A thematic analysis of alcohol and alcohol-related harm across health and social policy in Aotearoa New Zealand

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Abstract

Objective: This study aims to: 1) explore how alcohol and alcohol harm are framed in New Zealand national policy, strategy, and action plan documents; and 2) examine how these documents align with the WHO SAFER framework.

Methods: Keyword searches across government websites and Google were conducted in January 2021. Inclusion and exclusion criteria were applied to all identified documents, resulting in 22 being included for analysis in this study. An inductive and deductive thematic analysis of those documents was performed.

Results: Our inductive thematic analysis identified three themes, of which one is detailed in this study: 'Location of responsibility for addressing alcohol harms' with a focus on individuals and non-specific government agencies. Thematic results from the deductive analysis found that the most consistently referenced SAFER policies included brief interventions (68% of documents), followed by drink driving measures (45%), alcohol marketing (36%), alcohol availability (27%), and alcohol price (23%). The conversion rate from a document mentioning a SAFER framework policy area to making specific policy recommendations was usually less than or around 50%.

Conclusions: The lack of alignment between New Zealand alcohol policy and the SAFER framework can be partially attributable to the absence of an updated national alcohol strategy (NAS). An updated NAS should identify responsible agencies, create a systematic monitoring and evaluation mechanism, and be consistent with the WHO SAFER framework.

Implications for public health: The analysis supports the need to update a national alcohol strategy to guide alcohol policy development.

Key words: alcohol, policy, SAFER, marketing, availability, national alcohol strategy

Introduction

Alcohol is a well-established risk factor across a range of illnesses, diseases, crime, violence, fetal alcohol spectrum disorder (FASD), drink driving and other health and social harms.[1] Alcohol consumption has significant and detrimental impacts on the health and social wellbeing of people in Aotearoa, New Zealand (A-NZ). Indeed, alcohol was recently found to be the most harmful drug in Aotearoa.[2] Alcohol harm data shows consistent and high rates of alcohol harm over the past two decades.[3,4] Hazardous drinking has remained persistently high, with nearly 20% of adults reporting alcohol consumption patterns scoring over 7 on the alcohol use disorder identification test (AUDIT) in the 2020–2021 New Zealand Health Survey.[3,5]

Ongoing concerns have been raised about the disproportionate harms from alcohol that Māori (the A-NZ indigenous population) experience compared to non-Māori.[6] Māori are more likely than non-Māori to have hazardous drinking patterns.[3,5] Forty-four percent of Māori men and 29% of Māori women reported consuming alcohol in a hazardous way.[5] Historically, Māori have experienced intergenerational alcohol-related trauma from the ongoing impacts of colonisation.[6] Major drivers of colonisation, such as cultural subjugation, extensive loss of Māori land, loss of political power and social deprivation have all contributed to the burden of alcohol harm among Māori whanau,[6] which must be addressed.

These inequities reflect government failings to uphold *Te Tiriti o Waitangi* (the Treaty of Waitangi),[6] one of A-NZ's constitutional

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documents that outlines the relationship between the government and Māori. Te Tiriti o Waitangi guarantees certain rights to Māori, which are outlined in three main articles. Article one guarantees good governance by the government and, thereby, the right for Māori to experience good and equitable health as a result.[7] Article two confirms Māori rights to Tino Rangatiratanga[7] and in this context it is about ensuring Māori rights to determine access, availability and management of alcohol in society.[8] Article three: Ōritetanga guarantees Māori the right to equitable protection from drivers of ill health, in this case alcohol and its harms, as well as the right to equitable health outcomes.[6,8]

Serious concerns about alcohol harm have been repeatedly raised by public health professionals, politicians and the public. However, there has been little consolidated effort by the government to respond to these concerns. In 2010, the Law Commission made 153 recommendations to address alcohol-related harm in A-NZ.[9] While the government adopted the majority of the Law Commission recommendations in some form, they notably excluded any major reform around alcohol marketing (which continues to be self-regulated) or price (no chance to adjust tax settings or minimum unit pricing).[9] The most substantial policy development arising from the Law Commission report was the implementation of the 2012 Sale and Supply of Alcohol Act (SSAA), which sought to further regulate alcohol availability. A 2018 analysis found the SSAA did not result in any substantial changes to alcohol trading hours or outlet density.[10] Additionally, a Waitangi Tribunal claim (WAI2575) further argues that the Act has not reduced the harm caused by alcohol in Māori communities.[6]

