Mental Health Foundation of New Zealand
mauri tū, mauri ora

Alcohol Healthwatch
Whakatūpato Waipiro

Protecting Aotearoa's mental wellbeing through effective alcohol policy

Position statement

April 2025

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Tuia te rangi e tū nei
Tuia te papa e takoto nei
Tuia i te here tangata
Tihei mauri ora.

He hōnore, he korōria ki te atua ki te runga rawa
He whakaaro maha ki a rātou kua haere ki te wāhi ngaro
Rau rangatira mā, ānei ngā whakaaro me ngā kōrero nā Te Hauora Hinengaro.

About the authors

Alcohol Healthwatch is a national charity dedicated to reducing and preventing alcohol-related harm. Our work functions through a health promotion approach by raising awareness, providing evidence-based information and advice, coordinating networks and projects, and supporting community action regarding alcohol policy and planning matters. Collaboration with professional and community groups at local, regional, and national levels is central to achieving our shared vision of an Aotearoa New Zealand free from alcohol-related harm.

The Mental Health Foundation of New Zealand is a leading mental health and wellbeing charity striving for a society where all people flourish. Our mission is to build an Aotearoa free from discrimination, where everyone can experience mauri ora or positive mental health and wellbeing. We work towards this by actioning our commitment as a Te Tiriti o Waitangi partner; giving people tools and encouragement to look after their own mental health and support others; and advocating for social conditions, policies and services that prevent the drivers of mental distress (such as racism, poverty, discrimination and trauma), reduce inequities, and lift the mental health and wellbeing of all people in Aotearoa.

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Summary

The Mental Health Foundation and Alcohol Healthwatch support prioritising "upstream" public health action on alcohol as part of an effective response to preventing mental health and addiction issues and promoting wellbeing in Aotearoa New Zealand.

Rates of mental distress are rising each year,[i] while our support system fails to meet the increasing need.[ii] The cost to individuals, communities, and society is significant – people using mental health and addiction services in Aotearoa New Zealand have more than double the risk of premature death (before the age of 65) compared to the general population[4] and in 2014, the economic cost of serious mental illness[iii] was estimated at 7.2 percent of GDP, or $17 billion.[5] In 2024, this equates to over $30 billion.[6]

Directly and indirectly, alcohol has an extensive influence on poor mental wellbeing, mental distress, and suicidal behaviour. One in six adults in Aotearoa New Zealand consume alcohol in a way that is considered high risk,[iv] with harms falling disproportionately on Māori,[7] Pacific peoples,[8] poorer communities,[9] and people already living with mental distress.[10] It is also important to note that harms can result from low-risk drinking.[v] In economic terms, alcohol-related harms are estimated to

[i] Since 2011/12, the prevalence of high or very high psychological distress has almost tripled in the general population and in Māori, to 13 percent and 19.5 percent respectively, and more than quadrupled in people aged 15-24 years, to 22.9 percent.[1] Since 2016/17, the prevalence of moderate to severe anxiety and/or depression has increased by 60 percent in the general population, to 14.1 percent, and almost doubled in people aged 15-24 years, to 28.7 percent.[2]

[ii] For example, unmet need for mental health and addiction services is rising[2] and there are gaps in staffing levels and expertise across the entire system.[3]

[iii] This study considers "serious mental illness" to include schizophrenia and other psychoses, bipolar disorder, severe depression and anxiety, and opioid dependence. Other conditions, including alcohol and other substance use disorders, were excluded due to limitations in information available at the time of publication.

[iv] I.e., their score on the Alcohol Use Disorders Identification Test (AUDIT) represents an established pattern of drinking that carries a high risk of future damage to physical or mental health.[13]

[v] I.e., drinking that does not meet the criteria to be considered "hazardous" or "disordered". Health New Zealand | Te Whatu Ora describes low-risk drinking as no more than three standard drinks per day and 15 standard drinkers per week for men, and no more than two standard drinks per day and ten standard drinks per week for women, with at least two alcohol-free days each week.

