Submission to the Government Inquiry into Mental Health and Addiction

December 2018

health promotion agency
TE HIRINGA HAUORA

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This paper contains the following documents:

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2. Supporting information supplied to the Inquiry on:
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Health Promotion Agency

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May 2018

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INTRODUCTION

This submission has been prepared to inform the Government Inquiry into Mental Health and Addiction 2018. It summarises the Health Promotion Agency's (HPA's) view on current gaps, unmet needs, and priority populations, and suggests a number of ideas and approaches to support the development of a cohesive, integrated mental health and wellbeing system that supports improved outcomes for all New Zealanders.

THE FOCUS OF THIS SUBMISSION

This submission focuses primarily on health promotion, prevention, early intervention and wellbeing approaches which HPA believes are central to transforming New Zealand's mental health and addiction system, improving outcomes and reducing inequities. It builds on two previous papers summarising HPA's current programmes and research that were submitted to the Inquiry in April 2018 and should be read in conjunction with them.

Underpinning this submission is HPA's acknowledgement of the special relationship between Māori and the Crown under the Treaty of Waitangi. Fundamental to the Treaty, are its principles of self-determination, partnership, participation and protection, which have much to offer in promoting the mental health of all New Zealanders. Any decisions on the future approach to mental health and addiction must embrace holistic Māori health models and ensure a commitment to equity of health outcomes and the protection Māori cultural concepts, values and practices.

The themes and suggested solutions outlined in this paper are described at a fairly high level and HPA would welcome an opportunity to meet with the Inquiry panel to discuss them in more detail.

GAPS, UNMET NEEDS AND PRIORITY POPULATIONS – CHALLENGES AND SUGGESTED SOLUTIONS

Over the last 20 years, New Zealand has made significant progress in its approach to improving mental health and wellbeing outcomes. The shift from institutional to community based services and a growing recognition of the importance of investing in health promotion, prevention and early intervention has taken us a long way to improving outcomes. In addition, national public awareness campaigns have greatly improved general awareness and help-seeking behaviour.

While current health promotion, prevention, early intervention and wellbeing initiatives are proving successful, significantly more focus and investment is needed in order to maximise their impact, improve equity and support New Zealand to move from an illness focused system to an integrated wellbeing system. HPA is of the view that health promotion in New Zealand should be more centralised, customised and democratised. Working alongside and connecting key national and local partners to provide targeted resources for priority populations, this type of approach will ensure communities are enabled to lead the development of their own health promotion initiatives and customise national resources and tools to their local contexts.

In order to democratise health we need to disrupt the status quo and shift from a reactive diagnostic and treatment based model to a proactive preventative model that shifts the power from services and professionals to individuals, families, whānau and communities. The potential of emerging digital technologies to facilitate this change through the development of products and interactive systems that shift the focus towards early identification and prevention, and give people the information they need to manage their own health and wellbeing more effectively, is yet to be fully realised. HPA has begun work in this area which is described in more detail in Section 7 below.

The power of health promotion approaches to drive behaviour change have been demonstrated in a number of HPA led initiatives. The significant shifts in behaviour that have been demonstrated across smoking, rheumatic fever, and alcohol are highlighted here to provide further evidence of the effectiveness of health promotion as part of a comprehensive package to improve health and wellbeing outcomes:

- Smoking prevalence for 14 to 15-year-olds has steadily decreased over the past 20 years from 15.6% in 1999 to 2.1% in 2017. Whilst inequities remain, the rate for young Māori has also declined significantly, from 30.3% to 5.3%[1]. These results were achieved through targeted, sustained and well-resourced health promotion, focused on mass media and sponsorship, alongside education, environmental and regulatory approaches.
- Rheumatic fever rates have decreased by 45% since 2012[2] as a result of a comprehensive prevention programme that included an effective national HPA awareness campaign[3].
- HPA's alcohol behaviour change programme, which includes an award winning social marketing component, has demonstrated sustained behaviour change with the number of adults encouraged to say 'no' when they didn't want a drink increasing from 17% to 34% over a five year period from 2013 to 2017. For Māori and Pacific people the results are even more encouraging, with Māori rates increasing from 22% to 43% and Pacific peoples rates increasing from 54% to 73%[4].

Following is a summary of the gaps, unmet needs, priority population groups and suggested areas of focus that HPA has identified to support improved mental health, addiction and wellbeing outcomes for all New Zealanders.

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[1] ASH year 10 smoking survey 2017

[2] https://www.health.govt.nz/about-ministry/what-we-do/better-public-services/previous-bps-target-reduce-rheumatic-fever

[3] Evaluation of the 2015 Rheumatic Fever Awareness Campaign (Allen and Clarke, December 2015)

[4] Drinking moderation campaign research 2017 preliminary results, TNS Research

1. REORIENT THE CURRENT SYSTEM

Strategic system level transformation is needed in order to maximise opportunities to improve mental health, addiction and wellbeing outcomes throughout peoples lives, particularly at times of adversity and during life stage transitions. In order to reduce the prevalence of mental distress, the system needs to move from a predominantly deficit based model to one where mental health and wellbeing is viewed as individual, family, whānau and community taonga to be supported, strengthened and protected. HPA has started to work more strategically towards this approach through the development and implementation of its Wellbeing Approach[5]. Although it is early days, HPA will be evaluating all activities to measure and monitor their effectiveness.

The system also needs to shift from one where the balance of power resides with professionals and services to one where the power resides with people and communities. At an individual level, support should be readily available, accessible, and focused on assisting individuals, family and whānau on a self-defined pathway to wellness and wellbeing. At a system level, people with lived experience need to be supported to be involved in all aspects of service design and delivery, funding, performance measurement and governance and accountability arrangements.

2. MENTAL HEALTH PROMOTION WORKFORCE

While there are great examples of community health promotion that is well linked into communities, often the health promotion workforce is seen as 'separate to' and not the business of the general health and social sector workforce. HPA believes that there is enormous potential to significantly increase health promotion and prevention efforts by changing the way that health promotion is conceptualised and delivered within the wider health and social sector system.

Health promotion needs to be seen as 'everyone's business' and all front line practitioners should be provided with the skills, tools and resources to be health promoters. We need to equip the whole of the health and social sector workforce, and a wide range of other disciplines, with the knowledge and skills to have a positive influence on mental health and wellbeing. There is potential for the development of opportunistic wellbeing screening and brief intervention tools, encompassing mental distress, addiction, sleep, nutrition and physical activity, which could support this approach.

Internationally there are good examples of approaches that aim to utilise the millions of day to day interactions that organisations and people have with other people to encourage changes in behaviour that have a positive effect on the health and wellbeing of individuals, communities and populations, e.g. www.makingeverycontactcount.com. Based on behavioural psychology, these

[5] For further detail on HPA's Wellbeing Approach, please refer to HPA's description of current programmes submitted to the Inquiry April 2018

programmes have the potential to be adapted to the New Zealand context to further support people to care for each other

3. DEVELOPING MENTALLY HEALTHY COMMUNITIES

It's not just the health and social sector workforce that have a role in promoting health and wellbeing. If we're going to make mental health promotion 'everyone's business' then a greater focus on communities is essential.

> *Health is created and lived by people within the settings of their everyday life; where they learn, work, play and love. Health is created by caring for oneself and others, by being able to make decisions and have control over one's life circumstances, and by ensuring that the society one lives in creates conditions that allow the attainment of health by all its members. Ottawa Charter*

Communities are the settings of everyday life – they include neighbourhoods, workplaces, marae, sports clubs, schools, and churches. Communities need the skills, knowledge, and tools to protect and improve their own mental health and wellbeing. Building resilient communities, increasing social connectedness and improving health literacy are all essential components of a strengths based wellbeing system.

There are a number of potential approaches and interventions that are effective in building social capital, promoting community wellbeing and addressing social isolation. They include:

- Approaches that address social isolation and loneliness with a specific focus on young people, rural communities and older people.
    - People of all ages experience isolation, but HPA research shows that it may be a particular issue for young people (15 to 24-years-old) with over half reporting some level of isolation[6]. The research findings for young people highlight an urgent need to break the destructive cycle of isolation and mental distress, shown in previous research to be an indicator of increased suicide risk.
    - Cultural connectedness may be a useful pathway for social inclusion for Māori. HPA suggests investment in partnering with Māori organisations and Iwi to develop approaches and initiatives to strengthen cultural connectedness.
    - HPA's research findings also support the exploration of strategies that provide opportunities for people to give as well as receive help, eg, volunteering, peer support, and befriending schemes.

[6] Wellbeing and Mental Distress in Aotearoa New Zealand: Snapshot 2016 (HPA, February 2018)

- Workplace mental health promotion.
    - Workplaces need to be supported to develop the capability to systematise wellbeing within the workplace and be provided with tools and resources to enable this. HPA suggests targeting specific industries that employ people from priority social, economic and ethnic backgrounds, eg, Māori, Pacific people, and young people who are particularly represented in the forestry, construction, retail, hospitality and manufacturing industries. This is a shared responsibility and industry need to play their part.
    - There is also potential for HPA to partner with other national organisations (eg, the NZ Drug Foundation and Mental Health Foundation) to develop initiatives that build the resilience of young people who live in hard to reach rural communities. These types of initiatives could be developed and trialled in partnership with regional economic development approaches eg, the Provincial Growth Fund.
- E-therapy coaching tools.
    - HPA is exploring an e-therapy coaching tool developed and piloted in Canada by Dr Simon Hatcher, University of Ottawa Institute of Mental Health Research, to support the National Depression Initiative (NDI) online self-help tool, The Journal. E-coaching has the potential to reduce primary care demand and/or be used as a support to people who are waiting to be referred to a service. Additional investment would allow HPA to trial the effectiveness of e-coaching with some of its existing partners, with a view to rolling this out nationally if deemed successful.
- Asset based community development7 approaches.
    - Approaches that build on the resources that are found in communities and mobilise individuals, community organisations, and institutions to come together to realise and develop their strengths. This approach can be supported through a number of initiatives and services including health champions, connectors and navigators; social prescribing; befriending schemes; and promotion of opportunities for increased civic engagement.
- School based wellbeing programmes.
    - As well as expanding school based health services, HPA recommend the development of programmes and initiatives that support a whole school wellbeing culture. For example, beyondblue, Australia's new national education initiative aims to transform Australia's approach to child and youth mental health care by providing a single end-to-

[7] http://www.nurturedevelopment.org/asset-based-community-development/

end school-based mental health framework. Covering the continuum from early childhood to secondary school, it will support mental health promotion and suicide prevention activity[8].

4. IMPROVING EQUITY

In general, the majority of mental health promotion and prevention activity has taken a universal approach, targeting the whole population. Whilst this approach benefits the general population it risks leaving parts of the population behind and increasing inequity.

In order to address inequities in mental health outcomes, HPA recommends a strengthened focus on universally proportionate approaches that prioritise people and populations that are at higher risk of poor mental health outcomes.

HPA recognise that Māori, Pacific people, youth, LGBTIQ communities, and people from lower socio-economic groups experience poorer mental health outcomes than the general population. While some targeted resources and local community initiatives are available for these groups, there is much more that could be done. For example, differences between Pacific peoples found in HPA research suggest diversifying what 'culturally appropriate' health promotion looks like for Pasifika to ensure the wide range of Pacific peoples and Pasifika identities, values and worldviews are recognised and reached by initiatives.

As well as targeting populations that experience poorer mental health outcomes, there is a need to target individuals to positively influence mental health outcomes by providing earlier and more effective responses for youth and adults who are at risk or involved with social, justice, or forensic mental health and addiction services.

Equity must also include new approaches to address the physical health disparities that exist between people who experience mental distress and addictions and people who don't. People with experience of mental distress and/or addiction die much earlier than their counterparts in the general population, with a two to three time's greater risk of premature death, two-thirds of which is due to cardiovascular disease, cancer and other physical illnesses. At a systems level, improved integration between mental health and physical health services is needed. At an individual level, interventions that integrate personalised support for smoking cessation, increasing physical activity, improving nutrition and general wellbeing are needed[9].