A contributing factor to A-NZ's failure to implement effective alcohol policy is the lack of a comprehensive national alcohol strategy (NAS). In the World Health Organisation's *Global Strategy to Reduce the Harmful Use of Alcohol*, 'leadership, awareness and commitment' is the first of ten priority areas for national action on alcohol harm.[11] A NAS identifies the different partners involved, their contributions and responsibilities, the objectives, approaches, and goals for addressing alcohol, and ultimately holds the government to account by benchmarking their performance against the NAS. Importantly, a NAS provides an opportunity for Māori to partner with the government to determine how alcohol use and harms may be managed in A-NZ society. The adverse effects of the absence of or outdated focus on national alcohol strategy on meaningful alcohol policy development have been documented across multiple jurisdictions.[12,13] In contrast, some jurisdictions have observed evidence-based alcohol policy gains shortly after the introduction or reformulation of their NAS.[13–16]

In A-NZ, the last NAS was published by the Ministry of Health in 2003. A 2007 review of the NAS made 31 recommendations for its next iteration.[17] These recommendations included improved leadership and governance by agencies responsible for the strategy, greater accountability and monitoring of the implementation of the strategy, better collaboration and communication between stakeholders, a greater focus on evidence-based strategies for reducing alcohol-related harm, and greater resourcing.[17] Ultimately, none of the review recommendations were implemented, as the NAS was never updated. Consequently, strategic government action on alcohol-related harm has largely relied on an ad hoc collection of broader policies from disparate government agencies (e.g. Ministry of Social Development strategy for youth offending or the Ministry of Justice strategy for reducing violence) rather than a dedicated alcohol strategy.[18,19]

Even when alcohol is part of a wider health and social strategy, there appears to be a reluctance to focus on those policies that the World Health Organization's (WHO) has identified as most effective within its SAFER framework.[20] The SAFER framework includes: **strengthening** restrictions on alcohol availability; **advancing** and enforcing drink driving counter measures; **facilitating** access to screening, brief intervention and treatment; **enforcing** bans or comprehensive restrictions on alcohol marketing, sponsorship and promotion; and **raising** prices on alcohol through excise taxes and pricing policies. Within this framework, price, availability and marketing have been defined as 'best buys' in that they are the most cost-effective policies.[20]

To date, there has not been a structured review of government-led alcohol strategies. The government has a responsibility to clearly articulate its approach to reducing alcohol-related harm in policy, strategy and action plan documents in order to: a) reduce harms from alcohol, particularly for Māori but also for all peoples in A-NZ and b) improve government responsiveness to Te Tiriti O Waitangi and uphold Māori rights to health and wellbeing. This research aims to: 1) explore how alcohol and alcohol harm are framed in A-NZ policy, strategy and action plan documents; and 2) examine how closely these documents align with the WHO SAFER framework.

Method

Data collection

The first author (TD) conducted an online systematic search of all national government health and social policy documents that: a) conceptualise and recognise the harms arising from alcohol use; or b) seek to address and minimise alcohol use and harms. Key documentation of interest included government-level policies, strategies, action plans and reports with significant mention of alcohol or alcohol-related harms. Key experts and organisations were also contacted for additional recommendations, and a snowball approach was applied. Given the search was focused on grey literature (e.g. A-NZ policy documents), our search strategy included two phases: 1) a keyword search across key government agency websites (e.g. health.govt.nz; see supplementary material for the exhaustive list); and 2) a keyword Google search. Both searches were conducted in January 2021.

In phase 1, for each government website, key word searches were undertaken using the following terms: "alcohol", "substance", "drink", "drug", "waipiro" and "intox*". In addition to keyword searches, each website was manually searched for relevant literature, action statements and strategic plans. In phase 2, a Google search was undertaken using the following search string: (alcohol OR alcoholism OR alcoholic OR alcoholics) AND (national OR policy OR policies OR strategy OR strategies OR nationwide OR "nationwide"). The reference lists of included documents from these searches were reviewed to identify any further potentially relevant documents.

Literature was included if it was published between 2000 and 2020 by national government agencies and had a clear focus on alcohol and alcohol-related harms. Exclusion criteria included a publication date before 2000, publication by a non-central government agency (e.g. local government), documents such as inquiries, reports, laws, proposals and/or regulatory impact statements, and if the document did not mention alcohol or had a specific focus on addiction service provision. Identified documents were assessed against the inclusion/

exclusion criteria, resulting in 22 documents being included in the analysis.

Data analysis

The analysis employed both an inductive and deductive thematic analysis informed by Braun and Clarke's (2012) phased approach.[21] The inductive analysis identified key themes relating to 1. how alcohol harm is framed in health and social policy, and 2. how health or social interventions to mitigating alcohol harm are framed in health and social policy. The deductive analysis was based on the World Health Organization's SAFER framework, with key policy solutions informing the coding framework to be included in the analysis (detailed below).

For the inductive analysis, the first author read and familiarised themselves with the data to get a sense of key ideas, with a focus on how alcohol was generally framed (Phase one). Informal notes were written to assist in the analysis process.[21] This was followed by a subsequent reading (Phase 2), in which line-by-line coding occurred and initial codes were generated. Codes were identified by frequency of mention and centrality to the data. The second author (SH) independently coded 10% of the dataset to complete an intercoder reliability check. Any discrepancies in coding were identified and addressed by consensus among the three authors.

