WHAT’S THE ISSUE WITH OUTLET DENSITY AND AVAILABILITY?
The Health Promotion Agency (HPA) leads and delivers innovative, high-quality and cost-effective programmes and activities that:

- promote health, wellbeing and healthy lifestyles
- prevent disease, illness and injury
- enable environments that support health and wellbeing and healthy lifestyles
- reduce personal, social and economic harm.

It also has functions specific to providing advice and research on alcohol issues.

The Health Promotion Agency is a Crown entity formed by the merger of the Alcohol Advisory Council (ALAC), the Health Sponsorship Council (HSC) and some health promotion programmes previously delivered by the Ministry of Health.

The New Zealand Public Health and Disability Amendment Act 2012 setting up the Health Promotion Agency was passed by Parliament in June 2012 and the HPA officially came into existence on 1 July 2012.

The aim of the Health Promotion Agency is to inspire New Zealanders to lead healthy lives.

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The work of the Alcohol Advisory Council (ALAC) has entered a new chapter, with ALAC, along with the Health Sponsorship Council (HSC) and some Ministry of Health functions, being merged into a new organisation, the Health Promotion Agency (HPA). The drivers of the change are to improve value-for-money, innovation and high quality public services. In particular, the Health Promotion Agency is intended to improve coordination, reduce fragmentation and result in greater effectiveness of services. The new agency will continue the work that was carried out by ALAC and the HSC (including ALAC’s autonomous advisory function and the alcohol levy) and has a broad health promotion focus based on the Ottawa Charter. These proposals received widespread support from the health sector, as was evident during the select committee hearings on the legislation setting up the new agency.

It is encouraging that many recognise the benefits the new agency will provide, with its strong focus on integrated health promotion.

The Government believes that the integration of ALAC, the HSC and other health promotion functions will lead to real administrative efficiencies and better health and wellbeing outcomes for New Zealanders. I know that many of ALAC’s stakeholders, while supportive of the establishment of the new entity, are also concerned to ensure the momentum around alcohol continues.

And many who appeared before the select committee raised specific concerns over the need to retain ALAC’s independent advisory function and to ensure all its functions were retained — not just its health promotion functions.

As the Minister responsible for ALAC for the past four years, and as someone who is well aware of the good work done by the organisation, I want to assure you, the stakeholders and partners of ALAC, that the work is continuing albeit in a different organisation. On a more personal note, many will be aware that early in my career I had the pleasure of working in some senior roles at ALAC before I embarked on my political career. Not only have I since then had huge respect for the organisation, I have also had a great affection for it. When change comes and an organisation comes to an end, there is always a degree of sadness. In the longer term, having one agency responsible, effectively, for the whole range of health promotion campaigns is extraordinarily exciting, and, I think, offers lots of exciting opportunities.

The new agency will provide, with its strong focus on integrated health promotion.

The Health Promotion Agency (HPA) has been formed by merging the Alcohol Advisory Council (ALAC) and the Health Sponsorship Council (HSC) and transferring some of the health promotion programmes from the Ministry of Health. The HPA’s key objective is to inspire New Zealanders to lead healthy lives.

The agency draws on a wide range of relationships and expertise to lead programmes that promote health, wellbeing and healthy lifestyles, disease prevention, and illness and injury prevention. The agency will be able to achieve greater coordination and integration of programmes that were previously delivered by a number of Government organisations.

The work of the HPA is not limited to only social marketing campaigns. Rather, there is sufficient scope for the HPA to carry out a wide range of interventions. This is crucial because many of the public health and preventive health issues the HPA is tackling are complex and challenging.

ALAC’s independent, evidence-based advisory function is retained within the new entity. Alcohol harm reduction programmes continue to be funded through a dedicated levy on alcohol consumption.

I would like to take this opportunity to recognise the work that has been carried out by both ALAC and the Health Sponsorship Council. This merger is not a negative reflection on those two agencies, which have both made a significant contribution to the wellbeing of our country. Rather, the formation of the HPA strengthens the focus on health promotion activity and is creating more opportunities for innovative and targeted approaches to those people and communities with multiple health issues. This is not a faceless organisation, it is one with true focus, and I look forward to working closely with the HPA Board and staff to deliver better health outcomes for New Zealanders.
Although ALAC is now part of a bigger organisation, the work and commitment to reducing alcohol-related harm continues. In fact, the legislation setting up the HPA sets out alcohol-specific functions.

The HPA has an overall function to lead and support activities for the following purposes:

- promoting health and wellbeing and encouraging healthy lifestyles
- preventing disease, illness and injury
- enabling environments that support health and wellbeing and healthy lifestyles
- reducing personal, social and economic harm.

It also has functions specific to providing advice and research on alcohol issues.

The ALAC levy has been retained by the HPA to fund the alcohol-related functions of the new agency. Along with a new organisation, we also have a new Board and a new management team.
AlcoholNZ

The HPA is governed by a seven-person Board.

**Dr Lee Mathias – Chairman**  
A nurse, Dr Lee Mathias has an extensive background in health service management and governance, and currently operates the consultancy firm Lee Mathias Ltd. Lee was elected to the Auckland DHB and appointed its Deputy Chair in 2010. She is also a current member of the Midwifery Council. Previous governance roles have included directorships of the Accident Compensation Corporation (Chairperson of ACC Healthwise), Birthcare Auckland Ltd, and Pacific Health Ltd.

**Rea Wikaira – Deputy Chairman**  
Rea Wikaira is the former Chair of ALAC. Rea is the National Operations Business Manager, and Board Secretariat, of the National Hauora Coalition (National Māori PHO Coalition). He is a former Executive Trustee of the Central Region Emergency Services Trust and prior to this he was Chief Executive of the Auckland Westpac Rescue Helicopter Trust. He has previously served on a number of government boards in various roles including: Director of Health Waikato; Vice Chair of the Lottery General committee of the New Zealand Lottery Grants Board, and Chair of the ‘Year of the Māori Language’ Grants Board committee. He has also been a serving justice of the Peace for the last 20 years.