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[8] https://www.beyondblue.org.au/about-us/about-our-work/childhood-and-education-program/the-beyondblue-national-education-initiative

[9] EquallyWell (https://www.tepou.co.nz/initiatives/equally-well-physical-health/37)

5. SUPPORTING GOOD MENTAL HEALTH AND WELLBEING

The primary focus of the National Depression Initiative (NDI) is currently on increasing awareness, encouraging help seeking, online self-help and sign-posting to support services. While this is proving highly successful, a recent survey undertaken by HPA showed that 95% of people (97% Māori and 95% Pacific) who visited depression.org.nz found it useful and 88% of people (91% Māori and 86% Pacific) who visited thelowdown.co.nz found it useful. The NDI is well place to broaden its scope and lead a national approach to the promotion of good mental health and wellbeing (as opposed to just the absence of illness) in order to raise awareness of the habits and skills that help people keep good mental health.

Empowering individuals, family, whānau and communities by giving them the knowledge, skills and tools to increase their psychological and emotional resilience will contribute to the collective wellbeing of New Zealand as a society and to the prevention of mental ill-health. Programmes that promote and teach people the skills to improve their mental and emotional wellbeing (health-literacy) and increase their ability to weather life's storms (self-care) have been proven to be effective.

There is a key role for HPA to continue to develop national mass communication strategies to change the landscape (social norms) backed up with digital tools to support behaviour change, and supported by local resources and initiatives. There is also a need to continue to raise awareness of the available mental health care pathways, including the national NDI websites, with a particular focus on Pacific people who HPA research shows have a low level of awareness of available support options.

6. DISCRIMINATION, STIGMA AND SOCIAL EXCLUSION

Work to enhance social inclusion through national efforts to reduce stigma and discrimination is still very much needed. HPA recommends continuing and refreshing of the *Like Minds, Like Mine* programme, with consideration given to incorporating addiction into the programme.

HPA support the recommendations outlined in *Social Inclusion and Exclusion, Stigma and Discrimination, and the Experience of Mental Distress (Gordon et al, 2017)*, New Zealand's most recent research in this area, including:

- Retain youth, Māori and Pasifika as priority audiences and tailor approaches to address their specific needs
- Establish a programme to support people to address self-stigma and self-exclusion
- Retain workplaces as a focus
- Consider adding sports teams and clubs, government agencies, health care services, and professionals as priority audiences
- Consider the appropriateness of the continued use of 'illness' throughout the programme

HPA research has also shown that people were more likely to report experiencing social exclusion if they are younger, female or gender diverse and therefore more targeted approaches to these groups should be considered[10].

A key component of reducing stigma and discrimination is reframing the language that we currently use. Language is powerful and can inadvertently add to stigma (including self-stigma), discrimination and social exclusion. We have an opportunity to change this and to promote language that shifts us from an illness focused, deficit based paradigm to one that promotes inclusion, respect, and wellbeing.

Supporting this paradigm shift, HPA research has found that peoples' definition of *mental distress* (as opposed to *mental illness*) goes beyond standard medical definitions of depression and anxiety to include feeling isolated, overwhelmed by stress and not able to cope[11]. Traditional labels such as depression, anxiety and mental illness do not capture the extent of mental distress and poor wellbeing. Moving away from such labels may help reduce stigma and make it easier for people experiencing distress to talk about their difficulties and seek support.

7. DIGITAL SOLUTIONS

Digital channels offer the sector potential to better reach and engage with those who are not currently engaged with mental health or wellbeing services or information, including priority audiences and communities most at risk.

How New Zealanders gather information and utilise services in their daily lives is shifting exponentially in an evolving digital world. In order to truly democratise health services – making health care services and systems operate within the context in which people live their lives, rather than solely in the domain of health professions dispensing health care – will require more integrated and sophisticated digital solutions. This means shifting our thinking beyond, eg, building a 'mental health portal', and expecting people to go there, to constructing a multi-dimensional digital ecosystem, with choices and personalised services that can be part of our daily lives.

A tiered level of services, within an ecosystem, would best enable us to deliver digital services across a spectrum of client needs. At one end of the spectrum, this may include core delivery of health promotion, wellbeing and early-intervention services. At the next level, it could provide digital 'concierge' and 'triage' services to enable choice and redirect clients to the support or service they need, whether that is digital, local face-to-face services or more intensive professional care. Another tier of services may enable community coaches and augment professional care, enabling check-ins and self-care between appointments.

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[10] Wellbeing and Mental Distress in Aotearoa New Zealand: Snapshot 2016 (HPA, February 2018)

[11] Wellbeing and Mental Distress in Aotearoa New Zealand: Snapshot 2016 (HPA, February 2018)

All of these initiatives may have significant positive impacts on both individual health and the health workforce - enabling those that are able to help themselves and others at an earlier stage; whilst professional and clinical services are more accessible and available for those most in need.

The digital solutions HPA are currently exploring include:

- 'Gateway' services: Opportunistic wellbeing screening and brief intervention tools that also offer a 'gateway' to other health services. These reach people on the channels they are using everyday – social media, message and search services - and provide insight and self-awareness.
- 'White labelling': A set of syndicated self-help tools and products, including chatbots and applications, that can be provided unbranded to range of front-line health and social services for reuse with their clients and communities. For example, HPA is currently trialling and evaluating Quitbot, a digital smoking cessation tool targeting priority populations.
- E-coaching: The Journal is New Zealand's free online depression and anxiety self-help programme. HPA is exploring the adaptation of e-coaching modules, which would enable community, family or whānau members to coach those completing the programme.
- Concierge and triage tools: Concierge tools offer the ability to ask people increasingly complex questions to direct them to the services that best meet their needs including (geo-targeted) local services and 'wellbeing' services other than health, eg, a gardening group, social club and/or financial advice. They could offer a personalised 'information service prescription' to people.
- Cognitive tools and artificial intelligence: Chatbots and 'virtual advisors' have the potential to deliver a spectrum of services and enable personalisation. An immediate application of these could include the development of 'concierge' services. Machine learning can potentially aggregate and structure our extensive and disparate range of information, such as websites, and enable its selective reuse by government and private industry, such as in software development.

8. ALCOHOL POLICY

Internationally, price, availability and advertising are recognised as the three most effective policy levers to address alcohol harm. The Sale and Supply of Alcohol Act 2012 (the Act) did not materially change price, availability or advertising settings, which remain far from what is known to be effective evidence-based policy. Instead, the Act more generally aimed to refocus regulation on reducing harm, and, through the introduction of local alcohol polices, aimed to give communities more control over outlet density in their local area.

In practice, communities do not feel they have more say, and overall, outlet density continues to increase. Increased availability of alcohol is positively linked to increased consumption, and increased consumption is linked to increased harm, including harm to both mental and physical health.

Healthy and resilient communities are those communities with a low prevalence of risk factors and a high prevalence of protective factors. There are both risk and protective factors that influence the likelihood of harm from alcohol. Risk factors include unemployment, having a high sense of disconnection from other people, trauma, mental distress, and lack of hope. Protective factors include the development of recreational activities like sport and hobbies, positive relationships with parents, family members and other role models, being engaged in a school or community environment, and spiritual beliefs. These factors can all help minimise risky behavior around alcohol and other drugs as well as improving mental wellbeing.

It is difficult to envision reversing the trend of increasingly available alcohol (in both number of outlets and increasing relative affordability), and thereby reducing alcohol harm, without meaningful changes to price and availability settings as set out in *Trends in Affordability of Alcohol in New Zealand (HPA, April 2018)* and HPA's submission to the Select Committee on the Sales and Supply of Alcohol[12]

In addition to lowering harm through reduced availability, hazardous drinking must become less socially acceptable. Restrictive alcohol advertising and sponsorship (particularly of sport) policy settings are best placed to both kick start and maintain drinking culture change. As with availability, such change would require legislation.

Beyond law change, a range of audiences, particularly youth, are telling us that they want holistic, positively framed help to be their best selves, and that they want input into the design of their own locally relevant behaviour change programmes. While there remains a place for national alcohol-specific campaigns, there is an opportunity to develop a new stream of initiatives that showcase positive stories and the motivations behind them. Integrating national campaigns and local initiatives would be the best approach. A more resilient New Zealand depends on doing more to both limit the availability of alcohol, and equip communities to share and build on their successes.

RECOMMENDATIONS TO SUPPORT THE DEVELOPMENT OF A CENTRALISED, CUSTOMISED AND DEMOCRATISED WELLBEING SYSTEM

In order to support the transformation of the current mental health and addiction system to a wellbeing system that gives greater priority to health promotion, prevention and early intervention, a number of system changes will be needed. Government policy and legislation, local funding systems, performance measures and accountability mechanisms will all need to be reengineered to enable and incentivise a wellbeing approach. This could include:

[12] Submission to the Governance and Administration Select Committee on the Sale and Supply of Alcohol (Renewal of Licenses) Amendment Bill (No 2)

- The development of local integrated or pooled budgets and governance arrangements across mental health, addictions, social services, iwi/hapū, corrections, education and housing
- Application of the principles and processes of successful cultural models such as tangihanga and pōwhiri; and funding models such as whānau ora
- The development of national system level measures and health targets for improved mental health and wellbeing outcomes and reduced inequities
- The development and promotion of language that shifts us from an illness focused, deficit based paradigm to one that promotes inclusion, respect, and wellbeing
- The requirement for District Health Boards to develop integrated local wellbeing strategies and annual plans
- The development of a health and social sector workforce wellbeing competency framework, supported by training and digital tools
- Further investment in national wellbeing awareness and social marketing campaigns that support local community activity
- Investment in a national consumer organisation to support people with lived experience to take a formal role in the national and local planning, funding and delivery of services, policy development and legislative change
- Further investment in community led social change, supported by national evidence based toolkits, guidance and resources for local planners, funders and community organisations.

Health Promotion Agency - Research

Information for the Government Inquiry into Mental Health and Addiction

April 2018

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KEY POINTS

Mental health and wellbeing:

- HPA endorses the development of a whole-of-population approach to promoting wellbeing and preventing or alleviating mental distress. HPA has developed a health promotion wellbeing framework to guide research and understanding of risk and protective factors associated with mental health across a range of social determinants.
- People of all ages experience isolation, but our research shows that it may be a particular issue for young people (15 to 24 years) with over half reporting some level of isolation.
- Many people (1 in 3) with lived experience of mental distress continue to experience discrimination and/or alter their behaviour out of fear of discrimination.
- Māori (38%) were more likely than non-Māori (27%) to rate their last year as being among their most difficult ever (survey conducted in 2016).
- Pacific peoples are a diverse population and mental health outcomes and connection to culture varies considerably within Pacific populations, particularly when multi-ethnic Pacific peoples' identity is considered.

Alcohol - ease of access:

- All major alcohol types, but particularly wine, have become increasingly affordable since the 1980s.
- High numbers and density of alcohol outlets is associated with a range of harms, including violence and crime, alcohol consumption and other alcohol-related harms.
- Restricting the hours when alcohol can be sold at on-licensed premises can reduce alcohol consumption, violent crime and a range of other alcohol-related harms.

Alcohol - cultural attitudes:

- New Zealand has several surveys that regularly measure cultural attitudes to alcohol. Significant results include the following:
    - 13% of adult respondents (25 years and over) agreed that "Drunkenness is acceptable in some situations", compared with 24% of 15 to 17-year-olds and 34% of 18 to 24-year-olds.
    - 16% of adult respondents (25 years and over) agreed that "It's OK to get drunk as long as it's not every day", compared with 33% of 15 to 17-year-olds and 43% of 18 to 24-year-olds.
    - Nearly 40% of adults agreed that it is difficult to go easy when drinking with friends.

Gambling harm:

- Three ethnic groups (Māori 14%; Pacific 15%; Asian 11%) were more likely to experience some degree of individual gambling harm compared with the European/Other ethnic group (4.6%).
- In 2016, 186,000 New Zealanders reported experiencing some degree of gambling harm.

Tobacco control:

- The 2016 ASH Year 10 survey of about 30,000 students show that daily smoking prevalence is higher for Māori students (5.3%) and Pacific students (3.2%) compared to 1% for New Zealand European students.
- People with mental disorders have a higher rate of smoking than the general population (Oakley Browne, Wells & Scott, 2006).
- People living in the most deprived areas are more than three times as likely to be daily smokers as those in the least deprived areas (Ministry of Health, 2018).

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1. CONTEXT AND HPA ROLE

Our research input covers four topic areas (mental health and wellbeing, alcohol, tobacco control, gambling). Because of HPA's specific alcohol-related functions, our input on alcohol is more detailed than on other topic areas.

HPA's functions and duties under the New Zealand Public Health and Disability Act 2000 are to lead and support activities that promote health and wellbeing, and to prevent disease, illness and injury. Specific alcohol-related functions are to:

- give advice and make recommendations to government (and others) on the sale, supply, consumption, misuse and harm of alcohol
- research the use of alcohol in New Zealand, public attitudes towards alcohol and problems associated with the misuse of alcohol.

