5 June 2018

The Mental Health and Addictions Inquiry

Thank you for the opportunity for Auckland Regional Public Health Service (ARPHS) to provide a submission on the Mental Health and Addictions Inquiry.

The following submission represents the views of ARPHS and does not necessarily reflect the views of the three District Health Boards it serves. Please refer to Appendix 1 for more information on ARPHS.

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1. Executive Summary

Auckland Regional Public Health Service (ARPHS) aims to improve the health and well-being of Auckland's diverse population through promotion, protection and prevention.

The relationship between alcohol and mental illness is significantly harmful and well established. Additionally, alcohol-related harms are major contributors to inequities in health and well-being outcomes. Therefore we have focused our submission towards recommendations that can decrease alcohol-related harm by reducing the ease of access and in turn promoting positive mental well-being.

Auckland Regional Public Health Service recommends the following:

1) Review and strengthen the Sale and Supply of Alcohol Act (SSAA) 2012 to address some of the current challenges that limit its effectiveness.
2) Build positive mental well-being through protective alcohol policies: implement recommendations made to the Government by the Law Commission report (2009)[1] to:
    a. Restrict the availability of alcohol
    b. Increase the minimum legal purchase age of alcohol
    c. Commit to investigating and implementing appropriate mechanisms to increase the price of alcohol
    d. Restrict alcohol advertising, promotion and sponsorship through implementation of recommendations made to the Government by The Ministerial Forum on Alcohol Advertising and Sponsorship.
3) Improve access to, and effectiveness of, early screening and brief interventions for alcohol.
4) Apply an equity focus to all strategies that aim to build positive mental well-being through protective alcohol policies, ensuring the principles of the Treaty of Waitangi are reflected throughout.

These recommendations are based on robust and sound international and New Zealand based evidence, and are consistent with those in the New Zealand Law Commission's Report, The Ministerial Forum on Alcohol Advertising and Sponsorship, World Health Organisation and ARPHS's submission on the Sale and Supply of Alcohol (renewal of licences) Amendment Bill (No. 2).

Additionally, in order for these recommendations to be effective, clear national leadership is needed for integrated and coordinated policy and service delivery across the justice, health and other relevant sectors.

[1] New Zealand Law Commission Alcohol in Our Lives: An Issues Paper on the Reform of New Zealand's Liquor Laws (NZLC IP15, 2009).

2. Alcohol is an Addictive Drug with both Acute and Chronic Health Risks

Although consumed by the majority of New Zealanders and deeply embedded in our culture, alcohol is no ordinary commodity[2]. Alcohol is an addictive psychotropic drug[2] and a type 1 carcinogen[3] that is cheap and readily available in New Zealand.

Alcohol is the fourth largest risk factor for health loss in New Zealand after obesity, smoking and high blood pressure[4]. New Zealanders have high rates of hazardous drinking with one in five adults drinking in a way that could harm themselves or others in the past year. Māori, Pacific men, youth (aged 18-24) and those in lower socio-economic areas are more likely to have high rates of hazardous drinking[5]. Māori women suffer more adverse effects as a result of other people's drinking than any other sub-group by ethnicity and gender[6].

Auckland has higher levels of alcohol related harm than the rest of New Zealand with rates of wholly alcohol-attributable hospitalisations 7% higher than the rest of the country. Additionally, Auckland has a higher rate of late night assaults with the rate between midnight and 3.59am being 38% higher than the national rate, and the 4am to 6.59am rate being 41% higher[7].

The harm caused by alcohol contributes to a large physical, psychological, social and economic burden to communities and to social and health services across the spectrum of care. Around 800 deaths a year are attributed to alcohol, mostly through injury, but alcohol-related cancers are increasingly dominant over the age of 45[8]. Additionally, alcohol-related harm in New Zealand is estimated to cost $5.3 billion per year[9].

An individual's hazardous drinking can have a significantly harmful impact on the mental and physical health of those around them, including, but not limited to:

- **Domestic violence** – Nearly a third (29%) of family violence incidents attended by the police in New Zealand involve alcohol as a factor[10]. This is likely an under-representation as family violence is typically under-reported and the involvement of alcohol difficult to measure.