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cost Aotearoa New Zealand $9.1 billion per year, with $3.1 billion due to "non-disordered" drinking.[11]

Public health approaches to prevent and minimise alcohol-related harm present a cost-effective solution to ease strain on the mental health and addiction system, improve mental wellbeing in the long term, and generate further benefits in other health, social, and economic outcomes. This can be achieved through evidence-based public health policy, and there are already many Aotearoa New Zealand-based recommendations[vi] to guide progress.

This position paper's principal recommendation is to progress the well-overdue review of the Sale and Supply of Alcohol Act 2012 to fully embed these policy measures. Implementing these changes will require strong leadership. In our view, the new Minister for Mental Health role provides the perfect platform to reinvigorate progress.

[vi] Noted in the reports *He Ara Oranga*, *Te Tiriti o Waitangi and alcohol law*, the 2014 Ministerial Forum on Alcohol Advertising and Sponsorship, the 2014 Ministry of Justice report on the effectiveness of alcohol pricing, and the 2010 Law Commission report on the review of regulatory framework for the sale and supply of liquor.

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Context

The impact of alcohol on mental health and social outcomes in Aotearoa New Zealand is a significant concern

Alcohol is linked to poor mental wellbeing

The complex, multi-directional relationship between alcohol and poor mental wellbeing is well established.

Alcohol is a depressant substance that can affect the balance of chemicals in the brain responsible for regulating mood, thoughts and behaviour.[12,13] Its effect on the brain, body, and behaviour can directly and indirectly contribute to poorer mental wellbeing and increased mental distress. The magnitude of impact varies significantly according to individual factors such as age, sex, medication use and physical and mental health state, and social, cultural and environmental risk and protective factors, as well as patterns of use. Patterns of use, in turn, are influenced by motives (the reasons people drink), and expectancies (perceptions or beliefs about the consequences of drinking).

Evidence on the wellbeing impact of lower-risk drinking patterns is mixed. Some research suggests moderate levels of drinking can disrupt brain chemistry and over time reduce brain chemicals essential for mental wellbeing,[14] contributing to low mood, sleep issues, anxiety and low motivation. Other research has established an association between low-risk drinking and reduced risk of depression (when compared with both abstinence and harmful drinking), and preliminary evidence suggests this relationship is causal.[15] Generally, social motives (drinking to facilitate social interactions) are most strongly associated with frequent moderate drinking.[16] Many people report wellbeing-related benefits from drinking, such as social connectedness, belonging and pleasure,[17] and at times may be willing to trade off risks (such as to long-term health and wellbeing) for these benefits.[18]

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On the other hand, it is clear that harmful drinking patterns[vii] are consistently associated with low mental wellbeing,[19] and non-drinkers and low-risk drinkers consistently report higher mental wellbeing than those who drink at harmful levels.[20] Heavy episodic (binge) drinking increases the risk of poor mental health and reduces experiences of positive mental health among New Zealanders.[21] Meanwhile, reductions in drinking frequency and quantity, especially among those misusing alcohol, are linked with improvements in mental distress symptoms, quality of life and contentment, social functioning and relationships, physical health, self-confidence, and physical pain.[22,23]

People who drink harmfully are at increased risk of various mental health conditions and symptoms, including depression, anxiety, bipolar disorder, schizophrenia and suicidal thoughts and behaviours, and people with a pre-existing mental health condition are also more likely to use alcohol.[24,25] Accordingly, co-existing mental health and substance use conditions (including alcohol use disorder) are common, with youth and people experiencing severe mental distress being most likely to experience a dual diagnosis.[26] Overall, the risk of mental distress is almost four times higher for people who drink heavily, and one in three people who report problems with alcohol also experience mental distress.[10,27,28]