As well as this specific role in alcohol, HPA undertakes a range of research activities that inform our work and others in the sector:

- HPA undertakes research into mental health to support the Like Minds, Like Mine and National Depression Initiative programme delivery.
- HPA is the national lead to monitor smoking prevalence and to inform policy and intervention development.
- HPA collects and reports on population data relating to gambling and gambling-related harm.

Regular surveys and data dissemination

Given our role, HPA delivers several nationwide surveys:

- The New Zealand Mental Health Monitor. A nationwide face-to-face survey (ages 15 years and over) that provides information on social connectedness and isolation, coping and stress, life satisfaction, knowledge of depression and anxiety (including help-seeking and behaviour), attitudes towards people experiencing mental distress (using measures of stigma behaviours and stigma in the community) and experience of mental distress and/or mental illness (depression, anxiety and psychological distress).
- The Health and Lifestyles Survey. A nationwide face-to-face survey (ages 15 years and over) that provides reliable estimates about several different topics including mental health, alcohol, tobacco control, and prevalence of gambling and gambling-related harm.
- The Attitudes and Behaviour towards Alcohol Survey. This collects information (from those aged 15 years and over) on behaviour and experiences of drinking alcohol together with attitudes towards alcohol use.

- The ASH Year 10 Snapshot. A collaboration between HPA and ASH (Action for Smokefree 2025). It is an annual national survey about smoking behaviour and attitudes, collected from about 30,000 Year 10 school students (aged 14 to 15).

- The Youth Insights Survey. A biennial survey of Year 10 students that collects information on youth lifestyle behaviours and attitudes relating to tobacco use, other risk behaviours, and personal interests. It is conducted alongside the ASH Snapshot.

- New Zealand Smoking Monitor. HPA conducts on-going monitoring of current smokers, and smoking quit-attempters. As it is a continuous monitor, new questions can be added on emerging issues very rapidly, to inform policy and/or assess the impact of policy changes or other interventions.

In addition, HPA developed and maintains the Tobacco Control Data Repository – a publicly available online clearinghouse of tobacco-related data in New Zealand. This includes interactive access to numerous datasets including census data, cancer mortality, a range of tobacco survey data, and administrative data.

MENTAL HEALTH AND WELLBEING

SCOPE

The focus of our brief includes research related to the wider social and economic determinants and risk or protective factors that contribute to mental health and addiction inequities. Specifically, we comment on evidence (mainly from HPA) related to the public's understanding of mental distress, isolation and social connectedness, experience of discrimination, the importance of within-Pacific ethnic differences, and early exploration of information on Māori cultural connectedness.

HPA has developed a Wellbeing Framework (see Appendix A for HPA's wellbeing framework logic model) that guides how we consider and examine issues and risk and protective factors, across a range of health behaviours, including mental health and addictions. The framework is informed by Māori and Indigenous views of mental wellbeing (Durie, 1998, 1999) that recognise the interdependence of good mental health with good physical, social, cultural and spiritual health.

The majority of the research highlighted here is based on nationally representative population surveys - the 2015 and 2016 New Zealand Mental Health Monitor and the 2016 Health and Lifestyles Survey.

MENTAL HEALTH AND MENTAL DISTRESS

The public's understanding of mental distress

Mental health problems are experienced on a spectrum from mental distress to enduring psychiatric illness. Prevention work is focused more at the mental distress end of the spectrum. HPA's research (Kvalsvig, 2018) has found that people living in Aotearoa New Zealand hold a broad view of mental distress. Besides associating mental distress with mental illness or mental health conditions, their understandings also include not coping or feeling overpowered, feeling stressed or under pressure, isolation, and trauma.

Isolation and social connectedness are important to wellbeing and mental health

Research shows that feeling isolated is strongly associated with mental distress and poor mental health outcomes (VanderWeele, Hawkley & Cacioppo, 2012; Kvalsvig, 2018; Russell & Kvalsvig, 2018). HPA research shows isolation is strongly positively associated with depression, anxiety and mental distress, and negatively associated with life satisfaction (Kvalsvig, 2018).

The Inquiry's Terms of Reference (ToR) recognise the importance of social isolation (or loneliness) as a risk factor for mental health and wellbeing. While older people and rural communities experience isolation (as mentioned in ToR) HPA's research suggests that other population groups, and in particular young people are also of concern (Kvalsvig, 2018):

- All age groups report some level of feeling isolated but HPA's research suggests the proportion of reported isolation decreases with age.

- Young people (aged 15 to 24 years) reported higher levels of isolation than any other age group. For example, over half of 15 to 24-year-olds reported experiencing some level of isolation during the past month, compared with 22% of 75+ year olds.

- In addition, 17% of young people (aged 15 to 24 years) reported both feeling isolated and that the things they did were not worthwhile, and in addition, they were seven times more likely than their peers to report moderate or higher level of depression. Similarly, 15% reported feeling both isolated and that they were not able to cope with every day stress, and young people in this group were 16 times more likely than their peers to report moderate or higher level of depression.

- Overall, 1 in 10 young people (aged 15 to 24 years) reported thoughts that they would be better off dead or about hurting themselves.

HPA research also shows (Kvalsvig, 2018):

- People who identify as LGBTI are more likely to report feeling some degree of isolation (62%) than non-LGBTI people (39%).

- People who identify as Māori (48%), Pacific peoples (47%) and Asian people (47%) are more likely to report feeling some degree of isolation than other ethnicities (37%).

- Māori who have experienced mental distress at any point in their lives are significantly more likely than Māori without such experience to report social isolation (69% versus 36%) or exclusion (45% versus 26%) (Russell & Kvalsvig, 2018).

- Being able to cope with stress, agreeing that the things you do are worthwhile, and family/whānau are doing well are positively associated with high life satisfaction. Personal experience of mental illness, experiencing difficult times and feeling isolated are negatively associated with high life satisfaction.

Research (non-HPA) provides reasons for the social isolation of Māori who experience mental distress, including multi-levelled discrimination from all sectors of society, and the effects of colonisation (Peterson, Pere, Sheehan & Surgenor, 2004; McFarlane-Nathan, 1994). Qualitative research has found that Māori with lived experience of mental distress who have also experienced social exclusion compounded by colonisation, racial discrimination and cultural disconnection, gain a sense of belonging through reconnection with tikanga Māori, whānau, iwi and hapū (Gordon, Davey, Waa, Tiatia & Waaka, 2017).

HPA research also shows (Russell & Kvalsvig, 2018):

- Māori are significantly less likely to report social isolation when whānau relationships are strong and they can both give and receive support.

- Māori who find it easy to provide help to others in need are significantly less likely to report feeling socially isolated.

- Māori who feel able to rely on a friend or whanaunga for support are significantly less likely to experience symptoms of psychological distress.

Mātauranga Māori has long recognised the importance for wellbeing of being able to practice reciprocity, to manaaki others, and to ensure whānau and other social relationships remain intact through whanaungatanga. Such Kaupapa Māori approaches to mental health (referred to in the ToR of the Inquiry) have underpinned Kaupapa Māori mental health service delivery for decades.

Social isolation and social exclusion are also both significantly associated with Pacific peoples' mental distress (Ataera-Minster & Trowland, 2018).

Disparities in mental health continue to exist between Māori and non-Māori

The Inquiry's ToR acknowledges the disparities and inequalities in Māori mental wellbeing and outcomes, and that Māori are more likely to experience depression, anxiety or psychological distress, than non-Māori. In addition to the findings in relation to isolation (described above), HPA research (Russell & Kvalsvig, 2018) shows Māori (38%) were more likely than non-Māori (27%) to rate their last year as being among their most difficult ever (survey conducted in 2016). Almost a quarter (24%) of Māori whose last year has been particularly tough also indicated they were not coping with every day stresses of life.

Pacific mental health: outcomes, diversity and literacy

Pacific peoples experience mental distress at higher rates than non-Māori and non-Pacific people. HPA research (Ataera-Minster & Trowland, 2018) shows that mental health outcomes and cultural connectedness vary within Pacific populations when multi-ethnic Pacific peoples' identity is considered. For example:

- Reporting ever personally having an experience of mental illness was higher for multi-ethnic Pacific/Other[1] people (36%) than sole-Pacific people (12%) (those who identify with just one ethnic group).

- Reporting ever personally being diagnosed with a mental illness was higher for multi-ethnic Pacific/Other people (26%) than sole-Pacific people (3%) or multi-ethnic Pacific/Māori people (5%).

- Sole-Pacific peoples (93%) reported significantly stronger connection to culture than multi-ethnic Pacific/Other peoples (56%) or multi-ethnic Pacific/Māori peoples (69%).

- The three Pacific ethnic groups (Cook Islands Māori, Niueans and Tokelauans) who have constitutional rights as Aotearoa New Zealand citizens were less likely to agree that feeling strongly connected to their culture was important (64%), than the two Pacific ethnic groups (Samoan and Tongan) who do not have Aotearoa New Zealand citizenship (90%).

Poor mental health literacy also means a significant proportion of Pacific peoples do not know where to go for help for mental distress. HPA research (Ataera-Minster & Trowland, 2018) showed

[1] Pacific/Other refers to a respondent with multiple ethnicities where one ethnicity is Pacific and the other ethnicity is neither Māori or Pacific.

that almost one-quarter (24%) of Pacific peoples report they do not know where to go for help for anxiety, and 15% of Pacific peoples report they do not know here to go for help for depression. It is unclear if this may be because they do not know what services are available to them or because the current services do not fit their needs.

CULTURAL CONNECTIONS AND MĀORI MENTAL WELLBEING

HPA's wellbeing framework includes the value of cultural connectedness as being potentially important for Māori and Pacific mental health and wellbeing. Cultural connectedness is considered a pathway for social inclusion for Māori: reconnecting with whānau, iwi, hapū, and tikanga Māori is a way to address the disproportionate social exclusion Māori experience (Gordon, Davey, Waa, Tiatia & Waaka, 2017). Research (non-HPA) has also shown a strong correlation between connectedness and the mental wellbeing of Māori, supporting the notion that strengthening and maintaining cultural relational ties, networks and whānau connections is significant, including in the prevention of suicide (Dallas-Katoa, Varona, Dallas, Kipa & Leahy, in draft; Russell, in draft; Hudson & Hughes, 2007; Pere, 2006; Kingi, 2002). A range of therapies are premised on the belief that ready access to culture and the sense of belonging or whanaungatanga that connection to culture brings are vital for mental wellbeing. These therapies have a focus on cultural reawakening (Durie, 2011).

The establishment of a positive cultural identity is similarly regarded by Indigenous peoples, including Māori and Pacific peoples. Research (non-HPA) supports the understanding that a strong cultural identity is protective for mental health and suicide prevention (Dee, 2016; Mila Schaaf, 2011, 2013; Pere, 2006; Durie, 2001; Edwards, 1999).

HPA research to date in this space has not examined direct relationships between cultural connectedness and mental health outcomes. However, we have some research examining links with isolation and what factors relate to cultural connectedness. For example, we found that having visited their ancestral marae, being able to speak te reo Māori well, and whether they felt strongly connected to their culture was not related to social isolation. However, Māori with greater knowledge of their pepeha (able to identify six aspects: iwi, hapū, maunga, awa or moana, waka, and tīpuna) were significantly less likely to report feeling isolated than those who can only identify some aspects of their pepeha (Russell and Kvalsvig, 2018).

Although the majority (over 90%) of Māori report that being involved in things to do with Māori culture is at least somewhat important to them, HPA's findings also show some need help with cultural reconnection:

- 1 in 10 (10%) Māori who think it is important to be involved in things to do with Māori culture do not feel connected to their culture.
- 1 in 5 (20%) rangatahi Māori (aged 15 to 24 years) feel this way.

EXPERIENCE OF DISCRIMINATION

Previous (non-HPA) research has identified the extent of discrimination experienced by people with lived experience of mental distress and illness (Peterson, Pere, Sheehan & Surgenor, 2004).

HPA research shows (Kvalsvig, 2018):

- Awareness of mental distress in themselves or others is strongly associated with more positive attitudes towards mental distress, illness and people with lived experience. For example, people who had experience of working with someone with mental distress were more willing to do so in the future, than those without.
- People were more likely to report experiencing social exclusion if they were younger, female or gender diverse.
- A third of those diagnosed with a mental illness (the wording used in the question) report experiencing discrimination and/or altering their behaviour out of fear of discrimination.
- Workplace, family and friends, and health services are the most common reported settings for discrimination (but of course, these settings may also be the most common for interactions).