Phase 3 involved codes being mapped into potential themes on the basis of similarity and overlap between codes. For example, we identified a group of related codes: "individual responsibility", "government responsibility", "whole of society responsibility", "community/community group responsibility" and "industry responsibility". In turn, we identified the potential theme of "who has responsibility for addressing those harms" as a way of grouping these codes together under a common theme or idea. Two other potential themes were identified during this phase: 'alcohol harms', and 'action needed to reduce alcohol-related harm'. Phase 4 involved reviewing the potential themes; this included a thorough review of the coded data and the entire data set by all authors. Phase 5 required us to define and label the themes resulting in three themes being identified: "location of responsibility for addressing alcohol harms", "harms caused by alcohol" and "alcohol harm minimisation actions". Phase 6 of our analysis (producing the report) was the culmination of the work resulting in this study.

For the deductive analysis, we developed a coding framework based on the WHO SAFER framework, with key policy solutions (themes) being used to formulate codes. The key policy solutions were: 1. strengthening restrictions on alcohol availability (codes = availabil*, hours, density, proximity, outlet, license); 2. advancing and enforcing drink driving counter measures (codes = blood, driving*, breath, road); 3. facilitating access to screening, brief intervention and treatment (codes = addiction, treatment, brief, pharmac*, screen*, general practitioner); 4. enforcing bans on comprehensive restrictions on alcohol marketing, sponsorship and promotion (codes = advert*, market*, sponsor*) and 5. raising prices on alcohol through excise taxes and pricing policies (codes = price, tax, min*, unit, levy). The first author tested the coding framework on a single document, with codes being applied to various excerpts in the data. Data were then grouped by documents mentioning or making specific recommendations related to one of the five SAFER policy areas (themes).t.

Results and discussion

Of the 22 documents included for analysis (outlined in). Sixteen documents were produced by the Ministry of Health (MoH), three from the New Zealand Police, and one each from the Ministry of Social Development, the Ministry of Justice and the New Zealand Government. While it is surprising that the MoH produced the majority of the documents, it is important to note that the Ministry of Justice is responsible for alcohol legislation in A-NZ and only produced one broader strategy document around violence. Of the 22 documents, only four (18%) had an explicit and total focus on alcohol, while the remaining documents focus on a range of broader issues including, violence, disability, cancer, smoking and road safety. The inductive analysis identified three themes: 1. location of responsibility for addressing alcohol harms, 2. harms caused by alcohol and 3. alcohol harm minimisation actions. In this study, we opted to discuss in detail the first theme 'location of responsibility for addressing alcohol harms', on the basis that the theme of 'harms caused by alcohol' did not provide any new/novel ideas related to the types of alcohol harms experienced in Aotearoa. Further, the theme 'alcohol harm minimisation actions' had significant overlap with the deductive portion of the analysis and was therefore not included to avoid repetition.

Location of responsibility for addressing alcohol harms

Regarding the theme 'location of responsibility for addressing alcohol harms', many documents do not explicitly attribute responsibility for alcohol-related harm to different entities. As such, our analysis assesses implied responsibility by looking at 1) the groups that are identified as experiencing the greatest harms; and 2) the groups that are identified as having the ability to change these harms (which implicitly suggests some responsibility for harms is attributed). Based on these criteria, implied responsibility for alcohol-related harms was attributed to individuals (in 18/22 of the documents), the government (18/22), the whole-of-society (13/22), communities (11/22) and industry (1/22).

Individual responsibility

Of the 22 policy documents, 18 framed alcohol harm as an issue occurring at the individual level and often, attributed it to individuals' problematic use of alcohol.[18,19,22–37] Alcohol-related harm was described as an avoidable issue at the individual level. Examples of this include:

> *While alcohol is embedded in New Zealand culture and most people manage to drink without harming themselves or others, the fact remains that misuse of alcohol results in considerable health, social and economic costs.* Alcohol Advisory Council of New Zealand, Ministry of Health (2001)[27] p. 8

> *We know that excessive and inappropriate consumption of alcohol is a significant contributor to social harm.* New Zealand Police (2018)[22] p. 3

> *By focusing on preventing illness and by making it easier to choose healthy options (like eating healthy food, not drinking alcohol or only drinking at low-risk levels, and undertaking regular physical activity), we can help people to avoid developing long-term health conditions or slow the development of those conditions.*Associate Minister of Health (2016)[25] p. 13

> In the NZP alcohol action plan, it states:"*There are many reasons individuals drink excessively and irresponsibly at times.*" New Zealand Police (2018)[22] p. 4

