This issue’s theme of ‘alcohol help intervention’ is relevant to many working in the health sector.

Working alongside people from other sectors, such as education providers, social services and justice services, helps to ensure that the people who need help with their alcohol use receive it.

People differ in how they seek and receive help for their alcohol use.

For some, support provided through helplines, peer-support groups, self-help tools, and online information and communities is crucial.

From my time working as a GP, I know first-hand that primary health care services are well positioned to discuss patients’ alcohol use and provide advice and support to those who have a problem.

It is important that the full range of services and tools is available and accessible to match people’s need for help with their drinking when and where they need it.

I commend the Health Promotion Agency in putting together this issue of *AlcoholNZ*. It provides interesting articles, research findings and other relevant information about alcohol help interventions. These include an international perspective and an analysis of interventions to make a difference for secondary school students’ alcohol use.

I expect that the information in this issue will stimulate action and further debate.
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Welcome to the Health Promotion Agency’s (HPA) AlcoholNZ magazine. AlcoholNZ provides evidence-based articles, topical commentaries and summaries of new alcohol-related research and guidelines to update readers’ knowledge and inform debate about alcohol issues in New Zealand. The theme of this issue is ‘alcohol help interventions’.

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.

This issue of AlcoholNZ provides articles on interventions that support and help people to reduce or stop drinking alcohol. Highlights include articles about: settings for alcohol help interventions; a whole-school approach to student alcohol use; and the use of online tools, in particular blogs, to support addiction recovery. It also features analysis of new HPA data about who is looking for and being given advice on cutting down on their drinking, HPA’s low-risk alcohol drinking advice, and information on HPA resources for people wanting to reduce or stop drinking alcohol and for those supporting them to do so.

The named articles prepared for AlcoholNZ are the express views of the authors of the articles.
ALCOHOL DRUG HELPLINE
0800 787 797
Alcohol help interventions
An introduction

Most people whose drinking puts them at risk do not decide to make changes unprompted, but often reduce their alcohol use following a prompt by a health professional or another influential person. A small minority of people seek professional help with their alcohol use, while others make changes with the support of someone in their community.

Changing drinking behaviour is often a gradual process that takes time and people may access a range of types of help to cut down or to stop drinking entirely. Early interventions include self-help tools and resources, identification and very brief advice, or a more structured screening and brief intervention using a validated screening tool. Early interventions tend to be delivered opportunistically by primary health care nurses and general practitioners or other health professionals, but can also be delivered by others, such as social or youth workers. Help may also be delivered via helpline phone or text conversations with trained brief intervention counsellors.

For people who require a more intensive intervention, specialist addiction services provide a range of interventions, including group work, peer support, community-based treatment, kaupapa Māori and residential programmes.

There is also a growing trend towards using social media, such as blogs, to support recovery from alcohol addiction. Although research on how social media interactions can impact recovery is still limited, there are many stories of people finding this means of support very helpful.

What is important is that people get help and that help is timely, effective and family centred. A culture of it being okay to seek and receive help without stigmatisation enables this.
Settings for alcohol help interventions
A Scottish perspective

The following article has been prepared by Dr Peter Rice, an addictions psychiatrist based in Scotland.

Dr Rice has recently visited New Zealand and was a keynote speaker at the 2014 Cutting Edge national addictions conference in Dunedin and participated in a series of meetings around New Zealand. He has worked for many years in a National Health Service (NHS) Alcohol Problems Service and is the chair of Scottish Health Action on Alcohol Problems (SHAAP). SHAAP was set up in 2006 by the Scottish Medical Royal Colleges. It provides the authoritative medical and clinical voice on the need to reduce the impact of alcohol-related harm on the health and wellbeing of people in Scotland and the evidence-based approaches to achieve this.

Setting the scene

Alcohol is everywhere. The World Health Organization (WHO)-sponsored publication which best summarises approaches to reducing alcohol harm is called Alcohol: No Ordinary Commodity (Babor et al., 2010). This is a title that is cleverly chosen to encourage us to consider why communities throughout history have regulated alcohol through controls on number and places where alcohol can be sold, who it can be sold to, who is allowed to sell it, how it is promoted, the price and other considerations.

Yet despite this acceptance that alcohol needs to be regulated, it is ubiquitous. It certainly is in the UK, and on my visit to New Zealand from Scotland in September 2014 the landscape looked very familiar, in more ways than one.

To pick out some of the UK data, Work in Wales found that 10 to 11-year-old children are more familiar with alcohol brands than confectionery brands (Alcohol Concern Cymru, 2012). TV viewers of English Premier League football see two alcohol promotions per minute (Graham & Adams, 2014) and Scottish Public Health departments tell us that 80% of the population of Edinburgh lives within 400 metres of an alcohol retail outlet and there is enough pub provision in Dundee for two-thirds of the city’s population to go to the pub at the same time (Dundee City Alcohol and Drug Partnership, 2014).
Where do or should interventions take place?

In our services, people with alcohol problems are readily found in Police stations, courts, family centres, GP clinics and pretty much every department of a hospital. All this will be familiar to readers of this journal. Looking for alcohol problems in our public services is like looking for hay in a haystack.

So if our guiding principle is that our response should take place wherever the problem is identified, the opportunities are many and varied. Being able to meet all the identified need would be nirvana, but real life is that we have to choose priorities and be open about the implications of those choices.

We could aim for the most visible problems – city centre public disorder on a Saturday night, homeless street drinkers and youngsters in the park. This tends to be popular in the short term with the general population, perhaps because it doesn't threaten their own behaviour. But many of the heavy drinkers in these settings may not be worried about their drinking, and/or want to do anything about it. The problem is defined by other people, not the individuals themselves.

We could be guided by the effect on others and link alcohol interventions into family and children's services. Again, this tends to be popular, but these services reach limited numbers within the population.