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2. ALCOHOL RESEARCH

SCOPE

This paper provides an overview of alcohol research, focusing on evidence related to the risk factors '**ease of access** and **cultural attitudes to alcohol**' that were identified in the Inquiry's ToR. Alcohol screening and brief intervention (SBI) will be discussed in input HPA will supply separately and later.

We have not provided an overview of the New Zealand statistics that demonstrate the levels and inequalities inherent in hazardous alcohol use, harms from drinking alcohol and addiction outcomes[2] as we assume that this information is well-known. Similarly, we have not summarised the evidence on the association between mental health and alcohol misuse, as this has already been established in the ToR. Previous work commissioned by the Alcohol Advisory Council (ALAC) of New Zealand has also described this issue (Mental Health Commission & Alcohol Advisory Council, 2008; Wells, Baxter, & Schaaf, 2007). We have focused on highlighting factors where there is significant international and New Zealand evidence for effectiveness in reducing alcohol consumption and alcohol-related harm, as well as providing more detail on relevant HPA research.

BACKGROUND AND CONTEXT

A range of factors can increase access to alcohol. These include price and affordability of alcohol, alcohol outlet density,[3] hours of sale of alcohol, alcohol advertising and sponsorship, and social supply of alcohol.[4] These factors were discussed in the Law Commission's report *Alcohol in Our Lives: Curbing the Harm* (New Zealand Law Commission, 2010), which reviewed the regulatory framework for the sale and supply of alcohol in 2010.

Recommendations from the Law Commission's report informed the development of the Sale and Supply of Alcohol Act 2012 (SSAA). However, not all of the recommendations to reduce alcohol-related harm by addressing these factors that increase access to alcohol were implemented.

Two subsequent reports were completed to consider whether further changes were needed, besides those included in SSAA. The Ministerial Forum on Alcohol Advertising and Sponsorship was established in 2014 to consider whether further restrictions on alcohol advertising and sponsorship were needed to reduce alcohol-related harm, particularly in young and vulnerable people. The Forum recommended a range of restrictions to alcohol-related sponsorship and advertising, as well as strengthening regulation (Ministry of Health, 2014). To date, there has been no government response to these recommendations.

[2] For more information on these, see http://www.healthspace.ac.nz/maps/maps_Alcohol.html and https://minhealthnz.shinyapps.io/nz-health-survey-2016-17-annual-data-explorer/

[3] Alcohol outlets include both off-licensed and on-licensed premises. Off-licensed premises can only sell alcohol for consumption away from (off) the location where it is sold (eg, supermarkets and liquor stores). On-licensed premises can sell alcohol to be consumed at the location where it is sold (eg, pubs, bars).

[4] Social supply of alcohol is defined as the supply of alcohol from parents/guardians, friends and others to those under the minimum purchase age of alcohol of 18 years.

Also in 2014, the Ministry of Justice reported on an investigation into the effectiveness of a minimum pricing regime (Ministry of Justice, 2014). Overall, this concluded that any price increase would effectively reduce harmful alcohol consumption and alcohol-related harm. Subsequently, the Ministry of Justice recommended that a minimum price for alcohol not be considered for five years, to allow the impact of SSAA to be assessed and to learn from the experiences of other countries that are introducing minimum pricing (eg, Scotland).

EASE OF ACCESS TO ALCOHOL

Price and affordability of alcohol

Raising the price of alcohol is a highly effective measure to reduce alcohol consumption and alcohol-related harm (Babor et al., 2010; Burton et al., 2017; Casswell, Huckle, Wall, & Yeh, 2014; Jiang & Livingston, 2015; Wagenaar, Salois, & Komro, 2009; Wagenaar, Tobler, & Komro, 2010; World Health Organization, 2010). This is particularly effective for young people, who are more likely to reduce harmful alcohol consumption with an increase in price. The price of alcohol can be raised through increased taxes on alcohol (eg, excise tax and/or levies), minimum pricing of alcoholic products, or other measures (eg, restrictions on discounted beverages, promotions and multi-sales).

The Law Commission review noted that alcohol had become more affordable from 1989 to 2008 (New Zealand Law Commission, 2010). HPA has investigated trends in alcohol affordability[5] up until 2017 (Health Promotion Agency, 2018b). This shows that all major alcohol types, but particularly wine, has become increasingly affordable since the 1980s. Wine was over 50% more affordable in 2017 than in 1989. Translating this into how much time an employed person on a median income would need to work to earn a standard drink in 2017, it would take only 2.1 minutes to earn an averagely priced standard drink of cask wine[6] (and 1.6 minutes to buy a discounted one).

Alcohol outlet density

Alcohol outlet density refers to the number of licensed premises within a geographical area. International evidence generally shows that high outlet density (where there are a large number of licensed premises in an area) is associated with a range of harms, including violence and crime, and other alcohol-related harms (Babor et al., 2010; Campbell et al., 2009; Livingston, Chikritzhs, & Room, 2007; Popova, Giesbrecht, Bekmuradov, & Patra, 2009). The effect may vary depending on type of outlet, type of area/population and level of area deprivation. In New Zealand, there are two existing mechanisms to reduce alcohol outlet density, through appealing against individual licences on an individual basis, and through development of Local Alcohol Policies by councils that restrict the number of licences in certain areas.

[5] Alcohol affordability is the price of alcohol relative to income, combining price and income data to create a measure of an 'average' person's ability to buy (and consume) alcohol. Alcohol affordability increases as prices of alcoholic beverages drop and/or if average incomes go up.

[6] Cask wine is the most affordable type of alcohol in New Zealand.

New Zealand research also finds an association between alcohol outlet density and crime (including research funded by HPA or ALAC) (Cameron et al., 2012; Cameron, Cochrane, Gordon, & Livingston, 2013, 2016a, 2016b; Cameron, Cochrane, & Livingston, 2016; Day, Breetzke, Kingham, & Campbell, 2012). The most recent study, using a more robust methodology than many others in this field, found a significant relationship between the number of off-licensed premises and crime, with an additional off-licensed outlet associated with 1.2% more violence (Cameron, Cochrane, & Livingston, 2016).

Hours of sale of alcohol

From the international literature, restricting the hours when alcohol can be sold at on-licensed premises can reduce alcohol consumption, violent crime and a range of other alcohol-related harms (Babor et al., 2010; Campbell et al., 2009; Fitterer, Nelson, & Stockwell, 2015; Hahn et al., 2010; Stockwell & Chikritzhs, 2009; Wilkinson, Livingston, & Room, 2016). There is insufficient evidence to assess the impact of restrictions of alcohol sales from off-licensed premises.

In New Zealand, a study in Wellington commissioned by the HPA investigated the relationship between purchases of alcohol from off-licensed premises and alcohol-related harms, by inviting customers from a range of off-licensed premises to participate in a survey at the time of purchase, with a follow-up online survey the next day. Later purchase time (9-11pm) was associated with more reported harms, but not with significantly more 'low-prevalence' harms, which included more serious harms that were only reported by 10% or less of participants (Health Promotion Agency, 2016a).

Alcohol advertising and sponsorship

Alcohol marketing (which includes advertising and sponsorship but also social media marketing) is associated with increased alcohol consumption and misuse in young people and more positive attitudes to drinking (Anderson, de Bruijn, Angus, Gordon, & Hastings, 2009; Babor et al., 2010; Jernigan, Noel, Landon, Thornton, & Lobstein, 2017; Lyons, McCreanor, Goodwin, & Moewaka Barnes, 2017; Ministry of Health, 2014; Smith & Foxcroft, 2009). Alcohol marketing is widespread in New Zealand. For example, a recent analysis of televised sports events found that audiences were exposed to 1.6 to 3.8 alcohol brand exposures per minute (Chambers et al., 2017).

Social supply of alcohol

The supply of alcohol to those under 18-years-old (social supply) is one factor that influences adolescent drinking behaviour and misuse of alcohol. Parental supply is the commonest source of social supply in New Zealand (eg, parents were the usual source of alcohol for 60% of youth drinkers from the Youth 2012 survey (Adolescent Health Research Group, 2013)). Internationally, parental supply is associated with an increase in risky drinking and alcohol-related harms in adolescence, compared to those adolescents who reported no supply, and is also associated with increased risk of other, non-parental, supply of alcohol (Mattick et al., 2018; Yap, Cheong, Zaravinos-Tsakos, Lubman, & Jorm, 2017). Non-parental supply (self-supply and peer supply) is even more strongly associated with alcohol misuse and alcohol-related harm, including dependence (Mattick et al, 2018).

Adolescent misuse of alcohol is associated with a wide range of adverse outcomes, including motor vehicle collisions, injuries and deaths, crime, violence, sexual risk taking, mental health problems and victimisation (Fergusson, D., Boden, 2011). A number of factors are associated both with alcohol use in adolescence and later mental health and/or substance use outcomes. These include socio-demographic factors and family living standards, the nature and treatment of the family environment, including child maltreatment, individual personality factors, and the influence of substance-using peers (Fergusson, D., Boden, 2011; Newton-Howes & Boden, 2016).

A recent report commissioned by HPA on patterns of social supply in New Zealand (Huckle & Romeo, 2018) found that adolescents were commonly supplied alcohol. Among drinkers aged 16 to 17 years, around 90% received alcohol from social sources. The average quantity of supply to those under 18 years was seven drinks, but the usual quantity provided to friends under 18 years was higher (around 12 drinks) than the usual quantities supplied to sons or daughters (around five drinks). The minority of suppliers (eg, 14% of suppliers to sons or daughters in 2015) thought the alcohol they supplied would be shared at least some of the time. There was also some evidence to support an early impact of SSAA on social supply. Between 2013 and 2015, there was a small decrease in the overall frequency of social supply. Friends were less commonly supplied to, were supplied with fewer drinks, and there was a tendency for suppliers to always supervise their social supply to friends.

CULTURAL ATTITUDES TO ALCOHOL

What is ‘drinking culture’ and why might it be important?

While there is no widely accepted definition of the term ‘drinking culture’, the concepts of shared values around the use of alcohol, customs and expectations about drinking (ie, social norms), and social control are central to the meaning of a drinking culture (Savic et al, 2016). Attitudes, social pressure, and informal and formal rules around alcohol are aspects of ‘drinking culture’.

A decline in drinking across a number of countries, in particular among young people that cannot be explained by changes in price, policy or availability, has highlighted the influence of cultural aspects of drinking. There is some evidence of a shift in attitudes towards some aspects of drinking in some cultures; recognising that culture refers not necessarily to a national-level drinking culture, but that norms and social controls around drinking differ across subpopulations, settings, and social and cultural contexts, and change over time (Pennay & Room, 2016; Savic et al, 2016). Evidence of how to affect a change in drinking cultures is less clear. However, acting to influence a shift in drinking cultures at subpopulation levels to reduce alcohol-related harm can complement policy action at the population level.

Key HPA research results about cultural attitudes to alcohol

HPA’s Health and Lifestyles Survey (HLS) and Attitudes and Behaviour towards Alcohol Survey (ABAS) regularly measure New Zealanders attitudes towards alcohol.

Attitudes towards the drinking culture in New Zealand consistently vary by sex, age, ethnicity and risky drinking behaviour (Health Promotion Agency, 2017, 2018a). Overall, 16% of adult respondents (aged 25 years and over) agreed that “It’s OK to get drunk as long as it’s not every

day". Agreement with this statement was higher in younger respondents (33% of 15 to 17-year-olds and 43% of 18 to 24-year-olds), males (compared with females), Māori and Pacific respondents (compared with European/Other respondents), and risky drinkers (compared with non-risky drinkers). Overall, 13% of adult respondents agreed that "Drunkenness is acceptable in some situations". Agreement with this statement was higher in younger respondents (24% of 15 to 17-year-olds and 34% of 18 to 24-year-olds), males, Māori respondents and risky drinkers. By contrast, most respondents (84%) disagreed that "During pregnancy, drinking small amounts of alcohol is OK", and most agreed that "I would encourage a friend or family member to stop drinking completely if she was pregnant" (88%) and "I would encourage a friend or family member to stop drinking completely if she thought there was a chance she could be pregnant" (84%) (Health Promotion Agency, 2016b).