The causal factors thought to be behind the high comorbidity of harmful alcohol use and mental distress are complex and reciprocal. While the impact of alcohol on the brain, body, and behaviour can promote and increase the severity of mental health challenges,[29] people experiencing mental distress may also use alcohol to cope with negative moods and stressors, in turn risking a cycle of harmful use.[30] Coping motives (drinking to manage negative emotions) are associated with an increased risk of alcohol-related harm and dependence compared to more positive (i.e., social or enhancement) motives.[16] Harmful drinking and mental distress also have shared genetic and social determinants and risk factors, such as isolation, poverty, trauma, stigma, and stress.[25]

[vii] In this paper we use "harmful drinking" to describe the broad spectrum of alcohol consumption patterns that can cause detrimental health and social consequences for the drinker, people around them, and wider society. This includes but is not limited to "problematic alcohol use" (a WHO ASSIST v3.0 score of 11 or higher), "hazardous drinking" (an AUDIT score of eight or higher), "heavy episodic (binge) drinking", and the diagnostic term "alcohol use disorder" (per the DSM-V), which integrates previously distinct diagnostic categories "alcohol abuse" and "alcohol dependence" (also described as "alcohol misuse").

Significantly, harmful drinking is also linked to low mental wellbeing and mental distress through its far-reaching societal impacts and indirect harms, including its role in crime, violence, injury, suicide, and premature death and disability,[31–33] and the trauma and distress caused by these events. At the population level, these harms (most significantly fetal alcohol spectrum disorder (FASD)) more severely impact those surrounding harmful drinkers rather than drinkers themselves.[34] Over one in four New Zealanders experience negative impacts on their wellbeing (including anxiety and depression) resulting from having a heavy drinker in their lives.[35]

Alcohol is a significant and persistent risk factor for suicide and suicidal behaviour

Alcohol consumption increases the risk of suicidal ideation, attempts, and deaths by influencing both proximal and distal risk factors for suicide.[36] Proximal risk factors include those associated with alcohol intoxication, including the development and increased severity of mental distress,[37,38] increased disinhibition, impulsivity, aggression, sadness, and despair,[39,40] impaired ability to identify coping strategies,[41] potentiating the effects of other drugs consumed in overdose,[42] and more lethal suicide means.[43] Acute alcohol use increases the risk of suicide attempt by seven times,[44] and is estimated to increase the risk of death by suicide by 94 percent.[45] An Aotearoa New Zealand study of youth (aged 15-24 years) presenting to emergency departments for suicide attempts found alcohol present in 29 percent of cases.[46]

Distal risk factors include those associated with long-term harmful drinking or alcohol dependence such as low social support and feelings of hopelessness, which in turn increase the risk of "precipitating" risk factors for suicide (i.e., depressive symptoms and life strains such as interpersonal conflict, relationship breakdown, unemployment, and financial insecurity).[36,47] Heavy alcohol is use causally associated with depression and increased risk of suicidal ideation,[viii] with alcohol dependence consistently identified as the second largest individual risk factor (falling only behind depression) for suicide.[49] An Aotearoa New Zealand study of deaths in people receiving specialist mental health care aligns with this evidence,

[viii] One Aotearoa New Zealand study found that alcohol dependence almost tripled the risk of suicidal ideation, and after controlling for variables such as trauma, physical health, mental health, and other substance abuse variables, suicidal ideation was 50 percent higher in those with alcohol dependence.[48]

identifying alcohol and drug abuse as the second leading mental health diagnosis (after depression) for those who died by suicide.[50]

Internationally, one in five suicide deaths can be attributed to alcohol use,[51] and higher population consumption patterns tend to be associated with higher suicide rates.[52] This pattern is pronounced in Aotearoa New Zealand, where acute alcohol use has been identified in almost 27 percent of adult suicide deaths (although this is likely an underestimate).[53] Younger New Zealanders and Māori are disproportionately impacted by suicide, including suicide deaths involving alcohol.[ix] Alcohol use among adolescents, especially when it begins in a person's pre-teen years, is an important risk factor for both suicidal ideation and suicide.[55]