Previous literature highlights an individualistic focus in policy responses to alcohol harm.[29,38] Such framing positions alcohol harm as the responsibility of certain individuals that misuse alcohol rather than recognising the broader social determinants of alcohol use such as economic deprivation, colonisation and the alcohol environment,[39] which influence alcohol consumption in society. As a consequence, often individual-focused policy solutions such as 'increasing knowledge' or 'promoting healthy behaviour' are proposed.[25,27,29,30,34] For example:

> "***Increase knowledge*** *about risk factors associated with alcohol."* Alcohol Advisory Council of New Zealand, Ministry of Health (2001)[27] p. 26

> *Our focus is therefore on* ***increasing*** *physical activity and* ***other healthy behaviours*** *among older people–for example, encourage good nutrition, not drinking alcohol or only drinking at low risk levels*. Associate Minister of Health (2016)[25] p. 20

Such solutions attempt to change individual alcohol use behaviours without changing the underlying drivers of alcohol consumption, which can set individuals up to fail and have adverse impacts.[40] Among Māori in particular, this individualistic focus has significant implications given the comprehensive, intergenerational and ongoing impacts of colonisation that Māori experience in Aotearoa, which are not recognised when the focus is on the individual. Previous research by Herbert (2017)[41] argues that individualistic approaches to minimising harm are divorced from social and cultural realities, particularly among Māori, with minimal change in harmful alcohol use statistics over the past two decades.[3,4]

Even when knowledge-based solutions were identified, these statements were commonly made in a general sense without detailing the nature of the information or how it should be disseminated to have a maximal impact among individuals. Nor did the solutions address the inequities, which are sometimes exacerbated by knowledge-based interventions.[42] Instead, the solutions within the policy documents typically included follow-up statements implying that the provision of information would generate more knowledge or understanding to make better or safer choices about their alcohol use. For example, the New Zealand Plan to reduce community and sexual violence states:

> *Providing effective evidence-based education, information, programs, and strategies to young people, families and communities on the nature and risks of alcohol abuse to encourage moderate use of alcohol*. Ministry of Justice (2004)[18] p.46

Government responsibility

Eighteen documents acknowledged the various responsibilities of the government for reducing alcohol harm.[18,22–32,34,35,37,43–45] Many (10/18) documents made generic statements such as "cross-sector"/"cross government"/"whole of government" approach.[22,24,25,27,29,32,34,35,37,43]

> *It takes a whole-of-government approach, providing central guidance to support professionals, non-government organisations (NGOs), communities, iwi, hapū, whānau and individuals to improve outcomes in their own spheres of influence.* FASD Working Group (2016)[37] p. 2

However, few documents identified specific actions or steps that particular government departments (e.g. NZ Police, MoH, MSD) needed to take in order to address alcohol-related harms, with a few notable exceptions:

> *To prevent and reduce alcohol-related offending and victimisation… The police will undertake preventative activities such as high-visibility patrols quality licence premises compliance checks and will effectively use Police's Graduated Response Model.* New Zealand Police (2010)[24] p. 7

On the one hand, the generalising of responsibility across government with a whole-of-government approach acknowledges the major challenge alcohol-related harm poses. On the other hand, this generalisation also avoids attributing direct responsibility for policy action or inaction to any particular government department. Further, such a generalisation fails to explicitly recognise Te Tiriti o Waitangi and Māori rights in the determination of policy action required to not only address alcohol harm but to address it equitably for Māori. Lack of direct responsibility thus makes it difficult to identify where the inefficiencies or failures of policy solutions are located and, therefore, the pressure points to implement effective alcohol policy.

Whole of society responsibility

Thirteen of the 22 policy documents reported that alcohol harm was an outcome of wider societal issues.[18,19,22,24,27–31,34,37,43,45] This was used in different contexts, such as explaining why alcohol harm is prevalent or simply outlining that all of society needs to coordinate to formulate a response.

> *While much has changed in attitudes to and practices around alcohol these days, alcohol certainly remains part of contemporary New Zealand society. It is a legal, regulated and widely available product, and the large majority of adults drink at least occasionally. Alcohol is a feature of New Zealand life. For many, it is a symbol of hospitality and is used on occasions to celebrate important events in people's lives.* Alcohol Advisory Council of New Zealand, Ministry of Health (2001)[27] p. 1

The framing of alcohol as a "wider issue" makes it appear as if alcohol is not harmful, or that alcohol harm is inevitable and, arguably, an accepted aspect of A-NZ society. Such framing shifts the responsibility for alcohol-related harm from organisations or groups with the power to reduce alcohol-related harm and therefore reduces the urgency for change by those responsible. The shifting responsibility for alcohol-related harm may also occlude the harm caused by alcohol via a lack of organisational commitment to monitoring and reporting on alcohol's varied harms. Importantly, Te Tiriti implications are that this shifting of responsibility enables ongoing failures by government and its agencies to ensure Māori the right to live free from alcohol harm (good and equitable health) as well as reducing Māori rights to meaningfully engage and determine alcohol harm minimisation approaches required across all of society.