HPA's monitoring of attitudes and experiences relating to the availability and promotion of alcohol shows that support for increasing restrictions on alcohol advertising or promotion seen or heard by people under 18 was high in 2016 (80%). A majority of people also support banning alcohol-related sponsorship of events that people under 18 years may attend (68%) and reducing the hours when alcohol can be sold (57%) (Health Promotion Agency, 2018c).

Other key New Zealand results about cultural attitudes to alcohol

Social pressure to drink in New Zealand is shown by just under 40% of adults agreeing that it is difficult to go easy when drinking with friends (from the Ministry of Transport's annual survey of public attitudes to road safety). This has remained fairly constant since 1996 (Ministry of Transport, 2016).

The legal age for purchasing alcohol is currently 18 years (and has been since 1999). The Nielsen Consumer and Media Insights Survey asks whether "the legal drinking age should be raised". Although New Zealand does not have a legal drinking age, it is assumed that most people who answer this question will be thinking of a legal purchasing age. Support for this has dropped from 67% in 2012 to 49% in 2016 (unpublished data). Unsurprisingly, support for this is higher in older people and lower in younger people.

Indications of attitudes to the current drinking culture from the same Nielsen source in 2016 include:

- Nearly 30% reported "I only buy wine when it is on special", showing the importance of price in purchasing and consumption.
- Just over a quarter reported "I worry about how much alcohol some friends drink".
- 17% reported "I am actively cutting down on how much I drink", showing some level of awareness of the need to minimise alcohol consumption.

- 7% reporting that “Drinking too much is an issue/problem for me”, which equates to 261,000 of the general population (18 years and over).[7]

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[7] Questions were asked of all respondents aged 18 years or older, regardless of drinking status. Results are from the 2016 survey.

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3. GAMBLING RESEARCH

SCOPE

This paper provides an overview of gambling research, focusing on evidence related to issues of both **social determinants and inequality,** and **where the gaps are, and which groups are missing out or being disadvantaged.** We have focused on highlighting factors where there is significant New Zealand evidence for inequity in gambling-related harm.

BACKGROUND

HPA's Health and Lifestyles Survey (HLS) series provides the most robust current data on the prevalence of gambling and gambling-related harm in New Zealand. It has population representative time-series data dating back over 10 years. The most recent HLS gambling report (Thimasarn-Anwar, Squire, Trowland, & Martin, 2018) is the source for all results provided here (unless another source is explicitly given).

KEY FINDINGS

Gambling participation

Approximately 2.7 million New Zealanders gambled in 2016; this translates to seven in ten adults having participated in at least one gambling activity in the past year.

Gambling expenditure

In 2016/17, $2.3 billion was spent on gambling in New Zealand; approximately $870 million of that was spent on gaming machines in pubs and clubs, one of the most risky forms of gambling (Department of Internal Affairs, 2017).

Gambling risk and harm

While gambling harm exists across the population, Māori are significantly more likely to be moderate-risk and problem gamblers than European/Other people.

The Problem Gambling Severity Index (PGSI; Ferris & Wynne, 2001) was used in the 2016 HLS to assess experience of gambling harm. The vast majority of people (95%) were either non-gamblers (30%) or non-problem gamblers (65%). The remaining 5% breaks down as follows: 3.3% were low-risk gamblers (approximately 125,000 people); 1.5% were moderate-risk gamblers, (approximately 55,000 people); and, 0.1% were problem gamblers (approximately 6,000 people). From these data we know that around 186,000 New Zealanders experience some degree of gambling harm.

Risky gambling at any level was associated with both ethnicity and smoking status. Māori (14%), Pacific (15%), and Asian (11%) people were more likely to experience some degree of individual gambling harm compared with European/Other people (5%). Both current smokers (15%), as well as people who have smoked in the past (6%), were also more likely to experience some degree of gambling harm compared with those who have never smoked (4%).

Half (49%) of those who played gaming machines in pubs or clubs at least monthly experienced some harm from their gambling. Over one quarter (26%) of those who bet on sports or racing events at least monthly also experienced some harm.

Second-hand gambling harm

Second-hand gambling harm refers to harm caused by another person's gambling. In 2016, 12% of people reported experiencing someone close to them spending too much time or money on gambling. Both those living in areas of mid and high deprivation, and Māori respondents, experienced greater levels of second-hand gambling harm.

TRENDS OVER TIME

Gambling participation

While past-year gambling participation has decreased over the last decade, the current level of past-year gamblers has remained steady since 2012.

Gambling expenditure

Annual gambling expenditure has been increasing incrementally since 2009/10. Between 2015/16 and 2016/17, there was an increase of $125 million, the largest annual increase since 2009/10 (Department of Internal Affairs, 2017).

Gambling risk and harm

At the population level, the proportion of non-problem and low-risk gamblers has decreased while the proportion of non-gamblers has increased. The levels of moderate-risk and problem gamblers have not significantly changed since 2010. Problem gambling prevalence has not decreased since 2006/07 (estimated at around 0.5% of the population; unpublished data from pooled analysis of 2012, 2014, and 2016 HLS).

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4. TOBACCO CONTROL RESEARCH

SCOPE

This paper provides an overview of tobacco research, focusing on evidence related to issues of both **social determinants and inequality,** and **which groups are missing out or being disadvantaged.** We have not provided evidence of tobacco-related health impacts, as these have been well established internationally. We have focused on highlighting factors where there is significant New Zealand evidence for inequity in smoking rates and opportunities to intervene, and providing more detail on intervention and policy-relevant HPA research.

BACKGROUND AND CONTEXT

The New Zealand government has an explicit policy goal of 'Smokefree 2025', which is generally interpreted as reducing smoking prevalence rates to less than 5%, including among all major population groups. While significant progress has been made toward this goal over the past decade, many inequities remain.

HPA's tobacco control programme targets the most at-risk population groups (ie, Māori and Pacific, in particular Māori women and young people), as well as initiatives to support the wider tobacco control sector. As an evidence-based organisation, HPA is the national lead in conducting a range of research activities to monitor smoking prevalence and to inform policy and intervention development.

INEQUALITY

There is significant ethnic inequality in smoking rates. The general population rate for current smoking is 16%, the rate for Māori is 35% and for Pacific peoples it is 25%. The rates for Māori women are especially elevated at 38% (Ministry of Health, 2017).

This pattern is also reflected in the smoking rates of school children aged 14 to15-years-old. The ASH Year 10 Snapshot is a collaboration between ASH and HPA to survey approximately 30,000 Year 10 students (aged 14 to15 years) annually. The 2017 Snapshot data show that 2.1% of year 10 students smoke daily (ASH, 2018). However, the results show that daily smoking prevalence is higher for Māori students (5.3%) and Pacific students (3.5%).

The available census data indicates that smoking prevalence rises dramatically from age 18. For young Māori, the rate increases from 30% at age 18, to 42% by age 24 (unpublished data for regular smoking).

People living in the most deprived areas are significantly more likely to be current smokers than those in the least deprived areas (27% compared with 8%; Ministry of Health, 2017).

Smoking has been associated with a range of mental disorders including schizophrenia, anxiety disorders and depression. People with mental disorders have been shown to have a higher rate of

smoking than the general population (30% compared with 21% in 2006) (Oakley Browne, Wells, & Scott, 2006).

FORMATIVE RESEARCH

HPA conducts qualitative research such as the recent Tipu Ora study of Māori women's attitudes to smoking (Russell, 2017). Among its useful findings were that young Māori women discounted the health warnings on tobacco packaging and they did not believe the "smoking kills". These and other findings were fed back to the health service provider who collaborated on the project to inform their programme content and service delivery model.

MONITORING

Tobacco Control Data Repository

- HPA developed and maintains the Tobacco Control Data Repository[8] – a publicly available online clearinghouse of tobacco-related data in New Zealand. This includes interactive access to numerous datasets including census data, cancer mortality, a range of tobacco survey data, and administrative data.

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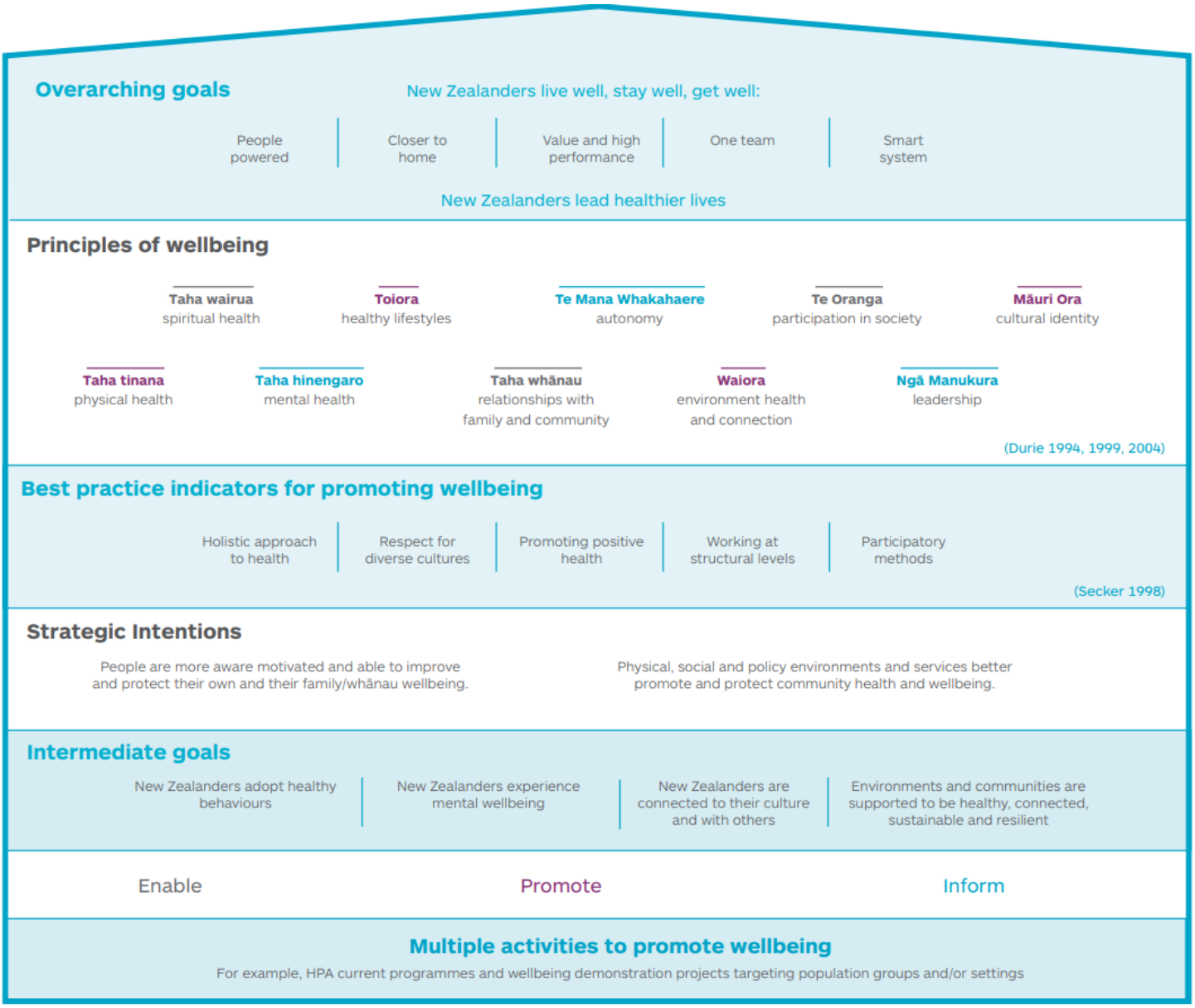
[8] www.tcdata.org.nz

Appendix A: HPA Wellbeing Logic Model



Health Promotion Agency - Programmes

Information for the Government Inquiry into Mental Health and Addiction

April 2018

health promotion agency
TE HIRINGA HAUORA

Contents

ABOUT HPA

HPA has an overall function to lead and support health promotion initiatives to:

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

In addition HPA has alcohol-specific functions to:

- give advice and make recommendations to government, government agencies, industry, non-government bodies, communities, health professionals and others on the sale, supply, consumption, misuse and harm of alcohol as those matters relate to HPA's general functions
- undertake, or work with others, to research alcohol use and public attitudes to alcohol in New Zealand and problems associated with, or consequent on, alcohol misuse.

HPA is funded from Vote Health, the levy on alcohol produced or imported for sale in New Zealand and part of the problem gambling levy.