The burden of alcohol-related mental distress and harm is inequitably distributed

Due to a combination of historical, social, economic, and systemic factors (including income inequality, discrimination, and the ongoing impact of colonisation), alcohol disproportionately impacts Māori, Pacific peoples, and those living in the most deprived areas, where Māori and Pacific peoples are also more likely to live.[56,57]

The "alcohol harm paradox" describes that alcohol-related harm generally disproportionately impacts poorer communities, even if alcohol consumption levels are the same or less than those of wealthier communities.[58,59] This paradox is demonstrated in findings that Māori, Pacific peoples, and people living in deprived neighbourhoods are not necessarily more likely to drink overall,[x] but those who do are at significantly higher risk of harmful drinking patterns in comparison to the overall population of drinkers.[1] This increased risk of harm therefore intersects with and exacerbates mental distress inequities patterned by ethnicity and socioeconomic status.[1]

Differences in availability and marketing are expected to play a role in these inequities. Alcohol outlets are over-concentrated in the most deprived areas,[28,60] and Māori and Pacific youth are exposed to alcohol marketing three to five times

[ix] For example, in one study of children and young people who died by suicide during 2012 to 2016 in Aotearoa New Zealand, alcohol was found to be a contributing factor in 41 percent of deaths overall, and 42 percent of deaths in rangatahi Māori.[54]
[x] Māori are only slightly (1.04 times) more likely, and Pacific people and people living in the most deprived neighbourhoods are less likely (1.3 and 1.16 times less, respectively) to be past-year drinkers than the total population.[1]

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more often than Pākehā youth.[61] Alcohol marketing exposure (for example, via sports sponsorship and at alcohol outlets) is causally linked to youth alcohol consumption,[62] which in turn increases the risk of alcohol-related harms throughout the life course.[61] At the population level, alcohol marketing increases the risk of heavy episodic drinking and makes it more difficult for people to reduce their alcohol intake.[63]

Despite Māori not producing alcohol prior to colonisation and mostly avoiding it during the early colonial period, alcohol has since become a major contributor to long-standing social, health, and economic inequities between Māori and non-Māori,[64] to the extent that it has been claimed the Crown has breached Te Tiriti o Waitangi in its continued failure to protect Māori from prejudicial levels of alcohol-related harm.[xi]

Public health approaches to address alcohol are a way forward to prevent rising mental distress

Rising rates of distress, unmet need, and the strain on our system have reached a point where it is not uncommon for mental health and addiction workers, researchers, and others to label the situation a "mental health crisis".[xii] There is an evident need to grow, strengthen, and improve access to mental health and addiction supports. However, the sheer extent of both the level of need and the gaps in our system also demand a shift toward public health strategies that address mental distress at its source.

The Mental Health Foundation and Alcohol Healthwatch have continually advocated for rebalancing focus and investment into addressing the wider determinants of mental health and wellbeing as a cost-effective and logical complement to improved services and supports. We maintain that building the social, cultural, environmental, and economic foundations for people to be well and stay well can prevent issues developing in the first place, reduce stressors for people currently experiencing mental distress or substance harm, and enable people and

[xi] See, for example: David Ratu's 2021 WAI 2624 (Alcohol Healthcare) Claim.
[xii] See, for example: https://theconversation.com/increased-mental-health-awareness-is-one-thing-but-new-zealanders-need-greater-mental-health-literacy-too-205286; https://www.nzdoctor.co.nz/article/undoctored/soul-destroying-aotearoas-mental-health-system-no-longer-fit-purpose-and; and https://www.phcc.org.nz/briefing/crisis-youth-mental-health-what-can-be-done.

communities to engage in things that keep them well.[65,66] However, we also acknowledge that many of the drivers of poor mental wellbeing, harmful substance use, and mental distress (such as inequality, poverty, violence, and discrimination) are complex social problems without straightforward solutions.