[2] Babor T, Caetono R, Casswell S, et al. (2003) *Alcohol: No Ordinary Commodity.* Oxford Medical Publications, Oxford University Press, UK.
[3] International Agency for Research on Cancer. IARC monographs on the evaluation of carcinogenic risks to humans. Volume 44. Alcohol drinking. Lyon, France: International Agency for Research on Cancer 1988.
[4] Institute for Health Metrics and Evaluation. Global Health Data Exchange: GBD Results Tool 2017. Available from: http://ghdx.healthdata.org/gbd-results-tool accessed 28 May 2018.
[5] Ministry of Health. 2017. Annual Data Explorer 2016/17: New Zealand Health Survey [Data File]. URL: https://minhealthnz.shinyapps.io/nz-health-survey-2016-17-annual-update
[6] Ministry of Health. Alcohol Use in New Zealand: Key results of the 2007/08 New Zealand Alcohol and Drug Use Survey. Wellington: Ministry of Health, 2009
[7] Huckle, T. (2016) *Alcohol-Related Harm Snapshot 2015. Auckland v Rest of New Zealand 2015.* SHORE and Whariki Research Centre, Massey University, Auckland.
[8] Connor, J., Kydd R., Shield, K., & Rehm, J. (2013). Alcohol-attributable burden of disease and injury in New Zealand: 2004 and 2007. Research report commissioned by the Health Promotion Agency. Wellington: Health Promotion Agency.
[9] Slack A, Nana G, Webster M, et al. 2009. Costs of harmful alcohol and other drug use. Final Report to the Ministry of Health and ACC.
[10] New Zealand Police Law Enforcement System, 2002

- **Road traffic accidents** - For every 100 alcohol or drug-impaired drivers or riders who died in road crashes, 37 of their passengers and 19 sober road users died with them[11].
- **Child maltreatment** - In families where an adult drinks heavily, children are at higher risk of a number of negative effects including depression and anxiety. New Zealand research showed that amongst respondents with children who had been exposed to at least one heavy drinker in their life, 17% had reported their children experiencing harm as a result of someone else's drinking[12].
- **Crime -** Half of all serious crimes involve alcohol and over 300 alcohol-related offences are committed each day[13].

3. The Relationship between Alcohol and Mental Health and Addictions

There is a large body of evidence that supports the complex and significantly harmful relationship between alcohol and mental health. Alcohol is frequently consumed to temporarily alleviate feelings of anxiety or depression. Research shows alcohol has a contributory role in the development of depression[14]. Additionally, alcohol consumption can exacerbate existing underlying mental health conditions. Those with severe mental illness are more likely to be alcohol dependent, adding complexity to recovery and treatment services.

Alcohol has been identified as a significant contributor to New Zealand's high suicide rates[15]. In 2014, over one third of all New Zealanders who had committed suicide had alcohol in their systems and a further 23% had a trace of alcohol in their urine and/or blood[16].

Māori, both male and female, have higher suicide rates than non-Māori (1.7 and 2.4 times respectively) demonstrating again the stark inequity between Māori and non-Māori[17].

4. Recommendations

To enable people to reduce alcohol-related harm and promote positive mental well-being, strong, evidence-based policies are recommended, including strengthening the current regulatory process. There is a large body of evidence that recognises the most effective policies are those that target the availability, accessibility and consumption of alcohol namely addressing the price of alcohol, the location and density of alcohol outlets, purchase age and the advertising, promotion and sponsorship of alcohol. ARPHS recommendations are as follows.

4.1 Strengthen the effectiveness of the Sale and Supply Act (the Act) 2012, particularly with regards to the local alcohol policy (LAP) process

[11] Ministry of Transport. (2017). Alcohol and Drugs Crash Facts 2017. Wellington: Ministry of Transport. Available from: https://www.transport.govt.nz/resources/road-safety-resources/crashfacts/alcohol-and-drugs/ accessed 22 May 2018.
[12] Casswell S., You R. Q., Huckle T. Alcohol's harm to others: reduced wellbeing and health status for those with heavy drinkers in their lives. Addiction 2011; 106: 1087–94.
[13] New Zealand Police. 2010 (in draft). National Alcohol Assessment. Wellington: New Zealand Police.
[14] World Health Organisation. Global status report on alcohol 2004. 2004. Geneva, WHO.
[15] Ministry of Health Strategy. *A Strategy to Prevent Suicide in New Zealand: Draft for public consultation. 2017*
[16] Rossiter P. *Coronial Services of New Zealand.* 2017
[17] Ministry of Health. (2017). Suicide Facts: 2015 data.

There has been a large body of evidence, internationally and nationally, that has stated that price, availability, advertising and purchase age are the most effective policy levers to address alcohol-related harm. The Act did not substantially influence the price, availability, purchase age and advertising of alcohol in New Zealand. Instead, the Act focuses on regulation to reduce alcohol-related harm at an individual licence level. It aims to give the community a greater voice in licensing decisions through involvement in the development of local alcohol policies, with the intention that these plans are the mechanism through which communities can have more control over alcohol density in their areas.