**Dame Susan Devoy**  
Dame Susan Devoy is a former squash champion and is a Dame Commander of the New Zealand Order of Merit. She is a former board member of the Health Sponsorship Council. She is the Director of Women Walking Ltd and is currently a board member of the Sustainability Council of New Zealand. She is also a current member and former Chair of the Halberg Trust as well as the former CEO and Chair of Sport Bay of Plenty. Dame Susan served as a board member of the Auckland District Health Board (2000–03). She is a trustee of TECT (Tauranga Energy Consumer Trust) and the Chairperson of BNZ Partners, Bay of Plenty.

**Katherine Rich**  
Katherine Rich is the current Chief Executive of the New Zealand Food & Grocery Council. She was a member of Parliament for three terms, holding a range of portfolios including Education, Social Welfare, ACC and Associate Health. Following her retirement from Parliament in 2008, she has held a range of governance roles including chairing the Planet Foundation and Child, Youth and Family’s Fresh Start Panel, a fund supporting innovative community programmes to support youth at risk.

**Professor Grant Schofield**  
Professor Grant Schofield is an expert in aspects of public health relating to physical activity and nutrition. He is currently Professor of Public Health at AUT University and Director of AUT’s Centre for Physical Activity and Nutrition. His research and teaching in New Zealand and Australia have focused on physical activity and nutrition, particularly as they relate to children and youth, primary care, and workplaces as settings for health promotion.

**Barbara Docherty**  
Barbara Docherty is a registered nurse, Clinical Lecturer at The University of Auckland and Director of the TADS (Training and Development Services) Behavioural Change training programme, delivered nationally to health workers in primary health care and community, Māori, Pacific and youth. Barbara’s background includes 23 years as a general practice and primary healthcare nurse with extensive research and practical experience in early prevention and early identification of unhealthy lifestyle behaviours and mental health risks.

**Jamie Simpson**  
Jamie Simpson is an insurance broker providing insurance and risk advice to commercial clients. He is Chair of Life Education Trust Canterbury. The Trust raises significant funds to support the health-based teaching programme of Life Education in local primary schools. Jamie has a Bachelor of Science and a Bachelor of Arts from the University of Canterbury. He also has a Diploma of Financial Services (Insurance Broking) and is a Senior Associate of the Australian and New Zealand Institute of Insurance and Finance.

**Chris Allen**  
Chris Allen is a member of the New Zealand Institute of Chartered Accountants (NZICA) and a member of the Institute of Directors in New Zealand (IoD). Chris has previously operated his own Wellington-based financial management firm, contracting to a variety of Government, Crown entity and local body agencies, and has a wealth of experience in the corporate services and finance industries. This includes service in senior management and consulting roles in both the public and private sectors. Before joining the Health Promotion Agency, Chris was the Corporate Services Manager at the Alcohol Advisory Council (ALAC).

**Clive Nelson**  
Clive Nelson has worked in senior roles with a strategy, communications and change management focus in both the public and private sectors. MBA qualified, he began his career as a journalist and newspaper editor before moving into general management and executive management roles. Clive previously worked for Watercare Services Ltd, Auckland’s publicly owned water utility, and was seconded to the Auckland Transition Agency for a major local government reorganisation.

**Dr Andrew Hearn**  
Dr Andrew Hearn has worked in senior management roles in a range of Government departments and Crown entities, where he has been responsible for strategy, policy, research, planning and monitoring. The majority of his work has been in the area of harm reduction. His career started in community corrections and then corrections policy, moving on to include road safety policy and strategy, and social housing and building issues. Most recently, he was the General Manager Strategy at the Alcohol Advisory Council of New Zealand (ALAC).

**Laurianne Reinsborough**  
Laurianne Reinsborough has extensive background in operational management and has worked in the hospitality, volunteer and injury prevention sectors prior to joining the Health Sponsorship Council (HSC) as their sun safety manager. Canadian-born, Laurianne has a Bachelor of Arts degree in Sociology from St Francis Xavier University, Antigonish, Nova Scotia, and an MBA with expertise in marketing and communications.
What’s the issue with outlet density & availability?

Pushback from communities opposed to more liquor outlets and greater availability of alcohol in their areas has attracted significant media attention of late.

Public marches, street and online petitions, lobbying of MPs and the hundreds of written and oral submissions received last year by the Alcohol Reform Bill Select Committee all signal community willingness to unite to limit the number of liquor outlets and the availability of alcohol in their area. Behind the opposition is alarm about social harm associated with alcohol and the effect this can have on individuals, their families and friends and the community surrounding them.

But should communities fear a rise in the number of outlets selling alcohol in their vicinity, or the greater availability of alcohol generally? Can links be drawn between levels of density and availability and social harm? And if so, are other factors involved?

While international studies confirm the impact of liquor outlets is likely to be highly context specific, a range of recent New Zealand studies has sought to better understand if indeed there is a correlation between density and availability and increased social harm in our communities.

One such study was that funded by ALAC, in partnership with Manukau City Council, and undertaken between 2008 and 2011 by Waikato University’s Population Studies Centre researchers.

Led by Waikato University senior lecturer in economics Dr Michael Cameron and released in January this year, research into the impact of liquor outlets in Manukau City examined the impact of liquor outlets in the south Auckland city.

Home to one of this country’s largest Māori and Pacific Island populations and densely peopled by New Zealand standards, Manukau is one of our poorest areas, and where the 2006 Census recorded 44 percent of people aged 15 years and over received an annual income of $20,000 or less.

It’s also an area where the loosening of regulations contained in the 1989 Sale of Liquor Act have had an obvious and marked effect, particularly around alcohol availability and liquor outlet numbers.

A principal effect of the Act was to liberalise the market in which premises supplying alcohol could operate, including allowing, for the first time, wine to be sold in supermarkets and grocery shops.