Preventing and reducing alcohol harm (and subsequently its impact on mental health, wellbeing, and addiction) is more straightforward. While alcohol is one of many risk factors for poor mental health, it is a uniquely modifiable risk factor. Globally, there are hundreds of studies demonstrating that alcohol harm can be prevented and minimised through a small number of feasible, cheap, and culturally acceptable policy interventions.[67] Increasing alcohol prices, reducing alcohol availability, and controlling alcohol advertising, promotion, and sponsorship are consistently shown to be effective in reducing both per capita alcohol consumption and harm, reducing rates of hazardous drinking and heavy episodic drinking, reducing suicidal behaviour and suicide rates, and improving public health overall, especially for young people who are particularly susceptible to alcohol-related harm, and for males, who are more likely to drink, develop alcohol dependence, die by suicide, and have positive blood alcohol concentration at the time of suicide death.[68] Meanwhile, the effectiveness of individual-level interventions (such as therapy- and counselling-based approaches) in reducing suicidal behaviour is far less proven in research, especially in reducing suicide deaths.[69,70]

Throughout the past 15 years, successive Aotearoa New Zealand governments have been presented with local analyses reinforcing this evidence, accompanied by a suite of policy recommendations to prevent harm and protect public health. But the most impactful of these recommendations have not yet been implemented.

The new Minister for Mental Health role provides a unique platform to address mental health, wellbeing, addiction, and substance harm in an integrated way, and champion the full vision of *He Ara Oranga* – with a stronger emphasis on prevention and wellbeing promotion, and an understanding that mental health is more than just a health care services issue. Strengthening our regulatory approach to alcohol is an untapped and relatively simple opportunity to achieve gains in preventing mental distress and suicide, and promote a range of other positive individual, whānau, and community wellbeing outcomes.

Recommendations

Principal recommendation: Strengthen our regulatory approach to the sale and supply of alcohol

The co-authors recommend reforming the Sale and Supply of Alcohol Act 2012 (the Act) to embed the outstanding recommendations of *He Ara Oranga, Te Tiriti o Waitangi and alcohol law,* the 2014 Ministerial Forum on Alcohol Advertising and Sponsorship, the 2014 Ministry of Justice report on the effectiveness of alcohol pricing, and the 2010 Law Commission report on the review of regulatory framework for the sale and supply of liquor.

Outstanding recommendations include:

- Increasing the purchase age for alcohol to 20 years
- Regulating alcohol advertising, promotion, and sponsorship
- Increasing excise taxes and minimum prices
- Reducing the default maximum trading hours for alcohol outlets, particularly for off-licenses (including remote and rapid delivery of alcohol)
- Fully enabling community input, including from tangata whenua, into local alcohol policy decisions
- Specifically referring to Te Tiriti o Waitangi in alcohol legislation, and ensuring any legislative reforms are Tiriti-consistent
- Facilitating the elimination of alcohol-related inequities between Māori and non-Māori, including by prioritising legislative provisions to reduce the number and density of off-licence premises in communities with a high proportion of Māori residents
- Enhancing mechanisms to provide clear cross-sector leadership and coordination within central government for policy in relation to alcohol and other drugs.

The Act has not had the desired impact on the alcohol environment in Aotearoa New Zealand, largely due to its failure to implement transformative policies to control alcohol affordability, availability, and advertising.[71] Alcohol affordability continues to increase over time,[72] our excise tax structure has remained largely unchanged since the late 1980s,[73] and alcohol advertising and sponsorship are weakly regulated and highly visible, including for children and young people.[61] The

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Act's lack of Tiriti-consistency continues to breach tangata whenua rights to tino rangatiratanga over alcohol-related decision-making processes, resulting in significant inequities.[74] Additionally, community input into local alcohol policies have been effectively muted by the Act, as these policies are optional and typically subject to endless litigation by the alcohol industry.[xiii] The 2023 Sale and Supply of Alcohol (Community Participation) Amendment Act's effectiveness in addressing these flaws is yet to be seen.