For more information about the organisation – hpa.org.nz

INFORMATION ON RELEVANT CURRENT SERVICES:

Attached is information on the current programmes we provide relevant to Mental Health and Addiction including:

- Wellbeing
- National Depression Initiative
- Like Minds, Like Mine
- Alcohol – this spans HPA's broader legislative role
- Minimising Gambling Harm
- Tobacco Control – though not specifically covered by the Inquiry, information about the Tobacco Control programme including scope, approaches and effectiveness may have valuable learning for mental health and addiction approaches
- Appended – HPA's Wellbeing Approach that provides a context for activities

Programme name	WELLBEING
Description	HPA has recently developed a wellbeing approach, in response to the NZ Health Strategy and HPA's Ministerial Letter of Expectation for 2016/17 (Appendix A – HPA's Wellbeing logic model). The primary outcome is that New Zealanders lead healthier lives. Strategic intentions are: • People are more aware, motivated and able to improve and protect their own and their whānau's wellbeing • Physical, social and policy environments and services better promote and protect community health and wellbeing. Intermediate goals are that: • New Zealanders adopt health behaviours • New Zealanders experience mental wellbeing • New Zealanders are connected to their culture and with others • Environments and communities are supported to be healthy, connected, sustainable and resilient.
Background	HPA has drawn on the work of Durie[1] to outline 10 principles of wellbeing, which include concepts such as physical health, cultural identity and relationships. These principles, while New Zealand-centric are also grounded in international evidence and best practice. They bring together dimensions that extend beyond mental wellbeing to cultural, community and physical wellbeing.

[1] Durie, Mason (1999), 'Te Pae Mahutonga: a model for Māori health promotion', *Health Promotion Forum of New Zealand Newsletter* 49, 2-5 December 1999.

	In addition, a framework has been developed (Appendix A) that links wellbeing initiatives to both long and medium-term objectives, and helps monitor and measure the health promotion initiatives undertaken by HPA.
Target populations	HPA's initial focus is on: • two population groups – young people (particularly Māori) aged 12 to 24 years and hapū mama/pregnant women • three different settings - workplaces, communities and primary health care.
Key partners	Community groups and organisations relevant to specific projects
Components	These are some examples of current HPA wellbeing initiatives. **Young people (in development)** Development of a wellbeing strategy (co-designed with young people) using a strengths based approach and a youth development focus Specific projects to support youth wellbeing and resilience: Examples include: Help for tough times - provides a quick guide to four New Zealand websites that were especially designed to support young people with issues like anxiety, stress, identity, relationships, and depression. The pocket guide was co-developed for young people by young people. Play your best card – a game/tool for young people (co-designed) to encourage conversations, critical thinking and solution finding for the challenges that face them (currently in final stages of development). **Wahine hapū and tamariki (in development)** *Whaioranga Mokopuna* – HPA has been working in partnership with the National Te Kōhanga Reo Trust on *whaioranga* - or the wellbeing of the mokopuna and whānau - and what this means to Kōhanga Reo whānau. This includes supporting the Trust to develop and deliver wahakura (woven sleeping baskets that allow baby to sleep

	safely in a co-bed sharing arrangement) and wānanga as a mechanism to explore concepts of wellbeing for pregnant women, their babies, and the wider whānau. **Communities** *Kapa Haka Oranga, Rangatahi Oranga* – HPA has been partnering with Te Matatini for many years. Recently we have moved from event-based messaging promoting healthier behaviours towards a partnership where the concept of kapa haka oranga is delivered not just during the bi-annual festival, but as part of a wider understanding of wellbeing owned and led by Te Matatini. This partnership supported the delivery of the traditional concept of manaakitanga (the process of showing respect, generosity and care for others) at both the build up to, and the culmination of, the 2017 Festival. We are continuing to partner with Te Matatini to support the delivery rangatahi development and wellbeing wānanga, as well as to continue to support and promote kapa haka concepts of wellbeing leading up to and during the 2019 Festival. The project is owned and led by iwi and builds on their aspirations and values. **Workplaces** HPA has developed practical health and wellbeing policy content for small to medium sized businesses. This will be launched in May 2018 and hosted on the business.govt.nz innovative workplace policy builder tool. The policy builder tool accompanies the business.govt.nz employment agreement builder which is highly utilised. In 2017 HPA worked with Ministry of Health and Health FamiliesNZ to develop Good4Work.nz to assist small to medium sized business owners to support wellbeing at work. It asks workplaces to rate themselves against 22 statements that cover the essential elements for a positive workplace culture and environment. It then guides them to complete actions.
Evaluations/Reviews	All wellbeing initiatives will be evaluated to ensure they achieve desired outcomes.
Link to related material eg tools/resources/campaign	Good4Work.nz Wellplace.nz

Programme name	NATIONAL DEPRESSION INITIATIVE
Description	The National Depression Initiative (NDI) is part of the Government's ongoing commitment to preventing suicide, along with improving the mental health and wellbeing of all New Zealanders. The NDI programme works to reduce the impact of depression and anxiety on the lives of New Zealanders and for the past 11 years has been improving the mental health and wellbeing of New Zealanders. The objectives of the NDI framework are to: • strengthen individual, family and social factors that protect against depression and anxiety • improve family, community and professional responsiveness to depression and anxiety. **Key strategies** 1. Identify and build on opportunities to create a social and physical environment that protects people from depression and anxiety. 2. Encourage people to recognise and become more responsive to depression and anxiety, including: ○ the importance of early identification and intervention ○ assisting people to recognise symptoms of depression and anxiety in themselves and others ○ encouraging people to seek appropriate help ○ increasing awareness of effective interventions for depression and anxiety, including self-help strategies. 3. Improve the capability of health professionals to respond appropriately to people seeking help with depression and anxiety. 4. Support coordination mechanisms between public health, primary health care and mental health care services, consistent with the objectives of the National Depression Initiative. 5. Support the above with research, monitoring and evaluation.
Background	First launched in 2006, the National Depression Initiative originated from the first New Zealand Suicide Prevention Strategy 2006–2016 (Goal 1: Promote mental health and wellbeing, and prevent mental health problems).

	Operational responsibility for NDI's population health and social marketing initiatives was transferred from the Ministry of Health (MoH) to HPA in 2012 following the establishment of the Crown entity to deliver the Government's health promotion functions. In November 2015, the depression helpline and counselling support services component of the National Depression Initiative became part of the integrated National Telehealth Service which is managed by Homecare Medical. The Ministry of Health retains strategic oversight of the NDI as part of its broader mental health work programme. A strategic governance group that consists of senior staff from HPA and Ministry of Health oversees both the NDI and Like Minds, Like Mine programmes (see below). This group is chaired by the HPA.
Target populations	Individuals, family/whānau, communities, and health professionals. People with signs and symptoms of mental distress. Populations with particular shared challenges: Māori, Pacific, Young People, LGBTI, men, deaf, rural.
Key partners	HPA works closely with Homecare Medical on the NDI and has an Interest Group to provide advice on strategic direction. The Group consists of a wide range of experts from clinicians to Māori and Pacific experts.
Components	**A comprehensive and integrated programme** The NDI is made up of a number of integrated components: the depression.org.nz website that includes an online self-help tool (The Journal), and a youth-focused website The Lowdown (www.thelowdown.co.nz). These tools are supported by a social marketing strategy to encourage help seeking and behaviour change, together with telephone triage and advice, and counselling services for people seeking help for themselves or others. Complementing the public-facing resources and services are support for health partners and engagement with wider sector stakeholders as well as research, evaluation and monitoring.

	Depression.org.nz Both depression.org.nz and thelowdown.co.nz websites and associated resources provide information about depression and anxiety, and where to find help. Fronted by Sir John Kirwan, depression.org.nz aims to support adults at risk of or experiencing depression and anxiety, along with their family and friends. The depression.org.nz website was comprehensively updated with new content and functionality in 2016, including an update to the online self-help tool The Journal, the inclusion of stories from those with lived experience, Māori and Pacific content developed with cultural experts, as well as content for other specific groups such as LGBTI Depression.org.nz had 305,000 New Zealand visitors in 2017 and 11,150 registrations for The Journal. ***Depression.org.nz 'small steps' campaign*** The current depression.org.nz marketing campaign promotes small steps that New Zealanders can take on the path to recovery from depression and anxiety, and encourages help-seeking by visiting the website. The campaign shows simple positive actions people can take such as connecting with others, or examples of physical, creative and sensory steps that people with lived experience have found helpful in managing depression and anxiety. It commenced in August 2017 and includes television advertisements as well as digital advertising and a small steps Facebook page. More information, including the advertisements can be found on the HPA website. **The Lowdown** The Lowdown thelowdown.co.nz was launched in 2007, with a focus on helping young people who may be experiencing depression. The key objectives of The Lowdown are to: • improve help-seeking behaviour • increase mental health literacy

	• reduce stigma. A refreshed Lowdown was launched in 2015 with an expanded scope looking at youth mental wellbeing, life issues, and including a focus on anxiety as well as depression. The site is also device responsive. The Lowdown had 92,000 New Zealand visitors in 2017. Complementing the Lowdown is a Facebook page, which aims to provide 'meme' humour-based posts which link to the life issues young people are facing eg, study stress. It was launched in 2016 and currently has over 33,000 followers. The page has moderation and clinical support. https://www.facebook.com/TheLowdownNZ/ ***The Lowdown 2017/18 Campaign*** The current Lowdown marketing campaign aims to encourage teenagers to start conversations about issues they are facing to help reduce the impact of depression and anxiety, and raise awareness of thelowdown.co.nz as a place to go for help. The campaign includes social media posts, social influencers, digital advertising.
Evaluations/Reviews	KPMG value for money review of the NDI for the Ministry of Health, 2013 https://www.health.govt.nz/system/files/documents/publications/value-for-money-review-ndi.pdf Depression.org.nz and The Journal review conducted by AUT 2016 https://www.hpa.org.nz/research-library/research-publications/review-of-the-national-depression-initiative-the-journal-and-depression-website Internal monitoring through: • Website pop up survey – key results (unpublished) ○ 94% of respondents found depression.org useful (94% all NZ, 97% Pasifika, 94% Māori)

	○ 87% of respondents found The Lowdown useful (87% all NZ, 90% Pasifika, 84% Māori) • Quantitative survey on the Small Steps advertising campaign (2018 Kantar TNS, unpublished) showed: ○ 68% of those surveyed and 78% of these who have experience of depression and anxiety feel the campaign message is an important message to promote ○ 63% of those shown the campaign were motivated by it, where motivation means they have a better idea of ways to manage anxiety and depression and are likely to discuss the campaign with others ○ 68% of those who have experienced anxiety or depression are motivated, which is significantly higher than all New Zealanders ○ 64% of Maori and 70% of Pacific People are motivated by the campaign, in line with all New Zealanders
Link to related material eg tools/resources/campaign	www.depression.org.nz www.thelowdown.co.nz https://www.hpa.org.nz/campaign/depression-org-nz-campaign https://www.hpa.org.nz/programme/mental-health

97% Pacific

Programme name	LIKE MINDS, LIKE MINE
Description	Like Minds, Like Mine is a New Zealand wide programme to counter stigma and discrimination associated with mental illness/distress. It combines community action, a national media campaign and research and evaluation to bring about social change.
Background	The programme is guided by the Like Minds, Like Mine National Plan 2014-2019. The Ministry of Health (MoH) has strategic responsibility for the programme in partnership with HPA. HPA is the lead operational organisation for Like Minds, Like Mine. The Like Minds, Like Mine programme was established in 1997 by the MoH in response to the 1996 Mason Report. It was one of the first comprehensive national programmes in the world to counter stigma and discrimination associated with mental illness. The programme has combined national television and other media and communication activities with community action to bring about social change. In July 2012, some funding for Like Minds, Like Mine was transferred to the HPA to contract services for national advertising, evaluation and coordination, while the MoH maintained funding for local delivery and support. Since 2015 HPA has been the single lead operational agency for Like Minds, Like Mine. Strategic development is supported through a joint MoH/HPA governance group. National coordination and communications for the programme is undertaken by the Mental Health Foundation of New Zealand (MHF) through a Master Services Agreement with HPA.
Target populations	People who have the potential to exclude, particularly in families and whānau, workplace and community settings.