The study reveals that the effect of the law change on the number of outlets supplying alcohol in Manukau City between 1990 and 1995 was immediate and substantial, with active liquor licences in the area increasing from 148 in 1990 to 494 by February 2008.

A key finding from the research was that in 2009 ‘off-licence’ liquor outlets – ie those selling alcohol to be consumed elsewhere such as retailers, bottle stores and supermarkets – tended to be located in areas of high social deprivation and high population density.

In contrast, ‘on-licence’ liquor outlets – ie where alcohol is sold to be consumed onsite such as bars, clubs, restaurants and cafes – were more likely to be found in main centres and areas of high amenity value.
Further key results included:

- Price and non-price competition had led to lower alcohol prices as well as longer opening hours where off-licence liquor outlets density was higher.
- On-licence and off-licence density of clubs, bars, restaurants and cafes was associated with a range of social harm indicators, including various police events and motor vehicle accidents.
- Areas with a high density of liquor outlets relative to other parts of the city were more likely to be sited in Manukau City’s more vulnerable communities, that is in areas of high social deprivation and high population density.
- Substantial increases in the number of both on- and off-licence liquor outlets had been matched with an escalation in the level of community unease about alcohol-related harm.

Research by other Kiwi academics has also raised concerns about the relationship of both liquor outlet density and the availability of alcohol to social harm.

This includes research published this year by Canterbury University’s Geography Department (Day, Breetzke, Kingham & Campbell, 2012) which put the association between geographic access to alcohol outlets and serious violent crime in New Zealand under the microscope.

Using data on violent offences recorded between 2005 and 2007 from New Zealand’s 286 police station areas, the study revealed significant negative associations between distance (access) to licensed outlets and the incidence of serious violent offences. Greater levels of violent offending were recorded in areas with close access to licensed premises, compared with areas with less access to on-licensed or off-licensed premises.

The report concluded that greater geographic access to alcohol outlets was associated with increased levels of serious violent offending across study areas, with the implication that alcohol availability and access promoted under the current liberalised licensing regime were important contextual determinants of alcohol-related harm within New Zealand communities.

Earlier research undertaken by Connor et al., reported in 2010 in the Journal of Epidemiology and Community Health (Connor, Kypri, Bell & Cousins, 2010) also used geocoded licensed premises to estimate outlet density, but focused on outlets within walking distance of home.

Entitled Alcohol outlet density, levels of drinking and alcohol-related harm in New Zealand: a national study, it explored the association of outlet density with self-reported patterns of drinking and related problems in the general population throughout New Zealand.

Here, cross-sectional data from a nationally representative alcohol survey was used with 1,925 participants asked detailed questions about their drinking patterns, including whether they had experienced any of a range of harms due to their drinking in the last 12 months.

The number of alcohol outlets of each type (off-licences, bars, clubs and restaurants) within 1 km of each participant’s home was independently identified by comparing the participants’ geocoded residential addresses with the distribution of outlets.

For each type of outlet, a clear association was established between outlet numbers and the level of harm due to drinking...
In 2008, the study Density of alcohol outlets and teenage drinking: living in an alcogenic environment is associated with higher consumption in a metropolitan setting (Huckle, Huakau, Sweetsur, Huisman & Casswell, 2008) examined the relationship between physical, socioeconomic and social environments and alcohol consumption and drunkenness among a general population sample of drinkers aged 12–17 years.

Conducted in Auckland, the study looked at environmental measures including alcohol outlet density, locality-based willingness to sell alcohol derived from purchase surveys of outlets, and a locality-based neighbourhood deprivation measure.

A random telephone survey was also utilised to collect information from respondents including ethnicity, frequency of alcohol supplied socially (for example, by parents, friends and others), the young person’s income, frequency of exposure to alcohol advertising, recall of alcohol brands, and self-reported purchase from alcohol outlets. The study found alcohol outlet density was associated with quantities consumed among teenage drinkers, as was neighbourhood deprivation.

In addition, supply by family, friends and others also predicted quantities consumed among underage drinkers, both social supply and self-reported purchase were associated with frequency of drinking and drunkenness. The ethnic status of young people also had an effect on consumption.

In 2007, the distribution of alcohol outlets by level of neighbourhood deprivation was the subject of a paper entitled Spatial variation in the association between neighbourhood deprivation and access to alcohol outlets (Hay, Whigham, Kypri & Langley, 2007) presented at the 19th Annual Colloquium of the Spatial Information Research Centre at the University of Otago. The study was published in 2009 as Neighbourhood deprivation and access to alcohol outlets national study (Hay, Whigham, Kypri & Langley, 2009).

The results of the study showed that in deprived urban areas distances to bars, licensed clubs, and off-licences were considerably shorter than in affluent areas. Conversely, distances to licensed restaurants and cafes were greatest in the most deprived areas. Findings were more complex for rural areas.

The paper concluded that research into the association between deprivation and access to alcohol should consider rural areas separately from urban areas, rather than combining the effects of the two areas together.

The authors note that:

“In public discourse about liquor licensing...an increase in the prevalence of licensed restaurants and cafes has been promoted as a means of encouraging entertainment whose primary focus is food rather than alcohol, by way of reducing public disorder.

“It is therefore a concern that in poorer areas of New Zealand, pubs and bars are more common and restaurants less common than they are in wealthier areas.

“The greater access evident for people in poorer communities may be a mechanism for increasing deprivation and thereby widening gaps in socioeconomic status and health.” (p 1092)
Michael Cameron is a senior lecturer in economics at Waikato University, where he gained his Ph.D. in 2007 with the thesis “The Relationship between Poverty and HIV/AIDS in Rural Thailand.” As well as the social impacts of liquor outlet density, Dr Cameron’s current research interests include population, health and development issues such as the economics of communicable diseases, especially HIV/AIDS, health applications of non-market valuation, and health and development policy monitoring and evaluation. He is also interested in population modelling and stochastic modelling, and economics education.

Manukau City versus the World

The most important take-away message for the public from this research is that concerns expressed in some communities about alcohol outlet numbers may be warranted.