We could choose our settings on the basis of where the need is, which may be different from the public or media demand. In Scotland, this approach led me to become involved in raising awareness of alcohol hospital admissions in older people, which were rising more rapidly than in younger age groups (and still are). This was not a popular move. I was accused of being a young whippersnapper (I'm neither of those things) depriving the retiree of the well-earned right of a reviving wee bevy, a routine which did no harm to anybody, albeit one which was ending up in the wards of the local hospital.

Which approach – at-risk, whole-population or both?

So there are choices to be made and the settings for alcohol interventions are part of that choice. One of the reasons for the interest in the Scottish approach to reducing alcohol harm is that, encouraged by the alcohol harm reduction sector, the Scottish Government made what was, for governments, an unusual choice. This is best described in the 2008 consultation paper Changing Scotland's Relationship with Alcohol.

Previous interventions have tended to target particular groups, such as those with alcohol dependency or young people, and over-relied on the promotion of general health information and education campaigns. The World Health Organization (WHO) has stated that alcohol interventions targeted at vulnerable populations can prevent alcohol-related harm, but that policies targeted at the population as a whole can have a protective effect on vulnerable populations and reduce the overall level of alcohol problems. Action on a wider scale, both population-based and targeted to particular groups, is now required (Scottish Government, 2008).

The statement above was an explicit sign that the Scottish Government was working to a whole-population approach rather than an exclusively 'problem minority' view. There was no reassuring message, of the type to be found in many Government policy statements, that most of us can carry on as we were and that this was a problem in the personal life choices of an irresponsible minority and the many should not be punished for the sins of the few. The fact that the Alcohol Harm Reduction Strategy for England (work out the acronym for yourself) (UK Cabinet Office, Prime Minister's Strategy Unit, 2004) had taken the latter approach was probably an encouragement to do something different.
The battle between whole-population and high-risk models had been played out for many years in the alcohol sector. The characteristics of the two approaches are outlined below.

<table>
<thead>
<tr>
<th>Population approach</th>
<th>High-risk approach</th>
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<tbody>
<tr>
<td>Overall reduction of consumption</td>
<td>Promotes responsible alcohol use</td>
</tr>
<tr>
<td>Target is whole population</td>
<td>Targets segments of the population</td>
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<tr>
<td>National action</td>
<td>Local solutions</td>
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<td>Regulation and legislation</td>
<td>Information on products and harm</td>
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<tr>
<td>Wider public interest</td>
<td>Personal choice and responsibility</td>
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<td>Wide range of outcomes</td>
<td>Specific targets (binge drinking, drink driving)</td>
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<td>Early interventions</td>
<td>Treatment for dependence</td>
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<td>Leadership</td>
<td>Partnership</td>
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So where there are two teams, there are usually two different kinds of supporters. Whole-population approaches, with their emphasis on interconnections, broad trends and political leadership, are favoured by public health specialists. High-risk models focused on personal choice (“It's not the drink, it’s the drinker who is the problem”), individually focused interventions and an avoidance of the regulation of the nanny state or wowserism are favoured by the alcohol industry. Politically, the Left likes whole-population, the Right, the high-risk approach. In truth, most strategies such as the WHO Global Alcohol Strategy have elements of both, for good reason (Anderson, 1993).

**Ideal settings for intervention**

So what does all this theory mean for where we should target our intervention efforts?

If you've chosen to go for a strong whole-population orientation, can you find a setting which:

- has contact with big numbers of people
- is likely to find acceptance from the public as appropriate for alcohol work
- has a track record of effectiveness in doing this kind of thing and even the holy grail of a decent research base of effectiveness?

In Scotland, the settings which fitted these requirements were in the health system. The National Health Service (NHS) performed well in international comparisons. Access is easy, it’s free, staff follow guidelines and the outcomes are good.

The access and reach are important. Compare the proportion of the population consulting primary health care services with the proportion arrested each year. The number will vary from place to place, but I'd be surprised if the number seeing a GP and nurse doesn't outnumber criminal justice services contacts 25:1.

People expect alcohol to be raised as part of health and wellbeing advice. More importantly, there is a very well-established evidence base for providing Alcohol Brief Interventions (ABI) in primary health care services (Kaner et al., 2007).

Interested readers will find much more information at the website of the International Network on Brief Interventions for Alcohol and Other Drugs, INEBRIA (www.inebria.net).

Internationally, there is a group of highly active researchers who are developing the evidence base in other settings, such as criminal justice services and emergency medicine departments. The UK SIPS project, headed by Colin Drummond from Kings College, London, is also an important project (www.sips.iop.kcl.ac.uk), looking at questions such as how brief can the intervention be, and can criminal justice services deliver ABIs effectively? The answer to the latter is a highly qualified yes.
While there is interest and enthusiasm for other settings such as community pharmacies, housing agencies and courts, clients need to be in a receptive mindset, and somewhere which deals mainly with people with serious alcohol problems and dependence will need to provide much more than a brief intervention.

So no setting rivals primary health care services for their access to the population or the proven effectiveness. This was the reason NHS Scotland established a national Alcohol Brief Intervention programme, focused on primary health care (including ante-natal care), in 2008. I had the opportunity to discuss this with groups in Whangarei, Christchurch, Invercargill, Dunedin, Wellington and Auckland. Many general medical practitioners and senior planners attended, and many of these opinion formers and clinical leaders were already well informed on Alcohol Brief Interventions. The project that Dr John McMenamin is running in Whanganui, with support from the Health Promotion Agency, is very similar to the Scottish national programme.