	The groups who will benefit most from our work are those who are discriminated against the most (one or a combination of the below groups): • people with severe mental illness • Māori • Pasifika • young people under the age of 25.
Key partners	Mental Health Foundation Multi-Agency Group (MAG). *Members include:* Office Disability Issues (ODI), Office of Ombudsman (OOTO), Human Rights Commission (HRC), Nga Hau e Whā (NHEW), Balance Aotearoa, Mental Health Foundation (MHF), Office of the Health and Disability Commissioner and Te Rau Matatini Education Fund Providers (see below for description of fund) Global Anti-Stigma Alliance Group (GASA) – HPA is a member of this international group. Seven countries form the core membership of the group share research and advice on best practice for the delivery and implementation of anti-stigma and discrimination programmes for people with lived experience of mental distress.
Components	**Anti-Stigma and Discrimination Education Fund** This fund supports anti-stigma and discrimination education projects in settings where discrimination mostly occurs. The projects are currently for a three year time period, 2018-2020. HPA provides oversight and contract management for these projects. The providers and projects are:

	Mind and Body Consultants Limited, supported by Mahitahi Trust and Vaka Tautua *Social Housing Two + Rethink Education Package* – This project centres on anti-stigma and discrimination education for selected Social Housing Providers ***Mind and Body Consultants Limited, supported by Mahitahi Trust and Vaka Tautua*** *Education Two + Rethink Education Package* - This project centres on anti-stigma and discrimination education for selected Education Providers (secondary, tertiary, alternative). ***University of Otago*** *Psychological Medicine Education* - This project focuses on reducing stigma and discrimination within health settings. ***University of Otago (with Kites Trust)*** *NZ Police anti-stigma and discrimination education* - This project focuses on delivering anti-stigma and discrimination education to Police staff and recruits. ***PeerZone Limited*** *'No Worries' workplaces initiative* - This project is focussed on delivering anti-stigma and discrimination education in workplace settings to a wide geographical area within New Zealand. **Community Grants Fund (***Administration of the fund contracted to Mental Health Foundation)* Established in 2018 to enhance the reach and impact of the Like Minds, Like Mine programme. These grants will enable communities to create and implement local initiatives that reduce stigma and discrimination and increase social inclusion of people with lived experience of mental illness/distress.

	Rakau Raroa (Tall trees) This lived experience leaders' initiative supports the Like Minds, Like Mine programme by training and supporting influencers in their communities. Through sharing stories of distress and recovery, these leaders will challenge assumptions and stereotypes of mental distress and equip people with new tools and understandings of mental distress and the process of recovery. Mentors and facilitators have been recruited and new leaders are currently being recruited across Aotearoa New Zealand. Led by Changing Minds (an Auckland-based NGO), these influencers will be from all walks of life with a special focus on priority communities – Māori, Pasifika, young people and others - and in key settings eg, workplaces, education, and health settings. **Marketing Campaigns** There have been seven national marketing campaigns for Like Minds, Like Mine since 2000 including Step Forward in 2015. A new national marketing campaign run by HPA is under development and will roll out in 2018. The target audience for the new campaign is family, friends and whānau. ***Take the Load off – run by the Mental Health Foundation -*** Launched in 2017 to help support those experiencing mental distress. More information can be found at http://www.taketheloadoff.nz/ ***Website and social media – administrated by the Mental Health Foundation*** The website https://www.likeminds.org.nz/ contains information on the programme for the public. Complementing the website is a Facebook page, which has almost 9000 followers, and posts information relevant to the Like Minds, Like Mine and the mental health sector.
Evaluation/reviews	Like Minds has tracked public attitudes since 1997 and commissioned a cost-benefit analysis of the programme in 2010.[1] The public attitudes surveys demonstrate that attitudes towards people with mental illness in the target group of 15 to 44-year-olds have improved significantly, especially among Māori, Pacific and young people.[2] The cost benefit analysis calculated that Like Minds had cost a total of $52m since its inception. The estimated economic benefits (increased access to employment, hours worked, and increased use of primary care) totalled $720m, or $13.80 for every dollar spent. (from the Like Minds Like Mine Programme 2014-2019) [3]

	1Vaithianathan, R. (2010). *Cost Benefit Analysis of the New Zealand National Mental Health Destigmatisation Programme*. Auckland: UniServices. 2Phoenix Research. (2011). *Impacts of National Media Campaign to Counter Stigma and Discrimination Associated with Mental Illness. Survey 11: Response to fifth phase of campaign*. Auckland: Phoenix Research. 3Vaithianathan, R. (2010). *Cost Benefit Analysis of the New Zealand National Mental Health Destigmatisation Programme*. Auckland: UniServices.
Link to related material eg tools/resources/campaigns	https://www.likeminds.org.nz/

Programme name	MINIMISING GAMBLING HARM
Description	HPA's minimising gambling harm programme contributes to MoH's Strategy to Prevent and Minimise Gambling Harm 2016/17-2018/19. The aim is that government, the gambling sector, communities and families/whānau work together to prevent and minimise gambling harm, and reduce related health inequalities. The programme aims to increase awareness of harmful gambling, get people to check whether their gambling is okay, and motivate people to seek help and take positive action early, both for themselves and for others they care about. The programme is implemented through the national Choice Not Chance campaign; online help and support; working with minimising gambling harm services and wider social services; and creating safer gambling environments and research. Goal: New Zealanders to experience less gambling related harm. Our work currently focuses on the following key areas: • Increasing the number of people at risk who check whether their gambling is okay. • Increasing the monitoring/reviewing of gambling behaviours. • Increasing early self-help/help-seeking behaviours by individuals and concerned others. • Increasing the implementation of harm minimisation practices in gambling venues.
Background	Gambling-related harm is a continuing health issue in New Zealand, with significant health, social and economic implications. While gambling is a popular form of entertainment and some communities benefit from funds raised from gambling, for many people and their families gambling has harmful consequences and the effects on the community can be far reaching.

	Harmful gambling occurs when people, and often their families or communities, experience harm or distress because of gambling. It can affect health, relationships, finances, employment, and the harms from gambling can extend to the entire community. MoH is responsible under The Gambling Act 2003 for the prevention and treatment of problem gambling, and for an integrated strategy focused on public health. This is funded by a levy paid by gambling operators. The Ministry's approach is outlined in the Strategy to Prevent and Minimising Gambling Harm 2016/17-2018/19. This Strategy includes provision for an 'Education and Awareness Programme' to "raise awareness, de-stigmatise the issue and encourage people to seek help" which is delivered by HPA. Link to Strategy to Prevent and Minimising Gambling Harm 2016/17-2018/19: http://www.health.govt.nz/publication/strategy-prevent-and-minimise-gambling-harm-2016-17-2018-19 .
Target populations	Priority audiences include: • at-risk gamblers – particularly those that play Electronic Gaming Machines (EGM/Pokie), Sports Betting, Racing, Māori /Pacific/Asian/low income • people in close contact with at-risk gamblers – those audiences who are concerned about gamblers or can in some way help (e.g. friends and family). HPA priority groups are 18 to 34-year-olds, low socioeconomic population, Māori, Pacific and Asian.
Key partners	Gambling industry Ministry of Health Department of Internal Affairs Minimising Gambling Harm Services who work directly with communities.

Components	**Choice Not Chance** The national Choice Not Chance campaign is informed by concept testing with at-risk Māori, Pakeha, Pacific and Asian gamblers. It recognises that gambling harm is often hidden and can escalate quickly. In addition, many people may have never contemplated whether their gambling could be having negative consequences for themselves or their loved ones. This campaign takes a preventative approach. It targets at-risk gamblers and aims to (1) motivate more people who are at risk to check whether their gambling is okay before harm escalates in severity, and (2) motivate more people who are at risk to get help earlier (or change their behaviour through self-help). The campaign prompts people to reflect on their situation and check whether their gambling is okay by taking an easy quiz at ChoiceNotChance.org.nz Once the quiz has been completed, people are provided with a summary of their situation and are offered a range of relevant digital self-help information/tools, as well as avenues for professional help through the Gambling Helpline and/or face-to-face support services. The campaign's central message is "Gambling can start out as #Fun, but there is a point for everyone where it can become #UnFun." This strengths-based message has been found to resonate well with the target audiences. https://www.hpa.org.nz/campaign/choice-not-chance https://www.youtube.com/watch?v=r0d4AWfkB0E&list=PLjG7ZP5Nacu2OOSV5ZADd4KeE58ijBsUa ***Local initiatives*** The programme also supports minimising gambling harm services to help implement national activities at the local level through provision of information, resources and tools.

	HPA enables services to raise awareness by creating messages and resources to support Gambling Harm Awareness Week (GHAW). GHAW typically takes place in the first week of September each year. https://www.choicenotchance.org.nz/gambling-harm-awareness-week **Safer Gambling Environments** HPA has led a body of work over the last three years to help create safer gambling environments in pubs and clubs. This work has involved the Department of Internal Affairs (DIA), Ministry of Health, Gaming Societies, venues, minimising gambling harm services and gambling patrons working together to develop a collective response to this issue. The venue resources and staff training materials developed through this project are now resulting in improved host responsibility in venues and a safer gambling environment for patrons.
Evaluation/Reviews	The programme is monitored through tracking the number of people who complete the gambling quiz. Provisional results as at 31 March 2018 • 13,520 people discovered that they were are at-risk on ChoiceNotChance.org.nz in the 12 months up to 31 March 2018 • This compares to 11,367 discovering they were at risk in the 12 months up to 31 March 2017. • The number of people discovering they are at risk is up by 19% YOY. Campaign Evaluation Research – Kiwi Lives IV 2014-2015 (unpublished) • Advertisements made 72% of people more aware of help available • 85% thought these advertisements show it is good to get help for someone affected by gambling as soon as possible

	• 63% of people would go to a website to get help with gambling • 53% of people thought the advertisements made them aware of the signs of gambling • 18% of people in low income households stopped gambling after viewing the ads In relation to the safer gambling environments, a DIA sector survey in 2015 reported that 86% of Gaming Societies found the materials useful and 66% agreed that venues were now better supported to minimise gambling harm. A DIA Mystery Shopper exercise in 2014 found a negligible number of pubs met or partially met harm minimisation responsibilities. By 2016 this had improved to 33% of staff responding to gamblers playing for a long time and 81% responding to concerns raised by a family member. DIA gambling inspectors have also reported improved host responsibility practices in venues. HPA's Health and Lifestyles Survey also found that about 20% more pokies players reported interactions with venue in 2016 than in 2014.
Link to related material eg tools/resources/campaign	Fun, Fun, Unfun national campaign: https://www.hpa.org.nz/campaign/choice-not-chance https://www.youtube.com/watch?v=r0d4AWfkB0E&list=PLjG7ZP5Nacu2OOSV5ZADd4KeE58ijBsUa https://www.hpa.org.nz/programme/minimising-gambling-harm ChoiceNotChance.org.nz https://www.facebook.com/ChoicenotChanceNZ https://gamblehostpack.choicenotchance.org.nz/

	Resources: https://order.hpa.org.nz/collections/minimising-gambling-harm

Programme name	TOBACCO CONTROL
Description	HPA's tobacco control programme is focused on helping achieve the Government's goal that New Zealand be smokefree by 2025 (with smoking prevalence less than 5%). The programme targets the most at-risk population groups ie, Māori and Pacific, in particular Māori women and young people, as well as initiatives to support the wider tobacco control sector. As an evidence-based organisation, HPA is the national lead in conducting a range of research activities to monitor smoking prevalence and to inform policy and intervention development.
Background	HPA's priorities are informed by the Ministry of Health's strategic direction for tobacco control. The three key objectives of tobacco control activities in New Zealand are: 1. to reduce smoking initiation 2. to increase quitting 3. to reduce exposure to second-hand smoke. New Zealand's tobacco control programme is comprehensive and evidence based and designed on international best practice. Being a Party to the global tobacco treaty, WHO Framework Convention on Tobacco Control (FCTC), has assisted New Zealand to develop an evidence-based programme through obligatory (large health warnings on tobacco products, prohibiting tobacco advertising) and voluntary (including graphic pictures in the health warnings) measures. Alongside this context, in 2010 the Government set an aspirational goal of achieving a Smokefree Aotearoa by 2025.