Community and community group responsibility

Eleven of the 22 policy documents located alcohol harms at the community level in general.[18,22,24,27–31,34,37,43] There was consistent framing of certain groups identified as being at risk from alcohol harm, including Māori,[23,25–28,31,32,34,44,45] Pacific Peoples,[25–28,32–34] youth,[27–30,44] elderly[25,27,34] and those who experience mental illness.[25–28,34,45] For example, the National Alcohol Strategy (2003) states:

> *It is clear that alcohol-related harm is greater amongst some groups than amongst others. As people go through life, there are stages at which they seem to be more at risk. The teenage years, young adulthood and later life are all stages at which people are*

> *particularly vulnerable. If they also come from the more marginalised groups in New Zealand society, for instance, Māori, then their risk factors are compounded.* Alcohol Advisory Council of New Zealand, Ministry of Health (2001), 27 p. 13

While a focus on specific priority populations is not inherently bad, nor does it necessarily attribute blame, there is still a failure to acknowledge the broader systemic drivers of alcohol use and harms that simply impact various groups and communities in inequitable ways. In the absence of acknowledgement of the structural drivers of alcohol-related harm, it can implicitly place responsibility for such harms on the identified communities, as well as locating those groups as being responsible for where change is needed. While arguably subtle, the impact among Māori is that tino rangatiratanga is not recognised; that is, Māori as active agents in determining community (and other) responses to alcohol harm and ensuring the resources are available to do so. Instead, Māori are positioned as merely one group in the population at risk of alcohol harm.

The majority of documents reported the importance of community in reducing alcohol harm, for example: ensuring community involvement,[18,27,31,37,43] resourcing communities[27,37] and engaging with communities[18,22,24,27,34] were described as important in reducing alcohol harm. Some documents highlighted specific areas, such as:

> *Resource Māori community development initiatives as a way of reducing alcohol-related harm.* Alcohol Advisory Council of New Zealand, Ministry of Health (2001)[27] p.30

Other documents reported that the local government had responsibility for protecting communities from alcohol-related harm despite only having a limited capacity to do so.[18,27,29] While this is an important and useful contribution to understanding alcohol harms, there must be recognition of and response to the structural drivers of alcohol-related harm, including access and availability of alcohol, the legal and social sanctioning of alcohol across society, and the way in which alcohol marketing is embedded in the everyday lives of individuals. Further, in line with Article 2 of Te Tiriti o Waitangi, Māori should be recognised as having authority (rangatiratanga) in, and afforded the right to, determining how alcohol harms in communities are addressed.

Industry responsibility

Only one of the 22 policy documents explicitly recognised the alcohol industry as being responsible for alcohol harm in A-NZ.[37]

> *Pregnancy warning labels on alcohol are covered by a trans-Tasman agreement that the Australian and New Zealand governments are currently reviewing. While this review is under way, the government will expect the industry to continue to increase the number of alcohol products that have messaging, such as the pictogram on the right.* FASD Working Group (2016) 37 p. 10

Alcohol companies are responsible for the externalities they impose on society.[46] While this is in part reflected in cost-recovery mechanisms such as the alcohol levy and alcohol excise tax in A-NZ, these tools do not address the total cost of alcohol-related harm, nor do they mitigate harms caused by alcohol in the first place. Further, there is minimal accountability placed on the equitable nature of those cost recovery mechanisms, which fails to recognise Māori rights to health equity and equitable health outcomes. Cost recovery tools should also not exonerate the alcohol industry from responsibility in these policy documents.

The alcohol industry maintains a large portion of control over how alcohol is marketed, made available and its associated costs. Alcohol is aggressively marketed through traditional and online media, making its messages readily accessible to a range of audiences.[47] In fact, alcohol is more available than ever before in A-NZ with the development of online alcohol sales and delivery as well as the low rates of successful community opposition to new alcohol licences.[48] The latter reflecting a system of alcohol control that ultimately fails to empower community members, and Māori in particular, to determine the availability of alcohol in their respective community areas. Price, too, is still largely controlled by the industry, and alcohol is more affordable today than it was in the 1990s.[49]

Proposed solutions to alcohol harm based on the World Health Organization SAFER policies

To assess the consistency of the policy documents with the WHO SAFER framework, our deductive analysis identified those documents that mentioned or recommended specific actions in a SAFER priority area (themes). Across the deductive results in the five key policy solution areas, there was a general failure to articulate specific recommendations or solutions for Māori, and in doing so, there are missed opportunities for such documents (organisations) to uphold Te Tiriti o Waitangi by recognising the role Māori may play in determining local, regional and national policy solutions to addressing alcohol harm.