So there is plenty of ‘bottom-up’ interest and knowledge in New Zealand. In Scotland we also had the advantage of top-down leadership. Brief Interventions became a national priority for the health system. Targets were set and health authority CEOs’ performance was measured against these. There was additional investment to cover the infrastructure and additional staff costs. In short, the exercise was similar to that undertaken for a health challenge like a flu epidemic or a cancer screening programme. This sent out the message that ABIs were important and needed to happen. Training materials were developed (now available at www.healthscotland.com/topics/health/alcohol/alcohol-brief-interventions-communications-and-guidance.aspx).

Alongside this, there was a range of other actions to tackle Scotland’s alcohol problems (www.healthscotland.com/scotlands-health/evaluation/planning/MESAS.aspx) including the pioneering step of introducing a minimum unit price for alcohol – a measure which has the support of the Scottish Parliament and the Scottish population. However, its implementation is being delayed by organisations representing the large alcohol producers, who have dismissed the views of others, including many in the alcohol industry who support effective regulation, to pursue their own commercial gain.

Scotland and New Zealand have many historical ties and many things in common. The countries look alike; are home to many sheep and cattle; have human populations of similar size; have a complex (mostly convivial) relationship with a larger neighbour; and share a sense of humour which is hard to describe but you know it when you see it.

We have much to learn from each other. My two visits to New Zealand, in 2009 and 2014, have taught me a lot and I hope there are some useful lessons for New Zealand in Scotland’s recent work on alcohol.
References


45% of secondary school students reported currently drinking alcohol.
Secondary school students and alcohol

Multiple levels of intervention can make a difference

The following article has been prepared by Ben Birks Ang.

Ben is the National Youth Services Adviser for the New Zealand Drug Foundation and Odyssey (a large addiction treatment provider). He has worked with Odyssey and youth organisations for a number of years across both residential and community treatment services. One of his key areas of work is leading the development of school-based alcohol and other drug treatment services.

Young people and alcohol

Whether or not alcohol is considered to be a rite of passage for New Zealand youth is debatable, but we do know that, statistically, alcohol use is commonplace among New Zealand youth. Fifty-seven percent of New Zealand secondary school students surveyed in 2012 reported having drunk alcohol at some point, and 45% reported currently drinking alcohol (Adolescent Health Research Group, 2013).

As a country, we can do more to help young people and reduce alcohol-related harm. Half of the people in New Zealand who experience alcohol dependence would have developed it by the time they were 19 years of age (Wells, Baxter, & Schaaf, 2007). Supporting those young people to make changes now would make a significant difference in the coming years.

The challenge is that during adolescence some of the more noticeable health and social harms associated with problematic alcohol use can be masked among a backdrop of typical adolescent changes. This makes it difficult for young people to identify when they need support for their alcohol use, let alone seek it out. Adolescence is a life stage when rapid changes in behaviour are expected, and bodies are designed to rejuvenate and repair at fast rates. It is also a life stage where taking risks and learning new skills is a daily occurrence. Choosing whether or not to drink alcohol is just one of the many choices that every teenager makes. Understanding and working with youth development philosophies to build young people’s strengths and equip them with the knowledge, connections and skills to have a positive life trajectory are crucial to reducing alcohol-related harm.
One effective solution is termed a ‘whole-school approach’. This involves creative, multi-level interventions at school that can proactively engage young people as part of their usual school routine, and provide them with support that matches their level of need.

**But is this a school or a community issue?**

Reducing alcohol-related harm for young people is both a school and a community issue. This is supported by the Ministry of Education, who state that the responsibility for reducing alcohol-related harm for young people is collectively held by young people, their parents and whānau, their schools, and the wider community (Ministry of Education, 2009).

The bigger picture is that alcohol use by young people is an issue that sits within the wider community. However, schools are a place where large numbers of young people spend time, which means they are the settings where wider issues in their lives can be the most visible.

There are two areas where schools clearly have a role to play. The first area is educating about alcohol and making good choices, which is part of the New Zealand Curriculum (Ministry of Education, 1999). The second area is responding to their students’ needs as they arise, or as incidents occur. To be able to respond, each school needs to have prepared in advance and be resourced to support students with alcohol problems. Schools that have not prepared will have limited options when an incident occurs.

One of these options is removing the young person from school. However, this should only be the last resort. Unfortunately the most common reason for a young person being expelled from a New Zealand secondary school during 2013 was ‘drugs (including substance abuse)’, with just over a third of expulsions being for this reason (Ministry of Education, 2014). Removing a student from school can have a large negative impact on a young person’s life trajectory, because there are multiple benefits associated with remaining engaged with education. Educational attainment is associated with higher employment rates (Organisation for Economic Co-operation and Development [OECD], 2013a), longer life expectancy, and enhanced skills (OECD, 2013b). It can also compensate for the effects of risk-taking on alcohol use for adolescents (Fergus & Zimmerman, 2005).

While responsibility for reducing alcohol-related harm is collectively held, there is more that can be done to help schools do this effectively.

**Matching school-based interventions to need – a whole-school approach**

A whole-school approach involves every member of a school community sharing the same philosophy and using many different levels of intervention to match each student’s needs. One way to conceptualise different types of need is as follows:

- **Every** young person will make a decision about whether or not they will consume alcohol. For some, this will be an easy decision, and, for many, a decision that they will repeatedly make as different situations arise.

- **Many** students will try using alcohol.

- **Some** of these will have some short-term harms.

- **A few** of these will develop longer-term problems.

Whole-school approaches focus on supporting student wellbeing for all these groupings of students, with approaches that:

- create **positive school environments** that promote wellbeing and positive social interactions
- deliver effective **education** as part of the curriculum
- provide **school-based support interventions** for students experiencing short-term alcohol-related harms
- involve **professional treatment interventions** for the few young people that need more extensive support (Dickinson, 2001).
The following diagram outlines how these approaches look within a secondary school context.