Although there may be some benefits of the Act, in practice, ARPHS and other public interest groups, including the communities themselves, do not feel they have a greater voice in the process. ARPHS, as well as the community, feel the process is challenging given the increasing litigiousness (industry very rarely attend hearings without lawyers), length and cost of the process, which can be a barrier for agencies and more so for the community. This is important because the ease of access of alcohol is positively associated to increased alcohol consumption, and increased consumption is linked to increased harm, including poorer mental and physical health outcomes.

The Government's recent Sale and Supply of Alcohol (Renewal of Licences) Amendment Bill (No 2) is an attempt to try and address some of the concerns communities have in relation to alcohol outlet density. The Bill seeks to ensure licensing authorities have the discretion to refuse a renewal of a licence if inconsistent with a LAPs location and density policies. ARPHS and other parties' submissions to the Bill can be found at:

https://www.parliament.nz/en/pb/bills-and-laws/bills-proposed-laws/document/BILL_76343/tab/submissionsandadvice?Criteria.PageNumber=2.

4.2 Restrict the Availability of Alcohol

Restrictions to the availability of alcohol have been recognised within a large body of international, and New Zealand[18] based evidence, as an effective way to address alcohol-related harm. Alcohol availability policies are based on the evidence that easier access to alcohol increases the overall population consumption levels, which in turn increases alcohol-related harm. Conversely when restrictions are made to the availability of alcohol, which involve the location and density of alcohol-outlets, and their trading hours, alcohol-related harm is reduced.

In regards to the location of alcohol-outlets in New Zealand, they are inequitably distributed, with more outlets situated in socio-economically deprived areas, which further contributes to the unequal distribution of alcohol-related harm. New Zealand research shows that alcohol-related harm is associated with both on and off-licensed alcohol-outlets, and although restrictions are recommended for both types of outlets, ARPHS recommends that there needs to be a focus on restrictions to off-licensed outlets in the first instance. This is due to a proportionally higher number of off-licensed premises being located in the most deprived areas

[18] Connor J, Kyprl., Bell M., & Cousins K. 2011. Alcohol outlet density, levels of drinking and alcohol related harm in New Zealand: a national study. Journal of Epidemiology and Community Health, 65 (10). Available from: http:/jech.bmj.com/content/65/10/841.full.pdf

of New Zealand, which often have high Māori populations, and, also due to the following points which were highlighted in the New Zealand Alcohol Supply and Demand Structures report[19]:

- Off-licence outlets account for the largest share of estimated sales by value (66%), just over twice that of on-licences (32%)
- The lower price levels of off-licence sales mean that off-licence outlets account for the largest share of sales by total beverage volume (estimated at 84%), with on-licence outlets accounting for 14%; and
- Supermarkets account for an estimated 31% of the national alcohol sales by total beverage volume; bottle stores an estimated 33%.

Furthermore, a recent New Zealand study found a significant relationship between the high density of off-licensed premises and crime, with an additional off-licensed outlet associated with 1.2% more violence[20].

Through the provisions in the Act, there are two mechanisms to reduce the location, density and trading hours of outlets in New Zealand; appeals against licence applications on an individual basis (for context ARPHS receives around 4200 applications per year) or, through the development of local alcohol policies by councils. As stated previously, it is ARPHS's assessment to date that both of these mechanisms have not achieved a reduction in the availability of alcohol (ease of access) and that it is unlikely to ever do so.

4.3 Increase the Minimum Legal Purchase Age of Alcohol

The purchase age for alcohol in New Zealand was lowered to 18 years in 1999 and, was a key issue in the Law Commissions Report[1]. Seventy-eight percent of the 2,272 submitters to the review supported an increase in the minimum legal purchase age.

International evidence shows that initiating alcohol use in adolescence is associated with an increased risk of binge drinking, higher volumes of consumption and alcohol dependence in adolescence[21] and/or adulthood[22]. Furthermore, young people up to the age of 25, but particularly for those under the age of 15, experience more harm per standard drink than older drinkers[23].

This body of evidence and evidence from the Law Commissions Report[1] presents a strong case towards increasing the minimum legal purchase age of alcohol as an effective policy to prevent alcohol-related harm, particularly for young people.