Reforming the law to enact these long-repeated and proven measures is likely to result in gains across multiple domains, many of which have been explicitly identified as government priorities.[xiv] These include reducing rates of mental distress, reducing hazardous drinking rates, preventing suicidal behaviour, preventing disproportionate harms to children and young people, improved population mental wellbeing, preventing FASD, preventing alcohol-related morbidity and mortality, and increasing government revenue (in the case of excise taxes).

These policy changes are not likely to significantly "penalise" the majority of New Zealanders. For example, people who enjoy alcohol in moderation will incur only minor cost increases if the Law Commission's proposal for a 50 percent rise in excise tax is implemented – and in fact, moderate drinkers are likely to benefit from the resulting reduction of alcohol-related costs and harms across society (a national saving estimated at $72 million annually).[76] There is strong public support for restricting alcohol advertising and sponsorship,[77] and the vast majority of territorial authorities have voted in favour of amending the Act to make local alcohol policies more effective.[78]

Additional recommendations

Implement cross-government action on mental distress prevention

[xiii] As seen for example in Hamilton City Council, Christchurch City Council, and Far North District Council. In 2017, only 24 percent of New Zealanders resided in a district with an adopted local alcohol policy.[75]

[xiv] For example, the Government Policy Statement on Health 2024-2027 seeks to achieve improved prevention of cancer, cardiovascular disease, respiratory disease, diabetes and poor mental health through addressing alcohol as a modifiable risk factor (alongside other factors), with associated expectations to decrease rates of psychological distress and hazardous alcohol consumption.

In line with the formative *He Ara Oranga* report, we recommend implementing an all-of-government approach to address the underlying determinants of mental wellbeing. Alcohol's impacts on mental health outcomes (particularly suicide) across the life course should be identified and addressed in this approach.

This could involve or align with adopting a "Mental Health in All Policies"[xv] approach in Aotearoa New Zealand, ensuring that even "non-mental health" government strategies and work programmes are accountable for improving mental health and wellbeing, including with common investment goals and integrated systems to assess collective wellbeing impact.

The upcoming Mental Health and Wellbeing Strategy (required by the Pae Ora (Healthy Futures) Act 2022) would be an opportune place to establish clear, measurable actions to drive cross-government collaboration for prevention.

Understand the scope of mental health, addiction, and wellbeing need

We tautoko calls from *He Ara Oranga*, Te Hiringa Mahara, Te Pou, and others to invest in Aotearoa New Zealand's mental health and addiction data and surveillance infrastructure, including to implement:

- A comprehensive mental health and addiction prevalence study (or series of interconnected studies) to better identify, understand, and respond to people's needs
- Investment in Māori and Pacific-led mental health and addiction research
- Toxicology screening in all suspected suicide cases including a consistent protocol for reporting and coding alcohol involvement and identifying treatment histories for alcohol use disorder
- Consistent cross-screening in mental health, addiction and other health care services, where people presenting with depression or suicidal thinking are screened for harmful alcohol use and vice versa.

Aotearoa New Zealand's last comprehensive prevalence survey was completed in 2004 and there are significant gaps in knowledge about severity of need, access and demand, service performance, and people's experience of mental health and

[xv] See: https://www.who.int/activities/promoting-health-in-all-policies-and-intersectoral-action-capacities

addiction services, as well as a lack of culturally-informed, wellbeing-focused data.[79]

While it is excellent to see recent commitment to implement a child and youth mental health prevalence study, we recommend expanding this commitment in the future to include other populations and conduct a comprehensive national prevalence study in the long term.

Filling these critical knowledge gaps will help us better understand the complex scope of need, and whether – and where – our system is working well. It will provide the foundation on which to develop an effective mental health and wellbeing strategy, set meaningful targets, and allocate investment wisely in the future.

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