A whole-school approach to reducing alcohol-related harm

**Who is involved**

- Entire school community, supported by parents and wider school community
- All students and school staff
- Students who drink alcohol with short-term harms, school support services and parents
- Students who drink alcohol that may develop into long-term problems (often interlinked with mental health and drug issues), parents and treatment providers

**Type of intervention**

- Positive school environment
  - Based on positive youth development
  - Policies and processes enable and encourage the below interventions
  - All interventions are integrated with each other

- Deliver effective education about alcohol

- School-based support

- Professional treatment

**Level of intervention**

- Whole-school community
- Part of school curriculum
- Support for students needing support with their substance use
- Professional help for students needing support with their substance use
Positive school environments

Positive school environments, based on positive youth development philosophies, are the broadest level of intervention for all members of the school community. These environments focus on student wellbeing, promoting positive relationships, and encouraging the development of social, emotional and intellectual skills. The culture of a school is driven by school management and boards of trustees, and it is role-modelled by all staff and students at the school. The importance of role-modelling from everyone in a school community cannot be underestimated, as, in a school environment, “values are mostly learned through students’ experience of the total environment, rather than through direct instruction” (Ministry of Education, 1993, p. 21).

There is New Zealand evidence that reinforces the benefits of positive school environments. One recent Education Review Office review found that all the schools where students were very well supported had a “strong ethos of care and shared understanding around the approach to guidance and counselling” (Education Review Office, 2014a). A second report found that a focus on the wellbeing of each student underpinned how schools with good engagement and achievement levels were able to keep their students engaged and at school (Education Review Office, 2014b).

In Australia, an evaluation of the Gatehouse Project took this even further. This project used multi-level, school-based interventions to address students’ emotional wellbeing and health risk behaviours. An evaluation of its effectiveness stated that a focus on school climate and student connectedness “may be equally, if not more effective in addressing health and problem behaviours than specific, single issue focused education packages” (Bond et al., 2004, p. 1002).

Despite this strong evidence, the challenge with changing a school environment is that a long-term commitment is needed to see significant outcomes and it is difficult to measure incremental change. From what I have seen in my work within schools, changing a school environment takes at least a five-year commitment. This is because it takes five years for a Year 9 student to become a Year 13 student, and these older students role-model the school climate for others. Short-term or drop-in interventions often do not have the sustained changes needed to make an impact on a school environment.

A positive school environment, driven by school management and actively role-modelled by everyone in the school community, is the foundation for the whole-school approach. In practice, I have noticed the environment considerably influences how much effort a young person needs to put in to change their alcohol use. Those who were students at a school that encouraged accessing support and had a holistic wellbeing and development focus appeared to find it much easier to make changes than those who were at a school that did not. In addition, the young people at these schools commonly reported that they saw their school management as key support people in their lives. This foundation sets up a school for the next three tiers of interventions.

Deliver effective education

Delivering effective education is the next tier of interventions, which targets all students and staff at a school. New Zealand secondary schools actively work in this area by teaching the New Zealand Curriculum, which requires that all students receive education in health and physical education up until they complete Year 10. This includes learning about alcohol, and developing skills to think critically and self-manage (Ministry of Education, 1999).

The type of education is important in how effective it will be. Approaches that attempt to scare young people away from using substances by emphasising their risks have not been shown to be effective (Tobler & Stratton, 1997). Successful approaches build on strengths; take into account the contexts that young people live in; and use a social influence approach that provides factual information, normative information, and skills training (Ministry of Youth Affairs, 2003).

While education about alcohol is a very important component, education on its own has been shown to have limited effects on changing alcohol consumption (Cresswell, Liggins, & Dickinson, 2008). Therefore, robust and proven interventions are needed in addition to effective education.
**School-based support**

The last tiers of interventions are about providing additional support for those young people who are already developing problematic patterns of alcohol consumption. These work best when they are strongly aligned with the school, and are seen as an essential component of support for students.

The first contact for a young person and school-based support varies between schools. This could be a school counsellor, nurse or dean. In addition, some schools also have full-time social workers and youth workers. Many schools have wellbeing and prevention programmes, which encourage self-awareness and skill development. These programmes can help student wellbeing when they are aligned with a positive school environment (Education Review Office, 2014a; Education Review Office, 2014b). These programmes can also work well for the young people who are experiencing short-term harms from their alcohol use.

One of the ideas around school-based support is that bringing services to young people can minimise some of the key barriers to accessing help. The main barriers to accessing health care for young people are hoping that the problem would go away, not wanting to make a fuss, and having no transport (Clark et al., 2013). It makes sense that integrating support services with an adolescent’s daily routine would help to increase their access.

The flip-side to this is that accessing a school-based service becomes a lot more visible to peers than going to a service outside of school. Receiving a note in class to attend an appointment can be quite embarrassing at the best of times. This is where the school climate of encouraging help-seeking behaviours comes into play. Reducing alcohol-related harm for secondary school students really does require a multi-level, whole-school approach.

**Professional treatment interventions**

The final tier in a whole-school approach is additional specialist support, including alcohol treatment, which can be brought into a school to complement its existing services. This can be on an as-needed basis, or through a regular arrangement. Whichever option is decided, the important aspect in a whole-school approach is that all the interventions need to operate with the same philosophies, and appear seamless and integrated to the young person.

One example of a specialist alcohol service integrated within secondary schools is Odyssey’s Stand Up! programme, where two alcohol and other drug practitioners become part of the school support team for one day a week. An independent evaluation of this service found that most young people referred themselves for support, and 78% of those involved in the service were either completely abstinent from substances or actively minimising harm with reduced use when they left the service (Kinnect Group, 2013). Most of the young people who accessed the service had not thought much about their substance use, and did not want to change.

What enabled these young people to make changes was that the alcohol counsellors focused on engaging young people and working in active partnership with them. Every aspect of the programme was focused on building skills and an internal locus of control. This included building the young person’s health literacy skills through collaboratively tailoring the intervention, to both build the young person’s protective factors and teach them the skills needed to reduce their substance use. The focus on positive youth development also enabled young people to engage earlier than other specialist interventions, without first identifying that they needed to change their alcohol use. However, none of this would have been possible without integration within the school community.

