: 'The more props they have available round them the more they'll use them rather than going and getting help' (VAWG). Several participants pointed to other damage that can be caused by using alcohol to cope with violence. One said,

They do realise that alcohol will cause a lot of problems for their relationships and yet they kind of rely on it, so that is what's coming up a lot – the alcohol is the cause of a lot of relationship breakdown for them and the domestic violence, neglecting of the children and their poor parenting. (CG)

3 Erosion of cultural values

Māori and Pacific women commonly discussed the erosion of cultural wellbeing as both an influence on and a result of heavy drinking. This was also implicit in some comments by Pākehā. One Māori group participant said that in cultural settings like some marae it was now

acceptable to drink, whereas this was previously not the case. Another said,

> Contemporary society is telling us that it is normal for us to get together, whakawhanaungatanga [build relationships] together, but you need a bottle to do it. I mean hello? It's not our culture. (AEG)

Pacific participants saw the dominant Kiwi drinking culture as eroding traditional protective factors, including female abstinence:

> The early days in coming to New Zealand there were few women that drink … But today it's just like a normal – drink wherever there's fundraising.

> [Group agreement] Yes. Yeah. (TF)

Alcohol has become embedded in Pacific hospitality, even when it seems incongruous with the event. One Samoan woman said,

> the leader of our Sunday School … said to me 'Because it is the guests out here and if there is no alcohol there … it will be talked down, it will be like "Oh, they didn't host us properly"'. (CG)

Pacific women described their struggle to maintain cultural values of respect, spirituality, and traditional boundaries in the face of what they described as overwhelming pressure.

Some Pākehā participants thought alcohol was contributing to a less caring society and wanted to build a culture of community care:

> One thing that I hate seeing is, you know, 4 o'clock in town in the morning and you see the girls just by themselves stumbling along and no one does anything, they just all watch her and they laugh. (CG)

> We've got a right as an individual in a caring society to be cared for … And alcohol allows people to abrogate their responsibility to be the carer or to think that someone deserves being cared about … And … that's shocking. (VAWG)

Suspicion and fatigue

Participants described two related responses – suspicion and fatigue – to what many saw as the repeated failure of governments to enact effective alcohol-control policies, despite strong research evidence of harm.

Some participants expressed distrust and cynicism about national and local government decisions, saying that industry lobbying and alcohol-related income may reduce their willingness to enact stricter legislation or cause them to abdicate their public health responsibilities about alcohol. They saw this as leaving communities with little influence and few options. One AODTM pointed to 'less control by government on alcohol as it has an income tax revenue that is needed', whereas the other manager said, 'legislation would be a protective factor [if] the Government decided to act on behalf of our youth, rather than on behalf of the liquor industry'. Pacific women said,

> The biggest ogre is the government of course, that condoned all these alcohols for getting all the money back from these breweries. (TF)

> Maybe the tobacco companies in the world are not as strong as the alcohol companies (laughs) … which are very, very, very strong. How do we think our little Pasifika communities, for example in South Auckland, how do we meet those kind of big money powers and the government? … Governments make policies to them and they give government the kind of money ... the government needs. (TF)

Others noted the inequity between the profits made by alcohol companies and the burden of damage from their products carried by others, especially those in poor suburbs with high densities of alcohol outlets. As one said,

As much as there is money being lost – particularly public money being lost because the problems around drinking – privately there is a lot of money to be made by a heavy drinking culture. (CG)

Many participants who dealt directly with damage from alcohol described exhaustion about the magnitude of the problems:

It's rare to not have a case where alcohol's significant to the point where we're just all burnt out with it … We've had it … Because that's a huge change over the last seven, eight, nine years. Alcohol's always been a major problem but now it's just, it's to the level of stupidity … we are really at the bottom of the cliff now. (VAWG)

Doctors at A&E all around the country are just sick of having to deal with obstreperous young people who at the time don't even want help, in fact, fight you and hurt you and … do damage and yet you have got to help them. (AODTM)

One Pacific woman said, 'So, you know, I felt quite helpless when I think about the bigger picture' (TF). Others expressed frustration over the lack of progress in alcohol policy despite huge community efforts:

I think there's been advocate groups going and petitions going right around South Auckland … from local body for years. I was part of a lobby group to council trying to get [new liquor store licences] stopped because of the effects that were occurring … (HG)

You … just get this [new liquor] business, and your energy is going nowhere, when next minute they're signing off another one. (HG)

Discussion

This study offers insights into the way a varied group of health and welfare workers perceived the results of women's drinking, and the adequacy of services to cope with alcohol harm. The social and health problems they described were consistent with those in the research literature (Connor & Casswell, 2012; Room et al., 2002). Most participants believed that women's alcohol consumption was increasing, as were the resulting problems. They noted the harmful spirals created by a widely promoted, easily available, and cheap drug that could briefly mute the pain of violence and marginalisation, but which was addictive, carcinogenic, and contributed to increasing violence, impoverishment, and inequity.

Participants were critical of policies allowing alcohol to be easily accessible, cheap, and strongly marketed, including online and in sport. However, positive changes in laws and behaviour about smoking and, to a lesser extent, drink driving gave participants hope, although they stressed that these social shifts had followed strong government laws and action.

These conversations depicted a dedicated but often exhausted community health and welfare sector dealing with preventable but ever-increasing alcohol-related damage. Community campaigns, for example against more liquor outlets, required sustained vigilance from poor neighbourhoods that were already beleaguered. Participants also pointed to ways in which uncoordinated and sometimes racist AOD services were failing many Māori and other women who needed them.

Many participants viewed the Sale and Supply of Alcohol Act 2012 as deeply disappointing. Some were dispirited or despairing at the government's refusal to adopt evidence-based measures, such as raising the purchase age, restricting alcohol marketing, and limiting alcohol outlets. Most said that strong legislation and government action would be necessary to reduce alcohol problems for women and to change the Kiwi culture of intoxication.

The suspicion of government and the exhaustion expressed by many participants indicated the degree to which health and welfare workers subsidise poor alcohol and social policies. Such exhaustion increases the risk of staff burnout and high turnover in these and other frontline services, which may further diminish their quality.

Although the study explored the views of predominantly Auckland service workers, the problems they face are likely to be experienced nationally, and the results may be useful for policy makers and practitioners elsewhere.

Conclusions

This study indicated the need for alcohol and other drug research to include a gender analysis. Researchers have argued that governments have 'an ethical imperative to measure effectiveness' of alcohol policies (Kypri, Langley, & Connor, 2010, p. 3), but this suggestion was omitted from the Law Commission's recommendations (Kypri, Maclennan, Langley, & Connor, 2011). This study indicates that qualitative research among experienced service providers may be a useful component of evaluating policy effectiveness.

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