While on-licence outlets tend to group together in areas such as town centres, off-licence outlets tend to spread themselves out throughout the area. They do this to reduce local competition.

Having said that, more off-licence outlets in Manukau are located in areas of high population density and in areas of high social deprivation. Because the outlets are located closer together in those areas, they compete more vigorously with each other, including by lowering prices and by opening longer hours.

We also showed that there is a clear association between the density of alcohol outlets and the number of police events. This association remains even after we control for local social deprivation, population density, and neighbourhood effects.

Clubs and bars were associated with more violent offences, property offences, anti-social behaviour, dishonesty offences and traffic offences. Off-licence outlets were associated with more violent offences, sexual offences, and drug and alcohol offences.

The Alcohol Reform Bill that is before Parliament at the moment would allow for local communities to have a bigger say in liquor licensing in their areas. If passed in its current form, the Bill will allow local authorities to develop binding Local Alcohol Policies, which may regulate the location and/or density of alcohol outlets.

Local communities could then have greater input into the number of outlets in their areas, both through engaging with the development of Local Alcohol Policies, and through making objections to licensing applications.

This research, and the follow-up research for the North Island, will provide further New Zealand evidence for communities to use in this process.

Dr Cameron says the Manukau City research findings are similar to a lot of international research, where alcohol outlet density has been shown to be associated with a range of negative effects including violent and other crime, property damage, drink driving, motor vehicle accidents, child abuse and neglect, and health costs and hospitalisations.
Outlet density is associated with increased consumption among young people both here and internationally.

Our study results fit with what is known overseas: namely, that outlet density is associated with increased consumption among young people. While our study showed that outlet density is an important predictor of increased quantities of alcohol consumed by young people, it also showed that the wider environment in which young people access alcohol is also very important.

One example is the ease with which young people can buy alcohol themselves, which highlights the importance of the minimum purchase age and the need for its effective enforcement, and the ease with which young people are supplied alcohol socially, for instance by friends, parents and others.

Our study revealed that social supply, in particular, was an important predictor of heavier consumption among teenagers in New Zealand. From a policy perspective, our research suggested that comprehensive policy action was needed to reduce heavier consumption among young people, including raising the minimum purchase age, reducing outlet density and introducing effective restrictions on the social supply of alcohol.
Previous research has found density of alcohol outlets to be associated with a range of alcohol-related harms. These harms have usually been measured ecologically—for example, as rates of assault or drink-driving crashes, and in urban populations.

However, confounding by socioeconomic factors may affect many of these studies and existing evidence of an association between outlet density and level or pattern of alcohol consumption has been mixed.

The study we undertook demonstrated the number of off-licence outlets within 1 km was associated with increased odds of binge drinking in an unselected national population. Associations were also seen between the number of off-licences, pubs/bars, clubs and restaurants within 1 km of home and the level of self-reported harm from alcohol.

In our study, socioeconomic confounding did not account for much of the association of outlets with binge drinking or harm, which supports the hypothesis of a causal relationship.

Most of the previous research used outcome measures such as that routinely collected by police or traffic authorities etc, and therefore represented the severe end of the spectrum and only events that had come to the attention of the authorities.

In contrast, we asked people to report on harm to themselves, in other words give a personal account.

We found that for the self-reported harms to people’s quality of life from alcohol there was a clear association with density of all types of alcohol outlets, and that this did not appear to be due to socioeconomic factors.

With serious events that involve more interaction with the environment (eg problems with employment, the law, or fighting due to drinking) the association with outlets was seen, but seemed to be partly explained by socioeconomic factors.

One of the main differences therefore between our study and others is that it involved a sample of the whole ‘normal’ population, not just urban or high risk, and showed that more outlets were linked to more binge drinking, and to more self-reported harm from alcohol.

Jennie Connor is head of Preventive and Social Medicine at the University of Otago. An advocate for evidence-based alcohol policy, Professor Connor is a public health physician and epidemiologist with a research interest in prevention of alcohol-related harm.
Announcing the new research, HPA Chief Executive Clive Nelson said it was hoped that this would for the first time provide local authorities in New Zealand with an evidence base to determine the impact of new liquor outlets on their communities.

The Alcohol Reform Bill currently before Parliament proposed making local authorities consider the effects on the community of renewing or issuing new liquor licences, and widening the grounds for objecting to the issue or renewal of a licence to include the effect “on the amenity or good order of a locality.”

Mr Nelson says if the law is changed to widen the grounds for refusing a liquor licence, evidence will still need to be produced around any resulting harms.

Although the Manukau results were specific to that area, the model it had developed could be used in other areas to determine what impact extra liquor outlets would have on a district.

The research project will be overseen by researchers in the National Institute of Demographic and Economic Analysis (NIDEA, formerly the Population Studies Centre) at the University of Waikato. The research will be led by Dr Michael Cameron, and will include Dr Bill Cochrane from NIDEA, Michael Livingston from Turning Point Alcohol and Drug Centre in Melbourne, and Dr Craig Gordon from the Health Promotion Agency.

The research will use data from 2005 to 2011, and will be able to develop locally-specific estimates of the relationship between alcohol outlet density and both police events and motor vehicle accidents, for every community in the North Island.

It is anticipated that preliminary results of this research will be presented at the Public Health Association and World Safety conferences later this year, with a final report available in early 2013.

Further research has been commissioned to build on the Manukau findings to cover all of the North Island.
The Alcohol Reform Bill currently before Parliament could provide New Zealand with a key opportunity to reduce alcohol harm, says Australian research fellow Michael Livingston.

My recent visit to New Zealand made it clear that there, as in Victoria, improved liquor licensing policy has the potential to dramatically reduce rates of alcohol-related harm.

The similarities between the two jurisdictions are striking: both have seen marked deregulation of their liquor licensing regimes in recent decades, both have seen sharp increases in rates of harm from alcohol and, in both places, local governments and communities are attempting to limit the continued growth of alcohol outlets.