**What does integration look like?**

Individually, all of these tiers of interventions can have some effects, but for a collective impact that reduces alcohol-related harm it is essential that they are linked together. Integration means that each intervention operates with the same philosophies and complements each other.

As an example, I remember working with a young man as his school drug and alcohol counsellor. One day he told me that he had run away from home, and asked for help to rebuild the relationship with his family so that he could return home. The first aspect that had enabled this conversation to even happen was that the school environment encouraged student wellbeing, and actively promoted help-seeking behaviours. The next aspect that enabled us to progress was that the school had put a lot of effort into helping all of its students and staff role-model helping each other out.
We identified a school dean who this young man trusted enough to bring into his support team. The dean helped co-facilitate a family meeting with me, and this led to not only rebuilding the relationship between the young man and his family but also strengthening the relationship between him and his school and between his family and the school. Family connection with school is a powerful protective factor (Fergus & Zimmerman, 2005), which in this case helped both that young man and his younger siblings.

In the previous example, the benefit of having a professional treatment intervention integrated as part of the school support team can be seen. Working as a wider support team meant the young man could feel confident that his school could provide a strong support network when he needed it. It also meant the underlying issues beneath his alcohol use could be addressed in a way that grew his protective factors. In this example, it strengthened his connection to school; his connection to trusted adults; and his family’s connection to his school. All of these are powerful protective factors that promote positive youth development and have been shown to support reduction of alcohol-related harm (Fergus & Zimmerman, 2005).

There are also several additional benefits from integrating services. It helps to reduce the stigma associated with accessing support, and adds in specialist skills and knowledge to complement the existing skill set of the student support team. A more confident and skilled student support team means more young people can be supported and supported earlier. Several deputy principals have spoken to me about how having an integrated specialist service enables young people to return to school earlier following an incident, knowing that in a couple of days they will be seen for support.

With these benefits also come complexities that can be worked through. While health, education and social services all aim to develop competent, confident and connected people, their priorities can be different. In practice, it takes a long-term commitment to working together, and creating the ability to be flexible in the way things are done. One common concern is that restorative practices, which enable a student to remain in school following an incident, could be perceived as permitting student alcohol use. I have seen this tension overcome many times through the development of a shared understanding of how the school and services can work together to provide appropriate boundaries and learning consequences for their students that take the young person’s context into account. It takes time to develop a trusting partnership, but once it is established the pay-offs can be significant.

**Where to next?**

There is a large amount of evidence that whole-school approaches are effective at reducing alcohol-related harm for young people. While there are benefits from individual, targeted interventions, the collective impact from positive school environments that have effective alcohol education, support, and partnerships with specialist alcohol services can be significant.

We know what works. It is all about young people, whānau, communities, specialist services, and schools working together to reduce alcohol-related harm for Aotearoa’s youth.
References


The following article has been prepared by **Lotta Dann**.

**Introduction**

I spent the first 20 years of my professional life working as a journalist, TV producer, director and reporter, writer, and researcher. I have a communications degree from the Christchurch Institute of Technology and a Master of Arts degree from the University of Auckland. I am a wife, and a mother to three young sons.

I am also an alcoholic who has been in recovery for over three years. I write a popular sober blog called ‘Mrs D Is Going Without’ and recently had a recovery memoir of the same name published by Allen & Unwin. I currently manage the community recovery website ‘Living Sober’, which is supported by the Health Promotion Agency, Matua Raki – National Addiction Workforce Development Centre, and the New Zealand Drug Foundation.

In this article I will explain how I got sober with the help of an online community and outline in detail what I understand the key benefits of online recovery to be.
What is online recovery?

At its most basic level, online recovery involves the coming together of addicts online. There is a powerful and growing network of blogs and community forums online which are helping thousands of addicts around the world get and stay sober.

Individuals can choose to participate in online recovery to varying degrees, but most commonly participation involves addicts sharing about their personal struggle and supporting and interacting with others who are doing the same. There are many reasons why online recovery is beneficial – the two most fundamental being the power of community and the opportunity for honest, unfiltered communication.

Any addict with a computer or smart device would gain a measure of help and support by tapping into online recovery. For some addicts, online recovery alone will be enough for them to achieve a robust and lasting sobriety. For others, more personal one-on-one, face-to-face support and interventions may be required, but online recovery would still be beneficial working in tandem with these treatments.

Online recovery works because it is free, it’s easy, it’s accessible, it’s safe, it’s supportive, it’s kind and it’s healing.

Personal experience

I got sober solely with web-based support. I had no other interventions in terms of doctors, counsellors, mentors, face-to-face meetings, or 12-step programmes. I self-identified as having an alcohol addiction and helped myself beat it by starting a personal blog in which I documented my thoughts and feelings as I transitioned from living as a high-functioning alcoholic to living sober.

My blog, ‘Mrs D Is Going Without’, was set up with the free service Blogger and has the web address www.livingwithoutalcohol.blogspot.com. From the day I stopped drinking, I wrote posts in this personalised online space, documenting my thoughts, feelings and experiences while learning to live without alcohol.

The process of blogging, articulating and externalising my thoughts and feelings was incredibly powerful and healing. I figured stuff out as I was typing it out, and because I was protected by an anonymous moniker I wasn’t filtering my communication for any audience. By sharing my secrets with brutal honesty on my blog, my shame started to lift and I began to heal.

Furthermore, the feedback and interactions I received on my blog posts were hugely helpful and made me realise I was not alone in my struggle. Support flowed around my blog in many different directions. All of the visitors to the blog were helped by reading about my struggle and recovery journey. Some readers left comments offering advice and support and in turn I would help other sober bloggers by leaving supportive comments on their blogs.