As shown in Table 1, the most consistently referenced strategies included brief interventions (68% of documents), followed by drink driving measures (45%), alcohol marketing (36%), alcohol availability (27%) and alcohol price (23%). Somewhat unsurprisingly, the policy references reflect those SAFER priorities geared more towards individual behaviours, consistent with the overall framing of alcohol-related harm identified in the above section.

The conversion rate from mentioning a SAFER framework area to making a specific policy recommendation was usually less than or around 50% for each policy area, meaning documents were twice as likely to mention a policy area than to make specific recommendations. The frequency of recommendations largely reflects the frequency of mentions except for alcohol marketing, where documents more readily acknowledged alcohol marketing as a driver of alcohol-related harm but were more reluctant to make specific recommendations.

Strengthening restrictions on alcohol availability

Six of the 22 (27%) policies mentioned the availability of alcohol as a contributor to problematic consumption or as an area that could reduce alcohol harm.[18,22,24,27–29] Three of the 22 documents (14%) made specific recommendations related to the availability of alcohol in the context of reducing alcohol harm.[18,22,27] The remaining three documents mentioned the availability of alcohol as a contributor to harm without specific recommendations to reduce harm.[24,28,29] Sixteen out of 22 documents made no mention of the availability of alcohol in relation to alcohol harm.[19,23,25,26,30–37,43–45,50]

Of the six policy documents that mentioned alcohol availability as a contributor to harm in general terms, three documents did not provide recommendations or solutions to reduce harm.[24,28,29] Within these documents, there was little context to define alcohol availability and, therefore, limited opportunity to develop plans or approaches to

Table 1: Policy coherence of documents with the WHO* SAFER framework.

SAFER framework areas	Mentioned n	Mentioned %	Recommendation n	Recommendation %	Example recommendation
Strengthening restrictions on alcohol availability.	6/22	27%	3/22	14%	Review local-level responses to liquor control, including monitoring and enforcement of current legislation[18,22,27]
Advancing and enforcing drink driving counter measures.	10/22	45%	4/22	18%	Increase the frequency of compulsory breath testing[24,27,36]
Facilitating access to screening, brief intervention and treatment.	15/22	68%	10/22	45%	Ensure equal access to appropriate AOD treatment services[19,24–27,29,30,37,43,45]
Enforcing bans or comprehensive restrictions on alcohol marketing, sponsorship and promotion.	8/22	36%	2/22	9%	Monitor new alcohol marketing strategies and provide advice on likely effects on alcohol consumption[27]
Raising prices on alcohol through excise taxes and pricing policies.	5/22	23%	3/22	14%	Increase tax on alcohol[23,27,44]

*WHO, World Health Organization.

feasibly reduce alcohol availability. The following quote from the New Zealand Police Alcohol Safety Strategy 2010-2014 highlights that alcohol availability is a wider issue contributing to harm without providing any potential solutions to the issue.

> *It is important to note that policing is but one contributor to the final outcome, with wider issues such as alcohol availability and New Zealand's drinking culture playing significant roles*. New Zealand Police (2010)[24] p. 8

Three of the 22 policy documents (14%) made specific recommendations to reduce the availability of alcohol and subsequent alcohol harm.[18,22,27] There was a particular focus on increased policing of compliance on licenced premises[18,22,27] and a significant push for local bodies to take responsibility over the regulation of licenced premises.[18,27] The New Zealand Plan to Reduce Community and Sexual Violence outlines actions to make alcohol consumption on licenced premises safer, such as;

> *Review local-level responses to liquor control, including monitoring and enforcement of current legislation*. Ministry of Justice (2004)[18] p. 12

> *Develop new standard policy and practice guidelines, including for local authorities*. Ministry of Justice (2004)[18] p. 12

None of the three policies made specific recommendations around limiting the number of outlets or reducing their operating hours. Failure to identify reductions in outlet numbers or hours is inconsistent with the WHO SAFER framework and favours the assumption that alcohol harm related to availability is from acute harm from bad actors within on-licence outlets (individual-focused) rather than increases in population consumption driven by the proliferation of off-licence outlets (population focused).

Advancing and enforcing drink driving counter measures

Ten policy documents (45%) mentioned drink driving as a harm related to alcohol.[22,24,27–29,32,34–36,43] Four out of the 22 documents made specific recommendations.[22,24,27,36] The remaining six documents made mention of drink driving as an alcohol harm without making any recommendations.[28,29,32,34,35,43] In the remaining 12/22 policy documents, 55% did not mention drink driving.[18,19,23,25,26,30,31,33,37,44,45,50]

Six documents mentioned drink driving in a general sense but provided no recommendations to reduce the associated alcohol-harm.[22,28,29,32,34,43] The documents tended to focus on the general harms associated with drunk driving. For example, the New Zealand Road Safety Strategy 2020-2030 mentions drink driving in general terms, stating:

> *Driving under the influence of drugs or alcohol, choosing not to wear seatbelts or use child restraints, driving while fatigued or driving while unlicensed or disqualified– are contributors to harm*. New Zealand Government (2019)[36] p. 51

Four of the 22 policy documents made specific recommendations to reduce the incidence of alcohol-impaired driving and related harms.[22,24,27,36] Including the enforcement of alcohol-related legislation and increasing the rate of breath testing. For example, the National Alcohol Strategy highlights alcohol reduction strategies.