The proposed New Zealand Alcohol Reform Act will provide New Zealand communities with a key opportunity not available to those in Victoria, namely the ability for local councils to set enforceable policies on the density of alcohol outlets and their hours of trade. This opportunity, if supported by reliable evidence and used in a public health framework, could provide the means to reduce alcohol-related harm substantially.

In Victoria, local controls over the density of alcohol outlets have never been available. Local governments can object to new licence applications, but have consistently found their objections either ignored by the state liquor licensing agency or overturned in tribunal hearings. This is despite a growing body of evidence that demonstrates the substantial health and social impacts of alcohol outlet density at the local level.

Since the late 1980s, Victoria has seen a series of deregulatory reforms to the legislation governing liquor licensing. These reforms have resulted in a dramatic expansion of the market, with the number of pubs increasing by 33 percent, off-licences by 100 percent and restaurants and bars by more than 700 percent since 1990 (Responsible Alcohol Victoria, unpublished data).

While reliable data on harms is not available from 1990, more recent trends suggest this expansion has occurred at the same time as substantial increases in rates of alcohol-related harm. For example, between 1999 and 2008, rates of alcohol-related hospital admissions increased by 47 percent, night-time assaults by 49 percent, alcohol-related domestic violence by 43 percent and alcohol-related ambulance presentations by 167 percent (Livingston, Matthews, Barratt, Lloyd & Room, 2010).

Increasingly, research is finding that these increases are more than coincidental, with studies demonstrating positive relationships between alcohol outlet density and:

- night-time assaults (Livingston, 2008)
- domestic violence (Livingston, 2011)
- chronic disease (Livingston, 2011)
- heavy drinking (Livingston, Lastlett & Dietze, 2008).

The findings of these studies have been particularly strong for off-licence alcohol outlets, which are the most associated with all of the problems examined except for night-time assaults. While supermarkets themselves cannot sell alcohol in Victoria, the off-licence sector is dominated by the two major supermarket chains, who own nearly 40 percent of all off-licence outlets and sell more than half of all alcohol sold in the state.

This is also the segment of the market that local governments have fought the hardest against in Victoria. In a series of hearings, councils representing socioeconomically disadvantaged communities with high rates of alcohol problems have objected to new off-licensed outlets (often large warehouse-style outlets) and have repeatedly been unsuccessful.

This lack of success reflects the limited legislative power given to local governments in the Victorian system and highlights the potential benefits of New Zealand’s new act. The Local Alcohol Policies that are outlined in the soon-to-be-passed Alcohol Reform Bill provide New Zealand councils and the communities they represent with meaningful controls over alcohol outlet density and trading hours. These powers are in line with community expectations.

A recent study found that nearly 60 percent of New Zealanders thought that “it is up to local government to make sure alcohol does not become a problem in the community” (Maclennan, Kypri, Langley & Room, 2012).

The emphasis on local controls over trading hours provides another avenue for local governments in New Zealand to reduce alcohol-related harm. There is growing international evidence that reducing late night trading hours is an effective way to reduce alcohol-related violence. For example, 2008 restrictions imposed in the New South Wales city of Newcastle that forced pubs to close by 3 am have produced sustained reductions in rates of assault and alcohol-related injury of more than 30 percent (Kypri, Jones, McElduff & Barker, 2011).

The formal incorporation of local controls over trading hours and outlet density in the proposed Alcohol Reform Bill thus represents a critical step towards a liquor licensing regime that is more responsive to community desires and more able to curb alcohol-related harm in New Zealand.

It is essential that these components of the new bill are robust to legal challenge, and that councils are adequately supported to develop sufficient evidence and expertise to produce appropriate local policies.

Local governments and alcohol researchers in Victoria will be watching with interest to see whether the local control that we have been advocating can fulfil its potential and produce lasting public health improvements.
Q: Where do you work in Melbourne?
A: I’m a public health researcher at Turning Point Alcohol and Drug Centre, specifically in the Alcohol Policy Research Centre.

Q: What does Turning Point do?
A: Turning Point was established in 1994 to provide leadership to the drug and alcohol field in Victoria, Australia. The organisation amalgamated with public health provider Eastern Health in 2009 and is these days formally affiliated with Monash University. Turning Point is also part of the International Network of Drug Treatment and Rehabilitation Resource Centres for the United Nations Office on Drugs and Crime, and a member of the International Harm Reduction Association. Plus we’re a Registered Training Organisation (RTO) and an accredited Higher Education Provider.

Q: What’s your role at Turning Point?
A: I work in a team of eight, led by Professor Robin Room, which undertakes quantitative and qualitative research into issues relevant to alcohol policy. My work focuses on studying the impact of alcohol policies and on policy-relevant alcohol epidemiology.

Q: What’s your background as a public health researcher?
A: My specific skills are quantitative, and my main area of work has been examining the relationship between changes to liquor licensing policies in Victoria and rates of alcohol-related problems. My PhD examined the impact of the liberalisation of the Victorian liquor licensing system that took place throughout the 1980s and 1990s. In particular, it focused on the local level implications of the changes to alcohol outlet density that occurred following the deregulation of the licensing system here.

Q: What were some of the key findings?
A: In particular that alcohol outlet density is associated with rates of violence, heavy drinking and chronic disease.

Q: Has this research had any impact outside academia?
A: It’s had significant impact on policy in Victoria and has also been widely published in academic literature, including *Addiction* and *Drug and Alcohol Review*.

Q: You’ve been presenting your findings recently at several seminars in New Zealand. Have you noticed any similarities between the two countries in this area?
A: The most striking thing about presenting my work in New Zealand has in fact been the similarity of the New Zealand experience to Victoria. New Zealand has gone through the same dramatic expansion of the alcohol market and, particularly at the local level, governments are wrestling with similar policy issues to those in Victoria.

Q: What are your thoughts on the content of our Alcohol Reform Bill currently before Parliament?
A: I’m impressed that the Bill proposes some direct local powers over outlet density and trading hours. Local governments in Victoria are crying out for mechanisms like this to give them more control over the alcohol environment in their community.