Powerful content

The written content provided by addicts online is raw, emotional and compelling, and the human connections made through interactions are warm, wise and supportive. Despite being without a formal structure, online recovery is extremely powerful, tangible and real.

The communication pathways that addicts share online are disjointed, amorphous and ever-changing, which makes it very difficult to quantify participant numbers and success rates. However, the unquantifiable nature of online recovery does not diminish its effectiveness. In the past three years that I have been a participant in online recovery, in addition to experiencing my own robust recovery I have ‘witnessed’ numerous others get and stay sober through blogging.

Here in New Zealand, we’re extremely fortunate that the addictions sector has recognised the power of online recovery and embraced this global movement by backing a community recovery forum. ‘Living Sober’ (www.livingsober.org.nz) brings all of the transformative and powerful aspects of online recovery into one virtual space. Not only does it offer multiple benefits for individuals wanting to get sober, but simply by existing it legitimises sobriety as an acceptable, attractive and attainable life choice.
Benefits

The key benefits of online recovery that I have learnt are as follows:

1. **Participants motivate themselves into it.** By choosing to visit websites relating to alcoholism and recovery, an individual has self-identified that they might have an issue with alcohol.

2. **Participants can do nothing but lurk.** Lurking is when an individual visits blogs and sites related to alcoholism and recovery and reads them privately but doesn’t interact by posting updates or leaving comments. Lurkers feel completely hidden and protected behind their computer screen. Lurking can often be an important first step on the road to recovery. I often receive comments or emails from people saying, “I've been lurking on your blog for months but only now have I got the courage to stop drinking.” Lurking is openly encouraged by active participants in online recovery.

3. **The participant quickly realises they are not alone in their struggle.** Many addicts feel locked in a private struggle and isolated. By reading other people's sobriety journeys, the participant starts to realise they are not alone and that there are many, many people going through exactly the same struggle. This can be immensely reassuring and empowering.

4. **Participants are welcome to interact anonymously.** Online recovery feels safe and secure because the participant is welcome to 'hide' by creating an anonymous profile. Anonymity is wholly acceptable in the online recovery community – participants do not judge others for concealing their full identity. Furthermore, using a cloak of anonymity does not diminish the real human connections that are formed by community members – strong identities and personalities can be developed from behind the cover of a generic moniker.

5. **Articulation.** To interact online you must use the written word and this process of writing is in itself incredibly beneficial. When blogging (or posting updates or commenting on other blogs etc), the participant is forced to choose words and formulate sentences in order to communicate feelings and opinions. Often this can result in previously unformed or unidentified thoughts being clarified. Additionally, the process of externalising (even anonymously and/ or privately) previously hidden internal truths can be immensely healing.

6. **Receiving support.** Participants can receive immediate feedback, acceptance, support and understanding from other community members. The simplest direct interaction, such as “You’re doing great”, “Keep going”, “I understand what you are going through”, can be hugely powerful and make a difference right in the moment.

7. **Offering support.** Being of service to others in recovery has long been identified as a powerful tool in helping an individual stay sober. Participants in online recovery have endless opportunity to offer support to others by leaving comments on other blogs or replies to forum updates.

8. **Lamplighting.** Early sobriety is the hardest. Participants who are through the tough early months and are starting to experience (and write about) positive changes act as 'lamplighters’ for those first starting out. New participants can see there is a path to sobriety that is challenging at first but ultimately immensely rewarding.

9. **It is open 24/7.** The internet never sleeps.

10. **It is mobile.** Online recovery can be fitted into a busy life because it can be accessed on any smart device anywhere.
Useful blogs and websites

**Personal blogs**

Mrs D Is Going Without  
www.livingwithoutalcohol.blogspot.co.nz

Unpicked  
www.unpickled.wordpress.com

Tired of Thinking About Drinking  
www.tiredofthinkingaboutdrinking.wordpress.com

Bye-Bye Beer  
www.byebyebeer.com

Running On Sober  
www.runningonsober.com

Soberbia  
www.sober-bia.blogspot.co.nz

Message In A Bottle  
www.messageinabottleblog.wordpress.com

A Hangover Free Life  
www.ahangoverfreelife.com

Mr Sponsorpants  
mrsponsorpants.typepad.com

**Community-based websites providing a platform for addicts to come together to share stories and offer support**

Living Sober  
www.livingsober.org.nz

Hello Sunday Morning  
www.hellosundaymorning.org

Crying Out Now  
www.cryingoutnow.com

Soberistas  
www.soberistas.com

SMART Recovery online forums  
www.smartrecovery.org/community

**Websites devoted to alcohol, drug and recovery news and information**

HPA’s alcohol site  
www.alcohol.org.nz

Alcohol Drug Helpline’s site  
www.alcoholdrughelplines.org.nz

Drug Help  
www.drughelp.org.nz

Like a Drink  
www.likeadrink.org.nz

Rethinking Drinking – NIAAA  
www.rethinkingdrinking.niaaa.nih.gov

The Fix  
www.thefix.com

Sober Nation  
www.sobernation.com

Substance  
www.substance.com
People looking for or being given help

What the data shows

Analysis of data from HPA’s 2013–2014 Attitudes and Behaviour towards Alcohol Survey (ABAS 2013) indicates that some people, in particular those who recently drank seven or more alcoholic drinks on one occasion, are considering cutting back. Smaller numbers report looking for or being given advice, information or help on how to cut back on the amount they drink.

ABAS is an annual telephone survey about alcohol. ABAS 2013 consisted of a sample of 4,001 New Zealanders aged 15 years and over and was conducted between November 2013 and February 2014. The data has been adjusted (weighted) to ensure it is representative of the New Zealand population. Responses were compared by ethnicity, age, gender, and drinking behaviour. Differences between demographic groups are only reported if they remained significantly different after drinking behaviour had been taken into account.