> "*Increase the frequency of compulsory breath testing. Actively promote initiatives designed to reduce alcohol-impaired driving (e.g. designated drivers, the availability of public transport options). Increase the emphasis on addressing drinking and driving in known areas of high risk, such as rural roads. Develop targeted strategies to reduce alcohol-related road crashes amongst Māori.*" Alcohol Advisory Council of New Zealand, Ministry of Health (2001)[27] p. 38

Facilitating access to screening, brief intervention and treatment

Fifteen of the 22 policy documents (68%) mentioned keywords related to brief intervention for individuals already impacted by alcohol harm.[18,19,24–27,29–31,33,34,37,43,45,50] Ten of those documents (45%) made specific recommendations related to brief intervention as a means of reducing alcohol harm.[19,24–27,29,30,37,43,45] The remaining five documents mentioned brief interventions in generic terms without providing clear recommendations.[18,31,33,34,50] Seven documents did not mention brief intervention in any aspect.[22,23,28,35,36,44,50]

Several key ideas arose across the 15 policy documents that mentioned brief interventions, such as the importance of growing the mental health and addiction workforce,[26,27,29,34,37,45] improving access to mental health and addiction treatment[18,19,24–27,29,30,34,37,43,45,50] and ensuring culturally appropriate interventions.[26,27,29,34,45] Importantly, most of these documents often grouped alcohol addiction, other drug addiction, and other mental health issues together. This made it difficult to meaningfully deduce specific details around what is specifically needed in the treatment of alcohol harm. For example, the following quote highlights the need for brief

intervention on a broad range of emerging issues without specific recommendations to implement change.

> *Provide advice and/or brief interventions to address emerging issues, including hazardous drinking, depression and anxiety*. Ministry of Health (2012)[34] p. 50

Some documents listed a number of different ways to strengthen the workforce, thereby increasing the capacity to provide intervention for alcohol harm. For example, the Mental Health and Addiction Workforce Plan 2017 highlights;

> *3.1 Build capability across the health workforce to respond to mental health, addiction and physical health issues.*
>
> *3.2 Support the development of the primary and community workforce to respond effectively and facilitate access to appropriate responses.*
>
> *3.3 Strengthen and sustain the capability and competence of the mental health and addiction workforce.*
>
> *3.4 Strengthen the workforce's capability to work in multidisciplinary ways.* Ministry of Health (2018)[26] p. viii

Other documents made recommendations targeted at increasing access to services (services are often used generically).[18,25–27,29,33,34,37,43,45] For example, the Healthy Ageing Strategy outlines;

> *Improve access to physical health services among people with high mental health and addiction needs, and improve integration of these services with residential care or home care services.* Associate Minister of Health (2016)[25] p. 50

Enforcing bans or comprehensive restrictions on alcohol marketing, sponsorship and promotion

Eight of the 22 (36%) policy documents[18,27–31,36,44] mentioned alcohol marketing as an important driver of alcohol consumption and harm in Aotearoa in general terms. Two of the 22 documents (9%) made specific recommendations regarding alcohol marketing and reducing alcohol harm.[27,44] The remaining six documents mentioned marketing in the literature review section but did not make specific recommendations.[18,28–31,36] The remaining 14 of the 22 documents (64%) did not mention the marketing of alcohol in any aspect.[19,22–26,32–35,37,43,45,50]

Seven of the eight documents (32%) that mentioned alcohol marketing specifically referred to "advertising",[27–31,36,44] five documents (23%) mentioned "marketing"[18,27–29,31] and two (9%) documents acknowledged alcohol sponsorship.[27,31] For example: The National Drug Policy 2015-2020 explains the importance of advertising and marketing in the context of demand reduction

> *Demand reduction aims to reduce the desire to use alcohol and other drugs. It includes activities that delay or prevent uptake. This means reducing use through education, health promotion, advertising and marketing restrictions, and influencing the conditions that make people turn to alcohol and other drugs through community action, such as keeping children in school.* Inter-Agency Committee on Drugs (2015)[29] p. 6

Two documents provided marketing-specific recommendations in their conclusions.[27,44] For example, the National Alcohol Strategy 2003 made specific recommendations related to marketing, including:

> *17.1 Require regular independent reviews of the ASA and BSA codes of practice and procedures governing alcohol advertising and sponsorship.*
>
> *17.2 Ensure reviews of alcohol advertising include the consideration of evidence about the possible need for tighter controls on such advertising.*
>
> *17.3 Support the continuation of the LAPS Committee.* Alcohol Advisory Council of New Zealand, Ministry of Health (2001)[27] p.33

While the Cancer Control Strategy 2003 outlined a number of broad areas for action, such as;

> *Raising awareness of the harmful effects of alcohol*
>
> *Reducing exposure to alcohol advertising*
>
> *Increasing taxation*
>
> *Considering* the *impact of age legislation on drinking patterns.* Minister of Health (2003)[44] p.28.