Q: Will we be seeing you back here in future?
A: One of the reasons for my trip to New Zealand was to meet with the project team that’s about to start a study examining the impact of alcohol outlet density on a wide range of harms across the North Island. I’ll be part of that project, and hope that it will produce specific estimates of how outlet density influences harm across the Island, and therefore give local communities critical evidence to help them develop future policies in their area.

Michael Livingston is the author of a PhD thesis examining the impact of liberalisation of the liquor licensing system in Victoria, Australia during the 1980s and 1990s. Recently in New Zealand on an ALAC-funded speaking tour, his presentations in Wellington, Auckland and Christchurch outlining the results of his research attracted significant public, industry and media interest.
A recent survey of drinking patterns among United Kingdom secondary school pupils has thrown up some surprising results. The Smoking, Drinking and Drug Use Among Young People in England in 2010 survey, carried out for the NHS Information Centre by the National Centre for Social Research and the National Foundation for Educational Research, is the latest in a series monitoring tobacco, alcohol and drug use among English secondary school pupils aged 11–15.

Published in 2011, the survey reports on information obtained from 7,286 pupils in 246 schools throughout England in the 2010 autumn term.

Perhaps surprisingly, the survey shows a steady decline in the proportion of pupils who drink alcohol, with a more pronounced decline than previously year-on-year between 2010 and 2009. While future surveys in the series will establish how the 2010 estimates fit into the longer-term trend, current results show that:

• the proportion of pupils who had never drunk alcohol rose from 39 percent in 2003 to 55 percent in 2010
• less than half (45 percent) of pupils aged between 11 and 15 said that they had drunk alcohol at least once in their lifetime. This increased with age from 30 percent of 11 year olds to 17 percent of 15 year olds.
• the proportion of pupils who had drunk alcohol in the last week fell from a peak of 26 percent in 2001 to 18 percent in 2009. In 2010, this trend was maintained, although the fall in prevalence was greater than expected, dropping five percentage points to 13 percent
• as in past years, similar proportions of boys and girls had drunk alcohol in the last seven days, and older pupils were more likely to have done so than younger pupils (from 1 percent of 11 year olds to 30 percent of 15 year olds)
• in 2010, the mean amount of alcohol consumed by pupils who had drunk in the last week was 12.8 units
• mean consumption levels have varied between 11.6 units and 14.6 units since 2007, with no clear trend
• most pupils who had drunk in the last week had done so on one or two days (56 percent and 29 percent respectively). On the days they did drink, more than half (59 percent) drank, on average, more than four units.

The survey showed pupils were more likely to be given alcohol than to buy it, and then most commonly by family or friends.

Perhaps surprisingly, the survey shows a steady decline in the proportion of pupils who drink alcohol...
Pupils who had never drunk alcohol were most likely to believe that people of their age drank to look cool (83 percent), or through peer pressure (70 percent).

About half (48 percent) of pupils who drank also said they bought alcohol, despite being well below the age when they can legally do so (ie 18 years old). The survey also showed that, in 2010, pupils who drank were most likely to buy alcohol from friends or relatives (26 percent), someone else (16 percent), an off licence (16 percent) or a shop or supermarket (12 percent). Since the late 1990s, the proportion of pupils who bought alcohol from other people has declined, as has the proportion of those who bought alcohol from off licences, pubs and bars.

Differences between the settings in which younger and older pupils were likely to drink were also highlighted in the survey, with 68 percent of 11 and 12 year olds who drank alcohol usually drinking with their parents, and a similar proportion (65 percent) saying they usually drank at home. However, by the age of 15, pupils were most likely to drink with friends of both sexes (74 percent of 15 year old drinkers), less likely than younger pupils to drink at home (45 percent) and more likely to drink in other locations.

Of these, 57 percent drank at parties with friends, 51 percent in someone else’s home, and 29 percent ‘outside’, that is on the street, in a park or somewhere else.

When it came to drinking behaviour, the survey revealed the extent to which pupils were influenced by the attitudes and behaviour of their families, with results highlighting that they were less likely to drink if their parents disapproved, and more likely to drink if drinking was tolerated by their parents. The survey showed that:

- more than half (51 percent) of pupils said their families didn’t like them drinking
- almost as many (48 percent) said their families didn’t mind them drinking, as long as they didn’t drink too much, while a small proportion (1 percent) said their parents let them drink as much as they liked
- most pupils (85 percent) who said that their parents would not like them to drink had never drunk alcohol, compared with 27 percent of those whose parents didn’t mind them drinking, as long as they didn’t drink too much.

Similarly, pupils were more likely to drink if they lived with other people who did. The proportion of pupils who drank alcohol in the last week increased from 4 percent of those who lived in non-drinking households to 26 percent of those who lived with three or more people who drank alcohol.

The survey showed pupils becoming less tolerant of drinking and drunkenness among their peers. For example, in 2010, 32 percent agreed that it was OK for someone of their age to get drunk once a week, compared with 46 percent in 2003. Over the same period, the proportion who thought it OK for someone of their age to get drunk once a week also fell, from 20 percent to 11 percent.

Pupils aged between 11 and 15 were most likely to believe that people of their own age drank to look cool in front of their friends (76 percent in 2010), to be more sociable with friends (65 percent), because their friends pressured them into it (62 percent) or because it gave them a rush or buzz (60 percent).

There were also differences between the perceptions of pupils who drank and those who did not.

Pupils who had never drunk alcohol were most likely to believe that people of their age drank to look cool (83 percent), or through peer pressure (70 percent).

Those who had drunk alcohol in the last week were most likely to think their peers drank to be more sociable (64 percent), or because it gave them a rush or buzz (78 percent), or to feel more confident (71 percent).

Interestingly, the survey showed behaviour patterns associated with having drunk alcohol in the last seven days were not unlike those related to smoking tobacco. Regular smokers and recent drug users had an increased likelihood of having drunk alcohol in the last week, along with pupils who had played truant from school.