Outlined in this article are the findings from responses of the survey respondents who had answered questions about their last drinking occasion. The last drinking occasion was defined as the last occasion, within the previous three months, that the respondent had consumed two or more drinks. A total of 2,179 people answered these questions. These respondents were then asked:

• “In the last 12 months, have you thought about cutting back on how much you drink?”

• “And in the last 12 months, have you looked or asked for advice, information or help to cut back on your drinking?”

• “Has anyone given you any advice, information or help on how to cut back on your drinking?”
Who is thinking about cutting back

The survey found that:

- nearly one in three people (32%) who had drunk alcohol reported that they had thought about cutting back
- those more likely to say they had thought of cutting back were people who had, in the previous four weeks, consumed seven or more alcoholic drinks on one or two occasions (38%) or more than two occasions (53%) compared with those who had not drunk this much on any occasion (28%).

Who is looking or asking for advice, information or help

The survey found that:

- of the people who had drunk alcohol, 3% said they had looked for advice, information or help on how to cut back on drinking
- those more likely to say they had looked for information on cutting back were people who:
  - had, in the previous four weeks, consumed seven or more alcoholic drinks on more than two occasions (8%) compared with those who had not drunk this much on any occasion (2%)
  - were of Māori (7%) and Asian (7%) ethnicities compared with people of New Zealand European/Other ethnicities (2%).

Who is being given advice, information or help

The survey found that:

- of the people who had drunk alcohol, 7% reported that someone had given them advice, information or help on how to cut back on drinking
- of those who had been given advice or information, nearly three in four (73%) had not looked for it themselves
- those more likely to say they had been given information about how to cut back were:
  - people who had, in the previous four weeks, consumed seven or more alcoholic drinks on one or two occasions (11%) or more than two occasions (18%) compared with those who had not drunk this much on any occasion (4%)
  - Māori (16%) compared with those of New Zealand European/Other ethnicities (6%)
  - people aged 18 to 24 years (11%) and 25 to 44 years (8%) compared with those aged 65 years and over (3%).

Summary points

- Drinking behaviour (specifically heavy drinking on recent occasions) is the most relevant factor in whether people consider cutting back or seek information about cutting back. Many apparent differences between demographic groups were no longer significant once drinking behaviour was taken into account.
- While nearly one in three drinkers had thought about cutting back on their drinking, a much smaller proportion had actively sought help, information or advice about how to do this.
HPA’s low-risk alcohol drinking advice

HPA’s low-risk alcohol drinking advice for adults is designed to help people make an informed choice and keep the risk of alcohol-related accidents, injuries, diseases and death low. Drinking advice is often used in the context of an alcohol intervention.

Low-risk is not, however, no-risk. Even when drinking within the low-risk limits, a range of factors can affect the level of risk, including the rate of drinking, body type or genetic makeup, gender, age, and existing health problems and associated medication use. There is currently no separate advice for older adults, but many of the reasons for when not to drink are more likely to apply as people age.

**Reduce your long-term health risks**

- No more than... 2 STANDARD DRINKS Daily
- and no more than 10 a week
- And at least 2 alcohol-free days per week

**Reduce your risk of injury**

- No more than... 3 STANDARD DRINKS Daily
- and no more than 15 a week

**Pregnant women**

- No alcohol

<table>
<thead>
<tr>
<th>Reduce your long-term health risks</th>
<th>Reduce your risk of injury</th>
<th>Pregnant women</th>
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<tr>
<td>2 STANDARD DRINKS Daily</td>
<td>3 STANDARD DRINKS Daily</td>
<td>No alcohol</td>
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<tr>
<td>and no more than 10 a week</td>
<td>and no more than 15 a week</td>
<td></td>
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<tr>
<td>at least 2 alcohol-free days per week</td>
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</tbody>
</table>

There is no known safe level of alcohol use at any stage of pregnancy.
Advice for adults

Reduce your long-term health risks by drinking no more than:

- two standard drinks\(^1\) a day for women and no more than 10 standard drinks a week
- three standard drinks a day for men and no more than 15 standard drinks a week.

AND have at least two alcohol-free days every week.

Reduce your risk of injury on a single occasion of drinking by drinking no more than:

- four standard drinks for women on any single occasion
- five standard drinks for men on any single occasion.

Advice for pregnant women or those planning to get pregnant is:

- no alcohol.

There is no known safe level of alcohol use at any stage of pregnancy.

When not to drink alcohol

It's advisable not to drink if a person:

- is pregnant or planning to get pregnant
- is on medication that interacts with alcohol
- has a condition that could be made worse by drinking alcohol
- feels unwell, depressed, tired or cold, as alcohol could make things worse
- is about to operate machinery or a vehicle or do anything that is risky or requires skill.

Advice for parents of children and young people under 18 years

For children and young people under 18 years, not drinking alcohol is the safest option.

- Those under 15 years of age are at the greatest risk of harm from drinking alcohol and not drinking in this age group is especially important.
- For young people aged 15 to 17 years, the safest option is to delay drinking for as long as possible.

If 15 to 17-year-olds do drink alcohol, they should be supervised, and should drink infrequently and at levels usually below and never exceeding the adult daily limits.

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\(^1\) In New Zealand and Australia a standard drink contains 10 grams of pure alcohol.
HPA's alcohol resources for people wanting help with their drinking and for those helping them

HPA has a range of resources to help people to cut down or stop drinking alcohol and also resources for people who are helping them. They are available free of charge electronically and to order at alcohol.org.nz

**Alcohol and your health series of booklets**

The *Alcohol and your health* series of six booklets includes: a guide for people working with people who need help with their alcohol use; an information and self-help guide for people who are concerned about a friend or family member's drinking; and four self-help guides to help people make and maintain changes to their drinking.