	HPA has a unique place in the history of New Zealand tobacco control. The Health Sponsorship Council (HSC) was established in 1990 following enactment of the Smoke-free Environments Act 1990. HPA was formed in 2010 from the merger of the HSC and the Alcohol Advisory Council.
Target populations	While smoking rates are dropping for some groups, for others there has been little decline, suggesting that different interventions are required. Reducing smoking among Māori is one of the fastest ways to address inequities in Māori health outcomes, to increase whānau well-being and to relieve the high burden and costs of smoking to communities and the health system. HPA's approach is to focus on strategies to reduce smoking among Māori, as well as protective strategies for at-risk young New Zealanders. Target populations: • Youth (12 to 17 years) • Young adults (17 to 24 years) • Māori women • Pregnant women
Key partners	HPA is a leader in the tobacco control sector, and is part of the National Tobacco Integration Network (the Network). The Network was established as part of the realignment of the sector in 2015/16. HPA represents the health promotion function on this group. Members of the Network are: • Ministry of Health • HomeCare Medical (provision of telehealth services) • Hāpai te Hauora (Advocacy)

	• Inspiring Limited (delivering the national training service) Other key HPA partners: • Local stop smoking services x 16 • Action for Smokefree 2025 (ASH) • ASPIRE 2025.
Components	**Youth** The main initiative in HPA's programme for youth is sponsorship of targeted events. Events are opportunities to build resilience and connectedness in youth, provide a platform to share messaging in an authentic and engaging way, as well as normalising a smokefree way of life. HPA has had a 28 year partnership with Rockquest Promotions, the organisers of Smokefreerockquest and Smokefree Tangata Beats since 1998 (formerly known as Smokefree Pacifica Beats). HPA worked closely with Rockquest Promotions to develop strategies that encourage more Māori and Pacific students enter the competition. In 2017 this resulted in a 32% increase in the number of Māori entries and a 16% increase in Pacific entries. **Young adults (17 to 24 years)** Mass media campaigns are a proven way to reach young adults with anti-smoking and pro-smokefree messaging to change their attitudes and behaviours. In 2014 HPA launched 'Stop Before You Start', a national campaign targeted to Māori and Pacific young adults. The new iteration of the campaign began in November 2017. It is based on the key insight that young people don't understand how quickly their 'social' and experimental smoking can turn into addiction. The campaign uses a wide range of media channels to effectively target this audience, and is in market again in May 2018.

	In early 2017 HPA formed a new partnership with Street Dance New Zealand, sponsoring the annual national championship and sharing the smokefree lifestyle and messaging with at-risk youth, and young adults. Over 80% of the participants in the events are Māori and Pacific. **Māori and Pacific** HPA recognises that new and innovative approaches are needed to better engage with and influence Māori and Pacific peoples, in particular Māori women as their smoking prevalence continues to remain high at 38%. In order to gain deeper knowledge of the lives of Māori women, HPA and the Tipu Ora stop smoking service (in Rotorua) undertook qualitative research in 2017. This comprised a series of focus groups and hui. This work produced insights around support, stress, and whānau relationships, negative and positive that influence smoking behaviour. HPA has supported a range of activities and produced resources to promote Tipu Ora and improve service delivery. This has influenced how Tipu Ora promotes itself and has resulted in an increase in quality referrals and self-referrals to the service and in improvements to Tipu Ora's stop smoking programme (more successful quit attempts). HPA has shared the research results with the Ministry of Health and offered the resources to other stop smoking service providers. HPA is currently developing partnerships with Māori organisations to make HPA's work more effective with this priority group. **Sector leadership** HPA undertakes a number of activities to support the wider tobacco control sector, including: • tobacco control regional seminars. This year's focus is on Māori women who smoke and their whānau. • management of the smokefree brand for the sector and the wider New Zealand public. This includes smokefree.org.nz (with an average of 4,000 visitors per month)

	• supporting Homecare Medical with their Quitline marketing activity. The most recent Pacific targeted campaign achieved a 71% increase of calls in four priority DHB regions when comparing year on year • provision of standardised smokefree signage, digital and printed resources • national facilitation of World Smokefree Day (31 May 2018), which includes supporting local health promoters, smokefree coalitions and NGOs • research and marketing collaboration both nationally and internationally. **Emerging settings** HPA is exploring innovative digital solutions to support at-risk groups to stop smoking and working in key settings, such as workplaces.
Evaluations/reviews	The impact of the tobacco control programme in monitored through: Campaign impact Satisfaction levels with information, resources and tools
Link to related material eg tools/resources/campaign	• Smokefree.org.nz, includes signage, campaign materials, resources for the sector, etc • Stop Before You Start: website https://www.stopbeforeyoustart.co.nz/; Facebook https://www.facebook.com/StopB4UStart/ • Smokefree Future Facebook page: https://www.facebook.com/smokefreefuture/ • Tobacco control data repository: http://www.tcdata.org.nz/

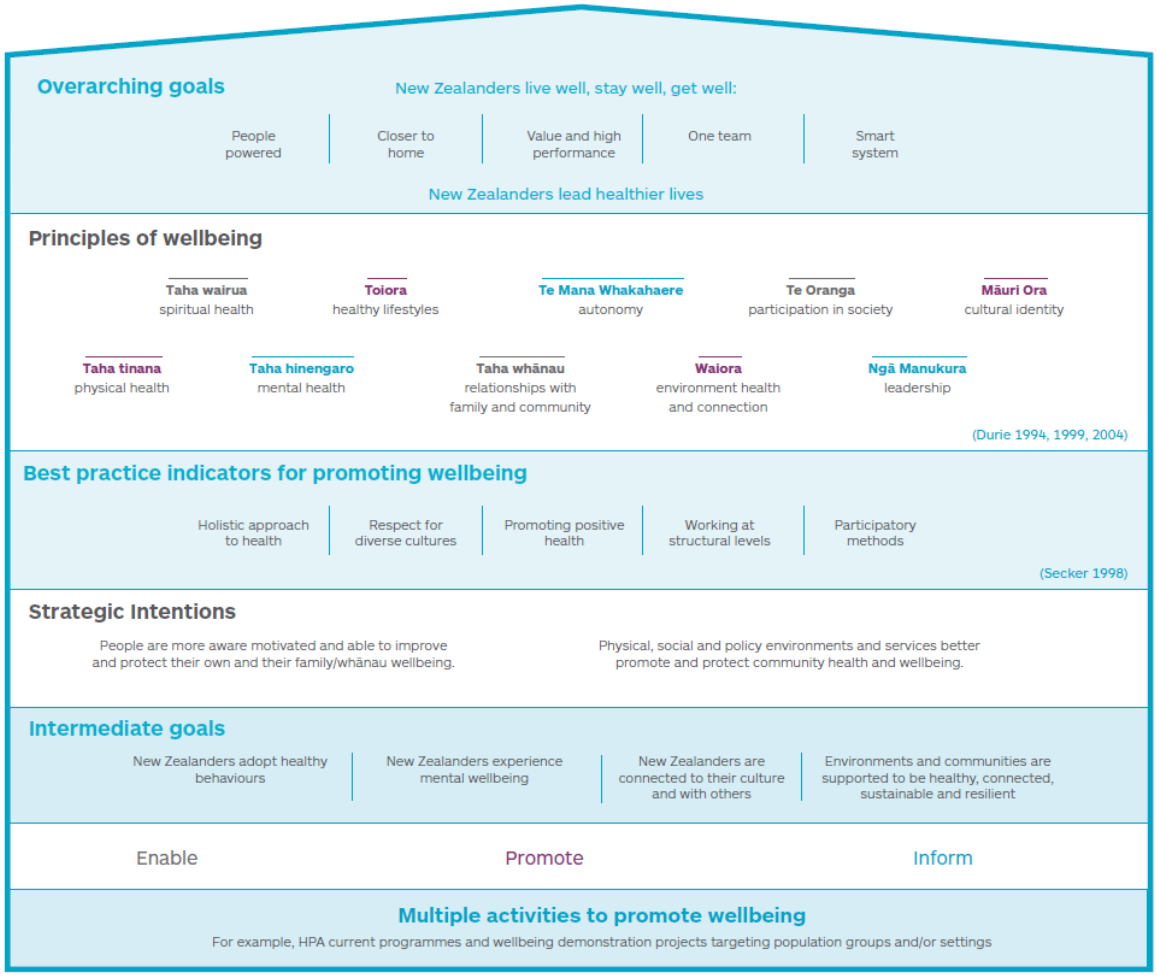
Programme name	ALCOHOL
Description including aim	HPA's work to reduce alcohol-related harm is comprehensive in its approach. The primary outcome is: • More New Zealanders drink at low-risk levels or choose not to drink. Strategic intentions are: • People are more aware, motivated and able to drink at low-risk levels. • Physical, social and policy environments and services support New Zealanders to drink at low-risk levels or not drink.
Background	On 1 July 2012, HPA took over all functions previously undertaken by the Alcohol Advisory Council (ALAC). The ALAC levy was also transferred to HPA. HPA has alcohol-specific statutory functions (New Zealand Public Health and Disability Act 2000) to: • give advice and make recommendations to government, government agencies, industry, non-government bodies, communities, health professionals, and others on the sale, supply, consumption, misuse and harms of alcohol • undertake, or work with others, to research alcohol use and public attitudes to alcohol in New Zealand and problems associated with, or consequent on, alcohol misuse. HPA helped to develop and has a key role in implementing the Government's National Drug Policy and the FASD Action plan. HPA also supports the implementation of the Sale and Supply of Alcohol Act 2012.
Target populations	HPA's alcohol work and strategy areas focus on those most at risk of, or experiencing, the greatest alcohol-related harm. This includes: • Young adults (18 to 25 years) (reduce alcohol use and harms) • Young people under 18 years (delay uptake & prevent escalation) • Women who are pregnant, might be pregnant or are trying to get pregnant (not drinking during pregnancy) • Mid-life adults (45 to 65 years) (changing drinking patterns and help-seeking)

Key partners	Stakeholders include: health sector agencies; the community and voluntary sector; central government agencies; the alcohol and hospitality industries; territorial authorities; businesses; health, education and social sector agencies; the media; and policymakers, academics and researchers.
Components	Components of HPA's alcohol work across four strategy areas are: • research, advice, and input into policy processes to fulfil HPA's statutory function to provide alcohol-related advice and research • national marketing campaigns • resources and tools, including online, for the public and stakeholders • support for regional and community action on alcohol. The main activities under the strategy areas are outline below: **1. Alcohol-free pregnancies** • Don't know, Don't drink marketing and communications campaign (mostly social media and aimed at young women) • Development of consistent messaging about not drinking alcohol during pregnancy • Development and provision of resources and tools to support health professionals to: have conversations with women about not drinking alcohol during pregnancy, undertake alcohol screening early in all pregnancies and provide referral to services for those that need help to stop drinking. • Input into to New Zealand/Australia policy work on pregnancy warning labels • The activities under this strategy also contribute to the implementation of the Government's FASD action plan **2. Alcohol-free teenagers** • Provision of advice, resources, and tools to support reduced supply, delayed onset of drinking and prevention of escalation of drinking for under-18s. • Development of a wellbeing marketing strategy (co-designed with young people using a peer crowd approach) that supports under-18s to be alcohol-free and promotes help-seeking options.

	• Support for under-18s with problematic alcohol use, including facilitator training for the delivery of the Smashed 'n Stoned programme. **3. Positive social norms & supportive environments** • Department of Lost Nights social marketing campaign (aimed at 18 to 24-year-olds, the s latest phase of the Say Yeah, Nah campaign). Elements include: television ads; online video; digital display; social media; bars and street posters; Māori and Pacific specific elements; and high-risk entertainment venues elements. The Say Yeah, Nah campaign aims to contribute to changing New Zealanders alcohol consumption behaviour from the current norm of high-risk drinking to one of moderation. • Development and provision of advice, resources and tools (print, online and eLearning) to support the implementation of the Sale and Supply of Alcohol Act 2012 (which regulates the physical availability of alcohol and licensed drinking environments). • Provision of support and advice for community action on alcohol, local alcohol health promotion and safe communities initiatives. This includes a focus on high-needs communities. **4. Alcohol, health & wellness** • Help-seeking social marketing activities to promote help-seeking and the use of the Alcohol Drug Helpline, with a focus on mid-life adults (45 to 65 years). • Funding the Alcohol Drug Helpline service. • Development and provision of resources (printed, online and eLearning) for consumers and for use in primary care alcohol screening and brief interventions and in treatment services.
Effectiveness/measures	Campaign monitors data/feedback on a range measures to assess campaign effectiveness. Evaluations of individual programmes on request if available
Link to related material eg tools/resources/campaign	HPA's alcohol website alcohol.org.nz – has HPA's alcohol advice, information, campaign material/videos, downloadable resources, and online tools HPA's main website hpa.org.nz – has HPA's alcohol research reports.

APPENDIX A: HPA WELLBEING LOGIC MODEL

HPA Wellbeing Framework



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