The full text of the survey, which also includes findings on pupils’ patterns of drinking, being drunk and other consequences of drinking, attitudes and beliefs, is available at www.ic.nhs.uk/pubs/sdd/fullreport
There are reports that young women now account for approximately 60 percent of drunken admissions to hospitals (Quigley cited in Palmer, 2009). But while there may be some women drinking to excess, are women really drinking more, say, on a population level? And can we call it a trend? Locating this attention within some of the broader concerns about New Zealand’s ‘culture of intoxication’, this paper takes a look at what the local data is really saying about how young women are drinking. It then looks at the risks of excessive alcohol use that are specific to women and explores some other times in which the subject of women and alcohol has attracted considerable interest.

New Zealanders have a history of alcohol misuse (McEwan, Campbell & Swain, 2010), and we are without doubt big drinkers. A Ministry of Health survey (Ministry of Health, 2009) found that 85 percent of New Zealanders aged 16–64 drank an alcoholic drink in the past year. Three in five (61.6 percent) of these persons drank more than is advisable for a single occasion at least once in the past year. An earlier study identified that one in six adults over 15 years of age have a potentially hazardous drinking pattern (Ministry of Health, 2008).

Much attention has been placed recently on the ways young women misuse alcohol. Headlines such as ‘Women hit the bottle like men’ (Coursey & Savage, 2007), ‘Rude, crude and drunk: women at their worst’ (Broatch, 2008), ‘Severely drunk women shock police’ (Ash, 2011) and ‘Girls just wanna get totally smashed’ (Newton, 2011) frequently grace our news sites.

There is an increase in the quantity binge drinkers consume per occasion. Figures and statistics aside, what is especially disquieting is that a number of young people feel that it is quite acceptable to drink to excess ‘as long as it’s not every day’ (ALAC, 2005; see also Hutton, 2012).

Our ‘culture of intoxication’ is not a stand-alone culture by any means. Measham and Bain (2005) argue that a distinctive post-industrial pattern of binge-drinking can be seen in most Western nations. Commentators argue it is due to the radical relaxation of alcohol laws over the past 20 years (see, for example, McEwan et al, 2010; McPherson, Casswell & Pledger, 2004; Measham & Bain, 2005). In New Zealand, for instance, a number of initiatives were implemented with a vision that the public would embrace a culture of moderate drinking like that of southern Europe.
In 1989, a review of the Sale of Liquor Act liberalised the licensing application process. As a result, New Zealanders saw a rapid expansion in the number of licensed premises and a broader range of places selling alcohol (Palmer, 2009). In 1992, alcohol advertising was permitted in mainstream media with little restriction or control, leading to a widespread increase in televised alcohol advertising (Huckle, Hedges & Casswell, 2002), ready-to-drink beverages (RTDs) were introduced to the New Zealand market in 1995 with changes to customs policies. These were instantly popular, especially amongst young women (Huckle, Sweetsur, Moys & Casswell, 2008). In 1999, the age of purchase was reduced from 20 to 18 years. Sunday trading was also extended at this time, and supermarkets, superettes and corner dairies were allowed to sell alcohol (Palmer, 2009). In 2008, the age of purchase was reduced to 18 years in the past decade (Ministry of Health, 2009). As two reports published by the New Zealand Law Commission (2009), “catalogue of harms” on behalf of professionals there are significant levels of concern about a “catalogue of harms” on behalf of professionals in the health, social, education and justice sectors, as well as from the public and from those in the alcohol industry itself. The fiscal cost of these harms is estimated to be in the billions (Palmer, 2009) and the “subtle, chronic and unseen” (Babor, 2001) social costs immense.

It is within these broader discussions that a heightened degree of concern has emerged about the level at which young women are drinking. This is also not particular to New Zealand, in debates about binge drinking in both Australia and the UK, there is a focus on young women (Brown & Gregg, 2012). The perception is that young women are “catching up with the boys”, which is predominately attributed to the increased social capital now enjoyed by young women. Young women are earning more money, are no longer bound by traditional female caretaking roles, and are not subjected to the same level of stigma attached to women who drink excessively as were their mothers and grandmothers (McLewitt et al, 2010).

Yet thus far, the evidence to suggest young women are indeed “catching up” is equivocal. While there is some data to suggest that women’s drinking as a whole did increase in the late 80s (MarkPherson et al, 2004; Ministry of Health, 2008; Ministry of Social Development, 2009), things appear to have since stabilised. Data from the New Zealand Alcohol and Drug Use Survey 2007/08 found no significant change in binge drinking behaviours between men and women ages 16–24 years in the past decade (Ministry of Health, 2009).

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It may be that women’s drinking attracts attention because the risks of excessive alcohol consumption are gender-specific. There are health risks, for example, that are particular to women. The protein in the stomach wall which breaks alcohol down is much less active in women than it is in men, as is the enzyme found in the liver (Institute of Alcohol Studies, 2008; Phillips cited in ‘Young women facing’, 2012). Alcohol is also connected with an increased risk of breast cancer (Ministry of Health, 2009; Room, Babor & Rehm, 2008). What is more, miscarriage, low birth weight, stillbirth and premature birth, and abnormalities in the developing fetus (leading to foetal alcohol spectrum disorder) are the recognised effects of alcohol misuse while pregnant (Abel, 1997; Fingerhood, 2007; Ministry of Health, 2009). Alcohol is also connected with an increased risk of breast cancer (Ministry of Health, 2009; Room, Babor & Rehm, 2008). What is more, miscarriage, low birth weight, stillbirth and premature birth, and abnormalities in the developing fetus (leading to foetal alcohol spectrum disorder) are the recognised effects of alcohol misuse while pregnant (Abel, 1997; Fingerhood, 2007; Ministry of Health, 2009). Alcohol is also connected with an increased risk of breast cancer (Ministry of Health, 2009; Room, Babor & Rehm, 2008). What is more, miscarriage, low birth weight, stillbirth and premature birth, and abnormalities in the developing fetus (leading to foetal alcohol spectrum disorder) are the recognised effects of alcohol misuse while pregnant (Abel, 1997; Fingerhood, 2007; Ministry of Health, 2009).