Raising prices on alcohol through excise taxes and pricing policies

Five of the 22 (22.7%) policy documents acknowledged the price of alcohol as a contributor to alcohol harm in general terms.[23,27,28,31,44] Three of those five documents made specific recommendations around alcohol pricing in view of reducing alcohol harm.[23,27,44] The remaining two documents[28,31] superficially highlighted how certain price-related changes could benefit the population but did not provide price-related recommendations to ensure meaningful action and change.

> *Within the range of factors that determine how people use alcohol, price is an important influence, both on total alcohol consumption and individual drinking patterns.*
> Alcohol Advisory Council of New Zealand, Ministry of Health (2001)[27] p. 34

The remaining 17/22 documents made no reference to alcohol pricing.[18,19,22,24–26,29,30,32–37,43,45,50]

Of the five documents that made mention of price in general terms, four specifically mentioned tax,[23,27,31,44] three mentioned price,[27,28,31] one referred to the existing alcohol levy,[27] while none mentioned minimum unit pricing. For example, the National Drug Policy 2007-2012 mentions price in the context of legal drug regulation, with no clear actions or interventions identified that may lead to meaningful change, stating:

> *Relevant drug health promotion interventions includes the use of the regulatory tools available for legal drugs, including pricing and tax policy*. Ministerial Committee on Drug Policy (2007)[28] p. 16

Among the three documents that made specific recommendations to alcohol pricing in the conclusion section, there was a particular focus on the taxation of alcohol,[23,27,44] demand reduction strategies,[27] and the mention of incorporating pricing strategies into policy.[27] For example, the National Alcohol Strategy 2003 outlines taxation as a specific objective with subsequent demand reduction strategies to support the reduction of alcohol harm, such as:

> *21. Develop a comprehensive taxation policy on alcohol to discourage excessive use and recoup some of the external costs caused by the misuse of alcohol.*
>
> *21.1 Retain an inflation-indexed excise tax on alcohol.*
>
> *21.2 Investigate the adoption of an excise tax based on alcohol content rather than beverage type.* Alcohol Advisory Council of New Zealand, Ministry of Health (2001)[27] p. 35

Conclusion

In this thematic analysis of A-NZ alcohol-related policy documents, we identified the responsibility for alcohol-related harm as largely focused on individual responsibility as well as non-specific government agency responsibility. The alcohol industry was almost never mentioned as a driver of alcohol consumption or its harm. The policy responses within these documents are consistent with the framing of alcohol-related harm, whereby those interventions that focus on individuals (e.g. drink driving or brief interventions) were prioritised over population-level interventions addressing price, marketing or availability.

Further, the lack of accountability and emphasis on policies within the SAFER framework can be partially attributable to the lack of national direction in the absence of an updated national alcohol strategy. In other jurisdictions, the implementation or maintenance of a national alcohol strategy (NAS) has led to alcohol policy gains consistent with the WHO SAFER framework.[13–16] The 2007 review of the 2000-2003 NAS provides a road map towards a more accountable, effective and equitable alcohol policy environment.[17] In particular, an updated NAS should clearly identify those agencies responsible for specific action points, create a systematic monitoring and evaluation mechanism to track implementation of the NAS, and be consistent with the WHO SAFER framework.

Importantly, the inequities in alcohol harm experienced among Māori are unacceptable. We have argued that these are the result of societal and structural drivers of harmful alcohol use and reflective of failures by the government to uphold Te Tiriti o Waitangi. The findings from this study reinforce the failure to uphold Māori rights in line with Te Tiriti o Waitangi, including the right to good and equitable health and well-being (Articles 1 and 3), as well as Māori rights to determine alcohol policy and the management of alcohol and its use across society (Article 2). The development of a NAS must provide the opportunity to meaningfully engage Māori, as equal partners, in determining a comprehensive and equitable response to alcohol harm minimisation that enables Māori leadership, offers Te Ao Māori solutions, and by Māori, for Māori approaches that uphold Te Tiriti o Waitangi and Māori rights, as well as enabling Pae Ora for all in A-NZ. The analysis provides further evidence for the adverse effects of the lack of a national alcohol strategy to guide national alcohol policy development.

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Conflicts of interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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Appendix A Supplementary data

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