[19] M. E Consulting. (2018). New Zealand alcohol and supply and demand structures: Research report. Wellington: Health Promotion Agency

[20] Cameron, M. O., Cochrane, W., & Livingston, M. (2016).*The relationship between alcohol outlets and harms: A spatial panel analysis for New Zealand 2007-2014. Wellington.*

[21] Aiken A, Clare PJ, Wadolowski M, et al. (2018).Age of alcohol initiation and progression to binge drinking in adolescence: A prospective cohort study. *Alcoholism: Clinical and Experimental Research. 42(1).*100-110

[22] Soundararajan, S. Narayanan, G., Agrawal, A., Prabakaran, D. & Murthy, P. (2017).Relation between age at first alcohol drink & adult life drinking patterns in alcohol-dependent patients. *Indian Journal of Medical Research,* 146(5). 606-611

[23] National Health and Medical Research Council Australian Guidelines to Reduce Health Risks from Drinking Alcohol (Canberra, 2009) at 63 [Australian Guidelines].

4.4 Increase the Price of Alcohol

Research shows that the purchases of alcohol and its consumption levels are linked to its level of affordability[2]. Each week, New Zealanders spend an estimated $85 million on alcohol[1].

Increasing the price of alcohol has been the most extensively researched and internationally recognised way to effectively reduce alcohol consumption and related harm[2]. More specifically, it delays the onset of drinking, reduces the volume of alcohol consumed and alcohol-related problems for all groups of drinkers, including young people, heavy and problem drinkers.

The large body of evidence to support the effectiveness of price has resulted in organisations such as the World Health Organisation, UK National Institute of Clinical Excellence, and US Center for Disease and Control recommending pricing policies as the most effective policy intervention to reduce both individual and population levels of consumption[24].

The price of alcohol can be increased through minimum pricing of alcohol products or through taxes on alcohol such as excise tax or levies. ARPHS recommends that the Government explores the appropriate mechanism and commits to implement this to increase the price of alcohol.

4.5 Restrict Alcohol Advertising, Promotion and Sponsorship

Alcohol is heavily advertised and promoted in New Zealand via a multitude of different avenues in everyday settings and interactions. In 2009, it was estimated that $200,000 was spent on alcohol advertising in New Zealand per day. Evidence shows that exposure to alcohol marketing is associated with the onset of alcohol consumption, increased consumption and the misuse of alcohol, especially for young people. Currently there is little regulation of alcohol advertising in New Zealand.

The Ministerial Forum on Alcohol Advertising and Sponsorship (the Forum) was appointed in 2014 to assess the appropriateness of introducing new restrictions for regulating alcohol advertising and sponsorship. A report was prepared by the Forum with a number of recommendations to protect the young and vulnerable from the exposure of alcohol advertising. However, these recommendations have not been actioned. ARPHS recommends that the Forum's recommendations are actioned by the Government.

5. Further Recommendations

As well as the above, ARPHS recommends the following to strengthen prevention strategies and ensure these are appropriate for those populations most affected by the burden of mental health and addiction such as Māori.

[24]Thaksaphon, T., Hill, L., & Casswell, S. (2005). *Alcohol taxation in the western pacific region* (Paper prepared for the world health organization regional office for the western pacific). Auckland, New Zealand: Centre for Social and Health Outcomes Research and Evaluation, Massey University. http://teaching.massey.ac.nz/massey/fms/Colleges/College%20of%20Humanities%20and%20Social%20Sciences/Shore/reports/Taxation%2013_9_06.pdf?D6E56924CB5F6920B5CF099E7C013C1E

5.1 Improve access to and effectiveness of early screening and brief interventions

The provision of early screening and brief opportunistic interventions is an internationally recognised approach to encourage positive behaviour change. In Auckland where the proportion of heavier drinkers (16-65 years) is higher than the rest of New Zealand, there is sound evidence to show brief interventions can reduce alcohol intake and related problems in this group[2].

Although there is good evidence to support the effectiveness of early screening and brief interventions, the unmet need for these services across New Zealand is considerable. The Alcohol Use 2012/13 New Zealand Heath Survey found that only a small percentage of drinkers (4.4%) reported having received help to reduce their alcohol use during their lifetime[25].

To support effective access to screening and brief interventions the following actions are recommended across a range of settings (police custody units, hospitals, primary care settings),[26] as under resourcing can result in missed opportunities to reduce alcohol-harm[27].