**Helping with problem drinking booklet**

The *Helping with problem drinking* booklet is a guide for those working with people who are having trouble with their drinking. It includes information and advice on boundaries, assessment tools, stages of change, motivational interviewing, taking a drinking history, and strategies used in changing drinking. This booklet also outlines how to use and when best to provide the self-help booklets in the *Alcohol and your health* series to a person they are working with.

**Concerned about someone’s drinking? booklet**

The *Concerned about someone’s drinking?* booklet provides information to better understand and help a friend or family member who needs help with their drinking. It also includes information and self-help tools for the person doing the helping.

**Is your drinking okay?, Stopping drinking, Cutting down, and Maintaining the change booklets**

These booklets are often used as part of an alcohol intervention, such as a counselling session. They help people to identify how much they are drinking and work through strategies to make changes that may involve cutting down or stopping drinking. The booklets present practical ideas and tools to help achieve and maintain change, including some ways of helping to stay on track or get back on track after a slip or relapse.
**Smashed’n stoned? programme resource**

Smashed’n stoned? is a small-group counselling intervention designed for 13 to 18-year-olds whose alcohol and drug use puts them at risk. It is recommended for groups of three to six young people working with a trained counsellor. It is not suitable for use as a whole-classroom activity or with larger groups of young people. Smashed’n stoned? facilitator training will take place in various locations over the next few months. People can register at www.alcohol.org.nz/events to attend a two-day training session.

**Alcohol & your kids – What can you do? booklet and DVD**

The booklet provides parents with useful information and advice on the impact of alcohol on young people, what the law says, how they can help their teenagers make good decisions about alcohol use, and where to go for help. At the back of the booklet is a DVD with three common scenarios parents may find themselves in with their teenagers. These videos can also be viewed on www.alcohol.org.nz.

**Ki te Ao Mārama – Had enough? Then make a change workbook and DVD**

This DVD and workbook resource is for Māori whose drinking is putting them at risk. It follows the journey of four tangata whenua through their addiction, treatment and into their life of recovery.

**Bewildered workbook and DVD**

The Bewildered DVD and workbook resource is for parents/caregivers of teenagers that have problematic alcohol and/or other drug use and associated behaviours. It focuses on the stories and the process of change for parents and young people.
Drink Check? pamphlet

This pamphlet is based on the World Health Organization’s AUDIT validated screening tool and helps people find out more about their drinking by completing a questionnaire and finding out what it means. It also includes HPA’s low-risk alcohol drinking advice and information about understanding standard drinks.

Online interactive tools

HPA’s alcohol website www.alcohol.org.nz has an interactive tool where people can complete the questionnaire (the AUDIT tool) online and interactive tools that help people learn more about standard drinks, including pouring a standard drink.
Alcohol Drug Helpline

The Alcohol Drug Helpline (0800 787 797) is an important first point of contact for many people concerned about their own or another person's alcohol or drug use. It is an information, brief intervention and referral service that is free and confidential. The Helpline telephone and text service (text adh to 234) is available seven days a week 10am to 10pm. Information about alcohol and drugs and a live chat service are also available online (www.alcoholdrughelp.org.nz).

The Helpline service is provided by trained brief intervention counsellors. Māori, Pacific people or young people can choose to talk with Māori, Pacific or youth counsellors through the service's Māori line – 0800 787 798, Pasifika line – 0800 787 799 or Youth line – 0800 787 YTH or 0800 787 984.

The Alcohol Drug Association New Zealand (ADANZ) operates the Alcohol Drug Helpline service. ADANZ also compiles and maintains a national online directory of all alcohol and drug and problem gambling services in New Zealand – www.addictionshelp.org.nz. The directory provides information, including contact information, on alcohol and drug treatment and advice services available throughout New Zealand.
**UNited Kingdom**

*Fetal damage caused by alcohol ‘equivalent to attempted manslaughter’*

“Lawyers pursuing a compensation claim on behalf of a child say the mother’s heavy drinking constitutes a crime of poisoning. The test case raises complex questions about whether the mother’s drinking constitutes a criminal act and whether the child was legally an individual within the law at the time she suffered injury. As many as 80 other UK claims on behalf of children suffering from foetal alcohol spectrum disorder are awaiting the outcome.”

www.theguardian.com/law/2014/nov/05/foetal-damage-mother-alcohol-manslaughter

*Children living with parental alcohol abuse are being missed by system, report finds*

An October 2014 report from the Office of the Children’s Commissioner for England has found social services support for alcohol misuse is failing to look beyond the impact on the individual. The report used local authority data and interviews with children, parents and professionals in three different local authorities. It found that existing support focuses on the adult or young person’s own alcohol use, but there is no specific strategy to support children dealing with the alcohol misuse of a parent. The report includes a recommendation that all professionals who work with children should be trained to understand and address: the impact on children of parental alcohol misuse; the views of affected children; how to protect them; and how their needs are best met.

www.childrenscommissioner.gov.uk/content/publications/content_877

**Australia**

*Alcohol harm in emergency departments*

In December 2013, over 2,000 emergency department (ED) doctors and nurses in Australia and New Zealand responded to a snapshot survey asking them about their experiences of alcohol-related presentations in their ED. The report of the Alcohol Harm in Emergency Departments 2014 Survey, undertaken for the Australasian College for Emergency Medicine, is now available along with a video summarising the findings. The survey found that alcohol presentations in Australasian emergency departments are having a serious and detrimental impact on staff and other patients.

Health Promotion Agency

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Freephone: 0508 258 258
Fax: (04) 473 0890
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Email: enquiries@hpa.org.nz

Southern Regional Office
Level 1, CBRE House
112 Tuam Street
PO Box 2688
Christchurch 8140
Freephone: 0508 258 258
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To order resources visit alcohol.org.nz
and go to Order Resources

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