The social consequences of young women’s risk-taking behaviours while drinking are also particular. Unwanted pregnancies are more likely to occur after an episode of binge drinking (Skanderwick, Davies, Tucker & Sheron, 2007). While young women who engage in binge drinking are seen in terms of behaving “like men” (Day, Gough & McSadden, 2004), drinking alcohol can be risky for women insofar as they may be seen as having invited unwanted attention from men, that is, “she was asking for it” (Abby & Hannah, 1995). There is also a view that the behaviour of young women operates as a barometer of sorts for the social health of a society, so if young women are behaving badly it is a clear indication that the nation is in trouble (see Skeggs, 2005; Jackson & Tinkler, 2007). This might explain why we see notions of disgust at the behaviour young women engage in when drinking, just as we do in some of the headlines quoted above. It is interesting that this behaviour does not have to transgress too far outside of traditional gender norms to be considered worthy of concern. Recent attention toward a photograph published in the ‘Taranaki Daily News’ of a bride who had entered a Bride of the Year competition swigging from a beer bottle illustrates this well. The paper received many calls from people expressing their displeasure and online comments called the photo “disgusting” (Rikoff & Burnell, 2012). An alcohol monitoring study commissioned by ALAC also found that drinking habits have not changed significantly over the past few years (Fyer, Jones & Kalafatelas, 2012). This study also found that non-drinkers are significantly more likely to be women. Further, all of these studies found that men drank more than women. An alcohol monitoring study commissioned by ALAC also found that drinking habits have not changed significantly over the past few years (Fyer, Jones & Kalafatelas, 2012). This study also found that non-drinkers are significantly more likely to be women. Further, all of these studies found that men drank more than women. An alcohol monitoring study commissioned by ALAC also found that drinking habits have not changed significantly over the past few years (Fyer, Jones & Kalafatelas, 2012). This study also found that non-drinkers are significantly more likely to be women. Further, all of these studies found that men drank more than women. An alcohol monitoring study commissioned by ALAC also found that drinking habits have not changed significantly over the past few years (Fyer, Jones & Kalafatelas, 2012). This study also found that non-drinkers are significantly more likely to be women. Further, all of these studies found that men drank more than women.
Indeed, it may be for these reasons that there have been recurring episodes of concern – across time – about alcohol use and women, particularly young women. Historians note, for example, a fervent public discourse about the ‘modern girl’ or flapper of the 1920s. The typical modern girl was depicted as a hedonistic consumer of cocktails and champagne, who would subsequently engage in behaviour that was deemed vulgar, immodest and unbecoming.

Further back in time, in the infamous gin craze of 18th century Britain, women began to drink alongside men in ‘gin shops’, an activity that was previously reserved for men in ale houses. These women were considered by reformers to be promiscuous, adulterous, and active in endangering the wellbeing of the next generation and whether young women would be ‘fit’ to bear the next generation. And, society was heading and whether young women were drinking excessive alcohol that was deemed immoral” (Skinner, 2007, p. 5).

Given that binge drinking certainly happens and that there are risks and harms resulting from excessive alcohol use that are particular to women, the topical nature of young women’s drinking is neither surprising nor inappropriate. However, it is essential that the evidence used to develop public health policies and practices is both accurate and reliable. In particular, we need to be sure that interventions in this area address the realities, rather than just perceptions, of young women’s binge-drinking.
Finland’s Social Affairs and Health Ministry has drafted a comprehensive law aimed at banning the public advertising of alcoholic beverages. The ban, which would cover places such as bus stops and sports facilities and even athletes’ shirts, would also limit alcohol ads to displaying a picture of the product and its price. As in France, the law aims to avoid positive associations between alcohol and sexual, social or professional success. Timeslots available for alcohol advertisements on TV would move from after 9 pm to after 11 pm under the proposed law.

This year’s Foundation for Alcohol Research and Education’s Annual Alcohol Poll found 79 percent of Australians see no end to the country’s alcohol-related problems and believe the issue will get worse or, at best, remain the same over the next five to ten years. Those polled were also critical of the alcohol industry, with 68 percent identifying alcohol companies as not doing enough to tackle alcohol-related harms. When asked which industry was doing the most to address harm from their products, only 5 percent of respondents nominated the alcohol industry, compared with 12 and 15 percent for the gambling and tobacco industries and 21 percent for the fast food industry.

Middle-class children are far more likely to have drunk alcohol by the age of 12 than those from lower social groups, according to the UK charity Drinkaware. Funded by the alcohol industry to promote sensible drinking, Drinkaware’s Ipsos Mori poll recently surveyed more than 500 middle-class parents and their children and found more than one in three children aged between 10 and 17 born in professional households had downed a full glass of alcohol before reaching their teenage years. This figure was almost twice the level found among 12 year olds across all economic groups. While some middle-class children secretly raided their parents’ drinks cabinets, many more were allowed to drink by parents who believed the approach helped them develop more mature attitudes towards alcohol.

A university is considering establishing alcohol-free zones on its campuses because many of its students consider drinking immoral. London Metropolitan University vice-chancellor Malcolm Gillies says selling alcohol is an issue of “cultural sensitivity” at his institution where a fifth of the student population is Muslim. With many students viewing drinking alcohol as “an immoral experience”, Professor Gillies says he saw little reason to continue to subsidise a student bar on campus when there were other bars just down the road. These days attending university was not about having a big drinking experience, and the university bar “is not as used as it used to be”, he says. 

Australian drug researchers believe the number of people in the country who will fit the criteria for problematic alcohol use will rise by about 60 percent—or half a million people—under new criteria recently added to the Diagnostic and Statistical Manual of Mental Disorders. 

Middle-class kids most likely to try alcohol by 12

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