ARPHS therefore recommends strengthened early screening and brief interventions that:

- Build workforce capacity and capability to deliver routine screening and interventions
- Ensure Kaupapa Māori approaches are integrated
- Ensure services are equitable, accessible and responsive to the needs of Māori, Pacific peoples, young people and their families and minority populations, and are sensitive to gender
- Ensure appropriate and coordinated referral pathways within and across the different sectors.

5.2 Equity focus

Significant equity gains can be achieved through effective policies that are aimed at reducing the persistent and growing disparities in harm**.** The Law Commission Report 2010 highlighted concerns that alcohol may not be reflecting inequalities for Māori but actively contributing to them. ARPHS acknowledges the unique relationship between Māori and the Crown under the Treaty of Waitangi. Therefore a focus on equity must take precedence with equity embedded in all alcohol and mental health policies. Additionally preventative approaches must reflect the principles of the Treaty of Waitangi and encompass Māori models of health, values and practices in order to address the current stark differences between Māori and non-Māori mental health and addictions outcomes.

6. The Role of Public Health in Mental Health and Addictions

ARPHS's involvement in programmes related to mental public health is limited, and has mainly concerned reduction of harm from alcohol through our regulatory and health promotion work,

[25] Ministry of Health. 2015. *Alcohol Use 2012/13: New Zealand Health Survey*. Wellington: Ministry of Health.
[26] Action on Alcohol 2013-2018. *A collaborative plan of action to reduce the harm from alcohol in Auckland.*
[27] New Zealand Medical Association Policy Briefing. (2015). *Reducing alcohol-related harm*.

and as a component of our workplace health promotion programme. We consider there are significant gaps in the area of public mental health within Auckland notably on improving socio-economic factors such as employment, family debt, housing, having public policy, improving child safety and development, family cohesiveness, preventing family violence, and addressing difficult service issues such as mental health in prisons.

Most public mental health programmes in the Auckland region are linked with national programmes such as the Health Promotion Agency's depression programme (depression.org.nz), or provided through regional and national NGOs such as the Mental Health Foundation (e.g. the previous Like Minds, Like Mine programme).

ARPHS commends the papers produced by the Office of the Prime Minister's Chief Science Advisor in 2017 "Toward a Whole of Government/Whole of Nation Approach to Mental Health" and "Youth Suicide in New Zealand: a Discussion Paper" as providing a sound summary of research on causal factors, and effective approaches to mental health issues.

There has not been a coherent national mental health promotion framework since the 2002 Building on Strengths strategy. The health sector's attention more recently has primarily been on mental health service issues. Public mental health has had attention elsewhere, including the UK, where the Chief Medical Officer's annual report in 2013 focused on public mental health priorities. This emphasised the importance of basing programmes on research, life course considerations (especially in child development), economic aspects, discrimination, service gaps, violence, addiction, suicide and self-harm, and inequalities of mental health outcome.

One key message in the UK CMO's report is that the conceptual division between physical and mental health is a barrier to improving general health, but most detrimental to mental health. Mental health cannot be seen as distinct from physical health, human development, or social functioning. Substandard housing, for example, can contribute to physical illness as readily as to mental illness or social problems such as educational delay in children. More recently the UK Faculty of Public Health and UK Mental Health Foundation prepared their Better Mental Health for All (2016) as a public health approach to improving mental health.

ARPHS considers the following topics of public mental health significance need to be addressed:

- Addressing the ease of access and culture of heavy alcohol use
- Reducing the social factors that increase drug addiction
- Urgently improving basic living and socio-economic conditions, such as housing, employment and debt
- Preventing family violence
- Parenting support and coaching to support child development and socialisation.

7. Conclusion

Thank you for the opportunity to submit on the Mental Health and Addictions Inquiry.

Appendix 1 - Auckland Regional Public Health Service

Auckland Regional Public Health Service (ARPHS) provides public health services for the three district health boards (DHBs) in the Auckland region (Counties Manukau Health and Auckland and Waitemata District Health Boards).

ARPHS has a statutory obligation under the New Zealand Public Health and Disability Act 2000 to improve, promote and protect the health of people and communities in the Auckland region. The Medical Officer of Health has an enforcement and regulatory role under the Health Act 1956 and other legislative designations to protect the health of the community.

ARPHS' primary role is to improve population health. It actively seeks to influence any initiatives or proposals that may affect population health in the Auckland region to maximise their positive impact and minimise possible negative effects on population health.

The Auckland region faces a number of public health challenges through changing demographics, increasingly diverse communities, increasing incidence of lifestyle-related health conditions such as obesity and type 2 diabetes, infrastructure requirements, the balancing of transport needs, and the reconciliation of urban design and urban intensification issues.